

TITLE 42 - THE PUBLIC HEALTH AND WELFARE
CHAPTER 7 - SOCIAL SECURITY
SUBCHAPTER XIX - GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

§ 1396p. Liens, adjustments and recoveries, and transfers of assets

(a) Imposition of lien against property of an individual on account of medical assistance rendered to him under a State plan

(1) No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan, except—

(A) pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual, or

(B) in the case of the real property of an individual—

(i) who is an inpatient in a 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, and

(ii) with respect to whom the State determines, after notice and opportunity for a hearing (in accordance with procedures established by the State), that he cannot reasonably be expected to be discharged from the medical institution and to return home,

except as provided in paragraph (2).

(2) No lien may be imposed under paragraph (1)(B) on such individual's home if—

(A) the spouse of such individual,

(B) such individual's child who is under age 21, or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1382c of this title, or

(C) a sibling of such individual (who has an equity interest in such home and who was residing in such individual's home for a period of at least one year immediately before the date of the individual's admission to the medical institution),

is lawfully residing in such home.

(3) Any lien imposed with respect to an individual pursuant to paragraph (1)(B) shall dissolve upon that individual's discharge from the medical institution and return home.

(b) Adjustment or recovery of medical assistance correctly paid under a State plan

(1) No adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan may be made, except that the State shall seek adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan in the case of the following individuals:

(A) In the case of an individual described in subsection (a)(1)(B) of this section, the State shall seek adjustment or recovery from the individual's estate or upon sale of the property subject to a lien imposed on account of medical assistance paid on behalf of the individual.

(B) In the case of an individual who was 55 years of age or older when the individual received such medical assistance, the State shall seek adjustment or recovery from the individual's estate, but only for medical assistance consisting of—

(i) nursing facility services, home and community-based services, and related hospital and prescription drug services, or

(ii) at the option of the State, any items or services under the State plan (but not including medical assistance for medicare cost-sharing or for benefits described in section 1396a(a)(10)(E) of this title).

- (C)** **(i)** In the case of an individual who has received (or is entitled to receive) benefits under a long-term care insurance policy in connection with which assets or resources are disregarded in the manner described in clause (ii), except as provided in such clause, the State shall seek adjustment or recovery from the individual's estate on account of medical assistance paid on behalf of the individual for nursing facility and other long-term care services.
- (ii)** Clause (i) shall not apply in the case of an individual who received medical assistance under a State plan of a State which had a State plan amendment approved as of May 14, 1993, and which satisfies clause (iv), or which has a State plan amendment that provides for a qualified State long-term care insurance partnership (as defined in clause (iii)) which provided for the disregard of any assets or resources—
- (I)** to the extent that payments are made under a long-term care insurance policy; or
- (II)** because an individual has received (or is entitled to receive) benefits under a long-term care insurance policy.
- (iii)** For purposes of this paragraph, the term “qualified State long-term care insurance partnership” means an approved State plan amendment under this subchapter that provides for the disregard of any assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a long-term care insurance policy if the following requirements are met:
- (I)** The policy covers an insured who was a resident of such State when coverage first became effective under the policy.
- (II)** The policy is a qualified long-term care insurance policy (as defined in section 7702B(b) of the Internal Revenue Code of 1986) issued not earlier than the effective date of the State plan amendment.
- (III)** The policy meets the model regulations and the requirements of the model Act specified in paragraph (5).
- (IV)** If the policy is sold to an individual who—
- (aa)** has not attained age 61 as of the date of purchase, the policy provides compound annual inflation protection;
- (bb)** has attained age 61 but has not attained age 76 as of such date, the policy provides some level of inflation protection; and
- (cc)** has attained age 76 as of such date, the policy may (but is not required to) provide some level of inflation protection.
- (V)** The State Medicaid agency under section 1396a (a)(5) of this title provides information and technical assistance to the State insurance department on the insurance department's role of assuring that any individual who sells a long-term care insurance policy under the partnership receives training and demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care.
- (VI)** The issuer of the policy provides regular reports to the Secretary, in accordance with regulations of the Secretary, that include notification regarding when benefits provided under the policy have been paid and the amount of such benefits paid, notification regarding when the policy otherwise terminates, and such other information as the Secretary determines may be appropriate to the administration of such partnerships.
- (VII)** The State does not impose any requirement affecting the terms or benefits of such a policy unless the State imposes such requirement on long-term care insurance policies without regard to whether the policy is covered under the partnership or is offered in connection with such a partnership.

In the case of a long-term care insurance policy which is exchanged for another such policy, subclause (I) shall be applied based on the coverage of the first such policy that was exchanged. For purposes of this clause and paragraph (5), the term “long-term care insurance policy” includes a certificate issued under a group insurance contract.

(iv) With respect to a State which had a State plan amendment approved as of May 14, 1993, such a State satisfies this clause for purposes of clause (ii) if the Secretary determines that the State plan amendment provides for consumer protection standards which are no less stringent than the consumer protection standards which applied under such State plan amendment as of December 31, 2005.

(v) The regulations of the Secretary required under clause (iii)(VI) shall be promulgated after consultation with the National Association of Insurance Commissioners, issuers of long-term care insurance policies, States with experience with long-term care insurance partnership plans, other States, and representatives of consumers of long-term care insurance policies, and shall specify the type and format of the data and information to be reported and the frequency with which such reports are to be made. The Secretary, as appropriate, shall provide copies of the reports provided in accordance with that clause to the State involved.

(vi) The Secretary, in consultation with other appropriate Federal agencies, issuers of long-term care insurance, the National Association of Insurance Commissioners, State insurance commissioners, States with experience with long-term care insurance partnership plans, other States, and representatives of consumers of long-term care insurance policies, shall develop recommendations for Congress to authorize and fund a uniform minimum data set to be reported electronically by all issuers of long-term care insurance policies under qualified State long-term care insurance partnerships to a secure, centralized electronic query and report-generating mechanism that the State, the Secretary, and other Federal agencies can access.

(2) Any adjustment or recovery under paragraph (1) may be made only after the death of the individual’s surviving spouse, if any, and only at a time—

(A) when he has no surviving child who is under age 21, or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1382c of this title; and

(B) in the case of a lien on an individual’s home under subsection (a)(1)(B) of this section, when—

(i) no sibling of the individual (who was residing in the individual’s home for a period of at least one year immediately before the date of the individual’s admission to the medical institution), and

(ii) no son or daughter of the individual (who was residing in the individual’s home for a period of at least two years immediately before the date of the individual’s admission to the medical institution, and who establishes to the satisfaction of the State that he or she provided care to such individual which permitted such individual to reside at home rather than in an institution),

is lawfully residing in such home who has lawfully resided in such home on a continuous basis since the date of the individual’s admission to the medical institution.

