

**TITLE 10. INVESTMENT
CHAPTER 5.8. MANAGED RISK MEDICAL INSURANCE BOARD HEALTHY
FAMILIES PROGRAM**

**ARTICLE 1. DEFINITIONS
Section 2699.6500**

**ARTICLE 3. HEALTH, DENTAL AND VISION BENEFITS
Sections 2699.6700, 2699.6707, and 2699.6721**

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Text proposed to be deleted since March 17, 2010, Board meeting is displayed in ~~**double underline**~~ text.

Section 2699.6500 is amended to read:

§ 2699.6500. Definitions.

- (a) "Access for Infants and Mothers (AIM) Program" means the State funded program operated pursuant to Part 6.3 (commencing with Section 12695) of Division 2 of the California Insurance Code, and that provides low-cost health care coverage for pregnant women and the newborns of subscribers who are enrolled in the AIM program prior to July 1, 2004.
- (b) "Agriculture" means farming in all its branches and includes; the cultivation and tillage of the soil, the production of dairy products, the production, cultivation growing, and harvesting of any agricultural or horticultural commodities, the raising of livestock, bees, forbearing animals, or poultry, any practice performed by a farmer or on a farm as an incident to or in conjunction with such farming operations, including preparation for market, delivery to storage or to market or to carriers for transportation to market.
- (c) "AIM infant" means a child born to an AIM subscriber who is enrolled in the AIM program on or after July 1, 2004.
- (d) "Alaskan Native" means any person who is an Eskimo or Aleut or other Alaska Native enrolled by the Secretary of the Interior pursuant to the Alaska Native Claims Settlement Act, 43 U.S.C. 1601.

- (e) "American Indian" means any person who is eligible under federal law (25 U.S.C. Section 1603) to receive health services provided directly by the United States Department of Health and Human Services, Indian Health Service, or by a tribal or an urban Indian health program funded by the Indian Health Service to provide health services to eligible individuals either directly or by contract.
- (f) "Anniversary date" means the day each year that corresponds to the day and month a person's coverage began in the program.
- (g) "Applicant" means:
- (1) A person age 18 or over who is a parent; a legal guardian; or a caretaker relative, foster parent, or stepparent with whom the child resides, who applies for coverage under the program on behalf of a child.
 - (2) A person who is applying for coverage on his or her own behalf and who is 18 years of age; or an emancipated minor; or a minor not living in the home of a parent, a legal guardian, caretaker relative, foster parent, or stepparent.
 - (3) A minor who is applying for coverage on behalf of his or her child.
 - (4) A person who is age 19 or over and who is applying for coverage on his or her own behalf and/or that of another child-linked adult.
- (h) (1) "Benefit year" means the twelve (12) month period commencing July 1 of each year at 12:01 a.m.
- (2) For the benefit year commencing July 1, 2009, "benefit year" shall mean the fifteen (15) month period commencing July 1, 2009 at 12:01 a.m. through September 30, 2010, and ending October 1, 2010 at 12:01 a.m.
- (3) Commencing October 1, 2010, "benefit year" shall mean the twelve (12) month period commencing October 1 of each year at 12:01 a.m. and ending the following October 1 at 12:01 a.m.
- (i) "Board" means the Managed Risk Medical Insurance Board.

* * * [Continued]

Note: Authority cited: Sections 12693.21, 12693.22 and 12693.755, Insurance Code.
Reference: Sections 12693.02, 12693.03, 12693.045, 12693.06, 12693.065, 12693.08, 12693.09, 12693.10, 12693.70, 12693.105, 12693.11, 12693.12,

12693.13, 12693.14, 12693.16, 12693.17, 12693.22, 12693.755 and 12693.91, Insurance Code.

Section 2699.6700 is amended to read:

§ 2699.6700. Scope of Health Benefits.

