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ResearchReport

Continuity of Care Requirements for Health Insurance

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Issue

Summarize Connecticut's continuity of care requirements for health insurance coverage and indicate when they were enacted. (This report updates and replaces OLR Report 2017-R-0332.)

Summary

Connecticut enacted health insurance continuity of care requirements in 2016 (PA 16-205). The legislature amended the requirements in 2018 (PA 18-115).

Continuity of care is generally impacted by network adequacy. As part of the state's network adequacy requirements, the law requires health carriers (e.g., insurers and HMOs) to (1) make a good faith effort to give written notice to the patients of a participating provider who is leaving the carrier's network and (2) provide for the continuity of care for patients in active courses of treatment with the provider so as to allow them to continue their treatments and transition to different participating providers (CGS § 38a-472f(g)).

Under the law, an "active course of treatment" is medically necessary (1) care provided during the second or third trimester of pregnancy or (2) ongoing treatment for a condition that, according to the treating provider, is life-threatening or serious or will worsen or interfere with anticipated outcomes if discontinued. A "serious condition" is one that requires complex, ongoing care such as chemotherapy, radiation therapy, or postoperative visits.

Written Notice When a Provider is Leaving a Network

The law requires that a health carrier and participating provider give each other at least 90 days' notice before the carrier removes the provider from the network or the provider leaves the network. It also requires a participating provider who has been removed from or is leaving the network to give the carrier a list of his or her patients covered under a network plan of the carrier (CGS § 38a-472f(g)(1)(A)&(B)).

By law, the carrier must make a good faith effort, within 30 days after providing or receiving a termination notice, to give written notice of the provider's departure from the network to each covered patient being treated on a regular basis by that provider. The carrier also must give the covered individual a list of the same type of available participating providers in the same geographic area and the procedures for requesting continuity of care (CGS § 38a-472f(g)(2)(B)(ii)).

Continuity of Care Requirements

By law, a carrier's continuity of care procedures must provide that:

1. a covered individual or his or her authorized representative may request continuity of care;
2. a continuity of care request for a covered individual undergoing an active course of treatment is reviewed by the carrier's medical director after consulting with the treating provider, as long as the treating provider is not leaving the network for cause; and
3. the continuity of care period for an individual in the second or third trimester of pregnancy extends through the postpartum period (CGS § 38a-472f(g)(2)(B)(iii)).

The continuity of care period for someone undergoing an active course of treatment must last until the earliest of the following:

1. the end of the course of treatment;
2. 90 days after the treating provider leaves the network, unless the health carrier's medical director decides a longer period is needed;
3. the date the individual's care is transitioned to another participating provider;
4. the date benefit limitations under the plan are met or exceeded; or
5. the date the carrier determines the care is no longer medically necessary (CGS § 38a-472f(g)(2)(B)(iv)).

A carrier can grant a continuity of care period only if the treating provider leaving the network agrees in writing to (1) accept the same payment and terms as when he or she was participating in

the network and (2) not seek any payment from a covered individual for any amount that would not have been part of the person's cost share if the provider was still in the network (CGS § 38a-472f(g)(2)(B)(v)).

Disputes Between Health Carriers and Hospitals

The network adequacy law also requires health carriers and hospitals involved in a contract dispute to continue to abide by the terms of their contract, including reimbursement terms, for 60 days after it expires or terminates (CGS § 38a-472f(g)(1)(C)).

This applies to contracts entered into, renewed, amended, or continued on or after July 1, 2018, between a health carrier and a participating provider hospital (i.e. a hospital that contracts with the carrier to be "in network") or the hospital's parent corporation. Except as otherwise agreed between a health carrier and a participating provider, the law requires the reimbursement terms of any new or renewed contract executed within the 60-day period to be retroactive to the date the original contract ended.

Health carriers and hospitals that mutually agree in writing to not renew or terminate a contract are exempt from the 60-day requirement as long as they provide the written notices described above, which include making a good faith effort to notify all impacted patients.

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