

§ 406.26

42 CFR Ch. IV (10–1–07 Edition)

the individual or a member of the individual's family.

(2) The SEP ends on the last day of the eighth consecutive month during which the individual is at no time enrolled in a GHP or an LGHP by reason of current employment status.

(c) *Conditions for use of a SEP.*³ In order to use a SEP, the individual must meet the following conditions:

(1) When first eligible to enroll for premium hospital insurance under § 406.20(b) or (c), the individual was—

(i) Age 65 or over and covered under a GHP by reason of the current employment status of the individual or the individual's spouse;

(ii) Under age 65 and covered under an LGHP by reason of the current employment status of the individual or a member of the individual's family ; or

(iii) Under age 65 and covered under a GHP by reason of the current employment status of the individual or the individual's spouse.

(2) For all the months thereafter, the individual has maintained coverage either under hospital insurance or a GHP or LGHP.

(d) *Special rule: Additional SEPs.* (1) Generally, if an individual fails to enroll during any available SEP, he or she is not entitled to any additional SEPs.

(2) However, if an individual fails to enroll during a SEP, because coverage under the same or a different GHP or LGHP was restored before the end of that particular SEP, that failure to enroll does not preclude additional SEPs.

(e) *Effective date of coverage.* (1) If the individual enrolls in a month during any part of which he or she is covered under a GHP or LGHP on the basis of current employment status, or in the first full month when no longer so covered, coverage begins on the first day of the month of enrollment or, at the individual's option, on the first day of any of the three following months.

³Before August 10, 1993, an individual under age 65 could qualify for a SEP only if he or she had LGHP coverage as an "active individual", which the statute defined as "an employee, employer, self-employed individual (such as the employer), individual associated with the employer in a business relationship, or as a member of the family of any of those persons".

(2) If the individual enrolls in any month of the SEP other than the months specified in paragraph (e)(1) of this section, coverage begins on the first day of the month following the month of enrollment.

[61 FR 40346, Aug. 2, 1996]

§ 406.26 Enrollment under State buy-in.

(a) *Enrollment of QMBs under a State buy-in agreement—*(1) *Effective date.* Beginning with calendar year 1990, a State may request and be granted a modification of its buy-in agreement to include enrollment and payment of Part A premiums for QMBs (as defined in section 1905(p)(1) of the Act) who can become entitled to Medicare Part A only by paying a premium.

(2) *Amount of premium.* Premiums paid under State buy-in are not subject to increase because of late enrollment or reenrollment.

(b) *Beginning of coverage under buy-in.* The coverage period begins with the latest of the following:

(1) The third month following the month in which the agreement modification covering QMBs is effectuated.

(2) The first month in which the individual is entitled to premium hospital insurance under § 406.20(b) and has QMB status.

(3) The date specified in the agreement modification.

(c) *End of coverage under buy-in.* Buy-in coverage ends with the earlier of the following:

(1) *Death.* Coverage ends on the last day of the month in which the QMB dies.

(2) *Loss of QMB status.* If the individual loses eligibility for QMB status, coverage ends on the last day of the month in which CMS receives the State's notice of ineligibility.

(3) *Termination of buy-in agreement.* If the State's buy-in agreement is terminated, coverage ends on the last day of the last month for which the agreement is in effect.

(4) *Entitlement to premium-free Part A.* If the individual becomes entitled to premium-free Part A, buy-in coverage ends on the last day of entitlement to premium Part A.

(d) *Continuation of coverage: Individual enrollment following termination of*

buy-in coverage—(1) *Deemed enrollment.* If coverage under a buy-in agreement ends because the agreement is terminated or the individual loses QMB status, the individual—

(i) Is considered to have enrolled during his or her initial enrollment period; and

(ii) Is entitled to Part A benefits and liable for Part A premiums beginning with the first month for which he or she is no longer covered under the buy-in agreement.

(2) *Voluntary termination.* (i) An individual may voluntarily terminate entitlement acquired under paragraph (d)(1) of this section by filing, with SSA or CMS, a request for disenrollment.

(ii) Voluntary disenrollment is effective as follows:

(A) If the individual files a request within 30 days after the date of CMS's notice that buy-in coverage has ended, the individual's entitlement ends on the last day of the last month for which the State paid the premium.

(B) If the individual files the request more than 30 days but not more than 6 months after buy-in coverage ends, entitlement ends on the last day of the month in which the request is filed.

(C) If the individual files the request later than the 6th month after buy-in coverage ends, entitlement ends at the end of the month after the month in which request is filed.

[56 FR 38080, Aug. 12, 1991]

§ 406.28 End of entitlement.

Any of the following actions or events ends entitlement to premium hospital insurance:

(a) *Filing of request for termination.* The beneficiary may at any time give CMS or the Social Security Administration written notice that he or she no longer wishes to participate in the premium hospital insurance program.

(1) If he or she files the notice before entitlement begins, he or she will be deemed not to have enrolled.

(2) If he or she files the notice after entitlement begins, that entitlement will end at the close of the month following the month in which he or she filed the notice.

(b) *Eligibility for hospital insurance without premiums.* (1) If an individual

meets the eligibility requirements for hospital insurance specified in § 406.10, § 406.11, § 406.13 or § 406.15, entitlement to premium hospital insurance ends with the month before the month in which he or she meets those requirements.

(2) If an individual meets the requirements of § 406.10, § 406.11, § 406.13, or § 406.15, he or she will be deemed to have filed the required application for hospital insurance benefits in his or her first month of eligibility under that section.

(c) *End of entitlement to supplementary medical insurance (SMI) for individual who has attained age 65.* In the case of an individual enrolled on the basis of § 406.20(b), entitlement to premium hospital insurance ends on the same date that entitlement to SMI ends.

(d) *Nonpayment of premium.* (1) If an individual fails to pay the premium bill, entitlement will end on the last day of the third month after the billing month.

(2) CMS may reinstate entitlement if the individual shows good cause for failure to pay on time, and pays all overdue premiums within 3 calendar months after the date specified in paragraph (d)(1) of this section.

(e) *Death.* Entitlement ends with the day of death. (A premium is due for the month of death.)

(f) *End of disabling impairment for individual under age 65.* In the case of an individual enrolled on the basis of § 406.20(c), entitlement to premium hospital insurance ends on the last day of the month after the month in which the individual is notified that he or she no longer has a disabling impairment.

[48 FR 12536, Mar. 25, 1983. Redesignated at 51 FR 41338, Nov. 14, 1986, as amended at 53 FR 47204, Nov. 22, 1988. Redesignated and amended at 56 FR 38080, Aug. 12, 1991]

§ 406.32 Monthly premiums.

(a) *Promulgation and effective date.* Beginning with 1984, premiums are promulgated each September, effective for the succeeding calendar year.

(b) *Monthly premiums: Determination of dollar amount.* (1) Effective for calendar years beginning January 1989, the dollar amount is determined based on an estimate of one-twelfth of the average per capita costs for benefits and