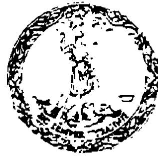
1998 ANNUAL REPORT OF

THE JOINT COMMISSION ON HEALTH CARE

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 62

COMMONWEALTH OF VIRGINIA
RICHMOND
1999



COMMONWEALTH *of* VIRGINIA

Joint Commission on Health Care

May 10, 1999

Delegate Kenneth R. Melvin
Chairman

Patrick W. Finnerty
Executive Director

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TO: The Honorable James S. Gilmore, III, 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, we have the honor of submitting herewith the Annual Report for the calendar year ending December 31, 1998.

This 1998 annual report includes a summary of the Joint Commission's 1998 activities and legislative recommendations to the 1999 General Assembly and a review of the impact of managed care on the availability and quality of ancillary medical services. Copies of the legislation sponsored by the Joint Commission and passed by the 1999 General Assembly also are included.

In addition to this annual report, a separate report was published as a House or Senate document for each study the Joint Commission conducted pursuant to a joint study resolution. The document numbers of the individual study reports we published are identified on page 5 of this document.

Sincerely,

Kenneth R. Melvin
Chairman

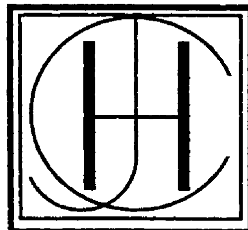
Patrick W. Finnerty
Executive Director

JOINT COMMISSION ON HEALTH CARE

Chairman
The Honorable Kenneth R. Melvin
Vice Chair
The Honorable Jane H. Woods

The Honorable William T. Bolling
The Honorable Joseph V. Gartlan, Jr.
The Honorable Benjamin J. Lambert, III
The Honorable Stephen H. Martin
The Honorable Edward L. Schrock
The Honorable Stanley C. Walker
The Honorable Thomas G. Baker, Jr.
The Honorable Robert H. Brink
The Honorable John J. Davies, III
The Honorable Jay W. DeBoer
The Honorable Alan A. Diamonstein
The Honorable Franklin P. Hall
The Honorable Phillip A. Hamilton
The Honorable Harvey B. Morgan

Secretary of Health and Human Resources
The Honorable Claude A. Allen



JOINT COMMISSION ON HEALTH CARE

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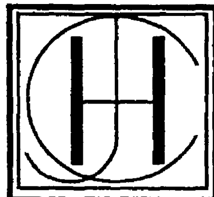
Office Manager
Mamie V. White

Access to the Internet

The Joint Commission's home page on the Internet is located at:
http://legis.state.va.us/jchc/jchchome.htm

Acknowledgements

The Joint Commission extends its sincere appreciation to the Office of the Clerk of the House, 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 1998.



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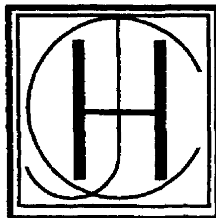

I. SUMMARY OF 1998 ACTIVITIES AND RELATED 1999 GENERAL ASSEMBLY ACTIONS

STATUTORY AUTHORITY

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).

The Joint Commission is authorized in §9-311 et. seq. of the Code of Virginia. The purpose of the Commission is to study, report and make recommendations on all areas of health care provision, regulation, insurance, liability, licensing, and delivery of services. In so doing, the Commission endeavors to ensure that the greatest number of Virginians receives quality health care.

1998 JOINT COMMISSION ACTIVITIES

The Joint Commission held eight meetings in 1998, as well as one additional meeting in January, 1999, prior to the 1999 Session of the General Assembly. All meetings were held in the General Assembly Building in Richmond. The following paragraphs summarize the proceedings of each meeting.

May 12th Meeting

At the May 12th meeting, staff presented a final status report on the Joint Commission's 1998 legislation and an overview of the 1998 workplan.

June 15th Meeting

At the June 15th meeting, a new Chairman and Vice Chairman were elected. Delegate Kenneth R. Melvin was elected Chairman and Senator Jane H. Woods was elected Vice Chairman.

During the June 15th meeting, staff presented reports on: (i) reimbursement and quality of care issues regarding telemedicine, and (ii) a centralized planning and funding mechanism for health workforce activities. Claude A. Allen, Secretary of Health and Human Resources, presented a status report on the State Children's Health Insurance Program (SCHIP). Dr. Ann Y. McGee, Commissioner of the Department for Aging, presented an update on Virginia's Public Guardian and Conservator Program and the Long-Term Care Ombudsman Program.

August 27th Meeting

At the August 27th meeting, staff presented reports on: (i) Phase I of a comprehensive study of long-term care focusing on licensure issues; and (ii) a study on an ombudsman program and external appeals mechanism for managed care health insurance.

Dennis G. Smith, Director, Department of Medical Assistance Services, and Clarence C. Carter, Commissioner of the Department of Social Services, presented a status report on the implementation of the State Children's Health Insurance Program (SCHIP). Nancy R. Hofheimer, Director of the Virginia Department of Health's Center for Quality Health Care Services and Consumer Protection, presented a status report on the Department's oversight of the quality of managed care health insurance.

September 23rd Meeting

At the September 23rd meeting, staff presented reports on: (i) a study of pooled purchasing arrangements; (ii) Phase II of the long-term care study focusing on financing issues; (iii) a study of how the Commonwealth's academic health centers can participate more fully in managed care provider networks; and (iv) a status report on the implementation of the State Children's Health Insurance Program (SCHIP). William R. Nelson, M.D., M.P.H., Acting State Health Commissioner, presented a status report on the "Turning Point" initiative.

October 20th Meeting

The October 20th meeting included staff presentations regarding: (i) a study on the feasibility of establishing a high risk insurance pool in Virginia; (ii) a study of health insurance coverage for anorexia nervosa and bulimia; and (iii) follow-up information on the study of an ombudsman program and external appeals mechanism presented at the September 23rd meeting. Staff also presented summaries of two other reports. The first report was prepared by the Commissioner of Health regarding local health

summits. The second report was prepared by several Virginia hospital conversion foundations regarding their charitable activities.

William R. Nelson, M.D., M.P.H., Acting State Health Commissioner, presented a study on ways the Commonwealth can support Free Clinics and Community Health Centers. Richard M. Surrusco, M.D., Carilion Health System, presented the results of Carilion Health System's study of access to prescription drugs by indigent persons. Lastly, Dennis G. Smith, Director, Department of Medical Assistance Services, and staff presented a status report on the State Children's Health Insurance Program (SCHIP).

November 17th Meeting

During the November 17th meeting, staff updated the Joint Commission on two studies which had been presented at previous meetings: the health workforce study; and the long-term care study. In addition, staff presented a report on state regulations and laws relating to midwifery and a review of organ transplant and donation issues.

Kathy R. Young, President of Virginia Health Information (VHI), presented a status report on VHI's strategic plan for health care cost and quality data initiatives. L. Robert Bolling, Director of the Office of Minority Health, Virginia Department of Health, reported on the study of the health status and conditions of African-Americans in the Commonwealth. John P. Pestian, Ph.D., Center for Pediatric Research, Children's Hospital of the King's Daughters, presented a report on the Center for Pediatric Research's study on pediatric care. Lastly, William R. Nelson, M.D., M.P.H., Acting State Health Commissioner, presented the Commissioner of Health's annual review of the certificate of public need program.

December 7th Meeting

The primary focus of the December 7th meeting was a discussion of a "decision matrix" presented by staff that summarized all of the issues addressed by the Joint Commission during 1998. The Joint Commission made decisions on a number of issues contained in the "decision matrix" and requested legislation to be drafted for the 1999 Session of the General Assembly. Several issues were held over until the December 10th meeting.

In addition to the discussion of the "decision matrix," a status report on the State Children's Health Insurance Program (SCHIP) was presented by Dennis G. Smith, Director of the Department of Medical Assistance Services, Clarence C. Carter, Commissioner of the Virginia Department of

Social Services, William R. Nelson, M.D., M.P.H., Acting State Health Commissioner, and staff.

December 10th Meeting

During the December 10th meeting, the Joint Commission completed its review of the "decision matrix," and requested additional legislation to be drafted for the 1999 Session of the General Assembly. Staff also presented an overview of the Robert Wood Johnson Foundation's process for applying for grant funding to support outreach efforts for the new children's health insurance program.

January 6, 1999 Meeting

At the January 6, 1999 meeting, staff presented a summary of the long-term care studies received from executive branch agencies and responded to unresolved issues from the December 10th meeting. Lastly, staff reviewed the public comments received on the Joint Commission's draft legislative proposals. The Commission made final decisions on proposed legislation and adopted its package of legislative proposals and budgetary recommendations to be introduced during the 1999 Session.

INDIVIDUAL STUDY REPORTS PUBLISHED BY THE JOINT COMMISSION ON HEALTH CARE

As reported in the previous section, the Joint Commission conducted a number of studies throughout 1998. These studies were presented in the form of "issue briefs" to the Commission during its 1998 meetings. Copies of each issue brief were distributed to persons attending the meetings at which the study was presented to the Joint Commission, as well as to interested parties who requested copies. The issue briefs also are posted on the Joint Commission's home page on the Internet enabling persons to download the report for review and comment.

Public comments were received on all of the issue briefs and presented to the Joint Commission members at the next meeting. Following the public comment period, each issue brief was finalized and printed as either a House or Senate Document. Figure 1 identifies each of the Joint Commission's 1998 studies which were printed as separate documents.

Figure 1

1998 Individual Study Reports Published by the Joint Commission on Health Care

Name of Study	Authority for Study	House/Senate Document
Reimbursement and Quality of Care Issues Regarding Telemedicine	HJR 210	House Document 48
Study of a Centralized Planning and Funding Mechanism for Health Workforce Activities	Item 12 of the 1998 Appropriation Act	House Document 49
Long-Term Care Issues	HJR 156/SJR 97	House Document 50
Pooled Purchasing Arrangement for Small Employers, Community Health Centers and Free Clinics	HJR 202/SJR 124	House Document 51
Health Care Coverage for Anorexia Nervosa and Bulimia	HJR 268	House Document 52
Feasibility of Establishing a High Risk Pool in Virginia	SJR 126	Senate Document 22
Ombudsman Program/External Appeals Mechanism	SJR 99	Senate Document 24
Participation of Academic Health Centers in Managed Care Provider Networks	SJR 108	Senate Document 25

Notes:

- Except as noted, all joint resolution and bill numbers are from the 1998 General Assembly Session. All House/Senate Document numbers are 1999 document numbers.

1999 LEGISLATIVE PROPOSALS

As a result of the work completed by the Joint Commission during 1998, a package of legislative proposals was introduced and approved during the 1999 Session of the General Assembly. The following paragraphs identify each legislative proposal. A copy of each bill and resolution approved by the General Assembly is provided in Appendix A with the page numbers identified below.

Bills

SB 1111	Allows surplus tangible property to be sold to Free Clinics and Community Health Centers. (Appendix A, page 1)
SB 1112	Allows the Virginia Department of Health to contract with Free Clinics and Community Health Centers without competitive procurement. (Appendix A, page 3)
SB 1153/ HB 2290	Adds pharmacists, nurse practitioners, physician assistants, optometrists, and dental hygienists to those providers who can receive tax credits for providing free health care services. (Appendix A, pages 5 and 31)
SB 1158	Authorizes access to hospital patient records by organ procurement organizations. This legislation resulted from the Joint Commission's study of organ donation issues. (Appendix A, page 6)
SB 1172	Directs the Joint Commission on Health Care to: (i) study the adequacy of state regulations for licensing nursing homes; (ii) examine the advisability of "deemed status" for certain nursing homes; and (iii) assess the use of "centers of excellence." This legislation resulted from the Joint Commission's study of long-term care issues published as 1999 House Document 50. (Appendix A, page 11)
SB 1173	Authorizes the Commissioner of Social Services to grant licenses for adult care residences (ACR) at intervals based on compliance history, and directs the Joint Commission on Health Care to examine various issues regarding current ACR licensing regulations. This legislation resulted from the Joint Commission's study of long-term care issues published as 1999 House Document 50. (Appendix A, page 12)

SB 1214 Directs the Commissioner of Health to report annually on telemedicine initiatives in the Commonwealth. This legislation resulted from the Joint Commission's study of telemedicine published as 1999 House Document 48. (Appendix A, page 13)

SB 1265 Adds research, policy analysis, long-range planning and aging education to the mission of the Department for Aging. This legislation resulted from the Joint Commission's study of long-term care issues published as 1999 House Document 50. (Appendix A, page 14)

HB 2229 Allows Free Clinics and Community Health Centers to purchase goods and services directly from state agency contracts. (Appendix A, page 16)

HB 2230 Resolves discrepancies between existing statutory provisions and the children's health insurance program that has been implemented in Virginia. (Appendix A, page 17)

