Pub. L. 111–148 added cl. (v).

2009—Subsec. (a)(7)(B). Pub. L. 111–3, § 501(a)(2), inserted ''and services described in section 1397cc(c)(5) of this title'' after ''emergency services''.

Subsec. (b)(1)(B)(iii), (iv). Pub. L. 111–3, §§ 111(b)(2), 501(b)(2), added cls. (iii) and (iv).

Subsec. (b)(4), (5). Pub. L. 111–3, § 212, added par. (4) and redesignated former par. (4) as (5).

Subsec. (c)(1). Pub. L. 111–3, § 201(b)(2)(B)(i), inserted ''(through community health workers and others)'' after ''Outreach''.

Subsec. (c)(3). Pub. L. 111–3, § 302(a), added par. (3).

EFFECTIVE DATE OF 2009 AMENDMENT

Amendment by sections 111(b)(2), 201(b)(2)(B)(i), 212, 302(a), and 501(b)(2) of Pub. L. 111–3 effective Apr. 1, 2009, and applicable to child health assistance and medical assistance provided on or after that date, with certain exceptions, see section 3 of Pub. L. 111–3, set out as an Effective Date note under section 1396 of this title.

Pub. L. 111–3, title V, § 501(a)(3), Feb. 4, 2009, 123 Stat. 85, provided that: ''The amendments made by paragraphs (1) and (2) [amending this section and section 1397cc of this title] shall apply to coverage of items and services furnished on or after October 1, 2009.''

§ 1397cc. Coverage requirements for children's health insurance

(a) Required scope of health insurance coverage

The child health assistance provided to a targeted low-income child under the plan in the form described in paragraph (1) of section 1397aa(a) of this title shall consist, consistent with paragraphs (5), (6), and (7) of subsection (c) of this section, of any of the following:

(1) Benchmark coverage

Health benefits coverage that is at least equivalent to the benefits coverage in a benchmark benefit package described in subsection (b) of this section.

(2) Benchmark-equivalent coverage

Health benefits coverage that meets the following requirements:

(A) Inclusion of basic services

The coverage includes benefits for items and services within each of the categories of basic services described in subsection (c)(1) of this section.

(B) Aggregate actuarial value equivalent to benchmark package

The coverage has an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages.

(C) Substantial actuarial value for additional services included in benchmark package

With respect to each of the categories of additional services described in subsection (c)(2) of this section for which coverage is provided under the benchmark benefit package used under subparagraph (B), the coverage has an actuarial value that is equal to at least 75 percent of the actuarial value of the coverage of that category of services in such package.

(3) Existing comprehensive State-based coverage

Health benefits coverage under an existing comprehensive State-based program, described in subsection (d)(1) of this section.

(4) Secretary-approved coverage

Any other health benefits coverage that the Secretary determines, upon application by a State, provides appropriate coverage for the population of targeted low-income children proposed to be provided such coverage.

(b) Benchmark benefit packages

The benchmark benefit packages are as follows:

(1) FEHBP-equivalent children's health insurance coverage

The standard Blue Cross/Blue Shield preferred provider option service benefit plan, described in and offered under section 8903(1) of title 5.

(2) State employee coverage

A health benefits coverage plan that is offered and generally available to State employees in the State involved.

(3) Coverage offered through HMO

The health insurance coverage plan that—

(A) is offered by a health maintenance organization (as defined in section 2791(b)(3) of the Public Health Service Act [42 U.S.C. 300gg–91(b)(3)]), and

(B) has the largest insured commercial, non-medicaid enrollment of covered lives of such coverage plans offered by such a health maintenance organization in the State involved.

(c) Categories of services; determination of actuarial value of coverage

(1) Categories of basic services

For purposes of this section, the categories of basic services described in this paragraph are as follows:

(A) Inpatient and outpatient hospital services.

(B) Physicians' surgical and medical services.

(C) Laboratory and x-ray services.

