REPORT OF THE

COMMISSION TO STUDY THE

CONTAINMENT OF HEALTH CARE COSTS

TO

THE GOVERNOR

AND

THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 31

COMMONWEALTH OF VIRGINIA
Richmond
1980

MEMBERS OF COMMISSION

Edward E. Willey, Chairman
Joseph A. Johnson, Vice-Chairman
Adelard L. Brault
John C. Buchanan
Theodore J. Burr, Jr.
Robert M. Freeman
George W. Grayson
Johnny S. Joannou
James B. Murray
Bonnie L. Paul
James W. Newman, Jr.
J. B. Kenley
Leo E. Kirven, Jr.

STAFF

Katherine L. Goolsby, Staff Attorney
Brenda H. Edwards, Legislative Research Associate

TABLE OF CONTENTS

Report of the
Commission to Study the
Containment of Health Care Costs
To
The Governor and the General Assembly of Virginia
Richmond, Virginia
December, 1979

To: Honorable John N. Dalton, Governor of Virginia
and
The General Assembly of Virginia

I. Introduction

The Commission to study the Containment of Health Care Costs was established in 1978 pursuant to Senate Joint Resolution No. 5. That resolution is as follows:

Senate Joint Resolution No. 5

Creating a commission to study the need for regulation of costs and charges of institution-based health services and the need for regulation of premium rates of insurance plans covering institution-based health services; allocating funds therefor.

WHEREAS, the cost of health institution-based services and of health insurance premiums have risen dramatically in recent years and may continue to rise as medical treatment becomes more sophisticated and utilization and third-party payments increase; and

WHEREAS, the future financial stability of health care institutions is a matter of public concern, and incentives for more efficient and effective operation of such institutions may need strengthening; and

WHEREAS, it would be valuable to assess the activities of all third-party payors and others in containing health care costs; and

WHEREAS, there is a direct relationship between the rate of increase in institution-based health service costs and charges and health insurance premium rates; and

WHEREAS, it is the belief of the General Assembly that consideration should be given to the most feasible and effective way to contain the cost of institution-based health care and related services and the premiums charged by third-party payors and to develop better ways to encourage the implementation of payment plans which will promote less costly but high quality health care; now, therfore, be it

RESOLVED by the Senate, the House of Delegates concurring, That a commission is hereby created to be known as the Commission to Study the Containment of Health Care Costs. The Commission shall consist of eleven members, five of whom shall be appointed by the Speaker of the House of Delegates from the membership thereof, three members who shall be appointed by the Committee on Privileges and Elections of the Senate from the membership of the Senate and three members who shall be appointed by the Governor and who shall be persons not affiliated with providers of health care or with the insurance industry. The Commissioner of Health, Commissioner of Mental Health and Mental Retardation, and the Commissioner of Insurance of the State Corporation Commission shall be members ex officio without a vote.

The Commission shall make a comprehensive study to accomplish the following: (i) to determine if State regulation of health institution charges and third-party payments would be in the public interest, (ii) to determine the extent to which conformance with federal law would make such regulation of rates desirable, (iii) to recommend the content of a proposed statute to establish a State Rate Review Program consistent with the public interest and federal law and (iv) to study and make recommendations to the General Assembly concerning premium charges, subscriber fees and other matters related to the cost of health care and health insurance.

All agencies of the Commonwealth are requested to cooperate with the Commission. The Commission shall hold such hearings as it deems appropriate.

The Commissioner of Health and the Commissioner of Insurance shall provide the expertise and services required for the Commission to begin and to conclude its work expeditiously.

The legislative members of the Commission shall receive such compensation as set forth in § 14.1-18 of the Code of Virginia. All members shall be paid their necessary expenses incurred in the performance of their duties but shall receive no other compensation. For such expenses as may be required, including secretarial and other professional assistance, there is hereby allocated from the general appropriations to the General Assembly the sum of fifty thousand dollars.

The Commission shall report to the Governor and the General Assembly not later than December one, nineteen hundred seventy-nine. An interim report shall be given not later than December one, nineteen hundred seventy-eight, if a final report is not completed by that date.

The members of the Commission were Senators Edward E. Willey of Richmond, Adelard L. Brault of Fairfax, and John C. Buchanan of Wise; Delegates Joseph A. Johnson of Abingdon, George W. Grayson of Williamsburg, Johnny S. Joannou of Portsmouth, James B. Murray of Earlysville and Bonnie L. Paul of Harrisonburg; and Theodore J. Burr, Jr. of Emporia, Robert M. Freeman of Richmond and Thomas M. McMurray of Annandale.[1] James B. Kenley, State Health Commissioner, Leo E. Kirven, Jr., Commissioner of Mental Health and Mental Retardation, and James W. Newman, Jr., Commissioner of Insurance, were ex officio members. Senator Willey was elected Chairman of the Commission and Mr. Johnson Vice-Chairman.

II. Activities of the Commission

To begin its study, the Commission approved a list of projects to be undertaken by the Bureau of Insurance of the State Corporation Commission and the State Health Department. Upon completion of the projects, reports were submitted to the Commission. The reports included:

1. "Alternatives for Regulation of Blue Cross and Blue Shield Plans in Virginia", Bureau of Insurance, 1978.

2. "Recommendations for Increasing Price Competition in the Health Care Delivery System", Bureau of Insurance, 1979.

3. "Rate Levels and Policy Forms for Individual Health Insurance Contracts", Bureau of Insurance, 1978.

4. "Mandated Health Insurance Coverge - A Study of Review Mechanisms", John C. Larson, 1979.

5. "Virginia Rate Review Study", Arthur Young and Company, 1979.

The Commission held numerous hearings to receive the suggestions of interested persons and to receive comments of interested persons on the reports and the various recommendations made in the reports or being considered by the Commission.

III. Recommendations

On the basis of the information and testimony submitted to it, the Commission makes the following recommendations:

1. That legislation specifically applicable to health maintenance organizations (HMO's) should be considered by the General Assembly in order to encourage the development of HMO's, to strengthen the State's regulatory posture with respect to HMO's and to assure the financial and administrative soundness of HMO's without State subsidization thereof.

2. That prepaid health plans and insurers issuing accident and sickness policies be required to offer deductibles of not less than $100 and co-insurance options under which the individual pays 20

percent of the first $1,000 in covered expenses.

3. That the General Assembly memorialize the United States Congress to enact tax incentives to purchase health insurance coverage with deductibles or co-insurance provisions.

4. That the State tax on gross premium income derived from the issuance of accident and sickness insurance policies be reduced from 2 3/4 percent to 2 percent.

5. That the Commission be continued to study the issue of mandatory insurance coverge of various providers and services, the advisibility of laws limiting the coordination of health insurance benefits, and such other matters related to the containment of health care costs as the Commission may deem advisable and that the General Assembly enact no laws mandating coverage of additional services or providers until the Commission completes its study.

