REPORT OF THE

COMMISSION TO STUDY THE CONTAINMENT OF

HEALTH CARE COSTS, PURSUANT TO

SENATE JOINT RESOLUTION NO. 32

TO

THE GOVERNOR

AND

GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 25

COMMONWEALTH OF VIRGINIA
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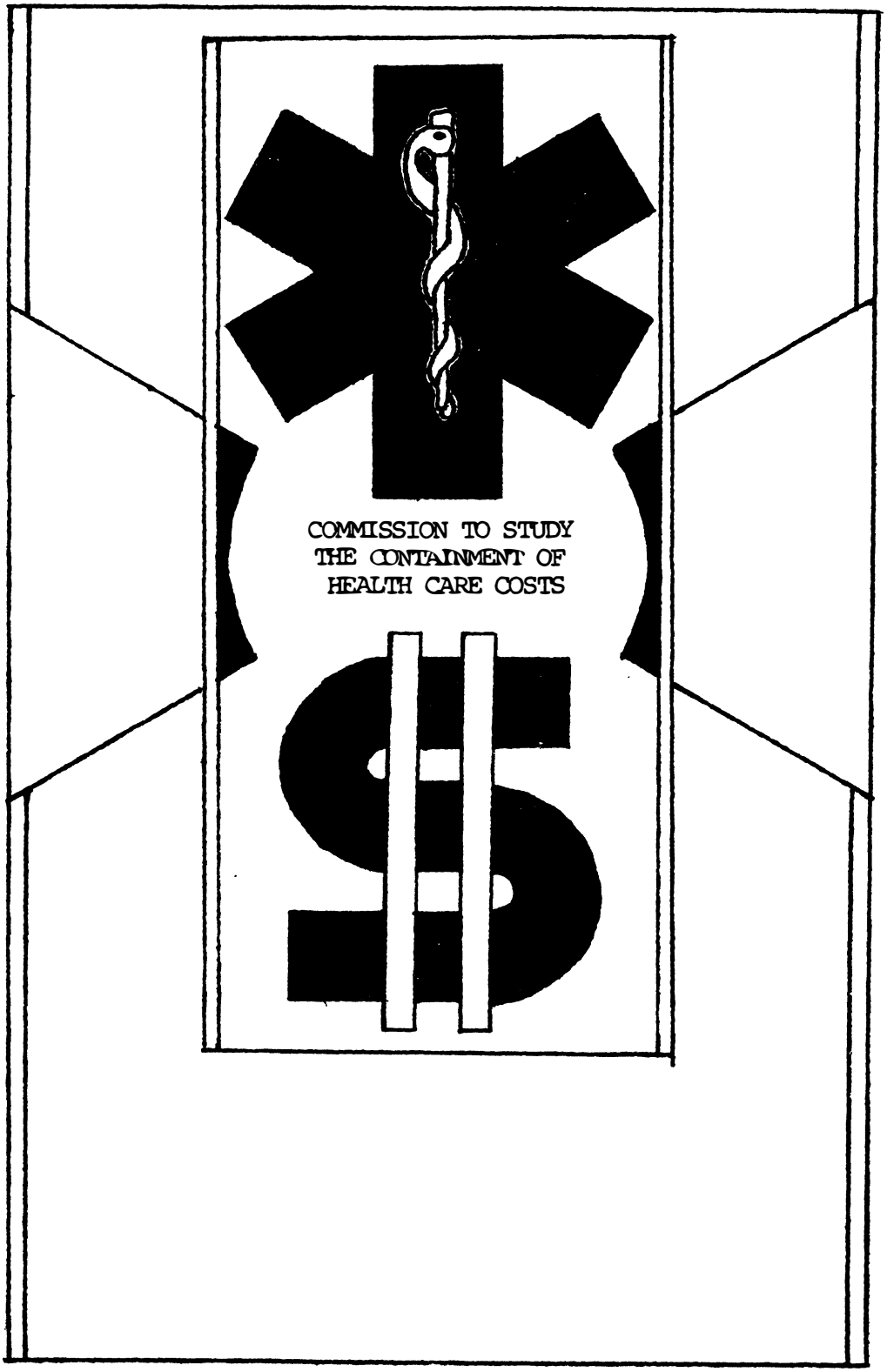
COMMISSION TO STUDY
THE CONTAINMENT OF
HEALTH CARE COSTS

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Report of the

Commission To Study the Containment Of
Health Care Costs
To
The Governor and the General Assembly of Virginia
Richmond, Virginia
January, 1982

To: The Honorable Charles S. Robb, Governor of Virginia
and
The General Assembly of Virginia

In 1978, the General Assembly passed Senate Joint Resolution No. 5 creating the Commission to Study the Containment of Health Care Costs. The text of Senate Joint Resolution No. 5 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 costs 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 changes 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, therefore, 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, the Commissioner of Mental Health and Mental Retardation and the Commissioner of Insurance of the State Corporation Commission shall be members ex officio with 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 $50,000.

The Commission shall report to the Governor and 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.

Pursuant to Senate Joint Resolution No. 5, the Speaker of the House of Delegates and the Chairman of the Privileges and Elections Committee of the Senate appointed members of their respective bodies to the Commission. Three citizen members, who were not affiliated with either the health care or the insurance industries, were also appointed by the Governor. The Commissioners of Health, Mental Health and Retardation, and Insurance assumed ex officio membership as provided in the resolution. In 1981, the Chairman, Senator Edward E. Willey, appointed Mrs. Barbara S. Bolton, Director of the Virginia Nurses Association as an ex officio member and Senator Elmo G. Cross as a member of the Commission. The members were: Senator Edward E. Willey, Chairman, Delegate Jospeh A. Johnson, Vice-Chairman, Mr. Daniel T. Balfour, Dr. Joseph J. Bevilacqua, Mrs. Barbara Bolton, Senator Adelard L. Brault, Senator John C. Buchanan, Mr. Theodore J. Burr, Jr., Senator Elmo G. Cross, Jr., Mr. Robert M. Freeman, Delegate George W. Grayson, Delegate Johnny S. Joannou, Dr. J. B.Kenley, Delegate Kevin G. Miller, Delegate James B. Murray, and Mr. James M. Thomson.

During the interim from 1978 to 1980, the Commission worked diligently to formulate alternatives to address the problems inherent in the containment of health care costs, particularly as related to third-party payment plans. As there were several proposals still to be studied, the General Assembly requested via Senate Joint Resolution No. 32 that the Commission continue its work. The text of Senate Joint Resolution No. 32 is as follows:

SENATE JOINT RESOLUTION NO. 32

Continuing the Commission to Study the Containment of Health Care Costs.

Agreed to by the Senate, February 15, 1980

Agreed to by the House of Delegates, February 29, 1980

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 reports and 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 requestd to cooperate with the Commission. The Commission shall hold 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 do its work expeditiously.

The legislative members of the Commission shall receive 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 Appropriations 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.

Scope of the Commission's Work: 1980

During 1980, the Commission's work was focused primarily on health insurance plans and the problems generated by the lack of risk incurred by the health industry because of the high percentage of third party payments. As a result of the Commission's investigations, § 38.1-348.12, which provided for certain prepaid health plan policies, was added to the Code of Virginia during the 1980 session. This new section required insurers issuing accident and sickness insurance on a prepaid plan to make available three higher deductibles and/or coinsurance provisions.

The rationale for requiring the offer of such policies was that the insured would make less frequent use of services if he was required to contribute substantially to the payment for these services. Less frequent use of health care services would mean a reduction in health care costs. Further, this type of policy is less expensive for the policyholder, thereby creating a double savings in terms of money expended for health care.

The three options provided in the 1980 bill, Senate Bill 184 (see Appendix A), created a hardship on certain companies by effectively excluding them from participation in the Virginia market. These three options provided that the individual insured or group certificate holder pay for: 1. The first $100 of the costs; 2. Twenty percent of the first $100 of the cost; 3. The first $100 and twenty percent of the next $100 of the cost.

In view of the difficulties experienced in implementing § 38.1-348.12, this section was repealed in 1981 and another section, § 38.1-348.12:1, containing four options for greater deductible, coinsurance, or cost-sharing provisions was added to the Code. This bill (S.B. No. 751) was an emergency bill due to the problems being experienced by the industry and, therefore, became effective on March 18, 1981.

The new section, 38.1-348.12:1 (See Appendix A), included the three options that had been included in § 38.1-348.12 plus a fourth, more flexible provision as follows: "Any other option containing a greater deductible, coinsurance, or cost-sharing provision; however, such option shall not be inconsistent with standards established with respect to deductibles, coinsurance, or cost-sharing pursuant to § 38.1-362.14."

Scope of the Commission's Work: 1981

In 1981, the scope of the Commission's work broadened to encompass considerations of such issues as hospital cost reimbursement systems, long-term care and Medicaid. The first meeting was held on June 25, 1981. This meeting was scheduled to provide the Commission with information on a grant for conducting a workshop on health care cost containment, which had been made available by the National Conference of State Legislatures.

Senator Willey, the Chairman, had approved the initial application for funds to conduct such a workshop; however, the response by the states to the NCSL's offer had been overwhelming and the original funds were quickly depleted. Russ Hereford of the NCSL had assured the Commission's staff that if additional funds were awarded the NCSL for this purpose, then Virginia would receive funding for its workshop. The Commission approved the draft agenda after adjusting the timing to cover two half days rather than the one full day included in the draft. The staff was directed to poll the members for the appropriate dates and to proceed with the arrangements for the workshop under Senator Willey's direction.

Mr. Raymond O. Perry, Assistant Commissioner of Health, reported on the status of the Certificate of Need law and the progress being made on the studies mandated by the Appropriations Act. Mr. Perry stated that Virginia's Certificate of Need law was not in compliance with the federal requirements and that the appropriate revisions would be requested during the 1982 session of the General Assembly. Mr. Perry pointed out that large sums of federal money will be lost to Virginia if this law is not brought into conformance with the new federal law.

Mr. Perry reviewed the nursing home patient origin survey revealing the following data:

66.3% of the patients surveyed were enrolled in the Medicaid program;

88.9% of the patients surveyed were intermediate care patients;

96.7% of the Medicaid patients surveyed were intermediate care patients;

47.2% of the patients surveyed were transferred from a hospital to the nursing home;

10.4% of the private paying patients surveyed had been residents of a nursing home for five or more years whereas 16.7% of the Medicaid recipients surveyed had been residents of a nursing home for five or more years.

The majority of nursing home residents are white (82.8%) and/or female (74.3%) and/or over 75 years of age (73%).

These data can be analyzed as follows:

1. The Medicaid program is being severely taxed to maintain the payment for a high percentage of the nursing home residents in Virginia (66.3%).

2. Many patients currently in nursing homes might be served by less costly, less restrictive, alternative programs (88.9% intermediate care patients).

3. Many Medicaid patients could be maintained through less costly, less restrictive programs (96.7% intermediate care patients).

4. A high percentage of patients may be shunted into nursing homes from an acute care facility (a hospital), thereby creating a flow of patients which may not be desirable. (47.2%).

5. Many private paying patients may quickly exhaust their resources and become Medicaid recipients (10.40% were institutionalized for five or more years as opposed to 16.7% of Medicaid recipients).

6. Medicaid recipients constitute a large segment of those patients residing in a nursing homes for five or more years (16.7%); therefore, less costly, equally effective programs should be planned and supported.

Mr. Perry also presented preliminary data collected for the surplus hospital bed study. Preliminary data indicated that by 1986, Virginia would have 2,064 surplus hospital beds. This is of great significance in view of the contention by many health industry experts that surplus beds result in significant additions to the operating costs of hospitals, costs which are then passed on to the consumer in the form of increased charges. The final data for this survey will be published in the report of the Department of Health to the House Appropriations and Senate Finance Committees (contact the Department of Health for copies). Exhibit III of the preliminary report indicated that

the areas of Virginia which will be most overserved by 1986 are the Richmond Metropolitan area, the Tidewater area and Northern Virginia (See Appendix A). Mr. Perry noted that one mechanism for controlling the number of surplus beds is the Certificate of Need Law, which requires facilities to substantiate the need for services before constructing new facilities or providing new services.

Dr. Karen Davis, a nationally known health care economists and professor of Health Services Administration at Johns Hopkins University, spoke to the Commission on health care issues in the 1980's and strategies for cost containment. Dr. Davis stated that in 1980 over nine percent or $230 billion of the Gross National Product represented health care expenditures. This amount could be interpreted to be the equivalent of over $1,000 for every person in the United States.

Dr. Davis then discussed the dramatic increases in hospital costs which she said are believed to be escalating by an annual rate of twenty percent. She cited four major reasons for this increase:

1. The pervasiveness of insurance coverage and other-third party payment systems for hospital services. Dr. Davis maintained that ninety percent of hospital costs are directly paid by some third-party payor, while most patients pay indirectly through taxes or insurance premiums;

2. The methods by which hospitals are reimbused. Dr. Davis noted that current reimbursement methods do not encourage efficiency on the part of hospitals. Hospitals are virtually assured that, whatever they charge or whatever their costs, these amounts will be recovered through third-party payments, which are made in several instances on the basis of operating costs.

