119th MAINE LEGISLATURE

FIRST REGULAR SESSION-1999

Legislative Document **No. 1890**

S.P. 668 In Senate, March 16, 1999

An Act to Establish a Patients' Bill of Rights for Managed Care.

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

JOY J. O'BRIEN
Secretary of the Senate

Presented by Senator PINGREE of Knox.
Cosponsored by Representative SAXL of Bangor and
Senators: DOUGLASS of Androscoggin, KILKELLY of Lincoln, LaFOUNTAIN of York, President LAWRENCE of York, RAND of Cumberland, TREAT of Kennebec,
Representatives: MAYO of Bath, SAXL of Portland.

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Sec. 1. 24 MRSA §2332-G, as reallocated by RR 1995, c. 2, §49 and affected by §50, is repealed.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 H, §1, is repealed.

Sec. 3. 24-A MRSA §4222, sub-§3, as enacted by PL 1975, c. 503, is repealed.

Sec. 4. 24-A MRSA §4241, as enacted by PL 1995, c. 617, §5 and affected by §6, is repealed.

Sec. 5. 24-A MRSA §4301, sub-§1, as amended by PL 1997, c. 604, Pt. A, §1, is further amended to read:

1. Carrier. "Carrier" means an insurance company licensed in accordance with this Title, a health maintenance organization licensed pursuant to chapter 56, a preferred provider organization licensed pursuant to chapter 32, a nonprofit hospital or medical service organization licensed pursuant to Title 24 ~~or~~, a multiple-employer welfare arrangement licensed pursuant to chapter 81 or an employer maintaining an uninsured employee health plan described in section 2848-A or an employer maintaining or an insurer providing employee benefit excess insurance defined in section 707, subsection 1, paragraph C-1 for medical claims. 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.

Sec. 6. 24-A MRSA §4301, sub-§§1-A, 2-A, 2-B, 4-A and 4-B are enacted to read:

~~1-A.~~ Approved clinical trial. "Approved clinical trial" means:

A. A clinical research study or clinical investigation approved and funded, including funding through in-kind contributions, by the National Institutes of Health or a cooperative group or center of the National Institutes of Health; or

B. A study or investigation that has been reviewed and approved through a system of peer review that is comparable to the system of peer review of studies and investigations used by the National Institutes of Health and that ensures unbiased review of the highest scientific standards by

qualified individuals who have no interest in the outcome of the review.

2-A. Externally appealable decision. "Externally appealable decision" means a determination, as defined in Bureau of Insurance Rule Chapter 850, Section 5(A), by a carrier of an enrollee's appeal of a denial of benefits or coverage if the amount involved equals or exceeds $200. "Externally appealable decision" does not include a denial of coverage for services that are specifically listed in plan or coverage documents as excluded from coverage.

2-B. Health care treatment decision. "Health care treatment decision" means a determination regarding the provision of medical services by the health or managed care plan that affects the quality of the diagnosis, care or treatment provided to the carrier's enrollees.

4-A. Medically necessary or appropriate care. "Medically necessary or appropriate care" means care that meets the standard for care for health care services in accordance with the professional standards of medical practice. At a minimum, care is "medically necessary or appropriate care" if that care is reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, ameliorate, correct or cure defects, physical or mental illnesses or conditions that endanger life, cause pain or suffering, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap or disability or result in illness or infirmity.

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

Sec. 7. 24-A MRSA §4301, sub-§6, as enacted by PL 1995, c. 673, Pt. C, §1 and affected by §2, is amended to read:

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

Sec. 8. 24-A MRSA §4301, sub-§§7, 8, 9 and 10 are enacted to read:

7. Qualified enrollee. "Qualified enrollee" means an enrollee who:

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

B. Is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of that illness;

C. Is offered meaningful potential for significant clinical benefit by participation in an approved clinical trial; and

D. Meets one of the following criteria:

(1) Is recommended for participation in the clinical trial by a participating provider who has concluded that the enrollee's participation in the trial is appropriate based upon the enrollee's meeting the conditions described in paragraphs A to C; or

(2) Provides medical and scientific information that reasonably establishes that the enrollee's participation in the trial would be appropriate based upon the enrollee's meeting the conditions described in paragraphs A to C.

8. Special condition. "Special condition" means a condition or disease that:

A. Is life-threatening, degenerative or disabling; and

B. Requires specialized medical care.

9. Specialist. "Specialist" means a participating provider that has adequate expertise through appropriate specialty training and experience, including, in the case of a child, appropriate pediatric expertise to provide high quality care in treating the condition.