IV. Discussion

The causes of the escalation in the costs of health care are exceedingly complex and controversial. Among the causes often cited are the general inflation being experienced in all sectors of the economy, rising labor, utility and malpractice insurance costs, the costs of compliance with regulatory and accreditation requirements, and the costs of newer technology. Also, the failure of federal programs (such as medicaid) to pay their fair share of the costs of the hospital care of persons in the programs is cited as increasing the costs charged to other hospital patients. Excess bed capacity is assessed a part of the blame because the costs of maintaining empty beds are quite high. Another cause is the inappropriate utilization of health care facilities, such as patients' use of costly hospital emergency rooms for cases that could be treated in physicians' offices and the use of acute care hospitals for patients who could be cared for in nursing homes. The increasing demand for health care services caused in large part by federal programs and pervasive health insurance coverage is also a contributing factor.

Because of the pervasiveness of health insurance coverage, the Commission considered at length the impact of prepaid health plans on health care costs. The Commission received a lengthy report ("Alternatives for Regulation of Blue Cross and Blue Shield Plans in Virginia", Bureau of Insurance, 1979, hereinafter cited as "Alternatives") and heard a great deal of testimony explaining and criticizing the system under which the plans operate as well as disputing many of those criticisms. A summary of the explanation of the system follows.

There are three Blue Cross type and three Blue Shield type plans in Virginia: Blue Cross and Blue Shield of Virginia, Blue Cross and Blue Shield of Southwestern Virginia, and Group Hospitalization, Inc., and Medical Service of the District of Columbia. As provided by law, each plan has the exclusive right to operate in a given geographic area. Because of the exclusive geograhic area and the number of subscribers each plan enrolls, each plan enjoys a dominant market position. The plans enter into agreements with participating hospitals and physicians (providers) under which the plan agrees to reimburse the participating provider for services rendered to plan subscribers on the basis of reimbursement methods set forth in the agreement and the provider agrees to accept that reimbursement as payment in full for covered services.

Most reimbursement agreements with physicians provide generally for the payment of the physicians' usual, customary and reasonable (UCR) charges. "Usual" is the fee usually charged by an individual so long as it does not exceed the "customary" charge. "Customary" is the maximum fee payable for a specific procedure and is determined on the basis of the usual fees of a group of physicians in, for example, a given speciality or geographic area. The 90th percentile of the fees is often used as the maximum fee which means that 90 percent of the physicians would be paid in full. The physician may be paid a larger fee if it is "reasonable" under the circumstances of the case. ("Alternatives", pp. 35-36).

This reimbursement mechanism has been criticized as providing no constraints on physician charges because fees are adjusted upward automatically and because frequently there are no controls on the amount of fee increases. ("Alternatives", pp. 37-38).

Reimbursement agreements between plans and hospitals are retrospective cost-based reimbursement agreements. In general terms, under these agreements the plan reviews the allowable

costs of the hospitals retrospectively and pays a share of these costs. In overly simple terms, a hospital is reimbursed for what it spent. This reimbursement mechanism has been criticized as inflationary since it promotes the expansion of services rather than efficiency and the plans have been criticized for not examining the reasonableness of hospital costs. ("Alternatives", pp. 50-52, 59). The plans defend these agreements, however, as containing costs because the plans do not pay the hospitals whatever rates the hospitals would like to charge, and the plans do attempt to negotiate cost containment measures. Moreover, the plans cannot impose reimbursement agreements but must negotiate them. There is some opinion in favor of reimbursement agreements that provide for payments to hospitals of rates prospectively set. The hospitals then, in theory, would have reason to practice efficiency in order to function within those rates.

Although it is not possible to demonstrate conclusively the effect of these reimbursement agreements on physician and hospital charges, the theory that they do not help to contain costs as sufficiently as they might appears to have some validity. Even if it is assumed that the reimbursement agreements do help to constrain hospital costs because the plans to not pay whatever price the hospital sets but base their reimbursement on costs, there may still be no effect on total costs because of "cost shifting". Cost shifting occurs when costs hospitals incur that are not reimbursed by government programs or plans are charged to other patients.

Despite the plans' dominant market position, the probable impact of the plans' policies on health care costs and the exemption of the plans from taxation, there is little regulation of the plans. The requirements that they must meet to operate relate to the liability of participating providers for contracts of the plans with subscribers, the composition of the board of directors of the plan, an open panel of providers, exclusive geographic area, required coverage of certain services and providers, and limitations on engaging in other business. Their charges to subscribers are not regulated, the amount of their reserves is not limited and they are not required in any other way to contain their own charges to subscribers or the health care costs on which their charges are based.

The plans have, nonetheless, engaged in some efforts to constrain health care costs and thus their rates to plan subscribers. These efforts include the provision of home health care benefits, pilot programs for hospice care and ambulatory surgery, evaluating a requirement of second opinions in surgery cases, encouraging the elimination of unnecessary hospital admission test batteries, programs to promote outpatient surgery and exploration of new hospital reimbursement mechanisms.

The Commission concluded that imposing on plans by law such requirements as cost containment programs, open enrollment periods, et cetera, and establishing by law minimum and maximum limits on reserves were not necessary or advisable at this time because of the voluntary practices in these regards by the plans and a belief that, on balance, governmental regulation is not the solution to containing health costs.

Aspects of the present system of health care delivery other than the plan reimbursement agreements with providers discussed above also have been criticized as having little that works to constrain costs. Individual commercial insurers issuing health insurance policies do not have a sufficient share of the market to negotiate cost containment measures with providers. Moreover, insurers obtain their profits from investment income from loss reserves and premium float. Higher health care costs lead to higher premiums and greater loss reserves. Hospitals do not compete for patients in the traditional sense. Physicians determine which patients will be admitted to which hospitals; therefore, hospitals compete for physicians rather than patients. Competition for physicians among hospitals may take the form of purchasing the latest and most advanced technology and thus increase rather than constrain costs. The great majority (approximately 90 percent) of hospital patients are covered by either a federal program, such as medicaid, or insurance. Insurance usually provides "first dollar" coverage so that the insured pays directly for little or none of his hospital care. Thus, when he receives the care, he is not concerned with or conscious of the costs of his care. In fact, the insured may even receive more expensive services because they are covered by his insurance rather than less costly alternatives which are not so covered. When patients are insured, physicians, who determine what services their patients will receive, do not need to worry about the strain on the patients' finances in determining those services. Employers, usually the purchasers of group policies, have tax incentives to increase health care coverage. In short, the traditional market mechanism of price competition is not applicable to the health care delivery system.

Because of tne absense of competition, a frequent proposal to control costs is government regulation. There have been various proposals for federal legislation, none of which have been enacted as of the writing of this report, and some states have enacted mandatory rate regulation laws. Virginia has a rate review program whereby hospital rates are reviewed by the Virginia Health Services Cost Review Commission, but the rates recommended by the Commission are merely advisory; hospitals are not required to adhere to them.

A study of a rate review system similar to Virginia's (Arizona) and of a mandatory rate regulation program (Washington) was done for the Study Commission by Arthur Young and Company. Because of the variety of factors which affect hospital costs within a state, the consultant was unable to analyze the effectiveness of either program but concluded that both programs have advantages and disadvantages. The chief advantage of the mandatory program is that the federal government may agree to pay the rates set by regulation under the medicaid program. Presently, payments for medicaid patients are not equal to the cost of the hospital care provided the patients. The costs not paid are, therefore, shifted to other patients.

Because there is the possibility of federal legislation in the area but uncertainty about its provisions and because Virginia's program is new and should be given a chance to develop before it is revised, the Commission decided to recommend no major changes in Virginia's program.

