1968, see section 133(g) of Pub. L. 90–248, set out as a note under section 1395k of this title.

REGULATIONS

Secretary of Health and Human Services required to provide, not later than 90 days after July 18, 1984, for revision of regulations as may be required to reflect amendment to subsec. (a) by section 2336(b) of Pub. L. 98–369, see section 2336(c)(2) of Pub. L. 98–369, set out as a note under section 1395f of this title.

MEDPAC STUDY ON DIRECT ACCESS TO PHYSICAL THERAPY SERVICES

Pub. L. 108–173, title VI, § 647, Dec. 8, 2003, 117 Stat. 2326, provided that:

''(a) STUDY.—The Medicare Payment Advisory Commission (in this section referred to as the 'Commission') shall conduct a study on the feasibility and advisability of allowing medicare fee-for-service beneficiaries direct access to outpatient physical therapy services and physical therapy services furnished as comprehensive rehabilitation facility services.

''(b) REPORT.—Not later than January 1, 2005, the Commission shall submit to Congress a report on the study conducted under subsection (a) together with recommendations for such legislation or administrative action as the Commission determines to be appropriate.

''(c) DIRECT ACCESS DEFINED.—The term 'direct access' means, with respect to outpatient physical therapy services and physical therapy services furnished as comprehensive outpatient rehabilitation facility services, coverage of and payment for such services in accordance with the provisions of title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], except that sections 1835(a)(2), 1861(p), and 1861(cc) of such Act (42 U.S.C. 1395n(a)(2), 1395x(p), and 1395x(cc), respectively) shall be applied—

''(1) without regard to any requirement that—

''(A) an individual be under the care of (or referred by) a physician; or

''(B) services be provided under the supervision of a physician; and

''(2) by allowing a physician or a qualified physical therapist to satisfy any requirement for—

''(A) certification and recertification; and

''(B) establishment and periodic review of a plan of care.''

HOME HEALTH PROSPECTIVE PAYMENT DEMONSTRATION PROJECT

Pub. L. 100–203, title IV, § 4027, Dec. 22, 1987, 101 Stat. 1330–75, as amended by Pub. L. 100–360, title IV, § 411(d)(6), July 1, 1988, 102 Stat. 775, directed Secretary of Health and Human Services to provide for a demonstration project to develop and test alternative methods of paying home health agencies on a prospective basis for services furnished under the medicare and medicaid programs, directed that the project be designed in a manner to enable the Secretary to evaluate the effects of various methods of prospective payment (including payments on a per-visit, per-case, and per-episode basis) on program expenditures, access to, and quality of, home health care, and home health agency operations, directed Secretary to assure that services are first furnished under the project not later than Apr. 1, 1989, and, for this purpose, authorized Secretary to reinstate a previously awarded contract, or award a sole source contract, to carry out the project, provided for funding, and directed Secretary to submit to Congress, not later than one year after Dec. 22, 1987, an interim report on the demonstration project and, not later than four years after Dec. 22, 1987, a final report on results of the project.

§ 1395o. Eligible individuals

(a) In general

Every individual who—

(1) is entitled to hospital insurance benefits under part A, or

(2) has attained age 65 and is a resident of the United States, and is either (A) a citizen or (B) an alien lawfully admitted for permanent residence who has resided in the United States continuously during the 5 years immediately preceding the month in which he applies for enrollment under this part,

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

(b) Individuals eligible for immunosuppressive drug coverage

(1) In general

Except as provided under paragraph (2), every individual whose entitlement to insurance benefits under part A ends (whether before, on, or after January 1, 2023) by reason of section 426–1(b)(2) of this title is eligible to enroll or to be deemed to have enrolled in the medical insurance program established by this part solely for purposes of coverage of immunosuppressive drugs in accordance with section 1395p(n) of this title.

(2) Exception if other coverage is available

(A) In general

An individual described in paragraph (1) shall not be eligible for enrollment in the program for purposes of coverage described in such paragraph with respect to any period in which the individual, as determined in accordance with subparagraph (B)—

(i) is enrolled in a group health plan or group or individual health insurance coverage, as such terms are defined in section 300gg–91 of this title;

(ii) is enrolled for coverage under the TRICARE for Life program under section 1086(d) of title 10;

(iii) is enrolled under a State plan (or waiver of such plan) under subchapter XIX and is eligible to receive benefits for immunosuppressive drugs described in this subsection under such plan (or such waiver);

(iv) is enrolled under a State child health plan (or waiver of such plan) under subchapter XXI and is eligible to receive benefits for such drugs under such plan (or such waiver); or

(v)(I) is enrolled in the patient enrollment system of the Department of Veterans Affairs established and operated under section 1705 of title 38;

(II) is not required to enroll under section 1705 of such title to receive immunosuppressive drugs described in this subsection; or

(III) is otherwise eligible under a provision of title 38, other than section 1710 of such title to receive immunosuppressive drugs described in this subsection.

