such other information as CMS may require to establish the payment rate.

(2) Annual reports. Within 90 days after the end of its reporting period, the clinic or center must submit, in such form and detail as may be required by CMS, a report of:

(i) Its operations, including the allowable costs actually incurred for the period and the actual number of visits for rural health clinic or Federally qualified health center services furnished during the period; and

(ii) The estimated costs and visits for rural health clinic services or Federally qualified health center services for the succeeding reporting period and such other information as CMS may require to establish the payment rate.

(3) Late reports. If the clinic or center does not submit an adequate annual report on time, the intermediary may reduce or suspend payments to preclude excess payment to the clinic or center.

(4) Inadequate reports. If the clinic or center does not furnish a report or furnishes a report that is inadequate for the intermediary to make a determination of program payment, CMS may deem all payments for the reporting period to be overpayments.

(5) Postponement of due date. For good cause shown by the clinic or center, the intermediary may, with CMS’s approval, grant a 30-day postponement of the due date for the annual report.

(6) Reports following termination of agreement or change of ownership. The report from a clinic or center which voluntarily or involuntarily ceases to participate in the Medicare program or experiences a change in ownership (see §§405.2436–405.2438) is due no later than 45 days following the effective date of the termination of agreement or change of ownership.

(d) Collection of additional claims data. Beginning January 1, 2011, a Medicare FQHC must report on its Medicare claims such information as the Secretary determines is needed to develop and implement a prospective payment system for FQHCs including, but not limited to all pertinent HCPCS (Healthcare Common Procedure Coding System) code(s) corresponding to the service(s) provided for each Medicare FQHC visit (as defined in §405.2463).

§405.2472 Beneficiary appeals.

A beneficiary may request a hearing by an intermediary (subject to the limitations and conditions set forth in subpart H of this part) if:

(a) The beneficiary is dissatisfied with an intermediary’s determination denying a request for payment made on his or her behalf by a rural health clinic or Federally qualified health center; or

(b) The beneficiary is dissatisfied with the amount of payment; or

(c) The beneficiary believes the request for payment is not being acted upon with reasonable promptness.

§ 406.22 Effect of month of enrollment on entitlement.
§ 406.24 Special enrollment period related to coverage under group health plans.
§ 406.26 Enrollment under State buy-in.
§ 406.28 End of enrollment.
§ 406.30 Monthly premiums.
§ 406.32 Determination of months to be counted for premium increase: Enrollment.
§ 406.34 Determination of months to be counted for premium increase: Reenrollment.
§ 406.36 Prejudice to enrollment rights because of Federal Government error.

Subpart D—Special Circumstances That Affect Entitlement to Hospital Insurance

§ 406.50 Nonpayment of benefits on behalf of certain aliens.
§ 406.52 Conviction of certain offenses.

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).


Subpart A—General Provisions

§ 406.1 Statutory basis.

Sections 226, 226A, 1818 and 1818A of the Social Security Act and section 103 of Public Law 89–97 establish the conditions for entitlement to hospital insurance benefits. Sections 202 (t) and (u) of the Act specify limitations that apply to certain aliens and to persons convicted of certain offenses.


§ 406.2 Scope.

Subparts A through D of this part specify the conditions of eligibility for hospital insurance and set forth certain specific conditions that affect entitlement to benefits. Hospital insurance is authorized under Part A of title XVIII and is also referred to as Medicare Part A. It includes inpatient hospital care, posthospital SNF care, home health services, and hospice care.


§ 406.3 Definitions.

First month of eligibility means the first month in which an individual meets all the requirements for entitlement to hospital insurance except application or enrollment if that is required.

First month of entitlement means the first month for which the individual meets all the requirements for entitlement to Part A benefits.

Insured individual means an individual who has the number of quarters of coverage required for monthly social security benefits.

Quarter of coverage means a calendar quarter that is counted toward the number of covered quarters required to make the individual eligible for monthly social security benefits. A quarter is counted if during that quarter (or that calendar year) the individual earned a required minimum amount of money. (For details, see 20 CFR part 404, subpart B.)

§ 406.5 Basis of eligibility and entitlement.

(a) Hospital insurance without premiums. Hospital insurance is available to most individuals without payment of a premium if they:

1) Are age 65 or over, or

2) Have received social security or railroad retirement disability benefits for 25 months; or

3) Have end-stage renal disease. Subpart B of this part explains the requirements such individuals must meet to obtain hospital insurance without premiums.

(b) Premium hospital insurance. Many individuals who are age 65 or over, but do not meet the requirements set forth in subpart B of this part, and certain individuals under age 65, may obtain the benefits by paying a premium. Section 406.20 of this part explains the requirements individuals must meet to obtain premium hospital insurance.


§ 406.6 Application or enrollment for hospital insurance.

(a) Basic provision. In most cases, eligibility for Medicare Part A is a result
Centers for Medicare & Medicaid Services, HHS § 406.7

of entitlement to monthly social security or railroad retirement cash benefits or eligibility for monthly social security cash benefits. This section specifies the individuals who need not file an application to become entitled to hospital insurance, those who must file an application, and those who must enroll.

