treatment services defined in section 1396d(r) of this title) and provided in accordance with section 1396a(a)(43) of this title, shall be deemed to satisfy the requirements of subparagraph (A).

**(7) Coverage of family planning services and supplies**

Notwithstanding the previous provisions of this section, a State may not provide for medical assistance through enrollment of an individual with benchmark coverage or benchmark-equivalent coverage under this section unless such coverage includes for any individual described in section 1396d(a)(4)(C) of this title, medical assistance for family planning services and supplies in accordance with such section.

**(c) Publication of provisions affected**

With respect to a State plan amendment to provide benchmark benefits in accordance with subsections (a) and (b) that is approved by the Secretary, the Secretary shall publish on the Internet website of the Centers for Medicare & Medicaid Services, a list of the provisions of this subchapter that the Secretary has determined do not apply in order to enable the State to carry out the plan amendment and the reason for each such determination on the date such approval is made, and shall publish such list in the Federal Register and[3] not later than 30 days after such date of approval.

(Aug. 14, 1935, ch. 531, title XIX, § 1937, as added Pub. L. 109–171, title VI, § 6044(a), Feb. 8, 2006, 120 Stat. 88; amended Pub. L. 111–3, title VI, § 611(a)–(c), Feb. 4, 2009, 123 Stat. 100, 101; Pub. L. 111–148, title II, §§ 2001(a)(5)(E), (c), 2004(c)(2), 2303(c), Mar. 23, 2010, 124 Stat. 275, 276, 283, 296.)

AMENDMENT OF SUBSECTION (a)(2)(B)(viii)

*Pub. L. 111–148, title II, § 2004(c)(2), (d), title X, § 10201(a)(3), Mar. 23, 2010, 124 Stat. 283, 918, provided that, effective Jan. 1, 2014, subsection (a)(2)(B)(viii) of this section is amended by inserting '', or the individual qualifies for medical assistance on the basis of section 1396a(a)(10)(A)(i)(IX) of this title'' before the period. See 2010 Amendment notes below.*

PRIOR PROVISIONS

A prior section 1937 of act Aug. 14, 1935, was renumbered section 1939 and is classified to section 1396v of this title.

AMENDMENTS

2010—Subsec. (a)(1)(B). Pub. L. 111–148, § 2001(a)(5)(E), inserted ''subclause (VIII) of section 1396a(a)(10)(A)(i) of this title or under'' after ''eligible under''.

Subsec. (a)(2)(B)(viii). Pub. L. 111–148, § 2004(c)(2), inserted '', or the individual qualifies for medical assistance on the basis of section 1396a(a)(10)(A)(i)(IX) of this title'' before period at end.

Subsec. (b)(1). Pub. L. 111–148, § 2001(c)(1), inserted ''subject to paragraphs (5) and (6),'' before ''each of the following'' in introductory provisions.

Subsec. (b)(2). Pub. L. 111–148, § 2001(c)(2)(A), inserted ''subject to paragraphs (5) and (6)'' after ''subsection (a)(1),'' in introductory provisions.

Subsec. (b)(2)(A)(iv) to (vii). Pub. L. 111–148, § 2001(c)(2)(B), added cls. (iv) and (v) and redesignated former cls. (iv) and (v) as (vi) and (vii), respectively.

Subsec. (b)(2)(C). Pub. L. 111–148, § 2001(c)(2)(C), redesignated cls. (iii) and (iv) as (i) and (ii), respectively, and struck out former cls. (i) and (ii) which read as follows:

''(i) Coverage of prescription drugs.

''(ii) Mental health services.''

Subsec. (b)(5), (6). Pub. L. 111–148, § 2001(c)(3), added pars. (5) and (6).

Subsec. (b)(7). Pub. L. 111–148, § 2303(c), added par. (7).

2009—Subsec. (a)(1)(A). Pub. L. 111–3, § 611(a)(1)(A), in introductory provisions, substituted ''Notwithstanding section 1396a(a)(1) of this title (relating to statewideness), section 1396a(a)(10)(B) of this title (relating to comparability) and any other provision of this subchapter which would be directly contrary to the authority under this section and subject to subsection (E)'' for ''Notwithstanding any other provision of this subchapter'' and ''coverage that'' for ''enrollment in coverage that provides''.

