

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

ARTICLE 2. ELIGIBILITY, APPLICATION, AND ENROLLMENT
Amend Sections 2699.6600, 2699.6607, 2699.6619, 2699.6621, and

ARTICLE 3. HEALTH, DENTAL AND VISION BENEFITS
Amend Sections 2699.6705, 2699.6715, and 2699.6725.

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Section 2699.6600 is amended to read:

Section 2699.6600. Application.

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(c) (1) The application shall contain the following:

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(BB) The applicant may provide the following optional information:

1. The applicant's choice of participating health, dental and/or vision plans.

(a) (i) In any geographic region or portion thereof, the program may designate one or more participating dental plans with the lowest per-subscriber costs to the program. For purposes of this section, "designated dental plan" means a participating dental plan that the program has designated in accordance with this section.

(ii) Except as otherwise provided in this section, designated dental plans, where available, shall be the only available dental plans for a household where no subscriber has at any time been enrolled in the program for two consecutive years following the subscriber's effective date.

(b) An applicant may choose from all available participating dental plans for the household and shall not be limited to designated dental plans in the following circumstances:

(i) There is no designated dental plan in the area where the subscribers reside.

(ii) (A) On November 1, 2009, one or more subscribers in the household were enrolled in the program since before November 1, 2009; and (B) at all times after November 1, 2009, there has been at least one subscriber in the household.

(iii) At least one subscriber in the household currently is enrolled in a participating dental plan that is not a designated dental plan. This exception shall apply even if (A) the subscribers move to an area where there is a designated dental plan; (B) the program makes a designated dental plan available in the area where the subscribers reside; or (C) the applicant must make a new choice of dental plan because the dental plan in which the subscribers were enrolled no longer is available.

2. The applicant's choice of primary care provider/clinic and provider/clinic code, and dentist/clinic and dentist/clinic code for the person(s) for whom application is being made.
3. An indication of whether there is more than one car in the children's household.
4. An indication of whether there is more than \$3,150 cash in bank accounts in the children's household.
5. An indication if the applicant does not want the application reviewed for eligibility for Medi-Cal or the Program.

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Note: Authority cited: Sections 12693.21, 12693.22, 12693.75 and 12693.755, Insurance Code; and Section 14005.41, Welfare and Institutions Code.
Reference: Sections 12693.02, 12693.21, 12693.22, 12693.43, 12693.46,

12693.70, 12693.71, 12693.73, 12693.74, 12693.75 and 12693.755, Insurance Code.

Section 2699.6607 is amended to read:

Section 2699.6607. Determination of Eligibility.

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(f) If the applicant does not select a health, dental and/or vision plan and the person being applied for is eligible for the program, the program shall assign the health, dental and/or vision plan as follows:

(1) Automatic assignment of the health plan to the community provider plan. If the community provider plan is not available, alternate assignment to an available health plan; and/or

(2) Alternate assignment of the dental and/or vision plan.

(3) Assignment of the dental plan shall be made pursuant to Section 2699.6600(c)(1)(BB)(1) and 2699.6623.

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Note: Authority cited: Sections 12693.21, 12693.22 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.22, 12693.70, 12693.71, 12693.73 and 12693.755, Insurance Code.

Section 2699.6619 is amended to read:

Section 2699.6619. Transfer of Enrollment.

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~~(b) A subscriber shall be transferred from one participating health, dental, or vision plan to another if the applicant so requests in writing once within the first three (3) months from the original effective date of coverage in the program, or the applicant so requests in writing once within the first thirty (30) days from the effective date of coverage in a new plan following open enrollment, for any reason.~~

A subscriber shall be transferred from one participating health, dental, or vision plan to another once for any reason upon the applicant's request as follows:

(i) Within the first three (3) months from the effective date of coverage after original enrollment into the program or re-enrollment into the program after a period of disenrollment.

(ii) Within the first thirty (30) days from the effective date of coverage in a new plan following open enrollment.

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(f) The transfers of enrollment shall comply with Sections 2699.6600(c)(1)(BB)(1).and 2699.6623.

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Note: Authority cited: Section 12693.21, and 12693.22, Insurance Code.
Reference: Sections 12693.21, 12693.22, 12693.326 and 12693.51 Insurance Code.

Section 2699.6621 is amended to read:

Section 2699.6621. Open Enrollment Period.