3. The central role of the physician. Dr. Davis explained that there is a little or no competition between hospitals, but rather competition to obtain the doctors who generate the greatest number of patients and required services. Because the physician decides if the patient will be hospitalized, for how long and what treatment the patient will receive, the hospitals compete to obtain the doctors who keep beds filled. The result is that hospitals have incentives not to compete to lower prices, but do have incentives to compete to increase utilization of their services.

4. Lack of information on the patients' part. A patient is rarely in a position to evaluate the need for service and the quality of the care, or to compare the costs of these services. The patient must frequently make decisions under stress or during an emergency.

Dr. Davis concluded that as a result of these factors that hospitals generate unnecessary services and ignore waste. She also discussed the serious implications for state budgets of the rising health care costs. She stated that hospital costs accounted for thirty percent of Medicaid expenditures. She noted that the impact of rising costs on the private employers and businesses is becoming prohibitive. These costs resulted in employers spending sixty million dollars on health insurance premiums in 1980. Frequently, these costs are passed on to the consumer in the form of higher prices in private product and service industries.

Dr. Davis analyzed four strategies for containing health care costs as follows:

1. Change the laws to enable the employer to choose the insurance plan that is most appropriate for his employees rather than requiring the employer to purchase costly options.

2. Promote the development of Health Maintenance Organizations (HMO's). This strategy would help reduce patients' reliance on expensive hospitalization, and is predicted to reduce such hospitalization by thirty to sixty percent with a consequential estimated reduction in health care costs of ten to forty percent. Dr. Davis pointed out that since HMO's are very few and slow to develop, this strategy would have only moderate effect immediately.

3. Maintain the certificate of public need programs. This program, according to Dr. Davis, has been and will continue to be for some time the only major tool available to state governments to effectively restrain increases in costs. Dr. Davis commented that COPN programs should be focused on examining those capital projects which are directly related to patient care.

4. Institute a mandatory hospital rate review system. Dr. Davis stated that eight states have established this regulatory program and have experienced significantly lower increases in costs.

She noted there are a variety of models for such systems, the best of which examine the level of costs and investigate all costs schedules as well as attempt to limit increases.

Senator Willey pointed out that Virginia has had a voluntary system of hospital rate review for a number of years, which has been working well to contain the increase in hospital costs. He stated that information received in Virginia indicates that the mandatory programs are not working as well to contain costs as Virginia's voluntary program.

The Commission approved a set of objectives which had been prepared by Richard E. Hickman of the Senate Finance Committee staff and Norma E. Szakal of the Commission's staff as follows:

Proposed Objectives

HEALTH CARE COST CONTAINMENT COMMISSION
(1981)

1. Consider the impact of proposed changes in federal health programs and funding in order to recommend adjustments to Virginia's programs and funding which would be in the best interests of the citizens of the Commonwealth.

2. Consider the impact of proposed changes in federal health laws and regulations in order to identify areas in which Virginia may need to enact compensating legislation or regulations.

3. Identify alternative strategies for containing health care costs by encouraging increased competition in the health care industry.

4. Review current state laws and regulations governing private health insurance in order to provide incentives for consumers as well as the industry to contain costs.

5. Review indigent health care in the Commonwealth as provided through Medicaid, state teaching hospitals, and other tax supported programs in order to provide consistency in eligibility and administrative efficiency.

6. Develop and present a workshop on "Legislative Strategies for Containing Health Care Costs in Virginia" in order to assist the General Assembly and other elected or appointed officials in controlling the inflationary spiral of health care costs.

7. Submit a report with recommendations, as appropriate, to the 1982 General Assembly.

Mr. Robert Treibley of the Health Department reported on the changes in the Virginia Medicaid program which were intended to contain costs as follows:

1. In the area of covered services, the frequency of dental bitewing x-rays has been limited to once a year, and dental patient education to once a lifetime, with an estimated savings of $350,000.

2. The plan will encourage prescribers to permit the use of Virginia voluntary formulary as a condition of Medicaid coverage of drugs. The estimated savings is $350,000.

3. The coverage of psychiatric sessions has been changed, dropping the rate for covered visits from fifty to twenty-six dollars, and limiting the number of sessions per week. This has an estimated impact of $250,000.

4. In the area of recipient eligibility, the plan will extend the waiting period for a recipient following transfer of assets to a minimum of two years. This has an impact of 6.5 million. (This change is still subject to federal regulation and has not been finalized).

5. The plan will mandate ineligibility of Medicaid recipients for twelve months upon investigation of Medicaid fraud. This has an impact of $57,000.

6. In the area of provider reimbursement, total changes in nursing home reimbursement will have an impact of just over two million dollars.

7. In the area of hospital out-patient services, the plan will reduce allowable reimbursable costs by Medicaid to hospitals for out-patient services. The estimated impact is $1.5 million.

8. The plan will reimburse emergency physicians at the standard fee schedule rates and require hospitals to eliminate combined billing for emergency physicians. The estimated impact is $500,000.

The Commissioner of Insurance, Mr. James W. Newman, then explained to the Commission the genesis of a problem in implementing the coinsurance and deductible law which had been passed as a result of the Commission's work. (See Appendix A for an analysis of this problem prepared by Norma E. Szakal, staff attorney for the Commission). Basically, the problem concerned a perceived reluctance on the part of participating physicians to honor the Usual, Customary and Reasonable rate for patients having one of the coinsurance and deductible policies. The rationale for this perceived resistance was that the physician would be put "at risk" in these situations and incur greater expenses in billing and personnel. The representatives of the Medical Association and Blue Cross/Blue Shield asked to be allowed to meet with the Commissioner to resolve this problem.

The Commission also heard Mr. Robert Sauter, a representative of the American Council for Life Insurance, on the trend to self-insure and its potential impact on the state and insurers. A fully self-insured employer does not have to comply with the state mandates or pay any substantial premium tax to the state. This minimizes the control of the state over such plans. Finally, the Commission was urged to consider strategies to encourage a positive coordinated effort from the business community, the public and the health care industry to contain the costs of health care.

Legislative Strategies for Containing Health Care Cost in Virginia: a workshop on health care cost containment. The workshop was set for October 7 and 8 to begin at 1:00 on the first day and continue at 8:30 the next morning. The National Conference of State Legislatures received additional funds and cosponsored the workshop with the Commission. Financial assistance was also given by the Intergovernmental Health Policy Project at George Washington University and the Bank of Virginia. Each half day was planned around a speaker and a reacting panel. The speakers and panel members were carefully chosen to represent as many constituencies of the health and business industry and as much breadth in expertise as possible. The staff prepared two issue papers and each panel member was asked to examine one issue (See Appendix B). A summarizer was employed to review the discussions and encapsulate them on each day.

The first session was focused on Medicaid/long-term Care and the second on hospital cost containment/reimbursement. A copy of the program is included here in Appendix B. Arrangements were made to have the workshop transcribed and video taped. A reception was held on the evening of the first session, October 7, 1981.

Mr. James L. Scott, Director of the Office of Intergovernmental Affairs, Health Care Finance Adminstration, Washington, D. C. spoke on Wednesday, October 7, 1981 on the substantive changes in Medicaid with specific references to long-term care. Mr. Scott pointed out that the Federal changes in the Medicaid program are focused on providing the states with more flexibility. To implement these changes, Mr. Scott noted:

> Our guiding principle in the preparation of these regulations was to give states maximum discretion to administer their Medicaid programs. States know best the needs of their people and should have the authority as well as the responsibility for seeing that these needs are met in the most efficient way possible.

Some of the provisions for flexibility mentioned by Mr. Scott were:

1. Limited use of a prudent buyer's rule: The state may now contract through competitive bidding for laboratory services and medical devices.

2. Hospital reimbursement is no longer tied to the Medicare system. States will be in a better position to control the reasonableness and adequacy of hospital costs.

3. Availability of waivers for certain covered services; e.g., Waivers may be obtained to allow states to cover nonmedical/home services and community-based services for Medicaid recipients who would otherwise require costly nursing home care.

4. Optional use of the Professional Standards Review Organizations for utilization review of Medicaid. States may now contract with the existing PRSO's or implement another system of utilization review.

5. Elimination of costly paperwork. States will have to spend less time in preparing federal paperwork because reporting and monitoring requirements have been reduced.

Mr. Scott noted that Virginia has an advantage over other states in implementing home-based/community-based programs for the disabled and elderly for we have been the leader in establishing a pre-admissions screening program.

The panel of experts then responded to Mr. Scott's statements. The panel members were: Mrs. Ann Cook, Director of the Bureau of Medical Social Services for the Division of Medical Assistance, Department of Health; Ms. Charlotte Carnes, Social Work Consultant for the Nursing Home Pre-Admissions Screening Program, Department of Health; Mr. Robert Jackson, Vice-president for Finance and Treasurer, United Service Industries, Charlottesville, Virginia; and Mr. Bruce Spitz, Medicaid Consultant with the Intergovernmental Health Policy Project, George Washington University. The panel was positive in its reactions especially for the reduction in regulation and paperwork; however, they all expressed a need to proceed with caution in order to avoid problems caused by the relationship between general relief programs, programs for indigent care in public hospitals and public clinics, public assistance programs such as aid to families with dependent children and supplemental security income and the Medicaid program.

Dr. Kenley, Commissioner of Health, also spoke on the need for flexibility and the problem of cost shifting between the different human services programs. Dr. Kenley said:

> Fifteen to thirty percent of the people in those nursing homes really should be in homes for adults or somewhere else. And that occurs through inappropriate admissions because of lack of facilities in the community and also because when people who go into nursing homes appropriately and improve, and they are ready to be discharged to homes for adults, there are not attractive facilities there.
> And when the homes do discharge them, their families write me and threaten to sue me because they don't have such nice places to go to. And I think that is something we've got to address.

A number of questions from the audience were addressed to Dr. Kenley.

Each panel member was asked to discuss a specific issue concerned with the problem of Medicaid/long-term care in Virginia. Ms. Cook addressed Issue Number 1: To Whom is the State obligated to provide care? Ms. Carnes addressed Issue Number 2: Given the State's overuse (in the opinion of many) of nursing home placements, what are some of the strategies that can be utilized to provide necessary services to the Commonwealth's older and disabled citizens? Mr. Jackson addressed Issue Number 3: Can we realistically expect to sustain the present level of health care services for those who cannot pay the costs in the present health care market? Would a competitive market make this maintenance of quality health services easier? And if so, in what ways? Mr. Spitz addressed Issue Number 4: What incentives/alternatives do we have available to reduce the burdens of third party payors, whether Medicaid, Medicare or health insurance? Dr. Karen Davis served as the summarizer of the session's discussions. The following are excerpts of her summary:

> The basic problem for which we're all struggling to find solutions is the fact that in the near term we're facing serious federal budgetary reductions. As you heard earlier this afternoon, the Budget Reconciliation Act reduces the federal sharing of Medicaid costs by 3 percent for the first year, 4 percent for the second year and 4.5 percent for the third year.
>
> This reduction in federal budgetary support for Medicaid comes at a time when the State itself is facing a lot of fiscal pressure, and so that reductions add on to an already serious problem for the state.
>
> The serious inflation we've had in the economy in the last few years has eroded the purchasing power and savings the elderly had put aside for retirement, so that the need for assistance from Medicaid and other public support programs is increasing.
>
> We've had presented today a number of options, a number of alternative directions to go, to

try to solve the conflict between reduced federal support, reduced ability of the state to pick up the difference, and the increasing demand on the Medicaid program.

The first option that we had discussed by Ms. Cook looked at changing eligibility and within that the need perhaps to tighten up on asset requirements for eligibility for long-term care. And basically feeling that given these times we simply must require the elderly to exhaust their resources and that while children would like to inherit assets from their parents, if their parents do require nursing home care, to continue fairly tight requirements that those assets must be used toward the cost of nursing home care and that there not be a widespread permission to pass on assets to children, that those resources be used toward meeting the long-term-care needs of the elderly.

We then turned to Ms. Carnes, those options and issues she discussed were encouraging community-based care where appropriate rather than nursing home placement. Again picking up on some of the themes that Ms. Cook discussed, she would suggest developing a uniform set of community-based services throughout the State so that individuals have access to the kinds of community-based services that they would need. So we must be sure that the services are in place and, secondly, to strengthen a coordination mechanism of all long-term-care services, both community based and institutional based, assuring that there's a single entry point into the system and that people are cared for at the least public cost.

The third option we discussed today goes beyond just eligibility or trying to encourage community-based alternatives to nursing home care, and that was to look at reimbursement and the way we pay for long-term care. Mr. Jackson indicated that there are some new rules in the State since 1978 for the payment of nursing home care. It gets away from automatic cost reimbursement -- retrospective cost reimbursment and leads more toward a prospective payment system.

And Mr. Jackson basically pointed out that we should give this new system time to work, that it is changing some of the incentives in the area.

Other options that might be raised with regard to reimbursement would be examining the 1-percent return on equity. Is that excessive if we're going to have to reduce the number of elderly people covered or the number of people covered under Medicaid generally, or cut back on benefits? Should nursing home providers be asked to share in these restraints by taking a reduction in the allowance for equity? Should one consider expanding limits on nursing home rates to private patients? It was pointed out that there are profits made on private patients. But many of those private patients will eventually exhaust their income and assets and become Medicaid patients.

The fourth area that Mr. Spitz reviewed--addressed--is what I like to call health system reform. Are there ways in these times when we have to cut back on expenditures to meet budgetary realities--are there ways of saving money that don't involve harming patients by reducing eligibility or reducing benefits, but would try to change the way in which health care services are delivered?