(3) (A) The State agency shall establish procedures (in accordance with standards specified by the Secretary) under which the agency shall waive the application of this subsection (other than paragraph (1)(C)) if such application would work an undue hardship as determined on the basis of criteria established by the Secretary.

- (B)** The standards specified by the Secretary under subparagraph (A) shall require that the procedures established by the State agency under subparagraph (A) exempt income, resources, and property that are exempt from the application of this subsection as of April 1, 2003, under manual instructions issued to carry out this subsection (as in effect on such date) because of the Federal responsibility for Indian Tribes and Alaska Native Villages. Nothing in this subparagraph shall be construed as preventing the Secretary from providing additional estate recovery exemptions under this subchapter for Indians.
- (4)** For purposes of this subsection, the term “estate”, with respect to a deceased individual—
- (A)** shall include all real and personal property and other assets included within the individual’s estate, as defined for purposes of State probate law; and
- (B)** may include, at the option of the State (and shall include, in the case of an individual to whom paragraph (1)(C)(i) applies), any other real and personal property and other assets in which the individual had any legal title or interest at the time of death (to the extent of such interest), including such assets conveyed to a survivor, heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement.
- (5)** **(A)** For purposes of clause (iii)(III), the model regulations and the requirements of the model Act specified in this paragraph are:
- (i)** In the case of the model regulation, the following requirements:
- (I)** Section 6A (relating to guaranteed renewal or noncancellability), other than paragraph (5) thereof, and the requirements of section 6B of the model Act relating to such section 6A.
- (II)** Section 6B (relating to prohibitions on limitations and exclusions) other than paragraph (7) thereof.
- (III)** Section 6C (relating to extension of benefits).
- (IV)** Section 6D (relating to continuation or conversion of coverage).
- (V)** Section 6E (relating to discontinuance and replacement of policies).
- (VI)** Section 7 (relating to unintentional lapse).
- (VII)** Section 8 (relating to disclosure), other than sections 8F, 8G, 8H, and 8I thereof.
- (VIII)** Section 9 (relating to required disclosure of rating practices to consumer).
- (IX)** Section 11 (relating to prohibitions against post-claims underwriting).
- (X)** Section 12 (relating to minimum standards).
- (XI)** Section 14 (relating to application forms and replacement coverage).
- (XII)** Section 15 (relating to reporting requirements).
- (XIII)** Section 22 (relating to filing requirements for marketing).
- (XIV)** Section 23 (relating to standards for marketing), including inaccurate completion of medical histories, other than paragraphs (1), (6), and (9) of section 23C.
- (XV)** Section 24 (relating to suitability).
- (XVI)** Section 25 (relating to prohibition against preexisting conditions and probationary periods in replacement policies or certificates).
- (XVII)** The provisions of section 26 relating to contingent nonforfeiture benefits, if the policyholder declines the offer of a nonforfeiture provision described in paragraph (4).
- (XVIII)** Section 29 (relating to standard format outline of coverage).
- (XIX)** Section 30 (relating to requirement to deliver shopper’s guide).

- (ii) In the case of the model Act, the following:
 - (I) Section 6C (relating to preexisting conditions).
 - (II) Section 6D (relating to prior hospitalization).
 - (III) The provisions of section 8 relating to contingent nonforfeiture benefits.
 - (IV) Section 6F (relating to right to return).
 - (V) Section 6G (relating to outline of coverage).
 - (VI) Section 6H (relating to requirements for certificates under group plans).
 - (VII) Section 6J (relating to policy summary).
 - (VIII) Section 6K (relating to monthly reports on accelerated death benefits).
 - (IX) Section 7 (relating to incontestability period).

(B) For purposes of this paragraph and paragraph (1)(C)—

- (i) the terms “model regulation” and “model Act” mean the long-term care insurance model regulation, and the long-term care insurance model Act, respectively, promulgated by the National Association of Insurance Commissioners (as adopted as of October 2000);
- (ii) any provision of the model regulation or model Act listed under subparagraph (A) shall be treated as including any other provision of such regulation or Act necessary to implement the provision; and
- (iii) with respect to a long-term care insurance policy issued in a State, the policy shall be deemed to meet applicable requirements of the model regulation or the model Act if the State plan amendment under paragraph (1)(C)(iii) provides that the State insurance commissioner for the State certifies (in a manner satisfactory to the Secretary) that the policy meets such requirements.

(C) Not later than 12 months after the National Association of Insurance Commissioners issues a revision, update, or other modification of a model regulation or model Act provision specified in subparagraph (A), or of any provision of such regulation or Act that is substantively related to a provision specified in such subparagraph, the Secretary shall review the changes made to the provision, determine whether incorporating such changes into the corresponding provision specified in such subparagraph would improve qualified State long-term care insurance partnerships, and if so, shall incorporate the changes into such provision.

(c) Taking into account certain transfers of assets

- (1)** **(A)** In order to meet the requirements of this subsection for purposes of section 1396a (a)(18) of this title, the State plan must provide that if an institutionalized individual or the spouse of such an individual (or, at the option of a State, a noninstitutionalized individual or the spouse of such an individual) disposes of assets for less than fair market value on or after the look-back date specified in subparagraph (B)(i), the individual is ineligible for medical assistance for services described in subparagraph (C)(i) (or, in the case of a noninstitutionalized individual, for the services described in subparagraph (C)(ii)) during the period beginning on the date specified in subparagraph (D) and equal to the number of months specified in subparagraph (E).
- (B)** **(i)** The look-back date specified in this subparagraph is a date that is 36 months (or, in the case of payments from a trust or portions of a trust that are treated as assets disposed of by the individual pursuant to paragraph (3)(A)(iii) or (3)(B)(ii) of subsection (d) of this section or in the case of any other disposal of assets made on or after February 8, 2006, 60 months) before the date specified in clause (ii).
- (ii)** The date specified in this clause, with respect to—

