119th MAINE LEGISLATURE

FIRST REGULAR SESSION-1999

Legislative Document **No. 1619**

S.P. 557 In Senate, March 2, 1999

An Act to Create a Patients' Bill of Rights.

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

JOY J. O'BRIEN
Secretary of the Senate

Presented by President LAWRENCE of York.
Cosponsored by Senators: LaFOUNTAIN of York, LONGLEY of Waldo, PINGREE of Knox,
Representatives: BROOKS of Winterport, KANE of Saco, SULLIVAN of Biddeford.

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Sec. 1. 24 MRSA §2332-G, as reallocated by RR 1995, c. 2, §49 and affected by §50, is repealed.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 H, §1, is repealed.

Sec. 3. 24-A MRSA §4241, as enacted by PL 1995, c. 617, §5 and affected by §6, is repealed.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

5-A. 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 data that support the proposed use of drug or device as generally safe and effective.

7. 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. 5. 24-A MRSA §4302, sub-§2, as enacted by PL 1995, c. 673, Pt. C, §1 and affected by §2, is amended to read:

2. Plan complaint; adverse decisions; prior authorization statistics. A carrier shall provide annually to the superintendent information for each health plan that it offers on plan complaints, adverse decisions ~~and~~, prior authorization statistics and uniform quality data. This statistical information must contain, at a minimum:

A. The ratio of the number of complaints received by the plan to the total number of enrollees, reported by type of complaint and category of enrollee;

B. The ratio of the number of adverse decisions issued by the plan to the number of complaints received, reported by category;

C. The ratio of the number of prior authorizations denied by the plan to the number of prior authorizations requested, reported by category;

D. The ratio of the number of successful enrollee appeals to the total number of appeals filed;

E. The percentage of disenrollments by enrollees and providers from the health plan within the previous 12 months and the reasons for the disenrollments. With respect to enrollees, the information provided in this paragraph must differentiate between voluntary and involuntary disenrollments; ~~and~~

F. Enrollee satisfaction statistics, including provider-to-enrollee ratio by geographic region and medical specialty and a report on what actions, if any, the carrier has taken to improve complaint handling and eliminate the causes of valid complaints~~.~~;

G. Data on aggregate utilization of health care services by enrollees;

H. Data on the demographic characteristics of enrollees;

I. Data on disease-specific and age-specific mortality rates and, to the extent feasible, disease-specific and age-specific morbidity rates of enrollees; and

J. Data on quality indicators and health outcomes, including, to the extent feasible and appropriate, data on pediatric cases and on a gender-specific basis.

Sec. 6. 24-A MRSA §4303, sub-§§3-B and 5 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 decision under the health plan to deny, reduce or terminate health care coverage or to deny payment for health care services. The independent external review is subject to the following requirements.

A. The decision to be reviewed requires the health plan to incur at least $100 in expenditures and the decision under the health plan to be 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; or

(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 pays 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 may 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 B and to adopt other rules as necessary to carry out the purposes of this subsection in accordance with section 4309.

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 provisions.

A. A carrier has the duty to 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. 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.

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

E. 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.

F. 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 that are 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.

§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 must 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 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 is 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 health plan, the carrier shall make or provide for a referral to a specialist who is available and accessible to provide the treatment for such condition or disease in accordance with the following provisions.

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 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 enrollees who have 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 such an illness;

C. The enrollee's participation in the trial offers meaningful potential for a 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. 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.

3. 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.

4. 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.

§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 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, 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 assistance program

Notwithstanding the requirements of section 4321, the State shall establish an independent consumer assistance program through a contract with a nonprofit organization that operates independent 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 providing 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 those plans.

SUMMARY

This bill establishes a "Patients' Bill of Rights" for Maine residents enrolled in HMO's and other health plans. It will protect access to appropriate physicians and proper medical care and provide a means of recourse for patients who have been improperly denied such access. The bill will:

1. Ensure access to obstetrical and gynecological care;

2. Ensure access to specialty care for seriously ill patients;

3. Ensure continuity of care when a physician is dropped from a health plan;

4. Ensure access to prescription drugs;

5. Ensure access to clinical trials;

6. Provide patients with access to an independent external review of decisions regarding health care coverage and services;

7. Prohibit offering financial incentives to providers to limit necessary and appropriate medical care;

8. Establish an independent consumer assistance program to provide assistance and advocacy services to patients in selecting a health insurance plan, utilizing the plan and filing grievances and appeals of plan decisions;

9. Provide patients with the right to sue their health plan if the plan's failure to exercise ordinary care in making treatment decisions causes an injury to a patient; and

10. Require health plans to disclose information about their costs, benefits and performance.