And this would be either through mandatory requirements or through a set of incentives. On the incentive side, you could have such things as coinsurance or something called bank account deposits, basically. If a Medicaid beneficiary did not spend a certain sum of money on medical services, they would get some of the difference in cash.

Other kinds of options along the health systems reform line that are being discussed include limiting patients' freedom of choice. We heard earlier from Mr. Scott that the Budget Reconciliation legislation permits a prudent buyer of purchases, contracting for a lab's services. If that means patients have to go to certain locations that may be very difficult for them to go to, does that create a problem?

Mr. Spitz specifically looked at the health system reform alternative of health maintenance organizations. He indicated that nationwide there isn't much experience with Medicaid enrollment in health maintenance organizations. A lot of that was an adverse reaction to the bad experience in California. Currently there are only four states with very extensive Medicaid enrollment in health maintenance organizations.

However, it is an option that needs to be re-examined. Studies show that health maintenance organizations are much lower cost than other forms of care. Their costs tend to run anywhere from ten to forty percent below that of traditional providers of health care services, in large part because health maintenance organizations succeed in reducing hospitalization.

In this time of fiscal strain, perhaps it's appropriate to ask the provider community to share with the state in the risk of expenditures and to ask more health care providers if they would be willing to accept capitation rates at fixed amounts per Medicaid beneficiary and in turn be financially responsible for the medical care services that the patient receives.

Another alternative that's being pursued, for example, in Boston would be to approach major

hospitals that are major sources of care for Medicaid beneficiaries and for the state to offer to enter into capitation payment agreements with those hospitals, saying that those hospitals would be financially at risk for all hospital care of a defined Medicaid population.

So a number of states are experimenting with different ways of getting the provider community to share in the financial risk in a Medicaid program, and I think many of these ideas about health system reform we'll return to tomorrow and explore it greater.

The second session of the workshop was focused on Hospital Cost Containment/Reimbursement and featured Dr. Walter McClure, a nationally known proponent of a competitive health care market, as the keynote speaker. Mr. McClure's speech can be summarized by the following quotes:

I would summarize everything I have to say to you this morning by saying that unless public and private leadership are willing to develop and come forward with a tough, creditable, private. competitive strategy the rising costs of medical care are going to force the federal government and the states to turn medical care into a public utility.

So this morning I want to do three things to help you understand why costs and other problems of the medical care system are happening and help you understand what creates those problems; not only to identify the problems, but more importantly to identify the underlying cause of the problems; and finally to suggest how competition might effectively work to resolve these problems.

And so that if we wish to contain costs, if we wish to get medical care and coverage to everyone in this country at a cost that they and the nation can afford, then we are talking about a massive shift in the way the physicians and hospitals render medicine.

The second point is – so I guess I will put it this way – it will take both time and pressure to achieve this kind of shift in consciousness and practice style. This is independent of how we do it whether we go to regulatory rules or competition. This is what I believe to accomplish it.

And the third conclusion is the plan involved. If cost containment is so wonderful, why aren't we all vigorously in pursuit of it? And I would raise Milton Friedman's analogy. It's why don't we stop drinking alcohol, and the reason is the pleasure comes first and the pain comes later.

It is clear that as we go to a conservative and efficient system that there's a lot of hospital capacity and even physician capacity that may not be there or at least will be engaged in other more constructive pursuits for society. And you'd better believe that "hell hath no fury like a hospital constituency threatened." I'm sure every legislator here knows what I'm talking about.

In other words, it seems to me in the short term before competition begins to work, if we go that route, that we can attempt to hold the line by doing what a competitive system would do for us. That is, we can try to redirect patients away from the high-style providers towards the low-style providers. That means we are not going to say that we will reimburse people to go to any provider, or at least we will not reimburse unlimited amounts of money to go to any provider. We have to end the free-lunch approach.

Why is it that the country and this state seems to be going towards the high end of the spectrum rather than the low end? What is it that causes us to operate in the costly style rather than the economical style?

Is it that our doctors and hospitals are greedy, rip-off artists? Absolutely not. I'm tired of the blame game. In every discussion of this kind you get these terrible accusations being hurled by one group against the other. You see politicians and insurers often accusing doctors and hospitals of abuse and so on. And, of course, the reverse goes on. Business is often blamed for writing a blank check, so they get in it. In other words, in every room you find plenty of fingers pointed at each interest group in the room, and all of it is true and all of it is unuseful.

If we could get market forces, sound market forces, the medical care system would respond to them appropriately. And that is the heart of our problems. The medical care system is presently not responding to market forces because the market forces are unsound.

So only when certain conditions are met can we expect competition to work for us. It is in fact true now that there is vicious competition in medical care, but it is competition in a system in market failure, in a system that violates the requirements of a sound market. And therefore it is cost-generating competition; it is a medical arms-race.

If we can establish structurally sound market conditions, then we believe the competition will serve us and that we can continue with the private system. In other words, the diagnosis is market failure, and I will immediately elaborate on that. And there are two basic policy options to deal with this. We will either restructure our private system to establish the conditions of a sound market structurally–and that will take a lot of work; that's not the status quo; the status quo is market failure–or we will give up on private markets and we will use economic controls, regulatory forces as an alternative to market forces.

And when you boil down all the details and variance and so on, the big choice that this

nation needs to make over the next ten years is whether it prefers to have market reform in medical care or wishes to convert medical care into some sort of public utility.

If you don't have a price mechanism that consumers and producers feel, you don't have a market. And if you're not willing to establish a price mechanism, then you might as well forget about markets and create a public utility right now. There will be no control through a market mechanism.

But it is not enough for a structurally sound market merely to have competitors. You must have these sound market conditions of price and entry. In order to get price and entry established, we demand something called fair-market choice where employers and the state as an employer and the state and federal government as buyer for public recipients -- Medicare, the old and the poor -- would offer the people in their responsibility annually a multiple choice amongst plans: the diversity of health care plans and one or more traditional insurance plans so that they could make a free choice of providers.

But, you see, the big savings from competition occur towards the end of this process. And that's why you need short-term and intermediate measures to hold the line while you wait for competition. Competition is nowhere proven. We are going on the basis of promising theory and scattered, promising supportive evidence, but no nation has done it. We're pioneering; it may go down in flames.

It's my best judgment that it's very worthwhile, that short of this there is no other alternative but a public utility. And so if you think that this kind of competitive scheme is unprofessional or undesirable, remember what the alternatives are realistically. It's not the present system, it's the public utility, and you must consider whether you think that is more seemly, professional, and desirable than this competitive approach, and make your choices accordingly.

There were a number of questions from the audience directed to Dr. McClure. The panel then reacted to his comments. This reaction can be summarized as follows:

In general, the panel members felt that Dr. McClure had expressed the problems in the health care industry accurately, however, some issues were raised. One panel member felt that many of the ideas presented by Dr. McClure were already underway and that Dr. McClure had underestimated the competitive spirit of physicians One panel member felt that Dr. McClure had failed to address the problem of unequal distribution among providers of care for the poor. He felt that a few hospitals assume most of the burden for care of the poor rather than most assuming some of this responsibility. He felt that it must be stated that hospitals only exist for the public need and the public interest and that as these change, the hospitals must adapt. One panel member questioned the mechanism for establishing HMO's, stating that he understood that a large sum of front money was necessary. He also asked about the incentives to the individual to join such a plan. Finally, one panel member questioned whether the consumer is sufficiently informed to make a judgment among several health care plans.

After an intermission, each of the panel members addressed his assigned issue. Dr. J. Latane Ware, M.D., President, Richmond Surgical and Gynecological Society, addressed Issue number 1: Since control of inflation appears impossible, is Virginia's only alternative to control utilization of and intensity of services? Mr. John N. Simpson, President, Richmond Memorial Hospital, addressed Issue number 2: Because the initiation of a competitive market is predicted to take at least ten years, what regulatory statutes/procedures should be implemented/maintained for the present and phased out over the years as competition becomes a reality? Mr. Robert Carter, Chairman of the Board, Virginia Tractor Company, addressed Issue number 3: Can voluntary incentives for health care costs containment be effectively implemented in Virginia? Mr. M. Roy Battista, President, Blue Cross of Southwestern Virginia, addressed Issue number 4: How can the different segments of the health care industry, (nursing homes, long-term care facilities, hospitals and third party payors) be restructured to promote competition and contain costs for the state?

Dr. Karen Davis served as the summarizer of the day's events. Excerpts of her summary as are follows:

We stated our session today by addressing the problem of rising health care costs. Health care costs are at a high level and increasing at a rapid rate.

Dr. McClure indicated that this has been true in part because of the wide variation in medical practice and may get worse in the future because of projected increases in the supply of physicians and the continuing growth in hospital capacity.

Our current system of insurance, both public programs and private insurance plans, provide

the wrong incentives in the health care market because of what's insured and the way providers are paid.

Dr. McClure stressed that solutions to this problem should not be restricted to the Medicaid program only, but must deal with the entire health care system.

In Dr. McClure's view there are only two choices: competition or a public utility model. For competition to work, he argued, certain conditions must be met: namely, that you must have many competitors with free entry and exit into the health care market, and secondly, that there must be price mechanism

In this multiple-choice system it is hoped that there will be an incentive for the employees, for the elderly, and for the poor to select lower-style practice settings. And it is hoped that this type of choice with fixed dollar contributions from employers and from Medicare and Medicaid would put pressure on traditional insurance plans such as Blue Cross and the commercial plans to negotiate better rates with providers.

One panelist pointed out that this solution may not be appropriate in rural areas; that there are problems in starting health maintenance organizations; that HMO's require a substantial capital investment and it requires good management expertise which are often missing; and that employees may not be interested in switching from their current kinds of care.

Another concern that was raised was the lack of information for consumers to make informed choices. Decisions about health care are frequently made in a time of crisis; therefore, it's hard to get consumers to change current patterns and hard to get providers to change current patterns.

A final problem that was raised about the competitive approach is the problem of adverse selection. If the employer, Medicare and Medicaid pay a fixed rate for everyone covered under their plan and the elderly, poor, and worker have to pay the amounts on top of that fixed rate if they choose a more expensive plan, that may penalize inefficient providers, but it may also penalize those plans that happen to get the sickest patients, and the highest risk patients.

Those elderly who are chronically ill or have multiple health problems may go into certain plans causing the premiums of those plans to become very high. If Medicare were to set a fixed voucher amount for coverage of the elderly and the sick, chronically ill elderly will be stuck with very substantial additional payments.

Given these concerns about the competitive approaches, we then moved on later in the morning to considering a spectrum of alternatives that would not look at simply an either/or situation of a competitive approach or a regulatory approach, but what combinations of competition and regulation make sense either in the short term, the intermediate term, or the long term. Should there be certain elements of competition introduced along with retaining certain elements of regulatory approaches?

We considered four different types of regulatory approaches. The first regulatory approach reviewed by one of our panelists limits utilization and intensity of service. Dr. Ware indicated that we should not ration services or set arbitrary limits on what will be covered by crippled children's programs, Medicaid, or other public or private programs.

He saw some value in educating consumers, providers, government, and employers. He thought this would be helpful and made a number of concrete suggestions about educational activities, but he was concerned that education alone is likely to do very little.

He also set forth the possibility of providing bonuses or rewards for those patients who agreed to reduce utilization or who had a lower utilization experience.

It was indicated that the issue of state-mandated benefits under insurance laws may need some review, that these mandates may contribute to excessive utilization.

The second type of regulatory approach that our panel reviewed was supply control. The number of physicians, it was noted, is expected to increase by forty percent between 1980 and 1990, an increase which may well lead to higher costs and inappropriate utilization patterns. This may call for a need to review, for example, medical school class sizes and state supported medical school institutions.

The certificate of need program, which is another type of supply control on capital expenditures for hospitals, was also examined. One panelist argued that attempts to create a monopoly may be counterproductive. On the other hand, in the current system proliferation of hospital beds and specialized facilites may not lead to lower costs, but, has lead to higher costs.

A third type of regulatory approach that our panel examined was rate setting. The State of Virginia took the leadership on the suggestion of this Commission by establishing a voluntary hospital rate setting commission.

One member of the panel pointed out that this has been helpful, but it hasn't done as much as it should or could do. The Commission was initially set up by the Hospital Association; therefore, the Hospital Association supported the law, and perhaps, because of these factors, the

Commission has tended to be a bit too generous toward the hospitals.

Legislative changes were suggested for consideration, including changes to permit the Commission to set somewhat tighter rates for hospitals, to provide a better legal basis for the dissemination of information and publicity, and to set rates in a way to support competition. This panel member also raised issues about who should lead the Commission, how it should be structured and the importance of giving businesses and employers stronger influence in the operation of the Commission.

Finally, the fourth element of regulation that the panel explored dealt with the structure of the health care industry. It was pointed out that our capacity far exceeds current demand. Much of this can be linked to current methods of capital financing For example, many hospitals use municipal bonds. If funds can be borrowed on a tax-exempt basis as municipal bonds at a seven to nine percent interest rate, hospitals, nursing homes or others can reinvest that on a short-term basis at seventeen to nineteen percent while construction takes place, thus, encouraging excessive building in general and also providing cash flow to the institution.