- (I) an institutionalized individual is the first date as of which the individual both is an institutionalized individual and has applied for medical assistance under the State plan, or
- (II) a noninstitutionalized individual is the date on which the individual applies for medical assistance under the State plan or, if later, the date on which the individual disposes of assets for less than fair market value.
- (C) (i) The services described in this subparagraph with respect to an institutionalized individual are the following:
- (I) Nursing facility services.
- (II) A level of care in any institution equivalent to that of nursing facility services.
- (III) Home or community-based services furnished under a waiver granted under subsection (c) or (d) of section 1396n of this title.
- (ii) The services described in this subparagraph with respect to a noninstitutionalized individual are services (not including any services described in clause (i)) that are described in paragraph (7), (22), or (24) of section 1396d (a) of this title, and, at the option of a State, other long-term care services for which medical assistance is otherwise available under the State plan to individuals requiring long-term care.
- (D) (i) In the case of a transfer of asset made before February 8, 2006, the date specified in this subparagraph is the first day of the first month during or after which assets have been transferred for less than fair market value and which does not occur in any other periods of ineligibility under this subsection.
- (ii) In the case of a transfer of asset made on or after February 8, 2006, the date specified in this subparagraph is the first day of a month during or after which assets have been transferred for less than fair market value, or the date on which the individual is eligible for medical assistance under the State plan and would otherwise be receiving institutional level care described in subparagraph (C) based on an approved application for such care but for the application of the penalty period, whichever is later, and which does not occur during any other period of ineligibility under this subsection.
- (E) (i) With respect to an institutionalized individual, the number of months of ineligibility under this subparagraph for an individual shall be equal to—
- (I) the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) on or after the look-back date specified in subparagraph (B)(i), divided by
- (II) the average monthly cost to a private patient of nursing facility services in the State (or, at the option of the State, in the community in which the individual is institutionalized) at the time of application.
- (ii) With respect to a noninstitutionalized individual, the number of months of ineligibility under this subparagraph for an individual shall not be greater than a number equal to—
- (I) the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) on or after the look-back date specified in subparagraph (B)(i), divided by
- (II) the average monthly cost to a private patient of nursing facility services in the State (or, at the option of the State, in the community in which the individual is institutionalized) at the time of application.
- (iii) The number of months of ineligibility otherwise determined under clause (i) or (ii) with respect to the disposal of an asset shall be reduced—

- (I)** in the case of periods of ineligibility determined under clause (i), by the number of months of ineligibility applicable to the individual under clause (ii) as a result of such disposal, and
- (II)** in the case of periods of ineligibility determined under clause (ii), by the number of months of ineligibility applicable to the individual under clause (i) as a result of such disposal.
- (iv)** A State shall not round down, or otherwise disregard any fractional period of ineligibility determined under clause (i) or (ii) with respect to the disposal of assets.
- (F)** For purposes of this paragraph, the purchase of an annuity shall be treated as the disposal of an asset for less than fair market value unless—
 - (i)** the State is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the institutionalized individual under this subchapter; or
 - (ii)** the State is named as such a beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if such spouse or a representative of such child disposes of any such remainder for less than fair market value.
- (G)** For purposes of this paragraph with respect to a transfer of assets, the term “assets” includes an annuity purchased by or on behalf of an annuitant who has applied for medical assistance with respect to nursing facility services or other long-term care services under this subchapter unless—
 - (i)** the annuity is—
 - (I)** an annuity described in subsection (b) or (q) of section 408 of the Internal Revenue Code of 1986; or
 - (II)** purchased with proceeds from—
 - (aa)** an account or trust described in subsection (a), (c), or (p) of section 408 of such Code;
 - (bb)** a simplified employee pension (within the meaning of section 408(k) of such Code); or
 - (cc)** a Roth IRA described in section 408A of such Code; or
 - (ii)** the annuity—
 - (I)** is irrevocable and nonassignable;
 - (II)** is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration); and
 - (III)** provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.
- (H)** Notwithstanding the preceding provisions of this paragraph, in the case of an individual (or individual’s spouse) who makes multiple fractional transfers of assets in more than 1 month for less than fair market value on or after the applicable look-back date specified in subparagraph (B), a State may determine the period of ineligibility applicable to such individual under this paragraph by—
 - (i)** treating the total, cumulative uncompensated value of all assets transferred by the individual (or individual’s spouse) during all months on or after the look-back date specified in subparagraph (B) as 1 transfer for purposes of clause (i) or (ii) (as the case may be) of subparagraph (E); and
 - (ii)** beginning such period on the earliest date which would apply under subparagraph (D) to any of such transfers.

(I) For purposes of this paragraph with respect to a transfer of assets, the term “assets” includes funds used to purchase a promissory note, loan, or mortgage unless such note, loan, or mortgage—

- (i)** has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration);
- (ii)** provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and
- (iii)** prohibits the cancellation of the balance upon the death of the lender.

In the case of a promissory note, loan, or mortgage that does not satisfy the requirements of clauses (i) through (iii), the value of such note, loan, or mortgage shall be the outstanding balance due as of the date of the individual’s application for medical assistance for services described in subparagraph (C).

(J) For purposes of this paragraph with respect to a transfer of assets, the term “assets” includes the purchase of a life estate interest in another individual’s home unless the purchaser resides in the home for a period of at least 1 year after the date of the purchase.

(2) An individual shall not be ineligible for medical assistance by reason of paragraph (1) to the extent that—

(A) the assets transferred were a home and title to the home was transferred to—

- (i)** the spouse of such individual;
- (ii)** a child of such individual who
 - (I)** is under age 21, or
 - (II)** (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1382c of this title;
- (iii)** a sibling of such individual who has an equity interest in such home and who was residing in such individual’s home for a period of at least one year immediately before the date the individual becomes an institutionalized individual; or
- (iv)** a son or daughter of such individual (other than a child described in clause (ii)) who was residing in such individual’s home for a period of at least two years immediately before the date the individual becomes an institutionalized individual, and who (as determined by the State) provided care to such individual which permitted such individual to reside at home rather than in such an institution or facility;

(B) the assets—

- (i)** were transferred to the individual’s spouse or to another for the sole benefit of the individual’s spouse,
- (ii)** were transferred from the individual’s spouse to another for the sole benefit of the individual’s spouse,
- (iii)** were transferred to, or to a trust (including a trust described in subsection (d)(4) of this section) established solely for the benefit of, the individual’s child described in subparagraph (A)(ii)(II), or
- (iv)** were transferred to a trust (including a trust described in subsection (d)(4) of this section) established solely for the benefit of an individual under 65 years of age who is disabled (as defined in section 1382c (a)(3) of this title);

(C) a satisfactory showing is made to the State (in accordance with regulations promulgated by the Secretary) that

- (i) the individual intended to dispose of the assets either at fair market value, or for other valuable consideration,
- (ii) the assets were transferred exclusively for a purpose other than to qualify for medical assistance, or
- (iii) all assets transferred for less than fair market value have been returned to the individual; or

(D) the State determines, under procedures established by the State (in accordance with standards specified by the Secretary), that the denial of eligibility would work an undue hardship as determined on the basis of criteria established by the Secretary.

