§ 440.315 Exempt individuals.

Individuals within one (or more) of the following categories are exempt from mandatory enrollment in benchmark or benchmark-equivalent coverage.

(a) The individual is a pregnant woman who is required to be covered under the State plan under section 1902(a)(10)(A)(i) of the Act.

(b) The individual qualifies for medical assistance under the State plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for Supplemental Security Income benefits under title XVI on the basis of being blind or disabled and including an individual who is eligible for medical assistance on the basis of section 1902(e)(3) of the Act.

(c) The individual is entitled to benefits under any part of Medicare.

(d) The individual is terminally ill and is receiving benefits for hospice care under title XIX.

(e) The individual is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, and is required, as a condition of receiving services in that 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.

(f) The individual is medically frail or otherwise an individual with special medical needs. For these purposes, the State’s definition of individuals who are medically frail or otherwise have special medical needs must at least include those individuals described in § 438.50(d)(3) of this chapter, children with serious emotional disturbances, individuals with disabling mental disorders, individuals with serious and complex medical conditions, and individuals with physical and/or mental disabilities that significantly impair their ability to perform one or more activities of daily living.

(g) The individual qualifies based on medical condition for medical assistance for long-term care services described in section 1917(c)(1)(C) of the Act.

(h) The individual is an individual with respect to whom child welfare services are made available under part B of title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of title IV, without regard to age.

(i) The individual is a parent or caretaker relative whom the State is required to cover under section 1931 of the Act.

(j) The individual is a woman who is receiving medical assistance by virtue of the application of sections 1902(a)(10)(ii)(XVIII) and 1902(aa) of the Act.


(l) The individual is only covered by Medicaid for care and services necessary for the treatment of an emergency medical condition in accordance with section 1903(v) of the Act.

(m) The individual is determined eligible as medically needy or eligible because of a reduction of countable income based on costs incurred for medical or other remedial care under section 1902(f) of the Act or otherwise based on incurred medical costs.

§ 440.320 State plan requirements: Optional enrollment for exempt individuals.

(a) General rule. A State plan that offers exempt individuals as defined in § 440.315 the option to enroll in benchmark or benchmark-equivalent coverage must identify in its State plan the exempt groups for which this coverage is available, and must comply with the following provisions:

(1) In any case in which the State offers an exempt individual the option to obtain coverage in a benchmark or benchmark-equivalent benefit package, the State must effectively inform the individual prior to enrollment that the enrollment is voluntary and that the individual may disenroll from the benchmark or benchmark-equivalent coverage at any time and regain immediate access to standard full Medicaid coverage under the State plan.
(2) Prior to any enrollment in benchmark or benchmark-equivalent coverage, the State must inform the exempt individual of the benefits available under the benchmark or benchmark-equivalent benefit package and the costs under such a package and provide a comparison of how they differ from the benefits and costs available under the standard full Medicaid program. The State must also inform exempt individuals that they may disenroll at any time and provide them with information about the process for disenrolling.

(3) The State must document in the exempt individual’s eligibility file that the individual was informed in accordance with this section prior to enrollment, was given ample time to arrive at an informed choice, and voluntarily and affirmatively chose to enroll in the benchmark or benchmark-equivalent benefit package.

(4) For individuals who the State determines have become exempt individuals while enrolled in benchmark or benchmark-equivalent coverage, the State must comply with the requirements in paragraphs (a)(1) through (a)(3) of this section above within 30 days after such determination.

(b) Disenrollment Process. (1) The State must act upon requests promptly for exempt individuals who choose to disenroll from benchmark or benchmark-equivalent coverage.

(2) The State must have a process in place to ensure that exempt individuals have access to all standard State plan services while disenrollment requests are being processed.

(3) The State must maintain data that tracks the total number of beneficiaries that have voluntarily enrolled in a benchmark plan and the total number of individuals that have disenrolled from the benchmark plan.

§ 440.325 State plan requirements: Coverage and benefits.

Subject to requirements in §§ 440.345 and 440.365, States may elect to provide any of the following types of health benefits coverage:

(a) Benchmark coverage in accordance with § 440.330.

(b) Benchmark-equivalent coverage in accordance with § 440.335.

§ 440.330 Benchmark health benefits coverage.

Benchmark coverage is health benefits coverage that is equal to the coverage under one or more of the following benefit plans:

(a) Federal Employees Health Benefit Plan Equivalent Coverage (FEHBP—Equivalent Health Insurance Coverage). A benefit plan equivalent to the standard Blue Cross/Blue Shield preferred provider option service benefit plan that is described in and offered to Federal employees under 5 U.S.C. 8903(1).

(b) State employee coverage. Health benefits coverage that is offered and generally available to State employees in the State.

(c) Health maintenance organization (HMO) plan. A health insurance plan that is offered through an HMO, as defined in section 2791(b)(3) of the Public Health Service Act) that has the largest insured commercial, non-Medicaid enrollment in the State.

(d) Secretary-approved coverage. Any other health benefits coverage that the Secretary determines, upon application by a State, provides appropriate coverage to meet the needs of the population provided that coverage. States wishing to elect Secretarial approved coverage should submit a full description of the proposed coverage, (including a benefit-by-benefit comparison of the proposed plan to one or more of the three other benchmark plans specified above or to the State’s standard full Medicaid coverage package under section 1905(a) of the Act), and of the population to which the coverage would be offered. In addition, the State should submit any other information that would be relevant to a determination that the proposed health benefits coverage would be appropriate for the proposed population. The scope of a Secretary-approved health benefits package will be limited to benefits within the scope of the categories available under a benchmark coverage package or the standard full Medicaid coverage package under section 1905(a) of the Act.

§ 440.335 Benchmark-equivalent health benefits coverage.

(a) Aggregate actuarial value. Benchmark-equivalent coverage is health