INTERIM REPORT OF THE
JOINT SUBCOMMITTEE ON

HEALTH CARE FOR ALL VIRGINIANS

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 35

COMMONWEALTH OF VIRGINIA
RICHMOND
1990

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EXECUTIVE SUMMARY

The Joint Subcommittee on Health Care for all Virginians was created by the 1988 General Assembly. In its report to the 1989 General Assembly, the Joint Subcommittee recommended several steps to address the problems of indigent health care. As a result, legislation was adopted in 1989 as a first step towards recognition of hospital charity care as a societal problem:

- Creation of a new indigent health care trust fund to equalize the burden of charity care among hospitals;
- Reorganization and strengthening of the State-local hospitalization program;
- Partial deregulation of hospitals under the Certificate of Public Need (COPN) program, and continuation of the moratorium on approval of new nursing home beds under COPN; and,
- Broadening of financial disclosure requirements on hospitals and nursing homes.

Following the 1989 session the Chairman of the Joint Subcommittee, Senator Stanley C. Walker, appointed two subcommittees. A Subcommittee on the Uninsured, chaired by Senator Hunter B. Andrews, and a Subcommittee on Long Term Care, chaired by Delegate Ford C. Quillen, met during the interim. The two subcommittees presented their reports to the Joint Subcommittee on December 4, 1989. Final recommendations were adopted on December 28, 1989. This interim report represents a second set of steps to make low-cost health insurance and primary care more available and affordable to the uninsured, and to make long term care more accessible to elderly Virginians.

Making Health Insurance More Affordable

(1) Create an Advisory Commission on Mandated Health Insurance Benefits, to review all proposed mandated benefits and providers prior to consideration by the General Assembly, and to develop a schedule for eventual evaluation of existing mandates.

(2) Require reporting by the insurance industry, on an annual basis to the State Corporation Commission, on the cost of state mandated benefits.

(3) Authorize the sale of low-cost health insurance products to individuals, groups, or companies, that have not had any health insurance for the preceding twelve months, or to newly organized companies, with a concurrent reduction in the scope of state mandated benefits and providers.

(4) Provide an appropriation to the Office of the Secretary of Health and Human Resources for a competitive grant (or series of grants) for the purpose of marketing low-cost health insurance to small businesses across Virginia. The grant(s) should be made to a business organization, coalition, or public-private partnership. Appropriate reporting should be required.

(5) Add three business representatives to the Technical Advisory Panel for the Indigent Health Care Trust Fund, to address technical questions relative to contributions to the trust fund by businesses that do not offer health insurance to their employees.

(6) Adopt certain technical amendments to the Indigent Health Care Trust Fund as recommended by the Technical Advisory Panel and the Board of Medical Assistance Services.

(7) Direct the Department of Medical Assistance Services to study the feasibility of a managed care or buy-in demonstration project, with or without federal funding.

Expanding Access to Primary Care

(8) Adopt legislation to create a primary care program within the Department of Health, directing the State Board of Health to designate medically underserved areas and authorize a series of initiatives to expand access to primary care, including scholarships, loan repayment, and continuing education, as described in the following recommendations 9, 10, and 11.

(9) Provide General Funds for scholarships for medical students who agree to practice in the field of primary care in medically underserved areas.

(10) Provide General Funds, to be matched with federal funds, for a loan repayment program for medical school graduates who agree to practice in the field of primary care in medically underserved areas.

(11) Provide General Funds, to be matched with federal funds, for Area Health Education Centers to expand continuing education for physicians in medically underserved areas; and,

(12) Establish a State Local Program to support public-private partnerships at the local and regional level, to improve the delivery of primary care to families and children.

Strengthening Coordination of Long Term Care

(13) Identify methods of providing support to family caregivers.

(14) Establish two positions to strengthen the role of the Long-term Care Coordinating Council.

(15) Provide General Funds the second year, for a series of pilot projects to expand the availability of case management services for elderly Virginians, to assist them in remaining in their own homes for as long as possible.

(16) Extend the moratorium on approving Certificates of Public Need for new nursing home beds, from January 1 to at least June 30, 1991, so that the issue of COPN can be addressed more fully during the 1991 session of the General Assembly.

(17) Study the Department of Health nursing home bed need projection methodology.

(18) Request that the Joint Legislative Audit and Review Commission conduct a follow-up study of Homes for Adults licensure, along with the eligibility for and level of auxiliary grant assistance for residents of Homes for Adults.

(19) Transfer the licensing of Homes for Adults from the Department of Social Services to the Department of Health, effective July 1, 1991.

(20) Encourage the State Corporation Commission to support coverage of community-based care in long term care insurance policies.

(21) Consider the expansion of Medicaid eligibility by eliminating the 209(b) restrictive eligibility criteria as of July, 1990.

Continuing the Study

(22) Continue the study until the 1992 General Assembly as the Commission on Health Care for all Virginians. *The following chart illustrates the budget amendments requested to support the recommendations included in this report during the 1990-92 biennium. These recommendations total $10.8 million in General Funds.*

JOINT SUBCOMMITTEE ON HEALTH CARE
For All Virginians (SJR 214)

Recommendations with Fiscal Impact	FY	General Fund	Non-General
Continuing the Study as a Commission	1991	$150,000	$0
Making Health Insurance More Affordable			
Marketing Grant to Business Coalitions	1991	$250,000	$0
Expanding Access to Primary Care			
Primary Care Medical Scholarships	1991	$500,000	$0
	1992	$500,000	$0
Physician Loan Repayment Program	1991	$50,000	$150,000
	1992	$50,000	$150,000
Area Health Education Centers	1991	$100,000	$300,000
	1992	$150,000	$450,000
Partnerships for Primary Care	1991	$2,200,000	$0
	1992	$2,200,000	$0
Coordinating Long Term Care			
Long Term Care Council	1991	$125,000	$0
	1992	$125,000	$0
Case Management Pilot Projects	1992	$4,400,000	$0
TOTAL APPROPRIATIONS		$10,800,000	$1,050,000

REPORT OF THE JOINT SUBCOMMITTEE

ON

HEALTH CARE FOR ALL VIRGINIANS

Report of the
Joint Subcommittee on Health Care
For All Virginians
To
The Governor and the General Assembly of Virginia
Richmond, Virginia
January 1990

To: Honorable L. Douglas Wilder, Governor of Virginia
and
The General Assembly of Virginia

AUTHORITY FOR THE STUDY

The Joint Subcommittee on Health Care For All Virginians resulted from the combination of two joint resolutions during the 1988 General Assembly. Senate Joint Resolution 99, proposed by Governor Gerald L. Baliles and introduced by Senator Stanley C. Walker, initiated a study of indigent health care. The scope of this study included hospital and long term care, Medicaid cost containment, and the role of the Certificate of Public Need program. House Joint Resolution 78, introduced by Delegate Ford C. Quillen, initiated a study to address the elimination of Virginia's 209(b) Medicaid status, involving certain restrictive eligibility criteria for elderly and disabled recipients of Supplemental Security Income. These two joint resolutions were combined under Senate Joint Resolution 99 and approved by the 1988 General Assembly.

During 1988, the Joint Subcommittee developed a number of proposals which were included in its report to the 1989 General Assembly (Senate Document No. 18). A summary of the legislation proposed by the Joint Subcommittee, as adopted by the 1989 General Assembly, is included in this document as Appendix B. Among the proposals was a resolution suggesting the study be continued (Senate Joint Resolution 214 of 1989). Pursuant to SJR 214, the Joint Subcommittee on Health Care For All Virginians was continued, with a final report due to the 1991 General Assembly.

This report includes a new Senate Joint Resolution to continue the study until 1992 as the Commission on Health Care for all Virginians (See Appendix B).

SUMMARY OF ACTIONS DURING 1989

The General Assembly has been addressing indigent health care and long term care for several years. The most recent legislative report was issued in 1989 by the Joint Subcommittee on Health Care For All Virginians (Senate Document No. 18). The Joint Subcommittee was directed to study issues including Certificate of Public Need (COPN), the problems facing Virginians who are uninsured for health care, the growing burden of uncompensated hospital care, and the growing need for long term care in an aging society, as well as the burgeoning cost of Medicaid and the need to contain costs.

Recommendations of the 1989 Interim Report

The 1989 interim report concluded that the problems of indigent health care are in the final analysis societal problems which affect all Virginians, and not just one industry. Likewise, the report concluded, solutions will involve actions by the business community and by health care providers as well as additional public financing. The report proposed a joint public-private partnership to enable all parties to share in the responsibility for addressing the rising cost of health care. Specific recommendations included the following:

- Establishment of a trust fund to equalize the burden of hospital charity care across Virginia;
- Deregulation of hospitals under the Certificate of Public Need (COPN) program, with certain specific exceptions;
- Continuation of the moratorium on COPN approval of new nursing home beds until January 1, 1991;
- Improvement of the State-Local Hospitalization (SLH) program;
- An increase in Medicaid physicians fees to the 15th percentile as a first step towards increasing fees to the 25th percentile over three years;
- A study of ways to make private insurance more affordable, including the social and financial impact of state mandated benefits and providers;

- A one-year moratorium on further mandated health insurance benefits and providers;

- A directive to the Department of Health to develop recommendations to expand availability of primary care services; and,

- Continuation of the Joint Subcommittee.

In summary, the intent of these recommendations was to make the commitment that the Commonwealth would share in the cost of charity hospital care for all Virginians whose family incomes fell below the poverty level ($10,060 for a family of three). For working Virginians above the poverty level, the report suggested a desire to make health insurance more affordable in the workplace. With respect to Medicaid, the report suggested that underlying weaknesses in reimbursement policies should be addressed before eligibility is expanded. For the growing number of elderly Virginians, the report recommended steps to improve the availability and coordination of long term care services to enable more of the elderly to continue to live in their own homes. The specific actions adopted during the 1989 session are summarized in the next section.

Actions of the 1989 General Assembly

During the 1989 Session, most of these recommendations of the Joint Subcommittee were adopted by the General Assembly, as summarized below. A more complete description of the legislative package adopted in 1989 is contained in Appendix A.

Indigent Health Care Trust Fund. A trust fund for indigent hospital care was adopted, establishing a partnership between the Commonwealth and the hospital industry to address the problem of financing charity care. The 1989 Appropriations Act (Chapter 668) committed $8.9 million from the General Fund to be matched by $5.9 million from hospital contributions. The trust fund is designed to reimburse 60 percent of each dollar spent on charity care costs (for persons below 100 percent of the poverty level) for those hospitals providing more than the state-wide median of charity care.

Concerns were raised that the definition of charity care (100 percent of the federal poverty level) is an inadequate measure of need in high-cost areas of the Commonwealth. Recognizing this concern, language was included in the Appropriations Act (Chapter 668, Item 389.1) directing the Technical Advisory Panel for the trust fund to report on the feasibility of adjusting the definition of charity care to account for variances in the cost of living in various regions of the state.

Affordability of Health Insurance. Senate Joint Resolution 215 was adopted, which expressed the concern of the legislature that steps are needed to make health insurance more affordable for the large number of working Virginians who currently do not have insurance. Recognizing that a growing number of mandated health care benefits and providers are required under Title 38.2, Chapters 34 and 42, *Code of Virginia*, to be included in both commercial and Blue Cross-Blue Shield plans, the resolution expressed concern that such mandates may increase the cost of health insurance. The resolution called for a moratorium on adoption of additional mandates, and a study of the social and financial impact of current and proposed mandates. The Bureau of Insurance of the State Corporation Commission was to conduct the study.

Certificate of Public Need. COPN requirements were modified to effect a partial deregulation of hospitals. Expenditures for services and equipment were deregulated as of July 1, 1989. Capital investment decisions (new beds or relocation of hospitals) were deregulated as of July 1, 1991. A report on the impact of deregulation is to be submitted by the new Secretary of Health and Human Resources in November, 1990. The moratorium on new Certificates of Public Need for nursing home beds was continued through January 1, 1991.

State-Local Hospitalization. The SLH program was strengthened by setting a statewide eligibility standard at the poverty level and adopting a proposed Joint Legislative Audit and Review Commission (JLARC) formula for distributing funds to localities. SLH was also moved from the Department of Social Services to the Department of Medical Assistance Services. A commitment was made to assist all persons under the poverty level in paying for hospital care through the SLH program, up to the limit of funds appropriated, leaving the trust fund as a last resort.

Medicaid. Physicians' fees in the Medicaid program were increased to the 15th percentile, with the intent that fees be raised to the 25th percentile over three years. Facility reimbursement was improved with the inclusion of a new inflation indicator. The Department of Medical Assistance Services was encouraged to apply for additional federal waivers to expand the availability of home and community-based care for the elderly.

Information and Reporting Requirements. Critical to the development of a working partnership with the hospital and nursing home industries is accurate and complete financial disclosure by the partners. Financial reporting requirements for hospitals were increased by requiring comprehensive annual audits of each hospital and its affiliate corporations. The additional requirements are needed to ascertain hospitals' economic status, due to significant hospital diversification in recent years. Nursing homes were brought under the prospective budget review system of the Virginia Health Services Cost Review Council The membership of the

Council was broadened to include representatives of the nursing home industry, and the method of appointing the council director was changed so that the Governor would appoint this position.

Appropriations for FY 1990. The total cost for adoption of these recommendations included in the 1989 Appropriations Act was $24.4 million in General Funds, as summarized in the following chart:

Phase One: Appropriations for FY 1990
(General Funds, $ Millions)

Recommendation	$ Millions
Indigent Health Care Trust Fund	$8.90
State-Local Hospitalization (SLH)	$4.00
Physicians' Fees -15th Percentile (1/1/90)	$6.00
Hospital & Nursing Home Reimbursement	$5.50
Total Appropriation - Phase One	$24.40

Phase Two of the Study

In order to examine more fully the concerns regarding access to hospitalization, primary care, and long term care for all Virginians, Senate Joint Resolution 214 extended the Joint Subcommittee's investigation of these issues and options.

At the conclusion of the 1989 session, the scope and complexity of the study were considered too great to be addressed by one subcommittee. Therefore, at the meeting of the full Joint Subcommittee on April 14, 1989, Senator Walker appointed two subcommittees -- one on the uninsured and a second on long term care.

The Subcommittee on the Uninsured, chaired by Senator Hunter B. Andrews, was initiated to address the following:

- Characteristics of the low-income and uninsured population;
- Description of available health care programs in the Commonwealth accessible to this population;
- Description of the services needed by this population; and,

- Alternatives to meet these needs.

The Subcommittee on Long Term Care, chaired by Delegate Ford C. Quillen, was initiated to address the following:

- Characteristics of the population at risk;
- Description of the current public and private long-term care system;
- Projections of the unmet needs of the at-risk population through 2005;
- Most appropriate state organizational structure for financing and delivery of services; and,
- Alternatives to meet these needs.

The Subcommittee on the Uninsured met four times in 1989: June 12; July 24; September 18; and October 30. The Subcommittee on Long-Term Care also met four times: May 10; June 9; September 11; and December 3. The two subcommittees presented their reports to the Joint Subcommittee on December 4. On December 27, a public hearing was held at which over 30 speakers presented their comments. The Joint Subcommittee met on December 28 to adopt its final recommendations.

Acknowledgments

The Joint Subcommittee wishes to express its sincere appreciation to the many interested persons and groups who contributed to this study during 1989. This includes the consultants who worked closely throughout the year with the two subcommittees. The Subcommittee on the Uninsured was ably assisted by Catherine Sreckovich and Elaine Peters, consultants from KPMG Peat Marwick, Chicago, Illinois. The Subcommittee on Long Term Care was similarly well assisted by Dr. Henry Miller, President, Center for Health Policy Studies, Columbia, Maryland, and Dr. James McAuley, Virginia Polytechnic Institute. The Joint Subcommittee is grateful for their many contributions.

INTRODUCTION

Health care is one of the most important issues of our time, affecting all levels of society from the poorest families to the wealthiest businesses. We as a nation and a Commonwealth face many difficult choices in addressing both changing trends in the delivery of health care and the changing health needs of our citizens. Efforts to educate our children, promote business growth, maintain a competitive labor force, and care for our growing elderly population are all predicated on the ability to face this challenge. Strong public and private sector leadership is needed as a catalyst in facing these changing trends and needs. However, given the probability that the federal government will not address the issues facing Virginia in the foreseeable future, the Commonwealth must now take the initiative.

The Challenge to the Commonwealth

The Commonwealth faces the unenviable task in the 1990's of balancing the conflicting demands of improving the quality of health care, increasing access to care, and at the same time controlling the cost of care.

The quality of health care has improved dramatically since mid-century. Today, most Virginians have access to modern health care facilities, advanced medical technology, and well trained health professionals. Much of this progress has been made possible by the widespread availability of health insurance, as well as by reimbursement systems which have encouraged investment in facilities and equipment, and by public funding for medical research and education.

Access to care for many Virginians and controlling the overall cost of health care have proven to be more difficult to achieve. The Joint Subcommittee notes with concern that 880,000 Virginians, or about 13 percent of all Virginians under age 65, do not have health insurance. In certain isolated areas of the Commonwealth, hospitals are experiencing fiscal stress and may be at risk of closing. In many medically-underserved areas, including many rural areas and parts of our inner cities, the supply of primary care physicians is not adequate to meet basic health care needs. For uninsured Virginians, lack of access to primary care is a fundamental problem.

The rapidly escalating cost of health care, however, makes the solutions to these problems all the more difficult. In 1965, only about six percent of our nation's economic output was devoted to health care. Last year, over half a trillion dollars, or almost 12 percent of our Gross National Product (GNP), was devoted to health care. With the aging of our population,

the cost of health care is expected to rise to 15 percent of GNP by the year 2000. If present trends continue, our expenditures on nursing home care alone will triple over the next 15 years.

The Joint Subcommittee believes a new partnership is needed in the Commonwealth between business, government, and health care providers to resolve these issues in the 1990's. This report suggests such a partnership.

PART ONE

HEALTH CARE FOR THE UNINSURED

VIRGINIA'S UNINSURED POPULATION

The first task of the Subcommittee on the Uninsured was to determine the characteristics of the uninsured population and its health care needs. In order to develop a profile of the uninsured, consultants from Peat Marwick analyzed Current Population Survey (CPS) census data, State Corporation Commission (SCC) survey data, Virginia Employment Commission data on employers, and national studies on the uninsured. To evaluate unmet health care needs, Peat Marwick conducted a survey of indigent care providers, examined SCC survey data, and conducted site visits and meetings with selected program managers.

From this research, it is evident that a significant number of Virginians do not have health insurance. Up to 880,000 Virginians (or 13 percent of non-elderly residents) are uninsured. This estimate is lower than the national average of 15-18 percent. Only two percent of the elderly (ages 65+) lack some type of coverage, though many more may be under-insured.

Those at high risk for being uninsured typically include: single heads of household, non-white persons, children and young adults, part-time workers and unemployed, low-income workers, and a significant number of persons in other income brackets. The majority of uninsured Virginians cite cost of coverage as an obstacle to obtaining health insurance. A smaller number do not perceive a need for insurance because they are currently in good health.

Who Are the Uninsured?

Children under age 18 constitute a large at-risk group, representing 31 percent of the uninsured (270,000). Children of unemployed parents are at a significant risk. Thirty percent of children in unemployed two-parent households and 43 percent in unemployed single households are uninsured. However, children of employed parents are also at risk. Even in two-parent households in which both parents are employed, 6.5 percent of children are not insured and this rate is more than double (13.7%) when only the head of household is employed.

