Continuity of Care

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➲ Instructions for Use

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Related Policies
None

Federal/State Mandated Regulations

Oklahoma

Oklahoma Statutes Title 36 Section 4509.1 – Liability of Carrier – Coverage by Succeeding Carrier-Benefits-Election of Coverage

https://law.justia.com/codes/oklahoma/2019/title-36/section-36-4509-1/

a. This section applies to determination of the liability of a carrier pursuant to a group or blanket accident or health insurance plan in those instances in which the contract of one carrier replaces a plan of similar benefits of another carrier. As used in this section, "carrier" means an insurer or other entity subject to the provisions of Title 36 of the Oklahoma Statutes, and includes but is not limited to a not-for-profit hospital service and medical indemnity corporation, a fraternal benefit society, a health maintenance organization and a multiple employer welfare arrangement.
b. The prior carrier shall be liable only to the extent of its accrued liabilities and extensions of benefits. The position of the prior carrier shall be the same whether the group policyholder or other entity responsible for making payments or submitting subscription charges to the carrier secures replacement coverage from a new carrier, self-insures, or foregoes the provision of coverage.
c. Each person who was covered by the plan of the prior carrier shall be covered by the plan of benefits of the succeeding carrier conditioned only upon the payment of the premium.
d. The succeeding carrier, in applying any deductibles or waiting periods in its plan, including but not limited to waiting periods for preexisting conditions, shall give credit for the satisfaction or partial satisfaction of the same or similar provisions under a prior plan providing similar benefits and shall not impose any additional waiting periods for coverage for any person who was covered by the plan of the prior carrier. In the case of deductible provisions, the credit shall apply for the same or overlapping benefit periods and shall be given for expenses actually incurred and applied against the deductible provisions of the prior plan during the ninety (90) days preceding the effective date of the succeeding plan but only to the extent these expenses are recognized under the terms of the plan of the succeeding carrier and are subject to similar deductible provision.
e. If a determination of the benefits of the prior plan is required and requested by the succeeding carrier, upon receiving such request, the prior carrier shall furnish a statement of the benefits available or pertinent information sufficient either to permit verification of the benefits available under the prior plan or to permit the determination of the benefits by the succeeding carrier. For the purposes of this subsection, benefits of the prior plan shall be determined in accordance with all of the definitions, conditions, and covered expense provisions of the prior plan and shall not be subject to the definitions, conditions, and covered expense provisions of the succeeding plan. The benefit determination shall be made as if coverage had not been replaced by the succeeding carrier.

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f. Nothing in this section shall prevent an individual from electing not to be covered under the plan of benefits of the succeeding carrier.

Oklahoma Statutes Title 36 §4509.2-Liability Duty of Succeeding Employer Lapse In Coverage

https://law.justia.com/codes/oklahoma/2019/title-36/section-36-4509-2/

a. When an insured individual or a dependent who was covered by group insurance pursuant to the provisions of the Health Insurance Portability and Accountability Act of 1996, 29 U.S.C.A., Section 1181 et seq., gains employment with an employer who provides for health insurance through a group plan, the succeeding group carrier shall accept the insured individual and dependents of the insured individual who were covered under the prior coverage and shall not apply limitations or exclusions based on preexisting conditions or apply waiting-period requirements for the insured individual or the dependents of the insured individual beyond the time when any surviving exclusion or waiting period with the prior carrier would have been fulfilled. The insured individual and any dependents of such individual must apply for the new coverage within sixty-three (63) days following the date of termination of prior creditable coverage.
b. When an insured individual or dependent who was covered by individual insurance pursuant to the provisions of the Health Insurance Portability and Accountability Act of 1996, 29 U.S.C.A., Section 1181 et seq., gains employment with an employer who provides for health insurance through a group plan, the succeeding group carrier shall accept the insured individual and dependents of the insured individual who were covered under the prior coverage and shall not apply limitations or exclusions based on preexisting conditions or apply waiting-period requirements for the insured individual or the dependents of the insured individual beyond the time when any surviving exclusion or waiting period with the prior carrier would have been fulfilled. The insured individual and any dependents of such individual must apply for the new coverage within sixty-three (63) days following the date of termination of prior creditable coverage.
c. Insurance carriers receiving an application for individual insurance may underwrite the risk or decline coverage based on the underwriting guidelines of the insurance carrier.
d. When there is a lapse in the coverage of the insured individual or a dependent of the insured individual provided for by subsections A, B, and C of this section for any reason other than a probationary period or similar waiting period imposed pursuant to personnel policies of an employer, the provisions of subsections A, B, and C of this section shall not apply to the person whose coverage lapsed.
e. When an individual employee who was covered under a group health insurance plan terminates employment with an employer and gains employment with another employer who provides for health insurance through a group plan, the carrier of the succeeding employer shall not apply preexisting conditions limitations or exclusions of preexisting conditions or apply waiting-period requirements for the individual employee or his dependents covered under the group plan of the previous employer beyond the time when any surviving exclusion or waiting period with the prior carrier would have been fulfilled, provided the individual employee applies for the new coverage within thirty-one (31) days following the date of eligibility for participation in the plan in accordance with the employment or personnel policies of the employer of such participation.
f. When there is a lapse in the coverage of the individual employee provided for by subsection E of this section for any reason other than a probationary period or similar waiting period imposed by the employment or personnel policies of the employer, the provisions of subsection E of this section shall not apply.

