CONSTRUCTION OF 2018 AMENDMENT

Pub. L. 115–271, title V, §5052(b), Oct. 24, 2018, 132 Stat. 3976, provided that: ''Nothing in the amendments made by subsection (a) [amending this section and section 1396d of this title] shall be construed as encouraging a State to place an individual in an inpatient or a residential care setting where a home or community-based care setting would be more appropriate for the individual, or as preventing a State from conducting or pursuing a demonstration project under section 1115 of the Social Security Act [42 U.S.C. 1315] to improve access to, and the quality of, substance use disorder treatment for eligible populations.''

APPLICATION TO CERTAIN STATES

Pub. L. 118–42, div. G, title I, §204(d), Mar. 9, 2024, 138 Stat. 405, provided that: ''Notwithstanding section 430.20 of title 42, Code of Federal Regulations, the Secretary of Health and Human Services may approve a request to renew a State plan amendment under section 1915(*l*) of the Social Security Act (42 U.S.C. 1396n(*l*)) with an effective date of October 1, 2023, if the State making such request—

''(1) had approval for a State plan amendment under such section as of September 30, 2023; and

''(2) submits the request to renew such amendment not later than 60 days after the date of enactment of this Act [Mar. 9, 2024].''

OVERSIGHT AND ASSESSMENT OF THE ADMINISTRATION OF HOME AND COMMUNITY-BASED SERVICES

Pub. L. 111–148, title II, §2402(a), Mar. 23, 2010, 124 Stat. 301, provided that: ''The Secretary of Health and Human Services shall promulgate regulations to ensure that all States develop service systems that are designed to—

''(1) allocate resources for services in a manner that is responsive to the changing needs and choices of beneficiaries receiving non-institutionally-based long-term services and supports (including such services and supports that are provided under programs other [than] the State Medicaid program), and that provides strategies for beneficiaries receiving such services to maximize their independence, including through the use of client-employed providers;

''(2) provide the support and coordination needed for a beneficiary in need of such services (and their family caregivers or representative, if applicable) to design an individualized, self-directed, community-supported life; and

''(3) improve coordination among, and the regulation of, all providers of such services under federally and State-funded programs in order to—

''(A) achieve a more consistent administration of policies and procedures across programs in relation to the provision of such services; and

''(B) oversee and monitor all service system functions to assure—

''(i) coordination of, and effectiveness of, eligibility determinations and individual assessments;

''(ii) development and service monitoring of a complaint system, a management system, a system to qualify and monitor providers, and systems for role-setting and individual budget determinations; and

''(iii) an adequate number of qualified direct care workers to provide self-directed personal assistance services.''

QUALITY OF CARE MEASURES

Pub. L. 109–171, title VI, §6086(b), Feb. 8, 2006, 120 Stat. 127, provided that:

''(1) IN GENERAL.—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality, shall consult with consumers, health and social service providers and other professionals knowledgeable about long-term care services and supports to develop program performance indicators, client function indicators, and measures of client satisfaction with respect to home and community-based services offered under State Medicaid programs.

''(2) BEST PRACTICES.—The Secretary shall—

''(A) use the indicators and measures developed under paragraph (1) to assess such home and community-based services, the outcomes associated with the receipt of such services (particularly with respect to the health and welfare of the recipient of the services), and the overall system for providing home and community-based services under the Medicaid program under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.]; and

''(B) make publicly available the best practices identified through such assessment and a comparative analyses of the system features of each State.

''(3) APPROPRIATION.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary of Health and Human Services, $1,000,000 for the period of fiscal years 2006 through 2010 to carry out this subsection.''