There is a common misconception that the uninsured are also unemployed. In fact, however, the majority of the uninsured are connected to the work-force. National figures indicate that 75 percent of the uninsured are members of households in which at least one person is employed. In Virginia, the figure appears to be somewhat lower. Approximately 60 percent of Virginia's uninsured households (520,000 persons) are headed by someone who is employed at least part-time. Conversely, the remaining 40 percent of families which have at least one uninsured member are headed by a person

who is not employed. Therefore, successful workplace initiatives can address most, but not all, of the uninsured population.

It is also a misconception that all uninsured people are poor. Fifty-nine percent of uninsured Virginians are above the federal poverty level ($10,060 for family of three). This compares with a national figure of 68 percent. Specifically, about one-third of the uninsured are estimated to have incomes below poverty; another third are between 100 and 200 percent of the federal poverty line. However, as many as one-third may have moderate to high incomes, that is above 200 percent of poverty. Medical indigence, therefore, does not necessarily imply economic indigence.

Many of the working uninsured are employed by small businesses. The Governor's Task Force on Indigent Health Care found that 35 percent of businesses with fewer than 51 employees do not offer insurance protection for their workers. This may translate into 165,000 uninsured employees. In Virginia, 86 percent of businesses have fewer than 20 employees. Not surprisingly, the proportion of small firms not offering coverage increases as the size of the firms decreases. It is estimated that more than half of very small firms (1-5 persons) do not offer insurance.

Lack of access to primary care is a fundamental problem for all uninsured Virginians. Uninsured or under-insured households are less likely to have a regular source of care and are more likely to have at least one family member in fair or poor health. Such households are also more likely to report they needed health care that they could not receive (25 percent) than households protected by comprehensive coverage (17.5 percent). A frequent response to the lack of primary care for the uninsured is the inappropriate use of hospital emergency rooms, which is a far more expensive source of care. This is a problem both in inner city and in rural areas of Virginia.

Goals of the Joint Subcommittee

With the intent of addressing the needs of Virginia's uninsured population, the Subcommittee on the Uninsured adopted the following goals for the Commonwealth's indigent care initiatives:

- Promote insurance through the workplace and to encourage a public/private partnership in addressing the problem;

- Ensure access to essential care in appropriate settings. This effort should aim at improving the health status of the medically indigent, including children at risk, and at reducing the probability of expensive interventions through prompt preventive and primary care; and,

- Foster cost-effective and efficient delivery of services by maximizing limited resources and minimizing cost increases.

A key concern facing the Joint Subcommittee in the next year will be to analyze the impact on Virginia's uninsured population of recently adopted federal mandates to expand Medicaid eligibility. In particular, the 1989 Congressional Omnibus Budget Reconciliation Act (OBRA '89) requires States to expand Medicaid coverage for all pregnant women and children (up to age six) with family incomes up to 133 percent of the poverty level. In effect, health insurance has now been provided for a key priority group of the uninsured -- by federal mandate. This expanded coverage will require that the Joint Subcommittee reexamine the many initiatives in primary and acute care now underway in the Commonwealth, to determine their relationship to the expanded Medicaid coverage.

PROMOTING MORE AFFORDABLE HEALTH INSURANCE

The Joint Subcommittee focused its attention during 1989 on the availability and affordability of health insurance, including insurance policies offered by Blue Cross and Blue Shield of Virginia and by commercial insurance companies. Blue Cross and Blue Shield plans have traditionally been exempt from some of the regulatory requirements imposed by States on the commercial accident and sickness insurance industry. This special treatment was justified on the basis that the plans were originally designed to make medical care affordable to as large a portion of the population as possible, on a non-profit basis.

This section of the report will review: (1) state oversight of Blue Cross-Blue Shield; (2) mandated benefits and providers; and (3) proposals to make health insurance more affordable for uninsured, working Virginians.

Oversight of Blue Cross-Blue Shield

The Joint Subcommittee was charged with determining the feasibility of subjecting the rates of Blue Cross-Blue Shield plans to prior approval, and with reviewing the interlocking directorships of the Blue Cross-Blue Shield Corporation, its holding company, and all affiliates of the holding company, to determine the effect on subscribers. The Bureau of Insurance of the State Corporation Commission (SCC) was directed in SJR 214 to assist in this study.

The Bureau did not suggest that any changes were needed in the regulation of Blue Cross-Blue Shield. In its report, the Bureau of Insurance reviewed rate regulation in other states to determine the impact of prior approval on rates in Virginia. The Bureau was not able to conclude that prior approval would benefit subscribers to any significant extent. The Bureau also reviewed the organizational structure of Blue Cross-Blue Shield of Virginia.

Legislation adopted in 1989 encouraged Blue Cross-Blue Shield to merge with its affiliated Virginia Healthcare Foundation. The legislative changes also made it less likely that transactions between Blue Cross-Blue Shield and its affiliates would adversely affect subscribers. Specifically, House Bill 1791 changed Virginia's insurance laws to establish a new standard for transactions among affiliates. The parties involved in the transactions must now demonstrate to the SCC that the transaction is in the best interest of the subscriber. Transactions which exceed certain threshold levels will now be subject to disclosure requirements and may need prior approval from the SCC. As a result, the risk of adverse effects of interlocking directorships on premiums paid by subscribers appears to be minimal, according to the Bureau of Insurance.

Mandated Benefits and Providers

Senate Joint Resolution 215 directed the Bureau of Insurance to study the social and financial impact of all current and proposed mandated benefits and providers, including recommendations to make private health insurance more affordable for working Virginians.

Current Mandates in Virginia. The following benefits are required to be included in accident and health insurance policies sold in Virginia, under current law:

1. Reimbursement of covered services provided by the following practitioners: chiropractors, optometrists, professional counselors, psychologists, clinical social workers, podiatrists, physical therapists, chiropodists, clinical nurse specialists, speech pathologists and audiologists, and opticians.

2. Coverage for mentally retarded or physically handicapped children of the insured beyond normal termination of coverage date for dependents.

3. Coverage for services provided by a dentist if such services would be covered if performed by a physician.

4. Coverage for newborn children from the moment of birth for injury or sickness, including care and treatment of medically diagnosed congenital defects and birth abnormalities.

5. Coverage for inpatient treatment for mental, emotional, and nervous disorders for at least 30 days per policy year.

6. Prohibition against including a provision in a group policy for coordinating benefits with respect to individually underwritten and individually issued accident and sickness policies for which the individual insured has paid the premium.

7. Provision allowing an individual whose eligibility terminates under the group policy to convert to an individual policy without evidence of insurability.

8. Coverage for pregnancy following an act of rape, provided certain reporting conditions are met.

Current Mandated Options in Virginia. The following benefits must be offered as options in accident and health insurance policies sold in Virginia:

1. Coverage for outpatient treatment of mental, emotional, and nervous disorders, at various levels of benefits.

2. Coverage for inpatient and outpatient treatment for alcohol and drug dependence for at least 45 days (inpatient) and 45 sessions (outpatient) per policy year or calendar year.

3. Coverage for obstetrical services.

4. Offer of at least one option for deductibles and co-insurance.

5. Coverage for mammograms.

Report of the Bureau of Insurance. In order to obtain more information about the cost of mandates, the Bureau conducted a survey of all insurance carriers offering health insurance in Virginia. Unfortunately, the Bureau learned that the insurance industry was unable to provide accurate cost data on mandates, because computerized data is not generally maintained in this format by the industry. As a result, the survey was not conclusive. A request from the State Corporation Commission to extend the study reporting date from September 1 until December 31, 1989 was approved by the Chairman of the Joint Subcommittee. The Bureau's report was subsequently presented on December 27, 1989.

In order to provide information in response to the Bureau's survey, Blue Cross-Blue Shield of Virginia contracted with KPMG Peat Marwick of Chicago to conduct a detailed claims analysis. This report was submitted by Blue Cross-Blue Shield to the Bureau of Insurance in October, 1989, but at that point there was insufficient time for the Joint Subcommittee to schedule a hearing on this report. The Joint Subcommittee may wish to place this report on its agenda during the coming year.

In its December, 1989, report, the Bureau of Insurance concluded that mandated benefits and providers account for almost 20 percent of the cost of group coverage. However, the number of mandates in Virginia is not excessive in comparison to other States. In fact, many of the mandates only require that the service be offered, not required. Several services required in Virginia were covered by the majority of insurers responding to the survey prior to the imposition of the mandate. Certain mandates are also now required in federal law. The cost of mandates that that would not be included in the absence of the mandate is estimated to be about 10 percent of policy premiums.

The Bureau recommended that the General Assembly require insurance companies to submit information about the cost of mandates, and consider establishing a separate, independent process to evaluate the impact of current and proposed mandates. The Bureau also suggested consideration of allowing the sale of policies without mandates, under appropriate disclosure requirements.

During the course of the study, Blue Cross-Blue Shield of Virginia suggested a plan by which it would offer a special, low cost insurance product, without mandates, to small businesses that had not offered insurance in the past year. This proposal is described in more detail in a subsequent section.

Impact of Health Care Costs on Employers. In recent years the business community has become increasingly concerned with the rising cost of health insurance premiums. For many employers, premiums are rising rapidly as a percent of profits. According to a survey by the National Association of Manufacturers, in 1988 health costs as a percentage of net profits ranged from a low of 27 percent to a high of 47 percent, with an average of 37 percent. Moreover, the percentage increase in health care costs from 1987 to 1988 ranged from a low of 24 percent to a high of 35 percent, with an average of 30 percent! As a result, many chief executive officers are increasingly concerned with the impact of health care costs on the competitiveness of American corporations.

One of the reasons health insurance premiums are rising is the shifting of costs incurred by hospitals for the 31 million Americans without health insurance. Another factor is the increasing cost of health insurance for retirees. The Financial Accounting Standards Board is expected to require that corporations report (as a liability on their balance sheets) the present value of future retiree health benefits. This change is expected to affect most corporations by the mid-1990's.

Mandated benefits and providers specified in Sections 38.2-3408 and 38.2-4221, *Code of Virginia*, do not apply equally to all Virginians who have health insurance. Large employers that are able to self-insure (including the Commonwealth of Virginia as of January 1, 1989) are not under the jurisdiction of the state mandates. This is because the Employee Retirement Income Security Act of 1974 preempted state regulation of certain employee benefit plans. Federal courts have interpreted this to mean that when companies are self-insured, states may not regulate these plans. With self-insurance, the company assumes all or part of the risk of paying claims submitted under the plan. An insurance company may be hired to administer the plan, without assuming the risk. According to the Bureau of Insurance report, a recent national survey found that 46 percent of large employers now self-insure.

Employers that elect to self-insure can obtain certain advantages, including: (1) avoiding Virginia's premium tax; (2) avoiding certain requirements with respect to capital reserves; and (3) determining for themselves the range of benefits and providers to be covered, without regard to state mandates. Nevertheless, the Bureau of Insurance, in submitting its report, noted there was no irrefutable evidence that companies self-insure solely to avoid the state mandates. Most companies that elect this option probably do so out of a desire to control their costs.

Evaluation of Proposed Mandates. In recent years several States have established review procedures to assess the social and financial impact of proposed mandated benefits or options. In each case, a report on the proposal must be submitted to the appropriate legislative committees before the mandate can be acted upon. For example:

- A Mandated Benefits Advisory Commission was created in Maine (1989).

- Reports to the appropriate legislative committees on the impact of proposed mandates (to be submitted by groups proposing the mandates) were required in Arizona (1985), Colorado (1989), Florida (1987), and Washington State (1984).

- Reports on proposed mandates must be submitted in several other States by the Commissioners of Insurance, Legislative Auditors, or Fiscal Review Committees, prior to legislative consideration.

In each statute creating such a review process, a finding of legislative intent is included which addresses the need to balance the cost of proposed mandates with the public interest in expanding access to the service or provider. In each statute, a series of questions is posed to assist in the preparation of the analysis of the proposal.

At this time, the Joint Subcommittee finds that steps are needed to formalize the evaluation of the social and financial impact of proposed and existing mandates, and to require better information from the insurance industry with respect to the cost of mandates.

Recommendation 1. *The Joint Subcommittee concludes that an independent, objective evaluation process, such as a commission, is needed to weigh the costs and benefits of proposed mandates, and eventually to review existing mandates. Therefore, the Joint Subcommittee will introduce legislation to establish an Advisory Commission on Mandated Health Insurance Benefits. Such a commission could review proposed mandates prior to consideration by the General Assembly, and could offer its*

independent judgment on each mandate. The commission should also develop a schedule for evaluating current mandates. Pending the outcome of this proposal, the Joint Subcommittee recommends no further mandated health insurance benefits or providers be adopted by the General Assembly.

Recommendation 2. *The Joint Subcommittee will propose legislation to amend Section 38.2-1905.2,* Code of Virginia, *to require organizations offering health insurance for sale in Virginia to provide information to the State Corporation Commission on the costs of existing state mandated benefits and providers. The Commission should determine appropriate data requirements, with a report on the data requirements to be provided to the Joint Subcommittee by December 1, 1990. The Commission should provide for a reporting date for the industry beginning between March and June, 1992, for activity during Calendar Year 1991. The Commission should provide its first report to the General Assembly based on the information submitted, by October 1, 1992.*

Promoting Low-Cost Insurance Products

Originating from the recommendations of the Joint Subcommittee to the 1989 Session, a major goal of this study was to find a way to make health insurance more affordable for uninsured, working Virginians. Recognizing the majority of uninsured Virginians are employed, the Joint Subcommittee believes work-based insurance offers a viable source of coverage for this population. Furthermore, the Joint Subcommittee is aware of concerns in the business community over the rising cost of insuring employees. Those businesses that do offer insurance for their employees are under pressure to shift more of the cost onto the employees. Those that do not offer insurance are likely to cite cost as the major obstacle.

Various approaches to addressing the uninsured population have been taken by other states. One approach is to mandate employment-based insurance coverage, requiring business to assume the cost. While businesses should be involved in insuring their employees, such mandates may only shift the burden rather than address problems with cost containment which make insurance products unaffordable to begin with. Other approaches include government subsidies, insurance pools, and expansion of Medicaid. Further review of all of these approaches and consideration of the experiences of other States is warranted, during the next phase of the study.

Blue Cross-Blue Shield Proposal. At the July 24 meeting of the Subcommittee on the Uninsured, Blue Cross-Blue Shield (BC/BS) of Virginia delineated a low-cost insurance package. The BC/BS package is designed to target employers of people earning $10,000-$25,000, or about 100-200 percent of the poverty level, who have been uninsured for a period of twelve months or

more. It is estimated that this income group represents 350,000 Virginians, or about 40 percent of the uninsured. The low-cost BC/BS plan aims at providing benefits that are affordable, meet fundamental health care needs, provide access to healthcare services, and emphasize preventive care.

This plan is designed to provide for routine medical needs of the target population, including: hospitalization, maternity and pre- and post-natal care, well-baby care, accidental injury, and preventive dental care for children. In addition, the plan encourages continuity of care for the early detection and treatment of illness. The proposed BC/BS benefit design is described in the following chart.

PROPOSED LOW-COST INSURANCE PRODUCT
BLUE CROSS-BLUE SHIELD OF VIRGINIA

Type of Coverage	*Description*	*Plan Payment*
Preventive Care	Well Baby Care (to age 5) Physician Visits (two annual visits/person) Dental Exam & Cleaning (one annual visit/child)	100% Co-insurance after $10 per visit co-pay
In-Patient Hospital	30 Days Per Calendar Year	$250/Admission Deductible 80% Co-insurance
Maternity	Pre & Post-Natal Care Risk Management	$250/Admission Deductible 80% Co-insurance
Out-Patient Services	Surgery Home Health Care	80% Co-insurance
Accidents	For Unexpected Treatment	80% Co-insurance (inpatient) $150 maximum payment (for outpatient care)
Mandated Benefits	Limited to Maternity	None
Benefit Limits	Calendar Year Limit	$50,000

Source: Presentation by BC/BS of Virginia (October 30, 1989)

At the October 30 Subcommittee meeting, Dr. Richardson Grinnan, BC/BS Chief Medical Officer, suggested the premium would be $98 per individual, and between $169 and $303 per family, depending upon family composition. The program would be designed to break even, with the premium covering only expected claims costs and administrative charges. The program would be offered for a two year period at a minimum, with subsequent analysis to determine the feasibility of continuing the program.

The Joint Subcommittee concurs that an exemption is needed to permit insurance companies to offer lower cost insurance to those persons, groups, or small business in Virginia that have not had any health insurance over the preceding twelve months. This exemption should also be available to newly organized companies. As suggested by Blue Cross/Blue Shield, a minimum threshold of benefits is essential to assure that the public policy objective of access to essential care in appropriate settings is achieved. Minimal benefits should include a basic level of primary and preventive care, including pre-natal and well baby care, and a minimum of 30 days inpatient hospitalization.

The Joint Subcommittee heard testimony during its public hearing on December from many providers whose services are covered by current mandates, including specialists in mental health, drug abuse, and alcoholism treatment. These services would not be affected by the proposed legislation, because those Virginians who already have insurance would not be eligible for this coverage. However, the 880,000 uninsured Virginians addressed in this report have no insurance at all, and the Joint Subcommittee concludes that the mandated benefits should be reduced for them, so that basic health insurance can be made more affordable.

Realizing that varying benefit designs could be developed to target different populations, the Joint Subcommittee encourages other commercial insurers to create diverse and innovative low-cost insurance products similar to that offered by BC/BS. In addition, the plans must take aggressive steps to control costs, through steps such as limiting the number of providers to which beneficiaries would have access. In the BC/BS plan, this allows for an estimated 15-18 percent reduction in costs.

In summary, steps are needed to promote the availability of basic, low-cost health insurance for uninsured Virginians, by minimizing state mandates for specialized, targeted insurance products.

Recommendation 3. *The Joint Subcommittee will propose legislation to amend Sections 38.2-3408 and 38.3-4221,* Code of Virginia, *to authorize low cost health insurance products for certain targeted groups or individuals, with a concurrent reduction in the scope of state mandated benefits and providers. This exemption should be applicable to all third party payers.*

The legislation should provide an option for third party payers to make this product available to individuals as well as to groups or employers, except that the particular individual, group or employer must not have had any health insurance during the preceding twelve months. An exception should be made in the case of newly organized companies.

The low-cost insurance products offered under this legislation should contain strong managed care provisions for cost containment. In addition, third party payers offering this product should provide a description of the product, with appropriate disclosures, in their promotional materials. These products should be accounted for by the third party payers as a separate line of business, with appropriate reports to the State Corporation Commission for monitoring and evaluation. The legislation should require community rating instead of individual ratings for each employer or individual, and there should be prior approval of rates by the Commission.

The legislation should define a minimum threshold of benefits to be included, recognizing the public policy objective is to promote access to a basic level of primary and preventive care. At minimum, this should include pre-natal, maternity, and well-baby care to age six, a minimum of 30 days inpatient hospitalization, and at least two physician visits per year..

This legislation should sunset as of July 1, 1994, with an independent evaluation to be provided to the General Assembly prior to the 1994 session.

Recommendation 4. *The Joint Subcommittee proposes a marketing grant in the amount of $250,000 to encourage business participation in expanding the availability of health insurance through the workplace. The marketing grant should be awarded on or shortly after July 1, 1990, on a competitive basis to one or more business coalitions to:*

- *Assist small employers in gathering technical information on insurance products;*
- *Provide market support and technical assistance to insurers offering affordable products to small businesses;*
- *Work with the Joint Subcommittee and state agencies to promote viable low-cost insurance products;*
- *Sponsor conferences, seminars, workshops, or other types of meetings for businesses and insurers to tailor suitable insurance products; and,*

- *Develop other strategies for increasing participation of employers in work-based insurance.*

A report to the Joint Subcommittee on the awarding of the grant or grants should be provided by September 1, 1990.

