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ISSUE BRIEF

Building the Path to Medicare Part A Buy-In: Strategies for Advocates

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INTRODUCTION

Medicare serves over 66 million people nationwide, providing coverage for hospital, primary, and specialty care to older adults 65 and over and people with disabilities.[1] For the vast majority of Medicare enrollees, Medicare's hospital benefit – known as Part A – does not require a monthly premium payment. However, approximately 1% of Medicare enrollees never paid into Medicare or worked too little to pay in enough to qualify.[2] As a result, they are uninsured for Part A and must pay Part A premiums in order to obtain coverage.

While 1% may seem a small number, the personal financial costs are extremely high.[3] The Part A premium in 2024 is as high as $505 a month and data shows that as of 2021, approximately 773,000 older adults owed a cumulative $4.1 billion in Part A premiums.[4] The populations subject to these premiums are often people of color, older immigrants, or family caregivers who provided care unpaid.

Thankfully, state Medicaid programs can pay Part A premiums for older adults with limited incomes and resources through the Qualified Medicare Beneficiary (QMB) program. But the process to sign up for state payment of Part A premiums is complicated and application rules vary by state. In all states, older adults must first apply for conditional Part A at the Social Security Administration (SSA) and then apply for the QMB program at their state or local Medicaid office. Adding to this complexity, in 14 states known as "group payer states," older adults can only conditionally enroll in Part A with a premium during the *first three months* of the year. In contrast, in all other states known as "Part A Buy-In" states, older adults can enroll at any time of the year, eliminating one of the barriers to obtaining Part A coverage.

California is currently one of the 14 group payer states, but will convert to Part A buy-in state starting January 1, 2025, after a successful advocacy campaign launched in 2022. Converting to Part A buy-in state has benefits for both individuals and state budgets, a rare opportunity to achieve two goals while preserving funding and resources.

Using lessons learned in California, this issue brief is intended to equip advocates in **Group Payer states with information and strategies to convert their state to a Part A buy-in state. The current group payer states are: Alabama, Arizona, Colorado, Illinois, Kansas, Kentucky, Missouri, Nebraska, New Jersey, New Mexico, South Carolina, Utah, and Virginia**. The brief begins with an overview of Medicare Part A, associated costs, and the financial relief available through Medicaid to pay for Part A premiums. The brief then outlines the significant advantages of converting to Part A buy-in status and the strategies advocates in group payer states can use to accomplish this change.

MEDICARE PART A OVERVIEW

Medicare health insurance is available to individuals 65 and over and also to individuals under age 65 who either have been determined disabled by SSA and have received disability benefits for 24 months, or have a diagnosis of End Stage Renal Disease (ESRD). Medicare enrollment is automatic for individuals who are entitled to free Part A and already receiving Social Security retirement or disability benefits. Meanwhile, individuals who have not filed for retirement benefits at age 65, individuals diagnosed with ESRD, and individuals who must pay a premium for Part A, have to affirmatively apply for Medicare at SSA and generally must do so during their initial enrollment period or the General Enrollment Period running January 1 through March 31st each year.[5]

Medicare Part A Premiums and Late Enrollment Penalties

The vast majority of people do not pay a monthly premium for Medicare Part A coverage, also called "free Part A,"[6] because they, or their spouse, paid Social Security and Medicare taxes while employed and accumulated the required work credits for free Part A, equivalent to 40 quarters of work or about 10 years of employment.[7] Others must pay for Part A (Part A with a premium)[8] if they do not qualify for free Part A. People who must pay a monthly premium for Part A may never have paid Social Security taxes or only worked part-time and did not accrue enough work credits to qualify for free Part A. Meanwhile, there is always a monthly premium for Part B.

People who do not have the requisite work credits are not required to enroll in Part A, but at age 65 can choose to buy into Part A by paying the monthly premium, which, in 2024, runs from $278 to $505 a month.[9] People who pay the higher premium of $505 will pay $6,060 out of pocket annually in Part A premiums alone. Approximately 90% of people who pay for Part A with a premium are responsible for paying the higher premium amount.[10] Many people who must pay a Part A premium choose not to enroll in Part A when they first become Medicare eligible because of the high monthly cost. For a person at 100% Federal Poverty Level (FPL) ($1,255/month), the highest Part A premium accounts for 40% of their monthly income. The remaining income leaves little for housing costs, utilities, food or transportation.