(B) Eligibility determinations

(i) In general

The Secretary, in coordination with the Commissioner of Social Security, shall establish a process for determining whether an individual described in paragraph (1)

who is to be enrolled or deemed to be enrolled in the medical insurance program described in such paragraph meets the requirements for such enrollment under this subsection, including the requirement that the individual not be enrolled in other coverage as described in subparagraph (A).

(ii) Attestation regarding other coverage

The process established under clause (i) shall include, at a minimum, a requirement that—

(I) the individual provide to the Commissioner an attestation that the individual is not enrolled and does not expect to enroll in such other coverage; and

(II) the individual notify the Commissioner within 60 days of enrollment in such other coverage.

(Aug. 14, 1935, ch. 531, title XVIII, § 1836, as added Pub. L. 89–97, title I, § 102(a), July 30, 1965, 79 Stat. 304; amended Pub. L. 92–603, title II, § 201(c)(1), Oct. 30, 1972, 86 Stat. 1372; Pub. L. 116–260, div. CC, title IV, § 402(a)(2)(A), Dec. 27, 2020, 134 Stat. 2998.)

Editorial Notes

AMENDMENTS

2020—Pub. L. 116–260 designated existing provisions as subsec. (a), inserted heading, and added subsec. (b).

1972—Pub. L. 92–603 designed former par. (2)(B) as par. (1), former par. (1) as introductory clause in par. (2), and former pars. (2)(A)(i) and (ii) as pars. (2)(A) and (B), and struck out ''(A)'' after ''(2)''.

Statutory Notes and Related Subsidiaries

PERSONS CONVICTED OF SUBVERSIVE ACTIVITIES

Pub. L. 89–97, title I, § 104(b)(2), July 30, 1965, 79 Stat. 334, provided that: ''An individual who has been convicted of any offense under (A) chapter 37 [section 792 et seq. of Title 18, Crimes and Criminal Procedure] (relating to espionage and censorship), chapter 105 [section 2151 et seq. of Title 18] (relating to sabotage), or chapter 115 [section 2381 et seq. of Title 18] (relating to treason, sedition, and subversive activities) of title 18 of the United States Code, or (B) section 4, 112, or 113 of the Internal Security Act of 1950, as amended [section 783, 822, or 823 of Title 50, War and National Defense], may not enroll under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.].''

§ 1395p. Enrollment periods

(a) Generally; regulations

An individual may enroll in the insurance program established by this part only in such manner and form as may be prescribed by regulations, and only during an enrollment period prescribed in or under this section.

(b) Repealed. Pub. L. 96–499, title IX, § 945(a), Dec. 5, 1980, 94 Stat. 2642

(c) Initial general enrollment period; eligible individuals before March 1, 1966

In the case of individuals who first satisfy paragraph (1) or (2) of section 1395*o*(a) of this title before March 1, 1966, the initial general enrollment period shall begin on the first day of the second month which begins after July 30, 1965, and shall end on May 31, 1966. For purposes of this subsection and subsection (d), an individual who has attained age 65 and who satisfies paragraph (1) of section 1395*o*(a) of this title but not paragraph (2) of such section shall be treated as satisfying such paragraph (1) on the first day on which he is (or on filing application would have been) entitled to hospital insurance benefits under part A.

(d) Eligible individuals on or after March 1, 1966

In the case of an individual who first satisfies paragraph (1) or (2) of section 1395*o*(a) of this title on or after March 1, 1966, his initial enrollment period shall begin on the first day of the third month before the month in which he first satisfies such paragraphs and shall end seven months later. Where the Secretary finds that an individual who has attained age 65 failed to enroll under this part during his initial enrollment period (based on a determination by the Secretary of the month in which such individual attained age 65), because such individual (relying on documentary evidence) was mistaken as to his correct date of birth, the Secretary shall establish for such individual an initial enrollment period based on his attaining age 65 at the time shown in such documentary evidence (with a coverage period determined under section 1395q of this title as though he had attained such age at that time).

(e) General enrollment period

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

(f) Individuals deemed enrolled in medical insurance program

Any individual—

(1) who is eligible under section 1395*o*(a) of this title to enroll in the medical insurance program by reason of entitlement to hospital insurance benefits as described in paragraph (1) of such section, and

(2) whose initial enrollment period under subsection (d) begins after March 31, 1973, and

(3) who is residing in the United States, exclusive of Puerto Rico,

shall be deemed to have enrolled in the medical insurance program established by this part.

(g) Commencement of enrollment period

All of the provisions of this section shall apply to individuals satisfying subsection (f), except that—

(1) in the case of an individual who satisfies subsection (f) by reason of entitlement to disability insurance benefits described in section 426(b) of this title, his initial enrollment period shall begin on the first day of the later of (A) April 1973 or (B) the third month before the 25th month of such entitlement, and shall reoccur with each continuous period of eligibility (as defined in section 1395r(d) of this title) and upon attainment of age 65;

(2)(A) in the case of an individual who is entitled to monthly benefits under section 402 or 423 of this title on the first day of his initial enrollment period or becomes entitled to monthly benefits under section 402 of this title during the first 3 months of such period, his enrollment shall be deemed to have occurred