Another possible avenue to remedying the absence of competition in the health care system is to encourage competition in the private sector. Such an avenue would be preferable to direct government regulation and, unlike direct regulation, might combat the underlying causes of cost escalation.

One such remedy is to encourage alternative health care delivery systems or health maintenance organizations (HMO's). There are various ways in which an HMO may be organized, but generally an HMO sells health care services at a fixed fee set prospectively and prepaid. The HMO then delivers the services, usually through a closed panel of providers. HMO's are unlike Blue Cross and Blue Shield type plans because those plans are basically a financing mechanism for an open pool of providers. They place no limits on the resources available to pay for health care and have little control over the quality and cost of care since they merely pay for it. HMO's must be cost efficient in order to provide the contracted services for the fee paid and can exercise more control over the type and quality of services available to its subscribers. HMO's can provide health care in an organized and efficient manner in contrast to the fragmented nature of the traditional health care delivery system.

Currently, there are three HMO's licensed to operate in Virginia, all in Northern Virginia. HMO's were authorized in Virginia in 1972 with the enactment of what is now § 38.1-813 of the Code of Virginia. That statute results in the regulation of HMO's similarly to Blue Cross and Blue Shield type plans. Because of the differences between HMO's and plans, some of these regulations are inappropriate. Examples are the open panel of physicians required to be provided plan subscribers, the liability of participating providers for contracts of the plan with subscribers, and the prescribed composition of a plan board of directors. This law may then inhibit the development of HMO's in Virginia.

While HMO's are not for everyone, the salutory effects of competition from HMO's on the traditional health care delivery system should be encouraged rather then inhibited. Consideration should be given by the General Assembly to laws providing a more appropriate regulatory scheme for HMO's than currently exists so as to encourage their development and a regulatory scheme that assures the quality of care provided by HMO's and their financial and administrative soundness. The State should not, however, subsidize HMO's. (An example of such legislation, the specific provisions of which the Commission has not endorsed, is set forth in Appendix 1).

Another possible method of encouraging competition in the private sector is to increase competition through consumer awareness. As pointed out earlier in this report, the prevalence of insurance coverage has reduced cost as a factor in health care decisions. The rapid increase in expenditures for health care may be due largely to increases in the quality and quantity of services, but may also be attributable in part to increased use and provision of marginally necessary or unnecessary services because of the existence of government programs and insurance.

While government programs increase demand and expenditures for health care and have adverse

effects on hospital costs charged to other patients, the major such programs are federal and not subject to control by the State. Thus, the Commission must confine itself to areas subject to State action.

The issue of unnecessary medical services is one of the most basic and controversial issues in cost containment. It brings in the issues of the quality of care and medical necessity. If all expenditures for health care are to improve the quality of care or to provide an adequate quality of care and if all services provided are medically necessary, then controlling the rise of health care costs will be exceedingly difficult. However, if any medical services that are not needed are provided to a patient, they should be eliminated for they merely drive up expenditures. Moreover, the cost of medical services that would be of marginal benefit to a patient should at least be considered before the service is rendered. The decision as to what services are to be provided are made by physicians. Patients do not have the knowledge to determine what services they need. Nonetheless, cost consciousness of consumers should be raised. This could be done through cost-sharing provisions in insurance policies and prepaid health plan contracts, such as deductibles and co-insurance requirements. And, because their patients would then be financially affected directly, physicians might weigh more carefully whether a service is necessary or whether the costs outweigh the possible benefits. The Commission, therefore, recommends that insurers and plans should be required to offer deductibles of not less than $100 and co-insurance provisions where the insured pays 20 percent of the first $1,000 of the cost of covered services. (Proposed legislation to implement this recommendation is set forth in Appendix 2).

Until the present tax laws are changed, however, the options suggested in the preceeding recommendation will probably have few takers. Under present federal tax laws, health insurance premiums are not included in the income of either the employer or the employee. Thus, both employer and employee prefer to increase these benefits rather than wages. No one will want to reduce their existing health coverage unless there is an incentive to do so, such as a tax deduction or exemption applicable only for policies that have deductibles. The Commission, therefore, recommends that the General Assembly adopt a resolution urging the United States Congress to take some such action. (A resolution to implement this recommendation is set forth in Appendix 3).

One other measure might serve to increase competition in another area. As had been pointed out, the prepaid health plans enjoy a large share of the health care coverage market. Because of this dominant position, they have the power to negotiate with providers some cost containment measures and discounted rates. They also enjoy tax exempt status. No single commercial insurer enjoys such a dominant market position. Insurers are placed at a competitive disadvantage with the plans because they must pay a 2 3/4 percent tax on their premium income. If the tax rate were reduced to 2 percent, insurers might be able to compete more effectively with the prepaid health plans. This competition might have favorable impact at least on premium rates for health care coverage and possibly on attempts by insurers and plans to get providers to contain costs in order to reduce their rates for coverage. In any case, the reduction would not have that great an effect on the State'e revenues and would make Virginia's tax rate more in line with that of other states. Accordingly, the Commission recommends that the State tax on gross premium income derived from the issuance of accident and sickness insurance policies be reduced from 2 3/4 percent to 2 percent. (Proposed legislation to implement this recommendation is set forth in Appendix 4).

Another development contributing to the prevalence of insurance coverage and the irrelevance of price in the consumption of health care is increasing State legislation requiring that certain services or services provided by certain providers be covered by plans and insurance policies. Although an argument frequently advanced in favor of some of such coverage is that of the covered service or provider offers a less costly alternative, this argument holds true only if the additional service or provider is utilized instead of, but not in addition to, the existing services or providers. Since there is nothing to encourage substitution, the general result of such mandates has been that there is no decline in utilization of and expenditures for the existing covered services and providers; rather, aggregate expenditures increase. Moreover, the health insurance premium rises each time another service or provider is added. While each increase may seem negligible per individual, the total per mandate for all subscribers and the cumulative total for all mandates per individual may be quite high. Furthermore, such mandates limit the ability of groups to purchase coverage to meet their perceived needs. Another effect may be to aggravate the maldistribution of health care providers since providers can remain in popular areas because of increased demand.

When legislation is introduced to require coverage of additional services and providers,

insufficient information is available for the General Assembly to weigh the actual costs and benefits to be derived from the legislation in making its decision. In view of the possible effects of this type of legislation and the lack of means of acquiring sufficient information on the costs and benefits and some means of insuring that coverage for less costly alternatives are actually used as alternatives rather than additions, the Commission recommends that the entire issue of mandatory coverage be studied by the Commission and that the General Assembly enact no additional mandates pending the outcome of the study.

Another matter that the Commission recommends for further study is the advisability of laws limiting coordination of insurance benefits. Virginia has at least two such laws (§§ 38.1-348.10 and 38.1-355 of the Code of Virginia). These laws prohibit insurance companies and prepaid health plans from denying payment of benefits if the insured has received or will receive payment of the same benefits under another policy. The insured may thus not only be indemnified for his expenses but also recover more than expended. If this is a possibility, an insured may have even less interest in the constraint of expenditures for health care services on his behalf than if he were covered by one policy only. Moreover, duplication of benefits almost certainly does not reduce the cost of health insurance and probably has the opposite effect. The Commission did not, however, have sufficient time to consider the advisability of these limitations thoroughly. Because of their possible effects on unnecessary utilization of health care services and on the costs of health insurance, limitations on coordination of benefits should be considered by the Commission in a continuation of its study.