Yet, the decision to forgo Part A enrollment, can lead to higher Medicare costs in the future for either the individual or the state. For people who do not enroll in Part A with a premium when first eligible, Medicare adds a 10% late enrollment penalty to the base premium for twice the number of years that enrollment was delayed, increasing the already high monthly premium.[11] In 2021, approximately 30,000 people cumulatively owed an additional 16 million dollars in Part A late enrollment penalties.[12]

For example, Maria became eligible for Part A with a premium in May 2015. Maria declined to enroll in Part A because she could not afford the high monthly premium. Maria decides to sign up for Part A with a premium in June 2023. Maria was without Part A for 8 years and will owe an added Part A late enrollment penalty for 16 years.

Older adults who are not eligible for free Part A can forgo Part A altogether and enroll in Medicare Part B only. However, this leaves them without health coverage for services otherwise covered under Part A including inpatient hospital care, as well as short-term skilled nursing facility stays, home health, surgery, and hospice. Other coverage options outside of Medicare may be available: low-income older adults may obtain hospital coverage through Medicaid if they qualify; those with higher incomes can enroll in coverage through the Affordable Care Act exchanges also known as Marketplace.[13]

FINANCIAL ASSISTANCE: QUALIFIED MEDICARE BENEFICIARY PROGRAM

State Medicaid programs can pay the full Part A premium, including late enrollment penalties, through the Qualified Medicare Beneficiary Program (QMB). QMB is a type of Medicare Savings Program and is administered by the State Medicaid agencies.

The QMB program pays for Part A premiums, Part B premiums, and Medicare coinsurance, deductibles, and copayments. QMB is the only Medicaid program that offers payment of Part A premiums. QMB also comes with enhanced protections against improper billing by Medicare providers.[14] To qualify for QMB, individuals must be entitled to Part A (either free Part A or Part A with a premium), and meet the income and resource limit.[15] The federally set income limit for an individual is 100% FPL—or $1,255 for an individual in 2024—and the resource limit is $9,430. States have the option of increasing the financial eligibility, but cannot go below these federal limits.

THE QUALIFIED MEDICARE BENEFICIARY PROGRAM IS UNDERUTILIZED

Because states' Medicaid financial eligibility limits vary, individuals can be enrolled in both full Medicaid and QMB or just in QMB. Even when people are eligible for QMB, however, they may not be enrolled in the program. CMS has recently taken regulatory action to increase enrollment in QMB. You can read more in Justice in Aging's Issue Brief: Final Rule to Streamline Enrollment in Medicare Savings Programs.

QMB Enrollment to Pay for Part A Premiums

The process for enrolling in QMB for payment of Part A premiums is complex. Individuals must meet the QMB financial eligibility limits as described above, be entitled to Part A, have Part B, or in the process of enrolling in Part B.[16] Because QMB requires entitlement to Part A, but low-income individuals cannot afford the high Part A premiums, individuals can enroll in Part A by submitting a "Conditional Part A" application with SSA, and then submit an application for QMB enrollment with their state Medicaid agency.[17] With Conditional Part A, individuals are enrolled in Part A only if their QMB application is approved. If approved for the QMB program, the state will pay the Part A premium on their behalf. If the QMB application is denied, Part A enrollment is cancelled and they are not liable for Part A premiums.

States have two ways they can pay for Part A premiums for QMB enrollees: 1) buy-in agreement or 2) group payer arrangement. As detailed below, the payment arrangement a state chooses can make the process smoother or further complicate it and hinder enrollment in Part A.

ADVOCACY TIPS

Navigating the Part A conditional application process is complicated. Justice in Aging has accumulated tips for advocates to use with SSA in [Medicare Part A Conditional Applications]() in both Buy-In and Group Payer states.