(b) Individuals who need not file an application for hospital insurance. An individual who meets any of the following conditions need not file an application for hospital insurance:

(1) Is under age 65 and has been entitled, for more than 24 months, to monthly social security or railroad retirement benefits based on disability.

(2) At the time of attainment of age 65, is entitled to monthly social security or railroad retirement benefits.

(3) Establishes entitlement to monthly social security or railroad retirement benefits at any time after attaining age 65.

(c) Individuals who must file an application for hospital insurance. An individual must file an application for hospital insurance if he or she seeks entitlement to hospital insurance on the basis of—

(1) The transitional provisions set forth in § 406.11;

(2) Deemed entitlement to disabled widow's or widower's benefit under certain circumstances as provided in § 406.12;

(3) A diagnosis of end-stage renal disease, as specified in § 406.13;

(4) Effective January 1, 1981, eligibility for social security cash benefits, as specified in § 406.10(a)(3), if the individual has attained age 65 without applying for those benefits; or

(5) The special provisions applicable to government employment as set forth in § 406.15.

(d) When application is deemed to be filed. (1) An application based on the transitional provisions or on ESRD is deemed to be filed in the first month of eligibility if it is filed not more than 3 months before the first month, and is retroactive to that month if filed within 12 months after the first month. An application filed more than 12 months after the first month of eligibility is retroactive to the 12th month before the month it is filed.

(2) An application for deemed entitlement to disabled widow's or widower's benefits, that is filed before the first month in which the individual meets all conditions of entitlement for this benefit, will be deemed a valid application if those conditions are met before an initial determination, reconsideration, or hearing decision is made on the application. If the conditions are met after the date of any hearing decision, a new application will have to be filed. An application validly filed within 12 months after the first month of eligibility is retroactive to that first month. If filed more than 12 months after that first month, it is retroactive to the 12th month before the month of filing.

(3) Effective June 8, 1980, an application based on eligibility for social security benefits at or after age 65, that is filed before the first month in which the individual meets all eligibility conditions for this benefit, will be deemed a valid application if those conditions are met before an initial determination, reconsideration, or hearing decision is made on the application. If the conditions are met after the date of any hearing decision, a new application will have to be filed.

(4) Effective March 1, 1981, an application under § 406.10 that is validly filed within 6 months after the first month of eligibility is retroactive to that first month. If filed more than 6 months after the first month, it is retroactive to the 6th month before the month of filing.

(e) Individuals who must enroll for hospital insurance. An individual who must pay a monthly premium for hospital insurance must enroll in accordance with the procedures set forth in § 406.21.

§ 406.7 Forms to apply for entitlement under Medicare Part A.

The following forms, available free of charge by mail from CMS or at any Social Security branch or district office, are used to apply for Medicare entitlement under the circumstances indicated:

CMS–18–F–5—Application for Hospital Insurance Entitlement. (For use by individuals
§ 406.10 Individual age 65 or over who is entitled to social security or railroad retirement benefits, or who is eligible for social security benefits.

(a) Requirements. An individual is entitled to hospital insurance benefits under section 226 of the Act if he or she has attained aged 65 and is:

(1) Entitled to monthly social security benefits under section 202 of the Social Security Act;

(2) A qualified railroad retirement beneficiary who has been certified as such to the Social Security Administration by the Railroad Retirement Board in accordance with section 7(d) of the Railroad Retirement Act of 1974; or

(3) Effective January 1, 1981, eligible for monthly social security benefits under section 202 of the Act and has filed an application for hospital insurance.

(b) Beginning and end of entitlement.

(1) Entitlement begins with the first day of the first month in which the individual meets the requirements of paragraph (a) of this section.

(2) Entitlement continues until the individual dies or no longer meets the requirements of paragraph (a) of this section. An individual is not entitled to railroad retirement benefits and is neither entitled to, nor eligible for, monthly social security benefits in the month in which he or she dies. However, an individual who meets all other requirements for hospital insurance entitlement is entitled to hospital insurance in the month in which he or she dies if he or she—

(i) Would have been entitled to monthly railroad retirement benefits or social security benefits in that month if he or she had not died; or

(ii) Has filed an application for hospital insurance and would have been eligible for monthly social security benefits in that month if he or she had not died.

§ 406.11 Individual age 65 or over who is not eligible as a social security or railroad retirement benefits beneficiary, or on the basis of government employment.

(a) Basis. Section 103 of the law that established the Medicare program in 1965 (Pub. L. 89–97) provided for eligibility for certain individuals who were age 65 or would soon attain age 65 but would not be able to qualify for social security or railroad retirement benefits.

(b) Requirements. Unless he or she is excluded under paragraph (c) of this section, an individual age 65 or over who does not meet the requirements of §406.10 or §406.15 (and who would not meet those requirements if he or she filed an application), is entitled to Medicare Part A benefits if he or she meets the following requirements:

(1) Age and quarters of coverage. (i) He or she attained age 65 before 1968; or

(ii) If he or she attained age 65 in 1968 or later, he or she must have at least 3 quarters of coverage for each year that elapsed after 1966 and before the year in which he or she attained age 65. (The quarters of coverage may have been acquired at any time, not necessarily during the elapsed years.)