10. Termination. "Termination" includes the expiration or nonrenewal of a contract but does not include termination of a contract by the carrier for failure to meet applicable quality standards or for fraud.

Sec. 9. 24-A MRSA §4302, sub-§1, ¶H, as enacted by PL 1995, c. 673, Pt. C, §1 and affected by §2, is 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 any formulary exceptions consistent with section 4313; 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 or an exception under section 4313. Enrollees may request additional information related to specific drugs that are not on the drug formulary; and

Sec. 10. 24-A MRSA §4302, sub-§2, ¶F, as enacted by PL 1995, c. 673, Pt. C, §1 and affected by §2, is amended to read:

F. Enrollee satisfaction statistics and demographic information, including demographic characteristics of enrollees, disease-specific and age-specific mortality rates, 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.

Sec. 11. 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. Bureau of Insurance Rule, Chapter 850, section 7, applies to all carriers offering or administering a managed care plan.

Sec. 12. 24-A MRSA §4303, sub-§2, ¶D is enacted to read:

D. The credentialling process:

(1) Must include verification of a health care provider's license and a history of suspension or revocation of a health care provider's license;

(2) May not use a high-risk patient base or location of a provider in an area with residents with poorer health status as a basis for excluding providers from participation; or

(3) May not discriminate in selection of a health care professional to be a participating health care provider or with respect to the terms and conditions of that participation based on the professional's race, color, religion, sex, national origin, age, sexual orientation

or disability consistent with the Federal Americans with Disabilities Act of 1990.

Sec. 13. 24-A MRSA §4303, sub-§3, as enacted by PL 1995, c. 673, Pt. C, §1 and affected by §2, is amended to read:

3. Provider's right to advocate for medically appropriate care. A carrier offering a managed care plan may not terminate or otherwise discipline a participating provider because the provider advocates for medically appropriate health care. A carrier may not restrict a provider from disclosing to any enrollee any information the provider determines appropriate regarding the nature of treatment and any risks or alternatives to treatment, financial incentives that may affect the treatment of the patient, the availability of other therapy, consultations or tests or the decision of any plan to authorize or deny health care services or benefits.

A. For the purposes of this section, "to advocate for medically appropriate health care" means to discuss or recommend a course of treatment to an enrollee; to appeal a managed care plan's decision to deny payment for a service pursuant to an established grievance or appeal procedure; or to protest a decision, policy or practice that the provider, consistent with the degree of learning and skill ordinarily possessed by reputable providers, reasonably believes impairs the provider's ability to provide medically appropriate health care to the provider's patients.

B. Nothing in this subsection may be construed to prohibit a plan from making a determination not to pay for a particular medical treatment or service or to enforce reasonable peer review or utilization review protocols.

Sec. 14. 24-A MRSA §4303, sub-3-B is enacted to read:

3-B. Prohibition of contingent compensation arrangements. A carrier may not permit or provide compensation or anything of value to its employees, agents, contractors or participating providers in a manner that is based, directly or indirectly, on the quantity or type of adverse determinations rendered.

Sec. 15. 24-A MRSA §4303, sub-§4, ¶¶ C and D are enacted to read:

C. Grievances and appeals may be communicated orally by the enrollee or the enrollee's designee.

D. If the carrier fails to comply with any of the deadlines for completion of grievances or appeals or if the carrier

expressly waives its rights to an internal review of a grievance or an appeal, the enrollee and the provider involved are relieved of any obligation to complete the grievance or appeal and may, at the enrollee's or the provider's option, seek further appeal through an applicable external appeals process.

Sec. 16. 24-A MRSA §4303, sub-§5 is enacted to read:

5. External appeals. The following provisions apply to external appeals.

A. The bureau shall provide for a fair hearing that meets the requirements of this subsection for the review of an externally appealable decision. The expenses incurred by the bureau in connection with a hearing must be paid by the carrier. The bureau may contract with other state agencies performing administrative fair hearings to provide the hearing in accordance with the requirements of this subsection.

B. A carrier may condition the use of the external appeals process hearing upon completion of the internal review process, but only if the internal review decision is made on a timely basis consistent with the deadlines imposed by bureau rules.

C. The external appeals process hearing must be conducted consistent with standards established by the superintendent in accordance with Title 5, chapter 375, subchapter IV and the following.

(1) The hearing must provide for a fair, de novo determination.

(2) As part of the hearing, the hearing officer shall determine whether a decision is an externally appealable decision, including:

(a) Whether the decision involves an expedited appeal;

(b) Whether appropriate deadlines for the internal review process were established based on medical exigencies; and

(c) Whether the internal review process has been completed.