- (a) The basic scope of benefits offered by participating health plans must comply with all requirements of the Knox-Keene Health Care Service Plan Act of 1975 including amendments as well as its applicable regulations, and shall include all of the benefits and services listed in this section, subject to the exclusions listed in this section and Section 2699.6703. No other benefits shall be permitted to be offered by a participating health plan as part of the program. The basic scope of benefits shall include:

* * * [Continued]

- (5) Prescription Drugs: Drugs when prescribed by a licensed practitioner acting within the scope of his or her licensure. Includes injectable medication and needles and syringes necessary for the administration of the covered injectable medication.

Insulin, glucagon, syringes and needles and pen delivery systems for the administration of insulin, blood glucose testing strips, kerotone urine testing strips, lancets and lancet puncture devices in medically appropriate quantities for the monitoring and treatment of insulin dependent, non-insulin dependent and gestational diabetes.

Prenatal vitamins and fluoride supplements included with vitamins or independent of vitamins which require a prescription.

All FDA approved oral and injectable contraceptive drugs and prescription contraceptive devices are covered including internally implanted time release contraceptives.

One cycle or course of treatment of tobacco cessation drugs ~~per benefit year~~ in each twelve (12) consecutive month period. The health plan must also require the subscriber to attend tobacco use cessation classes or programs in conjunction with tobacco cessation drugs.

For subscriber parents, plans can require subscribers to pay a portion or all the cost of the smoking cessation classes or programs. Plans can also

require the subscriber parent to pay the cost of the smoking cessation drug initially and reimburse the subscriber parent minus the copayment(s) upon the successful completion of a smoking cessation program.

Drugs administered while a subscriber is a patient or resident in a rest home, nursing home, convalescent hospital or similar facility when prescribed by a plan physician in connection with a covered service and obtained through a plan designated pharmacy.

Health plans may specify that generic equivalent prescription drugs must be dispensed if available, provided that no medical contraindications exist. The use of a formulary, maximum allowable cost (MAC) method, and mail order programs by health plans is encouraged.

Exclusions: Experimental or investigational drugs; drugs or medications prescribed solely for cosmetic purposes; patent or over-the-counter medicines, including non-prescription contraceptive jellies, ointments, foams, condoms, etc., even if prescribed by a doctor; medicines not requiring a written prescription order (except insulin and smoking cessation drugs as previously described); and dietary supplements (except for formulas or special food products to treat phenylketonuria or PKU); and appetite suppressants or any other diet drugs or medications, unless necessary for the treatment of morbid obesity.

* * * [Continued]

(10) Mental Health

(A) Inpatient:

1. Mental health care during a certified confinement in a participating hospital when ordered and performed by a participating mental health provider for the treatment of a mental health condition. ~~For subscriber children determined by their county mental health department to meet the criteria for Serious Emotional Disturbances (SED) of a child or for a serious mental disorder, pursuant to Section 5600.3 of the Welfare and Institutions Code, plans may limit services to 30 days per benefit year.~~

2. a. Plans shall be responsible for identifying subscriber children who may have a Serious Emotional Disturbances (SED) condition, as defined in California Health and Safety Code section 1374.72, or may have a serious mental disorder, as defined in Welfare and Institutions Code

section 5600.3, and shall refer these individuals to their respective county mental health department for evaluation. ~~For subscriber children who are determined to have a SED condition or a serious mental disorder by their county mental health department, participating plans shall provide up to 30 days of inpatient care, including related professional services. After 30 days, the responsibility for providing inpatient and related professional services for continued treatment of the condition will transfer to the county mental health department. The plan and the county shall coordinate services for the subscriber.~~

b. The plan is not responsible for providing a covered service to treat a subscriber child's serious emotional disturbance or serious mental disorder only to the extent that the treatment is authorized and provided by a County Mental Health Department as defined in Welfare and Institutions Code Section 5600.3.

3. ~~Except as limited pursuant to the previous paragraph for subscribers who are determined to have a SED condition or a serious mental disorder by their county mental health department, p~~Plans must provide services with no inpatient day limits for severe mental illnesses including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa.

