REPORT OF THE
JOINT SUBCOMMITTEE STUDYING

Acquired Immunodeficiency Syndrome (AIDS)

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

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COMMONWEALTH OF VIRGINIA
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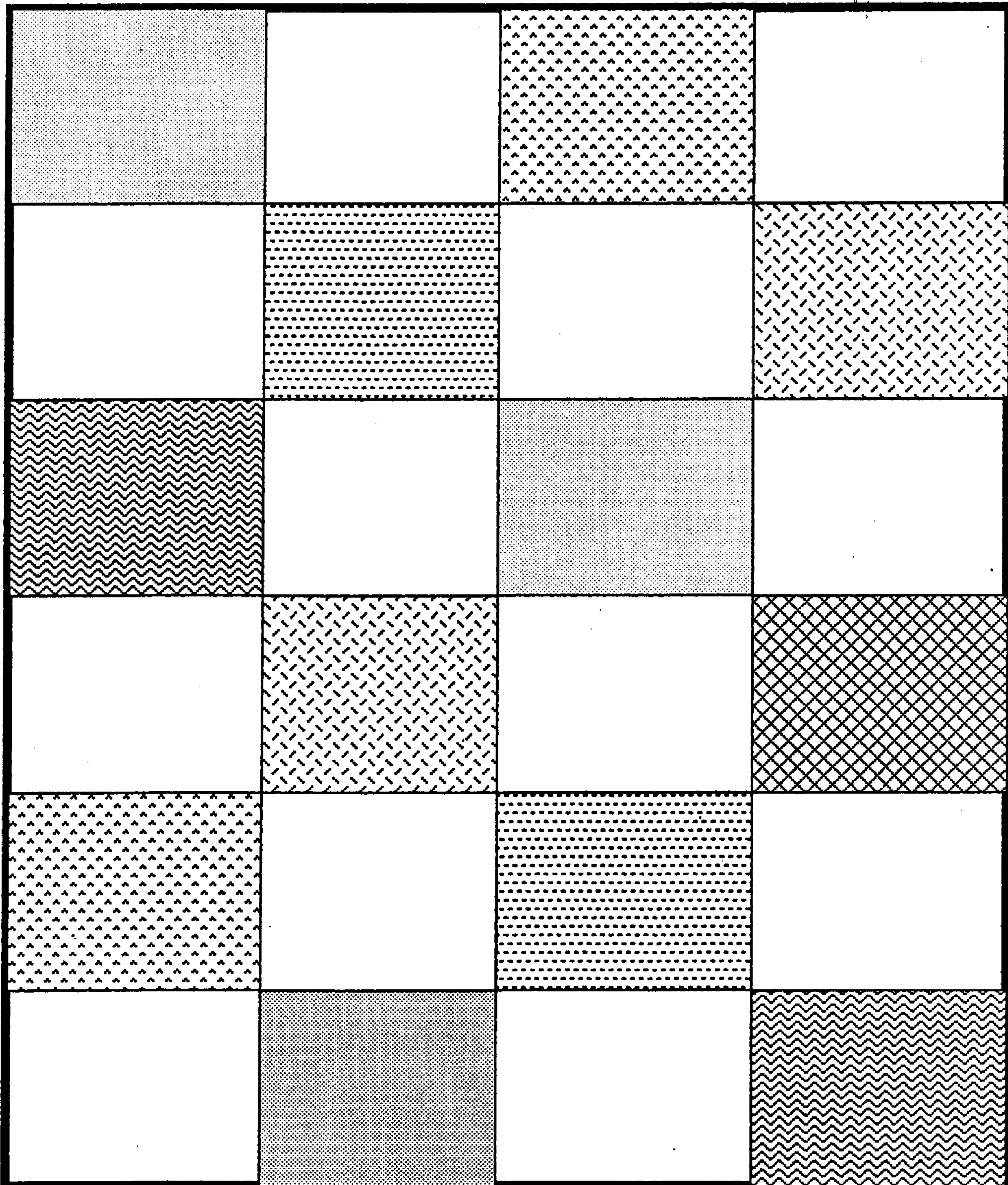

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REPORT OF THE
JOINT SUBCOMMITTEE STUDYING
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TO
THE GOVERNOR AND THE GENERAL ASSEMBLY OF VIRGINIA
RICHMOND, VIRGINIA
JANUARY 1991

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

I. AUTHORITY FOR THE STUDY

In response to the growing concerns of the citizens of the Commonwealth, a number of resolutions were introduced during the 1988 Session of the General Assembly calling for studies of acquired immunodeficiency syndrome (AIDS) and the impact of the AIDS epidemic on Virginia. House Joint Resolution 31 and Senate Joint Resolution 28 of 1988 were approved, thereby establishing this study.

House Joint Resolution 31 and Senate Joint Resolution 28 noted that, because of the complexity of the issues related to AIDS and the lack of a cure for this disease, public officials are confronted with many difficult issues in determining the most appropriate policies for prevention and treatment. These resolutions also recognized the potentially crippling effect that an increase in the incidence of AIDS could have on Virginia's health care industry and noted that, until an appropriate medical means of preventing the spread of the disease can be developed, methods of containing the epidemic might include testing, education, and behavior modification. The Joint Subcommittee was directed to assess prevention efforts to abate the spread of the disease; determine the appropriate role of state and local agencies for establishing public policy; determine whether state policies exist concerning the containment of the virus, the care and treatment of infected individuals, and Medicaid coverage; determine the need for and advisability of criminal statutes to prohibit the knowing and willful exposure to HIV infection; evaluate policies related to testing and contact tracing; analyze issues related to privacy, confidentiality, disclosure, insurance, employment, and school attendance; and identify any other related issues deemed appropriate.

Due to the subtlety of the issues posed by the AIDS epidemic, including concerns for the containment of ever-escalating health care costs, the Joint Subcommittee recommended to the General Assembly that the study be continued. This action was authorized pursuant to HJR 431 of 1989. During the second year of its study, the Joint Subcommittee was charged with determining the feasibility of placement and isolation policies as an alternative to criminalization of knowing and willful transmission of HIV infection; determining the procedures to be prescribed by any such statutes; the circumstances, if any, under which criminal sanctions should be imposed, and any appropriate penalties for such actions; deter-

mining the feasibility of health insurance risk pools and any other cost containment mechanisms that may serve to control the spiraling costs of health care services for persons infected with HIV; assessing the costs of recommended services and the appropriate revenue streams for such funds; determining whether, and under what circumstances or conditions, the test results of an unemancipated minor who tests positive for HIV infection should be reported to the minor's parent or legal custodian; and any other related issues deemed appropriate.

In 1990, the Joint Subcommittee recommended continuation again. House Joint Resolution 129 of 1990 reflected the members' consensus that the AIDS epidemic remained a crisis which required legislative monitoring and, possibly, intervention. The Joint Subcommittee was directed to maintain and update, as necessary, data on the effectiveness of state policies designed to address the impact of human immunodeficiency viruses, and programs and policies for assisting persons infected with such viruses; conduct a careful and judicious evaluation of the Commonwealth's response to the epidemic; monitor the effectiveness of the programs established as a result of its recommendations and determine whether any revisions to such programs were necessary to meet the evolving needs of the health care system in addressing the AIDS crisis; determine new initiatives as necessary to ameliorate the effects of the AIDS epidemic in Virginia; and address any other related issues deemed appropriate.

The Joint Subcommittee consisted of 15 members appointed as follows: two members of the House Committee on Health, Welfare and Institutions and one member each of the House Committees for Courts of Justice, Corporations, Insurance and Banking, Education, and Appropriations; one member each of the Senate Committees on Education and Health, Courts of Justice, Commerce and Labor, Rehabilitation and Social Services, and Finance; one attorney for the Commonwealth; and three citizen members with expertise in research regarding infectious diseases, in care and treatment of AIDS patients, and in medical ethics. Various ex officio members were also required.

Those appointed to serve were Delegates J. Samuel Glasscock of Suffolk, Edward R. Harris, Jr., of Lynchburg, Joan H. Munford of Blacksburg, Warren G. Stambaugh of Arlington, Marian Van Landingham of Alexandria, and S. Vance Wilkins, Jr., of Amherst; Senators John H. Chichester of Fredericksburg, Clive L. Duval 2d of Arlington, Mark L. Earley of Chesapeake, Yvonne B. Miller of Norfolk, and Frank W. Nolen of New Hope; and four citizen members, Dr. Lisa G. Kaplowitz of Richmond, Dr. Richard P. Keeling of Charlottesville, Mr. John E. Kloch of Alexandria, and Dr. James L. Levenson of Richmond. Ex officio members were Dr. C.M.G. Buttery, Commissioner of Health; Mr. Howard M. Cullum, Commissioner of Mental Health, Mental Retardation and Substance Abuse Services (1988 and 1989); Dr. King E. Davis, Commissioner of Mental Health, Mental Retardation and Substance Abuse Services (1990); Dr. S. John Davis, Superintendent of Public Instruction (1988 and 1989); Dr. Joseph A. Spagnolo, Superintendent of Public Instruction (1990); Mr. Steven T. Foster, Commissioner of Insurance; Mr. Larry D. Jackson, Commissioner of Social Services; Mr. Bruce U. Kozlowski, Director of the Department of Medical Assistance Services; Mr. Edward W. Murray, Director of the Department of Corrections; and Dr. Albert W. Tiedemann, Jr., Director of the Division of Consolidated Laboratories. Delegate J. Samuel Glasscock served as the chairman and Senator Clive L. DuVal 2d served as the vice chairman.

II. AIDS: THE EPIDEMIC

In the late 1970s, physicians in certain urban areas in this country began to notice unusual numbers of cases of a rare pneumonia known as pneumocystis carinii pneumonia and a rare skin cancer known as Kaposi's sarcoma. The patients with these diseases were young, mostly male, and did not respond to treatment. Medical evidence pointed to an infectious agent, probably a virus. Retrospective studies of blood samples have revealed that the first cases of the disease known as acquired immunodeficiency syndrome may have appeared in the mid-1970s. However, it was not until 1981 that private physicians and public health officials recognized the epidemic.

In 1983, Dr. Jean-Claude Cernmann, member of the research team headed by Dr. Luc Montagnier at the Pasteur Institute in France, made a presentation stating that the virus causing AIDS had been identified. The French called this virus LAV, lymphadenopathy-associated virus. In April of 1984, Margaret Heckler, then U.S. Secretary of Health and Human Services, called a press conference to announce that Dr. Robert Gallo had discovered the virus causing AIDS. Dr. Gallo named his virus HTLV-III, human T-lymphotropic virus type III. In 1987, an international scientific committee settled the controversy surrounding the official terminology for the virus by naming it human immunodeficiency virus-1 (HIV-1). A second and somewhat less lethal virus causing AIDS has been identified as human immunodeficiency virus-2 (HIV-2).

The human immunodeficiency virus is a retrovirus, which appears to be a newly evolved microbe. Dr. Temple F. Smith of the Dana-Farber Cancer Institute in Boston has been quoted as stating that viruses causing AIDS "appeared not later than 40 years ago, and probably are not more than a century old" (*Science News*, June 11, 1988, 373). The virus kills the cells it infects, can replicate within infected cells, and induces, in most cases, a progressive, but slow, debilitation. This virus is highly mutable and "has been shown to exhibit a high rate of genetic variation over time within infected hosts" (Nancy Mueller, "The Epidemiology of the Human Immunodeficiency Virus Infection," *Law, Medicine & Health Care*, 14: 5-6, 1986, 253).

Although the disease was originally thought to have an incubation period of two years or less, recent projections are that an average of 4.5 years may elapse between infection and the appearance of disease (Mueller, 254). Scientists also recognize that the disease may have a latency period of eight to ten years, possibly longer. Persons who are HIV seropositive may not exhibit any symptoms of the disease, but may pass the virus to others if they engage in at-risk behavior. Present knowledge of the virus indicates that an infected individual will remain infectious for life. While it also appears that virtually all infected individuals will develop AIDS, advances in drug therapy may delay the onset of the disease.

One measure of the progression of AIDS is a reduction in T-helper cells. T-helper cells are of primary importance in the functioning of the body's immune system. It appears that initial infection may be in these T-helper cells and that as these cells are reduced in number a mononucleosis-like disease appears. Individuals may develop antibodies to the virus (seroconversion) within a few weeks or a few months. A very few individuals do not appear to develop antibodies.

Others appear to lose their seropositive status over time. However, the virus may become latent. Because AIDS decimates the immune system, individuals who are infected are subject to many "opportunistic" or "indicator" diseases which uninfected individuals would rarely contract, such as candidiaisis, a skin or mucous membrane infection caused by a genus of yeastlike fungi; Kaposi's sarcoma, a malignant skin disease; and pneumocystis carinii pneumonia, a form of pneumonia caused by a protozoan.

The AIDS virus has been found in blood, semen, vaginal secretions, tears, and saliva as well as other body fluids; however, there is no evidence that the virus is transmitted through casual contact. Data indicate that some body fluids contain very few viruses and that transmission of the virus is dose related. Therefore, contact with sweat, tears, or saliva of an infected individual presents little, if any, risk. Transmission of the virus requires intimate sexual contact or parenteral contact with infected blood or other infected body fluids. Avoiding promiscuous or casual sexual activity, intravenous drug abuse, and invasive exposure to infected body fluids removes the risk of contracting this disease.

In the early stages of the AIDS epidemic in this country, the disease appeared to be confined to homosexual/bisexual men and some intravenous drug users. The public perceptions of the epidemic, as well as concerns for its containment, began to evolve rapidly when it became apparent that AIDS was also a heterosexually transmitted disease, spreading bidirectionally (woman to man, man to woman) and to recipients of contaminated blood transfusions, babies born to infected mothers, hemophiliacs receiving factor VIII blood compounds, and women undergoing artificial insemination. These changes in the epidemic's scenario resulted in tremendous public fear and appeals for research to identify the cause of the disease, to develop a vaccine to prevent infection, and to discover a cure for the infection.

Licensed in 1984, the ELISA (enzyme-linked immunosorbent assay) test for the presence of HIV antibodies, and, subsequently, the Western blot confirmatory test, enabled identification of HIV seropositive individuals for the first time. Before these tests became available, it was virtually impossible to confirm that an individual was infected with the virus, and diagnosis was based on the manifestation of symptoms of ARC (AIDS Related Complex) or AIDS. New tests are under development, some of which are intended to detect HIV antigens or the AIDS virus.

In Virginia, the Department of Health, Bureau of Sexually Transmitted Disease Control, prepares up-to-date surveillance reports on the prevalence of AIDS in the Commonwealth. Through May 10, 1990, Virginia had a total of 1,634 AIDS cases with 1,044 deaths. In addition, the Virginia Department of Health indicated that 1,070 reports of persons infected with HIV had been received; a total of 570 such reports had been investigated and confirmed as meeting the Department's case definition of HIV infection. An additional 500 cases were under investigation by the Department.

The majority of AIDS cases in the Commonwealth, as in the United States, are among individuals who are 20 years of age or older, white and male. However, HIV infection is increasing among women, children, and adolescents. The greatest number of Virginia's AIDS cases have been reported in Northern Virginia, Central Virginia, and the Tidewater area; however, every region of the Commonwealth has reported some cases of the disease.

III. WORK OF THE JOINT SUBCOMMITTEE: 1988

In 1988, the Joint Subcommittee conducted six day-long meetings, two of which included segments devoted to public hearings. A seventh meeting was held during the first week of the 1989 Session. The initial meeting was both organizational and educational in focus. The Subcommittee received technical briefings on the disease, the epidemic, and Virginia HIV statistics. During this meeting, existing state activities were described in considerable detail and the tests to determine the presence of the antibodies were explained. The members also engaged in preliminary deliberations concerning the study schedule and direction.

At the first meeting, it was pointed out that HIV tests are not 100 percent accurate; as with any clinical laboratory test, there is always the possibility for human error, false positive or false negative results, or indeterminate results. Experts stressed the need for good quality control practices in addition to maintaining the confidentiality of the tested individuals at all times.

A primary topic of the first meeting was the issue of public and professional education on AIDS. Several of the experts maintained that education, in conjunction with behavior modification, may be the single most effective weapon for containment of the epidemic.

Among the issues identified during this meeting as warranting investigation were: when and where testing should be available; mandatory versus voluntary testing; confidentiality of test results; the availability of care; the need for education of the public and professionals; the need for education tailored for various groups such as teenagers, college students, minorities, and intravenous drug abusers; the difficulties with the quarantine law in relation to persons with HIV infection; concerns about appropriate handling of patients who are infected with HIV in the state facilities for the mentally ill and mentally retarded; concerns about HIV infection among inmates in state correctional facilities; and the potential impact of the AIDS epidemic on the health care industry and various social services.

At the second meeting, the Joint Subcommittee received presentations from Mr. Steven T. Foster, Commissioner of Insurance with the State Corporation Commission; Dr. Cleto DiGiovanni, a psychiatrist with the Johns Hopkins Hospital; Dr. Donnie Conner, a consultant to the Richmond AIDS Information Network; Mr. Richard E. Merritt of the Intergovernmental Health Policy Project, George Washington University; Mr. Bill Harrison with the Richmond AIDS Information Network; a person with AIDS residing in Virginia Beach; an HIV positive individual from Norfolk; Mr. Arthur Runyon of the Metropolitan Community Church of Richmond; Dr. Rochelle Klinger of the Medical College of Virginia; Mr. Thomas DePriest, an attorney and community activist from Arlington; and Mr. Paul Kelly, co-founder of Awakening, Inc., of Richmond.

During this meeting, the Subcommittee considered issues related to prevention, the role of testing in prevention efforts, testing for HIV by insurance companies, AIDS dementia and related psychiatric disorders, barriers to services for AIDS and HIV positive individuals, state funding for AIDS programs, pre-test and post-test counseling, reporting of positive test results, contact tracing and notification of partners, confidentiality and protection of the infection-free population, the viability of criminal sanctions for willful and knowing transmission

of HIV infection, the efficacy of quarantine or isolation of certain persons, and appropriate policies for individuals residing in state correctional institutions and mental health or mental retardation facilities.

Many questions were raised concerning mandatory reporting of positive test results; the purpose of such reporting; who should be required to report; the purpose, costs, and constitutional ramifications of mandatory testing; the efficacy of voluntary testing in relationship to prevention efforts; the extent to which those at high risk seek testing; the availability and accessibility of testing; the factors which act as deterrents to testing for high risk groups; the efficacy of requiring testing of any specific groups, such as drug offenders, sex offenders, male and female prostitutes, and prisoners; the possible negative effects of mandatory testing of target group(s); and the appropriateness of testing by health care institutions.

Issues relating to counseling received prolonged discussion, focusing on the availability, accessibility, and goals of counseling; components of effective counseling; incentives to encourage individuals who are HIV positive to obtain counseling; who should be required to provide counseling, e.g., the Department of Health, insurance companies requiring testing, etc.; whether effective counseling modifies behavior; and the effectiveness of counseling among members of certain at-risk groups, such as intravenous drug abusers.

Contact tracing and notification of partners were also discussed. The deliberations related to the efficacy of requiring contact tracing, the adequacy of the Department of Health policy of restricting contact tracing to one year, the benefits of contact tracing and notification of partners, and the available alternatives upon refusal of the HIV positive individual to cooperate in contact tracing and notification of partners.

Other issues brought to the Joint Subcommittee's attention were the need for confidentiality and the ways to ensure such confidentiality; the appropriateness of disclosure of test results to health care workers, co-workers, spouses, parents, other family members, or employers; the delicate balance between confidentiality and appropriate disclosure; the difficulties related to proving intent for knowing and willful transmission of HIV infection; the appropriateness of isolation as an alternative to criminal penalties; the need to develop workable and reasonable policies for individuals residing in correctional institutions and mental health facilities vis-a-vis testing, counseling, reporting, contact tracing, notification of partners, confidentiality, isolation, treatment and care; and possible ways, e.g., education, counseling, or isolation, to limit at-risk behavior in such institutions and facilities, particularly sexual activities.