PERMITTING ADJUSTMENT IN ESTIMATES TO TAKE INTO ACCOUNT PREADMISSION SCREENING REQUIREMENT

Pub. L. 101–508, title IV, §4742(e), Nov. 5, 1990, 104 Stat. 1388–198, provided that: ''In the case of a waiver under section 1915(c) of the Social Security Act [42 U.S.C. 1396n(c)] for individuals with mental retardation or a related condition in a State, the Secretary of Health and Human Services shall permit the State to adjust the estimate of average per capita expenditures submitted under paragraph (2)(D) of such section, with respect to such expenditures made on or after January 1, 1989, to take into account increases in expenditures for, or utilization of, intermediate care facilities for the mentally retarded resulting from implementation of section 1919(e)(7)(A) of such Act [42 U.S.C. 1396r(e)(7)(A)].''

EXTENSIONS OF WAIVERS UNDER SUBSECTION (c)

Pub. L. 100–203, title IV, §4102(c), Dec. 22, 1987, 101 Stat. 1330–146, provided that: ''In the case of a State which, as of December 1, 1987, has a waiver approved with respect to elderly individuals under section 1915(c) of the Social Security Act [42 U.S.C. 1396n(c)], which waiver is scheduled to expire before July 1, 1988, if the State notifies the Secretary of Health and Human Services of the State's intention to file an application for a waiver under section 1915(d) of such Act (as amended by subsection (a) of this section), the Secretary shall extend approval of the State's waiver, under section 1915(c) of such Act, on the same terms and conditions through September 30, 1988.''

Pub. L. 99–272, title IX, §9502(f), Apr. 7, 1986, 100 Stat. 204, provided that: ''The Secretary of Health and Human Services shall extend, upon request of the State, any waiver under section 1915(c) of the Social Security Act [42 U.S.C. 1396n(c)] which expires on or after September 30, 1985, and before September 30, 1986. Such extension shall be for a period of not less than one year nor more than five years, subject to section 1915(e)(1) of such Act.''

§ 1396o. Use of enrollment fees, premiums, deductions, cost sharing, and similar charges

(a) Imposition of certain charges under plan in case of individuals described in section 1396a(a)(10)(A) or (E)

Subject to subsections (g), (i), and (j), the State plan shall provide that in the case of individuals described in subparagraph (A) or (E)(i) of section 1396a(a)(10) of this title who are eligible under the plan—

(1) no enrollment fee, premium, or similar charge will be imposed under the plan (except for a premium imposed under subsection (c));

(2) no deduction, cost sharing or similar charge will be imposed under the plan with respect to—

(A) services furnished to individuals under 18 years of age (and, at the option of the State, individuals under 21, 20, or 19 years of age, or any reasonable category of individuals 18 years of age or over),

(B) services furnished to pregnant women, if such services relate to the pregnancy or to any other medical condition which may complicate the pregnancy, and counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in section 1396d(bb) of this title) and covered outpatient drugs (as defined in subsection (k)(2) of section 1396r–8 of this title and including nonprescription drugs described in subsection (d)(2) of such section) that are prescribed for purposes of promoting, and when used to promote, tobacco cessation by pregnant women in accordance with the Guideline referred to in section 1396d(bb)(2)(A) of this title (or, at the option of the State, any services furnished to pregnant women),

(C) services furnished to any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of his income required for personal needs,

(D) emergency services (as defined by the Secretary), family planning services and supplies described in section 1396d(a)(4)(C) of this title,

(E) services furnished to an individual who is receiving hospice care (as defined in section 1396d(*o*) of this title),

(F) any in vitro diagnostic product described in section 1396d(a)(3)(B) of this title that is administered during any portion of the emergency period described in such section beginning on or after March 18, 2020 (and the administration of such product),

(G) COVID–19 testing-related services for which payment may be made under the State plan,

(H) during the period beginning on March 11, 2021, and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1320b–5(g)(1)(B) of this title, a COVID–19 vaccine and the administration of such vaccine (for any individual eligible for medical assistance for such vaccine (and administration)),

