§ 1399.857. Requirements not placed on carriers

(a) A health care service plan shall not be required to offer an individual

health benefit plan or accept applications for the plan pursuant to Section 1399.849 in the case of any of the following:

(1) To an individual who does not live or reside within the plan's approved service areas.

(2)(A) Within a specific service area or portion of a service area, if the plan reasonably anticipates and demonstrates to the satisfaction of the director both of the following:

(i) It will not have sufficient health care delivery resources to ensure that health care services will be available and accessible to the individual because of its obligations to existing enrollees.

(ii) It is applying this subparagraph uniformly to all individuals without regard to the claims experience of those individuals or any health status-related factor relating to those individuals.

(B) A health care service plan that cannot offer an individual health benefit plan to individuals because it is lacking in sufficient health care delivery resources within a service area or a portion of a service area pursuant to subparagraph (A) shall not offer a health benefit plan in that area to individuals until the later of the following dates:

(i) The 181st day after the date coverage is denied pursuant to this paragraph.

(ii) The date the plan notifies the director that it has the ability to deliver services to individuals, and certifies to the director that from the date of the notice it will enroll all individuals requesting coverage in that area from the plan.

(C) Subparagraph (B) shall not limit the plan's ability to renew coverage already in force or relieve the plan of the responsibility to renew that coverage as described in Section 1365.

(D) Coverage offered within a service area after the period specified in subparagraph (B) shall be subject to this section.

(b)(1) A health care service plan may decline to offer an individual health benefit plan to an individual if the plan demonstrates to the satisfaction of the director both of the following:

(A) It does not have the financial reserves necessary to underwrite additional coverage. In determining whether this subparagraph has been satisfied, the director shall consider, but not be limited to, the plan's compliance with the requirements of Section 1367, Article 6 (commencing with Section 1375), and the rules adopted thereunder.

(B) It is applying this subdivision uniformly to all individuals without regard to the claims experience of those individuals or any health status-related factor relating to those individuals.

(2) A plan that denies coverage to an individual under paragraph (1) shall not offer coverage before the later of the following dates:

(A) The 181st day after the date that coverage is denied pursuant to this subdivision.

(B) The date the plan demonstrates to the satisfaction of the director that the plan has sufficient financial reserves necessary to underwrite additional coverage.

(3) Paragraph (2) shall not limit the plan's ability to renew coverage already in force or relieve the plan of the responsibility to renew that coverage as described in Section 1365.

(4) Coverage offered within a service area after the period specified in paragraph (2) shall be subject to this section.

(c) Nothing in this article shall be construed to limit the director's authority to develop and implement a plan of rehabilitation for a health care service plan whose financial viability or organizational and administrative capacity has become impaired, to the extent permitted by PPACA.

(d) This section shall not apply to an individual health benefit plan that is a grandfathered health plan.

HISTORY:
Added Stats 2013 1st Ex Sess 2013-2014 ch 2 § 18 (SBX1-2), effective September 30, 2013.

§ 1399.858. Discontinuing of offering contracts or acceptance of ap- plications

The director may require a plan to discontinue the offering of contracts or acceptance of applications from any individual, or responsible party for an individual, upon a determination by the director that the plan does not have sufficient financial viability, or organizational and administrative capacity to ensure the delivery of health care services to its enrollees. In determining whether the conditions of this section have been met, the director shall consider, but not be limited to, the plan's compliance with the requirements of Section 1367, Article 6 (commencing with Section 1375), and the rules adopted thereunder.

HISTORY:
Added Stats 2013 1st Ex Sess 2013-2014 ch 2 § 18 (SBX1-2), effective September 30, 2013.