At the third meeting, the members received presentations from Dr. Judith B. Bradford of Virginia Commonwealth University; Dr. Andrew Heaton, medical director of Tidewater Regional Blood Services; Mr. Steven T. Foster, Commissioner of the Bureau of Insurance, State Corporation Commission; Ms. Roberta Meyer, senior counsel to the American Council of Life Insurance; Dr. Martin Block with Blue Cross/Blue Shield of Virginia; Mr. George Phillips with the Virginia Health Care Association; Mr. Bruce U. Kozlowski of the Department of Medical Assistance Services; Ms. Katharine M. Webb of the Virginia Hospital Association; Ms. Jane Settle, nurse coordinator of the Medical College of Virginia AIDS Clinic; and Ms. Linda Lesniak, coordinator for the statewide education program for health care

workers, Medical College of Virginia. The Joint Subcommittee also received testimony from 16 individuals during the public hearing portion of the meeting.

This meeting focused on issues relating to patient services. Examples of the issues were provision of services; continuity of care; availability of appropriate levels of care; the kinds of social services needed by AIDS patients and their families; the adequacy and safety of the blood supply; concerns relating to testing for HIV in blood banks; statewide assessment of knowledge, attitudes, and beliefs relating to AIDS; whether insurance companies that test individuals for HIV should be required to provide counseling services; and financing of care, including Medicaid and health insurance. The primary issues addressed by speakers during the public hearing included discrimination against persons with AIDS, opposition to mandatory testing, advocacy for comprehensive and long term health care for persons with AIDS, confidentiality for the AIDS patient, and access to treatment with AZT.

The questions posed during this third meeting were broadly focused on access to care; ways to increase the number of internists and family practitioners who are willing to provide primary care to asymptomatic HIV positive individuals; the possible effects on health care for the general population of incentives for family practitioners to care for HIV infected individuals, especially in rural areas in view of the existing shortage of family practitioners; the need for and availability and accessibility of specialty care; the lack of access to long term care since many homes for adults do not appear to knowingly accept individuals with AIDS and only one nursing home allocates any beds for AIDS patients; the appropriate role for hospitals in caring for AIDS patients; the problem of "dumping" AIDS patients on the teaching hospitals; the availability and accessibility of hospice care; the desirability of utilizing community and home-based programs to avoid institutionalization for AIDS patients; the nature of social services needed by AIDS patients and their families; the needs of children with AIDS, especially those children who are abandoned or who are in custody of the social services system; Medicaid eligibility and services and projected costs; and the interaction between Medicaid reimbursement and availability of care for AIDS patients and HIV infected persons. The Joint Subcommittee also examined issues related to precautions to ensure the safety and adequacy of the blood supply, including concerns that the fear of donating (which does not carry any risk of infection) has decreased the blood supply in Virginia. It was noted that the safety of donated blood has been adequately ensured since the advent of HIV testing.

During the fourth meeting, the Subcommittee received presentations from Dr. John F. Bunker of The Circle, Inc.; Ms. Susan E. Witter with the Department of Personnel and Training; Dr. Beatrice Cameron with the Fairfax County School Division; Ms. Chai Feldblum, counsel to the ACLU; Mr. Phillip Schellhaas, program director of IBM Government Relations; Dr. Donald M. Poretz, chairman of the Medical Society of Virginia Committee on AIDS; Ms. Regina Jamerson, counsel to the Health Insurance Association of America; and Ms. Dorothy N. Moga, assistant vice president of INOVA Health Systems, Inc. The Joint Subcommittee also heard testimony from 33 speakers during the public hearing portion of the meeting.

The fourth meeting focused on issues pertaining to AIDS education in public and professional settings, administrative policies and AIDS in the workplace, school attendance policies for children with AIDS, the concerns of the health insur-

ance industry, and an assessment of social services available or recommended for persons with AIDS. Speakers at the public hearing targeted their concerns for discrimination against persons with AIDS, opposition to any mandatory testing proposal, advocacy for accessible health care, and confidentiality for persons with the disease.

Many questions were examined related to the effectiveness of AIDS education with the general population and target groups, such as the gay community and intravenous drug abusers; the extent to which attitudes and behaviors have been modified by AIDS education; and necessary changes in education programs to reach sexually active adolescents, other at-risk populations, the general public, and employers.

During the Joint Subcommittee's deliberations related to administrative policies, particularly employment policies and school attendance policies, the discussion included questions concerning the scope of discrimination in the workplace, in public schools and institutions of high education, and in housing. Further, some comments focused on the appropriate components of state policy vis-a-vis discrimination, in view of already existing law and the Supreme Court decision in *School Board of Nassau County, Fla. v. Arline*, 480 U.S. 273 (1987).

The fifth meeting served as a work session, although the members also received presentations from Mr. Stephen D. Rosenthal, Deputy Attorney General, on criminalization issues; Kathy Hafford, Department of Health, on the first publication of an attitudes assessment survey; and Mr. Lester H. Hill, Virginia Capital Chapter of the American Red Cross, on the education activities of the Red Cross. The Joint Subcommittee also conducted its first review of the issues and alternatives paper prepared by its staff and made some tentative decisions on legislative recommendations to the 1989 Session of the General Assembly.

During the sixth meeting, the Subcommittee received presentations from Mr. Steven T. Foster, Commissioner of the Bureau of Insurance, State Corporation Commission, concerning proposed legislation to authorize the promulgation of insurance regulations related to HIV infection; Ms. Roberta Meyer, senior counsel to the American Council of Life Insurance, relating to the concerns of the life insurance industry about regulations on HIV infection; Dr. Theodore M. Hammett, consultant to the National Institute of Justice, concerning issues relating to HIV infection among inmates in correctional institutions; Mr. Ray Goodwin with the Department of Social Services, concerning social services for persons with AIDS; and Dr. Grayson Miller of the Department of Health, concerning a proposal for regional AIDS resource and consultation centers. The Subcommittee continued its discussion of the issues and alternatives paper including the efficacy of Medicaid waivers, education, and administration policies. The Joint Subcommittee's tentative proposals were also reviewed.

The Joint Subcommittee focused, during its seventh meeting, on review of the draft legislation required to implement its recommendations as well as an evaluation of the carry-over bills from 1988. The consensus was not to support any of the carry-over provisions. However, some of the concepts of these bills were the subject of recommendations.

IV. SUMMARY OF TESTIMONY, DISCUSSION, AND FINDINGS: 1988

COUNSELING

The issue of pre-test and post-test counseling, in addition to ongoing counseling services for individuals who are the subjects of tests for the presence of HIV antibodies, was the cynosure of an ongoing debate throughout the study in 1988. Virtually all speakers, as well as a majority of the Joint Subcommittee members, maintained that counseling is an appropriate and essential component of HIV antibody testing; at issue was the determination of who should be required to provide counseling. In addressing the members, all invited representatives of the insurance industry opposed the proposition that insurance companies should provide pre-test or post-test counseling when testing applicants for infection with HIV. Representatives of the industry stated that it is inappropriate and unprecedented that insurance companies should be required to provide counseling services for individuals with whom the companies have no business or contractual relationship.

TESTING

Issues related to when mandatory testing is appropriate and who should be required to submit to the test were debated vehemently during the course of the study. The Joint Subcommittee's discussion focused primarily on whether a policy of mandatory testing or voluntary testing should be recommended and under what circumstances. The members expressed concern for ensuring the full informed consent of the individual being tested under most circumstances. Cost of testing was another issue that received discussion; experts told the committee that a full protocol of tests to determine HIV antibody status costs approximately $30 per tested individual. The consensus of the Subcommittee was that widespread mandatory testing would not be cost effective or good public health policy. On the issues related to the testing of prostitutes and sexual offenders, the Joint Subcommittee was divided. Although several members supported testing requirements for prostitutes under certain circumstances, the Subcommittee as a whole did not support this concept. However, a majority of the members did recommend that a proposal for requiring testing of sexual offenders was appropriate so long as such a proposal provided a hearing mechanism specifically related to the test.

CONFIDENTIALITY

Confidentiality of tested individuals as well as infected persons was stressed repeatedly throughout the course of the meetings. Discussion revolved around the establishment of criteria for those who may have access to sensitive medical information, as well as ensuring the privacy and personal interests of tested individuals. The Joint Subcommittee came to believe that confidentiality concerns were paramount and must be addressed; therefore, staff was directed to develop a proposal requiring strict confidentiality with certain exceptions.

WORKERS' COMPENSATION

Members addressed the efficacy of clarifying and expanding the ordinary disease of life coverage and providing a specific statute of limitations for HIV infection under the workers' compensation laws of Virginia. The Subcommittee felt

that, because of the unique modes of transmission of HIV infection and the concerns of health care personnel, that the workers' compensation law should be amended to ensure that individuals who may be exposed to HIV infection in the work environment are protected in a reasonable manner.

PATIENT CARE

Discussion of patient care included every aspect of services, either available or recommended, for persons with AIDS, ARC, and those who are HIV seropositive. Members focused on the availability of care, the need for additional services including funding mechanisms for AZT treatments for indigent persons with AIDS, and determining the most efficient means of cost-effective service delivery (hospital, nursing home, hospice, or home care setting). The Joint Subcommittee became convinced that it is essential to develop a mechanism for educating the health care community. Therefore, two grant programs were developed to promote care. One of these programs was designed to be a component of community efforts in the delivery of home and community-based care and mental health services. The other program was conceived as a unique method of promoting and providing education to physicians, hospitals, nursing homes, and all other constituencies of the health care industry by establishing and funding a limited number of regional AIDS resource and consultation centers to assist the private sector in developing expertise in the care of persons with HIV infection and remaining current in the treatment and care of such patients.

DISCRIMINATION AGAINST HIV INFECTED PERSONS

Comments presented during the meetings focused primarily on the need to protect patients from all forms of discrimination including, but not limited to, employment, health care, and housing. After a careful review of Title 51.5 of the *Code of Virginia*, with particular focus on Chapter 9 (§ 51.5-40 et seq.), Rights of Persons with Disabilities, the Joint Subcommittee emphasized emphatically that this law applies to and provides the necessary protections for persons with AIDS and HIV infection. The members noted that § 51.5-3 defines "person with a disability" as "any person who has a physical or mental impairment which substantially limits one or more of his major life activities or **has a record of such impairment**" which is unrelated to the person's ability to perform in his employment or to his qualifications for a position; is unrelated to the person's educational capabilities; is unrelated to the person's ability to use and benefit from public accommodations or services; or is unrelated to the person's ability to buy, rent, or maintain property.

It was also noted that "physical impairment" is defined in this same section of the *Code* as "any physical condition, anatomic loss, or cosmetic disfigurement which is caused by bodily injury, birth defect, or **illness**." Therefore, it is noted that the two definitions interact to provide protections for persons with AIDS or persons with HIV infection because they, as persons with an **illness**, are persons with physical impairment or records of physical impairment pursuant to these definitions.

EDUCATION ON AIDS

Discussion and comments on presentations from AIDS education providers focused on education and accompanying behavior modification as the most effective

tools presently available to combat the spread of the AIDS epidemic. Misinformation and ignorance of the disease were discussed as primary factors that have contributed to the wave of fear that has gripped many citizens. A multifaceted, ongoing approach to AIDS education, conducted within all appropriate state agencies and private organizations, was discussed. Additionally, comments involved the usefulness of special training for physicians and other health care professionals. Discussion also included the need for programs designed to reach minority groups and hard-to-reach populations, such as intravenous drug users and prostitutes. Based on expert testimony, the Joint Subcommittee discussed the possibility that, too frequently, the concern for AIDS education is couched in terms of individual liberties versus the protection of the public. Comments centered on the idea that education should protect both of these interests.

The Subcommittee also discussed the need for education of teenagers and young adults, particularly because these groups are likely to be sexually active; are frequently beset by feelings of invulnerability; and, therefore, may engage in at-risk behavior. To paraphrase Thomas Wolfe, they are young, and, of course, they know they will never die. For these reasons, the members adopted a proposal focused on education of college students and expressed the hope that the family life education curricula will diligently comply with the statutory mandate to cover the etiology, effects, and prevention of sexually transmitted diseases.

HEALTH AND LIFE INSURANCE

Availability, affordability, and adequacy of coverage as well as discrimination were discussed. Joint Subcommittee members commented on the desirability of innovative approaches to cost containment, such as risk pools, while maintaining or improving the quality of insurance coverage to infected individuals. Experts stated that insurance companies were presently allowed to test individuals for presence of HIV antibodies, but were not required to reveal the purpose of such tests to applicants. Comments on this matter centered on the need for insurance companies to be able to test, although discussion also included a consideration of the individual's right to know the nature and purpose of administered tests. Experts commented on the need for confidentiality of testing, excluding information exchanges between insurance companies. Joint Subcommittee discussion included an assessment of the need for alternative approaches to reimbursement for health care in light of some predictions that, with respect to AIDS, the projected demands on the insurance industry may cause some companies to become insolvent.

Since the authority of the Bureau of Insurance to promulgate regulations governing the use of tests for antibodies against HIV was challenged, the Joint Subcommittee decided that specific authority for such regulatory activity should be granted to the State Corporation Commission.

AIDS IN THE CORRECTIONAL SETTING

Discussion included testing of inmates, confidentiality, housing of infected persons, the right of personnel to know who is infected, and problems involving the release of information. Presentations by experts in the correctional field focused on the inappropriateness of mass testing of prison populations. Experts stated that this may be a pointless and expensive activity, as there may be no real use for such

information; i.e., it is unclear what value any testing of the prison population would have. Experts noted that the problem of AIDS in correctional facilities will exist regardless of a mass testing policy. Because the policies related to HIV infection among inmates were vague, the Joint Subcommittee discussed the need for the Department of Corrections to develop a clear, comprehensive, and rational policy.

AIDS DEMENTIA

Expert testimony on the psychiatric disorders that can manifest in individuals with AIDS, ARC, or those who are HIV seropositive was presented. After hearing these presentations, the Joint Subcommittee discussed the need for increased psychiatric treatment and counseling for persons infected with the AIDS virus. Comments also focused on the fact that, although some individuals may have adequate health coverage, their insurance may not provide needed coverage for psychiatric treatment. Other discussion involved society's unwillingness to openly discuss sex, drugs, and alcohol and how this reticence may contribute to feelings of isolation and mental depression in some individuals who are infected with the AIDS virus.

CRIMINALIZATION

The Joint Subcommittee discussed the issue of criminalization of willful and knowing transmission of the AIDS virus. Comments centered on the difficulties of demonstrating the necessary burden of proof by prosecutors.

The Subcommittee, as a body, rejected the concept of criminalization of willful and knowing transmission of the disease as untenable. However, discussion included the possibility of criminalization of knowing donations of infected blood, other infected body fluids, organs, and tissues.

AIDS IN NURSING HOMES

Upon receiving expert testimony, the Joint Subcommittee discussed the issue of AIDS in nursing homes, staffing levels in these homes, and alternative approaches to long term care for persons with AIDS. Experts commented that the difficulty of recruiting nurses for any amount of money and in attracting nurses to a facility that cares for AIDS patients, as well as the strenuous demands AIDS patients place on existing staff levels, may make it difficult to obtain placements in nursing homes for the AIDS patient. Comments also focused on expert recommendations for the establishment of a regional network of facilities to render care and case management that would have the resources to assist persons with AIDS in a long term care environment.

AIDS AND MEDICAL ASSISTANCE SERVICES

Personnel of the Department of Medical Assistance Services told the Joint Subcommittee that the Department anticipates an expenditure of $5.4 million to assist AIDS patients in Virginia over the next biennium. Experts stated that this figure is probably an underestimation. As a result of this testimony, the members discussed home-based care as a cost effective way of serving AIDS patients. The implementation of community-based waivers for the Virginia Medicaid program to

include expanded home care services, greater reimbursement for home health care aides, and case management was discussed. The Subcommittee also discussed the need to revise the reimbursement system for nursing homes based on the intensity of the required services in order to improve access to long term care for AIDS patients.

AIDS, HEMOPHILIA, AND THE BLOOD SUPPLY

Basing its opinion on presentations by specialists in the care of hemophilia patients, as well as representatives of regional blood banks, the Joint Subcommittee felt that the blood supply is effectively protected. The Subcommittee emphasized that donating blood does not present a risk and urged citizens to assist the blood banks in maintaining essential supplies by continuing to be or becoming blood donors. Comments concerning the plight of the many hemophiliacs, particularly children, who contracted AIDS through contaminated blood factor, were accompanied by descriptions of the state programs for hemophiliacs. Also discussed were recommendations for universal precautions similar to the Centers for Disease Control guidelines on handling blood and blood products; such policies would treat all body fluids, particularly blood, as potentially infected.

AIDS IN THE WORKPLACE

Discussion of this issue centered on protection of infected individuals against discrimination in the workplace, employee education programs, and management training. Other comments included recommendations for revising the Commonwealth's employment policy related to HIV infection to reflect a more realistic understanding of transmission of the disease, directing the Department of Health to establish an AIDS in the workplace initiative, and demonstrating appropriate leadership at the state level among managers and supervisors in the workplace.

Discussion on education in the workplace focused on expert recommendations that persons with AIDS or HIV infected individuals should be treated no differently than other employees with life-threatening diseases. Confidentiality, employee assistance, and lists of available resources were additional topics discussed by the Joint Subcommittee.

SCHOOL ATTENDANCE POLICIES FOR CHILDREN WITH AIDS

Based on the testimony of medical experts, who indicated that there are no recorded incidences of casual transmission of the AIDS virus, the Joint Subcommittee discussed school attendance policies for infected children. Comments were made about the need for certain exceptions to this proposed recommendation, which would take into account a child's behavior, medical condition, and expected interactions with others. Issues of confidentiality and determining which school employees, if any, should be informed of a child's medical condition were additional topics of discussion.

V. RECOMMENDATIONS: 1989

The Joint Subcommittee's recommendations to the 1989 General Assembly were:

■ That the Bureau of Insurance within the State Corporation Commission be given specific authority to promulgate regulations governing insurers' practices related to AIDS and infection with HIV. This authority was intended to include group and individual life and health insurance (see HB 1971 of 1989).

■ That, within the workers' compensation law, the ordinary disease of life coverage be clarified by extending coverage to all laboratory workers and health care workers engaged in direct delivery of health care and that a specific statute of limitations of two years after a positive test for infection for symptomatic or asymptomatic HIV infection be established (see HB 1972 of 1989).

■ That the Boards of Health; Mental Health, Mental Retardation and Substance Abuse Services; Rehabilitative Services; Social Services; and Medical Assistance Services be required to ascertain and eliminate any discriminatory regulations or policies (see HB 1974 of 1989, § 2.1-51.14:1).

■ That the Board of Education develop model guidelines for school attendance in cooperation with the Board of Health by December 1, 1989, and that every school board adopt guidelines for school attendance consistent with the Board's guidelines by July 1, 1990 (see HB 1974 of 1989, § 22.1-271.3).

■ That Virginia public institutions of higher education, in cooperation with the State Council of Higher Education and the Department of Health, develop a model education program for college students on the etiology, effects, and prevention of HIV infection, and that all boards of visitors or other governing bodies of public institutions of higher education adopt an education program on HIV infection by July 1, 1990 (see HB 1974 of 1989, § 23-9.2:3.2).

■ That a two-pronged system of community grants be developed and funded within the Department of Health to provide for the development of direct patient services and broad-based community AIDS education efforts (see HB 1974 of 1989, § 32.1-11.1).

■ That no more than five regional AIDS resource and consultation centers be established through a second grant program to be administered by and funded through the Department of Health. These centers were intended to address various needs for expanded medical care and support services for persons with HIV infection through education of health care professionals on a broad range of AIDS related issues; clinical training for health care practitioners and students; medical consultation to community physicians and other health care providers; provision of current technical medical materials such as manuals and protocols for the management of HIV infection and medical literature; and facilitation of access to health care services, mental health services, substance abuse services, support services, and case management for HIV infected persons (see HB 1974 of 1989, § 32.1-11.2).