Subsec. (a)(1)(A)(i). Pub. L. 111–3, § 611(a)(1)(B), inserted ''provides'' before ''benchmark coverage''.

Subsec. (a)(1)(A)(ii). Pub. L. 111–3, § 611(a)(1)(C), added cl. (ii) and struck out former cl. (ii) which read as follows: ''for any child under 19 years of age who is covered under the State plan under section 1396a(a)(10)(A) of this title, wrap-around benefits to the benchmark coverage or benchmark equivalent coverage consisting of early and periodic screening, diagnostic, and treatment services defined in section 1396d(r) of this title.''

Subsec. (a)(1)(C). Pub. L. 111–3, § 611(a)(2), substituted ''additional'' for ''wrap-around'' in heading and struck out ''wrap-around or'' before ''additional'' in text.

Subsec. (a)(1)(E). Pub. L. 111–3, § 611(a)(3), added subpar. (E).

Subsec. (a)(2)(B)(viii). Pub. L. 111–3, § 611(b), substituted ''child welfare services are made available under part B of subchapter IV on the basis of being a child in foster care or'' for ''aid or assistance is made available under part B of subchapter IV to children in foster care and individuals''.

Subsec. (c). Pub. L. 111–3, § 611(c), added subsec. (c).

EFFECTIVE DATE OF 2010 AMENDMENT

Amendment by section 2004(c)(2) of Pub. L. 111–148 effective Jan. 1, 2014, see section 2004(d) of Pub. L. 111–148, set out as an Effective and Termination Dates of 2010 Amendment note under section 1396a of this title.

Amendment by section 2303(c) of Pub. L. 111–148 effective Mar. 23, 2010, and applicable to items and services furnished on or after such date, see section 2303(d) of Pub. L. 111–148, set out as an Effective and Termination Dates of 2010 Amendment note under section 1396a of this title.

EFFECTIVE DATE OF 2009 AMENDMENT

Pub. L. 111–3, title VI, § 611(d), Feb. 4, 2009, 123 Stat. 101, provided that: ''The amendments made by subsections (a), (b), and (c) of this section [amending this section] shall take effect as if included in the amendment made by section 6044(a) of the Deficit Reduction Act of 2005 [Pub. L. 109–171].''

EFFECTIVE DATE

Pub. L. 109–171, title VI, § 6044(b), Feb. 8, 2006, 120 Stat. 92, provided that: ''The amendment made by subsection (a) [enacting this section] takes effect on March 31, 2006.''

## § 1396u–8. Health opportunity accounts

**(a) Authority**

**(1) In general**

Notwithstanding any other provision of this subchapter, the Secretary shall establish a demonstration program under which States may provide under their State plans under this subchapter (including such a plan operating under a statewide waiver under section 1315 of this title) in accordance with this sec-

[3] So in original.

tion for the provision of alternative benefits consistent with subsection (c) for eligible population groups in one or more geographic areas of the State specified by the State. An amendment under the previous sentence is referred to in this section as a ''State demonstration program''.

**(2) Initial demonstration**

**(A) In general**

The demonstration program under this section shall begin on January 1, 2007. During the first 5 years of such program, the Secretary shall not approve more than 10 States to conduct demonstration programs under this section, with each State demonstration program covering 1 or more geographic areas specified by the State. After such 5-year period—

(i) unless the Secretary finds, taking into account cost-effectiveness, quality of care, and other criteria that the Secretary specifies, that a State demonstration program previously implemented has been unsuccessful, such a demonstration program may be extended or made permanent in the State; and

(ii) unless the Secretary finds, taking into account cost-effectiveness, quality of care, and other criteria that the Secretary specifies, that all State demonstration programs previously implemented were unsuccessful, other States may implement State demonstration programs.

**(B) GAO report**

**(i) In general**

Not later than 3 months after the end of the 5-year period described in subparagraph (A), the Comptroller General of the United States shall submit a report to Congress evaluating the demonstration programs conducted under this section during such period.

**(ii) Appropriation**

Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Comptroller General of the United States, $550,000 for the period of fiscal years 2007 through 2010 to carry out clause (i).

