actively extended to October 1, 1981, if the individual files a request before January 1, 1983, for such retroactive extension and pays the monthly premiums for the months so covered.

''(c)(1) For purposes of section 1839(d) of the Social Security Act [42 U.S.C. 1395r(d)] with respect to the monthly premium for months after September 1981, if an individual described in subsection (a) has enrolled in the insurance program under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] at any time before the end of the enrollment period described in subsection (a), any month (before the end of that enrollment period) in which he was not enrolled in that program shall not be treated as a month in which he could have been enrolled in the program.

''(2) Paragraph (1) shall not apply to an individual—

''(A) if the individual has enrolled in the insurance program before March 10, 1981, unless the enrollment was terminated solely because the individual lost eligibility to be so enrolled, or

''(B) unless the individual applies for the benefit of such paragraph before January 1, 1983.

''(d)(1) The Secretary of Health and Human Services, beginning as soon as possible but not later than 30 days after the date of the enactment of this Act [Sept. 3, 1982], shall provide for the dissemination of information—

''(A) to unions and other associations representing or assisting seamen,

''(B) to offices enrolling individuals under the respective programs, and

''(C) to such other entities and in such a manner as will effectively inform individuals eligible for benefits under this section,

concerning the special benefits provided under this section.

''(2) An individual may establish that the individual was entitled at a date to medical, surgical, and dental treatment and hospitalization under section 322(a) of the Public Health Service Act [42 U.S.C. 249(a)] (as in effect before October 1, 1981) by providing—

''(A) documentation relating to the status under which the individual was provided care in (or under arrangements with) a Public Health Service facility on that date,

''(B) the individual's seamen's papers covering that date, or

''(C) such other reasonable documentation as the Secretary may require.''

§ 1395i–2a. Hospital insurance benefits for disabled individuals who have exhausted other entitlement

(a) Eligibility

Every individual who—

(1) has not attained the age of 65;

(2)(A) has been entitled to benefits under this part under section 426(b) of this title, and

(B)(i) continues to have the disabling physical or mental impairment on the basis of which the individual was found to be under a disability or to be a disabled qualified railroad retirement beneficiary, or (ii) is blind (within the meaning of section 416(i)(1) of this title), but

(C) whose entitlement under section 426(b) of this title ends due solely to the individual having earnings that exceed the substantial gainful activity amount (as defined in section 423(d)(4) of this title); and

(3) is not otherwise entitled to benefits under this part,

shall be eligible to enroll in the insurance program established by this part.

(b) Enrollment

(1) An individual may enroll under this section only in such manner and form as may be prescribed in regulations, and only during an enrollment period prescribed in or under this section.

(2) The individual's initial enrollment period shall begin with the month in which the individual receives notice that the individual's entitlement to benefits under section 426(b) of this title will end due solely to the individual having earnings that exceed the substantial gainful activity amount (as defined in section 423(d)(4) of this title and shall end 7 months later.

(3) There shall be a general enrollment period during the period beginning on January 1 and ending on March 31 of each year (beginning with 1990).

(c) Coverage period

(1) The period (in this subsection referred to as a ''coverage period'') during which an individual is entitled to benefits under the insurance program under this part shall begin on whichever of the following is the latest:

(A) In the case of an individual who enrolls under subsection (b)(2) before the month in which the individual first satisfies subsection (a), the first day of such month.

(B) In the case of an individual who enrolls under subsection (b)(2) in the month in which the individual first satisfies subsection (a), the first day of the month following the month in which the individual so enrolls.

(C) In the case of an individual who enrolls under subsection (b)(2) in the month following the month in which the individual first satisfies subsection (a), the first day of the second month following the month in which the individual so enrolls.

(D) In the case of an individual who enrolls under subsection (b)(2) more than one month following the month in which the individual first satisfies subsection (a), the first day of the third month following the month in which the individual so enrolls.

(E) In the case of an individual who enrolls under subsection (b)(3), the July 1 following the month in which the individual so enrolls.

(2) An individual's coverage period under this section shall continue until the individual's enrollment is terminated as follows:

(A) As of the month following the month in which the Secretary provides notice to the individual that the individual no longer meets the condition described in subsection (a)(2)(B).

(B) As of the month following the month in which the individual files notice that the individual no longer wishes to participate in the insurance program established by this part.

(C) As of the month before the first month in which the individual becomes eligible for hospital insurance benefits under section 426(a) or 426–1 of this title.

(D) As of a date, determined under regulations of the Secretary, for nonpayment of premiums.

