ANNUAL REPORT OF

THE JOINT COMMISSION ON HEALTH CARE

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 60

COMMONWEALTH OF VIRGINIA
RICHMOND
1994

COMMONWEALTH *of* VIRGINIA
Joint Commission on Health Care

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Executive Director

May 2, 1994

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TO: The Honorable George F. Allen, Governor of Virginia
and Members of the General Assembly

Pursuant to the provisions of the Code of Virginia (Title 9, Chapter 38, §§9-311 through 9-316) establishing the Joint Commission on Health Care and setting forth its purpose, I have the honor of submitting herewith the Annual Report for the calendar year ending December 31, 1993.

This report was originally prepared in December, 1993 and contained the findings and recommendations of the Joint Commission on Health Care that were presented to the 1994 General Assembly. The report was finalized in May, 1994 to include the final actions of the Governor and 1994 General Assembly on the Commission's recommendations.

Sincerely,

Stanley C. Walker
Chairman

SCW/pwf

JOINT COMMISSION ON HEALTH CARE

Chairman
The Honorable Stanley C. Walker

Vice Chairman
The Honorable Ford C. Quillen

The Honorable Hunter B. Andrews
The Honorable Clarence A. Holland
The Honorable Edward M. Holland
The Honorable Benjamin J. Lambert, III
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The Honorable Jane H. Woods
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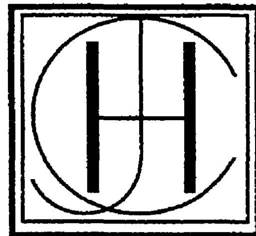
The Honorable Kenneth R. Melvin
The Honorable Harvey B. Morgan
The Honorable S. Wallace Stieffen

Secretary of Health and Human Resources
The Honorable Howard M. Cullum



JOINT COMMISSION ON HEALTH CARE

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The Commission acknowledges the significant contributions of Lina Sue Crowder, M.D., MCV Health Policy Fellow; Beth H. Gantt, the principal author of the Workforce Chapter of this report; Kimberly H. Gillespie, graphics support; and Dorothy K. Holmes, the principal author of the Health Insurance Chapter.

Acknowledgements

The Commission extends its sincere appreciation to the Office of the Clerk of the Senate, the Division of Legislative Services, and the Division of Legislative Automated Systems for their assistance and support throughout 1993.

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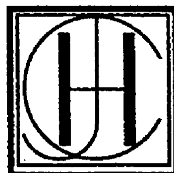


The Commonwealth's Role in Health Care Reform

Increasing Access

Cost Containment

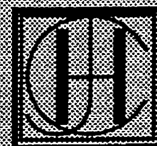
Insurance and Provider Regulator

Direct Provider

Financier

Educator of Health Care Professionals

Catalyst for State and Local Reform



Joint Commission on Health Care

- Virginia's Response to Federal Health Care Reform Plan
- Community Care Networks
- Health Insurance Reform and Development of Health Purchasing Cooperatives
- Development of Patient Level Data Base and Outcomes Research
- Long-term Role of Teaching Hospitals
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- Physician Location and Sub-Specialty Tracking

Department of Medical Assistance Services

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- Refocus of Indigent Health Care Trust Fund

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- AHEC/Dental Study
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Secretary of Health and Human Resources

- Restructure Long-Term Care Services at State level
- Implementation plan for Levels of Care in Homes for Adults

Joint Commission on Health Care

1993 Major Legislative Studies

EXECUTIVE SUMMARY

Authority for Study

The Joint Commission on Health Care was created by the 1992 Session of the Virginia General Assembly, pursuant to Senate Bill 501 and House Bill 1032. This sixteen-member legislative commission, with a separately staffed agency, continues the work of the Commission on Health Care for All Virginians (Senate Joint Resolution 118, 1990 Session).

1993 Commission Activities

The Joint Commission's 1993 activities included regional Commission meetings, a number of subcommittee meetings, and oversight of several task groups. The three subcommittees reviewed issues related to health insurance, the health workforce, the academic medical centers, and indigent care financing. Four task groups, consisting of Joint Commission staff, executive branch staff, and citizens, also reported to the Joint Commission. Individual task groups were charged with reviewing federal reform efforts, the organization of the long-term care system, health care fraud, and organized delivery systems. The work of the subcommittees and the task groups was reported to the Joint Commission at its monthly meetings.

The Joint Commission held seven meetings in 1993 at locations across the State. The May meeting was held at the General Assembly Building in Richmond. At this meeting staff reviewed the status of the 1993 legislative and budget recommendations, and the 1993 Joint Commission workplan. The May meeting also featured the first of a series of monthly staff reports on the status of federal health care reform. Finally, Secretary Cullum provided a status report on the State's efforts to reorganize the long-term care system.

The June meeting, also held in Richmond, focused on health insurance reform. The Joint Commission heard public comment on Virginia's small group insurance market reform bill, House Bill 2353. Insurance Commissioner Foster also offered his perspective on the bill. The comments of the public and the Commissioner were taken into consideration by the Health Insurance Subcommittee in its efforts to refine House Bill 2353.

The July meeting was held in Charlottesville. Representatives from the Commonwealth's three academic medical centers -- the Medical College of Virginia of Virginia Commonwealth University, the Medical College of Hampton Roads, and the University of Virginia Health Sciences Center -- presented their collaborative plans to increase the supply of generalist physicians in the Commonwealth. These proposals were then reviewed by the Health Workforce Subcommittee.

The vice presidents from the three academic medical centers also presented their response to House Joint Resolution (HJR) 623. HJR 623 requested the Joint Commission to work with the Governor in developing a long-term policy for the role of the academic medical centers in indigent care and medical education. The meeting concluded with a presentation by Mark R. Warner, Chairman of the Virginia Health Care Foundation, on grants awarded throughout the Commonwealth for programs addressing primary care needs.

The September meeting, held in Norfolk, featured a review of eastern Virginia health care issues by C. Donald Combs, Ph.D., of the Medical College of Hampton Roads. Secretary Cullum presented a proposal to request information from providers on their willingness to serve Medicaid enrollees on a capitated payment basis. Roice D. Luke, Ph.D., presented an overview of the growing trend toward integrated delivery systems in the nation and in the Commonwealth. Louis F. Rossiter, Ph.D., provided the Joint Commission with a comparison between the Virginia Essential Benefits Plan and the national benefits plan proposed by the Clinton Administration.

The September meeting concluded with testimony from two citizens. Ms. Nancy Davenport Ennis presented the findings of the Citizens' Task Force on Coverage of Autologous Bone Marrow Transplants and the implications for the future of health care delivery and finance. Mr. Frank K. Mattson presented his views on health care reform, stressing the value of preventive services in controlling health care costs.

The October meeting was held in Roanoke. The Joint Commission heard a staff analysis of Virginia's reform efforts compared to other states and the Clinton proposal. Various members of the Roanoke community addressed the Joint Commission about the strengths and limitations of the health care system in the region, as well as concerns about the Clinton reform proposal. Finally, Secretary Cullum provided a comprehensive overview of long-term care in the Commonwealth with particular emphasis on the need for restructuring and consolidation at the State level.

The November meeting was a two-day retreat held at Airlie, in Northwest Virginia. The retreat gave the Joint Commission an opportunity to refine the information it had received during the year into a preliminary annual report and legislative agenda. The Joint Commission reviewed proposals for legislative action pertaining to health insurance, the health workforce, health care costs and quality, the academic medical centers, Medicaid, and long-term care. A number of citizens representing providers, insurers, and purchasers of health care attended the retreat, and many addressed the Joint Commission individually or as part of a panel.

At the December meeting in Richmond, the Joint Commission's legislative agenda and annual report were further refined. The Joint Commission also received information on a controversial practice in which some insurance companies fail to pass on the benefits of their negotiated discounts to subscribers in the form of reduced coinsurance payments. The Joint Commission heard from the Insurance Commissioner as well as representatives of the insurance industry and consumers.

Recent Reform Efforts

The Joint Commission's 1993 activities reflected its commitment to build upon its recent reform efforts. In recent years, Virginia has enacted a number of reforms related to health insurance, the health workforce, health care costs and quality, Medicaid, and long-term care. The Joint Commission's recommendations for 1994 are designed to move the State forward in each of these areas.

Health Workforce

Virginia has enacted a number of major policies for expanding and redistributing the Commonwealth's primary care workforce. These include:

- The Robert Wood Johnson Foundation Generalist and Practice Sights Initiatives aimed at increasing the number of generalist physicians in the Commonwealth and developing a statewide recruitment and retention strategy
- Continued support for the work of the Area Health Education Center Program
- Establishment of the Office of Rural Health in the Department of Health
- Expansion of Medical, Nurse Practitioner/Nurse Midwife, Dental and Dental Hygiene Scholarship programs
- Establishment of a state-sponsored Physician Loan Repayment Program
- Authorization of limited prescriptive authority for Nurse Practitioners
- Establishment of a statewide health professions data base
- Establishment of a statewide Office of Health Professions, Recruitment and Retention
- Continued support for the work of the Virginia Health Care Foundation.

In 1994, the Joint Commission is recommending a number of initiatives which would build upon those already in place. These initiatives are explained in Chapter 2.

<u>Covering The Uninsured</u>

Over the past five years, Virginia has enacted a number of reforms designed to bring health coverage to the uninsured. Major initiatives include:

- Establishment of the Indigent Health Care Trust Fund to reimburse hospitals for a portion of their charity care
- Expanded coverage for women and children under Virginia Medicaid
- Development of a state-sponsored preventive and primary care program for low income children
- Establishment of the Virginia Health Care Foundation to promote private sector initiatives to expand access to primary care
- Small group insurance market reform aimed at expanding access to insurance coverage for small employers.

In 1994, the Joint Commission is recommending several additional actions, including revisions to the small group insurance reforms passed last year, and revising the Virginia Indigent Health Care Trust Fund to

support pilot programs for subsidizing health insurance for the uninsured. These issues and recommendations are discussed in Chapter 3.

Costs and Quality

Over the last several years, Virginia has taken several important steps toward creating a more cost-effective health care system. Major enactments include:

- Strengthening the Certificate of Public Need Program
- Developing a new Health Services Cost Review Council methodology aimed at identifying efficient and effective providers
- Establishing a patient level data base which will eventually be used to assess the quality of health care services
- Establishing requirements for uniform claims forms
- Placing limitations on physician self-referrals

In 1994, the Joint Commission is recommending several actions to expand the Commonwealth's ability to control health care costs and quality, including a resolution to study the development of "report cards" for health plans. In addition, as explained in Chapter 5, the Joint Commission is recommending consideration of legislation to grant the State teaching hospitals additional administrative flexibility so that they can be more cost-effective.

Long-Term Care

Long-term care reform has been a priority of the Joint Commission. In recent years, Virginia has implemented a number of strategies to create a better coordinated, more streamlined long-term care system. Major initiatives include:

- Development of a two-tiered system of licensure for homes for adults
- Articulation of a long-term care policy for the Commonwealth
- Establishment of a case management system for persons receiving publicly supported long-term care services
- Enactment of a moratorium on nursing home beds approved by the Certificate of Public Need Program.

In 1994, the Joint Commission is recommending additional structural changes as well as further study of key issues. As explained in Chapter 6, recommendations include:

- Establishment of a consolidated state long-term care and aging agency
- Extension of the moratorium on the issuance of certificates of public need for nursing facilities until July, 1995
- A study of incentives to encourage citizens to purchase private long-term care insurance
- A study of local implementation issues related to the restructuring of the state long-term care system.

Medicaid

In addition to expanding Medicaid eligibility, Virginia has implemented policies aimed at improving the cost-effectiveness of the Virginia Medicaid program. These include:

- Establishment of Medallion, a managed care program for certain types of Medicaid enrollees
- Limitations on assets which may be transferred in efforts to win eligibility for Medicaid long-term care services.

In 1994, the Joint Commission continues to support the Medallion program and is recommending the introduction of voluntary, capitated managed care to the Medicaid program.

1994 Legislative Recommendations

The following legislative proposals were introduced during the 1994 Session of the General Assembly. For each legislative proposal, the parenthetical expression indicates the 1994 General Assembly's actions on the recommendation. A copy of each bill and resolution approved by the General Assembly is provided in Appendix A.

Health Workforce

Proposed Legislation

1. Legislation (SB 459) to require health care professionals (physicians, nurse practitioners, certified nurse midwives, physician assistants, dentists and dental assistants) to supply information regarding their area of specialty, subspecialty and practice profiles as part of the licensure process.

   (Legislation approved by General Assembly. Governor Allen requested that the bill be amended to require the Department of

Health Professions to attempt to collect the information from other sources prior to collecting the information from licensees. The General Assembly approved the Governor's amendment.)

2. Legislation (HB 716) which provides that: 1) the Virginia Department of Health reallocate any remaining funds from awards given through the Medical Scholarship Program to other participating Virginia medical schools and the Quillen School of Medicine at East Tennessee State University; and 2) students eligible for the Southwest Virginia Medical Scholarship Program need not reside in Southwest Virginia. To be eligible for the scholarship, students need only agree to practice in Southwest Virginia.

   (Legislation approved by General Assembly.)

3. Legislation (SB 409) and a budget amendment ($100,000 in general funds for 1994-96 biennium) establishing a state-sponsored Physician Loan Repayment Program.

   (Legislation approved by General Assembly; program did not receive additional appropriation.)

4. Legislation (SB 584) establishing a dental hygiene scholarship; moving the dental scholarship program to the Department of Health; and revising the medical scholarship program to give preference to minorities and residents of medically underserved areas. A budget amendment ($28,000 in general funds for the 1994-96 biennium) also was proposed to fund the dental hygiene scholarship.

   (Legislation approved by General Assembly; Governor Allen requested that the legislation be amended such that the scholarship programs would give preference to "students of economically disadvantaged backgrounds;" the General Assembly approved the Governor's amendment; program did not receive additional appropriation.)

5. A joint study resolution (SJR 113) requesting the Commissioner of Health to reallocate existing resources for the creation of an Office of Health Professions, Recruitment and Retention to coordinate recruitment and retention activities.

   (Resolution adopted by General Assembly.)

6. A joint resolution (HJR 166) encouraging Virginia's private sector to continue to support the efforts of the Virginia Health Care Foundation to enhance access to primary and preventive care for Virginia's uninsured.

   (Resolution adopted by General Assembly.)

7. A joint study resolution (SJR 164) requesting that the Joint Commission evaluate existing statutes and regulations governing nurse practitioners, and determine whether mandatory direct reimbursement for advanced practice nurses would improve access to more affordable primary care services in Virginia.

   (Resolution adopted by General Assembly.)

8. A joint study resolution (HJR 173) requesting that the Virginia Department of Health continue it study of women's health status in Virginia.

   (Resolution adopted by General Assembly.)

9. A joint study resolution (SJR 185) requesting the Area Health Education Center Program to assess pharmaceutical practice needs in the Commonwealth, and to develop criteria for a statewide network of model pharmacy care centers.

   (Resolution adopted by General Assembly.)

Budget Amendments

1. Budget amendment ($10.3 million in general funds during the 1994-96 biennium) to support the Generalist Physicians Initiative at Virginia's three medical schools: the University of Virginia, the Medical College of Virginia, and the Medical College of Hampton Roads. The Generalist Physicians Initiative seeks to increase the number of medical school graduates entering generalist physician practices.

   ($3.4 million appropriation for 1994-96 biennium.)

2. A language and budget amendment ($140,000 in general funds for the 1994-96 biennium) to expand the Virginia Medical Scholarship Program by funding an additional 28 scholarships at the three state

medical schools: the University of Virginia, the Medical College of Virginia, and the Medical College of Hampton Roads.

(Language approved; $90,000 appropriation provided for 1994-96 biennium.)

3. Language amendments requesting that the current funding guidelines for each of the three state medical schools' first-professional medical students be modified over four years to provide an additional incentive for the three schools to increase the production of general medical practitioners to equal 50 percent of each graduating class.

   (Language approved for each school.)

4. Language amendments for each of the three state medical schools which provide that the General Internal Medicine and General Pediatrics Residency Programs and related undergraduate programs are considered low-revenue producing. Amendments also express intent of General Assembly that Medicare, Medicaid, Champus and Indigent Care funding, along with other revenues, should ultimately fund 75% of these programs.

   (Language approved for each school.)

5. Budget amendment ($50,000 in general funds for the 1994-96 biennium) to expand the state-sponsored Mary Marshall Nurse Practitioner and Nurse Midwife Scholarship Program.

   (No additional appropriation provided for 1994-96 biennium.)

6. Budget amendment ($600,000 in general funds for the 1994-96 biennium) to support the Area Health Education Center Program.

   ($80,000 appropriation provided for 1994-96 biennium.)

7. Budget amendment ($150,000 in general funds for the 1994-96 biennium) to expand the dental scholarship program.

   (No additional appropriation provided for 1994-96 biennium.)

Health Insurance

Proposed Legislation

1. Legislation (HB 638) to allow donations to be accepted by the Virginia Indigent Health Care Trust Fund to support pilots which subsidize health coverage for the uninsured.

   (Legislation approved by General Assembly.)

2. Legislation (HB 1344 and HB 1345) which provides several substantive and technical revisions to the small group insurance reforms passed by the 1993 General Assembly.

   (Legislation approved by General Assembly.)

3. Legislation (SB 480) which requires insurers to calculate subscribers' coinsurance amounts based on actual payments to health care facilities.

   (Legislation approved by General Assembly.)

4. Legislation (SB 531) to establish an insurer fraud and abuse statute.

   (Legislation carried over to the 1995 General Assembly session.)

5. A joint resolution (HJR 140) memorializing the U.S. Congress to enact legislation to equalize the tax treatment of health insurance purchased outside of employer groups and to equalize the tax treatment of medical care savings accounts.

   (Resolution adopted by General Assembly.)

6. A joint study resolution (HJR 183) requesting the Joint Commission to examine options for expanding access to health coverage for children.

   (Resolution adopted by General Assembly.)

7. A joint study resolution (SJR 132) requesting the Joint Commission to continue studying health plan purchasing cooperatives with a focus on specific planning and operational issues.

(Resolution adopted by General Assembly.)

8. A joint study resolution (SJR 171) requesting the Bureau of Insurance to study individual and conversion health insurance coverage and market reform possibilities to determine measures which might increase access to affordable health care coverage for these individuals and families.

   (No action taken by the General Assembly.)

<u>Health Care Cost and Quality</u>

Proposed Legislation

1. Legislation (HB 639) requiring the submission of outpatient encounter data for state-supported patients for inclusion in the patient level data base.

   (Legislation approved by General Assembly.)

2. Legislation (SB 333) to establish a health care fraud statute.

   (Legislation carried over to the 1995 General Assembly session.)

3. A joint resolution (HJR 267) requesting the Virginia Health Services Cost Review Council to identify data needs for developing report cards on accountable health plans.

   (Resolution adopted by General Assembly.)

4. A joint study resolution (SJR 110) requesting the Joint Commission to study for-profit and not-for-profit hospitals and their contributions to the health care community.

   (Resolution adopted by General Assembly.)

5. A joint study resolution (SJR 111) requesting the Joint Commission to continue studying the impact of third-party reimbursement practices, with a focus on retail pharmacy services.

   (Resolution adopted by General Assembly.)

6. A joint study resolution (SJR 126) requesting the Joint Commission to continue its study of organized delivery systems with a focus on community health networks.

   (Resolution adopted by General Assembly.)

Budget Amendments

1. Budget amendments to provide $141,000 in FY 1994 and $422,000 in FY 1995 to the University of Virginia Medical Center to support the Blue Ridge Poison Control Center. Funds are to be used to provide poison control services in those portions of northern Virginia affected by the closing of the National Capital Poison Center.

   ($110,000 appropriated for FY 94 and $330,000 appropriated for FY 1995.)

2. Language amendment requesting the Department of Planning and Budget to study the delivery and financing of poison control services in the Commonwealth.

   (Language included in Appropriation Act.)

<u>Academic Medical Centers</u>

Legislation

1. Legislation (SB 545) to provide flexibility for the Medical College of Virginia and the University of Virginia Medical Center to enter into joint venture arrangements.

   (Legislation approved by General Assembly.)

Budget Amendments

1. Language amendment to exclude joint venture losses from indigent care cost reports used to determine State funding at the University of Virginia Medical Center and the Medical College of Virginia Hospitals.

   (Language included in Appropriation Act.)

Long-Term Care

Legislation

1. Legislation (SB 575 and HB 1267) to establish a consolidated state long-term care and aging agency effective January 1, 1995.

   (Legislation carried over to the 1995 General Assembly session.)

2. Legislation (HB 670) to continue the Long-Term Care Council until July 1, 1995.

   (Legislation approved by General Assembly.)

3. Legislation (HB 671) extending the moratorium on issuance of certificates of public need for nursing facilities from July 1, 1995 to July 1, 1996.

   (Legislation approved by General Assembly.)

4. Legislation (SB 263) to delete the reference to "mobility" from the definitions of "assisted" and "residential" living levels of care.

   (Legislation approved by General Assembly.)

5. A joint resolution (HJR 209) requesting the Secretary of Health and Human Resources to develop a plan to incorporate certain long-term care and aging services within a single agency, and establish a task force to consider issues related to the delivery of such services at the local level.

   (Resolution was amended by the General Assembly to request that the Secretary of Health and Human Resources review the plan for state level consolidation of certain long-term care and aging services within a single agency, and develop a plan for coordinated delivery of services at the state and local levels.)

6. A joint resolution (SJR 103) requesting the Secretary of Health and Human Resources to study the benefits and costs of tax incentives to encourage citizens to purchase private long-term care insurance.

   (Resolution adopted by General Assembly.)

CHAPTER 1

HEALTH CARE ISSUES FACING VIRGINIA AND THE NATION

The mission of the Joint Commission on Health Care continues unchanged: to enjoin Virginia's multiple health care efforts into a union of purpose to deliver to Virginians, individually and collectively, needed health services at reasonable cost. Today, a significant portion of Virginia's citizenry lacks access to health coverage, adequate health services, or both. All Virginians, including those with and without health coverage, lack adequate information on the quality of health services. Meanwhile, health care costs continue to make it difficult for individuals and employers to afford coverage.

Virginia has enacted a number of initiatives to address these problems. To improve access, the Commonwealth has enacted small group insurance reform as well as a number of major initiatives to subsidize health care services for the uninsured. In recognition of the need to measure quality, Virginia has established a patient level data base which will be used to assess the effectiveness of various health care providers and services. In the area of cost containment, Virginia has strengthened its certificate of need and cost review functions. Virginia also has taken steps to improve the efficiency and effectiveness of long-term care services. These initiatives, along with those recommended for 1994, represent important steps forward on the road to reform.

Nevertheless, it must be recognized that Virginia's health care reforms to date are partial solutions to a systemic problem. Ultimately, access to health coverage for all Virginians can only be achieved through either major new subsidies or a fundamental restructuring of the health care system. In today's environment, massive subsidies are simply unaffordable. Even if such an approach were feasible, it would not be sound public policy to support major new subsidies without also participating in the restructuring of a health care system which is fraught with distorted incentives.

Consequently, the debate over health care reform in Virginia appropriately has been focused on how to restructure the health care system. The system is in need of restructuring because price competition has not had the same

impact in the health care system as in other markets. Further, the influence that suppliers have on demand, and the variance between supply and demand from one region to another limit the efficiency and effectiveness of the system. The result is a system without adequate incentives to control costs and quality. Until this system is altered, health care costs will continue to put private health coverage out of reach for many, as well as fuel continued increases in government spending for health care.

The challenge for Virginia is to develop an overall strategy for containing costs, improving quality, and expanding access. This plan must be based upon a clear understanding of the problems facing Virginia's health care system today. We must be aware of the dynamics of the health care system and the major options being discussed at the national level and in other states. Through this annual report, the Joint Commission on Health Care would like to call on all interested citizens to help chart a course for health care reform in Virginia.

Costs, Access, and Quality In Virginia's Health Care System

The health care system may be evaluated in terms of costs, access to services, and the quality of services. Health care costs continued to spiral upward in 1993, although at a lower rate than in years past. High costs are one reason that access to health coverage continued to be a problem in 1993. Widely available measures of quality also remained elusive. Given these issues, it is clear that the need for health care reform has not diminished.

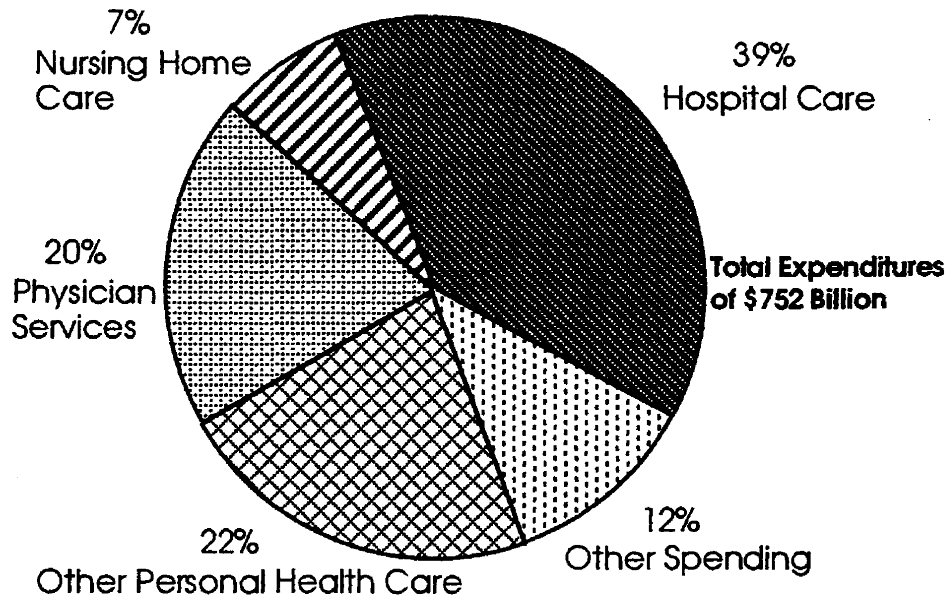
Health Care Spending Is A Continuing Concern, Although Medical Price Inflation Is Slowing

The growth in total health care spending continues to be a concern in the nation and in the Commonwealth. According to the Virginia Health Services Cost Review Council's 1993 Annual Report, America's health expenditures in 1991 reached $752 billion, up 11.4 percent from the 1990 level. This increase marked the fourth consecutive year in which health spending grew at a rate exceeding ten percent. The nation's health expenditures in 1991 amounted to an estimated average of $2,686 for every person in the country.

The majority of the nation's health care dollar went toward hospital and physician care in 1991. Hospital services accounted for 39 percent of total spending, while physician services accounted for 20 percent of the total. Long-term care accounted for an additional 7 percent of the total. Drugs,

home health care, and other medical services and products accounted for 22 percent of total spending. Research, administration, and construction costs accounted for the remaining 12 percent.

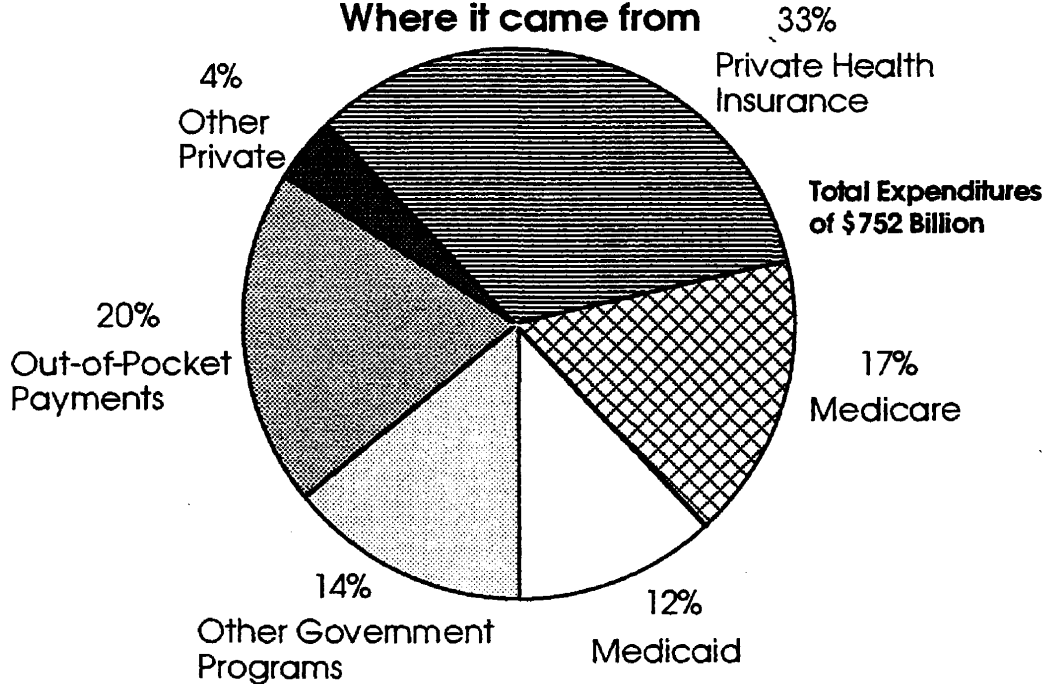
Exhibit 1.1



Source: Health Care Financing Administration

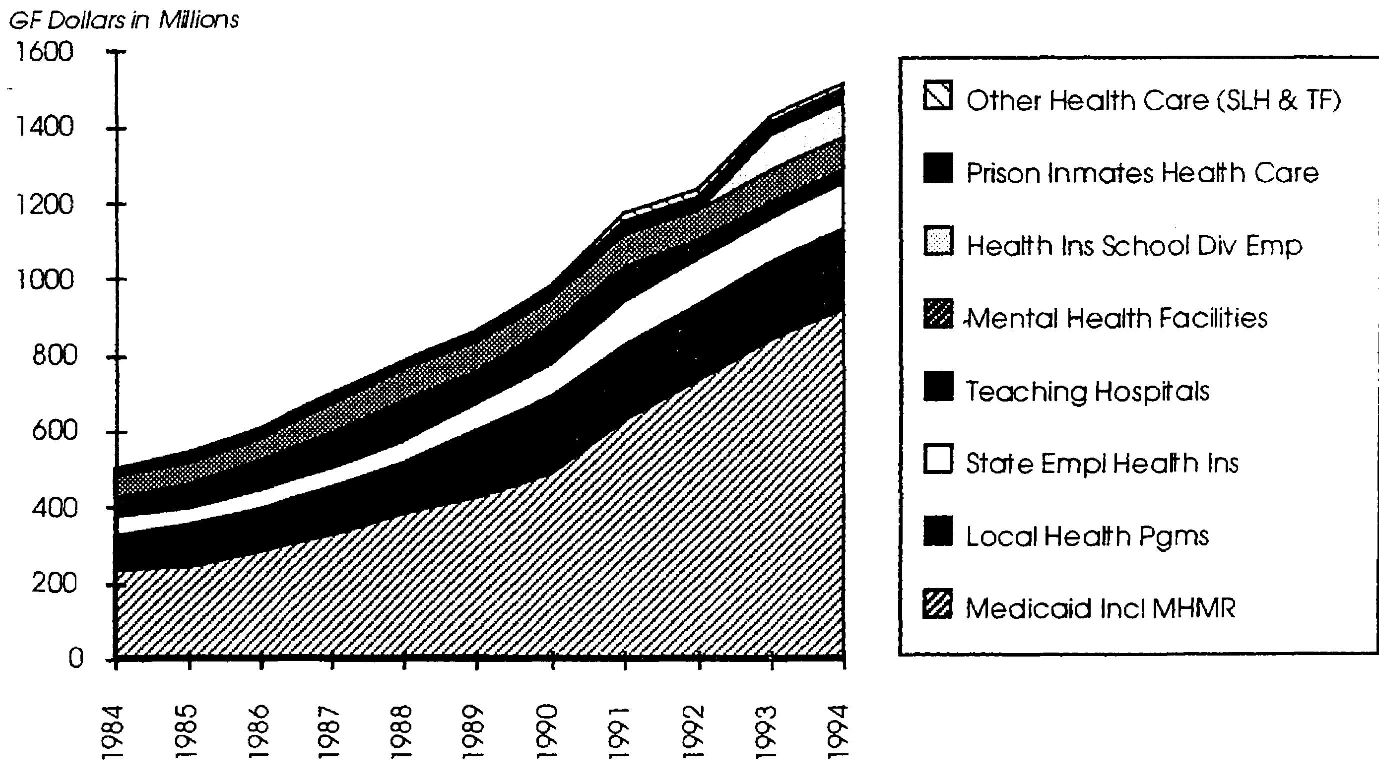
More than four out of every ten dollars spent on health care came from government programs. Federal, state, and local governments financed approximately 43 percent of the health care purchased in this country in 1991. Private health insurance paid for about 33 percent of the total. Consumers' out-of-pocket expenditures and other private sources accounted for the remaining 24 percent.

Exhibit 1.2



Source: Health Care Financing Administration

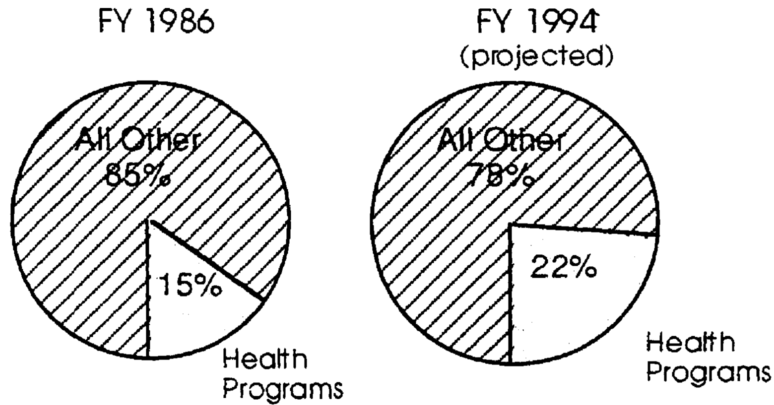
The growth in health care expenditures has had a profound impact on the Commonwealth's budget. According to the Virginia Department of Planning and Budget, Virginia will spend approximately $1.5 billion in State general funds on health care services in FY 1994. In recent years, the growth in general fund health care spending has significantly outpaced the growth in the general fund budget. As a result, in FY 1994 Virginia expects to spend approximately 22 percent of its general fund budget on health care services, compared to 15 percent in FY 1986 .



Source: Department of Planning and Budget

Health care spending is driven by several factors, including population growth, price inflation, and increased utilization of services. Throughout the 1980s and early 1990s, medical care price inflation has been a major concern for all purchasers. However, medical care price inflation has slowed over the last several years. The rise in medical care costs in 1993 -- 5.4 percent -- was the lowest annual increase since 1973. This trend helped to slow the rate of increase in health insurance premiums to 8 percent in 1993, the lowest growth rate in five years. Analysts are still studying these trends to determine why cost inflation has slowed, and whether these levels of cost inflation might be expected in the future. Although the slowdown in medical price inflation is a positive sign, it is important to note that medical prices still rose at twice the rate of general inflation in 1993.

Exhibit 1.4
General Fund Expenditures



Source: Department of Planning and Budget

Increases in the utilization of services are driven by a variety of factors. As the population ages the demand for health care services, particularly long-term care services, increases as well. At the same time, new technologies are expanding the possibilities for treating medical problems. The economic incentives within the health care system also drive expansions in both the demand and supply of health care services, as will be discussed shortly. Finally, it is important to recognize that while most health care reform efforts are focused on the delivery system, lifestyle choices are the cause of many medical problems which are treated by the health care system, and that healthy lifestyles can greatly reduce the demand for health care services.

Many Virginians Lack Adequate Access To Health Care Services

The Joint Commission on Health Care was established to find ways to expand access to affordable health care. Lack of access to health coverage and services takes a heavy toll on the health and well-being of a person. A recent study by the Agency for Health Care Policy and Research in the U.S. Department of Health and Human Resources shows that people without insurance see their doctor less often, may delay or forego medical care for serious symptoms, and are more likely to have hospitalizations which could have been avoided with better primary care. Moreover, the study indicates that uninsured patients are more likely to die prematurely than

insured patients. This is just one of a number of studies which suggest that uninsured people are more susceptible to health problems.

Ideally, all Virginians should have access to health coverage as well as access to necessary health care services. The Joint Commission has been concerned about both types of access. Recent statistics indicate that about one in seven Virginians lacks access to health insurance or government health coverage, and the cost of government coverage for the uninsured is substantial. At the same time, access to health services is not optimal, as indicated by the maldistribution of the health workforce as well as the oversupply of hospital beds and certain specialty services.

Access To Health Coverage. According to a recent study conducted by the Survey Research Laboratory at Virginia Commonwealth University, an estimated fifteen percent of all Virginians lack health insurance. The most important predictor of whether an individual has health insurance is, not surprisingly, total family income. Only three percent of individuals in families with incomes above $50,000 per year are uninsured, compared with 29 percent in families with annual incomes under $10,000. In between, there is a steady increase in the likelihood of coverage as incomes rise.

Reflecting differences in family incomes between African-Americans and whites, there are also substantial racial differences in insurance coverage. Twenty-one percent of African-Americans in the survey had no insurance, compared with 12 percent of whites. Individuals in other racial groups fell between African-Americans and whites in the rate of coverage.

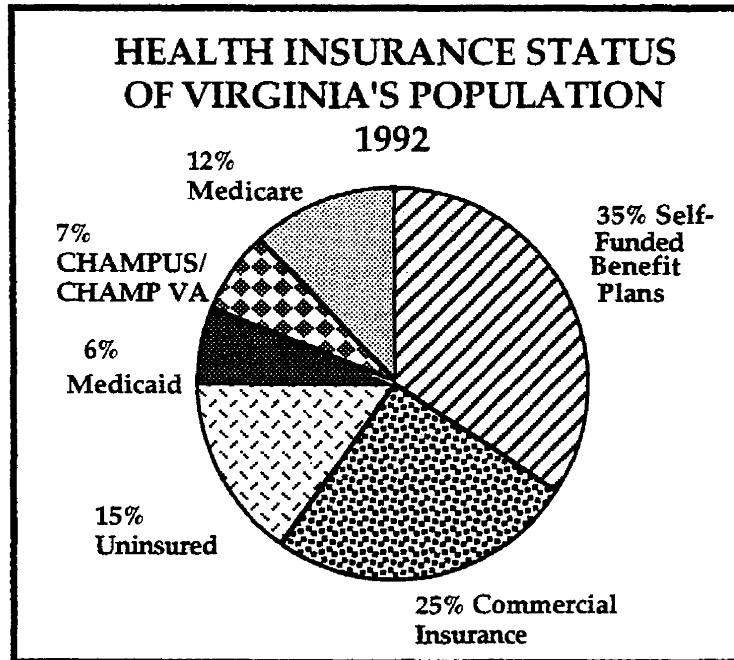
Of all age groups, adults (age 18-29) were the most likely to be uninsured, with 29 percent having no coverage. The non coverage rate for children (9 percent) was below the statewide average for all individuals, and nearly all residents aged 65 or older had at least some insurance.

Lack of insurance is a problem in all regions of the state, although the non-coverage rate in Northern Virginia (10 percent) was lower than the statewide average of 15 percent. The similarities in the non-coverage rates across regions masks an important difference, however. Individuals in southwestern and central Virginia are less likely than those in other regions to be covered by a comprehensive policy.

Focusing on those with health coverage, about 60 percent of all Virginians purchase health coverage through self-funded benefit plans or commercial

insurance plans. Government-sponsored programs cover another 25 percent of Virginians, with the remainder being uncovered.

Exhibit 1.5



Source: Virginia Commonwealth University, Survey Research Laboratory, U.S. Health Care Financing Administration, CHAMPUS Staff, Joint Commission on Health Care Staff

Access to Necessary Health Services. One of the most important indicators of access to necessary health services is the proportion of the population living in medically underserved areas. The Virginia Board of Health has established criteria for assessing the level of access to primary medical services in an area. These criteria account for such factors as the incidence of infant mortality, the availability of primary care resources, and poverty levels. Areas without an adequate supply of primary care resources to match the estimated demand in the area are designated as medically underserved areas.

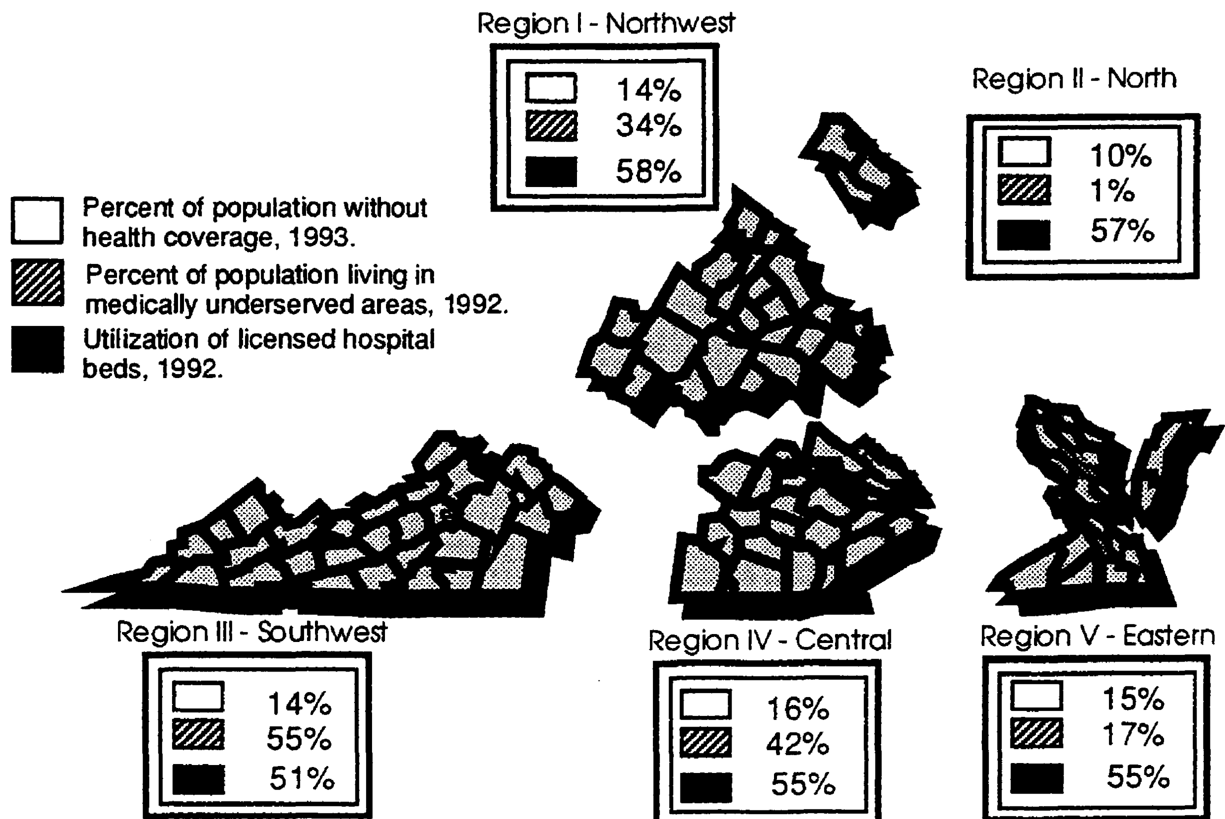
As of 1992, the majority of Virginia localities were identified as areas of high or great need of primary medical services. More than 800,000 Virginians were living in medically underserved regions during 1992. The problem was most acute in the southwest and central regions of the State.

In these regions, between 42 percent and 55 percent of the population lived in medically underserved areas in 1992.

At the root of this problem is the maldistribution of the health care workforce. Most experts agree that the optimal mix of physicians in a given service area should be about one primary care physician for every one specialty physician. At present, the mix is estimated to be about three primary care physicians for every seven specialty physicians. Virtually every major health care reform proposal recognizes the importance of addressing this imbalance through changes in the way we train and compensate health care providers.