The Commission received various other ideas and recommendations, some of which many also warrant further study. The Commission, therefore, recommends that it be given discretion to study such other matters related to the containment of health care costs as it deems pertinent in its continuing study. (A proposed resolution continuing the Commission is set forth in Appendix 5).

Respectfully submitted,

Edward E. Willey
Joseph A. Johnson
Adelard L. Brault
John C. Buchanan
Theodore J. Burr, Jr.
Robert M. Freeman
George W. Grayson
Johnny S. Joannou
James B. Murray
Bonnie L. Paul

FOOTNOTES

[1]Mr. McMurray resigned from the Commission in August, 1979. In view of the fact that the Commission had practically concluded its work, the Governor determined that it would be inappropriate to appoint a replacement for Mr. McMurray at that late date since he would have missed all the previous deliberations.

Appendix 1

A BILL to amend and the Code of Virginia by adding in Title 38.1 a chapter numbered 26 containing sections numbered 38.1-863 through 38.1-891 and to repeal § 38.1-813 of the Code of Virginia to provide for the establishment and regulation of health maintenance organizations.

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Title 38.1 a chapter numbered 26 containing sections numbered 38.1-863 through 38.1-891 as follows:

Chapter 26

Health Maintenance Organizations

§ 38.1-863. Definitions.—As used in this chapter:

1. "Basic health care services" means in and out of area emergency services, inpatient hospital and physician care, outpatient medical services, laboratory and radiologic services, and preventive health services.

2. "Co-payment" means a nominal payment required of enrollees as a condition of the receipt of specific health services.

3. "Enrollee" or "member" means an individual who has been enrolled in a health care plan.

4. "Subscriber" means a contract-holder, or individual enrollee or the enrollee in an enrolled family who is responsible for payment to the health maintenance organizations or on whose behalf such payment is made.

5. "Evidence of coverage" means any certificate, agreement or contract, or identification card issued in conjunction with any one of the foregoing, issued to a subscriber setting out the coverage and other rights to which an enrollee is entitled.

6. "Health care plan" means any arrangement whereby any person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care services and a significant part of such arrangement consists of arranging for or the provision of health care services, as distinguished from mere indemnification against the cost of such services, on a prepaid basis.

7. "Health care services" means the furnishing to any individual of any and all services for the purpose of preventing, alleviating, curing, or healing human illness, injury or physical disability.

8. "Health maintenance organization" means any person who undertakes to provide or arrange for one or more health care plans.

9. "Provider" or "health care provider" means any physician, hospital, or other person which is licensed or otherwise authorized in the Commonwealth to furnish health care services. §

38.1-864. Establishment of health maintenance organizations.—A. Any person desiring to establish and operate a health maintenance organization may apply to the Commission for and obtain a license to establish and operate a health maintenance organization in compliance with this chapter. No person shall establish or operate a health maintenance organization in this Commonwealth without obtaining a license under this chapter. A foreign corporation may apply to the Commission for and obtain a license to operate a health maintenance organization in compliance with this chapter.

B. Every health maintenance organization operating in the Commonwealth on July one, nineteen hundred eighty, shall submit an application for a license within one hundred eighty days after that date. Each such applicant may continue to operate until the Commission acts upon the

application. Such organization may submit only those items required in subsection C. hereof which have not already been filed with the Commission. In the event that an application is denied, the applicant shall henceforth be treated as a health maintenance organization whose license has been revoked.

C. Each application for a license shall be verified by an officer or authorized representative of the applicant, shall be in a form prescribed by the Commission, and shall set forth or be accompanied by the following:

1. A copy of the basic organizational document, if any, of the applicant such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all amendments thereto;

2. A copy of the by-laws, rules and regulations, or similar document, if any, regulating the conduct of the internal affairs of the applicant;

3. A list of the names, addresses and official positions of each member of the governing body, and a full disclosure in the application of any financial interest between any officer or member of the governing body or any provider or any organization or corporation owned or controlled by such person and the health maintenance organization and the extent and nature of the financial arrangements between such persons and the health maintenance organization;

4. A copy of any contract made or to be made between any providers, sponsors or organizers of the health maintenance organization, or persons listed in paragraph 3. of this subsection and the applicant;

5. A copy of the form of evidence of coverage to be issued to subscribers;

6. A copy of the form of the group contract, if any, which is to be issued to employers, unions, trustees, or other organizations. All group contracts shall set forth the right of subscribers to convert their coverages to an individual contract issued by the health maintenance organization.

7. Financial statements showing the applicant's assets, liabilities, and sources of financial support or, if the applicant's financial affairs are audited by independent certified public accountants, a copy of the applicant's most recent regular certified financial statement unless the Commission directs that additional or more recent financial information is required for the proper administration of this chapter;

8. A complete description of the health maintenance organization and its method of operation, including the method of marketing the plan, a financial plan which includes a three-year projection of the initial operating results anticipated, a statement as to the sources of working capital as well as any other sources of funding, and a description of any insurance, reinsurance or alternative coverage arrangements proposed;

9. A statement describing the geographic area or areas to be served;

10. A description of the complaint procedures to be utilized as required pursuant to § 38.1-872.

11. A description of the procedures and programs established by the health maintenance organization to assure both availability and accessibility of adequate personnel and facilities and to assess the quality of health care services provided.

12. A description of the mechanism by which enrollees will be afforded an opportunity to participate in matters of policy and operation as provided in subsection B. of § 38.1-867.

13. Any and all such other information as the Commission may require to make the determinations required pursuant to § 38.1-865.

D. A health maintenance organization shall, unless otherwise provided for in this chapter, file notice with the Commission describing any modification of the operation set out in the information required by subsection C. Such notice shall be filed with the Commission within thirty days after the effective date of any such modification.

§ 38.1-865. Application for and issuance of license.—A. No license shall be issued by the Commission to any health maintenance organization submitting an application in accordance with § 38.1-864 unless a copy of a valid Virginia medical care facilities certificate of public need issued pursuant to §§ 32.1-93 to 32.1-102 of the Code or letter of exemption therefrom from the State Health Commissioner is filed with the Commission. An application by a health maintenance organization for the issuance of a license by the Commission shall be filed concurrently with the organization's application for a certificate of public need from the State Health Commissioner in order to provide the Commission with ample time for review of the application for license.

B. The Commission shall issue or deny a license to a health maintenance organization within thirty days of filing of such certificate of public need or letter of exemption. A license shall be granted upon payment of the application fee prescribed in § 38.1-883 if the Commission is satisfied that the following conditions are met:

1. The persons responsible for the conduct of the affairs of the applicant are competent, trustworthy, and possess good reputations;

2. The health care plan constitutes an appropriate mechanism whereby the health maintenance organization will effectively provide or arrange for the provision of, as a minimum, basic health care services on a prepaid basis, except to the extent of reasonable requirements for co-payments.

