119th MAINE LEGISLATURE

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Legislative Document **No. 631**

H.P. 468 House of Representatives, January 26, 1999

An Act to Establish a Patient's Bill of Rights.

Reference to the Committee on Banking and Insurance suggested and ordered printed.

JOSEPH W. MAYO, Clerk

Presented by Representative BROOKS of Winterport.
Cosponsored by Senator PINGREE of Knox and
Representatives: HATCH of Skowhegan, KANE of Saco, SAXL of Bangor, SAXL of Portland, STANWOOD of Southwest Harbor, Senators: DAGGETT of Kennebec, FERGUSON of Oxford, PARADIS of Aroostook.

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 24 MRSA §2332-G, as reallocated by RR 1995, c. 2, §49 and affected by §50, is repealed.

Sec. 2. 24-A MRSA §2847-F, as reallocated by PL 1997, c. 370, Pt. H, §1, is repealed.

Sec. 3. 24-A MRSA §4241, as enacted by PL 1995, c. 617, §5 and affected by §6, is repealed.

Sec. 4. 24-A MRSA §4301, sub-§§2-A, 4-A, 4-B and 7 are enacted to read:

2-A. Health care treatment decision. "Health care treatment decision" means a determination made when medical services are provided by the health plan or a decision that affects the quality of the diagnosis, care or treatment provided to an enrollee of a health plan.

4-A. Medically appropriate care. "Medically appropriate care" means care that meets the standard for care for health care services as determined by health care providers in accordance with the prevailing practices and standards of the medical profession and community.

4-B. Ordinary care. "Ordinary care" means, in the case of a carrier, the degree of care that a carrier of ordinary prudence would use under the same or similar circumstances. For a person who is an employee, agent, ostensible agent or representative of a carrier, "ordinary care" means the degree of care that a person of ordinary prudence in the same profession, specialty or area of practice would use in the same or similar circumstances.

7. Point-of-service option. "Point-of-service option" means a health care delivery system that permits a health plan enrollee to receive services outside the network of participating providers without a referral from the enrollee's primary care provider.

Sec. 5. 24-A MRSA §4303, sub-§3-B is enacted to read:

3-B. Prohibition on financial incentives. A carrier offering a managed care plan in this State may not offer or pay any type of material inducement, bonus or other financial incentive to a participating provider to deny, reduce, withhold, limit or delay specific medically necessary and appropriate health care services covered under the plan to an enrollee.

Sec. 6. 24-A MRSA §4303, sub-§§5 and 6 are enacted to read:

5. Independent external review of coverage decisions. An enrollee who has exhausted all internal grievance and appeal procedures provided by a carrier offering a health plan in this State has the right to an independent external review of a health plan's decision to deny, reduce or terminate health care coverage or to deny payment for health care services. The independent external review must be conducted in accordance with the following.

A. The decision to be reviewed must require the health plan to incur at least $100 in expenditures and the health plan's decision must have been based on one of the following reasons.

(1) The health care service is a covered benefit that the carrier has determined to be not medically necessary.

(2) A limitation is placed on the selection of a health care provider that is claimed by the enrollee to be inconsistent with limits imposed by the health plan and any applicable laws and rules.

(3) The health care treatment has been determined to be experimental or investigational.

(4) The health care service involves a medically based decision that a condition is preexisting.

B. The independent external review must be requested in writing by the affected enrollee and the enrollee must pay a filing fee of not more than $50 that reflects the administrative costs of processing a request for review under this subsection. The filing fee may be waived or reduced based on a determination by the superintendent that the financial circumstances of the enrollee warrant a waiver or reduction.

C. Enrollees may use outside assistance during the review process and submit evidence relating to the health care service.

D. Independent external reviews must be conducted by independent review organizations pursuant to a contract with the bureau. The reviewers must be health care providers credentialed with respect to the health care service under review and have no conflict of interest relating to the performance of their duties under this subsection.

E. The independent review organization shall issue a written review decision based on the evidence presented to the health plan and the enrollee. The decision

of the review organization is binding on the health plan and the enrollee.

F. The superintendent may develop additional standards and adopt rules to set the fee required in paragraph A and to adopt other rules as necessary to carry out the purposes of this subsection in accordance with section 4309.

6. Offer of point-of-service option required. A carrier that restricts access to providers shall offer all eligible enrollees in a managed care plan a point-of-service option as an additional benefit for the enrollee to accept or reject.

Sec. 7. 24-A MRSA §4308, sub-§2 is enacted to read:

2. Right to sue. An enrollee's right to sue a carrier is governed by the following.

A. A carrier shall exercise ordinary care when making health care treatment decisions and is liable for damages for harm to an enrollee proximately caused by the failure of the carrier to exercise ordinary care.

