screening, diagnostic, and treatment services under the medicaid program under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] in accordance with the requirements of section 1905(r) of such Act (42 U.S.C. 1396d(r)).

''(2) REQUIRED CONTENTS.—The study conducted under paragraph (1) shall include examination of the actuarial value of the provision of such services under the medicaid program and an examination of the portions of such actuarial value that are attributable to paragraph (5) of section 1905(r) of such Act and to the second sentence of such section.

''(b) REPORT.—Not later than 12 months after the date of the enactment of this Act [Aug. 5, 1997], the Secretary of Health and Human Services shall submit a report to Congress on the results of the study conducted under subsection (a).''

REFERENCES TO PROVISIONS OF PART A OF SUBCHAPTER IV CONSIDERED REFERENCES TO SUCH PROVISIONS AS IN EFFECT JULY 16, 1996

For provisions that certain references to provisions of part A (§ 601 et seq.) of subchapter IV of this chapter be considered references to such provisions of part A as in effect July 16, 1996, see section 1396u–1(a) of this title.

LIMITATION ON DISALLOWANCES OR DEFERRAL OF FEDERAL FINANCIAL PARTICIPATION FOR CERTAIN INPATIENT PSYCHIATRIC HOSPITAL SERVICES FOR INDIVIDUALS UNDER AGE 21

Pub. L. 101–508, title IV, § 4706, Nov. 5, 1990, 104 Stat. 1388–173, provided that:

''(a) IN GENERAL.—(1) If the Secretary of Health and Human Services makes a determination that a psychiatric facility has failed to comply with certification of need requirements for inpatient psychiatric hospital services for individuals under age 21 pursuant to section 1905(h) of the Social Security Act [42 U.S.C. 1396d(h)], and such determination has not been subject to a final judicial decision, any disallowance or deferral of Federal financial participation under such Act [42 U.S.C. 301 et seq.] based on such determination shall only apply to the period of time beginning with the first day of noncompliance and ending with the date by which the psychiatric facility develops documentation (using plan of care or utilization review procedures) of the need for inpatient care with respect to such individuals.

''(2) Any disallowance of Federal financial participation under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] relating to the failure of a psychiatric facility to comply with certification of need requirements—

''(A) shall not exceed 25 percent of the amount of Federal financial participation for the period described in paragraph (1); and

''(B) shall not apply to any fiscal year before the fiscal year that is 3 years before the fiscal year in which the determination of noncompliance described in paragraph (1) is made.

''(b) EFFECTIVE DATE.—Subsection (a) shall apply to disallowance actions and deferrals of Federal financial participation with respect to services provided before the date of enactment of this Act [Nov. 5, 1990].''

INTERMEDIATE CARE FACILITY; ACCESS AND VISITATION RIGHTS

Pub. L. 100–360, title IV, § 411(*l*)(3)(C)(i), formerly § 411(*l*)(3)(C), July 1, 1988, 102 Stat. 803, as redesignated by Pub. L. 100–485, title VI, § 608(d)(27)(E), Oct. 13, 1988, 102 Stat. 2423, provided that: ''Effective as of the date of the enactment of this Act [July 1, 1988] and until the effective date of section 1919(c) of such Act [42 U.S.C. 1396r(c), see Effective Date note set out under 42 U.S.C. 1396r], section 1905(c) of the Social Security Act [42 U.S.C. 1396d(c)] is deemed to include the requirement described in section 1919(c)(3)(A) of such Act (as inserted by section 4211(a)(3) of OBRA).''

REGULATIONS FOR INTERMEDIATE CARE FACILITIES FOR MENTALLY RETARDED

Pub. L. 99–272, title IX, § 9514, Apr. 7, 1986, 100 Stat. 213, provided that: ''The Secretary of Health and Human Services shall promulgate proposed regulations revising standards for intermediate care facilities for the mentally retarded under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] within 60 days after the date of the enactment of this Act [Apr. 7, 1986].''