(I) during the period beginning on March 11, 2021, and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1320b–5(g)(1)(B) of this title, testing and treatments for COVID–19, including specialized equipment and therapies (including preventive therapies), and, in the case of an individual who is diagnosed with or presumed to have COVID–19, during the period during which such individual has (or is presumed to have) COVID–19, the treatment of a condition that may seriously complicate the treatment of COVID–19, if otherwise covered under the State plan (or waiver of such plan), or

(J) vaccines described in section 1396d(a)(13)(B) of this title and the administration of such vaccines; and

(3) any deduction, cost sharing, or similar charge imposed under the plan with respect to other such individuals or other care and services will be nominal in amount (as determined by the Secretary in regulations which shall, if the definition of ''nominal'' under the regulations in effect on July 1, 1982 is changed, take into account the level of cash assistance provided in such State and such other criteria as the Secretary determines to be appropriate); except that a deduction, cost-sharing, or similar charge of up to twice the nominal amount established for outpatient services may be imposed by a State under a waiver granted by the Secretary for services received at a hospital emergency room if the services are not emergency services (referred to in paragraph (2)(D)) and the State has established to the satisfaction of the Secretary that individuals eligible for services under the plan have actually available and accessible to them alternative sources of nonemergency, outpatient services.

(b) Imposition of certain charges under plan in case of individuals other than those described in section 1396a(a)(10)(A) or (E)

The State plan shall provide that in the case of individuals other than those described in subparagraph (A) or (E) of section 1396a(a)(10) of this title who are eligible under the plan—

(1) there may be imposed an enrollment fee, premium, or similar charge, which (as determined in accordance with standards prescribed by the Secretary) is related to the individual's income,

(2) no deduction, cost sharing, or similar charge will be imposed under the plan with respect to—

(A) services furnished to individuals under 18 years of age (and, at the option of the State, individuals under 21, 20, or 19 years of age, or any reasonable category of individuals 18 years of age or over),

(B) services furnished to pregnant women, if such services relate to the pregnancy or to any other medical condition which may complicate the pregnancy, and counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in section 1396d(bb) of this title) and covered outpatient drugs (as defined in subsection (k)(2) of section 1396r–8 of this title and including nonprescription drugs described in subsection (d)(2) of such section) that are prescribed for purposes of promoting, and when used to promote, tobacco cessation by pregnant women in accordance with the Guideline referred to in section 1396d(bb)(2)(A) of this title (or, at the option of the State, any services furnished to pregnant women),

(C) services furnished to any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institu-

tion, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of his income required for personal needs,

(D) emergency services (as defined by the Secretary), family planning services and supplies described in section 1396d(a)(4)(C) of this title,

(E) services furnished to an individual who is receiving hospice care (as defined in section 1396d(*o*) of this title),

(F) any in vitro diagnostic product described in section 1396d(a)(3)(B) of this title that is administered during any portion of the emergency period described in such section beginning on or after March 18, 2020 (and the administration of such product),

(G) COVID–19 testing-related services for which payment may be made under the State plan,

(H) during the period beginning on March 11, 2021, and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1320b–5(g)(1)(B) of this title, a COVID–19 vaccine and the administration of such vaccine (for any individual eligible for medical assistance for such vaccine (and administration)),

(I) during the period beginning on March 11, 2021, and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1320b–5(g)(1)(B) of this title, testing and treatments for COVID–19, including specialized equipment and therapies (including preventive therapies), and, in the case of an individual who is diagnosed with or presumed to have COVID–19, during the period during which such individual has (or is presumed to have) COVID–19, the treatment of a condition that may seriously complicate the treatment of COVID–19, if otherwise covered under the State plan (or waiver of such plan), or

(J) vaccines described in section 1396d(a)(13)(B) of this title and the administration of such vaccines; and

(3) any deduction, cost sharing, or similar charge imposed under the plan with respect to other such individuals or other care and services will be nominal in amount (as determined by the Secretary in regulations which shall, if the definition of ''nominal'' under the regulations in effect on July 1, 1982 is changed, take into account the level of cash assistance provided in such State and such other criteria as the Secretary determines to be appropriate); except that a deduction, cost-sharing, or similar charge of up to twice the nominal amount established for outpatient services may be imposed by a State under a waiver granted by the Secretary for services received at a hospital emergency room if the services are not emergency services (referred to in paragraph (2)(D)) and the State has established to the satisfaction of the Secretary that individuals eligible for services under the plan have actually available and accessible to them alternative sources of nonemergency, outpatient services.

