§ 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 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 coverage that apply more restrictive criteria than the Supplemental Security Income program, the State plan criteria.

(h) The individual is eligible and enrolled for Medicaid under §435.145 of this chapter based on current eligibility for assistance under title IV–E of the Act or under §435.150 of this chapter based on current status as a former foster care child.
benchmark or benchmark-equivalent benefit package.

(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 Secretarial-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.

EFFECTIVE DATE NOTE: At 78 FR 42306, July 15, 2013, § 440.330 was amended by revising paragraph (d), effective Jan. 1, 2014. For the convenience of the user, the revised text is set forth as follows:

§ 440.330 Benchmark health benefits coverage.

* * * * *

(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. Secretarial coverage may include benefits of the type that are available under 1 or more of the standard benchmark coverage packages defined in paragraphs (a) through (c) of this section, State plan benefits described in section 1905(a), 1915(i), 1915(j), 1915(k) or section 1945 of the Act, any other Medicaid State plan benefits enacted under title XIX, or benefits available under base benchmark plans described in 45 CFR 156.100.

(1) States wishing to elect Secretary-approved coverage should submit a full description of the proposed coverage (including a