The procedures established under subparagraph (D) shall permit the facility in which the institutionalized individual is residing to file an undue hardship waiver application on behalf of the individual with the consent of the individual or the personal representative of the individual. While an application for an undue hardship waiver is pending under subparagraph (D) in the case of an individual who is a resident of a nursing facility, if the application meets such criteria as the Secretary specifies, the State may provide for payments for nursing facility services in order to hold the bed for the individual at the facility, but not in excess of payments for 30 days.

(3) For purposes of this subsection, in the case of an asset held by an individual in common with another person or persons in a joint tenancy, tenancy in common, or similar arrangement, the asset (or the affected portion of such asset) shall be considered to be transferred by such individual when any action is taken, either by such individual or by any other person, that reduces or eliminates such individual's ownership or control of such asset.

(4) A State (including a State which has elected treatment under section 1396a (f) of this title) may not provide for any period of ineligibility for an individual due to transfer of resources for less than fair market value except in accordance with this subsection. In the case of a transfer by the spouse of an individual which results in a period of ineligibility for medical assistance under a State plan for such individual, a State shall, using a reasonable methodology (as specified by the Secretary), apportion such period of ineligibility (or any portion of such period) among the individual and the individual's spouse if the spouse otherwise becomes eligible for medical assistance under the State plan.

(5) In this subsection, the term "resources" has the meaning given such term in section 1382b of this title, without regard to the exclusion described in subsection (a)(1) thereof.

(d) Treatment of trust amounts

(1) For purposes of determining an individual's eligibility for, or amount of, benefits under a State plan under this subchapter, subject to paragraph (4), the rules specified in paragraph (3) shall apply to a trust established by such individual.

(2) (A) For purposes of this subsection, an individual shall be considered to have established a trust if assets of the individual were used to form all or part of the corpus of the trust and if any of the following individuals established such trust other than by will:

- (i) The individual.
- (ii) The individual's spouse.
- (iii) A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse.
- (iv) A person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

(B) In the case of a trust the corpus of which includes assets of an individual (as determined under subparagraph (A)) and assets of any other person or persons, the provisions of this subsection shall apply to the portion of the trust attributable to the assets of the individual.

(C) Subject to paragraph (4), this subsection shall apply without regard to—

- (i) the purposes for which a trust is established,
 - (ii) whether the trustees have or exercise any discretion under the trust,
 - (iii) any restrictions on when or whether distributions may be made from the trust, or
 - (iv) any restrictions on the use of distributions from the trust.
 - (3) (A) In the case of a revocable trust—
 - (i) the corpus of the trust shall be considered resources available to the individual,
 - (ii) payments from the trust to or for the benefit of the individual shall be considered income of the individual, and
 - (iii) any other payments from the trust shall be considered assets disposed of by the individual for purposes of subsection (c) of this section.
 - (B) In the case of an irrevocable trust—
 - (i) if there are any circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of the corpus from which, or the income on the corpus from which, payment to the individual could be made shall be considered resources available to the individual, and payments from that portion of the corpus or income—
 - (I) to or for the benefit of the individual, shall be considered income of the individual, and
 - (II) for any other purpose, shall be considered a transfer of assets by the individual subject to subsection (c) of this section; and
 - (ii) any portion of the trust from which, or any income on the corpus from which, no payment could under any circumstances be made to the individual shall be considered, as of the date of establishment of the trust (or, if later, the date on which payment to the individual was foreclosed) to be assets disposed by the individual for purposes of subsection (c) of this section, and the value of the trust shall be determined for purposes of such subsection by including the amount of any payments made from such portion of the trust after such date.
- (4) This subsection shall not apply to any of the following trusts:
 - (A) A trust containing the assets of an individual under age 65 who is disabled (as defined in section 1382c (a)(3) of this title) and which is established for the benefit of such individual by a parent, grandparent, legal guardian of the individual, or a court if the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual under a State plan under this subchapter.
 - (B) A trust established in a State for the benefit of an individual if—
 - (i) the trust is composed only of pension, Social Security, and other income to the individual (and accumulated income in the trust),
 - (ii) the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual under a State plan under this subchapter; and
 - (iii) the State makes medical assistance available to individuals described in section 1396a (a)(10)(A)(ii)(V) of this title, but does not make such assistance available to individuals for nursing facility services under section 1396a (a)(10)(C) of this title.
 - (C) A trust containing the assets of an individual who is disabled (as defined in section 1382c (a)(3) of this title) that meets the following conditions:
 - (i) The trust is established and managed by a non-profit association.
 - (ii) A separate account is maintained for each beneficiary of the trust, but, for purposes of investment and management of funds, the trust pools these accounts.

(iii) Accounts in the trust are established solely for the benefit of individuals who are disabled (as defined in section 1382c (a)(3) of this title) by the parent, grandparent, or legal guardian of such individuals, by such individuals, or by a court.

(iv) To the extent that amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the trust, the trust pays to the State from such remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary under the State plan under this subchapter.

(5) The State agency shall establish procedures (in accordance with standards specified by the Secretary) under which the agency waives the application of this subsection with respect to an individual if the individual establishes that such application would work an undue hardship on the individual as determined on the basis of criteria established by the Secretary.

(6) The term "trust" includes any legal instrument or device that is similar to a trust but includes an annuity only to such extent and in such manner as the Secretary specifies.

(e) Disclosure and treatment of annuities

(1) In order to meet the requirements of this section for purposes of section 1396a (a)(18) of this title, a State shall require, as a condition for the provision of medical assistance for services described in subsection (c)(1)(C)(i) (relating to long-term care services) for an individual, the application of the individual for such assistance (including any recertification of eligibility for such assistance) shall disclose a description of any interest the individual or community spouse has in an annuity (or similar financial instrument, as may be specified by the Secretary), regardless of whether the annuity is irrevocable or is treated as an asset. Such application or recertification form shall include a statement that under paragraph (2) the State becomes a remainder beneficiary under such an annuity or similar financial instrument by virtue of the provision of such medical assistance.

(2) (A) In the case of disclosure concerning an annuity under subsection (c)(1)(F), the State shall notify the issuer of the annuity of the right of the State under such subsection as a preferred remainder beneficiary in the annuity for medical assistance furnished to the individual. Nothing in this paragraph shall be construed as preventing such an issuer from notifying persons with any other remainder interest of the State's remainder interest under such subsection.

(B) In the case of such an issuer receiving notice under subparagraph (A), the State may require the issuer to notify the State when there is a change in the amount of income or principal being withdrawn from the amount that was being withdrawn at the time of the most recent disclosure described in paragraph (1). A State shall take such information into account in determining the amount of the State's obligations for medical assistance or in the individual's eligibility for such assistance.

(3) The Secretary may provide guidance to States on categories of transactions that may be treated as a transfer of asset for less than fair market value.

(4) Nothing in this subsection shall be construed as preventing a State from denying eligibility for medical assistance for an individual based on the income or resources derived from an annuity described in paragraph (1).