(c) Imposition of monthly premium; persons affected; amount; prepayment; failure to pay; use of funds from other programs

(1) The State plan of a State may at the option of the State provide for imposing a monthly premium (in an amount that does not exceed the limit established under paragraph (2)) with respect to an individual described in subparagraph (A) or (B) of section 1396a(*l*)(1) of this title who is receiving medical assistance on the basis of section 1396a(a)(10)(A)(ii)(IX) of this title and whose family income (as determined in accordance with the methodology specified in section 1396a(*l*)(3) of this title) equals or exceeds 150 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 9902(2) of this title) applicable to a family of the size involved.

(2) In no case may the amount of any premium imposed under paragraph (1) exceed 10 percent of the amount by which the family income (less expenses for the care of a dependent child) of an individual exceeds 150 percent of the line described in paragraph (1).

(3) A State shall not require prepayment of a premium imposed pursuant to paragraph (1) and shall not terminate eligibility of an individual for medical assistance under this subchapter on the basis of failure to pay any such premium until such failure continues for a period of not less than 60 days. The State may waive payment of any such premium in any case where the State determines that requiring such payment would create an undue hardship.

(4) A State may permit State or local funds available under other programs to be used for payment of a premium imposed under paragraph (1). Payment of a premium with such funds shall not be counted as income to the individual with respect to whom such payment is made.

(d) Premiums for qualified disabled and working individuals described in section 1396d(s)

With respect to a qualified disabled and working individual described in section 1396d(s) of this title whose income (as determined under paragraph (3) of that section) exceeds 150 percent of the official poverty line referred to in that paragraph, the State plan of a State may provide for the charging of a premium (expressed as a percentage of the medicare cost-sharing described in section 1396d(p)(3)(A)(i) of this title provided with respect to the individual) according to a sliding scale under which such percentage increases from 0 percent to 100 percent, in reasonable increments (as determined by the Secretary), as the individual's income increases from 150 percent of such poverty line to 200 percent of such poverty line.

(e) Prohibition of denial of services on basis of individual's inability to pay certain charges

The State plan shall require that no provider participating under the State plan may deny care or services to an individual eligible for such care or services under the plan on account of such individual's inability to pay a deduction, cost sharing, or similar charge. The requirements of this subsection shall not extinguish the liability of the individual to whom the care or

services were furnished for payment of the deduction, cost sharing, or similar charge.

(f) Charges imposed under waiver authority of Secretary

No deduction, cost sharing, or similar charge may be imposed under any waiver authority of the Secretary, except as provided in subsections (a)(3) and (b)(3) and section 1396*o*–1 of this title, unless such waiver is for a demonstration project which the Secretary finds after public notice and opportunity for comment—

(1) will test a unique and previously untested use of copayments,

(2) is limited to a period of not more than two years,

(3) will provide benefits to recipients of medical assistance which can reasonably be expected to be equivalent to the risks to the recipients,

(4) is based on a reasonable hypothesis which the demonstration is designed to test in a methodologically sound manner, including the use of control groups of similar recipients of medical assistance in the area, and

(5) is voluntary, or makes provision for assumption of liability for preventable damage to the health of recipients of medical assistance resulting from involuntary participation.

