# MAINE STATE LEGISLATURE

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# 119th MAINE LEGISLATURE

## FIRST REGULAR SESSION-1999

**Legislative Document** **No. 750**

H.P. 543 House of Representatives, January 28, 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 SAXL of Bangor.
Cosponsored by Senators: DOUGLASS of Androscoggin, PINGREE of Knox, Senator LaFOUNTAIN of York and
Representatives: AHEARNE of Madawaska, BAGLEY of Machias, BROOKS of Winterport, FRECHETTE of Biddeford, HATCH of Skowhegan, LaVERDIERE of Wilton, SAVAGE of Buxton, STANLEY of Medway.

Printed on recycled paper

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**Sec. 1. 24 MRSA §2332-G,** as reallocated by RR 1995, c. 2, §49 and affected by §50, is repealed.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 H, §1, is repealed.

**Sec. 3. 24-A MRSA §4241,** as enacted by PL 1995, c. 617, §5 and affected by §6, is repealed.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

**4-B. Ordinary care.** "Ordinary care" means, in the case of a carrier, the degree of care that any 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 any 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, 5 and 6** are 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.

**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 is 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) The enrollee claims that the limitation placed on the selection of a health care provider is 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; or

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

B. The enrollee must request an independent external review and must pay a filing fee of not more than $50 for 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 must 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 B 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 who 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. 6. 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 coverage of emergency services in accordance with the requirements of Bureau of Insurance Rule Chapter 850, Health Plan Accountability.

**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 conditions.

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 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** is enacted to read:

**§4310. Access to prescription drugs**

**1. Formulary.** If a health plan provides coverage for prescription drugs but the coverage limits the 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 who 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.

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

**Sec. 9. 24-A MRSA §4311** is enacted to read:

**§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 who 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 would be covered if the services were performed by the enrollee's primary care physician. The carrier must treat the ordering of other gynecological care by such a participating provider as the authorization of the primary care physician with respect to that 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 so 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 such referrals, procedures, tests and other medical services as 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 the 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 who is not a participating provider unless the carrier does not have an appropriate specialist who is available and accessible to treat the enrollee's condition.

C. If a carrier refers an enrollee to a nonparticipating specialist, the specialist shall 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 who 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 the 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 the specialist.

**Sec. 10. 24-A MRSA §4312** is enacted to read:

**§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 the 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 the trial would be 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 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, 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.

**Sec. 11. 24-A MRSA §4313** is enacted to read:

**§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 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:

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 under subsection 1 except in the following instances.

A. If the 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.

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 the care on the date of notice of termination.

C. If an enrollee is terminally ill at the time of termination of the provider and the provider is 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 make coverage of continued treatment by a provider under subsection 1 conditional upon the provider 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 under subsection 1.

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.

## SUMMARY

This bill incorporates into law many of the provisions contained in the proposed federal patient bill of rights legislation. The provisions govern the following:

1. Coverage of emergency services;

2. Access to out-of-network providers;

3. Access to obstetrical and gynecological care;

4. Access to specialty care;

5. Continuity of care;

6. Access to prescription drugs;

7. Access to clinical trials;

8. Availability of independent external review of appeals;

9. Prohibition on financial incentives for providers; and

10. Right of enrollees to sue health plans.