010481840

HOUSE BILL NO. 2350

Offered January 10, 2001

Prefiled January 10, 2001

A BILL to amend the Code of Virginia by adding in Title 8.01 a chapter numbered 21.1:01, consisting of a section numbered 8.01-581.20:1, relating to managed care health insurance plans; liability for health care treatment decisions.

Patrons—McEachin, Baskerville, Brink, Day, Deeds, Diamonstein, Grayson, Hull, Jones, J.C., Moran, Spruill, Van Landingham and Watts

---

Referred to Committee on Corporations, Insurance and Banking

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Title 8.01 a chapter numbered 21.1:01, consisting of a section numbered 8.01-581.20:1 as follows:

CHAPTER 21.1:01.

LIABILITY FOR HEALTH TREATMENT DECISIONS BY MANAGED CARE HEALTH INSURANCE PLANS.

§ 8.01-581.20:1. Managed care health insurance plans; liability for health care treatment decisions.

A. For purposes of this section:

"Appropriate and medically necessary" means the standard for health care services as determined by physicians and health care providers in accordance with the prevailing practices and standards of the medical profession and community.

"Covered person" means a subscriber, policyholder, member, enrollee or dependent, as the case may be, under a policy or contract issued or issued for delivery in Virginia by a managed care health insurance plan licensee, insurer, health services plan, or preferred provider organization.

"Health care treatment decision" means a determination made when medical services are actually provided by the health care plan and a decision which affects the quality of the diagnosis, care, or treatment provided to a covered person.

"Managed care health insurance plan" means an arrangement for the delivery of health care in which a health carrier as defined in § 38.2-5800 undertakes to provide, arrange for, pay for, or reimburse any of the costs of health care services for a covered person on a prepaid or insured basis which (i) contains one or more incentive arrangements, including any credentialing requirements intended to influence the cost or level of health care services between the health carrier and one or more providers with respect to the delivery of health care services; and (ii) requires or creates benefit payment differential incentives for covered persons to use providers that are directly or indirectly managed, owned, under contract with or employed by the health carrier. Any health maintenance organization as defined in § 38.2-4300 or health carrier that offers preferred provider contracts or policies as defined in § 38.2-3407 or preferred provider subscription contracts as defined in § 38.2-4209 shall be deemed to be offering one or more managed care health insurance plans. For the purposes of this definition, the prohibition of balance billing by a provider shall not be deemed a benefit payment differential incentive for covered persons to use providers who are directly or indirectly managed, owned, under contract with or employed by the health carrier. A single managed care health insurance plan may encompass multiple products and multiple types of benefit payment differentials; however, a single managed care health insurance plan shall encompass only one provider network or set of provider networks.

"Ordinary care" means that degree of care that a managed care health insurance plan of reasonable prudence would use under the same or similar circumstances. In the case of a person who is an employee, agent, or representative of a managed care health insurance plan, "ordinary care" means that degree of care that a person of ordinary prudence in the same profession, specialty, or area of practice as such person would use in the same or similar circumstances.

B. A managed care health insurance plan has the duty to exercise ordinary care when making health care treatment decisions and is liable for damages for harm to a covered person proximately caused by its failure to exercise such ordinary care.

C. A managed care health insurance plan is also liable for damages for harm to a covered person proximately caused by the health care treatment decisions made by its (i) employees, (ii) agents, or (iii) representatives who are acting on its behalf and over whom it has the right to exercise influence or control or has actually exercised influence or control which result in the failure to exercise ordinary care.

D. It shall be a defense to any action asserted against a managed care health insurance plan that:

1. Neither the managed care health insurance plan nor any employee, agent, or representative for whose conduct such managed care health insurance plan is liable under subsection C, controlled, influenced, or participated in the health care treatment decision; and

2. The managed care health insurance plan did not deny or delay payment for any treatment prescribed or recommended by a provider to the covered person.

E. The standards in subsections B and C create no obligation on the part of the managed care health insurance plan to provide to a covered person treatment which is not covered by the plan.

F. The provisions of Article 1.2 (§ 32.1-137.7 et seq.) and Article 2.1 (§ 32.1-138.6) of Chapter 5 of Title 32.1 governing utilization review standards and appeals and private review agents, respectively, shall not apply to actions brought pursuant to this chapter.

G. The provisions of this chapter are not applicable to any employee welfare benefit plan as defined in section 3 (1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002(1) which is self-insured or self-funded.

H. Nothing in this chapter shall be construed to create a right of action against the purchaser of the managed care health insurance plan, whether such purchaser is an individual or an employer providing a managed care health insurance plan based upon the selection of a particular plan.

I. The provisions of § 8.01-581.15 shall apply to any verdict returned against a managed care health insurance plan pursuant to this section.