FAQ: Continuity of Care for New Covered California QHP Enrollees

This year, many Californians have enrolled in health coverage through Covered California for the first time. These plans, known as Qualified Health Plans or QHPs, are regulated by either the Department of Managed Health Care (DMHC) or the California Department of Insurance (CDI). If enrollees are not sure which agency regulates their plan, they can check online at www.dmhc.org. Enrollees in these plans may wish to continue receiving services, or continue seeing providers, from another plan in which they were previously enrolled. This FAQ will explain an enrollee’s right to continue care in different situations.

Can an enrollee continue treatment with an existing doctor who is not part of his/her new plan’s network?

A: Only if s/he is enrolled in a CDI regulated plan. When an enrollee in a CDI plan seeks care from out-of-network provider the plan may require him/her to pay higher copays or coinsurance to see that out-of-network provider. Most CDI plans do not require prior authorization for an enrollee to seek treatment from an out-of-network provider, but some EPO plans may require authorization. Enrollees should check with their plans to understand the rules about seeking care out-of-network.

DMHC-regulated plans in Covered California are not required to allow an enrollee to continue seeing a doctor if the doctor is not part of the plan's network, unless the subscriber was enrolled in an individual market plan that terminated between December 1, 2013 and March 31, 2014.1 To continue seeing an out-of-network provider, enrollees who were previously enrolled in an individual market plan that terminated between December 1, 2013 and March 31, 2014 must also have a qualifying condition, such as a chronic or terminal illness, pregnancy or care for a baby or toddler, or a scheduled or recommended treatment or procedure.2 For other enrollees, a DMHC regulated plan may always authorize continued treatment with an out-of-network doctor at its option, or refer enrollees to a doctor who is part of its network. Enrollees should talk to their plan and their primary care provider (PCP) about their

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1 While other DMHC plans are required to provide access to out-of-network providers to continue care for certain conditions, Covered California QHPs are considered individual subscriber plans, and are exempt from those requirements. Cal. Health & Safety Code § 1373.96(f).
2 Id. § 1373.96(c).
options. A new enrollee must choose a PCP within the plan’s network, or the plan will assign one for the person.³

Can an enrollee change plans if his/her treating providers were incorrectly listed as part of the plan in Covered California’s Provider Directory?

A: Yes, but only during open enrollment. After March 31, an enrollee may termination his/her enrollment with the current plan, but will not be allowed to sign-up with a new Covered California plan. Enrollees will be able to switch plans for enrollment starting January 1, 2015 at the next open enrollment period, which will start on November 15, 2014.

Can an enrollee continue to receive prescription medications that he/she is currently taking if the medication is not listed on the new plan’s formulary?

A: Enrollees have a right to receive medically necessary prescription drugs from his/her plan.⁴ To obtain medication that is not currently on the plan’s formulary, enrollees should first ask their plan provider to prescribe the medication. If their provider determines the medication is medically necessary, then the provider can submit a request to have the medication covered by the plan. If their plan provider doesn’t believe that the medication is necessary, or simply denies this request, then the enrollee can request a second opinion from another provider (see below for appeal rights).

If the provider submits a request for a non-formulary medication, the plan must have an “expeditious process” to approve or deny the request.⁵ If the plan denies this request, then the enrollee can appeal that decision (see below for appeal rights). In addition, DMHC regulated plans are required to have an internal process for a doctor to prescribe a medication that the doctor determines is medically necessary but is not on the plan’s formulary.⁶ A DMHC plan also must continue to cover a prescription medication (even if the plan’s

³ Id. § 1367(d).
⁴ Id. §§ 1367.005(a)(1), (d); CAL. INS. CODE § 10112.27(a)(1), (d).
⁵ CAL. HEALTH & SAFETY CODE § 1367.24(a); CAL. INS. CODE § 10123.135.
formulary changes) if it covered the drug before and the plan doctor agrees that the enrollee needs the medication to treat his/her condition. 

Is a plan required to continue previous treatment or honor an existing authorization for a previously scheduled medical procedure for a newly enrolled member?

A: An enrollee has a right to receive medically necessary care for most conditions. For specialty care services that may be considered medically necessary, see the HCA's KKA Chart pages 6-9; see also CHBRP’s January chart of mandates. A new enrollee must request that their new plan provider continue treatment or authorize a specific procedure. The plan provider will then need to document the medical necessity for the treatment or procedure to obtain plan authorization. If the new plan provider agrees, the new enrollee has a right to request that review and authorization by the plan be expedited in cases where further delay in treatment would be a risk to his/her health; in those cases the plan must decide within 72 hours whether or not to authorize treatment.

If an enrollee has an already-scheduled procedure that is at a facility or with a provider that is not part of their new plan’s network, the enrollee may be required to switch to a provider and facility that is part of his/her new plan to cover the procedure. If the enrollee chooses to continue treatment with an out-of-network provider, a plan regulated by DMHC will likely deny payment for the procedure. Most CDI plans will allow enrollees to continue treatment with the out-of-network provider but the enrollee may have to pay additional cost-sharing amounts to receive care out-of-network. Some CDI plans may require authorization before they will pay for out-of-network care.

Enrollees should check with their plans to understand the rules about seeking care out-of-network.

If an enrollee’s new plan denies authorization for a needed treatment or procedure, the enrollee can appeal that decision. (See appeal rights below).

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7 CAL. HEALTH & SAFETY CODE § 1367.22(a).
8 CAL. HEALTH & SAFETY CODE §§ 1345(b), 1367.005(a); CAL. INS. CODE § 10112.27(a).
9 CAL. HEALTH & SAFETY CODE §§ 1363.5, 1367.01; CAL. INS. CODE § 10123.135.
10 CAL. HEALTH & SAFETY CODE § 1367.01(h)(2); CAL. INS. CODE § 10123.135(h)(2).
How does an enrollee request a second opinion or appeal a denial of ongoing medication or continued treatment under his/her new plan?

A: If the enrollee’s new plan provider refuses to authorize ongoing treatment or medication, an enrollee has a right to request a second opinion. The plan must allow an enrollee to see a different plan doctor to review the request for continued treatment or medication.11 An enrollee may request a second opinion by filing a grievance with the plan. A grievance can be filed by simply contacting the plan’s member services department.

If the new plan denies authorization for ongoing treatment or medication because the plan does not consider it medically necessary, an enrollee has a right to file a grievance to request reconsideration of the plan’s decision.12 If the grievance is not resolved in the enrollee’s favor, or the plan does not resolve the grievance within 30 days, the enrollee can request an Independent Medical Review (IMR) from DMHC or CDI.13 IMR is a process wherein a medical expert who doesn’t work for the plan will review the plan’s decision to deny the request and will make an independent decision about whether or not to follow the plan’s decision.

When an enrollee has an urgent health need and waiting poses a serious threat to her health, she may ask for both a grievance and an IMR on an expedited basis.14 In these cases, the enrollee may request IMR if the plan has not responded to his or her grievance within 3 calendar days.15 The IMR organization must issue a decision within 3 days of receiving the request from the applicable department.16

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14 Cal. Health & Safety Code §§ 1368.01(b) (expedited grievances), 1374.31 (expedited IMRs); Cal. Ins. Code §§ 10169(j)(3) (expedited grievances), 10169.1 (expedited IMR).
16 This deadline can be extended by up to 3 days “for extraordinary circumstances or good cause.” Cal. Health & Safety Code § 1374.33(c); Cal. Ins. Code § 10169.3(c).