(g) Individuals provided medical assistance under section 1396a(a)(10)(A)(ii)(XV) or (XVI)

With respect to individuals provided medical assistance only under subclause (XV) or (XVI) of section 1396a(a)(10)(A)(ii) of this title—

(1) a State may (in a uniform manner for individuals described in either such subclause)—

(A) require such individuals to pay premiums or other cost-sharing charges set on a sliding scale based on income that the State may determine; and

(B) require payment of 100 percent of such premiums for such year in the case of such an individual who has income for a year that exceeds 250 percent of the income official poverty line (referred to in subsection (c)(1)) applicable to a family of the size involved, except that in the case of such an individual who has income for a year that does not exceed 450 percent of such poverty line, such requirement may only apply to the extent such premiums do not exceed 7.5 percent of such income; and

(2) such State shall require payment of 100 percent of such premiums for a year by such an individual whose adjusted gross income (as defined in section 62 of the Internal Revenue Code of 1986) for such year exceeds $75,000, except that a State may choose to subsidize such premiums by using State funds which may not be federally matched under this subchapter.

In the case of any calendar year beginning after 2000, the dollar amount specified in paragraph (2) shall be increased in accordance with the provisions of section 415(i)(2)(A)(ii) of this title.

(h) Indexing nominal cost sharing

In applying this section and subsections (c) and (e) of section 1396*o*–1 of this title, with respect to cost sharing that is ''nominal'' in amount, the Secretary shall increase such ''nominal'' amounts for each year (beginning with 2006) by the annual percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) as rounded up in an appropriate manner.

(i) State option to impose income-related premiums for families of disabled children

(1) With respect to disabled children provided medical assistance under section 1396a(a)(10)(A)(ii)(XIX) of this title, subject to paragraph (2), a State may (in a uniform manner for such children) require the families of such children to pay monthly premiums set on a sliding scale based on family income.

(2) A premium requirement imposed under paragraph (1) may only apply to the extent that—

(A) in the case of a disabled child described in that paragraph whose family income—

(i) does not exceed 200 percent of the poverty line, the aggregate amount of such premium and any premium that the parent is required to pay for family coverage under section 1396a(cc)(2)(A)(i) of this title and other cost-sharing charges do not exceed 5 percent of the family's income; and

(ii) exceeds 200, but does not exceed 300, percent of the poverty line, the aggregate amount of such premium and any premium that the parent is required to pay for family coverage under section 1396a(cc)(2)(A)(i) of this title and other cost-sharing charges do not exceed 7.5 percent of the family's income; and

(B) the requirement is imposed consistent with section 1396a(cc)(2)(A)(ii)(I) of this title.

(3) A State shall not require prepayment of a premium imposed pursuant to paragraph (1) and shall not terminate eligibility of a child under section 1396a(a)(10)(A)(ii)(XIX) of this title for medical assistance under this subchapter on the basis of failure to pay any such premium until such failure continues for a period of at least 60 days from the date on which the premium became past due. The State may waive payment of any such premium in any case where the State determines that requiring such payment would create an undue hardship.

(j) No premiums or cost sharing for Indians furnished items or services directly by Indian health programs or through referral under contract health services

(1) No cost sharing for items or services furnished to Indians through Indian health programs

(A) In general

No enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge shall be imposed against an Indian who is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services for which payment may be made under this subchapter.

(B) No reduction in amount of payment to Indian health providers

Payment due under this subchapter to the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or a health care provider through referral under contract health services for the furnishing of an item or service to an Indian who is eligible for assistance under such subchapter, may not be reduced by the amount of any enrollment fee, premium, or similar charge, or any deduction, copayment, cost sharing, or similar charge that would be due from the Indian but for the operation of subparagraph (A).

(2) Rule of construction

Nothing in this subsection shall be construed as restricting the application of any other limitations on the imposition of premiums or cost sharing that may apply to an individual receiving medical assistance under this subchapter who is an Indian.

