R. & S.

L.D. 750

DATE: 4-5-00 (Filing No. H-1062)

REPORT B

BANKING AND INSURANCE

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STATE OF MAINE
HOUSE OF REPRESENTATIVES
119TH LEGISLATURE
SECOND REGULAR SESSION

COMMITTEE AMENDMENT "B" to H.P. 543, L.D. 750, Bill, "An Act to Establish a Patient's Bill of Rights"

Amend the bill by striking out everything after the enacting clause and before the summary and inserting in its place the following:

'**Sec. 1. 24-A MRSA §4301,** as amended by PL 1999, c. 256, Pt. A, §1, is repealed.

Sec. 2. 24-A MRSA §4301-A is enacted to read:

§4301-A. Definitions

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings.

1. Adverse health care treatment decision. "Adverse health care treatment decision" means a health care treatment decision made by or on behalf of a carrier offering a health plan denying in whole or in part payment for or provision of otherwise covered services requested by or on behalf of an enrollee.

2. Authorized representative. "Authorized representative" means:

A. A person to whom an enrollee has given express written consent to represent the enrollee in an external review;

B. A person authorized by law to provide consent to request an external review for an enrollee; or

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C. A family member of an enrollee or an enrollee's treating health care provider when the enrollee is unable to provide consent to request an external review.

3. Carrier. "Carrier" means:

A. An insurance company licensed in accordance with this Title to provide health insurance;

B. A health maintenance organization licensed pursuant to chapter 56;

C. A preferred provider arrangement administrator registered pursuant to chapter 32;

D. A fraternal benefit society, as defined by section 4101;

E. A nonprofit hospital or medical service organization or health plan licensed pursuant to Title 24;

F. A multiple-employer welfare arrangement licensed pursuant to chapter 81; or

G. A self-insured employer subject to state regulation as described in section 2848-A.

An employer exempted from the applicability of this chapter under the federal Employee Retirement Income Security Act of 1974, 29 United States Code, Sections 1001 to 1461 (1988) is not considered a carrier.

4. Clinical peer. "Clinical peer" means a physician or other licensed health care practitioner who holds a nonrestricted license in a state of the United States in the same or similar specialty as typically manages the medical condition, procedure or treatment under review, or other physician or health care practitioner with demonstrable expertise necessary to review a case.

5. Enrollee. "Enrollee" means an individual who is enrolled in a health plan or a managed care plan.

6. Health care treatment decision. "Health care treatment decision" means a decision regarding diagnosis, care or treatment when medical services are provided by a health plan, or a benefits decision involving issues of medical necessity, preexisting condition determinations and determinations regarding experimental or investigational services.

7. Health plan. "Health plan" means a plan offered or administered by a carrier that provides for the financing or delivery of health care services to persons enrolled in the plan, other than a plan that provides only accidental injury, specified disease, hospital indemnity, Medicare supplement, disability income, long-term care or other limited benefit coverage.

8. Independent review organization. "Independent review organization" means an entity that conducts independent external reviews of adverse health care treatment decisions.

9. Managed care plan. "Managed care plan" means a plan offered or administered by a carrier that provides for the financing or delivery of health care services to persons enrolled in the plan through:

A. Arrangements with selected providers to furnish health care services; and

B. Financial incentives for persons enrolled in the plan to use the participating providers and procedures provided for by the plan.

A return to work program developed for the management of workers' compensation claims may not be considered a managed care plan.

10. Medical necessity. "Medical necessity" means health care services or products that a prudent physician or other health care practitioner would provide to an enrollee for the purpose of preventing, diagnosing or treating an illness, injury, disease or the symptoms of an illness, injury or disease in a manner that is:

A. In accordance with generally accepted standards of medical practice;

B. Clinically appropriate in terms of type, frequency, extent, site and duration; and

C. Not primarily for the convenience of the enrollee or physician or other health care practitioner.

11. Participating provider. "Participating provider" means a licensed or certified provider of health care services, including mental health services, or health care supplies that has entered into an agreement with a carrier to provide those services or supplies to an individual enrolled in a managed care plan.