B. A carrier is liable for damages for harm to an enrollee proximately caused by the health care treatment decisions made by its employees, agents, ostensible agents or representatives who are acting on behalf of the carrier and over whom the carrier has the right to exercise influence or control when that influence or control results in the failure to exercise ordinary care.

C. In an action under this subsection, the burden is on the carrier to prove that a length of hospital stay or course of treatment approved or denied by the carrier was consistent with medically appropriate care.

D. Standards of care required by paragraphs A and B do not require a carrier to provide to an enrollee treatment that is not covered by the health plan provided by the carrier.

E. The laws of the State prohibiting a person from practicing medicine may not be asserted by a carrier as a defense in any action.

F. In an action against a carrier, a finding that a physician or other health care provider is an employee, agent, ostensible agent or representative of the carrier may not be based solely on proof that the person's name appears in a listing of approved physicians or health care providers made available to enrollees under a health plan.

G. This subsection does not apply to workers' compensation insurance coverage.

Sec. 8. 24-A MRSA §§4310 to 4313 are enacted to read:

§4310. Access to prescription drugs

1. Formulary. If a health plan provides coverage for prescription drugs but the coverage limits such benefits to drugs included in a formulary, a carrier shall:

A. Ensure participation of participating physicians and pharmacists in the development of the formulary; and

B. Provide exceptions from the formulary limitation when a nonformulary alternative is medically indicated, consistent with the utilization review standards in section 4304.

2. Coverage of approved drugs and medical devices. A carrier that provides coverage for prescription drugs and medical devices may not deny coverage of a prescribed drug or medical device on the basis that the use of the drug or device is investigational when the intended use of the drug or device is included in the labeling authorized by the federal Food and Drug Administration.

3. Construction. This section may not be construed to require a carrier to provide coverage of prescription drugs or medical devices.

§4311. Access to specialists

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Specialist" means, with respect to a condition, a health care provider that has adequate expertise through appropriate training and experience to provide high-quality care in treating the condition.

B. "Special condition" means a condition or disease that is life-threatening, degenerative or disabling and requires specialized medical care over a prolonged period of time.

2. Obstetrical and gynecological services. The following requirements apply to the coverage of obstetrical and gynecological services.

A. With respect to health plans that require an enrollee to designate a primary care physician, the carrier shall allow

female enrollees to designate a participating physician who specializes in obstetrics and gynecology as the enrollee's primary care physician.

B. If a female enrollee has not designated a physician who specializes in obstetrics and gynecology as her primary care physician, the carrier may not require authorization or referral by the enrollee's primary care physician for coverage of routine gynecological care, including annual examinations, and pregnancy-related services provided by a participating health care professional who specializes in obstetrics and gynecology to the extent such care is otherwise covered. The carrier shall treat the ordering of other gynecological care by such a participating provider as the authorization of the primary care physician with respect to such care under the plan.

C. This subsection may not be construed as waiving any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of gynecological care ordered.

3. Specialists as primary care physicians. A carrier shall have a procedure to allow an enrollee who has an ongoing special condition to receive a referral to a specialist who is responsible for and capable of providing and coordinating the enrollee's primary and specialty care. If the enrollee's care would most appropriately be coordinated by such a specialist, the carrier shall allow the specialist to serve as the enrollee's primary care physician. A specialist treating an enrollee in accordance with this subsection must be permitted to treat the enrollee without a referral from the enrollee's primary care physician and may authorize any referrals, procedures, tests and other medical services the enrollee's primary care physician would otherwise be permitted to provide or authorize, subject to the terms of a treatment plan.

4. Referrals to specialists. If an enrollee has a condition or disease of sufficient seriousness and complexity to require treatment by a specialist and benefits for such treatment are provided under the plan, the carrier shall make or provide for a referral to a specialist who is available and accessible to provide the treatment for that condition or disease in accordance with the following.

A. A carrier may require that the care provided to an enrollee as a result of a referral under this subsection be pursuant to a treatment plan developed by the specialist and approved by the carrier in consultation with the enrollee and the enrollee's primary care physician in accordance with applicable quality assurance and utilization review standards of the carrier.

B. A carrier is not required to provide for a referral to a specialist that is not a participating provider unless the carrier does not have an appropriate specialist that is available and accessible to treat the enrollee's condition.

C. If a carrier refers an enrollee to a nonparticipating specialist, the specialist must provide the services pursuant to the treatment plan at no additional cost to the enrollee beyond what the enrollee would otherwise pay for services rendered by such a specialist that is a participating provider.

5. Standing referrals to specialists. A carrier shall have a procedure to allow an enrollee who has a condition that requires ongoing care from a specialist to receive a standing referral to such a specialist for treatment of the condition. If the carrier, or the enrollee's primary care physician in consultation with the carrier's medical director, determines that a standing referral is appropriate, the carrier shall make a referral to a specialist.