3. The health maintenance organization is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the Commission may consider:

a. The financial soundness of the health care plan's arrangements for health care services and the schedule of charges used in connection therewith;

b. The adequacy of working capital;

c. Any agreement with an insurer, a prepaid health plan, a government, or any other organization for insuring the payment of the cost of health care services or the provision for automatic applicability of an alternative coverage in the event of discontinuance of the plan;

d. Any contracts with health care providers which set forth the health care services to be performed as well as the provider's responsibilities for fulfulling the health maintenance organization's obligations to its enrollees;

e. The deposit of a surety bond or deposit of securities in an amount satisfactory to the Commission, submitted in accordance with § 38.1-874 as a guarantee that the obligations to the enrollees will be duly performed.

4. The enrollees will be afforded an opportunity to participate in matters of policy and operation pursuant to § 38.1-867.

5. Nothing in the method of operation, as shown in the information submitted pursuant to § 38.1-864 or by independent investigation, is contrary to the public interest.

§ 38.1-866. Powers of health maintenance organizations.—A. The powers of a health maintenance organization shall include, but shall not be limited to, the following, provided such activities are in conformance with all applicable State statutes and regulations:

1. The purchase, lease, construction, renovation, operation, or maintenance of hospitals, medical or other health care facilities, and their ancillary equipment and such property as may reasonably be required for its principal office or for such other purposes as may be necessary in the transaction of the business of the organization;

2. The making of loans to health care providers under contract with it in furtherance of its program or the making of loans to a corporation or corporations under its control for the purpose of acquiring or constructing medical or other health care facilities and hospitals or in furtherance of a program providing health care services to enrollees;

3. The furnishing of health care services through providers which are under contract with or employed by the health maintenance organization;

4. The contracting with any person for the performance on its behalf of certain functions such as marketing, enrollment and administration;

5. The contracting with an insurance company licensed in this State, or with a prepaid health plan licensed in this State, for the provision of insurance, indemnity, or reimbursement against the cost of health care services provided by the health maintenance organization;

6. The offering, in addition to basic health care services, of:

a. additional health care services;

b. indemnity benefits covering out-of-area services; and

c. indemnity benefits, in addition to those relating to out-of-area services, provided through insurers or prepaid health plans.

B. 1. A health maintenance organization shall file notice with the Commission within thirty days after the exercise of any power granted in paragraph l. or 2. of subsection A. which exceeds one per centum of the admitted assets of the organization or twenty-five thousand dollars, whichever is less. A health maintenance organization shall file notice, with adequate supporting information, with the Commission prior to the exercise of any power granted in paragraph l. or 2. of subsection A. which exceeds five per centum of the admitted assets of the organization or one hundred fifty thousand dollars, whichever is less. Any series of transactions occurring within a twelve-month period which are sufficiently similar in nature so as to be reasonably construed as a single transaction shall be subject to the limitations set forth herein. The Commission shall disapprove such exercise of power if in its opinion it would substantially and adversely affect the financial soundness of the health maintenance organization and endanger its ability to meet its obligations. If the Commission does not disapprove within thirty days of the filing, it shall be deemed approved.

2. The Commission may, upon application by the health maintenance organization, exempt from the filing requirement of subsection B. 1. those activities having a de minimis effect.

§ 38.1-867. Governing body.— A. The governing body of any health maintenance organization may include providers or other individuals, or both.

B. Such governing body shall establish a mechanism to afford the enrollees an opportunity to participate in matters of policy and operation through the establishment of advisory panels, by the use of advisory referenda on major policy decisions, or through the use of other mechanisms.

§ 38.1-868. Fiduciary responsibilities.—Any director, officer or partner of a health maintenance organization who receives, collects, disburses, or invests funds in connection with the activities of such organization shall be responsible for such funds in a fiduciary relationship to the enrollees.

§ 38.1-869. Evidence of coverage and charges for health care services.—A. 1. Every subscriber shall be entitled to evidence of coverage under a health care plan.

2. No evidence of coverage, or amendment thereto, shall be issued or delivered to any person in the Connonwealth until a copy of the form of the evidence of coverage, or amendment thereto, has been filed with and approved by the Commission, subject to the provisions of subsection C. hereof.

3. Any evidence of coverage shall contain:

a. No provisions or statements which are unjust, unfair, inequitable, misleading, deceptive or misrepresentative or which are untrue, misleading or deceptive as defined in subsection A. of § 38.1-876.

b. A clear and complete statement if a contract, or a reasonably complete summary if a

certificate, of:

(1) The health care services and the insurance or other benefits, if any, to which the enrollee is entitled under the health care plan;

(2) Any limitations on the services, kind of services, benefits, or kind of benefits to be provided, including any deductible or co-payment feature;

(3) Where and in what manner information is available as to how services may be obtained;

(4) The total amount of payment for health care services and the indemnity or service benefits, if any, which the enrollee is obligated to pay with respect to individual contracts, or an indication whether the plan is contributory or non-contributory with respect to group certificates; and

(5) A clear and understandable description of the health maintenance organization's method for resolving enrollee complaints. Any subsequent change may be evidenced in a separate document issued to the enrollee.

B.1. No schedule of charges for enrollee coverage for health care services, or amendment thereto, may be used in conjunction with any health care plan until a copy of such schedule, or amendment thereto, has been filed with the Commission. The Commission may disapprove such charges if it finds such charges to be excessive, inadequate or unfairly discriminatory.

2. Such charges may be established for various categories of enrollees based upon sound actuarial principles, provided that charges applicable to an enrollee shall not be individually determined based on the status of his health. A certification, by a qualified actuary or other qualified professional approved by the Commission, as to the appropriateness of the charges, based upon reasonable assumptions, may be required by the Commission to be filed along with adequate supporting information.

3. No change in coverage or benefits or premiums may be made following approval by the Commission except upon at least thirty days' prior written notice to all subscribers or group contract holders.

C. The Commission shall, within a reasonable period, approve any from if the requirements of subsection A. are met. It shall be unlawful to issue such form until approved. If the Commission disapproves such filing, it shall notify the filer. In the notice, the Commission shall specify the reasons for its disapproval. A written request may be made to the Commission, within thirty days after notice of such disapproval, for a hearing thereon. If the Commission does not disapprove any form within thirty days of the filing of such form, it shall be deemed approved.

D. The Commission may require the submission of whatever relevant information it deems necessary in determining whether to approve or disapprove a filing made pursuant to this section.

§ 38.1-870. Annual report.—A. Every health maintenance organization shall annually, on or before the first day of March, file with the Commission a report, verified by at least two principal officers, covering the preceding calendar year and shall send a copy to the State Health Commissioner.

B. Such a report shall be on forms prescribed by the Commission and shall include:

1. A financial statement of the organization, including its balance sheet and receipts and disbursements for the preceding year;

2. Any material changes in the information submitted pursuant to subsection C. of § 38.1-864;

3. The number of persons enrolled during the year, the number of enrollees as of the end of the year and the number of enrollments terminated during the year;

4. Such other information relating to the performance and utilization of the health maintenance organization as may be required by the Commission in consultation with the State Health Commissioner to carry out its duties under this chapter.

C. If the health maintenance organization is audited annually by an independent certified public accountant, a copy of such certified audit report shall be filed with the Commission not later than the thirtieth day of June.