■ That mandatory reporting of positive test results for infection with HIV be implemented (see HB 1974 of 1989, § 32.1-36).

■ That confidentiality protections be provided for individuals testing positive for HIV infection with a civil penalty of not more than $5,000 per violation and the right of the subject of an unauthorized disclosure to sue for actual damages or $100, whichever is greater. The subject of the unauthorized disclosure may also recover reasonable attorney's fees and court costs (see HB 1974 of 1989, § 32.1-36.1).

■ That informed consent for testing for HIV be required with certain narrow exceptions relating to anonymous testing sites, seroprevalence studies, and blood donations (see HB 1974 of 1989, § 32.1-37.2, subsection A).

■ That opportunity for face-to-face disclosure and appropriate counseling be afforded every person who is the subject of any test to determine HIV infection, except for insurance companies which would be governed by the Bureau of Insurance's regulations and blood collection agencies which would be required to notify the Department of Health of positive tests (see HB 1974 of 1989, § 32.1-37.2, subsections B, C, and D).

■ That the Board of Health's authority to conduct contact tracing of sex partners of persons infected with HIV be clarified (see HB 1974 of 1989, § 32.1-39).

■ That deemed consent to testing and release of test results related to HIV infection be statutorially accorded when any health care worker is exposed to the body fluids of a patient in a manner which may transmit HIV infection or when any patient is exposed to the body fluids of a health care worker in a manner which may transmit HIV infection (see HB 1974 of 1989, § 32.1-45.1).

■ That anonymous testing for infection with HIV be made available in all health services areas in the Commonwealth (see HB 1974 of 1989, § 32.1-55.1).

■ That any person who donates or sells blood, other body fluids, organs, and tissues, knowing that the donor is infected with HIV and who has been instructed that such donations may transmit the infection, shall be subject to a Class 6 felony upon conviction (see HB 1974 of 1989, § 32.1-289.2).

■ That a mechanism be provided to ensure that testing for HIV infection can be obtained in the case of certain sexual offenders (see HB 1973 of 1989).

■ That the Joint Board Liaison Committee of the Secretary of Health and Human Resources promote the development of interagency coordinating committees and local protocols designed to reduce red tape, ensure cooperation between agencies, and facilitate coordination of services to individuals who are infected with HIV (see HJR 425 of 1989).

■ That the health regulatory boards within the Department of Health Professions promote appropriate provider education on HIV infection which is related to the scope of practice of the regulated health professions and emphasizes the responsibilities and ethical duty of health care providers for the care and treatment of all individuals who are sick (see HJR 426 of 1989).

■ That the Board and Department of Medical Assistance Services seek certain waivers to provide unique services to adults and children with HIV infection (see HJR 427 of 1989).

■ That the Board and Department of Medical Assistance Services develop a methodology for reimbursement for licensed and certified nursing home beds based on the intensity of the required services (see HJR 428 of 1989).

■ That the Secretary of Administration examine and revise the Commonwealth's employment policy related to infection with HIV and AIDS in order to correct any inequities and to avoid creating any false public perceptions concerning the transmission of HIV infection (HJR 429 of 1989).

■ That the Department of Corrections develop a comprehensive, long-range plan for the management of HIV among inmates in its facilities (HJR 430 of 1989).

■ That this study be continued for a second year in order to examine placement and isolation policies, funding mechanisms (including risk pools), and other issues related to infection with HIV (HJR 431 of 1989).

VI. WORK OF THE JOINT SUBCOMMITTEE: 1989

During the second year of its study, the Joint Subcommittee conducted five meetings, one of which was devoted to a public hearing. All of the meetings were held in Richmond. At the first meeting, presentations were made by Dr. C.M.G. Buttery, Commissioner of Health; Ms. Sarah H. Jenkins of Health and Human Resources; Mr. Bruce U. Kozlowski, Director, Department of Medical Assistance Services; Ms. Susan E. Witter, Department of Personnel and Training; and Mr. R. Forrest Powell, Department of Corrections. During this first meeting, the members received progress reports on state agency activities, as authorized by HB 1974 and House Joint Resolutions 425 through 430 of 1989.

The Department of Health reported that 21 proposals were received for funding under the AIDS services and education grants program, eight of which received funds. The eight funded organizations were the Richmond Street Outreach Project, the Tidewater AIDS Crisis Task Force, the Virginia Beach Health Department (in collaboration with the University of Virginia's Division of Student Health), the Rappahannock-Rapidan Health District, the AIDS Support Group of Charlottesville, the Council of Community Services in Roanoke, the Prison Outreach Program of the Hampton/Newport News Area, and the University of Virginia Office of Medical Information.

Organizations receiving state funding for the development of AIDS regional resource and consultation centers were the Medical College of Virginia Hospitals, Fairfax Hospital, and the Medical School at Hampton Roads. Only three centers were funded in 1989 based upon an evaluation of monies needed to establish adequate centers; the determination was made to provide at least $300,000 to each organization. A total of $915,000 was awarded for this purpose. In addition, a pilot treatment program was established in Lynchburg. Department officials noted that money was, in fact, a limiting factor in determining the number of proposals to be funded and that other good proposals had been received.

The Department of Health also reported that anonymous testing for HIV infection would be available in 16 health districts by October 1, 1989. It was noted

that the mandatory reporting of positive test results took effect on July 1, 1989. The regulations for disease reporting and control were amended to include HIV infection as a reportable disease. By mid-September of 1989, 117 reports were received by the Department. Progress was also reported on the development of guidelines for school attendance of HIV infected children in cooperation with the Department of Education, and preliminary discussions had been held between the Department of Health and the State Council of Higher Education for Virginia on the development of model AIDS education programs for college students.

The Joint Subcommittee was informed that cases of AIDS continue to increase in Virginia, although the rate of increase appears to be declining.

The Office of the Secretary of Health and Human Resources presented the Subcommittee with an update on the directives of HJR 425 requiring the development of interagency coordinating committees and local protocols to improve delivery of services to HIV infected persons. The Joint Board Liaison Committee reported that policies to remove obstacles to interagency cooperation were being prepared. The Committee is composed of the Departments of Education; Health; Mental Health, Mental Retardation and Substance Abuse Services; Rehabilitative Services; Social Services; and Corrections. Each of the member agencies was reviewing its policies.

The Department of Medical Assistance Services noted progress in developing an application for Medicaid AIDS waivers to provide services to HIV infected adults and children. The Director of the Department stated that, based on a review and comparison of national and Virginia statistics on AIDS cases, it is apparent that Virginia has a higher incidence of whites and blacks with AIDS in its total patient population, as compared to the national average. Virginia has a lower incidence of hispanics and intravenous drug abusers with AIDS in its patient population than does the nation. It was also noted that Virginia is experiencing an increase in the number of women with AIDS. An analysis of pediatric AIDS cases indicates that, although children do not seem to be having difficulties in obtaining care, Medicaid costs for children with AIDS are one and one-half times greater than for adults.

The 1989 Medicaid statistics for Virginia AIDS patients were characterized as 86 percent male patients and 63 percent black, with 70 percent age 35 or younger. Twenty-nine percent were recommended for nursing home care and 53 percent for personal home care. Twenty-two percent of these Medicaid cases came from the Eastern region of the Commonwealth.

The average length of time that Medicaid provided services to AIDS patients, according to data available in 1989, was 10.3 months. The average Medicaid lifetime payment for services for AIDS patients was $21,000. The life-prolonging drug AZT costs approximately $2,000 per Medicaid patient. The average hospital stay for AIDS patients in Virginia lasts 12.3 days, about five days longer than for the average hospital patient. Medicaid officials emphasized that Medicaid costs for AIDS patients are predicted to escalate dramatically in Virginia; 1991 costs are anticipated to exceed $5.6 million.

The Joint Subcommittee was informed that the Department of Medical Assistance Services reimbursement methodology will concentrate on ensuring nursing home access (when necessary); implementing waiver programs; improving

reimbursement for transportation costs; continuing efforts to reimburse the expense of durable medical equipment; preventive health care; and availability of hospice services. It was noted that the difficulty of providing hospice care pivots on the limited number of these facilities which are certified for Medicare/Medicaid reimbursement. Of the 33 hospices in Virginia in 1989, only six were qualified for Medicare/Medicaid reimbursement, 10 were considering taking the steps to become qualified, and 17 were not pursuing certification.

The Director of the Department of Medical Assistance Services stated that offering Medicaid reimbursement for respite care for home providers may be the best investment the Department could make, as informal home care is the least expensive form of long term care available for persons with AIDS.

He stated that the Department is continuing to work on the development of a waiver for case management services, personal care, respite care, and nursing care. He stressed that, given the expansion of Medicaid services to persons with AIDS and depending on the future policies of insurance companies, it is estimated that the number of persons with AIDS receiving some level of Medicaid services may reach 40 percent of the total Medicaid population and that Medicaid will pay 25 percent of the health care costs of these patients.

A status report on the implementation of HJR 429, which relates to an examination and revision of the Commonwealth's employment policy with respect to HIV infected individuals and persons with AIDS, was presented. According to the report, new guidelines, incorporating language from the Federal Office of Personnel Management's bulletin on AIDS (March 1988), have been initiated. Specifically, the guidelines address issues of inability to work, privacy, confidentiality, and leaves of absence, while providing detailed information on available resources to assist employees and management. The new guidelines corrected information in the original guidelines that appeared to indicate that employees who refused to work with fellow employees who they suspect may be HIV infected would receive preferential treatment. Following the evaluation of the AIDS Policy and Review Task Force in the Attorney General's Office, the new guidelines were to be submitted to the Governor for approval.

The Department of Corrections presented an update on the status of implementation of HJR 430, relating to the Department's development of a comprehensive, long-range plan for the management of HIV infection and AIDS. This report stated that the Department was engaged in efforts to protect inmates who may be vulnerable to sexual attacks; identify high-risk individuals; initiate education programs and counseling to inmates, prison workers and officials; identify appropriate use of segregation or isolation policies of aggressive individuals who are HIV infected; address the need for universal precautions; and examine when and why testing should be offered or required in correctional institutions. Preliminary findings appeared to indicate that HIV infection in the Virginia correctional system is primarily confined to intravenous drug abusers and survey data indicated that most inmates were knowledgeable about AIDS. Projected cases of incarcerated persons with AIDS were approximately 130, with the estimated cost of providing these individuals with AZT being about $650,000 per year.

The Department's revised policy was described as allowing voluntary testing for HIV infection. There was no regular testing of the prison population, nor did the Department recommend mandatory testing. Studies of inmates who have been

provided education on AIDS were cited to demonstrate that these persons show an increased and active interest in their own health and medical conditions. Treatment, education, and counseling programs were described as essential.

During this first meeting, the staff of the Joint Subcommittee presented a review of the insurance buy-in program in Michigan which is designed to reduce and delay Medicaid expenditures by the state for care of persons with AIDS. After discussing the efficacy of implementing this program in Virginia, members concurred on the need to have input from the State Corporation Commission's Bureau of Insurance, as well as a status report on the Bureau's development of regulations for insurance industry underwriting practices with respect to AIDS and HIV infection.

At the second meeting, the Subcommittee received presentations from Mr. Steven T. Foster, Commissioner, Bureau of Insurance, State Corporation Commission; Ms. Roberta Meyer, legislative director, and Mr. William Shands, Virginia counsel, American Council of Life Insurance; and Ms. Joan Gardner, spokeswoman for Blue Cross/Blue Shield of Virginia.

The Commissioner of Insurance, State Corporation Commission, presented a review of the proposed rules governing underwriting practices and coverage limitations and exclusions for AIDS. He stated that, because the insurance industry insists that testing for the presence of HIV infection is appropriate and ought to be allowed, the SCC will agree with this position, preconditioned, however, on the stipulation that companies may not issue an adverse underwriting decision in the absence of test results. He noted that the only exception to this SCC policy is if a prospective insurance buyer refuses to take a test for presence of HIV infection. The Commissioner explained that testing must be done in a nondiscriminatory manner; companies will be allowed to set certain age and threshold limits on testing. He said that written consent for testing must be obtained from the applicant and confidentiality of test results must be maintained. Insurance companies will not be required to provide counseling for applicants in the event of adverse underwriting decisions. The Commissioner stated that the SCC did not feel it would be appropriate to place such a requirement on companies which have no contractual relationship with an applicant. However, companies will be required to make applicants aware of the availability of face-to-face counseling from the Department of Health.

On the issue of preexisting conditions, it was explained that insurance companies will be required to prove misrepresentation by applicants who show HIV infection within a two-year period following policy issue.

Insurance industry concerns were addressed by representatives of the American Council of Life Insurance (ACLI). It was noted that the ACLI believed that the issues relating to HIV infection and insurance underwriting practices that are addressed in the SCC's rules are more appropriately handled by regulation than by legislation and that the ACLI appreciated the fact that both testing and related questions are permitted under the SCC's regulation.

The ACLI generally supported the rules' prohibition on underwriting on the basis of sexual orientation and requirements relating to written informed consent for testing and strict confidentiality for applicants. However, the ACLI continued to be concerned about prohibitions of adverse underwriting decisions solely on the basis of HIV related symptoms and requirements that insurers provide applicants

notification of both positive and negative test results. The notification requirements were described as constituting an unnecessary administrative burden on the insurance industry and the prohibition on considering preexisting conditions as a basis for underwriting decisions was characterized as a deviation from an accepted practice.

Concerning the issuance of living benefits products, it was explained that the U.S. life insurance industry is in the process of developing a new generation of policies which provide, under certain circumstances, for payment of death benefits prior to the time such benefits would otherwise have been available. The premiums for these products can be significant, although cost-effective approaches to the high cost include use of life insurance policies as a foundation to provide long term care benefits or benefits in the event of the onset of specific diseases or terminal illnesses. Coverage of this sort can be included as part of an original policy or added as a rider to a policy. Attaching riders to existing contracts eliminates the administrative costs of creating new contracts.

Three types of these products are under national development and are referred to generally as accelerated death benefits, accelerated benefits, advanced death benefits, and advanced benefits. The Virginia Bureau of Insurance refers to all of these products as living benefits. These products fall into three basic categories, long term care; terminal illness or advanced death benefits; and dread, catastrophic or specified disease. There are also dependent and independent riders, the former referring to long term benefits which are related to underlying life insurance benefits; the latter indicative of long term benefits which are unrelated to underlying life insurance benefits. With dependent riders, the insured becomes essentially his own beneficiary, although the cash value of the benefit commonly is lower. Independent riders pay benefits that are exclusive of other benefits, including death benefits and the cash value of the policy. Therefore, when long term benefits are paid under an independent rider, neither the death benefit nor the cash value of the contract is reduced.

Long term care riders typically provide coverage for not less than 12 consecutive months for one or more necessary diagnostic, preventive, therapeutic, rehabilitative, or maintenance or personal care services provided in a setting other than an acute care unit of a hospital.

A spokeswoman with Blue Cross/Blue Shield of Virginia presented an evaluation of Michigan's insurance buy-in program for persons with AIDS and those who are HIV infected and remarked on the Blue Cross/Blue Shield open enrollment policy. Blue Cross/Blue Shield is statutorially required to provide open enrollment policies to individual subscribers and small group subscribers, such as small businesses with 50 employees or less. The policies are offered without any underwriting criteria. HIV related conditions are not segmented out from coverage in underwriting decisions with respect to open enrollment policies. Blue Cross/Blue Shield is considered the insurance underwriter of last resort based, in part, on such open enrollment policies and other insurance products the company offers.

Blue Cross/Blue Shield does maintain a preexisting conditions clause. During the first year of a policy, Blue Cross/Blue Shield can deny coverage for preexisting conditions which may become manifest in that time period. HIV related conditions would fall under this clause. It was stated that preexisting conditions clauses are necessary to ensure policy affordability.

It was averred that, based on a number of considerations, the Michigan insurance buy-in program may or may not be appropriate for Virginia. The Michigan program was developed by that state's social services agency as a solution to Medicaid budget problems in order to ensure greater participation from the private sector. The program is available to AIDS patients who are no longer able to work and, therefore, may stand to lose insurance benefits as offered through an employer. The federal law, COBRA, requires employers to offer 18 months of extended group benefits to a former employee, provided that the employee pays the premiums. Thus, a former employee has some assurance--for at least 18 months after employment termination--that insurance coverage is available.

However, it was pointed out that persons with AIDS often become financially incapable of meeting the cost of premiums because of the extraordinary expenses incurred through their medical conditions. These persons are then faced with no alternative but to "spend down," thereby becoming eligible for Medicaid benefits at the state's expense.

The Michigan buy-in program is administered through the state's Medicaid program. The costs of insurance premiums of persons with AIDS are picked up by Medicaid, thereby postponing the cost to Medicaid of health care services for persons with AIDS who otherwise would be unable to afford their own care.

With respect to the applicability of such a buy-in program to the needs of AIDS patients in Virginia, the Joint Subcommittee was asked to postpone any implementation of a buy-in program for at least a year so that the Michigan program might be monitored and evaluated. It was noted that insurance buy-in programs have the potential to raise insurance premiums among group and individual policy holders, particularly small employers.

The Joint Subcommittee staff provided a review of due process and isolation procedures in Minnesota and Florida. It was explained that the Virginia law on isolation, as it existed in 1989, would probably present difficulties to the Commissioner of Health where isolation or quarantine of HIV infected persons posing a threat to the health and welfare of the public is concerned. The steps necessary for isolating or quarantining a person who is identified as posing a risk to the public health were described.

It was emphasized that, because there is neither a cure for AIDS nor an effective treatment for neutralizing HIV infectiousness, there remains the question of what purpose isolation would serve. Because HIV infected individuals remain infectious for life, any evaluation of isolating or quarantining persons engaged in knowing, at-risk behavior would have to address the question of the length of time such individuals would be quarantined or isolated.

During this lengthy meeting, the Joint Subcommittee also discussed insurance risk pools, following a staff presentation on this issue.

In recent years, several studies have been conducted at the request of the General Assembly on health insurance risk pools, health insurance for the unemployed, and the extent of health insurance coverage. In 1989, several legislative study committees were examining related issues. Examples of previous studies of significance to this study were cited as follows:

● In 1985, as a result of a legislative study of the availability of health insurance for the chronically ill, the insurance laws were amended to require Blue Cross/Blue Shield to maintain open enrollment at all times to all persons. This study committee recommended that in exchange for maintaining continuous open enrollment, the companies be provided tax exempt status. The bill which implemented the study committee's recommendation also required any company electing to terminate open enrollment to notify the Bureau of Insurance of its intention. This study committee did not recommend the implementation of a risk pool because of the availability of health insurance through open enrollment. However, additional study of these mechanisms was recommended (*The Interim Report of the Joint Subcommittee Studying Health Insurance Coverage Available in the Commonwealth for Individuals with Chronic Health Problems*, House Document No. 17, 1985).

● In 1986, a study conducted by the State Corporation Commission's Bureau of Insurance reported that 10 percent of Virginians did not have any health insurance coverage. The survey conducted as part of this study also demonstrated that another eight percent of Virginians were underinsured, i.e., did not have comprehensive health insurance coverage. The survey indicated that more than 83,000 people in Virginia were not able to obtain health insurance because of some existing health problem (*The Report of the State Corporation Commission's Bureau of Insurance on Degree of Health Insurance Coverage of the General Population of Virginia*, House Document No. 20, 1987).

● In 1987, the Bureau of Insurance conducted, pursuant to HJR 329, a study of health insurance risk pools. The establishing resolution also requested the Bureau to prepare a contingency plan for implementing a Virginia risk pool. In view of the Blue Cross/Blue Shield continuous open enrollment, this study did not find any need for the implementation of a risk pool in Virginia. However, as required by HJR 329, the Bureau's report included a proposal for a Virginia risk pool in the event that either of the Blue Cross/Blue Shield plans notifies the State Corporation Commission of the intention to eliminate the continuous open enrollment program (*The Report of the State Corporation Commission's Bureau of Insurance on a Contingency Plan for Implementing a Health Insurance Pooling Mechanism in Virginia*, House Document No. 21, 1988).