HB 2283 Requires insurance carriers to include questions on their application forms to identify persons eligible for the protections and benefits provided by the Health Insurance Portability and Accountability Act of 1996. The bill also includes limits on the use of pre-existing condition waiting periods for certain types of insurance. (Appendix A, page 19)

HB 2314 Eliminates certificate of public need (COPN) review for replacement of certain diagnostic imaging equipment. (Appendix A, page 32)

HB 2751 Extends the sunset provision for health care cost and quality data collection, analysis and reporting for an additional four years. New sunset date will be July 1, 2003. (Appendix A, page 34)

Senate Joint Resolutions (SJR) and House Joint Resolutions (HJR)

SJR 453 Requests the Virginia Transplant Council to develop a strategic plan for organ donation education and outreach. This legislation resulted from the Joint Commission's study of organ donation and transplant issues. (Appendix A, page 35)

SJR 454	Requests the Joint Commission to continue its study of various issues regarding organ donation and transplant activities. This legislation resulted from the Joint Commission's initial study of organ donation and transplant issues. (Appendix A, page 36)
SJR 463	Requests the Joint Legislative Audit and Review Commission to study the current Medicaid reimbursement methodology for nursing homes. This legislation resulted from the Joint Commission's study of long-term care issues published as 1999 House Document 50. (Appendix A, page 38)
SJR 464	Requests the Joint Commission to conduct a more comprehensive study of academic health centers. This legislation resulted from the Joint Commission's initial study of academic health centers published as 1999 Senate Document 25. (Appendix A, page 39)
SJR 489	Requests the Joint Commission to develop a pooled purchasing model for health insurance for small employers. This legislation resulted from the Joint Commission's study of pooled purchasing published as 1999 House Document 51. (Appendix A, page 41)
HJR 644	Requests the Joint Commission to study access to dental care in the Commonwealth. (Appendix A, page 43)
HJR 646	Requests the Joint Commission to study whether direct-entry midwifery should be authorized and regulated. This legislation resulted from the Joint Commission's initial study of midwifery. (Appendix A, page 44)
HJR 647	Requests the Commissioner of Health to establish a task force on the health status of African-Americans. (Appendix A, page 45)
HJR 648	Requests the Commissioner of Health to sponsor a forum or congress on African-American health access issues. (Appendix A, page 46)
HJR 675	Requests the Technical Advisory Panel of the Indigent Health Care Trust Fund to consider establishing an Indigent Pharmacy Pilot Program. (Appendix A, page 47)

HJR 683 Requests the Secretary of Technology to develop guidelines for purchasing telemedicine equipment. This legislation resulted from the Joint Commission's study of telemedicine published as 1999 House Document 48. (Appendix A, page 48)

II. REVIEW OF THE IMPACT OF MANAGED CARE ON THE AVAILABILITY AND QUALITY OF ANCILLARY MEDICAL SERVICES

Virginia's "Freedom of Choice " Law Was Enacted in 1994

The 1994 Session of the General Assembly passed House Bill 840 which provided that health insurers and health maintenance organizations (HMOs) issuing policies or contracts requiring use of network providers could not prohibit an enrollee from receiving pharmacy or ancillary medical services from the provider of his/her choice so long as the provider accepted the insurer/HMO's reimbursement as payment in full. This legislation commonly is referred to as Virginia's "freedom of choice" law.

While the term "ancillary medical services" had not been defined in statute, the Bureau of Insurance, through its regulatory authority, ruled that carriers and HMOs should interpret the term very broadly to include durable medical equipment companies, home health agencies, medical laboratories, and other related medical service providers.

"Freedom of Choice" Provisions Relating to Ancillary Medical Services Were Repealed in 1995

The General Assembly amended the "freedom of choice" law in 1995 (House Bill 2304) by repealing the provisions which had applied to ancillary service providers. In addition, a third enactment clause was included in HB 2304 directing the Joint Commission on Health Care to conduct a three-year study of ancillary medical services insofar as the availability and quality of these services are affected by managed care. The legislation directed the Joint Commission to include its findings in its annual reports to the Governor and the General Assembly for a three-year period. This section of the Joint Commission's 1998 Annual Report represents the final phase of the three-year study.

The Initial Review Of The Impact Of Managed Care On The Availability And Quality Of Ancillary Medical Services Was Included In The 1996 Annual Report

The initial phase of this three-year review of the impact of managed care on the availability and quality of ancillary medical services was included in the Joint Commission's 1996 Annual Report. The 1996 report included the following major findings:

- due to methodological limitations, measuring the true impact of managed care on the availability and quality of ancillary medical services is difficult at best;
- while managed care has limited the number of ancillary service providers from whom enrollees receive services, there are little or no quantitative data to suggest that the availability or quality of ancillary medical services have been adversely affected;
- many ancillary service providers believe the quality of care is less under managed care insurance plans; managed care organizations argue there has been no diminution in access or quality;
- managed care organizations and the Department of Medical Assistance Services (DMAS), which administers the Medicaid program, reported having received very few complaints about ancillary medical services; and
- ancillary service providers believe the "freedom of choice" law should be reinstated; the managed care industry believes the law should not be reinstated.

The Findings Reported In 1996 Are Still Relevant In 1998; However, Ancillary Service Providers Report A Few Additional Concerns

The findings reported in 1996 are still relevant today. Moreover, there are no new data sources available to conduct any quantitative analysis of the impact of managed care on ancillary medical services. As in 1996, due to the absence of any previous research, primary data collection or other quantitative measures, interviews were held with various ancillary service providers and representatives of the insurance/HMO industry to obtain information from different perspectives as to how the repeal of the "freedom of choice" law has affected the availability and quality of ancillary medical services for managed care enrollees.

The ancillary service providers interviewed for this report cited examples of clients whom they believe are not receiving quality ancillary medical services from their managed care organizations. However, the

providers indicated that they were unaware of any studies, reports, or research that analyzed these issues on a broader, more methodologically sound basis. The providers also recognized the limitations of the available information (i.e., case examples).

While many of the concerns mentioned by ancillary service providers were the same as those reported in 1996 (e.g., serving fewer patients, patients receiving lower quality of services), the interviews conducted during this phase of the study identified a few additional issues.

Medicaid Managed Care Enrollees Changing Plans: One issue raised during the interviews conducted this year relates to the impact of Medicaid patients changing HMO plans. An ancillary service provider in the Tidewater area where the Medallion II program is in place raised this concern. The provider indicated that there have been instances wherein a Medicaid patient has received authorization from his/her Medicaid HMO to receive an ancillary medical service or supply. The service/supply is provided; however, prior to the HMO receiving a bill from the provider for the service/supply; the enrollee has changed HMOs. The concern is that, in some cases, the HMO which authorized the service/supply does not pay the bill because the recipient is not a member when the bill arrives and the new HMO in which the recipient is now enrolled denies payment because it did not authorize the service/supply.

Staff at the Department of Medical Assistance Services (DMAS) indicated that this situation had been occurring in the past. However, it has been addressed in the newest HMO contracts. The new Medicaid HMO contracts now require that if a person moves from one HMO to another, the receiving HMO must honor any authorization for ancillary medical services approved by the patient's former HMO. Article II (G), item 35(a) of the new Medallion II HMO contract states: "The Contractor (the recipient's current HMO) shall assume responsibility for all out patient managed care services authorized by either the Department or a previous HMO, which are rendered after the enrollment effective date, in the absence of a written agreement otherwise." This new contract language should eliminate the problem of providers not being reimbursed for these services.

Health Care Market Trends Are Having An Increasing Affect On Ancillary Service Providers: Ancillary service providers interviewed this year indicated that, in addition to the impact of managed care provider networks, other health care market trends are having an increasing impact on their businesses.

One such market trend is the move to more integrated delivery systems. Some managed care organizations own and operate an ancillary service company which provides these services to their enrollees, thus limiting the number of patients receiving services from other providers. Similarly, some hospitals and hospital systems also operate an ancillary medical service component which provides services to many of the patients discharged from the hospital. These managed care organizations and hospitals pursue this market strategy as a means of staying competitive. The impact on more traditional ancillary service providers is that they are seeing fewer and fewer patients. However, there is little empirical evidence that this market trend has reduced the availability or quality of ancillary medical services.

Some Patients In Rural Areas May Have To Travel Further For Services: An additional concern cited by some ancillary service providers is related to the market changes noted above. As a result of the exclusive contracts that some managed care organizations have negotiated with a single ancillary service provider, ancillary providers indicated that some patients in rural areas are having to travel greater distances to access these services. The services are still available to these patients; however, there is concern that the additional travel is unnecessary and inconvenient.

Managed Care Organizations, DMAS And The Virginia Department of Health Report Very Few Complaints Regarding Ancillary Medical Services

The Virginia Association of Health Plans reports that the number of complaints its members receive regarding the availability and quality of ancillary medical services are very few. Similarly, staff at DMAS and the Virginia Department of Health indicate that they receive very few complaints about ancillary medical services.

Ancillary Service Providers Continue To Believe The "Freedom Of Choice" Law Should Be Reinstated; HMOs And The Insurance Industry Believe The Law Should Not Be Reinstated

The positions of the various interested parties have not changed during the three-year period since the passage of HB 2304. Ancillary service providers continue to believe that the "freedom of choice" provisions should be reinstated to assure the availability and quality of these services. The HMO/insurance industry believes the law should not be reinstated and that there is no evidence to suggest that such a change is needed.

The Commonwealth Has Enacted Managed Care Reforms That Address Issues Regarding Access To Providers And Quality Of Care

Since the initial report on managed care's impact on ancillary medical services, the Commonwealth has enacted several insurance reforms to improve the availability and quality of care received through managed care insurance plans.

Oversight of the Quality of Managed Care: The 1998 Session of the General Assembly passed Senate Bill 712 which requires the State Health Commissioner to examine the quality of care provided by managed care health insurance plans (MCHIPs). On or before July 1, 2000, in order to be licensed in Virginia, MCHIPs must receive a certificate of quality from the Commissioner. The quality of care provided by a MCHIP will be based on 10 criteria, including reasonable and adequate availability of and accessibility to health care services; reasonable and adequate standards for credentialing providers with whom it contracts; and a reasonable and adequate system for assessing the satisfaction of its covered members.

The new responsibilities of the Department of Health in overseeing the quality of care provided by MCHIPs will provide a system-level means of monitoring and addressing quality of care concerns.

Mandated "Point-of-Service" (POS) Plans: The 1997 General Assembly also passed House Bill (HB) 1075 which requires HMOs to offer a POS plan in conjunction with its closed panel HMO offering. A POS plan allows enrollees to receive services from providers who do not participate in the HMO panel. The POS plan must be offered at the "employee level" so that each employee is able to decide in which plan (HMO or POS) he/she wishes to enroll. Typically, POS enrollees are required to pay higher co-payments, deductibles or premiums for the ability to receive services "out-of-network." In sum, the POS law provides enrollees with a greater choice of providers, including ancillary service providers, from whom to receive services.

External Appeals/State Ombudsman: The 1999 General Assembly passed Senate Bill 1235 and House Bill 871 which enact a number of managed care protections. Among the many provisions of these bills is the establishment of an independent external appeals process for managed care enrollees to appeal certain claim denials. Another key provision of this legislation is the establishment of the Office of the Managed Care Ombudsman within the Bureau of Insurance. The ombudsman will promote and protect the interest of covered persons and assist persons in understanding their rights and processes available to them under their managed care plan.

Recent Managed Care Reforms Should Help Ensure Access To Quality Care

While the recent managed care reforms are not focused specifically on ancillary medical services, the combined effect of these initiatives should help ensure that managed care enrollees have appropriate access to quality health care services.

APPENDIX A:

1999 Legislation

Joint Commission on Health Care
1999 Legislation
(As Approved)

Bills:		Page
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SB 1173	Authorizes the Commissioner of Social Services to grant licenses for adult care residences (ACR) at intervals based on compliance history, and directs the Joint Commission on Health Care to examine various issues regarding current ACR licensing regulations. This legislation resulted from the Joint Commission's study of long-term care issues published as 1999 House Document 50.	12
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Joint Commission on Health Care
1999 Legislation
(As Approved)

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HB 2230	Resolves discrepancies between existing statutory provisions and the children's health insurance program that has been implemented in Virginia.	17
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HB 2314	Eliminates certificate of public need (COPN) review for replacement of certain diagnostic imaging equipment.	32
HB 2751	Extends the sunset provision for health care cost and quality data collection, analysis and reporting for an additional four years. New sunset date will be July 1, 2003.	34

Resolutions:

SJR 453	Requests the Virginia Transplant Council to develop a strategic plan for organ donation education and outreach. This legislation resulted from the Joint Commission's study of organ donation and transplant issues.	35
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SJR 489	Requests the Joint Commission to develop a pooled purchasing model for health insurance for small employers. This legislation resulted from the Joint Commission's study of pooled purchasing published as 1999 House Document 51.	41
HJR 644	Requests the Joint Commission to study access to dental care in the Commonwealth.	43
HJR 646	Requests the Joint Commission to study whether direct-entry midwifery should be authorized and regulated. This legislation resulted from the Joint Commission's initial study of midwifery.	44
HJR 647	Requests the Commissioner of Health to establish a task force on the health status of African-Americans.	45
HJR 648	Requests the Commissioner of Health to sponsor a forum or congress on African-American health access issues.	46
HJR 675	Requests the Technical Advisory Panel of the Indigent Health Care Trust Fund to consider establishing an Indigent Pharmacy Pilot Program.	47
HJR 683	Requests the Secretary of Technology to develop guidelines for purchasing telemedicine equipment. This legislation resulted from the Joint Commission's study of telemedicine published as 1999 House Document 48.	48

CHAPTER 159

An Act to amend and reenact § 2.1-457.2 of the Code of Virginia, relating to surplus tangible state property.