§ 38.1-87l. Open enrollment.—A. After a health maintenance organization has been in operation twenty-four months, it shall have an annual open enrollment period of at least one month during which it accepts enrollees up to the limits of its capacity, as determined by the health maintenance organization, in the order in which they apply for enrollment.

B. Where the health maintenance organization demonstrates to the satifisfaction of the Commission that such open enrollment period would jeopardize its economic viability, the Commission may, upon application by the organization:

1. Waive the requirement for open enrollment; or

2. Authorize the organization to impose such underwriting restrictions upon the open enrollment as are necessary to:

a. Preserve its financial stability;

b. Prevent excessive adverse selection by prospective enrollees; and

c. Avoid unreasonably high or unmarketable charges for enrollee coverage of health services.

The Commission shall approve or deny such application within thirty days of the receipt thereof from the health maintenance organization. Such action shall be effective for a period of not more than one year. At the expiration of such time a new showing of need for such waiver or authorization by the organization must be made before a new waiver or authorization shall be issued.

§ 38.1-872. Complaint system.—A. Every health maintenance organization shall establish and maintain a complaint system which has been approved by the Commission, after consultation with the State Health Commissioner, to provide reasonable procedures for the resolution of written complaints.

B. Each health maintenance organization shall submit to the Commission and the State Health Commissioner an annual report in a form prescribed by the Commission, after consultation with the State Health Commissioner, which shall include (i) a description of the procedures of such complaint system, (ii) the total number of complaints handled through such complaint system and a compilation of causes underlying the complaints filed and (iii) the number, amount, and disposition of malpractice claims settled or adjudicated during the year by the health maintenance organization and any of the providers used by it.

C. The Commission or the State Health Commissioner may examine such complaint system.

§ 38.1-873. Investments.—The investable funds of a health maintenance organization shall be invested only in securities or other investments permitted by the laws of this Commonwealth for the investment of assets constituting the legal reserves of life insurance companies or such other securities or investments as the Commission may permit.

§ 38.1-874. Protection against insolvency.—Each health maintenance organization shall furnish a surety bond in an amount satisfactory to the Commission, or deposit with the State Treasurer securities acceptable to him in at least the same amount, as a guarantee that the obligations to the enrollees will be performed. The Commission may waive this requirement whenever satisfied that the assets of the organization or its contract with insurers, prepaid health plans, governments, or other organizations are sufficient reasonably to assure the performance of its obligations.

§ 38.1-875. Approval of provider contracts.—Any contracts made with health care providers enabling a health maintenance organization to provide health care services authorized under this chapter shall be filed with the Commission. The Commission shall have power to require immediate renegotiation of such contracts whenever it determines that they fail to include reasonable incentives for cost control or they otherwise substantially and unreasonably contribute to escalation

of the costs of providing health care services to enrollees or to other members of the public.

§ 38.1-876. Prohibited practices.—A. No health maintenance organization or representative thereof may cause or knowingly permit the use of advertising which is untrue or misleading, solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive. For purposes of this chapter:

1. A statement or item of information shall be deemed to be untrue if it does not conform to fact in any respect which is or may be significant to an enrollee of, or person considering enrollment in, a health care plan;

2. A statement or item of information shall be deemed to be misleading, whether or not it may be literally untrue, if, in the total context in which such statement is made or such item of information is communicated, such statement or item of information may be reasonably understood by a reasonable person, not possessing special knowledge regarding health care coverage, as indicating benefit or advantage or the absense of any exclusion, limitation or disadvantage of possible significance to an enrollee of, or person considering enrollment in, a health care plan, if such benefit or advantage or absense of limitation, exclusion or disadvantage does not in fact exist;

3. An evidence of coverage shall be deemed to be deceptive if the evidence of coverage taken as a whole, and with consideration given to typography and format as well as language, shall be such as to cause a reasonable person, not possessing special knowledge regarding health care plans and evidences of coverage therefor, to expect benefits, services, charges, or other advantages which the evidence of coverage does not provide or which the health care plan issuing such evidence of coverage does not regularly make available for enrollees covered under such evidence of coverage.

B. The provisions of Article 6 of Chapter 1 of this title shall be construed to apply to health maintenance organizations, health care plans and evidences of coverage except to the extent that the Commission determines that the nature of health maintenance organizations, health care plans and evidences of coverage render any such provisions clearly inappropriate.

C. No health maintenance organization may cancel or refuse to renew the coverage of an enrollee on the basis of the status of the enrollee's health.

D. No health maintenance organization, unless licensed as an insurer, may use in its name, contracts, or literature any of the words "insurance", "casualty," "surety", "mutual," or any other words descriptive of the insurance, casulty, or surety business or deceptively similar to the name or description of any insurance or surety corporation doing business in this Commonwealth.

§ 38.1-877. Licensing of agents.—Enrollee contracts may be solicited outside the principal office of a health maintenance organization only through licensed salesmen. The requirements and procedures governing the issuance of salesmen's licenses and the payment of fees related thereto shall be the same as those for agents as provided in Article 4 (§ 38.1-327.33 et. seq.) of Chapter 7.1 of this title. No salesman's license shall be issued unless the Commission is satisfied that the applicant is a person of good character and reputation and competent to perform the duties of a salesman of enrollee contracts.

§ 38.1-878. Powers of insurers and prepaid health plans.—An insurance company licensed in this Commonwealth or a prepaid health plan licensed in this Commonwealth may, either directly or through a subsidiary or affiliate, organize and operate a health maintenance organization under the provisions of this chapter. Notwithstanding any other law which may be inconsistent herewith, any two or more such insurance companies, prepaid health plans, or subsidiaries or affiliates thereof, may jointly organize and operate a health maintenance organization.

B. An insurer or a prepaid health plan may contract with a health maintenance organization to provide insurance or similar protection against the cost of care provided through health maintenance organizations and to provide coverage in the event of the failure of the health maintenance organization to meet its obligations. The enrollees of a health maintenance organization constitute a permissible group for purposes of laws applicable to insurers and prepaid health plans. Among other things, under such contracts, the insurer or prepaid health plans may make benefit payments to health maintenance organizations for health care services rendered by providers pursuant to the health care plan.

§ 38.1-879. Examinations.—A. The Commission may make an examination of the affairs of any health maintenance organization as often as it deems it necessary for the protection of the interests of the people of this Commonwealth, but no less often than once in every five years. The Commission may make an examination of the affairs of providers with whom any health maintenance organization has contracts, agreements, or other arrangements pursuant to its health care plan as often as it deems necessary for the protection of the interests of the people of this Commonwealth.

B. The State Health Commissioner amy make an examination concerning the quality of health care services of any health maintenance organization and providers with whom such organization has contracts, agreements, or other arrangements pursuant to its health care plan as often as he deems it necessary for the protection of the interests of the people of this Commonwealth.

C. The report of the examination of a health maintenance organization prepared by the Commission shall be handled in the manner provided by § 38.1-177. Every health maintenance organization and provider shall submit its books and records relating to the health care plan to such examinations and in every way facilitate them. For the purpose of examinations, the Commission and the State Health Commissioner may administer oaths to and examine the officers and agents of the health maintenance organization and the principals of such providers concerning their business.

D. The expenses of examinations under this section shall be assessed against the organization being examined and remitted to the Commission or the State Health Commissioner for whom the examination is being conducted.