4. a. For the benefit year commencing July 1, 2009, Pplans may limit inpatient coverage to ~~30~~38 days per benefit year for illnesses that meet neither the criteria for severe mental illnesses nor the criteria for SED of a child or for a serious mental disorder. Plans, with the agreement of the subscriber or applicant or other responsible adult if appropriate, may substitute for each day of inpatient hospitalization any of the following: two (2) days of residential treatment, three (3) days of day care treatment, or four (4) outpatient visits.

b. Effective October 1, 2010, plans shall provide services with no day limits for in patient mental health treatment.

(B) Outpatient:

1. Mental health care when ordered and performed by a participating mental health provider. This includes the treatment of children who have experienced family dysfunction or trauma, including child abuse and neglect, domestic violence, substance abuse in the family, or divorce and bereavement. Family members may be involved in the treatment to the extent the plan determines it is appropriate for the health and recovery of the child.

~~Plans must provide services with no visit limits for severe mental illnesses, including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa and bulimia nervosa.~~

2. a. Plans shall be responsible for identifying subscriber children who may have a Serious Emotional Disturbances (SED) condition, as defined in California Health and Safety Code section 1374.72, or may have a serious mental disorder, as defined in Welfare and Institutions Code section 5600.3, and shall refer these individuals to their county mental health department for evaluation. ~~Notwithstanding the first sentence of the previous paragraph, participating plans shall refer subscriber children who are determined by their county mental health department to have a SED or a serious mental disorder, to their county mental health department for treatment of the condition. For subscriber children who are determined to have a SED condition or a serious mental disorder by their county mental health department, outpatient and related professional services pertaining to the condition will be provided by the county mental health department. The plan and the county shall coordinate services for the subscriber.~~
- b. The plan is not responsible for providing a covered service to treat a subscriber child's serious emotional disturbance or serious mental disorder only to the extent that the service is authorized and provided by a County Mental Health Department as defined in Welfare and Institutions Code Section 5600.3.

3. Plans must provide services with no out patient visit limits for severe mental illnesses including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa.
4. a. For the benefit year commencing July 1, 2009, Pplans must provide up to 2025 visits per benefit year for illnesses that meet neither the criteria for severe mental illnesses, nor the criteria for SED of a child or a serious mental disorder. Participating plans may elect to provide additional visits. Plans may provide group therapy at a reduced copayment.
 - b. Effective October 1, 2010, plans shall provide services with no visit limits for out patient mental health treatment.

(11) Alcohol and Drug Abuse Treatment Services:

- (A) Inpatient: Hospitalization for alcoholism or drug abuse to remove toxic substances from the system.
- (B) Outpatient: Crisis intervention and treatment of alcoholism or drug abuse on an outpatient basis.

For the benefit year commencing July 1, 2009, Pparticipating health plans shall provide at least 2025 visits per benefit year. Participating health plans may elect to provide additional visits.

- (C) Effective October 1, 2010, a plan may not limit the number of visits for alcohol and drug abuse treatment services.

(12) Home Health Services: Health services provided at the home by health care personnel. Includes visits by Registered Nurses, Licensed Vocational Nurses, and home health aides; physical, occupational and speech therapy; and respiratory therapy when prescribed by a licensed practitioner acting within the scope of his or her licensure.

Home health services are limited to those services that are prescribed or directed by the attending physician or other appropriate authority designated by the plan. If a basic health service can be provided in more than one medically appropriate setting, it is within the discretion of the attending physician or other appropriate authority designated by the plan

to choose the setting for providing the care. Plans shall exercise prudent medical case management to ensure that appropriate care is rendered in the appropriate setting. Medical case management may include consideration of whether a particular service or setting is cost-effective when there is a choice among several medically appropriate alternative services or settings.

Exclusions: Custodial care.

(13) Skilled Nursing Care:

(A) Services prescribed by a plan physician or nurse practitioner and provided in a licensed skilled nursing facility. Includes skilled nursing on a 24-hour per day basis; bed and board; x-ray and laboratory procedures; respiratory therapy; physical, occupational and speech therapy; medical social services; prescribed drugs and medications; medical supplies; and appliances and equipment ordinarily furnished by the skilled nursing facility. This benefit shall be limited to a maximum of 100 days per benefit year.

(B) For the benefit year commencing July 1, 2009, this benefit shall be limited to a maximum of 125 days per benefit year.