Cost reimbursement further encourages excessive capitalization in hospitals and nursing homes. One of our panelists quoted an interview with the president of the Hospital Corporation of America, who pointed out that cost reimbursement guaranteed payment for depreciation and interest. Hospitals can do quite well since they're only required to pay interest expenses plus retirement of the debt, which tends to be much less than depreciation expenses So cost reimbursement usually exceeds the debt-financing costs to the institutions and provides an incentive for excessive capitalization.

Attention was also given to the growth of proprietary chains. It was pointed out that this adds to excess capacity and the costs can be a lot higher as propriety hospitals are allowed certain reimbursements that nonprofit institutions are not. And that this also creates a problem in that such institutions may be less willing to serve uninsured patients and the entire community.

Finally, there were suggestions made about wide-spread reimbursement reform, such as a shift to capitation and risk sharing and many of the elements of both the competitive and regulatory approaches. Thank you.

CONCLUSIONS:

The Commission believes that it has played an important role as an oversight committee. The presence of the Commission has acted as a deterrent for excesses in the insurance industry. Further, the Commission's work has initiated General Assembly considerations which have had concrete results, notably the creation of the Virginia Health Services Cost Review Commission, the Certificate of Need Law, coinsurance and deductible law and the beginning of a dialogue between the various communities involved in consuming and delivering of health care services. The Commission sincerely hopes that the discussions which took place during the workshop will be continued and will provide an avenue for cooperation and interaction among the state government, the business community, the experts and the institutions.

In the opinion of the Commission, the problems inherent in containment of health care costs are not the result of the actions of any one sector of the health care industry. This issue has been generated by the interdependence of social programs such as Medicaid and Medicare, the increases in insurance coverage, the development of medical technology, the ballooning of inflation, the implementation of ill-conceived payment systems, the lack of knowledge on the part of the consumers, the lack of understanding on the part of the physicians, the development of the hospital and nursing home segments into "industries" and many other factors. Problems associated with one issue in health care costs cannot be approached without consideration of the effects on the other issues.

The specter of rising health care costs will not, in the view of the Commission, be exorcised in the near or, perhaps, even the distant future. The Commission believes that the Commonwealth's elected and appointed officials must remain vigilant in examining and investigating the State's options and in providing a forum for innovative ideas and cooperative efforts. The causes of this problem are intertwined like strings tied in a knot--if one end is pulled, another end must give or be pulled into a tighter knot. Each remedy must be carefully analyzed to ascertain its effects on the other elements of the problem. For this reason, the Commission concludes that vigilance, cooperation and communication are more important than a move to more stringent regulation of the segments of the health care industry at this time.

RECOMMENDATIONS:

1. That the Commonwealth maintain an effective Certificate of Public Need Law in order to contain the increase in duplicative services, surplus beds in hospitals, and the effects of rising operating costs on patients' expenditures.

2. That the Commonwealth examine alternatives and strategies to reduce nursing home placements, specifically that such less costly programs as community-based activities be made available to eligible Medicaid recipients.

3. That consideration be given to requiring the nursing home industry to participate in the rate review program which is presently compulsory for hospitals.

4. That the Commonwealth repeal the state-mandated insurance provisions.

5. That the Commonwealth encourage the development of alternative health care delivery systems.

6. That the Commonwealth maintain a comprehensive, statewide health planning mechanism and increase the involvement of the business community.

The Commission wishes to thank all of the people who helped make the workshop possible, especially Mr. Russ Hereford of the National Conference of State Legislatures, Mr. Dick Merritt of the Intergovernmental Health Policy Project and Mr. Robert Freeman of the Bank of Virginia, the speakers - Mr. Scott and Dr. McClure, the panelists - Ms. Cook, Ms. Barnes, Mr. Jackson, Mr. Spitz, Dr. Ware, Mr. Simpson, Mr. Carter and Mr. Battista and the summarizer, Dr. Davis. Without the assistance of these people and many others, it would have been impossible to conduct the workshop.

The Commission wishes to make the video tape available to the members of the General Assembly and the Commission as desired and to the business and medical community on a limited basis.

Respectfully submitted,

Edward E. Willey, Chairman

Joseph A. Johnson, Vice-Chairman

Daniel T. Balfour

Dr. Joseph J. Bevilacqua

Barbara S. Bolton

Adelard L. Brault

John C. Buchanan

Theodore J. Burr, Jr.

Elmo G. Cross, Jr.

Robert M. Freeman

George W. Grayson

Johnny S. Joannou

Dr. J. B. Kenley

Kevin G. Miller

James B. Murray

The record shall show that Senator Edward E. Willey voted no on recommendation #4.

CONCURRING-BUT-DIFFERING OPINION OF

DELEGATE JAMES B. MURRAY

I endorse the findings and recommendations of the Commission but believe that the report's recommendation #5 could have been stronger and more specific. Recommendation #5 states:

> That the Commonwealth encourage the development of alternative health care delivery systems.

During the course of its investigations, the Commission invited and heard from four nationally recognized experts on the economics of health care: Dr. Robert Zelton, Ph.D., of the Wharton School; Dr. Karen Davis, Ph.D., of John Hopkins University; Dr. Walter McClure of Interstudy, Minneapolis; and Mr. Bruce Spitz, Medicaid Consultant with Intergovernmental Health Policy Project.

They all testified that the "alternative delivery systems" known as health maintenance organizations (HMOs) have succeeded in many areas of the nation in curbing significantly the rise of total medical costs. Our Medicaid consultant, Mr. Spitz, informed us that with recent changes in Federal regulations, many states have contracted or are planning to contract with HMOs for Medicaid eligibles as part of their strategies to control budgetary overruns. Establishment of HMOs would enable Virginia to move in this direction.

Nationwide, there are 243 HMOs in 39 states. Over 10.2 million people subscribe to them, and enrollment is growing at the rate of 13% per year. Largely because of resistance from medical providers, none are based in Virginia, although thousands of persons in Northern Virginia have opted to join one of the three Washington, D. C. based HMOs.

In Virginia, much of the groundwork has been laid for establishing an HMO at the University of Virginia Medical Center. If brought to fruition, it could serve as a model and inducement for the development of these pro-competitive organizations in other parts of the state. Therefore, in addition to general recommendations about "alternative delivery systems", I believe that the Commission should have seized the opportunity to recommend encouragement and support for the HMO project at this state institution.

I am confident that a University of Virginia HMO will eventually develop, but it will be at a slower pace than would be possible with state support. This is regrettable. Blue Cross/Blue shield premiums for state employees and others have risen 70 percent in the last three years, and it may not be long before the Commonwealth, like Maryland and others, has to consider some form of public utility type of regulation of the health industry. Instead of public utility regulation, which is bureaucratic, burdensome and ineffective, we should encourage free market forces to contain health care costs. Free market forces come best into effect when alternative delivery systems (like HMOs) are available to consumers. Virginia has a unique chance to support the development of a model HMO, and the final report of the Commission ought to make this known to the Governor and the General Assembly.

DISSENTING-IN-PART OPINION OF

JAMES M. THOMSON, COMMISSION OF INSURANCE

I have now had an opportunnity to review the above report and I am in agreement with its contents with the exception of Recommendation No. 4 on lines 9-11 on page 39. [Original Draft]

My dissent with Recommendation No. 4 which relates to repeal of state-mandated insurance provisions is that the ~~expression~~ "mandated insurance provisions" is too inclusive since it relates to policy provisions other than specific "benefits", mandated benefits being that to which this recommendation is addressed.

Among the mandated benefits now required by the Insurance Laws of Virginia are:

Section 38.1-348.1 which relates to the continuance of insurance on dependent children even into their adulthood when they are incapable of supporting themselves and remain dependent upon the chief policyholder;

Section 38.1-348.6 which provides for automatic coverage for newborn children;

Section 38.1-348.7 which relates to limited in-patient coverage for mental, emotional or nervous disorders in certain health expense insurance policies, amended to show that this coverage is deemed to include treatment for alcohol and drug abuse.

There are other provisions of the insurance laws, of course, which relate to insurance companies having to make available certain coverages which, if selected by the applicant, would render them at least partially mandatory. Among these are:

Section 38.1-348.9 which relates to obstetrical services to be included in certain group health insurance policies;

Section 38.1-348.10 which prohibits certain indemnity exclusions or reductions from group coverage because of individual policies held by the same insured;

Section 38..1-348.11 which pertains to the right of a holder of the group insurance certificate to certain conversion privileges;

Section 38.1-348.13 which extends the definition of accident or accidental injury to include benefits for pregnancy following an act of rape or incest when properly reported to the police.

In view of the many types of mandated benefits provisions or optional provisions which, if selected, serve as a mandate upon insurers, it is recommended that Recommendation No. 4 be reworded. I could not approve the provisions of Recommendation No. 4 if they went further than to provide for an "examination of the mandated and optional benefit provisions applicable to health insurance policies and prepaid health care plans to determine the effect of such provisions on the availability of insurance and prepaid health care plans as well as the effect upon premiums or subscriber fees charged."

Although I am in agreement with the report except Recommendation No. 4, I have attached the signature sheet (unsigned) which expresses my strong disapproval of this recommendation.

DISSENTING-IN-PART OPINION OF

JOSEPH J. BEVILACQUA, Ph.D.

I have reviewed the Report of the Commission to Study Containment of Health Care Costs and approve the recommendations which the Commission has made with the exception of No. 4. "That the Commonwealth repeal the state mandated insurance provisions". My recommendation for change addressing No. 4 are as follows:

After thorough study by my staff, I am convinced that the repeal of the mandated services would severely effect services for the mentally ill, mentally retarded, emotionally ill and other nervous disorders as well as those many in need of services for substance abuse. We intend this letter to be our dissenting opinion on recommendation No. 4.

In lieu of repeal of Section 38.1-348.8 we would support placing a cap on the per diem costs and the period of coverage for detoxification, intermediate care and would recommend consideration of extending coverage for the far less costly but effective intensive outpatient and day care services. We are of the opinion that more persons could receive effective services at a lower cost by making such changes without repealing this mandated and sorely needed service.

We cannot support the repeal of Code Section 38.1-348.7 which provides coverage for mental, emotional and nervous disorders. The repeal of this Section would have adverse effect on many Virginia citizens who are dependent upon some coverage by their insurance to enable them to obtain care. The repeal would also effect funding of mental health, mental retardation, and substance abuse services now provided and which face severe fiscal restraints. We would support a cap on length of coverage and the per diem costs in lieu of repeal of this coverage.

I commend the Commission under your leadership for its dedication towards solving high health costs. I regret that the responsibilities during my first four months with the Department of Mental Health and Mental Retardation prevented my active participation on the Commission but assure you of my enthusiastic support. I am grateful for your many years of outstanding leadership in Virginia.

DISSENTING-IN-PART OPINION OF

SENATORS ADELARD L. BRAULT AND ELMO G. CROSS, JR.

AND DELEGATES GEORGE W. GRAYSON AND JOHNNY S. JOANNOU

We endorse the findings and recommendations of the Commission with the exception of recommendation #4. We favor recommendation #4 as presented in the original draft of the report, namely:

> 4. That the Commonwealth examine the state-mandated insurance provisions to ascertain the role such requirements play in the increase of utilization of services and costs.

Undoubtedly, the state-mandated benefits have served to increase the costs and use of services. This recommendation would have been appropriate as it expressed the Commission's concerns and the need to examine the effects of these mandates. It is our belief that the causes of rising health care costs are many, complicated, and interwoven. The impact of the various elements of health care costs is not easily ascertained and these elements must be considered together. Removing state-mandated health insurance provisions could have adverse effects on the consumers of health care services; therefore, it is our feeling that some other courses of action, for example, revision of the per diem costs and periods of coverage, should be evaluated.

Perhaps the mandates, rather than be repealed, should be revised after careful consideration of the effects of revisions on the consumer, the State, the health care industry, and the health insurance industry. We favor development of competition in the health care industry and less government intrusion into business However, the plight of the ordinary citizen at the time of an economic recession must be considered and evaluated carefully before precipitious actions are taken; therefore, we wish to express our strong disapproval of recommendation #4 as stated in the Commission's report.

An Act to amend the Code of Virginia by adding a section numbered 38.1-348.12 and to amend and reenact §§ 38.1-360, 38.1-818, 38.1-841, and 38.1-855 of the Code of Virginia, so as to require insurers and prepaid health, dental and optometric plans to make available deductibles and coinsurance options.

[S 184]

Approved [illegible] 1980

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding a section numbered 38.1-348.12 and that §§ 38.1-360, 38.1-818, 38.1-841, and 38.1-855 of the Code of Virginia are amended and reenacted as follows:

§ 38.1-348.12. Deductibles and coinsurance options required.—A. An insurer or offeror of a prepaid hospital, medical, surgical, dental or optometric service plan shall, before issuing a policy of accident and sickness insurance providing coverage on an expense incurred basis or a service or indemnity type contract, make available to the potential insured or contract holder three options under which the individual insured or group certificate holder pays for:

1. The first one hundred dollars of the cost of the services covered or benefits payable by the policy or contract during a twelve-month period;

2. Twenty per centum of the first one thousand dollars of the cost of the services covered or benefits payable by the policy or contract during a twelve-month period; or

3. The first one hundred dollars and twenty per centum of the next one thousand dollars of the cost of the services covered or benefits payable by the policy or contract during a twelve-month period.