LIFE SAFETY CODE RECOGNITION

Pub. L. 99–272, title IX, § 9515, Apr. 7, 1986, 100 Stat. 213, provided that: ''For purposes of section 1905(c) of the Social Security Act [42 U.S.C. 1396d(c)], an intermediate care facility for the mentally retarded (as defined in section 1905(d) of such Act) which meets the requirements of the relevant sections of the 1985 edition of the Life Safety Code of the National Fire Protection Association shall be deemed to meet the fire safety requirements for intermediate care facilities for the mentally retarded until such time as the Secretary specifies a later edition of the Life Safety Code for purposes of such section, or the Secretary determines that more stringent standards are necessary to protect the safety of residents of such facilities.''

STUDY OF FEDERAL MEDICAL ASSISTANCE PERCENTAGE FORMULA AND OF ADJUSTMENTS OF TARGET AMOUNTS FOR FEDERAL MEDICAID EXPENDITURES; REPORT TO CONGRESS

Pub. L. 97–35, title XXI, § 2165, Aug. 13, 1981, 95 Stat. 806, directed the Comptroller General, in consultation with the Advisory Committee for Intergovernmental Relations, to study the Federal medical assistance percentage formula as applicable to distribution of Federal funds to States, with a view to revising the medicaid matching formula so as to take into account factors which might result in a more equitable distribution of Federal funds to States under this chapter, and to report to Congress on such study not later than Oct. 1, 1982.

COSTS CHARGED TO PERSONAL FUNDS OF PATIENTS IN INTERMEDIATE CARE FACILITIES; COSTS INCLUDED IN CHARGES FOR SERVICES; REGULATIONS

Pub. L. 95–292, § 8(c), (d)(2), June 13, 1978, 92 Stat. 316, required the Secretary of Health, Education, and Welfare to issue regulations, within 90 days after enactment of Pub. L. 95–292 but not later than July 1, 1978, defining those costs that may be charged to the personal funds of patients in intermediate care facilities who are individuals receiving medical assistance under a State plan approved under title XIX of the Social Security Act, and those costs that are to be included in the reasonable cost or reasonable charge for intermediate care facility services. See section 1302 of this title.

§ 1396e. Enrollment of individuals under group health plans

(a) Requirements of each State plan; guidelines

Each State plan—

(1) may implement guidelines established by the Secretary, consistent with subsection (b), to identify those cases in which enrollment of an individual otherwise entitled to medical assistance under this subchapter in a group health plan (in which the individual is otherwise eligible to be enrolled) is cost-effective (as defined in subsection (e)(2));

(2) may require, in case of an individual so identified and as a condition of the individual being or remaining eligible for medical assistance under this subchapter and subject to subsection (b)(2), notwithstanding any other provision of this subchapter, that the individual

(or in the case of a child, the child's parent) apply for enrollment in the group health plan; and

(3) in the case of such enrollment (except as provided in subsection (c)(1)(B)), shall provide for payment of all enrollee premiums for such enrollment and all deductibles, coinsurance, and other cost-sharing obligations for items and services otherwise covered under the State plan under this subchapter (exceeding the amount otherwise permitted under section 1396*o* of this title), and shall treat coverage under the group health plan as a third party liability (under section 1396a(a)(25) of this title).

(b) Timing of enrollment; failure to enroll

(1) In establishing guidelines under subsection (a)(1), the Secretary shall take into account that an individual may only be eligible to enroll in group health plans at limited times and only if other individuals (not entitled to medical assistance under the plan) are also enrolled in the plan simultaneously.

(2) If a parent of a child fails to enroll the child in a group health plan in accordance with subsection (a)(2), such failure shall not affect the child's eligibility for benefits under this subchapter.

(c) Premiums considered payments for medical assistance; eligibility

(1)(A) In the case of payments of premiums, deductibles, coinsurance, and other cost-sharing obligations under this section shall be considered, for purposes of section 1396b(a) of this title, to be payments for medical assistance.

(B) If all members of a family are not eligible for medical assistance under this subchapter and enrollment of the members so eligible in a group health plan is not possible without also enrolling members not so eligible—

(i) payment of premiums for enrollment of such other members shall be treated as payments for medical assistance for eligible individuals, if it would be cost-effective (taking into account payment of all such premiums), but

(ii) payment of deductibles, coinsurance, and other cost-sharing obligations for such other members shall not be treated as payments for medical assistance for eligible individuals.

(2) The fact that an individual is enrolled in a group health plan under this section shall not change the individual's eligibility for benefits under the State plan, except insofar as section 1396a(a)(25) of this title provides that payment for such benefits shall first be made by such plan.