[S 1111]

Approved March 17, 1999

Be it enacted by the General Assembly of Virginia:

1. That §2.1-457.2 of the Code of Virginia is amended and reenacted as follows:

§2.1-457.2. Disposition of surplus materials.

A. "Surplus materials" means personal property including, but not limited to, materials, supplies, equipment, and recyclable items, but does not include property as defined in §2.1-504 that is determined to be surplus. Surplus materials shall not include finished products which a mental health or mental retardation facility sells for the benefit of its patients or residents, provided that most of the supplies, equipment, or products have been donated to such facility, and whose patients or residents have substantially altered such supplies, equipment, or products in the course of occupational or other therapy, and such substantial alterations have resulted in a finished product.

B. The Department of General Services (the "Department") shall establish procedures for the disposition of surplus materials from departments, divisions, institutions, and agencies of the Commonwealth. Such procedures shall:

1. Permit surplus materials to be transferred between or sold to departments, divisions, institutions, or agencies of the Commonwealth;

2. Permit surplus materials to be sold to Virginia charitable corporations granted tax-exempt status under § 501 (c) (3) of the Internal Revenue Code and operating as clinics for the indigent and uninsured that are organized for the delivery of primary health care services (i) as federally qualified health centers designated by the Health Care Financing Administration or (ii) at a reduced or sliding fee scale or without charge;

~~2.~~ *3.* Permit public sales or auctions, provided that such procedures provide for sale to all political subdivisions any surplus materials prior to the public sale or auction;

~~3.~~ *4.* Permit donations to political subdivisions of the Commonwealth under the circumstances specified in this section;

~~4.~~ *5.* Permit other methods of disposal when (a) the cost of the sale will exceed the potential revenue to be derived therefrom or (b) the surplus material is not suitable for sale;

~~5.~~ *6.* Permit any dog especially trained for police work to be sold at an appropriate price to the handler who last was in control of such dog, which sale shall not be deemed a violation of the State and Local Government Conflict of Interests Act (§2.1-639.1 et seq.);

~~6.~~ *7.* Permit the transfer of surplus clothing to an appropriate department, division, institution, or agency of the Commonwealth for distribution to needy individuals by and through local social services boards;

~~7.~~ *8.* Encourage the recycling of paper products, beverage containers, and used motor oil; and

~~8.~~ *9.* Require that the proceeds from any sale or recycling of surplus materials be promptly deposited into the state treasury in accordance with §2.1-180 and report the deposit to the State Comptroller.

C. The Department shall dispose of surplus materials pursuant to the procedures established in subsection B or permit any department, division, institution, or agency of the Commonwealth to dispose of its surplus materials consistent with the procedures established in subsection B. No surplus materials shall be disposed of without prior consent of the head of the department, division, institution, or agency of the Commonwealth in possession of such surplus materials or the Governor.

D. Departments, divisions, institutions, or agencies of the Commonwealth or the Governor may donate surplus materials only under the following circumstances: (i) emergencies declared in accordance with §44-146.18:2 or § 44-146.28; (ii) as set forth in the budget bill as defined by §2.1-399, provided that (a) the budget bill contains a description of the surplus materials, the method by which the surplus materials shall be distributed, and the anticipated recipients, and (b) such information shall be provided by the Department to the Department of Planning and Budget in sufficient time for inclusion in the budget bill; (iii) when the market value of the surplus materials, which shall be donated for a public purpose, is less than

$200; however, the total market value of all surplus materials so donated by any department, division, institution, or agency shall not exceed five percent of the revenue generated by such department's, division's, institution's, or agency's sale of surplus materials in the fiscal year; or (iv) during a local emergency, upon written request of the head of a local government or a political subdivision in the Commonwealth to the head of a department, division, institution, or agency.

E. On or before October 1 of every year, the Department shall prepare, and file with the Secretary of the Commonwealth, a plan that describes the expected disposition of surplus materials in the upcoming fiscal year pursuant to subdivision B 4 5 .

CHAPTER 160

An Act to amend and reenact § 11-45 of the Code of Virginia, relating to the Department of Health: exemptions from the Public Procurement Act.

[S 1112]

Approved March 17, 1999

Be it enacted by the General Assembly of Virginia:

1. That §11-45 of the Code of Virginia is amended and reenacted as follows:

§11-45. Exceptions to requirement for competitive procurement.

A. Any public body may enter into contracts without competition for the purchase of goods or services (i) which are performed or produced by persons, or in schools or workshops, under the supervision of the Virginia Department for the Visually Handicapped; or (ii) which are performed or produced by nonprofit sheltered workshops or other nonprofit organizations which offer transitional or supported employment services serving the handicapped.

B. Any public body may enter into contracts without competition for (i) legal services, provided that the pertinent provisions of Chapter 11 (§2.1-117 et seq.) of Title 2.1 remain applicable; or (ii) expert witnesses and other services associated with litigation or regulatory proceedings.

C. Any public body may extend the term of an existing contract for services to allow completion of any work undertaken but not completed during the original term of the contract.

D. An industrial development authority may enter into contracts without competition with respect to any item of cost of "authority facilities" or "facilities" as defined in §15.2-4902.

E. The Department of Alcoholic Beverage Control may procure alcoholic beverages without competitive sealed bidding or competitive negotiation.

F. Any public body administering public assistance programs as defined in §63.1-87, the fuel assistance program, community services boards as defined in §37.1-1, or any public body purchasing services under the Comprehensive Services Act for At-Risk Youth and Families (§2.1-745 et seq.) may procure goods or personal services for direct use by the recipients of such programs without competitive sealed bidding or competitive negotiations if the procurement is made for an individual recipient. Contracts for the bulk procurement of goods or services for the use of recipients shall not be exempted from the requirements of §11-41.

G. Any public body may enter into contracts without competitive sealed bidding or competitive negotiation for insurance if purchased through an association of which it is a member if the association was formed and is maintained for the purpose of promoting the interest and welfare of and developing close relationships with similar public bodies, provided such association has procured the insurance by use of competitive principles and provided that the public body has made a determination in advance after reasonable notice to the public and set forth in writing that competitive sealed bidding and competitive negotiation are not fiscally advantageous to the public. The writing shall document the basis for this determination.

H. The Department of Health may enter into contracts with laboratories providing cytology and related services without competitive sealed bidding or competitive negotiation if competitive sealed bidding and competitive negotiations are not fiscally advantageous to the public to provide quality control as prescribed in writing by the Commissioner of Health.

I. The Director of the Department of Medical Assistance Services may enter into contracts without competitive sealed bidding or competitive negotiation for special services provided for eligible recipients pursuant to §32.1-325 E, provided that the Director has made a determination in advance after reasonable notice to the public and set forth in writing that competitive sealed bidding or competitive negotiation for such services is not fiscally advantageous to the public, or would constitute an imminent threat to the health or welfare of such recipients. The writing shall document the basis for this determination.

J. The Virginia Code Commission may enter into contracts without competitive sealed bidding or competitive negotiation when procuring the services of a publisher, pursuant to §§9-77.7 and 9-77.8, to publish the Code of Virginia or the Virginia Administrative Code.

K. (Effective until July 1, 1999) The State Health Commissioner may enter into agreements or contracts without competitive

sealed bidding or competitive negotiation for the compilation, storage, analysis, evaluation, and publication of certain data submitted by health care providers and for the development of a methodology to measure the efficiency and productivity of health care providers pursuant to Chapter 7.2 (§32.1-276.2 et seq.) of Title 32.1, if the Commissioner has made a determination in advance, after reasonable notice to the public and set forth in writing, that competitive sealed bidding or competitive negotiation for such services is not fiscally advantageous to the public. The writing shall document the basis : this determination. Such agreements and contracts shall be based on competitive principles.

L. A community development authority formed pursuant to Article 6 (§15.2-5152 et seq.) of Chapter 51 of Title 15.2, with members selected pursuant to such article, may enter into contracts without competition with respect to the exercise of any of its powers permitted by § 15.2-5158; however, this exception shall not apply in cases where any public funds other than special assessments and incremental real property taxes levied pursuant to §15.2-5158 are used as payment for such contract.

M. Virginia Correctional Enterprises may enter into contracts without competitive sealed bidding or competitive negotiation when procuring materials, supplies, or services for use in and support of its production facilities, provided such procurement is accomplished using procedures which ensure the efficient use of funds as practicable and, at a minimum, shall include obtaining telephone quotations. Such procedures shall require documentation of the basis for awarding contracts under this section.

N. The Virginia Baseball Stadium Authority may enter into agreements or contracts without competitive sealed bidding or competitive negotiation for the operation of any facilities developed under the provisions of Chapter 58 (§15.2-5800 et seq.) of Title 15.2, including contracts or agreements with respect to the sale of food, beverages and souvenirs at such facilities.

O. The Department of Health may procure child restraint devices, pursuant to §46.2-1097, without competitive sealed bidding or competitive negotiation.

P. With the consent of the Governor, the Jamestown-Yorktown Foundation may enter into agreements or contracts with private entities without competitive sealed bidding or competitive negotiation for the promotion of tourism through marketing provided a demonstrable cost savings, as reviewed by the Secretary of Education, can be realized by the Foundation and such agreements or contracts are based on competitive principles.

Q. The Virginia Racing Commission may designate an entity to administer and promote the Virginia Breeders Fund created pursuant to §59.1-372.

R. The Chesapeake Hospital Authority may enter into contracts without competitive sealed bidding or competitive negotiation in the exercise of any power conferred under Chapter 271, as amended, of the Acts of Assembly of 1966.

S. The Hospital Authority of Norfolk may enter into contracts without competitive sealed bidding or competitive negotiation in the exercise of any power conferred under Chapter 53 (§15.2-5300 et seq.) of Title 15.2. The Authority shall not discriminate against any person on the basis of race, color, religion, national origin, sex, pregnancy, childbirth or related medical conditions, age, marital status, or disability in the procurement of goods and services.

T. The Department of Health may enter into contracts without competitive sealed bidding or competitive negotiation for health care services with Virginia corporations granted tax-exempt status under § 501 (c) (3) of the Internal Revenue Code and operating as clinics for the indigent and uninsured that are organized for the delivery of primary health care services in a community (i) as federally qualified health centers designated by the Health Care Financing Administration or (ii) at a reduced or sliding fee scale or without charge.

CHAPTER 894

An Act to amend and reenact § 63.1-325 of the Code of Virginia, relating to donations of professional services.

[S 1153]

Approved March 29, 1999

Be it enacted by the General Assembly of Virginia:

1. That §63.1-325 of the Code of Virginia is amended and reenacted as follows:

§63.1-325. Donations of professional services.

A. A sole proprietor, partnership or limited liability company engaged in the business of providing professional services shall be eligible for a tax credit under this chapter based on the time spent by the proprietor or a partner or member, respectively, who renders professional services to a program which has received an allocation of tax credits from the Commissioner of Social Services or his designee. The value of the professional services, for purposes of determining the amount of the tax credit allowable, rendered by the proprietor or a partner or member to an approved program shall not exceed the lesser of (i) the reasonable cost for similar services from other providers or (ii) $125 per hour.

B. A business firm shall be eligible for a tax credit under this chapter for the time spent by a salaried employee who renders professional services to an approved program. The value of the professional services, for purposes of determining the amount of tax credit allowed to a business firm for time spent by its salaried employee in rendering professional services to an approved project, shall be equal to the salary that such employee was actually paid for the period of time that such employee rendered professional services to the approved program.