(a) The program shall provide for an annual open enrollment period of at least forty-five (45) calendar days. During this period, applicants may for any reason request that subscribers be transferred from one participating health, dental, or vision plan to another. Open enrollment plan Plan selection rules set forth in shall comply with Sections 2699.6600(c)(1)(BB)(1) and 2699.6623 apply for open enrollment.

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Note: Authority cited: Section 12693.21, 12693.22, Insurance Code. Reference: Sections 12693.21, 12693.22 and 12693.51 Insurance Code.

ARTICLE 3. HEALTH, DENTAL AND VISION BENEFITS

Section 2699.6705 is amended to read:

2699.6705. Share of Cost for Health Benefits.

- (a) Every participating health plan shall require copayments for benefits provided to subscribers, except as provided under federal law to subscribers who are American Indians or Alaska Natives receiving services at an Indian Health Service Facility, subject to the following:

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- (3) The following specific copayments shall apply: except that subscribers with household income at or below 150% of the Federal Poverty Level shall pay a \$5 copayment when a copayment is required.

* * *

- (C) Facility Services on an Outpatient Basis for Subscribers: No copayment, except for a \$515 copayment per visit for Emergency Health Care Services. The emergency health care services copayment is waived if the subscriber is hospitalized.
- (D) Outpatient Professional Services: \$510 copayment per office or home visit. No copayment for surgery or anesthesia; radiation, chemotherapy, or dialysis treatments.
- (E) Outpatient Mental Health: \$510 copayment per visit.
- (F) Home Health Care: No copayment except for \$510 per visit for physical, occupational, and speech therapy visits performed in the home.

- (G) Alcohol and Drug Abuse Services: No copayment for inpatient services. \$510 per visit for outpatient services.
- (H) Hospice: No copayment for any services provided under this benefit.
- (I) Transplants: No copayment for any services provided under this benefit.
- (J) Physical, Occupational, and Speech Therapy: No copayment for therapy performed on an inpatient basis. \$510 copayment per visit for therapy performed in the home or other outpatient setting.
- (K) Biofeedback, Acupuncture, and Chiropractic Visits, when offered at the participating health plan's option: \$510 copayment per visit. For subscriber parents, copayment of \$510 for each biofeedback visit for mental health.

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(M) Prescription Drugs:

- (i) No copayment for prescription drugs provided in an inpatient setting, or for drugs administered in the doctor's office or in an outpatient facility setting during the subscriber's stay at the facility. For subscriber children, no copayment for FDA approved contraceptive drugs.
- (ii) For subscribers with household income at or below 150% of the Federal Poverty Level: a \$5 copayment per prescription for up to 30 day supply for brand name or generic drugs, including tobacco use cessation drugs. \$5 copayment per 90 day supply of maintenance drugs purchased either through a participating health plan's participating pharmacies or through its mail order program.

(iii) For subscribers with household income greater than 150% of the Federal Poverty Level:

(a) \$510 copayment per prescription for up to 30 day supply for brand name or generic drugs, including tobacco use cessation drugs. \$510 copayment per 90 day supply of generic maintenance drugs purchased either through a participating health plan's participating pharmacies or through its mail order program. Maintenance drugs are drugs that are prescribed for 60 days or longer and are usually prescribed for chronic conditions such as arthritis, heart disease, diabetes, or hypertension.

(b) \$15 copayment per prescription for up to 30 day supply for brand name drugs, including tobacco use cessation drugs. \$10 copayment if no generic equivalent is available for the drug prescribed or if the use of a brand name drug is medically necessary.

(c) \$15 copayment per 90 day supply of brand name maintenance drugs purchased either through a participating health plan's participating pharmacies or through its mail order program. \$10 copayment per 90 day supply of brand name maintenance drugs purchased either through a participating health plan's participating pharmacies or through its mail order program if no generic equivalent is available for the drug prescribed or if the use of a brand name drug is medically necessary.

(iv) Maintenance drugs are drugs that are prescribed for 60 days or longer and are usually prescribed for chronic conditions such

as arthritis, heart disease, diabetes or hypertension.

- (v) For subscriber parents, \$5 copayment for 90 day supply of FDA approved oral and injectable contraceptives and contraceptive devices. No refund if the medication is removed. (Represents the copayment for oral contraceptives at \$5 copayment for each 90-day supply for the approximate number of months the medication will be effective).

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NOTE: Authority cited: Sections 12693.21, 12693.22 and 12693.755, Insurance Code.
Reference: Sections 12693.21, 12693.615, 12693.22 and 12693.755, Insurance Code.