(2) Residence and citizenship. He or she is a resident of the United States and—

(i) A citizen of the United States; or

(ii) An alien lawfully admitted for permanent residence who has continuously resided in the United States for 5 years immediately preceding the first month in which he or she meets all other requirements for entitlement to hospital insurance.

(3) Application. He or she has filed an application for Medicare Part A no earlier than the third month before the first month of eligibility.
(c) **Bases for exclusion.** An individual who meets the requirements of paragraph (b) of this section is excluded from Medicare Part A if he or she—

(1) Has been convicted of spying, sabotage, or treason, sedition, and subversive action under chapter 37, 105, or 115 of title 18 of the United States Code;

(2) Has been convicted of conspiracy to establish a dictatorship under section 4 of the Internal Security Act of 1950;

(3) On February 16, 1965, was or could have been covered under the Federal Employees Health Benefits Act (FEHBA) of 1959; or

(4) In his or her first month of eligibility;

(i) Is covered by an enrollment under the FEHBA; or

(ii) Could have been covered by an enrollment under that Act if he or she (or any other person who could provide him or her with coverage) was a Federal employee at any time after February 15, 1965, and had enrolled and retained coverage under that Act.

d) **End of exclusion.** An individual excluded under paragraph (c)(3) or (4) of this section can become entitled beginning with the first month in which he or she loses the right to FEHBA coverage solely because he or she or the other person leaves Federal employment.

e) **Beginning and end of entitlement.**

(1) Entitlement begins—

(i) In the first month of eligibility if the application is filed no later than 12 months after the first month of eligibility;

(ii) In the 12th month before the month of application if the application is filed more than 12 months after the first month of eligibility.

(2) Entitlement continues until death or until the month before the month in which the individual becomes entitled under §406.10 or §406.15.

§406.12 **Individual under age 65 who is entitled to social security or railroad retirement disability benefits.**

(a) **Basic requirements.** An individual under age 65 is entitled to hospital insurance benefits if, for 25 months, he or she has been—

(1) Entitled or deemed entitled to social security disability benefits as an insured individual, child, widow, or widower who is "under a disability" or

(2) A disabled qualified beneficiary certified under Section 7(d) of the Railroad Retirement Act.

(b) **Previous periods of disability benefits entitlement.** Months of a previous period of entitlement or deemed entitlement to disability benefits count toward the 25-month requirement if any of the following conditions is met:

(1) Entitlement was as an insured individual or a disabled qualified railroad retirement beneficiary, and the previous period ended within the 60 months preceding the month in which the current disability began.

(2) Entitlement was as a disabled child, widow, or widower, and the previous period ended within the 84 months preceding the month in which the current disability began.

(3) The previous period ended on or after March 1, 1988 and the current impairment is the same as, or directly related to, the impairment on which the previous period of entitlement was based.

c) **Deemed entitlement to disabled widow’s or widower’s monthly benefits.**

(1) **Purpose.** The provisions of paragraphs (c) (2), (3), and (4) of this section are intended to enable individuals—

(i) To meet the 25-month requirement of paragraph (a) of this section; or

(ii) To retain hospital insurance entitlement when they are no longer entitled to monthly disability benefits.

(2) **Deemed entitlement for certain individuals entitled to old-age insurance benefits.** An individual who becomes entitled to monthly old-age insurance benefits before age 65, is, by law, precluded from establishing or retaining entitlement to disabled widow’s or widower’s monthly benefits. However, for purposes of meeting the 25-month requirement, a widow or widower who meets all other requirements for disability benefits and is excluded solely because of entitlement to old-age insurance benefits, shall be deemed to be (or to continue to be) entitled to disability benefits. A widow or widower who is not entitled to disability benefits for
the month before attaining age 60 must file two applications, one for old-age insurance benefits and one for hospital insurance.

(3) Deemed entitlement for certain individuals entitled to mother’s benefits. An individual entitled to mother’s insurance benefits under section 202(g) of the Social Security Act cannot at the same time be entitled to disabled widow’s benefits. However, if she applies for hospital insurance, she will be deemed to be entitled to disabled widow’s benefits in the first month (of the 12 months before application) in which she would have been entitled to those benefits if she had filed an application for them.

(4) Deemed entitlement for certain individuals entitled to father’s benefits. An individual who is entitled to father’s insurance benefits under section 202(g) of the Act cannot at the same time be entitled to disabled widower’s benefits. However, if he applies for hospital insurance benefits, he will be deemed to be entitled to disabled widower’s monthly benefits as follows:

(i) If he applied for hospital insurance benefits before May 1984, he was deemed entitled to disabled widower’s benefits for any month after April 1981 for which he would have been entitled to those benefits if he had filed an application for them.

(ii) If he applies for hospital insurance benefits in or after May 1984, he is deemed entitled to disabled widower’s benefits for any month, up to 12 months before the month of application, for which he would have been entitled to those benefits if he had filed an application for them.