**(3) Approval**

The Secretary shall not approve a State demonstration program under paragraph (1) unless the program includes the following:

(A) Creating patient awareness of the high cost of medical care.

(B) Providing incentives to patients to seek preventive care services.

(C) Reducing inappropriate use of health care services.

(D) Enabling patients to take responsibility for health outcomes.

(E) Providing enrollment counselors and ongoing education activities.

(F) Providing transactions involving health opportunity accounts to be conducted electronically and without cash.

(G) Providing access to negotiated provider payment rates consistent with this section.

Nothing in this section shall be construed as preventing a State demonstration program from providing incentives for patients obtaining appropriate preventive care (as defined for purposes of section 223(c)(2)(C) of the Internal Revenue Code of 1986), such as additional account contributions for an individual demonstrating healthy prevention practices.

**(4) No requirement for statewideness**

Nothing in this section or any other provision of law shall be construed to require that a State must provide for the implementation of a State demonstration program on a Statewide[1] basis.

**(b) Eligible population groups**

**(1) In general**

A State demonstration program under this section shall specify the eligible population groups consistent with paragraphs (2) and (3).

**(2) Eligibility limitations during initial demonstration period**

During the initial 5 years of the demonstration program under this section, a State demonstration program shall not apply to any of the following individuals:

(A) Individuals who are 65 years of age or older.

(B) Individuals who are disabled, regardless of whether or not their eligibility for medical assistance under this subchapter is based on such disability.

(C) Individuals who are eligible for medical assistance under this subchapter only because they are (or were within the previous 60 days) pregnant.

(D) Individuals who have been eligible for medical assistance for a continuous period of less than 3 months.

**(3) Additional limitations**

A State demonstration program shall not apply to any individual within a category of individuals described in section 1396u–7(a)(2)(B) of this title.

**(4) Limitations**

**(A) State option**

This subsection shall not be construed as preventing a State from further limiting eligibility.

**(B) On enrollees in Medicaid managed care organizations**

Insofar as the State provides for eligibility of individuals who are enrolled in Medicaid managed care organizations, such individuals may participate in the State demonstration program only if the State provides assurances satisfactory to the Secretary that the following conditions are met with respect to any such organization:

(i) In no case may the number of such individuals enrolled in the organization who participate in the program exceed 5 percent of the total number of individuals enrolled in such organization.

(ii) The proportion of enrollees in the organization who so participate is not sig-

[1] So in original. Probably should not be capitalized.

nificantly disproportionate to the proportion of such enrollees in other such organizations who participate.

(iii) The State has provided for an appropriate adjustment in the per capita payments to the organization to account for such participation, taking into account differences in the likely use of health services between enrollees who so participate and enrollees who do not so participate.

**(5) Voluntary participation**

An eligible individual shall be enrolled in a State demonstration program only if the individual voluntarily enrolls. Except in such hardship cases as the Secretary shall specify, such an enrollment shall be effective for a period of 12 months, but may be extended for additional periods of 12 months each with the consent of the individual.

**(6) 1-year moratorium for reenrollment**

An eligible individual who, for any reason, is disenrolled from a State demonstration program conducted under this section shall not be permitted to reenroll in such program before the end of the 1-year period that begins on the effective date of such disenrollment.

**(c) Alternative benefits**

**(1) In general**

The alternative benefits provided under this section shall consist, consistent with this subsection, of at least—

(A) coverage for medical expenses in a year for items and services for which benefits are otherwise provided under this subchapter after an annual deductible described in paragraph (2) has been met; and

(B) contribution into a health opportunity account.

Nothing in subparagraph (A) shall be construed as preventing a State from providing for coverage of preventive care (referred to in subsection (a)(3)) within the alternative benefits without regard to the annual deductible.

**(2) Annual deductible**

The amount of the annual deductible described in paragraph (1)(A) shall be at least 100 percent, but no more than 110 percent, of the annualized amount of contributions to the health opportunity account under subsection (d)(2)(A)(i), determined without regard to any limitation described in subsection (d)(2)(C)(i)(II).