12. Peer-reviewed medical literature. "Peer-reviewed medical literature" means scientific studies published in at least 2 articles from major peer-reviewed medical journals that present supporting data that the proposed use of a drug or device is safe and effective.

13. Plan sponsor. "Plan sponsor" means an employer, association, public agency or any other entity providing a health plan.

14. Provider. "Provider" means a practitioner or facility licensed, accredited or certified to perform specified health care services consistent with state law.

15. Religious nonmedical provider. "Religious nonmedical provider" means a provider who provides only religious nonmedical treatment or religious nonmedical nursing care.

16. Special condition. "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.

17. Specialist. "Specialist" means an appropriately licensed and credentialed health care provider with specialized training and clinical expertise.

18. Standard reference compendia. "Standard reference compendia" means:

A. The United States Pharmacopeia Drug Information or information published by its successor organization; or

B. The American Hospital Formulary Service Drug Information or information published by its successor organization.

Sec. 3. 24-A MRSA §4302, sub-§1, ¶¶H and I, as enacted by PL 1995, c. 673, Pt. C, §1 and affected by §2, are amended to read:

H. Procedures an enrollee must follow to obtain drugs and medicines that are subject to a plan list or plan formulary, if any; a description of the formulary; and a description of the extent to which an enrollee will be reimbursed for the cost of a drug that is not on a plan list or plan formulary. Enrollees may request additional information related to specific drugs that are not on the drug formulary; and

I. Information on where and in what manner health care services may be obtained.;

Sec. 4. 24-A MRSA §4302, sub-§1, ¶¶J and K are enacted to read:

J. A description of the independent external review procedures and the circumstances under which an enrollee is entitled to independent external review as required by this chapter; and

K. A description of the requirements for enrollees to obtain coverage of routine costs of clinical trials and information on the manner in which enrollees not eligible to participate in clinical trials may qualify for the compassionate use program of the federal Food and Drug Administration for use of investigational drugs pursuant to 21 Code of Federal Regulations, Section 312.34, as amended.

Sec. 5. 24-A MRSA §4303, sub-§1, as enacted by PL 1995, c. 673, Pt. C, §1 and affected by §2, is amended to read:

1. Demonstration of adequate access to providers. A carrier offering a managed care plan shall provide to its members reasonable access to health care services in accordance with standards developed by rule by the superintendent ~~before January 1, 1997~~. These standards must consider the geographical and transportational problems in rural areas. All managed care plans covering residents of this State must provide reasonable access to providers consistent with the access-to-services requirements of any applicable bureau rule.

Sec. 6. 24-A MRSA §4303, sub-§3-B is enacted to read:

3-B. Prohibition on financial incentives. A carrier offering a managed care plan 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. This subsection may not be construed to prohibit contracts that contain incentive plans that involve general payments such as capitation payments or risk-sharing agreements that are made with respect to providers or groups of providers or that are made with respect to groups of enrollees.

Sec. 7. 24-A MRSA §4303, sub-§4, ¶A, as enacted by PL 1995, c. 673, Pt. C, §1 and affected by §2, is amended to read:

A. The grievance procedure must include, at a minimum, the following:

(1) Notice to the enrollee promptly of any claim denial or other matter by which enrollees are likely to be aggrieved, stating the basis for the decision, the right to file a grievance, the procedure for doing so and the time period in which the grievance must be filed;

(2) Timelines within which grievances must be processed, including expedited processing for exigent circumstances. Timelines must be sufficiently expeditious to resolve grievances promptly;

(3) Procedures for the submission of relevant information and enrollee participation;

(4) Provision to the aggrieved party of a written statement upon the conclusion of any grievance process, setting forth the reasons for any decision. The statement must include notice to the aggrieved party of any subsequent appeal or external review rights ~~within the plan~~, the procedure and time limitations for ~~taking such an appeal~~, exercising those rights and notice of the right to file a complaint with the Bureau of Insurance and the toll-free telephone number of the bureau; and

(5) Decision-making by one or more individuals not previously involved in making the decision subject to the grievance.