(iii) Hospital insurance entitlement under this paragraph (c)(4) could not begin before May 1983.

(5) Deemed retroactive entitlement for certain disabled widows and widowers. In some cases, disabled widows or widowers cannot become entitled to monthly cash benefits in the first month in which they file application. However, for purposes of meeting the 25-month requirement, disability benefit entitlement will be deemed to have begun with the earliest month (of the 12 months before the application for cash benefits) in which the individual met all the requirements except the filing of an application. (This provision is effective for applications filed on or after January 1, 1978.)

(d) When entitlement begins and ends.

(1) Entitlement to hospital insurance begins with the 25th month of an individual’s entitlement or deemed entitlement to disability benefits. Although an individual is not entitled to disability benefits for the month in which he or she dies, for purposes of this paragraph the individual will be deemed to be entitled for the month of death.

(2) Except as provided in paragraph (e) of this section, entitlement to hospital insurance ends with the earliest of the following:

(i) The last day of the last month in which he or she was entitled or deemed entitled to disability benefits or was qualified as a disabled railroad retirement beneficiary, if he or she was notified of the termination of entitlement before that month.

(ii) The last day of the month following the month in which he or she is mailed a notice that his or her entitlement or deemed entitlement to disability benefits, or his or her status as a qualified disabled railroad retirement beneficiary, has ended.

(iii) The last day of the month before the month he or she attains age 65. (An individual who is entitled to social security or railroad retirement cash benefits for the month of attainment of age 65 is automatically entitled to hospital insurance under §406.10.)

(iv) The day of death.

(e) Continuation of Medicare entitlement when disability benefit entitlement ends because of substantial gainful activity (SGA) —

(1) Definitions. As used in this section—

Trial work period means the 9-month period provided under title II of the Act and as defined 20 CFR 404.1592, during which the individual may test his or her ability to work and still receive disability cash benefits; and

Reentitlement period means a period as defined in 20 CFR 404.1592a that begins with the first month after the trial work period and ends with the 36th month after the trial work period or, if earlier, with the first month in which the impairment no longer exists or is
Centers for Medicare & Medicaid Services, HHS § 406.13

no longer disabling. (During the reentitlement period, benefits may be discontinued because of SGA. However, if SGA is later discontinued, benefits may be reinstated without a new application and a new disability determination.)

(2) **Duration of continued Medicare entitlement.** If an individual’s entitlement to disability benefits or status as a qualified disabled railroad retirement beneficiary ends because he or she engaged in, or demonstrated the ability to engage in, substantial gainful activity after the 36 months following the end of the trial work period, Medicare entitlement continues until the earlier of the following:

(i) The last day of the 78th month following the first month of substantial gainful activity occurring after the 15th month of the individual’s reentitlement period or, if later, the end of the month following the month the individual’s disability benefit entitlement ends.

(ii) The last day of the month in which notice is mailed to the individual indicating that he or she is no longer entitled to hospital insurance because of an event or circumstance (for example, there has been medical improvement, or the disabled widow has remarried) that would terminate disability benefit entitlement if it had not already been terminated because of substantial gainful activity.


§ 406.13 Individual who has end-stage renal disease.

(a) **Statutory basis and applicability.** This section explains the conditions of entitlement to hospital insurance benefits on the basis of end-stage renal disease, and specifies the beginning and end of the period of entitlement. It implements section 226A of the Social Security Act.

(b) **Definitions.** As used in this section:

*End-stage renal disease (ESRD)* means that stage of kidney impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplantation to maintain life.

*Child or spouse* means a child or spouse whose relationship to the parent or spouse meets the relationship requirements for entitlement to child’s monthly social security benefits or to wife’s, husband’s, widow’s, widower’s, mother’s or father’s monthly benefits, as set forth in 20 CFR part 404. However, the duration of relationship requirements apply only to divorced spouses. (See 20 CFR 404.321.

*Dependent child* means a person who, on the first day he or she has end-stage renal disease, is unmarried and meets the dependency requirements for entitlement to child’s social security benefits on the basis of a parent’s earnings (see 20 CFR 404.350–404.365) and who—

(1) Is under age 22;

(2) Is under a disability that began before age 22; or

(3) Is under age 26, is receiving at least one-half support from that parent, and has continuously received at least one-half support from that parent since the day before attaining age 22.

*One-half support* means regular contributions, in cash or in kind, that equals or exceeds one-half of the child’s total support.

(c) **Requirements.** An individual is entitled to hospital insurance benefits if—

(1) He or she is medically determined to have ESRD;

(2) He or she is:

(i) Fully or currently insured under the social security program (title II of the Act) or would be fully or currently insured if his or her employment (after 1936) as defined under the Railroad Retirement Act were considered “employment” under the Social Security Act;

(ii) Entitled to monthly social security or railroad retirement benefits; or

(iii) The spouse or dependent child of a person who meets the requirements of paragraph (c)(2)(i) or (c)(2)(ii) of this section;

(3) He or she has filed an application for Medicare Part A; and

(4) He or she has satisfied the waiting period explained in paragraph (e) of this section.
(d) **Filing an application.**

(1) An individual may obtain an application form, and help in completing it, from any social security office.