B. For the purposes of this section "make available" means that the insurer or prepaid service plan shall disseminate information concerning the options described in subsection A. of this section and make such options available to potential insureds or contract holders in the same manner as the insurer or prepaid service plan disseminates information concerning other contracts and coverage options and makes other contracts and coverage options available.

C. This section shall apply to policies or contracts delivered or issued for delivery in this State on or after September one, nineteen hundred eighty, and to group policies or contracts issued prior to September one, nineteen hundred eighty, at the first renewal thereof on or after September one, nineteen hundred eighty; but shall not apply to short-term travel, accident only, limited or specified disease, or individual conversion policies or contracts, to policies or contracts with an annual premium of ten dollars or less, nor to policies on contracts designed for issuance to persons eligible for coverage under Title XVIII of the United States Social Security Act or any other similar coverage under State or federal government plans.

§ 38.1-360. Nonapplication to certain policies.—Nothing in this article shall apply to or affect (1) any policy of workmen's compensation insurance or any policy of liability insurance with or without supplementary expense coverage therein or when issued with or supplemental to a policy of motor vehicle liability insurance, as provided for in § 38.1-21 (2) to a coverage providing weekly indemnity or other specific benefits to persons who are injured and specific death benefits to dependents, beneficiaries or personal representatives of persons who are killed, provided such benefits are irrespective of legal liability of the insured or any other person, if such injury or death is caused by accident and sustained while in or upon, entering or alighting from, or through being struck by a motor vehicle; or (2) any policy or contract of reinsurance; or (3) any blanket or group policy of insurance, except that the provisions of §§ 38.1-347.1, 38.1-348.1, 38.1-348.6, 38.1-348.7, 38.1-348.8, 38.1-348.10 ~~and~~ , 38.1-348.11 *and 38.1-348.12* shall be applicable to such policies of insurance; or (4) life insurance, endowment or annuity contracts, or contracts supplemental thereto which contain only such provisions relating to accident and sickness insurance as (a) provide additional benefits in case of death or dismemberment or loss of sight by accident or as (b) operate to safeguard such contracts against lapse, or to give a special surrender value or special benefit or an annuity in the event that the insured or annuitant shall become totally and permanently disabled, as defined by the contract or supplemental contract, or (5) any policy of industrial sick benefit insurance.

§ 38.1-818. Application of certain provisions of law relating to insurance; payments under plan.—Unless otherwise specifically provided, no provision of this title except this

chapter and §§ 38.1-29, 38.1-44 to 38.1-57, 38.1-99 to 38.1-104, 38.1-159 to 38.1-165, 38.1-174 to 38.1-178, 38.1-342.1, 38.1-342.2, 38.1-348.6 ~~to 38.1-348.11~~ *through 38.1-348.12* , 38.1-354.1, 38.1-360 and 38.1-362.7 to 38.1-362.9 shall, ~~insofar as~~ they are not inconsistent with this chapter, apply to the operation of a plan. No payments shall be made by a plan to a person included in a subscription contract unless it be for breach of contract or unless it be for contractually included costs incurred by such person or for services received by such person and rendered by a nonparticipating hospital or physician.

§ 38.1-841. Application of certain Code provisions relating to insurance.—Unless otherwise specifically provided, no provision of this title except this chapter and §§ 38.1-29, 38.1-44 to 38.1-57, 38.1-99 to 38.1-104, 38.1-159 to 38.1-165, 38.1-174 to 38.1-178, ~~and~~ 38.1-342.1 *and 38.1-348.12* shall, insofar as they are not inconsistent with this chapter, apply to the operation of corporations and plans hereunder.

§ 38.1-855. Application of certain Code provisions relating to insurance.—Unless otherwise specifically provided, no provision of this title except this chapter and §§ 38.1-29, 38.1-44 to 38.1-57, 38.1-99 to 38.1-104, 38.1-159 to 38.1-165, 38.1-174 to 38.1-178, ~~and~~ 38.1-342.1 *and 38.1-348.12* shall, insofar as they are not inconsistent with this chapter, apply to the operation of corporations and plans hereunder.

_____

President of the Senate

_____

Speaker of the House of Delegates

Approved:

_____

Governor

CHAPTER 322

An Act to amend the Code of Virginia by adding a section numbered 38.1-348.12:1, and to repeal § 38.1-348.12 of the Code of Virginia, regulating the issue of certain prepaid health plan policies.

[S 750]

Approved MAR 1 8 1981

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding a section numbered 38.1-348.12:1 as follows:

§ 38.1-348.12:1. Deductibles and coinsurance options required.—A. An insurer issuing accident and sickness insurance on an expense incurred basis or a prepaid hospital, medical, or surgical service plan shall make available in offering such coverage or contract to the potential insured or contract holder one or more of the following options under which the individual insured or group certificate holder pays for:

1. The first one hundred dollars of the cost of the services covered or benefits payable by the policy or contract during a twelve-month period;

2. Twenty percent of the first one thousand dollars of the cost of the services covered or benefits payable by the policy or contract during a twelve-month period;

3. The first one hundred dollars and twenty percent of the next one thousand dollars of the cost of the services covered or benefits payable by the policy or contract during a twelve-month period; or

4. Any other option containing a greater deductible, coinsurance, or cost-sharing provision; however, such option shall not be inconsistent with standards established with respect to deductibles, coinsurance, or cost-sharing pursuant to § 38.1-362.14.

B. For the purposes of this section "make available" means that the insurer or prepaid service plan shall disseminate information concerning such option or options and make a policy or contract containing such option or options available to potential insureds or contract holders at the same time and in the same manner as the insurer or prepaid service plan disseminates information concerning other policies or contracts and coverage options and makes other policies or contracts and coverage options available.

C. This section shall apply to policies or contracts delivered or issued for delivery in this Commonwealth on or after the effective date of this act, and to group policies or contracts issued prior to that date at the first renewal thereof; but shall not apply to short-term travel, accident only, limited or specified disease, or individual conversion policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the United States Social Security Act or any other similar coverage under State or federal government plans.

2. That § 38.1-348.12 of the Code of Virginia is repealed.

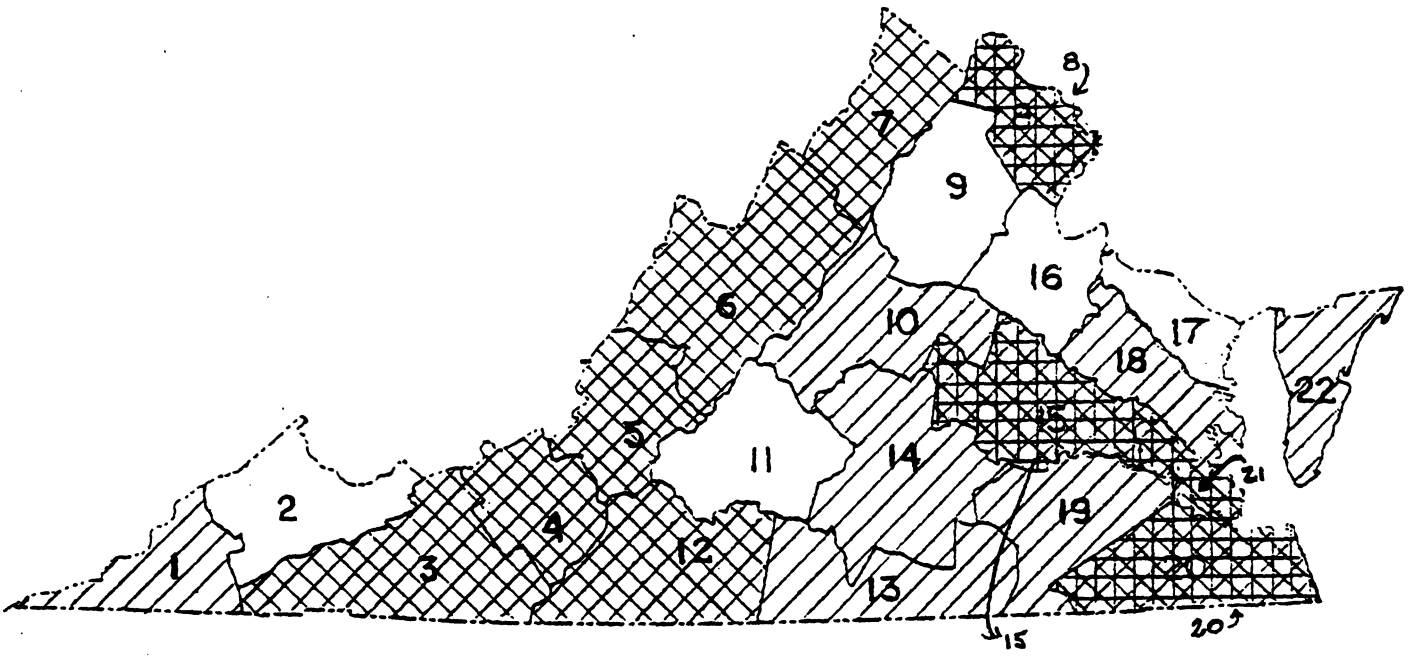
3. That an emergency exists and this act is in force from its passage.

EXHIBIT III

PROJECTED SURPLUS BEDS BY PLANNING DISTRICT

1986

(Medical, Surgical, Pediatric, Obstetric)



KEY	PROJECTED NUMBER OF SURPLUS BEDS
	None
	1-50
	51-200
	201+

Review of Insurance Problems

Norma E. Szakal

Division of Legislative Services

Co-insurance and Deductibles Law

As a result of the work of this Commission, the first version of this law was passed in 1980. The law generated problems in that it effectively excluded certain companies from participation in Virginia and was, therefore, amended during the past session. See Senate Bill No. 751, attached.

This law provides that insurers issuing accident and sickness insurance must make available lower premium options for prepaid health plans and policies. These options were intended as a means of containing health costs by providing incentives for reducing the length of hospital stay and eliminating requests for unnecessary procedures. The consumer would be persuaded to chose such a policy because of its lower rate.

Physicians are concerned about the increased risk of non-payment by the patient having one of these policies. This concern has therefore prompted the doctors to ask for a clause in these plans or policies relieving them from the limitations of the usual, customary and reasonable charge. It should be remembered that the insurance companies will still calculate payment under these policies on the basis of the UCR (usual, customery and reasonable charge). It must also be noted that participating physicians enter into contracts with Blue Cross/Blue Shield in which they agree, under certain conditions, to observe the UCR.

If a clause exempting the physicians from observing the UCR is inserted in the co-insurance and deductible plans and policies and the doctors are thereby free to bill for more than the UCR, these options may, indeed, increase the costs of health care as well as cause confusion and consternation among the insured. For example, a patient with a policy under option 1 goes to the hospital for an operation, the UCR for which is $350.00. The doctor bills him for $500.00 as the limitations of the UCR do not apply. The insurance company, on receiving the bill, calculates its payment as follows: The UCR for this procedures is $350.00 less the $100 deductible, therefore, the payment is $250.00. The patient will then receive a bill for $250.00 rather than the $100 he had expected.

II. Self-insurance Health Plans

As group health insurance has become more and more expensive, business and industry have sought cheaper alternatives to the expensive health insurance plans traditionally offered their employees. Self-insurance has developed as one alternative that takes several forms and has the potential to impact the state income.

Three variations of self-insured health plans that may have impact on the Commonwealth are:

A. Self-insurance -- This trend among industry and business towards straight self-insurance results in a substantial loss of general funds to the Commonwealth through the loss of tax revenues. Further, these self-isured employers are not subject to the State mandated benefit laws. This can result in not only a loss of revenue to the State, but possibly an increase in outlays in Medicaid and welfare. For example, if an individual covered by such a plan and receiving only minimal benefits, is forced through ill health to resign or is dismissed, this individual might have to apply for welfare and Medicaid.

B. A minimum premium plan -- In this instance, the employer assumes as much as 90 percent of the losses. This type of policy also has severe tax implications as the premiums are quite low therefore, the tax paid on them is quite small. Although these policies are subject to the mandated benefits, the loss to general revenues is a potentially serious problem.

C. An umbrella policy -- This type of policy is a kind of aggregate stop loss policy for the self-insuring employer. Although these policies generate the same tax and cost considerations for the State, they also raise technical questions. Is such a policy a health insurance or a contractual liability insurance? If it is a health insurance, then is it subject to State mandated benefits? If it is not a health insurance, then the life insurance companies may not sell them. Such policies, if termed contractual liability insurance policies, must be sold by the casualty companies.

III. Issues for Consideration

Should the State look at comprehensive health insurance laws to determine if there are alternative ways to deal with these problems?

Should the State look at the mandated benefits with an eye towards moving away from this approach towards a "make available" approach?

