



The following legislation effective January 2005 may impact your Individual and Small Group clients. Please call your RSM if you have any questions.

• AB254	Elimination of Senior COBRA
• AB 321	Contract Termination Date Information
• AB 1596	Comparative Benefit Matrices Accessible via Regulator's Web Site and Continuation of Services from a Terminated Network Provider
• AB 2185	Asthma Treatment Care Mandate
• AB 2208	Health Care and Insurance Benefits for Domestic Partners
• AB 2759	Continuation Coverage: Withdrawal from Individual Market
• SB 142 / SB 1103	Trailer Bill: Genetic Disease Testing

AB 254 Elimination of Senior COBRA

Effective 1.1.05

Affects DOI and DMHC regulated plans

Existing law requires any health care service plan/insurance company that provides certain benefits under an employer-sponsored group plan for an employer subject to COBRA/Cal-COBRA continuation coverage, to offer specified health coverage to former employees who were 60 years old or older on the date of employment termination and to meet certain other requirements. These other requirements allow former employees who were over 60 years old or older to continue COBRA/Cal-COBRA essentially until they turn 65.

This bill repeals senior COBRA continuation protections in order to allow seniors to enroll in lower priced HIPAA coverage and makes the senior COBRA requirements applicable only to an individual who meets the eligibility requirements for continuation coverage prior to January 1, 2005.

Impact:

- Language will be removed in the Small Group EOCs regarding this continuation option on next revision.
- Currently working through operational changes.

AB 321 Contract Termination Date Information

Effective Immediately

Affects DMHC regulated plans only

Existing law requires health care service plans to provide affected enrollees with written notice of certain information prior to the termination date of its contract with a provider group or general acute care hospital.

This bill requires a health care service plan, to make available to group subscribers the termination date of all "major" health care provider contracts, for services in the geographic area for which the group subscriber has secured coverage, when the contract specifies a termination date.

Because this bill is an "urgency measure", the provisions of AB 321 took effect on September 9, 2004, when the bill was signed.

Impact:

- Company wide task force in place to implement this requirement.



AB 1596 Comparative Benefit Matrices Accessible via Regulator's Web Site: Continuation of Services from a Terminated Network Provider

Effective 1.1.05

Affects DOI and DMHC regulated plans

Under existing law, the DMHC and DOI are required to prepare comparative benefit matrices comparing specified benefit packages. Existing law requires a health care service plan and a health insurer to make a downloadable copy of these matrices available through their Internet Web sites.

This bill changes this requirement. We must make these matrices available through a link on our Web site to the Web sites of the DMHC and the DOI.

Under existing law, a health care service plan and a health insurer are required to arrange for the completion of covered services by a terminated or nonparticipating provider to an enrollee and to an insured by a terminated provider, if the enrollee or insured is undergoing a course of treatment for specified conditions, including a terminal illness, as defined, and subject to written agreement by the provider as to certain points. Existing law requires that completion of covered services be provided for the duration of a terminal illness.

This bill provides that the duration of covered services for a terminal illness may exceed 12 months from the contract termination date or the effective date of coverage for a new enrollee.

The bill also excludes from these out-of-network continuation provisions a newly covered enrollee of a health care service plan who had an option to enroll for coverage which includes out-of-network benefits, or who had the option to continue with a health plan or provider and voluntarily chose to change health plans.

Impact:

- Links to DMHC and DOI Web sites already available on BCC Web site
- Current EOC language regarding treatment for a terminal illness may exceed 12 months; therefore no EOC revision is required.

AB 2185 Asthma Treatment Care Mandate

Effective 1.1.05

Affects DMHC regulated plans only

This bill requires a health care service plan that covers outpatient prescription drug benefits to provide coverage for inhaler spacers, nebulizers (including face masks and tubing), and peak flow meters when medically necessary for the management and treatment of pediatric asthma.

Impact:

- Currently, all the items listed in this bill are covered on plans with prescription coverage. Usually most of these items are covered through the plan's DME benefit.
- Benefits will be administered to comply with the requirements of this bill as of its effective date.
- Internal policy will be written to reflect that coverage of these items is mandated and that if there is a DME cap on a plan, the cost of this equipment will apply to that cap, but will continue to be paid even after cap is met.
- Language will be added to EOCs on next revision.