(f) Disqualification for long-term care assistance for individuals with substantial home equity

(1) (A) Notwithstanding any other provision of this subchapter, subject to subparagraphs (B) and (C) of this paragraph and paragraph (2), in determining eligibility of an individual for medical assistance with respect to nursing facility services or other long-term care services, the individual shall not be eligible for such assistance if the individual's equity interest in the individual's home exceeds \$500,000.

(B) A State may elect, without regard to the requirements of section 1396a (a)(1) of this title (relating to statewideness) and section 1396a (a)(10)(B) of this title (relating to comparability),

to apply subparagraph (A) by substituting for “\$500,000”, an amount that exceeds such amount, but does not exceed \$750,000.

(C) The dollar amounts specified in this paragraph shall be increased, beginning with 2011, from year to year based on the percentage increase in the consumer price index for all urban consumers (all items; United States city average), rounded to the nearest \$1,000.

(2) Paragraph (1) shall not apply with respect to an individual if—

(A) the spouse of such individual, or

(B) such individual’s child who is under age 21, or (with respect to States eligible to participate in the State program established under subchapter XVI) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1382c of this title,

is lawfully residing in the individual’s home.

(3) Nothing in this subsection shall be construed as preventing an individual from using a reverse mortgage or home equity loan to reduce the individual’s total equity interest in the home.

(4) The Secretary shall establish a process whereby paragraph (1) is waived in the case of a demonstrated hardship.

(g) Treatment of entrance fees of individuals residing in continuing care retirement communities

(1) In general

For purposes of determining an individual’s eligibility for, or amount of, benefits under a State plan under this subchapter, the rules specified in paragraph (2) shall apply to individuals residing in continuing care retirement communities or life care communities that collect an entrance fee on admission from such individuals.

(2) Treatment of entrance fee

For purposes of this subsection, an individual’s entrance fee in a continuing care retirement community or life care community shall be considered a resource available to the individual to the extent that—

(A) the individual has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, to pay for care should other resources or income of the individual be insufficient to pay for such care;

(B) the individual is eligible for a refund of any remaining entrance fee when the individual dies or terminates the continuing care retirement community or life care community contract and leaves the community; and

(C) the entrance fee does not confer an ownership interest in the continuing care retirement community or life care community.

(h) Definitions

In this section, the following definitions shall apply:

(1) The term “assets”, with respect to an individual, includes all income and resources of the individual and of the individual’s spouse, including any income or resources which the individual or such individual’s spouse is entitled to but does not receive because of action—

(A) by the individual or such individual’s spouse,

(B) by a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual’s spouse, or

(C) by any person, including any court or administrative body, acting at the direction or upon the request of the individual or such individual’s spouse.

(2) The term “income” has the meaning given such term in section 1382a of this title.

NB: This unofficial compilation of the U.S. Code is current as of Jan. 4, 2012 (see <http://www.law.cornell.edu/uscode/uscodeprint.html>).

(3) The term “institutionalized individual” means an individual who is an inpatient in a nursing facility, who is an inpatient in a medical institution and with respect to whom payment is made based on a level of care provided in a nursing facility, or who is described in section 1396a (a)(10)(A)(ii)(VI) of this title.

(4) The term “noninstitutionalized individual” means an individual receiving any of the services specified in subsection (c)(1)(C)(ii) of this section.

(5) The term “resources” has the meaning given such term in section 1382b of this title, without regard (in the case of an institutionalized individual) to the exclusion described in subsection (a)(1) of such section.

(Aug. 14, 1935, ch. 531, title XIX, § 1917, as added Pub. L. 97–248, title I, § 132(b), Sept. 3, 1982, 96 Stat. 370; amended Pub. L. 97–448, title III, § 309(b)(21), (22), Jan. 12, 1983, 96 Stat. 2410; Pub. L. 100–203, title IV, § 4211(h)(12), Dec. 22, 1987, 101 Stat. 1330–207; Pub. L. 100–360, title III, § 303(b), title IV, § 411(l)(3)(I), July 1, 1988, 102 Stat. 760, 803; Pub. L. 100–485, title VI, § 608(d)(16)(B), Oct. 13, 1988, 102 Stat. 2417; Pub. L. 101–239, title VI, § 6411(e)(1), Dec. 19, 1989, 103 Stat. 2271; Pub. L. 103–66, title XIII, §§ 13611(a)–(c), 13612(a)–(c), Aug. 10, 1993, 107 Stat. 622–628; Pub. L. 109–171, title VI, §§ 6011(a), (b), (e), 6012 (a)–(c), 6014(a), 6015(b), 6016(a)–(d), 6021(a)(1), Feb. 8, 2006, 120 Stat. 61–68; Pub. L. 109–432, div. B, title IV, § 405(b)(1), Dec. 20, 2006, 120 Stat. 2998; Pub. L. 110–275, title I, § 115(a), July 15, 2008, 122 Stat. 2507; Pub. L. 111–5, div. B, title V, § 5006(c), Feb. 17, 2009, 123 Stat. 507.)

References in Text

The Internal Revenue Code of 1986, referred to in subsecs. (b)(1)(C)(iii)(II) and (c)(1)(G)(i), is classified generally to Title 26, Internal Revenue Code.

Amendments

2009—Subsec. (b)(3). Pub. L. 111–5 designated existing provisions as subpar. (A) and added subpar. (B)

2008—Subsec. (b)(1)(B)(ii). Pub. L. 110–275 inserted “(but not including medical assistance for medicare cost-sharing or for benefits described in section 1396a (a)(10)(E) of this title)” before period at end.

2006—Subsec. (b)(1)(C)(ii). Pub. L. 109–171, § 6021(a)(1)(A)(i), inserted “and which satisfies clause (iv), or which has a State plan amendment that provides for a qualified State long-term care insurance partnership (as defined in clause (iii))” after “1993,” in introductory provisions.

Subsec. (b)(1)(C)(iii) to (vi). Pub. L. 109–171, § 6021(a)(1)(A)(ii), added cls. (iii) to (vi).

Subsec. (b)(5). Pub. L. 109–171, § 6021(a)(1)(B), added par. (5).

Subsec. (c)(1)(B)(i). Pub. L. 109–171, § 6011(a), inserted “or in the case of any other disposal of assets made on or after February 8, 2006” before “, 60 months”.

Subsec. (c)(1)(D). Pub. L. 109–171, § 6011(b), designated existing provisions as cl. (i), substituted “In the case of a transfer of asset made before February 8, 2006, the date” for “The date”, and added cl. (ii).

Subsec. (c)(1)(E)(iv). Pub. L. 109–171, § 6016(a), added cl. (iv).