Part A Buy-In

"Buy-in" is the process states use to enroll individuals into Medicare and pay for Medicare premiums and cost-sharing through the Medicaid program.[18] State buy-in agreements include the process for payment of Medicare premiums and cost sharing for both Part A and Part B, waiving standard Medicare enrollment periods, and eliminating late enrollment penalties for specific, qualifying groups. All states have buy-in agreements with CMS for the payment of Part B premiums while buy-in for Part A premiums is optional.[19] States were given the option to add Part A to their buy-in agreements for QMB enrollees in 1990.[20] Today, thirty-six states and Washington D.C. have opted to use a buy-in arrangement for Part A.

With Part A buy-in, states can independently enroll eligible individuals into Part A with a premium and the QMB program *year-round*. In other words, individuals do not have to wait to enroll in Medicare during the general enrollment period. The buy-in agreement waives this requirement. Whether a person must first apply for conditional Part A depends on the applicant's Part B enrollment. Those already enrolled in Part B do not need to apply for Conditional Part A.[21] These individuals can apply for QMB and the state will automatically enroll them into Part A with a premium with their QMB application and initiate state payment of their Part A premium. If a person is not already enrolled in Part B, they must submit a conditional Part A application with SSA first and can do so at any time during the year and then apply for QMB. Under a Part A Buy-In agreement, CMS waives the late enrollment penalties for any QMB enrollee who did not enroll during their initial enrollment period.[22]

Part A Group Payer

In the 14 group payer states, people applying for Part A with a premium and QMB navigate additional barriers in the process. Unlike in Part A buy-in states, even if a person is already enrolled in Part B, they still need to conditionally enroll in Part A at the SSA office in a group payer state. Additionally, in Part A buy-in states, individuals can enroll in Conditional Part A anytime of the year, but an older adult in a group payer state must submit their Conditional Part A application to SSA during the Medicare General Enrollment Period that runs from January to March each year. Those who miss this three-month window must wait until the next year. Many advocates report people do not often come back again next year to reapply. And for people with language needs other than English, this process can be even more confusing. The group payer process requires the lowest income older adults to take an additional application step that is not necessary in the 36 other states and Washington, D.C.

The application process is simplified under Part A buy-in compared to group payer arrangements. Buy-in eliminates the short three-month application window and results in more successful Part A and QMB applications since individuals do not need to remember to reapply the following year or rely on advocates to reach out and remind clients to reapply, many of whom do not have the capacity to do so. Because advocates report SSA staff often provide incorrect or conflicting information about the conditional enrollment process, QMB-eligible enrollees are often turned away and discouraged from applying for Part A, delaying their QMB enrollment. Furthermore, unlike under buy-in agreements, states must pay late enrollment penalties under group payer arrangements.[23]

GROUP PAYER STATES

The current group payer states are Alabama, Arizona, California, Colorado, Illinois, Kansas, Kentucky, Missouri, Nebraska, New Jersey, New Mexico, South Carolina, Utah, and Virginia. California will become a Part A buy-in state on January 1, 2025.[24]

Part A Enrollment Under Part A Buy-In States Versus Group Payer States

Part A Buy-In States

ENROLLED IN PART A WITH A PREMIUM	ENROLLED IN PART B	ACTION
Yes	Yes	Individual applies for QMB with Medicaid office
No	Yes	Individual applies for QMB and State enrolls them in premium Part A
No	No	Individual applies for Conditional Part A and Part B at SSA office, and after must file QMB application with Medicaid office