(C) Exclusions: Custodial care.

(14) Physical, Occupational, and Speech Therapy: Therapy may be provided in a medical office or other appropriate outpatient setting, hospital, skilled nursing facility or home. Plans may require periodic evaluations as long as therapy is provided.

(15) Acupuncture and Chiropractic:

(A) These are optional benefits which plans may offer. If offered, the plan must provide a self referral benefit, and cannot require referral from a primary care or other physician or health professional. Coverage is limited to a maximum of 20 visits each per benefit year. Plans may provide a combined chiropractic/acupuncture benefit with a minimum of 20 visits allowed for both disciplines.

(B) For the benefit year commencing July 1, 2009, coverage is limited to a maximum of 25 visits each per benefit year. Plans may provide a combined chiropractic/acupuncture benefit with a minimum of 25 visits allowed for both disciplines.

- (16) Biofeedback is an optional benefit which health plans may offer.
- (17) Blood and Blood Products: Processing, storage, and administration of blood and blood products in inpatient and outpatient settings. Includes the collection and storage of autologous blood when medically indicated.
- (18) Hospice: The hospice benefit is provided to subscribers who are diagnosed with a terminal illness with a life expectancy of twelve months or less and who elect hospice care for such illness instead of the traditional services by the plan.

The hospice benefit shall include nursing care, medical social services, home health aide services, physician services, drugs, medical supplies and appliances, counseling and bereavement services, physical therapy, occupational therapy, speech therapy, short-term inpatient care, pain control, and symptom management.

The hospice benefit may include, at the option of the health plan, homemaker services, services of volunteers, and short-term inpatient respite care.

Individuals who elect hospice care are not entitled to any other benefits under the plan for the terminal illness while the hospice election is in effect. The hospice election may be revoked at any time.

- (19) Transplants: Coverage for organ transplants and bone marrow transplants which are not experimental or investigational. Includes reasonable medical and hospital expenses of a donor or an individual identified as a prospective donor if these expenses are directly related to the transplant for a subscriber.

Charges for testing of relatives for matching bone marrow transplants.

Charges associated with the search and testing of unrelated bone marrow donors through a recognized Donor Registry and charges associated with the procurement of donor organs through a recognized Donor Transplant Bank, if the expenses are directly related to the anticipated transplant of a subscriber.

- (20) Reconstructive Surgery: Surgery to restore and achieve symmetry and surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to do either of the following:

- (A) Improve function
 - (B) Create a normal appearance to the extent possible. Includes reconstructive surgery to restore and achieve symmetry incident to mastectomy.
- (21) Clinical Trial for Cancer Patients: Coverage for a subscriber's participation in a clinical trial when the subscriber has been diagnosed with cancer and has been accepted into a phase I through phase IV clinical trial for cancer, and the subscriber's treating physician recommends participation in the clinical trial after determining that participation will have a meaningful potential to benefit the subscriber. Coverage includes the payment of costs associated with the provision of routine patient care, including drugs, items, devices and services that would otherwise be covered if they were not provided in connection with an approved clinical trial program; services required for the provision of the investigational drug, item, device or service; services required for the clinically appropriate monitoring of the investigational drug, item, device, or service; services provided for the prevention of complications arising from the provision of the investigational drug, item, device, or service; and services needed for the reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including diagnosis or treatment of complications.
- Exclusions: Provisions of non-FDA-approved drugs or devices that are the subject of the trial; services other than health care services, such as travel, housing, and other non-clinical expenses that a member may incur due to participation in the trial; any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the patient; services that are otherwise not a benefit (other than those excluded on the basis that they are investigational or experimental); and services that are customarily provided by the research sponsors free of charge for any enrollee in the trial. Coverage for clinical trials may be restricted to participating hospitals and physicians in California, unless the protocol for the trial is not provided in California.
- (22) Phenylketonuria (PKU): Testing and treatment of PKU, including those formulas and special food products that are part of a diet prescribed by a licensed physician and managed by a health care professional in consultation with a physician who specializes in the treatment of metabolic disease, provided that the diet is deemed necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU.