The regulations under subparagraph (D) may provide a grace period of not longer than 90 days, which may be extended to not to exceed 180 days in any case where the Secretary determines that there was good cause for failure to pay the overdue premiums within such 90-day

period. Termination of coverage under this section shall result in simultaneous termination of any coverage affected under any other part of this subchapter.

(3) The provisions of subsections (h), (i), and (m) of section 1395p of this title apply to enrollment and nonenrollment under this section in the same manner as they apply to enrollment and nonenrollment and special enrollment periods under section 1395i–2 of this title.

(d) Payment of premiums

(1)(A) Premiums for enrollment under this section shall be paid to the Secretary at such times, and in such manner, as the Secretary shall by regulations prescribe, and shall be deposited in the Treasury to the credit of the Federal Hospital Insurance Trust Fund.

(B)(i) Subject to clause (ii), such premiums shall be payable for the period commencing with the first month of an individual's coverage period and ending with the month in which the individual dies or, if earlier, in which the individual's coverage period terminates.

(ii) Such premiums shall not be payable for any month in which the individual is eligible for benefits under this part pursuant to section 426(b) of this title.

(2) The provisions of subsections (d) through (f) of section 1395i–2 of this title (relating to premiums) shall apply to individuals enrolled under this section in the same manner as they apply to individuals enrolled under that section.

(Aug. 14, 1935, ch. 531, title XVIII, §1818A, as added Pub. L. 101–239, title VI, §6012(a)(2), Dec. 19, 1989, 103 Stat. 2161; amended Pub. L. 101–508, title IV, §4008(m)(3)(C), Nov. 5, 1990, 104 Stat. 1388–54; Pub. L. 116–260, div. CC, title I, §120(a)(2)(C)(i), Dec. 27, 2020, 134 Stat. 2954.)

Editorial Notes

AMENDMENTS

2020—Subsec. (c)(3). Pub. L. 116–260 substituted ''subsections (h), (i), and (m) of section 1395p of this title'' for ''subsections (h) and (i) of section 1395p of this title''.

1990—Subsec. (d)(1)(A). Pub. L. 101–508, §4008(m)(3)(C)(i), inserted ''for enrollment under this section'' after ''Premiums''.

Subsec. (d)(1)(C). Pub. L. 101–508, §4008(m)(3)(C)(ii), struck out subpar. (C) which read as follows: ''For purposes of applying section 1395r(g) of this title and section 59B(f)(1)(B)(i) of the Internal Revenue Code of 1986, any reference to section 1395i–2 of this title shall be deemed to include a reference to this section.''

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE

Pub. L. 101–239, title VI, §6012(b), Dec. 19, 1989, 103 Stat. 2163, provided that: ''The amendments made by this section [enacting this section and amending section 1395i–2 of this title] shall take effect on the date of the enactment of this Act [Dec. 19, 1989], but shall not apply so as to provide for coverage under part A of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.] for any month before July 1990.''

§ 1395i–3. Requirements for, and assuring quality of care in, skilled nursing facilities

(a) "Skilled nursing facility" defined

In this subchapter, the term ''skilled nursing facility'' means an institution (or a distinct part of an institution) which—

(1) is primarily engaged in providing to residents—

(A) skilled nursing care and related services for residents who require medical or nursing care, or

(B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons,

and is not primarily for the care and treatment of mental diseases;

(2) has in effect a transfer agreement (meeting the requirements of section 1395x(*l*) of this title) with one or more hospitals having agreements in effect under section 1395cc of this title; and

(3) meets the requirements for a skilled nursing facility described in subsections (b), (c), and (d) of this section.

(b) Requirements relating to provision of services

(1) Quality of life

(A) In general

A skilled nursing facility must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident.

(B) Quality assessment and assurance

A skilled nursing facility must maintain a quality assessment and assurance committee, consisting of the director of nursing services, a physician designated by the facility, and at least 3 other members of the facility's staff, which (i) meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary and (ii) develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this subparagraph.

(2) Scope of services and activities under plan of care

A skilled nursing facility must provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, in accordance with a written plan of care which—

(A) describes the medical, nursing, and psychosocial needs of the resident and how such needs will be met;

(B) is initially prepared, with the participation to the extent practicable of the resident or the resident's family or legal representative, by a team which includes the resident's attending physician and a registered professional nurse with responsibility for the resident; and

(C) is periodically reviewed and revised by such team after each assessment under paragraph (3).

(3) Residents' assessment

(A) Requirement

A skilled nursing facility must conduct a comprehensive, accurate, standardized, re-