(3) Each party to an external appeal may submit and review evidence related to the issues in dispute, use the assistance or representation of one or more individuals, including an attorney, and make an oral presentation. The enrollee has the option of a decision by the hearing officer based upon the documentary record by the parties without live testimony.

(4) The bureau or any state agency conducting a fair hearing pursuant to contract with the bureau may contract with a health care provider who is appropriately credentialed with respect to the health care service under review to obtain additional information concerning disputed medical issues. The health care provider may have no conflict of interest relating to the performance of the provider's duties under this subsection.

(5) The carrier involved shall provide the aggrieved enrollee or the enrollee's representative with adequate notice of appeal rights in a form to be approved by the bureau and, prior to a hearing, timely access to the carrier's records relating to the externally appealable decision and to all provisions of the plan or health insurance coverage, including any policies, procedures, criteria, guidelines, protocols or coverage manuals.

(6) The determination by the hearing officer on the external appeal must:

(a) Be made orally or in writing, and, if the determination is made orally, it must be supplied to the parties in writing within 5 working days of oral notification of the determination;

(b) Be binding on the carrier;

(c) Be made in accordance with the medical exigencies of the case involved but in no event later than 30 calendar days, or 72 hours in the case of an expedited appeal, from the date of completion of the filing of notice of external appeal of the decision;

(d) State, in layperson's language, the basis for the determination in conformance with the requirements of any applicable rule or interpretation of such a rule regarding the content of adverse determinations and include, if

relevant, any basis in the terms or conditions of the plan or coverage; and

(e) Inform the enrollee of the enrollee's rights to seek further review by the courts, or other process, of the external appeal determination.

This subsection may not be construed as removing or limiting any legal rights of enrollees and others under state or federal law, including the right to file judicial actions to enforce rights.

A decision under this subsection is not considered final agency action pursuant to Title 5, chapter 375, subchapter VII.

Sec. 17. 24-A MRSA §4305, sub-§1, as enacted by PL 1995, c. 673, Pt. C, §1 and affected by §2, is amended to read:

1. Internal quality assurance program. A ~~health--plan~~ carrier that subjects plan benefits to review for medical necessity or appropriateness must have an ongoing quality assurance program for the health care services provided or reimbursed by the ~~health-plan~~ carrier that meets the following requirements.

A. The carrier has a separate identifiable unit with responsibility for administration of the program.

B. The carrier has a written plan for the program that is updated annually and that specifies at least the following: the activities to be conducted; the organizational structure; the duties of the medical director; and criteria and procedures for the assessment of quality.

C. The program provides for systematic review of the types of health services provided, the consistency of services provided with good medical practice and patient outcomes.

D. The program:

(1) Uses criteria that are based on performance and patient outcomes when feasible and appropriate;

(2) Includes criteria that are directed specifically at meeting the needs of at-risk populations and enrollees with chronic conditions or severe illnesses, including gender-specific criteria and pediatric-specific criteria when available and appropriate; and

(3) Includes methods for informing enrollees of the benefits of preventive care and the specific preventive care benefits that are covered under the plan.

E. The program has procedures for the reporting of possible quality concerns by providers and enrollees and for remedial actions to correct quality problems, including written procedures for responding to concerns and taking appropriate corrective action.

F. The program provides for an analysis of the carrier's performance on quality measures using data that include the data collected under section 4302.

Sec. 18. 24-A MRSA §§4310 to 4316 are enacted to read:

§4310. Access to specialty care

1. Obstetrical and gynecological care. If a carrier requires or provides for an enrollee to designate a participating primary care provider:

A. The carrier shall permit a female enrollee to designate a participating provider who specializes in obstetrics and gynecology as that enrollee's primary care provider; or

B. If a female enrollee has not designated such a provider as a primary care provider, the carrier:

(1) May not require authorization or a referral by the enrollee's primary care provider for coverage of primary, preventive or therapeutic obstetrics and gynecologic services indicated for women's health care or required as a result of any gynecological examination or as a result of a gynecologic condition that are performed by a participating provider who specializes in obstetrics and gynecology, including a certified nurse practitioner or a certified nurse midwife, to the extent those services are otherwise covered;

(2) May treat the ordering of other gynecological care by such a participating provider as the authorization of the primary care provider with respect to that care under the plan or coverage; and

(3) May require such a participating provider to provide a written notice of services and any treatment plan to the female enrollee's primary care provider.