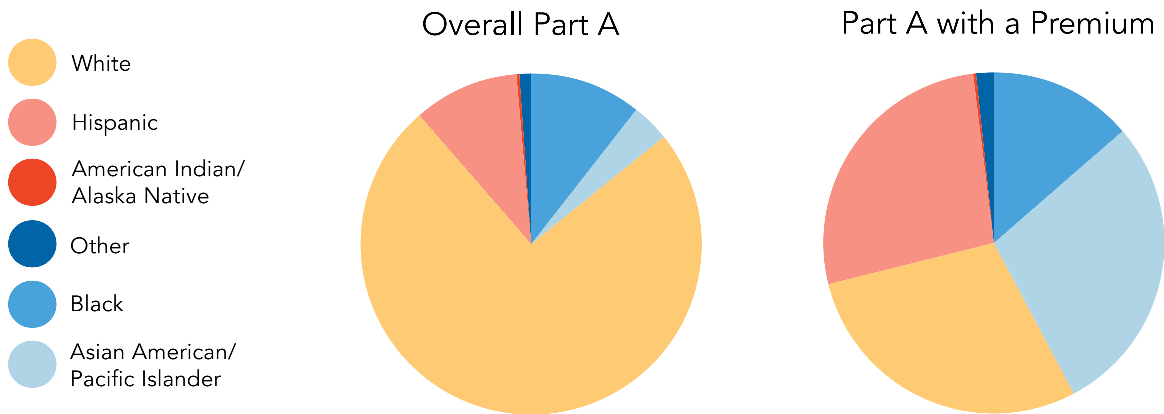
Group Payer States

ENROLLED IN PART A WITH A PREMIUM	ENROLLED IN PART B	ACTION
Yes	Yes	Individual applies for QMB with Medicaid office
No	Yes	Individual applies for Conditional Part A at SSA during General Enrollment Period, and after must file QMB application with Medicaid office
No	No	Individual must apply for Conditional Part A and Part B at SSA during General Enrollment Period, and after must file QMB application with Medicaid office

The Group Payer Arrangement Impacts People with Disabilities, Women, and Immigrants the Most

Certain populations are more negatively impacted by a state's decision to use a group payer arrangement rather than a buy-in agreement. Because free Part A requires approximately ten years of paid work history in the U.S., the group with a Part A premium is composed of people who, for various reasons, do not have the required work credits to qualify. This includes people with disabilities who, due to their disability, did not work, worked less, or were underpaid in sheltered workshops; women who are more likely to have provided unpaid care for their children or relatives; and immigrants who emigrated to the U.S. at an older age and did not work long enough in the U.S. to qualify. Data shows that nationwide, people who pay for Part A with a premium are more likely to be people of color and female.[25] Women are overwhelming the majority of Part A with a premium enrollees, making up approximately 69% of the population.[26] CMS also found, after an internal analysis, that QMB-eligible individuals who must pay for Part A with a premium tend to be non-native speakers and to be lower income than their free Part A counterparts.[27]

Race & Ethnicity of Part A Enrollees



Source: CMS, CMS Program Statistics - Medicare Total Enrollment (2021), Tab MDCR Enroll AB 5.[28]

ADVANTAGES TO BECOMING A PART A BUY-IN STATE

Converting to a Part A buy-in state has significant advantages for both individuals and for states:

- Simplifies Enrollment: Converting to a Part A buy-in state would increase the number of people enrolled in QMB and Medicare Part A.[29] This would eliminate an unnecessarily confusing and frustrating process for populations with the fewest resources to navigate the process, such as people with disabilities, women, people of color, and non-English speakers. Converting to a Part A buy-in state does not increase the number of people eligible for the QMB program because it does not expand the eligibility criteria for the QMB program. Rather, using Part A buy-in simplifies the enrollment process for people who would qualify for QMB but do not enroll because of barriers in the group payer process.

- Improves Health Access and Coordination of Care: Many low-income older adults who have Part A with a premium are enrolled in Medicare Part B, but rely on Medicaid for hospital services. Under this enrollment scenario, people must juggle between Medicaid and Medicare providers for their medical care. Providers of Part B services who refer patients for hospital related services or surgery, for example, must be sure the hospital providers accept Medicaid. Making the process simpler to enroll in Part A would increase the pool of medical providers low-income older adults can access.

- Provides More Medicare Enrollment Options: Individuals without Part A are prohibited from enrolling in Medicare Advantage plans – private plans that Medicare enrollees can choose in lieu of traditional Medicare. With Part A coverage, low-income older adults would become fully dually eligible and have the option to enroll in Medicare Advantage plans and specifically, Dual Eligible Special Needs Plans (D-SNPs). D-SNPs are a type of Medicare Advantage Plan specifically designed for dually eligible individuals and are required to provide care coordination between Medicare and Medicaid, a requirement not found in other types of Medicare Advantage plans. Medicare Advantage plans, including D-SNPs, may also offer supplemental benefits, such as dental or transportation, which may be especially attractive in states whose Medicaid program does not offer these services.