Employer Assessments. To encourage the business community to work actively with the Commonwealth in reducing the number of uninsured Virginians, the Joint Subcommittee should consider the feasibility of an assessment on employers who do not offer or contribute to health insurance for their employees. Assessment revenues could be channeled to the Indigent Care Trust Fund or used to support small business insurance initiatives. Depending on the availability of revenues, possible steps might include direct subsidies or tax incentives for small employers.

Recommendation 5. *The Joint Subcommittee will propose legislation to amend Section 32.1-335,* Code of Virginia, *to expand the membership of the Technical Advisory Panel to the Indigent Health Care Trust Fund, by adding three representatives of the business community, to be appointed by the Board of Medical Assistance Services. The purpose of adding these three new members would be to enable the panel to address the many technical questions which would be raised during the consideration of a business contribution to the trust fund, from employers that do not offer or contribute to health insurance for their employees.*

THE HOSPITAL INDUSTRY

A major reason for initiating this study was the desire to share more equitably the burden of hospital care for uninsured Virginians. In 1987 the total charges for uncompensated care for non-state hospitals were $213 million, or $149 million in actual costs. However, much of that burden consists of bad debts of patients with incomes above the poverty level. Non-state hospitals wrote off an estimated $51.4 million in charity care charges in 1987. When converted from charges to costs, however, charity care in 1987 cost $35.5 million. In the future, with more accurate determination of patients' family incomes, this amount will probably increase.

Indigent Health Care Trust Fund

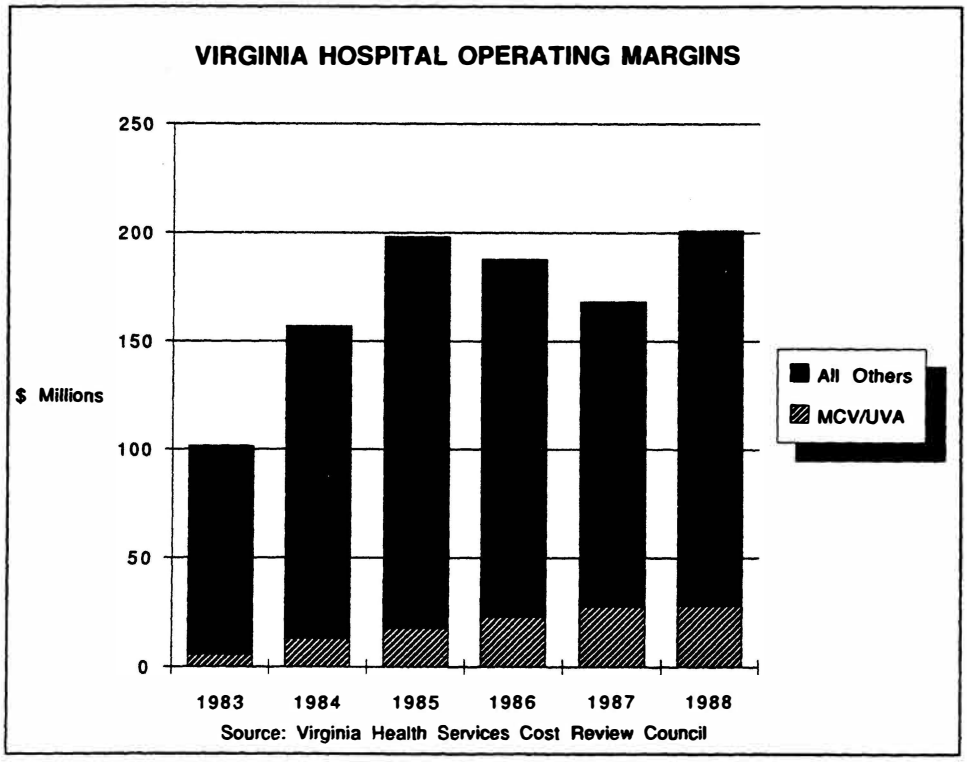
The Indigent Health Care Trust Fund created in 1989 provides a mechanism for taxing those hospitals which provide less than the median level of charity care, and providing a payment to those hospitals that provide more than the median. It was not the intent of the General Assembly to subsidize those hospitals which were experiencing operating losses.

For its first year of operation, the trust fund is based on certain assumptions. The cost of charity care is conservatively estimated at $64.3 million for 1987 (this includes the reported cost of $3.5 million plus an added amount equal to 25 percent of reported bad debt writeoffs). Of this amount, $24.8 million is the estimated cost of charity care for all of the hospitals that provided more than the statewide median of 1.955 percent of gross patient revenues. The trust fund reimbursement rate of 60 percent is then applied to the $24.8 million cost, yielding an estimated payout from the trust fund of $14.8 million. The first payments under from the Trust Fund will not be made until early 1991. At this time, the Joint Subcommittee does not believe any policy changes are required to alter the Trust Fund. Certain technical amendments are recommended to extend the reporting date, clarify procedures for calculating hospital contributions and payments, and change the month in which contributions are to be made.

Recommendation 6. *The Joint Subcommittee will propose legislation to amend Section 32.1-332 through 32.1-342,* Code of Virginia, *to extend the reporting date for hospitals under the trust fund and allow one thirty day extension; clarify the process for calculating hospital contributions and payments; change the month in which hospitals are required to contribute to the fund from December to January, beginning in January, 1991; and, correct certain citations of the* Code of Virginia *which were incorrectly cited in the 1989 act.*

Financial Changes in the Hospital Industry

In its report to the Joint Subcommittee on December 4, the hospital rate review program (of the Virginia Health Services Cost Review Council) found that hospitals in Virginia have increased their operating margins since 1983. Operating margins, or the difference between net revenues and expenditures, have increased 97.6 percent since 1983, from $101.8 million to $201.2 million, as shown in the chart below. Excluding the Medical College of Virginia and University of Virginia Hospitals, operating margins for all other (non-state) hospitals have increased 80.3 percent. This is a favorable performance in light of the adoption by Congress in 1983 of Diagnostic Related Groups (DRGs) to contain Medicare costs. The Virginia Hospital Association expresses concern that government payers (especially Medicare and Medicaid) reimburse at less than cost for services rendered to elderly and indigent patients.



Report on Consolidated Audits. Legislation adopted by the 1989 General Assembly required hospitals to submit consolidated audits, including audits of their affiliates, to the Health Services Cost Review Council, beginning July 1, 1989. In its report to the Joint Subcommittee on December 4, 1989, the rate review program presented the initial results from this new consolidated reporting requirement. The information is included in the hospital commercial diversification survey, conducted by the Health Services Cost Review Council, pursuant to House Bill 1,058 of 1988.

Of the 123 hospitals included in the survey, 35 were for-profit while the remaining 88 were non-profit. A total of 221 affiliates were reported, of which 123 were for-profit and 96 were non-profit The tax status of the remaining two was not reported. Of the 221 reported affiliates, 52 (or 24 percent) were engaged in activities unrelated to health care. Of the total, 113 (or over 50 percent) were less than five years old.

- The total consolidated assets of the hospitals and their affiliates increased 22.6 percent from 1988 to 1989, or from $4.3 to $5.3 billion. The hospitals themselves account for about four-fifths of this total.

- The total consolidated net equity of the hospitals and their affiliates increased 14.7 percent from 1988 to 1989, or from $2.3 to $2.7 billion. The hospitals themselves account for about four-fifths of this total.

- The hospitals as a whole generated a net profit while the entities engaged in other businesses generated a net loss.

The report itself, issued as of December 1, 1989, provides a preliminary analysis of the financial status of each hospital and each of their affiliates. Further analysis of this information will be conducted by the Joint Subcommittee during the next phase of the study.

Analysis of Hospitals with Negative Margins. While the hospital industry overall is financially healthy, concern is expressed that the number of hospitals with negative operating margins has increased from 21 in 1983 to 36 in 1988. Of these 36, four are psychiatric hospitals and five are ambulatory surgery centers. The remaining 27 are general acute care facilities. A common characteristic of these 27 unprofitable general hospitals appears to be a decrease in patient days coupled with an increase in Medicaid days, although additional study of these factors is needed.

The Joint Subcommittee on December 4 requested additional information on the 36 hospitals with operating losses. According to the staff of the Health Services Cost Review Council, the location or tax status of a hospital does not appear to have a major impact on profitability. Council staff suggests the common characteristic of unprofitable hospitals is a decrease in patient days, coupled with an increase in Medicaid patient days. However, in the absence of more detailed analysis, it may be premature to assume a strong cause and effect relationship between these factors. Further analysis is needed in the coming year.

With the additional information available from hospital consolidated audits, the Joint Subcommittee should be able to provide a meaningful

analysis of the true position of the hospital industry. Given the current information available to the Joint Subcommittee, the following points are evident at this time:

- The combined operating margins for all hospitals with positive operating margins increased 18 percent from $197.4 million in 1987 to $233.2 million in 1988. This represented an increase from 5.2 to 5.8 percent of gross revenues.

- The combined operating losses for all hospitals with negative operating margins increased 10 percent from ($29.0 million) in 1987 to ($32.0 million) in 1988. Operating losses were 6.2 percent of gross revenues in both years.

- Patient days for all hospitals declined from 6.2 million in 1983 to 5.3 million in 1988, a decline of 14.5 percent. For hospitals with positive operating margins, patient days declined only 13.5 percent, while hospitals with negative margins experienced a decline of 22 percent.

- Medicaid patient days as a percentage of total days for all hospitals decreased 9.4 percent from 1983 to 1988. For hospitals with positive operating margins, Medicaid patient days declined 14.1 percent, while hospitals with negative margins experienced an increase of 6.2 percent.

- The Indigent Health Care Trust Fund does not materially alter the bottom line of any of the hospitals with negative operating margins. Inclusion of trust fund payments would not create positive operating margins.

Conclusion

The Joint Subcommittee may wish to conduct further study of the 14 acute care hospitals in Virginia which had negative operating margins, and which are located more than 12 miles from the nearest hospital. The combined criteria of fiscal stress and geographic isolation suggest that continued operation of the following hospitals may be important from the perspective of preserving access to care:

1. Bath County Community Hospital (Hot Springs)
2. Community Memorial Hospital (South Hill)
3. Dickenson County Medical Center (Clintwood)
4. Franklin Memorial Hospital (Rocky Mount)
5. Giles Memorial Hospital (Pearisburg)

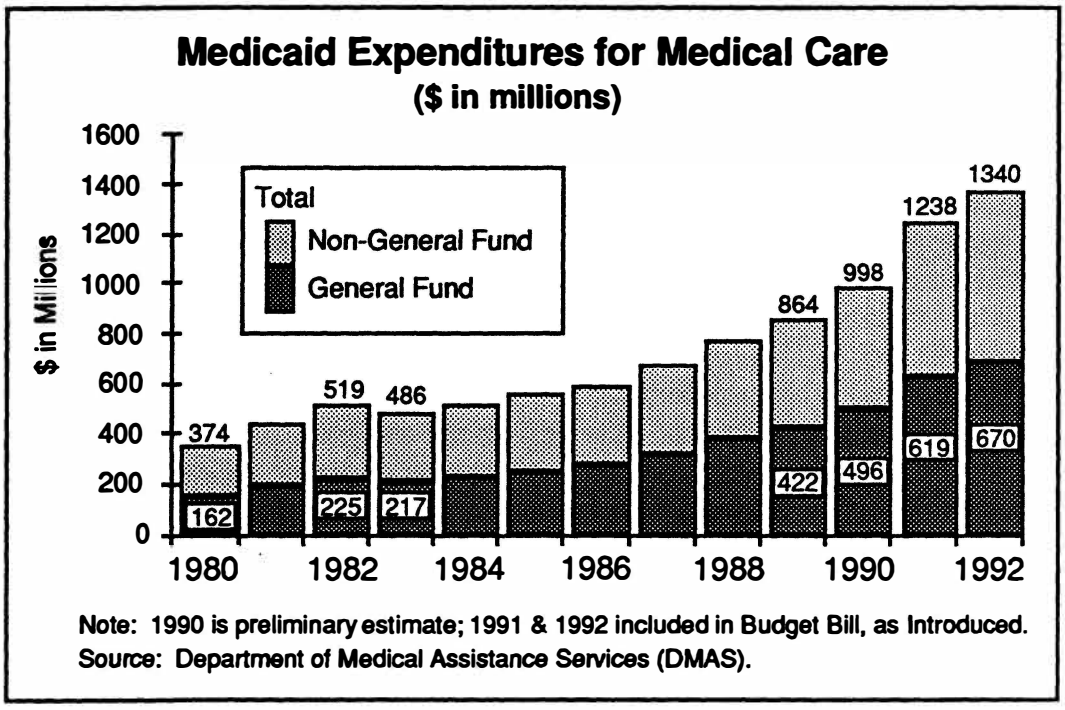
6. Lee County Community Hospital (Pennington Gap)
7. Lonesome Pine Hospital (Big Stone Gap)
8. Loudoun Hospital Center (Leesburg)
9. Obici Memorial Hospital (Suffolk)
10. Page Memorial Hospital (Luray)
11. Pulaski Community Hospital (Pulaski)
12. Rappahannock Hospital (Kilmarnock)
13. Southside Community Hospital (Farmville)
14. Tidewater Memorial Hospital (Tappahannock)

Further research is needed to determine whether or not a causal relationship exists between the factors described in this section. In addition, before the Joint Subcommittee can determine whether any additional public funds are warranted to address these concerns, a detailed review of the consolidated audits of hospitals and their affiliates is required. As required by the 1989 General Assembly, these consolidated audits will provide better information about the actual financial position of Virginia's hospitals. A key area of study for the Joint Subcommittee in 1990 will be the feasibility of developing criteria for determining whether assistance to certain hospitals may be desirable in order to preserve access to care in isolated areas of Virginia.

MEDICAID

Medicaid is the major source of health care funding for the poor. In 1988, Medicaid served 28 million poor, elderly, and disabled persons at a cost of $52 billion nationwide. In Virginia, the cost of the program has risen dramatically in recent years for several reasons: (1) increased cost and utilization of existing services, including the current increase in the number of nursing home beds; and (2) the growing cost of federal mandates. The States have been unsuccessful so far in persuading Congress to agree to a moratorium on new Medicaid mandates. As a result, mandates enacted by Congress since 1986 are expected to account for 20 percent of the total Medicaid budget by 1995.

In Virginia, Medicaid now exceeds $1.0 billion per year, with the federal and state government sharing the cost on a 50/50 matching basis. As Virginia's per capita income has risen relative to the rest of the nation, the federal matching share has declined from 57 to 50 percent during the past decade. From 1985 to 1990, General Fund appropriations for Medicaid have climbed 103 percent, a far higher rate of growth than that provided for mental disabilities (73 percent), corrections (71 percent), public education (60 percent), or higher education (54 percent). As a result, growth in the Medicaid budget is one of the key issues facing the new Administration.



Note: 1990 is preliminary estimate; 1991 & 1992 included in Budget Bill, as Introduced.
Source: Department of Medical Assistance Services (DMAS).

Federal Medicaid Mandates

Recent federal mandates will expand the number of persons eligible for health care paid by the Medicaid program. While the mandates will contribute to improved access to care for low-income, uninsured persons, the Commonwealth's costs will increase significantly.

- The Congressional Omnibus Budget Reconciliation Act of 1989 (OBRA '89) mandates additional coverage of lower-income families and children. By April 1990, pregnant women and children up to age six, with family incomes up to 133 percent of the federal poverty level, will be eligible for Medicaid. Currently, the Commonwealth provides Medicaid coverage to pregnant women and children up to age two and up to 100 percent of the poverty level. This mandate may impact 74,000 people at a cost of $65 million to the Commonwealth.

- The Family Support Act of 1988 ("Welfare Reform") extended Medicaid benefits to additional low-income families receiving Aid to Dependent Children (ADC) payments for longer periods of time. The Welfare Reform bill mandates extension of Medicaid coverage for 12 months (formerly four months) after termination of ADC benefits. Also, Medicaid coverage will be extended on a statewide basis to ADC-eligible two-parent families during periods of unemployment. (The program was previously restricted to high unemployment areas such as Southwest Virginia.) This may affect 25,000 people at a cost of $22.7 million to the Commonwealth.

- Due to a recent federal court decision in Virginia that eliminates the 209(b) option under the Supplemental Security Income (SSI) program, a larger number of elderly and disabled individuals will also become eligible for Medicaid. The principal change is in the valuation of resources when determining eligibility. In determining eligibility for Medicaid, the SSI program exempts the home and all contiguous property, regardless of value. Under the 209(b) option, Virginia had disqualified persons with contiguous property with a value greater than $5,000. As of this writing, the Commonwealth has been granted a stay on elimination of the more restrictive 209(b) option, pending the outcome of litigation. This may ultimately affect 20,000 people at a cost of $35.2 million to the Commonwealth.

- Provisions in the Catastrophic Coverage Act of 1988 mandate Medicaid coverage for additional elderly and disabled persons as the definition of "low-income" increases. Eligibility will expand from 85 percent of the federal poverty level as of January 1, 1989, to 100 percent of poverty by January 1, 1992.

- Obstetric and pediatric physician payment rates must be sufficient to enlist enough providers so that covered services will be available to Medicaid beneficiaries to at least the extent they are available to the general population in a particular geographic area. States will be required to submit annual rates for review by the Health Care Financing Administration.

Medicaid Managed Care Demonstration

Recognizing the growing impact of federal mandates on the numbers of eligibles and program costs, it is essential that the Commonwealth continue to explore new ways of maximizing Medicaid dollars. Provision for such a study is included in the 1989 Omnibus Budget Reconciliation Act (OBRA) package which contains $10 million each year for federal fiscal years 1990, 1991, and 1992, for Medicaid buy-in demonstration projects for pregnant women and children to age 20, whose family income is below 185 percent of poverty. The Joint Subcommittee may wish to explore the feasibility of such a demonstration project. The Joint Subcommittee may also wish to consider a demonstration project to test the concept of managed care for families with children up to age six, with incomes between 133 and 185 percent of the poverty level. Such a project may or may not involve applying for federal waivers or demonstration funds. Federal funds should only be sought if it appears such support would be in the best interests of the Commonwealth.

Recommendation 7. *The Joint Subcommittee recommends that the Department of Medical Assistance Services study the feasibility of developing a managed care or buy-in demonstration project under authority of the OBRA '89 package, or separately without federal funds. The project should be intended to test the concepts of coordinated care for recipients, income-related premiums, and capitated payments to providers. A report on waivers or other steps needed to initiate this project should be made available to the Joint Subcommittee by July 1, 1990. This study should be initiated through a language amendment to the Appropriations Act.*

PRIMARY CARE INITIATIVES

In its 1989 report, the Joint Subcommittee directed the State Department of Health to develop strategies to make primary health care more available. Subsequently, the Board of Health reported that many Virginians do not have a family physician and do not receive basic medical services in their own communities simply because there is no doctor close to their home or they cannot afford to see a doctor. Rural and inner city areas are particularly affected by the growing shortage of primary care physicians.

The consultant to the Joint Subcommittee also pointed out that lack of access to primary care is a fundamental problem for uninsured Virginians. This often leads the uninsured to seek medical care in hospital emergency rooms (or other inappropriate settings) thereby driving up the cost of services. Another factor which is beginning to restrict access is the declining number of physicians practicing in medically underserved areas of the Commonwealth. The following initiatives address these two issues.

Primary Care Physician Supply

A major obstacle in improving access to primary care is the declining number of primary care physicians practicing in medically underserved areas. In 1988, the report of the Joint Subcommittee recommended that the Department of Health (DOH) make recommendations regarding primary care. Pursuant to this request, the Board of Health published the report entitled: "Primary Health Care in Virginia: Strengthening the System, Increasing Access," in August, 1989. In this report, DOH estimates that only 58 physicians graduating from Virginia's Primary Care residency programs each year remain and practice in Virginia. For those physicians who do remain in Virginia, only 11 percent practice in medically underserved areas. Thus, there is a shortage of primary care physicians trained in Virginia, who practice in the areas that need them the most.