APPENDIX B

LEGISLATIVE STRATEGIES FOR CONTAINING HEALTH CARE COSTS IN VIRGINIA
OCTOBER 7 AND 8, 1981
SENATE ROOM B, GENERAL ASSEMBLY BUILDING

* * *

Wednesday, October 7, 1981

1:00-1:15 p.m. -------- Registration
1:15-1:30 p.m. -------- Welcome And Introduction
1:30-2:30 p.m. -------- An Overview Of The Substantive Changes In Medicaid With Specific References To Long-Term Care, Mr. James L. Scott, Director Of The Office Of Intergovernmental Affairs, Health Care Finance Administration
2:30-2:45 p.m. -------- Questions And Answers
2:45-3:15 p.m. -------- Panel On Medicaid/Long-Term Care: Reactions To Overview
3:15-3:30 p.m. -------- Coffee Break
3:30-4:10 p.m. -------- Panel On Medicaid/Long-Term Care And Mr. Scott: Medicaid Issues In Virginia
4:10-4:45 p.m. -------- Discussion (Audience Participation Encouraged)
4:45-5:00 p.m. -------- Summary, Dr. Karen Davis, Professor Of Health Services Administration, The Johns Hopkins School Of Hygiene And Public Health

PANEL MEMBERS AND ASSIGNMENT OF ISSUES

Mr. Robert Jackson, Vice-President For Finance And Treasurer, United Service Industries, Charlottesville, Virginia (# 3)
Ms. Charlotte Carnes, Social Work Consultant For The Nursing Home Pre-Admissions Screening Program, Department of Health (# 2)
Ms. Ann Cook, Director Of The Bureau Of Medical Social Services For The Division of Medical Assistance, Department of Health (# 1)
Mr. Bruce Spitz, Medicaid Consultant With The Intergovernmental Health Policy Project, George Washington University (# 4)

Thursday, October 8, 1981

8:30-8:45 a.m. --------- Registration
8:45-9:00 a.m. --------- Opening Statement
9:00-10:00 a.m. -------- Initiation Of A Competitive Health Care Market In Virginia, Dr. Walter McClure, Nationally Known Proponent Of A Competitive Health Care Market
10:00-10:15 a.m. ------- Questions And Answers
10:15-10:45 a.m. ------- Panel On Hospital Cost Containment/Reimbursement, Reactions To Competitive Health Care Market Address
10:45-11:00 a.m. ------- Coffee Break
11:00-11:45 a.m. ------- Panel On Hospital Cost Containment/Reimbursement and Dr. McClure: Cost Containment Issues in Virginia
11:45-12:15 p.m. ------- Discussion (Audience Participation Encouraged)
12:15-12:30 p.m. ------- Summary, Dr. Karen Davis, Professor of Health Services Administration, The Johns Hopkins School of Hygiene and Public Health

PANEL MEMBERS AND ASSIGNMENT OF ISSUES

Mr. M. Roy Battista, President, Blue Cross Of Southwestern Virginia (# 4)
Mr. Robert Carter, Chairman Of The Board, Virginia Tractor Company (# 3)
J. Latane Ware, M.D., President, Richmond Surgical And Gynecological Society (# 1)
Mr. John N. Simpson, President, Richmond Memorial Hospital (# 2)

MEDICAID/LONG-TERM CARE ISSUES IN VIRGINIA

In view of the drastic changes in federal policy which are presently taking place, we as a nation appear to have drawn back from the position that government has the responsibility to provide health care for all of its citizens. The impact of this withdrawal from human services on the part of the federal government, the increasing number of older people, and the deficits already experienced in Virginia's Medicaid program have created issues that Virginia must address:

1. TO WHOM IS THE STATE OBLIGATED TO PROVIDE CARE?

   [Should a specific group, e.g., the categorically needy, be the only group targeted for care? Should individuals who have led productive lives be expected to exhaust all of their assets in order to provide their own care? When should an individual within the medically needy class move into the categorically needy class? Should care be guaranteed only for the older categorically needy? Or only for the young and old categorically needy? Should the financial eligibility be restricted narrowly so that the percentage of the population defined as categorically needy would shrink? Should only the rehabilitably disabled be provided certain kinds of assistance (as in the Rehabilitation Act) or should all handicapped and disabled individuals be treated as though rehabilitable?]

2. GIVEN THE STATE'S OVERUSE (IN THE OPINION OF MANY) OF NURSING HOME PLACEMENTS, WHAT ARE SOME OF THE STRATEGIES THAT CAN BE UTILIZED TO PROVIDE NECESSARY SERVICES TO THE COMMONWEALTH'S OLDER AND DISABLED CITIZENS?

   [Should the care of those not in need of intensive services be shifted back to the communities? If so, what kinds of programs (health maintenance plus necessary medical services; social maintenance service and necessary medical services; or only necessary medical services), and how should these programs be designed in order to deliver the services in the most efficient and cost effective way? What alternative programs are most easily accepted by the clients? Is there resistance to these programs on the part of the recipients or their families? If so, how can this resistance be challenged and channeled toward positive use of these programs?]

3. CAN WE REALISTICALLY EXPECT TO SUSTAIN THE PRESENT LEVEL OF HEALTH CARE SERVICES FOR THOSE WHO CANNOT PAY THE COSTS IN THE PRESENT HEALTH CARE MARKET? WOULD A COMPETITIVE MARKET MAKE THIS MAINTENANCE OF QUALITY HEALTH SERVICES EASIER? AND IF SO, IN WHAT WAYS?

   [Should the nursing home industry be evaluating itself in view of the fortunes which have been made by certain individuals through the profits of the industry? Is it, in other words, ethical for the industry to be accruing large profits through the care of the old and unfortunate while government foots the bill? What incentives can be given to the industry to curtail its costs on its own? Would the initiation of a competitive market increase costs as the corporations must show a profit? Will Virginia's long-term care industry be dominated by three or four corporations? And if so, how would this oligarchy fit into a competitive health care market? What controls are appropriate for state government to exert on the industry to protect its interests? What incentives can be used to promote efficiency among the institutions in the industry? In other words, to reduce operating costs and the captial costs per bed?]

4. WHAT INCENTIVES/ALTERNATIVES DO WE HAVE AVAILABLE TO REDUCE THE BURDENS OF THIRD PARTY PAYORS, WHETHER MEDICAID, MEDICARE OR HEALTH INSURANCE?

   [Should we advocate tax deductions of 100% of the reasonable value of the services for doctors and proprietaries who are willing to provide pro bono services to persons eligible for health services under publicly funded programs? What effects do incentives for user reduction of utilization of services have? For example, why not implement some variation of the Mendocino plan, that is, why not pay recipients for not using the available services even in publicly funded programs? Would such programs result in recipients doing without necessary services in order to qualify for the reward? Do co-insurance and deductible provisions play a significant role in containing use of services? Is it necessary or appropriate to provide freedom of choice among recipients of publicly funded health programs? Should Virginia be able to decide to be a prudent buyer of all services? Now that the option exists to be a prudent buyer and do comparative shopping, how far is the State justified in carrying out the prudent buyer's rule? At what point would serious infringement of individual freedom occur? Can the prudent buyer's rule be implemented by the State while still maintaining a semblance of freedom of choice for the individual? Are alternative delivery systems, such as independent provider agreements and

HMO's, satisfactory means of reducing third party payments? Would these or other alternative delivery systems provide adequate/effective care for recipients? Are these types of "at risk" programs appealing to doctors and other health professionals under the present market conditions? How would conditions have to change for these programs to become attractive to more doctors and health care professionals? What other reductions in services or adjustments in approaches should the Virginia Medicaid program consider implementing?]

HOSPITAL COST CONTAINMENT/REIMBURSEMENT ISSUES IN VIRGINIA

Hospital costs are estimated to represent 40% of the total cost of health care, which was over 9% or approximately 230 billion dollars of the Gross National Product in 1980. This year, hospital costs are said to be increasing by 18 to 20 percent. The traditional stresses of the free enterprise market do not affect the hospital industry, principally because the reimbursement system is cost based and the majority of payments are made by third party payors. Only the health care industry is assured of recouping its costs and no other industry runs so little "risk" of non-payment. The health care industry, especially hospitals, has been stimulated for unnecessary growth and inefficient operation without incurring any of the penalties of the competitive market place. As the costs skyrocket, the Commonwealth's budget is strained, and the federal government backs out of health planning, Virginia must consider the initiation of a competitive health market, which raises the following critical issues:

1. SINCE CONTROL OF INFLATION APPEARS IMPOSSIBLE, IS VIRGINIA'S ONLY ALTERNATIVE TO CONTROL UTILIZATION OF AND INTENSITY OF SERVICES?

   [Would a comprehensive consumer education program be cost-effective as it would enlighten the citizenry about the effects of indiscriminate use of medical services? How can the consumer be induced to comparative shop for health care? And how would this affect utilization and intensity of services? Could this kind of educational program be coupled with rewards or penalties for reduction in use? These might include money payments, reduced insurance premiums, or coverage of certain expensive services (which are ordinarily not offered) on a one-time basis, such as eye examinations, specific dental procedures, or cosmetic surgery? Should the functions of the Professional Standards Review Organizations be assumed by the private sector in order to modify physicians' behavior to eliminate unnecessary or duplicative services and unnecessarily extended hospital stays? Should the State carefully examine the role of some of the paraprofessionals and allied health professionals as providers of "extras" which are not always necessary or cost effective? Are the state health insurance mandates driving up utilization and costs? Is it, then, appropriate for the State to require the purchase of certain services? Or does the State have to protect the citizens by requiring these coverages? If these coverages are necessary for the protection of the citizenry, then how can the health industry in Virginia, specifically the psychiatric hospitals, be induced to provide treatment to patients, whenever possible, that does not exhaust the patients' eligibility for third party payment? Can prepaid programs be designed for Virginia that will provide adequate care for the consumer and reduce utilization? If so, what are the ideal programs for Virginia?]

2. BECAUSE THE INITIATION OF A COMPETITIVE MARKET IS PREDICTED TO TAKE AT LEAST TEN YEARS, WHAT REGULATORY STATUTES/PROCEDURES SHOULD BE IMPLEMENTED/MAINTAINED FOR THE PRESENT AND PHASED OUT OVER THE YEARS AS COMPETITION BECOMES A REALITY?

   [Should Virginia design and implement a local/regional/statewide health planning program in view of the federal withdrawal from this program? Will health planning become a critical necessity for the Commonwealth as the restraints of the planning organizations are removed? How can the Commonwealth provide a forum which would allow the health industry spokespersons, state health department officials, business people and insurance industry executives to reach a consensus on Virginia's health planning? Should certificate of public need be retained regardless of the federal requirements? Should the certificate of need program reevaluate its criteria in light of the revised assessment of individuals' needs taking place in Medicaid and other programs? Should certain construction projects such as parking lots and energy retrofits only or reductions in services and discontinuation of beds be automatically approved under certificate of need or not subject to it? Are there additions or alternatives to the certificate of need program which would place limitations on or apply pressures to capital investments in the medical/health care market? Should the present advisory hospital cost review program be made a mandatory program in view of possible future federal incentive payments? And if so, should this program be extended to other segments of the health care industry such as nursing homes?]

3. CAN VOLUNTARY INCENTIVES FOR HEALTH CARE COSTS CONTAINMENT BE EFFECTIVELY IMPLEMENTED IN VIRGINIA?

   [Should Virginia initiate an industry-state government coalition to help control health care industry costs ? Since industry represents 80% of the buyers of health care insurance, could

such a coalition provide business people with information needed to choose the best and cheapest insurance coverage for their companies' employees? Could a coalition of this kind promote such concepts as swing beds, buy backs of under-utilized beds from facilities or publication of comparative data on hospital cost in order to control the market more effectively? If comparative data could be collected and disseminated, should the focus of the Professional Standards Review Organizations be revised to more closely parallel the Virginia Hospital Rate Review Program's work by evaluating services on an item basis rather than as a whole, for example, the length of stays for specific procedures and the cost of specific services? Would comparative data provide the business community with a better understanding of the health care market? And if published and widely distributed, would such data provide a voluntary incentive for the health care industry to contain its cost and become more competitive?]

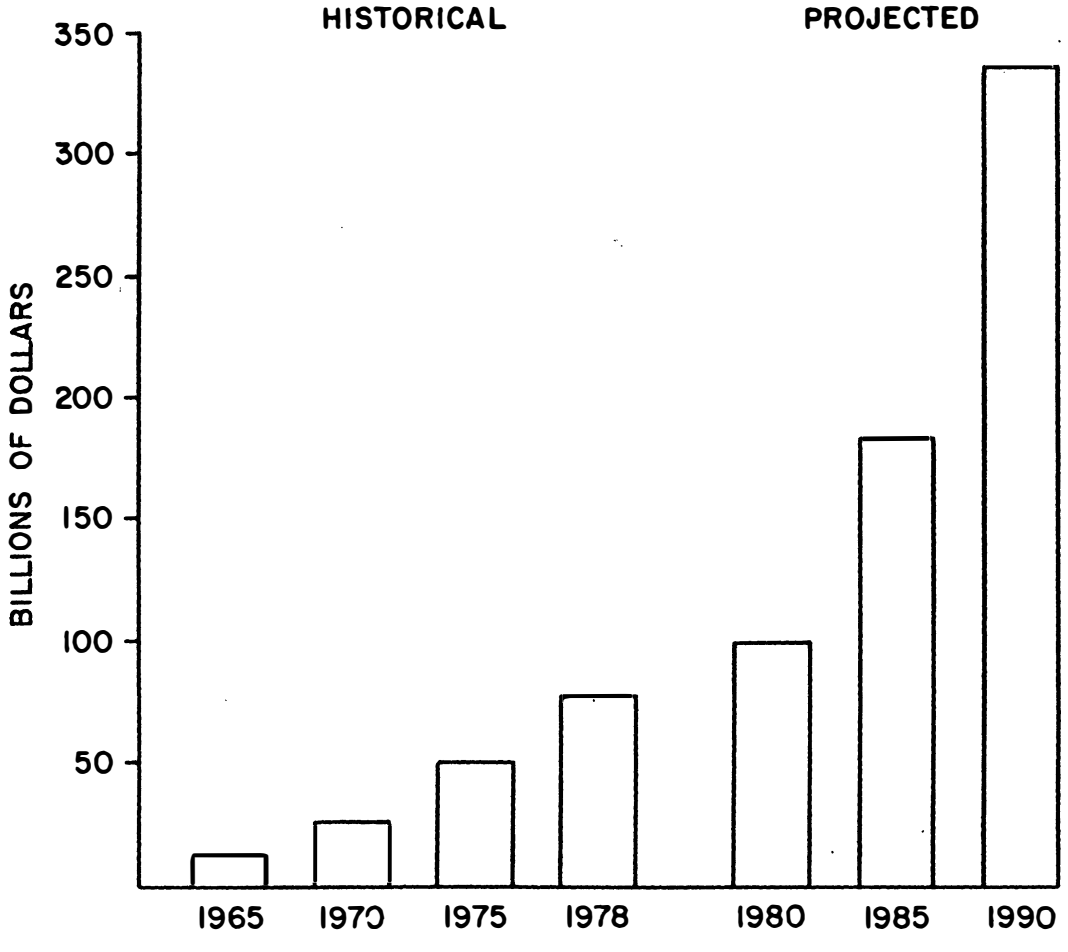
4. HOW CAN THE DIFFERENT SEGMENTS OF THE HEALTH CARE INDUSTRY, (NURSING HOMES, LONG-TERM CARE FACILITIES, HOSPITALS AND THIRD PARTY PAYORS) BE RESTRUCTURED TO PROMOTE COMPETITION AND CONTAIN COSTS FOR THE STATE?