- (23) Participating health plans shall be responsible for identifying subscribers under the age of 21 who have conditions for which they may be eligible to receive services under the California Children's Services (CCS) Program and shall refer these individuals to the local CCS Program for determination of eligibility. If a subscriber is determined by the CCS Program to be eligible for CCS benefits, participating health plans shall provide primary care and services all unrelated to the CCS eligible condition and shall ensure coordination of services between plan providers, CCS providers, and the local CCS Program.
- (24) Participating health plans shall be responsible for identifying subscriber children who are severely emotionally disturbed and shall refer these individuals to their county mental health department for continued treatment of the condition.
- (b) This part shall not be construed to prohibit a plan's ability to impose cost-control mechanisms. Such mechanisms may include but are not limited to requiring prior authorization for benefits or providing benefits in alternative settings or using alternative methods.
- (c) (1) The scope of benefits shall include all benefits which are covered under the California Children's Services (CCS) Program (Health and Safety Code Section 123800, et seq.), provided the subscriber meets the medical eligibility requirements of that program, as determined by that program.
- (2) When a subscriber under the age of 21 is determined by the CCS Program to be eligible for benefits under that program, a participating health plan shall not be responsible for the provision of, or payment for, the particular services authorized by the CCS Program for the particular subscriber for the treatment of CCS eligible medical condition. All other services provided under the participating health plan shall be available to the subscriber.
- (d) (1) The scope of benefits shall include benefits provided by a county mental health department to a subscriber child the department has determined is seriously emotionally disturbed or has a serious mental disorder pursuant to Section 5600.3 of the Welfare and Institutions Code.
- ~~(2) When a subscriber child is determined by a county mental health department to be seriously emotionally disturbed or to have a serious mental disorder pursuant to Section 5600.3 of the Welfare and Institutions Code, the participating health plan shall not be responsible for the provision of, or payment for, services provided by the county mental health department. This does not relieve the participating health plan from~~

~~providing the mental health coverage specified in Section 2699.6700(a)(10).~~

- (2) The plan is not responsible for providing a covered service to treat a subscriber child's serious emotional disturbance or serious mental disorder only to the extent that the treatment is authorized and provided by a County Mental Health Department as defined in Welfare and Institutions Code Section 5600.3.
- (e) If, pursuant to any Workers' Compensation, Employer's Liability Law, or other legislation of similar purpose or import, benefits are provided or payable or payable to treat any bodily injury or sickness arising from or sustained in the course of any occupation or employment for compensation, profit or gain, the participating health plan shall provide the services at the time of need, and the subscriber or applicant shall cooperate to assure that the participating health plan is reimbursed for such services.
- (f) Coverage provided under the Healthy Families Program is secondary to all other coverage, except Medi-Cal. Benefits paid under this Program are determined after benefits have been paid as a result of a subscriber's enrollment in any other health care program. If medical services are eligible for reimbursement by insurance or covered under any other insurance or health care service plan, the participating health plan shall provide the services at the time of need, and the subscriber or applicant shall cooperate to assure that the participating health plan is reimbursed for such services.

Note: Authority cited: Sections 12693.21, 12693.22 and 12693.755, Insurance Code.
Reference: Sections 12693.21, 12693.22, 12693.60, 12693.61, 12693.62 and 12693.755, Insurance Code.

Section 2699.6707 is amended to read:

§ 2699.6707. Annual or Lifetime Benefit Maximums.

- (a) There shall be no annual or lifetime financial benefit maximums in any of the coverage under the program.
- (b) (1) For the benefit year commencing July 1, 2009, the covered dental benefit for each subscriber shall be limited to eighteen hundred seventy-five dollars (\$1,875) per benefit year.

(2) Effective October 1, 2010, the covered dental benefit for each subscriber is shall be limited to fifteen hundred dollars (\$1,500) per benefit year, effective July 1, 2009.

