[amending this section] shall take effect as if included in the enactment of section 1936 of the Social Security Act [42 U.S.C. 1396u–6], as added by section 6034(a) of the Deficit Reduction Act of 2005 (Public Law 109–171).''

Pub. L. 110–379, §5(b)(2), Oct. 8, 2008, 122 Stat. 4079, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply to conferences conducted under the authority of section 1936(b)(4) of the Social Security Act (42 U.S.C. 1396u–6(b)(4)) after the date of enactment of this Act [Oct. 8, 2008].''

§ 1396u–7. State flexibility in benefit packages

(a) State option of providing benchmark benefits

(1) Authority

(A) In general

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[1] (E), a State, at its option as a State plan amendment, may provide for medical assistance under this subchapter to individuals within one or more groups of individuals specified by the State through coverage that—

(i) provides benchmark coverage described in subsection (b)(1) or benchmark equivalent coverage described in subsection (b)(2); and

(ii) for any individual described in section 1396d(a)(4)(B) of this title who is eligible under the State plan in accordance with paragraphs (10) and (17) of section 1396a(a) of this title, consists of the items and 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 the requirements of section 1396a(a)(43) of this title.

(B) Limitation

The State may only exercise the option under subparagraph (A) for an individual eligible under subclause (VIII) of section 1396a(a)(10)(A)(i) of this title or under an eligibility category that had been established under the State plan on or before February 8, 2006.

(C) Option of additional benefits

In the case of coverage described in subparagraph (A), a State, at its option, may provide such additional benefits as the State may specify.

(D) Treatment as medical assistance

Payment of premiums for such coverage under this subsection shall be treated as payment of other insurance premiums described in the third sentence of section 1396d(a) of this title.

(E) Rule of construction

Nothing in this paragraph shall be construed as—

(i) requiring a State to offer all or any of the items and services required by subparagraph (A)(ii) through an issuer of benchmark coverage described in subsection (b)(1) or benchmark equivalent coverage described in subsection (b)(2);

(ii) preventing a State from offering all or any of the items and services required by subparagraph (A)(ii) through an issuer of benchmark coverage described in subsection (b)(1) or benchmark equivalent coverage described in subsection (b)(2); or

(iii) affecting a child's entitlement to care and services described in subsections (a)(4)(B) and (r) of section 1396d of this title and provided in accordance with section 1396a(a)(43) of this title whether provided through benchmark coverage, benchmark equivalent coverage, or otherwise.

(2) Application

(A) In general

Except as provided in subparagraph (B), a State may require that a full-benefit eligible individual (as defined in subparagraph (C)) within a group obtain benefits under this subchapter through enrollment in coverage described in paragraph (1)(A). A State may apply the previous sentence to individuals within 1 or more groups of such individuals.

(B) Limitation on application

A State may not require under subparagraph (A) an individual to obtain benefits through enrollment described in paragraph (1)(A) if the individual is within one of the following categories of individuals:

(i) Mandatory pregnant women

The individual is a pregnant woman who is required to be covered under the State plan under section 1396a(a)(10)(A)(i) of this title.

(ii) Blind or disabled individuals

The individual qualifies for medical assistance under the State plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for supplemental security income benefits under subchapter XVI on the basis of being blind or disabled and including an individual who is eligible for medical assistance on the basis of section 1396a(e)(3) of this title.

(iii) Dual eligibles

The individual is entitled to benefits under any part of subchapter XVIII.

(iv) Terminally ill hospice patients

The individual is terminally ill and is receiving benefits for hospice care under this subchapter.

(v) Eligible on basis of institutionalization

The individual is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, and 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 the individual's income required for personal needs.

[1] So in original. Probably should be ''subparagraph''.

(vi) Medically frail and special medical needs individuals

The individual is medically frail or otherwise an individual with special medical needs (as identified in accordance with regulations of the Secretary).

(vii) Beneficiaries qualifying for long-term care services

The individual qualifies based on medical condition for medical assistance for long-term care services described in section 1396p(c)(1)(C) of this title.

(viii) Children in foster care receiving child welfare services and children receiving foster care or adoption assistance

The individual is an individual with respect to whom child welfare services are made available under part B of subchapter IV on the basis of being a child in foster care or with respect to whom adoption or foster care assistance is made available under part E of such subchapter, without regard to age, or the individual qualifies for medical assistance on the basis of section 1396a(a)(10)(A)(i)(IX) of this title.

