paragraph (A) [amending this section] shall not apply with respect to any waiver if such waiver was granted, and the arrangement covered by the waiver was in place, prior to August 10, 1982.''

Amendment by section 137(b)(20)–(25) of Pub. L. 97–248 effective as if originally included as part of this section as this section was amended by the Omnibus Budget Reconciliation Act of 1981, Pub. L. 97–35, see section 137(d)(2) of Pub. L. 97–248, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1981 AMENDMENT

Pub. L. 97–35, title XXI, § 2177(b), Aug. 13, 1981, 95 Stat. 813, provided that: ''The amendment made by this section [amending this section] shall become effective 90 days after the date of the enactment of this Act [Aug. 13, 1981]''.

REGULATIONS

Pub. L. 109–171, title VI, § 6052(b), Feb. 8, 2006, 120 Stat. 95, provided that: ''The Secretary shall promulgate regulations to carry out the amendment made by subsection (a) [amending this section] which may be effective and final immediately on an interim basis as of the date of publication of the interim final regulation. If the Secretary provides for an interim final regulation, the Secretary shall provide for a period of public comments on such regulation after the date of publication. The Secretary may change or revise such regulation after completion of the period of public comment.''

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) of this section, 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) of this section);

(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, or

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

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

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

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) of this section''.

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) of this section, 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) of this section)'' 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) of this section'' 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''.

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].''

§ 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) of this title shall continue to apply, in the case of an individual whose family income does not exceed 100 percent of the poverty line applicable to a family of the size involved.

(B) Limit on aggregate cost sharing

To the extent cost sharing under subsections (c) and (e) or under section 1396*o* of this title is imposed against individuals described in subparagraph (A), the limitation under subsection (b)(1)(B)(ii) on the total aggregate amount of cost sharing shall apply to such cost sharing for all individuals in a family described in subparagraph (A) in the same manner as such limitations apply to cost sharing and families described in subsection (b)(1)(B)(ii).

(3) Definitions

In this section:

(A) Premium

The term ''premium'' includes any enrollment fee or similar charge.

(B) Cost sharing

The term ''cost sharing'' includes any deduction, copayment, or similar charge.

(b) Limitations on exercise of authority

(1) Individuals with family income between 100 and 150 percent of the poverty line

In the case of an individual whose family income exceeds 100 percent, but does not exceed 150 percent, of the poverty line applicable to a family of the size involved—

(A) no premium may be imposed under the plan; and

(B) with respect to cost sharing—

(i) the cost sharing imposed under subsection (a) with respect to any item or service may not exceed 10 percent of the cost of such item or service; and

(ii) the total aggregate amount of cost sharing imposed under this section (including any cost sharing imposed under subsection (c) or (e)) for all individuals in the family may not exceed 5 percent of the family income of the family involved, as applied on a quarterly or monthly basis (as specified by the State).

(2) Individuals with family income above 150 percent of the poverty line

In the case of an individual whose family income exceeds 150 percent of the poverty line applicable to a family of the size involved—

(A) the total aggregate amount of premiums and cost sharing imposed under this section (including any cost sharing imposed under subsection (c) or (e)) for all individuals in the family may not exceed 5 percent of the family income of the family involved, as applied on a quarterly or monthly basis (as specified by the State); and

(B) with respect to cost sharing, the cost sharing imposed with respect to any item or service under subsection (a) may not exceed 20 percent of the cost of such item or service.

(3) Additional limitations

(A) Premiums

No premiums shall be imposed under this section with respect to the following:

(i) Individuals under 18 years of age that are required to be provided medical assistance under section 1396a(a)(10)(A)(i) of this title, and including individuals 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 and individuals with respect to whom adoption or foster care assistance is made available under part E of such subchapter, without regard to age.

(ii) Pregnant women.

(iii) Any terminally ill individual who is receiving hospice care (as defined in section 1396d(*o*) of this title).

(iv) 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 the individual's income required for personal needs.

(v) Women who are receiving medical assistance by virtue of the application of sections 1396a(a)(10)(A)(ii)(XVIII) and 1396a(aa) of this title.

(vi) Disabled children who are receiving medical assistance by virtue of the application of sections 1396a(a)(10)(A)(ii)(XIX) and 1396a(cc) of this title.