Exhibit 1.6

Key Indicators of Health Care Access and Utilization in Virginia



Source: VCU Survey Research Laboratory, Virginia Department of Health

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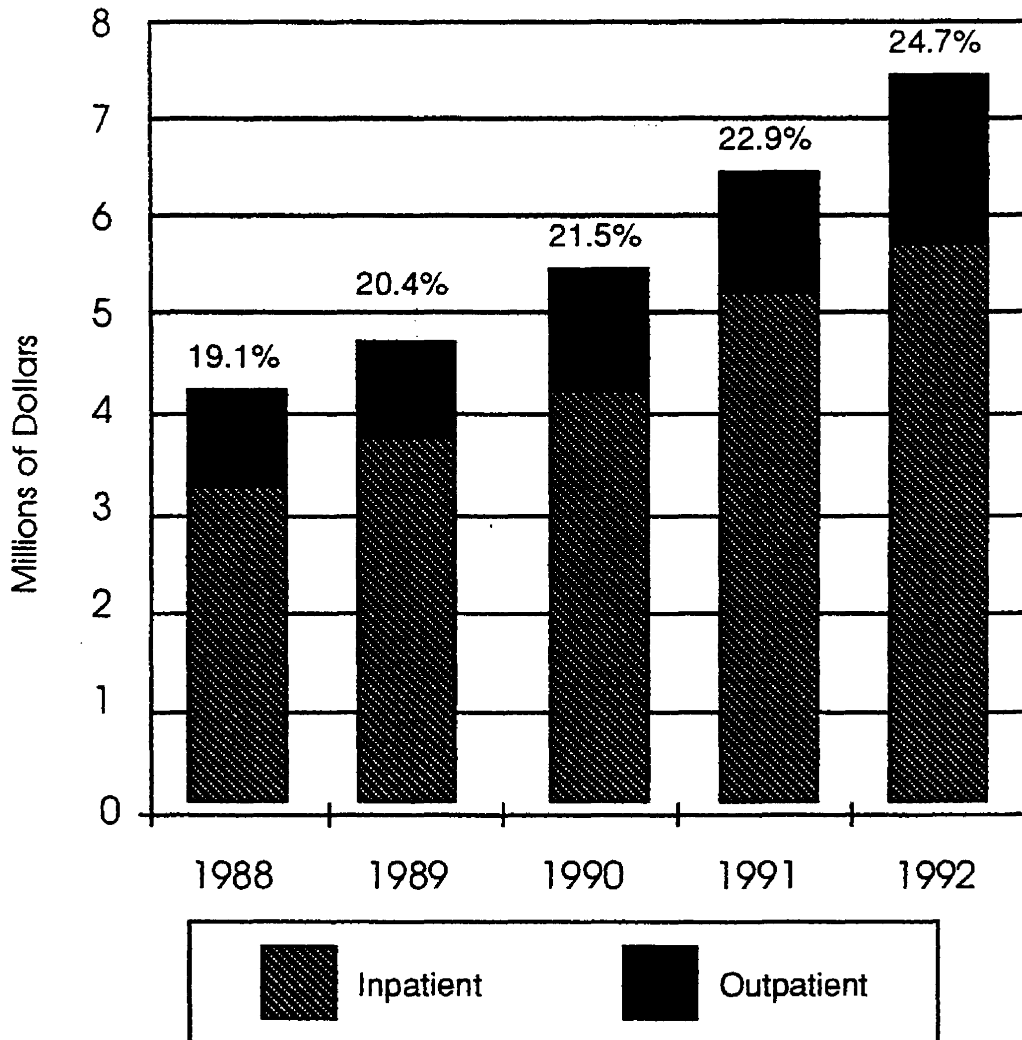
While the problem of inadequate access to primary health care services persists, so does the problem of excess hospital capacity. In 1992, nearly half of Virginia's hospital beds went unutilized. This problem was particularly acute in the southwest region of the state. Low inpatient utilization rates reflect national trends toward outpatient services and managed care. New technologies have made it possible for a growing stream of services to be moved from the inpatient to the outpatient setting. At the same time, the growth in managed care services has created new economic incentives to shift care to the outpatient setting. The impact of these trends are readily apparent in Virginia -- between 1988 and 1992 the percentage of hospital revenue obtained from outpatient services grew from 19.1 percent to 24.7 percent.

Virginians Have A Limited Capacity To Assess Health Care Quality

The value of health care services depends on both the cost and quality of those services. While elaborate systems have been developed to track health care costs, useful measures of quality have been elusive. Part of the problem is that health care quality is a complex concept with many different facets. While quality is often measured in terms of mortality rates, infection rates, and other quantitative measures of health, our judgments about health care quality also are shaped by our interactions with individual health care providers. We also know that for many people, longevity is less important than quality of life.

Another obstacle to quality assessment is uncertainty about appropriate medical treatments. Numerous studies have documented wide variations in medical treatments for the same medical problems. This is a critically important issue because costs vary according to treatment, and the most costly treatments are not necessarily the most effective. For example, it has been estimated that between ten and twenty percent of all hospital admissions may be unnecessary. Consequently, there is growing concern about waste in the system.

Exhibit 1.7
Gross Inpatient and Outpatient Revenue in Va. Acute and Rehab. Hospitals, 1988 - 1992



Source: Virginia Health Services Cost Review Council

In addition, it is difficult to assess the quality of a fundamentally fragmented health care system. Despite the emergence of managed care programs, most people are served by independent health care providers including physicians, hospitals, pharmacists, and other providers. While individual providers maintain extensive documentation of the experiences of patients in their care, they have no incentive to monitor the satisfaction

and long-term health status of patients who leave their care. These factors make it difficult to collect data on a comprehensive course of treatment in order to evaluate the outcomes of that treatment.

Despite these obstacles, progress has been made in the development of systems to assess health care quality. At the national level, the Agency for Health Care Policy and Research has been created within the Department of Health and Human Services for the purpose of analyzing the effectiveness of health care services. The National Commission for Quality Assessment has developed the Health Plan Employer Data and Information System (HEDIS) which has been used by health maintenance organizations to assess health plan quality. A number of states, including Virginia, have created patient level data bases which can be used to assess variations in the treatment of different medical problems. Perhaps most importantly, health care providers have recognized the need for better quality assessment, and they are devoting more attention to the development of clinical practice guidelines and other tools for assuring the quality of health care services.

While this progress is encouraging, there is much work to be done before consumers will have the ability to make informed judgments about the quality of health care services. Ultimately, consumers and payers should be able to access a "report card" on their health plan which would include information on enrollee satisfaction, costs, and the effectiveness of services delivered by the participating providers. The critical elements for the development of such report cards will be agreed-upon indicators of patient satisfaction as well as accepted indicators of cost and effectiveness. More research and development will be needed before Virginians will be able to benefit from this type of information.

Market Failure In Health Care

Many of the problems outlined in the previous discussion are symptoms of "market failure" in health care. That is, the health care market is not structured in such a way as to allow a competitive response of supply to demand which will produce cost efficiency.

Health Insurance

One of the root causes of market failure is the impact of health insurance on incentives. Once one has exhausted his or her co-payments and deductibles, people with health insurance or with government health coverage generally have no incentives to reduce the amount of care they

buy. If anything, they have an incentive to purchase more care. At the same time, physicians being paid on a fee-for-service basis have an incentive to resolve medical doubts with additional testing or other services knowing that they will be reimbursed by the third-party payer.

This situation has contributed to the maldistribution of health services. The incentives of fee-for-service medicine, coupled with the expansion of technology, have helped to fuel the growth in the number of specialist physicians. Fee-for-service payment and other government policies have stimulated substantial growth in the supply of hospital facilities in the post-World War II period, so that today we have many more hospital beds than we need for an efficient health care system. There is an oversupply of certain outpatient services as well, as indicated by the fact that Virginia has 2.5 times as many Magnetic Resonance Imaging (MRI) facilities as all of Canada.

Managed Care

A variety of managed health care plans have developed in response to these problems. Many of these plans integrate the insurance function and the delivery function into one organization through the use of a prepaid fee per covered enrollee. Others operate on a fee-for-service basis, but with tight controls on utilization. Managed care plans seek to correct the distorted incentives at every level of service by channeling funds into services which have the greatest impact on the health status of the population they are serving. Many managed care plans have in fact kept cost inflation well below the average for fee-for-service health plans.

Nevertheless, there is still resistance to managed care plans. Some employers do not offer managed care plans due to concerns about quality, lack of physician choice, or administrative complexity. Other employers offer managed care plans, but require employees to pay the same amount for these plans as for a fee-for-service plan. This reduces the incentive for the individual employee to choose the more efficient plan. Still other employers are only willing or able to offer one managed care plan. In this situation, the managed care plan need only keep its price increases in line with those of the other fee-for-service plans offered to the group.

Prospective Payments

In an effort to control cost increases, government programs have used prospective payment in addition to managed care plans. For example, Medicare pays hospitals a predetermined fee for each admission based on

the diagnosis. Virginia Medicaid pays hospitals a predetermined, fixed payment per day of care derived from a base year cost plus an inflation factor. Prospective payment has been effective in controlling inflation in the unit cost (cost per day, cost per admission) of care. However, it has not slowed the growth in the volume of care provided.

Furthermore, because government prospective payment has not been comprehensively applied, it has lead to cost shifting to the private sector. As health care costs have increased, government prospective payments have financed a decreasing percentage of the reported costs of care. Hospitals have responded to this trend by raising prices for private sector payers. This in turn has resulted in higher insurance premiums as well as growing interest in health plans which actively manage care through utilization review and primary care case management.

Reduced Access to Health Care

While health care market failure has meant steady cost increases for those with health coverage, it has also meant a deterioration in the percentage of people with access to health coverage. Health care cost inflation has made it difficult for employers, especially small employers, to afford health coverage for their employees. This in turn has created incentives for all health insurance entities, in an effort to hold down premiums, to exclude from coverage those individuals who are most at risk of needing medical services. This phenomenon, which became particularly acute during the 1980s and 1990s, has lead to the widely publicized problems of pre-existing condition clauses and non-portability of coverage.

This brief discussion illustrates the problems in the health care market which cause it to be an inefficient mechanism for controlling health care costs. Fee-for-service insurance coverage, which is the predominant mode of health care financing, results in financial incentives for physicians and other providers to oversupply services. Individuals, once they complete their co-payment requirements, have no financial disincentive to demand more services. In addition, it is difficult for purchasers to make judgments about the appropriateness of the services, and they may be hesitant to question their providers. Alternative approaches such as managed care plans and prospective payment have had a limited impact for a variety of reasons. The end result is a health care system which is able to create a portion of its own demand, leading to economic inefficiency.

While most would agree that the health care system is in need of repair, there are sharp disagreements about how to fix the problem. These

differences are reflected across the country in public debates about the need for health care reform as well as the best approach, be it a single payer system, managed competition, a market approach, or some variation on these themes. Moreover, these differences are not merely a reflection of disagreements about the appropriate technology for implementing health care reform. They reflect much deeper philosophical differences about whether health care is a right or a privilege, the value of market-based versus regulatory approaches, the appropriate role of government in the health care sector, and the responsibility of providers, insurers, purchasers, and individuals to change their ways. These differences are apparent in the various federal and state health care reform plans.

Federal Proposals

There have been at least six federal proposals for health care reform, as outlined below. Not all of these plans are aimed at achieving universal access to health coverage. The plans also differ in terms of the degree of government involvement. However, all of the plans require coverage of pre-existing conditions and portability of insurance. Costs estimates for these plans are still uncertain.

Affordable Health Care Now Act. This plan is sponsored by House Minority Leader Robert Michel (R-IL). While it seeks to expand coverage, it is not a universal coverage plan. Employers would be required to offer, but not necessarily pay for, health coverage. It would allow individuals to put $2,500 annually into tax-favored Medical Savings Accounts to create incentives to minimize health care expenditures.

American Health Security Act. This is a single payer proposal sponsored by Rep. Jim McDermott (D-WA), and Senator Paul Wellstone (D-MN). It is a universal coverage plan which would be highly dependent on government regulation. It would give all legal residents access to a standard medical benefits package, administered by the states, with the federal government paying the bills. It would be financed through substantial payroll taxes on employers and workers. Costs would be contained through the use of annual national health budgets. Benefits and prices would be set by a national health board. Under this plan, most private health insurance would be eliminated.

Consumer Choice Health Security Act. This plan is sponsored by Senator Don Nickles (R-OK), and would use the tax code to transform the health care system. It is not a universal access plan. Individuals would purchase health coverage with taxable dollars. The plan would give tax credits to

individuals, with the poor and the sick receiving the highest credits. People who choose not to purchase catastrophic coverage would be penalized under the tax code. The plan would allow individuals to put $3,000 annually into tax-favored Medical Savings Accounts to create incentives to minimize health expenditures.

Health Equity and Access Reform Today. This plan is a variation on managed competition sponsored by Senator John Chafee (R-RI) and Rep. Bill Thomas, (R-CA). It is a universal coverage plan which would require individuals to purchase health coverage. Employers would not be required to sponsor coverage. Subsidies would be available for low-income individuals. As with the other managed competition plans, individuals would be allowed to purchase care through purchasing alliances. However, such alliances would be voluntary and would not have the same powers as the alliances under the Health Security Act. Health Equity and Access Reform Today would rely on competition among health plans to hold down costs, with no government price controls.

Health Security Act. This plan is a variation on managed competition proposed by the Clinton Administration. It is a universal coverage plan which is less regulatory than the single payer approach, but significantly more regulatory than our current system. Employers would be required to sponsor 80 percent of the cost of coverage, and employees would be required to purchase coverage from certified health plans through health plan purchasing cooperatives. Subsidies would be provided for low-wage workers and firms. Costs would be contained through competition among health plans, but there would also be a cap on annual premium increases.

Managed Competition Act. The Managed Competition Act is sponsored by Rep. Jim Cooper (D-TN), and Senator John Breaux (D-LA). It would not require universal coverage, but would attempt to create incentives to achieve universal coverage. Individuals and employers with fewer than 100 workers would have tax incentives to join purchasing cooperatives. Those who failed to join would lose the tax deductibility of their insurance premiums. Costs would be contained through competition among accountable health plans. Unlike the Health Security Act, there would be no government price controls under the Managed Competition Act.

<u>Reform Efforts In Other States</u>

In charting a course for health care reform in Virginia, it is informative to review reform efforts in other states. In conducting such a review, it is

important to recognize that the reform environment is different in every state. Differences in such factors as state wealth, the traditional role of government, and overall culture lead states along different paths to reform. With this in mind, these profiles show a range of possible options for states, as well as constraints.

Florida. Florida has enacted a number of policies aimed at achieving universal coverage by 1995. Florida's approach is essentially voluntary managed competition. Eleven Community Health Purchasing Alliances (CHPAs) have been established to offer businesses a menu of accountable health plans (AHPs). Florida has also created the Med-Access program, which is a low-cost health plan for individuals below 250 percent of poverty. Other features of Florida's reform plan include small group insurance reform, rural health networks, practice parameters, and Medicaid managed care. Critics of this plan doubt whether managed competition can work on a voluntary basis, and without the participation of self-insured plans.

Hawaii. Hawaii was the first state to attempt universal coverage, with the passage of the Prepaid Health Care Act in 1974. All employers in the state must offer health insurance. Hawaii is exempt from the federal Employee Retirement and Income Security Act (ERISA), which has the effect of preventing states from regulating self-insured employers' health plans. In addition, Hawaii has expanded Medicaid eligibility and created the State Health Insurance Program (SHIP) to provide coverage for the unemployed. There is still a small portion of Hawaii's population (about 3 percent) that lacks health coverage. Hawaii is currently attempting to combine Medicaid, SHIP, and general assistance into a single program with income eligibility up to 300 percent of the federal poverty level.

Maryland. Maryland has taken an incremental approach to health care reform, while relying on regulation to hold down costs. Maryland has recently enacted small group insurance reform in an effort to expand access. It has also established a patient level data base to monitor quality. Since 1977, Maryland has used an all-payer hospital rate-setting system which has been successful in controlling hospital cost inflation. It is currently developing a physician payment system that would provide a framework for physician rate setting. The system will set values for services and providers relative to one another, but the actual price will depend on what insurers and individuals are willing to pay.

Minnesota. Minnesota has adopted a comprehensive, highly regulatory approach to universal health coverage. Minnesota's plan, which is still

largely in the development stage, features public subsidies for low-income uninsured people, a state-sponsored purchasing pool for small businesses, insurance market reform, provider and insurer taxes, and cigarette taxes. The plan also specifies annual growth limits for health care expenditures and provider revenues. In an additional effort to contain costs, the plan will eventually require providers to either contract with integrated service networks (ISNs) or participate in an all-payer system. Minnesota is facing difficulties with both the financing and the logistics of implementing this plan.

Tennessee. The centerpiece of Tennessee's health care reform effort has been the Tenncare program. Under Tenncare, the existing Medicaid acute care program is eliminated, and uninsured individuals and Medicaid recipients are being enrolled in managed care networks. The state plans to subsidize premiums, on a sliding scale basis, for individuals with incomes below 200 percent of poverty, with individuals above that income level paying the full amount. A federal waiver has recently been granted, and Tennessee is now trying to implement this program. The startup of the program has not been smooth as there have not been enough doctors willing to treat Tenncare patients. Administrative problems have also resulted in a great deal of confusion among providers and patients. Tennessee officials have been working to revise payment rates and solve administrative problems in an effort to place all program enrollees with a primary care physician.

This summary illustrates some of the typical opportunities and constraints facing states interested in health care reform. Florida is an example of an experiment in voluntary managed competition. The question remains as to whether a voluntary approach can generate enough pressure on health plans to get them to reduce their cost increases. A key to Hawaii's program has been its ability to regulate self-insured programs by virtue of its ERISA exemption. Other states have had difficulty imposing universal access requirements because of their inability to regulate self-insured plans due to ERISA. Maryland has had some success in controlling cost increases through regulation, but there would still be a need for additional resources and insurance reform if Maryland wanted to adopt a universal coverage policy. Tennessee is developing an innovative approach to providing health coverage for the low-income uninsured, but it is uncertain whether the Tenncare program will be able to attract and retain the necessary pool of managed care providers.

The Challenge In Virginia

Virginia has taken an active, incremental approach to health care reform. Virginia's major initiatives have been in the areas of insurance reform, reconfiguration of the health workforce, strengthening cost and quality review, and long-term care reform. All of these initiatives are critical pieces of a growing foundation for health care reform. Nevertheless, it is clear that more work is needed to expand access to needed health services, contain costs, and assure quality. This work must reflect the values of Virginians -- our views on universal coverage, individual responsibility, taxes, and regulation.

These issues will form the framework for health care reform in the 1990s. They are of great importance because they have the potential to affect the health and welfare of each of us. As the Joint Commission on Health Care embarks on the next phase of its journey, it will need the help of all interested citizens in charting a course for health care reform in Virginia.

Chapters 2-6 of this report outline the Joint Commission's efforts throughout 1993 to coordinate Virginia's response to health care reform, and address the critical health care issues in the Commonwealth.

CHAPTER 2

HEALTH WORKFORCE AND PRIMARY CARE

A Shortage and Maldistribution of Primary Care Providers

The increasing public demand for greater access to and delivery of primary care services has led to the redefinition and elevation of the primary care provider in national health care reform.

Health care reform efforts across the nation are shifting the emphasis of the medical care delivery system toward primary care providers. This shift is placing an increasing demand upon those providers now available.

Individual states are now called upon to respond as this national crisis grows. The maldistribution and shortage of primary care providers in Virginia is a major barrier to access and impedes the system's ability to channel persons into lower cost preventive and primary care.

In 1993, there were 3,214 primary care physicians in Virginia. To meet the primary care needs in underserved areas, the Medical College of Virginia (MCV) has estimated a current undersupply of approximately 500 physicians. This undersupply is exacerbated by the fact that 24% of primary care physicians in non-metropolitan Virginia are over the age of 60, with the projected retirement of 400 rural primary care physicians in the next six years. Based on practice site selection of past Virginia medical school graduates, new graduates will replace only 130 of these retiring physicians.

The statistics for mid-level providers are equally concerning. Of the 680 primary care nurse practitioners (NPs) residing in Virginia, only 11 percent practice in underserved areas. Of the 163 physicians assistants (PAs) in Virginia, only 8 percent practice in underserved areas. There are fifty-three nurse midwives in Virginia, with almost one-half residing in urban Northern Virginia.

Increasing Primary Care Services in Virginia

The solution to the primary care problem in Virginia lies in the dynamic between the community, the academic medical centers and the various public and private entities within the state whose missions are access to and delivery of primary care services. These include the Medical College of Virginia, the University of Virginia, the Medical College of Hampton Roads, the Area Health Education Centers Program, the Robert Wood Johnson Foundation Generalist Physician and Practice Sights Initiatives, the Health Policy Group and the Office of Rural Health within the State Department of Health, the Virginia Health Care Foundation, the Virginia Primary Care Association, the Virginia Hospital Association and the Virginia Department of Health Professions. No one group can affect the fundamental diverse changes needed for enduring success. All are needed to work together.

The Commission already has created many of the essential building blocks to the formation of an effective primary care system in the Commonwealth. In recent years, legislation and general fund support for initiatives have been aimed at 1) academic, institutional and curricular reform; 2) development of recruitment and retention strategies; 3) modification of regulatory programs; 4) implementation of financial incentives for providers who practice in medically underserved areas; and 5) support for needs assessment studies to identify underserved areas and recommend solutions. Continued support and expansion of these initiatives is vital to ensuring access to and delivery of primary care for all Virginians.

The Commission has developed a useful conceptual model which identifies the areas in which health workforce interventions can lead to improved access to and delivery of primary care services. This model also conveys the fragility of each step in the continuum of the interventions as well as the tenuous nature of the relationships among the various groups involved. For example, an individual who receives mentoring for a health professions career throughout his or her primary and secondary education and college years may very well decide to opt out of such a career before entering formal education for the health profession. The loss of health manpower is far more frequent than the gain at any one point along the continuum.

Improvement of access and delivery demands that the right hand know what the left hand is doing (i.e. that each group be cognizant of the other groups' missions and activities). The Commission is working to optimize

Exhibit 2.1

Virginia Primary Care Development

Primary and Secondary Education

- Career Development
- Early Identification of Potential Students
- Mini-Medical Schools
- Public Information Campaign
- Tracking
- Teacher/Counselor Visits to Medical Schools

College Education

- Regional Conferences with Admissions Directors
- Generalist Mentorship Opportunities
- BS/MD Programs
- Pre-medical Career Advising
- Financial Aid
- Tracking

Medical Education

- Admissions Reform
- Curriculum Reform
- Community Based Preceptorships
- Scholarships
- Tracking

Graduate Education

- Community Based Training and Residency Programs
- Tracking

Recruitment and Career Placement

- Needs Assessment
- Center for Health Professions Recruitment and Retention
- Marketing Strategies
- Loan Repayment/ Scholarships
- Tracking
- Management Information System
- Community Development

Retention and Support

- Practice Support/ Technical Assistance
- Reimbursement Policies
- Income Subsidies
- Continuing Medical Education

Communities

each group's contribution to this process. Only in this way can these groups optimize existing resources and avoid duplication of task.

Virginia's three medical schools--the University of Virginia, the Medical College of Virginia, and the Medical College of Hampton Roads, have shown impressive leadership in addressing the public need for a greater number and better distribution of primary care providers. In their response to House Joint Resolution 391 (1991), the medical schools committed themselves to ensuring that 50% of their graduates would enter generalist practice.

In November, 1992, the schools were successful in receiving a $150,000 planning grant from the Robert Wood Johnson Foundation to develop a comprehensive strategy to increase the supply of generalist physicians. Eighty-three proposals were submitted to the Foundation. Virginia was one of only 15 applications that was approved and the only statewide proposal that successfully secured a grant award. In 1993, the General Assembly appropriated $100,000 in state funds to supplement grant funds for this project.

Generalist Initiative

The Virginia Generalist Initiative is a unique and novel proposal to balance the current inadequate supply and distribution of primary care physicians through reform of medical education. Since the medical schools have received their award, they have been engaged in a collaborative effort to reform the institution, admissions and curriculum of medical education to support an increased production of generalist physicians. These academic reforms are inextricably linked with the other areas of intervention.

In January, 1994, the three state medical schools submitted a proposal to the Robert Wood Johnson (RWJ) Foundation to fund a six year plan, beginning in July 1994, to reform the institution, recruitment, admissions and curriculum of medical education to increase the supply of generalist physicians in the Commonwealth.

Admissions Reform. Funding for recruitment and admissions reform under the Generalist Initiative will allow the three state medical schools to: (1) increase the number of students who have a high likelihood of becoming generalists, with an emphasis on those likely to practice in underserved areas; (2) institute admissions policies at each school that will enhance the

likelihood of these students being admitted, including an increase in generalist representation on medical school admissions committees; (3) implement and analyze a common data base of applicant and matriculant information to provide guidance for future changes in recruitment and admissions strategies; and (4) launch new and expand upon existing exemplary programs designed to encourage high school students pursuing careers in health professions.

Curriculum Reform. Funding for curriculum reform of both undergraduate medical education and graduate medical education will be used by the three state medical schools to: (1) develop external or community based curricula, including the development of an active community-based preceptorship program for generalist education during the first through the fourth years of medical school; (2) establish curricula for first through fourth year medical students with increased primary care content and participation of generalist faculty; (3) provide all third year medical students with substantial experiences in required ambulatory care training in generalist pediatrics, internal medicine and family practice clerkships; (4) provide all fourth year medical students with the opportunity for a one-month elective community experience with a generalist physician in an underserved area; (5) implement a longitudinal generalist mentorship experience in the first two years of medical school; (6) develop interdisciplinary generalist residency criteria; and (7) include community experiences/continuity experiences as part of the residency curricula.

Funding. To successfully achieve these critical objectives, the medical schools have identified a total need of $14.1 million in general funds. The schools request $3,935,006 in general funds from the Commonwealth for 1994-95, and $6,401,919 in general funds for 1995-96. The total general fund request for the 1994-96 biennium is $10,336,925. The reforms anticipated by the Generalist Initiative are essential to the comprehensive health workforce strategy envisioned by the Commonwealth.

In addition to the Generalists Initiative, the Commission continues to work with the Academic Medical Centers to produce a greater number of primary care providers through refinements in the funding and administration of the respective centers.

Needs Assessment

Valid data on provider specialty and areas of service are fundamental to the integrity of any comprehensive primary care system. The Commission

has already implemented three legislative initiatives within the past four years to gather, assess and distribute data on specific health care professions.

In 1993, the General Assembly passed Senate Joint Resolution (SJR) 326 requesting that the Virginia Statewide Area Health Education Center (AHEC) Program, in cooperation with public and private dental organizations, assess Virginia's primary care dental needs and develop a plan for addressing those needs in future years.

In this same year, the General Assembly passed SJR 327 requesting that the Department of Health Professions study the supply and distribution of Virginia's physicians by specialty and location.

Also in 1993, the General Assembly passed SJR 343 requesting that the Virginia Statewide AHEC Program, in cooperation with other public and private entities, develop a plan by which nurses can assume a more significant role in meeting the primary care needs of the communities within the Commonwealth.

While several initiatives have been undertaken to develop a complete needs assessment of primary care services throughout the Commonwealth, integration and updating of existing data, as well as the refinement of current methodologies, are the next tasks for the Commonwealth. More importantly, Virginia has no data on how many health care professionals have been placed in medically underserved areas in the state. Comprehensive data on all health care professions, including specialty and location of practice, are essential to ensuring access to and delivery of primary care services to the most needy areas within the Commonwealth.

Recruitment and Retention Strategies

Successful recruitment and retention of primary care providers depend upon a strong dynamic between our communities, our health care providers and the various public and private entities whose missions are access to and delivery of quality primary care services.

In January 1993, the Joint Commission was awarded a $99,994 18-month Practice Sights planning grant from the Robert Wood Johnson Foundation to develop a recruitment and retention strategy for Virginia.

The Practice Sights Initiative expands the scope of the Generalist Physicians Initiative to include mid-level providers, such as nurse practitioners and physicians assistants. Greater attention than ever before is being given to this group and their essential role in guaranteeing access to and delivery of primary care in medically underserved areas. The existence of mid-level providers in underserved areas can help extend the practice of an existing primary care physician or, in some instances, serve as an incentive to a primary care physician to locate and/or remain in an underserved area. In conjunction with the Generalist Physician's Initiative, the Commission has begun to articulate the framework for a statewide recruitment and retention effort through the Practice Sights Initiative.

Recruitment

Successful recruitment of primary care providers for the Commonwealth's medically underserved areas begins with the mentoring and education of secondary school students and the nurturing of their educational and career development through clinical practice.

Primary and Secondary Education. In 1990, Virginia established the Statewide Area Health Education Center (AHEC) Program to offer continuing medical education and other support resources. The AHEC Program is unique from other public and private organizations in its inclusion of all health care providers. In 1993, the Southside AHEC implemented a Middle College Program in Blackstone, Virginia to encourage secondary school students to pursue health professions careers. Other local AHECs are developing similar initiatives at the primary and secondary school level.

Each of the state's three medical schools has its own independent recruitment program aimed at encouraging primary and secondary school students to enter health professions careers. The Medical College of Virginia, in conjunction with the State Department of Education, established the Governor's School which brings thirty gifted high school juniors to the Medical College of Virginia for a six week summer program. Each student is assigned a medical faculty mentor, participates in labs and observes clinical work. The School follows up with each student every year after the program is completed to track his or her educational and career path. The Governor's School is the only one of its kind in the United States.

Through the Generalist Physicians Initiative, the state medical schools are proposing the establishment of another Governor's school which would target students from rural and medically underserved areas. Those students who demonstrate an interest in generalist medicine will be assigned to a community preceptor and will observe and participate in the work of the generalist physician in a rural or underserved area.

College Education. The AHEC program has continued its interventions on the college level, especially among minority and disadvantaged populations. During 1992-93, approximately 420 students were introduced to health professional careers or received reinforcement in their current health professional programs as a result of AHEC supported programs and activities. Each of the State's three medical schools also has its own independent recruitment programs aimed at encouraging college students to enter careers in health professions.

Health Professions Education. Recruitment initiatives aimed at health professions education have focused on targeting individuals who have those characteristics that best predict that an individual applying to health professions schools will proceed in a primary care career path. These initiatives include the Robert Wood Johnson Generalist Physicians Initiative (discussed above), the continued work of the local AHECs, the Virginia Medical Scholarship Program, the Southwest Virginia Medical Scholarship Program, the Virginia Dental Scholarship Program and the Mary Marshall Nurse Practitioner/Nurse Midwife Scholarship Program.

In 1990, the Commonwealth restructured the primary care medical scholarship program, consolidating scholarships within the State Department of Health and increasing loan support from $2,000 to $10,000 per year. In 1991, Virginia directed the academic medical centers to encourage medical students to pursue careers in rural and primary health care. In 1992, Virginia increased financial support for the medical scholarship program and established primary care medical scholarships for southwest Virginians attending East Tennessee State University who agree to practice in medically underserved areas of southwest Virginia. In 1993, Virginia established a nurse practitioner/nurse midwife scholarship program. Also in 1993, AHEC financial support provided education and training activities in rural or underserved areas for approximately 445 students. Education and training occurred in 45 delivery sites with an additional 44 new sites identified as a result of AHEC activities.

Continued support for the Generalist Physicians Initiative, AHEC and expansion of Virginia's medical, dental and nursing scholarships is imperative to meeting the public need for more primary care providers, especially in the Commonwealth's underserved areas.

Postgraduate Medical Education. Primary care recruitment interventions at the postgraduate education level include: 1) the continued role of the Generalist Physicians Initiative to supply a greater pool of applicants for residency training programs in medically underserved areas; 2) the Virginia Hospital Association's grant from the PEW Health Professions Commission to examine accreditation, licensure and utilization restrictions in light of broader health care reforms; and 3) the continued work of the local AHECs to provide continuing education, library and learning resources.

As a means of increasing the financial incentives for physicians to practice in underserved areas, the Commission proposes that a state-sponsored physician loan repayment program be established. This program would provide financial assistance to graduates from accredited medical schools who enter primary care practices of family medicine, general internal medicine, pediatrics and obstetrics/gynecology, and who agree to practice in a medically underserved area.

Retention

Effective recruitment strategies are a necessary, but not sufficient, determinant of whether a primary care provider will continue to practice in a medically underserved area. While no one retention effort or combination of efforts guarantees that a provider will remain in a medically underserved area for an extended period of time, identifying factors that deter providers from staying and creating solutions increases the probability that a provider will remain. These solutions must address both the non-monetary and monetary barriers to choosing a generalist career, particularly in a medically underserved area. Often, the non-monetary barriers are more intractable than the financial ones.

The development and introduction of telemedicine and other similar technologies into daily clinical practice is one solution on the near horizon which undoubtedly will allay the sense of isolation common to many primary care providers in underserved areas. National surveys indicate that quality of life supersedes income as a factor which leads to a physician's choice of remaining in a rural or medically underserved area. Improved access to information, continuing education, specialists and the

larger hospital setting will provide a critical missing link for providers between remote communities and the medical centers.

Retention Strategies. Because recruitment strategies are often costly and the average turnover in any practice occurs in the first three years, retention strategies are vital to ensuring an adequate supply and distribution of primary care providers in Virginia.

In 1990, Virginia began participating in the federally sponsored Physician Loan Repayment Program with up to $20,000 provided to primary care physicians through repayment of educational debt in return for practicing for two years in a medically underserved area. In this same year, Virginia also increased Medicaid reimbursement for primary care physicians.

The ongoing work of the local AHECs has also provided an important link between primary care providers in remote areas and the larger hospital setting. During 1992-93, over 300 health care professionals received continuing education through AHEC sponsored programs. The majority of these professionals practice in rural or underserved communities. Approximately 40 health care delivery sites were supported by AHEC for activities supporting education and training of health professions students or existing professionals.

The work of both the Virginia Health Care Foundation and the Virginia Primary Care Association plays a key role in the retention and support of primary care providers in the Commonwealth's underserved areas. The Virginia Health Care Foundation is a non-profit, public-private entity which was created to encourage locally based organizations to develop programs to improve primary health delivery. Since its establishment, the Foundation has financed and implemented thirty-one projects throughout the Commonwealth for a total of $2.2 million. Each project is responsive to individual community needs, elicits strong community support (at least 25% of a project's cost) and ensures that funding is sustained after the grants are depleted. Projects include a mobile health clinic, a pharmacy access program, a mobile dental clinic, an elementary school primary care clinic, support for several free clinics and development of primary care capacity in local health departments in partnership with health providers. Every dollar contributed to the Foundation generates three dollars in health services.

The Virginia Primary Care Association works independently as an association of over thirty Community and Migrant Health Centers in

underserved areas recruiting physicians and mid-level providers to practice in its health centers. The Community Health Center model has demonstrated continued success in achieving its goals of universal access, cost control and community governance. The Association offers the Commonwealth particular expertise in the process of: (1) community organization and primary care systems development; (2) practice start-up and technical support; (3) health professional recruitment and retention; and (4) high need community identification and strategy development.

Coordination of Recruitment/Retention Efforts

As noted in the preceding paragraphs, a number of different entities are involved in the recruitment and retention of primary care providers in Virginia. These entities have enhanced the recruitment and retention of primary care providers. However, to become more effective, Virginia needs to streamline and coordinate these efforts. The establishment of an Office of Health Professions, Recruitment and Retention within the Virginia Department of Health would provide central coordination of these efforts and would maximize the effectiveness of Virginia's recruitment and retention initiatives.

Primary Care Provider Reimbursement

Maintaining a sufficient supply and adequate distribution of the Commonwealth's primary care providers requires change in the reimbursement system. On the federal level, reforms in Medicare reimbursement have realigned primary care services with those of specialists. In January 1992, the U.S. Department of Health and Human Services adjusted its Medicare physician payment methodology to give greater weight and remuneration to the care rendered by primary care physicians through the Resource-Based Relative Value Scale (RBRVS). While some primary care physicians argue that RBRVS has not rendered material improvement in reimbursement, such reform indicates at least the intention on the federal level to create a more egalitarian reimbursement system between primary care providers and specialists.

Increasing the reimbursement of primary care physicians will help to reduce the significant disparity in physician incomes by specialty--which is a primary deterrent to physicians choosing to practice generalist medicine. The average net income of general/family practice physicians is significantly less than that of other physicians. Moreover, the recent national trend indicates that general/family practitioners' incomes have

declined slightly while other physician specialty earnings continue to increase.

In November, 1993, the RBRVS Physicians' Advisory Council within the Virginia Department of Medical Assistance Services recommended to the State Medicaid Board that a budget-neutral implementation of the Medicare RBRVS system be implemented. A budget-neutral implementation of RBRVS would eliminate the use of geographic adjusters in the calculation for reimbursement. Currently, geographic adjusters (e.g. cost of living etc.) raise the fees in urban areas and lower fees in rural areas, thereby discouraging physician practice in rural and underserved areas. The Medicaid Board has recently passed a motion authorizing the Department of Medical Assistance Services to explore solutions to such implementation either through legislation or amendments to regulations.

The Commission has also begun to explore the options of income tax credits and subsidies for primary care physicians practicing in rural and medically underserved areas.

Logic dictates that redressing the imbalance in reimbursement for primary care physicians in Virginia will create the equity deserved and reward physicians for providing those health care services most in demand (i.e. primary care and case management) to those populations most in need. Moreover, these reforms will echo the message of other states and the nation that primary care providers are vital to our health care system.

Summary of Health Workforce Recommendations

Recommendation 1

Introduce a budget amendment for a total of $3,935,006 in 1994-95 and $6,401,919 in 1995-96 for the funding of the Robert Wood Johnson Generalist Physicians Initiative. This is a total general fund request of $10,336,925 for the 1994-96 biennium.

Recommendation 2

Introduce legislation to require health care professionals (physicians, nurse practitioners, certified nurse midwives, physician assistants, dentists and dental hygienists) to supply information on their area of specialty, subspecialty and practice profile as part of the licensure process. Practice profile includes the address(es) of practice location(s) and the

number of hours spent at each location. The goal of this mandate would be the development of an accurate and reliable long term data base for workforce planning. Such legislation would include an exclusion to the Virginia Freedom of Information Act to guard the confidentiality of individual providers within the Commonwealth.

Recommendation 3

Introduce a joint resolution requesting that the Commissioner of Health reallocate existing resources for the creation of an Office of Health Professions, Recruitment and Retention to provide coordination of recruitment and retention activities performed by the several public and private entities engaged in such activity for the state.

Recommendation 4

Introduce legislation and a budget amendment establishing a state-sponsored Physician Loan Repayment Program. The budget amendment totals $100,000 in general funds for the 1994-96 biennium.

Recommendation 5

Introduce a budget and language amendment requesting $600,000 for the 1994-96 biennium to support the efforts of the Area Health Education Centers Program in recruiting, retaining and supporting health care providers in Virginia.

Recommendation 6

Introduce a budget and language amendment totaling $140,000 in general funds for the 1994-96 biennium to expand the Virginia Medical Scholarship Program by funding an additional fourteen (14) medical scholarships at the three state medical schools: the Medical College of Hampton Roads, the Medical College of Virginia, and the University of Virginia.

Recommendation 7

Introduce legislation which provides that: 1) the Virginia Department of Health reallocate any remaining funds from awards given through the Medical Scholarship Program to the other participating Virginia medical schools and the Quillen School of Medicine at East Tennessee State University proportional to their need; and 2) students awarded the

Southwest Virginia Medical Scholarship need not reside or be from Southwest Virginia. They need only agree to return to practice in Southwest Virginia.

Recommendation 8

Introduce language amendments requesting that the current funding guidelines for the University of Virginia, Virginia Commonwealth University, and the Medical College of Hampton Roads first-professional medical students be modified over four years to provide an additional incentive for the three medical schools to increase the production of generalist medical practitioners to equal 50 percent of each graduating class.

Recommendation 9

Introduce language amendments requesting that the appropriations for the University of Virginia, Virginia Commonwealth University and the Medical College of Hampton Roads include an amount not to exceed $200,000 in the first year and $750,000 in the second year for the creation and operation of additional General Internal Medicine and General Pediatrics Residency Programs and related undergraduate medical student programs at each institution.

Recommendation 10

Introduce a budget amendment totaling $50,000 to expand the state-sponsored Mary Marshall Nurse Practitioner and Nurse Midwife Scholarship Program. This amount includes $25,000 for FY 1995 and $25,000 in FY 1996, in addition to the $50,000 already appropriated for five students in each biennium, to provide a total of five new nurse practitioner/nurse midwife scholarships each year of the biennium.

Recommendation 11

Introduce a joint resolution requesting the Joint Commission to evaluate existing statutes and regulations governing nurse practitioners, and determine whether mandatory direct reimbursement for advanced practice nurses, including nurse practitioners, would improve access to more affordable primary care services for citizens of the Commonwealth.

Recommendation 12

Introduce a joint resolution encouraging Virginia's private sector to continue to support the efforts of the Virginia Health Care Foundation to enhance access to primary and preventive care for Virginia's uninsured citizens.

Recommendation 13

Introduce a joint resolution to continue the study of women's health status in the Commonwealth, focusing on women between the ages of 12 and 64.

Recommendation 14

Introduce legislation to: 1) establish a dental hygiene scholarship program; 2) transfer the dental scholarship program to the Department of Health to consolidate all scholarship programs in one state agency; and 3) revise the medical scholarship program to give preference to minorities and residents of medically underserved areas.

A budget amendment in the amount $28,000 also is recommended to fund the dental hygiene scholarship program.

Recommendation 15

Introduce a joint resolution requesting the Area Health Education Center Program to assess pharmaceutical practice needs in the Commonwealth, and to develop criteria for a statewide network of model pharmacy care centers.

CHAPTER 3

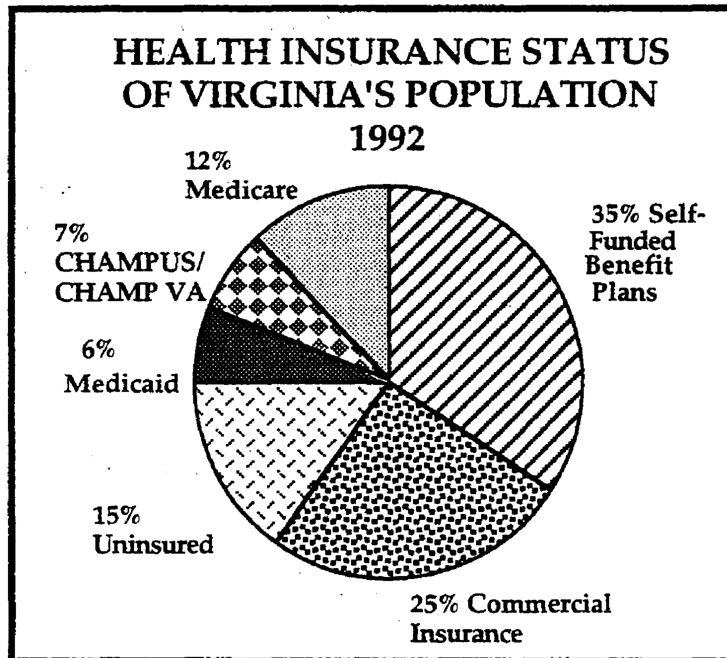
HEALTH INSURANCE

Despite efforts to reduce the numbers of uninsured in Virginia, the problem is a persistent one. Health care costs have risen in a stagnant economy, forcing firms that historically have provided health insurance to take actions such as eliminating cost sharing for family coverage, increasing the employee's share of health insurance, and in some cases, entirely eliminating benefits.

Health Insurance Status of the Population

Medicaid, Medicare, CHAMPUS, self-funded private plans and commercial insurance products represent the main categories of payers of health care in the Commonwealth, as seen in the chart below.

Exhibit 3.1



Source: Virginia Commonwealth University, Survey Research Laboratory, U.S. Health Care Financing Administration, CHAMPUS Staff, Joint Commission on Health Care Staff

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Each of the categories in the above chart is subjected to a different body of regulation. This reality contributes to the complexity of health reform. Federal regulations drive the Medicare and CHAMPUS programs and have substantial influence over Medicaid. Even self-funded plans are regulated by the federal government through the Employee Retirement Income Security Act (ERISA) of 1974. Plans covered by ERISA are exempt from state mandates. The commercial market is subjected to much state regulation.

Small Employer Insurance Market Reform

The uninsured and the small employer insurance market are closely linked. Nationally, in 1990 only 36% of firms with fewer than 25 employees offered their workers health insurance as compared with 87% to 99% of larger firms. In Virginia, the Joint Commission has found that 96% of large firms (50 or more employees) offer health insurance, while many small firms do not offer health coverage for their employees. Based on a survey conducted by Virginia Commonwealth University in the summer of 1993, among adult Virginians, a majority of the uninsured are employed full time.

Affordability has been a key issue in the small employer market. In the small employer insurance market in Virginia, rating practices have created a spread of 800% on individual rates and a 600% spread on group rates.

Obviously, one way to enhance affordability of health insurance products is to reduce the benefits in the package. High deductibles, for example, are one way to reduce price. However, high deductibles are unattractive to certain small businesses and their employees, e.g., small businesses that pay minimum wage.

In recent years, the General Assembly, at the request of the Commission on Health Care for All Virginians, and later the Joint Commission on Health Care, has enacted numerous initiatives aimed at the issue of small employer insurance market reform. These have included the establishment of an Advisory Commission on Mandated Health Insurance Benefits, requirements that the insurance industry report on the cost of state-mandated benefits, and the establishment of a low-cost insurance product. The 1992 General Assembly enacted legislation which required carriers writing to small groups of under 50 to include everyone in the group, guarantee renewable coverage, and provide credits for continuous coverage against waiting periods for pre-existing conditions.