(d) Repealed. Pub. L. 105–33, title IV, § 4741(b)(2), Aug. 5, 1997, 111 Stat. 523

(e) Definitions

In this section:

(1) The term ''group health plan'' has the meaning given such term in section 5000(b)(1) of the Internal Revenue Code of 1986, and includes the provision of continuation coverage by such a plan pursuant to title XXII of the Public Health Service Act [42 U.S.C. 300bb–1 et seq.], section 4980B of the Internal Revenue Code of 1986, or title VI[1] of the Employee Retirement Income Security Act of 1974.

(2) The term ''cost-effective'' has the meaning given that term in section 1397ee(c)(3)(A) of this title.

(Aug. 14, 1935, ch. 531, title XIX, § 1906, as added Pub. L. 101–508, title IV, § 4402(a)(2), Nov. 5, 1990, 104 Stat. 1388–161; amended Pub. L. 105–33, title IV, § 4741(b), Aug. 5, 1997, 111 Stat. 523; Pub. L. 111–148, title X, § 10203(b)(1), Mar. 23, 2010, 124 Stat. 927.)

Editorial Notes

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in subsec. (e)(1), is classified generally to Title 26, Internal Revenue Code.

The Public Health Service Act, referred to in subsec. (e)(1), is act July 1, 1944, ch. 373, 58 Stat. 682, as amended. Title XXII of the Act is classified generally to subchapter XX (§ 300bb–1 et seq.) of chapter 6A 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.

The Employee Retirement Income Security Act of 1974, referred to in subsec. (e)(1), is Pub. L. 93–406, Sept. 2, 1974, 88 Stat. 829, as amended. Title VI of the Act probably means part 6 of subtitle B of title I of the Act which is classified generally to part 6 (§ 1161 et seq.) of subtitle B of subchapter I of chapter 18 of Title 29, Labor, because the Act has no title VI. For complete classification of this Act to the Code, see Short Title note set out under section 1001 of Title 29 and Tables.

PRIOR PROVISIONS

A prior section 1396e, act Aug. 14, 1935, ch. 531, title XIX, § 1906, as added Jan. 2, 1968, Pub. L. 90–248, title II, § 226, 81 Stat. 903, created Advisory Council on Medical Assistance, set forth composition of Council, term of membership of members, and purposes of Council, and provided for compensation of members, prior to repeal by Pub. L. 92–603, title II, § 287, Oct. 30, 1972, 86 Stat. 1457, effective on the first day of the third calendar month following Oct. 30, 1972.

AMENDMENTS

2010—Subsec. (e)(2). Pub. L. 111–148 substituted ''has the meaning given that term in section 1397ee(c)(3)(A) of this title.'' for ''means, as established by the Secretary, that the reduction in expenditures under this subchapter with respect to an individual who is enrolled in a group health plan is likely to be greater than the additional expenditures for premiums and cost-sharing required under this section with respect to such enrollment.''

1997—Subsec. (a). Pub. L. 105–33, § 4741(b)(1), in introductory provisions, substituted ''Each'' for ''For purposes of section 1396a(a)(25)(G) of this title and subject to subsection (d) of this section, each'' and, in pars. (1) and (2), substituted ''may'' for ''shall''.

Subsec. (d). Pub. L. 105–33, § 4741(b)(2), struck out subsec. (d) which read as follows:

''(1) In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1315 of this title, the Secretary shall require the State to meet the requirements of this section in the same manner as the State would be required to meet such requirement if the State had in effect a plan approved under this subchapter.

''(2) This section, and section 1396a(a)(25)(G) of this title, shall only apply to a State that is one of the 50 States or the District of Columbia.''

[1] See References in Text note below.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–148, title X, §10203(b), Mar. 23, 2010, 124 Stat. 927, provided that the amendment made by section 10203(b)(1) of Pub. L. 111–148 is effective as if included in the enactment of the Children's Health Insurance Program Reauthorization Act of 2009 (Pub. L. 111–3).

EFFECTIVE DATE

Section applicable, except as otherwise provided, to payments under this subchapter for calendar quarters beginning on or after Jan. 1, 1991, without regard to whether or not final regulations to carry out the amendments by section 4402 of Pub. L. 101–508 have been promulgated by such date, see section 4402(e) of Pub. L. 101–508, set out as an Effective Date of 1990 Amendment note under section 1396a of this title.