**(3) Access to negotiated provider payment rates**

**(A) Fee-for-service enrollees**

In the case of an individual who is participating in a State demonstration program and who is not enrolled with a Medicaid managed care organization, the State shall provide that the individual may obtain demonstration program Medicaid services from—

(i) any participating provider under this subchapter at the same payment rates that would be applicable to such services if the deductible described in paragraph (1)(A) was not applicable; or

(ii) any other provider at payment rates that do not exceed 125 percent of the payment rate that would be applicable to such services furnished by a participating provider under this subchapter if the deductible described in paragraph (1)(A) was not applicable.

**(B) Treatment under medicaid managed care plans**

In the case of an individual who is participating in a State demonstration program and is enrolled with a Medicaid managed care organization, the State shall enter into an arrangement with the organization under which the individual may obtain demonstration program Medicaid services from any provider described in clause (ii) of subparagraph (A) at payment rates that do not exceed the payment rates that may be imposed under that clause.

**(C) Computation**

The payment rates described in subparagraphs (A) and (B) shall be computed without regard to any cost sharing that would be otherwise applicable under sections 1396*o* and 1396*o*–1 of this title.

**(D) Definitions**

For purposes of this paragraph:

(i) The term ''demonstration program Medicaid services'' means, with respect to an individual participating in a State demonstration program, services for which the individual would be provided medical assistance under this subchapter but for the application of the deductible described in paragraph (1)(A).

(ii) The term ''participating provider'' means—

(I) with respect to an individual described in subparagraph (A), a health care provider that has entered into a participation agreement with the State for the provision of services to individuals entitled to benefits under the State plan; or

(II) with respect to an individual described in subparagraph (B) who is enrolled in a Medicaid managed care organization, a health care provider that has entered into an arrangement for the provision of services to enrollees of the organization under this subchapter.

**(4) No effect on subsequent benefits**

Except as provided under paragraphs (1) and (2), alternative benefits for an eligible individual shall consist of the benefits otherwise provided to the individual, including cost sharing relating to such benefits.

**(5) Overriding cost sharing and comparability requirements for alternative benefits**

The provisions of this subchapter relating to cost sharing for benefits (including sections 1396*o* and 1396*o*–1 of this title) shall not apply with respect to benefits to which the annual deductible under paragraph (1)(A) applies. The provisions of section 1396a(a)(10)(B) of this title (relating to comparability) shall not apply with respect to the provision of alternative benefits (as described in this subsection).

**(6) Treatment as medical assistance**

Subject to subparagraphs (D) and (E) of subsection (d)(2), payments for alternative benefits under this section (including contributions into a health opportunity account) shall be treated as medical assistance for purposes of section 1396b(a) of this title.

**(7) Use of tiered deductible and cost sharing**

**(A) In general**

A State—

(i) may vary the amount of the annual deductible applied under paragraph (1)(A) based on the income of the family involved so long as it does not favor families with higher income over those with lower income; and

(ii) may vary the amount of the maximum out-of-pocket cost sharing (as defined in subparagraph (B)) based on the income of the family involved so long as it does not favor families with higher income over those with lower income.

**(B) Maximum out-of-pocket cost sharing**

For purposes of subparagraph (A)(ii), the term ''maximum out-of-pocket cost sharing'' means, for an individual or family, the amount by which the annual deductible level applied under paragraph (1)(A) to the individual or family exceeds the balance in the health opportunity account for the individual or family.

**(8) Contributions by employers**

Nothing in this section shall be construed as preventing an employer from providing health benefits coverage consisting of the coverage described in paragraph (1)(A) to individuals who are provided alternative benefits under this section.

**(d) Health opportunity account**

**(1) In general**

For purposes of this section, the term ''health opportunity account'' means an account that meets the requirements of this subsection.

**(2) Contributions**

**(A) In general**

No contribution may be made into a health opportunity account except—

(i) contributions by the State under this subchapter; and

(ii) contributions by other persons and entities, such as charitable organizations, as permitted under section 1396b(w) of this title.

**(B) State contribution**

A State shall specify the contribution amount that shall be deposited under subparagraph (A)(i) into a health opportunity account.