[Should the components of the hospital industry be examined carefully in order to understand the factors involved in health care, for example, labor needs and practices, hospital competition for professional staff, staffing of beds, use of medication, duplication of services, and the methods of calculating operating costs? Should the control of the hospital industry be examined carefully to assess possible conflict of interest situations, such as contractors entering the hospital/nursing home industry through the use of municipal bonds to build facilities which may not be needed? How can the practice of engaging in unrelated profit-making ventures by nonprofit institutions be controlled? How can the increase in proprietary chains be influenced and the proliferation of take-overs by proprietary chains of nonproprietary institutions be controlled? Do such capital investments, which are commonplace occurences in a free enterprise system, represent a trend towards an even more restricted market? How are these take-overs in the health care industry different from similar business transactions in other industries? Do these acquisitions serve to increase costs? If so, how can the Commonwealth protect itself from this phenomenon? Would restructuring the reimbursement system accomplish this end? Should the Commonwealth close under-utilized hospitals or require discontinuation of under-utilized services in view of the State's share in the bill and the limitations on funds? How can qualified, experienced physicians be induced to engage in "risk taking" ventures or other forms of prepaid care in which profits are not as high as presently expected? Can physicians take control of the policing of their profession? Should the Board of Medicine's authority be increased for this purpose? Should the State require insurance companies operating in the State to form pools to issue or reinsure policies on the uninsured, thereby shifting the burden of this cost to the private insurer risk pool? Should the State revise or eliminate state mandates? Should the State consider a comprehensive State Health Insurance Law? Should the increase in self-insurers among undercapitalized industries be subjected to scrutiny and some controls considered? Should the role of the professional licensing officer in the health care market be reexamined vis-a-vis the rising costs of care and the glamorous appeal of the health care industry which is considered synonymous with status and money? Have we been promoting duplication of expertise and expectations of income through licensure? Or is licensure necessary regulation for the public safety? Can alternative methods of service delivery be introduced and flourish in Virginia and how can the State assist efficient, cost-effective development of these alternatives while ensuring quality, sensitive care for their users?]

APPENDIX C

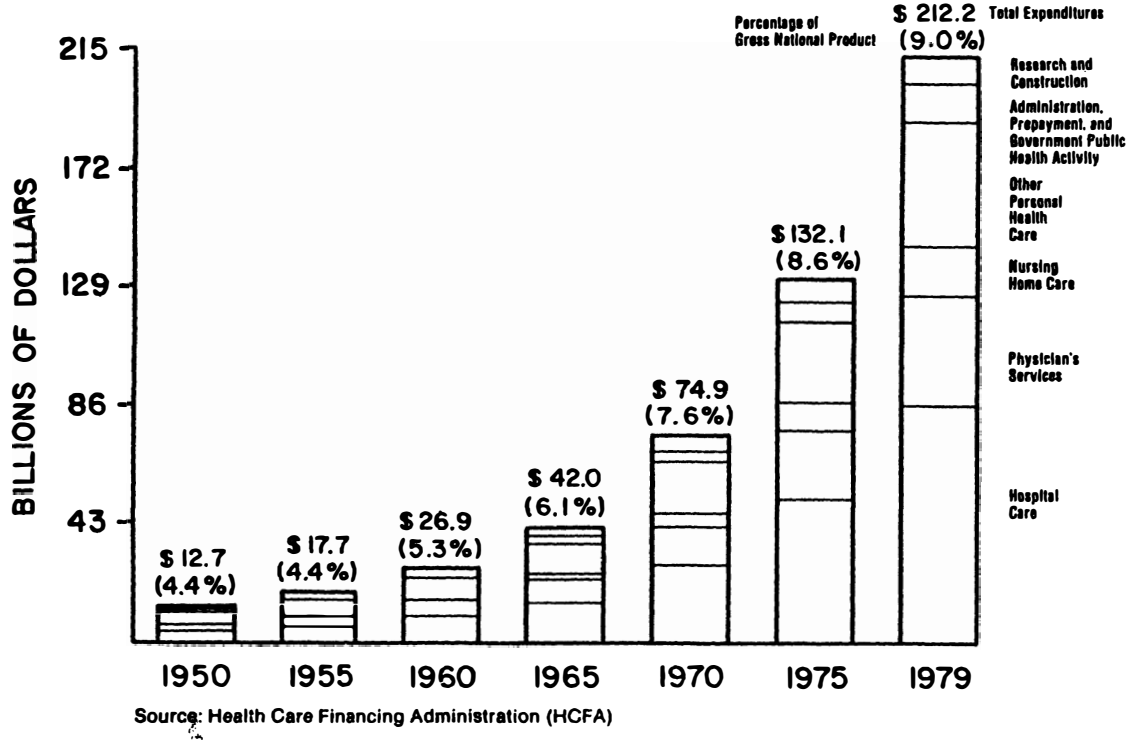
Data derived by the Department of Preventive Medicine, School of Medicine, Medical College of Virginia, Virginia Commonwealth University

EXPENDITURES FOR HOSPITAL CARE
Selected Years 1965 to 1990



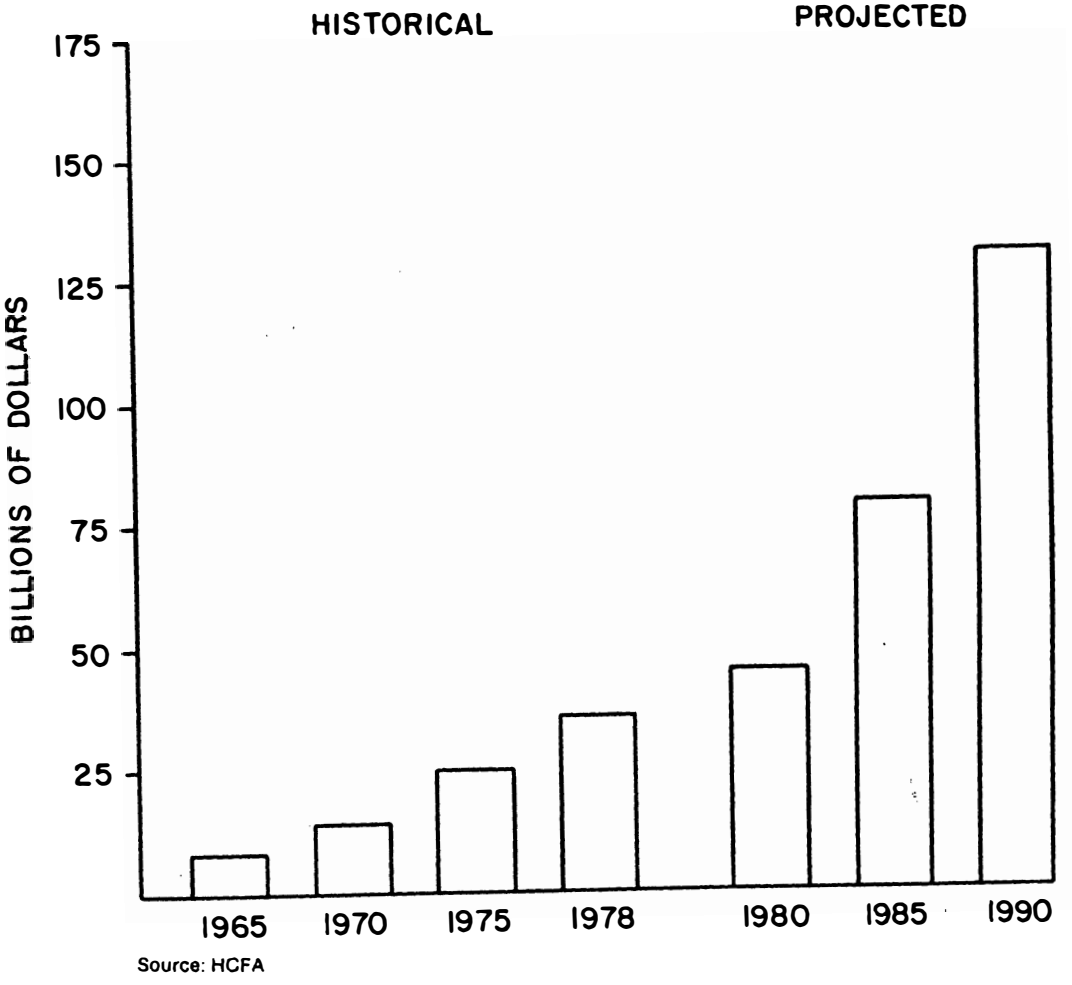
Source: HCFA

NATIONAL HEALTH EXPENDITURES
Selected Calendar Years 1950-79



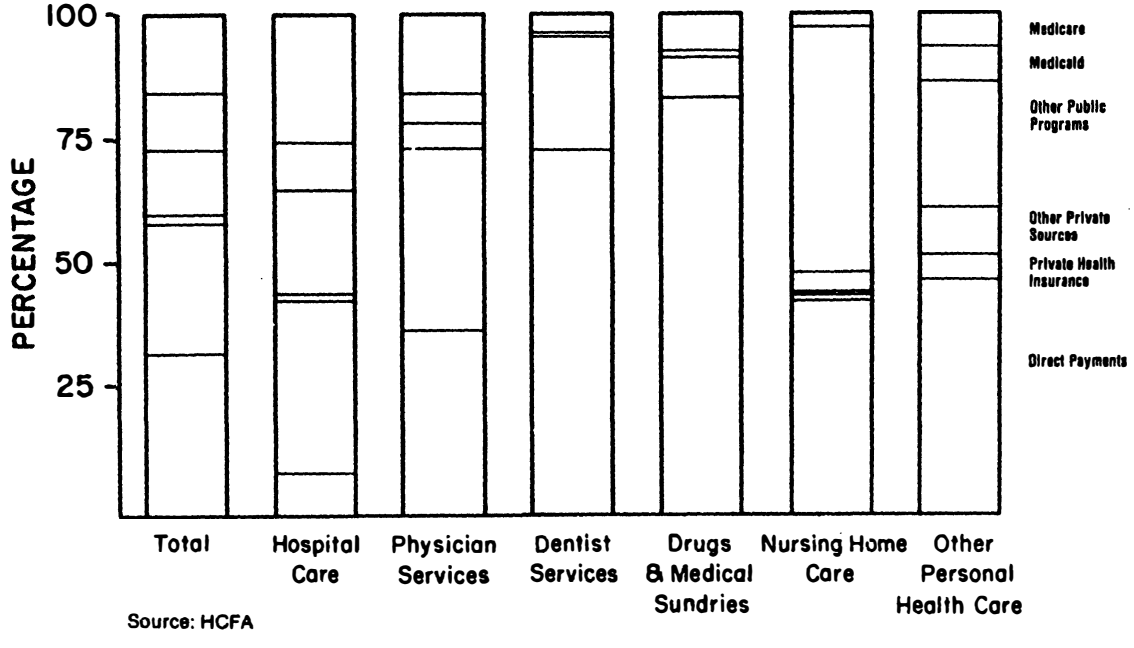
Source: Health Care Financing Administration (HCFA)