§4312. Access to clinical trials

1. Qualified individual. An enrollee is eligible for coverage for participation in an approved clinical trial if the enrollee meets the following conditions:

A. The enrollee has a life-threatening or serious illness for which no standard treatment is effective;

B. The enrollee is eligible to participate according to the clinical trial protocol with respect to treatment of that illness;

C. The enrollee's participation in the trial offers meaningful potential for significant clinical benefit to the enrollee; and

D. The enrollee's referring physician has concluded that the enrollee's participation in such a trial is appropriate based upon the satisfaction of the conditions in paragraphs A, B and C.

2. Coverage. A carrier may not deny an enrollee participation in an approved clinical trial or deny, limit or impose additional conditions on the coverage of routine patient costs for items and services furnished in connection with participation in the clinical trial. For the purposes of this subsection, "routine patient costs" do not include the costs of

the tests or measurements conducted primarily for the purpose of the clinical trial involved.

3. Payment. A carrier shall provide payment for routine patient costs but is not required to pay for costs of items and services that are reasonably expected to be paid for by the sponsors of an approved clinical trial. In the case of covered items and services, the carrier shall pay participating providers at the rate agreed upon and pay nonparticipating providers at the same rate the carrier would pay for comparable services performed by participating providers.

4. Approved clinical trial. For the purposes of this section, an "approved clinical trial" means a clinical research study or clinical investigation approved and funded by the National Institutes of Health or a cooperative group or center of the National Institutes of Health.

§4313. Continuity of care

1. Termination of provider. If a contract between a carrier and a provider is terminated or benefits or coverage provided by a provider are terminated because of a change in the terms of provider participation in a health plan and an enrollee is undergoing a course of treatment from the provider at the time of termination, the carrier shall:

A. Notify the enrollee on a timely basis of the termination; and

B. Permit the enrollee to continue or be covered with respect to the course of treatment with the provider during a transitional period in accordance with subsections 2 and 3.

2. Transitional period. The transitional period must extend for at least 90 days from the date of notice to the enrollee of the provider's termination except in the following instances.

A. If the enrollee has entered the 2nd trimester of pregnancy at the time of the provider's termination and the provider has been treating the enrollee during the pregnancy, the transitional period must extend through the provision of postpartum care directly related to the pregnancy.

B. The transitional period for institutional or inpatient care must extend until the discharge or termination of the period of institutionalization and also include institutional care provided within a reasonable time of the

date of termination of the provider if the care was scheduled before the date of the notice of termination or if the enrollee was on an established waiting list or otherwise scheduled to have such care on the date of notice of termination.

C. If an enrollee was terminally ill at the time of termination of the provider and the provider was treating the terminal illness before the date of termination, the transitional period must extend for the remainder of the enrollee's life for care directly related to the treatment of the terminal illness.

3. Terms and conditions of continuity of care. A carrier may condition coverage of continued treatment by a provider under subsection 1 upon the provider's agreeing to the following terms and conditions.

A. The provider agrees to accept reimbursement from the carrier at the rates applicable prior to the start of the transitional period as payment in full and not to impose cost-sharing with respect to the enrollee in an amount that would exceed the cost-sharing that could have been imposed if the contract between the carrier and the provider had not been terminated.

B. The provider agrees to adhere to the quality assurance standards of the carrier responsible for payment and to provide the carrier necessary medical information related to the care provided.

C. The provider agrees otherwise to adhere to the carrier's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to any treatment plan approved by the carrier.

Sec. 9. 24-A MRSA §4323 is enacted to read:

§4323. Independent consumer ombudsman program

Notwithstanding the requirements of section 4321, the State shall establish an independent consumer ombudsman program through a contract with a nonprofit organization that operates independently of health plans and carriers. The program must provide consumer assistance and advocacy to health plan enrollees in choosing among carriers or among coverage options offered by health plans and provide counseling and assistance to enrollees dissatisfied with their treatment by carriers in regard to health plan coverage and with respect to grievances and appeals regarding coverage determinations under such plans.

SUMMARY

This bill incorporates into Maine law many of the provisions contained in the proposed federal "Patients' Bill of Rights" legislation. The provisions govern the following:

1. Access to out-of-network providers;

2. Access to obstetrical and gynecological care;

3. Access to specialty care;

4. Continuity of care;

5. Access to prescription drugs;

6. Access to clinical trials;

7. Availability of independent external review of appeals;

8. Prohibition of financial incentives for providers;

9. Establishment of an independent nonprofit health care ombudsman program; and

10. Right of enrollees to sue health plans.