Sec. 8. 24-A MRSA §4303, sub-§4, ¶C is enacted to read:

C. In any appeal under the grievance procedure, the carrier shall provide auxiliary telecommunications devices or qualified interpreter services by a person proficient in American Sign Language when requested by an enrollee who is deaf or hard-of-hearing or printed materials in an accessible format, including Braille, large-print materials, computer diskette, audio cassette or a reader when requested by an enrollee who is visually impaired to allow the enrollee to exercise the enrollee's right to an appeal under this subsection.

Sec. 9. 24-A MRSA §4303, sub-§§6 and 7 are enacted to read:

6. Standing referrals to specialists. A carrier shall

establish and maintain a procedure to allow an enrollee with a special condition requiring ongoing care from a specialist to receive a standing referral to a specialist participating in the carrier's network for treatment of that special condition. If the carrier or the enrollee's primary care provider, in consultation with the carrier's medical director, determines that a standing referral is appropriate, the carrier shall ensure that the enrollee receives such a referral to a specialist. If a specialist able to treat the enrollee's special condition does not participate in the carrier's network, then the carrier shall ensure that the enrollee receives a standing referral to a nonparticipating specialist. A standing referral must be made pursuant to a treatment plan approved by the carrier's medical director in consultation with the enrollee's primary care provider. After the standing referral is made, the specialist is authorized to provide health care services to the enrollee in the same manner as the enrollee's primary care provider, subject to the terms of the treatment plan.

7. Continuity of care. If a contract between a carrier and a provider is terminated or benefits or coverage provided by a provider is 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 provide continuity of care in accordance with the requirements in paragraphs A to C. This section does not apply to provider terminations exempt from the requirements of subsection 3-A.

If a managed care contract for the provision of health insurance coverage between a plan sponsor and a carrier is replaced within the meaning of section 2849 with a different managed care contract and a health care provider that has been providing health care services to an enrollee is not in the replacement carrier's network, the replacement carrier shall provide continuity of care in accordance with the requirements in paragraphs A to C in the same manner as if the provider had been terminated from the replacement carrier's network as of the date of the policy replacement, but only with respect to benefits that are covered under the replacement contract.

A. The carrier shall notify an enrollee of the termination of the provider's contract at least 60 days in advance of the date of termination. When circumstances related to the termination render such notice impossible, the carrier shall provide affected enrollees as much notice as is reasonably possible. The notice given to the enrollee must include instructions on obtaining an alternate provider and must offer the carrier's assistance with obtaining an alternate provider and ensuring that there is no inappropriate disruption in the enrollee's ongoing treatment.

B. The carrier shall permit the enrollee to continue or be covered, with respect to the course of treatment with the provider, for a transitional period of at least 60 days from the date of notice to the enrollee of the provider's termination except that if an enrollee is in the 2nd trimester of pregnancy at the time of the provider's termination and the provider is treating the enrollee during the pregnancy, the transitional period must extend through the provision of postpartum care directly related to the pregnancy.

C. A carrier may make coverage of continued treatment by a provider under paragraph B conditional upon the provider's agreeing to the following terms and conditions.

(1) The provider agrees to accept reimbursement from the carrier at 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.

(2) 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.

(3) The provider agrees otherwise to adhere to the carrier's policies and procedures, including procedures regarding referrals and prior authorizations and providing services pursuant to any treatment plan approved by the carrier.

Sec. 10. 24-A MRSA §4304, first ¶, as enacted by PL 1995, c. 673, Pt. C, §1 and affected by §2, is amended to read:

The following requirements apply to health plans doing business in this State that require prior authorization by the plan of health care services or otherwise subject payment of health care services to review for clinical necessity, appropriateness, efficacy or efficiency. A carrier offering a health plan subject to this section that contracts with other entities to perform utilization review on the carrier's behalf is responsible for ensuring compliance with this section and chapter 34.