**(C) Limitation on annual State contribution provided and permitting imposition of maximum account balance**

**(i) In general**

A State—

(I) may impose limitations on the maximum contributions that may be deposited under subparagraph (A)(i) into a health opportunity account in a year;

(II) may limit contributions into such an account once the balance in the account reaches a level specified by the State; and

(III) subject to clauses (ii) and (iii) and subparagraph (D)(i), may not provide contributions described in subparagraph (A)(i) to a health opportunity account on behalf of an individual or family to the extent the amount of such contributions (including both State and Federal shares) exceeds, on an annual basis, $2,500 for each individual (or family member) who is an adult and $1,000 for each individual (or family member) who is a child.

**(ii) Indexing of dollar limitations**

For each year after 2006, the dollar amounts specified in clause (i)(III) shall be annually increased by the Secretary by a percentage that reflects the annual percentage increase in the medical care component of the consumer price index for all urban consumers.

**(iii) Budget neutral adjustment**

A State may provide for dollar limitations in excess of those specified in clause (i)(III) (as increased under clause (ii)) for specified individuals if the State provides assurances satisfactory to the Secretary that contributions otherwise made to other individuals will be reduced in a manner so as to provide for aggregate contributions that do not exceed the aggregate contributions that would otherwise be permitted under this subparagraph.

**(D) Limitations on Federal matching**

**(i) State contribution**

A State may contribute under subparagraph (A)(i) amounts to a health opportunity account in excess of the limitations provided under subparagraph (C)(i)(III), but no Federal financial participation shall be provided under section 1396b(a) of this title with respect to contributions in excess of such limitations.

**(ii) No FFP for private contributions**

No Federal financial participation shall be provided under section 1396b(a) of this title with respect to any contributions described in subparagraph (A)(ii) to a health opportunity account.

**(E) Application of different matching rates**

The Secretary shall provide a method under which, for expenditures made from a health opportunity account for medical care for which the Federal matching rate under section 1396b(a) of this title exceeds the Federal medical assistance percentage, a State may obtain payment under such section at such higher matching rate for such expenditures.

**(3) Use**

**(A) General uses**

**(i) In general**

Subject to the succeeding provisions of this paragraph, amounts in a health oppor-

tunity account may be used for payment of such health care expenditures as the State specifies.

**(ii) General limitation**

Subject to subparagraph (B)(ii), in no case shall such account be used for payment for health care expenditures that are not payment of medical care (as defined by section 213(d) of the Internal Revenue Code of 1986).

**(iii) State restrictions**

In applying clause (i), a State may restrict payment for—

(I) providers of items and services to providers that are licensed or otherwise authorized under State law to provide the item or service and may deny payment for such a provider on the basis that the provider has been found, whether with respect to this subchapter or any other health benefit program, to have failed to meet quality standards or to have committed 1 or more acts of fraud or abuse; and

(II) items and services insofar as the State finds they are not medically appropriate or necessary.

**(iv) Electronic withdrawals**

The State demonstration program shall provide for a method whereby withdrawals may be made from the account for such purposes using an electronic system and shall not permit withdrawals from the account in cash.

**(B) Maintenance of health opportunity account after becoming ineligible for public benefit**

**(i) In general**

Notwithstanding any other provision of law, if an account holder of a health opportunity account becomes ineligible for benefits under this subchapter because of an increase in income or assets—

(I) no additional contribution shall be made into the account under paragraph (2)(A)(i);

(II) subject to clause (iii), the balance in the account shall be reduced by 25 percent; and

(III) subject to the succeeding provisions of this subparagraph, the account shall remain available to the account holder for 3 years after the date on which the individual becomes ineligible for such benefits for withdrawals under the same terms and conditions as if the account holder remained eligible for such benefits, and such withdrawals shall be treated as medical assistance in accordance with subsection (c)(6).

**(ii) Special rules**

Withdrawals under this subparagraph from an account—

(I) shall be available for the purchase of health insurance coverage; and

(II) may, subject to clause (iv), be made available (at the option of the State) for such additional expenditures (such as job training and tuition expenses) specified by the State (and approved by the Secretary) as the State may specify.

**(iii) Exception from 25 percent savings to Government for private contributions**

Clause (i)(II) shall not apply to the portion of the account that is attributable to contributions described in paragraph (2)(A)(ii). For purposes of accounting for such contributions, withdrawals from a health opportunity account shall first be attributed to contributions described in paragraph (2)(A)(i).