There are approximately seven or eight states with various forms of operational health risk pools. These pools have short histories; however, financing difficulties have developed in some of these programs.

A health insurance risk pool is a mechanism designed to make health insurance available to individuals who are uninsurable because of existing health conditions. It is important to note that these plans are intended to improve the availability of health insurance coverage and that they do not provide, necessarily, affordable insurance for the working poor.

As with other health insurance plans, risk pools have the following components: preexisting condition requirements, eligibility requirements, deductibles, benefits, and premiums. In addition to these components, risk pool programs include residency requirements and funding mechanisms.

Risk pools are most often intended to provide access to insurance for those who can afford it, but cannot obtain it. Therefore, residency requirements are included to ensure that the citizens of the relevant state--those who live, work, and contribute to the well-being of the state--are the beneficiaries of the plan.

Because risk pools provide coverage to individuals who have the potential for generating expensive claims and because the premiums must be set at a level that will increase the accessibility of coverage and provide an incentive for individuals to buy risk pool coverage, assessments are, in the usual case, made against the licensed insurance companies providing various kinds of health care insurance. These funds are used to defray "expenses that exceed the total amount of premiums collected" (House Document No. 21, 1988, page 8). In most states, the premium taxes are reduced according to the assessments paid by these insurance companies. One reason for residency requirements is that many states having risk pools provide "insurers a credit for assessments that reduce tax revenues, so the state is in effect paying part of the cost of the care" (House Document No. 21, 1988, page 7).

All health insurance plans include restrictions on preexisting conditions in order to provide disincentives for individuals to wait until they are ill to purchase health insurance. In the case of the risk pools, there appears to be a considerable variation in the length of these waiting periods. Because the pools are intended to provide coverage to those who cannot obtain it because of existing health conditions, a balance must be struck in setting the waiting period--not too short to provide individuals with an incentive to buy health insurance prior to needing it and not too long to provide a disincentive because of the possible need for the individual to pay for expensive care during the waiting period. The waiting periods are generally shorter than those of the commercial insurance companies and Blue Cross/Blue Shield (which may range from six months to two years). Most states have set the risk pool exclusion for six months.

The issue of what type of individual should be targeted for participation in the risk pool is very important. Although there are many variations from state to state in eligibility criteria, most states require eligible individuals to be rejected by at least one insurer. Some states do not allow eligibility for Medicare beneficiaries or Medicaid recipients. Some programs allow coverage of small groups. One state provides eligibility for individuals with specific preexisting conditions. Eligibility must be designed to make coverage available to those who cannot obtain coverage in the voluntary market; however, eligibility must also be designed to provide as broad a base of participants as possible in order to enhance the financial viability of the program without infringing on the activities of private enterprise.

Although there have been reports of low participation from some of these programs, most of the programs have premium caps to ensure accessibility of the coverage. "The premiums charged are expressed as a percentage of the average individual standard premium that is charged by the five largest insurers by market share in the state" (House Document No. 21, 1988, page 8). It appears that the premiums for most pools have been set at a maximum of 150 percent of this average individual standard premium. If the premiums were established actuarially, the costs would be prohibitive. Deficits have been reported in some pools which have resulted in substantial assessments against the state's licensed health insurers.

Deductibles are used in risk pools as in other health insurance programs to sensitize the individual to the cost of health care and to help lower the premium for the coverage. In many plans, a variety of deductibles are offered so that clients can make viable financial decisions. Of course, the premiums vary according to the amount and application of the deductibles.

The benefits provided by the pool must be broad because the target groups include chronically ill individuals. Therefore, major medical, basic medical, and hospital coverage are necessary and might include outpatient emergency services, prescription drugs, home health care, hospice care, outpatient mental health services, laboratory tests, durable medical equipment, hospital care, oral surgery, etc.

In its report, *a Contingency Plan for Implementing a Health Insurance Pooling Mechanism in Virginia* (House Document No. 21, 1988), the Bureau of Insurance made the following recommendations for a contingency risk pool in the event either of the Blue Cross/Blue Shield plans decides to eliminate the open enrollment program:

▲ That a six-month preexisting condition period be provided in order to alleviate the concerns about lack of coverage for existing chronic health conditions.

▲ That participants be required to reside in Virginia for six months prior to application for coverage to be eligible because of the potential incentive for individuals with chronic health problems who reside in neighboring states that do not have risk pools to move to Virginia.

▲ That eligibility for participation in the pool be limited to individuals who have been rejected twice by the commercial market; and that family and individual coverage be made available in order to "allow other family members to obtain coverage as a unit in the event that the wage earner in the household is the uninsurable individual" (House Document No. 21, 1988, page 11). The Bureau's proposal also recommended that Medicare beneficiaries and Medicaid recipients not be permitted to participate since they already have health care coverage and that inclusion of small groups under 10 be considered.

▲ That a cap of 150 percent of the standard individual premium rate be established for any Virginia risk pool in order to accomplish the purpose of making health care coverage available to uninsurable individuals without pricing the coverage so high that only the most ill individuals would find it attractive.

▲ That in the event of losses that exceed the revenues generated by the premiums, an assessment be levied against all organizations regulated by the SCC.

▲ That any such risk pool offer a variety of deductibles to provide individuals with options to fit their financial needs and that one deductible be offered that would "provide coverage that is comparable to coverage now offered in open enrollment contracts" (House Document No. 21, 1988, page 13).

▲ That the benefits or covered services offered by any risk pool include a range similar to those offered by the Blue Cross/Blue Shield of Virginia standard plan, i.e., hospital services, outpatient emergency services, prescription drugs, skilled nursing facility care, home health care, hospice care, outpatient mental health services, diagnostic tests, etc.

The Joint Subcommittee noted that the open enrollment policy of Blue Cross/Blue Shield is required in Virginia in exchange for a reduction in the premium tax. An individual who is rejected by a commercial insurance company can thus turn to Blue Cross/Blue Shield for coverage under the open enrollment

policy. The only instance in which an individual who has been rejected by a commercial company will not be eligible for open enrollment is when the individual is eligible for group insurance with a commercial carrier through his employer, but has been rejected for such group coverage. Under these circumstances, Blue Cross/Blue Shield has the right not to accept the individual.

Risk pools are not generally a mechanism to provide affordable insurance to low income persons. The crucial difference is that risk pools are meant to increase availability of health insurance to individuals who are high-risk insureds. However, in most cases, these programs do not increase accessibility because of their costs to the individual.

Although some new mechanisms have been developed in various states which are meant to provide health insurance coverage to low income persons and small groups, these programs involve complicated agreements between the pool and various health care providers (similar to preferred provider agreements or health maintenance organizations) and can involve direct subsidies from the state. At this time, such projects are demonstration or pilot programs and only time will tell if these programs will be viable.

In those states which have implemented risk pools, there appears to be an emerging trend of significant deficits because of low participation and high utilization due to the participation of persons with serious health problems. In the event deficits develop in these programs and assessments are made against the licensed insurers, the offset in the premium taxes has resulted in a significant reduction in revenues to the implementing state.

Members of the Subcommittee agreed that, regardless of what form in which the Commonwealth might shape an insurance risk pool program, ultimately the public would bear the costs of such a program, either through higher taxes or by an increase in the cost of insurance premiums.

During its third meeting, the Joint Subcommittee received testimony from Dr. Stuart P. Adler, a pediatrician with the Medical Colleges of Virginia; Ms. Betsy Brinson, volunteer director of the Richmond AIDS Ministry; Ms. Kathryn A. Hafford, Virginia Department of Health; Mr. Jon Klein, executive director, Richmond Street Outreach Project; Ms. Joyce McCray, Tidewater AIDS Crisis Taskforce; Mr. McDennis Thomas, Hopkins House, Inc.; and Mr. R. Forrest Powell, Virginia Department of Corrections. Dr. Adler was accompanied by Dr. Gilberto Rodriguez of MCV, Dr. Thomas Rubio of Eastern Virginia Medical School, and Dr. Frank Saulsbury of the University of Virginia; all are pediatricians.

Dr. Adler stated that in Virginia no unified program for children with AIDS exists. He said that, moreover, the state-funded AIDS resource and consultation centers will neither directly nor indirectly benefit children with AIDS. In his opinion, even if the resource centers would be beneficial to children in need of services, by combining children with adults in the program, the state would in effect be placing children in competition with adults for scarce resources. By way of example, Dr. Adler pointed out that departments of pediatrics are separate from departments of internal medicine within the medical schools and noted that, in Virginia, there is not a single program for children that is administered concurrently with a program for adults.

It was noted that the illnesses developed by HIV infected children are different from the illnesses developed by infected adults. The testifying pediatricians recommended that the Joint Subcommittee consider an individual education program for children with AIDS. An estimated 270 children were said to be born of HIV infected mothers in Virginia annually. Data from the Virginia Department of Health, Division of Epidemiology, indicated that the HIV infection rate for pregnant women and women of child bearing age across the state is 0.3 percent.

Specialized care for children is available at four locations in Virginia: Children's Hospital of the King's Daughters in Eastern Virginia, the Medical College of Virginia in Central Virginia, the University of Virginia in Western Virginia, and, in Northern Virginia, children who are HIV infected are referred to metropolitan Washington hospitals, including Georgetown, the National Institutes of Health, and Walter Reed.

Dr. Adler and his colleagues proposed that funding be recommended to establish a statewide pediatric AIDS committee and pediatric health care teams at each medical center to coordinate individual education programs for each HIV infected child and his family in the Commonwealth. Each pediatric health care team would be comprised of a staff pediatrician and a nurse practitioner. A state-wide pediatric AIDS committee would maintain confidential records of HIV infected children, review problems occurring at each treatment center, track children with AIDS, and monitor demographic changes in seroprevalence of HIV infection in pregnant women, intravenous drug abusers, and individuals attending state STD clinics. This proposal was focused on helping Virginia prepare for increases or decreases in the rate of HIV infection among children.

Issues relating to Virginia Department of Health guidelines and mandatory in-service training for nursing home employees were also addressed. It was alleged that the outlook is not favorable for increased numbers of persons with AIDS to be accepted into nursing facilities. It was suggested that some level of in-service AIDS education be required for all nursing home employees in order to alleviate the fear many nursing home employees have of persons with AIDS. Additionally, education would serve the further purpose of increasing volunteers' willingness to assist persons with AIDS who live at home, but need some level of in-home assistance.

The delivery of AIDS education to target populations with an emphasis on street outreach programs was also addressed through descriptions of various programs such as the Richmond Street Outreach Program, the outreach program of the Tidewater AIDS Crisis Taskforce, and Hopkins House in Alexandria. These programs strive to develop a rapport with at-risk individuals through various activities, e.g., distribution of literature, condoms, and bleach for sterilization of syringe needles. Outreach programs typically attempt to contact at-risk individuals where such persons congregate.

It was stated that a direct approach--one which does not speak euphemistically to at-risk persons--is needed if efforts to reduce incidences of HIV infection are to succeed, e.g., street slang, the language of at-risk populations, must be used to communicate successfully with the at-risk population.

Abuse of intravenous drugs, several speakers emphasized, presents the greatest risk of infection with HIV among minority populations. Without adequate

facilities to treat intravenous drug abusers, these speakers said there can be little meaningful progress in reducing incidences of HIV infection among this population. Because most intravenous drug abusers are alienated from the general population and resistant to contact with individuals outside their subculture, effective outreach becomes difficult. The outreach programs concentrate on educating at-risk populations, especially minorities who may be at risk for exposure to HIV, women of childbearing age, the homeless, incarcerated persons arrested for substance abuse, and male and female prostitutes. The approach to education focuses on behavior modification. Intensive training on HIV transmission, as well as how to handle themselves on the street, is essential for all volunteer staff in outreach programs.

The Virginia Department of Corrections presented its AIDS Comprehensive Plan which was developed in response to HJR 430 of 1989. The plan includes five major objectives: collection and assimilation of AIDS information, AIDS education for staff and clients, treatment of persons with AIDS, counseling in risk assessment and risk reduction, and initiatives to control disease transmission. Based upon the current incidence and prevalence of active cases of AIDS among prisoners within the correctional system, it was determined that the major theme of the plan should be one of education and training. The plan would be supplemented by appropriate ancillary treatment and counseling services and the application of intensive interventions with those persons continuing high risk behaviors. An estimate of $3,035,000 was proposed to fund and implement the Department's plan over the 1990-1992 budget biennium.

During the summer of 1989, the Department of Corrections conducted a testing survey of incoming prisoners and parole violators which indicated an approximate 2.5 percent prevalence of HIV infection among those tested. The national prison population infected with HIV is estimated to be about 4 percent.

The Subcommittee continued its review of a proposal for isolation provisions for HIV infected persons who present a threat to the health and welfare of the public. With respect to HIV infection, several factors were noted to create problems with quarantine or isolation procedures. These factors include the fact that AIDS is fatal and incurable, persons infected with HIV remain infectious for life, HIV infection is more prevalent among populations which have traditionally been subjected to discrimination, and that the manifestations of active disease varies among individuals.

Upon the recommendation of the Commissioner of Health, the Joint Subcommittee decided that any proposal allowing for isolation or quarantine of HIV infected persons would be designed to include AIDS with other contagious diseases in a generic provision. The members commented that individuals so quarantined or isolated might be monitored electronically in their homes, perhaps coupled with a policy limiting access into the home by other persons as well as ensuring that the isolated individual remains separate.

Subcommittee members deliberated on the efficacy of introducing an isolation provision as well as the problems inherent in proposals to criminalize knowing, willful transmission of HIV. The Joint Subcommittee directed staff to provide materials during the December meeting on the issues, including a revision of the isolation proposal, testing of certain populations such as prostitutes, treatment of pediatric patients, street outreach, insurance, and indigent care.

Half of the fourth meeting was devoted to a public hearing. The Joint Subcommittee received testimony from experts in the insurance and medical industries, as well as from concerned citizens. Issues discussed included school attendance policies, access to care, the responsibilities of the insurance industry, the need for special pediatric programs, and immunity from liability for practitioners.

During the afternoon of the fourth meeting, discussion focused on an updated proposal for isolation (or quarantine) of persons with AIDS or those who are HIV infected, who, through their knowing, at-risk behavior, pose an immediate and substantial threat to the health and welfare of the public.

At the fifth meeting, the Joint Subcommittee received additional testimony from Dr. Stuart P. Adler of the Medical College of Virginia regarding a proposal for a program for HIV infected pediatric patients. Ex officio member Dr. C.M.G. Buttery presented a review of proposed expanded primary care services for HIV positive individuals.

After a review by its staff of the revised proposals for an isolation procedure, procedures for requiring HIV testing of charged and convicted sex offenders, provisions for immunity from civil liability, and budget addendums requested by the Joint Subcommittee during its fourth meeting, members debated the merits of the tentative recommendations which had been discussed and developed during the 1989 study year.

VII. FINDINGS: 1989

A major issue faced by the Joint Subcommittee during the second year of this study concerned the need to assess the impact on the Commonwealth of ever-escalating health care costs for persons with AIDS and those who are HIV infected.

Determining effective ways to control and contain these costs was the focus of much of the Subcommittee's evaluation of this issue. One possible solution which received prominent consideration was the analysis of so-called health insurance risk pools.

Another mechanism receiving close attention was the Michigan buy-in plan or insurance assistance plan, a funding program for paying the health insurance premiums of persons with AIDS who have been employed, covered by a group plan carried by their employers, and can no longer work. One of the drawbacks of such programs is the lack of matching federal funds for their support. However, the Joint Subcommittee's discussions were primarily focused on the fairness and long term effects of these provisions. The members felt that the brunt of such programs will eventually be felt by those who pay for health insurance, whether they be employers or private citizens. The Joint Subcommittee determined that the effects of the Michigan buy-in plan should be carefully monitored; however, the Subcommittee did not endorse it.

Many hours were spent discussing the viability of isolation as a means of protecting the public from individuals who knowingly and willfully transmit the disease. In the opinion of the Joint Subcommittee, a generic isolation policy, requiring as a trigger more than allegations, providing careful and detailed due

process, and resting authority in the Commissioner of Health for determining contagious diseases of public health significance and when to apply this action, was much preferable to criminalization provisions. The burden of proof in criminal actions would be too difficult to meet and the possibility of discrimination too real. Limited isolation, however, when applied after counseling, reconsideration of the circumstances, and ample due process, appears to have the potential to ameliorate concerns related to knowing and willful transmission.

It is important to remember that HIV infection is not casually transmitted and that at-risk behavior has been characterized and described by medical authorities. Therefore, a procedure for all contagious diseases of public health significance which is keyed to at-risk behavior will not present the potential for selective application when a careful definition is designed, e.g., "acts which a person, who has been informed that he is infected with a communicable disease, knows may infect other persons without taking appropriate precautions to protect the health of the other persons." "Appropriate precautions" has been defined as "those specific measures which have been demonstrated by current scientific evidence to assist in preventing transmission of a communicable disease. Appropriate precautions will vary according to the disease."

The Joint Subcommittee also developed a proposal to provide further protection from liability for practitioners. HIV infection continually presents difficult and unusual ethical and medical situations to physicians. This protection was considered necessary to relieve the persistent concerns about notification or the failure to provide notification. It is the Subcommittee's hope that these protections, the education programs initiated by the health regulatory boards, and the technical assistance available through the resource and consultation centers will motivate private practitioners to share in the care of HIV infected persons.

During the 1988 interim study, the Joint Subcommittee had recommended a provision requiring testing of sexual offenders who refused a request to submit to testing after according these persons with a hearing to determine probable cause. During the 1989 Session, this proposal was amended to include testing of prostitutes and was left resting, because of the controversy surrounding such testing. In order to avoid repeating this scenario, the proposal for testing of sexual offenders was revised and resubmitted in 1990 and, although a majority of the members of the Subcommittee was not in favor of requiring testing of convicted prostitutes, a proposal for this testing was developed as a companion bill. Unanimity was not achieved by the Joint Subcommittee on the issue of whether required testing of convicted prostitutes should be recommended as legislation to the General Assembly. This matter was subjected to protracted and, not infrequently, polarized debate. The decision to recommend mandatory testing of such individuals was approved by only a narrow margin of the members present.

VIII. RECOMMENDATIONS: 1990

The Joint Subcommittee's recommendations to the 1990 General Assembly were:

■ That testing of convicted prostitutes be required. This provision requires that, as soon as practicable following conviction of violations of § 18.2-346 or § 18.2-361, the convicted person submit to testing for infection with HIV. Tests to confirm any

positive tests are required and confidentiality is provided. The results of the test are not admissible in any criminal proceeding related to prostitution (see SB 340 of 1990).

■ That a procedure be established to require testing of charged and convicted sexual offenders. The procedure for testing such individuals first requires the attorney for the Commonwealth, after consulting with the victim, to request the accused to submit to testing. A probable cause hearing will be held if the charged person refuses to submit to testing. The court is authorized to order the accused to undergo testing upon a finding of probable cause. The attorney for the Commonwealth may also request, after consultation with any victim, and the court must order that convicted individuals be tested. Tests conducted after conviction are in addition to any tests conducted following arrest in order to provide two opportunities to determine the HIV status of the perpetrator. Confirmatory tests are required if test results are positive for HIV infection. Under this procedure, the Virginia Department of Health is required to disclose test results to the victim and to conduct appropriate surveillance and investigation. Confidentiality of test results is referenced in the procedure and test results are not admissible as evidence in criminal proceedings. Testing costs will be borne by the Commonwealth and are to be taxed as part of the criminal proceedings (see HB 815 of 1990).