Sec. 11. 24-A MRSA §4304, sub-§2, as enacted by PL 1995, c. 673, Pt. C, §1 and affected by §2, is amended to read:

2. Prior authorization of nonemergency services. Requests by a provider for prior authorization of a nonemergency service must be answered by a carrier within 2 business days. Both the provider and the enrollee on whose behalf the authorization was requested must be notified by the carrier of its determination. If the information submitted is insufficient to make a decision, the carrier shall notify the provider within 2 business days of the additional information necessary to render a decision. If the carrier determines that outside consultation is necessary, the carrier shall notify the provider and the enrollee for whom the service was requested within 2 business days. The carrier shall make a good faith estimate of when the final determination will be made and contact the enrollee and the provider as soon as practicable. Notification requirements under this subsection are satisfied by written notification postmarked within the time limit specified.

Sec. 12. 24-A MRSA §4304, sub-§5 is enacted to read:

5. Emergency services. When conducting utilization review or making a benefit determination for emergency services, a carrier shall provide benefits for emergency services consistent with the requirements of any applicable bureau rule.

Sec. 13. 24-A MRSA §4305, first ¶, as enacted by PL 1995, c. 673, Pt. C, §1 and affected by §2, is amended to read:

A carrier offering a health plan that subjects payment of benefits for otherwise covered services to review for clinical necessity, appropriateness, efficacy or efficiency must meet the following requirements relating to quality of care.

Sec. 14. 24-A MRSA §4306, as amended by PL 1999, c. 396, §6 and affected by §7, is further amended to read:

§4306. Enrollee choice of primary care provider

A carrier offering a managed care plan shall allow enrollees to choose their own primary care providers, as allowed under the managed care plan's rules, from among the panel of participating providers made available to enrollees under the managed care plan's rules. A carrier shall allow physicians, and certified nurse practitioners who have been approved by the State Board of Nursing to practice advanced practice registered nursing without the supervision of a physician pursuant to Title 32, section 2102, subsection 2-A, to serve as primary care providers for managed care plans. A carrier is not required to contract with certified nurse practitioners or physicians as primary care providers in any manner that exceeds the access and provider

network standards required in this chapter or chapter ~~56-A~~ 56, or any rules adopted pursuant to those chapters. A ~~managed--care plan~~ carrier must allow enrollees in a managed care plan to change primary care providers without good cause at least once annually and to change with good cause as necessary. When an enrollee fails to choose a primary care provider, the ~~managed care plan~~ carrier may assign the enrollee a primary care provider located in the same geographic area in which the enrollee resides.

Sec. 15. 24-A MRSA §4307, sub-§§2 and 3, as enacted by PL 1995, c. 673, Pt. C, §1 and affected by §2, are amended to read:

2. Additional benefits. Prohibit any plan sponsor from providing additional coverage for benefits, rights or protections not set out in this chapter; ~~or~~

3. Provider participation. Require a carrier to admit to a managed care plan a provider willing to abide by the terms and conditions of the managed care plan~~.~~; or

Sec. 16. 24-A MRSA §4307, sub-§4 is enacted to read:

4. Treatment by religious nonmedical providers. With respect to coverage of treatment by religious nonmedical providers:

A. Restrict or limit the right of a carrier to include a religious nonmedical provider as a participating provider in a managed care plan;

B. Require a carrier to:

(1) Utilize medically based eligibility standards or criteria in deciding provider status of religious nonmedical providers;

(2) Use medical professionals or criteria to decide enrollee access to religious nonmedical providers;

(3) Utilize medical professionals or criteria in making decisions in internal or external appeals regarding coverage for care by religious nonmedical providers; or

(4) Compel an enrollee to undergo a medical examination or test as a condition of receiving coverage for treatment by a religious nonmedical provider; or

C. Require a carrier to exclude religious nonmedical

providers because the providers do not provide medical or other required data, if such data is inconsistent with the religious nonmedical treatment or nursing care provided by the provider.

Sec. 17. 24-A MRSA §4308, as enacted by PL 1995, c. 673, Pt. C, §1 and affected by §2, is repealed and the following enacted in its place:

§4308. Indemnification

A contract between a carrier offering a health plan and a provider for the provision of services to enrollees may not require the provider to indemnify the carrier for any expenses and liabilities, including, without limitation, judgments, settlements, attorney's fees, court costs and any associated charges incurred in connection with any claim or action brought against the health plan based on the carrier's own fault. Nothing in this section may be construed to remove responsibility of a carrier or provider for expenses or liabilities caused by the carrier's or provider's own negligent acts or omissions or intentional misconduct.