A major factor in this dilemma is educational debt. The University of Virginia School of Medicine reports that the average debt of graduates from the Class of 1989 was $31,464. The comparable figure from the Medical College of Virginia is approximately $36,000, while the Medical College of Hampton Roads average debt is $54,225. The result of this debt is that physicians will seek established practice settings which offer the opportunity for financial gain. For this reason, monetary incentives could be used in recruiting primary care physicians and placing them in medically underserved areas.

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Primary care scholarships and physician loan repayments would provide such incentives to increase manpower development and placement. Providing scholarships to medical students expressing the intention to enter primary care practice would attract students for primary care training. Another financial incentive is to assist graduated medical students in repaying their debt, in exchange for practicing in medically underserved areas. This program would also serve the goal of placing primary care physicians in the Commonwealth's underserved areas.

During six years of the Medical Scholarship Program (1978-83), 64 percent of the persons with scholarships repaid their loans with money, rather than practicing in Virginia. The remaining 36 percent remained and practiced in Virginia. Of those who stayed in Virginia, 32 percent (or 11 percent of all students in the program) practiced in medically underserved areas. While many students made use of scholarship funds, the majority chose to repay the debt in money, rather than through service. The possibility of monetary repayment should be minimized in future use of the Medical Scholarship Program.

Another method of encouraging primary care physicians to practice in medically underserved areas is to extend education and training activities of Virginia's medical and health science schools and programs into these areas. Improving the connection between primary care physicians and their peers contributes to a more fulfilling medical environment. The Area Health Education Center Program (AHEC) currently links underserved communities and medical schools together to increase the number of health care professionals practicing in underserved areas. Although the emphasis of AHEC is on medical education, the program also stresses cost containment, support and participation of local health providers and organizations, and patient care management. This program also provides a long term strategy for augmenting state and local partnerships to improve the delivery of primary care services in underserved areas.

In summary, the Joint Subcommittee finds that a series of steps is needed to provide the statutory basis for a strengthened primary care system, and finds that additional funds are needed to expand the supply of primary care physicians in medically underserved areas and to promote innovate approaches to the delivery of primary care.

Recommendation 8. *The Joint Subcommittee proposes legislation to establish a foundation for a new Virginia Primary Health Care System. Such legislation should include a directive to the Board of Health to develop criteria for determining medically underserved areas, as well as authority for funding for the education of primary care physicians and for developing a statewide area health education program. The proposed legislation adds in*

Chapter 4 of Title 32.1, an article numbered 8, consisting of Sections number 32.1-122.5 through 323.1-122.9, Code of Virginia.

Recommendation 9. *The Joint Subcommittee recommends funding for primary care medical scholarships. Recipients would commit to one year of practice in a medically underserved area per year of loan support. Loans in the amount of $10,000 should be granted by the State Health Commissioner to not more than 20 students from each Virginia medical school. The Joint Subcommittee recommends consideration of General Funds for this purpose.*

Recommendation 10. *The Joint Subcommittee recommends funding for primary care physician loan repayments. The program should provide financial assistance (up to $20,000 per year) to primary care physicians through repayment of educational debt. Loan repayment should be granted in return for agreement to practice (for a minimum of two years) in a medically underserved area. The program should provide General Funds to match federal funds and should be administered by the State Department of Health.*

Recommendation 11. *The Joint Subcommittee recommends funding for continuing medical education for primary care physicians in medically underserved areas. A state-wide Area Health Education Center program should offer continuing medical education opportunities to local providers within their community as well as the educational, training, and other support resources of Virginia's health science institutions. The program should be developed in cooperation with the Virginia Health Planning Board and the three medical schools in the Commonwealth. This program would provide funds to match federal grant monies (75% federal/25% state). The Joint Subcommittee recommends consideration of General Funds to be matched with federal funds.*

Public-Private Partnerships

There are a growing number of primary care initiatives under development in the Commonwealth, many of which provide ambulatory care for children. The initiatives generally use one of two approaches, or may combine aspects of both. One approach offers special programs or incentives to increase the use of preventative care through special well-child and medical clinics (Alexandria, Eastern Shore, Hampton, Central Virginia, Southside). Another approach involves the development of organized community networks to provide an array of services using case management and/or HMO mechanisms to encourage and improve access to comprehensive primary care (Roanoke, Fairfax). Both types of initiatives provide excellent models for the target population and exemplify the possibility for successful private/public partnerships.

The Joint Subcommittee heard testimony from the Roanoke District Health Director describing the CHIP, or Comprehensive Health Investment Project, in Roanoke. This program is a public-private partnership involving the local health department, the local medical society, and the business community in the Roanoke Valley. Participating physicians agree to accept children in CHIP whose family incomes are below the federal poverty level. The physicians also agree to accept Medicaid payment rates. The local health department provides case management and transportation to ensure that patients make their appointments and follow their doctors' advice. Staff visited the CHIP program in October, 1989, and also received extensive briefings from local health officials involved in similar programs underway or under consideration across Virginia. The goal of each of these programs is to expand the availability of primary care to families and children.

The Joint Subcommittee encourages the development of local and regional public-private partnerships. Such partnerships should involve the district health departments, the local medical societies, and the business community in developing workable approaches to providing primary care for children and families. A variety of models should be encouraged, recognizing that varying conditions in different regions of the Commonwealth may call for different types of solutions. The recommended approach is to establish a block grant, to be awarded on a competitive basis.

Recommendation 12. *The Joint Subcommittee recommends establishment of a state block grant to support local and regional primary care initiatives. Grants should be awarded competitively and should require demonstration of local financial commitment and emphasis on comprehensive primary care through the development of a public-private partnership. An initial grant from the General Fund is recommended for each year of the 1990-92 biennium.*

PART TWO

LONG TERM CARE FOR THE ELDERLY

LONG-TERM CARE IN VIRGINIA

Long-term care is the system of medical, health, and social services that provides care to those with some level of functional limitation, primarily the elderly. The increased presence of chronic conditions among elderly Virginians, and the growing number of elderly, are creating expanding demand for these services. The elderly population is the segment of our society most in need of long-term care, so the anticipated growth of this population will result in continual demand for long-term care services.

This increasing demand is very apparent in the rise in public expenditures, through Medicaid, for nursing home care. Presently, the emphasis in Virginia's long-term care is on nursing homes. Yet, despite consuming most of the public long-term care budget, nursing home care represents only a small part of needed long-term care services in Virginia. The majority of impaired older Virginians (81 percent) live in the community, while less than one fifth of the impaired reside in nursing homes. Continuing to rely on a system of care favoring institutional care will prove to be unaffordable and inadequate for addressing the range of services needed by the elderly.

In its study, the Joint Subcommittee examined the array of long-term care services available in Virginia and nationally, as well as the reimbursement, organization, and delivery of these services. Long-term care services in Virginia, both public and private, have generally developed independently of one another, with various funding sources, oversight agencies, and delivery systems. This trend has produced a collection of individual services, rather than a comprehensive system of care with a clear policy direction.

Specifically, the Subcommittee on Long Term Care identified the following problems in Virginia's long-term care system as it presently exists:

- A lack of strong leadership at the state level to coordinate services among state agencies;
- A fragmented service delivery system at the local level in most localities;
- Reimbursement rates and funding streams that favor more costly care;
- A lack of state policy on eligibility thresholds for publicly supported programs to provide uniformity; and,

- An inadequate supply of community services.

The following sections of this chapter describe findings and recommendations of the Subcommittee on Long Term Care. Additionally, the Subcommittee adopted the following mission statement to guide the development of a long-term care system in the Commonwealth.

Mission Statement

The number of elderly citizens in the Commonwealth of Virginia is growing rapidly. This growth will continue for some time and will create a continuing demand for long term care. For this reason, there is a need to support the services that *foster opportunities for Virginia's residents to remain independent for as long as possible.* Maintenance of independence requires:

- Maintenance of the family as a primary source of care;
- Availability of community-based services;
- Coordination of services through a comprehensive case management system;
- Use of a single long-term care system to include all Virginians, regardless of ability to pay;
- Use of a sliding fee schedule for those who can pay;
- Establishment of reimbursement policies that support these goals; and,
- Cooperative initiatives between public and private providers.

PROFILE OF VIRGINIA'S ELDERLY

Virginia's older population, those aged 65 years and above, is growing. In 1990 there are about 677,000 Virginians 65 and older. In 20 years, this number will increase by almost 40 percent. The most dramatic increase will occur in the more aged segment of the population; the number of those 85 and older will more than double by 2010. This group is most likely to experience some level of impairment, so the expected increase is particularly significant. The number of elderly persons with impaired ability to perform some daily tasks is expected to increase 68 percent by that time.

The great majority of the 65+ population in Virginia (78 percent) does not experience impairments requiring long-term care services. This leaves about 22 percent with some level of impairment. About 4 percent of the 65 and over population (about 26,950 people) is seriously enough impaired to require nursing home services. Between those requiring complete institutional care and requiring no care are those who need help with self-care tasks such as eating, bathing, and toileting (Activities of Daily Living), and those who need help with household tasks including cooking, handling money, and taking medicine (Instrumental Activities of Daily Living).

Three Planning Districts account for the majority of the impaired elderly: Planning Districts 8, 15, and 20. The study found that by 1990, residents of these three areas will still represent the majority of the impaired elderly in Virginia. However, significant growth relative to the current population of impaired will also occur in Planning Districts 12, 16, and 21.

Most of the 141,343 estimated impaired older Virginians live at home. About 76 percent of the impaired population reside in a home setting, frequently receiving help from family members or other informal care givers. Over 7,600 (5 percent) of the impaired live in homes for adults, and the remainder are cared for in nursing homes.

Several notable trends have occurred over the last 30 years regarding living arrangements of the elderly. A recent federal study found that in 1960 almost one-fifth of the elderly lived alone; in 1984 nearly one-third did so. The proportion of the elderly residing with adult children or other family members declined by almost half, from about 40 percent to 22 percent. The structure and support of the living arrangements of the elderly will influence the needs they experience and the available methods for meeting them.

COORDINATION OF LONG-TERM CARE SERVICES

Long-term care services in Virginia are provided by both public and private providers. Private providers offer nursing home and home for adults services, as well as a variety of in-home services including home health care and personal assistance services. Many of these services are supported with public funds.

Five separate state agencies regulate, reimburse, or provide directly a variety of long-term care services in Virginia: the Department for the Aging, Department of Medical Assistance Services, Department of Social Services, Department of Health, and Department of Mental Health, Mental Retardation, and Substance Abuse Services. In most cases, direct services are provided through local agencies. For example, the Department for the Aging provides all its services (except the Ombudsman program) through local Area Agencies on Aging.

In addition to different delivery and administrative structures, these agencies use multiple and distinct sources of funds. The agencies use varying combinations of state, federal and local funds to support these services. In 1989, a total of $357.7 million was expended in public funds for long-term care services for the elderly.

Virginia's public long-term care services are not well coordinated. Policy and resource allocation decisions are made by individual agencies, and frequently do not reflect the needs of the system as a whole. As a consequence, policies are at times inconsistent or contradictory to the interests of the Commonwealth. For instance, payment rates provide no incentives for construction of homes for adults, although they represent an appropriate and less costly alternative for care for many of the impaired elderly than more adequately reimbursed nursing homes.

The administration and delivery of services is also marked by a lack of uniformity. Income levels determining eligibility for services vary among agencies. One agency places limits below the poverty level, while another provides services to those with incomes well above poverty. Services provided by one agency may not require any eligibility determination, while comparable services in another agency do have such requirements.

PUBLIC LONG-TERM CARE SERVICES IN VIRGINIA

Secretary of Human Resources ---------- **Long Term Care Council**

Department for the Aging

- Provides the following services through the Area Agencies on Aging
  - Information/Referral
  - Case management
  - Transportation
  - In-home services
    - Home care/Companion
    - Homemaker/Personal Care
  - Home delivered meals
  - Congregate Meals
  - Weatherization
  - Day care
  - Home health (one AAA)
- Administers the Long-term Care Ombudsman Program

Department of Medical Assistance Services

- Finances the following services through Medicaid:
  - Nursing homes
  - Home health
  - Personal Care (waiver)
  - Transportation
  - Adult Day Care (waiver)
  - State mental health facilities for elders
  - Respite care
  - Mental retardation facilities

Department of Social Services

- Licenses Homes for Adults
- Finances the Auxiliary Grant Program for:
  - Homes for Adults
  - Adult Family Care
- Through Community Action Agencies, provides:
  - Weatherization
  - Other Aging Services
- Through local social services agencies provides:
  - Nutrition
  - Adult Day Care
  - In-home Services

Department of Health

- Licenses/Certifies Nursing Homes and Home Health Agencies
- Through local health departments provides:
  - In-home services
- Administers the Certificate of Public Need program
- Primarily through Area Agencies on Aging, provides:
  - Respite Care

Department of Mental Health, Mental Retardation, and Substance Abuse Services

- Finances and manages Geriatric Mental Health Facilities
- Through Community Services Boards provides:
  - Case management

Note: Home Repair is administered by the Department of Housing and Community Development

In the absence of coordination, it is difficult to determine and address the varying needs of the different localities. Localities differ both in the number and needs of their impaired elderly, and in the availability of resources. More effective oversight will allow better identification of disparities in local needs and service availability. Additionally, state level coordination may in turn reduce the fragmentation of service delivery which is also apparent at the local level.

The Joint Subcommittee identified the absence of effective coordination of long-term care services at the state level as a major shortcoming of the system as it currently exists. An improved oversight and coordination function must be developed to adequately integrate resource and policy decision of the various state agencies involved in long-term care services

Recommendation 13. *The Joint Subcommittee recommends that methods of providing support to family caregivers be evaluated prior to the 1991 General Assembly..*

Recommendation 14. *The Joint Subcommittee recommends that the Long Term Care Council should provide statewide coordination and oversight of long-term care services and that the activities of the Council should be strengthened by providing the Council with a Director and one staff position The Council, chaired by the Secretary of Health and Human Resources, currently has no staff. The Joint Subcommittee will submit a legislative budget amendment for $125,000 each year and two positions to be located within the Department for the Aging.*

COMMUNITY-BASED CARE

About 78 percent or over 120,000 of Virginia's impaired elderly live in the community. The presence of adequate community-based services enhances the quality of life for those who would not qualify for nursing home care. For those who would be eligible for nursing home admission, based on their level of impairment, the availability of these services may delay or prevent their entry into a nursing home. In both cases, community-based care is fundamental to the goal of fostering opportunities for Virginia's elderly to remain independent for as long as possible.

Public funds, including Medicaid, are used to support several categories of community care, including in-home care and care provided in supervised settings, such as adult day care. Other services include personal care, home health, companion, chore, and home-maker services. Additionally, the Commonwealth supports respite care in certain areas. Respite care provides temporary relief for family members who care for an elderly, impaired person at home.

The Subcommittee on Long Term Care reviewed the administration and delivery systems used for community-based care in nine other states. Some states, including Oregon and Georgia, use Area Agencies on Aging as the designated local case management agencies. Others use local social service agencies or local offices of state agencies, and one state selects the local agency using a competitive bidding process. The study also examined the degree of state control of local programs. Several states maintain strong state control; the others ranged from moderate to minimal control. The trend in terms of the state role is toward tighter state control of local program management.

The study also examined the different services and funding sources. All the states reviewed have a core set of services similar to those found in Virginia, and also use a combination of state, federal, local, and private funds. Within these similarities there are a variety of different approaches.

Families and informal care givers remain the major source of care for the non-institutionalized impaired elderly. The Joint Subcommittee recognizes the significant contribution provided by the family, and endorses the maintenance of the family as the primary source of care. However, it also acknowledges that services that will assist the family to continue to provide care, such as respite care and care giver training, are necessary elements of the community care system.

STATE OF VIRGINIA
SUPPORT FOR LONG-TERM CARE SERVICES FOR THE ELDERLY
1988

DEPARTMENT	FEDERAL	STATE	LOCAL	TOTAL
AGING				
Nutrition	$8.7	$1.4	$1.8	$11.9
Companion	$0.9	$1.0	$0.8	$2.7
Transportation	$2.0	$1.0	$0.7	$3.7
Subtotal				$18.3
SOCIAL SERVICES				
Auxiliary Grants		$7.1	$1.4	$8.5
In-Home/Adult Day Care	$2.8	$3.0	$1.4	$7.2
Subtotal				$15.7
MEDICAL ASSISTANCE				
Nursing Homes	$124.0	$124.0		$248.0
Personal Care	$9.8	$9.8		$19.6
Home Health	$4.7	$4.7		$9.4
State Geriatric Mental Health	$16.4	$15.6		$32.0
Subtotal				$309.0
MH, MR & SA				
State Geriatric Mental Health		$8.5		$8.5
Subtotal				$8.5
HEALTH				
Home Health/ Personal Care		$3.3	$2.4	$5.7
Respite Care		$0.3		$0.3
Subtotal				$6.0
TOTAL	$169.3	$179.7	$8.5	$357.5

Case Management

Although many long-term care services are available in most communities, the delivery of these services is often fragmented. As noted previously, different agencies provide different services and often use varying eligibility requirements. The degree of agency coordination at the local level varies. Some localities appear to have enviable systems of coordinated care, some are significantly weaker. For the client or the client's family, the fragmentation frequently means learning the services and requirements of multiple agencies, identifying available services without central guidance, and spending considerable time and effort making the pieces fit together.

Case management helps people identify appropriate services and provides assurances that services are provided. It can also assist in managing resources, by assuring that the least costly services appropriate to the needs of the client are used. Presently case management is offered in some localities and is also offered to a limited extent to clients eligible for Medicaid nursing home pre-admission screening.

The Joint Subcommittee concluded that the expansion of community-based services will not be effective in promoting independence for the long-term care population unless it is accompanied by a case management system able to coordinate care for individual recipients.

The case management approach that is recommended includes the following characteristics:

- Case management should be comprehensive – all Virginians should be eligible for services;

- A sliding fee schedule should be required for those who can afford to pay;

- Case managers should act as brokers for all long-term care services. In this role, they will assess the client's needs, identify appropriate services, and assist the client in receiving them. This will include both initial and ongoing contact, to monitor current needs;

- Case managers should seek to match clients with the most cost effective care appropriate to their needs;

- All long-term care services should be part of the network of services to be used, as appropriate, in the case management process;

- Case management services should be provided by local private or public agencies that meet state-wide standards. One agency should oversee the delivery of case management services in each locality; and,

- A common patient assessment instrument should be used throughout the Commonwealth.

Additionally, to implement a comprehensive community-based program, a state-wide data system will be required. The data system will provide local agencies with comprehensive information to assist with case management. On a state level, the data will be used to provide additional information about the availability of community services. Efforts to identify and address gaps in service will depend in part on the information gathered through the data system.

Recommendation 15. *The Joint Subcommittee recommends the establishment of six pilot projects for long term care case management in the second year of the biennium. A total of $4.4 million will be requested for this initiative.*

The Long-Term Care Council will be responsible for setting policies and implementation standards for the case management projects. The Department of Medical Assistance Services will be the designated state agency responsible for implementing case management including evaluating and monitoring case management activities, carrying out policy and standards, and managing data bases. The pilot project grants will be awarded to regional entities, which will be responsible for local level operations.