(D) Well-baby and well-child care, including age-appropriate immunizations.

(2) Categories of additional services

For purposes of this section, the categories of additional services described in this paragraph are as follows:

(A) Coverage of prescription drugs.

(B) Vision services.

(C) Hearing services.

(3) Treatment of other categories

Nothing in this subsection shall be construed as preventing a State child health plan from providing coverage of benefits that are not within a category of services described in paragraph (1) or (2).

(4) Determination of actuarial value

The actuarial value of coverage of benchmark benefit packages, coverage offered under the State child health plan, and coverage of any categories of additional services under benchmark benefit packages and under coverage offered by such a plan, shall be set forth in an actuarial opinion in an actuarial report that has been prepared—

(A) by an individual who is a member of the American Academy of Actuaries;

(B) using generally accepted actuarial principles and methodologies;

(C) using a standardized set of utilization and price factors;

(D) using a standardized population that is representative of privately insured children of the age of children who are expected to be covered under the State child health plan;

(E) applying the same principles and factors in comparing the value of different coverage (or categories of services);

(F) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and

(G) taking into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under the State child health plan that results from the limitations on cost sharing under such coverage.

The actuary preparing the opinion shall select and specify in the memorandum the standardized set and population to be used under subparagraphs (C) and (D).

(5) Dental benefits

(A) In general

The child health assistance provided to a targeted low-income child shall include coverage of dental services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions.

(B) Permitting use of dental benchmark plans by certain States

A State may elect to meet the requirement of subparagraph (A) through dental coverage that is equivalent to a benchmark dental benefit package described in subparagraph (C).

(C) Benchmark dental benefit packages

The benchmark dental benefit packages are as follows:

(i) FEHBP children's dental coverage

A dental benefits plan under chapter 89A of title 5 that has been selected most frequently by employees seeking dependent coverage, among such plans that provide such dependent coverage, in either of the previous 2 plan years.

(ii) State employee dependent dental coverage

A dental benefits plan that is offered and generally available to State employees in the State involved and that has been selected most frequently by employees seeking dependent coverage, among such plans that provide such dependent coverage, in either of the previous 2 plan years.

(iii) Coverage offered through commercial dental plan

A dental benefits plan that has the largest insured commercial, non-medicaid enrollment of dependent covered lives of such plans that is offered in the State involved.

(6) Mental health services parity

(A) In general

In the case of a State child health plan that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan shall ensure that the financial requirements and treatment limitations applicable to such mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act[1] in the same manner as such requirements apply to a group health plan.

(B) Deemed compliance

To the extent that a State child health plan includes coverage with respect to an individual described in section 1396d(a)(4)(B) of this title and covered under the State plan under section 1396a(a)(10)(A) of this title of the services described in section 1396d(a)(4)(B) of this title (relating to early and periodic screening, diagnostic, and treatment services defined in section 1396d(r) of this title) and provided in accordance with section 1396a(a)(43) of this title, such plan shall be deemed to satisfy the requirements of subparagraph (A).

(7) Construction on prohibited coverage

Nothing in this section shall be construed as requiring any health benefits coverage offered under the plan to provide coverage for items or services for which payment is prohibited under this subchapter, notwithstanding that any benchmark benefit package includes coverage for such an item or service.

(8) Availability of coverage for items and services furnished through school-based health centers

Nothing in this subchapter shall be construed as limiting a State's ability to provide child health assistance for covered items and services that are furnished through school-based health centers (as defined in section 1397jj(c)(9) of this title).

(d) Description of existing comprehensive State-based coverage

(1) In general

A program described in this paragraph is a child health coverage program that—

(A) includes coverage of a range of benefits;

(B) is administered or overseen by the State and receives funds from the State;

(C) is offered in New York, Florida, or Pennsylvania; and

(D) was offered as of August 5, 1997.