C. Notwithstanding any provision of this chapter limiting eligibility for tax credits to business firms, physicians ~~and~~, dentists, *nurse practitioners, physician assistants, optometrists, dental hygienists and pharmacists* licensed pursuant to Title 54.1 who provide health care services within the scope of their licensure, without charge, at a clinic which has received an allocation of tax credits from the Commissioner of Social Services or his designee and is organized in whole or in part for the delivery of health care services without charge, or to a clinic operated not for profit providing health care services for charges not exceeding those set forth in a scale prescribed by the State Board of Health pursuant to §32.1-11 for charges to be paid by persons based upon ability to pay, ~~or~~ shall be eligible for a tax credit pursuant to §63.1-324 based on the time spent in providing health care services at such clinic. The value of such services, for purposes of determining the amount of the tax credit allowable, rendered by the physician ~~or~~, dentist, *nurse practitioner, physician assistant, optometrist, dental hygienist, or pharmacist*, shall not exceed the lesser of (i) the reasonable cost for similar services from other providers or (ii) $125 per hour.

CHAPTER 812

An Act to amend and reenact § 32.1-127.1:03 of the Code of Virginia, relating to patient records.

[S 1158]

Approved March 29, 1999

Be it enacted by the General Assembly of Virginia:

1. That §32.1-127.1:03 of the Code of Virginia is amended and reenacted as follows:

§32.1-127.1:03. Patient health records privacy.

A. There is hereby recognized a patient's right of privacy in the content of a patient's medical record. Patient records are the property of the provider maintaining them, and, except when permitted by this section or by another provision of state or federal law, no provider, or other person working in a health care setting, may disclose the records of a patient.

Patient records shall not be removed from the premises where they are maintained without the approval of the provider, except in accordance with a court order or subpoena consistent with §8.01-413 C or with this section or in accordance with the regulations relating to change of ownership of patient records promulgated by a health regulatory board established in Title 54.1.

No third party to whom disclosure of patient records was made by a provider shall redisclose or otherwise reveal the records of a patient, beyond the purpose for which such disclosure was made, without first obtaining the patient's specific consent to such redisclosure. This redisclosure prohibition shall not, however, prevent any provider who receives records from another provider from making subsequent disclosures permitted under this section.

B. As used in this section:

"Agent" means a person who has been appointed as a patient's agent under a power of attorney for health care or an advance directive under the Health Care Decisions Act (§54.1-2981 et seq.).

"Guardian" means a court-appointed guardian of the person.

"Health services" includes but is not limited to examination, diagnosis, evaluation, treatment, pharmaceuticals, aftercare, habilitation or rehabilitation and mental health therapy of any kind.

"Parent" means a biological, adoptive or foster parent.

"Patient" means a person who is receiving or has received health services from a provider.

"Provider" shall have the same meaning as set forth in the definition of "health care provider" in §8.01-581.1, except that state-operated facilities shall also be considered providers for the purposes of this section. Provider shall also include all persons who are licensed, certified, registered or permitted by any of the health regulatory boards within the Department of Health Professions, except persons regulated by the Board of Funeral Directors and Embalmers or the Board of Veterinary Medicine.

"Record" means any written, printed or electronically recorded material maintained by a provider in the course of providing health services to a patient concerning the patient and the services provided. "Record" also includes the substance of any communication made by a patient to a provider in confidence during or in connection with the provision of health services to a patient or information otherwise acquired by the provider about a patient in confidence and in connection with the provision of health services to the patient.

C. The provisions of this section shall not apply to any of the following:

1. The status of and release of information governed by §§65.2-604 and 65.2-607 of the Virginia Workers' Compensation Act; or

2. Except where specifically provided herein, the records of minor patients.

D. Providers may disclose the records of a patient:

1. As set forth in subsection E of this section, pursuant to the written consent of the patient or in the case of a minor patient, his custodial parent, guardian or other person authorized to consent to treatment of minors pursuant to § 54.1-2969; also, in emergency cases or situations where it is impractical to obtain the patient's written consent, pursuant to the patient's oral consent for a provider to discuss the patient's records with a third party specified by the patient;

2. In compliance with a subpoena issued in accord with subsection H of this section, pursuant to court order upon good cause shown or in compliance with a subpoena issued pursuant to subsection C of § 8.01-413;

3. In accord with subsection F of §8.01-399 including, but not limited to, situations where disclosure is reasonably necessary to establish or collect a fee or to defend a provider or the provider's employees or staff against any accusation of wrongful conduct; also as required in the course of an investigation, audit, review or proceedings regarding a provider's conduct by a duly authorized law-enforcement, licensure, accreditation, or professional review entity;

4. In testimony in accordance with §§8.01-399 and 8.01-400.2;

5. In compliance with the provisions of § 8.01-413;

6. As required or authorized by any other provision of law including contagious disease, public safety, and suspected child or adult abuse reporting requirements, including but not limited to those contained in §§32.1-36, 32.1-36.1, 32.1-40, 32.1-41, 32.1-276.5, 32.1-283, 32.1-283.1, 37.1-98.2, 53.1-40.10, 54.1-2403.3, 54.1-2906, 54.1-2907, 54.1-2966, 54.1-2966.1, 54.1-2967, 54.1-2968, 63.1-55.3 and 63.1-248.11;

7. Where necessary in connection with the care of the patient;

8. In the normal course of business in accordance with accepted standards of practice within the health services setting; however, the maintenance, storage, and disclosure of the mass of prescription dispensing records maintained in a pharmacy registered or permitted in Virginia shall only be accomplished in compliance with §§54.1-3410, 54.1-3411 and 54.1-3412;

9. When the patient has waived his right to the privacy of the medical records;

10. When examination and evaluation of a patient is undertaken pursuant to judicial or administrative law order, but only to the extent as required by such;

11. To the guardian ad litem in the course of a guardianship proceeding of an adult patient authorized under §§37.1-128.1, 37.1-128.2 and 37.1-132;

12. To the attorney appointed by the court to represent a patient in a civil commitment proceeding under § 37.1-67.3;

13. To the attorney and/or guardian ad litem of a minor patient who represents such minor in any judicial or administrative proceeding, provided that the court or administrative hearing officer has entered an order granting the attorney or guardian ad litem this right and such attorney or guardian ad litem presents evidence to the provider of such order;

14. With regard to the Court Appointed Special Advocate (CASA) program, a minor's records in accord with § 9-173.12;

15. To an agent appointed under a patient's power of attorney or to an agent or decision maker designated in a patient's advance directive for health care or to any other person consistent with the provisions of the Health Care Decisions Act (§54.1-2981 et seq.);

16. To third-party payors and their agents pursuant to the deemed consent provisions of §§37.1-226 and 37.1-227 when the patient has requested the provider to submit bills to the third-party payor for payment under a contract or insurance policy;

17. As is necessary to support an application for receipt of health care benefits from a governmental agency or as required by an authorized governmental agency reviewing such application or reviewing benefits already provided;

18. Upon the sale of a medical practice as provided in § 54.1-2405; or upon a change of ownership or closing of a pharmacy pursuant to regulations of the Board of Pharmacy;

19. In accord with §54.1-2400.1 B, to communicate a patient's specific and immediate threat to cause serious bodily injury or death of an identified or readily identifiable person;

20. To the patient, except as provided in subsections E and F of this section and subsection B of § 8.01-413;

21. In the case of substance abuse records when permitted by and in conformity with requirements of federal law found in 42

U.S.C. 290dd-2 and 42 C.F.R. Part 2;

22. In connection with the work of any entity established as set forth in §8.01-581.16 to evaluate the adequacy or quality of professional services or the competency and qualifications for professional staff privileges; ~~and~~

23. *If the* records *are those* of a deceased or mentally incapacitated patient, to the personal representative or executor of the deceased patient or the legal guardian or committee of the incompetent or incapacitated patient or if there is no ~~such person~~ *personal representative, executor, legal guardian or committee* appointed, to the following persons in the following order of priority: a spouse, an adult son or daughter, either parent, an adult brother or sister, or any other relative of the deceased patient in order of blood relationship*; and*

24. For the purpose of conducting record reviews of inpatient hospital deaths to promote identification of all potential organ, eye, and tissue donors in conformance with the requirements of applicable federal law and regulations, including 42 C.F.R. § 482.45, (i) to the provider's designated organ procurement organization certified by the United States Health Care Financing Administration and (ii) to any eye bank or tissue bank in Virginia certified by the Eye Bank Association of America or the American Association of Tissue Banks.

E. Requests for copies of medical records shall (i) be in writing, dated and signed by the requester; (ii) identify the nature of the information requested; and (iii) include evidence of the authority of the requester to receive such copies and identification of the person to whom the information is to be disclosed. Within fifteen days of receipt of a request for copies of medical records, the provider shall do one of the following: (i) furnish such copies to any requester authorized to receive them; (ii) inform the requester if the information does not exist or cannot be found; (iii) if the provider does not maintain a record of the information, so inform the requester and provide the name and address, if known, of the provider who maintains the record; or (iv) deny the request (a) under subsection F, (b) on the grounds that the requester has not established his authority to receive such records or proof of his identity, or (c) as otherwise provided by law. Procedures set forth in this section shall apply only to requests for records not specifically governed by other provisions of this Code or of federal law.

F. Except as provided in subsection B of §8.01-413, copies of a patient's records shall not be furnished to such patient or anyone authorized to act on the patient's behalf where the patient's attending physician or the patient's clinical psychologist has made a part of the patient's record a written statement that, in his opinion, the furnishing to or review by the patient of such records would be injurious to the patient's health or well-being. If any custodian of medical records denies a request for copies of records based on such statement, the custodian shall permit examination and copying of the medical record by another such physician or clinical psychologist selected by the patient, whose licensure, training and experience relative to the patient's condition ~~is~~ *are* at least equivalent to that of the physician or clinical psychologist upon whose opinion the denial is based. The person or entity denying the request shall inform the patient of the patient's right to select another reviewing physician or clinical psychologist under this subsection who shall make a judgment as to whether to make the record available to the patient. Any record copied for review by the physician or clinical psychologist selected by the patient shall be accompanied by a statement from the custodian of the record that the patient's attending physician or clinical psychologist determined that the patient's review of his record would be injurious to the patient's health or well-being.

G. A written consent to allow release of patient records may, but need not, be in the following form:

CONSENT TO RELEASE OF CONFIDENTIAL HEALTH CARE

INFORMATION

Patient Name...

Provider Name..

Person, agency or provider to whom

disclosure is to be made...

Information or Records to be disclosed.............................

As the person signing this consent, I understand that I am giving my

permission to the above-named provider or other named third party for

disclosure of confidential health care records. I also understand that

I have the right to revoke this consent, but that my revocation is not

effective until delivered in writing to the person who is in possession

of my records. A copy of this consent and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original records. The person who receives the records to which this consent pertains may not redisclose them to anyone else without my separate written consent unless such recipient is a provider who makes a disclosure permitted by law.

This consent expires on (date)..

Signature of Patient .... Date ....

H. 1. No party to an action shall request the issuance of a subpoena duces tecum for an opposing party's medical records unless a copy of the request for the subpoena is provided to opposing counsel or the opposing party if they are pro se, simultaneously with filing the request. No party to an action shall request the issuance of a subpoena duces tecum for the medical records of a nonparty witness unless a copy of the request for the subpoena is provided to the nonparty witness simultaneously with filing the request.

In instances where medical records being subpoenaed are those of a pro se party or nonparty witness, the party requesting the issuance of the subpoena shall deliver to the pro se party or nonparty witness together with the copy of the request for subpoena, a statement informing them of their rights and remedies. The statement shall include the following language and the heading shall be in boldface capital letters:

NOTICE TO PATIENT

The attached Request for Subpoena means that (insert name of party requesting subpoena) has asked the court to issue a subpoena to your doctor or other health care providers (names of health care providers inserted here) requiring them to produce your medical records. Your doctor or other health care provider is required to respond by providing a copy of your medical records. If you believe your records should not be disclosed and object to their disclosure, you have the right to file a motion with the clerk of the court to quash the subpoena. You may contact the clerk's office to determine the requirements that must be satisfied when filing a motion to quash and you may elect to contact an attorney to represent your interest. If you elect to file a motion to quash, it must be filed as soon as possible before the provider sends out the records in response to the subpoena. If you elect to file a motion to quash, you must notify your doctor or other health care provider(s) that you are filing the motion so that the provider knows to send the records to the clerk of court in a sealed envelope or package for safekeeping while your motion is decided.

. Any party filing a request for a subpoena duces tecum for a patient's medical records shall include a Notice to Providers in .e same part of the request where the provider is directed where and when to return the records. Such notice shall be in boldface capital letters and shall include the following language:

NOTICE TO PROVIDERS

IF YOU RECEIVE NOTICE THAT YOUR PATIENT HAS FILED A MOTION TO QUASH (OBJECTING TO) THIS SUBPOENA, OR IF YOU FILE A MOTION TO QUASH THIS SUBPOENA, SEND THE RECORDS ONLY TO THE CLERK OF THE COURT WHICH ISSUED THE SUBPOENA USING THE FOLLOWING PROCEDURE: PLACE THE RECORDS IN A SEALED ENVELOPE AND ATTACH TO THE SEALED ENVELOPE A COVER LETTER TO THE CLERK OF COURT WHICH STATES THAT CONFIDENTIAL HEALTH CARE RECORDS ARE ENCLOSED AND ARE TO BE HELD UNDER SEAL PENDING THE COURT'S RULING ON THE MOTION TO QUASH THE SUBPOENA. THE SEALED ENVELOPE AND THE COVER LETTER SHALL BE PLACED IN AN OUTER ENVELOPE OR PACKAGE FOR TRANSMITTAL TO THE COURT.