Subsec. (c)(1)(F). Pub. L. 109–171, § 6012(b), added subpar. (F).

Subsec. (c)(1)(F)(i). Pub. L. 109–432 substituted “institutionalized individual” for “annuitant”.

Subsec. (c)(1)(G). Pub. L. 109–171, § 6012(c), added subpar. (G).

Subsec. (c)(1)(H). Pub. L. 109–171, § 6016(b), added subpar. (H).

Subsec. (c)(1)(I). Pub. L. 109–171, § 6016(c), added subpar. (I).

Subsec. (c)(1)(J). Pub. L. 109–171, § 6016(d), added subpar. (J).

Subsec. (c)(2). Pub. L. 109–171, § 6011(e), substituted period for semicolon at end and inserted concluding provisions.

Subsec. (e). Pub. L. 109–171, § 6012(a), added subsec. (e). Former subsec. (e) redesignated (f).

Subsec. (f). Pub. L. 109–171, § 6014(a), added subsec. (f). Former subsec. (f) redesignated (g).

NB: This unofficial compilation of the U.S. Code is current as of Jan. 4, 2012 (see <http://www.law.cornell.edu/uscode/uscprint.html>).

Pub. L. 109–171, § 6012(a), redesignated subsec. (e) as (f).

Subsec. (g). Pub. L. 109–171, § 6015(b), added subsec. (g). Former subsec. (g) redesignated (h).

Pub. L. 109–171, § 6014(a), redesignated subsec. (f) as (g).

Subsec. (h). Pub. L. 109–171, § 6015(b), redesignated subsec. (g) as (h).

1993—Subsec. (b)(1). Pub. L. 103–66, § 13612(a), substituted “except that the State shall seek adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan in the case of the following individuals:” and subpars. (A) to (C) for “except—” and former subpars. (A) and (B) which read as follows:

“(A) in the case of an individual described in subsection (a)(1)(B) of this section, from his estate or upon sale of the property subject to a lien imposed on account of medical assistance paid on behalf of such individual, and

“(B) in the case of any other individual who was 65 years of age or older when he received such assistance, from his estate.”

Subsec. (b)(3). Pub. L. 103–66, § 13612(b), added par. (3).

Subsec. (b)(4). Pub. L. 103–66, § 13612(c), added par. (4).

Subsec. (c)(1). Pub. L. 103–66, § 13611(a)(1), amended par. (1) generally. Prior to amendment, par. (1) read as follows: “In order to meet the requirements of this subsection (for purposes of section 1396a (a)(51)(B) of this title), the State plan must provide for a period of ineligibility for nursing facility services and for a level of care in a medical institution equivalent to that of nursing facility services and for services under section 1396n (c) of this title in the case of an institutionalized individual (as defined in paragraph (3)) who, or whose spouse, at any time during or after the 30-month period immediately before the date the individual becomes an institutionalized individual (if the individual is entitled to medical assistance under the State plan on such date) or, if the individual is not so entitled, the date the individual applies for such assistance while an institutionalized individual, disposed of resources for less than fair market value. The period of ineligibility shall begin with the month in which such resources were transferred and the number of months in such period shall be equal to the lesser of—

“(A) 30 months, or

“(B)(i) the total uncompensated value of the resources so transferred, divided by (ii) the average cost, to a private patient at the time of the application, of nursing facility services in the State or, at State option, in the community in which the individual is institutionalized.”

Subsec. (c)(2)(A). Pub. L. 103–66, § 13611(a)(2)(A), substituted “assets” for “resources” in introductory provisions.

Subsec. (c)(2)(B). Pub. L. 103–66, § 13611(a)(2)(B), amended subpar. (B) generally. Prior to amendment, subpar. (B) read as follows: “the resources were transferred (i) to or from (or to another for the sole benefit of) the individual’s spouse, or (ii) to the individual’s child described in subparagraph (A)(ii)(II);”

Subsec. (c)(2)(C). Pub. L. 103–66, § 13611(a)(2)(C), in introductory provisions, substituted “with regulations” for “with any regulations”, in cl. (i), substituted “assets” for “resources” and struck out “or” at end, in cl. (ii), substituted “assets” for “resources” and “, or” for “; or”, and added cl. (iii).

Subsec. (c)(2)(D). Pub. L. 103–66, § 13611(a)(2)(D), amended subpar. (D) generally. Prior to amendment, subpar. (D) read as follows: “the State determines that denial of eligibility would work an undue hardship.”

Subsec. (c)(3). Pub. L. 103–66, § 13611(a)(2)(E), added par. (3) and struck out former par. (3) which read as follows: “In this subsection, the term ‘institutionalized individual’ means an individual who is an inpatient in a nursing facility, who is an inpatient in a medical institution and with respect to whom payment is made based on a level of care provided in a nursing facility, or who is described in section 1396a (a)(10)(A)(ii)(VI) of this title.”

Subsec. (c)(4). Pub. L. 103–66, § 13611(a)(2)(F), inserted at end “In the case of a transfer by the spouse of an individual which results in a period of ineligibility for medical assistance under a State plan for such individual, a State shall, using a reasonable methodology (as specified by the Secretary), apportion such period of ineligibility (or any portion of such period) among the individual and the individual’s spouse if the spouse otherwise becomes eligible for medical assistance under the State plan.”

Subsec. (d). Pub. L. 103–66, § 13611(b), added subsec. (d).

Subsec. (e). Pub. L. 103–66, § 13611(c), added subsec. (e).

1989—Subsec. (c)(1). Pub. L. 101–239, § 6411(e)(1)(A), inserted “or whose spouse,” after “an institutionalized individual (as defined in paragraph (3)) who,”.

Subsec. (c)(2)(B)(i). Pub. L. 101–239, § 6411(e)(1)(B)(i), amended cl. (i) generally. Prior to amendment, cl. (i) read as follows: “to (or to another for the sole benefit of) the community spouse, as defined in section 1396r–5 (h)(2) of this title,,”.

NB: This unofficial compilation of the U.S. Code is current as of Jan. 4, 2012 (see <http://www.law.cornell.edu/uscode/uscp.html>).

Subsec. (c)(2)(B)(ii), (iii). Pub. L. 101–239, § 6411(e)(1)(B)(ii), struck out “, or” after “subparagraph (A)(ii)(II)” in cl. (ii) and struck out cl. (iii) which read as follows: “to (or to another for the sole benefit of) the individual’s spouse if such spouse does not transfer such resources to another person other than the spouse for less than fair market value”.

1988—Subsec. (c). Pub. L. 100–360, § 303(b), amended subsec. (c) generally, substituting pars. (1) to (4) relating to taking into account certain transfers of assets, for former pars. (1) to (3) relating to denial of medical assistance, period of eligibility, and exceptions.