(2) Modifications

A State may modify a program described in paragraph (1) from time to time so long as it continues to meet the requirement of subparagraph (A) and does not reduce the actuarial value of the coverage under the program below the lower of—

[1] See References in Text note below.

(A) the actuarial value of the coverage under the program as of August 5, 1997, or

(B) the actuarial value described in subsection (a)(2)(B) of this section,

evaluated as of the time of the modification.

(e) Cost-sharing

(1) Description; general conditions

(A) Description

A State child health plan shall include a description, consistent with this subsection, of the amount (if any) of premiums, deductibles, coinsurance, and other cost sharing imposed. Any such charges shall be imposed pursuant to a public schedule.

(B) Protection for lower income children

The State child health plan may only vary premiums, deductibles, coinsurance, and other cost sharing based on the family income of targeted low-income children in a manner that does not favor children from families with higher income over children from families with lower income.

(2) No cost sharing on benefits for preventive services or pregnancy-related assistance

The State child health plan may not impose deductibles, coinsurance, or other cost sharing with respect to benefits for services within the category of services described in subsection (c)(1)(D) of this section or for pregnancy-related assistance.

(3) Limitations on premiums and cost-sharing

(A) Children in families with income below 150 percent of poverty line

In the case of a targeted low-income child whose family income is at or below 150 percent of the poverty line, the State child health plan may not impose—

(i) an enrollment fee, premium, or similar charge that exceeds the maximum monthly charge permitted consistent with standards established to carry out section 1396*o*(b)(1) of this title (with respect to individuals described in such section); and

(ii) a deductible, cost sharing, or similar charge that exceeds an amount that is nominal (as determined consistent with regulations referred to in section 1396*o*(a)(3) of this title, with such appropriate adjustment for inflation or other reasons as the Secretary determines to be reasonable).

(B) Other children

For children not described in subparagraph (A), subject to paragraphs (1)(B) and (2), any premiums, deductibles, cost sharing or similar charges imposed under the State child health plan may be imposed on a sliding scale related to income, except that the total annual aggregate cost-sharing with respect to all targeted low-income children in a family under this subchapter may not exceed 5 percent of such family's income for the year involved.

(C) Premium grace period

The State child health plan—

(i) shall afford individuals enrolled under the plan a grace period of at least 30 days from the beginning of a new coverage period to make premium payments before the individual's coverage under the plan may be terminated; and

(ii) shall provide to such an individual, not later than 7 days after the first day of such grace period, notice—

(I) that failure to make a premium payment within the grace period will result in termination of coverage under the State child health plan; and

(II) of the individual's right to challenge the proposed termination pursuant to the applicable Federal regulations.

For purposes of clause (i), the term ''new coverage period'' means the month immediately following the last month for which the premium has been paid.

(4) Relation to medicaid requirements

Nothing in this subsection shall be construed as affecting the rules relating to the use of enrollment fees, premiums, deductions, cost sharing, and similar charges in the case of targeted low-income children who are provided child health assistance in the form of coverage under a medicaid program under section 1397aa(a)(2) of this title.

(f) Application of certain requirements

(1) Restriction on application of preexisting condition exclusions

(A) In general

Subject to subparagraph (B), the State child health plan shall not permit the imposition of any preexisting condition exclusion for covered benefits under the plan.

(B) Group health plans and group health insurance coverage

If the State child health plan provides for benefits through payment for, or a contract with, a group health plan or group health insurance coverage, the plan may permit the imposition of a preexisting condition exclusion but only insofar as it is permitted under the applicable provisions of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1181 et seq.] and title XXVII of the Public Health Service Act [42 U.S.C. 300gg et seq.].

(2) Compliance with other requirements

Coverage offered under this section shall comply with the requirements of subpart 2 of part A of title XXVII of the Public Health Service Act[1] insofar as such requirements apply with respect to a health insurance issuer that offers group health insurance coverage.