- **Generates Significant Savings for States**: Beyond the impact on individuals, Part A buy-in generates significant savings for states by increasing the number of people on Medicare Part A, which in turn shifts costs away from the Medicaid program and onto Medicare. Right now, if someone does not have Part A coverage, state Medicaid programs are paying for high costs associated with hospital admissions, short-term nursing facility stays, and home health benefits. Furthermore, group payer states today are footing the bill for late enrollment penalties that are waived under buy-in agreements.[30] In 2021 alone, California could have saved 8.5 million in Part A late enrollment penalties if it were a Part A buy-in state.[31]

- **Consistent with Federal Changes**: Due to a recent CMS rule, it will be mandatory for Part A buy-in states to automatically enroll *all* Supplemental Security Income (SSI) recipients into QMB without a separate application, regardless of their Part A premium status.[32] In group payer states, automatic enrollment into QMB will remain optional for those with Part A with a premium. Yet, group payer states will be required to automatically enroll SSI recipients with free Part A into QMB.[33] Because it is not mandatory for group payer states to apply this policy to the entire SSI population, this policy excludes all other eligible individuals who do not receive SSI as well as SSI recipients without free Part A. As a result, two different processes will apply for different populations, creating administrative complexity and confusion when Part A buy-in would provide consistency across populations.

ADVOCACY STRATEGIES FOR CONVERTING FROM A GROUP PAYER TO A PART A BUY-IN STATE

The process for converting to a Part A buy-in State from a group payer state with the Centers for Medicare & Medicaid Services (CMS) is simple. A state just needs to submit a state plan amendment to CMS, which can be made at any time of the year.[34] In fact, CMS has repeatedly encouraged group payer states to convert to a buy-in state. For example, in a 2018 State Medicaid Director letter, CMS encouraged group payer states to enter into a buy-in agreement to better serve individuals dually eligible for Medicare and Medicaid.[35]

With CMS fully supportive of this change, advocates need only convince their state Medicaid agencies to take action. Yet, this is not always an easy or fast process as demonstrated by Justice in Aging's experience in California detailed below.

Advocates in California spent many years providing education to both advocates and state policymakers on the Part A enrollment process and barriers. Advocates developed and disseminated factsheets with instructions on the "buzzwords" to use with SSA and county Medicaid offices to facilitate enrollment. Yet, advocates helping their clients reported that local eligibility workers and SSA staff continued to wrongly turn away individuals applying for Conditional Part A enrollment, either due to ignorance of the process or language barriers. Advocates began to in earnest advocate for California to become a buy-in state, employing a number of different strategies:

Administrative Advocacy

Justice in Aging and partners first approached California's Medicaid agency in 2022 with the proposal of converting to a Part A buy-in state administratively by submitting a state plan amendment at their discretion. At that time, advocates shared resources from CMS and the Integrated Care Resource Center outlining the significant advantages of converting to a buy-in state. While amenable to converting to a buy-in state, the Medicaid agency declined to commit to making a change in the short-term.

Legislative Advocacy

When administrative advocacy proved unsuccessful, Justice in Aging turned to the state's legislature for support. Justice in Aging approached State Senator Susan Eggman to author a legislative bill in 2023, Senate Bill 311 (Eggman) to require the state Medicaid agency to submit a state plan amendment to become a Part A buy-in state by January 1, 2025. This was an appealing policy proposal to legislators because it increased access to health care, without costing the state additional funds. Senator Eggman was also the Chair of the Senate Health Committee. Advocates should consider approaching legislators who hold leadership positions. Throughout the legislative process, Justice in Aging developed and disseminated educational factsheets to legislative staffers, had ongoing conversations with the California State Medicaid Agency, discussed funding and system processing needs, requested and obtained data and demographics on the impacted populations, solicited letters of support from partner organizations, and negotiated amendments to the enacting state regulations. Advocates can consider broadly who partner organizations could be, including legal services and aging providers, as well as health plans in states with mandatory Medicaid managed care. Health plans may also have a common interest in increasing the number of full Medicare enrollees to reduce Medicaid spending.