(Aug. 14, 1935, ch. 531, title XIX, §1916, as added Pub. L. 97–248, title I, §131(b), Sept. 3, 1982, 96 Stat. 367; amended Pub. L. 97–448, title III, §309(b)(18)–(20), Jan. 12, 1983, 96 Stat. 2409, 2410; Pub. L. 99–272, title IX, §9505(c)(2), Apr. 7, 1986, 100 Stat. 209; Pub. L. 99–509, title IX, §9403(g)(4)(B), Oct. 21, 1986, 100 Stat. 2056; Pub. L. 100–203, title IV, §§4101(d)(1), 4211(h)(11), Dec. 22, 1987, 101 Stat. 1330–142, 1330–207; Pub. L. 100–360, title IV, §411(k)(2), July 1, 1988, 102 Stat. 791; Pub. L. 101–239, title VI, §6408(d)(3), Dec. 19, 1989, 103 Stat. 2269; Pub. L. 105–33, title IV, §4708(b), Aug. 5, 1997, 111 Stat. 506; Pub. L. 106–170, title II, §201(a)(3), Dec. 17, 1999, 113 Stat. 1893; Pub. L. 109–171, title VI, §§6041(b), 6062(b), Feb. 8, 2006, 120 Stat. 84, 98; Pub. L. 111–5, div. B, title V, §5006(a)(1), Feb. 17, 2009, 123 Stat. 505; Pub. L. 111–148, title IV, §4107(c)(1), Mar. 23, 2010, 124 Stat. 561; Pub. L. 116–127, div. F, §6004(a)(2)(A), Mar. 18, 2020, 134 Stat. 204; Pub. L. 117–2, title IX, §9811(a)(3)(A), Mar. 11, 2021, 135 Stat. 209; Pub. L. 117–169, title I, §11405(a)(2)(A), Aug. 16, 2022, 136 Stat. 1900.)

Editorial Notes

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in subsec. (g)(2), is classified generally to Title 26, Internal Revenue Code.

AMENDMENTS

2022—Subsec. (a)(2)(G). Pub. L. 117–169, §11405(a)(2)(A)(i)(I), inserted a comma after ''State plan''.

Subsec. (a)(2)(J). Pub. L. 117–169, §11405(a)(2)(A)(i)(II)–(IV), added subpar. (J).

Subsec. (b)(2)(G). Pub. L. 117–169, §11405(a)(2)(A)(ii)(I), inserted a comma after ''State plan''.

Subsec. (b)(2)(J). Pub. L. 117–169, §11405(a)(2)(A)(ii)(II)–(IV), added subpar. (J).

2021—Subsecs. (a)(2)(H), (I), (b)(2)(H), (I). Pub. L. 117–2 added subpars. (H) and (I).

2020—Subsecs. (a)(2)(F), (G), (b)(2)(F), (G). Pub. L. 116–127 added subpars. (F) and (G).

2010—Subsecs. (a)(2)(B), (b)(2)(B). Pub. L. 111–148 inserted '', and counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in section 1396d(bb) of this title) and covered outpatient drugs (as defined in subsection (k)(2) of section 1396r–8 of this title and including nonprescription drugs described in subsection (d)(2) of such section) that are prescribed for purposes of promoting, and when used to promote, tobacco cessation by pregnant women in accordance with the Guideline referred to in section 1396d(bb)(2)(A) of this title'' after ''complicate the pregnancy''.

2009—Subsec. (a). Pub. L. 111–5, §5006(a)(1)(A), substituted '', (i), and (j)'' for ''and (i)'' in introductory provisions.

Subsec. (j). Pub. L. 111–5, §5006(a)(1)(B), added subsec. (j).

2006—Subsec. (a). Pub. L. 109–171, §6062(b)(1), substituted ''subsections (g) and (i)'' for ''subsection (g)'' in introductory provisions.

Subsec. (f). Pub. L. 109–171, §6041(b)(1), inserted ''and section 1396*o*–1 of this title'' after ''(b)(3)''.

Subsec. (h). Pub. L. 109–171, §6041(b)(2), added subsec. (h).

Subsec. (i). Pub. L. 109–171, §6062(b)(2), added subsec. (i).

