§ 1394.7. Definitions; Insolvency of health care service plan

(a) As used in this section the following definitions shall apply:

(1) "Health care service plan" means any plan as defined in Section 1345, but this section does not apply to specialized health care service contracts.

(2) "Carrier" means a health care service plan, an insurer issuing group disability coverage which covers hospital, medical, or surgical expenses, a nonprofit hospital service plan, or any other entity responsible for either the payment of benefits or the provision of hospital, medical, and surgical benefits under a group contract.

(3) "Insolvency" means that the director has determined that the health care service plan is not financially able to provide health care services to its enrollees and (A) the director has taken an action pursuant to Section 1386, 1391, or 1399, or (B) an order requested by the director or the Attorney General has been issued by the superior court under Section 1392, 1393, or 1394.1.

(b) In the event of the insolvency of a health care service plan and upon order of the director, any health care service plan which the director determines to have sufficient health care delivery resources and sufficient financial and administrative capacity and that participated in the enrollment process with the insolvent health care service plan at the last regular open enrollment period of a group shall offer enrollees of the group in the insolvent health care service plan a 30-day enrollment period commencing upon the date specified by the director. Each health care service plan shall offer enrollees of the group in the insolvent health care service plan the same coverages and rates that it offered to enrollees of the group at the last regular open enrollment period of the group. Coverage shall be effective upon receipt by the successor plan of an application for enrollment by or on behalf of a subscriber or enrollee of the insolvent plan. The director shall send a notice of the insolvency of a health care service plan to the Insurance Commissioner.

(c) If no other carrier had been offered to groups enrolled in the insolvent health care service plan, or if the director determines that the other carriers do not include a sufficient number of health care service plans that have adequate health care delivery resources or the financial or administrative capacity to assure that health care services will be available and accessible to all of the group enrollees of the insolvent health care service plan, then the director shall allocate equitably the insolvent health care service plan's group contracts for the groups, except for Medi-Cal contracts made pursuant to Section 14200 of the Welfare and Institutions Code, among all health care service plans which operate within at least a portion of the service area of the insolvent health care

service plan, taking into consideration the health care delivery resources and the financial and administrative capacity of each health care service plan. The director shall also have the authority to allocate equitably enrollees, except Medi-Cal enrollees, if he or she has been unable to successfully place them through the open enrollment procedure in subdivision (b). The director shall make every reasonable effort to allocate enrollees within 30 days of the insolvency of the plan, but not later than 45 days after insolvency. Each health care service plan to which a group or groups are so allocated shall offer the group or groups the health care service plan's coverage which is most similar to each group's coverage with the insolvent health care service plan, as determined by the director, at rates determined in accordance with the successor health care service plan's existing rating methodology. Coverage shall be effective upon the date specified by thedirector. Further, except to the extent benefits for any condition would have been reduced or excluded under the insolvent health care service plan's contract or policy, no provision in a successor health care service plan's contract of coverage that would operate to reduce or exclude benefits on the basis that the condition giving rise to benefits preexisted on the effective date of the enrollee's assignment to the succeeding health care service plan shall be applied with respect to those enrollees validly covered under the insolvent health care service plan's contract or policy on the date of the assignment.

The State Department of Health Services shall have the authority to allocate Medi-Cal enrollees to other carriers with valid Medi-Cal contracts, which operate within the same service area of an insolvent Medi-Cal contractor and that have sufficient capacity to absorb the Medi-Cal enrollees allocated to them.

(d) The director shall also allocate equitably the insolvent health care service plan's nongroup enrollees among all health care service plans which operate within at least a portion of the service area of the insolvent health care service plan, taking into consideration the health care delivery resources or the financial and administrative capacity of each health care service plan. Each health care service plan to which nongroup enrollees are allocated shall offer the nongroup enrollees the health care service plan's most similar coverage for individual or conversion coverage, as determined by the director, taking into consideration his or her type of coverage in the insolvent health care service plan, at rates determined in accordance with the successor health care service plan's existing rating methodology. Coverage shall be effective upon the date specified by the director. Further, except to the extent benefits for any condition would have been reduced or excluded under the insolvent health care service plan's contract or policy, no provision in a successor health care service plan's contract of coverage that would operate to reduce or exclude benefits on the basis that the condition giving rise to benefits preexisted on the effective date of the enrollee's assignment to the succeeding health care service plan shall be applied with respect to those enrollees validly covered under the insolvent health care service plan's contract or policy on the date of the assignment. Successor health care service plans which do not offer direct nongroup enrollment may aggregate all allocated nongroup enrollees into one group for rating and coverage purposes.

(e) Contracting providers shall continue to provide services to enrollees of an insolvent plan until the effective date of an enrollee's coverage in a

successor plan selected pursuant to either open enrollment or the allocation process but in no event for the period exceeding that required by their contract or 45 days in the case of allocation, whichever is greater; or for a period exceeding that required by their contract or 30 days in the case of open enrollment, whichever is greater.

(f) The failure to comply with an order under this section shall constitute a violation of this section.

HISTORY:

Added Stats 1990 ch 1043 § 8 (SB 785). Amended Stats 1991 ch 422 § 3 (SB 244); Stats 1999 ch 525 § 148 (AB 78), effective January 1, 2000, operative July 1, 2000.