(2) An application is not valid if it is filed earlier than the third month before the month in which the individual meets the conditions of paragraphs (c)(1), (c)(2), and (c)(4) of this section.

(3) If an individual who has ESRD dies before he or she has filed an application, or is unable to file because of physical or mental condition, a relative or other person responsible for his or her affairs may file on his or her behalf. If a responsible person is not available, the hospital or dialysis facility that furnished treatment may file the application.

(e) **Beginning of entitlement—(1) Basic limitations.** Entitlement can begin no earlier than the first month in which the individual meets the conditions specified in paragraph (c) of this section, or the 12th month before the month of application, whichever is later.

(2) **Waiting period.** Entitlement begins on the first day of the third month after the month in which the individual initiates a regular course of renal dialysis, if the course is maintained throughout the waiting period, unless entitlement would begin earlier under paragraph (e)(3) or (4) of this section. This means that if dialysis began in January, entitlement would begin April 1.

(3) **Exceptions: Early kidney transplant.** If the individual receives a transplant, entitlement begins with the first day of the month in which the transplant was performed. However, if the individual is admitted as an inpatient to a hospital that is an approved renal transplantation center or renal dialysis center (see §405.2102) for procedures preliminary to transplant surgery, entitlement begins—

(i) On the first day of the month in which he or she initially enters the hospital, if the transplant is performed in that month or in either of the next 2 months; or

(ii) On the first day of the second month before the month of kidney transplantation, if the transplant is delayed more than 2 months after the month of initial hospital stay.

For example, if an individual enters the hospital in January, and the transplant is performed in January, February, or March, entitlement would begin January 1. However, if the transplant is performed in April, entitlement would begin February 1.

(4) **Exceptions: Self-dialysis training.** Entitlement begins on the first day of the month in which a regular course of renal dialysis began if:

(i) Before the end of the waiting period, the individual participates in a self-dialysis training program offered by a participating Medicare facility that is approved to provide such training;

(ii) The patient’s physician has certified that it is reasonable to expect the individual will complete the training program and will self-dialyze on a regular basis; and

(iii) The regular course of dialysis is maintained throughout the time that would otherwise be the waiting period (unless it is terminated earlier because the individual dies).

(f) **End of entitlement.** Entitlement ends with—

(1) The end of the 12th month after the month in which a regular course of dialysis ends; or

(2) The end of the 36th month after the month in which the individual has received a kidney transplant.

(g) **Resumption of entitlement.** Entitlement is resumed under the following conditions:

(1) An individual who initiates a regular course of renal dialysis or has a kidney transplant during the 12-month period after the previous course of dialysis ended is entitled to Part A benefits and eligible to enroll in Part B with the month the regular course of dialysis is resumed or the month the kidney is transplanted.

(2) An individual who initiates a regular course of renal dialysis or has a kidney transplant during the 36-month period after an earlier kidney transplant is entitled to Part A benefits and eligible to enroll in Part B with the month the regular course of dialysis begins or with the month the subsequent kidney transplant occurs.

(3) An individual who initiates a regular course of renal dialysis more than 12 months after the previous course of
Centers for Medicare & Medicaid Services, HHS § 406.15

§ 406.15 Special provisions applicable to Medicare qualified government employment.

(a) Definition. As used in this section, Medicare-qualified government employment means Federal, State, or local government employment that is subject only to the hospital insurance portion of the tax imposed by the Federal Insurance Contributions Act (F.I.C.A.). This includes—


(2) Wages paid to State and local government employees hired after March 31, 1986.

(3) Wages paid to State and local government employees hired before April 1, 1986 but whose employment after March 31, 1986 is covered, for Medicare purposes only, under an agreement under section 218 of the Act.

(b) Crediting of wages that are taxable only for Medicare purposes. Medicare qualified government employment is credited in the same way and in the same amount as social security covered employment is credited for monthly social security cash benefit purposes. However, since only the Medicare portion (not the social security portion) of the F.I.C.A. tax is imposed, Medicare qualified government employment does not help qualify the individual for monthly Social Security cash benefits.

(c) Required quarters of coverage. (1) To qualify for hospital insurance on the basis of Medicare qualified government employment, an individual must have the number of quarters of coverage necessary to qualify for hospital insurance under § 406.10, § 406.12, or § 406.13.

(2) An individual who has worked in Medicare qualified government employment may qualify for hospital insurance on the basis of Medicare qualified government employment exclusively, or a combination of Medicare qualified government employment and social security covered employment.

(d) Transitional provision for Federal employment. Any individual who was a Federal employee at any time both during and before January 1983 will receive credit for quarters of Federal employment before January 1983 without paying tax. This transitional provision applies even if the Federal employee did not receive Federal wages for January 1983, for instance, because he or she was on approved leave without pay or on loan to a State or foreign agency.

(e) Conditions of entitlement. An individual who has worked in Medicare qualified government employment (or any related individual who would be entitled to social security cash benefits on the employee’s record if Medicare qualified government employment qualified for those benefits) is entitled to hospital insurance benefits if he or she—

(1) Would meet the requirements of § 406.10, § 406.12, or § 406.13 if Medicare qualified government employment were social security covered employment; and

(2) Has filed an application for hospital insurance.