E. In lieu of such examination, the Commision or State Health Commissioner may accept the report of an examination of a foreign health maintenance organization made by the Commission or similar regulatory agency or the State Health Commissioner of another state.

§ 38.1-880. Suspension or revocation of license.—A. The Commission may suspend or revoke any license issued to a health maintenance organization under this chapter if it finds that any of the following conditions exist:

1. The health maintenance organization is operating significantly in contravention of its basic organizational document, its health care plan, or in a manner contrary to that described in and reasonably inferred from any other information submitted under § 38.1-864, unless amendments to such submissions have been filed with and approved by the Commission;

2. The health maintenance organization issues evidence of coverage or uses a schedule of charges for health care services which do not comply with the requirements of § 38.1-869;

3. The health care plan does not provide or arrange for basic health care services;

4. The State Health Commissioner certifies to the Commission that the health maintenance organization is unable to fulfill its obligations to furnish quality health care services as set forth under its health care plan consistent with prevailing medical care standards and practices in the Commonwealth;

5. The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligtions to enrollees or prospective enrollees;

6. The health maintenance organization has failed to implement a mechanism affording the enrollees an opportunity to participate in matters of policy and operation as provided in § 38.1-867;

7. The health maintenance organization has failed to implement the complaint system required by § 38.1-872 in a manner to resolve valid complaints reasonably;

8. The health maintenance organization, or any person on its behalf, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner;

9. The continued operation of the health maintenance organization would be hazardous to its enrollees;

10. The health maintenance organization has otherwise failed to substantially comply with the provisions of this chapter.

B. When the license of a health maintenance organization is suspended, the health maintenance organization shall not, during the period of such suspension, enroll any additional enrollees except newborn children or other newly acquired dependents of existing enrollees, and shall not engage in any advertising or solicitation whatsoever.

C. The Commission shall not revoke or suspend the license of a health maintenance organization upon any of the grounds set out in subsection A. hereof until it has given the organization ten days' notice of the proposed revocation or suspension and the grounds therefor, and has afforded the organization an opportunity to introduce evidence and be heard. Any hearing authorized herein may be informal and the required notice may be waived by the Commission and the health maintenance organization.

D. When the license of a health maintenance organization is revoked, such organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of such organization. It shall engage in no further advertising or solicitation whatsoever. The Commission may, by written order, permit such further operation of the organization as it may find to be in the best interests of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing health care coverage.

§ 38.1-881. Rehabilitation, liquidation, or conservation of health maintenance organization.—Any regabilitation, liquidation or conservation of a health maintenance organization shall be deemed to be the rehabilitation, liquidation, or conservation of an insurance company and shall be conducted under the supervision of the Commission pursuant to the law governing the rehabilitation, liquidation, or conversation of insurance companies. The Commission may enter an order directing the rehabilitation, liquidation, or conservation of a health maintenance organization upon any one or more grounds set out in §§ 38.1-126 to 38.1-145 of this Code or when in the Commission's opinion the continued operation of the health maintenance organization would be hazardous either to the enrollees or to the people of this Commonwealth.

§ 38.1-882. Regulations.—The Commission may, after notice and opportunity for all interested parties to be heard, issue regulations and orders necessary to carry out the provisions of this chapter.

§ 38.1-883. Fees.—A. Every health maintenance organization subject to the provisions of this chapter shall pay to the Commission for filing an application for a license one hundred dollars.

B. Every health maintenance organization licensed pursuant to the provisions of this chapter shall obtain from the Commission annually a renewal of its license. No such renewal license shall be issued unless and until the health maintenance organization has paid all fees and charges imposed on it and has complied with all other requirements of law. The renewal fee shall be one hundred dollars and shall be payable on the first day of March of each year.

The Commission shall not fail or refuse to renew the license of any health maintenance organization without giving the health maintenance organization ten days' notice thereof and affording it an opportunity to be heard and to introduce evidence on its behalf. Any such hearing may be informal, and the required notice may be waived by the Commission and the health maintenance organization.

D. Sections 38.1-44 through 38.1-48 of this Code shall apply to the operation of a health maintenance organization.

§ 38.1-884. Injunctions.—The Commission shall have the jurisdiction and power of a court of equity to issue temporary and permanent injunctions restraining violations or attempted violations of this chapter and to enforce such injunctions by fine or imprisonments.

§ 38.1-885. Appeals.—Any person aggrieved by any final or interlocutory judgment, order or decree of the Commission may appeal, as a matter of right, to the Supreme Court of Virginia.

§ 38.1-886. Penalties.—The Commission may, by judgment entered after a hearing on notice duly served on the defendant not less than ten days before the hearing, if it be proved that the defendant has violated any provision of this chapter or any lawful order of the Commission issued under this chapter, impose a penalty not exceeding one thousand dollars, which shall be collectible by the process of the Commission as provided by law. In addition to imposing such penalty, or without imposing such penalty, the Commission, in any such case, may revoke any license issued by it to the defendant.

§ 38.1-887. Statutory construction and relationship to other laws.—A. Except as otherwise provided in this chapter, provisions of the insurance laws of the Commonwealth shall not be applicable to any health maintenance organization granted a license under this chapter. The provisions of this chapter shall not apply to an insurer or prepaid health plan licensed and regulated pursuant to the insurance laws or the prepaid health plan laws of this Commonwealth except with respect to the activities of its health maintenance organization authorized and regulated pursuant to this chapter.

B. Solicitation of enrollees by a health maintenance organization granted a license or by its representatives shall not be construed to violate any provisions of law relating to solicitation or advertising by health professionals.

C. Any health maintenance organization licensed under this chapter shall not be deemed to be engaged in the unlawful practice of medicine. All health care providers associated with a health maintenance organization shall be subject to all provisions of law.

§ 38.1-888. Confidentiality of medical information.—Any data or information pertaining to the diagnosis, treatment, or health of any enrollee or applicant obtained from such person or from any provider by any health maintenance organization shall be held in confidence and shall not be disclosed to any person except to the extent that it may be necessary to carry out the purposes of this chapter; or upon the express consent of the enrollee or applicant; or pursuant to statute or court order for the production of evidence or the discovery thereof. In the event of claim or litigation between such person and the health maintenance organization wherein such data or information is pertinent, a health maintenance organization shall be entitled to claim any statutory privileges against such disclosure which the provider who furnished such information to the health maintenance organization is entitled to claim.

§ 38.1-889. Authority of Commonwelath to contract with health maintenance organizations.—The Commonwealth of Virginia is hereby authorized to enter into contracts with health maintenance organizations on behalf of its employees and the citizens of the Commonwealth, including contracts to furnish to recipients of medical assistance under Title XIX of the United States Social Security Act, 42 U.S.C. § 1396, et. seq., health care services.

§ 38.1-890. Health maintenance organization affected by chapter.—Except as otherwise specifically provided by law, no health maintenance organization shall be operated in this Commonwealth other than in the manner set forth in this chapter.

§ 38.1-891. Severability.—If any section, term, or provision of this chapter shall be adjudged invalid for any reason, such judgment shall not affect, impair, or invalidate any other section, term, or provision of this chapter, but the remaining sections, terms, and provisions shall be and remain in full force and effect.