3. Health care providers shall provide a copy of all records as required by a subpoena duces tecum or court order for such medical records. If the health care provider has, however, actual receipt of notice that a motion to quash the subpoena has been filed or if the health care provider files a motion to quash the subpoena for medical records, then the health care provider shall produce the records to the clerk of the court issuing the subpoena, where the court shall place the records under seal until a determination is made regarding the motion to quash. The securely sealed envelope shall only be opened on order of the judge. In the event the court grants the motion to quash, the records shall be returned to the health care provider in the same sealed envelope in which they were delivered to the court. In the event that a judge orders the sealed envelope to be opened to review the records in camera, a copy of the judge's order shall accompany any records returned to the provider. The records returned to the provider shall be in a securely sealed envelope.

4. It is the duty of any party requesting a subpoena duces tecum for medical records to determine whether the patient whose records are sought is pro se or a nonparty. Any request for a subpoena duces tecum for the medical records of a nonparty or of a pro se party shall direct the provider (in boldface type) not to produce the records until ten days after the date on which the provider is served with the subpoena duces tecum and shall be produced no later than twenty days after the date of such service.

In the event that the individual whose records are being sought files a motion to quash the subpoena, the court shall decide whether good cause has been shown by the discovering party to compel disclosure of the patient's private records over the patient's objections. In determining whether good cause has been shown, the court shall consider (i) the particular purpose for which the information was collected; (ii) the degree to which the disclosure of the records would embarrass, injure, or invade the privacy of the individual; (iii) the effect of the disclosure on the individual's future health care; (iv) the importance of the information to the lawsuit or proceeding; and (v) any other relevant factor.

The provisions of this subsection have no application to subpoenas for medical records requested under §8.01-413, or issued by a duly authorized administrative agency conducting an investigation, audit, review or proceedings regarding a provider's conduct. The provisions of this subsection apply to the medical records of both minors and adults.

A subpoena for substance abuse records must conform to the requirements of federal law found in 42 C.F.R. Part 2, Subpart E.

Providers may testify about the medical records of a patient in compliance with §§ 8.01-399 and 8.01-400.2.

CHAPTER 813

An Act requiring the Joint Commission on Health Care to study nursing home licensure regulations and centers of excellence in nursing homes.

[S 1172]
Approved March 29, 1999

Be it enacted by the General Assembly of Virginia:

1. *§ 1. Study of nursing home licensure regulations and centers of excellence in nursing homes.*

A. The Joint Commission on Health Care shall (i) study the adequacy of current Virginia regulations for licensure of nursing homes and the advisability of utilizing "deemed status" for nationally accredited nursing homes with the assistance of the Department of Health and (ii) examine the concept of centers of excellence in long-term care in cooperation with the Secretary of Health and Human Resources.

B. The Joint Commission shall examine the Commonwealth's nursing home licensure regulations to determine: (i) means for making such regulations more outcome oriented and focused on continuous quality improvement, (ii) opportunities for gathering additional resident and family input as part of the licensure process for nursing homes, (iii) the advisability of accepting national accreditation as evidence of compliance with state licensure standards, and (iv) other states' laws regarding deemed status for state licensure of nursing homes.

C. The Joint Commission shall examine the concept of centers of excellence with regard to long-term care reimbursement, specialized care programs, best management practices, and other issues as appropriate in cooperation with the Secretary of Health and Human Resources.

D. The Joint Commission shall submit its report to the Senate Committee on Education and Health and the House Committee on Health, Welfare and Institutions prior to October 1, 1999.

CHAPTER 964

An Act to amend and reenact §§ 63.1-175 and 63.1-177 of the Code of Virginia, relating to adult care residences.

[S 1173]

Approved April 7, 1999

Be it enacted by the General Assembly of Virginia:

1. That §§63.1-175 and 63.1-177 of the Code of Virginia are amended and reenacted as follows:

§63.1-175. Licenses required; expiration and renewal; maximum number of residents; restrictions on nomenclature.

A. Every person who constitutes, or who operates or maintains, an adult care residence shall obtain the appropriate license from the Commissioner, which may be renewed. The Commissioner or his designated agents, upon request, shall consult with, advise, and assist any person interested in securing and maintaining any such license.

B. The licenses shall be issued on forms prescribed by the Commissioner. Any two or more licenses may be issued for concurrent operation of more than one adult care residence. Each license and renewals thereof may be issued for periods of up to three successive years, unless sooner revoked or surrendered. *The length of each license or renewal thereof shall be based on the judgment of the Commissioner regarding the compliance history of the facility and the extent to which the adult care residence meets or exceeds state licensing standards. Based on this judgment, the Commissioner may issue licenses or renewals thereof for periods of six months, one year, two years, or three years.*

C. Each license shall indicate whether the residence is licensed to provide residential living or residential living and assisted living and shall stipulate the maximum number of persons who may be cared for in the adult care residence for which it is issued.

D. Any facility licensed exclusively as an adult care residence shall not use in its title the words "convalescent," "health," "hospital," "nursing," "sanatorium," or "sanitarium," nor shall such words be used to describe the facility in brochures, advertising, or other marketing material. No facility shall advertise or market a level of care which it is not licensed to provide. Nothing in this subsection shall prohibit the facility from describing services available in the facility.

§63.1-177. Inspections and interviews.

A. Applicants and licensees shall at all times afford the representatives of the Commissioner reasonable opportunity to inspect all of their facilities, books and records, and to interview their agents and employees and any person living in such facilities.

B. The Commissioner and his authorized agents shall have the right to inspect and investigate all adult care residences, interview their residents and have access to their records.

C. ~~The Commissioner or his authorized agents shall make at least two inspections of each licensed adult care residence each year, one of which shall be unannounced. The Commissioner may authorize such other announced or unannounced inspections as he considers appropriate.~~ *For any adult care residence issued a license or renewal thereof for a period of six months, the Commissioner or his authorized agents shall make at least two inspections during the six-month period, one of which shall be unannounced. For any adult care residence issued a license or renewal thereof for a period of one year, the Commissioner or his authorized agents shall make at least three inspections each year, at least two of which shall be unannounced. For any adult care residence issued a license or a renewal thereof for a period of two years, the Commissioner or his authorized agents shall make at least two inspections each year, at least one of which shall be unannounced. For any adult care residence issued a three-year license, the Commissioner or his authorized agents shall make at least one inspection each year, which shall be unannounced.*

D. For any licensed adult care residence, the Commissioner may authorize such other announced or unannounced inspections as the Commissioner considers appropriate.

2. That the Joint Commission on Health Care and the Secretary of Health and Human Resources shall report by October 1, 1999, to the chairpersons of the House Committee on Health, Welfare and Institutions, and the Senate Committee on Rehabilitation and Social Services regarding (i) options for making adult care resident regulations more outcome oriented, (ii) means for making such regulations more focused on obtaining resident and family input, and (iii) the advisability of deemed status for nationally accredited adult care residences.

CHAPTER 1031

An Act to amend the Code of Virginia by adding a section numbered 32.1-19.1, relating to duties of the Commissioner regarding telemedicine.

[S 1214]
Approved May 7, 1999

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding a section numbered 32.1-19.1 as follows:

§ 32.1-19.1 . Reporting of telemedicine initiatives.

The Commissioner shall annually report to the Governor and the General Assembly on the status of telemedicine initiatives by agencies of the Commonwealth. For the purposes of this section, telemedicine shall mean the use of telecommunications technology to deliver health care services and health professions education to sites that are distant from the host site or educator.

The report shall be issued by October 1 of each year and shall include, but not be limited to, (i) a summary of telemedicine initiatives by agencies of the Commonwealth; (ii) an analysis of the cost-effectiveness and medical efficacy of health services provided using telemedicine; (iii) recommendations regarding any improvements needed in current telemedicine initiatives; and (iv) identification of additional opportunities for use of telemedicine to improve access to quality health care and to health professions education for citizens of the Commonwealth.

CHAPTER 712

An Act to amend and reenact § 2.1-373 of the Code of Virginia, relating to powers and duties of the Department for the Aging.

[S 1265]
Approved March 28, 1999

Be it enacted by the General Assembly of Virginia:

1. That §2.1-373 of the Code of Virginia is amended and reenacted as follows:

§2.1-373. Powers and duties of Department with respect to aging persons; area agencies on aging; Commonwealth Council on Aging.

(a) The mission of the Department for the Aging shall be to improve the quality of life for older Virginians; *and to act as a focal point among state agencies for research, policy analysis, long-range planning, and education on aging issues.* In this chapter, older Virginians means persons aged sixty or older. The Department's policies and programs shall be designed to enable older persons to be as independent and self-sufficient as possible. The Department shall promote local participation in programs for the aging, evaluate and monitor the services provided for older Virginians and provide information to the general public. In furtherance of this mission, the Department's duties shall include, but not be restricted to:

(1) To study the economic and physical condition of the residents in the Commonwealth whose age qualifies them for coverage under Public Law 89-73 or any law amendatory or supplemental thereto of the Congress of the United States, hereinafter referred to as the aging, and the employment, medical, educational, recreational and housing facilities available to them, with the view of determining the needs and problems of such persons;

(2) To determine the services and facilities, private and governmental and state and local, provided for and available to the aging and to recommend to the appropriate person or persons such coordination of and changes in such services and facilities as will make them of greater benefit to the aging and more responsive to their needs;

(3) To act as the single state agency, under Public Law 89-73 or any law amendatory or supplemental thereto of the Congress of the United States, and as the sole agency for administering or supervising the administration of such plans as may be adopted in accordance with the provisions of such law or laws. As such agency, the Department shall have authority to prepare, submit and carry out state plans and shall be the agency primarily responsible for coordinating state programs and activities related to the purposes of, or undertaken under, such plans or laws;

(4) With the approval of the Governor, to apply for and expend such grants, gifts or bequests from any source as may become available in connection with its duties under this section, and is authorized to comply with such conditions and requirements as may be imposed in connection therewith;

(5) To hold such hearings and conduct such investigations as are necessary to pass upon applications for approval of a project under the plans and laws set out in subdivision (3) hereof, and shall make such reports to the Secretary of the United States Department of Health and Human Services as may be required;

(6) [Repealed.]

(7) To designate area agencies on aging pursuant to Public Law 89-73 or any law amendatory or supplemental thereto of the Congress of the United States and to promulgate rules and regulations for the composition and operation of such area agencies on aging;

(8), (9) [Repealed.]

(10) To provide information to consumers and their representatives concerning the recognized features of special care units. Such information shall educate consumers and their representatives on how to choose special care and may include brochures and electronic bulletin board notices;

(11) To provide staff support to the Commonwealth Council on Aging;

(12) To ~~serve as a focal point for research, policy analysis, long-range planning, and education on aging issues~~ *assist state, local, and nonprofit agencies, including, but not limited to, area agencies on aging, in identifying grant and public-private partnership opportunities for improving services to elderly Virginians.*

(b) The governing body of any county, city or town may appropriate funds for support of area agencies on aging designated pursuant to subdivision (a) (7) hereof.

(c) All agencies of the Commonwealth shall assist the Department in effectuating its functions in accordance with its designation as the single state agency as required in subdivision (a) (3) above.

CHAPTER 784

An Act to amend the Code of Virginia by adding a section numbered 2.1-447.1, relating to direct purchases by charitable corporations.

[H 2229]
Approved March 28, 1999

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding a section numbered 2.1-447.1 as follows:

§ 2.1-447.1. Direct purchases by charitable corporations.

The Division shall allow corporations operating in Virginia and granted tax exempt status under § 501 (c) (3) of the Internal Revenue Code and operating as clinics for the indigent and uninsured that are organized for the delivery of primary health care services (i) as federally qualified health centers designated by the Health Care Financing Administration or (ii) at a reduced or sliding fee scale or without charge, to purchase directly from contracts established for state agencies and public bodies by the Division.

CHAPTER 1034

An Act to amend and reenact §§ 32.1-351 and 32.1-352 of the Code of Virginia, relating to the Virginia Children's Medical Security Insurance Plan.

[H 2230]
Approved May 7, 1999

Be it enacted by the General Assembly of Virginia:

1. That §§32.1-351 and 32.1-352 of the Code of Virginia are amended and reenacted as follows:

§32.1-351. Virginia Children's Medical Security Insurance Plan established.

