STATE OF MAINE
119TH LEGISLATURE

SECOND REGULAR SESSION

BILL SUMMARIES
JOINT STANDING COMMITTEE
ON
BANKING AND INSURANCE

JULY 2000

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Maine State Legislature

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ONE HUNDRED NINETEENTH LEGISLATURE
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Summary Of Legislation Before The Joint Standing Committees
July 2000

We are pleased to provide this summary of bills that were considered by the Joint Standing and Select Committees of the Maine Legislature this past session. The document is a compilation of bill summaries which describe each bill and relevant amendments, as well as the final action taken. Also included are statistical summaries of bill activity this session for the Legislature and each of its joint standing and select committees.

The document is organized for convenient reference to information on bills considered by the committees. It is organized by committees and within committees by bill (LD) number. The committee report(s), prime sponsor for each bill and the lead co-sponsor(s), if designated, are listed below each bill title. All adopted amendments are listed by paper number. Two indices, a subject index and a numerical index by LD number are provided for easy reference to bills. They are located at the back of the document. A separate publication, History and Final Disposition of Legislative Documents, may also be helpful in providing information on the disposition of bills. These bill summaries also are available at the Law and Legislative Reference Library and on the Internet (www.state.me.us/legis/opla).

Final action on each bill is noted to the right of the bill title. The abbreviations used for various categories of final action are as follows:

CON RES XXX	*Chapter # of Constitutional Resolution passed by both Houses*
CONF CMTE UNABLE TO AGREE	*Committee of Conference unable to agree; bill died*
DIED BETWEEN BODIES	*House & Senate disagree; bill died*
DIED IN CONCURRENCE	*One body accepts ONTP report; the other indefinitely postpones the bill*
DIED ON ADJOURNMENT	*Action incomplete when session ended; bill died*
EMERGENCY	*Enacted law takes effect sooner than 90 days*
FAILED EMERGENCY ENACTMENT/FINAL PASSAGE	*Emergency bill failed to get 2/3 vote*
FAILED ENACTMENT/FINAL PASSAGE	*Bill failed to get majority vote*
FAILED MANDATE ENACTMENT	*Bill imposing local mandate failed to get 2/3 vote*
NOT PROPERLY BEFORE THE BODY	*Ruled out of order by the presiding officers; bill died*
INDEF PP	*Bill Indefinitely Postponed*
ONTP	*Ought Not To Pass report accepted*
OTP ND	*Committee report Ought To Pass In New Draft*
OTP ND/NT	*Committee report Ought To Pass In New Draft/New Title*
P&S XXX	*Chapter # of enacted Private & Special Law*
PUBLIC XXX	*Chapter # of enacted Public Law*
RESOLVE XXX	*Chapter # of finally passed Resolve*
UNSIGNED	*Bill held by Governor*
VETO SUSTAINED	*Legislature failed to override Governor's Veto*

Please note the effective date for all non-emergency legislation enacted in the Second Regular Session (unless otherwise specified in a particular law) is August 11, 2000.

David E. Boulter, Director
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Joint Standing Committee on Banking and Insurance

LD 750 **An Act to Establish a Patient's Bill of Rights** **PUBLIC 742**

Sponsor(s)	Committee Report		Amendments Adopted
SAXL J	OTP-AM	A	H-1061
LAFOUNTAIN	OTP-AM	B	H-1165 SAXL J
	OTP-AM	C	

LD 750, which was carried over from the First Regular Session, proposed to incorporate into law many of the provisions contained in the proposed federal patient bill of rights legislation including:

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.

Committee Amendment "A" (H-1061) is the majority report of the committee and replaced the bill. The amendment proposed to do the following:

1. It requires all managed care plans to provide reasonable access to providers in accordance with the access standards of Bureau of Insurance Rule Chapter 850.

2. It prohibits carriers offering managed care plans from using financial incentives for participating providers to deny, reduce, withhold, limit or delay specific medically appropriate health care services to enrollees.

3. It requires carriers to provide services requested by enrollees who are deaf or hard-of-hearing or visually impaired during the internal and external review processes.

4. It requires carriers to establish policies to allow enrollees with special conditions to receive standing referrals to specialists.

5. It requires carriers to provide continuity of care to enrollees undergoing a course of treatment when the enrollee's provider is terminated as a participating provider by the carrier or the enrollee's coverage changes to another carrier.

6. It requires coverage of emergency services by carriers in accordance with the requirements of Bureau of Insurance Rule Chapter 850.

7. It requires that carriers provide coverage of routine patient costs for qualified enrollees with life-threatening illnesses that participate in clinical trials. The amendment requires carriers to provide coverage for those costs not reasonably expected to be paid for by the sponsors of an approved clinical trial. Approved clinical trials are defined as clinical research studies and clinical investigations approved and funded by the National Institutes of Health.