OAC-365:40-5-72 Continuation of Benefits

http://okrules.elaws.us/oac/365:40-5-72

a) If group or individual contracts are terminated by the HMO, provision shall be made for continuation of benefits to enrollees who, on the date of termination, are confined in an inpatient facility until their discharge or expiration of benefits according to the group or individual contract, and provision shall be made for pregnant enrollees through delivery and discharge. An HMO is not required to continue further benefits for an enrollee or group terminated for cause.
b) Each HMO shall have a plan for handling insolvency that allows for continuation of benefits for the duration of the contract period for which premiums have been paid, continuation of benefits for enrollees who are confined on the date of insolvency in an inpatient facility until their discharge or expiration of benefits, and continuation of benefits for pregnant enrollees through delivery and discharge. The Department shall require the plan to include one or more of the following:
   (1) Insurance to cover the expenses to be paid for continued benefits after the HMO's insolvency;
   (2) Provisions in provider contracts that obligate the provider to provide services for the duration of the period after the HMO's insolvency for which premium payment has been made and until the enrollees' discharge from inpatient facilities;
   (3) Insolvency reserves;

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(4) Acceptable letters of credit; and
(5) Any other arrangements to assure that benefits are continued as specified above.

Oregon

ORS 743B.341

https://www.oregonlaws.org/ors/743B.341
Continuation of benefits after termination of a group health insurance policy rules.

(1) Every group health insurance policy that provides coverage for hospital or medical services or expenses shall provide that the insurer shall continue its obligation for benefits under the policy for any person insured under the policy who is hospitalized on the date of termination if the policy is terminated and immediately replaced by a group health insurance policy issued by another insurer. Any payment required under this section is subject to all terms, limitations and conditions of the policy except those relating to termination of benefits. Any obligation by an insurer under this section continues until the hospital confinement ends or hospital benefits under the policy are exhausted, whichever is earlier.
(2) The Director of the Department of Consumer and Business Services may adopt rules providing for uninterrupted coverage for individuals insured under a group health insurance policy providing coverage for hospital or medical expenses, when such a policy is replaced by a policy of similar benefits, whether issued by the same insurer or another.

Texas

Texas Insurance Code §1252.202 - Effective Date of Coverage under Replacement Plan

https://statutes.capitol.texas.gov/DocViewer.aspx?DocKey=IN%2fIN.1252&Phrases=1252.202&HighlightType=1&ExactPhrase=False&QueryText=1252.202

a. An individual who was covered by a previous carrier's health benefit plan on the date on which that plan was discontinued shall be provided coverage under the succeeding carrier's health benefit plan as of the replacement plan's effective date if the individual:
   1) Is eligible for coverage because the individual is a member of a class eligible for coverage under the replacement plan and satisfies the replacement plan's actively at work and nonconfinement requirements; and
   2) Elects to be covered under the replacement plan
b. An individual who would be covered by the succeeding carrier under Subsection (a) but who does not satisfy the replacement plan's actively at work and nonconfinement requirements shall be covered under the replacement plan when the individual satisfies those requirements.

Texas Insurance Code §1252.207-Liability of Previous Carrier

https://statutes.capitol.texas.gov/DocViewer.aspx?DocKey=IN%2fIN.1252&Phrases=1252.207&HighlightType=1&ExactPhrase=False&QueryText=1252.207
A carrier of a health benefit plan that is being discontinued is liable only for any accrued liabilities regarding the plan and for any extension of benefits provided under the plan, regardless of whether the group policyholder or any other entity responsible for making payments or for submitting subscription charges to the carrier:

1. Replaces the coverage provided under the discontinued plan with health benefit plan coverage provided by another carrier;
2. Self-insures a health benefit plan; or
3. Does not provide health benefit plan coverage

Health Plan Note: In accordance with UnitedHealthcare’s Evidence of Coverage, a Member’s new carrier becomes responsible for all healthcare services as of the Member’s first date of eligibility with the plan. The Medical Group/IPA and Capitated Hospital become responsible to authorize and direct a Member’s care and pay claims as of the Member’s first date of eligibility with the new health plan, regardless of the Member’s inpatient status.

Washington

RCW 48.46.440 Continuation Option to be Offered

RCW 48.46.440: Continuation option to be offered. (wa.gov)
Every health maintenance organization that issues agreements providing group coverage for hospital or medical care shall offer the agreement holder an option to include an agreement provision granting a person who becomes ineligible for coverage under the group agreement, the right to continue the group benefits for a period of time and at a rate agreed upon. The

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agreement provision shall provide that when such coverage terminates the covered person may convert to an agreement as provided in RCW 48.46.450.