Subsec. (c)(1). Pub. L. 100–485, § 608(d)(16)(B)(i), substituted “period of ineligibility for nursing facility services and for a level of care in a medical institution equivalent to that of nursing facility services and for services under section 1396n (c) of this title in the case of an institutionalized individual (as defined in paragraph (3)) who, at any time during or after the 30-month period immediately before the date the individual becomes an institutionalized individual (if the individual is entitled to medical assistance under the State plan on such date) or, if the individual is not so entitled, the date the individual applies for such assistance while an institutionalized individual” for “period of ineligibility in the case of an institutionalized individual (as defined in paragraph (3)) who, at any time during the 30-month period immediately before the individual’s application for medical assistance under the State plan”.

Subsec. (c)(2)(A)(ii). Pub. L. 100–485, § 608(d)(16)(B)(ii), inserted subcl. (I) and (II) designations.

Subsec. (c)(2)(A)(iii). Pub. L. 100–485, § 608(d)(16)(B)(iii), substituted “the individual becomes an institutionalized individual” for “of the individual’s admission to the medical institution or nursing facility”.

Subsec. (c)(2)(A)(iv). Pub. L. 100–485, § 608(d)(16)(B)(iv), substituted “the individual becomes an institutionalized individual” for “of such individual’s admission to the medical institution or nursing facility”.

Subsec. (c)(2)(B). Pub. L. 100–485, § 608(d)(16)(B)(v), inserted cl. (i) designation, substituted “section 1396r–5 (h)(2) of this title,” for “section 1396r–5 (h)(2) of this title, or the individual’s child who is blind or permanently and totally disabled”, and added cl. (ii).

Subsec. (c)(2)(B)(ii). Pub. L. 100–360, § 411(l)(3)(I), amended Pub. L. 100–203, § 4211(h)(12)(B), see 1987 Amendment note below.

Subsec. (c)(3). Pub. L. 100–485, § 608(d)(16)(B)(vi), substituted “in a nursing facility, who is an inpatient in a medical institution and with respect to whom payment is made based on a level of care provided in a nursing facility, or who is described in section 1396a (a)(10)(A)(ii)(VI) of this title” for “in a medical institution or nursing facility”.

Subsec. (c)(5). Pub. L. 100–485, § 608(d)(16)(B)(vii), added par. (5).

1987—Subsecs. (a)(1)(B)(i), (c)(2)(B)(i). Pub. L. 100–203, § 4211(h)(12)(A), substituted “nursing facility, intermediate care facility for the mentally retarded” for “skilled nursing facility, intermediate care facility”.

Subsec. (c)(2)(B)(ii). Pub. L. 100–203, § 4211(h)(12)(B), as amended by Pub. L. 100–360, § 411(l)(3)(I), substituted “a nursing facility” for “a skilled nursing facility” in two places each in subcls. (I) and (II).

1983—Subsec. (b)(2)(B). Pub. L. 97–448, § 309(b)(21), substituted “who” for “and” before “has lawfully resided”.

Subsec. (c)(2)(B)(iii). Pub. L. 97–448, § 309(b)(22), substituted in subcl. (I) “can” for “cannot” and struck out from subcl. (IV) the introductory word “if”.

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 2008 Amendment

Pub. L. 110–275, title I, § 115(b), July 15, 2008, 122 Stat. 2507, provided that: “The amendment made by subsection (a) [amending this section] shall take effect as of January 1, 2010.”

Effective Date of 2006 Amendment

Pub. L. 109–432, div. B, title IV, § 405(b)(2), Dec. 20, 2006, 120 Stat. 2998, provided that: “The amendment made by paragraph (1) [amending this section] shall be effective as if included in the enactment of section 6012 of the Deficit Reduction Act of 2005 [Pub. L. 109–171].”

Pub. L. 109–171, title VI, § 6011(c), Feb. 8, 2006, 120 Stat. 62, provided that: “The amendments made by this section [amending this section] shall apply to transfers made on or after the date of the enactment of this Act [Feb. 8, 2006].”

Pub. L. 109–171, title VI, § 6012(d), Feb. 8, 2006, 120 Stat. 64, provided that: “The amendments made by this section [amending this section] shall apply to transactions (including the purchase of an annuity) occurring on or after the date of the enactment of this Act [Feb. 8, 2006].”

NB: This unofficial compilation of the U.S. Code is current as of Jan. 4, 2012 (see <http://www.law.cornell.edu/uscode/uscprint.html>).

Pub. L. 109–171, title VI, § 6014(b), Feb. 8, 2006, 120 Stat. 65, provided that: “The amendment made by subsection (a) [amending this section] shall apply to individuals who are determined eligible for medical assistance with respect to nursing facility services or other long-term care services based on an application filed on or after January 1, 2006.”

Pub. L. 109–171, title VI, § 6016(e), Feb. 8, 2006, 120 Stat. 67, provided that:

“(1) In general.—Except as provided in paragraphs (2) and (3), the amendments made by this section [amending this section] shall apply to payments under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) for calendar quarters beginning on or after the date of enactment of this Act [Feb. 8, 2006], without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

“(2) Exceptions.—The amendments made by this section shall not apply—

“(A) to medical assistance provided for services furnished before the date of enactment;

“(B) with respect to assets disposed of on or before the date of enactment of this Act; or

“(C) with respect to trusts established on or before the date of enactment of this Act.

“(3) Extension of effective date for state law amendment.—In the case of a State plan 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 a provision of 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. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session is considered to be a separate regular session of the State legislature.”

Effective Date of 1993 Amendment

Section 13611(e) of Pub. L. 103–66 provided that:

“(1) The amendments made by this section [amending this section and sections 1396a and 1396r–5 of this title] shall apply, except as provided in this subsection, to payments under title XIX of the Social Security Act [this subchapter] for calendar quarters beginning on or after October 1, 1993, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

“(2) The amendments made by this section shall not apply—

“(A) to medical assistance provided for services furnished before October 1, 1993,

“(B) with respect to assets disposed of on or before the date of the enactment of this Act [Aug. 10, 1993], or

“(C) with respect to trusts established on or before the date of the enactment of this Act.

“(3) In the case of a State plan for medical assistance under title XIX of the Social Security Act [this subchapter] which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendment made by subsection (b) [amending this section], the State plan shall not be regarded as failing to comply with the requirements imposed by such amendment 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 [Aug. 10, 1993]. For purposes of the preceding sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.”