■ That a procedure be established for isolation of persons with communicable diseases under certain circumstances. A due process procedure for isolation of persons infected with communicable diseases is provided when such persons engage in at-risk behavior. This provision will apply to communicable diseases of public health significance as determined by the Commissioner of Health. Examples of such communicable diseases might be tuberculosis, hepatitis, and infection with HIV. The Commissioner will have the authority to investigate verified reports or medical evidence that a person who has a communicable disease is engaging in at-risk behavior. The person may then be required to report for counseling. After the individual has been counseled, the Commissioner may petition the court for a hearing to determine if isolation is necessary upon receiving a verified report or medical evidence that the individual is continuing to engage in at-risk behavior. The court is authorized to order temporary detention of 48 hours in the individual's home or another's home or an institution, but not a jail. Right to counsel is provided as well as the right to appeal an isolation order. The court must find that the person has a relevant communicable disease, is engaging in at-risk behavior, has demonstrated an intentional disregard for the health of the public by so behaving, and that there is no other reasonable alternative means of reducing the risk to public health. Isolation orders are valid for no more than 120 days and may include other requirements such as participation in counseling or education programs. Electronic devices may be used to enforce these orders (see HB 816 of 1990).

■ That immunity from civil liability or criminal penalty be clarified for health care providers who comply with the confidentiality statute. The immunity from liability provision for persons making reports of disease was strengthened by clarifying that no civil liability or criminal penalty would be incurred by persons making a report or disclosure required or authorized by the law. The present law requires the reporting of certain diseases including infection with HIV to the Department of Health, provides confidentiality protections for the results of HIV tests, and prohibits disclosure of HIV test results except to certain persons. Disclosure is permissive except for the mandatory reporting to the Department of Health.

This proposal makes it clear that the authority to disclose test results to certain persons does not create any duty on the part of any person to release the test results. The immunity statute was also amended to note specifically that blood collection agencies and tissue banks are not under a duty to provide notice except as required by law and that no cause of action will arise from any failure of these organizations to notify others (see HB 814 of 1990).

■ That the proposal of the Joint Subcommittee Studying Access to Health Care for All Virginians for the marketing of a low-cost insurance product to small businesses be strongly supported.

■ That the regulations promulgated by the State Corporation Commission, Bureau of Insurance, affecting insurance industry underwriting practices with respect to AIDS or HIV infection be endorsed.

■ That the Joint Subcommittee Studying Access to Health Care for All Virginians monitor the results of the Michigan insurance buy-in plan.

■ That increased funding for the regional AIDS resource and consultation centers be sought to provide expanded support of the three existing centers and to establish two additional centers. Pending budget approval, this expanded funding would further extend coverage to the Western region of the Commonwealth. The Joint Subcommittee is convinced that continued commitment to education of private health-care providers will facilitate access to health care by persons with AIDS or those who are HIV infected.

■ That the public health clinics be provided an expanded role for primary care of HIV infected persons. The Joint Subcommittee supports the Department of Health's request for state funding for routine monitoring of asymptomatic persons with HIV infection who are indigent.

■ That Medicaid policies be reassessed to increase the reimbursement rate for all physicians in order to increase the number of physicians willing to treat Medicaid recipients, particularly persons who are HIV infected.

■ That the Department of Health's request for funding to expand AZT treatment be supported. Although the federal AZT program has been extended, the Department of Health requested funds for AZT to treat asymptomatic persons who are HIV positive.

■ That, in order to expand drug prevention and treatment programs so that rates of HIV transmission among intravenous drug abusers may be reduced, the budget requests of the Department of Mental Health, Mental Retardation and Substance Abuse Services to achieve this objective be supported.

■ That, in order to plan for the anticipated transition of HIV infection from an acute to a chronic disease, mechanisms be developed throughout the state's agencies which would provide for primary health care, education of providers and the public, and early intervention.

■ That the Federal Drug Administration soon approve more flexible uses of AZT in the care of persons who are HIV infected. The Joint Subcommittee recommends that Medicaid coverage of AZT be expanded to include such an increase in use.

■ That this study be continued for another year. The Joint Subcommittee proposes to hold meetings in late 1990 in order to reassess and evaluate state initiatives to address the impact of AIDS on the Commonwealth.

The Joint Subcommittee wishes to note that implementation on July 1, 1990, of a Virginia law approved in 1989 requiring school attendance guidelines will resolve concerns for children infected with HIV who attend public schools. The Subcommittee strongly supports the Board of Education's attendance policy in this regard. Further, based on available medical evidence, as well as the expert testimony of medical professionals throughout the country, the Joint Subcommittee wished to emphasize and reinforce the fact that there is no medical indication for excluding HIV infected children from attending school or for notifying school authorities of children who are so infected. The members note that school divisions need to educate personnel in prevention techniques in order that such individuals may be protected from exposure to all communicable diseases, especially those which are far more infectious than HIV.

IX. CONCLUSION

In 1988, when this study was begun, the emotional tension surrounding the AIDS epidemic was almost palpable. In 1990, however, the aura related to HIV infection has settled into a dull, gray perturbing anxiety. Even though medical advances have been significant and public attitudes have improved, the specter of this disease continues to increase in visibility. Although the crisis mentality which was so useful in achieving these dramatic results appears to have faded, the Joint Subcommittee wishes to stress its urgent sense that policy makers must not relinquish their vigilance.

The Joint Subcommittee has attempted to develop a reasonable AIDS public policy for the provision of services, education, and protection of the Commonwealth's citizens. The members sincerely hope that the programs modeled by this study will be effective in stemming the epidemic in Virginia. There are many reasons to be optimistic, e.g., new services, programs, research, diagnostic tests, and therapeutic drugs.

Yet, there are also many reasons to remain concerned. National and international authorities such as the World Health Organization and the Centers for Disease Control note the alterations in the demography of the disease as it spreads from the large cities to small ones and rural areas. These same authorities estimate that "[m]ost of the 1 million infected in the United States will be sick by 2000; worldwide six times that many." Experts observe the sharp increase in the incidence of HIV infection among heterosexuals and newborns and comment that 20 percent or more of current AIDS patients may have been infected as teens ("AIDS: The Next Ten Years," *Newsweek*, June 25, 1990).

Therefore, the Joint Subcommittee feels compelled to caution all public officials and private citizens in Virginia that the full force of this epidemic may yet to be felt and that indifference and complacency will have devastating results. Other epidemics have been conquered and this one can be deflected with prudence, hard work, and commitment.

The Joint Subcommittee wishes to express sincere thanks to its ex officio members, the many other state agency officials who appeared before it, as well as the experts, advocates, activists, and citizens who have assisted in its work.

Respectfully submitted,

J. Samuel Glasscock, Chairman
Clive L. DuVal 2d, Vice Chairman
Edward R. Harris, Jr.
Joan H. Munford
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Lisa G. Kaplowitz
Richard P. Keeling
John E. Kloch
James L. Levenson

STATEMENT OF SENATOR CLIVE L. DUVAL 2d

Although I am in general agreement with this report, I wish to express my disagreement with the Joint Subcommittee's position on testing of prisoners. I am firmly convinced that testing of the prison population, although admittedly expensive, would be of benefit to both the inmates and the Commonwealth. I do not believe that it is possible to develop effective policies to deal with AIDS in correctional institutions without this data. Such testing would, in my opinion, provide officials with the information upon which rational policy and long term planning concerning the education, medical care, and treatment of inmates could be based. All inmates must be educated about the cause, transmission, and effects of this dread disease. In particular, I believe that the Commonwealth has an obligation to make prisoners who are HIV positive aware of this fact. Further, I believe that HIV positive inmates should receive intensive education on AIDS, should be counseled, and should have access to appropriate medical care geared to maintaining their health for as long as possible.

STATEMENT OF DELEGATE S. VANCE WILKINS, Jr.

I am in general agreement with this report; however, I wish to state that I have appended my signature with some reservations.

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SELECTED CASE CITATION

School Board of Nassau County, Fla. v. Arline, 480 U.S. 273 (1987).

APPENDICES

Sample Questions

Enabling resolution - 1988
House Joint Resolution No. 31

1989 legislation
H.B. 1971
H.B. 1972
H.B. 1973 (as introduced)
H.B. 1973 (substitute)
H.B. 1974
HJR 425
HJR 426
HJR 427
HJR 428
HJR 429
HJR 430

Continuing resolution - 1989
HJR 431

1990 legislation
H.B. 814
H.B. 815
H.B. 816
S.B. 340

Continuing resolution - 1990
HJR 129

SAMPLE QUESTIONS: JOINT SUBCOMMITTEE STUDYING AIDS

I. ISSUES RELATED TO PREVENTION

MANDATORY/VOLUNTARY TESTING

Sample questions: What is the purpose of testing? Does voluntary testing work? To what extent do those at high risk seek to be tested? What are the problems related to voluntary testing as it is presently implemented in Virginia? Is testing available and accessible to all those who want it? Are there any factors which act as deterrents to testing for high risk groups? Should testing be required of any specific groups, e.g., drug offenders, sex offenders, male and female prostitutes, and prisoners? Why? Does mandatory testing run the target group(s) "underground"? Should health care institutions be authorized to test? Under what circumstances? Upon admission? Prior to surgery? What about informed consent? What benefits, if any, would accrue from such testing? What are the contraindications for such testing? What are the constitutional ramifications of various kinds of mandatory testing?

COUNSELING

Sample questions: What is counseling? Why is counseling necessary? What should the goals of counseling be? Should counseling be required or provided for every individual testing positive for HIV infection? For what purpose? How could such a requirement be implemented? What incentives are there to encourage individuals who are HIV positive to obtain counseling? What are the components of effective counseling? Does effective counseling modify behavior? What are the alternatives when counseling fails to modify behavior? Will counseling be effective with intravenous drug abusers? Will it be necessary to initiate new programs to reach the intravenous drug abuser, such as distribution of clean needles or packets to clean needles? What effect do such programs have on drug abuse? What effects would such programs have on state activities to control drug abuse? Would such programs be legal in Virginia? Is there a need for a second generation of counseling to be provided to the AIDS patient who is exhibiting neurological symptoms or has AIDS dementia when the patient is becoming or has become incompetent?

REPORTING OF POSITIVE TEST RESULTS

Sample questions: Should reporting of positive test results be mandatory? For what purpose? To whom? By whom, e.g., blood banks, physicians, health care institutions, local departments of health, insurance companies, etc.? How can confidentiality be ensured?

CONTACT TRACING AND NOTIFICATION OF PARTNERS

Sample questions: Should contact tracing and notification of partners be required for every HIV positive individual regardless of the testing site? Should contact tracing and notification of partners as conducted by the Department of Health continue to be restricted to one year or extended beyond the present one year period? What are the benefits of contact tracing and notification of partners? What can be done if the HIV positive individual refuses to cooperate in contact tracing and notification of partners?

CONFIDENTIALITY/PROTECTION OF THE INFECTION-FREE POPULATION

Sample questions: How can confidentiality be ensured for individuals infected with HIV? Do the difficulties in ensuring confidentiality require the development of a code to protect the identity of test subject such the French have designed? Are there circumstances under which confidentiality is not appropriate? If so, what are these circumstances? Is there ever a "right to know"? For health care workers? For coworkers in certain other occupations or professions? For spouses? For other family members? For employers? Is there a need to balance confidentiality with the need to protect individuals who are not infected? Where do the rights of the individual collide with the rights of society?

CRIMINAL TRANSMISSION OF HIV INFECTION

Sample questions: Should there be a statute providing a criminal penalty for knowing and willful transmission of HIV infection? If so, how should knowing and willful transmission be defined? What actions would constitute knowing and willful transmission? Would malice be required to prove knowing and willful transmission? How can the requisite intent be proven? If the infected individual has neurological symptoms or AIDS dementia, would he be capable of formulating the requisite intent? What sanctions would be appropriate for knowing and willful transmission?

QUARANTINE/ISOLATION

Sample questions: Under what circumstances, if any, would isolation be appropriate? What sites would be appropriate for isolation? How long should isolation be allowed? When should isolation be terminated? Who should make the determination that isolation is warranted? Who would provide the necessary services to the isolated individual? What of minors? Are there appropriate alternatives to isolation?

CORRECTIONS AND MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

Sample questions: What should the appropriate policies be for individuals residing in correctional institutions and mental health facilities, e.g., testing, counseling, reporting, contact tracing, notification of partners, confidentiality, isolation, treatment and care, etc.? What actions can be taken to limit at-risk behavior in such institutions and facilities, particularly sexual activities, e.g., education, counseling, and isolation?

II. ISSUES RELATED TO PATIENT SERVICES

PROVISION OF SERVICES, CONTINUITY OF CARE, AND AVAILABILITY OF APPROPRIATE LEVELS OF CARE

Sample questions: Do AIDS patients have access to appropriate levels of care? Primary physician care? Specialized medical treatment? Homes for adults? Nursing homes? Hospital care? Hospice care? Community-based and home-based care? If not, why?

What can be done to increase the number of internists and family practitioners who are willing to provide primary care to asymptomatic HIV positive individuals? Since Virginia has a shortage of family practitioners now, what effect would incentives to encourage them to care for HIV infected individuals have on health care for the general population, especially in rural areas? At what point in the progression of the disease is specialty care required?

Are there enough infectious disease specialists to care for the AIDS patients in Virginia? If not, what steps can be taken to increase their numbers? If there is an adequate supply of infectious disease specialists, are they willing to treat AIDS patients?

Since homes for adults do not appear to be knowingly accepting individuals with AIDS and only one nursing home allocates any beds for AIDS patients, are there incentives to encourage these institutions to care for AIDS patients? Since many nursing homes already have waiting lists, what effect would such incentives have on the availability of long term care for the elderly and disabled?

Are hospitals assuming their appropriate responsibility for caring for AIDS patients? Is acute care of the AIDS patient being "dumped" on the teaching hospitals? If so, what effects will this dumping have on the ability of the medical school hospitals to attract a variety of patients; scope of services; quality of the training; ability to attract students, faculty, and personnel; resources for research; level of uncompensated care; utilization of beds; and state funding? Are there enough hospice beds or services to accommodate Virginia's AIDS patients?

Do AIDS patients have access to hospice care? Are community and home-based programs adequate to serve AIDS patients? To what extent are the home companion (Social Services) and personnel care services (Medicaid) programs serving AIDS patients? What is the potential for utilization of these services to avoid institutionalization for AIDS patients?

SOCIAL SERVICES

Sample questions: What kinds of social services are needed by AIDS patients and their families? What policy or procedures should be in place for handling children with AIDS who are abandoned or who are in custody? What case management services are necessary? What percentage of social services clients with AIDS are eligible for or will become eligible for Medicaid? How will the AIDS epidemic affect the delivery of social services?

BLOOD SUPPLY-ITS SAFETY AND ADEQUACY

Sample questions: Are there any steps which can be taken to provide additional precautions to ensure the safety and adequacy of the blood supply? Has fear of donating (which does not carry any risk of infection) decreased the blood supply in Virginia? How should designated blood donations be handled? What of autologous blood donations? Is a state policy on these issues necessary?

FINANCING CARE-MEDICAID/INSURANCE

Sample questions: What services for AIDS patients are being reimbursed by Medicaid? At what cost? What are the projections for Medicaid costs for AIDS patients as the epidemic progresses? Are there needed services which are not covered by Medicaid? What is the interaction between Medicaid reimbursement and availability of care for AIDS patients? How are health insurance companies handling coverage of services to AIDS patients? When is AIDS considered a preexisting condition for purposes of health insurance coverage? Is a positive HIV test considered a preexisting condition? If so, what waiting period is being imposed?

III. ISSUES RELATED TO EDUCATION, ADMINISTRATIVE POLICIES, AND DISCRIMINATION

EDUCATION-
DISTRIBUTION OF INFORMATION,
EFFECTIVENESS OF AIDS EDUCATION, AND
DEVELOPMENT OF INFORMED ATTITUDES

Sample questions: Is AIDS education effective? With the general population? With the gay community? With intravenous drug abusers? Have attitudes and behaviors been modified by AIDS education? What are the needs for additional education efforts in Virginia? What changes will be necessary in the education programs to reach sexually active adolescents and certain at-risk populations, such as intravenous drug abusers? What educational efforts will be necessary to reach employers? Others?

ADMINISTRATIVE POLICIES

Sample questions: What administrative policies are necessary? Employment policies including job competency, employee safety issues, and required precautions? What consideration should be given to the Supreme Court decision in School Board of Nassau County, Fla. v. Arline, 480 U.S. 273 (1987), vis-a-vis administrative policies? What administrative policies are presently in effect in Virginia? Employment policies? School attendance policies? Are these policies appropriate? What are the components of appropriate administrative policies? Should there be uniform requirements for administrative policies? For public school attendance? For institutions of higher education? For state personnel? For all employers?

DISCRIMINATION

Sample questions: What is the scope of workplace discrimination? Discrimination in public schools, institutions of higher education, and other postsecondary schools? Discrimination in housing? What should state policy be vis-a-vis discrimination? In view of already existing law? What effect, if any, does the Arline decision have on these concepts?

GENERAL ASSEMBLY OF VIRGINIA -- 1988 SESSION

HOUSE JOINT RESOLUTION NO. 31

Establishing a joint subcommittee to study acquired immunodeficiency syndrome (AIDS).

Agreed to by the House of Delegates, March 11, 1988
Agreed to by the Senate, March 9, 1988

WHEREAS, AIDS and conditions known as Aids-Related Complex (ARC) are caused by retroviruses known as human immunodeficiency viruses (HIV); and

WHEREAS, acquired immunodeficiency syndrome or AIDS, a fatal disease for which there is no cure, destroys the body's immune system, leaving its victims prey to a myriad of opportunistic diseases; and

WHEREAS, AIDS was first identified in the early 1980's among young homosexual men suffering from Kaposi's Sarcoma, and Pneumocystis Carinii pneumonia, conditions now associated with persons whose immune systems have been compromised; and

WHEREAS, this disease is transmitted primarily through sexual activity, and also can be transmitted through the use of unsterilized hypodermic needles, intrauterine exposure and other parenteral contact, increasing the risk of exposure to the community at large; and

WHEREAS, because precise scientific information on human immunodeficiency viruses is unknown at this time and tests are not available to determine conclusively the diagnosis of AIDS, and due to the unique characteristics of HIV, public officials are confronted with many difficult issues in determining the most efficacious course of action to prevent the spread of the disease; and

WHEREAS, acquired immune deficiency syndrome (AIDS) has become a serious medical problem facing the nation and the Commonwealth, and according to the most recent estimates of the National Academy of Sciences, as many as one and one-half million people in the United States already may be infected by the human immunodeficiency virus (HIV); and

WHEREAS, in the absence of any medical means of arresting the spread of the disease or the virus that causes it, methods of containing the virus include screening and testing, isolation, education and behavior modification; and

WHEREAS, victims of AIDS suffer from painful and debilitating "opportunistic diseases" which frequently require institutional care; and

WHEREAS, in at least one state, a crisis has developed because the hospital industry has become inundated with AIDS patients and does not have the capacity to treat other seriously ill individuals; and

WHEREAS, a crisis of this magnitude should be avoided in Virginia at all costs; and

WHEREAS, public awareness and education are an important defense against the spread of the virus, but cannot be relied upon to assure responsible behavior in all cases; and

WHEREAS, many states are now grappling with the possible development and application of public policies regarding the containment of AIDS and criminal sanctions to be imposed upon individuals infected with HIV for knowingly or through reckless actions, exposing another to the risk of becoming infected with HIV; and

WHEREAS, there may be few criminal laws in the Commonwealth that adequately address the steps that could be taken to contain this disease and to deter, punish or prevent actions by an individual infected with HIV that could expose others to the virus; and

WHEREAS, the serious adverse health consequences and potentially fatal nature of the diseases associated with HIV infection require that, to ensure and protect the health and safety of its citizens, the Commonwealth accord the highest priority to preventing the spread of HIV, including consideration of the advisability of deterring or punishing behavior dangerous to others through imposition of criminal sanctions; and

WHEREAS, stemming the spread of AIDS has raised perplexing, unresolved public policy questions concerning the delivery of health care services, privacy issues, public education and awareness, insurance and employment issues, medical research, experimentation and testing, cost of care and treatment of victims, appropriate health care facilities, child welfare issues, the rights of victims and the noninfected, and other public and social policy issues which must be addressed; and

WHEREAS, due to the complexity of the issues posed by AIDS, it would be prudent to address these issues in a comprehensive and judicious manner in order to avoid public policy developed in haste and in response to hysteria; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That a joint subcommittee be established to study acquired immunodeficiency syndrome. The joint subcommittee shall be composed of fifteen members to be appointed as follows: two members of the House Committee on Health, Welfare and Institutions and one member

each of the House Committees for Courts of Justice, on Corporations, Insurance and Banking, on Education and on Appropriations to be appointed by the Speaker of the House, and one member each of the Senate Committees on Education and Health, for Courts of Justice, on Commerce and Labor, on Rehabilitation and Social Services and on Finance to be appointed by the Senate Committee on Privileges and Elections. A Commonwealth's Attorney and three citizen members shall be appointed by the Governor, of whom one shall have expertise in research regarding infectious diseases, one with expertise in the care and treatment of AIDS victims, and one with expertise in medical ethics. The Commissioners of Health, Social Services, and Mental Health, Mental Retardation and Substance Abuse Services, the Directors of the Department of Medical Assistance Services, of the Department of Corrections and of the Division of Consolidated Laboratory Services and the Superintendent of Public Instruction shall serve ex officio.