The 1993 General Assembly enacted HB 2353, which built upon the small employer insurance reform process initiated in 1992. This law has the following key provisions:

- requires primary small employer carriers to issue the essential and standard benefit plans to primary small employers (2-25 employees) that elect to be covered by one of them;

- directs the Commissioner of Insurance to promulgate regulations defining the essential and standard benefit packages pursuant to the final report of the Essential Benefits Panel;

- defines a rating mechanism for the essential and standard plans. The rating bands allow carriers to deviate from the community rate by 20% in either direction based upon claims experience, health status, and duration. In addition, the community rate is adjusted for age, gender, and geographic variations; and

- allows all carriers which offer guarantee issue products to continue to market current products with no rating restrictions.

In summary, HB 2353 will assure that all primary small employers will have the opportunity to purchase either an essential or standard benefits product with the same benefits and be rated within a modified community rating formula. These provisions will provide an "apples-to-apples" comparison for at least two products.

Since HB 2353 was enacted, various parties have suggested modifications to the law. The Joint Commission is proposing several amendments for legislative action in the 1994 General Assembly.

During the Joint Commission's review of small group reforms, a number of issues regarding individual and conversion health insurance coverage were raised. (Conversion coverage refers to insurance coverage available to persons who leave an employer group, and "convert" their group coverage to individual coverage.) The Joint Commission concluded that while many of these issues are closely linked to small group reform, further analysis is needed before implementing actions to reform individual and conversion health insurance coverage.

Indigent Health Care Trust Fund Reconfiguration

Background

Senate Joint Resolution 315 (1993) directed the Technical Advisory Panel (TAP) of the Virginia Indigent Health Care Trust Fund, in cooperation with the Board of Medical Assistance Services and the Joint Commission on Health Care, to develop a proposal to increase the number of Virginians with health insurance. The TAP's proposal could include recommendations to reconfigure the Trust Fund as a continuing fund to support the development of comprehensive insurance programs targeted to Virginia's uninsured as well as suggesting other methods of developing alternate financing sources.

After its initial review of the problem of the uninsured in the Commonwealth, the TAP decided to focus its efforts on the working uninsured. The following recommendations were approved in response to SJR 315.

1. The Virginia Indigent Health Care Trust Fund should be converted in stages to provide a continuing source of funds to help finance alternative essential services health insurance plans.

2. The health insurance program should be structured within the framework of a public/private partnership involving the employer, employee, health care providers, insurance industry, and the Trust Fund.

3. A federal waiver should be submitted by the Virginia Medicaid Program to investigate the availability of federal funding for low wage employees.

Principles for Addressing Problem of the Working Uninsured

In its deliberations the Technical Advisory Panel (TAP) formulated certain principles to be followed in designing a proposal to address the problem of the working uninsured in Virginia.

1. The insurance proposal must be consistent with prior insurance reform measures adopted by the legislature.

2. The insurance proposal to be tested in a pilot should be capable of being applied state-wide.

3. The insurance proposal must represent a sustainable partnership between the employer, employee, health care providers, insurance industry and the Trust Fund.

Conclusions

The TAP's report provides specific recommendations to overcome the major problems in the small group insurance market which include: (1) lack of affordability; (2) lack of access to insurance coverage; (3) unstable insurance rates; (4) ineffective marketing; and (5) a lack of desire to offer insurance at any cost.

Expanding health insurance coverage to the working uninsured through a voluntary Trust Fund sponsored program will test whether employers will choose to offer health insurance under more favorable conditions. If this is not the case, then an employer mandate may be the only other option most readily available in an employer based insurance system. The demonstration project will help the Commonwealth address this difficult policy issue while attempting to cover additional lives.

Taking what is learned from a successful demonstration project, it would be the intent of the TAP to recommend the Trust Fund be phased out as a direct hospital subsidy program so that these funds can be used state-wide to expand health insurance to the working uninsured.

Health Insurance Purchasing Cooperatives

Senate Joint Resolution 332 (1993) requested the Joint Commission on Health Care to study health insurance purchasing cooperatives (HIPCs) and report the findings and recommendations from this study to the Governor and the 1994 General Assembly. The study results indicate that the creation of one or more HIPCs is a complex task requiring extensive planning. It is essential that state policy makers clarify their goals for the HIPC before a HIPC is constructed because there are many alternative ways in which a HIPC might be organized and governed. Whatever the specific policy goals, effective planning for a HIPC requires accurate data on health care costs, utilization, and access in the different regions of the state. It is also important to understand a number of legal issues which could constrain the development of HIPCs.

Considering the complexity of the issues, there will be a need for a significant amount of additional discussion and analysis before the Joint Commission is able to make final decisions about constructing one or more HIPCs in Virginia. The following sections outline the key policy and planning questions which must be addressed. It is recommended that the Joint Commission continue its study of HIPCs in an effort to develop a clearer picture of the desirability and feasibility of creating HIPCs in Virginia.

Background

The basic concept of bringing small groups and/or individuals together to pool risk or to share administrative costs is not new. Multiple Employer Trusts (METS) and trade association plans were developed in the 1960s and 1970s to create the same advantages previously wielded only by larger businesses in the health insurance market.

The basic functions of health insurance purchasing cooperatives may include:

- contracting with health plans on behalf of subscribers;
- providing consumers with information about plan characteristics and performance;
- enrolling individuals or families in the health plans of their choice;
- collecting premiums and distributing funds to health plans;
- arranging a risk-adjustment methodology for compensating plans fairly for differences in risk of enrolled populations; and
- establishing grievance procedures and representing the interest of consumers/purchasers in disputes with health plans.

Most of the federal proposals include health insurance purchasing cooperatives, although their responsibilities vary significantly from one proposal to another. The Clinton Plan uses the term "Health Alliance" and distinguishes between regional alliances at the state level and corporate alliances for employers with over 5,000 employees. The Clinton Plan is mandatory, whereby all individuals will eventually choose their health plan through an alliance. Alliances will also serve as the mechanism for keeping growth in spending for the comprehensive benefits package within budgeted levels.

The Managed Competition Act of 1993, which is sponsored by Representative Cooper with support from a bi-partisan coalition of the

House of Representatives, establishes health insurance purchasing cooperatives for individuals and employees employed by businesses with under 100 employees. States would have the flexibility to increase that number as long as no more than half of all employees in a state purchase health insurance through this vehicle. This model does not require the health insurance purchasing cooperative to enforce any budgetary limits on health care expenditures.

Several states, including Minnesota, Ohio, Florida, and California, are leading the nation in the development of health insurance purchasing cooperatives. These models include state-sponsored initiatives and a private cooperative housed in the Cleveland Chamber of Commerce. A summary of several of these models follows.

Council of Smaller Enterprises (COSE) is the small business division of the Greater Cleveland Growth Association (Cleveland's Chamber of Commerce). COSE has been in operation since the early 1970's and is available for groups with 1 to 50 employees. It operates as a voluntary pool in competition with all other products in the market. Due to rising premiums, the program changed from community rating to experience rating a few years ago.

The California Public Employees' Retirement System (CAL-PERS) provides health benefits to state employees and public employees, including employees of school districts and counties. It was not created as a purchasing coalition, but it has evolved into this role. Employers can select any carrier in the pool, with rates based on carrier-specific statewide averages. Participating carriers must make a special commitment to serving underserved areas. By 1994, a standardized benefit package will be required.

Employer Purchasing Alliance (EPA) is an alliance of small and large private employers in the Tampa Bay area of Florida. Most of the members have over 100 employees. It is a single purchasing pool for businesses which opt into this program, and it chooses its carriers based upon competitive bidding.

Policy Goals for HIPCs

In considering the feasibility of creating a HIPC, the fundamental policy question is who the HIPC would serve. The logical target population is the people who work in small firms that have difficulty purchasing health insurance. However, a HIPC that serves only those firms that have been

unable to obtain insurance might simply create a pool of high-risk individuals. Therefore, the population within a HIPC should be as diversified as possible. This raises the possibility of including public employees and medium-size firms in the HIPC. Ultimately, the HIPC must be large enough to wield market power if it is to be effective.

HIPC Organization and Governance

Organization. A HIPC may be organized as a corporation, a voluntary association, a business entity, a state agency, or a true cooperative. Effectiveness, independence, and accountability are three guiding principles which should guide the decision of how to organize a HIPC.

Single vs. Multiple HIPCs. A state could create a single HIPC, multiple HIPCs, or a single HIPC with multiple jurisdictions. Key considerations include administrative efficiencies, the creation of broad risk pools, and responsiveness to local needs.

Composition of Governing Boards. The composition of HIPC governing boards is a critical issue. Decisions would have to be made about power of appointment, whether the board should include consumers only or providers and insurers as well, and terms of appointment. There is also the option of having elected HIPC boards.

Planning Issues

Mandatory vs. Voluntary Participation. The issue of mandatory vs. voluntary participation in HIPCs continues to be controversial. Mandatory participation gives the HIPC greater market power, but also raises concerns about government regulation and ERISA conflicts. Voluntary participation is less controversial in the business community, but it remains to be seen whether voluntary HIPCs can generate the necessary size and diversity of membership to wield market power. The remainder of this section assumes that HIPC participation would be voluntary.

Role in Price Setting. HIPCs may play the role of "price taker" or the role of "price maker." As price taker, the HIPC offers plans which meet certain basic requirements regardless of their price. As price maker, the HIPC plays a role in deciding which plans are too expensive to be offered through the HIPC. Critics of the price taker approach claim that health plans will "shadow price" to maintain consistent annual price increases unless there is a cap on price inflation. Critics of the price maker

approach claim that HIPCs will become politicized as a result of their negotiating power. Critics also claim that price controls will make it difficult for health plans to attract capital, and that this could possibly drive health plans out of the market.

Role in Certifying Health Plans. Decisions will have to be made about whether to set standards for health plans. The decision of whether to set standards for health plans is particularly important in a voluntary market because if standards for participation in the HIPC are more stringent than standards for participation outside the HIPC, the HIPC will be at a competitive disadvantage. At the same time, there is likely to be a need for some type of standard so that health plans can be compared by HIPC members. There will also be a need to decide whether the HIPC should certify the health plans, or whether this should be done by some other entity.

Types of Plans Offered. To facilitate comparison shopping, all participating health plans must offer the same benefits package. There will be a need to decide whether this should be the essential benefits package, the standard benefits package, or both. There could be an option to offer supplemental benefits. However, the value of this option would have to be weighed against the potential for creating risk segmentation in which healthier, wealthier firms gravitate toward the supplemental plans.

Degree of Employee and Employer Cost Sharing and Choice. Cost sharing and choice are closely related issues. If employer cost sharing differs according to the type of plan selected by the employee, some employers will argue that they should have a say in the types of plans offered. This may also occur if the employer's administrative burden is related to the number of plans offered.

Rating, Underwriting, and Open Enrollment Requirements. If rating, underwriting, and open enrollment requirements inside the HIPC are different than the requirements outside the HIPC, the HIPC could be placed at a competitive disadvantage. If Medicaid enrollees or public employees are included in the HIPC, these groups may have to be considered as separate accounts to avoid cross-subsidization.

Risk Adjustment. There would be a need for an appropriate risk adjustment methodology to compensate health plans for risk differentials in the health status of enrollees.

Extending Access to Underserved Areas. It may be difficult for a HIPC to provide access in certain underserved areas. Extensive planning would be required to identify underserved populations and to decide the best approach for extending access.

Interest Among the Target Population. The target population must be interested in purchasing health coverage through a HIPC if the HIPC is to be effective. In this context, the perspectives of employers and individuals in the target population will be important for deciding whether and how to create HIPCs.

<u>Implementation Issues</u>

Carving the State Into HIPC Regions. If there are to be multiple HIPCs, there will be a need for logical criteria for setting regional boundaries. These criteria might include geo-political boundaries; Metropolitan Statistical Area boundaries; health planning boundaries; regional differences in costs, utilization, access, and health status; and the availability of delivery systems which could deliver the essential and standard benefits packages.

Employer Size Threshold. The employer size threshold is a key decision in HIPC design. The threshold should be high enough to create a HIPC population large enough to spread risk and to attract competition. The employer size threshold in various state and federal proposals ranges from 50 to 5,000.

Phase-In of Individuals in Public Programs. If the state were to purchase coverage for Medicaid recipients through the HIPC, federal waivers may be required. Planning would be required to determine the cost effectiveness of transitioning Medicaid recipients into the HIPC. Planning would also be required to determine which recipients should be transitioned into the HIPC, and at what pace.

Controlling for Risk Selection. Even under a system with a uniform benefits package and standard marketing information, health plans will still have opportunities to encourage or discourage enrollment or disenrollment by people with different risk profiles. Consumers themselves may also cause risk segmentation by choosing certain plans over others based on their geographic location and historical utilization patterns. Options for controlling risk selection include insurance market reforms and risk adjusted premiums. However, there is little consensus on what methodology should be used to implement risk adjustment across health plans.

Standards for Health Plans. Standards will be required to ensure that health plans are comparable. Standards might encompass marketing, quality assurance, reporting, and other aspects of plan performance.

Extending Access to Underserved Areas. There are several options for expanding access to underserved areas. Government subsidies could be used to encourage health plans to develop the necessary capacity in underserved areas. The HIPC might also offer an exclusive franchise to a health plan in return for the plan's commitment to extend its services to an underserved region. Another option could be geographic adjustments to premiums to reflect the true cost of extending services to underserved regions. HIPCs could also assign underserved regions to health plans which are already serving profitable areas. Each of these options has its own trade-offs which should be clarified before any action is taken.

Use of Private Administrators. The state could use private administrators to perform certain HIPC functions. The pros and cons of this strategy would have to be analyzed in the context of a specific HIPC design.

Impact on Agents. The creation of a HIPC could substantially change if not eliminate the role of insurance agents as many of the traditional agent roles are allocated to the HIPC. The impact of a HIPC on the agent industry should be clearly understood if the state moves forward with HIPCs.

Costs. Administrative costs must be minimized if a HIPC is to be effective. Costs could differ significantly depending on the purpose and design of the HIPC.

Legal Issues

The creation of a HIPC could raise a variety of legal issues which should be clearly understood. Because of their ability to pool purchasing power, HIPCs may be subject to anti-trust challenges. The ERISA preemptions make it impossible for the state to require self-insured employers to purchase care through a HIPC. Also, it is unclear whether federal health care fraud statutes might prohibit certain information sharing activities between Medicaid agencies, HIPCs, and health plans. These issues will have to be researched further prior to creation of a HIPC in Virginia.

Recommendation

Health insurance purchasing cooperatives will continue to receive close attention as the states and possibly the federal government test the ability of HIPCs to reform the health care market. The experience of other states indicates that HIPCs are not a simple solution to a complex problem. While HIPCs hold strong potential, extensive planning is required to design a HIPC structure which matches the needs of local regions. It is recommended that the Joint Commission continue to study the policy, planning, implementation, and legal issues surrounding HIPCs, and make a final report to the 1995 Session of the General Assembly.

Tax Treatment of Individual Health Insurance and Medical Care Savings Accounts

House Joint Resolution 589 (1993) directs the Joint Commission on Health Care to consider the feasibility of augmented tax subsidies for (1) individually-paid health insurance (as distinct from that financed via employer groups), and for (2) the health insurance form known as "Medical Care Savings Accounts."

Individually-Paid Health Insurance

Current Situation Regarding Tax Deductibility. Employer contributions to employee health insurance premiums (and toward cost sharing under such coverage) are presently fully exempt from federal income tax.

Self-employed individuals, and those who are not otherwise covered by an employer health plan, are currently allowed to deduct 25 percent of the amount that they pay for medical insurance. (This provision, which had expired in mid-1992, was retroactively extended by OBRA-93 tax provisions through the end of 1993; further extension is likely.)

Virginia is a "federal conformity state" for the purposes of calculating both corporate and individual state income tax liability. Thus, for individuals, the calculation of Federal 1040 adjusted gross income forms the basis for state taxes, with allowances for some additional deductions and addbacks. Any decision to deviate from the federal standards of deductibility for insurance expense would break this link, necessarily adding to monitoring and enforcement costs for the Department of Taxation; costs of compliance for taxpayers would also increase.

The current situation of greater tax deductibility in employer group policies adversely affects worker mobility, limits individual choice of coverage level, and is unable to concentrate the subsidy on persons most likely to need it in order to induce purchase of insurance.

Proposed Changes to Tax Deductibility Due to National Health Reform. In the current version of the Clinton Health Security Act (HSA), a cap would be placed on employer deductibility for the costs of health insurance coverage in the year 2003. This cap would be set at a level equal to the cost of the nationally guaranteed minimum benefit package then in effect. In the interim, full tax preferences are "grandfathered" in for employer plans at levels in effect as of January 1, 1993.

Under the HSA, the deductibility for those obtaining coverage independent of an employer would be 100 percent (increasing from the current 25 percent). Individuals would be subject to the same type of dollar cap as employer groups in 2003.

Virtually all of the competing reform plans make the tax privileges available to individuals equal to those available in employer-sponsored groups.

Issue. The current differential between deductibility for those purchasing health insurance outside of an employer group and purchases made within an employer group seems inequitable.

Options.

- ❐ Memorialize the U.S. Congress to request that federal tax deductibility for health insurance purchased outside of employer groups be expanded to equal the tax advantage provided to insurance purchased within employer groups.

- ❐ For the purposes of state taxes, follow the probable expansion of individual deductibility at the federal level, preserving "strict conformity" while achieving subsidies for individuals that match those afforded to persons in employer groups.

- ❐ If federal action is not forthcoming, expansion of full deductibility for individuals could be undertaken by Virginia for state tax purposes only, albeit with the added costs of parting from federal conformity.

Medical Care Savings Accounts

Description of Medical Care Savings Accounts. Medical Care Savings Accounts (MCSAs) are an extension of current insurance forms, combining "catastrophic" coverage (having a deductible of, for example, $3000 to $5000) with a provision for a special tax-exempt savings account dedicated to meeting medical expenses. Employers would contribute all or part of the savings in premiums associated with the lower cost, high-deductible policy into each employee's MCSA. Employees could also supplement the employer contribution. Individuals without access to employer groups would have equivalent contribution privileges. Funds in the MCSA would be available for medical expenses up to the deductible amount. Funds remaining in the MCSA after the policy period could be removed and spent for non-medical purposes, or rolled over for future use.

Proposals for MCSAs make the employer's contribution to the fund tax exempt, just as premium contributions now are. Individual contributions to, and interest earnings on, the MCSA would also be tax exempt. In the more expansive proposals, removals for non-medical purposes would not be taxable, at least after the annual deductible or over a set minimum balance, or when the employee reaches retirement age. More typically, removals for non-medical purposes would be subject to a penalty, and also considered taxable income for the year in which withdrawn.

Pros and Cons of MCSAs. MCSAs would make the consumer face the full cost of care at the margin, just as does any insurance deductible provision. Data show clearly that medical consumers respond to such changes in effective price by reducing consumption -- sometimes dramatically. In this respect MCSAs clearly would reduce health care expenditures, although it is unclear by how much.

Whether the consumption reductions obtained would be desirable is a point of debate. Consumers would presumably reduce consumption of elective items, such as primary and preventive care. The current thinking is that expenditures for primary and preventive care ultimately save money by preventing the need for more expensive care later. While this presents an argument for not reducing expenditures for these items, there is little empirical data to support this position. And, even if not strictly cost-saving, these expenditures may be cost-effective in that the associated improvements in health outcomes may be worth the added price. It is also thought by many that individuals consistently undervalue such care, so that it ought to be subsidized at the margin. (MCSAs do subsidize these expenses somewhat, given the tax deductibility; but not as much as would

coverage under policies with minimal copayments and/or low deductibles.) A related concern is that MCSAs do not encourage managed care models, and do not provide the benefits that gatekeepers and integrated delivery can bring.

While MCSAs would probably reduce expenditures on primary and preventive care, they would appear to do little to curb costs for very expensive episodes of care, such as lengthy hospitalizations, where expenses run well past the deductible and are more under the control of the provider than the consumer.

It is argued that MCSAs would reap savings in administrative costs, since individuals would pay their own small claims (under the deductible) without costly, third-party involvement. It should be remembered that some of this "savings" is simply a shift. While private administrative costs might not appear in any government accounts, such burdens are no less real. Further, enforcement of restrictions on spending out of the MCSAs (whether by insurers, employers or tax authorities) also would seem likely to generate significant administrative costs.

It is more difficult to understand how MCSAs would substantially improve access to coverage for medical expenses. While the high-deductible policies would be cheaper for employers to offer (or individuals to buy), this advantage evaporates if most or all of the premium differential is used to fund the savings account.

Current Situation Regarding Tax Deductibility. MCSAs as described above are not currently tax deductible. However, employers may now make tax-exempt contributions to certain "flexible reimbursement" programs, which create funds to support employee medical expense (or expenses for dependent care). The amount of the contribution must be designated in advance by each employee; funds are forfeited if not used for an eligible expense within the tax year. Except for the "use-or-lose" aspect, these "section 125" accounts (as they are sometimes also called) are very similar to MCSA proposals.

MCSAs Under National Health Reform Proposals. The major Republican proposals all make provisions for medical care savings accounts or analogous devices. The major Democratic plans do not.

Other States' Policies Re: MCSAs. Missouri and Colorado are the only two states to have passed legislation on MCSAs. Missouri passed its legislation in this year's session, and Colorado passed its legislation in

1986. Under the Colorado law only the interest earned by MCSA-deposited funds is tax-exempt; contributions by employer or employee are not. (Colorado's budgetary crisis at the time would not allow for greater tax exemptions.) Colorado's small deductibility benefit -- which applies only to the state income tax -- has made for a very limited impact to date. A bill to allow the full MCSA package of deductibility benefits will be introduced in Colorado in the 1994 session.

Recently, there has been considerable state activity elsewhere. California, Maryland and Montana have had MCSA legislation introduced, but not passed, in the last few years. In Georgia, Indiana, Michigan and Oklahoma, MCSA legislation has passed one house and is now pending in the other. Bills have also been introduced in New York, Pennsylvania, and South Carolina. Minnesota and Mississippi, like Virginia, have passed legislation or resolutions mandating that the issue of MCSAs be studied. Texas and Utah have passed resolutions to the Congress regarding MCSAs; resolutions to Congress were introduced but failed to pass in Indiana and West Virginia.

Issue. Employer contributions to MCSAs are currently not tax deductible, whereas employer contributions to other forms of health insurance are. This seems inequitable.

Options.

- ❒ Memorialize the U.S. Congress to request that employers be given the same federal tax deductibility for MCSAs as for other forms of health insurance.
- ❒ For the purposes of state taxes, preserve strict conformity.
- ❒ If federal action is not forthcoming, expansion of deductibility for MCSAs could be undertaken by Virginia for state tax purposes only, albeit with the added costs of parting from federal conformity.

Discussion and Recommendations

For the sake of equity, it seems appropriate to extend the tax advantages provided to health insurance purchases made through employer groups to those purchasing insurance outside of employer groups. It would also seem fair to extend to MCSAs the same tax advantages as are provided to other forms of health insurance.

It must be noted that there will be a loss of state revenue if tax-based subsidies are increased. Reductions in expenses for care of the uninsured may offset some of these losses, if coverage levels increased significantly as a consequence. But it seems unlikely the cost offset would be more than partial. A simulation model would be necessary to predict the net effects with any accuracy. In a preliminary analysis, using 1991 data, the Department of Taxation estimated the cost of expansion of deductibility for the self employed from 25% to 100% to be between $3.9 and $4.6 million. Deductibility expansions for MCSAs could involve additional revenue losses.

Nonetheless, it is suggested that the current tax inequities be corrected. Therefore, the following recommendations are made:

- ❒ Memorialize the U.S. Congress to expand federal tax deductibility for health insurance purchased outside of employer groups to equal the tax advantage provided to insurance purchased within employer groups. For the purposes of state taxes, preserve strict conformity and follow the expansion of tax deductibility.

- ❒ Memorialize the U.S. Congress to request that employers be given the same federal tax deductibility for MCSAs as for other forms of health insurance. For the purposes of state taxes, preserve strict conformity.

Insurer Practices

<u>Background</u>

During 1993, concerns were raised about the practices of Blue Cross and Blue Shield of Virginia (BCBSVA) with regard to co-insurance payments by insureds for services received in a hospital. The policies in question are those that allocate the payment on a percentage basis between BCBSVA and the insured for a hospital-based service. For example, many policies call for BCBSVA to pay 80% of the bill for an inpatient hospital stay, while the insured would pay 20%. BCBSVA had been calculating insureds' required co-payments based on 20% of hospital "charges". However, BCBSVA typically does not reimburse hospitals at the level of full charges. Rather, BCBSVA has negotiated discounts with almost all hospitals. As a result, when an insured was paying 20% of the full charges, he or she was paying greater than 20% of the amount the hospital actually received in reimbursement.

Issues

The first issue is the fact that the insured was paying greater than 20% of the bill, when the policy was represented as an "80/20" contract. The second issue is that the "Explanation of Claims Processed" (ECP) form sent by BCBSVA to insureds implied that the hospital was receiving the full charge amount, and that BCBSVA was paying 80% of the amount, and the insured was to pay 20% of the amount. In reality, the hospital was not receiving the full charge amount but a lesser, discounted amount, and BCBSVA was paying less than 80% of this discounted amount and the insured was paying more than 20% of it. As such, the information contained in the ECP form was misleading.

It should be noted that BCBSVA has begun to address these issues. As of January 1, 1994, BCBSVA is calculating the insured's portion of the bill based on 20% (in the above example) of the "average" discounted payment rate negotiated with the hospital. The average discounted payment rate is utilized because the negotiated payment rate often varies by service, and in many cases depends on factors, such as volume, which can only be an estimated figure until the end of the accounting year period. BCBSVA has also modified its "Explanation of Claims Processed" form to more accurately portray the actual payment the provider will receive, and the amounts that BCBSVA and the insured must pay.

Summary of Health Insurance Recommendations

Recommendation 1

Introduce legislation to amend HB 2353 based on the Joint Commission's review of proposed amendments by interested parties.

Recommendation 2

Endorse the proposal of the Virginia Indigent Health Care Trust Fund Technical Advisory Panel. Introduce legislation to allow for the receipt of contributions into the Trust Fund which are above the contribution level required by the existing formula.

Recommendation 3

Introduce a resolution requesting the State Corporation Commission's Bureau of Insurance to study individual and conversion health insurance coverage and market reform possibilities to determine measures which

might increase access to affordable health care coverage for these individuals and families.

Recommendation 4

Introduce a resolution requesting the Joint Commission to examine options for expanding access to health coverage for Virginia's uninsured children.

Recommendation 5

Introduce a resolution requesting the Joint Commission to continue its study of health insurance purchasing cooperatives, with a focus on specific planning and operational issues.

Recommendation 6

Memorialize the U.S. Congress to (1) give individuals the same tax deductibility for health insurance premiums that employers have; and (2) make the tax treatment of MCSAs equivalent to the tax treatment of other forms of health insurance. Preserve federal conformity for the purposes of calculating Virginia corporate and individual income tax liability.

Recommendation 7

Introduce legislation to require insurers to calculate insureds' percentage co-insurance payments based on the actual amount paid to the provider, rather than the provider's full charges. Also, introduce legislation to make it a crime for an insurer to willfully misrepresent or conceal a material fact in the communication or explanation of benefits or payments made to an insured.

Recommendation 8

Introduce legislation to establish an insurer fraud and abuse statute.

CHAPTER 4

HEALTH CARE COST AND QUALITY

Virtually all of the health care reform proposals now before the public recognize that universal access to health coverage will be unaffordable without reductions in the growth of health care costs. Even for businesses and individuals who already have coverage, the affordability of that coverage in the future will depend on whether health care cost inflation can be controlled. At the same time, no one is willing to sacrifice the quality of necessary health services for the sake of savings. This situation raises a difficult question: how can Virginia reduce health care cost inflation without limiting access to high quality, necessary health services?

During the past year, the Joint Commission on Health Care has reviewed a variety of strategies for addressing health care costs and quality. One strategy is the development of organized health care delivery systems which are accountable for both cost and quality. Recognizing that accountability can only be achieved if there is appropriate information available, a second strategy is for the Commonwealth to forge ahead with its revised Health Services Cost Review Council methodology and continue to develop its patient level data base. A third strategy for controlling costs and quality is to develop state strategies to combat the problem of health care fraud. While these three general strategies are not a complete solution to the problem, they do have the potential to move Virginia forward in the effort to provide more citizens with access to affordable, high quality health care.

Organized Delivery Systems

In response to growing interest in organized delivery systems, in 1993 the General Assembly passed Senate Joint Resolution (SJR) 316 requesting the Joint Commission to study organized delivery systems in general and community health networks in particular. SJR 316 raised a number of questions about organized delivery systems, including their potential in rural and urban underserved areas, the potential of regional delivery systems, their potential for serving the uninsured, their relationship with the public health system, how organized delivery systems might be held accountable, and how community health networks might be organized to

assume risk for the delivery of services. The resolution asked the Joint Commission to determine the appropriate role of the Commonwealth in the development of organized delivery systems, and to make recommendations for the development of community health networks in the Commonwealth.

Organized delivery systems are evolving within the Commonwealth in response to market forces. There are a variety of types of organized delivery systems, and many of these hold the potential to improve access, quality, or cost effectiveness. At this time, the appropriate role of the Commonwealth is to facilitate the development of organized delivery systems while also protecting consumer interests. The remainder of this section provides background and specific recommendations for the role of the Commonwealth in the development of organized delivery systems.

Growing Interest in Organized Delivery Systems

For some time now the health care delivery system has been reorganizing in fundamental ways. Public programs and private health plans are turning toward managed care in an attempt to serve patients in a more cost-effective fashion. Group practice has become the predominant mode of physician practice, and physician groups are aligning with hospitals and insurers to find more cost effective ways of delivering services. Hospitals and other health care providers are realizing that they cannot afford to compete for high technology services, and they are finding ways to cooperate in service delivery. Projecting this trend to its logical end, most of the major health care reform proposals call for organized health care delivery systems which will provide a continuum of health care services, with strong primary care case management, and strong financial incentives for cost effective care.

These proposals are an attempt to rationalize a health care market which has failed to allocate resources effectively. The traditional system of indemnity insurance and fee-for-service medicine has created financial incentives for providers to over-utilize services, with no financial incentives for providers to focus on wellness. At the same time, independent providers in the same market have often competed by expanding capacity beyond the need of the community, which in turn has created additional incentives to overuse services. The fragmentation within the system has made it difficult to develop norms of professional practice, and as a result there are wide variations in the practice of medicine which are not fully explained by differences in patient characteristics. As a result of these forces, purchasers and patients must

negotiate their way through a fragmented system of providers and facilities with little or no useful information on the cost and quality of services.

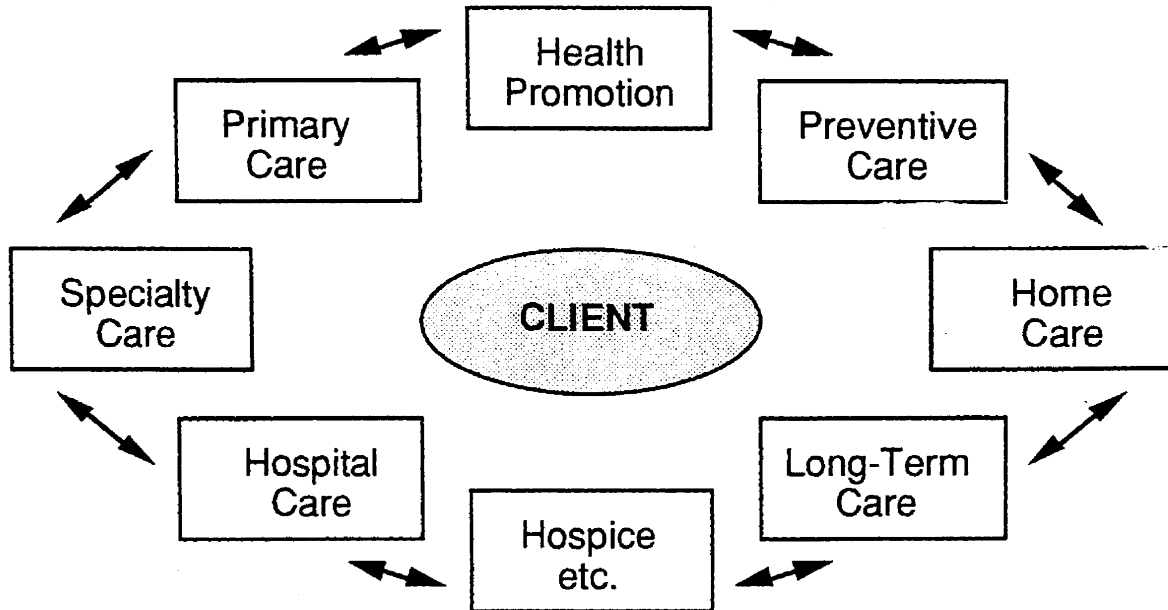
Advocates believe that organized delivery systems can provide the economic discipline required to remedy some of the problems in the health care market. The belief is that if providers of primary, acute, and other types of care cooperate to offer services on a risk-sharing basis, financial incentives to overuse services could be dramatically reduced or eliminated, and incentives to provide primary and preventive services would increase. At the same time, organized delivery systems with responsibility for serving a defined population would have the ability to monitor the health status of that population over time and assess the cost and quality of the services they are providing. This information could be used by purchasers to make decisions about the value of their health services.

The potential of organized delivery systems is evidenced not only by their importance in recent health care reform proposals, but also in the market itself. In recent years there has been a significant trend toward managed health care programs in which a primary care provider coordinates the care of patients within a network of providers. HMOs, which manage the care of enrollees in return for a pre-paid fee, are also having a growing impact on the health care system. In response to these trends, providers are organizing in a variety of ways to meet the demands of the market. Most in the health care industry would agree that the major question for the future is not whether to organize, but how.

Types of Organized Delivery Systems

The descriptor "organized delivery system" could refer to a number of different kinds of health care organizations. A range of organized delivery system models is described below. This is not an exhaustive description of all of the possible organized delivery system models, but it does illustrate the major conceptual differences among different types of organized delivery systems.

Exhibit 4.1



- UNIVERSAL COVERAGE AND ACCESS
- ORGANIZED CONTINUUM OF SERVICES/PROVIDERS
- SERVICE INTEGRATION AND LINKAGES
- CARE COORDINATION FUNCTION
- UNIFORM DATA AND ACCOUNTABILITY

SUPPORTIVE INCENTIVES: FINANCING AND STRUCTURE

"Unorganized" Delivery Systems. At one end of the spectrum is an "unorganized" delivery system in which hospitals, physicians, and other providers operate independently in the marketplace. Each entity competes with other providers in the community for the business of health plans, self-insured employers, and individuals. The incentive is to duplicate service capacity in an effort to gain a competitive advantage over other independent providers. This incentive is one of the major reasons for the certificate of public need process .

Health Care Cooperative Agreements. The first level of system organization might be called a "health care cooperative agreement." Under this model, two or more health care providers cooperate to offer a specific service. This might involve two hospitals undertaking a joint venture to provide medical testing services, or two physician group practice plans cooperating to share administrative costs. This initial level of organization could potentially help to avoid or reduce over capacity in a community by allowing providers to joint venture rather than compete for market share for a specific service. For example:

> *The Augusta Hospital Corporation and the University of Virginia Medical Center are planning to collaborate on the establishment of a heart catheterization service to be offered at the future Augusta Medical Center. The service will begin when the new hospital opens in the summer of 1994. Negotiations between the two hospitals have focused on issues of access, cost, quality, and continuity of care. Under the agreement, Augusta Medical Center will supply support services for University of Virginia staff to perform procedures at the hospital.*

Horizontally Organized Delivery Systems. At the next level of organization is the horizontal organized delivery system. In this model physicians from two or more group practices might affiliate to form a preferred provider organization. Or, two or more hospitals might affiliate to form a hospital system. At the September Joint Commission meeting, Dr. Roice Luke of the Medical College of Virginia/Virginia Commonwealth University presented data showing that 29 percent of Virginia's hospitals were participating in local hospital systems, making Virginia ninth among the states on this measure. The primary benefits of a horizontally organized system are an expanded scope of services and administrative economies of scale. For example:

> *Effective this year, Warren Memorial Hospital, a 111-bed facility offering basic hospital services, became a subsidiary of the Winchester Regional Health System. This system is the parent company of the 408-bed Winchester Medical Center, a surgical center, and several medical business enterprises. By joining the network, Warren Memorial expects to be able to provide local citizens with access to a full array of services. Warren Memorial also benefits from group purchasing agreements and from administrative services it and other subsidiary facilities receive from the parent company.*

A horizontally organized delivery system could contract with self-insured firms and other insurance entities to provide services to subscribers.

Vertically Organized Delivery Systems, Including Community Health Networks. The next level of organization might be called the vertically organized delivery system. Vertically organized systems are capable of providing primary and secondary or tertiary care under one organizational umbrella. An emerging type of vertically organized delivery system is the physician-hospital organization or PHO. Under this model a physician group practice and a hospital would join forces to offer a range of health services to a health plan or directly to a self-insured organization. For example:

> *Earlier this year, Halifax Regional Hospital and its medical staff initiated efforts to develop a PHO. The PHO is being formed as a vehicle for collaboration between the hospital and the medical staff on health care ventures including: (1) contracting with industries for the provision of health care services to employee groups; (2) direct contracting with mental health providers, long-term care facilities, and tertiary care centers for those services which Halifax Regional does not provide; and (3) integration of medical practices to allow small group practices to benefit from economies of scale, and to ensure better service coverage.*

The vertically organized system is the first stage in which hospitals and physicians have a shared economic incentive to work together in deciding the most cost-effective site of care for a patient.

To many, the ideal form of a vertically organized delivery system would be a community health network. A community health network may be defined as a locally organized delivery system in which providers join together to offer a continuum of health services, possibly including long-term care, home health care, and other health services. These services would be coordinated over time and across different providers, and would emphasize prevention and primary care. A community health network would be accountable to purchasers for the cost and quality of care it delivered.

Risk-Bearing Community Health Networks. The next level of organization might be called the risk-bearing community health network. This type of organization would have the same responsibilities as community health networks described above, with the providers assuming the additional responsibility of bearing insurance risk. This would mean that the

network would be responsible for making sure that its customers continued to receive services in the case of network failure. Advocates propose that the assumption of insurance risk would create additional incentives for providers to keep people healthy through primary and preventive services. Critics caution that the financial burden of risk-bearing could create incentives for providers to underserve their patients.

Provider/Insurer Joint Ventures. The next level of organization might be called the provider/insurer joint venture. Under this model, a network of providers and an insurance entity join forces to offer services directly to purchasers on a risk-sharing basis. Many health maintenance organizations fall under this category of organization.

Variations and Combinations. As noted earlier, the preceding examples are intended to illustrate the range of possibilities rather than to provide an exhaustive description of organized delivery systems. Numerous variations and combinations of these models are possible. For example, there may be PHOs in existence right now which have many of the same characteristics of a community health network. Also, providers and an insurance entity could engage in a joint venture to produce a delivery system with the same features as a risk-bearing community health network.

Anti-Trust Issues

By definition, most organized delivery systems involve cooperation among providers. In the case of health care cooperative agreements, the major advantage is the potential to slow the "medical arms race" by allowing providers the option to joint venture instead of unnecessarily expanding their individual capacity. In the case of PHOs and community health networks, there is the potential for additional advantages such as cooperative agreements to coordinate the full range of services for the benefit of the patient.

On the other hand, there is the potential for anti-competitive activity by an organized delivery system. The overriding concern is that through collaboration, health care providers could garner enough market share to significantly reduce or even eliminate competition in a service area. This could hurt self-insured firms, insurance companies, and individual consumers who lose their leverage to shop for cost-effective services. In these situations, costs could rise while quality deteriorates. This is a particularly important issue in underserved areas where there are relatively few providers.

This is not to say that cooperative ventures necessarily engage in anti-competitive activities. In fact, there is some uncertainty among legal experts about the extent to which federal anti-trust provisions apply to the collaborative activities of health care providers. Nevertheless, the sanctions for anti-trust violations are substantial enough to have a chilling effect on the development of cooperative ventures. This is especially true for smaller providers without the financial and legal resources to fight an anti-trust challenge.

Organized Delivery Systems In Rural Areas

Many rural residents have unique health care needs which are exacerbated by a lack of access to affordable primary and acute health care. Therefore, the success of organized delivery systems in rural areas will depend on the availability of primary care providers. Another problem in rural areas is the status of small acute-care hospitals struggling to provide the full array of hospital services to the local community. In response to this problem, a number of states are trying to develop regional rural health networks in which smaller regional hospitals coordinate services with larger secondary and tertiary hospitals. The earlier example of Warren Memorial Hospital joining the Winchester Regional Health System is an illustration of the development of a rural hospital network.

In the area of financing and cost containment, it must be recognized that Virginia as a whole, and rural Virginia in particular, remains primarily an indemnity-based market with little penetration of managed care insurance products. It will be a challenge to develop rural community health networks which are large enough to bear risk but local enough to provide geographic access to patients. This difficulty is evidenced by a relative lack of HMO penetration in rural areas across the country.

There are also legitimate concerns about competition among organized delivery systems in rural areas. Ideally, multiple organized delivery systems would compete for business, but it is difficult to envision how competition would work in geographically isolated areas with few providers. Although provider collaboration may be a viable solution to this problem, in communities with few providers the anti-trust risks may be substantial.

Organized Delivery Systems in Urban Areas

As is the case with rural underserved areas, the success of organized delivery systems in urban areas will depend on the availability of primary care providers. Beyond this, urban underserved areas pose a different set of opportunities and constraints compared to rural areas. In terms of opportunities, geographic access to providers is typically less of a problem in urban areas. Also, managed care penetration tends to be higher in urban areas. Urban areas tend to have more providers than rural areas, which improves the possibilities for competition among organized delivery systems, and reduces the likelihood of anti-trust violations. At the same time, the presence of this competition makes the development of organized delivery systems in urban areas a controversial undertaking. As they ponder the future, some independent providers are concerned that they will be left out of organized delivery systems without being able to demonstrate their ability to deliver high quality, cost effective care.

Organized Delivery Systems and the Uninsured

There are three general ways in which organized delivery systems might serve the uninsured. One way is for the individual members of the system -- hospitals, physicians, and others -- to continue their service to the uninsured on an individual basis. A second way is for the organized delivery system to contract with the state or local governments to serve the uninsured, including Medicaid patients. For example, some states have contracted with HMOs to serve certain types of Medicaid patients. This type of arrangement requires a federal waiver due to the restriction of patient choice to the providers in the organized delivery system.

A third approach is to use organized delivery systems as a major vehicle for serving the uninsured as part of a global reform initiative. For example, in 1992 Minnesota enacted its MinnesotaCare plan which is designed to eventually give all Minnesotans access to health coverage within a global budget. Under this plan, one of the major cost containment mechanisms is expected to be integrated service networks or ISNs. An ISN is an organized delivery system which offers integrated health care services on a risk-sharing basis. An ISN may be developed by providers alone or by providers in cooperation with an insurance organization. The Minnesota plan includes a number of incentives for the creation of ISNs, including net worth and solvency requirements which are more flexible than those for Minnesota HMOs. It was felt that this flexibility was needed in order to encourage the formation of ISNs in some rural areas. The exact requirements are still being developed.

Florida is another example of a state which is using organized delivery systems as part of a global reform strategy. Florida's approach to health care reform is based on a voluntary form of managed competition. The state has established 11 community health purchasing alliances to pool buying power and share information. These alliances will develop requests for proposals from "accountable health partnerships" which will integrate services, assume risk, and provide data on health outcomes.

Relationship With Public And Voluntary Health Systems

Over the years there has developed a system of public and voluntary health agencies which play an important role in serving those without health coverage. These include the public health system, the public mental health system, community health clinics, and schools. The prospect of organized delivery systems which would provide the full array of health care services raises questions about the future role of public and voluntary health care providers.

In the absence of state or federal action to provide universal access to health coverage, it is not likely that the role of the public and voluntary health systems will change significantly in the near future. There will be a continuing need to serve those without coverage in either the public or voluntary system. While it is possible that widespread growth in HMOs and other organized delivery systems could result in many preventive services being provided by the private sector, such growth is not anticipated in Virginia without the impetus of major state or federal action. However, one possibility would be for organized delivery systems, particularly community health networks, to work with the public and voluntary health systems to pursue public health objectives within the community.

Measures to Promote Accountability

Measures to promote accountability of organized delivery systems vary according to the type of organization. From the standpoint of health care reform, the most important issue is how to hold organized delivery systems accountable for the cost and quality of care they deliver. In this context, the focus here is on organized delivery systems which manage the continuum of care for the patient. There are four general mechanisms which might be used to promote accountability: public report cards, internal practice guidelines, accreditation, and community governance.