AB 2208 Health Care and Insurance Benefits for Domestic Partners
Effective 1.2.05

Affects DOI and DMHC regulated plans

This bill requires that a health care service plan provide coverage under group plans to the registered domestic partner, under applicable law, of an employee or subscriber that is equal to the coverage it provides to the spouse of those persons on the same terms and conditions as to a spouse of those persons. This bill also requires that an insurance company provide coverage to the registered domestic partner, under applicable law, of an employee, subscriber, insured, or policyholder that is equal to the coverage it provides to the spouse of those persons on the same terms and conditions as to a spouse of those persons.

Also, as a result of this bill, we can no longer require employees verify the status of the domestic partnership by providing to the plan a copy of a valid Declaration of Domestic Partnership or an equivalent document issued by a local agency of this state or another state where the partnership was created. We can only require documentation of the domestic partnership, including documentation of the termination of that domestic partnership, if we also request verification of marital status (a marriage license) from the employee whose spouse is provided coverage as well as notification of dissolution of the marriage. The same applies for the termination of the domestic partnership.

Group plans must inform employees of this coverage.

Impact:

- EOCs and individual policies will be revised as appropriate.
- Also, language will be added regarding the requirement of written documentation if requesting to cancel a domestic partner (or a spouse) to make it equal on next revision.
- Applications will be revised to delete language regarding the employer's option to offer domestic partner coverage and regarding the requirement of a copy of the Declaration of Domestic Partnership upon next revision.
- Sales Collateral will need to be revised to delete language regarding the requirement of a copy of the Declaration of Domestic Partnership when each affected piece of collateral comes up for reprint/revision.

AB 2759 Continuation Coverage – Withdrawal from Individual Market
Effective 1.1.05

Affects DOI and DMHC regulated plans

Existing law provides for regulation of health care service plans by the Department of Managed Health Care. Existing law provides for regulation of health insurers by the Insurance Commissioner. A willful violation of the provisions governing health care service plans is a crime.

This bill, on and after January 1, 2005, would require a health care service plan or health insurer issuing individual plan contracts or individual policies of health insurance and that ceases to offer individual coverage in this state, to continue to provide specified coverage to the subscribers or policyholders who had been covered by those contracts and policies at the time of withdrawal under certain terms and conditions. The bill would also require a health care service plan that ceases to offer individual coverage in a service area other than coverage provided by a preferred provider organization, to continue to offer specified coverage to subscribers who had been covered by those contracts at the time of withdrawal if it continues to offer group coverage in the service area.

The bill would also provide that these provisions would not apply when a plan participating in a contract to provide health coverage with a government entity no longer contracts with the government entity to provide that coverage in the state or a specified area of the state or when a plan ceases to offer and issue any and all forms of coverage in any part of the state after the effective date of this section.

Impact:

- No impact unless Individual withdraws from market in the future
- SBA/Policy will be written



SB 142/SB 1103 Genetic Disease Testing
Effective 1.1.05

Existing law requires the State Department of Health Services (DHS) to establish a program for the development and evaluation of genetic disease testing to provide genetic screening and follow-up services for persons who elect to have the screening. Existing law requires the DHS to report to the Legislature regarding the progress of the program on or before January 1, 2002.

Existing law requires the DHS expand statewide screening of newborns to include tandem mass spectrometry screening for fatty acid oxidation, amino acid, organic acid disorders, and congenital adrenal hyperplasia, and to provide information with respect to these disorders and testing resources to all women receiving prenatal care and admitted to a hospital for delivery. If the department is unable to provide statewide screening for these disorders by July 1, 2005, existing law requires the department to temporarily obtain statewide screening for these disorders from one or more laboratories, through a competitive bid process.

This bill would extend the date by which the department would be required to obtain screening from laboratories by competitive bid to August 1, 2005.

Impact:

- ICD-9 codes/pricing will need to be updated because these new procedures are going to be required to be covered.