SB 311 passed the California Legislature unanimously, and was signed by Governor Newsom in October 2023. The final 2024-2025 California budget estimated millions of dollars in savings for both the state and federal government as a result of Part A buy-in.[36]

Education

In addition to the educational resources Justice in Aging developed, California advocates also shared the Integrated Care Resource Center technical assistance tool that summarizes the savings and other benefits associated with becoming a Part A buy-in state. Advocates highlighted the impact that the state's group payer status had on specific populations, especially in a diverse state such as California. Advocates in other states can approach their state Medicaid agencies with similar arguments, and, if possible, request demographic data to enhance their position. Since Part A late enrollment penalties are waived for Part A buy-in states, advocates can highlight these automatic savings to their Medicaid agencies along with shifting costs to Medicare from Medicaid for Part A covered services.

CONCLUSION

Part A buy-in is an equitable strategy to removing administrative barriers that prevent older adults from getting help with expensive Part A premiums. Converting to a Part A buy-in state does not modify eligibility limits and increase caseloads by expanding eligibility. It simply removes barriers that prevent low-income older adults from accessing assistance they otherwise qualify to receive. It is also timely and in line with CMS's other efforts to increase enrollment into Medicare Savings Programs. Part A buy-in is a straightforward solution with a two-fold impact: savings for state Medicaid programs and reducing inequities by removing administrative burdens for older adults who are disproportionately women and people of color.

RESOURCES

- Integrated Care Resource Center, Assessing the Fiscal Viability of a Medicare Part A Buy-in Agreement in Group Payer States, (December 2021).
- CMS, CMS Program Statistics - Medicare Premiums.
- CMS, Frequently Asked Questions about Medicare Part A and B "Buy-in, (March 2021).
- CMS, Manual for State Payment of Medicare Premiums, Chapter 1: Program Overview and Policy (Revision 6, Issued April 2024).

ENDNOTES

1 As of December 2023, there are 66.9 million Medicare enrollees. Center for Medicare and Medicaid Services ("CMS"), Medicare Monthly Enrollment, accessed April 1, 2024.

2 Approximately 99% of Medicare enrollees do not have a Part A premium. Center for Medicare and Medicaid Services, 2024 Medicare Parts A & B Premiums and Deductibles, (October 12, 2023).

3 CMS, Medicare Monthly Enrollment, accessed April 1, 2024.

4 Part A late enrollment penalties may increase the base Part A premium. CMS, CMS Program Statistics - Medicare Premiums, MDCR Premiums 1 tab, 2021, accessed April 23, 2024

5 Certain special enrollment periods may also be available. See Social Security Administration, Program Operations Manual System ("POMS"), HI 00801.133 Enrollment and Coverage Periods; see also CMS, When Does Coverage Start?.

6 CMS uses the term "premium-free Part A." Premium-free Part A refers to individuals who do not pay a monthly premium to obtain Part A coverage. This brief will use the term "free Part A" to refer to premium-free Part A.

7 The number of work credits depends on whether a person is applying for Part A based on age, disability, or End Stage Renal Disease. See 42 U.S.C. § 1395c; 42 C.F.R. § 406.10; CMS, Original Medicare (Part A and B) Eligibility and Enrollment.

8 CMS uses the term "premium Part A." Premium Part A refers to individuals who do not have the necessary work credits to qualify for free Part A and obtain Part A by paying a monthly premium. This brief will use the term "Part A with a premium" to refer to premium Part A.

9 People with at least 30 quarters of work pay $278 a month. Those with less than 30 quarters, pay $505 a month in 2024. CMS, 2024 Medicare Parts A & B Premiums and Deductibles.

10 CMS Program Statistics - Medicare Premiums, excel spreadsheet MDCR Premiums 1 tab.

11 42 CFR 406.32(d).