The joint subcommittee shall in its deliberations:

1. Identify the high risk groups for AIDS in Virginia, their needs and existing programs and services available to assist them;

2. Determine whether state policies exist concerning the containment of the virus, and the care and treatment of victims;

3. Review applicable state laws and regulations pertaining to the identification, screening, reporting, isolating and treatment of communicable diseases, and such criminal statutes as may be relevant;

4. Assess the need for and the advisability of criminal statutes to prohibit the knowing and willful exposure of another to the human immunodeficiency virus (HIV) by one so infected;

5. Determine the type of actions to be proscribed by any such statute, the circumstances, if any, under which criminal sanctions should be imposed, and any appropriate penalty for such actions;

6. Assess prevention efforts to abate the spread of AIDS in the Commonwealth, including education, testing and isolation, and develop strategies to enhance such efforts;

7. Determine whether voluntary or mandatory testing should be required or allowed for marriage licenses, insurance coverage, admissions to health care facilities, and prior to surgery and other health care and treatment;

8. Determine whether the reporting of positive test results for exposure to the AIDS virus should be required;

9. Determine the need and efficacy of sexual contact tracing;

10. Analyze privacy, confidentiality and disclosure issues related to AIDS and determine the need to balance the rights of AIDS victims and those of the uninfected;

11. Evaluate the efficacy of utilizing the Uniform Medical Records Act with respect to the reporting of AIDS, and evaluate the legal sufficiency of the pertinent state and federal laws and regulations prohibiting discrimination in insurance, employment and against the handicapped relative to AIDS;

12. Determine the need to require public schools to develop and implement a policy and protocol for managing AIDS victims and AIDS-related complex within the school environment, and assess child welfare issues relative to the care of abandoned children with AIDS;

13. Assess the eligibility for and coverage under Medicaid, the availability of health care for AIDS victims, the need for hospice care, and the need to establish policies for the management of AIDS victims in health care facilities in the Commonwealth;

14. Determine the appropriate role of state and local agencies respecting the health and insurance needs and rights of AIDS victims, public awareness, health care, research and treatment, screening, public assistance and access to nursing home care; and

15. Any other related issues deemed appropriate by the joint subcommittee.

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

The joint subcommittee shall complete its work in time to submit its findings and recommendations to the Governor and the 1989 General Assembly.

The indirect costs of this study are estimated to be $14,790; the direct costs of this study shall not exceed $20,860.

1989 SESSION

VIRGINIA ACTS OF ASSEMBLY - CHAPTER 653

An Act to amend and reenact §§ 38.2-501, 38.2-3401, 38.2-4214, 38.2-4319 and 38.2-4509 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 38.2-3100.1, relating to jurisdiction over individual and group life, accident and sickness insurance.

[H 1971]

Approved MAR 2 7 1989

Be it enacted by the General Assembly of Virginia:
1. That §§ 38.2-501, 38.2-3401, 38.2-4214, 38.2-4319 and 38.2-4509 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding a section numbered 38.2-3100.1 as follows:

§ 38.2-501. Definitions.–As used in this chapter:

"Insurance policy" or "insurance contract" shall include annuities and any *group or individual* contract ~~of~~ , *certificate, or evidence of coverage, including, but not limited to, those issued by* a health services plan, health maintenance organization, legal organization, legal services plan, or dental or optometric services plan as provided for in Chapters 42, 43, 44 and 45 of this title issued, proposed for issuance, or intended for issuance, by any person.

"Person," in addition to the definition in Chapter 1 (§ 38.2-100 et seq.) of this title, extends to any other legal entity transacting the business of insurance, including agents, brokers and adjusters. "Person" shall also mean health, legal, dental, and optometric service plans and health maintenance organizations, as provided for in Chapters 42 (§ 38.2-4200 et seq.), 43 (§ 38.2-4300 et seq.), 44 (§ 38.2-4400 et seq.) and 45 (§ 38.2-4500 et seq.) of this title. For the purposes of this chapter, such service plans shall be deemed to be transacting the business of insurance. "Person" shall also mean premium finance companies.

§ 38.2-3100.1. Forms of insurance authorized.–A. Life insurance and annuities shall be issued only in the following forms:

1. Individual life insurance and annuities; or

2. Group life insurance and annuities.

B. Pursuant to the authority granted by § 38.2-223, the Commission may promulgate such regulations as may be necessary or appropriate to govern insurers' practices with regard to Acquired Immunodeficiency Syndrome (AIDS) or presence of the Human Immunodeficiency Virus (HIV), including advertising practices, underwriting practices, policy provisions, claim practices, or other practices with regard to individual or group life insurance and annuities, delivered or issued for delivery in the Commonwealth of Virginia and certificates or evidences of coverage, issued under any contract delivered or issued for delivery in the Commonwealth of Virginia.

§ 38.2-3401. Forms of insurance authorized.– *A.* Accident and sickness insurance shall be issued only in the following forms:

1. Individual accident and sickness policies; or
2. Group accident and sickness policies.

B. Pursuant to the authority granted by § 38.2-223, the Commission may promulgate such regulations as may be necessary or appropriate to govern insurers' practices with regard to Acquired Immunodeficiency Syndrome (AIDS) or the presence of the Human Immunodeficiency Virus (HIV), including advertising practices, underwriting practices, policy provisions, claim practices, or other practices with regard to individual or group accident and sickness insurance policies delivered or issued for delivery in the Commonwealth of Virginia and certificates or evidences of coverage, issued under any contract delivered or issued for delivery in the Commonwealth of Virginia.

§ 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 38.2-1340, 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, 38.2-3501, 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.

The provisions of § 38.2-1336 shall apply to any insurance holding company as referred to in Article 5 (§ 38.2-1322 et seq.) of Chapter 13 of this title that controls a nonstock corporation subject to this chapter.

§ 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,* and § 38.2-3405 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.

§ 38.2-4509. Application of certain laws.–No provision of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 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, 38.2-900 through 38.2-904, 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 38.2-1321, 38.2-1400 through 38.2-1444, 38.2-1800 through 38.2-1836, *38.2-3401,* 38.2-3404, 38.2-3405, 38.2-3415, 38.2-3541, and 38.2-3600 through 38.2-3603 shall apply to the operation of a plan.

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President of the Senate

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Speaker of the House of Delegates

Approved:

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Governor

1989 SESSION

VIRGINIA ACTS OF ASSEMBLY – CHAPTER 502

An Act to amend and reenact §§ 65.1-46.1 and 65.1-52 of the Code of Virginia, relating to workers' compensation.

[H 1972]

Approved MAR 22 1989

Be it enacted by the General Assembly of Virginia:
1. That §§ 65.1-46.1 and 65.1-52 of the Code of Virginia are amended and reenacted as follows:

§ 65.1-46.1. "Ordinary disease of life" coverage.–An ordinary disease of life to which the general public is exposed outside of the employment may be treated as an occupational disease for purposes of this Act if it is established by clear and convincing evidence, to a reasonable medical certainty, that it arose out of and in the course of employment as provided in § 65.1-46 with respect to occupational diseases and did not result from causes outside of the employment, and that:

1. It follows as an incident of occupational disease as defined in this title; or

2. It is an infectious or contagious disease contracted in the course of one's employment in a hospital or sanitarium or ~~public health~~ laboratory or nursing home as defined in subdivision 2 of § 32.1-123, *or while otherwise engaged in the direct delivery of health care,* or in the course of employment as emergency rescue personnel and those volunteer emergency rescue personnel as are referred to in § 65.1-4.1; or

3. It is characteristic of the employment and was caused by conditions peculiar to such employment.

§ 65.1-52. Limitation upon claim; "injurious exposure" defined; diseases covered by limitation.–The right to compensation under this chapter shall be forever barred unless a claim be filed with the Industrial Commission within one of the following time periods:

1. For coal miners' pneumoconiosis, three years after a diagnosis of the disease is first communicated to the employee or within five years from the date of the last injurious exposure in employment, whichever first occurs;

2. For byssinosis, two years after a diagnosis of the disease is first communicated to the employee or within seven years from the date of the last injurious exposure in employment, whichever first occurs;

2a. For asbestosis, two years after a diagnosis of the disease is first communicated to the employee;

2b. For symptomatic or asymptomatic infection with human immunodeficiency virus including acquired immunodeficency syndrome, two years after a positive test for infection with human immunodeficiency virus;

3. For all other occupational diseases, two years after a diagnosis of the disease is first communicated to the employee or within five years from the date of the last injurious exposure in employment, whichever first occurs.

If death results from an occupational disease within any of such periods, the right to compensation under this chapter shall be barred, unless a claim therefor be filed with the Commission within three years after such death. The limitations imposed by this section as amended shall be applicable to occupational diseases contracted before and after July 1, 1962, and § 65.1-87 shall not apply to pneumoconiosis.

"Injurious exposure" as used in this section and in § 65.1-50 means an exposure to the causative hazard of such disease which is reasonably calculated to bring on the disease in question. Exposure to the causative hazard of pneumoconiosis for ninety work shifts shall be conclusively presumed to constitute injurious exposure. This limitation on time of filing will cover all occupational diseases, except:

Cataract of the eyes due to exposure to the heat and glare of molten glass or to radiant rays such as infrared;

Epitheliomatous cancer or ulceration of the skin or of the corneal surface of the eye due to pitch, tar, soot, bitumen, anthracene, paraffin, mineral oil or their compounds, products or residues;

Radium disability or disability due to exposure to radioactive substances and X ray;

Ulceration due to chrome compound or to caustic chemical acids or alkalies and undulant fever caused by the industrial slaughtering and processing of livestock and handling of hides;

Mesothelioma due to exposure to asbestos;

Angiosarcoma of the liver due to vinyl chloride exposure.

In any case in which a claim is being made for benefits for a change of condition in an occupational disease (that is, advancing from one stage or category to another) the claim must be filed with the Commission within three years from the date for which compensation was last paid for an earlier stage of the disease, except that a claim for benefits for a change in condition in asbestosis must be filed within two years from the date when diagnosis of the advanced stage is first communicated to the employee and no claim for benefits for an advanced stage of asbestosis shall be denied on the ground that there has been no subsequent accident. For a first or an advanced stage of asbestosis, if the employee is still employed in the employment in which he was injuriously exposed, the weekly compensation rate shall be based upon the employee's weekly wage as of the date of communication of the first or advanced stage of the disease, as the case may be. If the employee is unemployed, or employed in another employment, the weekly compensation rate shall be based upon the average weekly wage of a person of the same or similar grade and character in the same class of employment in which the employee was injuriously exposed and preferably in the same locality or community on the date of communication to the employee of the advanced stage of the disease. The weekly compensation rates herein provided shall be subject to the same maximums and minimums as provided in § 65.1-54.

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President of the Senate

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Speaker of the House of Delegates

Approved:

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Governor

LD6899466

1 **HOUSE BILL NO. 1973**
2 Offered January 24, 1989
3 *A BILL to amend the Code of Virginia by adding in Article 7 of Chapter 4 of Title 18.2 a*
4 *section numbered 18.2-61.01, relating to testing of persons charged with certain crimes*
5 *for human immunodeficiency virus.*
6 ———
7 Patrons—Glasscock, Harris, E. R., Van Landingham, Munford, Wilkins, Brown, Morgan and
8 Cunningham, R. K.; Senators: Nolen, Miller, Y. B., Houck, DuVal, Chichester and Earley
9 ———
10 Referred to the Committee for Courts of Justice
11 ———
12 Be it enacted by the General Assembly of Virginia:
13 1. That the Code of Virginia is amended by adding in Article 7 of Chapter 7 of Title 18.2 a
14 section numbered 18.2-61.01 as follows:
15 *§ 18.2-61.01. Testing of certain persons for human immunodeficiency virus.—As soon as*
16 *practicable following arrest, the attorney for the Commonwealth may request, after*
17 *consultation with any victim, that any person charged with any crime involving sexual*
18 *assault pursuant to this article or any offenses against children as prohibited by §§*
19 *18.2-361, 18.2-366, 18.2-370 and 18.2-370.1 be requested to submit to testing for infection*
20 *with human immunodeficiency virus. The person so charged shall be counseled about the*
21 *meaning of the test, about acquired immunodeficiency syndrome and about the*
22 *transmission and prevention of infection with human immunodeficiency virus.*
23 *In the event the person so charged refuses to submit to the test, a hearing shall be*
24 *conducted in camera before the court to determine probable cause by a preponderance of*
25 *the evidence that the individual has committed the crime with which he is charged. Upon*
26 *a finding of probable cause, the court shall order the accused to undergo testing for*
27 *infection with human immunodeficiency virus.*
28 *Confirmatory tests shall be conducted before any test result shall be determined to be*
29 *positive. The results of such test shall be confidential and shall only be disclosed to the*
30 *person who is the subject of the test and to the Department of Health for the purpose of*
31 *contacting any victim and conducting surveillance and investigation in accordance with §*
32 *32.1-39 of this Code. The results of such test shall not be admissible in evidence in any*
33 *criminal proceeding involving the charge initiating the test.*
34 *The cost of such test shall be paid by the Commonwealth and taxed as part of the*
35 *cost of such criminal proceedings.*
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Official Use By Clerks

Passed By The House of Delegates		**Passed By The Senate**	
without amendment	☐	without amendment	☐
with amendment	☐	with amendment	☐
substitute	☐	substitute	☐
substitute w/amdt	☐	substitute w/amdt	☐

Date: ____________ Date: ____________

Clerk of the House of Delegates Clerk of the Senate

LD7574466

HOUSE BILL NO. 1973
AMENDMENT IN THE NATURE OF A SUBSTITUTE
(Proposed by the House Committee for Courts of Justice
on February 5, 1989)
(Patron Prior to Substitute—Delegate Glasscock)

A BILL to amend the Code of Virginia by adding in Article 7 of Chapter 4 of Title 18.2 a section numbered 18.2-61.01. relating to testing of persons charged with certain crimes for human immunodeficiency virus.

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Article 7 of Chapter 7 of Title 18.2 a section numbered ~~numbered~~ 18.2-61.01 as follows:

§ 18.2-61.01. Testing of certain persons for human immunodeficiency virus.—As soon as practicable following conviction of any person for any crime involving sexual assault pursuant to §§ 18.2-61. 18.2-63. 18.2-64.1. 18.2-67.1. 18.2-67.2:1. 18.2-67.3. 18.2-67.4 or 18.2-68 or any offense against children as set out in § 18.2-361 or § 18.2-366. such person shall be required to submit to testing as prescribed by the Board of Health for infection with human immunodeficiency virus. The person convicted shall be counseled by the Board of Health or persons designated by such Board about (i) the meaning of the test. (ii) acquired immunodeficiency syndrome and (iii) the transmission and prevention of infection with human immunodeficiency virus.

Tests shall be conducted to confirm initial positive test results before any test result shall be determined to be positive. The results of such test shall be confidential and shall only be disclosed to the person who is the subject of the test and to the Department of Health for the purpose of contacting any victim and conducting surveillance and investigation in accordance with § 32.1-39.

The results of the test shall not be admissible in any criminal proceeding involving the charge initiating such test.

The cost of such test shall be paid by the Commonwealth and taxed as part of the cost of such criminal proceedings.

Official Use By Clerks

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

1989 SESSION

VIRGINIA ACTS OF ASSEMBLY - CHAPTER 613

An Act to amend and reenact §§ 32.1-36 and 32.1-39 of the Code of Virginia and to amend the Code of Virginia by adding sections numbered 2.1-51.14:1, 22.1-271.3, 23-9.2:3.2, 32.1-11.1, 32.1-11.2, 32.1-36.1, 32.1-37.2, 32.1-45.1, 32.1-55.1 and 32.1-289.2, relating to infection with human immunodeficiency virus; penalties.

[H 1974]

Approved MAR 25 1989

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-36 and 32.1-39 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding sections numbered 2.1-51.14:1, 22.1-271.3, 23-9.2:3.2, 32.1-11.1, 32.1-11.2, 32.1-36.1, 32.1-37.2, 32.1-45.1, 32.1-55.1 and 32.1-289.2 as follows:

§ 2.1-51.14:1. Responsibility of certain agencies within the Secretariat.—The Boards of Health, Mental Health, Mental Retardation and Substance Abuse Services, Rehabilitative Services, Social Services, and Medical Assistance Services shall review their regulations and policies related to service delivery in order to ascertain and eliminate any discrimination against individuals infected with human immunodeficiency virus.

§ 22.1-271.3. Guidelines for school attendance for children infected with human immunodeficiency virus.—A. The Board of Education, in cooperation with the Board of Health, shall develop, and revise as necessary, model guidelines for school attendance for children infected with human immunodeficiency virus. The first such guidelines shall be completed by December 1, 1989. The Board shall distribute copies of these guidelines to each division superintendent and every school board member in the Commonwealth immediately following completion.

B. Each school board shall, by July 1, 1990, adopt guidelines for school attendance for children with human immunodeficiency virus. Such guidelines shall be consistent with the model guidelines for such school attendance developed by the Board of Education.

§ 23-9.2:3.2. Education program on human immunodeficiency virus infection.—A. Virginia public colleges and universities, in cooperation with the State Council of Higher Education and the Department of Health, shall develop, and revise as necessary, a model education program for college students on the etiology, effects and prevention of infection with human immunodeficiency virus. The Council shall also encourage private colleges and universities to develop such programs.

B. Each board of visitors or other governing body of a public institution of higher education shall, by July 1, 1990, adopt an education program on human immunodeficiency virus infection for the students in its institution.

§ 32.1-11.1. Board to establish acquired immunodeficiency syndrome services and education grants program.—With such funds as are appropriated for this purpose, the Board of Health shall establish the acquired immunodeficiency syndrome services and education grants program. The Board may award grants for (i) the provision of direct patient services including, but not limited to, mental health services, and home and community based health services; and (ii) broad-based community AIDS education efforts including, but not limited to, education of high risk populations, street outreach efforts and improvement of public knowledge, awareness and attitudes about human immunodeficiency virus infection and persons with acquired immunodeficiency syndrome.

The Board shall appoint an advisory committee of experts in the delivery of services to persons with AIDS and AIDS education to assist in the development of the criteria for awarding such grants, the contents of the request for proposals, evaluation and ranking of the applications and making recommendations for the awarding of the grants.