(3) The \$1,500 limitations contained in this subsection shall not apply to dental benefits provided to a subscriber under the age of 21 who is determined by the California Children's Services Program (Health and Safety Code Section 123800 et seq.) to be eligible for dental benefits under that program and the particular services are authorized by the California Children's Services Program for the particular subscriber for the treatment of a California Children's Services Program eligible medical condition.

Note: Authority cited: Section 12693.21 and 12693.22, Insurance Code. Reference: Sections 12693.21, 12693.22, 12693.60, 12693.615, 12693.63 and 12693.64, Insurance Code.

Section 2699.6721 is amended to read:

§ 2699.6721. Scope of Vision Benefits.

- (a) The basic scope of benefits offered by a participating vision plan must comply with all requirements of the Knox-Keene Health Care Service Plan Act of 1975, including amendments as well as its applicable regulations, and shall include all of the benefits and services listed in this section, subject to the exclusions listed in Section 2699.6723. No other vision benefits shall be permitted to be offered by a participating vision plan as part of the program. The basic scope of vision benefits shall be as follows:
- (1) Examinations: Each subscriber shall be entitled to a comprehensive vision examination, including a complete analysis of the eyes and related structures, as appropriate, to determine the presence of vision problems or other abnormalities as follows:
 - (A) Case history: Review of subscriber's main reason for the visit, past history, medications, general health, ocular symptoms, and family history.
 - (B) Evaluation of the health status of the visual system; including:
 1. External and internal examination, including direct and/or indirect ophthalmoscopy;

2. Assessment of neurological integrity, including that of pupillary reflexes and extraocular muscles;
 3. Biomicroscopy of the anterior segment of the eye, including observation of the cornea, lens, iris, conjunctiva, lids and lashes;
 4. Screening of gross visual fields; and
 5. Pressure testing through tonometry.
- (C) Evaluation of refractive status, including:
1. Evaluation for visual acuity;
 2. Evaluation of subjective, refractive, and accommodative function; and
 3. Subjective testing of a patient's prescription through retinoscopy.
- (D) Binocular function test.
- (E) Diagnosis and treatment plan, if needed.
- (F) Examinations are limited to once each twelve consecutive month benefit period, beginning July first of each year.
- (2) When the vision examination indicates that corrective lenses are necessary, each subscriber is entitled to necessary frames and lenses, including coverage for single vision, bifocal, trifocal, lenticular, and polycarbonate lenses as appropriate.

Frames and lenses are limited to once each twelve consecutive month benefit period, beginning July first of each year.

- (3) Contact lenses shall be covered as follows:
- (A) Necessary contact lenses shall be covered in full upon prior authorization from the vision plan, for certain conditions. These conditions may include the following:
1. Following cataract surgery;
 2. To correct extreme visual acuity problems that cannot be corrected with spectacle lenses;

3. Certain conditions of Anisometropia; and

4. Keratoconus.

(B) Elective contact lenses may be chosen instead of corrective lenses and a frame a maximum benefit allowance of \$110, which includes examinations, fittings and lenses.

(C) Contact lenses are limited to once each twelve consecutive month benefit period, ~~beginning July first of each year.~~

(4) A low vision benefit shall be provided to subscribers who have severe visual problems that are not correctable with regular lenses. This benefit requires prior approval from the participating vision plan. With this prior approval, supplementary testing and supplemental care, including low vision therapy as visually necessary or appropriate, shall be provided.

For subscriber parents, the covered person is required to pay a \$5 copayment for any approved Low Vision services.

* * * [Continued]

Note: Authority cited: Sections 12693.21, 12693.22 and 12693.755, Insurance Code.
Reference: Sections 12693.21, 12693.22, 12693.65, 12693.66 and 12693.755, Insurance Code.

ADOPTION OF EMERGENCY REGULATIONS

Insurance Code Section 12693.22 provides, in part:

During the 2009-10 and 2010-11 fiscal years, the adoption and readoption of regulations to modify health, dental and vision benefits or otherwise modify program requirements and operations consistent with the provisions of this part shall be deemed to be an emergency and necessary for the immediate preservation of public peace, health and safety, or general welfare for purposes of Section 11346.1 and 11349.6 of the Government Code. . .