Section 2699.6715 is amended to read:

Section 2699.6715. Share of Cost for Dental Benefits for Subscriber Children.

- (a) Every participating dental health plan shall require copayments for the dental benefits listed in Subsection 2699.6709 (a) of these regulations provided to subscribers subject to the following except that subscribers with household income at or below 150% of the Federal Poverty Level shall pay a \$5 copayment when a copayment is required:

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- (3) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(3), "Oral Surgery", with the following exceptions:
- (A) Removal of impacted teeth is subject to a copayment per tooth as follows:
1. Soft tissue impaction -- No copayment.

2. Bony impaction -- \$510 copayment per tooth.
 - (B) Root recovery -- \$510 per root.
- (4) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(4), "Endodontics", with the following exceptions:
 - (A) Root canal therapy -- \$510 per canal. ~~\$5.00~~\$10 copayment per canal for retreatment of previous root canal.
 - (B) An apicoectomy performed in conjunction with root canal therapy is subject to a copayment of \$510 per canal. When performed as a separate procedure, an apicoectomy is subject to a copayment of \$510 per canal.
- (5) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(5), "Periodontics", with the following exceptions:
 - (A) Osseous or muco-gingival surgery -- \$510 per quadrant.
 - (B) Gingivectomy -- no copayment.
- (6) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(6), "Crowns and Fixed Bridges" with the following exceptions:
 - (A) Porcelain crowns; porcelain fused to metal crowns; full metal crowns; and gold onlays or 3/4 crowns; are each subject to a copayment of \$510.
 - (B) Pontics are each subject to a copayment of \$510.
- (7) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(7), "Removable Prosthetics", with the following exceptions:
 - (A) Dentures are subject to copayments as follows:

1. Complete maxillary denture --\$510.
 2. Complete mandibular denture -- \$510.
 3. Partial acrylic upper or lower denture with clasps --\$510.
 4. Partial upper or lower denture with chrome cobalt alloy lingual or palatal bar, clasps and acrylic saddles -- \$510.
 5. Removable unilateral partial denture -- \$510.
- (B) Reline for an upper, lower or partial denture is subject to a copayment per unit as follows:
1. Office reline -- No copayment.
 2. Laboratory reline -- \$510.
- (C) Denture duplication -- \$510.

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- (11) Notwithstanding any other provision in this section, an alternative copayment shall apply under the following circumstances: For children under six years of age, who are unable to be treated by their panel provider, and who have been referred to a pedodontist/pediatric dentist, the copayment is \$510.
- (b) A fee of \$510 shall be charged for failure to cancel an appointment without 24 hours prior notification.

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NOTE: Authority cited: Section 12693.21, and 12693.22 Insurance Code.
Reference: Sections 12693.21, 12693.22 and 12693.63, Insurance Code.

Section 2699.6725 is amended to read:

Section 2699.6725. Share of Cost for Vision Benefits.

(a) A participating vision plan shall require copayments for benefits provided to subscribers utilizing the services of a vision plan's panel of approved providers subject to the following: except that subscribers with household income at or below 150% of the Federal Poverty Level shall pay a \$5 copayment when a copayment is required:

(1) Examinations: \$510 copayment per examination.

(2) Frames and lenses: \$510 copayment, for frames with lenses, or for frames or lenses when purchased separately. No additional copayment for tinted or photochromic lenses when otherwise deemed medically necessary, or polycarbonate lenses.

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(5) Low vision benefits:

(A) Supplementary testing: No copayment; and

(B) Supplemental care: \$510 copayment.

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

ADOPTION EMERGENCY OF 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 Sections 11346.1 and 11349.6 of the Government Code . . .

The Board confirms that the emergency situation addressed by these regulations, which modify health, dental and vision benefit co-pays and dental plan choice and otherwise modify program requirements and operations, clearly poses such an immediate, serious harm that delaying action to allow notice and public comment provided for in Government Code section 11346.1(a)(2) would be inconsistent with the public interest and hereby adopts the modified proposed amendment to the Healthy Families Program regulations which were originally adopted by the Board at its August 27, 2009 meeting and modified at its September 16, 2009 meeting.

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CERTIFICATION

I, Lesley Cummings, Executive Director of the Managed Risk Medical Insurance Board, do hereby certify that the foregoing finding was duly adopted by the Managed Risk Medical Insurance Board at an official meeting thereof on October 15, 2009.

Dated this 15th day of October 2009.

Lesley Cummings, Executive Director
Managed Risk Medical Insurance Board