Section 13612(d) of Pub. L. 103–66 provided that:

“(1)(A) Except as provided in subparagraph (B), the amendments made by this section [amending this section] shall apply to payments under title XIX of the Social Security Act [this subchapter] for calendar quarters beginning on or after October 1, 1993, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

“(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) 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 imposed by such amendments 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 [Aug. 10, 1993]. For purposes of the preceding sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

“(2) The amendments made by this section shall not apply to individuals who died before October 1, 1993.”

Effective Date of 1989 Amendment

Amendment by Pub. L. 101–239 applicable to transfers occurring after Dec. 19, 1989, see section 6411(e)(4) of Pub. L. 101–239, set out as a note under section 1396a of this title.

Effective Date of 1988 Amendments

Amendment by Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Amendment by section 303(b) of Pub. L. 100–360 applicable to payments under this subchapter for calendar quarters beginning on or after July 1, 1988 (except in certain situations requiring State legislative action), without regard to whether or not final regulations to carry out such amendment have been promulgated by such date, and subsection (c) of this section, as amended by section 303(b) of Pub. L. 100–360, applicable to resources disposed of on or after July 1, 1988, but not applicable with respect to inter-spousal transfers occurring before Oct. 1, 1989, see section 303(g)(2), (5) of Pub. L. 100–360, set out as an Effective Date note under section 1396r–5 of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(1)(3)(I) of 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

Amendment by 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 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

Section 132(d) of Pub. L. 97–248 provided that: “The amendments made by this section [enacting this section and amending section 1396a of this title] shall become effective on the date of the enactment of this Act [Sept. 3, 1982], but the provisions of section 1917(c)(2)(B) of the Social Security Act [subsec. (c)(2)(B) of this section] shall not apply with respect to a transfer of assets which took place prior to such date of enactment.”

Availability of Hardship Waivers

Pub. L. 109–171, title VI, § 6011(d), Feb. 8, 2006, 120 Stat. 62, provided that: “Each State shall provide for a hardship waiver process in accordance with section 1917(c)(2)(D) of the Social Security Act (42 U.S.C. 1396p (c)(2)(D))—

“(1) under which an undue hardship exists when application of the transfer of assets provision would deprive the individual—

“(A) of medical care such that the individual’s health or life would be endangered; or

“(B) of food, clothing, shelter, or other necessities of life; and

“(2) which provides for—

“(A) notice to recipients that an undue hardship exception exists;

“(B) a timely process for determining whether an undue hardship waiver will be granted; and

“(C) a process under which an adverse determination can be appealed.”

Expansion of State Long-Term Care Partnership Program

Pub. L. 109–171, title VI, § 6021, Feb. 8, 2006, 120 Stat. 68, as amended by Pub. L. 111–148, title VIII, § 8002(d), title X, § 10801(c), Mar. 23, 2010, 124 Stat. 847, 1015, provided that:

“(a) Expansion Authority.—

“(1) In general.—[Amended this section.]

NB: This unofficial compilation of the U.S. Code is current as of Jan. 4, 2012 (see <http://www.law.cornell.edu/uscode/uscprint.html>).

“(2) State reporting requirements.—Nothing in clauses (iii)(VI) and (v) of section 1917(b)(1)(C) of the Social Security Act [subsec. (b)(1)(C)(iii)(VI), (v) of this section] (as added by paragraph (1)) shall be construed as prohibiting a State from requiring an issuer of a long-term care insurance policy sold in the State (regardless of whether the policy is issued under a qualified State long-term care insurance partnership under section 1917(b)(1)(C)(iii) of such Act) to require the issuer to report information or data to the State that is in addition to the information or data required under such clauses.

“(3) Effective date.—A State plan amendment that provides for a qualified State long-term care insurance partnership under the amendments made by paragraph (1) may provide that such amendment is effective for long-term care insurance policies issued on or after a date, specified in the amendment, that is not earlier than the first day of the first calendar quarter in which the plan amendment was submitted to the Secretary of Health and Human Services.

“(b) Standards for Reciprocal Recognition Among Partnership States.—In order to permit portability in long-term care insurance policies purchased under State long-term care insurance partnerships, the Secretary of Health and Human Services shall develop, not later than January 1, 2007, and in consultation with the National Association of Insurance Commissioners, issuers of long-term care insurance policies, States with experience with long-term care insurance partnership plans, other States, and representatives of consumers of long-term care insurance policies, standards for uniform reciprocal recognition of such policies among States with qualified State long-term care insurance partnerships under which—

“(1) benefits paid under such policies will be treated the same by all such States; and

“(2) States with such partnerships shall be subject to such standards unless the State notifies the Secretary in writing of the State’s election to be exempt from such standards.

“(c) Annual Reports to Congress.—

“(1) In general.—The Secretary of Health and Human Services shall annually report to Congress on the long-term care insurance partnerships established in accordance with section 1917(b)(1)(C)(ii) of the Social Security Act (42 U.S.C. 1396p (b)(1)(C)(ii)) (as amended by subsection (a)(1)). Such reports shall include analyses of the extent to which such partnerships expand or limit access of individuals to long-term care and the impact of such partnerships on Federal and State expenditures under the Medicare and Medicaid programs. Nothing in this section shall be construed as requiring the Secretary to conduct an independent review of each long-term care insurance policy offered under or in connection with such a partnership.

“(2) 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 paragraph (1).

“(d) National Clearinghouse for Long-Term Care Information.—

“(1) Establishment.—The Secretary of Health and Human Services shall establish a National Clearinghouse for Long-Term Care Information. The Clearinghouse may be established through a contract or interagency agreement.

“(2) Duties.—

“(A) In general.—The National Clearinghouse for Long-Term Care Information shall—

“(i) educate consumers with respect to the availability and limitations of coverage for long-term care under the Medicaid program and provide contact information for obtaining State-specific information on long-term care coverage, including eligibility and estate recovery requirements under State Medicaid programs;

“(ii) provide objective information to assist consumers with the decisionmaking process for determining whether to purchase long-term care insurance or to pursue other private market alternatives for purchasing long-term care and provide contact information for additional objective resources on planning for long-term care needs;

“(iii) maintain a list of States with State long-term care insurance partnerships under the Medicaid program that provide reciprocal recognition of long-term care insurance policies issued under such partnerships; and

“(iv) include information regarding the CLASS program established under title XXXII of the Public Health Service Act [42 U.S.C. 300ll et seq.] and information regarding how benefits provided under a CLASS Independence Benefit Plan differ from disability insurance benefits.

“(B) Requirement.—In providing information to consumers on long-term care in accordance with this subsection, the National Clearinghouse for Long-Term Care Information shall not advocate in favor of a specific long-term care insurance provider or a specific long-term care insurance policy.

“(3) Appropriation.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to carry out this subsection, \$3,000,000 for each of fiscal years 2006 through 2015.”