2. Specialty care. If an enrollee in a managed care plan requiring referral for specialty services has a condition or disease of sufficient seriousness or complexity to require treatment by a specialist and benefits for such treatment are provided under the plan or coverage, 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 pursuant to this subsection be:

(1) Pursuant to a treatment plan developed by the specialist and approved by the carrier in consultation with the enrollee's primary care provider or specialist and the enrollee or the enrollee's designee; and

(2) In accordance with applicable quality assurance and utilization review standards of the carrier.

Nothing in this paragraph may be construed to prevent such a treatment plan for an enrollee from requiring a specialist to provide the primary care provider with regular updates on the specialty care provided as well as all necessary medical information.

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

C. If a carrier refers an enrollee to a nonparticipating specialist pursuant to paragraph A, services provided pursuant to the approved treatment plan must be provided at no additional cost to the enrollee beyond what the enrollee would otherwise pay for services received from such a specialist who is a participating provider.

3. Specialists as primary care providers. A carrier shall have a procedure by which an enrollee who has a special condition may receive a referral to a specialist for treatment of that condition. That specialist must be 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 refer the enrollee to the specialist in accordance with the following.

A. The specialist must be permitted to treat the enrollee without a referral from the enrollee's primary care provider

and may authorize referrals, procedures, tests and other medical services the enrollee's primary care provider would be permitted to provide or authorize, subject to the terms of the treatment plan under subsection 2, paragraph A.

B. Subsection 2, paragraphs A to C apply to referrals under this subsection as they apply to referrals under subsection 2.

4. Standing referrals. The following applies to standing referrals.

A. A carrier shall have a procedure by which an enrollee who has a condition that requires ongoing care from a specialist may receive a standing referral to a specialist for treatment of that condition. If the carrier or the primary care provider in consultation with the medical director of the carrier and the specialist determines that a standing referral is appropriate, the carrier shall make a standing referral to the specialist.

B. Subsection 2, paragraphs A to C apply to referrals under this subsection as they apply to referrals under subsection 2.

§4311. Continuity of Care

1. Termination of provider. If a contract between a carrier and a health care provider is terminated or benefits or coverage provided by a health care provider are terminated because of a change in the terms of provider participation in a managed care plan and an enrollee in the plan or receiving the coverage is undergoing a course of treatment from the provider at the time of that termination, the carrier shall notify the enrollee on a timely basis of the termination and pursuant to subsection 3, shall permit the enrollee to continue coverage for that course of treatment with the provider during a transitional period provided under subsection 2. If a contract for the provision of health insurance coverage between a plan sponsor and a carrier is terminated and, as a result of that termination, coverage of services of a health care provider is terminated with respect to an enrollee, this section applies to the managed care plan as if a contract between the carrier and the provider had been terminated, but only with respect to benefits that are covered under the managed care plan after the contract termination.

2. Transitional period. The following requirements apply.

A. Except as provided in paragraphs B to D, the transitional period under this subsection extends for at least 90 days from the date the enrollee receives the notice of the provider's termination under in subsection 1.

B. The transitional period for institutional or inpatient care from a provider extends until the discharge or termination of the period of institutionalization and includes institutional care provided within a reasonable time of the date of termination of the provider if the care was scheduled before the date of announcement of the termination under subsection 1 or if the enrollee on that date was on an established waiting list or otherwise scheduled to have such care.

C. If an enrollee has entered the 2nd trimester of pregnancy at the time of a provider's termination and the provider was treating the pregnancy before the date of the termination, the transitional period under this subsection for the provider's treatment of the pregnancy extends through the provision of postpartum care directly related to the delivery.

D. If an enrollee is terminally ill, as determined under the federal Social Security Act, Section 1861(dd)(3)(A), at the time of a provider's termination and the provider was treating the terminal illness before the date of termination, the transitional period under this subsection extends for the remainder of the enrollee's life for care directly related to the treatment of the terminal illness.

3. Permissible terms and conditions. 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 and the enrollee involved with respect to cost-sharing at the rates applicable prior to the start of the transitional period as payment in full or, in the case of a plan sponsor's termination of a contract with a carrier, at the rates applicable under the replacement carrier after the date of the termination of the contract with the prior carrier. The provider agrees not to impose cost-sharing for the enrollee in an amount that exceeds the cost-sharing that could have been imposed if the contract referred to in subsection 1 had not been terminated.

B. The provider agrees to adhere to the quality assurance standards of the carrier responsible for payment and to

provide to that carrier necessary medical information related to the care provided.

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

4. Construction. This section may not be construed to require the coverage of benefits that would not have been covered if the provider involved had remained a participating provider.