(ix) TANF and section 1396u–1 parents

The individual qualifies for medical assistance on the basis of eligibility to receive assistance under a State plan funded under part A of subchapter IV (as in effect on or after the welfare reform effective date defined in section 1396u–1(i) of this title).

(x) Women in the breast or cervical cancer program

The individual is a woman who is receiving medical assistance by virtue of the application of sections 1396a(a)(10)(A)(ii)(XVIII) and 1396a(aa) of this title.

(xi) Limited services beneficiaries

The individual—

(I) qualifies for medical assistance on the basis of section 1396a(a)(10)(A)(ii)(XII) of this title; or

(II) is not a qualified alien (as defined in section 1641 of title 8) and receives care and services necessary for the treatment of an emergency medical condition in accordance with section 1396b(v) of this title.

(C) Full-benefit eligible individuals

(i) In general

For purposes of this paragraph, subject to clause (ii), the term ''full-benefit eligible individual'' means for a State for a month an individual who is determined eligible by the State for medical assistance for all services defined in section 1396d(a) of this title which are covered under the State plan under this subchapter for such month under section 1396a(a)(10)(A) of this title or under any other category of eligibility for medical assistance for all such services under this subchapter, as determined by the Secretary.

(ii) Exclusion of medically needy and spend-down populations

Such term shall not include an individual determined to be eligible by the State for medical assistance under section 1396a(a)(10)(C) of this title or by reason of section 1396a(f) of this title or otherwise eligible based on a reduction of income based on costs incurred for medical or other remedial care.

(b) Benchmark benefit packages

(1) In general

For purposes of subsection (a)(1), subject to paragraphs (5) and (6), each of the following coverages shall be considered to be benchmark coverage:

(A) FEHBP-equivalent 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.

(B) State employee coverage

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

(C) Coverage offered through HMO

The health insurance coverage plan that—

(i) is offered by a health maintenance organization (as defined in section 300gg–91(b)(3) of this title), and

(ii) 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.

(D) Secretary-approved coverage

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

(2) Benchmark-equivalent coverage

For purposes of subsection (a)(1), subject to paragraphs (5) and (6)[2] coverage that meets the following requirement shall be considered to be benchmark-equivalent coverage:

(A) Inclusion of basic services

The coverage includes benefits for items and services within each of the following categories of basic services:

(i) Inpatient and outpatient hospital services.

(ii) Physicians' surgical and medical services.

(iii) Laboratory and x-ray services.

(iv) Coverage of prescription drugs.

(v) Mental health services.

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

(vii) Other appropriate preventive services, as designated by the Secretary.

(B) Aggregate actuarial value equivalent to benchmark package

The coverage has an aggregate actuarial value that is at least actuarially equivalent

[2] So in original. Probably should be followed by a comma.

to one of the benchmark benefit packages described in paragraph (1).

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

With respect to each of the following categories of additional services 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:

(i) Vision services.

(ii) Hearing services.

(3) Determination of actuarial value

The actuarial value of coverage of benchmark benefit packages 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 the population involved;

(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 this subchapter 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).

(4) Coverage of rural health clinic and FQHC services

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—

(A) the individual has access, through such coverage or otherwise, to services described in subparagraphs (B) and (C) of section 1396d(a)(2) of this title; and

(B) payment for such services is made in accordance with the requirements of section 1396a(bb) of this title.

(5) Minimum standards

Effective January 1, 2014, any benchmark benefit package under paragraph (1) or benchmark equivalent coverage under paragraph (2) must provide at least essential health benefits as described in section 18022(b) of this title.

(6) Mental health services parity

(A) In general

In the case of any benchmark benefit package under paragraph (1) or benchmark equivalent coverage under paragraph (2) that is offered by an entity that is not a medicaid managed care organization and that provides both medical and surgical benefits and mental health or substance use disorder benefits, the entity 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 300gg–4(a) of this title in the same manner as such requirements apply to a group health plan.

(B) Deemed compliance

Coverage provided 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, 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.)

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''.

[3] So in original.

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 section 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.