1999—Subsec. (a). Pub. L. 106–170, §201(a)(3)(A), substituted ''Subject to subsection (g), the State plan'' for ''The State plan'' in introductory provisions.

Subsec. (g). Pub. L. 106–170, §201(a)(3)(B), added subsec. (g).

1997—Subsec. (a)(2)(D). Pub. L. 105–33, §4708(b)(1), struck out ''or services furnished to such an individual by a health maintenance organization (as defined in section 1396b(m) of this title) in which he is enrolled,'' after ''section 1396d(a)(4)(C) of this title,''.

Subsec. (b)(2)(D). Pub. L. 105–33, §4708(b)(2), struck out ''or (at the option of the State) services furnished to such an individual by a health maintenance organization (as defined in section 1396b(m) of this title) in which he is enrolled,'' after ''section 1396d(a)(4)(C) of this title,''.

1989—Subsec. (a). Pub. L. 101–239, §6408(d)(3)(A), substituted ''subparagraph (A) or (E)(i)'' for ''subparagraph (A) or (E)'' in introductory provisions.

Subsecs. (d) to (f). Pub. L. 101–239, §6408(d)(3)(B), (C), added subsec. (d) and redesignated former subsecs. (d) and (e) as (e) and (f), respectively.

1988—Subsec. (c)(1). Pub. L. 100–360 struck out ''nonfarm'' after ''150 percent of the''.

1987—Subsec. (a)(1). Pub. L. 100–203, §4101(d)(1)(A), inserted ''(except for a premium imposed under subsection (c))'' after ''plan''.

Subsecs. (a)(2)(C), (b)(2)(C). Pub. L. 100–203, §4211(h)(11), substituted ''nursing facility, intermediate care facility for the mentally retarded'' for ''skilled nursing facility, intermediate care facility''.

Subsecs. (c) to (e). Pub. L. 100–203, §4101(d)(1)(B), (C), added subsec. (c) and redesignated former subsecs. (c) and (d) as (d) and (e), respectively.

1986—Subsec. (a). Pub. L. 99–509 substituted ''subparagraph (A) or (E) of section 1396a(a)(10) of this title'' for ''section 1396a(a)(10)(A) of this title''.

Subsec. (a)(2)(E). Pub. L. 99–272 added subpar. (E).

Subsec. (b). Pub. L. 99–509 substituted ''subparagraph (A) or (E) of section 1396a(a)(10) of this title'' for ''section 1396a(a)(10)(A) of this title''.

Subsec. (b)(2)(E). Pub. L. 99–272 added subpar. (E).

1983—Subsec. (c). Pub. L. 97–448, §309(b)(18), substituted ''subsection'' for ''subparagraph''.

Subsec. (d). Pub. L. 97–448, §309(b)(19), (20), substituted in introductory text '', except as provided in subsections (a)(3) and (b)(3)'' for ''unless authorized under this section'', and in cl. (5) substituted ''is voluntary, or makes provision'' for ''in which participation is voluntary, or in which provision is made''.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2022 AMENDMENT

Amendment by Pub. L. 117–169 effective on the 1st day of the 1st fiscal quarter that begins on or after the date that is 1 year after Aug. 16, 2022, and applicable to expenditures made under a State plan or waiver of such

plan under title XIX of the Social Security Act or under a State child health plan or waiver of such plan under title XXI of such Act on or after such effective date, see section 11405(c) of Pub. L. 117–169, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 2010 AMENDMENT

Amendment by Pub. L. 111–148 effective Oct. 1, 2010, see section 4107(d) of Pub. L. 111–148, set out as a note under section 1396d of this title.

EFFECTIVE DATE OF 2009 AMENDMENT

Amendment by Pub. L. 111–5 effective July 1, 2009, see section 5006(f) of Pub. L. 111–5, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–171, title VI, § 6041(c), Feb. 8, 2006, 120 Stat. 85, provided that: ''The amendments made by this section [enacting section 1396*o*–1 of this title and amending this section] shall apply to cost sharing imposed for items and services furnished on or after March 31, 2006.''