Sec. 18. 24-A MRSA §§4310 to 4312 are enacted to read:

§4310. Access to clinical trials

1. Qualified enrollee. 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 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 such 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 would be appropriate based upon the satisfaction of the conditions in paragraphs A, B and C.

2. Coverage. A carrier may not deny a qualified 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 section, "routine patient costs" does 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 agreed upon rate 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, "approved clinical trial" means a clinical research study or clinical investigation approved and funded by the federal Department of Health and Human Services, National Institutes of Health or a cooperative group or center of the National Institutes of Health.

§4311. 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 to 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 if the intended use of the drug or device is included in the labeling authorized by the federal Food and Drug Administration or if the use of the drug or device is recognized in one of the standard reference compendia or in peer-reviewed medical literature.

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

§4312. Independent external review

An enrollee has the right to an independent external review of a carrier's adverse health care treatment decision made by or on behalf of a carrier offering a health plan in accordance with the requirements of this section. An enrollee's failure to obtain authorization prior to receiving an otherwise covered service may not preclude an enrollee from exercising the enrollee's rights under this section.

1. Request for external review. An enrollee or the enrollee's authorized representative shall make a written request for external review of an adverse health care treatment decision to the bureau. Except as provided in subsection 2, an enrollee may not make a request for external review until the enrollee has exhausted all levels of a carrier's internal grievance procedure. A request for external review must be made within 12 months of the date an enrollee has received a final adverse health care treatment decision under a carrier's internal grievance procedure. An enrollee may not be required to pay any filing fee as a condition of processing a request for external review.

2. Expedited request for external review. An enrollee or an enrollee's authorized representative is not required to exhaust all levels of a carrier's internal grievance procedure before filing a request for external review if:

A. The carrier has failed to make a decision on an internal grievance within the time period required;

B. The carrier and the enrollee mutually agree to bypass the internal grievance procedure;

C. The life or health of the enrollee is in serious jeopardy; or

D. The enrollee has died.

3. Notice to enrollees. A carrier shall notify an enrollee of the enrollee's right to request an external review in large type and easy-to-read language in a conspicuous location on the written notice of an adverse health care treatment decision. The notice must include:

A. A description of the external review procedure and the requirements for making a request for external review;

B. A statement informing an enrollee how to request assistance in filing a request for external review from the carrier;

C. A statement informing an enrollee of the right to attend the external review, submit and obtain supporting material relating to the adverse health care treatment decision under review, ask questions of any representative of the carrier and have outside assistance; and

D. A statement informing an enrollee of the right to seek assistance or file a complaint with the bureau and the toll-free number of the bureau.

4. Independent external review; bureau oversight. The bureau shall oversee the external review process required under this section and shall contract with approved independent review organizations to conduct an external review and render an external review decision. At a minimum, an independent review organization approved by the bureau shall ensure the selection of qualified and impartial reviewers who are clinical peers with respect to the adverse health care treatment decision under review and who have no professional, familial or financial conflict of interest relating to a carrier, enrollee, enrollee's authorized representative or health care provider involved in the external review.

5. Independent external review decision; timelines. An external review decision must be made in accordance with the following requirements.

A. In rendering an external review decision, the independent review organization must give consideration to the appropriateness of the requested covered service based on the following:

(1) All relevant clinical information relating to the enrollee's physical and mental condition, including any competing clinical information;

(2) Any concerns expressed by the enrollee concerning the enrollee's health status; and

(3) All relevant clinical standards and guidelines, including, but not limited to, those standards and guidelines relied upon by the carrier or the carrier's utilization review entity.

B. An external review decision must be issued in writing and must be based on the evidence presented by the carrier and the enrollee or the enrollee's authorized representative. An enrollee may submit and obtain evidence relating to the adverse health care treatment decision under

review, attend the external review, ask questions of any representative of the carrier present at the external review and use outside assistance during the review process at the enrollee's own expense.