8. It requires carriers that provide coverage of prescription drugs through a drug formulary to ensure the participation of physicians and pharmacists in the development of the formulary and to provide exceptions to formulary limitations when a nonformulary drug is medically indicated. The amendment also prohibits carriers from denying coverage of a prescribed drug or 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 is recognized in one of the standard reference compendia or in peer-reviewed medical literature.

9. It creates a process for the independent external review of adverse health care treatment decisions. The amendment allows an enrollee in a health plan to request external review after the enrollee has exhausted all levels of a carrier's internal grievance procedure or has met the requirements for expedited review. An enrollee must request the review in writing within 12 months of the date an enrollee has received a final adverse health care treatment decision under the internal grievance procedure. The adverse health care treatment decisions that may be reviewed are those decisions that involve issues of medical necessity, preexisting condition determinations and determinations regarding experimental or investigational services or decisions regarding diagnosis, care and treatment when medical services are provided by a health plan. The external review decision will be made by an independent review organization under contract with the Department of Professional and Financial Regulation, Bureau of Insurance. The external review decision is binding on the carrier but not on the enrollee.

10. It gives enrollees the right to sue carriers. The amendment creates a statutory cause of action by an enrollee against a carrier offering a health plan or its agents for harm to an enrollee proximately caused by the failure of a carrier to exercise ordinary care when making health care treatment decisions. An enrollee must exhaust the internal and external review processes before bringing a cause of action and must initiate the action within 3 years after the issuance of an external review decision. The right-to-sue provision allows an enrollee to recover actual damages and limits the recovery of noneconomic damages to a maximum of $400,000. The recovery of punitive damages is precluded.

The amendment also proposed to add an allocation section and a fiscal note to the bill.

Committee Amendment "B" (H-1062) is a minority report of the committee and replaced the bill. The amendment is the same as the majority report except that it does not contain a right-to-sue provision. Committee Amendment "B" was not adopted.

Committee Amendment "C" (H-1063) is a minority report of the committee and replaced the bill. The amendment differed from the majority report in the right-to-sue provision only.

The amendment proposed to give enrollees the right to sue carriers by creating a statutory cause of action by an enrollee against a carrier offering a health plan or its agents for harm to an enrollee directly caused by the failure of a carrier to exercise ordinary care when making health care treatment decisions that affect the quality of the diagnosis, care or treatment provided to an enrollee. Under this amendment, an enrollee must exhaust the internal and external review processes before bringing a cause of action and must initiate the action within one year after the issuance of an external review decision; the majority report requires that the action be brought within 3 years. Under this amendment, the right-to-sue provision allows an enrollee to recover actual damages and limits the recovery of noneconomic damages to a maximum of $150,000 and precludes the recovery of punitive damages. The majority report allows a maximum recovery for noneconomic damages of $400,000

Under this amendment, a carrier has an affirmative defense against a cause of action that the carrier or its agents did not influence, participate in or control the health care treatment decision. The majority report does not provide for an affirmative defense. The amendment also proposed to limit an enrollee's remedy against a carrier for its health care treatment decisions to the statutory cause of action except for other remedies specifically available under other provisions of the Maine Revised Statutes, Title 24-A.

The amendment also proposed to add an allocation section and a fiscal note to the bill. Committee Amendment "C" was not adopted.

House Amendment "A" to Committee Amendment "A" (H-1077) proposed to allow residents of the State to establish medical savings accounts for payment of eligible medical expenses, including the payment of health insurance premiums and deductibles. Contributions to, interest earned on and qualified withdrawals from medical savings accounts would have been exempted from Maine state income tax. House Amendment "A" to Committee Amendment "A" was not adopted.

House Amendment "B" to Committee Amendment "A" (H-1084) proposed to allow health insurers, nonprofit hospital and medical service organizations and health maintenance organizations to offer a catastrophic health plan that does not include any mandated benefits to individuals and small groups. House Amendment "B" to Committee Amendment "A" was not adopted.

House Amendment "C" to Committee Amendment "A" (H-1092) proposed to appropriate $900,000 to the State Employee Health Insurance Reserve to be used in the event that Blue Cross Blue Shield of Maine increases premiums for health insurance provided to state employees due to the effects of the Patient's Bill of Rights. House Amendment "C" to Committee Amendment "A" was not adopted.

House Amendment "D" to Committee Amendment "A" (H-1165) proposed to add clarifying language to the right-to-sue provision and add language giving carriers an affirmative defense. The amendment also proposed to add language making the right-to-sue provision the sole and exclusive remedy against a carrier except for statutory causes of action under the Maine Insurance Code. It also allows a cause of action to be brought seeking remedies under either the right-to-sue provision or under wrongful death, but not both.