A. The Department of Medical Assistance Services shall develop, *implement and administer* the Virginia Children's Medical Security Insurance Plan to provide coverage for individuals, up to the age of ~~eighteen~~ *nineteen* , when such individuals (i) ~~are in families with~~ *have family* incomes at *or below* 200 percent of the *federal* poverty level ~~or less,~~ *as set forth in the appropriation act,* and (ii) are ~~not insured or are underinsured by any policy, plan or contract providing health benefits~~ *otherwise eligible for such benefits in compliance with Title XXI of the Social Security Act, as amended, and the Commonwealth's plan for the State Children's Health Insurance Program (SCHIP) as established in Subtitle J of the federal Balanced Budget Act of 1997 (P. L. 105-33).*

B. The Department of Medical Assistance Services shall develop ~~a proposal~~ *and submit to the federal Secretary of Health and Human Services a Title XXI plan* for this program ~~by December 1, 1997~~ *and may revise such plan as may be necessary . Such plan and any subsequent revisions shall comply with the requirements of federal law, this chapter, and any conditions set forth in the appropriation act.*

~~In developing this proposal, the Department shall consider, but need not limit its proposal to: (i) the services recommended by the American Academy of Pediatrics in its Child Health Insurance Reform Plan (CHIRP); (ii) the provision of services through a network of participating providers; (iii) the development of public/private partnerships; (iv) a schedule for providing universal coverage for uninsured and underinsured children in families with incomes at 200 percent of the poverty level or less, to be phased in over a period of five years; and (v) alternatives for soliciting or requiring contributions from employers. The Department shall also include in its proposal criteria for determining "underinsured."~~

C. Funding for this program shall be provided through *state and federal appropriations and may include appropriations of any funds which may be generated through* the Virginia Children's Medical Security Insurance Plan Trust Fund.

D. The Board of Medical Assistance Services ~~may~~ *shall* promulgate such regulations pursuant to the Administrative Process Act (§9-6.14:1 et seq.) as may be necessary for the implementation *and administration* of the program ~~consistent with this chapter.~~

§32.1-352. Virginia Children's Medical Security Insurance Plan Trust Fund.

A. ~~For the purpose of providing primary and preventive care to certain individuals up to the age of eighteen,~~ There is hereby created in the state treasury a special nonreverting fund to be known as the Virginia Children's Medical Security Insurance Plan Trust Fund, hereinafter referred to as the "Fund." The Fund shall be established on the books of the Comptroller and shall be administered by the Director of the Department of Medical Assistance Services. The Fund shall consist of the premium differential, any employer contributions which may be solicited or received by the Department of Medical Assistance Services, and all grants, donations, gifts, and bequests from any source, public or private. As used in this section, "premium differential" means an amount equal to the difference between (i) 0.75 percent of the direct gross subscriber fee income derived from eligible contracts and (ii) the amount of license tax revenue generated pursuant to subdivision A 4 of §58.1-2501 with respect to eligible contracts. As used in this section, "eligible contract" means any subscription contract for any kind of plan classified and defined in §38.2-4201 or §38.2-4501 issued other than to (i) an individual or (ii) a primary small group employer if income from the contract is subject to license tax at the rate of 2.25 percent pursuant to subdivision D of §38.2-4229.1. The State Corporation Commission shall annually, on or before June 30, calculate the premium differential for the immediately preceding taxable year and notify the Comptroller of the Commonwealth to transfer such amount to the Virginia Children's Medical Security Insurance Plan Trust Fund as established on the books of the Comptroller.

B. Any moneys remaining in the Fund, including interest thereon, at the end of each fiscal year shall not revert to the general fund but shall remain in the Fund. Moneys in the Fund shall be used solely to support the Virginia Children's Medical Security Insurance Plan~~, developed by the Department of Medical Assistance Services pursuant to §32.1-351. No more than~~

~~five percent of such Fund may be used for administration~~ *in accordance with the requirements of Title XXI of the Social Security Act, as amended, the Commonwealth's plan for the State Children's Health Insurance Program (SCHIP), as established in Subtitle J of the federal Balanced Budget Act of 1997 (P. L. 105-33), and any conditions set forth in the appropriation act*.

C. The Director of the Department of Medical Assistance Services shall report annually on December 1 to the Governor, the General Assembly, and the Joint Commission on Health Care on the status of the Fund, the number of children served *by this program* , the costs of such services, and any issues related to the Virginia Children's Medical Security Insurance Plan that may need to be addressed. ~~The first such report shall, however, consist of the proposal for implementation of the Virginia Children's Medical Security Insurance Plan as required by this chapter.~~

CHAPTER 1004

An Act to amend and reenact §§ 38.2-3430.2, 38.2-3430.3, 38.2-3430.8, 38.2-3431, 38.2-3432.3, and 38.2-3514.1 of the Code of Virginia, relating to individual health insurance coverage.

[H 2283]

Approved April 7, 1999

Be it enacted by the General Assembly of Virginia:

1. That §§38.2-3430.2, 38.2-3430.3, 38.2-3430.8, 38.2-3431, 38.2-3432.3, and 38.2-3514.1 of the Code of Virginia are amended and reenacted as follows:

§38.2-3430.2. Definitions.

A. The terms defined in §38.2-3431 that are used in this article shall have the meanings set forth in that section.

B. For purposes of this article:

"Eligible individual" means an individual:

1. (i) for whom, as of the date on which the individual seeks coverage under this section, the aggregate of the periods of creditable coverage is eighteen or more months~~,~~ and (ii) whose most recent prior creditable coverage was under *individual health insurance coverage,* a group health plan, governmental plan or church plan or health insurance coverage offered in connection with any such plan;

2. Who is not eligible for coverage under (i) a group health plan, (ii) part A or part B of Title XVIII of the Social Security Act, or (iii) a state plan under Title XIX of such Act, or any successor program, and does not have other health insurance coverage;

3. With respect to whom the most recent coverage within the coverage period described in subdivision 1 was not terminated based on a factor described in subdivision B 1 or B 2 of §38.2-3430.7 relating to nonpayment of premiums or fraud;

4. If the individual had been offered the option of continuation coverage under a COBRA continuation provision or under a similar state program, who elected such coverage; ~~and~~

5. Who, if the individual elected such continuation coverage, has exhausted such continuation coverage under such provision or program*; and*

6. In the case where individual health insurance coverage is the most recent creditable coverage, the coverage was nonrenewed by the health insurance issuer under the conditions allowed in subdivision C 2 of § 38.2-3430.7, in which case the aggregate period of creditable coverage required is reduced to twelve months.

For the purposes of determining the aggregate of the periods of creditable coverage under subdivision B 1 (i) of this section, a period of creditable coverage shall not be counted with respect to enrollment of an individual under a health benefit plan if, after such period, there was a sixty-three-day period during all of which the individual was not covered under any creditable coverage or was not serving a waiting period for coverage under a group health plan, or for group health insurance coverage or was in an affiliation period.

§38.2-3430.3. Guaranteed availability of individual health insurance coverage to certain individuals with prior group coverage.

A. Guaranteed availability.

1. All eligible individuals shall be provided a choice of all individual health insurance coverage currently being offered by a health insurance issuer and the chosen coverage shall be issued.

2. Such coverage provided as required in subdivision A 1 shall not impose any preexisting condition exclusion with respect to such coverage.

B. Health insurance issuers are prohibited from imposing any limitations or exclusions based upon named conditions that apply to eligible individuals.

C. Health insurance issuers shall include on all applications for health insurance coverage questions which will enable the health insurance issuer to determine if an applicant is applying for coverage as an eligible individual as defined in § 38.2-3430.2 .

§ 38.2-3430.8. Certification of coverage.

The provisions of ~~subsections F through I of~~ §38.2-3432.3 shall apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as they apply to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.

§38.2-3431. Application of article; definitions.

A. This article applies to group health plans and to health insurance issuers offering group health insurance coverage, and individual policies offered to employees of small employers.

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 individual or group coverage to the small employer market in this Commonwealth shall be subject to the provisions of this article. Any issuer of individual coverage to employees of a small employer 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 employer;

2. The eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the employer for any portion of the premium;

3. The employer has permitted payroll deduction for the covered individual or any portion of the premium is paid by the 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 health insurance issuer is in compliance with the provisions of 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 health insurance issuer in establishing premium rates for applicable insurance coverage.

"Affiliation period" means a period which, under the terms of the health insurance coverage offered by a health maintenance organization, must expire before the health insurance coverage becomes effective. The health maintenance organization is not required to provide health care services or benefits during such period and no premium shall be charged to the participant or beneficiary for any coverage during the period.

1. Such period shall begin on the enrollment date.

2. An affiliation period under a plan shall run concurrently with any waiting period under the plan.

"Beneficiary" has the meaning given such term under section 3(8) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (8)).

"Bona fide association" means, with respect to health insurance coverage offered in this Commonwealth, an association which:

1. Has been actively in existence for at least five years;

2. Has been formed and maintained in good faith for purposes other than obtaining insurance;

3. Does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of an employee);

4. Makes health insurance coverage offered through the association available to all members regardless of any health

status-related factor relating to such members (or individuals eligible for coverage through a member);

5. Does not make health insurance coverage offered through the association available other than in connection with a member of the association; and

6. Meets such additional requirements as may be imposed under the laws of this Commonwealth.

"Certification" means a written certification of the period of creditable coverage of an individual under a group health plan and coverage provided by a health insurance issuer offering group health insurance coverage and the coverage, ~~(~~if any~~)~~, under such COBRA continuation provision, and the waiting period, ~~(~~if any~~)~~, and affiliation period, ~~(~~if applicable~~)~~, imposed with respect to the individual for any coverage under such plan.

"Church plan" has the meaning given such term under section 3(33) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (33)).

"COBRA continuation provision" means any of the following:

1. Section 4980B of the Internal Revenue Code of 1986 (26 U.S.C. § 4980B), other than subsection (f) (1) of such section insofar as it relates to pediatric vaccines;

2. Part 6 of subtitle B of Title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1161 et seq.), other than section 609 of such Act; or

3. Title XXII of P.L. 104-191.

"Community rate" means the average rate charged for the same or similar coverage to all small employer groups with the same area, age and gender characteristics. This rate shall be based on the health insurance issuer's combined claims experience for all groups within its small employer market.

"Creditable coverage" means with respect to an individual, coverage of the individual under any of the following:

1. A group health plan;

2. Health insurance coverage;

3. Part A or B of Title XVIII of the Social Security Act (U.S.C. § 1395c or § 1395);

4. Title XIX of the Social Security Act (42 U.S.C. § 1396 et seq.), other than coverage consisting solely of benefits under section 1928;

5. Chapter 55 of Title 10, United States Code (10 U.S.C. § 1071 et seq.);

6. A medical care program of the Indian Health Service or of a tribal organization;

7. A state health benefits risk pool;

8. A health plan offered under Chapter 89 of Title 5, United States Code (5 U.S.C. § 8901 et seq.);

9. A public health plan (as defined in federal regulations); ~~or~~

10. A health benefit plan under section 5 (e) of the Peace Corps Act (22 U.S.C. § 2504(e))*; or*

11. Individual health insurance coverage.

Such term does not include coverage consisting solely of coverage of excepted benefits.

"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.

"Eligible individual" means such an individual in relation to the employer as shall be determined:

1. In accordance with the terms of such plan;

2. As provided by the health insurance issuer under rules of the health insurance issuer which are uniformly applicable to employers in the group market; and

3. In accordance with all applicable law of this Commonwealth governing such issuer and such market.

"Employee" has the meaning given such term under section 3(6) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (6)).

"Employer" has the meaning given such term under section 3(5) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (5)), except that such term shall include only employers of two or more employees.

"Enrollment date" means, with respect to an eligible individual covered under a group health plan or health insurance coverage, the date of enrollment of the eligible individual in the plan or coverage or, if earlier, the first day of the waiting period for such enrollment.

"Essential and standard health benefit plans" means health benefit plans developed pursuant to subsection C of this section.

"Excepted benefits" means benefits under one or more (or any combination thereof) of the following:

1. Benefits not subject to requirements of this article:

a. Coverage only for accident, or disability income insurance, or any combination thereof;

b. Coverage issued as a supplement to liability insurance;

c. Liability insurance, including general liability insurance and automobile liability insurance;

d. Workers' compensation or similar insurance;

e. Medical expense and loss of income benefits;

f. Credit-only insurance;

g. Coverage for on-site medical clinics; and

h. Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

2. Benefits not subject to requirements of this article if offered separately:

a. Limited scope dental or vision benefits;

b. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and

c. Such other similar, limited benefits as are specified in regulations.

3. Benefits not subject to requirements of this article if offered as independent, noncoordinated benefits:

a. Coverage only for a specified disease or illness; and

b. Hospital indemnity or other fixed indemnity insurance.

4. Benefits not subject to requirements of this article if offered as separate insurance policy:

a. Medicare supplemental health insurance (as defined under section 1882 (g) (1) of the Social Security Act (42 U.S.C. § 1395ss (g) (1));

b. Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (10 U.S.C. § 1071 et seq.); and

c. Similar supplemental coverage provided to coverage under a group health plan.