The Council will be guided by the following principles in the development of this program:

a.) All elderly citizens should be eligible for services on a sliding fee basis;

b.) The use of Medicaid funds should be optimized;

c.) Case managers should serve as brokers for all private and public services in long-term care;

d.) The program should promote public/private partnerships;

e.) A uniform assessment tool which is incorporated into a statewide data base should be used;

f.) The program should be responsive to varying local demands; and,

g.) The most cost-effective forms of care should be used.

NURSING HOMES

Nursing homes provide care for about 18 percent of Virginia's impaired elderly. For the most severely disabled, nursing homes are the most appropriate and cost-effective placement.

Concern about the significant and increasing expenditures by the Commonwealth for nursing home care in part prompted Senate Joint Resolution 99 in 1988 and SJR 214 in 1989. The state plays a large role in the financing of nursing home care through Medicaid. As a result, discussion about what role the state should play in regulating the growth of nursing homes has received considerable legislative attention, in the interest of both containing escalating expenditures for nursing homes and shifting emphasis to home and community-based care.

In 1986, the Governor's Commission on Medical Care Facilities Certificate of Public Need was established to examine the effectiveness of the Certificate of Public Need (COPN) program at controlling health care costs, availability of services, and access to those services. The commission recommended partial deregulation of hospitals, including deregulation of the purchase new equipment and the addition of new clinical services. However, the commission recommended COPN be retained for nursing homes. In 1988, the General Assembly approved a moratorium on nursing home construction, effective July 1, 1988 through January 1, 1991.

The Joint Subcommittee has not come to a resolution concerning the effectiveness of COPN at containing health care costs. However, the Subcommittee has a continued interest in controlling nursing home growth and in promoting expansion of other long term care services. Therefore, until it is possible to determine the effectiveness of COPN, the Joint Subcommittee recommends continuation of the moratorium to allow expansion and funding of other long-term care services.

Recommendation 16. *The Joint Subcommittee recommends that the moratorium on the issuance of Certificates of Public Need for nursing homes be extended from January 1, 1991 to June 30, 1991, so that this issue can be more fully addressed by the 1991 General Assembly.*

Recommendation 17. *The Department of Health should conduct a study of the Certificate of Public Need nursing home bed need methodology to be completed by September 1, 1990.*

HOMES FOR ADULTS

About five percent of Virginia's impaired elderly population lives in a home for adults. These facilities provide maintenance and supervision, including room, meals, housekeeping, laundry, and some degree of personal assistance to residents (e.g. help bathing, dressing, getting in and out of bed, taking medications, and arranging transportation). Homes for adults are appropriate residences for people who may require some supervision and assistance but who do not need the extensive medical services and supervision provided by a nursing home. The homes are licensed by the Department of Social Services. Public funding for eligible residents is provided through the Auxiliary Grant Program, also administered by the Department of Social Services.

While the Joint Subcommittee recognized that homes for adults play a vital role in serving the elderly and disabled, concerns were expressed about the quality of the care currently being provided residents of these facilities. This is not a new concern. A number of reports have been completed in the past ten years which have addressed the homes for adults system. While the earlier studies focused upon the quality of care being provided in licensed homes and made recommendations to change licensure and auxiliary grant procedures, recent studies have focused upon the additional service needs of the mentally disabled and elderly populations, and how best to restructure the current system to address those needs.

Specifically, while homes for adults are licensed to provide basic room and board and general supervision, many residents of these homes require additional services to meet their health and mental health needs. How to restructure the licensure and reimbursement systems to address client needs has been a source of debate. The Department of Mental Health, Mental Retardation and Substance Abuse Services recently completed a study on how to address the mental health needs of this population. However, how to restructure the system to meet the health needs of the elderly is unresolved.

Expansion of community services which may enable the impaired elderly to delay or totally avoid nursing home placement is a priority of the Joint Subcommittee. For this reason, the Joint Subcommittee has developed several recommendations regarding homes for adults.

Recommendation 18. *The Joint Subcommittee has asked the Joint Legislative Audit and Review Commission to conduct a follow-up study of its 1979 report on this issue. The study will include a review of current licensing and monitoring systems, reimbursement under the Auxiliary Grant Program, and an assessment of the health and mental health needs of homes for adults residents.*

Recommendation 19. *The Joint Subcommittee recommends that licensing of homes for adults be transferred from the Department of Social Services to the Department of Health, effective July 1, 1991. This transfer will consolidate the licensing for hospitals, nursing homes and homes for adults within a single agency.*

To prepare for this transfer, the Department of Health and the Department of Social Services should develop a transition plan, to be completed by October 1, 1990.

LONG-TERM CARE INSURANCE

By the year 2000, more than eight million Americans over age 65 will need some form of care. This represents a 56 percent increase from 1980. The Joint Subcommittee believes the development of long-term care insurance may offer a potential source of coverage for the elderly. Interest has been stimulated by the dramatic increase in the availability of long-term care insurance products in the last decade. The number of companies selling long-term care insurance policies increased from 16 in 1984 to more than 100 in 1988. The number of long-term care insurance policyholders also has grown from 150,000 in 1986 to more than one million by the end of 1988. Of the policies sold, 83 percent are individual policies, six percent are employer group plans, and three percent are Continuing Care Retirement Community plans. Of these, over 20,000 people are now covered by employer-sponsored plans

However, recent analysis of available policies indicates that, generally, they do not offer a comprehensive source of coverage for the elderly. An analysis of 77 private long-term care insurance plans and options offered by 21 companies in Virginia, Maryland and the District of Colombia (April-July, 1988) revealed that more than 80 percent of the options have severe restrictions for nursing home coverage. Moreover, two-thirds of the companies do not offer inflation protection. Thus the role of long-term care insurance and its potential as a comprehensive source of coverage is still in question.

Under planning grants from the Robert Wood Johnson Foundation, several states are currently investigating the potential for a public-private insurance partnership in financing long-term care. These states are developing strategies to encourage the development of private insurance products for those who can afford them, to subsidize those who cannot afford them, and to assure coordination with programs that are publicly funded. In developing strategies, several issues must be addressed:

- Consumer awareness -- The elderly must be informed about the limits of Medicare coverage and appropriate long-term care options for the best coverage.

- Development of actuarial data -- States and insurers need to work together to develop a data base that can be used to predict future utilization patterns.

- Policy Design and Consumer Protection -- Policies must assure product renewability. Current policies range from optionally renewable to non-cancelable.

- Regulation -- The need exists for a positive regulatory environment at both the state and federal level in developing long-term care insurance. States can devise procedures for buyer protection to assure fair rates and protection against unscrupulous sellers, and these procedures should be balanced by a regulatory framework that will encourage expanded marketing.

The Joint Subcommittee recognizes the potential benefit of long-term care insurance for the elderly and encourages development and implementation of policies which cover nursing home and community based care.

Recommendation

Recommendation 20. *The Joint Subcommittee encourages the State Corporation Commission to support coverage of community-based care in long-term care insurance policies.*

MEDICAID – PUBLIC FINANCIER OF SERVICES FOR THE ELDERLY AND DISABLED

In Virginia, like the rest of the nation, Medicaid is the major financier of long-term care for the elderly and disabled. While much public debate in Virginia has been focused upon her, this program should be refocused to emphasize community-based services over institutional services, one major eligibility issue still remains unresolved.

Specifically, Virginia is one of a few states which choose to enforce more restrictive resource limits than required by the federal Supplemental Security Income (SSI) program. The major restrictions affect elderly and disabled persons who have contiguous property valued over $5,000 and institutionalized persons who do not choose to sell their home after six months of placement.

A Federal Court ruling on October 25, 1989, and current language in OBRA '89 eliminate the more restrictive resource methodology used by Virginia under the 209(b) option. Medicaid eligibles would increase by approximately 12.5 percent, or 20,000 people, according to the Department of Medical Assistance Services, at a cost of $35.2 million to the Commonwealth during the 1990-92 biennium. The Federal Court decision is currently being appealed by the Commonwealth.

Recommendation

Recommendation 21. *The Joint Subcommittee recommends considering expansion of Medicaid 209(b) eligibility beginning in July, 1990.*

CONCLUSION

Health care is one of the most difficult challenges facing state governments in the 1990's. The General Assembly will continue to be faced with the dilemma of balancing the public's interest in improving the quality of health care, expanding access to health care, and controlling the cost of care. It is the conclusion of the Joint Subcommittee that these three factors can never completely be achieved at the same time. Instead, these and other competing goals must be balanced and adjusted each year on an incremental basis. At this time, it is not expected that the federal government will provide a comprehensive solution at the national level, so the states must act to develop their own solutions.

In an aging society, there is no question that the cost of health care will continue to rise. In fact, if current trends continue, the share of our Gross National Product (GNP) devoted to health care will likely rise to 15 percent by the end of the century. Nevertheless, there is much we can do at the state level to manage health care costs, expand access, and improve quality.

This report has suggested several steps, which constitute the second phase of the Joint Subcommittee's work. Fundamental to the Joint Subcommittee's recommendations are the beliefs that all parts of society should contribute to the care of those whose family incomes fall below the poverty line, and that the Commonwealth must share in that commitment. Also, for those who are able to pay for their own care, sliding fees should be required so that public funds are reserved for those least able to pay. For health insurance, we should encourage lower-cost coverage through the workplace, and for long term care, we should encourage the family care-givers who help the elderly remain in their own homes for as long as possible. The state government should help provide a level playing field among providers, create incentives for less costly and more appropriate care, encourage case management, and provide adequate funding for essential services.

During the coming year, the Joint Subcommittee will confront several very controversial issues, including the future of the Certificate of Public Need program, the need for additional contributions to the trust fund, the need for additional long term care services, including a methodology to balance the need for nursing home beds and other, less costly forms of care, and a variety of reimbursement issues. In order to provide sufficient time to address these issues, Senate Joint Resolution 118 continues the study for two additional years, with a final report due to the General Assembly by 1992.

APPENDIX A

SUMMARY OF 1989 LEGISLATION, AS ADOPTED

- SB 759/HB 1858 State Local Hospitalization
- SB 760/HB 1859 Indigent Health Care Trust Fund
- SB 761/HB 1860 Health Services Cost Review Council
- SB 762 Certificate of Public Need
- Senate Joint Resolution 214 (Continuation of the study)
- Senate Joint Resolution 215 (Health Insurance Mandates)

STATE-LOCAL HOSPITALIZATION
(SB 759/HB 1858)

Key Points

- Administration. The State-Local Hospitalization (SLH) program is moved from the Department of Social Services to the Department of Medical Assistance Services, effective July 1, 1989.

- Local Participation. All localities will be required to participate in the SLH program.

- Services. A standard set of services will be covered statewide, including impatient, outpatient, and emergency room services.

- Eligibility. Local Departments of Social Services or Welfare will determine eligibility, which is already the case in most localities. However, under the new legislation, eligibility criteria will be made uniform across the state. Persons whose family income is below the federal poverty level will qualify for SLH, with one restriction. In order to qualify, their net countable resources must fall below current resource standards. Also, any locality which has already adopted an income eligibility standard which is higher than the federal poverty level will be permitted to maintain the higher standard.

- Local Allocations. Each year the Director of the Department of Medical Assistance Services will allocate available funds to each locality on the basis of the estimated total cost of required services in each city or county, less local funds.

- Local Matching Rate. Each locality will contribute up to 25 percent of the cost of SLH services. The actual local percentage will vary according to a new revenue capacity formula, adjusted for local per capita income. This formula was recommended by JLARC.

- Appropriations. The Appropriation Act includes $4.0 million in General Funds for fiscal 1990 to cover the cost of the new formula for determining local shares. Overall, the state will now pay about 80 percent of the SLH program. Currently, the state share is only 75 percent.

INDIGENT HEALTH CARE TRUST FUND
(SB 760/HB 1859)

Key Points

- **Creation of the Fund.** A new Indigent Health Care Trust Fund is created as of July 1, 1989. An initial General Fund contribution of $8.9 million is included in the budget for fiscal 1990. Hospital contributions, which will be assessed annually beginning in December, 1990, are estimated to be $5.9 million. This will create a total fund of $14.8 million.

- **Purpose.** The purpose of the fund is to reimburse hospitals for part of the cost of charity care, which is defined as hospital care for which no payment is received and which is provided to any person whose annual family income is equal to or less than 100 percent of the federal poverty level ($11,650 for a family of four in 1988).

- **Administration.** The fund is to be administered by the Board and Department of Medical Assistance Services. A technical advisory panel will be appointed to recommend policies and procedures to the Board.

- **Contributions.** Some, but not all, hospitals will make contributions to the Trust Fund -- based on the amount of charity care they provide. Proprietary hospitals will receive a credit for the amount of state corporate taxes they actually pay. No hospital will pay more than 6.25 percent of its operating margin (the excess of income over expenses).

- **Payments.** The remaining hospitals will receive a payment from the Trust Fund. The first payments will be made in January 1991. Payments will be made for charity care provided in excess of the median amount, but will be adjusted by each hospital's cost to charge ratio. The Trust Fund will then pay up to 60 percent of these charity care costs.

- **Disproportionate Share.** A Disproportionate Share Level is established, which will be no more than three percentage points above the median level of charity care. Payments for charity care provided above this Disproportionate Share Level will be made entirely from General Funds. Payments for charity care provided above the median but below the Disproportionate Share Level will be shared equally between the General Fund and hospital contributions.

- Limitations. The Trust Fund is not an entitlement program. For those person whose family incomes are above the Medicaid eligibility levels, but below the federal poverty level, the State-Local Hospitalization program will be the payer of first resort, within the limits of funds appropriated. After the SLH funds are exhausted, the Trust Fund becomes the payer of last resort -- within the limits of funds available.

- Adjustment of Charity Care. A language amendment is included in the Appropriation Act which requires the Board of Medical Assistance, with the help of the technical advisory panel, to study the feasibility of adjusting the definition of charity care to account for variation in the cost of living in various regions of the state. The report is due by November 1, 1989.

- Fiscal Year. The Trust Fund will initially pay for charity care provided during each hospital's most recent fiscal year ending during the twelve month period from July 1, 1989 through June 30, 1990.

HEALTH SERVICES COST REVIEW COUNCIL
(SB 761/HB 1860)

Key Points

- **Hospital Audits.** Each hospital (or corporation which controls the hospital) will be required to submit a comprehensive annual audit of its financial operations, detailing its total assets, liabilities and net worth, as well as a statement of income and expenses, including all of its affiliates.

- **Nursing Home Reporting.** Nursing homes will be brought under the prospective budget reporting system of the Council. This system now applies only to hospitals. Additional expenses incurred by the Council in implementing this system will be paid from special revenues generated by a new fee (an amount no greater than eleven cents per patient day) imposed on nursing homes. These special revenues are included in the Governor's proposed budget bill.

- **Paperwork Reduction.** It is the intent of this legislation that data and forms used by other state agencies receiving similar information shall be used in order to eliminate duplicate reporting and reduce the administrative and financial burden of compliance to the absolute minimum.

- **Composition of the Council.** The size of the Council is increased from eleven to fifteen members. The Director of the Department of Medical Assistance Services is added, along with three representatives of the nursing home industry.

- **Executive Director.** The Council's executive director is to be appointed by the Governor instead of by the Council.

CERTIFICATE OF PUBLIC NEED
(SB 762)

Key Points

- Hospital Deregulation (July 1, 1989). Hospital decisions to acquire new equipment or add new services will no longer be subject to review by the Commissioner of Health under the Certificate of Public Need (COPN) statute, as of July 1, 1989. Similar services provided on an outpatient basis in the community (such as outpatient renal dialysis, radiation therapy, and computerized tomography scanning) will also be deregulated as of July 1, 1989.

  However, upon initiating a new clinical health service or upon acquiring any new medical equipment costing $400,000 or more, any medical care facility, licensed hospital, or physician's office shall register the new services or equipment with the Commissioner.

  Specialized centers or clinics for provision of radiation therapy, magnetic resonance imaging, computerized tomography scanning, positron emission tomography scanning, lithotripsy, cardiac catheterization, open heart surgery, or such other treatment procedures as are designated by the Commissioner, shall register and provide periodic data on patient volumes, morbidity and mortality, aggregate costs and charges the services provided.

  The following types of facilities and changes in services will still be regulated under COPN:

  Outpatient or ambulatory surgery centers, and psychiatric and rehabilitation hospitals will still require COPN approval.

  No hospital will be permitted to convert hospital beds to nursing home beds for a period of more than thirty days, in order to maintain a level playing field with the nursing home industry during the COPN moratorium.

  Facilities of the Department of Mental Health, Mental Retardation and Substance Abuse Services are exempt from COPN review, along with any nonhospital substance abuse residential treatment program operated by or contracted primarily for the use of a Community Services Board.

- **Hospital Deregulation (July 1, 1991).** General hospitals and outpatient or ambulatory surgery centers will no longer be subject to COPN review as of July 1, 1991, except with respect to the establishment of nursing home beds in general hospitals.

- **Nursing Home Moratorium.** The moratorium on approval of new nursing home beds is extended until January 1, 1991. The Commissioner of Health may not accept COPN applications for new beds during the moratorium.

  Capital projects for renovation or replacement which are required to comply with life safety codes, licensure, certification, or accreditation standards will continue to be exempt from this moratorium.

  Also exempted are projects to convert existing licensed beds to skilled nursing beds when the following three conditions are met:

  (1) The number of beds to be converted does not exceed 20 or 10 percent of the beds in the facility;

  (2) The facility demonstrates that the skilled care beds are needed specifically to serve a specialty heavy care patient population, such as ventilator-dependent and AIDS patients and that such patients otherwise will not have reasonable access to such services in existing or approved facilities; and,

  (3) The facility further commits to admit such patients on a priority basis.

- **Study of Deregulation.** The Secretary of Health and Human Resources is to report by November 1, 1990, on the impact of deregulation. The report is to address the accessibility, affordability and quality of health care, including, but not limited to:

  An analysis of changing federal, state and third party reimbursement of health care providers and the impact of such changes on the economic viability of providers;

An analysis of the effects of the deregulation steps adopted as of July 1, 1989, on price competition and affordability; and,

An analysis of the effect of deregulation on the budget of the Commonwealth.

This report is to be submitted to the House Committee on Health, Welfare and Institutions, and the Senate Committee on Education and Health, and the Joint Subcommittee on Health Care For All Virginians.

These committees will review the report and make recommendations to the General Assembly by January 1, 1991, as to whether the provisions of this act shall expire July 1, 1991, or whether this act shall continue to be effective in whole or in part.

SENATE JOINT RESOLUTION NO. 214

Continuing the joint subcommittee on health care for all Virginians.

Agreed to by the Senate, February 23, 1989
Agreed to by the House of Delegates, February 21, 1989

WHEREAS, the joint subcommittee on health care for all Virginians was created by Senate Joint Resolution No. 99 and House Joint Resolution No. 78 of the 1988 General Assembly; and

WHEREAS, the joint subcommittee met six times during the 1988 interim and conducted a detailed review of the major issues facing the Commonwealth in the field of health care finance, including the projected increase in the Medicaid budget, new federal mandates contained in the Medicare Catastrophic Coverage Act of 1988, the extent to which Virginians are not covered by health insurance, indigent hospital care, primary care, long-term care for the aging, the Certificate of Public Need program, and other issues which will have significant fiscal impact over the next several years; and

WHEREAS, the joint subcommittee has submitted an interim report to the 1989 General Assembly outlining a series of steps to begin to address these concerns; and

WHEREAS, the diversification, corporate realignment, and financial reorganization of the Blue Cross/Blue Shield Plans have caused continuing concern over the effects of such on the Plans' subscribers; and

WHEREAS, many are concerned that the premiums being paid by subscribers of the Blue Cross/Blue Shield Plans are being used to subsidize the for-profit activities of such Plans; and

WHEREAS, although the rates of their individual plans are subject to the State Corporation Commission oversight, the rates of their group plans are not, and it is important that the citizens of the Commonwealth be guaranteed that the premiums that they are paying for their insurance coverage are relevant to the benefits being provided; and

WHEREAS, the joint subcommittee recognizes that these issues are of such magnitude and complexity that further study and recommendations are required; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the joint subcommittee on health care for all Virginians is continued. The current membership of the joint subcommittee shall continue to serve, with the addition of three members to be appointed as follows: one member of the Senate Committee on Finance to be appointed by the Senate Committee on Privileges and Elections, and two members of the House of Delegates at-large to be appointed by the Speaker of the House. Vacancies shall be filled in the manner in which the original appointments were made.