RCW 48.46.450 Conversion Agreement to be Offered – Exceptions, Conditions

https://app.leg.wa.gov/rcw/default.aspx?cite=48.46.450

(1) Except as otherwise provided by this section, any group health maintenance agreement that provides benefits for hospital or medical care must contain a provision granting a person covered by the group agreement the right to obtain a conversion agreement from the health maintenance organization upon termination of the person's eligibility for coverage under the group agreement.

(2) A health maintenance organization need not offer a conversion agreement to:
  - (a) A person whose coverage under the group agreement ended when the person's employment or membership was terminated for misconduct: PROVIDED, that when a person's employment or membership is terminated for misconduct, a conversion policy shall be offered to the spouse and/or dependents of the terminated employee or member. The policy shall include in the conversion provisions the same conversion rights and conditions which are available to employees or members and their spouses and/or dependents who are terminated for reasons other than misconduct;
  - (b) A person who is eligible for federal medicare coverage; or
  - (c) A person who is covered under another group plan, policy, contract, or agreement providing benefits for hospital or medical care.

(3) To obtain the conversion agreement, a person must submit a written application and the first premium payment for the conversion agreement not later than thirty-one days after the date the person's eligibility for group coverage terminates or thirty-one days after the date the person received notice of termination of coverage, whichever is later. The conversion agreement shall become effective without lapse of coverage, immediately following termination of coverage under the group agreement.

(4) If a health maintenance organization or group agreement holder does not renew, cancels, or otherwise terminates the group agreement, the health maintenance organization must offer a conversion agreement to any person who was covered under the terminated agreement unless the person is eligible to obtain group benefits for hospital or medical care within thirty-one days after such nonrenewal, cancellation, or termination of the group agreement or thirty-one days after the date the person received notice of termination of coverage, whichever is later.

(5) The health maintenance organization shall determine the premium for the conversion agreement in accordance with the organization's table of premium rates applicable to the age and class of risk of each person to be covered under the agreement and the type and amount of benefits provided.

State Market Plan Enhancements

None

Covered Benefits

Important Note: Covered benefits are listed in *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits* sections. Always refer to the *Federal/State Mandated Regulations* and *State Market Plan Enhancements* sections for additional covered services/benefits not listed in this section.

Refer to the member's evidence of coverage (EOC)/schedule of benefit (SOB) to determine coverage eligibility.

Under certain circumstances, new members of UnitedHealthcare may be able to temporarily continue receiving services from an out-of-network provider. This short-term transition assistance is intended for new members who are experiencing an acute episode of care while making the transition to UnitedHealthcare. Typically, this condition requires prompt medical attention and is of limited duration. (Examples include but are not limited to: pregnancy in the second or third trimester; being in an acute hospital or scheduled to be in the hospital immediately after your UnitedHealthcare coverage becomes effective; undergoing a course of chemotherapy, radiation therapy, or psychiatric counseling; being on a transplant list.)

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Continuing Care with a Terminated Provider

You may be eligible to continue receiving care from a terminated provider if the doctor didn't voluntarily end participation with UnitedHealthcare or a network medical group. The care must be medically necessary and the terminated provider must agree to the previous terms and conditions of his or her contract with UnitedHealthcare. The cause of termination by UnitedHealthcare or your network medical group also has to be for a reason other than a medical disciplinary cause, fraud or any criminal activity.

Continued care from the terminated provider may be provided for an acute or serious chronic condition for up to:

- Ninety (90) calendar days for members in the states of Oklahoma, Texas and Washington; or
- One hundred and twenty (120) calendar days for members in the state of Oregon; or
- A longer period until you can be safely transferred to another provider.

Continued care from a terminated provider may also be provided if you have a high-risk pregnancy or a pregnancy in the second or third trimester. Care may be extended through completed treatment of pregnancy-related and postpartum conditions, or until your care can be safely provided by another provider.

Continuity of Care (COC) for Members Transitioning from One Plan to Another Plan

Members transitioning from one plan to another plan with a provider that is not in-network may be eligible for COC. The member can apply for COC. Refer to the continuity of care section in the member's evidence of coverage (EOC)/schedule of benefit (SOB) for detailed instructions on applying for COC.

Not Covered

Continuity of care is not covered except as mentioned above in the *Federal/State Mandated Regulations*, *State Market Plan Enhancements* and *Covered Benefits* sections.

Policy History/Revision Information

Date	State(s) Affected	Summary of Changes
02/01/2024	All	**Supporting Information** • Archived previous policy version BIP024.M
	Oregon	**Covered Benefits** ***Continuing Care with a Terminated Provider*** • Replaced language indicating "continued care from the terminated provider may be provided for an acute or serious chronic condition for up to *ninety (90)* calendar days" with "continued care from the terminated provider may be provided for an acute or serious chronic condition for up to *one hundred and twenty (120)* calendar days"

Instructions for Use

Covered benefits are listed in three (3) sections: *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits*. All services must be medically necessary. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB). If there is a discrepancy between this policy and the member's EOC/SOB, the member's EOC/SOB provision will govern.

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