Public Report Cards. One of the major flaws in the health care market is the lack of information on the costs and quality of services. Public report cards are one way to address this problem. The idea is to make available periodic reports on the activities of the organized delivery system, the cost of services, and the quality of services in terms of service activity, enrollee health status and enrollee satisfaction.

The technology for assessing enrollee satisfaction is available. In recent years the HMO industry in particular has used enrollee satisfaction data in efforts to improve services. HMOs also have an enrollee complaint process which is established in statute. Enrollee satisfaction surveys and complaint processes could be used for other types of organized delivery systems as well.

The technology for assessing health status and health outcomes is less well developed. Historically, it has been difficult to track patient outcomes because under the prevailing fee-for-service/indemnity insurance system, providers were not responsible for tracking patients after rendering their services. Recently, the National Commission for Quality Assessment has developed the Health Plan Employer Data and Information System (HEDIS) which is designed to measure a variety of indicators of health plan quality. Twenty-five HMOs across the country are currently participating in a pilot test of the third version of HEDIS. HEDIS may be an important building block for developing useful report cards on health plans.

Internal Practice Parameters. There is a growing body of research which reveals wide variations in medical practice which are not fully explained by differences in patient characteristics. This research further indicates that the most costly treatments are not always the most cost effective treatments. One response to this problem could be for providers within an organized delivery system to make a commitment to monitor treatments and outcomes on an ongoing basis in order to develop parameters for cost effective medical practice. As an accountability mechanism, providers within an organized delivery system could be required to make a demonstrable commitment to such internal monitoring.

Accreditation. Another evolving accountability mechanism is accreditation. The Joint Commission on Accreditation of Health Care Organizations (JCAHO) is in the process of drafting standards for accreditation of provider networks. These standards would address such issues as the philosophy, management, and quality of community health networks. Network accreditation would be in addition to, as opposed to a

replacement of, accreditation of individual providers within a network. At this time it is unclear whether the JCAHO will actually implement a program to accredit networks, but this development bears watching.

Community Governance. Locally-organized delivery systems should be accountable to the communities they serve. One way to achieve such accountability is to include community representatives on the governing board for the system. Community representatives might include representatives of the business community as well as individual consumers. Their role would be to ensure that the organized delivery system was actively assessing the needs of the community and tailoring its programs to meet those needs. Critics of this approach would argue that purchasers on the board could have too much power to set their own prices for health care.

<u>The Role of the Commonwealth</u>

Organized delivery systems, if properly structured and regulated, can enhance the quality and affordability of care within a community. This is apparent from the market's movement toward organized delivery systems and managed care. The role of the Commonwealth should be to remove obstacles to the development of organized delivery systems without compromising its commitment to consumer protection. In the process, the Commonwealth should allow for the development of a diversity of organized delivery system models.

In this context, there are several actions which the Commonwealth might take to facilitate the development of organized delivery systems. These include: (1) providing anti-trust protection for health care providers who cooperate for the public good; (2) developing systems to monitor the costs and quality of health plans; (3) continuing to study the idea of community health networks; (4) exploring the feasibility of serving Medicaid patients through organized delivery systems; and (5) continuing efforts to expand the supply of primary care providers.

1. Providing Anti-Trust Protection In Certain Situations. In testimony before the Joint Commission, representatives of the provider community have spoken of the "chilling effect" of possible anti-trust challenges on the development of organized delivery systems. This is a particular problem in rural areas where there may be little competition. This raises the question of whether the State might play a role in providing anti-trust relief, without abandoning its commitment to consumer protection, to allow for the development of additional health care cooperative

agreements as well as horizontal and vertical organized delivery systems including community health networks.

In response to this same issue, over the last three years at least 13 other states have passed legislation to grant anti-trust immunity to cooperating providers if the providers can demonstrate that the reduction in competition resulting from the cooperative venture is justified by improvements in cost-efficiency, quality, and access. This "state action immunity" approach is based on the principle that states may substitute regulation for competition and impose anti-competitive restraints as an act of government. The process for granting immunity is typically administered through a newly created authority or an existing state agency with advisory assistance from the state attorney general.

Exhibit 4.2

States With Legislation To Immunize Cooperating Providers From Anti-Trust Challenges

Colorado
Florida
Kansas
Maine
Minnesota
Montana
North Carolina
North Dakota
Ohio
Tennessee
Texas
Washington
Wisconsin

Cooperating providers who win anti-trust immunity are awarded a "certificate of public advantage." One of the important issues surrounding state action immunity is whether the state action will provide adequate protection in court. The U.S. Supreme Court has established a two-part test to determine whether anti-competitive conduct engaged in by private parties should be deemed state action and thus exempt from anti-trust laws. First, the state policy to replace competition with regulation must be clearly articulated. Second, the anti-competitive conduct must be actively

supervised and periodically reviewed by the state. The latter requirement was emphasized in a 1992 U.S. Supreme Court case, *Federal Trade Commission v. Ticor Title Insurance Co.*

Typically, state action immunity legislation establishes a certificate of public advantage process to be administered through the health department. Applicants are required to document their proposed cooperative activities, and demonstrate that the resulting reduction in competition is justified by the resulting benefits. Certificates are reviewed periodically, and revoked in situations where the public good was no longer being served by the cooperative venture.

2. *Develop State-level Capacity to Monitor Costs and Quality.* A key element of an efficient health care system is the ability of consumers to make judgments about the costs and quality of health care providers. As will be explained in more detail in subsequent sections of this chapter, Virginia has taken important steps in recent years to develop methods for assessing the costs and efficiency of institutional providers and to collect patient level data which will eventually be used to assess the quality of individual providers. The evolution of organized delivery systems points to the need for a new type of accountability in which health plans should be held accountable for the health of enrollees and the costs of providing a full array of services to those enrollees. At present, there is uncertainty about the appropriate technology and method for producing such accountability measures, and the State could play a role in addressing this problem.

3. *Examining Community Health Networks.* The community health network could be an important addition to the Virginia health care market because of its community focus and its commitment to accountability. In Virginia and in other states, questions have been raised about the appropriate regulatory framework for community health networks. These questions revolve around the value of community health networks to consumers, who should be able to form and participate in community health networks, appropriate consumer protection requirements for community health networks, and ways in which state government might encourage the formation of community health networks. While the Joint Commission initiated an extensive review of the community health network concept in 1993, there is still much work to be done.

4. *Purchasing Health Care From Organized Delivery Systems.* Virginia could help to foster the development of organized delivery systems by purchasing care for Virginia Medicaid clients from PHOs, HMOs,

community health networks, and other organized delivery systems which meet established criteria. The Department of Medical Assistance Services has already implemented an effective managed care program (Medallion), and is currently exploring options for purchasing care for Medicaid patients on a prepaid basis. With the continued development of organized delivery systems, the Commonwealth and its Medicaid clients could have additional choices for managed care services.

5. *Continuing Efforts to Expand the Primary Care Workforce.* The development of effective organized delivery systems is predicated on the availability of an adequate supply of primary care providers. Virginia has undertaken several major initiatives to transition the health workforce toward primary care. These efforts will aid the development of organized delivery systems which rely on primary care physicians for case management.

Accountability for Costs and Quality

It is widely recognized that one of the fundamental problems in the health care market is that consumers are unable to compare the cost and quality of the health care services they purchase. This problem exists because there has been a lack of publicly available, user-friendly information on the performance of health care providers. The result is that purchasers have a limited ability to shop among health care providers for the best value in terms of both cost and quality. Without this market force, providers have less of an incentive to reduce their costs and improve their quality.

In 1992 the General Assembly laid two major pieces of a foundation for a system to collect and disseminate information on health care costs and quality. The General Assembly directed the Virginia Health Services Cost Review Council (VHSCRC) to develop and adopt a methodology to identify efficient and effective providers of health care. Also, the Virginia Patient Level Data System Act created a single source of patient level data which will ultimately be used to assess the quality of health care in the Commonwealth.

Virginia Health Services Cost Review Council Methodology

During 1991, concerns were expressed concerning the VHSCRC's continued use of its old methodology in which the VHSCRC reviewed aggregate charges of facilities to determine if they were reasonably related to aggregate costs. To address these concerns, the 1992 Session of the

General Assembly enacted Senate Bill (SB) 518 which, in part, contained a requirement that the VHSCRC develop a new methodology:

> *By January 1, 1993, the Council shall promulgate regulations establishing a methodology for the review and measurement of the efficiency and productivity of health care institutions. The methodology shall provide for, but not be limited to, comparisons of health care institutions' performance to national and regional data.*

In addition, Senate Joint Resolution 118 (1992) required the VHSCRC to develop a methodology which would improve the identification of the most efficient providers of high quality health care within the Commonwealth.

Following the enactment of SB 518, the VHSCRC contracted with the Williamson Institute of the Medical College of Virginia/Virginia Commonwealth University to assist the VHSCRC in the development of the new methodology. The primary issue was to determine what would be the least complex and most easily understood methodology to identify efficient and productive providers of health care. The consultants to the Council indicated that a ratio analysis methodology would be easily understood. This process was discussed with representatives of the relevant trade associations throughout the entire process of developing the new methodology. These associations have been supportive of the effort.

The VHSCRC established two work groups to work with the Williamson Institute -- one for hospitals and one for nursing homes. In addition to hiring consultants and establishing work groups, the VHSCRC also developed a list of groups to be involved in periodic external constituency reviews of the proposed methodology as it evolved. Finally, VHSCRC staff and members of the Williamson Institute worked on a regular basis with representatives of the Department of Health and the Department of Medical Assistance Services as the proposed methodology was developed, seeking their input in this process.

The VHSCRC's new methodology seeks to stimulate competition in the markets for acute care, psychiatric and rehabilitation hospitals, the nursing home industry, and for ambulatory surgical services by improving the availability of information regarding efficiency and productivity to various groups of consumers. A matrix will be used to identify the most efficient and productive acute care hospitals and nursing homes. The eventual combination of cost data from the VHSCRC and

quality data from the patient level data base should empower consumers to shop for the best value.

A key requirement of the new methodology is an electronic or automated data system to ensure that data can be promptly reviewed, analyzed, and disseminated. Such a system, called the Efficiency and Productivity Information Collection System (EPICS), is currently being developed. The first version of EPICS was completed and distributed to providers on September 20, 1993. The data is currently transmitted to the VHSCRC by disk, but eventually data will be transmitted via modem. The cumulative data base will be subjected to analysis that will facilitate public policy decisions and provide information to the market for health care services.

Another important requirement of the new methodology is a public relations plan. A public relations plan has been developed, including:

- pre- and post-measures of consumer and provider awareness of the VHSCRC to increase knowledge and use of health care data;

- training/education sessions for target groups such as insurers, employers, business groups, and the press for the purpose of informing them of the new methodology and the automated collection system; and

- dissemination of information by direct mail campaigns.

In conclusion, the VHSCRC will be continually evaluating the effectiveness of this new methodology during the next two years. This process will include the input of outside constituency groups, including the relevant trade associations.

<u>Patient Level Data Base</u>

The Virginia Patient Level Data Base Act of 1992 created a single source of patient level data for hospital discharges in the Commonwealth. The purpose, as stated in the legislation, was:

> *"...the establishment and administration of an integrated system for collection and analysis of data which shall be used by consumers, employers, providers, and purchasers of health care and by state government to continuously assess and improve the quality, appropriateness, and accessibility of health care in the*

Commonwealth and to enhance their ability to make effective health care decisions."

Generally speaking, this system would allow purchasers to compare providers in terms of utilization rates, charges, and outcomes for various common or expensive inpatient hospital treatments. The objective is to allow providers to use this information to improve their services, as well as to help consumers make informed choices about their health care providers.

The Commonwealth selected Virginia Health Information (VHI), an independent, non-profit organization, to administer the patient level data base system under a contractual agreement with the Virginia Health Services Cost Review Council (VHSCRC). The patient level data base system has been operating since July 1, 1993. Thus far, VHI has completed the process of developing an electronic data record which hospitals can use to submit patient level data on inpatient admissions. Through individual and group educational sessions, all hospitals have become engaged in the process of data submission. In addition, three study groups of health care experts have convened to discuss the plans for use of patient level data.

Looking to the future, VHI is planning to disseminate the results of its work beginning in 1994. Hospitals will be provided comparative information on such factors as preoperative and postoperative length of stay; mortality, readmission, and complication rates; and average charges, discharge status, and other information. By the end of 1994, VHI will provide the public with hospital-specific information on utilization rates, charges, and outcomes for at least one condition, such as Cesarean section rates or neonatal outcomes. In subsequent years, VHI plans to publish information on two to three conditions annually.

In addition, House Bill 2351 (1993) requested VHI to make recommendations regarding the feasibility of collecting outpatient data to augment the patient level data system. This study was requested because outpatient services represent an increasing percentage of the volume and costs of health care, fast approaching 30 percent at many hospitals. As a result, patient level data on inpatient care alone misses critical data related to quality and access to care. Moreover, episodes of care often include both inpatient and outpatient treatments for a single condition.

VHI engaged a study committee comprised of experts in the field of ambulatory care to evaluate the feasibility of collecting this information.

Recommendations from the committee were carefully considered by the VHI Board of Directors for the utility and the cost for collection of information. Several issues surfaced:

- Outpatient care can be fragmented, involving many different providers. Across insurers or other payers, there are no standard identifiers used to tie all health care encounters together.

- Information is not uniformly collected. Clinical information varies and is recorded using different forms.

- Unlike inpatient information, the vast majority of this information is not currently submitted in an electronic format. Collection of data for all care today would be difficult and expensive.

- Federal plans for health care reform are expected to result in standard submission of outpatient data. Attempts to standardize in the Commonwealth will likely be pre-empted by a national format for data submission. As a result, a State effort to standardize all submissions is likely to be an expensive short-term solution.

Nonetheless, VHI believes that there is a need to collect outpatient information now that takes into account the limitations and considerations noted above. There are several options, not all of which address these considerations:

- Mandate collection of all outpatient data, and seek substantial funding for collection and use of this data.

- Mandate collection of certain types of outpatient data, and attempt to integrate these with inpatient data.

- Do nothing, and await federal requirements.

- Require collection of all outpatient data from State-paid programs using existing formats from payers. Integrate this information into the Commonwealth's health care reform strategy.

The final option has the greatest potential to position the Commonwealth as a leader in the development and use of a comprehensive health care information system at a reasonable cost, because VHI will be able to utilize these data in their existing formats.

Health Care Fraud and Abuse

House Joint Resolution 667 (1993) requested the Joint Commission on Health Care to work with the Office of the Attorney General to study the problem of health care fraud and abuse, and to make recommendations for solving identified problems. The Joint Commission formed a voluntary Task Group to conduct the study, including individuals from the Office of the Attorney General, the insurance industry, the Department of Medical Assistance Services, the Department of State Police, and a legal representative of provider groups.

The Problem of Health Care Fraud and Abuse

Health care fraud and abuse is a major and growing problem in the national health care industry. The most common estimates of losses due to health care fraud and abuse range from 3 to 10 percent of total health care spending. In a national economy spending more than $800 billion on health care, $80 billion may be wasted due to fraudulent or abusive practices. These are dollars which could go a long way toward easing the burden on businesses and individuals who purchase insurance, or helping more people to purchase insurance.

Health care fraud and abuse refers to improper billing practices which have the effect of misrepresenting or overcharging for health services. Fraud refers to a willful act to defraud or deceive, while abuse typically involves actions that are inconsistent with acceptable business and medical practices. While there are moral and legal differences between fraud and abuse, they both have the same impact on the health care system: wasted dollars and, in some cases, useless and even harmful medical practice. Several examples of recent fraud cases are summarized in Exhibit 4.3.

Within Virginia, health care fraud and abuse is perceived to be a significant problem in the Virginia Medicaid program as well as in the insurance industry. It is difficult to quantify the magnitude of the problem in Virginia because fraudulent and abusive practices are surreptitious by nature. Fraud and abuse investigators interviewed for the study believe

Exhibit 4.3

EXAMPLES OF HEALTH CARE FRAUD

Overbilling One common type of fraud and abuse is overbilling for services. For instance, a California hospital routinely changed the diagnoses on patient files and overcharged Medicare by more than $3 million. As another example, an anesthesiologist practice in Massachusetts "unbundled" service bills by charging for intravenous lines and catheters once as part of a single procedure, and once again under separate claims for independent procedures. The practice agreed to pay over $200,000 to settle the case.(GAO, 1992)

Billing for Services Never Rendered Another common form of fraud and abuse is the practice of charging for services never rendered. For example, in 1992 the Virginia Medicaid Fraud Control Unit in the Office of the Attorney General obtained a felony conviction against a psychiatric provider's licensed social worker. The defendant was caught billing the Medicaid program for psychotherapy sessions for children which either never occurred or were not supervised by the provider. The defendant was ordered to pay $51,000 in restitution and received a jail sentence.(Medicaid Fraud Control Unit, 1993)

Rendering Inappropriate or Unnecessary Services Providers may also bill for inappropriate or unnecessary services. For example, one Tennessee physician billed the government for hundreds of tests which were performed improperly, such as putting patients on treadmills without bothering to connect them to a monitor. He also billed for tests which were incompatible with the patient's condition, such as a pregnancy test for a 60-year-old woman. In another case, an Illinois physician billed Medicare for services not medically necessary by using the name of another doctor with amnesia and endorsing the payment checks with that doctor's name. (FBI, 1992)

Improperly Acquiring or Soliciting Drugs There are numerous fraud and abuse cases involving drugs. For instance, a New York pharmacy and its owners were indicted for billing the Medicaid program for drugs never provided to patients. In their alleged scheme, the owners bought prescriptions from Medicaid recipients, billed the program for the drugs in question, but never dispensed the drugs. The pharmacy also filed claims for drugs based on fabricated physicians' telephone requests.(GAO, 1992)

Rolling Labs One of the most infamous fraud cases occurred in California. This ongoing case has been under investigation for six years, involves an estimated $1 billion in fraudulent billings to health insurance companies, has involved over 200 physicians, and has led to the indictment of 12 individuals.(GAO, 1992) In this case, mobile laboratories, or "rolling labs," offered heart, blood-pressure, and other physiological tests. The rolling labs attracted insured individuals by waving co-payments, and by paying physicians kickbacks for referrals. The labs then billed the patients' third-party payers for the tests. The owners of the rolling labs are facing trial on fraud charges.

that Virginia probably falls within the range of national estimates indicating that 3 to 10 percent of health care expenditures are attributable to fraud and abuse. Given this assumption, a rough, conservative estimate would place the cost of health care fraud and abuse in Virginia at around $390 million per year.

The costs of health care fraud and abuse are felt by individuals beyond the third-party payers who pay the illegitimate claims. Only a small fraction of health care fraud and abuse activities are identified and stopped each year. The unrecovered costs of fraud and abuse show up in the form of higher premiums for the privately insured, and greater allocations of tax dollars for public programs. Consumers also pay with their personal health when fraud schemes involve over-prescribing of drugs or providing useless or even harmful treatments.

Federal, state, and local entities all play a role in investigating and prosecuting fraud and abuse in Virginia. At the federal level, the Inspector General of the Department of Health and Human Services (HHS) is the primary investigative unit for Medicare and Medicaid cases. The FBI and the Postal Inspection Service also investigate certain types of fraud cases. The Department of Justice prosecutes federal cases.

Private insurers and other third-party payers often use their claims review processes to identify potential defrauders and abusers. They then work with the appropriate investigative and prosecuting agencies, including the Virginia State Police, to pursue cases of fraud and abuse.

Virginia Medicaid cases are investigated by the Medicaid Fraud Control Unit within the Office of the Attorney General. The Medicaid Fraud Control Unit is a federally-funded program under the oversight of the Inspector General of HHS. The Program Compliance Division of the Department of Medical Assistance Services works closely with the Medicaid Fraud Control Unit to identify possible lawbreakers. The Unit then works with federal and State investigators and prosecutors as necessary.

In FY 1993, Virginia's Medicaid Fraud Control Unit closed 28 investigations, with 37 cases still pending. Of the 28 cases closed, 4 were closed with criminal resolutions, 1 was closed with a civil resolution, and 23 were closed due to insufficient evidence with no further action. The Unit collected over $400,000 in reimbursements and criminal and civil fines and interest, with another $240,000 outstanding.

The General Assembly took an important step toward controlling health care fraud and abuse with the passage of the Practitioner Self-Referral Act in 1993. This act limits the ability of providers to refer patients to health facilities in which the provider is invested. Self-referral statutes are intended to reduce the cost of fraudulent and abusive self-referrals.

Those convicted of health care fraud may also be subject to disciplinary action by their licensing board. The Code of Virginia gives the Board of Medicine leeway to revoke licensure for deceitful or fraudulent acts. The Code requires the Board to suspend or revoke the license of a provider who has lost his or her license and has not had it reinstated in another state or country. Suspension or revocation is also required when a provider is convicted of a felony.

Problems In The Fight Against Health Care Fraud

The major problem in the fight against health care fraud is the lack of an adequate state statutory basis to investigate and prosecute fraud cases. Currently, the *Code of Virginia* contains no specific statutes which address health care fraud against private insurance companies. Several states have encountered these same problems and have recently taken steps to strengthen their ability to combat fraud and abuse. For example:

> *In Maryland, HB 607 (1993) establishes a new insurance fraud division within the Attorney General's Office. The division will be responsible for investigation, prosecution, compiling information, cooperating with the insurance industry and law enforcement officials, establishing a toll-free hot-line, and conducting public outreach and awareness programs. The law also establishes a nine-member Insurance Fraud Advisory Council to advise and assist the Attorney General, the Governor, and the General Assembly.*
>
> *In Tennessee, HB 821 (1993) defines fraud and establishes civil penalties for those who are guilty of fraud.*
>
> *In Texas, SB 203 (1993) defines fraud and prescribes both civil and criminal penalties, depending on the dollar magnitude of the fraud.*
>
> *In Connecticut, SB 1008 (1993) broadens the statutory framework for detecting, investigating, reporting, and prosecuting insurance fraud. The bill: (1) expands the definition of health insurance fraud, (2) requires restitution from those convicted of health insurance fraud, (3) requires disclosure of fraud to the insurance commissioner,*

and (4) permits disclosure of personal or privileged information to detect, investigate, or prevent fraud.

In the absence of a State health fraud statute, private insurance companies are required to use the existing state larceny statutes and obtaining goods and services by fraud statutes. These statutes allow for the prosecution of fraud on a claim by claim basis, but they do not allow prosecution for misrepresentation to third-party payers. The other option is for private insurers to turn to the federal code and pursue cases under the federal mail and wire fraud statutes, so long as the case is substantial enough to warrant Justice Department resources. The General Assembly could consider a Virginia health payment fraud statute which could be used by both private insurers and public programs. Such a statute could define health payment fraud and the penalties for committing fraud, while addressing the problems outlined above.

Poison Control Services

Background

Poison control services have proven to be an effective means of improving health care, and, at the same time, controlling health care costs. Poison control services include providing emergency consultations to victims of poison exposures, educating citizens and school teachers about how to prevent poisonings, and training health care providers how to treat poison exposures.

In Virginia, poison control services are provided by three poison centers: the Blue Ridge Poison Center at the University of Virginia (UVA) Medical Center, the Virginia Poison Center at the Medical College of Virginia (MCV), and the National Capital Poison Center (NCPC) at Georgetown University Medical Center.

In 1991, 54,922 poison exposures were handled by the three Virginia poison centers. Most of the 1991 poisoning victims were children (62%). The vast majority of poisonings (88%) were accidental. During the same period, the centers responded to an additional 14,000 inquiries for poisoning, drug, or medical information.

The Virginia poison centers are able to handle 77% of poisoning victims at home, thus, eliminating unnecessary hospital visits. Without the emergency consultations provided by the poison centers, many poisoning victims likely would resort to hospital emergency rooms where

the cost of medical care is significantly greater. The educational and training services provided by the centers enable parents, teachers and health care professionals to treat poisonings responsibly and with minimal costs.

Funding of Poison Control Services

Historically, the cost of operating the poison centers has been paid by the host medical center and/or university. There are no specific appropriations to fund the poison centers. The directors of the three poison centers have expressed concern that their host medical centers may not be able to continue supporting the full cost of operating the centers, and that additional funding sources will be required in the future.

In 1992, the Joint Commission recommended that the Blue Ridge Poison Center (UVA), the Virginia Poison Center (MCV) and those costs incurred by NCPC (Georgetown Medical Center) to provide services to northern Virginia be funded through a revenue enhancement of $0.07 per month to be charged to each phone line in Virginia. However, this action was not implemented.

In late 1993, the Joint Commission was informed that, due to a lack of funding available from Georgetown Medical Center, the NCPC was going to close in early 1994. Because NCPC provides poison control services to Arlington, Fairfax, Loudoun and Prince William counties, these areas will be without poison control services.

As previously noted, the poison control centers offer cost-effective services which contribute to the overall health of Virginians. The Joint Commission is committed to ensuring that poison control services are provided throughout the Commonwealth. Funding is needed in the short term to make certain that citizens in northern Virginia have access to poison control services. Moreover, a long-term strategy for providing and funding poison control services in the Commonwealth is needed.

Summary of Health Care Costs and Quality Recommendations

Recommendation 1

Introduce a resolution requesting the Virginia Health Services Cost Review Council to create a methodology to develop report cards on health plans.

Recommendation 2

Introduce a resolution continuing the Joint Commission's study of community health networks.

Recommendation 3

Introduce legislation requiring submission of outpatient encounters for State-supported patients for inclusion in the patient level data base.

Recommendation 4

Introduce legislation to establish a Virginia health care fraud statute.

Recommendation 5

Introduce a resolution requesting the Joint Commission to study for-profit and not-for-profit hospitals and their contribution to the health care community.

Recommendation 6

Introduce a resolution requesting the Joint Commission to continue studying the impact of third-party reimbursement practices on retail pharmacy services.

Recommendation 7

Introduce budget amendments to provide $141,000 in FY 94 and $422,000 in FY 95 to the University of Virginia Medical Center to support the Blue Ridge Poison Center. These funds are to be used to provide poison control services in the areas affected by the closing of the National Capital Poison Center.

Recommendation 8

Introduce a budget language amendment requesting the Department of Planning and Budget to study the delivery of poison control services in Virginia, and to recommend an appropriate mechanism for long-term financing of these services.

CHAPTER 5

ACADEMIC MEDICAL CENTERS

The Commonwealth is served by three academic medical centers (AMCs). The two State-owned AMCs are the University of Virginia Health Sciences Center (UVAHSC), and Virginia Commonwealth University's Medical College of Virginia and its hospitals (VCU/MCV). The third AMC, the Medical College of Hampton Roads and its affiliated teaching hospitals (MCHR), is not a state-owned institution. The Commonwealth provides funding support to these institutions for undergraduate education, graduate education, indigent care, and other special initiatives.

The AMCs are critical components in the State's efforts to reform the health care system. Their three-part mission of education, service, and research makes them important resources for virtually all of the State's major reform initiatives. They are the linchpins of the Commonwealth's efforts to educate and place more generalists. They are the State's major providers of indigent care, making them an important consideration in attempts to reform the Medicaid program and overall financing of indigent care. In addition, they are an important resource for basic and applied medical research, research on more effective ways to deliver health services, and research on state and national health policy.

House Joint Resolution (HJR) 623 from the 1993 Session requested the Joint Commission on Health Care, in cooperation with the Governor, to develop a long-term policy for the role of Virginia's academic medical centers (AMCs) in indigent care and medical education. HJR 623 has its roots in a 1993 Joint Legislative Audit and Review Commission (JLARC) report, *Funding of Indigent Hospital Care in Virginia*. The JLARC study, which was requested by the Joint Commission, raised concerns about the future of the AMCs in a rapidly changing health care environment. HJR 623 was passed in response to these concerns, with a final reporting date of fall 1994.

The resolution requested the AMCs to report to the Joint Commission on options for long-term policies regarding indigent care and medical education at these institutions, which they did in July of 1993. The three institutions presented six proposals for ensuring the long-term viability of Virginia's AMCs.

Exhibit 5.1

Academic Medical Center Proposals
Pursuant To House Joint Resolution 623

Proposal 1: Enable the AMCs to compete in the health care market by authorizing flexibility through creation of a non-profit authority or other governance structure for the teaching hospitals, and facilitating the development of regional care systems through protection from federal anti-trust exposure.

Proposal 2: Contract managed care for the Commonwealth's patients (i.e. indigent, Medicaid, and State employees) through the AMCs up to volumes needed to protect patient bases for the AMC educational mission.

Proposal 3: Develop a contingency plan to assure adequate funding of AMC indigent care costs.

Proposal 4: Develop a long-term plan to address medical education funding for the AMCs with particular attention to primary care, prevention, health maintenance, health care system management, and health policy.

Proposal 5: Authorize the AMCs collectively to manage the supply (i.e. numbers, kinds, and distribution) of health care professionals educated to meet the needs of the Commonwealth.

Proposal 6: Create a contingency pool of $60 to $100 million as a safety net for the AMCs to be used only as needed to protect the Commonwealth's investment in AMC patient care, education, and research capabilities.

The first proposal to be reviewed in depth by the Joint Commission is the request for increased administrative flexibility for the State teaching hospitals -- the University of Virginia Medical Center (UVAMC) and the Medical College of Virginia Hospitals (MCVH). This proposal was made out of concern that existing State regulations may limit the ability of the State teaching hospitals to compete in a market which is quickly moving toward managed care and provider networks. This is an important issue because if these institutions are unable to compete for paying patients, the need for State financial support will escalate. It is for this reason that the proposal was given serious consideration this year.

The Role Of The Academic Medical Centers In Indigent Care and Medical Education

Virginia's AMCs are major providers of indigent care and medical education, and they receive substantial State financial support for these activities. The AMCs serve indigent patients who are enrolled in the Virginia Medicaid program as well as many patients who are indigent, but do not qualify for Medicaid benefits. The most costly services are those provided through the AMC teaching hospitals. While the following analysis focuses on teaching hospital costs, it is important to recognize that AMC faculty physicians provide substantial amounts of care to Medicaid patients as well as patients with no ability to pay.

Indigent Care Services

The AMC teaching hospitals are among the Commonwealth's largest providers of Medicaid hospital care. In FY 1992, the MCVH accounted for more than 55,000 Medicaid inpatient days, or 12 percent of the statewide total. The UVAMC accounted for nearly 27,000 Medicaid inpatient days, or six percent of the statewide total. MCHR's major teaching affiliates (Children's Hospital of the King's Daughters, Depaul, and Sentara Norfolk) accounted for as much as 14 percent of the total.

The AMC teaching hospitals are also among the Commonwealth's largest providers of charity care for poor people who are not eligible for Medicaid. In FY 1992, these institutions accounted for 66 percent of total charity care costs in the Commonwealth. MCVH accounted for 35 percent, UVAMC accounted for 26 percent, and the MCHR-affiliated hospitals accounted for four percent of the total. While these figures reflect a high number of charity care visits, they also reflect the relatively high cost of care at major teaching hospitals.

Medical Education Programs

All of the AMC hospitals are important training sites for residents and other health professionals. UVAMC trains more than 1800 health professionals a year, including medical students, nursing students, residents, and allied health professionals. MCVH provides the clinical teaching environment for more than 3300 students and residents. The MCHR-affiliated teaching hospitals provide a clinical setting for more than 380 medical students and more than 330 medical residents in various specialties. The cost of these training programs are significant, as will be discussed shortly.

Exhibit 5.2

Indigent Hospital Care Services At Virginia's Academic Medical Centers (Fiscal Year 1992)

	MCHR Affiliates	UVAMC	MCVH
Medicaid Inpatient Days and Percent of Statewide Total	63,766 (14%)	26,711 (6%)	55,394 (12%)
Charity Care Costs and Percent of Statewide Total	$8.5 m (5%)	$45.1 m (26%)	$62 m (35%)

Source: Virginia Health Services Cost Review Council

Note: Charity care costs include the uncompensated costs of services delivered to patients with family incomes below the poverty level.

State Funding

The AMC teaching hospitals receive substantial State support for their indigent care and education activities. All of the AMC teaching hospitals participate in the Medicaid program and the State/Local Hospitalization program. The MCHR affiliates participate in the Indigent Health Care Trust Fund, which is a State/provider partnership designed to partially compensate hospitals which carry large charity care loads.

Exhibit 5.3

Indigent Hospital Care Funding
At Virginia's Academic Medical Centers
(Fiscal Year 1992 Except as Noted)

	MCHR Affiliates	UVAMC	MCVH
Medicaid	$58.4 m*	$47.2 m	$68.9 m
SLH Program	$2.3 m*	$1.0 m*	$0.6 m*
Indigent Health Care Trust Fund	$1.7 m*	--	--
General Fund Appropriation	--	$22.9 m	$29.2 m
Special Medicaid DSH Payments	--	$12.0 m	$23.2 m
Estimated Total	$62.4 m	$83.1 m	$121.9 m
Estimated State Share	$32.2 m	$53.4 m	$75.7 m

* Calendar Year 1992 Data

Source: Virginia Department of Medical Assistance Services, The Statistical Record of the Virginia Medicaid Program, September 1993; University of Virginia Medical Center data; Medical College of Virginia Hospitals data; Joint Legislative Audit and Review Commission, Funding of Indigent Hospital Care in Virginia, 1993.

UVAMC and MCVH do not participate in the Indigent Health Care Trust Fund because they receive special appropriations for their indigent care and educational activities. In addition, both institutions receive special Medicaid disproportionate share or "DSH" payments for non-Medicaid indigent care and medical education. The DSH mechanism has allowed

the Commonwealth to obtain federal matching funds for non-Medicaid indigent care and medical education, thereby reducing the amount of State general funds required. While the table shows special Medicaid DSH funds for FY 1992, it is important to note that the use of Medicaid DSH funds was expanded in FY 1993 and FY 1994 to obtain even more federal matching funds.

As shown in the table, in FY 1992 MCVH received an estimated $121.9 million in indigent care funding, of which about $75.7 million came from the State general fund. In this same year, UVAMC received a total of $83.1 million in indigent care funding, including about $53.4 million in State general funds. The MCHR-affiliated hospitals received indigent care payments totaling more than $62 million in calendar year 1992, including about $32.2 million in State general funds. (Not listed in the table is an additional general fund appropriation to MCHR of about $4 million to support non-Medicaid indigent care and medical education provided through its faculty practice plans.)

Funding for non-Medicaid indigent care and medical education is particularly important at MCVH and UVAMC. In FY 1992 MCVH received about $52.4 million from the general fund appropriation and the special Medicaid DSH payments. These dollars covered about 16 percent of total hospital expenses for the year. UVAMC received about $34.9 million from these funding sources, which covered about 10 percent of total hospital expenses for the year. The general fund and special Medicaid DSH payments have been critical to the ability of both teaching hospitals to maintain strong positive margins in recent years.

The Academic Medical Centers In A Changing Health Care Environment

Today's health care environment is characterized by rapid shifts in the delivery of services and the organization of providers. In an effort to control costs, more and more payers, including the Commonwealth of Virginia, are turning to managed care delivery systems. At the same time, providers are forming networks for the dual purposes of achieving economic efficiencies and developing administrative mechanisms for managing patient care. All indications are that this trend will continue until most Americans are covered under some type of managed care system.

It is widely recognized that major academic medical centers are not favorably positioned to compete in this environment. Major teaching

hospitals are expensive providers, in large part because of the added costs of their teaching mission. For instance, in FY 1991 UVAMC reported more than $84 million in medical education costs which accounted for more than 26 percent of total hospital expenses. For the same year, MCVH reported more than $60 million in medical education costs which accounted for about 19 percent of total hospital expenses.

The cost of the education mission is reflected in the average cost of State teaching hospital services relative to other hospitals in the Commonwealth which do not maintain such large teaching programs. In FY 1992 UVAMC and MCVH were ranked one and two, respectively, among Virginia acute care hospitals (other than specialty hospitals with unusually long lengths of stay) in terms of the average cost of a hospital admission. The problem of high costs is exacerbated by a large indigent care volume. In most hospitals, government rates for indigent care tend to be at or below the reported cost of care, while private insurers pay at or above cost. A high mix of private patients relative to government-sponsored and charity care patients allows a hospital to use private payments to "cross-subsidize" losses incurred on indigent patients. Hospitals with a relatively high mix of indigent patients, such as the State teaching hospitals, may have a greater need to cross-subsidize those patients through higher prices for private payers.

Regulatory constraints are an additional obstacle for the State teaching hospitals. In today's environment, a critical success factor is the ability to participate in a network for the purpose of attracting patients and assuring referrals. Currently, the faculty physicians at UVAMC and MCVH are able to enter into joint ventures with hospitals and other providers for the formation of a network. As State agencies, the State teaching hospitals have a limited ability to become formal partners in such joint ventures. They are also limited in their ability to share risk under a capitated payment arrangement.

The impact of this competitive challenge extends beyond the State teaching hospitals and into the State medical schools. Clinical income from the faculty practice plans and the hospitals support approximately 50 percent of the State medical school budgets. To the extent that hospital revenues are placed at risk due to an inability to compete, medical school funding may also be threatened.

The Need For Administrative Flexibility At The State Teaching Hospitals

The preceding discussion points out that the competitive environment for hospitals is clearly changing. In the near and long term, those hospitals which can attract paying patients into managed care programs will be highly competitive. Those hospitals which cannot participate in managed care networks will be challenged to survive. The ability to compete for paying patients, particularly private paying patients, is critical to the economic viability of the State teaching hospitals and the State medical schools.

This situation raises a difficult challenge for the Commonwealth. The challenge is to reconcile the need to control State expenditures for indigent care with the need to support the teaching mission of the academic medical centers. On the one hand, the Commonwealth could save money on its Medicaid program if it actively channeled Medicaid patients to more cost-efficient settings than the State teaching hospitals. On the other hand, to do so would jeopardize the financial viability of both the hospitals and the medical schools.

Administrative flexibility is proposed as one response to this dilemma. To the extent that the State teaching hospitals have the necessary flexibility to enter into joint ventures and share risk, they may be better positioned to compete for private patients as well as serve Medicaid patients in managed care programs. At the same time, it is important to recognize that administrative flexibility would only be a partial solution to the competitive challenge facing the State teaching hospitals. While administrative flexibility could allow the institutions to reduce their operating costs to some degree, it would not eliminate the impact of medical education and indigent care on the prices at these institutions. Medical education is a broader issue which will be reviewed by the Joint Commission in 1994.

Summary of Academic Medical Center Recommendations

Recommendation 1

Introduce legislation granting greater administrative flexibility for the two State teaching hospitals.

Recommendation 2

Continue to study during 1994 the financing of medical education and indigent care as it relates to the future of Virginia's academic medical centers.

Recommendation 3

Introduce a language amendment to exclude joint venture losses from indigent care cost reports used to determine State funding at the University of Virginia Medical Center and the Medical College of Virginia.

CHAPTER 6

LONG-TERM CARE SERVICES

Each year since its inception, the Joint Commission on Health Care has recommended actions to the Governor and the General Assembly to improve the long-term care system. While some of these actions have impacted the entire population accessing particular long-term care services in the Commonwealth, the Commission's work has focused primarily on the elderly population. It must be noted however, that the Commission is aware of the broad array of populations which are accessing or in need of long term care services, including but not limited to the physically and mentally disabled of all ages. Our emphasis on the elderly is not intended to be exclusionary, rather it is intended to be the foundation for broader reforms for other populations.

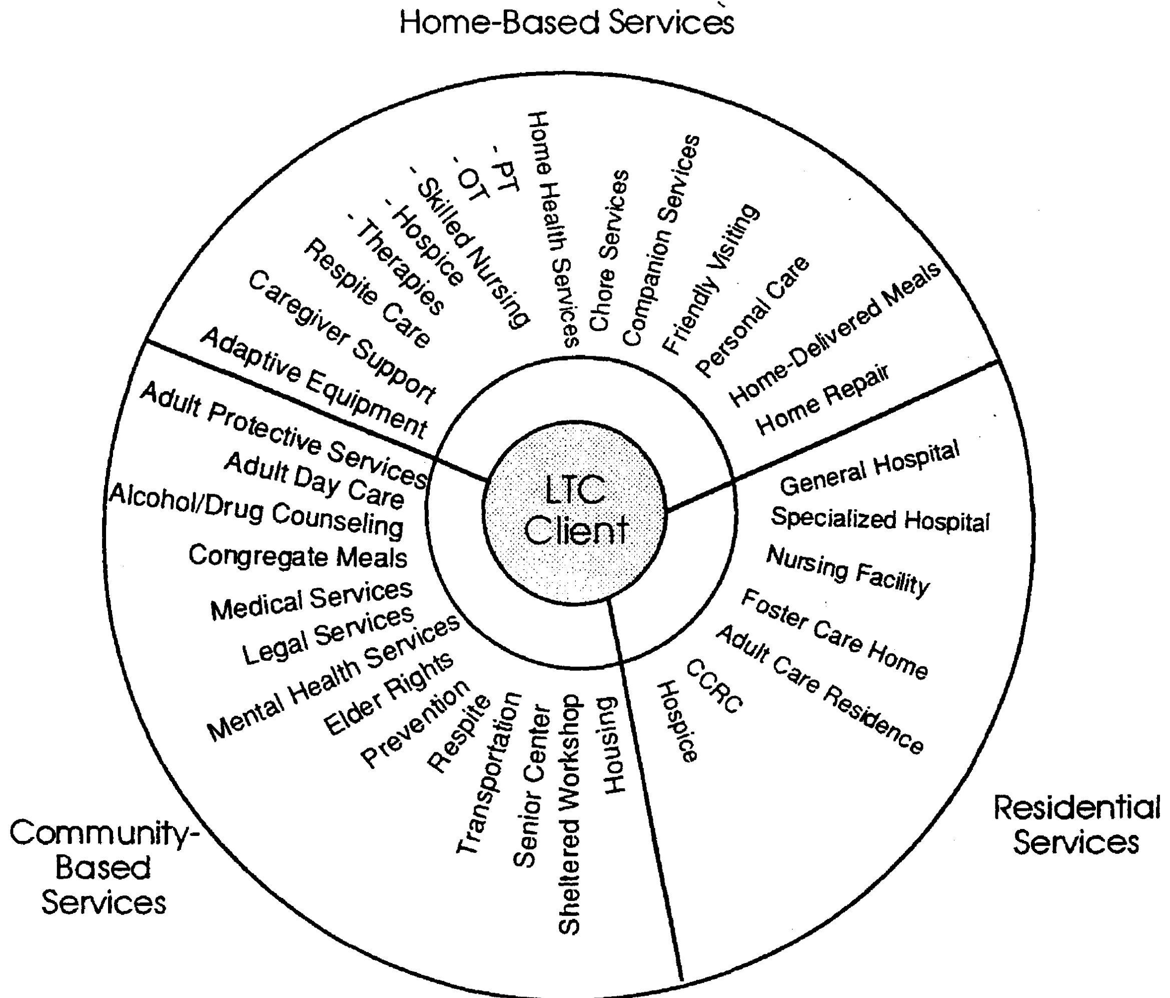
In 1989, the Commission determined that the long-term care system serving the elderly in Virginia was not well coordinated at the state level or the local level, and did not include the continuum of services available in many other states. The Commission was particularly concerned that elderly Virginians in need of long-term care services and their families often had to access a multitude of local agencies in a care plan without any coordination. Elderly persons or their families who did not know how to navigate through the system were left without any care, without adequate care or, in some cases, with a care plan that was not appropriate given the physical and cognitive needs of the elderly person. The figure on page 96 identifies the array of long-term care services.

The Virginia General Assembly has initiated a series of reforms in the long-term care system which were initiated by the Joint Commission on Health Care and its predecessors. In 1990, two staff persons were authorized for the Long-term Care Council, and $3 million was appropriated to establish 3 case management projects at the local level to coordinate long-term care services for the elderly.

The 1993 General Assembly, at the Commission's request, supported legislation to adopt the long-term care policy of the Commonwealth. This policy statement envisions a long-term care system which will provide

Exhibit 6.1

ARRAY OF LONG-TERM CARE SERVICES



maximum independence for older and disabled adults, will maximize community based care alternatives for publicly funded long-term care services, ensure a continuum of long-term care services for each locality, allow individual choice in the selection and provision of long-term care services, and support families and other informal care givers.

This policy served as the predominant philosophy and basis for the variety of actions supported by the Joint Commission on Health Care over this past year. The remainder of this chapter gives a description of the long-term care initiatives developed over the past two years.

Consolidation Of Long-Term Care And Aging Services

In 1989, the Joint Subcommittee on Health Care for All Virginians completed a study of the Commonwealth's long-term care delivery system. The Subcommittee identified a fragmented system and indicated a need for state leadership and the development of home and community-based services. The Subcommittee subsequently sought and obtained funding to provide staff support to the Long-Term Care Council and to begin implementation of a statewide case management system for elderly Virginians.