§ 32.1-11.2. Regional AIDS resource and consultation centers; pilot treatment centers.—Utilizing existing state and local facilities and from such funds as are appropriated for this purpose, the Board of Health shall provide grants for no more than five regional AIDS resource and consultation centers and two pilot treatment centers.

Each regional AIDS resource and consultation center shall be designed to address the need for expanded medical care and support services for persons with human immunodeficiency virus infection through education of health care professionals on a broad range of AIDS-related issues, clinical training for health care practitioners and students, medical consultation to community physicians and other health care providers, provision of current technical medical materials such as manuals and protocols for the management of HIV infection and medical literature, facilitation of access to health services, mental

health and substance abuse services, support services and case management for HIV-infected persons. The regional AIDS resource and consultation centers shall cooperate with at least one of the medical schools located in the Commonwealth.

Each pilot treatment center shall supply medical care and support services for persons with human immunodeficiency virus infection.

The Board shall establish criteria for award of the grants. The criteria for the grants for the regional AIDS resource and consultation centers shall include, but not be limited to: (i) priority targeting of funds for services to high risk populations; (ii) geographical distribution of the centers in order to provide equal access to services throughout the Commonwealth; (iii) pro rata apportionment of funds according to the number of cases of acquired immunodeficiency syndrome in the various areas of the Commonwealth; (iv) development of innovative and flexible approaches to provision of services tailored to the specific needs of patients in the region; and (v) extensive community involvement.

§ 32.1-36. Reports by physicians and laboratory directors.–A. Every physician practicing in this Commonwealth who shall diagnose or reasonably suspect that any patient of his has any disease required by the Board to be reported and every director of any laboratory doing business in this Commonwealth which performs any test whose results indicate the presence of any such disease shall make a report within such time and in such manner as may be prescribed by regulations of the Board.

B. Any physician who diagnoses a venereal disease in a child twelve years of age or under shall, in addition to the requirements of subsection A hereof, report the matter, in accordance with the provisions of § 63.1-248.3, unless the physician reasonably believes that the infection was acquired congenitally or by a means other than sexual abuse.

C. Any physician practicing in this Commonwealth ~~may~~ *shall* report to the local health department the identity of any patient of his who has tested positive for exposure to human immunodeficiency virus as demonstrated by such test or tests as are approved by the Board for this purpose. *However, there is no duty on the part of the physician to notify any third party other than the local health department of such test result, and a cause of action shall not arise from any failure to notify any other third party.*

§ 32.1-36.1. Confidentiality of test for human immunodeficiency virus; civil penalty; individual action for damages or penalty.– A. The results of every test to determine infection with human immunodeficiency virus shall be confidential. Such information may only be released to the following persons:

1. The subject of the test or his legally authorized representative.

2. Any person designated in a release signed by the subject of the test or his legally authorized representative.

3. The Department of Health.

4. Health care providers for purposes of consultation or providing care and treatment to the person who was the subject of the test.

5. Health care facility staff committees which monitor, evaluate, or review programs or services.

6. Medical or epidemiological researchers for use as statistical data only.

7. Any person allowed access to such information by a court order.

8. Any facility which procures, processes, distributes or uses blood, other body fluids, tissues or organs.

9. Any person authorized by law to receive such information.

10. The parents of the subject of the test if the subject is a minor.

11. The spouse of the subject of the test.

B. In any action brought under this section, if the court finds that a person has willfully or through gross negligence made an unauthorized disclosure in violation of this section, the Attorney General, any Attorney for the Commonwealth, or any attorney for the county, city or town in which the violation occurred may recover for the Literary Fund, upon petition to the court, a civil penalty of not more than $5,000 per violation.

C. Any person who is the subject of an unauthorized disclosure pursuant to this section shall be entitled to initiate an action to recover actual damages, if any, or $100, whichever is greater. In addition, such person may also be awarded reasonable attorney's fees and court costs.

§ 32.1-37.2. Informed consent for testing for human immunodeficiency virus; condition on disclosure of test results; counseling required; exceptions.–A. Prior to performing any test to determine infection with human immunodeficiency virus, the subject of the test shall be given an oral or written explanation of the meaning of the test. Except as otherwise authorized in this Code, informed consent shall be obtained before such a test is performed.

Informed consent for testing for infection with human immunodeficiency virus shall be deemed to have been obtained (i) when an individual seeks the services of a facility offering anonymous testing for infection with human immunodeficiency virus; (ii) when blood specimens which were obtained for routine diagnostic purposes are tested in order to conduct seroprevalence studies of infection with human immunodeficiency virus if such studies are designed to prevent any specimen from being identified with any specific individual; and (iii) when an individual donates or sells his blood.

B. Every person who is the subject of any test to determine infection for human immunodeficiency virus shall be afforded the opportunity for individual face-to-face disclosure of the test results and appropriate counseling. Appropriate counseling shall include, but not be limited to, the meaning of the test results, the need for additional testing, the etiology, prevention and effects of acquired immunodeficiency syndrome, the availability of appropriate health care, mental health care and social services, the need to notify any person who may have been exposed to the virus and the availability of assistance through the Department of Health in notifying such individuals.

C. Opportunity for face-to-face disclosure of the test results and appropriate counseling shall not be required when the tests are conducted by blood collection agencies. However, all blood collection agencies shall notify the Board of Health of any positive tests.

D. In the case of a person applying for accident and sickness or life insurance who is the subject of a test to determine infection for human immunodeficiency virus, insurers' practices including an explanation of the meaning of the test, the manner of obtaining informed consent, the method of disclosure of the test results and any counseling requirements shall be as set forth in the regulations of the State Corporation Commission.

§ 32.1-39. Surveillance and investigation.—The Board shall provide for the surveillance of and investigation into all preventable diseases and epidemics in this Commonwealth and into the means for the prevention ~~thereof~~ *of such diseases and epidemics. Surveillance and investigation may include contact tracing in accordance with the regulations of the Board*. When any outbreak or unusual occurrence of a preventable disease shall be identified through reports required pursuant to Article 1 (§ 32.1-35 et seq.) of this chapter, the Commissioner or his designee shall investigate the disease in cooperation with the local health director or directors in the area of the disease. If in the judgment of the Commissioner the resources of the locality are insufficient to provide for adequate investigation, he may assume direct responsibility and exclusive control of the investigation, applying such resources as he may have at his disposal. The Board may issue emergency regulations and orders to accomplish the investigation.

§ 32.1-45.1. Deemed consent to testing and release of test results related to infection with human immunodeficiency virus.—A. Whenever any health care provider, or any person employed by or under the direction and control of a health care provider, is directly exposed to body fluids of a patient in a manner which may, according to the then current guidelines of the Centers for Disease Control, transmit human immunodeficiency virus, the patient whose body fluids were involved in the exposure shall be deemed to have consented to testing for infection with human immunodeficiency virus. Such patient shall also be deemed to have consented to the release of such test results to the person who was exposed. In other than emergency situations, it shall be the responsibility of the health care provider to inform patients of this provision prior to providing them with health care services which create a risk of such exposure.

B. Whenever any patient is directly exposed to body fluids of a health care provider, or of any person employed by or under the direction and control of a health care provider, in a manner which may, according to the then current guidelines of the Centers for Disease Control, transmit human immunodeficiency virus, the person whose body fluids were involved in the exposure shall be deemed to have consented to testing for infection with human immunodeficiency virus. Such person shall also be deemed to have consented to the release of such test results to the patient who was exposed.

C. For the purposes of this section, "health care provider" means any person, facility or agency licensed or certified to provide care or treatment by the Department of Health, Department of Mental Health, Mental Retardation and Substance Abuse Services, Department of Rehabilitative Services, or the Department of Social Services, any person licensed or certified by a health regulatory board within the Department of Health Professions except for the Boards of Funeral Directors and Embalmers and Veterinary Medicine or any personal care agency contracting with the Department of Medical Assistance Services.

§ 32.1-55.1. Anonymous testing sites for human immunodeficiency virus.— From such funds as are appropriated for this purpose, the Board of Health shall make available in all

health services areas of the Commonwealth anonymous testing for infection with human immunodeficiency virus.

§ 32.1-289.2. Donation or sale of blood, body fluids, organs and tissues by persons infected with human immunodeficiency virus.–Any person who donates or sells, who attempts to donate or sell, or who consents to the donation or sale of blood, other body fluids, organs and tissues, knowing that the donor is, or was, infected with human immunodeficiency virus, and who has been instructed that such blood, body fluids, organs or tissues may transmit the infection, shall be guilty, upon conviction, of a Class 6 felony.

This section shall not be construed to prohibit the donation of infected blood, other body fluids, organs and tissues for use in medical or scientific research.

2. That § 32.1-37.2 of this act shall become effective on October 1, 1989.

President of the Senate

Speaker of the House of Delegates

Approved:

Governor

GENERAL ASSEMBLY OF VIRGINIA -- 1989 SESSION

HOUSE JOINT RESOLUTION NO. 425

Requesting the Joint Board Liaison Committee of the Secretary of Health and Human Resources to promote certain interagency activities.

Agreed to by the House of Delegates, February 2, 1989
Agreed to by the Senate, February 14, 1989

WHEREAS, the Joint Subcommittee Studying Acquired Immunodeficiency Syndrome has held eight meetings, two of which have been public hearings; and

WHEREAS, the joint subcommittee has patiently listened to the comments of many experts, activists and persons who have AIDS or are infected with human immunodeficiency virus; and

WHEREAS, during the course of its study, the joint subcommittee has heard many complaints concerning the difficulties in accessing services; and

WHEREAS, some individuals have stated that they have been shunted from agency to agency without being provided crucial information about where and how to access services; and

WHEREAS, although the missions of the various health and human services agencies may differ, the basic purpose of all such agencies is to assist the citizens of the Commonwealth with needed support and health services; and

WHEREAS, in certain areas of the Commonwealth, interagency coordinating committees have developed protocols for cooperation between agencies which are models for the provision of services; and

WHEREAS, coordination and cooperation between agencies are essential to the provision of cost-effective and efficient services; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Board Liaison Committee of the Secretary of Health and Human Resources is hereby requested to promote the development of interagency coordinating committees and local protocols designed to reduce red tape, assure cooperation between agencies and facilitate coordination of services to individuals who are infected with human immunodeficiency virus.

GENERAL ASSEMBLY OF VIRGINIA -- 1989 SESSION

HOUSE JOINT RESOLUTION NO. 426

Requesting the health regulatory boards within the Department of Health Professions to promote appropriate provider education on human immunodeficiency virus infection.

Agreed to by the House of Delegates, February 6, 1989
Agreed to by the Senate, February 14, 1989

WHEREAS, the Joint Subcommittee Studying acquired immunodeficiency syndrome has conducted an arduous study of this unprecedented epidemic; and

WHEREAS, the joint subcommittee has come to understand and be sensitive to the many difficult and tragic situations occurring as a result of this disease; and

WHEREAS, one of the recurrent issues presented to the joint subcommittee concerned the denial of appropriate care or the lack of access to appropriate care for persons with acquired immunodeficiency syndrome (AIDS); and

WHEREAS, the joint subcommittee realizes that this disease is new and that the technology related to it is constantly changing and sympathizes with the dilemma of health care providers in trying to remain current; and

WHEREAS, the joint subcommittee also understands that many providers are concerned about losing their other patients if they accept patients who are known to be infected with human immunodeficiency virus (HIV); and

WHEREAS, the joint subcommittee hopes that this problem can be ameliorated through education of providers and the public; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the health regulatory boards within the Department of Health Professions are hereby requested through their authority or any other viable means to promote appropriate provider education on human immunodeficiency virus infection. Such education should relate to the scope of practice of the regulated health professions and emphasize the responsibilities and ethical duty of health care providers for the care and treatment of all individuals who are sick.

GENERAL ASSEMBLY OF VIRGINIA -- 1989 SESSION

HOUSE JOINT RESOLUTION NO. 427

Requesting the Board and Department of Medical Assistance Services to seek certain waivers to provide services to adults and children with human immunodeficiency virus infection (HIV).

Agreed to by the House of Delegates, February 4, 1989
Agreed to by the Senate, February 14, 1989

WHEREAS, the Joint Subcommittee Studying Acquired Immunodeficiency Syndrome (AIDS) has held several public hearings and has met eight times during this interim; and

WHEREAS, the joint subcommittee has spent many hours receiving testimony from experts, persons with AIDS and the family members and friends of persons with AIDS; and

WHEREAS, all of these individuals have emphasized the many gaps in services for individuals who are infected with human immunodeficiency virus and the unique circumstances in which these individuals are enmeshed; and

WHEREAS, the costs of treatment for these individuals are increased by the lack of available nursing home beds for persons with this infection and the necessity of seeking treatment and care in acute care facilities; and

WHEREAS, the Department of Medical Assistance Services operates a waiver program to provide personal care services in the home in order to prevent institutionalization of recipients; and

WHEREAS, such a waiver to provide services in their homes for individuals with AIDS could provide a less costly alternative for delivery of care; and

WHEREAS, many individuals with AIDS have family and friends who are willing to provide support and care; and

WHEREAS, however, these family members and volunteers cannot be expected to continue to carry the disproportionate share of the burden of care and support for persons with HIV infection; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Board and Department of Medical Assistance Services are hereby requested to seek waivers to provide unique services to adults and children who are infected with human immunodeficiency virus including the disease known as AIDS.

GENERAL ASSEMBLY OF VIRGINIA -- 1989 SESSION

HOUSE JOINT RESOLUTION NO. 428

Requesting the Board and Department of Medical Assistance Services to develop a methodology for reimbursement for licensed and certified nursing home beds based on the intensity of the required services.

Agreed to by the House of Delegates, February 6, 1989
Agreed to by the Senate, February 14, 1989

WHEREAS, the Joint Subcommittee Studying Acquired Immunodeficiency Syndrome (AIDS) has been informed that only one nursing home in the Commonwealth knowingly accepts patients who have acquired immunodeficiency syndrome; and

WHEREAS, the joint subcommittee has examined this issue and has concluded that in many cases, many patients with acquired immunodeficiency syndrome are only able to obtain care in sophisticated and costly tertiary centers; and

WHEREAS, the joint subcommittee believes that there are many reasons for the lack of access to nursing home care on the part of AIDS patients; and

WHEREAS, however, the joint subcommittee understands that the prospective, regional reimbursement rates of the Department of Medical Assistance Services act as a disincentive for accepting patients, such as those with AIDS, who require many additional nursing hours or other such intensive services; and

WHEREAS, this situation does not appear to be equitable to the nursing home providers or the many patients including, but not limited to, those with AIDS, who cannot obtain appropriate long-term care; and

WHEREAS, in addition, the Commonwealth's efforts to contain health care costs are circumvented when patients who are indigent must seek care in its medical school hospitals instead of other less costly facilities; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Board and Department of Medical Assistance Services are hereby requested to develop a methodology for reimbursement based on the intensity of the required services for licensed and certified nursing home beds. The Department is requested to report on its progress in developing this methodology to the Joint Subcommittee Studying Acquired Immunodeficiency Syndrome during the next year of its study.

GENERAL ASSEMBLY OF VIRGINIA -- 1989 SESSION

HOUSE JOINT RESOLUTION NO. 429

Requesting the Secretary of Administration to examine and revise the Commonwealth's employment policy related to infection with human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS).

Agreed to by the House of Delegates, February 6, 1989
Agreed to by the Senate, February 14, 1989

WHEREAS, the Joint Subcommittee Studying Acquired Immunodeficiency Syndrome has come to understand that human immunodeficiency virus infection is transmitted through sexual contact, mucous membrane contact, parenteral contact with certain infected body fluids and perinatal contact from mother to child; and

WHEREAS, in conformance with medical knowledge, the joint subcommittee has concluded that there is no basis for fear of contracting HIV infection through casual contact in the workplace; and

WHEREAS, the present employment policy of the Commonwealth allows workers to seek transfers to avoid contact with persons infected with human immunodeficiency virus; and

WHEREAS, such a policy may be perceived by the employees and citizens of the Commonwealth as validating fear of casual, social contact with AIDS patients; and

WHEREAS, the joint subcommittee wishes to emphasize that this perception is inaccurate and that the transfer policy sends an erroneous message to the people of the Commonwealth which must be corrected; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Secretary of Administration is hereby requested to examine and revise the employment policy of the Commonwealth related to infection with human immunodeficiency virus and the disease known as acquired immunodeficiency syndrome in order to correct any inequities and to avoid creating any false public perceptions concerning the transmission of HIV infection.

GENERAL ASSEMBLY OF VIRGINIA -- 1989 SESSION

HOUSE JOINT RESOLUTION NO. 430

Requesting the Department of Corrections to develop a comprehensive. long-range plan for the management of human immunodeficiency virus (HIV) and the disease known as AIDS.

Agreed to by the House of Delegates, February 6, 1989
Agreed to by the Senate, February 14, 1989

WHEREAS, the Joint Subcommittee Studying Acquired Immunodeficiency Syndrome was charged with accessing the programs of state agencies related to the management of the AIDS epidemic; and

WHEREAS, the joint subcommittee received a presentation from the Department of Corrections on the impact of HIV infection on Virginia's correctional institutions; and

WHEREAS, the joint subcommittee also received expert testimony on AIDS in the Virginia correctional system and the management of HIV infection among prisoners; and

WHEREAS, many of the members of the joint subcommittee believe that careful steps should be taken to contain infection with HIV in the prison population; and

WHEREAS, at this time, it does not appear that the policies of the Department of Corrections are adequate to provide effective management of this disease; and

WHEREAS, many initiatives could be developed to contain the spread of the infection among prisoners and to inform prisoners about at-risk behavior; and

WHEREAS, the joint subcommittee believes that it is imperative that steps be taken now to plan for increased rates of infection in the prison population and to avoid a crisis in the correctional system; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Department of Corrections is hereby requested to develop a comprehensive, long-range plan for the management of human immunodeficiency virus and the disease known as AIDS. The Department is requested to focus on the following issues: (i) effective steps to protect inmates who are vulnerable to sexual attacks; (ii) effective ways to provide education and counseling to prison workers and officials and inmates in order to inform them about the etiology, prevention and effects of infection with human immunodeficiency virus; (iii) the appropriate use of segregation or isolation of aggressive individuals who are infected; (iv) the appropriate circumstances and proper use of universal precautions to reduce the risk of exposure; (v) when and why testing should be required or offered; (vi) appropriate counseling of HIV infected individuals; and (vii) any other relevant issue.

The Department shall report on its progress in developing the comprehensive long-range plan for management of human immunodeficiency virus to the joint subcommittee in the next year of its study.

GENERAL ASSEMBLY OF VIRGINIA -- 1989 SESSION

HOUSE JOINT RESOLUTION NO. 431

Continuing the Joint Subcommittee Studying Human Immunodeficiency Viruses.