For purposes of this section not more than 12 months before the month of application may be counted towards the 25-month qualifying period specified in § 406.12(a).

(f) Beginning and end of entitlement—

(1) Basic rule. Subject to the limitations specified in paragraph (f)(2) and (f)(3) of this section, entitlement begins and ends as specified in § 406.10, § 406.12 or § 406.13, whichever is used to establish hospital insurance entitlement for the Federal, State, or local government employee or related individual.

(2) Limitations: Federal government employment. (i) Hospital insurance entitlement based on Federal employment could not begin before January 1983.
§ 406.20 Basic requirements.

(a) General provisions. Hospital insurance benefits are available to most individuals age 65 or over and to certain individuals under age 65 who do not qualify for those benefits under subpart B of this part and are willing to pay a monthly premium. This is called premium hospital insurance.

(b) Eligibility of individuals age 65 or over to enroll for premium hospital insurance. Any individual is eligible to enroll for Medicare Part A if he or she—

1. Has attained age 65;
2. Is a resident of the United States and is either—
   - A citizen of the United States; or
   - An alien lawfully admitted for permanent residence who has resided in the United States continuously for the 5-year period immediately preceding the month in which he or she meets all other requirements;
3. Is not eligible for Part A benefits under subpart B of this part; and
4. Is entitled to supplementary medical insurance (Part B of Medicare) or is eligible and has enrolled for it during an enrollment period.

(c) Eligibility of individuals under age 65 to enroll for premium hospital insurance. An individual who has not attained age 65 is eligible to enroll for Medicare Part A if he or she meets the following conditions:

1. Has been entitled to Medicare Part A (under § 406.12 or § 406.15) on the basis of entitlement or deemed entitlement to social security disability benefits, as provided under section 226(b) of the Act.
2. Continues to have a disabling physical or mental impairment.
3. Loses entitlement to disability benefits (and therefore also loses entitlement to Medicare Part A under § 406.12) solely because his or her earnings exceed the amount allowed under the social security regulations pertaining to ''substantial gainful activity'' (20 CFR 404.1571–404.1574); and
4. Is not otherwise entitled to Medicare Part A.

§ 406.21 Individual enrollment.

(a) Basic provision. An individual who meets the requirements of § 406.20 (b) or (c) may enroll for premium hospital insurance only during his or her “initial enrollment period”, “general enrollment period”, “special enrollment period”, or, for HMO/CMP enrollees, a “transfer enrollment period”, as set forth in paragraphs (b) through (f) of this section.

(b) Initial enrollment periods—(1) Initial enrollment period for individual age 65 or over. The initial enrollment period extends for 7 months, from the third month before the month the individual first meets the requirements of § 406.20 (b)(1) through (b)(3) through the third month after that first month of eligibility.

(2) Initial enrollment period of individual under age 65. The initial enrollment period begins with the month in which the individual receives notice that entitlement to Medicare Part A will end because he or she has lost entitlement to disability benefits solely because of earnings in excess of the amounts allowed under the social security regulations on substantial gainful activity (20 CFR 404.1571–404.1574). It continues for 7 full months after that month.
failed to enroll during the initial enrollment period, or whose previous period of entitlement had terminated.

(3) If the individual enrolls or re-enrolls during a general enrollment period, his or her entitlement begins on July 1 of the calendar year.

(4) During the period April 1 through September 30, 1981, the general enrollment period was any time after the end of the individual’s initial enrollment period. Any eligible individual whose initial enrollment period had ended, or whose previous period of entitlement had terminated, could enroll or re-enroll during that 6-month period.

(d) “Deemed” initial enrollment period for individual age 65 or over. (1) If an individual who has attained age 65 fails to enroll during the initial enrollment period because of reliance on incorrect documentary information which led him or her to believe that he or she was not yet age 65, an initial enrollment period may be established for him or her as though he or she had attained age 65 on the date indicated by the incorrect documentary information.

(2) The deemed initial enrollment period will be used to determine the individual’s premium and right to enroll in a general enrollment period if such use is advantageous to the individual.

(e) [Reserved]

(f) Transfer enrollment period for HMO/CMP enrollees—(1) Terminology. HMO or CMP means an eligible organization as defined in §417.401 which has a contract with CMS under part 417, subpart L of this chapter.

(2) Basic rule. Effective February 1, 1991, individuals enrolled in an HMO or CMP under part 417, subpart K of this chapter who meet the requirements of §406.20(b) may enroll in premium hospital insurance during a transfer enrollment period. This transfer enrollment period begins with any month or any part of a month in which the individual is enrolled in an HMO or CMP and ends with the last day of the 8th consecutive month in which the individual is no longer enrolled in the HMO or CMP.

(3) Effective date of coverage. (i) If the individual enrolls in premium hospital insurance while still enrolled in an HMO or CMP, part A coverage will begin on the first day of the month of part A enrollment, or, at the option of the individual, on the first day of any of the following 3 months.