In October, 1992, the Secretary of Health and Human Resources presented to the Joint Commission a report on the delivery of long-term care services in the Commonwealth and presented a "vision" for long-term care. The report identified state agency consolidation as a means to improve the long-term care system in the Commonwealth. The Secretary's report followed an extensive review of other states' efforts and an evaluation of the activities in Virginia. It was noted that the elderly often have problems obtaining necessary health and social services because of fragmented responsibilities among state and local agencies, each with varying responsibilities, application procedures and policies. This fragmentation creates difficulties in coordinating the timing, availability and appropriateness of services for the elderly. In addition, the cost of long-term care services is expected to continue to escalate as the number of elderly citizens increases rapidly through the first half of the 21st century.

During the 1993 General Assembly Session, the Joint Commission on Health Care sponsored HJR 603 requesting the Secretary of Health and Human Resources to develop a plan to restructure and consolidate all aging and long-term care programs. To ensure that the plan had the input and guidance of major stakeholders, the Secretary appointed the Long-Term Care and Aging Task Force. The Task Force was composed of individuals and organizations with an interest in aging and long-term care services. The recommendations which follow reflect the deliberations of the Task Force and its three subcommittees. The Task Force also gave consideration to comments received at its public forums for input before the deliberations began, and at public hearings on the draft plan.

The recommendations set forth a plan to consolidate long-term care and aging functions from four state agencies into a restructured agency which

would be responsible for the planning, administration, management, development, regulation and funding of long-term care and aging services. These functions are currently carried out across four agencies. The consolidation would offer the opportunity to provide for the efficient and effective development and management of a system of long-term care and aging services. Such a system would offer the Commonwealth the opportunity to plan and respond to current and future needs of the citizens of the Commonwealth.

The Task Force also discussed local level systems development and recommended the creation of an advisory group to assist in the further development of local level systems. Such an advisory group would be made up of representatives of local government, providers of services, and consumers. Included in the Task Force report are issues to be considered in the development of local level long-term care systems and in the implementation of the state level consolidation.

In October, 1993, the Secretary of Health and Human Resources, in his report on long-term care to the Joint Commission indicated his endorsement of the recommendations of the Long-Term Care and Aging Task Force. The recommendations are as follows:

1. **A consolidated and restructured state-level long-term care and aging agency should be established and operational by January 1, 1995.**

Long-term care and aging related programs, services and functions of the following agencies should be consolidated:

- ❒ Department for the Aging - all programs, services and functions including the Long-Term Care Ombudsman Program, in-home and community-based services, elder rights and transportation.
- ❒ Department of Medical Assistance Services - nursing home and home health provider rate setting, audit, and cost settlement; long-term care information management support; quality care assurance including the administration of home and community-based services, nursing home patient class validations and utilization review and long-term care service pre-authorization and nursing home pre-admission screening.
- ❒ Department of Social Services - adult services and adult protective services, Auxiliary Grant payments, central and regional office administration of the adults services, Medicaid

and Auxiliary Grant programs and licensing of homes for adults and adult day care providers.

- Department of Health - licensing and certification of nursing homes and home health providers and nursing home pre-admission screening.

2. **The consolidated agency should be served by a policy board comprised of citizens, consumers, providers and other persons with expertise or interest in long-term care and aging services.**

3. **The long-term care system should serve individuals of all ages needing long-term care services.**

Younger persons receiving long-term care services in nursing homes, homes for adults and through Medicaid-funded home and community-based services for the elderly and disabled have been included in the Task Force's deliberations. Programs at the Department of Medical Assistance Services which serve younger disabled persons and programs at the Department of Social Services which serve disabled and elderly adults are included in the recommended consolidation. The Task Force recognized that the long-term care needs of all populations were beyond its charge and urged future consideration of the long-term care needs of all Virginians.

4. **The client Uniform Assessment Instrument (UAI) should be used and a "short form" of the UAI should be developed for use when appropriate.**

5. **The state entity should establish a local implementation planning group in July 1994 to begin to consider the issues related to local service delivery. The local long-term care and aging services delivery system should be established and operational as soon as possible and no later than January 1, 1998.**

The Task Force recognized the need to acknowledge the diversity across Virginia in delivering long-term care and aging services. There was consensus that local flexibility in administration and delivery of services was required at the local level but that guidance about expectations for statewide service delivery needed to be given. The Task Force agreed on principles for local level responsibilities and a list of such responsibilities. The Task Force also identified issues for consideration as the local level delivery system is further developed. The Task Force indicated that

additional time was needed to allow for full discussion of issues and to offer detailed recommendations for improving the local delivery system.

Statewide Case Management System

Upon recognition of Virginia's expanding elderly population and the need to improve access to and the coordination of long-term services, the Joint Subcommittee on Health Care for All Virginians recommended the implementation of a statewide case management system for elderly Virginians. The Case Management for Elderly Virginians Pilot Project was subsequently funded, beginning July 1, 1991 with $1.7 million in general funds, of which $500,000 was to be used to secure matching federal funds for the Medicaid Program. Funding was continued through the 1993-94 biennium.

Virginia's Long-Term Care Council was given the responsibility of overseeing the development of the Project, including the development of policies and guidelines. Three pilot sites are involved:

- Fairfax County (an urban local department of social services model);
- Southwest Virginia (a rural area agency on aging model serving Planning Districts 1 - 4); and
- Southeast Virginia (an urban and rural area agency on aging model serving Planning Districts 17, 18, 20 - 22).

The goals of the Case Management for Elderly Virginians Pilot Project are to:

- target limited resources to those elderly at highest risk of institutionalization, regardless of income;
- coordinate the delivery of multiple services;
- facilitate client access to services;
- support family caregiving;
- provide cost-effective services; and
- field test a uniform assessment instrument.

Through the Project, one person or organization assumes the responsibility for locating, coordinating and monitoring services. Specific responsibilities include: case finding and screening; in-person comprehensive assessment of client needs and resources; development of care plans to meet identified needs; implementation of the care plans; monitoring services that clients receive for quality and appropriateness, and periodic reassessment of client needs. A comprehensive data base is maintained on all clients served through the Project.

A significant number of elderly Virginians and their families have benefited from the Project. Since July 1991, more than 16,000 individuals have been screened; 5,000 individuals have received a comprehensive, multidimensional assessment and 4,200 individuals have been provided case management. Thirty-four percent of all clients enrolled were Medicaid eligible.

An evaluation of the Project was completed by the Center for Gerontology at Virginia Polytechnic Institute and State University (VPI&SU). In their September 1993 report, Evaluation of the Case Management for Elderly Virginians Pilot Project: Final Report - Year Two, they reported the following:

- Although most of the case management clients are not at the same level of impairment as recent Medicaid nursing home admissions in Virginia, they do appear to be at risk of admission to a nursing home if their needs are not met.
- Service coordination has improved as a result of the Project.
- The Project has served to facilitate client access to services.
- The Project is providing an appropriate level of support for family caregiving.
- The Project has offered strong evidence that case management can be cost-effective, provided there are careful restraints on the cost of both case management and the client services package.
- The Project has provided the context for developing an effective client Uniform Assessment Instrument (UAI) for the assessment of the need for long-term care services in the Commonwealth.

During the 1993 General Assembly Session, HJR 601, proposed by the Joint Commission, requested the Secretary of Health and Humans Resources to develop and implement a statewide comprehensive case management system which would be available to serve all elderly citizens; have authority to approve eligibility for all publicly financed long-term care services; be supervised and managed at the state level but administered at the local level; and be funded through a combination of funding sources including federal, state and local funds and consumer fees (based on ability to pay). Two specific tasks outlined in the resolution are: (i) requirement that all public health and human resources agencies use a UAI, common definitions and common criteria for all long-term care programs by July 1, 1994; and (ii) that a statewide client level data base for

all publicly funded long-term care services be developed and implemented by July 1, 1995. Through the Case Management Project, significant progress has been made on the development and implementation of a UAI and client level data base.

With the support of the Long-Term Care Council a preliminary work plan has been developed to implement the use of the UAI for all publicly-funded long-term care and aging services. It is anticipated that the UAI will be adopted by the public human services agencies by October, 1994. The client level data base is expected to be in place by October, 1995.

Tiered Licensing And Case Management In Homes For Adults/Adult Care Residences

In 1992, the Joint Legislative Audit and Review Commission (JLARC) report, Follow-up Review of Homes for Adults, included recommendations in response to their findings that the current statutory and regulatory systems were not providing sufficient safeguards for the diverse physically and mentally impaired populations served by the homes. Changes recommended by JLARC included a modification of the regulatory system to address levels of care and the problems affecting state funding including cost reporting and the rate setting process, and linking of the Auxiliary Grant to regulations.

Following the JLARC report, the Homes for Adults Task Force was convened to examine options for implementing the JLARC recommendations. In 1992, the Home for Adults Task Force proposed the implementation of tiered licensure in homes for adults. During the 1993 Session of the General Assembly, through HB 2280/SB 1064, the Joint Commission on Health Care sponsored legislation to establish the framework for:

- two-tiered licensing (residential living and assisted living);
- case management and uniform assessment of the residents;
- restructuring of Auxiliary Grant payments; and
- intensity of service needs survey of the residents.

HB 2280/SB 1064 became effective July 1, 1993 with the expectation that regulations would be in place for implementation on June 1, 1994. Funding was also provided to allow for implementation of the restructured Auxiliary Grant payment (which includes an increase in the reimbursement rates to the facilities) and the provision of case management for publicly funded residents of the homes.

Subsequent to the passage of HB 2280/SB 1064, the Levels of Care Task Force was convened by the Secretary of Health and Human Resources. The group, comprised of providers, resident advocates and regulators, began drafting regulations in May 1993. As stated by the Task Force, "the purpose of these regulations is to set minimum and reasonable standards for licensure." The regulations include a requirement that applicants to the homes be assessed to determine their need for residential or assisted living. The regulations also list the services covered by the Auxiliary Grant payment and address how the rate is established. The regulations mandate the use of a client UAI and delineate the criteria for placement in residential and assisted living facilities. The proposed regulations were approved for public comment in November, 1993 by the State Board of Social Services.

In response to HB 2280/SB 1064, a survey of the intensity of service needs in Virginia's adult care residents was also conducted. Under the direction of the Long-Term Care Council, a survey of 1,970 residents in 225 homes was completed. The Center for Gerontology at VPI&SU designed the methodology and analyzed the data. The resident assessments were completed by experienced, trained local and state human service agency staff using a modified version of the UAI from the Case Management for Elderly Virginians Pilot Project.

The survey results provide a description of the residents in the homes statewide. The data also provided the information needed to develop the levels of care criteria. The following are some of the findings:

- the adult care residence (ACR) population is distinct from the nursing home population; only 8% of the ACR population meets the home criteria;
- 68% of all residents were found to have dependencies in fewer than two activities of daily living; and
- of the 32% of the residents with two or more limitations in activities of daily living, 18% were at a level of intensity that would qualify them for federal Medicaid coverage under a modified community-based waiver program.

Long-Term Care Insurance

Recognizing the increasing elderly population potentially in need of long-term care services and the anticipated tremendous increase in costs of such services, especially for the Medicaid Program, several states have been exploring ways to encourage individuals to purchase long-term care insurance. People faced with paying for years of care themselves often

transfer their assets to others to qualify for Medicaid. States have therefore been developing programs to encourage the purchase of private long-term care insurance while also offering the policyholder Medicaid coverage after the private coverage expires. This allows individuals to avoid impoverishment in the event that they need extended long-term care and also saves the state money because private insurers, not Medicaid, pay the costs of care, at least initially.

Through the Robert Wood Johnson Foundation's Program to Promote Long-Term Care Insurance for the Elderly, the Foundation gave grants to eight states to investigate the potential role of a public-private insurance partnership in long-term care financing. These demonstration projects are only possible with the approval of the U. S. Department of Health and Human Services. Recent Congressional legislation limits the attractiveness of these types of partnerships. The legislation requires states to recover, or attempt to recover, the costs of long-term care services from the estate of an individual whose assets were protected (disregarded) for Medicaid eligibility determination in connection with long-term care insurance. This removes the major incentive the partnerships were building on, which is the desire to retain assets to pass on to heirs.

Due to changes in the regulatory environment which have resulted in the development of improved products, and the insurance industry's recognition of the potential market for long-term care insurance, viable policies are more available. Approximately 40 companies are authorized to sell policies in the Commonwealth.

Through the Health Care Financing Administration, funds have been made available to the states for the operation of consumer insurance counseling programs. In Virginia, the Virginia Insurance Counseling and Advocacy Project (VICAP), began operations in 1993. The Project is administered by the Virginia Department for the Aging through the area agencies on aging and in cooperation with the State Corporation Commission's Bureau of Insurance. Through VICAP, trained volunteers provide information and counseling to individuals regarding Medicare coverage, public benefits and Medigap and long-term care insurance. Through the Project, many individuals have sought information on the purchase of long-term care insurance.

Through the experiences of such agencies as the Department for the Aging, we have learned that often times many individuals believe that long-term care services, nursing home as well as home-based care, will be available to them through Medicare. As a result, agencies like the Department for

the Aging have increased their efforts to educate the public about the financing of long-term care services. Information on long-term care insurance is often provided.

President Clinton's health care reform proposal includes provisions to establish federal regulations for private long-term care insurance. Policies could not discriminate against someone with Alzheimer's Disease or other dementials, or anyone with mental illness, mental retardation or HIV infections or AIDS.

Streamlining Regulations For Nursing Homes

The Joint Commission on Health Care also reviewed the recommendations of Delegate Joan Munford regarding the paperwork and regulatory burdens on nursing home providers. Secretary of Health and Human Resources, Howard M. Cullum, requested the relevant agencies to review Delegate Munford's recommendations. The following are highlights of their reports:

- Although the majority of the inspections of nursing homes are conducted by state agency personnel, the requirement for most inspections lies within federal statute or regulations. In Virginia, the Department of Health has been designated the State Survey Agency. It is responsible for conducting the certification surveys for both Medicare and Medicaid participation and for state licensure. The annual recertification process consists of two components: the health care survey (conducted by the Department of Health) and the Life Safety Code survey (conducted under contract by the State Fire Marshal). Coordination of these two inspections is impeded by federal law which imposes a $2,000 fine per incident where an advance notice of an impending inspection occurs. This provision also impedes coordination with other federally required inspections.

- Most forms required to be completed by nursing home providers are dictated by federal regulations. Any provider participating in the Medicare/Medicaid programs must maintain and submit certain data elements.

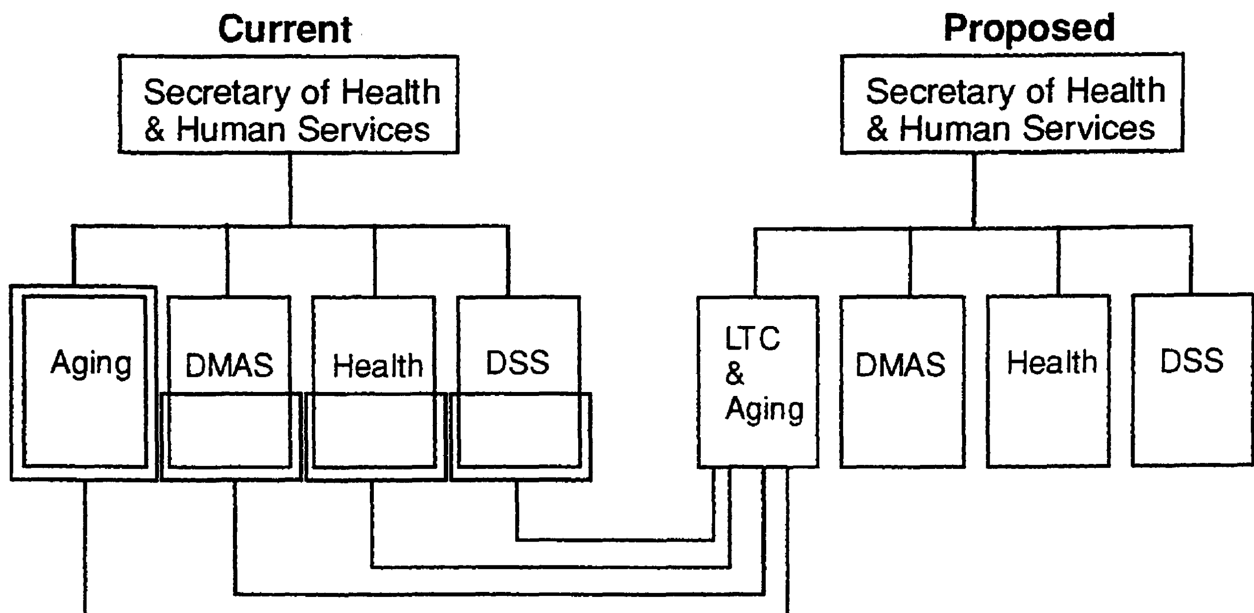
- Pursuant to new methodology, the work involved for nursing home providers to provide information requested by the Health Services Cost Review Council has been reduced. The

requirement that nursing homes produce audited financial statements is a requirement for participation in the Medicaid program.

- The Department of Health is currently working with the Richmond Aids Ministry to address the request for more flexibility in providing care for persons with AIDS.

There are several options for streamlining the current regulatory and paperwork requirements on the nursing home industry. The best opportunity for achieving such streamlining exists with the establishment of the consolidated state long-term care agency. Other options include the implementation of the use of the Uniform Assessment Instrument for all long-term care services in the Commonwealth.

Exhibit 6.2



Summary of Long-Term Care Recommendations

Recommendation 1

Introduce legislation to establish the consolidated state long-term care and aging agency effective July 1, 1995. However, only services currently provided by the Department for Aging and the Department of Medical Assistance Services combined with a centralized licensing agency shall be consolidated in the first phase.

Recommendation 2

Introduce legislation to continue the Long-Term Care Council. The responsibilities of the Council should be incorporated in the consolidated agency when it is established.

Recommendation 3

Introduce a resolution requesting that the Secretary of Health and Human Resources develop a plan to incorporate certain long-term care and aging services within a consolidated state agency, and establish a task force to consider issues relating to the delivery of long-term care and aging services in communities and to develop a plan for the delivery of such services.

Recommendation 4

Support the funding recommendation included in the budget as introduced to implement the 1993 legislation which established a two-tiered licensing system in adult care residences and which includes targeted case management of auxiliary grant residents funded through Medicaid.

Recommendation 5

Introduce legislation to continue the moratorium on Certificates of Public Need for nursing home beds from July 1995 until July 1996.

Recommendation 6

Introduce a resolution to explore the benefits and costs of tax incentives to encourage the purchase of long-term care insurance.

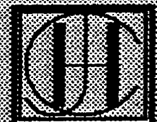
Recommendation 7

Request the Secretary of Health and Human Resources to review the regulatory and paperwork requirements for long-term care providers to consider whether or not they can be reduced without lessening the quality of care provided.

Recommendation 8

Introduce legislation to delete the reference to "mobility" from the definitions of "assisted" and "residential" living levels of care.

APPENDICES



APPENDIX A:

1994 Legislation
(As Approved)

VIRGINIA ACTS OF ASSEMBLY -- 1994 SESSION

CHAPTER 107

An Act to amend and reenact § 63.1-172 of the Code of Virginia, relating to adult care residences.

[S 263]

Approved March 28, 1994

Be it enacted by the General Assembly of Virginia:
1. That § 63.1-172 of the Code of Virginia is amended and reenacted as follows:
§ 63.1-172. Definitions.
As used in this article, unless the context requires a different meaning:
"Adult care residence" means any place, establishment, or institution, public or private, operated or maintained for the maintenance or care of four or more adults who are aged, infirm or disabled and who are cared for in a primarily residential setting, except (i) a facility or portion of a facility licensed by the State Board of Health or the Department of Mental Health, Mental Retardation and Substance Abuse Services, but including any portion of such facility not so licensed, and (ii) the home or residence of an individual who cares for or maintains only persons related to him by blood or marriage, and (iii) a facility or portion of a facility serving infirm or disabled persons between the ages of eighteen and twenty-one, or twenty-two if enrolled in an educational program for the handicapped pursuant to § 22.1-214, when such facility is licensed by the Virginia Department of Social Services as a child-caring institution under Chapter 10 (§ 63.1-195 et seq.) of this title, but including any portion of the facility not so licensed. Included in this definition are any two or more places, establishments or institutions owned or operated by a single entity and providing maintenance or care to a combined total of four or more aged, infirm or disabled adults.
"Assisted living" means a level of service provided by an adult care residence for adults who may have physical or mental impairments~~,~~ ~~may be independently mobile, semimobile or nonambulatory~~ and require at least a moderate level of assistance with activities of daily living.
"Independently mobile" means a resident of an adult care residence who is physically and mentally able to exit the residence without assistance in an emergency and who can ascend or descend stairs if present in any necessary exit path.
"Maintenance or care" means the protection, general supervision and oversight of the physical and mental well-being of the aged, infirm or disabled individual.
"Nonambulatory" means a resident of an adult care residence who by reason of physical or mental impairment is unable to exit the residence in an emergency without the assistance of another person.
"Residential living" means a level of service provided by an adult care residence for adults who may have physical or mental impairments ~~but~~ *and* require only minimal assistance with the activities of daily living ~~and are independently mobile~~. This definition includes independent living facilities that voluntarily become licensed.
"Semimobile" means a resident of an adult care residence who because of physical or mental impairment requires limited assistance, such as the assistance of a wheelchair, walker, cane, prosthetic device, or a single verbal command, to exit the residence in an emergency.

VIRGINIA ACTS OF ASSEMBLY -- 1994 SESSION

CHAPTER 111

An Act to amend the Code of Virginia by adding in Article 6 of Chapter 4 of Title 32.1 section numbered 32.1-122.6:1, relating to the Physician Loan Repayment Program.

[S 409]

Approved March 28, 1994

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Article 6 of Chapter 4 of Title 32.1 a section numbered 32.1-122.6:1 as follows:

§ 32.1-122.6:1. Physician Loan Repayment Program.

With such funds as are appropriated for this purpose, the Board of Health shall establish a physician loan repayment program for graduates of accredited medical schools who have a specialty in the primary care areas of family practice medicine, general internal medicine, pediatrics, and obstetrics/gynecology, and who meet other criteria as determined by the Board. The Commissioner shall act as the fiscal agent for the Board in administration of these funds. Prior to awarding any funds, the Board shall require the recipient to agree to perform a period of medical service in this Commonwealth in a medically underserved area as defined in § 32.1-122.5.

The Board shall promulgate regulations for the implementation of the Physician Loan Repayment Program. Applications for participation in the program will be accepted from a graduate of any accredited medical school, but preference will be given to graduates of medical schools located in the Commonwealth.

REENROLLED

CHAPTER 853

An Act to amend and reenact § 2.1-342 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 54.1-2506.1, relating to submission of information by certain health care professionals.

[S 459]

Approved April 20, 1994

Be it enacted by the General Assembly of Virginia:
1. That § 2.1-342 of the Code of Virginia is amended and reenacted and that the Code of Virginia is amended by adding a section numbered 54.1-2506.1 as follows:

§ 2.1-342. Official records to be open to inspection; procedure for requesting records and responding to request; charges; exceptions to application of chapter.

A. Except as otherwise specifically provided by law, all official records shall be open to inspection and copying by any citizens of this Commonwealth during the regular office hours of the custodian of such records. Access to such records shall not be denied to citizens of this Commonwealth, representatives of newspapers and magazines with circulation in this Commonwealth, and representatives of radio and television stations broadcasting in or into this Commonwealth. The custodian of such records shall take all necessary precautions for their preservation and safekeeping. Any public body covered under the provisions of this chapter shall make an initial response to citizens requesting records open to inspection within five work days after the receipt of the request by the public body which is the custodian of the requested records. Such citizen request shall designate the requested records with reasonable specificity. A specific reference to this chapter by the requesting citizen in his request shall not be necessary to invoke the provisions of this chapter and the time limits for response by the public body. The response by the public body within such five work days shall be one of the following responses:

1. The requested records shall be provided to the requesting citizen.

2. If the public body determines that an exemption applies to all of the requested records, it may refuse to release such records and provide to the requesting citizen a written explanation as to why the records are not available with the explanation making specific reference to the applicable Code sections which make the requested records exempt.

3. If the public body determines that an exemption applies to a portion of the requested records, it may delete or excise that portion of the records to which an exemption applies, disclose the remainder of the requested records and provide to the requesting citizen a written explanation as to why these portions of the record are not available to the requesting citizen with the explanation making specific reference to the applicable Code sections which make that portion of the requested records exempt. Any reasonably segregatable portion of an official record shall be provided to any person requesting the record after the deletion of the exempt portion.

4. If the public body determines that it is practically impossible to provide the requested records or to determine whether they are available within the five-work-day period, the public body shall so inform the requesting citizen and shall have an additional seven work days in which to provide one of the three preceding responses.

Nothing in this section shall prohibit any public body from petitioning the appropriate court for additional time to respond to a request for records when the request is for an extraordinary volume of records and a response by the public body within the time required by this chapter will prevent the public body from meeting its operational responsibilities. Before proceeding with this petition, however, the public body shall make reasonable efforts to reach an agreement with the requester concerning the production of the records requested.

The public body may make reasonable charges for the copying, search time and computer time expended in the supplying of such records; however, such charges shall not exceed the actual cost to the public body in supplying such records, except that the public body may charge, on a pro rata per acre basis, for the cost of creating topographical maps developed by the public body, for such maps or portions thereof, which encompass a contiguous area greater than fifty acres. Such charges for the supplying of requested records shall be estimated in advance at the request of the citizen. The public body may require the advance payment of charges which are subject to advance determination.

In any case where a public body determines in advance that search and copying charges for producing the requested documents are likely to exceed $200, the public body may, before continuing to process the request, require the citizen requesting the information to agree to payment of an amount not to exceed the advance determination by five percent. The period within which the public body must respond under this section shall be tolled for the amount of time that elapses between notice of the advance determination and the response of the citizen requesting the information.

Official records maintained by a public body on a computer or other electronic data processing system which are available to the public under the provisions of this chapter shall be made reasonably accessible to the public at reasonable cost.

Public bodies shall not be required to create or prepare a particular requested record if it does not already exist. Public bodies may, but shall not be required to, abstract or summarize information from official records or convert an official record available in one form into another form at the request of the citizen. The public body shall make reasonable efforts to reach an agreement with the requester concerning the production of the records requested.

Failure to make any response to a request for records shall be a violation of this chapter and deemed a denial of the request.

B. The following records are excluded from the provisions of this chapter but may be disclosed by the custodian in his discretion, except where such disclosure is prohibited by law:

1. Memoranda, correspondence, evidence and complaints related to criminal investigations; reports submitted to the state and local police, to investigators authorized pursuant to § 53.1-16 and to the campus police departments of public institutions of higher education as established by Chapter 17 (§ 23-232 et seq.) of Title 23 in confidence; portions of records of local government crime commissions that would identify individuals providing information about crimes or criminal activities under a promise of anonymity; records of local police departments relating to neighborhood watch programs that include the names, addresses, and operating schedules of individual participants in the program that are provided to such departments under a promise of confidentiality; and all records of persons imprisoned in penal institutions in this Commonwealth provided such records relate to the imprisonment. Information in the custody of law-enforcement officials relative to the identity of any individual other than a juvenile who is arrested and charged, and the status of the charge or arrest, shall not be excluded from the provisions of this chapter.

Criminal incident information relating to felony offenses shall not be excluded from the provisions of this chapter; however, where the release of criminal incident information is likely to jeopardize an ongoing criminal investigation or the safety of an individual, cause a suspect to flee or evade detection, or result in the destruction of evidence, such information may be withheld until the above-referenced damage is no longer likely to occur from release of the information.

2. Confidential records of all investigations of applications for licenses and all licensees made by or submitted to the Alcoholic Beverage Control Board or the State Lottery Department.

3. State income, business, and estate tax returns, personal property tax returns, scholastic records and personnel records containing information concerning identifiable individuals, except that such access shall not be denied to the person who is the subject thereof, and medical and mental records, except that such records can be personally reviewed by the subject person or a physician of the subject person's choice; however, the subject person's mental records may not be personally reviewed by such person when the subject person's treating physician has made a part of such person's records a written statement that in his opinion a review of such records by the subject person would be injurious to the subject person's physical or mental health or well-being.

Where the person who is the subject of medical records is confined in a state or local correctional facility, the administrator or chief medical officer of such facility may assert such confined person's right of access to the medical records if the administrator or chief medical officer has reasonable cause to believe that such confined person has an infectious disease or other medical condition from which other persons so confined need to be protected. Medical records shall be reviewed only and shall not be copied by such administrator or chief medical officer. The information in the medical records of a person so confined shall continue to be confidential and shall not be disclosed to any person except the subject by the administrator or chief medical officer of the facility or except as provided by law.

For the purposes of this chapter such statistical summaries of incidents and statistical

data concerning patient abuse as may be compiled by the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services shall be open to inspection and releasable as provided in subsection A of this section. No such summaries or data shall include any patient-identifying information. Where the person who is the subject of scholastic or medical and mental records is under the age of eighteen, his right of access may be asserted only by his guardian or his parent, including a noncustodial parent, unless such parent's parental rights have been terminated or a court of competent jurisdiction has restricted or denied such access. In instances where the person who is the subject thereof is an emancipated minor or a student in a state-supported institution of higher education, such right of access may be asserted by the subject person.

4. Memoranda, working papers and correspondence held or requested by members of the General Assembly or by the office of the Governor or Lieutenant Governor, Attorney General or the mayor or other chief executive officer of any political subdivision of the Commonwealth or the president or other chief executive officer of any state-supported institution of higher education. This exclusion shall not apply to memoranda, studies or other papers held or requested by the mayor or other chief executive officer of any political subdivision which are specifically concerned with the evaluation of performance of the duties and functions of any locally elected official and were prepared after June 30, 1992.

5. Written opinions of the city, county and town attorneys of the cities, counties and towns in the Commonwealth and any other writing protected by the attorney-client privilege.

6. Memoranda, working papers and records compiled specifically for use in litigation or as a part of an active administrative investigation concerning a matter which is properly the subject of an executive or closed meeting under § 2.1-344 and material furnished in confidence with respect thereto.

7. Confidential letters and statements of recommendation placed in the records of educational agencies or institutions respecting (i) admission to any educational agency or institution, (ii) an application for employment, or (iii) receipt of an honor or honorary recognition.

8. Library records which can be used to identify both (i) any library patron who has borrowed material from a library and (ii) the material such patron borrowed.

9. Any test or examination used, administered or prepared by any public body for purposes of evaluation of (i) any student or any student's performance, (ii) any employee or employment seeker's qualifications or aptitude for employment, retention, or promotion, or (iii) qualifications for any license or certificate issued by any public body.

As used in this subdivision 9, "test or examination" shall include (i) any scoring key for any such test or examination, and (ii) any other document which would jeopardize the security of such test or examination. Nothing contained in this subdivision 9 shall prohibit the release of test scores or results as provided by law, or limit access to individual records as is provided by law. However, the subject of such employment tests shall be entitled to review and inspect all documents relative to his performance on such employment tests.

When, in the reasonable opinion of such public body, any such test or examination no longer has any potential for future use, and the security of future tests or examinations will not be jeopardized, such test or examination shall be made available to the public. However, minimum competency tests administered to public school children shall be made available to the public contemporaneously with statewide release of the scores of those taking such tests, but in no event shall such tests be made available to the public later than six months after the administration of such tests.

10. Applications for admission to examinations or for licensure and scoring records maintained by the Department of Health Professions or any board in that department on individual licensees or applicants. However, such material may be made available during normal working hours for copying, at the requester's expense, by the individual who is the subject thereof, in the offices of the Department of Health Professions or in the offices of any health regulatory board, whichever may possess the material.

11. Records of active investigations being conducted by the Department of Health Professions or by any health regulatory board in the Commonwealth.

12. Memoranda, legal opinions, working papers and records recorded in or compiled exclusively for executive or closed meetings lawfully held pursuant to § 2.1-344.

13. Reports, documentary evidence and other information as specified in §§ 2.1-373.2 and 63.1-55.4.

14. Proprietary information gathered by or for the Virginia Port Authority as provided

in § 62.1-132.4 or § 62.1-134.1.

15. Contract cost estimates prepared for the confidential use of the Department of Transportation in awarding contracts for construction or the purchase of goods or services and records, documents and automated systems prepared for the Department's Bid Analysis and Monitoring Program.

16. Vendor proprietary information software which may be in the official records of a public body. For the purpose of this section, "vendor proprietary software" means computer programs acquired from a vendor for purposes of processing data for agencies or political subdivisions of this Commonwealth.

17. Data, records or information of a proprietary nature produced or collected by or for faculty or staff of state institutions of higher learning, other than the institutions' financial or administrative records, in the conduct of or as a result of study or research on medical, scientific, technical or scholarly issues, whether sponsored by the institution alone or in conjunction with a governmental body or a private concern, where such data, records or information has not been publicly released, published, copyrighted or patented.

18. Financial statements not publicly available filed with applications for industrial development financings.

19. Lists of registered owners of bonds issued by a political subdivision of the Commonwealth, whether the lists are maintained by the political subdivision itself or by a single fiduciary designated by the political subdivision.

20. Confidential proprietary records, voluntarily provided by private business pursuant to a promise of confidentiality from the Department of Economic Development, used by that Department for business, trade and tourism development.

21. Information which was filed as confidential under the Toxic Substances Information Act (§ 32.1-239 et seq.), as such Act existed prior to July 1, 1992.

22. Documents as specified in § 58.1-3.

23. Confidential records, including victim identity, provided to or obtained by staff in a rape crisis center or a program for battered spouses.

24. Computer software developed by or for a state agency, state-supported institution of higher education or political subdivision of the Commonwealth.

25. Investigator notes, and other correspondence and information, furnished in confidence with respect to an active investigation of individual employment discrimination complaints made to the Department of Personnel and Training; however, nothing in this section shall prohibit the disclosure of information taken from inactive reports in a form which does not reveal the identity of charging parties, persons supplying the information or other individuals involved in the investigation.

26. Fisheries data which would permit identification of any person or vessel, except when required by court order as specified in § 28.2-204.

27. Records of active investigations being conducted by the Department of Medical Assistance Services pursuant to Chapter 10 (§ 32.1-323 et seq.) of Title 32.1.

28. Documents and writings furnished by a member of the General Assembly to a meeting of a standing committee, special committee or subcommittee of his house established solely for the purpose of reviewing members' annual disclosure statements and supporting materials filed under § 2.1-639.40 or of formulating advisory opinions to members on standards of conduct, or both.

29. Customer account information of a public utility affiliated with a political subdivision of the Commonwealth, including the customer's name and service address, but excluding the amount of utility service provided and the amount of money paid for such utility service.

30. Investigative notes and other correspondence and information furnished in confidence with respect to an investigation or conciliation process involving an alleged unlawful discriminatory practice under the Virginia Human Rights Act (§ 2.1-714 et seq.); however, nothing in this section shall prohibit the distribution of information taken from inactive reports in a form which does not reveal the identity of the parties involved or other persons supplying information.

31. Investigative notes; proprietary information not published, copyrighted or patented; information obtained from employee personnel records; personally identifiable information regarding residents, clients or other recipients of services; and other correspondence and information furnished in confidence to the Department of Social Services in connection with an active investigation of an applicant or licensee pursuant to Chapters 9 (§ 63.1-172 et seq.) and 10 (§ 63.1-195 et seq.) of Title 63.1; however, nothing in this section shall prohibit disclosure of information from the records of completed investigations in a form that does not reveal the identity of complainants, persons supplying information, or other individuals

involved in the investigation.

32. Reports, manuals, specifications, documents, minutes or recordings of staff meetings or other information or materials of the Virginia Board of Corrections, the Virginia Department of Corrections or any institution thereof to the extent, as determined by the Director of the Department of Corrections or his designee or of the Virginia Board of Youth and Family Services, the Virginia Department of Youth and Family Services or any facility thereof to the extent as determined by the Director of the Department of Youth and Family Services, or his designee, that disclosure or public dissemination of such materials would jeopardize the security of any correctional or juvenile facility or institution, as follows:

(i) Security manuals, including emergency plans that are a part thereof;

(ii) Engineering and architectural drawings of correctional and juvenile facilities, and operational specifications of security systems utilized by the Departments, provided the general descriptions of such security systems, cost and quality shall be made available to the public;

(iii) Training manuals designed for correctional and juvenile facilities to the extent that they address procedures for institutional security, emergency plans and security equipment;

(iv) Internal security audits of correctional and juvenile facilities, but only to the extent that they specifically disclose matters described in (i), (ii), or (iii) above or other specific operational details the disclosure of which would jeopardize the security of a correctional or juvenile facility or institution;

(v) Minutes or recordings of divisional, regional and institutional staff meetings or portions thereof to the extent that such minutes deal with security issues listed in (i), (ii), (iii), and (iv) of this subdivision;

(vi) Investigative case files by investigators authorized pursuant to § 53.1-16; however, nothing in this section shall prohibit the disclosure of information taken from inactive reports in a form which does not reveal the identity of complainants or charging parties, persons supplying information, confidential sources, or other individuals involved in the investigation, or other specific operational details the disclosure of which would jeopardize the security of a correctional or juvenile facility or institution; nothing herein shall permit the disclosure of materials otherwise exempt as set forth in subdivision 1 of subsection B of this section;

(vii) Logs or other documents containing information on movement of inmates, juvenile clients or employees; and

(viii) Documents disclosing contacts between inmates, juvenile clients and law-enforcement personnel.

Notwithstanding the provisions of this subdivision, reports and information regarding the general operations of the Departments, including notice that an escape has occurred, shall be open to inspection and copying as provided in this section.

33. Personal information, as defined in § 2.1-379, (i) filed with the Virginia Housing Development Authority concerning individuals who have applied for or received loans or other housing assistance or who have applied for occupancy of or have occupied housing financed, owned or otherwise assisted by the Virginia Housing Development Authority, (ii) concerning persons participating in or persons on the waiting list for federally funded rent-assistance programs, or (iii) filed with any local redevelopment and housing authority created pursuant to § 36-4 concerning persons participating in or persons on the waiting list for housing assistance programs funded by local governments or by any such authority. However, access to one's own information shall not be denied.

34. Documents regarding the siting of hazardous waste facilities, except as provided in § 10.1-1441, if disclosure of them would have a detrimental effect upon the negotiating position of a governing body or on the establishment of the terms, conditions and provisions of the siting agreement.

35. Appraisals and cost estimates of real property subject to a proposed purchase, sale or lease, prior to the completion of such purchase, sale or lease.

36. Records containing information on the site specific location of rare, threatened, endangered or otherwise imperiled plant and animal species, natural communities, caves, and significant historic and archaeological sites if, in the opinion of the public body which has the responsibility for such information, disclosure of the information would jeopardize the continued existence or the integrity of the resource. This exemption shall not apply to requests from the owner of the land upon which the resource is located.

37. Official records, memoranda, working papers, graphics, video or audio tapes, production models, data and information of a proprietary nature produced by or for or collected by or for the State Lottery Department relating to matters of a specific lottery

game design, development, production, operation, ticket price, prize structure, manner of selecting the winning ticket, manner of payment of prizes to holders of winning tickets, frequency of drawings or selections of winning tickets, odds of winning, advertising, or marketing, where such official records have not been publicly released, published, copyrighted or patented. Whether released, published or copyrighted, all game-related information shall be subject to public disclosure under this chapter upon the first day of sales for the specific lottery game to which it pertains.

38. Official records of studies and investigations by the State Lottery Department of (i) lottery agents, (ii) lottery vendors, (iii) lottery crimes under §§ 58.1-4014 through 58.1-4018, (iv) defects in the law or regulations which cause abuses in the administration and operation of the lottery and any evasions of such provisions, or (v) use of the lottery as a subterfuge for organized crime and illegal gambling where such official records have not been publicly released, published or copyrighted. All studies and investigations referred to under subdivisions (iii), (iv) and (v) shall be subject to public disclosure under this chapter upon completion of the study or investigation.

39. Those portions of engineering and construction drawings and plans submitted for the sole purpose of complying with the building code in obtaining a building permit which would identify specific trade secrets or other information the disclosure of which would be harmful to the competitive position of the owner or lessee; however, such information shall be exempt only until the building is completed. Information relating to the safety or environmental soundness of any building shall not be exempt from disclosure.

40. [Repealed.]

41. Records concerning reserves established in specific claims administered by the Department of General Services through its Division of Risk Management as provided in Article 5.1 (§ 2.1-526.1 et seq.) of Chapter 32 of this title, or by any county, city, or town.

42. Information and records collected for the designation and verification of trauma centers and other specialty care centers within the Statewide Emergency Medical Care System pursuant to § 32.1-112.

43. Reports and court documents required to be kept confidential pursuant to § 37.1-67.3.

44. [Repealed.]

45. Investigative notes; correspondence and information furnished in confidence with respect to an investigation; and official records otherwise exempted by this chapter or any Virginia statute, provided to or produced by or for the Auditor of Public Accounts and the Joint Legislative Audit and Review Commission; or investigative notes, correspondence, documentation and information furnished and provided to or produced by or for the Department of the State Internal Auditor with respect to an investigation initiated through the State Employee Fraud, Waste and Abuse Hotline; however, nothing in this chapter shall prohibit disclosure of information from the records of completed investigations in a form that does not reveal the identity of complainants, persons supplying information or other individuals involved in the investigation.

46. Data formerly required to be submitted to the Commissioner of Health relating to the establishment of new or expansion of existing clinical health services, acquisition of major medical equipment, or certain projects requiring capital expenditures pursuant to former § 32.1-102.3:4.

47. Documentation or other information which describes the design, function, operation or access control features of any security system, whether manual or automated, which is used to control access to or use of any automated data processing or telecommunications system.

48. Confidential financial statements, balance sheets, trade secrets, and revenue and cost projections provided to the Department of Rail and Public Transportation, provided such information is exempt under the federal Freedom of Information Act or the federal Interstate Commerce Act or other laws administered by the Interstate Commerce Commission or the Federal Rail Administration with respect to data provided in confidence to the Interstate Commerce Commission and the Federal Railroad Administration.

49. In the case of corporations organized by the Virginia Retirement System, RF&P Corporation and its wholly owned subsidiaries, (i) proprietary information provided by, and financial information concerning, coventurers, partners, lessors, lessees, or investors, and (ii) records concerning the condition, acquisition, disposition, use, leasing, development, coventuring, or management of real estate the disclosure of which would have a substantial adverse impact on the value of such real estate or result in a competitive disadvantage to the corporation or subsidiary.

50. Confidential proprietary records related to inventory and sales, voluntarily provided

by private energy suppliers to the Department of Mines, Minerals and Energy, used by that Department for energy contingency planning purposes or for developing consolidated statistical information on energy supplies.

51. Confidential proprietary information furnished to the Board of Medical Assistance Services or the Medicaid Prior Authorization Advisory Committee pursuant to Article 4 (§ 32.1-331.12 et seq.) of Chapter 10 of Title 32.1.

52. Patient level data collected by the Virginia Health Services Cost Review Council and not yet processed, verified, and released, pursuant to § 9-166.7, to the Council by the nonprofit organization with which the Executive Director has contracted pursuant to § 9-166.4.

53. Proprietary, commercial or financial information, balance sheets, trade secrets, and revenue and cost projections provided by a private transportation business to the Virginia Department of Transportation and the Department of Rail and Public Transportation for the purpose of conducting transportation studies needed to obtain grants or other financial assistance under the Intermodal Surface Transportation Efficiency Act of 1991 (P.L. 102-240) for transportation projects, provided such information is exempt under the federal Freedom of Information Act or the federal Interstate Commerce Act or other laws administered by the Interstate Commerce Commission or the Federal Rail Administration with respect to data provided in confidence to the Interstate Commerce Commission and the Federal Railroad Administration. However, the exemption provided by this subdivision shall not apply to any wholly owned subsidiary of a public body.

54. Names and addresses of subscribers to Virginia Wildlife magazine, published by the Department of Game and Inland Fisheries, provided the individual subscriber has requested in writing that the Department not release such information.

55. Information required to be provided pursuant to § 54.1-2506.1.

C. Neither any provision of this chapter nor any provision of Chapter 26 (§ 2.1-377 et seq.) of this title shall be construed as denying public access to contracts between a public official and a public body, other than contracts settling public employee employment disputes held confidential as personnel records under subdivision 3 of subsection B of this section, or to records of the position, job classification, official salary or rate of pay of, and to records of the allowances or reimbursements for expenses paid to, any public officer, official or employee at any level of state, local or regional government in this Commonwealth or to the compensation or benefits paid by any corporation organized by the Virginia Retirement System, RF&P Corporation and its wholly owned subsidiaries, to their officers or employees. The provisions of this subsection, however, shall not apply to records of the official salaries or rates of pay of public employees whose annual rate of pay is $10,000 or less.

§ 54.1-2506.1 Submission of required information.