Agreed to by the House of Delegates, February 6, 1989
Agreed to by the Senate, February 23, 1989

WHEREAS, House Joint Resolution 31 and Senate Joint Resolution 28, introduced during the 1988 Session of the Virginia General Assembly, established a joint subcommittee to study acquired immunodeficiency syndrome (AIDS), a disease caused by human immunodeficiency viruses; and

WHEREAS, the joint subcommittee was directed to assess prevention efforts to abate the spread of this fatal disease, determine the appropriate role of state and local agencies for establishing public policy for the disease, determine whether state policies exist concerning the containment of human immunodeficiency viruses and the care and treatment of infected individuals, and identify any other related issues deemed appropriate; and

WHEREAS, during the course of its work the joint subcommittee received testimony on the potential impact of the human immunodeficiency virus epidemic from representatives of state agencies, medical and insurance industries within and outside the Commonwealth and from many concerned citizens of Virginia; and

WHEREAS, in its deliberations the joint subcommittee has identified public policy issues including, but not limited to, education and awareness, delivery of health care, the rights of infected and noninfected citizens, child welfare issues, insurance, employment of infected citizens, antidiscrimination, testing, cost of care and treatment of citizens infected with human immunodeficiency virus, privacy and confidentiality, medical research and the implementation of appropriate health care services; and

WHEREAS, the joint subcommittee has developed legislation to address a number of these issues for recommendation to the General Assembly; and

WHEREAS, further assessment of these issues in a comprehensive and judicious manner would be in the interests of sound public policy on the containment of human immunodeficiency viruses; and

WHEREAS, due to the complexity of the many issues posed by human immunodeficiency viruses, including placement and isolation of infected individuals who pose an immediate and substantial threat to the public, waivers for the Department of Medical Assistance Services to provide services to adults and children with acquired immunodeficiency syndrome, the feasibility of establishing risk pools for insurance of persons infected and other issues that require additional research and scrutiny; and

WHEREAS, it is the consensus of the joint subcommittee that the need for and the development and implementation of a thorough response to the issues posed by human immunodeficiency viruses deserve careful and judicious planning and consideration; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Subcommittee Studying Human Immunodeficiency Viruses be continued. The current membership of the joint subcommittee shall continue to serve. The joint subcommittee shall in its deliberations:

1. Determine the feasibility of placement and isolation policies for citizens who are infected with human immunodeficiency viruses who present an immediate and substantial threat to the health and welfare of the public as an alternative to criminalization of knowing and willful transmission of HIV infection;
2. Determine the procedures to be proscribed by any such statutes, the circumstances, if any, under which criminal sanctions should be imposed, and any appropriate penalties for such actions;
3. Determine the feasibility of health insurance risk pools and any other cost containment mechanisms deemed appropriate by the joint subcommittee that may serve to control the spiraling costs of health care services for persons infected with human immunodeficiency virus;
4. Assess the costs of recommended services and the appropriate revenue streams for such funds;
5. Determine whether, and under what circumstances or conditions, the tests results of an unemancipated minor who tests positive for human immunodeficiency virus shall be reported to the parent or lawful custodian of such minor; and
6. Any other related issues deemed appropriate by the joint subcommittee.

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

1990 SESSION

VIRGINIA ACTS OF ASSEMBLY - CHAPTER

An Act to amend and reenact §§ 32.1-36.1 and 32.1-38 of the Code of Virginia, relating to reporting of disease and immunity from liability.

[H 814]

Approved

Be it enacted by the General Assembly of Virginia:
1. That §§ 32.1-36.1 and 32.1-38 of the Code of Virginia are amended and reenacted as follows:

§ 32.1-36.1. Confidentiality of test for human immunodeficiency virus; civil penalty; individual action for damages or penalty.—A. The results of every test to determine infection with human immunodeficiency virus shall be confidential. Such information may only be released to the following persons:

1. The subject of the test or his legally authorized representative.
2. Any person designated in a release signed by the subject of the test or his legally authorized representative.
3. The Department of Health.
4. Health care providers for purposes of consultation or providing care and treatment to the person who was the subject of the test.
5. Health care facility staff committees which monitor, evaluate, or review programs or services.
6. Medical or epidemiological researchers for use as statistical data only.
7. Any person allowed access to such information by a court order.
8. Any facility which procures, processes, distributes or uses blood, other body fluids, tissues or organs.
9. Any person authorized by law to receive such information.
10. The parents of the subject of the test if the subject is a minor.
11. The spouse of the subject of the test.

B. In any action brought under this section, if the court finds that a person has willfully or through gross negligence made an unauthorized disclosure in violation of this section, the Attorney General, any attorney for the Commonwealth, or any attorney for the county, city or town in which the violation occurred may recover for the Literary Fund, upon petition to the court, a civil penalty of not more than $5,000 per violation.

C. Any person who is the subject of an unauthorized disclosure pursuant to this section shall be entitled to initiate an action to recover actual damages, if any, or $100, whichever is greater. In addition, such person may also be awarded reasonable attorney's fees and court costs.

D. This section shall not be deemed to create any duty on the part of any person who receives such test results, where none exists otherwise, to release the results to a person listed herein as authorized to receive them.

§ 32.1-38. Immunity from liability.—Any person making a report *or disclosure* required or authorized by this chapter shall be immune from civil liability or criminal penalty connected therewith unless it is proved that such person acted with *gross negligence or* malicious intent. *Further, except for such reporting requirements as may be established in this chapter or by any regulation promulgated pursuant thereto, there shall be no duty on the part of any blood collection agency or tissue bank to notify any other person of any reported test results, and a cause of action shall not arise from any failure by such entities to notify others.* Neither the Commissioner nor any local health director shall disclose to the public the name of any person reported or the name of any person making a report pursuant to this chapter.

1990 RECONVENED SESSION

VIRGINIA ACTS OF ASSEMBLY - CHAPTER 957 **REENROLLED**

An Act to amend the Code of Virginia by adding in Article 7 of Chapter 4 of Title 18.2 a section numbered 18.2-62, relating to testing of persons for human immunodeficiency virus.

[H 815]

Approved APR 1 8 1990

Be it enacted by the General Assembly of Virginia:
1. That the Code of Virginia is amended by adding in Article 7 of Chapter 4 of Title 18.2 a section numbered 18.2-62 as follows:

§ 18.2-62. Testing of certain persons for human immunodeficiency virus.—A. As soon as practicable following arrest, the attorney for the Commonwealth may request, after consultation with any victim, that any person charged with any crime involving sexual assault pursuant to this article or any offenses against children as prohibited by §§ 18.2-361, 18.2-366, 18.2-370, and 18.2-370.1 be requested to submit to testing for infection with human immunodeficiency virus. The person so charged shall be counseled about the meaning of the test, about acquired immunodeficiency syndrome, and about the transmission and prevention of infection with human immunodeficiency virus.

In the event the person so charged refuses to submit to the test, a hearing shall be conducted in camera before the circuit court to determine probable cause by a preponderance of the evidence that the individual has committed the crime with which he is charged. Upon a finding of probable cause, the court shall order the accused to undergo testing for infection with human immunodeficiency virus.

B. Upon conviction of any crime involving sexual assault pursuant to this article or any offenses against children as prohibited by §§ 18.2-361, 18.2-366, 18.2-370, and 18.2-370.1, the attorney for the Commonwealth may request, after consultation with any victim, and the court shall order the defendant to submit to testing for infection with human immunodeficiency virus. Any test conducted following conviction shall be in addition to such tests as may have been conducted following arrest pursuant to subsection A.

C. Confirmatory tests shall be conducted before any test result shall be determined to be positive. The results of the tests for infection with human immunodeficiency virus shall be confidential as provided in § 32.1-36.1; however, the Department of Health shall also disclose the results to any victim. The Department shall conduct surveillance and investigation in accordance with § 32.1-39 of this Code.

The results of such tests shall not be admissible as evidence in any criminal proceeding.

The cost of such tests shall be paid by the Commonwealth and taxed as part of the cost of such criminal proceedings.

1990 RECONVENED SESSION

VIRGINIA ACTS OF ASSEMBLY - CHAPTER 958 **REENROLLED**

An Act to amend and reenact §§ 32.1-43, 32.1-44 and 32.1-45 of the Code of Virginia and to amend the Code of Virginia by adding in Chapter 2 of Title 32.1, an article numbered 3.01, consisting of sections numbered 32.1-48.01 through 32.1-48.04 and to repeal §§ 32.1-51 and 32.1-52 of the Code of Virginia, all relating to isolation of certain persons infected with communicable diseases.

[H 816]

Approved APR 18 1990

Be it enacted by the General Assembly of Virginia:
1. That §§ 32.1-43, 32.1-44 and 32.1-45 of the Code of Virginia are amended and reenacted and the Code of Virginia is amended by adding in Chapter 2 of Title 32.1, an article numbered 3.01, consisting of sections numbered 32.1-48.01 through 32.1-48.04, as follows:

§ 32.1-43. Authority of Commissioner to require quarantine, etc.—The Commissioner shall have authority to require ~~isolation,~~ quarantine, vaccination or treatment of any individual when he determines any such measure to be necessary to control the spread of any disease of public health importance.

§ 32.1-44. Isolated or quarantined person may choose method of treatment.— ~~Nothing contained in §§ 32.1-42 and 32.1-43~~ *The provisions of this chapter* shall *not* be construed to prevent or restrict any isolated or quarantined person from choosing his own method of treatment or to limit any diseased person in his right to choose or select whatever method or mode of treatment he may believe to be the most efficacious in the cure of his ailment.

§ 32.1-45. Expense of treatment.— ~~Any person required to be treated pursuant to § 32.1-42 or § 32.1-43 shall bear~~ *Except as specifically provided by law, the provisions of this chapter shall not be construed as relieving any individual of* the expense, if any, of ~~such~~ *any* treatment.

Article 3.01.

Isolation Of Certain Persons With Communicable Diseases.

§ 32.1-48.01. Definitions.—As used in this article, unless the context requires a different meaning:

"Appropriate precautions" means those specific measures which have been demonstrated by current scientific evidence to assist in preventing transmission of a communicable disease. Appropriate precautions will vary according to the disease.

"At-risk behavior" means engaging in acts which a person, who has been informed that he is infected with a communicable disease, knows may infect other persons without taking appropriate precautions to protect the health of the other persons.

"Communicable disease" means an illness of public health significance, as determined by the Commissioner of Health, caused by a specific infectious agent which may be transmitted directly or indirectly from one person to another.

§ 32.1-48.02. Investigations of verified reports or medical evidence; counseling.—A. Upon receiving at least two verified reports or upon receiving medical evidence that any person who is reputed to know that he is infected with a communicable disease is engaging in at-risk behavior, the Commissioner or his designee may conduct an investigation through an examination of the records of the Department and other medical records to determine the disease status of the individual and that there is cause to believe he is engaging in at-risk behavior.

B. If the investigation indicates that the person has a communicable disease and that there is cause to believe he is engaging in at-risk behavior, the Commissioner or his designee may issue an order for such person to report to the local or district health department in the jurisdiction in which he resides to receive counseling on the etiology, effects and prevention of the specific disease. The person conducting the counseling shall prepare and submit a report to the Commissioner or his designee on the counseling session or sessions in which he shall document that the person so counseled has been informed about the acts that constitute at-risk behavior, appropriate precautions, and the need to use appropriate precautions. The counselor shall also report any statements indicating the intentions or understanding of the person so counseled.

§ 32.1-48.03. Petition for hearing; temporary detention.—A. Upon receiving a verified report or upon receiving medical evidence that any person who has been counseled pursuant to § 32.1-48.02 has continued to engage in at-risk behavior, the Commissioner or his designee may petition the general district court of the county or city in which such

person resides to order the person to appear before the court to determine whether isolation is necessary to protect the public health.

B. If such person cannot be conveniently brought before the court, the court may issue an order of temporary detention. The officer executing the order of temporary detention shall order such person to remain confined in his home or another's residence or in some convenient and willing institution or other willing place for a period not to exceed forty-eight hours prior to a hearing. An electronic device may be used to enforce such detention in the person's home or another's residence. The institution or other place of temporary detention shall not include a jail or other place of confinement for persons charged with criminal offenses.

If the specified forty-eight-hour period terminates on a Saturday, Sunday or legal holiday, such person may be detained until the next day which is not a Saturday, Sunday or legal holiday. In no event may the person be detained for longer than seventy-two hours or ninety-six hours when the specified forty-eight-hour period terminates on a Saturday, Sunday or legal holiday. For purposes of this section, a Saturday, Sunday, or legal holiday shall be deemed to include the time period up to 8:00 A.M. of the next day which is not a Saturday, Sunday, or legal holiday.

C. Any person ordered to appear before the court pursuant to this section shall be informed of his right to be represented by counsel. The court shall provide the person with reasonable opportunity to employ counsel at his own expense, if so requested. If the person is not represented by counsel, the court shall appoint an attorney-at-law to represent him. Counsel so appointed shall be paid a fee of seventy-five dollars and his necessary expenses.

§ 32.1-48.04. Isolation hearing; conditions; order for isolation; right to appeal.—A. The isolation hearing shall be held within forty-eight hours of the execution of any temporary detention order issued or, if the forty-eight-hour period terminates on a Saturday, Sunday or legal holiday, the isolation hearing shall be held within seventy-two or ninety-six hours of the execution of any such temporary detention order.

Prior to the hearing, the court shall fully inform the person of the basis for his detention, if any, the basis upon which he may be isolated, and the right of appeal of its decision.

B. An order for isolation in the person's home or another's residence or an institution or other place, including a jail when no other reasonable alternative is available, may be issued upon a finding by the court that the following conditions are met:

1. The person is infected with a communicable disease.

2. The person is engaging in at-risk behavior.

3. The person has demonstrated an intentional disregard for the health of the public by engaging in behavior which has placed others at risk for infection.

4. There is no other reasonable alternative means of reducing the risk to public health.

C. Any order for isolation in the person's home or another's residence or an institution or other place shall be valid for no more than 120 days, or for a shorter period of time if the Commissioner or his designee, or the court upon petition, determines that the person no longer poses a substantial threat to the health of others. Orders for isolation in the person's home or another's residence may be enforced through the use of electronic devices. Orders for isolation may include additional requirements such as participation in counseling or education programs. The court may, upon finding that the person no longer poses a substantial threat to the health of others, issue an order solely for participation in counseling or educational programs.

D. Isolation orders shall not be renewed without affording the person all rights conferred in this article.

Any person under an isolation order pursuant to this section shall have the right to appeal such order to the circuit court in the jurisdiction in which he resides. Such appeal shall be filed within thirty days from the date of the order. Notwithstanding the provisions of § 19.2-241 relating to the time within which the court shall set criminal cases for trial, any appeal of an isolation order shall be given priority over all other pending matters before the court, except those matters under appeal pursuant to § 37.1-67.6, and shall be heard as soon possible by the court. The clerk of the court from which an appeal is taken shall immediately transmit the record to the clerk of the appellate court.

The appeal shall be heard de novo. An order continuing the isolation shall only be entered if the conditions set forth in subsection B are met at the time the appeal is heard.

If the person under an isolation order is not represented by counsel, the judge shall appoint an attorney-at-law to represent him. Counsel so appointed shall be paid a fee of $150 and his necessary expenses. The order of the court from which the appeal is taken

shall be defended by the attorney for the Commonwealth.
2. That §§ 32.1-51 and 32.1-52 of the Code of Virginia are repealed.

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President of the Senate

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Speaker of the House of Delegates

Approved:

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Governor

1990 RECONVENED SESSION

VIRGINIA ACTS OF ASSEMBLY - CHAPTER 913 **REENROLLED**

An Act to amend the Code of Virginia by adding in Article 3 of Chapter 8 of Title 18.2 a section numbered 18.2-346.1, relating to testing of persons convicted of prostitution for infection with human immunodeficiency virus.

[S 340]

Approved APR 18 1990

Be it enacted by the General Assembly of Virginia:
1. That the Code of Virginia is amended by adding in Article 3 of Chapter 8 of Title 18.2 a section numbered 18.2-346.1 as follows:

§ 18.2-346.1. Testing of convicted prostitutes for infection with human immunodeficiency virus.—As soon as practicable following conviction of any person for violation of § 18.2-346 or § 18.2-361, such person shall be required to submit to testing for infection with human immunodeficiency virus. The convicted person shall receive counseling from personnel of the Department of Health concerning (i) the meaning of the test, (ii) acquired immunodeficiency syndrome and (iii) the transmission and prevention of infection with human immunodeficiency virus.

Tests shall be conducted to confirm any initial positive test results before any test result shall be determined to be positive for infection. The results of such test shall be confidential as provided in § 32.1-36.1 and shall be disclosed to the person who is the subject of the test and to the Department of Health as required by § 32.1-36. The Department shall conduct surveillance and investigation in accordance with the requirements of § 32.1-39.

The results of the test shall not be admissible in any criminal proceeding related to prostitution.

The cost of the test shall be paid by the Commonwealth and taxed as part of the cost of such criminal proceedings.

President of the Senate

Speaker of the House of Delegates

Approved:

Governor

GENERAL ASSEMBLY OF VIRGINIA--1990 SESSION

HOUSE JOINT RESOLUTION NO. 129

Continuing the Joint Subcommittee Studying Human Immunodeficiency Viruses.

Agreed to by the House of Delegates, February 13, 1990
Agreed to by the Senate, February 27, 1990

WHEREAS, House Joint Resolution 431, introduced during the 1989 Session of the Virginia General Assembly, authorized the continuance of the Joint Subcommittee Studying Human Immunodeficiency Viruses, a study established by House Joint Resolution 31 and Senate Joint Resolution 28 of 1988; and

WHEREAS, during the second year of its study, the joint subcommittee was directed to determine the feasibility of placement and isolation policies for citizens who are infected with human immunodeficiency viruses who present an immediate and substantial threat to the health and welfare of the public; determine the procedures to be proscribed by any such statutes, circumstances under which criminal sanctions, if any, should be imposed and appropriate penalities for such actions; assess the viability of health insurance risk pools and other cost containment mechanisms that may serve to control the spiraling costs of health care services for persons infected with human immunodeficiency viruses; assess the costs of recommended services and appropriate revenue streams for such funds; determine whether and under what circumstances test results of an unemancipated minor shall be released to the parent or lawful custodian of such minor; and to study other issues as deemed appropriate; and

WHEREAS, during the course of its work the joint subcommittee received regular progress reports from state agencies which were directed, pursuant to the 1989 legislative proposals of the joint subcommittee, to develop and implement certain policies to address the impact of acquired immunodeficiency syndrome (AIDS) and human immunodeficiency viruses on the Commonwealth; and

WHEREAS, the joint subcommittee received testimony from many medical and insurance professionals, and from many concerned citizens of Virginia; and

WHEREAS, basing its opinion upon statistical and medical information concerning the morbidity and mortality among persons infected with human immunodeficiency viruses among the population of Virginia, as well as throughout the United States, the joint subcommittee agreed that acquired immunodeficiency syndrome is evolving from an acute disease which is almost always fatal, to a chronic disease which is amenable to treatment but continues to spread among the population without any reliable indication of imminent decline or abatement; and

WHEREAS, the joint subcommittee has recommended and secured appropriations for substantial policy and program initiatives to address the impact of this fatal disease on the Commonwealth and to assist citizens who are infected with human immunodeficiency viruses; and

WHEREAS, although many of these policies and programs administered through state agencies are in place and appear to be functioning effectively, until a means of eliminating this terrible disease can be identified, it is the consensus of the joint subcommittee that extended monitoring of these policy initiatives and on-going tracking of the morbidity and mortality rate of human immunodeficiency viruses would serve the best interests of the citizens of the Commonwealth; and

WHEREAS, it is the consensus of the joint subcommittee that the policies and programs implemented to address the impact of human immunodeficiency viruses in Virginia be reevaluated in late 1990 so that modifications and revisions can be made, as necessary, in order to assure that the policy objectives attain maximum benefit and effect; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Subcommittee Studying Human Immunodeficiency Viruses be continued. The current membership of the joint subcommittee shall continue to serve. Any vacancies shall be filled as originally provided in House Joint Resolution 31 and Senate Joint Resolution 28 of 1988.

In its deliberations the joint subcommittee shall:

1. Through its staff and the resources of the Department of Health, maintain and update, as necessary, data on the effectiveness of state policies designed to address the impact of human immunodeficiency viruses, and programs and policies for assisting persons infected with such viruses;

2. Conduct a careful and judicious evaluation of the Commonwealth's response to this epidemic, monitor the effectiveness of the programs established as a result of its recommendations and determine whether any revisions to such programs are necessary to meet the evolving needs of the health care system in addressing the AIDS crisis;

3. Determine new initiatives as necessary to ameliorate the effects of the AIDS epidemic in Virginia;

4. Address any other related issues deemed appropriate by the joint subcommittee.

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

The joint subcommittee shall submit its findings and recommendations to the Governor and the 1991 Session of the General Assembly. The report shall comply with the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

The indirect costs of this study are estimated to be $5,860; the direct costs of this study shall not exceed $5,400.