(ii) If the individual enrolls in premium hospital insurance during any of the last 7 months of the transfer enrollment period, coverage will begin on the first day of the month after the month of enrollment.

§406.22 Effect of month of enrollment on entitlement.

(a) Individual age 65 or over. For an individual who has attained age 65, the following rules apply:

(1) If the individual enrolls during the 3 months before the first month of eligibility, entitlement begins with the first month of eligibility.

(2) If the individual enrolls in the first month of eligibility, entitlement begins with the following month.

(3) If the individual enrolls during the month after the first month of eligibility, entitlement begins with the second month after the month of enrollment.

(4) If the individual enrolls in either of the last 2 months of the enrollment period, entitlement begins with the third month after the month of enrollment.

(b) Individual under age 65. For an individual who has not attained age 65, the following rules apply:

(1) If the individual enrolls before the month in which he or she meets the requirements of §406.20(c), entitlement begins with the month in which the individual meets those requirements.

(2) If the individual enrolls in the month in which he or she first meets the requirements of §406.20(c), entitlement begins with the following month.

(3) If the individual enrolls in the month following the month in which he or she meets the requirements of §406.20(c), entitlement begins with the second month after the month of enrollment.
§ 406.24 Special enrollment period related to coverage under group health plans.

(a) Terminology. As used in this subpart, the following terms have the indicated meanings.

1. Current employment status has the meaning given this term in §411.104 of this chapter.

2. Family member has the meaning given this term in §411.201 of this chapter.

3. Group health plan (GHP) and large group health plan (LGHP) have the meanings given those terms in §411.101 of this chapter, except that the “former employee” language of those definitions does not apply with respect to SEPs because—

(i) Section 1837(i)(1)(A) of the Act explicitly requires that GHP coverage of an individual age 65 or older be by reason of the individual’s (or the individual’s spouse’s) current employment status; and

(ii) The sentence following section 1837(i)(1)(B) of the Act refers to “large group health plan”. Under section 1862(b)(1)(B)(i), as amended by OBRA ’93, LGHP coverage of a disabled individual must be “by virtue of the individual’s or a family member’s current employment status with an employer”.

(4) Special enrollment period (SEP) is a period provided by statute to enable certain individuals to enroll in Medicare without having to wait for the general enrollment period.

(b) Duration of SEP. (1) The SEP includes any month during any part of which—

(i) An individual over age 65 is enrolled in a GHP by reason of the current employment status of the individual or the individual’s spouse; or

(ii) An individual under age 65 and disabled—

(A) Is enrolled in a GHP by reason of the current employment status of the individual or the individual’s spouse; or

(B) Is enrolled in an LGHP by reason of the current employment status of 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. 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

2Before 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”.

2Before March 1995, SEPs began on the first day of the first month the individual was no longer covered under a GHP or LGHP by reason of current employment status.
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.

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]

§ 406.25 Special enrollment period for volunteers outside the United States.

(a) General rule. A SEP, as defined in § 406.24(a)(4) of this subchapter, is provided for an individual that meets the following requirements:

(1) The individual is serving as a volunteer outside of the United States in a program that covers at least a 12-month period.

(2) The individual is in a program that is sponsored by an organization described in section 501(c)(3) of the Internal Revenue Code of 1986 and is exempt from taxation under section 501(a) of Internal Revenue Code of 1986.

(3) The individual can demonstrate that he or she has health insurance that covers medical services that the individual receives outside the United States while serving in the program.

(4) The individual—

(i) At the time he or she first met the requirements of § 406.10 through 406.15 or § 406.20(b), elected not to enroll in premium hospital insurance during the individual's initial enrollment period; or

(ii) Terminated enrollment in premium hospital insurance during a month in which the individual met the requirements of this section for a SEP.

(b) Duration of SEP. The SEP is the 6-month period beginning on the first day of the month that includes the date that the individual no longer meets the requirements of paragraph (a) of this section.

(c) Effective date of coverage. Coverage under a SEP authorized by this section begins on the first day of the month following the month in which the individual enrolls.

[73 FR 36468, June 27, 2008]

§ 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.

(d) 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.

(e) 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.


§ 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 administrative costs that will be payable with respect to individuals age 65...
or over from the Federal Hospital Insurance Trust Fund during the succeeding calendar year.

(2) Before 1989, the dollar amount was determined by multiplying $33 by the ratio of the next year’s inpatient deductible to $76, which was the inpatient deductible determined for 1973. (Because of cost controls, the deductible actually charged for that year was $72.)

(3) Effective for months beginning January 1994, if an individual meets the requirements in paragraph (c) of this section, the monthly premium determined under paragraph (b)(1) of this section is reduced in each month in which the individual meets the requirements by 25 percent in 1994, 30 percent in 1995, 35 percent in 1996, 40 percent in 1997 and 45 percent in 1998 and thereafter.

(4) The amount determined under paragraphs (b)(1), (2), or (3) of this section is rounded to the next nearest multiple of $1. (Fifty cents is rounded to the next higher dollar.)