The joint subcommittee's deliberations shall include the following:

1. The appropriate role of the Certificate of Public Need program and the need for procedural and administrative changes in this program as well as other improvements to the statewide health planning process, including, but not limited to:

a. Determination of the appropriate role for the Certificate of Public Need program in the regulation of both psychiatric and rehabilitation hospitals, and in the regulation of the conversion of hospital beds to nursing home beds; and

b. Determination of an effective methodology for projecting future needs for long-term care services, including nursing home beds, and steps to ensure executive and legislative review of the fiscal and programmatic impact of proposed nursing home beds before they are approved, and consideration of cost-effective alternative programs such as home and community based care;

2. Appropriate steps to strengthen the statewide planning, coordination and management of long-term care services in the Commonwealth;

3. Appropriate methods to make private health insurance more affordable for working Virginians including a social and financial impact analysis of mandated health care benefits, and other cost-containment initiatives and incentives;

4. Appropriate ways to expand primary care services for the uninsured population and in medically underserved areas, including potential roles and responsibilities for local health departments in cooperation with other public and private entities in the health care industry and in the medical community;

5. Monitoring, evaluation, and refinement as needed of the interim steps as recommended to the 1989 General Assembly, and determination of further initiatives as needed to finance uncompensated hospital care, including the appropriateness of receiving contributions from other entities into the Virginia Indigent Health Care Trust Fund;

6. Assessment of the need for further enhancements and the potential for further

cost-containment steps in the Medicaid program; and

7. Determine the feasibility of subjecting the rates of Blue Cross/Blue Shield Plans to prior approval. The joint subcommittee shall also review the interlocking directorships of the boards of directors of the Blue Cross/Blue Shield Corporation, its holding company and all affiliates of the holding company to ascertain the impact of such corporate alignment on premiums paid by subscribers, the relevance of premiums to benefits, and whether premiums paid by subscribers are being used to subsidize for-profit activities of the Plans and the Bureau of Insurance of the State Corporation Commission will assist the joint subcommittee with the preparation of this report and shall report its findings and recommendations by December 1, 1989; and

8. Such other related matters as the joint subcommittee may deem appropriate.

Staff support for the joint subcommittee shall be provided by the staff members of the Senate Committee on Finance and the House Committee on Appropriations.

All agencies of the Commonwealth shall provide assistance upon request as the joint subcommittee may deem appropriate.

The joint subcommittee shall complete its work in time to submit its findings and recommendations to the Governor and the 1991 General Assembly as provided in the procedures of the Division of Legislative Automated Systems for processing legislative documents.

The indirect costs of this study are estimated to be $15,860; the direct costs of this study shall not exceed $18,360.

SENATE JOINT RESOLUTION NO. 215

Requesting the Bureau of Insurance of the State Corporation Commission, with the assistance of the Department of Health, to study mandated benefits and providers, and recommending a one-year moratorium on the adoption of any additional mandated health insurance benefits and providers.

Agreed to by the Senate, February 23, 1989
Agreed to by the House of Delegates, February 21, 1989

WHEREAS, the joint subcommittee on Health Care For All Virginians was created by Senate Joint Resolution No. 99 and House Joint Resolution No. 78 of the 1988 General Assembly; and

WHEREAS, the joint subcommittee has requested that it be extended for further study of several issues, including the disturbing fact that 880,000 Virginians, more than two-thirds of whom live in households in which at least one family member is currently employed, are not covered by any health insurance of any kind, either public or private; and

WHEREAS, the joint subcommittee has determined that further study is needed to address this situation through determination of appropriate steps to make private health insurance more affordable for working Virginians; and

WHEREAS, the joint subcommittee recognizes that a growing number of mandated health insurance benefits and health care providers are required under Title 38.2, Chapters 34 and 42, of the Code of Virginia, to be included in both commercial and Blue Cross/Blue Shield health insurance plans; and

WHEREAS, the joint subcommittee is concerned that additions to such mandated benefits and providers may have the effect of significantly increasing the cost of health insurance to the consumer; and

WHEREAS, many large employers, including the Commonwealth of Virginia, have chosen in recent years to move towards self-insurance, and are therefore not governed by the mandates contained in state law, and as a result the additional costs imposed by such mandates may fall disproportionately on small businesses and their employees; and

WHEREAS, the joint subcommittee anticipates that legislation may be proposed during the 1989 General Assembly to mandate additional benefits and providers, which would further increase the cost of private health insurance for working Virginians; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Bureau of Insurance of the State Corporation Commission, with the assistance of the Department of Health, is requested to study the social and financial impact of all current and proposed mandated benefits and providers, including recommendations to make private health insurance more affordable for working Virginians. In addition, the Joint Subcommittee on Health Care for All Virginians recommends the adoption of a one-year moratorium on the approval of any additional mandated benefits and direct reimbursement to providers pending completion of the study by the Bureau of Insurance.

The Bureau of Insurance shall complete its work in time to submit its findings and recommendations to the Governor and the General Assembly by September 1, 1989, as provided in the procedures of the Division of Legislative Automated Systems for processing legislative documents.

A True Copy, Teste:

J. T. Shropshire

Clerk of the Senate

APPENDIX B

SENATE JOINT RESOLUTION 118 OF 1990, AS ENGROSSED

LD4144137

SENATE JOINT RESOLUTION NO. 118

Offered January 23, 1990

Continuing the Joint Subcommittee on Health Care for All Virginians as the Commission on Health Care for All Virginians.

Patrons–Walker, Schewel and Holland, C.A.; Delegates: Quillen, Ball, Heilig, Glasscock, Stambaugh and Marshall

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Referred to the Committee on Rules

WHEREAS, the issues associated with health care are among the most complex and difficult issues of the 1990's; and

WHEREAS, these issues require that the Commonwealth develop a balanced approach to the conflicting goals of improving the quality of health care, expanding access to necessary health care, and controlling the costs of such care; and

WHEREAS, advancements in medical technology have raised the expectations of the public in terms of access to sophisticated and expensive diagnostic and treatment modalities; and

WHEREAS, health care issues include rapidly increasing costs in both the public and private sectors; for example, the rising costs of health insurance and the burden these costs impose on employers and employees, and the escalating expenditures for Medicare and Medicaid; and

WHEREAS, concerns have also been expressed about the substantial operating losses which have been incurred by inpatient hospitals in the Commonwealth in the last several years and the need to analyze the factors affecting hospital operating margins in order to determine whether commitment of additional public funds is warranted to address these concerns; and

WHEREAS, new federal mandates will expand eligibility for Medicaid to include pregnant women and children up to age six in families with incomes up to 133 percent of the federal poverty level in April of 1990; and

WHEREAS, the Joint Subcommittee on Health Care for All Virginians was created by Senate Joint Resolution 99 and House Joint Resolution 78 of 1988 and continued by Senate Joint Resolution 214 of 1989; and

WHEREAS, The Joint Subcommittee has submitted an interim report to the 1990 General Assembly which recommends steps to increase access and affordability of health insurance and primary health care and to strengthen the coordination and delivery of long term care; and

WHEREAS, the Joint Subcommittee is required to submit a final report to the Governor and the General Assembly in 1991; however, many difficult issues remain to be resolved; and

WHEREAS, the continuing study involving both the legislative and executive branches of government in the Commonwealth and providing opportunity for input from the provider and business communities is essential to enable Virginia to manage costs while responding to the changing health care needs of her citizens in the 1990's; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Subcommittee on Health Care for All Virginians is hereby continued until 1992 as the Commission on Health Care for All Virginians which shall consist of twenty-two members. The membership of the Commission shall remain as established in Senate Joint Resolution 214 of 1989. In order to assure continuity, the members so appointed shall be requested to continue to serve, notwithstanding any resignation or failure to seek reelection or reappointment to the office which was the basis of such members' appointments to the Joint Subcommittee in 1989. However, in addition to the original members appointed pursuant to the enabling resolutions of 1989, the duly appointed Secretaries of Health and Human Services and Finance shall be members of the Commission. Any vacancies shall be

filled as originally provided in the enabling resolutions.

In its deliberations, the Commission shall examine:

1. The feasibility of expanding the Virginia Indigent Health Care Trust Fund through adding contributors or covered services and the efficacy of consolidating the Trust Fund and the State/Local Hospitalization program.

2. The need for providing assistance to certain hospitals in order to preserve access to acute care in isolated areas of the Commonwealth.

3. Health insurance issues including, but not limited to, incentives for businesses to offer health insurance to their employees, ways to assure that health insurance is provided for children by absent parents as an essential component of child support orders, the impact of mandated insurance benefits and providers and a process for evaluating the social and financial effects of these mandates, and ways to encourage the availability of private long term care insurance which covers institutional and community-based care.

4. Medicaid issues including, but not limited to, the impact of new federal mandates on reducing the numbers of uninsured Virginians and improving their health, the concept of managed care and its effects on access and costs, the relationship between recent expansions of Medicaid eligibility and initiatives to expand the role of local health departments in the delivery of primary care for families with children, and Medicaid reimbursement for physicians' services, hospitals, and nursing homes.

5. Long term care issues including, but not limited to, services that foster independence for as long as possible, the need to recognize the family as the primary source of care for elderly Virginians and to identify methods to increase support of family care givers, the development of pilot programs to ensure appropriate types and levels of services to elderly Virginians, eligibility for and the level of auxiliary grants for residents of homes for adults, and the efficacy of making case management available to all elderly Virginians on a sliding fee basis.

6. Issues related to the Certificate of Public Need Program including, but not limited to, a review of the current methodology for projecting the need for new nursing facility beds, recommendations for this methodology, and the future of the COPN program in Virginia.

Staff support shall be provided to the Commission jointly by the personnel of the Senate Committee on Finance, the House Committee on Appropriations, and the Division of Legislative Services.

The Commission shall submit its interim findings and recommendations to the Governor and the 1991 Session of the General Assembly and shall submit its final report to the 1992 Session of the General Assembly. Both reports shall comply with the procedures of the Division of Legislative Automated Systems for processing legislative documents.

The indirect costs of this study are estimated to be $ 23,950; the direct costs shall not exceed $34,200.

Official Use By Clerks	
Agreed to By The Senate	**Agreed to By The House of Delegates**
without amendment ☐	without amendment ☐
with amendment ☐	with amendment ☐
substitute ☐	substitute ☐
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Date: _____	Date: _____
Clerk of the Senate	Clerk of the House of Delegates

APPENDIX C

PROPOSED LEGISLATION FOR 1990

SUMMARY OF 1990 LEGISLATION

Bill Number	Purpose of Bill
SB 478/HB 1,106	Creates Advisory Commission on Mandated Health Insurance Benefits
SB 479/HB 1,107	Requires insurance industry reports on cost of state-mandated health insurance benefits
SB 480/HB 1,108	Authorizes low-cost health insurance products with an exemption from most state mandates
SB 481/HB 1,109	Adds three business representatives to the Technical Advisory Panel of the Indigent Health Care Trust Fund
SB 482/HB 1,110	Makes technical changes to trust fund
SB 483/HB 1,111	Authorizes primary care program
SB 484/HB 1,112	Extends moratorium on COPN for nursing home beds until June 30, 1991
SB 485/HB 1,113	Transfers licensing of Homes for Adults from Department of Social Services to Department of Health (Carried over until 1991)
SJR 118	Continues study as Commission on Health Care for all Virginians, until 1992

1990 SESSION

LD2760137

SENATE BILL NO. 478
AMENDMENT IN THE NATURE OF A SUBSTITUTE
(Proposed by the Senate Committee on Education and Health on February 1, 1990)
(Patron Prior to Substitute–Senator Holland, C. A.)

A BILL to amend the Code of Virginia by adding in Title 9 a chapter numbered 34, consisting of sections numbered 9-297 through 9-300, relating to the Special Advisory Commission on Mandated Health Insurance.

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Title 9 a chapter numbered 34, consisting of sections numbered 9-297 through 9-300, as follows:

CHAPTER 34.

SPECIAL ADVISORY COMMISSION ON MANDATED HEALTH INSURANCE BENEFITS.

§ 9-297. Commission established; appointment of members; terms; eligibility; meetings.–A. The Special Advisory Commission on Mandated Health Insurance Benefits is hereby established to advise the Governor and the General Assembly on the social and financial impact of current and proposed mandated benefits and providers, in the manner set forth in this chapter. The Advisory Commission shall be comprised of fourteen members and two ex officio members. Ten members shall be appointed by the Governor as follows: one physician, one chief executive officer of a general, acute care hospital, one allied health professional, one representative of small business, one representative of a major industry, one expert in the field of medical ethics, two representatives of the accident and health insurance industry, and two citizen members. The Senate Committee on Privileges and Elections shall appoint one member from the Senate Committee on Education and Health and one member from the Senate Committee on Commerce and Labor, and the Speaker of the House of Delegates shall appoint one member from the House Committee on Health, Welfare and Institutions and one member from the House Committee on Corporations, Insurance and Banking. The State Commissioner of Health and the State Commissioner of Insurance shall serve as ex officio, nonvoting members.

All members shall be appointed for terms of four years each, except that appointments to fill vacancies shall be made for the unexpired terms.

B. No person shall be eligible to serve for or during more than two successive four-year terms; but after the expiration of a term of two years or less, or after the expiration of the remainder of a term to which appointed to fill a vacancy, two additional four-year terms may be served by such a member if so appointed.

C. The Advisory Commission shall meet regularly and at the request of the Governor. The first meeting of the Advisory Commission shall be held no later than July 31, 1990, at which time the Advisory Commission shall select a chairman and a vice chairman, as determined by the membership.

§ 9-298. Duties of the Special Advisory Commission; reimbursement.–A. The Special Advisory Commission shall:

1. Develop and maintain, with the Bureau of Insurance, a system and program of data collection to assess the impact of mandated benefits and providers, including costs to employers and insurers, impact of treatment, cost savings in the health care system, number of providers and other data as may be appropriate.

2. Advise and assist the Bureau of Insurance on matters relating to mandated insurance benefits regulations.

3. Provide assessments of proposed and existing mandated benefits and other studies of mandated benefits issues as requested by the General Assembly.

4. Provide additional information and recommendations, relating to any system of mandated health insurance benefits, to the Governor and the General Assembly upon request.

5. Report annually on its activities to the joint standing committees of the General Assembly having jurisdiction over insurance by December 1 of each year.

B. Members of the Special Advisory Commission shall receive reimbursement for expenses incurred in the performance of their duties pursuant to Article 1 (§ 14.1-1 et seq.) of Chapter 1 of Title 14.1.

§ 9-299. Assessment of proposed and existing mandated benefits and providers.—A. Whenever a legislative measure containing a mandated health insurance benefit or provider is proposed, the standing committee of the General Assembly having jurisdiction over the proposal shall request that the Special Advisory Commission prepare and forward to the Governor and the General Assembly, by a date certain, a study that assesses the social and financial impact and the medical efficacy of the proposed mandate.

B. The standing committees of the Generel Assembly having jurisdiction over health insurance matters shall request that the Special Advisory Commission on Mandated Benefits assess the social and financial impact and the medical efficacy of existing mandated benefits and providers. The committees shall submit a schedule of evaluations to the Special Advisory Commission by February 1, 1991, setting forth the dates by which particular mandates shall be evaluated by the Special Advisory Commission.

§ 9-300. Bureau of Insurance to provide assistance.—The Bureau of Insurance shall provide staff assistance to the Special Advisory Commission.

Official Use By Clerks

Passed By The Senate		**Passed By The House of Delegates**	
without amendment	☐	without amendment	☐
with amendment	☐	with amendment	☐
substitute	☐	substitute	☐
substitute w/amdt	☐	substitute w/amdt	☐
Date: _____		Date: _____	
Clerk of the Senate		Clerk of the House of Delegates	

1990 SESSION

LD1601340

SENATE BILL NO. 479

Offered January 23, 1990

A BILL to amend and reenact §§ 38.2-4214 and 38.2-4319 of the Code of Virginia and to amend the Code of Virginia by adding in Article 2 of Chapter 34 in Title 38.2 a section numbered 38.2-3419.1, relating to accident and sickness insurance.

Patrons–Walker, Schewel and Holland, C.A.; Delegates: Quillen, Ball, Glasscock, Stambaugh and Marshall

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Referred to the Committee on Education and Health

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-4214 and 38.2-4319 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding in Article 2 of Chapter 34 in Title 38.2 a section numbered 38.2-3419.1 as follows:

§ 38.2-4214. Application of certain provisions of law.–No provision of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-200, 38.2-203, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-230, 38.2-316, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, 38.2-700 through 38.2-705, 38.2-900 through 38.2-904, 38.2-1017, 38.2-1018, 38.2-1038, 38.2-1040 through 38.2-1044, 38.2-1300 through 38.2-1310, 38.2-1312, 38.2-1314, 38.2-1317 through 38.2-1328, 38.2-1334, 38.2-1340, 38.2-1400 through 38.2-1444, 38.2-1800 through 38.2-1836, 38.2-3400, 38.2-3401, 38.2-3404, 38.2-3405, 38.2-3409, 38.2-3411 through ~~38.2-3419~~ *38.2-3419.1* , 38.2-3501, 38.2-3502, 38.2-3516 through 38.2-3520 as they apply to Medicare supplement policies, §§ 38.2-3500, 38.2-3541 and 38.2-3600 through 38.2-3607 shall apply to the operation of a plan.

§ 38.2-4319. Statutory construction and relationship to other laws.–A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-200, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-229, 38.2-316, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 of this title, 38.2-1317 through 38.2-1321, 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, ~~and~~ 38.2-3418.1 *, and 38.2-3419.1* shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 of this title except with respect to the activities of its health maintenance organization.

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

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

§ 38.2-3419.1. Report of costs and utilization of mandated benefits.–A. Beginning with the calendar year 1991, every insurer, health services plan, and health maintenance organization shall report to the Commission cost and utilization information for each of the mandated benefits and providers set forth in this article on an annual basis. Each report shall be submitted no later than the next May 1 following the reporting period. The reports shall be in detail and form as required under regulations adopted by the Commission so as to provide the information deemed necessary by the Commission to determine the financial impact of each mandated benefit and provider.

B. The Commission shall prepare a consolidation of these reports to provide to the General Assembly such information concerning the costs of mandated benefits, the utilization of services under mandated benefits, and such other information as the Commission or the General Assembly may deem appropriate. Such consolidated reports shall be submitted to the General Assembly no later than the next October 31 following

the reporting period.

Official Use By Clerks	
Passed By The Senate	**Passed By The House of Delegates**
without amendment ☐	without amendment ☐
with amendment ☐	with amendment ☐
substitute ☐	substitute ☐
substitute w/amdt ☐	substitute w/amdt ☐
Date: _____	Date: _____
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Clerk of the Senate	Clerk of the House of Delegates

1990 SESSION

LD3018137

SENATE BILL NO. 480
AMENDMENT IN THE NATURE OF A SUBSTITUTE
(Proposed by the House Committee on Corporations, Insurance & Banking on February 20, 1990)
(Patron Prior to Substitute–Senator Walker)

A BILL to amend and reenact § 38.2-4214 of the Code of Virginia and to amend the Code of Virginia by adding in Chapter 34 of Title 38.2 an article numbered 4, consisting of sections numbered 38.2-3425 through 38.2-3430, relating to accident and sickness insurance.