The Department is authorized to require individuals applying for initial licensure and individuals who are licensed to practice medicine, osteopathic medicine, dentistry, or to practice as a physician's assistant, nurse practitioner or dental hygienist, to provide information in addition to that which is required to determine the individual's qualifications to be licensed. Such additional information shall identify the individual's specialty and subspecialty; credentials and certifications issued by professional associations, institutions and boards; and locations of practice and number of hours spent practicing at each practice location. Such information shall be collected and maintained by the Department for manpower planning purposes in cooperation with agencies and institutions of the Commonwealth and shall be released by the Department only in the aggregate without reference to any licensee's name or other individual identifying particulars. Prior to collecting any information described in this section from individual licensees, the Department shall first attempt to obtain from other sources information sufficient for manpower planning purposes.

CHAPTER 320

An Act to amend and reenact §§ 38.2-514, 38.2-4214 and 38.2-4319 of the Code of Virginia and to amend the Code of Virginia by adding in Article 1 of Chapter 34 of Title 38.2 sections numbered 38.2-3407.2 and 38.2-3407.3, relating to accident and sickness insurance; calculation of cost sharing provisions; explanation of benefits.

[S 480]

Approved April 5, 1994

Be it enacted by the General Assembly of Virginia:
1. That §§ 38.2-514, 38.2-4214 and 38.2-4319 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding in Article 1 of Chapter 34 of Title 38.2 sections numbered 38.2-3407.2 and 38.2-3407.3 as follows:

§ 38.2-514. Failure to make disclosure.

A. No person shall solicit or effect the sale of an annuity, a life insurance policy or an accident and sickness insurance policy without furnishing the disclosure information required by any rules and regulations of the Commission.

B. Any lending institution, bank holding company, savings institution holding company or subsidiary or affiliate of either the lending institution or holding company, including any officer or employee thereof, licensed as an insurance agency or insurance agent in this Commonwealth shall, prior to the sale of any policy of life insurance in which there is or will be an accumulation of cash value during the term of the policy, make a written disclosure to the purchaser of the policy's "interest adjusted net cost index" in compliance with regulations or forms approved by the Commission.

C. No person shall provide to an insured, claimant, subscriber or enrollee under an accident and sickness insurance policy, subscription contract, or health maintenance organization contract, an explanation of benefits which does not clearly and accurately disclose the method of benefit calculation and the actual amount which has been or will be paid to the provider of services.

§ 38.2-3407.2. Explanation of Benefits.

A. Each insurer issuing an accident and sickness insurance policy, a corporation issuing subscription contracts, and each health maintenance organization shall file for approval explanation of benefits forms. These explanation of benefit forms shall be subject to the requirements of § 38.2-316 or § 38.2-4306 as applicable.

B. The explanation of benefits shall accurately and clearly set forth the benefits payable under the contract.

C. The Commission may issue regulations to establish standards for the accuracy and clarity of the information presented in an explanation of benefits.

D. The term "explanation of benefits" as used in this section shall include any form provided by an insurer, health services plan or health maintenance organization which explains the amounts covered under a policy or plan or shows the amounts payable by a covered person to a health care provider.

§ 38.2-3407.3. Calculation of cost sharing provisions.

A. An insurer, health services plan or health maintenance organization that issues an accident and sickness insurance policy or contract pursuant to which the insured, subscriber or enrollee is required to pay a specified percentage of the cost of covered services, shall calculate such amount payable based upon the total amount actually paid or payable to the provider of such services for the services provided to the insured, subscriber or enrollee.

B. Any insurer, health services plan or health maintenance organization failing to administer its contracts as set forth herein shall be deemed to have committed a knowing and willful violation of this section, and shall be punished as set forth in subsection A of § 38.2-218. Each claim payment found to have been calculated in noncompliance with this section shall be deemed a separate and distinct violation, and shall further be deemed a violation subject to subdivision D 1 c of § 38.2-218, permitting the Commission to require restitution in addition to any other penalties.

§ 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, 38.2-232, 38.2-316, 38.2-322, 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,

CHAPTER 621

An Act to amend and reenact § 2.1-399.1 of the Code of Virginia and to amend the Code of Virginia by adding in Chapter 6.1 of Title 23 a section numbered 23-50.16 and by adding a section numbered 23-77.3, relating to the operation of Virginia Commonwealth University and University of Virginia Medical Centers.

[S 545]

Approved April 10, 1994

Be it enacted by the General Assembly of Virginia:
1. That § 2.1-399.1 of the Code of Virginia is amended and reenacted and that the Code of Virginia is amended by adding in Chapter 6.1 of Title 23 a section numbered 23-50.16 and by adding a section numbered 23-77.3 as follows:

§ 2.1-399.1. Capital projects.

A. On or before December 20 of the year immediately prior to the beginning of each regular session held in an even-numbered year of the General Assembly, the Governor shall submit to the presiding officer of each house of the General Assembly copies of any tentative bill or bills involving proposed capital appropriations for each year in the ensuing biennial appropriation period. Such bill or bills shall include each capital project to be financed through revenue bonds or other debt issuance, the amount of each such project, and identify the entity which will issue such debt. *Notwithstanding any other provision of law, the Governor may recommend, and the General Assembly may make, an appropriation of special fund revenues derived from the operations of the medical centers of Virginia Commonwealth University and the University of Virginia that may be used, as directed by such universities, in connection with the ownership and operation of their medical centers and related health care and educational activities, including operating expenses and debt service.*

B. On or before December 20 of the year immediately prior to the beginning of each regular session held in an odd-numbered year of the General Assembly, the Governor shall submit to the presiding officer of each house printed copies of all gubernatorial amendments proposed to capital appropriations acts adopted in the immediately preceding even-numbered year session.

C. The Governor shall ensure that a summary of budget highlights be sent to a newspaper of general circulation in the following geographical areas of the Commonwealth: Northern Virginia, Hampton Roads, Richmond/Petersburg, Central Virginia, Shenandoah Valley, Roanoke Valley, Southside, and Southwest Virginia prior to the convening of such session of the General Assembly.

D. The standing committees of the House of Delegates and of the Senate in charge of appropriation measures shall hold four regional public hearings on the budget bill submitted by the Governor. The four public hearings shall be held prior to the convening of such session of the General Assembly, at hearing sites and times as selected by the chairmen of the two committees.

§ 23-50.16. Operations of Medical Center.

A. In enacting this section, the General Assembly recognizes that the ability of Virginia Commonwealth University to provide medical and health sciences education and related research is dependent upon the maintenance of high-quality teaching hospitals and related health care and health maintenance facilities, collectively referred to in this section as the Medical Center, and that the maintenance of a medical center serving such purposes requires specialized management and operation that permit the Medical Center to remain economically viable and to participate in cooperative arrangements reflective of changes in health care delivery.

B. Without limiting the powers provided in §§ 23-50.8 and 23-50.10, Virginia Commonwealth University may create, own in whole or in part or otherwise control corporations, partnerships, insurers or other entities whose activities will promote the operations of the Medical Center and its mission, may cooperate or enter into joint ventures with such entities and government bodies and may enter into contracts in connection therewith. Without limiting the power of Virginia Commonwealth University to issue bonds, notes, guarantees, or other evidence of indebtedness under subsection C in connection with such activities, no such creation, ownership or control shall create any responsibility of the University, the Commonwealth or any other agency thereof for the operations or obligations of any entity or in any way make the University, the

Commonwealth, or any other agency thereof responsible for the payment of debt or other obligations of such entity. All such interests shall be reflected on the financial statements of the Medical Center.

C. Notwithstanding the provisions of Chapter 3 (§ 23-14 et seq.) of this title, Virginia Commonwealth University may issue bonds, notes, guarantees, or other evidence of indebtedness without the approval of any other governmental body subject to the following provisions:

1. Such debt is used solely for the purpose of paying not more than fifty percent of the cost of capital improvements in connection with the operation of the Medical Center or related issuance costs, reserve funds, and other financing expenses, including interest during construction or acquisition and for up to one year thereafter;

2. The only revenues of the University pledged to the payment of such debt are those derived from the operation of the Medical Center and related health care and educational activities, and there are pledged therefor no general fund appropriation and special Medicaid disproportionate share payments for indigent and medically indigent patients who are not eligible for the Virginia Medicaid Program;

3. Such debt states that it does not constitute a debt of the Commonwealth or a pledge of the faith and credit of the Commonwealth;

4. Such debt is not sold to the public;

5. The total principal amount of such debt outstanding at any one time does not exceed twenty-five million dollars;

6. The Treasury Board has approved the terms and structure of such debt;

7. The purpose, terms, and structure of such debt are promptly communicated to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees; and

8. All such indebtedness is reflected on the financial statements of the Medical Center.

Subject to meeting the conditions set forth above, such debt may be in such form and have such terms as the board of visitors may provide and shall be in all respects debt of the University for the purposes of §§ 23-23, 23-25, and 23-26.

§ 23-77.3. Operations of Medical Center.

A. In enacting this section, the General Assembly recognizes that the ability of the University of Virginia to provide medical and health sciences education and related research is dependent upon the maintenance of high quality teaching hospitals and related health care and health maintenance facilities, collectively referred to in this section as the Medical Center, and that the maintenance of a Medical Center serving such purposes requires specialized management and operation that permit the Medical Center to remain economically viable and to participate in cooperative arrangements reflective of changes in health care delivery.

B. Without limiting the powers provided in this chapter, the University of Virginia may create, own in whole or in part or otherwise control corporations, partnerships, insurers or other entities whose activities will promote the operations of the Medical Center and its mission, may cooperate or enter into joint ventures with such entities and government bodies and may enter into contracts in connection therewith. Without limiting the power of the University of Virginia to issue bonds, notes, guarantees, or other evidence of indebtedness under subsection C in connection with such activities, no such creation, ownership or control shall create any responsibility of the University, the Commonwealth or any other agency thereof for the operations or obligations of any such entity or in any way make the University, the Commonwealth, or any other agency thereof responsible for the payment of debt or other obligations of such entity. All such interests shall be reflected on the financial statements of the Medical Center.

C. Notwithstanding the provisions of Chapter 3 (§ 23-14 et seq.) of this title, the University of Virginia may issue bonds, notes, guarantees, or other evidence of indebtedness without the approval of any other governmental body subject to the following provisions:

1. Such debt is used solely for the purpose of paying not more than fifty percent of the cost of capital improvements in connection with the operation of the Medical Center or related issuance costs, reserve funds, and other financing expenses, including interest during construction or acquisitions and for up to one year thereafter;

2. The only revenues of the University pledged to the payment of such debt are those derived from the operation of the Medical Center and related health care and educational activities, and there are pledged therefor no general fund appropriation and special Medicaid disproportionate share payments for indigent and medically indigent patients who are not eligible for the Virginia Medicaid Program;

3. Such debt states that it does not constitute a debt of the Commonwealth or a pledge of the faith and credit of the Commonwealth;

4. Such debt is not sold to the public;

5. The total principal amount of such debt outstanding at any one time does not exceed twenty-five million dollars;

6. The Treasury Board has approved the terms and structure of such debt;

7. The purpose, terms, and structure of such debt are promptly communicated to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees; and

8. All such indebtedness is reflected on the financial statements of the Medical Center.

Subject to meeting the conditions set forth above, such debt may be in such form and have such terms as the board of visitors may provide and shall be in all respects debt of the University for the purposes of §§ 23-23, 23-25, and 23-26.

VIRGINIA ACTS OF ASSEMBLY -- 1994 RECONVENED SESSION

REENROLLED

CHAPTER 867

An Act to amend and reenact § 32.1-122.6 of the Code of Virginia; to amend the Code of Virginia by adding in Article 6 of Chapter 4 of Title 32.1 sections numbered 32.1-122.9 and 32.1-122.10; and to repeal §§ 23-35.1 through 23-35.8 of the Code of Virginia, relating to medical and dental scholarships.

[S 584]

Approved April 20, 1994

Be it enacted by the General Assembly of Virginia:
1. That § 32.1-122.6 of the Code of Virginia is amended and reenacted and that the Code of Virginia is amended by adding in Article 6 of Chapter 4 of Title 32.1 sections numbered 32.1-122.9 and 32.1-122.10 as follows:

§ 32.1-122.6. Conditional grants for certain medical students.

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

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

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

1. Qualifications of applicants;
2. Criteria for award of the scholarships to assure that recipients will fulfill the practice obligations established in this section;
3. Standards to assure that these scholarships increase access to primary health care for individuals who are indigent or who are recipients of public assistance;
4. Assurances that bona fide residents of Virginia, as determined by § 23-7.4, *students of economically disadvantaged backgrounds and residents of medically underserved areas* are given preference over nonresidents in determining scholarship eligibility and awards;
5. Assurances that scholarship recipients will begin medical practice in one of the designated specialties in an underserved area of the Commonwealth within two years following completion of their residencies;
6. Methods for reimbursement of the Commonwealth by recipients who fail to complete medical school or who fail to honor the obligation to engage in medical practice for a period of years equal to the number of annual scholarships received;
7. Procedures for reimbursing any recipient who has repaid the Commonwealth for part or all of any scholarship and who later fulfills the terms of his contract;
8. Procedures for transferring unused funds upon the recommendation of the Commissioner and the approval of the Department of Planning and Budget in the event any of the medical schools has not recommended the award of its full complement of scholarships by January of each year and one or both of the other medical schools has a demonstrated need for additional scholarships for that year; and
9. Reporting of data related to the recipients of the scholarships by the medical schools.

C. Prior to the award of any scholarship, the applicant shall sign a contract in which he agrees to pursue the medical course of the school nominating him for the award until his graduation or to pursue his first year of postgraduate training at the hospital or institution approved by the school nominating him for the award and upon completing a term not to exceed three years, or four years for the obstetric/gynecology specialty, as an intern or resident at an approved institution or facility intends to promptly begin and

thereafter engage continuously in one of the designated specialties of medical practice in an underserved area in Virginia for a period of years equal to the number of annual scholarships received. The contract shall specify that no form of medical practice such as military service or public health service may be substituted for the obligation to practice in one of the designated specialties in an underserved area in the Commonwealth.

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

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

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

E. In the event the recipient dies or becomes permanently disabled so as not to be able to engage in the practice of medicine, the recipient or his estate may, upon certification of the Commissioner, be relieved of the obligation under the contract to engage in medical practice in an underserved area upon repayment to the Commonwealth of the total amount of scholarship funds plus interest on such amount computed at eight percent per annum from the date of receipt of scholarship funds. This obligation may be waived in whole or in part by the Commissioner in his discretion upon application by the recipient or his estate to the Commissioner with proof of hardship or inability to pay.

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

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

§ 32.1-122.9. Conditional grants for certain dental students.

A. With such funds as are appropriated for this purpose, the Board of Health shall establish annual dental scholarships for students in good standing at Virginia Commonwealth University. No recipient shall be awarded more than five scholarships. The amount and number of such scholarships shall be determined annually as provided in the appropriations act. The Commissioner shall act as fiscal agent for the Board in administration of the scholarship funds.

The governing board of Virginia Commonwealth University shall submit to the Commissioner the names of those eligible applicants who are most qualified as determined by the regulations of the Board for these dental scholarships. The Commissioner shall award the scholarships to the applicants whose names are submitted by the governing board.

B. The Board, after consultation with the School of Dentistry of Virginia Commonwealth University, shall promulgate regulations to administer this scholarship program which shall include, but not be limited to:

1. Qualifications of applicants;

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

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

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

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

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

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

8. Reporting of data related to the recipients of the scholarships by the dental schools.

C. Prior to the award of any scholarship, the applicant shall sign a contract in which he agrees to pursue the dental course of Virginia Commonwealth University until his graduation and, upon graduation or upon completing a term not to exceed four years as an intern or resident at an approved institution or facility, to promptly begin and thereafter engage continuously in dental practice in an underserved area in Virginia for a period of years equal to the number of annual scholarships received. The contract shall specify that no form of dental practice such as military service or public health service may be substituted for the obligation to practice in an underserved area in the Commonwealth.

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

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

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

E. In the event the recipient dies or becomes permanently disabled so as not to be able to engage in the practice of dentistry, the recipient or his estate may, upon certification of the Commissioner, be relieved of the obligation under the contract to engage in dental practice in an underserved area upon repayment to the Commonwealth of the total amount of scholarship funds plus interest on such amount computed at eight percent per annum from the date of receipt of scholarship funds. This obligation may be waived in whole or in part by the Commissioner in his discretion upon application by the recipient or his estate to the Commissioner with proof of hardship or inability to pay.

F. Except as provided in subsections D and E, any recipient of a scholarship who fails or refuses to fulfill his obligation to practice dentistry in an underserved area for a period of years equal to the number of annual scholarships received shall reimburse the Commonwealth three times the total amount of the scholarship funds received plus interest at the prevailing bank rate for similar amounts of unsecured debt. If the recipient has fulfilled part of his contractual obligations by serving in an underserved area, the total amount of the scholarship funds received shall be reduced by the amount of the annual scholarship multiplied by the number of years served.

G. The Commissioner shall collect all repayments required by this section and may establish a schedule of payments for reimbursement consistent with the regulations of the Board. No schedule of payments shall amortize the total amount due for a period of longer than two years following the completion of the recipient's postgraduate training or the recipient's entrance into the full-time practice of dentistry, whichever is later. All such funds shall be transmitted to the Comptroller for deposit in the general fund. If any recipient fails to make any payment when and as due, the Commissioner shall notify the

Attorney General. The Attorney General shall take such action as he deems proper. In the event court action is required to collect a delinquent scholarship account, the recipient shall be responsible for the court costs and reasonable attorneys' fees incurred by the Commonwealth in such collection.

§ 32.1-122.10. Conditional grants for certain dental hygiene students.

A. The Board of Health shall establish annual dental hygiene scholarships for students who intend to enter an accredited dental hygiene program in the Commonwealth. The amounts and numbers of such scholarships shall be determined annually as provided in the appropriation act. The Commissioner shall act as fiscal agent for the Board in administration of the scholarship program.

B. To administer the scholarship program, the Board shall promulgate regulations which shall include, but are not limited to:

1. Qualifications of applicants;

2. Criteria for award of the scholarship to assure that a recipient will fulfill the practice obligations established in this section;

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

4. Assurances that residents of Virginia, as determined by § 23-7.4, students of economically disadvantaged backgrounds and residents of medically underserved areas are given preference in determining scholarship eligibility and awards;

5. Assurances that a scholarship recipient will practice as a dental hygienist in an underserved area of the Commonwealth within two years following completion of training;

6. Methods for reimbursement to the Commonwealth by a recipient who fails to complete the educational program or who fails to honor the obligation to engage in practice as a dental hygienist for a period of years equal to the number of annual scholarships received;

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

8. Methods for reporting data related to the recipients of the scholarships.

2. That §§ 23-35.1 through 23-35.8 of the Code of Virginia are repealed.

3. That the procedures and criteria currently utilized by Virginia Commonwealth University to implement the provisions of §§ 23-35.1 through 23-35.8, as repealed by this act, shall remain in effect until the Board of Health promulgates regulations to implement §§ 32.1-122.9 and 32.1-122.10, as added by this act.

CHAPTER 466

An Act to amend and reenact §§ 32.1-332, 32.1-333, 32.1-334, 32.1-335, 32.1-337, and 32.1-338 of the Code of Virginia, relating to the Virginia Indigent Health Care Trust Fund.

[H 638]

Approved April 8, 1994

Be it enacted by the General Assembly of Virginia:
1. That §§ 32.1-332, 32.1-333, 32.1-334, 32.1-335, 32.1-337, and 32.1-338 of the Code of Virginia are amended and reenacted as follows:

§ 32.1-332. Definitions.

As used in this chapter unless the context requires a different meaning:

"Board" means the Board of Medical Assistance Services.

"Charity care" means hospital care for which no payment is received and which is provided to any person whose gross annual family income is equal to or less than 100 percent of the federal nonfarm poverty level as published for the then current year in the Code of Federal Regulations.

"The Fund" means the Virginia Indigent Health Care Trust Fund created by this chapter.

"Hospital" means any acute care hospital which is required to be licensed as a hospital pursuant to Chapter 5 (§ 32.1-123 et seq.) of this title.

"Panel" means the Technical Advisory Panel appointed pursuant to the provisions of this chapter.

"Pilot health care project" means any arrangement for purchasing or providing health care, including, but not limited to, any accident and sickness insurance, health services plan, or health care plan.

"Voluntary contributions or donations" means any money voluntarily contributed or donated to the Fund by hospitals or other private sources for the purpose of subsidizing pilot health care projects for the uninsured.

§ 32.1-333. Creation of Fund; administration.

A. There is hereby created the Virginia Indigent Health Care Trust Fund whose purpose is to receive moneys appropriated by the Commonwealth and contributions from certain hospitals and others for the purpose of distributing these moneys to certain hospitals subject to restrictions as provided in this chapter.

B. The Fund shall be the responsibility of the Board and Department of Medical Assistance Services~~. However, the Fund~~ *and* shall be maintained and administered separately from any other program or fund of the Board and Department. *However, all funds voluntarily contributed or donated to the Fund for the purpose of subsidizing pilot health care projects for the uninsured shall be administered by the Technical Advisory Panel in accordance with Board regulations.*

C. The Board may promulgate rules and regulations pursuant to the Administrative Process Act (§ 9-6.14:1 et seq.) for the administration of the Fund consistent with this chapter, including but not limited to:

1. Uniform eligibility criteria to define those medically indigent persons whose care shall qualify a hospital for reimbursement from the Fund. Such criteria shall define medically indigent persons as only those individuals whose gross family income is equal to or less than 100 percent of the federal nonfarm poverty level as published for the then current year in the Code of Federal Regulations.

2. Hospital inpatient and outpatient medical services qualifying for reimbursement from the Fund. Such medical services shall be limited to those categories of inpatient and outpatient hospital services covered under the Medical Assistance Program, but shall exclude any durational or newborn infant service limitations.

3. A mechanism to ensure that hospitals are compensated from the Fund only for charity care as defined in this chapter.

4. Terms, conditions and reporting requirements for hospitals participating in the Fund.

5. Terms, conditions, and reporting requirements for pilot health care projects for the uninsured.

§ 32.1-334. Fund contributions.

The Fund shall be comprised of such moneys as may be appropriated by the General Assembly for the purposes of the Fund and by contributions from hospitals made in

accordance with the provisions of this chapter. The Fund may also receive *voluntary* contributions from *hospitals and* other entities as specified by law.

§ 32.1-335. Technical Advisory Panel.

The Board shall annually appoint a Technical Advisory Panel whose duties shall include recommending to the Board (i) policy and procedures for administration of the Fund, (ii) methodology relating to creation of charity care standards, eligibility and service verification, and (iii) contribution rates and distribution of payments. The Panel shall also advise the Board on any matters relating to the governance or administration of the Fund as may from time to time be appropriate and on the establishment of ~~alternative~~ *pilot* health ~~insurance programs~~ *care projects* for the uninsured. *In addition to these duties, the Panel shall, in accordance with Board regulations, establish pilot health care projects for the uninsured and shall administer any money voluntarily contributed or donated to the Fund by private sources for the purpose of subsidizing pilot health care projects for the uninsured.*

The Panel shall consist of fifteen members as follows: the Chairman of the Board, the Director of the Department of Medical Assistance Services, the Executive Director of the Virginia Health Services Cost Review Council, the Commissioner of the Bureau of Insurance or his designee, the chairman of the Virginia Health Care Foundation or his designee, two additional members of the Board, one of whom shall be the representative of the hospital industry, and two chief executive officers of hospitals as nominated by the Virginia Hospital Association.

In addition, there shall be three representatives of private enterprise, who shall be executives serving in business or industry organizations. Nominations for these appointments may be submitted to the Board by associations representing constituents of the business and industry community in Virginia including, but not limited to, the Virginia Manufacturers Association, the Virginia Chamber of Commerce, the Virginia Retail Merchants Association, and the Virginia Small Business Advisory Board. There shall be two representatives from the insurance industry who shall be executives serving in insurance companies or industry organizations. Nominations for these appointments may be submitted to the Board by associations representing constituents of the insurance industry in Virginia including, but not limited to, Blue Cross/Blue Shield of Virginia, Health Insurance Association of America and the Virginia Association of Health Maintenance Organizations. There shall be one physician member. Nominations for this appointment may be submitted to the Board by associations representing medical professionals, including, but not limited to, the Medical Society of Virginia and the Old Dominion Medical Society.

§ 32.1-337. Hospital contributions; calculations.

Hospitals shall make contributions to the Fund in accordance with the following:

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

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

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

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

E. A charity care and corporate tax credit shall be calculated, the numerator of which shall be each hospital's cost of charity care plus state corporate taxes and the denominator of which shall be each hospital's net patient revenues as defined by the Virginia Health Services Cost Review Council.

F. An annual hospital contribution rate shall be calculated, the numerator of which shall be the sum of one-half the contribution plus the sum of the product of the contributing hospitals' credits multiplied by the contributing hospitals' positive operating margins and the denominator of which shall be the sum of the positive operating margins for the contributing hospitals. The annual hospital contribution rate shall not exceed 6.25

percent of a hospital's positive operating margin.

G. For each hospital, the contribution dollar amount shall be calculated as the difference between the rate and the credit multiplied by each hospital's operating margin. *In addition to the required contribution, hospitals may make voluntary contributions or donations to the Fund for the purpose of subsidizing pilot health care projects for the uninsured.*

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

§ 32.1-338. Distribution of Fund moneys.

A. The Fund shall compensate a hospital for such hospital's charity care percent less the charity care standard as follows:

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

2. That portion of a hospital's charity care percent which is below the disproportionate share shall be paid from the total amount of the contribution.

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

B. Each hospital eligible to receive a Fund payment may elect to return such payment or a portion thereof to the Fund to be used at the discretion of the Board, upon the recommendation of the Technical Advisory Panel, for the purpose of establishing ~~alternative~~ *pilot* health ~~insurance systems~~ *care projects* for the uninsured.

C. Money voluntarily contributed or donated to the Fund by private sources for the purpose of subsidizing pilot health care projects for the uninsured shall not be included in the calculations set forth in this section.

CHAPTER 645

An Act to amend and reenact §§ 9-166.3, 9-166.5, and 9-166.7 of the Code of Virginia, relating to the Virginia Patient Level Data System.

[H 639]

Approved April 10, 1994

Be it enacted by the General Assembly of Virginia:
1. That §§ 9-166.3, 9-166.5, and 9-166.7 of the Code of Virginia are amended and reenacted as follows:

§ 9-166.3. Reporting requirements.

A. Every inpatient hospital shall submit to the Council patient level data as set forth in subsection B of this section. Any such hospital may report the required data directly to the nonprofit organization cited in § 9-166.4. Notwithstanding the provisions of Chapter 26 (§ 2.1-377 et seq.) of Title 2.1, it shall be lawful to provide information in compliance with the provisions of this chapter.

B. Patient level data elements for hospital inpatients reported by any source shall include:

1. Hospital identifier;
2. Attending physician identifier;
3. Operating physician identifier;
4. Payor identifier;
5. Employer identifier;
6. Patient identifier;
7. Patient sex, race, date of birth (including century indicator), zip code, patient relationship to insured, employment status code, status at discharge, and birth weight (for infants);
8. Admission type, source, date and hour, and diagnosis;
9. Discharge date and status;
10. Principal and secondary diagnoses;
11. External cause of injury;
12. Co-morbid conditions existing but not treated;
13. Procedures and procedure dates;
14. Revenue center codes, units, and charges; and
15. Total charges.

C. State agencies providing coverage for outpatient services shall submit patient level data regarding paid outpatient claims to the Council. Information to be submitted shall be extracted from standard claims forms and, where available, shall include:

1. Provider identifier;
2. Patient identifier;
3. Physician identifier;
4. Dates of service and diagnostic, procedural, demographic, pharmaceutical, and financial information; and
5. Other related information.

The Council shall promulgate regulations specifying the format for submission of such outpatient data. State agencies may submit this data directly to the nonprofit organization cited in § 9-166.4. Notwithstanding the provisions of Chapter 26 (§ 2.1-377 et seq.) of Title 2.1, it shall be lawful to provide information in compliance with the provisions of this chapter.

§ 9-166.5. Fees for processing and verification of data.

A. The Council shall prescribe a reasonable fee, not to exceed one dollar per discharge, for each hospital submitting patient level data pursuant to this article to cover the costs of the reasonable expenses in processing and verifying such data. The fees shall be established and reviewed annually by the Council. The payment of such fees shall be at such time as the Council designates. The Council may assess a late charge on any fees paid after their due date. The Council shall maintain records and account for and deposit such fees pursuant to § 9-163.

B. The nonprofit organization providing data compilation, storage, analysis, and evaluation services pursuant to an agreement or contract with the Council shall be authorized to charge and collect the fees prescribed by the Council for processing and verification of such data when the data are provided directly to the nonprofit organization.

The Council shall promulgate regulations permitting hospitals submitting patient level data pursuant to this article to pay fees to the nonprofit organization compiling, storing, analyzing, and evaluating patient level data pursuant to an agreement or contract with the Executive Director. Such fees shall not exceed the amount authorized by the Council as provided in subsection A of this section and such regulations shall specify that the fees provided in subsection A of this section shall be waived for any hospital that submits the required data elements directly to the nonprofit organization and pays the fees charged by the nonprofit organization. Such regulations also shall include provisions for the nonprofit organization, at its discretion, to grant a reduction or waiver of such fees upon a determination by the nonprofit organization that the hospital has submitted processed, verified data.

C. State agencies shall not be assessed fees for the submission of data required by § 9-166.3 C. Individual employers, insurers, and other organizations may voluntarily provide the nonprofit organization with outpatient data for processing, storage, and comparative analysis and shall be subject to fees negotiated with and charged by the nonprofit organization for services provided.

§ 9-166.7. Confidentiality, subsequent release of data and relief from liability for reporting; penalty for wrongful disclosure; individual action for damages.

A. Patient level data collected by the Council pursuant to this article shall be exempt from the provisions of the Virginia Freedom of Information Act (§ 2.1-340 et seq.), shall be considered confidential, and shall not be disclosed other than as specifically authorized by this ~~Article~~ *article*; however, upon processing and verification by the nonprofit organization, all patient level data shall be publicly available, except patient, physician, and employer identifier elements, which shall be released only as provided in subsection B of this section. No report published by the nonprofit organization, the Council, or other person may present information that reasonably could be expected to reveal the identity of any patient. Publicly available information shall be designed to prevent persons from being able to gain access to combinations of patient characteristic data elements that reasonably could be expected to reveal the identity of any patient.

B. Any agreement or contract between the Executive Director and a nonprofit organization made pursuant to this article shall specify that, upon processing, verification, and release by the nonprofit organization of patient level data, the patient identifier information may, if otherwise permitted by law, be released for research purposes only, provided that such identifier is encrypted and cannot be reasonably expected to reveal the patient's identity. Such nonprofit organization may, in its discretion, release physician and employer identifier information. All other processed and verified patient level data specified in ~~subsection~~ *subsections* B *and C* of § 9-166.3 shall be publicly available. Data not specified in ~~subsection~~ *subsections* B *and C* of § 9-166.3 that are collected by the nonprofit organization may be released by the nonprofit organization at its discretion.

C. No person or entity, including the nonprofit organization contracting with the Executive Director, shall be held liable in any civil action with respect to any report or disclosure of information made under this article unless such person or entity has knowledge of any falsity of the information reported or disclosed.

D. Any disclosure of information made in violation of this article, and any disclosure by any person of information provided for research purposes in accordance with subsection B of this section that permits identification of any patient, or that permits identification from information not publicly available of any physician or employer without approval of the nonprofit organization, shall be subject to a civil penalty of not more than $5,000 per violation. This provision shall be enforceable upon petition to the appropriate circuit court by the Attorney General, any attorney for the Commonwealth, or any attorney for the county, city or town in which the violation occurred. Any penalty imposed shall be payable to the Literary Fund. In addition, any person or entity who is the subject of any disclosure in violation of this article shall be entitled to initiate an action to recover actual damages, if any, or $500, whichever is greater, together with reasonable attorney's fees and court costs.

VIRGINIA ACTS OF ASSEMBLY -- 1994 SESSION

CHAPTER 278

An Act to amend and reenact § 2.1-373.4 of the Code of Virginia, relating to the Long-Term Care Council.

[H 670]

Approved April 4, 1994

Be it enacted by the General Assembly of Virginia:
1. That § 2.1-373.4 of the Code of Virginia is amended and reenacted as follows:

§ 2.1-373.4. Creation of Long-Term Care Council; designation of Department as agency responsible for coordination.

The General Assembly declares that it is the policy of the Commonwealth to support the development of community-based resources to avoid inappropriate institutionalization of the impaired elderly. These community-based services should reflect a continuum of long-term care services needed to deter institutionalization.

To this end, the Governor shall establish a Long-Term Care Council. The membership of the Council shall include the Secretary of Health and Human Resources, the Commissioner of the Department of Health, the Commissioner of the Department of Social Services, the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services, the Commissioner of the Department of Rehabilitative Services, the Commissioner of the Department for the Visually Handicapped, the Commissioner of the Department for the Aging, the Director of the Department for Rights of Virginians With Disabilities, and the Director of the Department of Medical Assistance Services. The chairman shall be appointed by the Governor.

The Virginia Department for the Aging is designated as the state agency responsible for coordinating all long-term care efforts of state and local human services agencies.

Provisions of this chapter which relate to the Long-Term Care Council shall expire on ~~July 1, 1994~~ *July 1, 1995.*

VIRGINIA ACTS OF ASSEMBLY -- 1994 SESSION

CHAPTER 711

An Act to amend and reenact § 32.1-102.3:2 of the Code of Virginia, relating to certificates of public need.

[H 671]

Approved April 10, 1994

Be it enacted by the General Assembly of Virginia:
1. That § 32.1-102.3:2 of the Code of Virginia is amended and reenacted as follows:
§ 32.1-102.3:2. Certificates of public need; moratorium; exceptions.

The Commissioner of Health shall not approve, authorize or accept applications for the issuance of any certificate of public need pursuant to this article for any project which would result in an increase in the number of beds in which nursing facility or extended care services are provided through June 30, ~~1995~~ *1996*. However, the Commissioner may approve or authorize:

1. The issuance of a certificate of public need for a project for the (i) renovation or replacement on site of an existing facility or any part thereof or (ii) replacement off-site of an existing facility at a location within the same city or county and within reasonable proximity to the current site when replacement on the current site is proven infeasible, in accordance with the law, when a capital expenditure is required to comply with life safety codes, licensure, certification or accreditation standards. Under no circumstances shall the State Health Commissioner approve, authorize, or accept an application for the issuance of a certificate for any project which would result in the continued use of the facility replaced as a nursing facility.

2. The issuance of a certificate of public need for any project for the conversion on site of existing licensed beds to beds certified for skilled nursing services (SNF) when (i) the total number of beds to be converted does not exceed the lesser of twenty beds or ten percent of the beds in the facility; (ii) the facility has demonstrated that the SNF beds are needed specifically to serve a specialty heavy care patient population, such as ventilator-dependent and AIDS patients and that such patients otherwise will not have reasonable access to such services in existing or approved facilities; and (iii) the facility further commits to admit such patients on a priority basis once the SNF unit is certified and operational.

3. The issuance of a certificate of public need for any project for the conversion on site of existing beds in an adult care residence licensed pursuant to Chapter 9 (§ 63.1-172 et seq.) of Title 63.1 as of March 1, 1990, to beds certified as nursing facility beds when (i) the total number of beds to be converted does not exceed the lesser of thirty beds or twenty-five percent of the beds in the adult care residence; (ii) the adult care residence has demonstrated that nursing facility beds are needed specifically to serve a patient population of AIDS, or ventilator-dependent, or head and spinal cord injured patients, or any combination of the three, and that such patients otherwise will not have reasonable access to such services in existing or approved nursing facilities; (iii) the adult care residence further commits to admit such patients once the nursing facility beds are certified and operational; and (iv) the licensed adult care residence otherwise meets the standards for nursing facility beds as set forth in the regulations of the Board of Health. Notwithstanding the conditions required by this exception related to serving specific patient populations, an adult care residence which has obtained by January 1, 1991, a certificate of public need for a project for conversion on site of existing beds in its facility licensed pursuant to Chapter 9 of Title 63.1 as of March 1, 1990, to beds certified as nursing facility beds may use the beds converted to nursing facility beds pursuant to this exception for patient populations requiring specialized care of at least the same intensity which meet the criteria for the establishment of a specialized care nursing facility contract with the Department of Medical Assistance Services.

4. The issuance of a certificate of public need for a project in an existing nursing facility owned and operated by the governing body of a county when (i) the total number of new beds to be added by construction does not exceed the lesser of thirty beds or twenty-five percent of the existing nursing facility beds in the facility; (ii) the facility has demonstrated that the nursing facility beds are needed specifically to serve a specialty heavy care patient population, such as dementia, ventilator-dependent, and AIDS patients; and (iii) the facility has executed an agreement with a state-supported medical college to provide training in geriatric nursing.

5. The issuance of a certificate of public need for a nursing facility project located in the City of Staunton when (i) the total number of new beds to be constructed does not exceed thirty beds; (ii) the facility is owned by and will be operated as a nonprofit entity; and (iii) the project is proposed as part of a retirement community that is a continuing care provider registered with the State Corporation Commission pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2.

6. The issuance of a certificate of public need for any project for an increase in the number of beds in which nursing home or extended care services are provided, or the creation of new beds in which such services are to be provided, by any continuing care provider registered with the State Corporation Commission pursuant to Chapter 49 of Title 38.2, if (i) the total number of new or additional nursing home beds plus any existing nursing home beds operated by the provider does not exceed twenty percent of the continuing care provider's total existing or planned independent living and adult care residence population when the beds are to be added by new construction, or twenty-five beds when the beds are to be added by conversion on site of existing beds in an adult care residence licensed pursuant to Chapter 9 of Title 63.1; (ii) such beds are necessary to meet existing or reasonably anticipated obligations to provide care to present or prospective residents of the continuing care facility pursuant to continuing care contracts meeting the requirements of § 38.2-4905; (iii) the provider agrees in writing not to seek certification for the use of such new or additional beds by persons eligible to receive medical assistance services pursuant to Title XIX of the United States Social Security Act; (iv) the provider agrees in writing to obtain, prior to admission of every resident of the continuing care facility, the resident's written acknowledgment that the provider does not serve recipients of medical assistance services and that, in the event such resident becomes a medical assistance services recipient who is eligible for nursing facility placement, such resident shall not be eligible for placement in the provider's nursing facility unit; and (v) the provider agrees in writing that only continuing care contract holders will be admitted to the nursing home beds after the first three years of operation.

Further, if a certificate is approved pursuant to this subdivision, admissions to such new or additional beds shall be restricted for the first three years of operation to patients for whose care, pursuant to an agreement between the facility and the individual financially responsible for the patient, private payment will be made or persons who have entered into an agreement with the facility for continuing care contracts meeting the requirements of § 38.2-4905.

7. The issuance of a certificate of public need for a nursing facility project associated with a continuing care provider which did not operate a nursing home on January 1, 1993, and was registered as of January 1, 1993, with the State Corporation Commission pursuant to Chapter 49 of Title 38.2, if (i) the total number of new beds to be constructed does not exceed sixty beds; (ii) the facility is owned by and will be operated as a nonprofit entity; (iii) after the first three years of operation, the facility will admit only retired officers of the United States uniformed forces and their surviving spouses; (iv) the provider agrees in writing not to seek certification for the use of such beds by persons eligible to receive medical assistance services pursuant to Title XIX of the United States Social Security Act; and (v) the provider agrees in writing to obtain, prior to admission of every resident of the continuing care facility, the written acknowledgment that the provider does not serve recipients of medical assistance services and that, in the event such resident becomes a medical assistance services recipient who is eligible for nursing facility placement, such resident shall not be eligible for placement in the provider's nursing facility unit. Further, if a certificate is approved, pursuant to this subdivision, admissions to such beds shall be restricted to persons for whose care, pursuant to an agreement with the facility, private payment will be made or persons who have entered into an agreement with the facility for continuing care contracts meeting the requirements of § 38.2-4905.

8. The issuance of a certificate of public need for a nursing facility project located in the City of Norfolk if (i) the total number of beds to be constructed does not exceed 120 beds; (ii) the facility will replace an existing facility in the City of Chesapeake; (iii) the construction of the facility has been delayed by environmental contamination caused by leaking underground storage tanks; and (iv) the total capital costs of the facility will not exceed $4,387,000.

Notwithstanding the foregoing and other provisions of Article 1.1 (§ 32.1-102.1 et seq.) of Chapter 4 of this title, the state home for aged and infirm veterans authorized by Chapter 668, 1989 Acts of Assembly, shall be exempt from all the 1993 certificates of public need review requirements as a medical care facility.

2. That the Commissioner of Health, in cooperation with the Department of Medical

Assistance Services and with other affected public and private entities, shall evaluate the continued need for the general moratorium on the issuance of certificates of public need for an increase in the number of beds in which nursing facility and extended care services are provided. The Commissioner shall report his findings and recommendations to the Secretary of Health and Human Resources and the Joint Commission on Health Care by November 1, 1994.

CHAPTER 281

An Act to amend and reenact §§ 32.1-122.5:1 and 32.1-122.6 of the Code of Virginia, relating to conditional grants for certain medical students.

[H 716]

Approved April 4, 1994

Be it enacted by the General Assembly of Virginia:
1. That §§ 32.1-122.5:1 and 32.1-122.6 of the Code of Virginia are amended and reenacted as follows:

§ 32.1-122.5:1. Conditional grants for certain medical students.

A. With such funds as are appropriated for this purpose, the Board of Health shall establish, in addition to the scholarships established pursuant to § 32.1-122.6, annual medical scholarships for students who (i) ~~are domiciled in Southwest Virginia, (ii)~~ intend to enter one of the designated specialties of family practice medicine, general internal medicine, pediatrics, and obstetrics/gynecology~~,~~ and ~~(iii)~~ *(ii)* commit to practicing in a medically underserved area of Southwest Virginia. Such scholarships shall be awarded to students in good standing at the Quillen School of Medicine of East Tennessee State University, *with preference being given to bona fide residents of Virginia, as determined by § 23-7.4 and specifically for bona fide residents of Southwest Virginia.* The Board of Health shall request the governing board of East Tennessee State University to submit to the Commissioner the names of those eligible applicants who are most qualified as determined by the regulations of the Board for these medical scholarships. The Commissioner shall award the scholarships to applicants whose names are submitted by the governing board.

B. The provisions of § 32.1-122.6 and all regulations of the Board promulgated pursuant to § 32.1-122.6 shall apply to the award of the scholarships established herein and to the applicants for and recipients of such scholarships. In addition to the regulations established pursuant to § 32.1-122.6, the Board shall define Southwest Virginia by designating *Planning Districts one, two, and three as* those jurisdictions in which eligible students shall be ~~domiciled~~ *required to serve.*

§ 32.1-122.6. Conditional grants for certain medical students.

A. With such funds as are appropriated for this purpose, the Board of Health shall establish annual medical scholarships for students who intend to enter the designated specialties of family practice medicine, general internal medicine, pediatrics, and obstetrics/gynecology for students in good standing at the Medical College of Virginia of Virginia Commonwealth University, the University of Virginia School of Medicine, and the Medical College of Hampton Roads. No recipient shall be awarded more than five scholarships. The amount and number of such scholarships and the apportionment of the scholarships among the medical schools shall be determined annually as provided in the appropriations act*; however, the Board shall reallocate annually any remaining funds from awards made pursuant to this section and § 32.1-122.5:1 among the schools participating in these scholarship programs, proportionally to their need, for additional medical scholarships for eligible students.* The Commissioner shall act as fiscal agent for the Board in administration of the scholarship funds.

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

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

1. Qualifications of applicants;
2. Criteria for award of the scholarships to assure that recipients will fulfill the practice obligations established in this section;
3. Standards to assure that these scholarships increase access to primary health care for individuals who are indigent or who are recipients of public assistance;
4. Assurances that bona fide residents of Virginia, as determined by § 23-7.4, are given preference over nonresidents in determining scholarship eligibility and awards;
5. Assurances that scholarship recipients will begin medical practice in one of the

designated specialties in an underserved area of the Commonwealth within two years following completion of their residencies;

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

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

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

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

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

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

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

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

E. In the event the recipient dies or becomes permanently disabled so as not to be able to engage in the practice of medicine, the recipient or his estate may, upon certification of the Commissioner, be relieved of the obligation under the contract to engage in medical practice in an underserved area upon repayment to the Commonwealth of the total amount of scholarship funds plus interest on such amount computed at eight percent per annum from the date of receipt of scholarship funds. This obligation may be waived in whole or in part by the Commissioner in his discretion upon application by the recipient or his estate to the Commissioner with proof of hardship or inability to pay.