The Board confirms that these regulations modify Healthy Families Program program requirements and operations consistent with the provisions of Part 6.2 of Division 2 of the Insurance Code.

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CERTIFICATION

I, Lesley Cummings, Executive Director of the Managed Risk Medical Insurance Board, do hereby certify that the foregoing action was duly passed and adopted by the Managed Risk Medical Insurance Board at an official meeting thereof on April 21, 2010.

Dated this 21st day of April, 2010.

Lesley Cummings, Executive Director
Managed Risk Medical Insurance Board



1415 L Street
Suite 850
Sacramento, CA 95814

March 16, 2010

Members of the Board
Managed Risk Medical Insurance Board
1000 G Street, Ste. 450
Sacramento, CA 95814

via e-mail

Re: March 17 Board Meeting Agenda Item 7.c., - Review of Emergency Regulations
Modifying Mental Health Benefits [and] Clarifying Plan Responsibilities for
Children with Severe Emotional Disturbance

Dear Members:

The California Association of Health Plans (CAHP) represents 38 health care service plans, including all of the health plans that serve as your partners in the Healthy Families Program (HFP). We understand that the Board is contemplating issuing emergency regulations to clarify plan responsibilities for services for children with serious emotional disturbances (SED) (Reference, Item 7.c. on the 03/17/2010 Board Meeting Agenda, "Review of Emergency Regulations Modifying Mental Health Benefits [and] Clarifying Plan Responsibilities for Children with Severe Emotional Disturbance"(ER 1-10)). These regulations are part of MRMIB's overall effort to implement programmatic changes purportedly to comply with the federal mental health parity law. However, CAHP strongly believes that any rulemaking on this issue is premature. The Centers for Medicare and Medicaid Services (CMS) has indicated that it will issue formal guidance on how state Children's Health Insurance Program (CHIP) plans are to implement the federal mental health parity law. We urge the Board to delay rulemaking until that time.

The federal Mental Health Parity and Addiction Equity Act of 2008 (Act) mandates that if a group health plan provides mental health or substance abuse services, the financial requirements and treatment limits for those services cannot be more restrictive than those for medical or surgical benefits. Section 502 of the Children's Health Insurance Program Reauthorization of 2009 (CHIPRA) incorporates the Act, making it applicable to state CHIP plans. Guidance was recently issued for group health plans in the form of interim regulations and CMS has indicated that guidance for state Medicaid and CHIP plans is forthcoming. (CMS SHO #09-014).

We understand that the state must make a good faith effort to comply with the federal mental health parity law. However, there are fundamental questions that need to be resolved by CMS prior to state rulemaking. Primarily, states need guidance on how mental health carve-outs comport with parity. Certainly, California is not alone in carving out mental health services. However, based on an informal survey of other states, California appears to be alone in moving ahead with altering its carve out to comply with parity before CMS has issued any guidance on the issue.

We have commented at length on the mental health services amendments that have been made to plans' contracts and proposed in evidences of coverage (EOCs). We anticipate these same changes will be made proposed for the HFP regulations. In short, these changes signal to counties that they can delay or stop providing services to children with SED. The result: the costs of providing these services will be shifted back onto the HFP. We understand that these changes may be intended to close any gaps that may exist in services for children with SED. However, plans are not aware of any data demonstrating that the existing carve-out creates a lapse in services that necessitates these changes. And, there has been no formal direction from CMS indicating that state's carve-outs must be altered in the manner being proposed.

Issuing these regulations before CMS provides formal guidance would be premature. We believe that the Board can take steps now to implement the Act in good faith without issuing emergency regulations. One suggestion is for MRMIB to provide an assurance to CMS that there is no significant difference in cost sharing, lifetime or annual dollar limits, or treatment limits (e.g. the number of inpatient days) between covered mental health/substance use disorder benefits and medical/surgical benefits.

Thank you for considering the foregoing comments. We look forward to a continued dialogue with your staff as you work to bring the HFP into compliance with federal mental health parity requirements.

Sincerely,

Brianna Lierman Hintze, Director
Legal & Regulatory Affairs