Amendment by section 6062(b) of Pub. L. 109–171 applicable to medical assistance for items and services furnished on or after Jan. 1, 2007, see section 6062(d) of Pub. L. 109–171, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1999 AMENDMENT

Amendment by Pub. L. 106–170 applicable to medical assistance for items and services furnished on or after Oct. 1, 2000, see section 201(d) of Pub. L. 106–170, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–33 effective Aug. 5, 1997, and applicable to contracts entered into or renewed on or after Oct. 1, 1997, see section 4710 of Pub. L. 105–33, set out as a note under section 1396b of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by Pub. L. 101–239 applicable, except as otherwise provided, to payments under this subchapter for calendar quarters beginning on or after July 1, 1990, without regard to whether or not final regulations have been promulgated by such date, see section 6408(d)(5) of Pub. L. 101–239, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–203, title IV, § 4101(d)(2), Dec. 22, 1987, 101 Stat. 1330–142, provided that: ''The amendments made by paragraph (1) [amending this section] shall become effective on July 1, 1988.''

Amendment by section 4211(h)(11) of Pub. L. 100–203 applicable to nursing facility services furnished on or after Oct. 1, 1990, without regard to whether regulations implementing such amendment are promulgated by such date, except as otherwise specifically provided in section 1396r of this title, with transitional rule, see section 4214(a), (b)(2) of Pub. L. 100–203, as amended, set out as an Effective Date note under section 1396r of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Amendment by Pub. L. 99–509 applicable to payments under this subchapter for calendar quarters beginning on or after July 1, 1987, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date, see section 9403(h) of Pub. L. 99–509, set out as a note under section 1396a of this title.

Amendment by Pub. L. 99–272 applicable to medical assistance provided for hospice care furnished on or after Apr. 7, 1986, see section 9505(e) of Pub. L. 99–272, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1983 AMENDMENT

Amendment by Pub. L. 97–448 effective as if originally included as a part of this section as this section was added by the Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97–248, see section 309(c)(2) of Pub. L. 97–448, set out as a note under section 426–1 of this title.

EFFECTIVE DATE

Pub. L. 97–248, title I, § 131(d), formerly § 131(c), Sept. 3, 1982, 96 Stat. 370, redesignated by Pub. L. 97–448, title III, § 309(a)(8), Jan. 12, 1983, 96 Stat. 2408, provided that:

''(1) Except as provided in paragraph (2), the amendments made by this section [enacting this section and amending section 1396a of this title] shall become effective on October 1, 1982.

''(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [Sept. 3, 1982].''

APPLICABILITY OF 2020 AMENDMENT TO TERRITORIES

Pub. L. 116–127, div. F, § 6004(a)(2)(C), Mar. 18, 2020, 134 Stat. 205, provided that: ''The amendments made [by] this paragraph [amending this section and section 1396*o*–1 of this title] shall apply with respect to a State plan of a territory in the same manner as a State plan of one of the 50 States.''

§ 1396*o*–1. State option for alternative premiums and cost sharing

(a) State flexibility

(1) In general

Notwithstanding sections 1396*o* and 1396a(a)(10)(B) of this title, but subject to paragraph (2), a State, at its option and through a State plan amendment, may impose premiums and cost sharing for any group of individuals (as specified by the State) and for any type of services (other than drugs for which cost sharing may be imposed under subsection (c) and non-emergency services furnished in a hospital emergency department for which cost sharing may be imposed under subsection (e)), and may vary such premiums and cost sharing among such groups or types, consistent with the limitations established under this section. Nothing in this section shall be construed as superseding (or preventing the application of) subsection (g), (i), or (j) of section 1396*o* of this title.

(2) Exemption for individuals with family income not exceeding 100 percent of the poverty line

(A) In general

Paragraph (1) and subsection (d) shall not apply, and sections 1396*o* and 1396a(a)(10)(B)