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

G. The Commissioner shall collect all repayments required by this section and may establish a schedule of payments for reimbursement consistent with the regulations of the Board. No schedule of payments shall amortize the total amount due for a period of longer than two years following the completion of the recipient's postgraduate training or the recipient's entrance into the full-time practice of medicine, whichever is later. All such funds shall be transmitted to the Comptroller for deposit in the general fund. If any recipient fails to make any payment when and as due, the Commissioner shall notify the

Attorney General. The Attorney General shall take such action as he deems proper. In the event court action is required to collect a delinquent scholarship account, the recipient shall be responsible for the court costs and reasonable attorneys' fees incurred by the Commonwealth in such collection.

CHAPTER 138

An Act to amend and reenact § 38.2-3430 of the Code of Virginia, as it is to become effective April 1, 1994, and to amend and reenact the second enactment of Chapter 960 of the 1993 Acts of Assembly, relating to accident and sickness insurance.

[H 1344]

Approved March 30, 1994

Be it enacted by the General Assembly of Virginia:
1. That § 38.2-3430 of the Code of Virginia is amended and reenacted as follows:
§ 38.2-3430. (Effective April 1, 1994) Sunset provisions.
The provisions of this article shall expire on ~~April 1, 1994~~ *January 1, 1995.*
2. That the second enactment of Chapter 960 of the 1993 Acts of Assembly is amended and reenacted as follows:
2. That the provisions of this act shall become effective on ~~April~~ *July* 1, 1994.
3. That an emergency exists and this act shall be effective on March 31, 1994.

VIRGINIA ACTS OF ASSEMBLY -- 1994 SESSION

CHAPTER 303

An Act to amend and reenact §§ 38.2-3431 through 38.2-3433 and 38.2-3523 of the Code of Virginia, relating to accident and sickness insurance.

[H 1345]

Approved April 4, 1994

Be it enacted by the General Assembly of Virginia:
1. That §§ 38.2-3431 through 38.2-3433 and 38.2-3523 of the Code of Virginia are amended and reenacted as follows:

§ 38.2-3431. Small employer market.

A. Each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense incurred basis, each corporation providing individual or group accident and sickness subscription contracts, and each health maintenance organization or multiple employer welfare arrangement providing health care plans for health care services that offers coverage to the small employer or primary small employer market shall be subject to the provisions of this article if any of the following conditions are met:

1. Any portion of the premiums or benefits is paid by or on behalf of the small employer;

2. The eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the small employer for any portion of the premium;

3. The small employer has permitted payroll deduction for the covered individual or any portion of the premium is paid by the small employer; or

4. The health benefit plan is treated by the employer or any of the covered individuals as part of a plan or program for the purpose of §§ 106, 125, or 162 of the United States Internal Revenue Code.

B. For the purposes of this article:

"Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the Commission that a small employer carrier is in compliance with the provisions of ~~§ 38.2-3432~~ *this article* based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

~~"Affiliated companies" means companies that are affiliated or that are eligible to file a consolidated tax return which shall be treated as one carrier; provided, however that any insurance company or health services plan that is an affiliate of a health maintenance organization located in Virginia or any health maintenance organization located in Virginia that is an affiliate of an insurance company, or a health services plan, may treat the health maintenance organization as a separate carrier and each health maintenance organization that operates only one health maintenance organization in a service area of Virginia may be considered a separate carrier.~~

"Carrier" means any person that provides one or more health benefit plans or insurance in this Commonwealth, including an insurer, a health services plan, a fraternal benefit society, a health maintenance organization, a multiple employer welfare arrangement, a third party administrator or any other person providing a plan of health insurance subject to the authority of the Commission.

"Community rate" means the average rate charged for the same or similar coverage to all *primary small employer* groups with the same area, age and gender characteristics. *This rate shall be based on the carrier's combined claims experience for all groups within its primary small employer market.*

"Dependent" means the spouse or child of an eligible employee, subject to the applicable terms of the policy, contract or plan covering the eligible employee.

"Eligible employee" means an employee who works for a small group employer on a full-time basis, has a normal work week of thirty or more hours, has satisfied applicable waiting period requirements, and is not a part-time, temporary or substitute employee.

"Essential and standard health benefit plans" means health benefit plans developed pursuant to subsection D of this section.

"Established geographic service area" means a broad geographic area of the Commonwealth in which a carrier sells or has sold insurance policies on or before January 1994, or upon its subsequent authorization to do business in Virginia.

"Health benefit plan" means any accident and health insurance policy or certificate, health services plan contract, health maintenance organization subscriber contract, plan provided by a MEWA or plan provided by another benefit arrangement. Health benefit plan does not mean accident only, credit, or disability insurance; coverage of Medicare services or federal employee health plans, pursuant to contracts with the United States government; Medicare supplement or long-term care insurance; dental only or vision only insurance; specified disease insurance; *hospital confinement indemnity coverage; limited benefit health coverage;* coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

"Initial enrollment period" means a period of at least thirty days.

"Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer after the initial enrollment period provided under the terms of the health benefit plan.

~~"Essential and standard health benefit plan" means health benefit plans developed pursuant to subsection D of this section.~~

"Preexisting conditions provision" means a policy provision that limits, denies, or excludes coverage for charges or expenses incurred during a specified period following the insured's effective date of coverage, for a condition that, during a specified period immediately preceding the effective date of coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek diagnosis, care, or treatment, or for which medical advice, diagnosis, care, or treatment was recommended or received within twelve months of the effective date of coverage.

"Premium" means all moneys paid by a small employer and eligible employees as a condition of coverage from a carrier, including fees and other contributions associated with the health benefit plan.

"Primary small employer," a subset of "small employer," means any person actively engaged in business that, on at least fifty percent of its working days during the preceding year, employed no more than twenty-five eligible employees and not less than two unrelated eligible employees, *except as provided in subdivision A 2 of § 38.2-3523*, the majority of whom are enrolled within this Commonwealth. Primary small employer includes companies that are affiliated companies or that are eligible to file a combined tax return. Except as otherwise provided, the provisions of this article that apply to a primary small employer shall apply until the earlier of the plan anniversary or one year following the date the employer no longer meets the requirements of this subsection.

"Rating period" means the twelve-month ~~calendar~~ period for which premium rates are determined by a small employer carrier and are assumed to be in effect.

"Small employer" or "small employer market" means any person actively engaged in business that, on at least fifty percent of its working days during the preceding year, employed less than fifty ~~full-time~~ *eligible* employees and not less than two unrelated ~~full-time~~ *eligible* employees, the majority of whom are employed within this Commonwealth. A small employer market group includes companies that are affiliated companies or that are eligible to file a combined tax return. Except as otherwise provided, the provisions of this article that apply to a small employer shall continue to apply until the earlier of the plan anniversary or one year following the date the employer no longer meets the requirements of this section.

"Small employer carrier" means any carrier that offers health benefit plans covering eligible employees of one or more small employers or one or more primary small employers.

C. A late enrollee may be excluded from coverage for *up to* eighteen months *or may have a preexisting condition limitation apply for up to twelve months; however, in no case shall a late enrollee be excluded from some or all coverage for more than eighteen months.* ~~However,~~ An eligible employee or dependent shall not be considered a late enrollee if all of the conditions set forth below in subdivisions 1 through 4 are met or one of the conditions set forth below in subdivision 5 or 6 is met:

1. The individual was covered under a public or private health benefit plan at the time the individual was eligible to enroll.

2. The individual certified at the time of initial enrollment that coverage under another health benefit plan was the reason for declining enrollment.

3. The individual has lost coverage under a public or private health benefit plan as a result of termination of employment or employment status eligibility, the termination of the other plan's entire group coverage, death of a spouse, or divorce.

4. The individual requests enrollment within thirty days after termination of coverage provided under a public or private health benefit plan.

5. The individual is employed by a small employer that offers multiple health benefit plans and the individual elects a different plan offered by that small employer during an open enrollment period.

6. A court has ordered that coverage be provided for a spouse or minor child under a covered employee's health benefit plan, the minor is eligible for coverage and is a dependent, and the request for enrollment is made within thirty days after issuance of such court order.

However, such individual may be considered a late enrollee for benefit riders or enhanced coverage levels not covered under the enrollee's prior plan.

D. The Commission shall adopt regulations establishing the essential and standard plans Such regulations shall incorporate the recommendations of the Essential Health Services Panel, established pursuant to Chapter 847 of the 1992 Acts of Assembly. Every small employer carrier shall, as a condition of transacting business in Virginia with *primary* small employers, ~~actively~~ offer to primary small employers at least the essential and standard plans. *However, any regulation adopted by the Commission shall contain a provision requiring all small employer carriers to offer an option permitting a primary small employer electing to be covered under either an essential or standard health benefit plan to choose coverage that does not provide dental benefits. The regulation shall also require a primary small employer electing such option, as a condition of continuing eligibility for coverage pursuant to this article, to purchase separate dental coverage for all eligible employees and eligible dependents from a dental services plan authorized pursuant to Chapter 45 of this title.* All small employer carriers shall issue the plans to every primary small employer that elects to be covered under either one of the plans and agrees to make the required premium payments, and ~~to~~ *shall* satisfy the following provisions:

1. Such plan may include cost containment features such as, but not limited to, utilization review of health care services including review of medical necessity of hospital and physician services; case management; selective contracting with hospitals, physicians and other health care providers, *subject to the limitations set forth in §§ 38.2-3407 and 38.2-4209 and Chapter 43 of this title*; reasonable benefit differentials applicable to providers that participate or do not participate in arrangements using restricted network provisions; or other managed care provisions. The essential and standard plans for health maintenance organizations shall contain benefits and cost-sharing levels which are consistent with the basic method of operation and benefit plans of federally qualified health maintenance organizations, *if a health maintenance organization is federally qualified*, and of nonfederally qualified health maintenance organizations, *if a health maintenance organization is not federally qualified*. The essential and standard plans of coverage for health maintenance organizations shall be actuarial equivalents of these plans for small employer carriers.

2. No law requiring the coverage or offering of coverage of a ~~health care service or~~ benefit shall apply to the essential *or standard* health care plan or riders thereof.

3. Within 180 days after the Commission's approval of essential and standard health benefit plans, every small employer carrier shall, *as a condition of transacting business in Virginia with primary small employers*, offer and make available to *primary* small employers an essential and a standard health benefit plan.

4. Within 180 days after the Commission's approval of essential and standard health benefit plans, every primary small employer that elects to be covered under either an essential or standard health benefit plan and agrees to make the required premium payments and to satisfy the other provisions of the plan shall be issued such a plan by the small employer carrier *to become effective upon renewal or termination of any group health benefit plan which the small employer may be party to.*

5. All essential and standard benefit plans issued to primary small employers shall use a policy form approved by the Commission providing coverage defined by the essential and standard benefit plans. Coverages providing benefits greater than *and in addition to* the essential and standard plans may be provided by rider, *separate policy or plan provided that no rider, separate policy or plan shall reduce benefit or premium.* A small employer carrier shall submit all policy forms, including applications, enrollment forms, policies, subscription contracts, certificates, evidences of coverage, riders, amendments, endorsements and disclosure plans to the Commission for approval in the same manner as required by § 38.2-316. Each rider, *separate policy or plan* providing benefits greater than the essential and standard benefit plans may require a specific premium for the benefits provided in

such rider, *separate policy or plan.* The premium for such riders shall be determined in the same manner as the premiums are determined for the essential and standard plans. The Commission at any time may, after providing notice and an opportunity for a hearing to a small employer carrier, disapprove the continued use by the small employer carrier of an essential or standard health benefit plan on the grounds that such plan does not meet the requirements of this article.

6. No small employer carrier is required to offer coverage or accept applications pursuant to ~~subdivision D~~ *subdivisions 3 and* 4 of this ~~section~~ *subsection*:

a. From a primary small employer already covered under a health benefit plan except for coverage that is to commence on the group's anniversary date, but this subsection shall not be construed to prohibit a group from seeking coverage or a small employer carrier from issuing coverage to a group prior to its anniversary date; or

b. If the Commission determines that acceptance of an application or applications would result in the carrier being declared an impaired insurer.

A small employer carrier that does not offer coverage pursuant to subdivision 6 b of this subsection may not offer coverage to small employers until the Commission determines that the carrier is no longer impaired.

7. Every small employer carrier shall uniformly apply the provisions of subdivision D 6 of this section and shall fairly market the essential and standard health benefit plans to all primary small employers in their established geographic service area of the Commonwealth. A small employer carrier that fails to fairly market as required by this subdivision may not offer coverage in the Commonwealth to new small employers until the later of 180 days after the unfair marketing has been identified and proven to the Commission or the date on which the carrier submits and the Commission approves a plan to fairly market to their established geographic service area.

8. No health maintenance organization is required to offer coverage or accept applications pursuant to ~~subdivision D~~ *subdivisions 3 and* 4 of this ~~section~~ *subsection* in the case of any of the following:

a. To ~~primary~~ small employers, where the policy would not be delivered or issued for delivery in the health maintenance organization's approved service areas;

b. To an employee, where the employee does not reside or work within the health maintenance organization's approved service areas; ~~or~~

c. To primary small employers if the health maintenance organization is a federally qualified health maintenance organization and it demonstrates to the satisfaction of the Commission that the federally qualified health maintenance organization is prevented from doing so by federal requirement; however, any such exemption under this subdivision would be limited to the essential plan; or

~~c.~~ *d.* Within an area where the health maintenance organization demonstrates to the satisfaction of the Commission, that it will not have the capacity within that area and its network of providers to deliver services adequately to the enrollees of those groups because of its obligations to existing group contract holders and enrollees.

A health maintenance organization that does not offer coverage pursuant to this subdivision may not offer coverage in the applicable area to new employer groups with more than fifty eligible employees until the later of 180 days after closure to new applications or the date on which the carrier notifies the Commission that it has regained capacity to deliver services to small employers.

In the case of a health maintenance organization doing business in the small employer market in one service area of this Commonwealth, the rules set forth in this subdivision shall apply to the health maintenance organization's operations in the service area, unless the provisions of subdivision 7 of this subsection apply.

9. In order to ensure the broadest availability of health benefit plans to small employers, the Commission shall set market conduct and other requirements for carriers, agents and third-party administrators, including requirements relating to the following:

a. Registration by each carrier with the Commission of its intention to be a small employer carrier under this article;

b. Publication by the Commission of a list of all small employer carriers, including a potential requirement applicable to agents, third-party administrators, and carriers that no health benefit plan may be sold to a small employer by a carrier not so identified as a small employer carrier;

c. The availability of a broadly publicized toll-free telephone number for the Commission's Bureau of Insurance for access by small employers to information concerning this article;

d. To the extent deemed to be necessary to ensure the fair distribution of primary

small employers among carriers, periodic reports by carriers about plans issued to primary small employers; provided that reporting requirements shall be limited to information concerning case characteristics and numbers of health benefit plans in various categories marketed or issued to primary small employers. Carriers shall maintain data relating to the essential and standard benefit plans separate from data relating to additional benefits made available by rider for the purpose of complying with the reporting requirements of this section; and

e. Methods concerning periodic demonstration by small employer carriers that they are marketing and issuing health benefit plans to small employers in fulfillment of the purposes of this article.

§ 38.2-3432. Small employer market subject to certain provisions.

A. Every individual or group policy, subscription contract or plan delivered, issued for delivery or renewal in this Commonwealth or providing benefits to or on behalf of a small employer pursuant to this article is subject to the following provisions:

1. Except in the case of a late enrollee, any preexisting-conditions provision may not limit, deny or exclude coverage for a period beyond twelve months following the insured's effective date of coverage and may only relate to conditions manifesting themselves in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment or for which medical advice, diagnosis, care, or treatment was recommended or received during the twelve months immediately preceding the effective date of coverage or as to a pregnancy existing on the effective date of coverage.

2. A condition which would otherwise be covered pursuant to subdivision A 1 may not be excluded from coverage.

3. In determining whether a preexisting-conditions provision applies to an insured, all coverage shall credit the time the person was covered under previous individual or group policies providing hospital, medical and surgical or major medical coverage on an expense incurred basis if the previous coverage was continuous to a date not more than thirty days prior to the effective date of the new coverage, whether or not the new coverage is provided by a different employer, exclusive of any applicable waiting period under such coverage.

B. Coverage shall be renewable with respect to all insureds at the option of the employer except:

1. For nonpayment of the required premiums by the policyholder, contract holder or enrollee;

2. For abuse or misuse of a provider network provision;

3. For fraud or misrepresentation of the policyholder, contract holder or enrollee, with respect to their coverage;

4. When the employer is no longer actively engaged in the business in which it was engaged on the effective date of the coverage;

5. For failure to comply with contribution and participation requirements defined by the health benefit plan;

6. For failure to comply with health benefit plan provisions that have been approved by the Commission;

7. When primary small employer new business ceases to be written by an insurer in the small employer market, provided that the following conditions are satisfied:

a. Notice of the decision to cease writing new business in the primary small employer market is provided to the Commission and to either the policyholder, contract holder, enrollee or employer;

b. Writing new business in the primary small employer market in this Commonwealth shall be prohibited for a period of three years from the date of notice to the Commission pursuant to this subdivision. In the case of a health maintenance organization which ceases to do new business in the small employer market in one service area of the Commonwealth, the rules set forth in this subdivision shall apply to the health maintenance organization's operations in that service area;

c. When a small employer carrier ceases to write new business and renew business in the primary small employer market, it may continue to participate in the market of small employers which are not primary small employers if it complies with the provisions of this article applicable to the small employer market. Nothing in this provision shall prohibit a small employer carrier from writing and renewing business in the primary small employer market if it has ceased writing and renewing business to small employers which are not primary small employers; and

d. Health benefit plans subject to this article shall not be canceled for 180 days after the date of the notice required under subdivision 7 a of this subsection and for that

business of a small employer carrier which remains in force, any small employer carrier that ceases to write new business in the small employer market shall continue to be governed by this article with respect to business conducted under this article; or

8. Benefits and premiums which have been added by rider to the essential or standard benefit plans issued to primary small employers shall be renewable at the sole option of the small employer carrier.

C. If coverage is offered under this article, such coverage shall be offered and made available to all of the eligible employees of a small employer and their dependents. No coverage may be offered to only certain eligible employees or their dependents and no employees or their dependents may be excluded or charged additional premiums because of health status~~.~~*; provided that small employer groups having policies, contracts or plans in effect prior to July 1, 1994, which charge different premiums to their employees or dependents because of health status, may, upon written request to the small employer carrier at the time of any renewal of such policy, contract or plan, continue to have different premiums charged to their employees and dependents because of health status; however, this ability to charge different premiums because of health status shall expire on July 1, 1997.*

D. If coverage to the small employer market pursuant to this article ceases to be written, administered or otherwise provided, such coverage shall continue to be governed by this article with respect to business conducted under this article that was transacted prior to the effective date of termination and that remains in force.

E. No coverage offered under this article shall exclude an employer based solely on the nature of the employer's business.

§ 38.2-3433. Small employer market premium and disclosure provisions.

A. New or renewal premium rates for essential or standard health benefit plans issued by a small employer carrier to a primary small employer not currently enrolled with that same employer carrier shall be based on a community rate subject to the following conditions:

1. A small employer carrier may use the following risk classification factors in rating small groups: demographic rating, including age and gender; and geographic area rating. A small employer carrier may not use claim experience, health status, duration or other risk classification factors in rating such groups, except as provided in subdivision 2 of this subsection.

2. The premium rates charged by a small employer carrier may deviate ~~above or below~~ *from* the community rate filed by the small employer carrier by not more than twenty percent *above or twenty percent below such rate* for claim experience, health status and duration only during a rating period for such groups within a similar demographic risk classification for the same or similar coverage ~~or the rates that could be charged to such groups under the rating system~~. *Rates for a health benefit plan may vary based on the number of the eligible employee's enrolled dependents.*

3. Small employer carriers shall apply rating factors ~~including case characteristics~~ consistently with respect to all primary small employers in a similar demographic risk classification. Adjustments in rates for claims experience, health status and duration from issue may not be applied individually. Any such adjustment must be applied uniformly to the rate charged for all participants of the primary small employer.

~~B. A small employer carrier shall not involuntarily transfer a primary small employer into or out of a class of business. A small employer carrier shall not offer to transfer a primary small employer into or out of a class of business unless such offer is made to transfer all primary small employers in the class of business without regard to case characteristics, claims experience, health status, or duration of coverage since issue.~~

~~C.~~ *B.* In connection with the offering for sale of any health benefit plan to a primary small employer, each small employer carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of:

1. The extent to which premium rates for a specific primary small employer are established or adjusted in part based upon the actual or expected variation in claims costs or actual or expected variation in health condition of the eligible employees and dependents of such primary small employer;

2. Provisions relating to renewability of policies and contracts; and

3. Provisions affecting any preexisting conditions provision.

~~D.~~ *C.* Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices pertaining to its primary small employer business, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted

actuarial assumptions and are in accordance with sound actuarial principles.

~~E.~~ *D.* Each small employer carrier shall file with the Commission annually on or before March 15 *the community rates and* an actuarial certification certifying that ~~it is~~ *the carrier and its rates are* in compliance with this article. A copy of such certification shall be retained by the small employer carrier at its principal place of business.

~~F.~~ *E.* A small employer carrier shall make the information and documentation described in subsection ~~D~~ *C* of this section available for review by the Commission upon request.

§ 38.2-3523. Group requirements.

A. A group accident and sickness insurance policy shall comply with the following requirements:

1. The members eligible for insurance under the policy shall be all the members of the group, or all of any class or classes of the group. However, an insurer may exclude or limit coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

2. A group accident and sickness insurance policy shall cover at least two persons, other than spouses or minor children, *unless determined to be an eligible employee as defined in § 38.2-3431,* at the issue date and at each policy anniversary date.

B. In addition to the requirements of subsection A of this section, group credit accident and sickness insurance as defined in § 38.2-3521 shall be subject to the following requirements:

1. The debtors eligible for insurance under the policy shall be all of the debtors of the creditor or creditors, or all of any class or classes of debtors. The policy may provide that the term "debtors" shall include (i) borrowers of money or purchasers or lessees of goods, services or property for which payment is arranged through a credit transaction; (ii) the debtors of one or more subsidiary corporations; and (iii) the debtors of one or more affiliated corporations, proprietors or partnerships if the business of the policyholder and of such affiliated corporations, proprietors or partnerships is under common control.

2. The premium for the policy shall be paid by the policyholder either from the creditor's funds or from charges collected from the insured debtors, or from both. Except as provided in subdivision 3 of this subsection, a policy on which no part of the premium is to be derived from the collection of such identifiable charges must insure all eligible debtors.

3. An insurer may exclude any debtors as to whom evidence of individual insurability is not satisfactory to the insurer.

4. The total amount of insurance payable with respect to an indebtedness shall not exceed the greater of the scheduled or actual amount of unpaid indebtedness to the creditor. The insurer may exclude any payments which are delinquent on the date the debtor becomes disabled as defined in the policy.

5. The insurance shall be payable to the creditor, or any successor of the right, title or interest of the creditor. Such payment shall reduce or extinguish the unpaid indebtedness of the debtor to the extent of such payment.

6. Notwithstanding the provisions of subdivisions 1 through 5 of this subsection, insurance on agricultural credit transaction commitments may be written up to the amount of the loan commitment on a nondecreasing or level term plan. Insurance on educational credit transaction commitments may be written up to the amount of the loan commitment less the amount of any repayments made on the loan.

SENATE JOINT RESOLUTION NO. 103

Requesting the Secretary of Health and Human Resources, in cooperation with the State Corporation Commission's Bureau of Insurance, to study the benefits and costs of tax incentives and other mechanisms to encourage the purchase of long-term care insurance.

Agreed to by the Senate, February 8, 1994

Agreed to by the House of Delegates, March 4, 1994

WHEREAS, consistent with a national trend, the Commonwealth's population is aging; and

WHEREAS, over the next decade, the Commonwealth's elderly population will increase four times as rapidly as the general population; and

WHEREAS, the need for extended services and care for individuals is generally inherent to longevity; and

WHEREAS, the financing of long-term care for services required to manage chronic conditions or to compensate for limited ability affects not only individuals but also the Commonwealth in its role as service provider; and

WHEREAS, long-term care expenditures represented 56 percent of the Commonwealth's Medicaid expenditures in FY 1991 and are expected to grow annually by nine percent if current trends continue; and

WHEREAS, studies by the Commonwealth's Department of Medical Assistance Services indicate that approximately one in five people needing long-term care will begin as private pay patients in nursing homes but will eventually spend down and become Medicaid recipients; and

WHEREAS, 43 percent of these individuals will, in fact, spend down within the first six months of their stay, and 64 percent will spend down during their first year; and

WHEREAS, the Joint Commission on Health Care, established by the 1992 General Assembly, is to study, report, and offer recommendations on health care issues within the Commonwealth, including long-term care; and

WHEREAS, SJR No. 304 and HJR No. 688 of 1993 requested the Department of Medical Assistance Services and the Bureau of Insurance to study public-private partnerships which encourage the purchase of long-term care insurance; and

WHEREAS, recent congressional legislation limits the attractiveness of these types of partnerships; and

WHEREAS, it is in the best interests of the Commonwealth's citizens to examine alternative methods of encouraging long-term care insurance, including tax incentives and other mechanisms; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Secretary of Health and Human Resources, in cooperation with the Bureau of Insurance, be requested to study the benefits and costs of tax incentives and other mechanisms to encourage the purchase of long-term care insurance.

The Secretary of Health and Human Resources and the Bureau of Insurance shall submit their findings and recommendations to the Joint Commission on Health Care by September 1994, and to the Governor and the 1995 Session of the General Assembly in accordance with the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

SENATE JOINT RESOLUTION NO. 110

Requesting the Joint Commission on Health Care to examine for-profit and not-for-profit hospitals and their contribution to the health care community.

Agreed to by the Senate, February 14, 1994

Agreed to by the House of Delegates, February 25, 1994

WHEREAS, the Commonwealth grants tax-exempt status for income and sales and use taxes to hospitals designated by the United States Internal Revenue Service as § 501 (c) (3), or not-for-profit, organizations; and

WHEREAS, a number of other states have developed community benefit standards that must be met by hospitals seeking the not-for-profit designation in such states; and

WHEREAS, the Commonwealth levies income and sales and use taxes on for-profit hospitals; and

WHEREAS, health care is undergoing extensive examination and therefore change leading to different delivery systems, new payment practices, better access to services, and greater accountability to those who use the system; and

WHEREAS, in examining the health care community, a thorough analysis of all hospitals, whether for-profit or not-for-profit, and their contributions to the health care community is essential; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Commission on Health Care be requested to examine for-profit and not-for-profit hospitals and their contribution to the health care community. The commission shall undertake a study of the nature and types of ownership of institutional health care providers, both inpatient and outpatient, with a special emphasis on community benefit and costs realized, taxation, relationship of charges to costs and profitability in aggregate and by ownership category, effects on health care purchasers and local governments of either imposing taxes on those exempt therefrom or relieving those subject to taxation from some portion thereof, the uses to which profits are put, the definition of markets served, variation of community need by locality and region, role in health professional education, financing alternatives as the same may bear on the cost of services, and such other matters as the commission may deem appropriate for its consideration.

The commission shall make use of such private resources as may be available.

The commission shall submit its findings and recommendations on this issue in its report to the Governor and the 1995 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

SENATE JOINT RESOLUTION NO. 111

Requesting the Joint Commission on Health Care to continue its study of third-party reimbursement, with a focus on pharmacy services.

Agreed to by the Senate, February 8, 1994

Agreed to by the House of Delegates, February 25, 1994

WHEREAS, House Joint Resolution No. 714 of 1993 requested the Joint Commission on Health Care to study the reimbursement of health care providers by third-party reimbursement programs; and

WHEREAS, a special focus of this resolution was the impact of third-party reimbursement practices on the retail pharmacy sector; and

WHEREAS, the value of special pharmacy services, including, but not limited to, compounding drugs and medicines, furnishing special containers or applicators, or utilizing special equipment in preparing or dispensing drugs or medicines, cannot be underestimated; and

WHEREAS, medications are frequently a cost-effective means of avoiding more costly care, such as hospitalization, when they are properly prescribed, dispensed, and used; and

WHEREAS, third-party reimbursements may not adequately cover the provider's actual cost of delivering pharmacy goods and services; and

WHEREAS, the advent of such third-party reimbursement for pharmacy goods and services has also contributed to an adversarial relationship between patrons and providers; and

WHEREAS, third-party reimbursement programs often either specify particular providers that insureds or enrollees must use or encourage or discourage use of particular providers; and

WHEREAS, third-party reimbursement may increase the administrative costs of the retail pharmacy sector; and

WHEREAS, the increase in third-party reimbursement programs may force providers to raise the prices charged to the diminishing direct-pay population; and

WHEREAS, many of these third-party payers are not insurance companies and are therefore not subject to regulation by the State Corporation Commission; and

WHEREAS, retail pharmacy providers may not have the ability to negotiate effectively with third-party reimbursement programs; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Commission on Health Care be requested to continue to study the reimbursement of retail pharmacy providers by third-party reimbursement programs. In its deliberations, the commission shall consider (i) the effect of such programs upon the quality of retail pharmacy services in the Commonwealth; (ii) whether such programs jeopardize or unfairly take advantage of retail pharmacy providers in the Commonwealth, and (iii) the value of special pharmacy services, including, but not limited to, compounding drugs and medicines, furnishing special containers or applicators, or utilizing special equipment in preparing or dispensing drugs, applicators, or medicines. In order to ensure the delivery of quality and cost-effective retail pharmacy services, the joint commission shall recommend any legislation deemed necessary to ensure reasonable participation by all sectors of the retail pharmacy provider community in third-party reimbursement programs and provider networks.

The joint commission shall complete its work in time to submit its findings and recommendations to the Governor and the 1995 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

SENATE JOINT RESOLUTION NO. 113

Requesting that the Commissioner of Health reallocate existing resources for the creation of an Office of Health Professions. Recruitment and Retention to provide a central coalition of public and private entities engaged in recruitment and retention activities for the Commonwealth.

Agreed to by the Senate, February 8, 1994

Agreed to by the House of Delegates, March 4, 1994

WHEREAS, consistent with the national trend, the Commonwealth's shortage and maldistribution of primary care providers are hindering access to and delivery of lower cost and preventative primary care services; and

WHEREAS, the number of medically underserved counties in Virginia, or those with one physician per 2,000 or more individuals, exceeds those which are well serviced; and

WHEREAS, the number of primary care physicians is steadily decreasing nationwide and throughout the Commonwealth; and

WHEREAS, numerous public and private entities in the Commonwealth, including the Area Health Education Centers, the Department of Health Professions, the Medical Society of Virginia, the Old Dominion Medical Society, the Virginia Hospital Association, the Virginia Health Care Foundation, the Virginia Health Council, and the Virginia Primary Care Association and third-party payors, engaged in recruitment and retention activities aimed at encouraging health care providers to establish and remain in practice in medically underserved areas in the Commonwealth; and

WHEREAS, the Code directs the Virginia Department of Health to make recommendations concerning health policy, including recruitment and retention activities, to the Governor, the General Assembly, and the Secretary of Health and Human Resources; and

WHEREAS, the Joint Commission on Health Care, established by the 1992 General Assembly, is to study, report, and offer recommendations on health care issues within the Commonwealth, including access to and delivery of primary care services; and

WHEREAS, the joint commission received an 18-month planning grant from the Robert Wood Johnson Foundation to explore public-private partnership opportunities for the development of a statewide recruitment and retention strategy; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Commissioner of Health of the Virginia Department of Health be requested to reallocate existing resources for the establishment of an Office of Health Professions, Recruitment, and Retention to provide central coordination of recruitment and retention activities of public and private entities engaged in these activities in the Commonwealth. The office shall give special attention to recruitment and retention of primary care providers for the Commonwealth's medically underserved counties and shall serve as an informational clearinghouse for health care provider recruitment activities. In establishing such an office, the Commissioner shall seek the assistance from existing public and private entities who are engaged in recruitment and retention activities. The Commissioner shall report annually to the Governor and General Assembly and the Joint Commission on Health Care on the status of recruitment and retention activities in the Commonwealth.

The Area Health Education Centers, the Department of Health Professions, the Medical Society of Virginia, the Old Dominion Medical Society, the Virginia Hospital Association, the Virginia Health Care Foundation, the Virginia Health Council, the Virginia Nurse's Association, and the Virginia Primary Care Association shall provide assistance to the Commissioner in this task.

SENATE JOINT RESOLUTION NO. 126

Requesting the Joint Commission on Health Care, in cooperation with the Commissioner of Insurance and the Commissioner of Health, to continue its study of organized health services delivery systems.

Agreed to by the Senate, February 8, 1994

Agreed to by the House of Delegates, February 25, 1994

WHEREAS, it is widely recognized that universal access to health care will be unaffordable in the absence of successful cost-containment efforts; and

WHEREAS, it is also recognized that cost containment should not be achieved at the expense of access to high-quality, necessary health care services; and

WHEREAS, various national health care reform proposals envision the use of organized health care delivery systems as a means of delivering cost-effective health care services; and

WHEREAS, a variety of organized delivery systems are developing across the Commonwealth, including hospital systems, physician-hospital organizations, health maintenance organizations, and other types of systems; and

WHEREAS, the Joint Commission on Health Care has studied organized delivery systems pursuant to Senate Joint Resolution No. 316 of the 1993 Session; and

WHEREAS, the Joint Commission on Health Care has specifically reviewed the community health network model of service delivery and financing; and

WHEREAS, this model would feature locally organized provider networks which provide patients with a continuum of health services, are accountable for costs and quality, and possibly assume insurance risk for the provision of services; and

WHEREAS, review and discussion of this model have raised a number of important questions related to the appropriate direction of health care reform in Virginia; and

WHEREAS, such questions must be resolved as part of the Commonwealth's ongoing health care reform efforts; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Commission on Health Care, in cooperation with the Commissioner of Insurance and the Commissioner of Health, be requested to continue its study of organized health services delivery systems; and, be it

RESOLVED FURTHER, That the Joint Commission on Health Care, in cooperation with the Commissioner of Insurance and the Commissioner of Health, examine the following issues: (i) the value of community health network characteristics, such as local organization, managed care, accountability for costs and quality, and the assumption of insurance risk; (ii) the similarities and differences between community health networks and health maintenance organizations; (iii) the extent to which statutory and regulatory requirements for health maintenance organizations should also be applied to community health networks which assume insurance risk, particularly with respect to protection against insolvency; and (iv) the extent to which the most desirable features of the community health network model should be required of health maintenance organizations, health plans, and other modes of health care delivery and finance; and, be it

RESOLVED FINALLY, That the Joint Commission on Health Care, in cooperation with the Commissioner of Insurance and the Commissioner of Health, shall solicit input from health care purchasers, health care providers and third party payers.

The commission shall include its findings and recommendations in its 1994 annual report to the Governor and the General Assembly in accordance with the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

SENATE JOINT RESOLUTION NO. 132

Requesting the Joint Commission on Health Care in cooperation with the Bureau of Insurance and other state agencies and private groups, to continue its study of health plan purchasing cooperatives.

Agreed to by the Senate, March 1, 1994

Agreed to by the House of Delegates, February 25, 1994

WHEREAS, a lack of insurance coverage continues to be a major problem in Virginia; and

WHEREAS, the Commonwealth has enacted various programs and policies designed to expand access to health coverage for the uninsured; and

WHEREAS, the Commonwealth makes major expenditures for the purchase of health care coverage for state and local public sector employees; and

WHEREAS, health plan purchasing cooperatives could enable small businesses, individuals, families, and other groups to benefit from the power of large purchasing cooperatives that negotiate and contract with competing partnerships of health care providers and insurers; and

WHEREAS, other states and the U.S. Congress are considering health plan purchasing cooperatives as major elements of health care reform; and

WHEREAS, the Joint Commission on Health Care, in cooperation with the Bureau of Insurance and other state agencies and private groups, has initiated a study of the feasibility of creating health plan purchasing cooperatives to increase access to affordable health care coverage for small businesses, individuals, families, and other groups that would benefit from the economics of cooperative purchasing; and

WHEREAS, the results of this study indicate that there are a number of complex operational issues involved in the creation of health plan purchasing cooperatives; and

WHEREAS, there is a need for additional public discussion and analysis before the General Assembly makes final decisions about the creation of health plan purchasing cooperatives; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Commission on Health Care, in cooperation with the Bureau of Insurance and other state agencies and private groups, continue to study the feasibility of creating health plan purchasing cooperatives. In this regard, the joint commission is requested to make recommendations in the following areas regarding health plan purchasing cooperatives (cooperatives): (i) the potential of cooperatives to expand access to necessary health coverage for the working uninsured, uninsured children, and other uninsured individuals; (ii) the potential of cooperatives to serve state employee benefit plans and the Virginia Medicaid program; (iii) the appropriate employer size threshold; (iv) the appropriate organizational model and governance structure for cooperatives; (v) whether participation in cooperatives should be mandatory or voluntary; (vi) the appropriate role of state employee benefit plans and the Medicaid program; (vii) the appropriate number of cooperatives and the corresponding regional responsibilities; (viii) the appropriate role of cooperatives in setting prices, certifying health plans, and extending access to underserved areas; (ix) the types of plans which should be offered through cooperatives; (x) the appropriate degree of employee and employer cost sharing and choice; (xi) appropriate rating, underwriting, and open enrollment requirements for participating health plans; (xii) the appropriate risk adjustment methodology to be used in cooperatives; (xiii) the appropriate use of private administrators in carrying out the responsibilities of cooperatives; (xiv) the anticipated costs of creating cooperatives; and (xv) the pertinent legal issues surrounding the creation of cooperatives; and, be it

RESOLVED FURTHER, That the Joint Commission on Health Care, in cooperation with the Bureau of Insurance and other state agencies and private organizations, shall: (i) gather information on the target population's interest in and views on purchasing health care through a health plan purchasing cooperative, (ii) identify legislation that may be required for the Commonwealth or other entities to establish health plan purchasing cooperatives, (iii) and report its findings on health plan purchasing cooperatives to the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

SENATE JOINT RESOLUTION NO. 164

Requesting the Joint Commission on Health Care to study the strategies and incentives necessary to promote cost-effective health care delivery by making optimum use of nurse practitioners.

Agreed to by the Senate, February 14, 1994

Agreed to by the House of Delegates, February 25, 1994

WHEREAS, in order to provide cost-effective, accessible, quality, health care it is necessary to coordinate teams of health-care practitioners in all delivery settings; and

WHEREAS, relationships between and among members of regulated health occupations and professions are governed by statute and regulations which define terms, such as "collaboration," that affect interdependent health-care practices; and

WHEREAS, national studies and studies in the Commonwealth, including studies conducted by the Area Health Education Center Nurse Task Force, have identified barriers to cost-effective care that are created or fostered by these regulatory definitions and relationships; and

WHEREAS, nurse practitioners in the Commonwealth are regulated by the Joint Boards of Medicine and Nursing within the Department of Health Professions; and

WHEREAS, the Joint Commission on Health Care is charged to "study, report and make recommendations on all areas of health-care provision, regulation, insurance, liability, licensing, and delivery of health-care services"; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Commission on Health Care be requested to study the strategies and incentives necessary to promote cost-effective health care delivery by making optimum use of nurse practitioners within the Commonwealth. The study shall specifically address: (i) the extent to which, if any, existing statutes and regulations governing nurse practitioners create barriers to cost-effective care; and (ii) the social and financial impact and medical efficacy of direct reimbursement to nurse practitioners, as well as the effect such reimbursement would have on access to primary health-care services in the Commonwealth.

The Joint Boards of Medicine and Nursing, the Area Health Education Centers program and other related public and private agencies and associations representing the affected health-care professions shall be requested to provide support to the commission in carrying out this study. Pursuant to the Administrative Process Act (§ 9-6.14:1 et seq.), the Joint Boards of Medicine and Nursing be requested to promulgate proposed appropriate definitions of the term "collaboration" and other terms affecting interdependent health-care practices that describe and govern the relationship between physicians and nurse practitioners. By October 1, 1994, the joint boards shall report to the Joint Commission on Health Care on the progress in developing such definitions.

The Joint Commission on Health Care shall complete its work in time to submit its findings and recommendations to the Governor and the 1995 Session of the General Assembly in accordance with the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

SENATE JOINT RESOLUTION NO. 185

Requesting the Virginia Statewide Area Health Education Centers to assess pharmaceutical practice needs and to develop a plan that will lead to the enhancement of pharmaceutical care delivery programs.

Agreed to by the Senate, February 8, 1994

Agreed to by the House of Delegates, March 4, 1994

WHEREAS, during the past 20 years the functions of pharmacists have become more information centered and patient oriented; and

WHEREAS, today, pharmacists are being educated to participate in medication therapy decisions in order to assure the appropriate drug therapy outcome; and

WHEREAS, preparing pharmacy students and practicing pharmacists to focus more on the outcomes of drug therapy will require the development of model practice environments wherein they will be exposed to significant patient interactions that involve medication monitoring and therapeutic counseling; and

WHEREAS, substantial evidence suggests that: (i) expanded pharmaceutical care is needed; (ii) drug misuse and drug-related illnesses are adding $2 to 3.5 billion annually to health care costs; and (iii) the incidence of adverse drug reactions, mismedication, patient noncompliance and other drug-related illness is high; and

WHEREAS, the reduction of drug-related problems and associated costs can be accomplished with increased involvement by pharmacists through enhanced pharmaceutical care services; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Virginia Statewide Area Health Education Centers' program, in cooperation with the School of Pharmacy, Medical College of Virginia/Virginia Commonwealth University, the State Council for Higher Education, the Virginia Pharmacists Association, the Virginia Society of Hospital Pharmacists, the Virginia Association of Chain Drug Stores, the Virginia Board of Pharmacy, the Medical Society of Virginia, the Old Dominion Medical Society, the Old Dominion Pharmaceutical Association, the Virginia Academy of Family Physicians and the Virginia Nurses' Association, be requested to (i) assess pharmaceutical practice needs in the Commonwealth in order to improve the delivery of primary health care and (ii) develop a plan that will lead to the enhancement of pharmaceutical care delivery programs by focusing on model ambulatory pharmacy practice care centers. This plan shall include identification of the basic characteristics required by pharmaceutical care delivery, appropriate standards for the monitoring of drug therapy, therapeutic categories to be evaluated, appropriate patient base to be served, and appropriate locations for coordination of pharmacy care with other health profession services; and, be it

RESOLVED FURTHER, That the Virginia Statewide Area Health Education Centers' program, in cooperation with the School of Pharmacy, Medical College of Virginia/Virginia Commonwealth University, the State Council for Higher Education, the Virginia Pharmacists Association, the Virginia Society of Hospital Pharmacists, the Virginia Association of Chain Drug Stores, the Virginia Board of Pharmacy, the Medical Society of Virginia, the Old Dominion Medical Society, the Old Dominion Pharmaceutical Association, the Virginia Academy of Family Physicians and the Virginia Nurses' Association, be requested to develop a plan to achieve these objectives, to report this plan to the Joint Commission on Health Care by October 1, 1994, and to make subsequent progress reports on implementation on October 1, 1995, October 1, 1996, and October 1, 1997.

GENERAL ASSEMBLY OF VIRGINIA -- 1994 SESSION

HOUSE JOINT RESOLUTION NO. 140

Memorializing the Congress of the United States to enact legislation to equalize the tax treatment of health insurance purchased outside of employer groups, and to equalize the tax treatment of the insurance form known as medical care savings accounts.

Agreed to by the House of Delegates, February 4, 1994

Agreed to by the Senate, March 8, 1994

WHEREAS, 38 million Americans were without health insurance at some time in the last year, many while between jobs or while employed in jobs that did not offer health insurance; and

WHEREAS, the rising costs of health care threaten access for even those currently insured, particularly as escalating costs force employers to trim the level and availability of health care benefits to their employees; and

WHEREAS, employer contributions to employee group health insurance are presently fully exempt from federal income tax; and

WHEREAS, insurance purchased by individuals outside of employer groups, by the unemployed, the self-employed, the part-time employed, and those otherwise unable to obtain group coverage through their employer, is limited to at most a 25 percent exemption; and

WHEREAS, even this smaller benefit to individuals has at times been threatened with removal; and

WHEREAS, those without access to employer coverage are likely to be more in need of subsidy to afford insurance; and

WHEREAS, aside from need, fairness suggests that those without access to employer coverage be accorded the same tax privileges for their health insurance purchases as those available within employer groups; and

WHEREAS, the continuation of a differential benefit to employer-sponsored health insurance may contribute to the perpetuation of a system that adversely affects worker mobility, since employer coverage is not portable and coverage outside an employer group is prohibitively expensive; and

WHEREAS, this arrangement may also limit individual choice of health coverage to the levels and forms of insurance chosen by the employer; and

WHEREAS, the form of health insurance known as medical care savings accounts, combining high-deductible insurance policies with dedicated funds to meet insurance expense, may offer a fruitful mechanism to control spending and spur consumer responsibility for health care choices, by forcing health services purchasers to consider the full cost of services for expenses under their deductibles; and

WHEREAS, the present system of tax privileges does not extend exemption to contributions to a dedicated savings account for medical purposes, except for the current Flexible Spending Accounts under § 125 of the Federal Tax Code; and

WHEREAS, § 125 account funds must be used by the end of the tax year or forfeited undermining consumer incentives to save; and

WHEREAS, the Clinton Health Security Act proposes to eliminate § 125 accounts; and

WHEREAS, states like Virginia that practice strict federal conformity are bound to accept the federal determination of taxable income and exemptions therefrom, or else engender the substantial costs of independent monitoring and enforcement for Tax Code compliance; and

WHEREAS, changes in state tax policy alone might not yield enough substantial benefits to induce appropriate changes in insurance coverage, given that a state can only provide exemptions from its own levies; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Congress of the United States be requested to enact legislation which makes the tax privileges accorded to health insurance purchased by individuals outside of employer groups equivalent to that available within employer groups; and to enact legislation which makes the tax privileges accorded to medical care savings accounts equivalent to that accorded other forms of health insurance; and, be it

RESOLVED FURTHER, That the Clerk of the House transmit copies of this resolution to the President of the United States, the Speaker of the United States House of Representatives, the President of the United States Senate, and all members of the Virginia Congressional Delegation so that they may be apprised of the sense of the General

GENERAL ASSEMBLY OF VIRGINIA -- 1994 SESSION

HOUSE JOINT RESOLUTION NO. 166

Encouraging Virginia's private sector to continue its support of efforts by the Virginia Health Care Foundation to enhance access to primary and preventive care for Virginia's uninsured citizens.