EXPENDITURES FOR PHYSICIANS' SERVICES
Selected Years 1965 to 1990



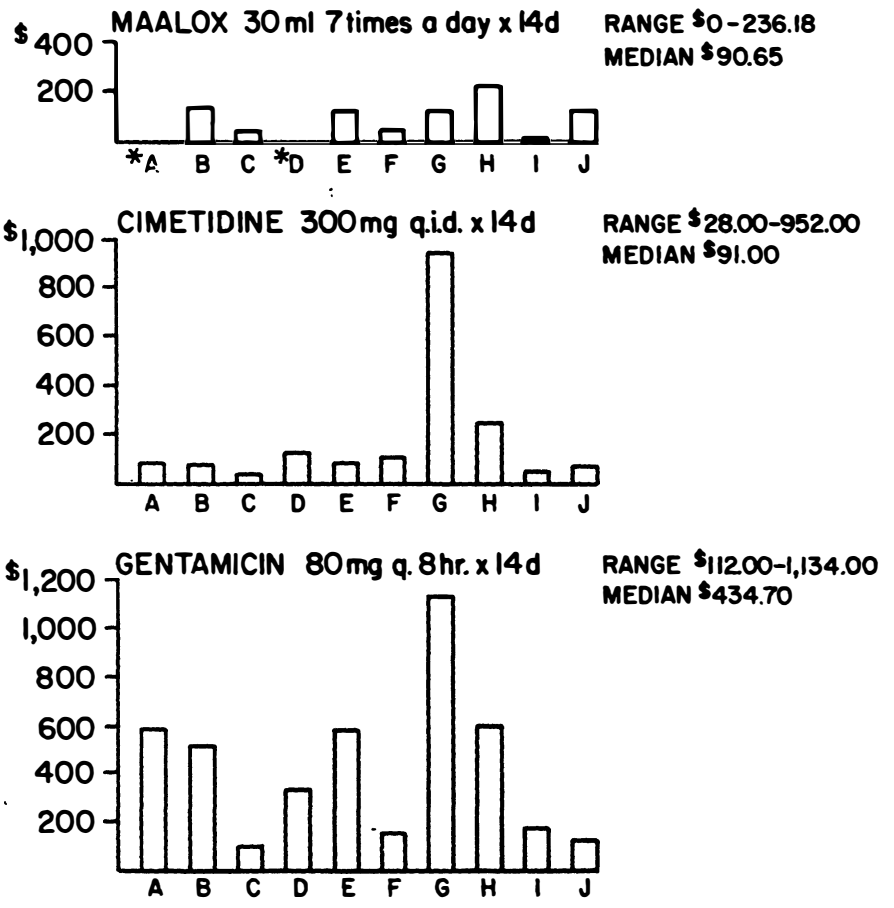
Source: HCFA

SOURCES OF FUNDS FOR PERSONAL HEALTH CARE EXPENDITURES, BY TYPE OF EXPENDITURE 1979



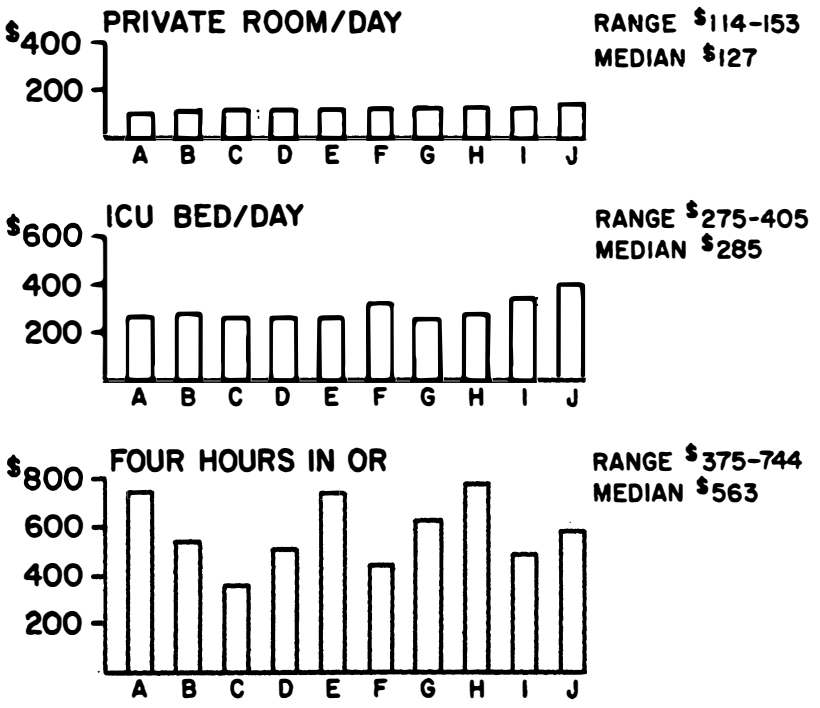
Source: HCFA

CHARGES FOR SELECTED MEDICATIONS COMPARED IN 10 RICHMOND HOSPITALS, February 1981

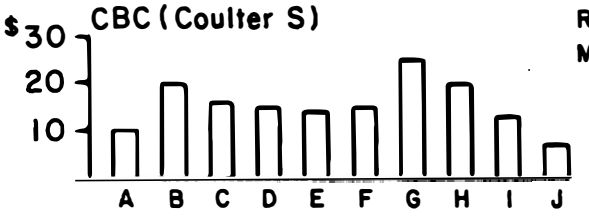


*No charge

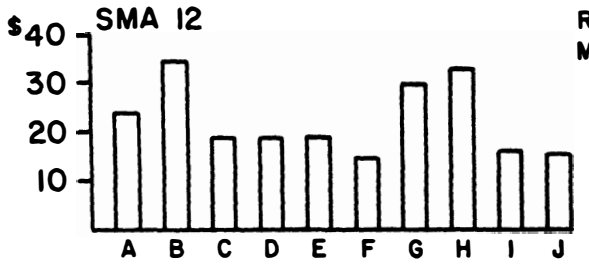
COMPARISON OF SELECTED CHARGES BY 10 RICHMOND HOSPITALS, February 1981



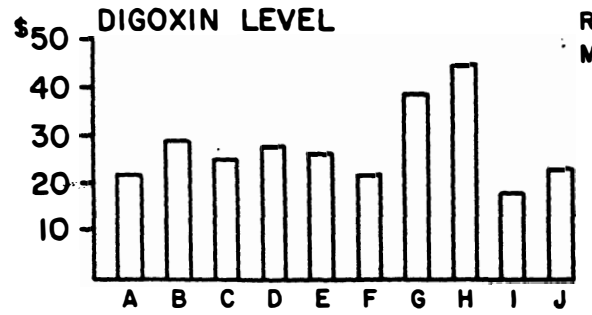
CHARGES FOR SELECTED LAB TESTS COMPARED IN 10 RICHMOND HOSPITALS, February 1981



RANGE $7.00-25.00
MEDIAN $15.00

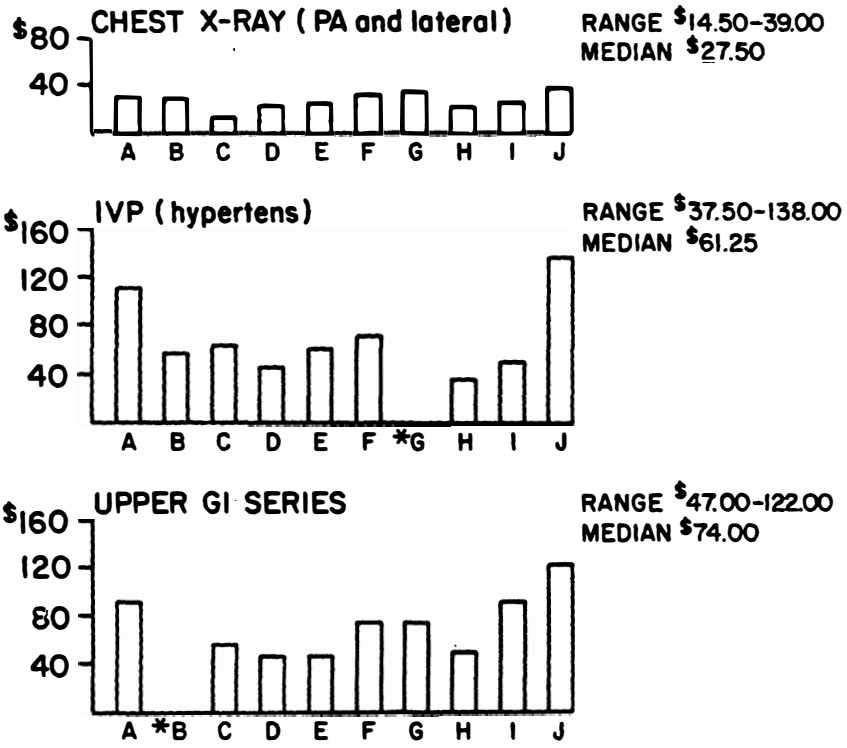


RANGE $15.00-35.00
MEDIAN $19.38



RANGE $18.00-44.88
MEDIAN $25.88

CHARGES FOR SELECTED RADIOLOGICAL PROCEDURES IN 10 RICHMOND HOSPITALS, February 1981



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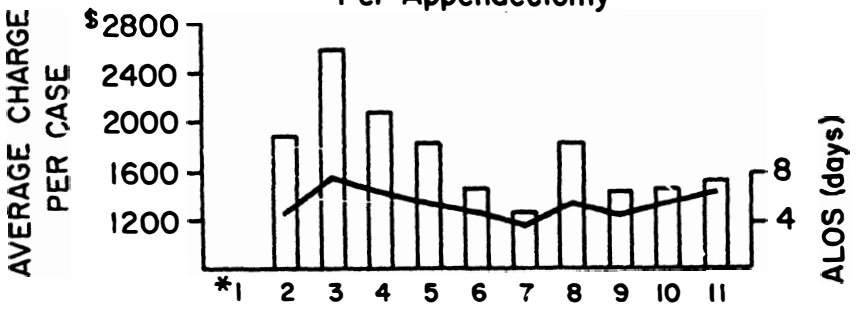
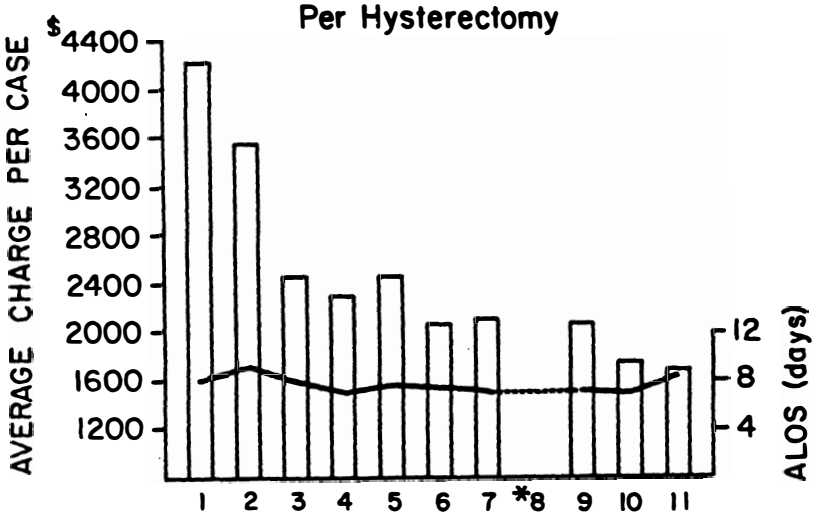
RICHMOND AREA HOSPITALS
Blue Cross Claims Experience – 1980

Average Charge & Average Length of Stay
Per Appendectomy



Average Charge & Average Length of Stay
Per Hysterectomy

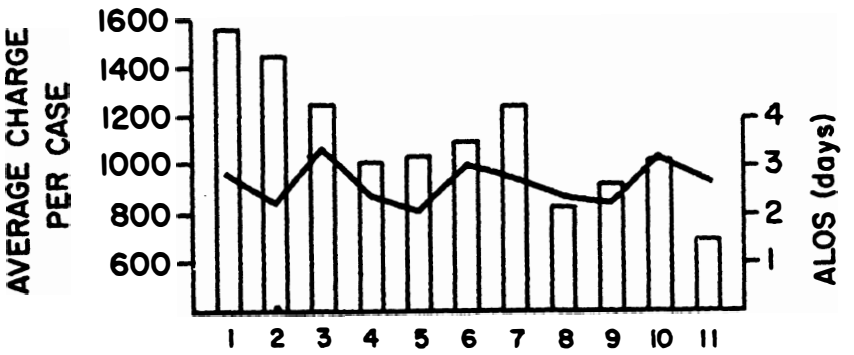


*Data not available

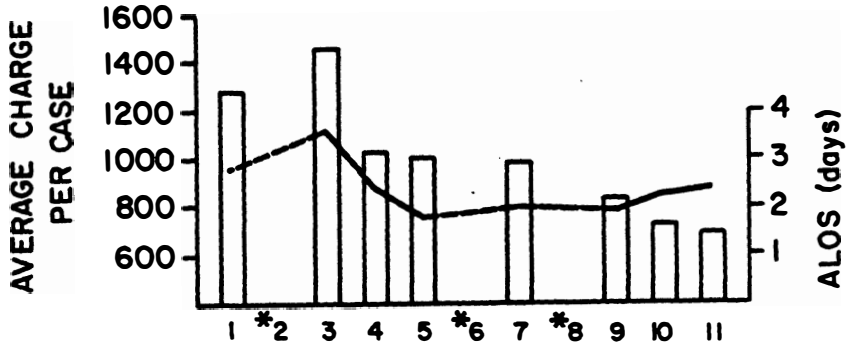
RICHMOND AREA HOSPITALS

Blue Cross Claims Experience — 1980

Average Charge & Average Length of Stay
Per Breast Biopsy



Average Charge & Average Length of Stay
Per Tubal Ligation



* Data not available