§ 1357.09. When plan not required to offer contract

No plan shall be required to offer a health care service plan contract or accept applications for the contract pursuant to this article in the case of any of the following:

(a) To a small employer, if the small employer is not physically located in a plan's approved service areas, or if an eligible employee and dependents who are to be covered by the plan contract do not work or reside within a plan's approved service areas.

(b)(1) Within a specific service area or portion of a service area, if a plan reasonably anticipates and demonstrates to the satisfaction of the director that it will not have sufficient health care delivery resources to assure that health care services will be available and accessible to the eligible employee and dependents of the employee because of its obligations to existing enrollees.

(2) A plan that cannot offer a health care service plan contract to small employers because it is lacking in sufficient health care delivery resources within a service area or a portion of a service area may not offer a contract in the area in which the plan is not offering coverage to small employers to new employer groups with more than 50 eligible employees until the plan notifies the director that it has the ability to deliver services to small employer groups, and certifies to the director that from the date of the notice it will enroll all small employer groups requesting coverage in that

area from the plan unless the plan has met the requirements of subdivision (d).

(3) 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.

(c) Offer coverage to a small employer or an eligible employee as defined under paragraph (2) of subdivision (b) of Section 1357 that, within 12 months of application for coverage, disenrolled from a plan contract offered by the plan.

(d)(1) The director approves the plan's certification that the number of eligible employees and dependents enrolled under contracts issued during the current calendar year equals or exceeds either of the following:

(A) In the case of a plan that administers any self-funded health coverage arrangements in California, 10 percent of the total enrollment of the plan in California as of December 31 of the preceding year.

(B) In the case of a plan that does not administer any self-funded health coverage arrangements in California, 8 percent of the total enrollment of the plan in California as of December 31 of the preceding year. If that certification is approved, the plan shall not offer any health care service plan contract to any small employers during the remainder of the current year.

(2) If a health care service plan treats an affiliate or subsidiary as a separate carrier for the purpose of this article because one health care service plan is qualified under the federal Health Maintenance Organization Act (42 U.S.C. Sec. 300e et seq.) and does not offer coverage to small employers, while the affiliate or subsidiary offers a plan contract that is not qualified under the federal Health Maintenance Organization Act (42 U.S.C. Sec. 300e et seq.) and offers plan contracts to small employers, the health care service plan offering coverage to small employers shall enroll new eligible employees and dependents, equal to the applicable percentage of the total enrollment of both the health care service plan qualified under the federal Health Maintenance Organization Act (42 U.S.C. Sec. 300e et seq.) and its affiliate or subsidiary.

(3)(A) The certified statement filed pursuant to this subdivision shall state the following:

(i) Whether the plan administers any self-funded health coverage arrangements in California.

(ii) The plan's total enrollment as of December 31 of the preceding year.

(iii) The number of eligible employees and dependents enrolled under contracts issued to small employer groups during the current calendar year.

(B) The director shall, within 45 days, approve or disapprove the certified statement. If the certified statement is disapproved, the plan shall continue to issue coverage as required by Section 1357.03 and be subject to disciplinary action as set forth in Article 7 (commencing with Section 1386).

(e) A health care service plan that, as of December 31 of the prior year, had

a total enrollment of fewer than 100,000 and 50 percent or more of the plan's total enrollment have premiums paid by the Medi-Cal program.

(f) A social health maintenance organization, as described in subdivision (a) of Section 2355 of the federal Deficit Reduction Act of 1984 (P.L. 98-369), that, as of December 31 of the prior year, had a total enrollment of fewer than 100,000 and has 50 percent or more of the organization's total enrollment premiums paid by the Medi-Cal program or Medicare programs, or by a combination of Medi-Cal and Medicare. In no event shall this exemption be based upon enrollment in Medicare supplement contracts, as described in Article 3.5 (commencing with Section 1358).

HISTORY:

Added Stats 1992 ch 1128 § 5 (AB 1672), operative July 1, 1993. Amended Stats 1993 ch 113 § 3 (AB 1742), effective July 12, 1993, ch 1146 § 3.5 (AB 28), effective October 10, 1993; Stats 1999 ch 83 § 97 (SB 966), ch 525 § 62 (AB 78), operative July 1, 2000; Stats 2006 ch 538 § 353 (SB 1852), effective January 1, 2007.