**(iv) Condition for non-health withdrawals**

No withdrawal may be made from an account under clause (ii)(II) unless the account holder has participated in the program under this section for at least 1 year.

**(v) No requirement for continuation of coverage**

An account holder of a health opportunity account, after becoming ineligible for medical assistance under this subchapter, is not required to purchase high-deductible or other insurance as a condition of maintaining or using the account.

**(4) Administration**

A State may coordinate administration of health opportunity accounts through the use of a third party administrator and reasonable expenditures for the use of such administrator shall be reimbursable to the State in the same manner as other administrative expenditures under section 1396b(a)(7) of this title.

**(5) Treatment**

Amounts in, or contributed to, a health opportunity account shall not be counted as income or assets for purposes of determining eligibility for benefits under this subchapter.

**(6) Unauthorized withdrawals**

A State may establish procedures—

(A) to penalize or remove an individual from the health opportunity account based on nonqualified withdrawals by the individual from such an account; and

(B) to recoup costs that derive from such nonqualified withdrawals.

(Aug. 14, 1935, ch. 531, title XIX, § 1938, as added Pub. L. 109–171, title VI, § 6082(2), Feb. 8, 2006, 120 Stat. 113.)

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in subsecs. (a)(3) and (d)(3)(A)(ii), is classified generally to Title 26, Internal Revenue Code.

PRIOR PROVISIONS

A prior section 1938 of act Aug. 14, 1935, was renumbered section 1939 and is classified to section 1396v of this title.

PROHIBITING INITIATION OF NEW HEALTH OPPORTUNITY ACCOUNT DEMONSTRATION PROGRAMS

Pub. L. 111–3, title VI, § 613, Feb. 4, 2009, 123 Stat. 101, provided that: ''After the date of the enactment of this Act [Feb. 4, 2009], the Secretary of Health and Human

Services may not approve any new demonstration programs under section 1938 of the Social Security Act (42 U.S.C. 1396u–8).''

### § 1396v. References to laws directly affecting medicaid program

#### (a) Authority or requirements to cover additional individuals

For provisions of law which make additional individuals eligible for medical assistance under this subchapter, see the following:

**(1) AFDC**

(A) Section 602(a)(32)[1] of this title (relating to individuals who are deemed recipients of aid but for whom a payment is not made).

(B) Section 602(a)(37)[1] of this title (relating to individuals who lose AFDC eligibility due to increased earnings).

(C) Section 606(h)[1] of this title (relating to individuals who lose AFDC eligibility due to increased collection of child or spousal support).

(D) Section 682(e)(6)[1] of this title (relating to certain individuals participating in work supplementation programs).

**(2) SSI**

(A) Section 1382(e) of this title (relating to treatment of couples sharing an accommodation in a facility).

(B) Section 1382h of this title (relating to benefits for individuals who perform substantial gainful activity despite severe medical impairment).

(C) Section 1383c(b) of this title (relating to preservation of benefit status for disabled widows and widowers who lost SSI benefits because of 1983 changes in actuarial reduction formula).

(D) Section 1383c(c) of this title (relating to individuals who lose eligibility for SSI benefits due to entitlement to child's insurance benefits under section 402(d) of this title).

(E) Section 1383c(d) of this title (relating to individuals who lose eligibility for SSI benefits due to entitlement to early widow's or widower's insurance benefits under section 402(e) or (f) of this title).

**(3) Foster care and adoption assistance**

Sections 672(h) and 673(b) of this title (relating to medical assistance for children in foster care and for adopted children).

**(4) Refugee assistance**

Section 1522(e)(5) of title 8 (relating to medical assistance for certain refugees).

**(5) Miscellaneous**

(A) Section 230 of Public Law 93–66 (relating to deeming eligible for medical assistance certain essential persons).

(B) Section 231 of Public Law 93–66 (relating to deeming eligible for medical assistance certain persons in medical institutions).

(C) Section 232 of Public Law 93–66 (relating to deeming eligible for medical assistance certain blind and disabled medically indigent persons).

(D) Section 13(c) of Public Law 93–233 (relating to deeming eligible for medical assistance certain individuals receiving mandatory State supplementary payments).