Agreed to by the House of Delegates, March 10, 1994

Agreed to by the Senate, March 8, 1994

WHEREAS, the General Assembly, the Governor and the Joint Commission on Health Care initiated the Virginia Health Care Foundation in June, 1992, to promote and support local public/private partnerships which extend primary and preventive health care services to Virginia's one million uninsured citizens; and

WHEREAS, over thirty innovative projects involving volunteer, business and community efforts have been funded, including a mobile health clinic, a pharmacy access program, a mobile dental clinic, an elementary school primary care clinic, collaborative clinics and a clinic for chronically ill adults; and

WHEREAS, Virginia Health Care Foundation projects must evidence: innovative service delivery models which respond to acknowledged community needs; seasoned local management and leadership; written pledges of commitment of cash and in-kind contributions of at least 25 percent; a plan to sustain funding after Foundation grants are depleted; and an evaluation process tailored to desired project impact; and

WHEREAS, while the Virginia Health Care Foundation has granted $ 2.1 million statewide, it has attracted $3 million in cash and $3.2 million in in-kind contributions at the state and local levels that have resulted in a leverage of three dollars in health services for each dollar contributed; and

WHEREAS, the first leadership cash gifts to the Virginia Health Care Foundation at the state level have been donated by Blue Cross and Blue Shield of Virginia, Johnston Memorial Hospital, Kaiser Permanente, The Mills Corporation and Potomac Mills Mall, and the Virginia Hospital Association; and

WHEREAS, leadership in in-kind gifts to the Virginia Health Care Foundation at the state level has been provided by Blue Cross and Blue Shield of Virginia, Columbia Capital Corporation, the Intergovernmental Health Policy Project, George Washington University, Jefferson National Bank, KPMG Peat Marwick, Martin Public Relations, and McGuire, Woods, Battle & Boothe; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That Virginia's other corporate citizens be encouraged to use their various talents and resources to support the efforts of the Virginia Health Care Foundation and to commit themselves to working in partnership with the Foundation to enhance access to primary and preventive care for Virginia's uninsured and underserved citizens; and, be it

RESOLVED FURTHER, That the Clerk of the House of Delegates prepare a copy of this resolution for presentation to the Executive Director of the Virginia Health Care Foundation in honor of its efforts to enhance access to primary and preventive care for Virginia's uninsured citizens.

GENERAL ASSEMBLY OF VIRGINIA -- 1994 SESSION

HOUSE JOINT RESOLUTION NO. 173

Requesting the Virginia Department of Health to continue the Women's Health Study.

Agreed to by the House of Delegates, February 10, 1994

Agreed to by the Senate, March 8, 1994

WHEREAS, the importance of women's health has been recognized by the Commonwealth and by the nation; and

WHEREAS, pursuant to House Joint Resolution No. 621 (1993), the Virginia Department of Health was requested to provide a profile of the status of women's health in the Commonwealth; and

WHEREAS, in the report on the status of women's health in Virginia, the Department acknowledged that relevant data are under-reported and that such data are not sufficiently quantified and analyzed; and

WHEREAS, such statistics are deemed to be vital to the quality and accessibility of health care provided to the women of this Commonwealth; and

WHEREAS, Virginia is committed to ensuring high quality, fiscally responsible health care to all its people, increasing the effectiveness of and accessibility to health care while containing costs; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Virginia Department of Health be requested to continue its review of women's health status in the Commonwealth, concentrating on women between the ages of 12 and 64. The Department shall include an assessment of (i) the current data systems measuring the health of women, including gaps in existing systems and recommendations for revisions to such systems to improve the data; (ii) the health-related problems which disproportionately affect women; and (iii) the incidence and effects of violence against women. The Department shall also develop a concise brochure on women's health status for use by employers, health care providers, educators, and state and local governments.

The Department of Health shall complete its work in time to submit its findings and recommendations to the Governor and the 1995 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

GENERAL ASSEMBLY OF VIRGINIA -- 1994 SESSION

HOUSE JOINT RESOLUTION NO. 183

Requesting the Joint Commission on Health Care, with the assistance of the Secretary of Health and Human Resources and the Maternal and Child Health Council, to study the issues impacting universal access to health care for Virginia's uninsured children and the extent to which current initiatives should be expanded or revised to ensure that such access exists.

Agreed to by the House of Delegates, February 10, 1994

Agreed to by the Senate, February 28, 1994

WHEREAS, over 200,000 children in Virginia, one out of every seven, live in families who cannot afford basic health care; and

WHEREAS, nationally, the number of children without health insurance has increased 40 percent in 14 years, and approximately 11 million children in the United States currently have no health insurance; and

WHEREAS, poor health care affects children in all Virginia communities, cities, rural areas, and affluent suburbs where over 13 percent of all children are uninsured; and

WHEREAS, the national debate on health care reform encompasses the goal of universal access to health care for all citizens, with a special emphasis on children, and proposals currently under consideration include various models for achieving this goal; and

WHEREAS, in 1990, the Governor established a Child Health Task Force to review the needs of these 200,000 uninsured children in Virginia and, based on its recommendations, the 1992 General Assembly approved expanded coverage to include an additional 30,000 children between the ages of five and eighteen with incomes of up to 100 percent of the federal poverty level under Virginia's Medicaid program; and

WHEREAS, the 1992 General Assembly also appropriated $3.4 million effective July 1, 1993, to implement a modified insurance program for the approximately 6,000 children under one year of age in families with incomes between 133 percent and 200 percent of the federal poverty level; and

WHEREAS, the Secretary of Health and Human Resources was directed to work with the Joint Commission on Health Care to identify the appropriate service delivery model for the child health initiative; and

WHEREAS, in response to the General Assembly's mandate, the Secretary of Health and Human Resources and the Child Health Task Force recommended that the modified health insurance program include core preventive and primary care services, that the Department of Medical Assistance Services serve as the central administering agency to contract with a third party for administration and service delivery, that the administrative services be provided at no cost to the Commonwealth, and that public and private partnerships with existing providers be maximized to the extent possible; and

WHEREAS, the Department of Medical Assistance Services contracted with the Virginia Caring Program, Inc., a not-for-profit subsidiary of Blue Cross and Blue Shield of Virginia, to implement the modified insurance product for these approximately 6,000 infants of up to one year of age, and beginning in November of 1993, the program, Kids Care, began to enroll children; and

WHEREAS, the Department of Medical Assistance Services is seeking a waiver for federal matching funds from the Health Care Financing Administration in order to expand the Kids Care program to include children up to age three who are in families at 200 percent of the poverty level; and

WHEREAS, the Virginia Health Care Foundation was established to foster and encourage public and private partnerships to advance numerous local initiatives aimed at improving access to primary health care for Virginia's children; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Commission on Health Care, in cooperation with the Secretary of Health and Human Resources , the Department of Medical Assistance Services and its contractor, the Virginia Caring Program, and with the advice of the Virginia Maternal and Child Health Council, shall evaluate (i) the impact of the expanded coverage for children under the Kids Care program; (ii) the need, if any, to modify the benefits provided under the plan; (iii) the extent to which the program should be expanded to include a larger target population and how federal funds can be maximized to support such expanded coverage; and (iv) the manner in which Virginia's expanded coverage for children can serve as a model in Virginia under any national reform calling for universal access.

GENERAL ASSEMBLY OF VIRGINIA -- 1994 SESSION

HOUSE JOINT RESOLUTION NO. 209

Requesting that the Secretary of Health and Human Resources, in cooperation with appropriate state and local agencies and organizations, review the plan for state-level consolidation of certain long-term care and aging services within a single state agency, and develop a plan for the coordinated delivery of such services at both the state and local levels.

Agreed to by the House of Delegates, March 10, 1994

Agreed to by the Senate, March 8, 1994

WHEREAS, the Commonwealth's policy for long-term care, as adopted by the 1993 General Assembly through House Joint Resolution No. 602, is to provide services to elderly individuals with programs and in settings which maximize their ability to function as independently as possible and which encourage the principles of personal dignity, a decent quality of life, individuality, privacy, and the right to make choices; and

WHEREAS, the number of elderly persons residing in the Commonwealth is expected to increase dramatically in the next 20 years; and

WHEREAS, long-term care has become the fastest growing component of the health care industry because of improved medical technology and changes in population demographics, longevity and morbidity; and

WHEREAS, long-term care and aging services should be delivered in the communities where the elderly and their families live; and

WHEREAS, the Long-term Care and Aging Task Force, established pursuant to House Joint Resolution No. 603 of the 1993 Session of the General Assembly, recommended a plan for the consolidation of state-level planning, administration, management, development, regulation, and funding of long-term care and aging; and

WHEREAS, the Task Force also reported that local flexibility in administration and delivery of services is essential but recommended that state guidance be provided regarding expectations for statewide service delivery; and

WHEREAS, any changes in the long-term care and aging services delivery systems at the state and local level should be accomplished in a manner that maximizes efficiency and effectiveness of the existing system and should not shift costs to localities or require any unfunded mandates for localities; and

WHEREAS, the Long-term Care and Aging Task Force recommended that a consolidated and restructured state-level long-term care and aging agency should be established and operational by January 1, 1995, and that there should be further study of the issues related to local service delivery systems; and

WHEREAS, the Joint Commission on Health Care concurred with the findings of the Task Force and recommended that long-term care services at the state level be consolidated by July 1, 1995, and that local service delivery systems become operational as soon as possible but by no later than January 1, 1998; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Secretary of Health and Human Resources, in cooperation with appropriate state agencies, including representatives of the Secretary of Finance, local service delivery agencies, local governments, affected consumer and provider organizations, and representatives of the Long-term Care Council and the Governor's Advisory Board on Aging, be requested to review the plan for state-level consolidation as proposed in House Bill 1267 and Senate Bill 575 of the 1994 Session of the General Assembly, and present a plan to ensure coordination and enhancement of service delivery at both the state and local levels; and, be it

RESOLVED FURTHER, That the Secretary's implementation plan shall address the manner in which long-term care and aging services currently available through the State Department of Social Services and local departments of social services, including adult services, adult protective services and auxiliary grant payments, will be delivered and shall identify any state and local costs associated with the plan; and, be it

RESOLVED FINALLY, That the Secretary's plan for delivery of services at the local level ensure that (i) the service delivery system include the development of a network of connected, collaborative care planning, authorizing and delivery entities which have comprehensive responsibility for consumer outcomes; (ii) the service delivery system emphasize accessibility by consumers, including resource co-location; (iii) informal, voluntary and private resources be fully used in the delivery of services; and (iv) any changes in the delivery system not shift costs to localities or require any unfunded

GENERAL ASSEMBLY OF VIRGINIA -- 1994 SESSION

HOUSE JOINT RESOLUTION NO. 267

Requesting the Virginia Health Services Cost Review Council, in cooperation with appropriate public and private entities, to examine data being compiled in the development of the patient level database and by other appropriate health-related state agencies and to propose additional elements and reporting formats to facilitate the evaluation and assessment of the cost, quality, and accessibility of health plans.

Agreed to by the House of Delegates, February 14, 1994

Agreed to by the Senate, March 8, 1994

WHEREAS, the 1993 Session of the General Assembly established a patient level data system for the "collection and analysis of data which shall be used by consumers, employers, providers, and purchasers of health care and by state government to continuously assess and improve the quality, appropriateness, and accessibility of health care in the Commonwealth and to enhance their ability to make effective health care decisions"; and

WHEREAS, pursuant to the authority conferred by § 9-166.4 of the Code of Virginia, the Executive Director of the Virginia Health Services Cost Review Council (VHSCRC) has entered into an agreement with Virginia Health Information, Inc., (VHI) for the compilation, storage, analysis, and evaluation of patient level data; and

WHEREAS, VHI has submitted a report to the Joint Commission on Health Care regarding the nature and type of specific analysis from the patient level data system that can be used to compare institutions based on certain hospital indicators of performance; and

WHEREAS, consistent with the directive of § 9-161.1 of the Code of Virginia, requiring the VHSCRC to promulgate regulations establishing a methodology for the review and measurement of the efficiency and productivity of health care institutions, the VHSCRC has entered into an interagency agreement with the Williamson Institute for Health Studies at Virginia Commonwealth University to provide statistical and economic expertise to identify efficient and productive providers of quality health care; and

WHEREAS, the National Committee for Quality Assurance has released a 1993 version of the Health Plan Employer Data and Information Set, which provides employers with an evaluation tool or report card to assess the performance of health plans; and

WHEREAS, while the Commonwealth currently collects a wide variety of health care information, this information has not been integrated into an effective policy information system, and there may be a need to collect additional, new types of data; and

WHEREAS, many of the national health care reform proposals focus on statewide evaluation of health plans to encourage competition among health plans and to assist employers and consumers in making informed choices; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Virginia Health Services Cost Review Council be requested, in cooperation with appropriate public and private entities, to examine data being compiled for the patient level database and by other appropriate health-related state agencies and to propose additional elements and reporting formats to facilitate the evaluation and assessment of the cost, quality, and accessibility of health plans. The study shall identify key cost, quality, and access indicators which would form the basis of a standardized report card for use by providers and consumers in health care decision making. The study shall also examine the feasibility and expense of collecting and analyzing necessary data; appropriate methods for housing and disseminating the information with necessary safeguards for patient confidentiality; and the appropriate role of the Commonwealth in such a process. The VHSCRC shall complete its study for inclusion in the 1994 annual report of the Joint Commission on Health Care and shall report its findings and recommendations to the Governor, the 1995 Session of the General Assembly, and the Joint Commission on Health Care as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

APPENDIX B:

Comparison of Federal Health Care Reform Proposals (As of September, 1993)

COMPARISON OF MAJOR FEDERAL HEALTH CARE REFORM PROPOSALS

	Clinton Administration Proposal	**Conservative Democratic Forum Proposal (Reps. Cooper (TN), Andrews (TX), Stenholm (TX), et. al.)**	**Senate Republican Health Care Task Force Proposal (Chafee (RI) et. al.)**	**House Republican Proposal (Michel, (IL), et. al.)**
TITLE	*American Health Security Act of 1993*	*Managed Competition Act of 1993*	*Health Equity and Access Reform Today (HEART)*	*Affordable Health Care Now Act of 1993*
ACCESS				
Universal Coverage	Yes	Yes	Yes	No
Benefits	National benefits package defined in proposal.	Standard benefit package developed by national board.	Standard benefit package to be designed by an independent commission.	An as-yet-undefined comprehensive benefits package (no further details available).
Employer Mandate	Yes. Employer must offer insurance and pay 80 percent of premium. Federal subsidies for small, low-wage firms.	No. Employer may pay a share of the premium, but is not required to do so.	No. Employer may pay a share of the premium, but is not required to do so.	Employers must offer, but do not have to pay for, insurance coverage for all their workers.
Individual Mandate	Yes. Individuals must purchase insurance. Federal subsidies for low-income individuals.	Yes. Individuals must purchase insurance. Federal subsidies for low-income individuals.	Yes. Federal subsidies for low-income individuals.	No individual mandate.
Insurance Reform	Guaranteed eligibility, community rating adjusted for family status, no pre-existing condition exclusions, portability.	Guaranteed eligibility, no pre-existing condition exclusions, no experience rating.	Guaranteed eligibility, no discrimination on basis of health status, and "adjusted community rated premiums" (no further details available on these premiums).	Requires insurers in small group market to offer health plans to all companies. Limits on use of pre-existing condition exclusions; also guaranteed renewability of insurance, and elimination "burdensome and expensive" state mandates.

	Clinton Administration Proposal	Conservative Democratic Forum Proposal	Senate Republican Health Care Task Force Proposal	House Republican Proposal
ACCESS *(continued)*				
Medicare	Current Medicare graduate medical education funding system replaced by a national payment system financed by a one-percent levy on health plan premiums. State option to bring Medicare beneficiaries into new system.	Current Medicare graduate medical education funding system replaced by a national payment system financed by a one-percent levy on health plan premiums.	Requests the Secretary of HHS to study the phase-in of Medicare enrollees into regionally-based purchasing cooperatives.	
Medicaid	Some Medicaid recipients will be brought into the new system.	Medicaid is replaced with a new federal program which will help purchase coverage for low-income individuals.	States may provide coverage to Medicaid recipients through a private purchasing cooperative, a managed care plan, or other alternative.	Option to use Medicaid funds to purchase private coverage for individuals up to 100 percent of the federal poverty level and sliding scale subsidies for those up to 200 percent of poverty .
Long-term Care	Provides for a new long-term care program including expanded home and community-based services, improvements in Medicaid coverage for institutional care, and tax incentives to purchase long-term care insurance.	As Medicaid is phased out, the states will gradually assume responsibility for long-term care, with greater flexibility to try innovative approaches.	Long-term care expenditures would receive the same federal tax treatment as other health care expenditures, and consumer protection standards would be established for long-term care insurance.	Provides same tax benefits for long-term care as for other health insurance plans. Provides option to use life insurance, IRA, or 401(k) funds to purchase long-term care insurance.
Health Workforce	Changes in the structure and funding of residency training to achieve goal of 50 percent generalists.	Higher funding for primary care residencies and mid-level practitioner education programs.		Provides seniors with asset protection plans to encourage purchasing of long-term care insurance.

COMPARISON OF MAJOR FEDERAL HEALTH CARE REFORM PROPOSALS

	Clinton Administration Proposal	Conservative Democratic Forum Proposal	Senate Republican Health Care Task Force Proposal	House Republican Proposal
PURCHASING SYSTEM				
Health Alliances	Coverage purchased through regional health insurance purchasing cooperatives or "health alliances."	Coverage purchased through regional health alliances.	States may establish health alliances but are not required to do so.	Employers have option to band together into insurance purchasing pools.
Employer Requirements	Firms with more than 5,000 employees may create their own health alliance.	Firms with fewer than 500 employees must join a health alliance. Larger firms have the option.	Employers are not required to join an alliance.	Employers are not required to join an alliance.
Individual Requirements	The individual chooses a health plan through the alliance.	The individual chooses a health plan through the employer or through the alliance.	Individuals purchase coverage through employer, individually, or through a voluntary health alliance.	Individuals purchase coverage through employer or individually.
HEALTH PLANS				
Contracting	Federally-qualified accountable health plans (AHP) compete for contracts with health alliances.	Health alliances will offer a menu of federally-qualified plans. (No details available on selective contracting).	All federally-qualified health plans will be allowed to offer services through an alliance.	
Types of Plans	The proposal encourages the development of managed care health plans, but alliances must offer at least one fee-for-service plan.	The proposal calls for prepaid health plans. Tax breaks will be allowed only for the least costly plans.	All federally-qualified health plans may participate.	
Quality Assurance	National Quality Management Program to develop core set of AHP quality indicators to be published in AHP performance reports.	Health plans must meet national standards of quality as developed by the National Health Board.	Health insurance plans would have to implement a quality assurance program recognized by the Department of Health and Human Services.	

COMPARISON OF MAJOR FEDERAL HEALTH CARE REFORM PROPOSALS

	Clinton Administration Proposal	Conservative Democratic Forum Proposal	Senate Republican Health Care Task Force Proposal	House Republican Proposal
FINANCING	Total cost 1995-2000: $700 b Revenues Medicare savings 124 b Medicaid savings 114 b Other federal program savings 47 b Sin taxes 105 b Revenue gains 51 b Former Medicare and Medicaid recipients now covered by alliances 259 b Expenditures Long-term care 80 b Medicare drug benefit 72 b Public health/ administration 29 b Subsidies for firms and workers 169 b Alliance coverage 259 b Deficit reduction 91 b	Total cost 1994-1998: $724 b Revenues Medicaid savings 569 b Capping tax deductibility 122 b Repeal Medicare taxable maximum 33 b Expenditures Extending tax deductibility to individuals and self-employed 44 b Low income assistance 654 b Long-term care phase-down assistance to states 11 b Other health initiatives 3 b Surplus for other initiatives 12 b	Subsidies expected to cost $210 b over a six-year phase-in period, from 1995-2000. Subsidies funded mostly from slowing the growth in Medicare and Medicaid, including: - reductions in Medicare graduate medical education payments - new Medicare copayments - means-testing Medicare Part B - elimination of Medicaid disproportionate share hospital payments - limit federal Medicaid spending through a per-capita payment based on historical costs.	

COMPARISON OF MAJOR FEDERAL HEALTH CARE REFORM PROPOSALS

	Clinton Administration Proposal	Conservative Democratic Forum Proposal	Senate Republican Health Care Task Force Proposal	House Republican Proposal
COST CONTAIN-MENT				
Competition	Competition among health plans to win health alliance contracts.	Competition among health plans to have lowest cost standard benefit package.	Competition among health plans to win employer and individual contracts.	Competition among health plans to win employer and individual contracts.
Budget Restrictions	Federal cap on annual premium increases	No federal budget restrictions.	No federal budget restrictions.	No federal budget restrictions.
Tax Incentives	Employer contributions for benefits in excess of the fully phased-in standard package are taxable for the individual. (Full phase-in expected by the year 2000). Payments must be made through an alliance to be deductible.	Tax cap based on cost of lowest priced qualified plans. Employer-paid premiums up to the tax cap are tax free for the employee and deductible for the employer and the self-employed. Premiums paid to non-qualified plans are not deductible for employers and are taxable for individuals.	Tax cap based on cost of lowest-priced qualified plans. Employer-paid premiums up to the tax cap are tax free for the employee and deductible for the employer and the self-employed. Limited deductibility of medical savings account contributions. Premiums paid to non-qualified plans are not deductible for employers and are taxable for individuals.	"Medical IRAs" to give individuals incentives to save tax-free and to control health expenditures. Full deductibility of the cost of health insurance premiums to individuals now lacking coverage as well as self-employed individuals.

COMPARISON OF MAJOR FEDERAL HEALTH CARE REFORM PROPOSALS

	Clinton Administration Proposal	Conservative Democratic Forum Proposal	Senate Republican Health Care Task Force Proposal	House Republican Proposal
COST CONTAIN-MENT				
Malpractice	Alternative dispute resolution, limits on attorneys fees, and use of physician practice guidelines as defense against malpractice claims.	New limits on non-economic damages, and reduction of unreasonably long statutes of limitations.	Alternative dispute resolution and $250,000 cap on non-economic damages.	Alternative dispute resolution process and $250,000 cap on non-economic damage awards.
Anti-Trust	Safety zones for small-hospital mergers, expedited federal review of proposals, safety zones for cost-effective joint ventures, and state action immunity.	Require the president to develop explicit guidelines on the application of federal anti-trust law to health plans.	Competition guidelines and safe harbor guidelines to encourage cost-effective joint ventures.	Anti-trust reforms to give health providers entering into joint ventures an anti-trust exemption if they can demonstrate expanded access, improved quality, or cost savings.
Adminis-tration	Standard forms, simplification of insurance regulations, streamlining of Medicare billing, and electronic billing and patient information systems.	Standard claims forms and electronic transmission of data.		Standard claims, forms electronic billing, and electronic patient care information systems.
Fraud and Abuse	Stiffer penalties and improved of enforcement.		Expands civil and criminal penalties.	Expands civil and criminal penalties.

COMPARISON OF MAJOR FEDERAL HEALTH CARE REFORM PROPOSALS

	Clinton Administration Proposal	Conservative Democratic Forum Proposal	Senate Republican Health Care Task Force Proposal	House Republican Proposal
TIME-TABLE	Plan as written would be phased in between 1995 and 2000. States must establish alliances no later than January 1, 1997, but may begin as early as 1995.	Plan as written would be phased in between 1994 and 1998.	Plan as written would be phased in between 1995 and 2000.	Implementation of major provisions would begin upon passage; no details on timetable for full phase-in.

APPENDIX C:

Comparison of Virginia to Selected Other States

How Does Virginia Compare to the States that Have Established A Goal of Universal Access?
(Florida, Hawaii, Massachusetts, Minnesota, Oregon, Vermont, Washington)

Comparison of Health Care Reform Initiatives

The states with universal access goals have not actually achieved universal access. The major problems are lack of funding and erosion of political support.

* Two of the universal access states (FL and WA) are using **voluntary health alliances**. The Joint Commission is currently studying the potential of health alliances in Virginia.

* Four of the universal access states have passed legislation to facilitate the development of **organized delivery systems**. The Joint Commission is currently studying the potential of community health networks in Virginia.

* The universal access states have increased access by **expanding Medicaid** beyond federal requirements and by implementing **Medicaid managed care** programs. Virginia has implemented Medicaid expansions and Medicaid managed care, but not to the same extent as some of the universal access states.

* Five of the seven universal access states have implemented **provider taxes to support the Medicaid program**. Virginia has not.

* The universal access states tend to be rely on **regulation** more than Virginia. Five of these states are using or plan to use global budgeting, insurance premium price controls, or hospital rate setting to contain costs.

* Virginia's **small group insurance reforms** are comparable to those passed in the universal access states.

* Virginia, Minnesota, and Washington have enacted policies for **standardized claims forms**.

* Like Virginia, the universal access states have enacted **policies to stimulate the supply of primary care physicians**.

* In an effort to build capacity for **quality assurance**, Virginia has established a patient level data base and is studying the potential of practice guidelines. Four of the seven universal access states are pursuing similar policies.

How Does Virginia Compare to the States that Have Established A Goal of Universal Access?
(Florida, Hawaii, Massachusetts, Minnesota, Oregon, Vermont, Washington)

Comparison of Health Care Reform Environments

* As of 1991, Virginia had about the same or a greater percentage of uninsured people under age 65 than the states with universal access policies, except for Florida.

* Virginia's Medicaid eligibility rate is lower than the rate for most of the states with universal access policies.

* Five of the seven states with universal access goals have higher federal match rates for Medicaid, meaning that Virginia has comparatively less leverage to expand the Medicaid program.

* Virginia has a remarkably lower HMO membership rate compared to the universal access states (except Vermont), indicating that Virginia is behind the national trend in managed care penetration.

* Reflecting a conservative state fiscal philosophy, Virginia tends to spend fewer general fund dollars per capita then the universal access states. However, Virginia is in the mid-range in terms of the percentage spent on health care.

* Virginia income levels are comparable to those for the states with universal access policies.

* Virginia's health care costs are generally comparable to those in the states with universal access policies.

* As an indicator of health status, Virginia's infant death rate is about the same as or higher than that for the other states. In Virginia, as in most states, there is a remarkable difference in the infant death rate for different races.

How Does Virginia Compare To The States That Have Established A Goal of Universal Access?

(Florida, Hawaii, Massachusetts, Minnesota, Oregon, Vermont, Washington)

REFORM INITIATIVE	VA	FL	HA	MA	MN	OR	VT	WA
Universal Access Legislation *(Implementation Date)*	No	Yes (1994)	Yes (Ongoing)	Yes (1995)	Yes (1994)	Yes (Studying)	Yes (Studying)	Yes (1999)
Health Alliances	Studying	Yes	No	No	No	No	No	Yes
Small Group Insurance Reform								
Guaranteed Issue	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
Guaranteed Renewal	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
Portability	No	Yes	No	Yes	Yes	Yes	Yes	No
Rating Restrictions	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
Basic Benefits	Yes	No	No	Yes	Yes	Yes	No	Yes
Organized Delivery Systems	Studying	Yes	No	No	Yes	No	Yes	Yes
Cost Containment								
Global Budget	No	No	No	No	Yes	No	No	No
Premium Caps	No	No	No	No	No	No	No	Yes
Hospital Rate Setting	No	Yes	No	Yes	Yes	No	Yes	No
Hospital Rate Review	Yes	--	No	--	--	No	No	No
Certificate of Need	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Standardized Forms	Yes	No	No	No	Yes	No	No	Yes
Malpractice Reform	No	No	No	No	Yes	No	Yes	No
Medicaid Reform								
Expanded Eligibility for Women and Children	Yes	No	Yes	Yes	Yes	No	Yes	Yes
Managed Care	Yes	Yes	Yes	Yes	Yes	Yes	Studying	Yes
Provider Taxes	No	Yes	Yes	Yes	Yes	Yes	No	No
Primary Care Provider Supply	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
Quality Assurance								
Patient Level Data	Yes	Yes	No	No	Yes	No	Yes	No
Practice Guidelines	Studying	Yes	No	No	Yes	Yes	No	No

(Florida, Hawaii, Massachusetts, Minnesota, Oregon, Vermont, Washington)

HEALTH POLICY ENVIRONMENT	VA	FL	HA	MA	MN	OR	VT	WA
Insurance Coverage for Those Under 65 Years Old (as of 1991)								
Uninsured %	16%	22%	11%	10%	11%	15%	11%	13%
Employer-Based Insurance %	70%	60%	72%	73%	68%	69%	71%	68%
Medicaid %	6%	7%	9%	8%	8%	7%	7%	8%
Medicaid Program								
Federal Match Rate (1993)	50%	55%	50%	50%	55%	62%	60%	55%
Medicaid Eligibility Rate (1991)	10%	16%	14%	13%	16%	12%	11%	11%
Income Level								
Median Family Income (1991)	$32,300	$25,142	$31,621	$34,029	$28,892	$26,869	$27,801	$28,654
Poverty Rate (1991)	12%	15%	14%	9%	13%	13%	9%	10%
Health Care Costs (1990)								
Cost Per Hospital Admission	$4,551	$5,341	$6,444	$5,647	$4,975	$4,272	$4,340	$4,574
Normalized Private Physician Fee Index	1.00	.99	1.23	1.11	.91	.91	.95	.92
Health Care Access and Utilization (1990)								
Hospital Beds Per 1000 Population	3.31	4.02	2.26	3.7	3.46	2.85	3.13	2.66
Patient Care Physicians Per 1000 Population	192	188	228	285	200	177	221	189
HMO Membership Per 1000 Pop.	62.29	107.89	216.99	260.85	250.05	249.49	64.98	143.22
Health Status (1988)								
Infant Deaths Per 1000 Births	10.38	10.6	7.19	7.88	7.81	8.56	6.78	9.02
White Infant Deaths Per 1000	8.13	8.54	7.2	7.25	7.19	8.54	6.75	8.71
Black Infant Deaths Per 1000	17.92	17.38	8.96	15.38	19.49	14.67	0.00	16.09
Government Fiscal Policy (1990)								
General Expenditures Per Capita	$3,351	$3,160	$3,974	$3,845	$3,914	$3,397	$3,600	$3,410
Percent of General Expenditures on Health/Hospitals	8.3%	8.59%	6.17%	9.46%	8.49%	6.27%	3.03%	7.26%

How Does Virginia Compare To Its Border States?
(Maryland, West Virginia, Kentucky, Tennessee, North Carolina)

Comparison of Health Care Reform Initiatives

* *Neither Virginia nor its border states have enacted a universal access policy. Tennessee is pursuing federal waiver which would allow the state to expand Medicaid to cover virtually all of its uninsured.*

* Among the Commonwealth and its border states, Virginia is the only state currently considering **health alliances**.

* Virginia and West Virginia are the only states to consider **organized delivery system** policies.

* Three of the border states have enacted **small group insurance reform** similar to Virginia's.

* With the exception of Maryland, the border states have not relied on regulation in their approach to **cost containment.** However, Virginia has recently strengthened its hospital cost review and certificate of need functions.

* Virginia and most of the border states have expanded **Medicaid** and introduced Medicaid managed care. Three of the border states use provider taxes to support the Medicaid program.

* Virginia and most of the border states have enacted policies to increase the supply of **primary care physicians**.

* Virginia and all of the border states except have taken steps to develop patient level data bases and examine the potential of practice guidelines in order to build their **quality assurance** capability.

(Maryland, West Virginia, Kentucky, Tennessee, North Carolina)

Comparison of Health Care Reform Environments

* As of 1991, Virginia's uninsured rate for those under 65 was about the same or higher than the rates for border states.

* Virginia's Medicaid eligibility rate was lower than rates for the border states.

* Virginia has a significantly lower federal Medicaid match rate than four of the five border states.

* Virginia has a higher median family income and lower poverty rate than four of its border states.

* The cost of care in Virginia is at the high end among the border states.

* Virginia is at the high end in HMO membership.

* Virginia compares favorably to the border states in terms of hospital bed supply.

* Virginia's infant death rate compares favorably to the border states.

* Compared to most of the border states, Virginia spends more general funds per capita.

* Maryland is remarkably different from Virginia and the other border states on all three measures of access and utilization. Also, Maryland is comparatively regulatory, with all-payer rate setting for hospital care, and plans to regulate physician fee schedules.

How Does Virginia Compare To Its Border States?

AREA OF REFORM	VA	KY	MD	NC	TN	WV
Universal Access Legislation	No	No	No	No	No	No
Health Alliances	Studying	No	No	No	No	No
Small Group Insurance						
Guaranteed Issue	Yes	No	Yes	Yes	Yes	No
Guaranteed Renewal	Yes	No	Yes	Yes	Yes	Yes
Portability	No	No	No	Yes	Yes	No
Rating Restrictions	Yes	No	Yes	Yes	Yes	Yes
Basic Benefits	Yes	No	Studying	Yes	Yes	Yes
Organized Delivery Systems	Studying	No	No	No	No	Yes
Cost Containment						
Global Budget	No	No	No	No	No	No
Hospital Rate Setting	No	No	Yes	No	No	No
Hospital Rate Review	Yes	No	--	No	No	No
Certificate of Need	Yes	Yes	Yes	Yes	No	Yes
Standardized Forms	Yes	Yes	Yes	Yes	Yes	No
Malpractice Reform	No	Yes	No	No	No	Yes
Medicaid Reform						
Expanded Eligibility for Women and Children	Yes	No	Yes	Yes	No	Yes
Managed Care	Yes	Yes	Yes	Yes	Yes	Yes
Provider Taxes	No	Yes	No	No	Yes	Yes
Primary Care Provider Supply	Yes	No	Yes	Yes	Yes	Yes
Quality Assurance						
Patient Level Data	Yes	Yes	Yes	Yes	Yes	Yes
Practice Guidelines	Studying	Studying	Studying	Studying	Studying	Studying

How Does Virginia Compare To Its Border States?

HEALTH POLICY ENVIRONMENT	VA	KY	MD	NC	TN	WV
Insurance Coverage For Those Under 65 Years Old (as of 1991)						
Uninsured %	16%	14%	11%	15%	15%	14%
Employer-Based Insurance %	70%	64%	74%	68%	66%	64%
Medicaid %	6%	12%	8%	7%	10%	13%
Medicaid Program						
Federal Match Rate (1993)	50%	71%	50%	65%	67%	76%
Eligibility Rate (Under 65) (1991)	10%	17%	12%	14%	16%	17%
Income Level (1991)						
Median Family Income	$32,300	$24,329	$32,780	$25,910	$24,100	$23,643
Poverty Rate (Under 65)	12%	17%	10%	14%	19%	19%
Health Care Costs (1990)						
Cost Per Hospital Admission	$4,551	$3,783	$4,616	$4,632	$4,180	$4,142
Normalized Private Physician Fee Index	1.00	.86	1.07	.96	.858	.98
Health Care Access and Utilization (1990)						
Hospital Beds Per 1000 Population	3.31	4.39	2.97	3.35	4.99	4.75
Patient Care Physicians Per 1000 Population	192	163	282	173	180	160
HMO Membership Per 1000 Pop.	62.29	81.16	153.01	48.29	39.98	40.31
Health Status (1988)						
Infant Deaths Per 1000 Births	10.38	10.65	11.27	12.45	10.76	9.02
White Infant Deaths Per 1000	8.13	9.95	8.48	9.57	8.23	8.51
Black Infant Deaths Per 1000	17.92	17.38	17.82	19.49	18.56	21.6
Government Fiscal Policy (1990)						
General Expenditures Per Capita	$3,151	$2,607	$3,479	$2,823	$2,605	$2,590
Percent of General Expenditures on Health/Hospitals	8.3	6.93	3.9	6.29	11.84	6.42

How Prepared Is Virginia For National Health Care Reform?

Major Elements of Clinton Reform Plan

* Universal access
* Employer mandate
* Individual mandate
* Regional and corporate alliances
* Accountable Health Plans (AHPs)
* National benefits package
* New long-term care program
* New quality assurance mechanisms
* Restructuring and new financing policies for graduate medical education
* Caps on average premium increases

How Prepared is Virginia For National Health Care Reform?

Major State Requirements Under Clinton Proposal	*Current Virginia Policies*	*Additional Actions Required Under Clinton Proposal*
1. Analyze impact of national health care reform in Virginia.	Established health policy commission (JCHC). Established a variety of mechanisms for collecting data on health care costs, utilization, access.	Analyze impact of universal coverage and financing policies on individuals, businesses, and Virginia's economy in general. Analyze impact on Virginia Medicaid. Analyze impact on other State programs which are currently supported with federal block grants and other federal funding. Analyze impact on vulnerable populations currently supported with state and local dollars. Analyze impact on academic medical centers. Analyze impact on rural and urban underserved areas. Analyze impact on public health system and mental health system. Analyze impact on State and local employee benefits programs.
2. Decide on managed competition or single payer approach, state role, and implementation schedule.	Reforms to date have been more consistent with managed competition.	Decide between managed competition and single payer, and decide State role in implementation.

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2. Decide on managed competition or single payer approach, state role, and implementation schedule.	Reforms to date have been more consistent with managed competition.	Decide between managed competition and single payer, and decide State role in implementation.

How Prepared Is Virginia For National Health Care Reform?

Major State Requirements Under Clinton Proposal	*Current Virginia Policies*	*Additional Actions Required Under Clinton Proposal*
3. Designate state agency or official to coordinate state responsibilities under federal law and delegate those responsibilities to state agencies or entities.	Established health policy commission (JCHC).	Decide whether to assign State coordinating responsibilities to an existing agency or a newly created agency.
4. Establish health alliances.	Currently studying advisability and feasibility of health alliances (SJR 332).	Establish one or more health alliances to serve the entire state by January 1, 1997. If more than one alliance, carve out appropriate geographic regions. Decide whether alliances should be state or non-profit organizations. Establish mechanism for selecting and training alliance board members. Ensure that each alliance establishes an acceptable risk-adjustment mechanism. Establish alliance policies and procedures in compliance with federal laws and regulations.

Major State Requirements Under Clinton Proposal	*Current Virginia Policies*	*Additional Actions Required Under Clinton Proposal*
5. Establish certification process for accountable health plans (AHPs).	Established regulatory process for insurance companies and HMOs. Currently studying advisability and feasibility of community health networks (SJR 316).	Establish mechanism to assess quality in addition to financial stability and capacity to deliver comprehensive benefit package to proper geographic market. Ensure that AHPs do not discriminate against consumers. Ensure the availability of AHPs at a price equal to or less than the weighted average premium. Establish minimum capital requirements for AHPs. Establish reporting requirements for AHPs. Establish procedures to handle the failure of AHPs, including a guarantee fund. Decide whether to offer incentives to serve disadvantaged groups. Evaluate special needs of rural and urban underserved areas, and ensure that AHPS meet these needs. Develop policies for border areas.

How Prepared Is Virginia For National Health Care Reform?

Major State Requirements Under Clinton Proposal	*Current Virginia Policies*	*Additional Actions Required Under Clinton Proposal*
6. Administer data collection and quality improvement programs.	Established a variety of health care data collection mechanisms, including patient level data base. Currently studying ways to measure and assess patient outcomes using patient level data (HJR 598).	Develop and implement plans to meet enrollment, access and quality standards established by the federal government. Assure that AHPs meet national standards through licensure and certification procedures. Monitor the extent to which all population groups are served by AHPs. Prepare reports on the performance of alliances and AHPs. Establish a program of technical assistance for health alliances and health plans. Participate in a national health plan data network. Participate in evaluations of health reform.
7. Develop policy on Medicaid under national reform.	Currently phasing in Medicaid managed care program (Medallion) for women and children.	Transition certain Medicaid populations into health alliances. Decide how to restructure Dept. of Medical Assistance Services in the wake of the transition.

Major State Requirements Under Clinton Proposal	*Current Virginia Policies*	*Additional Actions Required Under Clinton Proposal*
8. Implement expansion of home and community-based services for long-term care patients.	Establishing a long-term care policy for the Commonwealth (HJR 602). Developing a statewide comprehensive case management system for long-term care (HJR 601). Established task force to implement restructuring of Virginia's long-term care system for the elderly (HJR 603).	Develop state plan to implement federal requirements. Develop policies in areas of state flexibility. Calculate cost to Virginia of different policy approaches.
9. Develop policy on academic medical centers under national reform.	Developing long-term policy for role of academic medical centers in indigent care and medical education (HJR 623).	Analyze impact of national policies for graduate medical education reform. Re-evaluate indigent care funding policies in light of universal coverage. Develop strategies for competition in managed care/provider network environment.
10. Develop policy on state and local employees under national reform.	Established choice of managed care programs for state employees.	Transition state employee program to health alliance structure.

How Prepared Is Virginia For National Health Care Reform?

Major State Requirements Under Clinton Proposal	*Current Virginia Policies*	*Additional Actions Required Under Clinton Proposal*
11. Develop policies on public health and mental health under national reform.	Studying role of mental health and public health in community health networks (SJR 316).	Develop policies on the role of public health and mental health systems under national reform (role in patient care, education, and prevention; role in AHPs).
12. Develop data bases to support state decision making.	Established a variety of health care data collection mechanisms, including patient level data base.	Coordinate current data collection mechanisms and create new ones as needed to support decision making: - Cost analysis - Health alliance decisions - AHP certification - Ensure statewide coverage - Quality assurance - Medicaid decisions - Identify underserved areas - Track economic impact - Premium costs - Other

Insurance Coverage

Data on health insurance coverage are for those under age 65. Data are taken from the three-year merged Current Population Survey (CPS) for 1989, 1990, and 1991, as reported in Loprest, P. and Gates, M., State-Level Data Book on Health Care Access and Financing. (Washington, D.C.: Urban Institute Press, 1993.)

Medicaid Program

Data on federal Medicaid match rates were obtained from the Virginia Department of Medical Assistance Services.

Medicaid eligibility rates are the percentage of the population eligible for Medicaid in each state. The source is the three-year merged Current Population Survey (CPS) for 1989, 1990, and 1991, as reported in Loprest, P. and Gates, M., State-Level Data Book on Health Care Access and Financing. (Washington, D.C.: Urban Institute Press, 1993.)

Personal Income/Poverty Rates

The source of median family income data was the three-year merged Current Population Survey (CPS) for 1989, 1990, and 1991, as reported in Loprest, P. and Gates, M., State-Level Data Book on Health Care Access and Financing. (Washington, D.C.: Urban Institute Press, 1993.)

Poverty rate data are for those under age 65. Data were obtained from the three-year merged Current Population Survey (CPS) for 1989, 1990, and 1991, as reported in Loprest, P. and Gates, M., State-Level Data Book on Health Care Access and Financing. (Washington, D.C.: Urban Institute Press, 1993.)

Health Care Costs

Cost per hospital admission data were obtained from Urban Institute analysis of the American Hospital Association's 1990 Annual Survey of Hospitals, as reported in Loprest, P. and Gates, M., State-Level Data Book on Health Care Access and Financing. (Washington, D.C.: Urban Institute Press, 1993.)

The normalized private physician fee index indicates how physician fees vary across geographic areas. The national average is given an index value of 1.0. The data were obtained from Urban Institute analysis of Health Insurance Association of America's Prevailing Healthcare Charges System, Sept. 1990, as reported in Loprest, P. and Gates, M., State-Level Data Book on Health Care Access and Financing. (Washington, D.C.: Urban Institute Press, 1993.)