House Amendment "E" to Committee Amendment "A" (H-1166) proposed to remove the right-to-sue provision. House Amendment "E" to Committee Amendment "A" was not adopted.

Senate Amendment "A" to Committee Amendment "A" (S-675) proposed to require an enrollee to exhaust the internal and external review processes before bringing a cause of action and must initiate the action within one year after the issuance of an external review decision; Committee Amendment "A" requires that the action be brought within 3 years. Under this amendment, the right-to-sue provision allows an enrollee to recover actual damages and limits the recovery of noneconomic damages to a maximum of $150,000 and precludes the recover of punitive damages. Committee Amendment "A" allows a maximum recovery for noneconomic damages of $400,000. Senate Amendment "A" to Committee Amendment "A" was not adopted.

Under this amendment, a carrier has an affirmative defense against a cause of action that the carrier or its agents did not influence, participate in or control the health care treatment decision. Committee Amendment "A" does not provide for an affirmative defense. This amendment also limits an enrollee's remedy against a carrier for its health care treatment decisions to the statutory cause of action except for other remedies specifically available under other provisions of the Maine Revised Statutes, Title 24-A. Senate Amendment "A" to Committee Amendment "A" was not adopted.

Enacted law summary

Public Law 1999, chapter 742 establishes additional requirements for health plans and managed care plans offered in this State and provides additional protections for health plan and managed care enrollees.

The law does the following.

1. It requires all managed care plans to provide reasonable access to providers in accordance with the access standards of Bureau of Insurance Rule Chapter 850.

2. It prohibits carriers offering managed care plans from using financial incentives for participating providers to deny, reduce, withhold, limit or delay specific medically appropriate health care services to enrollees.

3. It requires carriers to provide services requested by enrollees who are deaf or hard-of-hearing or visually impaired during the internal and external review processes.

4. It requires carriers to establish policies to allow enrollees with special conditions to receive standing referrals to specialists.

5. It requires carriers to provide continuity of care to enrollees undergoing a course of treatment when the enrollee's provider is terminated as a participating provider by the carrier or the enrollee's coverage changes to another carrier.

6. It requires coverage of emergency services by carriers in accordance with the requirements of Bureau of Insurance Rule Chapter 850.

7. It requires that carriers provide coverage of routine patient costs for qualified enrollees with life-threatening illnesses that participate in clinical trials. The provision requires carriers to provide

coverage for those costs not reasonably expected to be paid for by the sponsors of an approved clinical trial. Approved clinical trials are defined as clinical research studies and clinical investigations approved and funded by the National Institutes of Health. This provision applies to all policies and contracts issued or renewed on or after January 1, 2001.

8. It requires carriers that provide coverage of prescription drugs through a drug formulary to ensure the participation of physicians and pharmacists in the development of the formulary and to provide exceptions to formulary limitations when a nonformulary drug is medically indicated. The provision also prohibits carriers from denying coverage of a prescribed drug or 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 is recognized in one of the standard reference compendia or in peer-reviewed medical literature. This provision applies to all policies and contracts issued or renewed on or after January 1, 2001.

9. It creates a process for the independent external review of adverse health care treatment decisions. The provision allows an enrollee in a health plan to request external review after the enrollee has exhausted all levels of a carrier's internal grievance procedure or has met the requirements for expedited review. An enrollee must request the review in writing within 12 months of the date an enrollee has received a final adverse health care treatment decision under the internal grievance procedure. The adverse health care treatment decisions that may be reviewed are those decisions that involve issues of medical necessity, preexisting condition determinations and determinations regarding experimental or investigational services or decisions regarding diagnosis, care and treatment when medical services are provided by a health plan. The external review decision will be made by an independent review organization under contract with the Department of Professional and Financial Regulation, Bureau of Insurance. The external review decision is binding on the carrier but not on the enrollee.

10. It gives enrollees the right to sue carriers. The provision creates a statutory cause of action by an enrollee against a carrier offering a health plan or its agents for harm to an enrollee proximately caused by the failure of a carrier to exercise ordinary care when making health care treatment decisions affecting the quality of care, diagnosis or treatment provided to an enrollee. An enrollee must exhaust the internal and external review processes before bringing a cause of action and must initiate the action within 3 years after the earlier of the issuance of an external review decision or the issuance of an underlying adverse first-level appeal or grievance determination notice. The right-to-sue provision allows an enrollee to recover actual damages and limits the recovery of noneconomic damages to a maximum of $400,000. The recovery of punitive damages is precluded. The provision gives carriers an affirmative defense that the carriers or its agents did not influence, participate in or control the health care treatment decision. The provision also makes the cause of action the sole and exclusive remedy against a carrier except for statutory causes of action under the Maine Insurance Code. It also allows a cause of action to be brought seeking remedies under either the right-to-sue provision or under the wrongful death statute, but not both.