2. That § 38.1-813 of the Code of Virginia is repealed.

Appendix 2

A BILL to amend the Code of Virginia by adding sections numbered 38.1-348.12, 38.1-821.1, 38.1-844.1 and 38.1-858.1 so as to require insurers and prepaid health, dental and optometric plans to offer deductibles and co-insurance options.

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding sections numbered 38.1-348.12, 38.1-821.1, 38.1-844.1 and 38.1-858.1 as follows:

§ 38.1-348.12. Deductibles and co-insurance options required.—No policy of accident and sickness insurance providing coverage on an expense incurred basis shall be issued or renewed unless, prior to the issuance or renewal of such policy, the insured was offered a policy under which the insured pays for (i) not less than the first one hundred dollars of the costs of the services covered by the policy and (ii) twenty per centum of the next one thousand dollars of the cost of the services covered by the policy.

§ 38.1-821.1. Deductibles and co-insurance options required.—Any person, group of persons or nonstock corporation organized or operating a plan authorized in this chapter shall, before issuing or renewing any contract issued under or pursuant to the plan, make available to the holder or potential holder of the contract a contract under which the subscriber pays (i) not less than the first one hundred dollars of the cost of the services provided for by such contract and (ii) twenty per centum of the next one thousand dollars of the cost of the services provided for by such contract.

§ 38.1-844.1. Deductibles and co-insurance options required.—Any corporation organizing or operating a plan shall, before issuing or renewing any contract issued under or pursuant to the plan, make available to the holder or potential holder of the contract a contract under which the subscriber pays (i) not less than the first one hundred dollars of the cost of the dental services provided for by such contract and (ii) twenty per centum of the next one thousand dollars of the cost of the dental services provided for by such contract.

§ 38.1-858.1. Deductibles and co-insurance options required.—Any corporation organizing or operating a plan shall, before issuing or renewing any contract issued under or pursuant to the plan, make available to the holder or potential holder of the contract a contract under which the subscriber pays (i) not less than the first one hundred dollars of the cost of the optometric services provided for by such contract and (ii) twenty per centum of the next one thousand dollars of the cost of the optometric services provided for by such contract.

Appendix 3

SENATE JOINT RESOLUTION NO.....

Memorializing the Congress of the United States to enact tax laws providing incentives to purchase certain insurance coverage in order to contain the rise in health care costs.

WHEREAS, the rise in the costs of health care is a problem of concern to many citizens of Virginia as well as the rest of the nation; and

WHEREAS, the causes of the increase in costs are many and complex, including inflation and improvements in the quality and quantity of services; and

WHEREAS, another extremely important cause is the increase in demand for health services because of medicare, medicaid, and other governmental programs and insurance coverage much of which is "first dollar" coverage; and

WHEREAS, the effects of "first dollar" coverage may be that the insured is unaware of and unconcerned about the costs of his medical care because he does not pay for it directly and thus there is no incentive for either the insured or his physician to contain expenditures; and

WHEREAS, federal tax laws encourage purchase of this coverage because individuals can deduct a portion of premiums paid therefor and because employer payments therefor are excluded from the taxable income of the employee and the employer; and

WHEREAS, if individuals paid directly for a greater portion of their hospital care through such means as deductibles or co-insurance, their increased awareness of the costs of their care would beneficially affect the rise in health care costs; but there are no existing incentives for individuals to pay directly for this care; now, therefore, be it

RESOLVED by the Senate of Virginia, the House of Delegates concurring, That the United States Congress is hereby memorialized to enact tax incentives to purchase health insurance coverage under which individuals pay directly for more of their hospital care; and be it

RESOLVED FURTHER, That the Clerk of the Senate is directed to send copies of this resolution to the Speaker of the United States House of Representatives, the President of the United States Senate, and the members of the delegation of this Commonwealth to Congress in order that they may be apprised of the sense of this body.

Appendix 4

A BILL to amend and reenact § 58-490 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 58-491.1 so as to reduce the license tax on premium income derived from accident and sickness insurance policies.

Be it enacted by the General Assembly of Virginia:

1. That § 58-490 of the Code of Virginia is amended and reenacted and the Code of Virginia is amended by adding a section numbered 58-491.1 as follows:

§ 58-490. Amount of license tax for insurance other than life insurance and annuities and accident and sickness insurance.–For every year every such company which issues policies or contracts for any kind of insurance classified and defined in §§ ~~38.1-5~~ *38.1-6* to 38.1-24 or chapter 22 (§ 38.1-790 et seq.) of Title 38.1, except workmen's compensation insurance on which a premium tax is imposed under the provisions of § ~~65-120~~ *65.1-129,* shall pay a license tax of two and three-fourths per centum of subscriber fee income or direct gross premium income derived from such business in this State during the preceding year ending the thirty-first day of December.

This section, as hereby amended, shall apply with respect to taxable years as defined in § 58-502.1, beginning after December thirty-one, nineteen hundred ~~and sixty-eight~~ *eighty* , and to license years beginning on and after ~~May~~ *July* one, nineteen hundred ~~and seventy~~ *eighty-two* .

§ 58-491.1. Amount of license tax for accident and sickness insurance.–Every year every such company which issues policies or contracts for accident and sickness insurance as defined in § 38.1-5 shall pay a license tax of two per centum of subscriber fee income or direct gross premium income derived from accident and sickness insurance business in the State during the preceding year ending the thirty-first day of December.

This section shall apply with respect to taxable years as defined in § 58-502.1 beginning after December thirty-one, nineteen hundred eighty, and to license years beginning on or after July one, nineteen hundred eighty-two.

Appendix 5

SENATE JOINT RESOLUTION NO.....

Continuing the Commission to Study the Containment of Health Care Costs

WHEREAS, during the 1978 session of the General Assembly, Senate Joint Resolution No. 5 was adopted, creating the Commission to Study the Containment of Health Care Costs; and

WHEREAS, the Commission has worked diligently for two years and has received many suggestions, several reportsand much testimony on the exceedingly complex problem of escalating health care costs; and

WHEREAS, the Commission has made several recommendations to this session of the General Assembly for containing health care costs but has not had sufficient time to consider several other proposals which merit consideration; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Commission to Study the Containment of Health Care Costs is continued. The membership of the Commission shall remain the same and any vacancy shall be filled in the same manner as the original appointment.

The Commission shall study (i) the issue of legislatively mandated coverage by health insurance policies and prepaid health care plans of various providers and services, (ii) the advisability of laws limiting the coordination of health insurance benefits and (iii) such other matters as the Commission may deem pertinent to the containment of health care costs.

All agencies of the Commonwealth are requested to cooperate with the Commission. The Commission shall hold such hearings as it deems appropriate.

The Commissioner of Health and the Commissioner of Insurance shall provide the expertise and services required by the Commission to its work expeditiously.

The legislative members of the Commission shall recieve such compensation as is set forth in § 14.1-18 of the Code of Virginia. All members shall be paid their necessary expenses incurred in the performance of their duties but shall receive no other compensation. For such expenses as may be required, including secretarial and other professional assistance, there is hereby allocated from the general appropriation to the General Assembly the sum of twenty-five thousand dollars.

The Commission shall report to the Governor and the General Assembly not later than December one, nineteen hundred eighty-one.