"Federal governmental plan" means a governmental plan established or maintained for its employees by the government of the United States or by an agency or instrumentality of such government.

"Governmental plan" has the meaning given such term under section 3(32) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (32)) and any federal governmental plan.

"Group health insurance coverage" means in connection with a group health plan, health insurance coverage offered in connection with such plan.

"Group health plan" means an employee welfare benefit plan (as defined in section 3 (1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (1)), to the extent that the plan provides medical care and including items and services paid for as medical care to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

"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; Medicaid coverage; 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; medical expense and loss of income benefits; 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.

"Health insurance coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

"Health insurance issuer" means an insurance company, or insurance organization (including a health maintenance organization) which is licensed to engage in the business of insurance in this Commonwealth and which is subject to the laws of this Commonwealth which regulate insurance within the meaning of section 514 (b) (2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1144 (b) (2)). Such term does not include a group health plan.

"Health maintenance organization" means:

1. A federally qualified health maintenance organization;

2. An organization recognized under the laws of this Commonwealth as a health maintenance organization; or

3. A similar organization regulated under the laws of this Commonwealth for solvency in the same manner and to the same extent as such a health maintenance organization.

"Health status-related factor" means the following in relation to the individual or a dependent eligible for coverage under a group health plan or health insurance coverage offered by a health insurance issuer:

1. Health status;

2. Medical condition (including both physical and mental illnesses);

3. Claims experience;

4. Receipt of health care;

5. Medical history;

6. Genetic information;

7. Evidence of insurability (including conditions arising out of acts of domestic violence); or

8. Disability.

"Individual health insurance coverage" means health insurance coverage offered to individuals in the individual market, but does not include coverage defined as excepted benefits. Individual health insurance coverage does not include short-term limited duration coverage.

"Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

"Large employer" means in connection with a group health plan or health insurance coverage with respect to a calendar year and a plan year, an employer who employed an average of at least fifty-one employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year.

"Large group market" means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a large employer or through a health insurance issuer.

"Late enrollee" means, with respect to coverage under a group health plan or health insurance coverage provided by a health insurance issuer, a participant or beneficiary who enrolls under the plan other than during:

1. The first period in which the individual is eligible to enroll under the plan; or

2. A special enrollment period as required pursuant to subsections J through M of §38.2-3432.3.

"Medical care" means amounts paid for:

1. The diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

2. Transportation primarily for and essential to medical care referred to in subdivision 1; and

3. Insurance covering medical care referred to in subdivisions 1 and 2.

"Network plan" means health insurance coverage of a health insurance issuer under which the financing and delivery of medical care (including items and services paid for as medical care) are provided, in whole or in part, through a defined set of providers under contract with the health insurance issuer.

"Nonfederal governmental plan" means a governmental plan that is not a federal governmental plan.

"Participant" has the meaning given such term under section 3(7) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (7)).

"Placed for adoption," or "placement" or "being placed" for adoption, in connection with any placement for adoption of a child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such person terminates upon the termination of such legal obligation.

"Plan sponsor" has the meaning given such term under section 3(16) (B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (16) (B)).

"Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date. Genetic information shall not be treated as a preexisting condition in the absence of a diagnosis of the condition related to such information.

"Premium" means all moneys paid by an employer and eligible employees as a condition of coverage from a health insurance issuer, including fees and other contributions associated with the health benefit plan.

"Rating period" means the twelve-month period for which premium rates are determined by a health insurance issuer and are assumed to be in effect.

"Service area" means a broad geographic area of the Commonwealth in which a health insurance issuer sells or has sold insurance policies on or before January 1994, or upon its subsequent authorization to do business in Virginia.

"Small employer" means in connection with a group health plan or health insurance coverage with respect to a calendar year and a plan year, an employer who employed an average of at least two but not more than fifty employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year.

"Small group market" means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a small employer or through a health insurance issuer.

"State" means each of the several states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

"Waiting period" means with respect to a group health plan or health insurance coverage provided by a health insurance issuer and an individual who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan. If an employee or dependent enrolls during a special enrollment period pursuant to subsections J through M of §38.2-3432.3 or as a late enrollee, any period before such enrollment is not a waiting period.

C. The Commission shall adopt regulations establishing the essential and standard plans for sale in the small employer market. Such regulations shall incorporate the recommendations of the Essential Health Services Panel, established pursuant to Chapter 847 of the 1992 Acts of Assembly. The Commission shall modify such regulations as necessary to incorporate any revisions to the essential and standard plans submitted by the Special Advisory Commission on Mandated Health Insurance Benefits pursuant to §9-298. Every health insurance issuer shall, as a condition of transacting business in Virginia with small employers, offer to small employers the essential and standard plans, subject to the provisions of §38.2-3432.2. However, any regulation adopted by the Commission shall contain a provision requiring all health insurance issuers to offer an option permitting a 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 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 health insurance issuers shall issue the plans to every small employer that elects to be covered under either one of the plans and agrees to make the required premium payments, and 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 (§38.2-4300 et seq.) 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 health insurance issuers.

2. No law requiring the coverage or offering of coverage of a benefit shall apply to the essential or standard health care plan or riders thereof.

3. Every health insurance issuer offering group health insurance coverage shall, as a condition of transacting business in Virginia with small employers, offer and make available to small employers an essential and a standard health benefit plan, subject to the provisions of §38.2-3432.2.

4. All essential and standard benefit plans issued to 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 health insurance issuer 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 health insurance issuer, disapprove the continued use by the health insurance issuer of an essential or standard health benefit plan on the grounds that such plan does not meet the requirements of this article.

5. No health insurance issuer offering group health insurance coverage is required to offer coverage or accept applications pursuant to subdivisions 3 and 4 of this subsection:

a. From a 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 health insurance issuer offering group health insurance coverage 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 health insurance issuer being declared an impaired insurer.

A health insurance issuer offering group health insurance coverage that does not offer coverage pursuant to subdivision 5 b may not offer coverage to small employers until the Commission determines that the health insurance issuer is no longer impaired.

6. Every health insurance issuer offering group health insurance coverage shall uniformly apply the provisions of subdivision C 5 of this section and shall fairly market the essential and standard health benefit plans to all small employers in their service area of the Commonwealth. A health insurance issuer offering group health insurance coverage 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 health insurance issuer submits and the Commission approves a plan to fairly market to the health insurance issuer's service area.

7. No health maintenance organization is required to offer coverage or accept applications pursuant to subdivisions 3 and 4 of this subsection in the case of any of the following:

a. To 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;

c. To 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

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 health maintenance organization 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 6 of this subsection apply.

8. In order to ensure the broadest availability of health benefit plans to small employers, the Commission shall set market conduct and other requirements for health insurance issuers, agents and third-party administrators, including requirements relating to the following:

a. Registration by each health insurance issuer offering group health insurance coverage with the Commission of its intention to offer health insurance coverage in the small group market under this article;

b. Publication by the Commission of a list of all health insurance issuers who offer coverage in the small group market, including a potential requirement applicable to agents, third-party administrators, and health insurance issuers that no health benefit plan may be sold to a small employer by a health insurance issuer not so identified as a health insurance issuer in the small group market;

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 small employers among carriers, periodic reports by health insurance issuers about plans issued to 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

small employers. Health insurance issuers 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 health insurance issuers offering group health insurance coverage that they are marketing and issuing health benefit plans to small employers in fulfillment of the purposes of this article.

9. All essential and standard health benefits plans contracts delivered, issued for delivery, reissued, renewed, or extended in this Commonwealth on or after July 1, 1997, shall include coverage for 365 days of inpatient hospitalization for each covered individual during a twelve-month period. If coverage under the essential or standard health benefits plan terminates while a covered person is hospitalized, the inpatient hospital benefits shall continue to be provided until the earliest of (i) the day the maximum amount of benefit has been provided or (ii) the day the covered person is no longer hospitalized as an inpatient.

§38.2-3432.3. Limitation on preexisting condition exclusion period.

A. Subject to subsection B, a health insurer offering ~~group~~ health insurance coverage, may, with respect to a participant or beneficiary, impose a preexisting limitation only if:

1. *For group health insurance coverage,* such exclusion relates to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the enrollment date;

2. *For individual health insurance coverage, such exclusion relates to a condition that, during a twelve-month 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 immediately preceding the effective date of coverage;*

~~2.~~ *3.* Such exclusion extends for a period of not more than twelve months (or ~~eighteen~~ *twelve* months in the case of a late enrollee) after the enrollment date; and

~~3.~~ *4*. The period of any such preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage, if any, applicable to the participant or beneficiary as of the enrollment date.

B. Exceptions:

1. Subject to subdivision 4 of this subsection, a health insurance issuer offering health insurance coverage, may not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the thirty-day period beginning with the date of birth, is covered under creditable coverage;

2. Subject to subdivision 4 of this subsection, a health insurance issuer offering health insurance coverage, may not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining eighteen years of age and who, as of the last day of the thirty-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. The previous sentence shall not apply to coverage before the date of such adoption or placement for adoption;

3. A health insurance issuer offering health insurance coverage, may not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition, *except in the case of individual health insurance coverage, where the health insurance issuer may impose a preexisting condition exclusion for a pregnancy existing on the effective date of coverage*; ~~and~~

4. Subdivisions 1 and 2 of this subsection shall no longer apply to an individual after the end of the first sixty-three-day period during all of which the individual was not covered under any creditable coverage*; and*

5. Subdivision A 4 of § 38.2-3432.3 shall not apply to health insurance coverage offered in the individual market on a "guarantee issue" basis without regard to health status including open enrollment policies or contracts issued pursuant to § 38.2-4216.1 and policies, contracts, certificates or evidences of coverage issued through a bona fide association or to students through school sponsored programs at a college or university unless the person is an eligible individual as defined in § 38.2-3430.2 .

C. A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a health benefit plan, if, after such period and before the enrollment date, there was a sixty-three-day period during all of which the individual was not covered under any creditable coverage.

D. For purposes of subdivision B 4 and subsection C, any period that an individual is in a waiting period for any coverage

under a group health plan (or for group health insurance coverage) or is in an affiliation period shall not be taken into account in determining the continuous period under subsection C.

E. Methods of crediting coverage:

1. Except as otherwise provided under subdivision 2 of this subsection, a health insurance issuer offering group health coverage shall count a period of creditable coverage without regard to the specific benefits covered during the period;

2. A health insurance issuer offering group health insurance coverage, may elect to count a period of creditable coverage based on coverage of benefits within each of several classes or categories of benefits rather than as provided under subdivision 1 of this subsection. Such election shall be made on a uniform basis for all participants and beneficiaries. Under such election a health insurance issuer shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within such class or category;

3. In the case of an election with respect to a group plan under subdivision 2 of this subsection (whether or not health insurance coverage is provided in connection with such plan), the plan shall: (i) prominently state in any disclosure statements concerning the plan, and state to each enrollee at the time of enrollment under the plan, that the plan has made such election and (ii) include in such statements a description of the effect of this election; and

4. In the case of an election under subdivision 2 of this subsection with respect to health insurance coverage offered by a health insurance issuer in the small or large group market, the health insurance issuer shall: (i) prominently state in any disclosure statements concerning the coverage, and to each employer at the time of the offer or sale of the coverage, that the health insurance issuer has made such election and (ii) include in such statements a description of the effect of such election.

F. Periods of creditable coverage with respect to an individual shall be established through presentation of certifications described in subsection G or in such other manner as may be specified in federal regulations.

G. A health insurance issuer offering group health insurance coverage, shall provide for certification of the period of creditable coverage:

1. At the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision;

2. In the case of an individual becoming covered under a COBRA continuation provision, at the time the individual ceases to be covered under such provision; and

3. At the request, or on behalf of, an individual made not later than twenty-four months after the date of cessation of the coverage described in subdivision 1 or 2 of this subsection, whichever is later. The certification under subdivision 1 of this subsection may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

H. To the extent that medical care under a group health plan consists of group health insurance coverage, the plan is deemed to have satisfied the certification requirement under this section if the health insurance issuer offering the coverage provides for such certification in accordance with this section.

I. In the case of an election described in subdivision E 2 by a health insurance issuer, if the health insurance issuer enrolls an individual for coverage under the plan and the individual provides a certification of coverage of the individual under subsection F:

1. Upon request of such health insurance issuer, the entity which issued the certification provided by the individual shall promptly disclose to such requesting group insurance issuer information on coverage of classes and categories of health benefits available under such entity's plan or coverage; and

2. Such entity may charge the requesting health insurance issuer for the reasonable cost of disclosing such information.

J. A health insurance issuer offering group health insurance coverage, shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if each of the following conditions is met:

1. The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent;

2. The employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or health insurance issuer (if applicable) required such a statement at such time and provided the employee with notice of such requirement (and the consequences of such requirement) at such time;

3. The employee's or dependent's coverage described in subdivision 1 of this subsection: (i) was under a COBRA continuation provision and the coverage under such provision was exhausted; or (ii) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions towards such coverage were terminated; and

4. Under the terms of the plan, the employee requests such enrollment not later than thirty days after the date of exhaustion of coverage described in subdivision 3 (i) of this subsection or termination of coverage or employer contribution described in subdivision 3 (ii) of this subsection.