(c) Qualifying for a reduction in monthly premium. An individual who qualifies for the reduction described in paragraph (b)(3) of this section must be an individual who—

(1) Has 30 or more quarters of coverage (QCs) as defined in 20 CFR 404.140 through 404.146;

(2) Has been married for at least the previous one year period to a worker who has 30 or more QCs;

(3) Had been married to a worker who had 30 or more QCs for a period of at least one year before the death of the worker;

(4) Is divorced from, after at least 10 years of marriage to, a worker who had 30 or more QCs at the time the divorce became final; or

(5) Is divorced from, after at least 10 years of marriage to, a worker who subsequently died and who had 30 or more QCs at the time the divorce became final.

(d) Monthly premiums: Increase for late enrollment and for reenrollment. For an individual who enrolls after the close of the initial enrollment period or reenrolls, the amount of the monthly premium, as determined under paragraph (b) of this section, is increased by 10 percent for each full 12 months in the periods described in §§ 406.33 and 406.34. Effective with beginning with premiums due for July 1986, the premium increase is limited to 10 percent and is payable for twice the number of full 12-month periods determined under those sections.

(e) Collection of monthly premiums. (1) CMS will bill the enrollee on a monthly basis and include an addressed return envelope with the bill.

(2) The enrollee must pay by check or money order that is payable to “CMS Medicare Insurance,” and shows his or her name and the claim number that appears on his or her Medicare card. He or she must return the bill with the check or money order.

(f) Months for which payment is due.

(1) A premium payment is due for each month beginning with the first month of coverage and continuing through the month of death or if earlier, the month in which coverage ends.

(2) A premium is due for the month of death if coverage is still in effect, even if the individual dies on the first day of the month.

(g) Option for group payments. A public or private organization may pay the premiums on behalf of one or more enrollees under a contract or other arrangement with CMS if CMS determines that this method of payment is administratively feasible. (The rules set forth in subpart E of part 408 of this chapter, for SMI premiums, also apply to group payment of Part A premiums.)

§ 406.33 Determination of months to be counted for premium increase: Enrollment.

(a) Enrollment before April 1, 1981, or after September 30, 1981. The months to be counted for premium increase are the months from the end of the initial enrollment period through the end of the general enrollment period, the special enrollment period, or the transfer enrollment period in which the individual enrolls, excluding the following:

(1) Any months before September 1973.
§ 406.34  Determination of months to be counted for premium increase: Re-enrollment.

(a) First reenrollment before April 1, 1981 or after September 30, 1981. The months to be counted for premium increase are:

(1) The months specified in § 406.33(a) or (b); plus

(2) The months from the end of the first period of entitlement through the month in which the individual reenrolled.

(b) First reenrollment during the period April 1, 1981 through September 30, 1981. The months to be counted for premium increase are—

(1) The months specified in paragraph (a) of this section; plus

(2) The months from the end of the first period of entitlement through the month in which the individual reenrolled.

(c) Subsequent reenrollment during the period April 1, 1981 through September 30, 1981. The months to be counted for premium increase are—

(1) The months specified in paragraph (a) of this section; plus

(2) The months from April 1, 1981 through the month in which the individual reenrolled for the second time. (Since only one reenrollment was permitted before April 1981, any months from the end of the individual’s first enrollment period of entitlement through March 1981 are not counted.)
(d) Subsequent reenrollment after September 30, 1981. The months to be counted for premium increase are—

(1) The months specified in paragraph (a) or (b) of this section, for the first and second periods of coverage; plus

(2) The months from the end of each subsequent period of entitlement through the end of the general enrollment period in which the individual reenrolled, excluding any months before April 1981.

(e) Example. Peter M enrolled during his initial enrollment period, terminated his first coverage period in August 1979 and reenrolled for the first time in January 1980. The 7 months to be counted (September 1979 through March, 1980) were not enough to require any increase in the premium. Peter terminated his second period of coverage in February 1981 and reenrolled for the second time in July 1981. Since the 4 months (April through July 1981), when added to the previous 7 months, bring the total to only 11 months, no premium increase is required.

§ 406.50 Nonpayment of benefits on behalf of certain aliens.

(a) Hospital insurance benefit payments may not be made for services furnished to an alien in any month in which his or her monthly social security benefits are suspended (or would be suspended if he or she were entitled to those benefits) because the alien remains outside the United States for more than 6 months.

(b) Benefits will be payable beginning with services furnished in the first full calendar month the alien is back in the United States.

§ 406.52 Conviction of certain offenses.

(a) Penalty that affects entitlement.

(1) If an individual is convicted of any of the crimes listed in § 406.11(c) (1) and (2), the court may impose, in addition to all other penalties, a penalty that affects entitlement to hospital insurance, beginning with the month of conviction.

(2) The additional penalty is that the individual’s income (or the income of the insured individual on whose earnings record he or she became or seeks to become entitled) for the year of conviction and any previous year may not be counted in determining the insured status necessary for entitlement to hospital insurance.

(b) Effect of pardon. If the President of the United States pardons the convicted individual, that individual regains (or may again seek) entitlement effective with the month following the month in which the pardon is granted.