Be it enacted by the General Assembly of Virginia:

1. That § 38.2-4214 of the Code of Virginia is amended and reenacted and that the Code of Virginia is amended by adding in Chapter 34 of Title 38.2 an article numbered 4, consisting of sections numbered 38.2-3425 through 38.2-3430, as follows:

Article 4.

Limited Mandated Benefit Accident and Sickness Insurance Policies and Subscription Contracts.

§ 38.2-3425. Issuance of limited mandated benefit accident and sickness insurance policies and subscription contracts permitted.—A. Insurers and health services plans may issue limited mandated benefit accident and sickness insurance policies or subscription contracts meeting the criteria set forth in this article.

B. For purposes of this article, "limited mandated benefit accident and sickness insurance policy or subscription contract" means a policy or subscription contract which the insurer or health services plan may choose to offer to individuals, families, or groups of less than fifty members formed for purposes other than obtaining insurance coverage, and which meets the following criteria:

1. The individual, family, or group obtaining coverage under the policy or subscription contract shall have been without accident and sickness insurance coverage, health services plan, or employer sponsored health care coverage for all of the twelve-month period immediately preceding the effective date of the limited mandated benefit accident and sickness insurance policy or subscription contract, provided that for groups in existence for less than twelve months, the group shall have been without accident and sickness insurance coverage, health services plan, or employer sponsored health care coverage since inception of the group.

2. The insurer or health services plan shall include the following managed care provisions to control costs:

a. An exclusion for services that are not medically necessary or are not covered preventive health services; and

b. A procedure for preauthorization by the insurer or health services plan, or its designees.

3. The insurer or health services plan may include the following managed care provisions to control costs:

a. A preferred panel of providers pursuant to §§ 38.2-3407 and 38.2-4209 who have entered into written agreements with the insurer or health services plan to provide services at specified levels of reimbursement. Any such written agreement between a provider and an insurer or health services plan shall contain a provision under which the parties agree that the insured individual or covered member will have no obligation to make payment for any medical service rendered by the provider that is determined not to be medically necessary;

b. Provisions requiring a second surgical opinion;

c. A procedure for utilization review by the insurer or health services plan or its designees.

Nothing herein shall be construed to prohibit an insurer or health services plan from including in its policy or subscription contract additional managed care and cost control provisions which, subject to the approval of the Commission, have the potential to control

costs in a manner which does not result in inequitable treatment of insureds or subscribers.

4. The policy or subscription contract shall provide basic levels of primary, preventive, and hospital care for covered individuals, including, but not limited to, the following:

a. A minimum of thirty days of inpatient hospitalization coverage per policy year;

b. Prenatal care, including a minimum of one prenatal office visit per month during the first two trimesters of pregnancy, two office visits per month during the seventh and eighth months of pregnancy, and one office visit per week during the ninth month and until term. Coverage for each such visit shall include necessary and appropriate screening, including history, physical examination, and such laboratory and diagnostic procedures as may be deemed appropriate by the physician based upon recognized medical criteria for the risk group of which the patient is a member. Coverage for each office visit shall also include such prenatal counseling as the physician deems appropriate;

c. Obstetrical care, including physicians' services, delivery room, and other medically necessary hospital services; and

d. Well-baby and well-child care, including periodic review of a child's physical and emotional status by a physician or under a physician's supervision. Such review shall include, but not be limited to, a history, a complete physical examination, a developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests in keeping with prevailing medical standards. Such reviews shall be covered when performed at approximately the following age intervals: (i) birth, (ii) two months, (iii) four months, (iv) six months, (v) nine months, (vi) twelve months, (vii) fifteen months, (viii) eighteen months, (ix) two years, (x) three years, (xi) four years, (xii) five years, and (xiii) six years.

e. For other covered individuals, a basic level of primary and preventive care, including but not limited to, two physician office visits per calendar year.

§ 38.2-3426. Exemption of limited mandated benefit accident and sickness policies and subscription contracts from certain mandates.—Any policy or subscription contract issued pursuant to this article may be issued without the requirements of §§ 38.2-3408, 38.2-3410, 38.2-3412, 38.2-3413, 38.2-3417, or 38.2-4221.

§ 38.2-3427. Disclosure requirements for limited mandated benefit accident and sickness insurance policies and subscription contracts.—A. Upon offering coverage under a limited mandated benefit accident and sickness insurance policy or subscription contract for any individual, family, or group member, the insurer or health services plan shall provide such individual, family, or member with a written disclosure statement containing at least the following:

1. An explanation of those mandated benefits and providers not covered by the policy or subscription contract;

2. An explanation of the managed care and cost control features of the policy or subscription contract, along with all appropriate mailing addresses and telephone numbers to be utilized by insureds in seeking information or authorization; and

3. An explanation of the primary and preventive care features of the policy or subscription contract.

Such disclosure statement shall be presented in clear and understandable form and format and shall be separate from the insurance policy or certificate or evidence of coverage provided to such individual, member, or dependent.

B. Before any insurer or health services plan issues a limited mandated benefit accident and sickness insurance policy or subscription contract, it shall obtain from the prospective policyholder a signed written statement in which the prospective policyholder:

1. Certifies as to eligibility for coverage under the limited mandated benefit accident and sickness insurance policy or subscription contract;

2. Acknowledges the limited nature of the coverage and an understanding of the managed care and cost control features of the insurance policy or subscription contract;

3. Acknowledges that, if misrepresentations are made regarding eligibility for coverage under a limited mandated benefit accident and sickness policy or subscription contract, the

person making such misrepresentations shall be guilty of a Class 1 misdemeanor and shall forfeit coverage provided by the limited mandated benefit accident and sickness policy or subscription contract; and

4. Acknowledges that the prospective policyholder had, at the time of application for this insurance policy or subscription contract, been offered the opportunity to purchase coverage which included all applicable mandated benefits and that the prospective policyholder had rejected such coverage.

A copy of such written statement shall be provided to the prospective policyholder no later than at the time of policy delivery, and the original of such written statement shall be retained in the files of the insurer or health services plan for (i) the period of time that the policy or subscription contract remains in effect or (ii) five years, whichever is longer.

C. Any material statement made by an applicant for coverage under a limited mandated benefit accident and sickness insurance policy or subscription contract which falsely certifies as to the applicant's eligibility for coverage pursuant to § 38.2-3425 B shall be deemed a Class 1 misdemeanor and shall serve as the basis for termination of coverage under the policy or subscription contract.

D. All marketing communications intended to be utilized in the marketing of a limited mandated benefit accident and sickness product in this Commonwealth shall be submitted for review by the Commission prior to use and shall contain the disclosures stated in subsection B above.

§ 38.2-3428. Forms and rates to be filed with and approved by the Commission.—A. All limited mandated benefit accident and sickness policy forms, including applications, enrollment forms, policies, subscription contracts, certificates, evidences of coverage, riders, amendments, endorsements, and disclosure forms shall be submitted to the Commission for approval in the same manner as required by § 38.2-316.

B. No limited mandated benefit accident and sickness insurance policy or subscription contract may be issued or issued for delivery in this Commonwealth unless the rates therefor have been filed with and approved by the Commission. The rates shall be supported by an actuarial memorandum meeting the requirements of the Commission's regulations governing the filing and approval of individual and certain group accident and sickness insurance rates as presently in effect or as may hereafter be amended. No rate shall be considered reasonable nor shall it be approved unless (i) it is based upon a pool or community rating formula and (ii) it is likely to produce a loss ratio, as certified by a qualified actuary, of no less than seventy-five percent for group contracts and sixty percent for individual contracts.

§ 38.2-3429. Recordkeeping and reporting requirement.—Each insurer or health services plan issuing limited mandated benefit accident and sickness policies or subscription contracts in this Commonwealth shall maintain separate and distinct records of enrollment, claim costs, premium income, utilization, and such other information as may be required by the Commission. Each insurer or health services plan providing such policies or plans shall furnish an annual report to the Commission. The report shall be in a form prescribed by the Commission and shall contain such information as the Commission may require to analyze the success of insurance coverage issued pursuant to this article.

§ 38.2-3430. Sunset provisions.—The provisions of this article shall expire on July 1, 1994.

§ 38.2-4214. Application of certain provisions of law.—No provision of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-200, 38.2-203, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-230, 38.2-316, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, 38.2-700 through 38.2-705, 38.2-900 through 38.2-904, 38.2-1017, 38.2-1018, 38.2-1038, 38.2-1040 through 38.2-1044, 38.2-1300 through 38.2-1310, 38.2-1312, 38.2-1314, 38.2-1317 through 38.2-1328, 38.2-1334, 38.2-1340, 38.2-1400 through 38.2-1444, 38.2-1800 through 38.2-1836, 38.2-3400, 38.2-3401, 38.2-3404, 38.2-3405, 38.2-3409, 38.2-3411 through 38.2-3419, *38.2-3425 through 38.2-3429, 38.2-3500,* 38.2-3501, 38.2-3502, 38.2-3516 through 38.2-3520 as they apply to Medicare

supplement policies, §§ ~~38.2-3500,~~ 38.2-541 and 38.2-3600 through 38.2-3607 shall apply to the operation of a plan.

Official Use By Clerks	
Passed By The Senate	**Passed By The House of Delegates**
without amendment ☐	without amendment ☐
with amendment ☐	with amendment ☐
substitute ☐	substitute ☐
substitute w/amdt ☐	substitute w/amdt ☐
Date: _____	Date: _____
Clerk of the Senate	Clerk of the House of Delegates

1990 SESSION

LD2752137

SENATE BILL NO. 481
AMENDMENT IN THE NATURE OF A SUBSTITUTE
(Proposed by the Senate Committee on Education and Health
on February 1, 1990)
(Patron Prior to Substitute—Senator Walker)

A BILL to amend and reenact § 32.1-335 of the Code of Virginia, relating to the Virginia Indigent Health Care Trust Fund.

Be it enacted by the General Assembly of Virginia:

1. That § 32.1-335 of the Code of Virginia is amended and reenacted as follows:

§ 32.1-335. Technical Advisory Panel.—The Board shall annually appoint a Technical Advisory Panel whose duties shall include recommending to the Board (i) policy and procedures for administration of the Fund, (ii) methodology relating to creation of charity care standards, eligibility and service verification, and (iii) contribution rates and distribution of payments. The Panel shall also advise the Board on any matters relating to the governance or administration of the Fund as may from time to time be appropriate.

The Panel shall consist of ~~seven~~ *ten* members as follows: the Chairman of the Board, the Director of the Department of Medical Assistance Services, the Executive Director of the Virginia Health Services Cost Review Council, two additional members of the Board, one of whom shall be the representative of the hospital industry, and two chief executive officers of hospitals as nominated by the Virginia Hospital Association.

In addition, there shall be three representatives of private enterprise, who shall be executives serving in business or industry organizations. Nominations for these appointments may be submitted to the Board by associations representing constituents of the business and industry community in Virginia including, but not limited to, the Virginia Manufacturers Association, the Virginia Chamber of Commerce, the Virginia Retail Merchants Association, and the Virginia Small Business Advisory Board.

2. That the Technical Advisory Panel shall study the technical and operational considerations related to requiring employers, who do not provide minimum health insurance benefits, as defined by the Commissioner of Insurance, to their employees or whose employees are not otherwise provided such benefits, to make reasonable contributions to the Fund, beginning on July 1, 1992. The Panel shall submit a report on this study to the Board of Medical Assistance Services, the Commission on Health Care for all Virginians, and the House Committees on Appropriations and Finance and the Senate Committee on Finance, by November 1, 1990. The report shall include alternative plans for requiring such contributions and shall address assessment rates, exemptions, and other administrative, collection, and operational specifics. The Commissioner of Insurance and the Commissioner of the Virginia Employment Commission shall provide the necessary assistance to the Panel in the development of this report.

Official Use By Clerks	
Passed By The Senate	**Passed By The House of Delegates**
without amendment ☐	without amendment ☐
with amendment ☐	with amendment ☐
substitute ☐	substitute ☐
substitute w/amdt ☐	substitute w/amdt ☐
Date: _____	Date: _____
Clerk of the Senate	Clerk of the House of Delegates

1990 SESSION

LD2013137

SENATE BILL NO. 482

Offered January 23, 1990

A BILL to amend and reenact §§ 32.1-336 through 32.1-339 and 32.1-341 of the Code of Virginia, relating to the Virginia Indigent Health Care Trust Fund.

Patrons--Walker, Schewel and Holland, C.A.; Delegates: Quillen, Ball, Glasscock, Stambaugh and Marshall

Referred to the Committee on Education and Health

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-336 through 32.1-339 and 32.1-341 of the Code of Virginia are amended and reenacted as follows:

§ 32.1-336. Annual charity care data submission.--No later than ~~ninety~~ *120* days following the end of each of its fiscal years, each hospital shall file with the Department a statement of charity care and such other data as may be required by the Department. *The Department may grant one thirty-day extension of the filing date to hospitals unable to meet the 120-day requirement.* Data required for carrying out the purposes of this chapter may be supplied to the Department by the Virginia Health Services Cost Review Council. The Board shall prescribe a procedure for alternative data gathering in cases of extreme hardship or impossibility of compliance by a hospital.

§ 32.1-337. Hospital contributions, calculations.--Hospitals shall make contributions to the Fund in accordance with the following:

A. A charity care standard shall be established annually as follows: For each hospital, a percentage shall be calculated of which the numerator shall be the charity care charges and the denominator shall be the gross patient revenues as reported by that hospital. This percentage shall be the charity care percent. The median of the percentages of all such hospitals shall be the standard.

B. Based upon the general fund appropriation to the Fund and the contribution, a disproportionate share level shall be established as a percentage above the standard not to exceed three percent above the standard.

C. The cost of charity care shall be each hospital's charity care charges multiplied by each hospital's cost-to-charge ratio as determined ~~from~~ *in accordance with* the Medicare ~~allowable cost-to-charge ratio where available~~ *cost finding principles* . For those hospitals whose mean Medicare patient days are greater than two standard deviations below the Medicare statewide mean, the hospital's individual cost-to-charge ratio shall be used.

D. An annual contribution shall be established which shall be equal to the total sum required to support charity care costs of hospitals between the standard and the disproportionate share level. This sum shall be equally funded by hospital contributions and general fund appropriations.

E. ~~An annual hospital contribution rate shall be calculated, the numerator of which shall be the sum of one-half the contribution plus the sum of state corporate taxes paid by the hospitals and the denominator of which shall be the sum of the hospitals' positive operating margins plus the sum of state corporate taxes paid by the hospitals. The annual hospital contribution rate shall not exceed 6.25 percent of a hospital's operating margin.~~ *A charity care and corporate tax credit shall be calculated, the numerator of which shall be each hospital's cost of charity care plus state corporate taxes and the denominator of which shall be each hospital's net patient revenues as defined by the Virginia Health Services Cost Review Council.*

F. ~~A charity care and corporate tax credit shall be calculated, the numerator of which shall be each hospital's cost of charity care plus state corporate taxes and the denominator of which shall be each hospital's total patient revenues as defined by the Virginia Health Services Cost Review Council.~~ *An annual hospital contribution rate shall be calculated, the numerator of which shall be the sum of one-half the contribution plus the sum of the*

product of the contributing hospital's credits multiplied by the contributing hospitals' positive operating margins and the denominator of which shall be the sum of the positi operating margins for the contributing hospitals. The annual hospital contribution n shall not exceed 6.25 percent of a hospital's positive operating margin.

G. For each hospital, the contribution dollar amount shall be calculated as the difference between the rate and the credit multiplied by each hospital's operating margin.

H. The fund shall be established on the books of the Comptroller so as to segregate the amounts appropriated and contributed thereto and the amounts earned or accumulated therein. No portion of the Fund shall be used for a purpose other than that described in this chapter. Any money remaining in the Fund at the end of a biennium shall not revert to the General Fund but shall remain in the Fund to be used only for the purpose described in this chapter.

§ 32.1-338. Distribution of Fund moneys.–The Fund shall ~~distribute moneys to hospitals in accordance with the following~~ *compensate a hospital for such hospital's charity care percent less the charity care standard as follows* :

~~A.~~ *1.* The payment to each hospital shall be determined as the standard subtracted from each hospital's charity care percent, multiplied by each hospital's gross patient revenues, multiplied by each hospital's cost-to-charge ratio and multiplied by a percentage not to exceed sixty percent.

~~B.~~ *2.* ~~Each hospital whose~~ *That portion of a hospital's* charity care percent *which* is ~~above the standard but~~ below the disproportionate share ~~level~~ shall be paid from the total amount of the contribution.

~~C.~~ *3.* That portion of a hospital's charity care percent which is above the disproportionate share ~~level~~ shall be paid solely from ~~appropriations~~ *general funds moneys as provided* by the General Assembly ~~to the Fund~~ *in the appropriations act* .

§ 32.1-339. Frequency of calculations, contributions and distributions.–Contributions to Fund by hospitals shall be made once annually in ~~December~~ *January* of each calend year beginning in ~~December 1990~~ *January 1991* , using financial data for the hospitals' most recent fiscal years ending on or before June 30 of ~~that~~ *the preceding* calendar year. Calculations for distributions shall be made under the same terms. The policy and details relating to receipt of contributions and distribution of the Fund moneys shall be prescribed by the Board.

§ 32.1-341. Failure to comply; fraudulently obtaining participation or reimbursement; criminal penalty.–A. Any person who engages in the following activities, on behalf of himself or another, shall be guilty of a Class 1 misdemeanor in addition to any other penalties provided by law:

1. Knowingly and willfully making or causing to be made any false statement or misrepresentation of a material fact in order to participate in or receive reimbursement from the Fund;

2. Knowingly and willfully failing to provide reports to the Department as required in this chapter; or

3. Knowingly and willfully failing to pay in a timely manner the contribution to the Fund by a hospital as calculated by the Department ~~as described in § 32.1-333~~ *pursuant to § 32.1-337* .

B. Conviction of any provider or any employee or officer of such provider of any offense under this section shall also result in forfeiture of any payments due.

SP2005137

1990 SESSION
ENGROSSED

REPRINT

SENATE BILL NO. 483

Senate Amendments in [ ] - February 5, 1990

A BILL to amend and reenact §§ 23-35.1 through 23-35.8 of the Code of Virginia and to amend the Code of Virginia by adding in Chapter 4 of Title 32.1 an article numbered 6, consisting of sections numbered 32.1-122.5 through 32.1-122.8, all relating to the primary health care system including criteria for determining underserved areas, funding of education of certain health care providers, and the development of the Statewide Area Health Education Center Program.

Patrons--Walker, Schewel and Holland, C.A.; Delegates: Quillen, Ball, Heilig, Stambaugh and Marshall

Referred to the Committee on Education and Health

Be it enacted by the General Assembly of Virginia:

1. That §§ 23-35.1 through 23-35.8 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding in Chapter 4 of Title 32.1 an article numbered 6, consisting of sections numbered 32.1-122.5 through 32.1-122.8, as follows:

§ 23-35.1. Dental scholarships authorized; reports concerning recipients.– ~~A. The Medical College of Hampton Roads and the governing boards of Virginia Commonwealth University and the University of Virginia are authorized to establish a total of seventy annual medical scholarships as follows: distribute fourteen to the Medical College of Hampton Roads, thirty-one to Virginia Commonwealth University and twenty-five to the University of Virginia. The Medical College of Hampton Roads shall award such scholarships as provided in §§ 23-35.1 through 23-35.8 to students at the Medical College of Hampton Roads. Whenever the terms "governing board" and "school awarding a scholarship" or similar terms are used in such sections, they shall be deemed to mean the Medical College of Hampton Roads and its governing body, respectively, with reference to scholarships awarded by the Medical College. If any of such schools has not awarded its full complement of scholarships by January of each year and one or both of the other schools has a demonstrated need for additional scholarships for that year, the unused funds may be transferred upon the recommendation of the State Health Commissioner and the approval of the Department of Planning and Budget.~~

~~Each of the seventy scholarships authorized in subsection A shall be of the value of $2,500 to be awarded and paid subject to the conditions and restrictions set out in the following sections.~~

~~B.~~ The governing board of Virginia Commonwealth University is authorized to establish ten annual dental scholarships, each of the value of $2,500 to be awarded and paid subject to the *following* conditions and restrictions ~~set out in the following sections~~ .