§ 1396e–1. Premium assistance

(a) In general

A State may elect to offer a premium assistance subsidy (as defined in subsection (c)) for qualified employer-sponsored coverage (as defined in subsection (b)) to all individuals who are entitled to medical assistance under this subchapter (and, in the case of an individual under age 19, to the parent of such an individual) who have access to such coverage if the State meets the requirements of this section and the offering of such a subsidy is cost-effective, as defined for purposes of section 1397ee(c)(3)(A) of this title.

(b) Qualified employer-sponsored coverage

(1) In general

Subject to paragraph (2)),[1] in this paragraph, the term ''qualified employer-sponsored coverage'' means a group health plan or health insurance coverage offered through an employer—

(A) that qualifies as creditable coverage as a group health plan under section 2701(c)(1) of the Public Health Service Act;[2]

(B) for which the employer contribution toward any premium for such coverage is at least 40 percent; and

(C) that is offered to all individuals in a manner that would be considered a nondiscriminatory eligibility classification for purposes of paragraph (3)(A)(ii) of section 105(h) of the Internal Revenue Code of 1986 (but determined without regard to clause (i) of subparagraph (B) of such paragraph).

(2) Exception

Such term does not include coverage consisting of—

(A) benefits provided under a health flexible spending arrangement (as defined in section 106(c)(2) of the Internal Revenue Code of 1986); or

(B) a high deductible health plan (as defined in section 223(c)(2) of such Code), without regard to whether the plan is purchased in conjunction with a health savings account (as defined under section 223(d) of such Code).

(3) Treatment as third party liability

The State shall treat the coverage provided under qualified employer-sponsored coverage as a third party liability under section 1396a(a)(25) of this title.

(c) Premium assistance subsidy

In this section, the term ''premium assistance subsidy'' means the amount of the employee contribution for enrollment in the qualified employer-sponsored coverage by the individual or by the individual's family. Premium assistance subsidies under this section shall be considered, for purposes of section 1396b(a) of this title, to be a payment for medical assistance.

(d) Voluntary participation

(1) Employers

Participation by an employer in a premium assistance subsidy offered by a State under this section shall be voluntary. An employer may notify a State that it elects to opt-out of being directly paid a premium assistance subsidy on behalf of an employee.

(2) Beneficiaries

No subsidy shall be provided to an individual under this section unless the individual (or the individual's parent) voluntarily elects to receive such a subsidy. A State may not require such an election as a condition of receipt of medical assistance. A State may not require, as a condition of an individual (or the individual's parent) being or remaining eligible for medical assistance under this subchapter, that the individual (or the individual's parent) apply for enrollment in qualified employer-sponsored coverage under this section.

(3) Opt-out permitted for any month

A State shall establish a process for permitting an individual (or the parent of an individual) receiving a premium assistance subsidy to disenroll the individual from the qualified employer-sponsored coverage.

(e) Requirement to pay premiums and cost-sharing and provide supplemental coverage

In the case of the participation of an individual (or the individual's parent) in a premium assistance subsidy under this section for qualified employer-sponsored coverage, the State shall provide for payment of all enrollee premiums for enrollment in such coverage and all deductibles, coinsurance, and other cost-sharing obligations for items and services otherwise covered under the State plan under this subchapter (exceeding the amount otherwise permitted under section 1396*o* of this title or, if applicable, section 1396*o*–1 of this title). The fact that an individual (or a parent) elects to enroll in qualified employer-sponsored coverage under this section shall not change the individual's (or parent's) eligibility for medical assistance under the State plan, except insofar as section 1396a(a)(25) of this title provides that payments for such assistance shall first be made under such coverage.

(Aug. 14, 1935, ch. 531, title XIX, §1906A, as added Pub. L. 111–3, title III, §301(b), Feb. 4, 2009, 123 Stat. 61; amended Pub. L. 111–148, title II, §2003(a), (b), title X, §10203(b)(2), Mar. 23, 2010, 124 Stat. 282, 283, 927.)

[1] So in original. The second closing parenthesis probably should not appear.

[2] See References in Text note below.