C. Except as provided in paragraph D, an external review decision must be rendered by an independent review organization within 30 days of receipt of a completed request for external review from the bureau.

D. An external review decision must be made as expeditiously as an enrollee's medical condition requires but in no event more than 72 hours after receipt of a completed request for external review if the time frame for review required under paragraph C would seriously jeopardize the life or health of the enrollee or would jeopardize the enrollee's ability to regain maximum function.

E. The carrier shall provide auxiliary telecommunications devices or qualified interpreter services by a person proficient in American Sign Language when requested by an enrollee who is deaf or hard-of-hearing or printed materials in an accessible format, including Braille, large-print materials, computer diskette, audio cassette or a reader when requested by an enrollee who is visually impaired to allow the enrollee to exercise the enrollee's right to an external review under this section.

6. Binding nature of decision. An external review decision is binding on the carrier. An enrollee or the enrollee's authorized representative may not file a request for a subsequent external review involving the same adverse health care treatment decision for which the enrollee has already received an external review decision pursuant to this section. An external review decision made under this section is not considered final agency action pursuant to Title 5, chapter 375, subchapter II.

7. Funding. A carrier against which a request for external review has been filed shall pay the cost of the independent external review to the bureau.

8. Rules. The bureau may adopt rules necessary to carry out the requirements of this section, including, without limitation, criteria for determining when multiple denials of benefits to the same enrollee for the same or similar reasons are considered the same adverse health care treatment decision. Notwithstanding the requirements of section 4309, rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter II-A.

9. Rights. This section may not be construed to remove or limit any legal rights or remedies of an enrollee or other person under state or federal law, including the right to file judicial actions to enforce rights.

10. Applicability. Decisions relating to the following health care services are subject to review pursuant to other review processes provided by applicable federal or state law and may not be reviewed pursuant to this section:

A. Health care services provided through Medicaid, Medicare, Title XXI of the Social Security Act or services provided under these programs through contracted health care providers;

B. Health care services provided to inmates by the Department of Corrections; or

C. Health care services provided pursuant to a health plan not subject to regulation by the State.

Sec. 19. Rules. Notwithstanding the Maine Revised Statutes, Title 24-A, section 4309, any rules adopted by the Superintendent of Insurance to amend Bureau of Insurance Rule Chapter 850, Health Plan Accountability to make that rule consistent with the requirements of this Act are routine technical rules as defined in Title 5, chapter 375, subchapter II-A.

Sec. 20. Application. Those sections of this Act that enact the Maine Revised Statutes, Title 24-A, sections 4310 and 4311 apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2001. For purposes of this Act, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

Sec. 21. Allocation. The following funds are allocated from Other Special Revenue funds to carry out the purposes of this Act.

2000-01

PROFESSIONAL AND FINANCIAL REGULATION, DEPARTMENT OF

Bureau of Insurance

All Other $15,000

Provides for the allocation of funds to contract with approved independent review organizations to conduct an external review of adverse health care treatment decisions and render external review decisions.'

Further amend the bill by inserting at the end before the summary the following:

'FISCAL NOTE

2000-01

APPROPRIATIONS/ALLOCATIONS

Other Funds $15,000

This bill includes an Other Special Revenue funds allocation of $15,000 beginning in fiscal year 2000-01 for the Bureau of Insurance within the Department of Professional and Financial Regulation to contract with approved independent review organizations to conduct an external review of adverse health care treatment decisions and render an external review decision.

Providing enrollees in a health plan or managed care plan access to prescription drugs and clinical trials for qualified members, standing referrals to specialists for enrollees with special conditions, and continuity of care to enrollees undergoing a course of treatment when the enrollees' provider is terminated or their coverage changes to another carrier. These provisions are addressed at varying levels within the State's employee health insurance program and, therefore, are not expected to appreciably affect the costs of the state employee health insurance program or the State's share of retired teachers' health insurance.

The additional costs associated with legal work can be absorbed by the Department of the Attorney General utilizing existing budgeted resources.'

SUMMARY

This amendment is a minority report of the committee and replaces the bill. The amendment is the same as the majority report except that it does not contain a right-to-sue provision.