(E) Section 503 of Public Law 94–566 (relating to deeming eligible for medical assistance certain individuals who would be eligible for supplemental security income benefits but for cost-of-living increases in social security benefits).

(F) Section 310(b)(1) of Public Law 96–272 (relating to continuing medicaid eligibility for certain recipients of Department of Veterans Affairs pensions).

#### (b) Additional State plan requirements

For other provisions of law that establish additional requirements for State plans to be approved under this subchapter, see the following:

(1) Section 1382g of this title (relating to requirement for operation of certain State supplementation programs).

(2) Section 212(a) of Public Law 93–66 (relating to requiring mandatory minimum State supplementation of SSI benefits program).

(Aug. 14, 1935, ch. 531, title XIX, § 1939, formerly § 1920, as added Pub. L. 99–272, title IX, § 9526, Apr. 7, 1986, 100 Stat. 218; renumbered § 1921, Pub. L. 99–509, title IX, § 9407(b), Oct. 21, 1986, 100 Stat. 2058; amended Pub. L. 99–514, title XVIII, § 1895(c)(5), Oct. 22, 1986, 100 Stat. 2936; Pub. L. 99–643, § 6(c), Nov. 10, 1986, 100 Stat. 3578; renumbered § 1922, Pub. L. 100–93, § 5(b), Aug. 18, 1987, 101 Stat. 690; renumbered § 1923 and § 1924 and amended Pub. L. 100–203, title IV, §§ 4112(a)(1), 4118(p)(9), 4211(a)(1), title IX, § 9116(d), Dec. 22, 1987, 101 Stat. 1330–148, 1330–159, 1330–182, 1330–306, as amended Pub. L. 100–360, title IV, § 411(k)(6)(B)(i), (10)(L), (n)(3), July 1, 1988, 102 Stat. 793, 797, as amended Pub. L. 100–485, title VI, § 608(d)(28), Oct. 13, 1988, 102 Stat. 2423; renumbered § 1925, Pub. L. 100–360, title III, § 303(a)(1)(A), July 1, 1988, 102 Stat. 754; renumbered § 1926 and amended Pub. L. 100–485, title II, § 202(c)(5), title III, § 303(a)(1), Oct. 13, 1988, 102 Stat. 2378, 2385; renumbered § 1927, Pub. L. 101–239, title VI, § 6402(b), Dec. 19, 1989, 103 Stat. 2260; renumbered § 1928, Pub. L. 101–508, title IV, § 4401(a)(3), Nov. 5, 1990, 104 Stat. 1388–143; Pub. L. 102–54, § 13(q)(3)(A)(v), June 13, 1991, 105 Stat. 279; renumbered § 1931, Pub. L. 103–66, title XIII, § 13631(b)(1), Aug. 10, 1993, 107 Stat. 637; renumbered § 1932, Pub. L. 104–193, title I, § 114(a)(1), Aug. 22, 1996, 110 Stat. 2177; renumbered §§ 1933, 1934, and 1935, Pub. L. 105–33, title IV, §§ 4701(a), 4732(c), 4802(a)(2), Aug. 5, 1997, 111 Stat. 489, 520, 538; renumbered § 1936, Pub. L. 108–173, title I, § 103(a)(2)(A), Dec. 8, 2003, 117 Stat. 2154; renumbered § 1937, renumbered § 1938, renumbered § 1939, Pub. L. 109–171, title VI, §§ 6034(a)(1), 6044(a), 6082(1), Feb. 8, 2006, 120 Stat. 74, 88, 113.)

REFERENCES IN TEXT

Section 602 of this title, referred to in subsec. (a)(1)(A), (B), was repealed and a new section 602 enacted by Pub. L. 104–193, title I, § 103(a)(1), Aug. 22, 1996, 110 Stat. 2112, and, as so enacted, subsec. (a) of section 602 no longer contains a par. (32) or (37).

Section 606 of this title, referred to in subsec. (a)(1)(C), was repealed and a new section 606 enacted by Pub. L. 104–193, title I, § 103(a)(1), Aug. 22, 1996, 110 Stat. 2112, and, as so enacted, no longer contains a subsec. (h).

[1] See References in Text note below.