(3) Compliance with managed care requirements

The State child health plan shall provide for the application of subsections (a)(4), (a)(5), (b), (c), (d), and (e) of section 1396u–2 of this title (relating to requirements for managed care) to coverage, State agencies, enrollment brokers, managed care entities, and managed care organizations under this subchapter in the same manner as such subsections apply to coverage and such entities and organizations under subchapter XIX.

(Aug. 14, 1935, ch. 531, title XXI, § 2103, as added Pub. L. 105–33, title IV, § 4901(a), Aug. 5, 1997, 111 Stat. 554; amended Pub. L. 111–3, title I, § 111(b)(1), title IV, § 403(a), title V, §§ 501(a)(1), 502, 504(a), 505(a), Feb. 4, 2009, 123 Stat. 28, 84, 89, 90.)

REFERENCES IN TEXT

Section 2705 of the Public Health Service Act, referred to in subsec. (c)(6)(A), is section 2705 of act July 1, 1944, which was classified to section 300gg–5 of this title, was renumbered section 2726 and amended by Pub. L. 111–148, title I, §§ 1001(2), 1563(c)(4), formerly § 1562(c)(4), title X, § 10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 265, 911, and was transferred to section 300gg–26 of this title. A new section 2705 of act July 1, 1944, related to prohibiting discrimination against individual participants and beneficiaries based on health status, was added, effective for plan years beginning on or after Jan. 1, 2014, and amended by Pub. L. 111–148, title I, § 1201(3), (4), Mar. 23, 2010, 124 Stat. 154, 156, and is classified to section 300gg–4 of this title.

The Employee Retirement Income Security Act of 1974, referred to in subsec. (f)(1)(B), is Pub. L. 93–406, Sept. 2, 1974, 88 Stat. 832. Part 7 of subtitle B of title I of the Act is classified generally to part 7 (§ 1181 et seq.) of subtitle B of subchapter I of chapter 18 of Title 29, Labor. For complete classification of this Act to the Code, see Short Title note set out under section 1001 of Title 29 and Tables.

The Public Health Service Act, referred to in subsec. (f), is act July 1, 1944, ch. 373, 58 Stat. 682. Title XXVII of the Act is classified generally to subchapter XXV (§ 300gg et seq.) of chapter 6A of this title. Subpart 2 of part A of title XXVII of the Act may refer to subpart II of part A of subchapter XXV of chapter 6A of this title. Pub. L. 111–148, title I, §§ 1001(5), 1563(c)(2), (11), formerly § 1562(c)(2), (11), title X, § 10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 265, 268, 911, amended part A by inserting ''SUBPART II—IMPROVING COVERAGE'' (preceding section 300gg–11 of this title), by striking out ''SUBPART 2—OTHER REQUIREMENTS'' (preceding section 300gg–4 of this title), and by redesignating subpart 4 as subpart 2 ''EXCLUSION OF PLANS; ENFORCEMENT; PREEMPTION'' (preceding section 300gg–21 of this title). For complete classification of this Act to the Code, see Short Title note set out under section 201 of this title and Tables.

AMENDMENTS

2009—Subsec. (a). Pub. L. 111–3, § 502(b)(1), inserted '', (6),'' after ''(5)'' in introductory provisions.

Pub. L. 111–3, § 501(a)(1)(A)(i), substituted ''paragraphs (5) and (7) of subsection (c)'' for ''subsection (c)(5)'' in introductory provisions.

Subsec. (a)(1). Pub. L. 111–3, § 501(a)(1)(A)(ii), inserted ''at least'' after ''that is''.

Subsec. (c)(2)(B) to (D). Pub. L. 111–3, § 502(b)(2), redesignated subpars. (C) and (D) as (B) and (C), respectively, and struck out former subpar. (B) which read as follows: ''Mental health services.''

Subsec. (c)(5). Pub. L. 111–3, § 501(a)(1)(B)(ii), added par. (5). Former par. (5) redesignated (7).