~~C. The Medical College of Hampton Roads and the~~ *The* governing ~~boards~~ *board* of Virginia Commonwealth University ~~and the University of Virginia~~ shall send the name of any recipient of a scholarship under the provisions of this chapter to the State Health Commissioner forthwith. Upon graduation, dimissal, or death of any recipient of a scholarship under the provisions of this chapter, the governing board ~~of the school awarding such scholarship~~ shall forthwith submit a report to the State Health Commissioner setting forth the name and address of such recipient, the length of time such recipient has held such scholarship, and the amount of money paid to or on behalf of such scholarship recipient thereunder. The State Health Commissioner shall maintain liaison with such recipients to determine whether they are complying fully with their contracts and the Commissioner shall submit a report each year to the State Board of Health and the governing ~~boards of the schools enumerated herein~~ *board* setting forth the names of all such recipients who shall have discharged the obligations imposed upon them by § 23-35.3.

~~D. The Medical College of Hampton Roads and the governing boards of Virginia Commonwealth University and the University of Virginia are also authorized to establish a~~

~~total of three annual medical scholarships and to distribute one each to the~~ Medical ~~College of Hampton Roads, Virginia Commonwealth University and the University of Virginia. All such scholarships shall be awarded to students who have signed a contract as provided in § 23-35.3 to serve, for a total number of years equal to those in which the scholarships were received, in an institution within the Department of Corrections. All three of these scholarships shall be of the value of $2,500 each. If any of such schools has not awarded its scholarship by January of each year and one of the other schools has a demonstrated need for additional scholarships for that year, the unused funds may be transferred upon the recommendation of the State Health Commissioner and the approval of the Department of Planning and Budget.~~

§ 23-35.2. Same; basis of awards.–The award of a scholarship, which ~~award~~ may be made to residents and nonresidents of the Commonwealth of Virginia, shall be made upon such basis, competitive or otherwise, as determined by the ~~Medical College of Hampton Roads or the president or other proper officer~~ *dean* of the school *of dentistry* awarding such scholarship, with due regard to scholastic attainments, character, financial need, and adaptability of the applicant to the service contemplated under such award ; ~~however, no~~ . *No* award shall be made unless the applicant possesses the requisite qualifications. Bona fide residents of the Commonwealth of Virginia shall be given preference over nonresidents in determining scholarship eligibility and awards.

§ 23-35.3. Same; written contract required; conditions and provisions; scholarship deemed repaid upon death of recipient.– ~~(a) [Repealed.]~~

~~(b)~~ Before any dental scholarship is awarded under the provisions of § 23-35.1 ~~B,~~ the applicant must sign a written contract, under which he agrees to pursue the dental course of the school awarding the scholarship until his graduation and, upon being graduated or upon completing a term not to exceed two years in an accredited general dentistry residency or intern program at a hospital or institution, shall promptly begin and thereafter engage continuously in the ~~general~~ practice of general dentistry in an area of need or as an employee of the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services, the Virginia ~~Health~~ Department *of Health* , the Virginia Department of Social Services, the Department of Youth Services, or the Virginia Department of Corrections for a period of years equal in number to the years which he has been a beneficiary of such scholarship. The State Board of Health shall define "area of need" and "practice of general dentistry" for the purposes of this subsection. In promulgating such definitions, the Board shall consider the distribution of dentists within the Commonwealth and the concept of the practice of general dentistry prevailing in the dental community.

~~(c) [Repealed.]~~

~~(d) No scholarship shall be awarded under the provisions of § 23-35.1 A unless and until the applicant shall have signed a written contract under the terms of which he agrees to pursue the medical course of the school awarding the scholarship until his graduation or to pursue his first year of postgraduate training at the hospital or institution approved by the school awarding the scholarship and upon completing a term not to exceed three years as an intern or resident at some hospital or institution approved by the school, shall promptly begin and thereafter engage continuously in the practice of family medicine in an area of need in Virginia or serve as an employee of the Virginia Department of Health, the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services, the Virginia Department of Social Services, the Department of Youth Services, or the Virginia Department of Corrections for a period of years equal to the number of years which he has been a beneficiary of such scholarship. In the case of a scholarship awarded pursuant to § 23-35.1 D, such contract shall stipulate services within the Department of Corrections.~~

~~The State Board of Health shall define "area of need" and "practice of family medicine" for the purposes of this subsection. In promulgating such definitions, the Board shall consider the distribution of physicians within the Commonwealth and the concept of~~

~~the practice of family medicine prevailing in the medical community.~~

~~(d1) As used in this section, the term "area of need" may include both rural and urban localities in the Commonwealth.~~

~~(c)~~ In the event the holder of any ~~medical or~~ dental school scholarship awarded pursuant to §§ 23-35.1 through 23-35.8 of this chapter dies while receiving instruction under such a scholarship or while practicing ~~family medicine or~~ general dentistry, pursuant to the contract provided for in this section, his obligation under the contract shall be deemed discharged, and no liability shall be attached to his estate.

§ 23-35.4. Same; military service; other provisions of contract.–The contract shall provide that the applicant will not voluntarily obligate himself for more than the minimum military service required for ~~physicians or~~ dentists by the laws of the United States. It shall further provide that on termination of the minimum period of obligatory military service, he shall promptly begin the discharge of his obligation by compliance with the conditions set forth in ~~paragraph (b) or (d) of~~ § 23-35.3 ~~, whichever is applicable~~ . The contract shall contain such other provisions as are considered necessary, in the opinion of the Attorney General and *the* State Health Commissioner, to accomplish the purpose of such scholarship.

§ 23-35.5:1. Dental scholarships; relief from contract.–A. Each contract provided for in § 23-35.3 shall provide that if, at any time, the recipient fails to maintain a scholastic standard at least equal to the standard required of the general student body in such school or if the recipient, at any time, becomes permanently disabled so as not to be able to engage in the practice of ~~medicine or~~ dentistry or if, at any time, the recipient demonstrates a peculiar and unusual ability and aptitude in a special branch of the ~~medical or~~ dental sciences and, in the opinion of the State Health Commissioner would be a loss to the field of ~~medical or~~ dental research and science if he did not go into that branch of ~~medical or~~ dental science for which he has demonstrated extraordinary ability, the recipient may, upon certification of the State Health Commissioner, be relieved of his obligation under the contract to engage in the practice of ~~family medicine or~~ general dentistry upon repayment to the Commonwealth of the amount he has received on account of such scholarship plus interest on such amount computed at eight ~~per centum~~ *percent* per annum from date of receipt of scholarship by the recipient.

B. Any contract made under this chapter may be terminated by the recipient while the recipient is regularly enrolled in school, after notice, upon immediate repayment of the entire scholarship with interest at the rate of eight ~~per centum~~ *percent* per annum from date of receipt of scholarship.

C. Any recipient of a scholarship provided for in § 23-35.1 who fails or refuses to fulfill his obligations under the contract required by § 23-35.3 other than as provided in subsections A and B of this section shall reimburse the Commonwealth for the amount he received on account of such scholarship plus interest on such amount computed at the rate of ten ~~per centum~~ *percent* per annum from the date of receipt of such scholarship.

D. If any recipient who has for any reason repaid all or any part of the amount received under a scholarship provided for in § 23-35.1 later fulfills the terms of his contract by completing his studies and engaging in ~~family practice or~~ general dentistry as provided in § 23-35.3 with the advance approval of the State Health Commissioner, such recipient shall have reimbursed to him from the general fund of the state treasury the amount repaid.

§ 23-35.6. Same; collection of repayments; disposition of funds repaid; notice to Attorney General of failure to abide by contract.–The ~~school awarding the scholarship~~ *School of Dentistry at the Medical College of Virginia* shall collect all repayments required pursuant to § 23-35.5:1. The ~~school~~ *School* may establish a schedule of payments in the case of recipients to whom the provisions of subsection A or C of § 23-35.5:1 are applicable. No schedule of payments in any case to which the provisions of subsection C of § 23-35.5:1 are applicable shall permit payments in full reimbursement to extend beyond two years following the completion of the recipient's postgraduate training or the recipient's entrance

into the full-time practice of ~~medicine or~~ dentistry, whichever is later. The ~~school collecting such payments~~ *School of Dentistry* shall pay all money so received into the state treasury promptly and such money shall become a part of the general fund ; ~~provided that~~ *However*, payments made on a contract entered into and terminated in the same school year shall be made to the ~~school awarding the scholarship~~ *School of Dentistry* and the ~~school~~ *School* may make a new award of the scholarship for that school year. If any recipient fails to make any payment when and as due, such fact shall be communicated to the Attorney General by the ~~school collecting the payments~~ *School of Dentistry* . The Attorney General shall take such action thereon as he deems proper. Further, should court action be required to effectuate collection of a delinquent scholarship account, the Commonwealth shall be allowed court costs and reasonable attorneys' fees incurred within such collection.

§ 23-35.7. Same; scholarship may be from year to year.—Each scholarship shall be awarded for a single year, but the same student shall, after making satisfactory progress toward his degree in the discretion of the ~~president or other proper officer of the school~~ *Dean of the School of Dentistry* , receive such award for any succeeding year or years, provided no student shall receive more than five scholarships.

§ 23-35.8. Same; payment of amount to student or to his account.—The funds making up such scholarship shall be paid to the recipient thereof , or ~~in the case of an undergraduate,~~ applied toward the payment of his expenses at the ~~school~~ *School* in such a manner and at such time during the school year as is determined by the ~~president or other proper officer of the school, provided that~~ *Dean of the School of Dentistry. However,* no recipient of any such scholarship shall receive less than $2,500.

Article 6.

Primary Health Care System.

§ 32.1-122.5. Criteria to identify underserved areas.—The Board of Health shall establish criteria to identify medically underserved areas within the Commonwealth. These criteria shall consist of quantifiable measures sensitive to the unique characteristics of urban and rural jurisdictions which may include the incidence of infant mortality, the availability of primary care resources, poverty levels, and other measures indicating the inadequacy of the primary health care system as determined by the Board. [*The Board shall also include in these criteria the need for medical care services in the state facilities operated by the Departments of Corrections, Youth Services, and Mental Health, Mental Retardation and Substance Abuse Services.*]

§ 32.1-122.6. Conditional grants for certain medical students.—A. With such funds as are appropriated for this purpose, the Board of Health shall establish annual medical scholarships for students who intend to enter the designated specialties of family practice medicine, general internal medicine, pediatrics, and obstetrics/gynecology for students in good standing at the Medical College of Virginia of Virginia Commonwealth University, the University of Virginia School of Medicine, and the Medical College of Hampton Roads. No recipient shall be awarded more than five scholarships. The amount and number of such scholarships and the apportionment of the scholarships among the medical schools shall be determined annually as provided in the appropriations act. The Commissioner shall act as fiscal agent for the Board in administration of the scholarship funds.

The governing boards of Virginia Commonwealth University, the University of Virginia, and the Medical College of Hampton Roads shall submit to the Commissioner the names of those eligible applicants who are most qualified as determined by the regulations of the Board for these medical scholarships. The Commissioner shall award the scholarships to the applicants whose names are submitted by the governing boards.

B. The Board, after consultation with the Medical College of Virginia, the University Virginia School of Medicine, and the Medical College of Hampton Roads, shall promulgate regulations to administer this scholarship program which shall include, but not be limited to:

1. Qualifications of applicants;

2. Criteria for award of the scholarships to assure that recipients will fulfill the practice obligations established in this section;

3. Standards to assure that these scholarships increase access to primary health care for individuals who are indigent or who are recipients of public assistance;

4. Assurances that bona fide residents of Virginia, as determined by § 23-7.4, are given preference over nonresidents in determining scholarship eligibility and awards;

5. Assurances that scholarship recipients will begin medical practice in one of the designated specialties in an underserved area of the Commonwealth within two years following completion of their residencies;

6. Methods for reimbursement of the Commonwealth by recipients who fail to complete medical school or who fail to honor the obligation to engage in medical practice for a period of years equal to the number of annual scholarships received;

7. Procedures for reimbursing any recipient who has repaid the Commonwealth for part or all of any scholarship and who later fulfills the terms of his contract;

8. Procedures for transferring unused funds upon the recommendation of the Commissioner and the approval of the Department of Planning and Budget in the event any of the medical schools has not recommended the award of its full complement of scholarships by January of each year and one or both of the other medical schools has a demonstrated need for additional scholarships for that year; and

9. Reporting of data related to the recipients of the scholarships by the medical schools.

C. Prior to the award of any scholarship, the applicant shall sign a contract in which he agrees to pursue the medical course of the school nominating him for the award until his graduation or to pursue his first year of postgraduate training at the hospital or institution approved by the school nominating him for the award and upon completing a term not to exceed three years as an intern or resident at an approved institution or facility intends to promptly begin and thereafter engage continuously in one of the designated specialties of medical practice in an underserved area in Virginia for a period of years equal to the number of annual scholarships received. The contract shall specify that no form of medical practice such as military service or public health service may be substituted for the obligation to practice in one of the designated specialties in an underserved area in the Commonwealth.

The contract shall provide that the applicant will not voluntarily obligate himself for more than the minimum period of military service required for physicians by the laws of the United States and that, upon completion of this minimum period of obligatory military service, the applicant will promptly begin to practice in an underserved area in one of the designated specialties for the requisite number of years. The contract shall include other provisions as considered necessary by the Attorney General and the Commissioner.

The contract may be terminated by the recipient while the recipient is enrolled in medical school upon providing notice and immediate repayment of the total amount of scholarship funds received plus interest at the prevailing bank rate for similar amounts of unsecured debt.

D. In the event the recipient fails to maintain a satisfactory scholastic standing the recipient may, upon certification of the Commissioner, be relieved of the obligations under the contract to engage in medical practice in an underserved area upon repayment to the Commonwealth of the total amount of scholarship funds received plus interest at the prevailing bank rate for similar amounts of unsecured debt.

E. In the event the recipient becomes permanently disabled so as not to be able to engage in the practice of medicine, the recipient may, upon certification of the Commissioner, be relieved of his obligation under the contract to engage in medical practice in an underserved area upon repayment to the Commonwealth of the total amount of scholarship funds plus interest on such amount computed at eight percent per annum from the date of receipt of scholarship funds.

F. Except as provided in subsections D and E, any recipient of a scholarship who fails

or refuses to fulfill his obligation to practice medicine in one of the designated specialties in an underserved area for a period of years equal to the number of annual scholarships received shall reimburse the Commonwealth three times the total amount of the scholarship funds received plus interest at the prevailing bank rate for similar amounts of unsecured debt. If the recipient has fulfilled part of his contractual obligations by serving in an underserved area in one of the designated specialties, the total amount of the scholarship funds received shall be reduced by the amount of the annual scholarship multiplied by the number of years served.

G. The Commissioner shall collect all repayments required by this section and may establish a schedule of payments for reimbursement consistent with the regulations of the Board. No schedule of payments shall amortize the total amount due for a period of longer than two years following the completion of the recipient's postgraduate training or the recipient's entrance into the full-time practice of medicine, whichever is later. All such funds shall be transmitted to the Comptroller for deposit in the general fund. If any recipient fails to make any payment when and as due, the Commissioner shall notify the Attorney General. The Attorney General shall take such action as he deems proper. In the event court action is required to collect a delinquent scholarship account, the recipient shall be responsible for the court costs and reasonable attorneys' fees incurred by the Commonwealth in such collection.

§ 32.1-122.7. Statewide Area Health Education Center Program.—[~~In cooperation with the three medical schools in the Commonwealth, the Board~~ The Board, in cooperation with the Virginia Health Planning Board and the three medical schools in the Commonwealth,] shall design and implement the Statewide Area Health Education Center Program in order to attract and retain medical care practitioners in underserved areas of Virginia. The Program shall be designed to (i) establish professional practice support systems by linking the benefits of the medical expertise and research of the three medical schools with the delivery of health services to indigent individuals and recipients of public assistance; (ii) encourage the graduates of the three medical schools to practice in the Commonwealth by recruiting students to enter primary care specialties and to practice in underserved areas; (iii) promote the development and implementation of innovations in the delivery of community health services such as afterhours clinics in the three medical schools and community-based service demonstration projects; (iv) anticipate and avoid critical physician shortages by expanding opportunities for family practice preceptorships, clerkships, and residencies.

§ 32.1-122.8. Board's authority to receive and expend funds.—The Board of Health is hereby authorized to apply for, receive, and expend federal and any other available funds for the enhancement of the primary health care system including, but not limited to, any funds designated for any physician loan repayment program, medical scholarships, and area health education centers.

Official Use By Clerks	
Passed By The Senate	**Passed By The House of Delegates**
without amendment ☐	without amendment ☐
with amendment ☐	with amendment ☐
substitute ☐	substitute ☐
substitute w/amdt ☐	substitute w/amdt ☐
Date: _____	Date: _____
Clerk of the Senate	Clerk of the House of Delegates

1990 SESSION

LD2009137

SENATE BILL NO. 484

Offered January 23, 1990

A BILL to amend and reenact § 32.1-102.3:2 of the Code of Virginia, relating to moratorium on certain certificates of public need.

Patrons--Walker, Schewel and Holland, C.A.; Delegates: Quillen, Ball, Heilig, Glasscock, Stambaugh and Marshall

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Referred to the Committee on Education and Health

Be it enacted by the General Assembly of Virginia:

1. That § 32.1-102.3:2 of the Code of Virginia is amended and reenacted as follows:

§ 32.1-102.3:2. Certificates of public need; moratorium.--The Commissioner of Health shall not approve, authorize or accept applications for the issuance of any certificate of public need pursuant to this article for any project which would result in an increase in the number of beds in which nursing home or extended care services are provided from the effective date of this act through ~~January 1~~ *June 30* , 1991. However, the Commissioner may approve or authorize the issuance of a certificate of public need for a project for the renovation or replacement on site of an existing facility or any part thereof, in accordance with the law, when a capital expenditure is required to comply with life safety codes, licensure, certification or accreditation standards. The Commissioner may also approve or authorize the issuance of a certificate of public need for any project for the conversion on site of existing licensed beds to beds certified for skilled nursing services (SNF) when (i) the total number of beds to be converted does not exceed the lesser of twenty beds or ten percent of the beds in the facility; (ii) the facility has demonstrated that the SNF beds are needed specifically to serve a specialty heavy care patient population, such as ventilator-dependent and AIDS patients and that such patients otherwise will not have reasonable access to such services in existing or approved facilities; and (iii) the facility further commits to admit such patients on a priority basis once the SNF unit is certified and operational.

Official Use By Clerks	
Passed By The Senate	**Passed By The House of Delegates**
without amendment ☐	without amendment ☐
with amendment ☐	with amendment ☐
substitute ☐	substitute ☐
substitute w/amdt ☐	substitute w/amdt ☐
Date: _____	Date: _____
Clerk of the Senate	Clerk of the House of Delegates