COLORADO
Department of Regulatory Agencies
Division of Insurance

Bulletin No. B-4.93

CONTINUITY OF CARE REQUIREMENTS FOR HEALTH BENEFIT PLANS

I. Background and Purpose

All health benefit plans must contain provisions to ensure continuity of care for the policyholder when certain events occur. The purpose of this bulletin is to provide consumers and carriers with the standards and requirements for ensuring continuity of care for health benefit plans, and help ensure carrier compliance with those requirements.

Bulletins are the Division's interpretations of existing insurance law or general statements of Division policy. Bulletins themselves establish neither binding norms nor a final determination of issues or rights.

II. Applicability and Scope

This bulletin is intended to inform both consumers, and carriers[1] that offer health benefit plans, of specific standards and requirements relating to continuity of care required by current Colorado law[2].

III. Continuity of Care Terms and Definitions

A. "Active course of treatment" means for the purpose of this bulletin :

1. An ongoing course of treatment for a life-threatening condition;

2. An ongoing course of treatment for a serious acute condition;

3. The second or third trimester of pregnancy; or

4. An ongoing course of treatment for a health condition for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes.

B. "Covered person" means, for the purpose of this bulletin, a person entitled to receive benefits or services under a health coverage plan[3].

[1] Which includes, but is not limited to, life and health carriers; non-profit hospital, medical-surgical, and health service corporations; health maintenance organizations (HMOs); limited service licensed provider networks (LSLPNs) offering individual and/or group health benefit plans; and dental carriers subject to the requirements of the Affordable Care Act" (ACA)

[2] § 10-16-704(9), C.R.S.

[3] § 10-16-102(15), C.R.S

C. "Life-threatening health condition" means, for the purpose of this bulletin, a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted.

D. "Network" means, for the purpose of this bulletin, a group of participating providers providing services to a managed care plan. Any subdivision or subgrouping of a network is considered a network if covered individuals are restricted to the subdivision or subgrouping for covered benefits under the managed care plan.[4]

E. "Primary care" means, for the purpose of this bulletin, health care services for a range of common physical, mental or behavioral health conditions provided by a physician or non-physician primary care professional.

F. "Serious acute condition" means, for the purpose of this bulletin, a disease or condition requiring complex on-going care which the covered person is currently receiving, such as chemotherapy, post-operative visits or radiation therapy.

IV. Division Position

A. Continuity of Care

Carriers shall ensure sufficient continuity of care provisions for their policyholders, pursuant to § 10-16-704(9)(j), C.R.S., including, but not limited to the following.

1. A health carrier and participating provider shall provide at least sixty (60) days written notice to each other before a provider is removed or leaves the network without cause.

2. The health carrier shall make a good faith effort to provide written notice of a provider's removal or leaving the network within thirty (30) days of receipt or issuance of a notice provided in accordance with Section IV.A.1. above to all covered persons who are patients seen on a regular basis by the provider being removed or leaving the network, irrespective of whether it is for cause or without cause.

3. When the provider being removed or leaving the network is a primary care provider, all covered persons who are patients of that primary care provider shall also be notified. When the provider either gives or receives the notice in accordance with Section IV.A.1. of this bulletin, the provider shall supply the health carrier with a list of those patients of the provider that are covered by a plan of the health carrier.

4. A covered person must have been undergoing treatment by the provider being removed or leaving the network on a regular basis for that covered person to be considered in an "active course of treatment."

5. When a covered person's provider leaves or is removed from the network, a health carrier shall establish reasonable procedures to transition the covered person who is in an active course of treatment to a participating provider in a manner that provides for continuity of care

[4] Managed Care Plan is defined at §10-16-102(45), C.R.S.

6. A health carrier shall provide the notices required under paragraphs 1., 2. and 3. above, and shall make available to the covered person a list of available participating providers in the same geographic area who are of the same provider type and information about how the covered person may request continuity of care as provided under this paragraph.

7. A carriers transition procedures shall provide that:

   a. Any request for continuity of care shall be made to the health carrier by the covered person or the covered person's authorized representative;

   b. Requests for continuity of care shall be reviewed by the health carrier's Medical Director after consultation with the treating provider for patients who meet the criteria listed in Paragraph (2) and are under the care of a provider who has not been removed or leaving the network for cause. Any decisions made with respect to a request for continuity of care shall be subject to the health benefit plan's internal and external grievance and appeal processes in accordance with applicable state or federal law or regulations;

   c. The continuity of care period for covered persons who are in their second or third trimester of pregnancy shall extend through the postpartum period; and

   d. The continuity of care period for covered persons who are undergoing an active course of treatment shall extend to the earlier of:

      (1) The termination of the course of treatment by the covered person or the treating provider;

      (2) Ninety (90) days, unless the Medical Director determines that a longer period is necessary;

      (3) The date that care is successfully transitioned to a participating provider;

      (4) Benefit limitations under the plan are met or exceeded; or

      (5) Care is not medically necessary.

8. In addition to the provisions of Section IV.A.7.d. a continuity of care request may only be granted when:

   a. The provider agrees in writing to accept the same payment from and abide by the same terms and conditions with respect to the health carrier for that patient as provided in the original provider contract; and

   b. The provider agrees in writing not to seek any payment from the covered person for any amount for which the covered person would not have been responsible if the physician or provider were still a participating provider.

B. In accordance with § 10-16-704(3), C.R.S., the obligation to hold the patient harmless for services rendered in the provider's capacity as a participating provider survives the termination of the provider contract. The hold harmless obligation does not apply to services rendered after the termination of the provider contract, except to the extent that the network relationship is extended to provide continuity of care.

V. Additional Division Resources

Colorado Insurance Bulletin No. B-4.87

For More Information Colorado

Division of Insurance
Life and Health Rates and Forms Section 1560
Broadway, Suite 850
Denver, CO 80202
Tel. 303-894-7499
Toll Free: 1-800-930-3745
Internet: http://www.dora.colorado.gov/insurance

VI. History

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