§4312. Coverage for participation in approved clinical trials

1. Coverage. If a carrier provides coverage to a qualified enrollee, the carrier:

A. May not deny that qualified enrollee participation in an approved clinical trial;

B. Subject to subsection 3, may not deny, limit or impose additional conditions on the coverage of routine patient costs for items and services furnished in connection with participation in the trial. If one or more participating providers are participating in a clinical trial, this section may not be construed to prevent a plan or issuer from requiring that a qualified enrollee participate in the trial through such a participating provider if the provider will accept the enrollee as a participant in the trial; and

C. May not discriminate against the enrollee on the basis of the enrollee's participation in the trial.

2. Payment. Under this section, a carrier shall provide for 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 provided by a participating provider, the payment rate must be at the agreed rate. If the services are provided by a nonparticipating provider, the payment rate must be at the rate the carrier would normally pay for comparable services.

3. Construction. This section may not be construed to limit a carrier's coverage of clinical trials.

§4313. Access to needed prescription drugs

1. Participation in formulary. If a carrier provides benefits for prescription drugs but the coverage limits those benefits to drugs included in a formulary, the carrier shall:

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

B. Consistent with the standards for a utilization review under section 4304, provide for exceptions from the formulary limitation when a nonformulary alternative is medically indicated.

2. Coverage of approved drugs and medical devices. A carrier that provides any coverage of prescription drugs or medical devices may not deny coverage of such a drug or device on the basis that the use is investigational if the use:

A. In the case of a prescription drug:

(1) Is included in the labeling authorized by the application in effect for the drug pursuant to the Federal Food, Drug, and Cosmetics Act, Section 505, subsection (b) or (j), without regard to any postmarketing requirements that may apply under that Act; or

(2) Is included in the labeling authorized by the application in effect for the drug under the federal Public Health Service Act, Section 351, without regard to any postmarketing requirements that may apply pursuant to that section; or

B. In the case of a medical device, is included in the labeling authorized by a regulation under the federal Food, Drug, and Cosmetics Act, Section 513, subsection (d) or (3); an order under Section 513, subsection (f) of that Act; or an application approved under Section 515 of that Act, without regard to any postmarketing requirements that may apply under that Act.

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

§4314. Nondiscrimination in delivery of services

1. Delivery of services. A carrier may not discriminate against an enrollee in the delivery of health care services that are consistent with the benefits under the plan or coverage or as

required by law based on race, color, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information or source of payment.

2. Construction. This section may not be construed to relate to eligibility, the offer or guarantee of coverage, the application of pre-existing condition exclusions or premiums charged under a health plan or managed care plan.

§4315. Remedy for carrier's failure to exercise ordinary care

1. Application. The following requirements apply.

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 carrier's failure to exercise ordinary care.

B. A carrier is also liable for damages for harm to an enrollee proximately caused by the health care treatment decisions made by its:

(1) Employees;

(2) Agents;

(3) Ostensible agents; or

(4) Representatives who are actually on the carrier's behalf and over whom it has the right to exercise influence or control or has actually exercised influence or control that resulted in the failure to exercise ordinary care.

C. Paragraphs A and B do not create an obligation on the part of the carrier to provide to an enrollee treatment that is not covered by the health or managed care plan.

D. A carrier may not assert as a defense to an action brought pursuant to this section any law of this State that prohibits a carrier from practicing medicine or being licensed to practice medicine.

2. Limitations on cause of action.

A. A person may not maintain a cause of action under this section against a carrier unless the affected enrollee has exhausted the applicable grievance and appeals process including external appeals. If the carrier fails to comply with any of the deadlines for completion of grievances or

appeals or if the carrier expressly waives its rights to an internal review of a grievance or appeal, the enrollee and the provider involved are relieved of any obligation to complete the grievance and appeals process and may, at the enrollee's or the provider's option, maintain a cause of action under this section against a carrier without exhausting the grievance and appeals process.

B. Notice of the claim must be delivered or mailed to the carrier against whom the action is made not later than the 30th day before the date the claim is filed.

C. This section does not prohibit an enrollee from pursuing other appropriate remedies, including injunctive relief, a declaratory judgment and relief available under law, if the requirement of exhausting the process for grievance and appeal places the enrollee's health in jeopardy.

D. This section may not be construed as removing or limiting any legal rights of enrollees under state or federal law, including the right to file judicial actions to enforce rights.

SUMMARY

This bill incorporates into state 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 on financial incentives for providers;

9. Remedy for a carrier's failure to exercise ordinary care; and

10. Nondiscrimination in the delivery of health care services.