12 CMS Program Statistics - Medicare Premiums, excel spreadsheet MDCR Premiums 1 tab.

13 People who do not qualify for free Part A may instead enroll in a Marketplace plan if they drop their Part A and B, or do not enroll in Part A with a premium or B when they first become eligible. This can lead to Part A and B late enrollment penalties if they subsequently enroll in Medicare Part A or B in the future. CMS, Frequently Asked Questions Regarding Medicare and the Marketplace, (August 2014), at Section A.6 p. 5.

14 Advocates can find more resources on Improper Billing and template sample letters at Justice in Aging's Improper Billing webpage.

15 Social Security Act 1905(p)(1)(A) and 42 CFR 435.123; POMS HI 00801.139 Qualified Medicare Beneficiary Provisions.

16 Enrollment in premium Part A requires simultaneous enrollment in Part B. POMS HI 00801.131 Eligibility for Premium-HI.

17 Georgia Burke, Social Security Agency Clarifies Handling of Medicare Part A Conditional Applications, Justice in Aging, (January 2023).

18 Social Security Administration, Program Operations Manual System ("POMS") HI 00815.001 State Payment of Medicare Premiums (Buy-In Program).

19 Sections 1843(a) and 1818(g) of the Social Security Act; CMS, Manual for State Payment of Medicare Premiums, Chapter 1: Program Overview and Policy, (Revised April 2024), Section 1.2.

20 POMS HI 00801.140 Premium-Part A Enrollments for Qualified Medicare Beneficiaries (QMBs) – Part A Buy-In States and Group Payer States

21 CMS, Manual for State Payment of Medicare Premiums, Chapter 1: Program Overview and Policy, Section 1.11.

22 42 CFR 406.26; POMS, HI 00815.001 State Payment of Medicare Premiums (Buy-In Program).

23 42 CFR 406.26(a)(2); State Payment of Medicare Premiums, Chapter 1, Section 1.10.

24 California Welfare & Institutions Code 14005.11(g); California Department of Health Care Services, All County Welfare Director's Letter MEDICARE PART A BUY-IN AND AUTOMATIC ENROLLMENT OF SUPPLEMENTAL SECURITY INCOME RECIPIENTS INTO QUALIFIED MEDICARE BENEFICIARY PROGRAM 24-01 (January 2024).

25 CMS Program Statistics - Medicare Premiums, MDCR Premiums 2 tab, 2021, accessed April 23,2024.

26 Id.

27 CMS, at 87 Fed. Reg. 54760 at 54773.

28 CMS Program Statistics – Medicare Total Enrollment, 2021, accessed August 22, 2024.

29 Additionally, converting to a Buy-In state can effectively eliminate Part A late enrollment penalties for individuals even if they lose Qualified Medicare Beneficiary eligibility in the future. If a person loses QMB eligibility and State payment of Part A premiums ends, the person will be liable for the standard Part A premium only, even if they owed a late enrollment penalty prior to Part A buy-in. See 42 CFR 406.26(d)(1)(i); Manual for State Payment of Medicare Premiums, Chapter 1: Program Overview and Policy, Section 1.15.

30 Andrew DuJack and Maria Dominiak et.al., Assessing the Fiscal Viability of a Medicare Part A Buy-in Agreement in Group Payer States, Integrated Care Resource Center, (December 2021).

31 CMS, CMS Program Statistics - Medicare Premiums, MDCR Premiums 3 tab, (2021).

32 42 C.F.R. § 435.909; Rachel Gershon, Final Rule to Streamline Enrollment in Medicare Savings Programs, Justice in Aging, (November 2023), at page 2.

33 Id.

34 42 CFR § 406.26(a).

35 CMS, Ten Opportunities to Better Serve Individuals Dually Eligible for Medicaid and Medicare, (December 2018); see also Frequently Asked Questions about Medicare Part A and B "Buy-in," at page 2.

36 California estimated approximately annual savings of $1.3 million General Fund and $40.1 million federal funds. California Senate Budget and Fiscal Review, Subcommittee No. 3 Agenda , at p. 17 (May 2024).