Subsec. (c)(6). Pub. L. 111–3, § 502(a), added par. (6).

Subsec. (c)(7). Pub. L. 111–3, § 501(a)(1)(B)(i), redesignated par. (5) as (7).

Subsec. (c)(8). Pub. L. 111–3, § 505(a), added par. (8).

Subsec. (e)(2). Pub. L. 111–3, § 111(b)(1), inserted ''or pregnancy-related assistance'' after ''preventive services'' in heading and ''or for pregnancy-related assistance'' before period at end.

Subsec. (e)(3)(C). Pub. L. 111–3, § 504(a), added subpar. (C).

Subsec. (f)(3). Pub. L. 111–3, § 403(a), added par. (3).

EFFECTIVE DATE OF 2009 AMENDMENT

Amendment by sections 111(b)(1), 502, and 505(a) of Pub. L. 111–3 effective Apr. 1, 2009, and applicable to child health assistance and medical assistance provided on or after that date, with certain exceptions, see section 3 of Pub. L. 111–3, set out as an Effective Date note under section 1396 of this title.

Pub. L. 111–3, title IV, § 403(b), Feb. 4, 2009, 123 Stat. 84, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to contract years for health plans beginning on or after July 1, 2009.''

Amendment by section 501(a)(1) of Pub. L. 111–3 applicable to coverage of items and services furnished on or after Oct. 1, 2009, see section 501(a)(3) of Pub. L. 111–3, set out as a note under section 1397bb of this title.

Pub. L. 111–3, title V, § 504(b), Feb. 4, 2009, 123 Stat. 90, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to new coverage periods beginning on or after the date of the enactment of this Act [Feb. 4, 2009].''

§ 1397dd. Allotments

(a) Appropriation; total allotment

For the purpose of providing allotments to States under this section, subject to subsection (d), there is appropriated, out of any money in the Treasury not otherwise appropriated—

(1) for fiscal year 1998, $4,295,000,000;
(2) for fiscal year 1999, $4,275,000,000;
(3) for fiscal year 2000, $4,275,000,000;
(4) for fiscal year 2001, $4,275,000,000;
(5) for fiscal year 2002, $3,150,000,000;
(6) for fiscal year 2003, $3,150,000,000;
(7) for fiscal year 2004, $3,150,000,000;
(8) for fiscal year 2005, $4,050,000,000;
(9) for fiscal year 2006, $4,050,000,000;
(10) for fiscal year 2007, $5,000,000,000;
(11) for fiscal year 2008, $5,000,000,000.[1]
(12) for fiscal year 2009, $10,562,000,000;
(13) for fiscal year 2010, $12,520,000,000;
(14) for fiscal year 2011, $13,459,000,000;
(15) for fiscal year 2012, $14,982,000,000;
(16) for fiscal year 2013, $17,406,000,000;
(17) for fiscal year 2014, $19,147,000,000; and
(18) for fiscal year 2015, for purposes of making 2 semi-annual allotments—

(A) $2,850,000,000 for the period beginning on October 1, 2014, and ending on March 31, 2015, and

(B) $2,850,000,000 for the period beginning on April 1, 2015, and ending on September 30, 2015.

(b) Allotments to 50 States and District of Columbia

(1) In general

Subject to paragraph (4) and subsections (d) and (m), of the amount available for allotment under subsection (a) of this section for a fiscal year, reduced by the amount of allotments made under subsection (c) of this section (determined without regard to paragraph (4) thereof) for the fiscal year, the Secretary shall allot to each State (other than a State described in such subsection) with a State child health plan approved under this subchapter the same proportion as the ratio of—

(A) the product of (i) the number of children described in paragraph (2) for the State for the fiscal year and (ii) the State cost factor for that State (established under paragraph (3)); to

(B) the sum of the products computed under subparagraph (A).

[1] So in original. The period probably should be a semicolon.