K. If: (i) a health insurance issuer makes coverage available with respect to a dependent of an individual; (ii) the individual is a participant under the plan (or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period); and (iii) a person becomes such a dependent of the individual through marriage, birth, or adoption or placement for adoption, the health insurance issuer shall provide for a dependent special enrollment period described in subsection L of this subsection during which the person (or, if not otherwise enrolled, the individual) may also be enrolled under the plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may also be enrolled as a dependent of the individual if such spouse is otherwise eligible for coverage.

L. A dependent special enrollment period under this subsection shall be a period of not less than thirty days and shall begin on the later of:

1. The date dependent coverage is made available; or

2. The date of the marriage, birth, or adoption or placement for adoption (as the case may be) described in subsection K.

M. If an individual seeks to enroll a dependent during the first thirty days of such a dependent special enrollment period, the coverage of the dependent shall become effective:

1. In the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

2. In the case of a dependent's birth, as of the date of such birth; or

3. In the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

N. A late enrollee may be excluded from coverage for up to eighteen months or may have a preexisting condition limitation apply for up to eighteen months; however, in no case shall a late enrollee be excluded from some or all coverage for more than eighteen months. 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.

§38.2-3514.1. Preexisting conditions provisions.

A. 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, exclusive of any applicable waiting period under such coverage.

B. As used herein, a "preexisting conditions provision" means a policy provision that limits, denies, or excludes coverage for charges or expenses incurred during a twelve-month period following the insured's effective date of coverage, for a condition that, during a twelve-month 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 immediately preceding the effective date of coverage or as to pregnancy existing on the effective date of coverage.

C. This section shall not apply to the following insurance policies or contracts:

1. Short-term travel;

2. Accident-only;

3. Limited or specified disease contracts;

4. Long-term care insurance;

5. Short-term nonrenewable policies or contracts of not more than six months' duration which are subject to no medical underwriting or minimal underwriting;

6. ~~Individual open enrollment policies or contracts issued pursuant to § 38.2-4216.1 to persons who were previously covered under a group health insurance policy or contract issued by another unaffiliated insurer, health services plan or health maintenance organization, and who, due to health status, are eligible for individual coverage only under §§38.2-3416 and 38.2-4216.1~~ *Policies subject to Article 4.1 (§ 38.2-3430.1 et seq.) of Chapter 34 of this title* ;

7. Policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal government plans; and

8. Disability income.

CHAPTER 917

An Act to amend and reenact § 63.1-325 of the Code of Virginia, relating to donations of professional services.

[H 2290]

Approved March 29, 1999

Be it enacted by the General Assembly of Virginia:

1. That §63.1-325 of the Code of Virginia is amended and reenacted as follows:

§63.1-325. Donations of professional services.

A. A sole proprietor, partnership or limited liability company engaged in the business of providing professional services shall be eligible for a tax credit under this chapter based on the time spent by the proprietor or a partner or member, respectively, who renders professional services to a program which has received an allocation of tax credits from the Commissioner of Social Services or his designee. The value of the professional services, for purposes of determining the amount of the tax credit allowable, rendered by the proprietor or a partner or member to an approved program shall not exceed the lesser of (i) the reasonable cost for similar services from other providers or (ii) $125 per hour.

B. A business firm shall be eligible for a tax credit under this chapter for the time spent by a salaried employee who renders professional services to an approved program. The value of the professional services, for purposes of determining the amount of tax credit allowed to a business firm for time spent by its salaried employee in rendering professional services to an approved project, shall be equal to the salary that such employee was actually paid for the period of time that such employee rendered professional services to the approved program.

C. Notwithstanding any provision of this chapter limiting eligibility for tax credits to business firms, physicians ~~and~~, dentists, *nurse practitioners, physician assistants, optometrists, and pharmacists* licensed pursuant to Title 54.1 who provide health care services within the scope of their licensure, without charge, at a clinic which has received an allocation of tax credits from the Commissioner of Social Services or his designee and is organized in whole or in part for the delivery of health care services without charge, or to a clinic operated not for profit providing health care services for charges not exceeding those set forth in a scale prescribed by the State Board of Health pursuant to §32.1-11 for charges to be paid by persons based upon ability to pay, ~~or~~ shall be eligible for a tax credit pursuant to §63.1-324 based on the time spent in providing health care services at such clinic. The value of such services, for purposes of determining the amount of the tax credit allowable, rendered by the physician ~~or~~, dentist, *nurse practitioner, physician assistant, optometrist or pharmacist,* shall not exceed the lesser of (i) the reasonable cost for similar services from other providers or (ii) $125 per hour.

CHAPTER 920

An Act to amend and reenact § 32.1-102.1 of the Code of Virginia, relating to certificate of public need.

[H 2314]

Approved March 29, 1999

Be it enacted by the General Assembly of Virginia:

1. That §32.1-102.1 of the Code of Virginia is amended and reenacted as follows:

§32.1-102.1. Definitions.

As used in this article, unless the context indicates otherwise:

"Certificate" means a certificate of public need for a project required by this article.

"Clinical health service" means a single diagnostic, therapeutic, rehabilitative, preventive or palliative procedure or a series of such procedures that may be separately identified for billing and accounting purposes.

"Health planning region" means a contiguous geographical area of the Commonwealth with a population base of at least 500,000 persons which is characterized by the availability of multiple levels of medical care services, reasonable travel time for tertiary care, and congruence with planning districts.

"Medical care facility," as used in this title, means any institution, place, building or agency, whether or not licensed or required to be licensed by the Board or the State Mental Health, Mental Retardation and Substance Abuse Services Board, whether operated for profit or nonprofit and whether privately owned or privately operated or owned or operated by a local governmental unit, (i) by or in which health services are furnished, conducted, operated or offered for the prevention, diagnosis or treatment of human disease, pain, injury, deformity or physical condition, whether medical or surgical, of two or more nonrelated mentally or physically sick or injured persons, or for the care of two or more nonrelated persons requiring or receiving medical, surgical or nursing attention or services as acute, chronic, convalescent, aged, physically disabled or crippled, or (ii) which is the recipient of reimbursements from third-party health insurance programs or prepaid medical service plans. For purposes of this article, only the following medical care facilities shall be subject to review:

1. General hospitals.

2. Sanitariums.

3. Nursing homes.

4. Intermediate care facilities.

5. Extended care facilities.

6. Mental hospitals.

7. Mental retardation facilities.

8. Psychiatric hospitals and intermediate care facilities established primarily for the medical, psychiatric or psychological treatment and rehabilitation of alcoholics or drug addicts.

9. Specialized centers or clinics or that portion of a physician's office developed for the provision of outpatient or ambulatory surgery, cardiac catheterization, computed tomographic (CT) scanning, gamma knife surgery, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI), positron emission tomographic (PET) scanning, radiation therapy, nuclear medicine imaging, or such other specialty services as may be designated by the Board by regulation.

10. Rehabilitation hospitals.

11. Any facility licensed as a hospital.

The term "medical care facility" shall not include any facility of (i) the Department of Mental Health, Mental Retardation and Substance Abuse Services; or (ii) any nonhospital substance abuse residential treatment program operated by or contracted

primarily for the use of a community services board under the Department of Mental Health, Mental Retardation and Substance Abuse Services' Comprehensive Plan; or (iii) a physician's office, except that portion of a physician's office described above in subdivision 9 of the definition of "medical care facility"; or (iv) the Woodrow Wilson Rehabilitation Center of the Department of Rehabilitative Services.

"Project" means:

1. Establishment of a medical care facility;

2. An increase in the total number of beds or operating rooms in an existing medical care facility;

3. Relocation at the same site of ten beds or ten percent of the beds, whichever is less, from one existing physical facility to another in any two-year period; however, a hospital shall not be required to obtain a certificate for the use of ten percent of its beds as nursing home beds as provided in § 32.1-132;

4. Introduction into an existing medical care facility of any new nursing home service, such as intermediate care facility services, extended care facility services, or skilled nursing facility services, regardless of the type of medical care facility in which those services are provided;

5. Introduction into an existing medical care facility of any new cardiac catheterization, computed tomographic (CT) scanning, gamma knife surgery, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI), medical rehabilitation, neonatal special care, obstetrical, open heart surgery, positron emission tomographic (PET) scanning, psychiatric, organ or tissue transplant service, radiation therapy, nuclear medicine imaging, substance abuse treatment, or such other specialty clinical services as may be designated by the Board by regulation, which the facility has never provided or has not provided in the previous twelve months;

6. Conversion of beds in an existing medical care facility to medical rehabilitation beds or psychiatric beds;

7. The addition or replacement by an existing medical care facility of any medical equipment for the provision of cardiac catheterization, computed tomographic (CT) scanning, gamma knife surgery, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI), open heart surgery, positron emission tomographic (PET) scanning, radiation therapy, or other specialized service designated by the Board by regulation. Notwithstanding the provisions of this subdivision, the Commissioner shall develop regulations (i) providing for the replacement by a medical care facility of existing medical equipment, which is determined by the Commissioner to be inoperable or otherwise in need of replacement without requiring issuance of a certificate of public need, if the applicant agrees to such conditions as the Commissioner may establish, in compliance with regulations promulgated by the Board, requiring the applicant to provide a level of care at a reduced rate to indigents or accept patients requiring specialized care; and (ii) providing for the replacement by a medical care facility of existing medical equipment without the issuance of a certificate of public need if the Commissioner has determined a certificate of public need has been previously issued for replacement of the specific equipment. Replacement or upgrade of existing magnetic resonance imaging (MRI), *computed tomographic (CT) scanning, magnetic source imaging (MSI), or positron emission tomographic (PET) scanning equipment* shall not have to obtain a certificate of public need; or

8. Any capital expenditure of five million dollars or more, not defined as reviewable in subdivisions 1 through 7 of this definition, by or in behalf of a medical care facility. However, capital expenditures between one and five million dollars shall be registered with the Commissioner pursuant to regulations developed by the Board.

"Regional health planning agency" means the regional agency, including the regional health planning board, its staff and any component thereof, designated by the Virginia Health Planning Board to perform the health planning activities set forth in this chapter within a health planning region.

"State Medical Facilities Plan" means the planning document adopted by the Board of Health which shall include, but not be limited to, (i) methodologies for projecting need for medical care facility beds and services; (ii) statistical information on the availability of medical care facilities and services; and (iii) procedures, criteria and standards for review of applications for projects for medical care facilities and services.

"Virginia Health Planning Board" means the statewide health planning body established pursuant to §32.1-122.02 which serves as the analytical and technical resource to the Secretary of Health and Human Resources in matters requiring health analysis and planning.

CHAPTER 691

An Act to amend and reenact the fifth enactment of Chapter 902 of the Acts of Assembly of 1996, relating to health care data reporting.

[H 2751]
Approved March 28, 1999

Be it enacted by the General Assembly of Virginia:

1. That the fifth enactment of Chapter 902 of the Acts of Assembly of 1996 is amended and reenacted as follows:

5. That Chapter 7.2 of Title 32.1 and subsection K of §11-45 of the Code of Virginia shall expire on July 1, ~~1999~~ *2003* .

SENATE JOINT RESOLUTION NO. 453

Requesting the Virginia Transplant Council to develop a strategic plan for increasing public awareness of the importance of organ donation, and for evaluating progress towards obtaining a greater number of organ donations from potential donors in the Commonwealth.

Agreed to by the Senate, February 9, 1999
Agreed to by the House of Delegates, February 18, 1999

WHEREAS, the Joint Commission on Health Care recently performed a review of organ donation issues in the Commonwealth; and

WHEREAS, organ transplantation is an increasingly common and successful medical procedure for improving the lives of individuals suffering from kidney, liver, heart, lung, and pancreatic failure; and

WHEREAS, Virginia is served by five organ procurement organizations (OPOs) and seven transplant centers; and

WHEREAS, the demand for human organs for transplantation far exceeds the available supply such that 1,451 individuals were on transplant waiting lists at Virginia transplant centers during 1997; and

WHEREAS, the number of deaths of individuals who were awaiting an organ transplant increased by 167 percent nationally from 1988 to 1996; and

WHEREAS, 111 individuals died in Virginia during 1997 while awaiting an organ transplant; and

WHEREAS, there were 121 organ donors in Virginia during 1997, representing 22 percent of the potential donors referred to OPOs; and

WHEREAS, the number of organs procured in Virginia during 1997 was 66 per one million population, a rate which was below the national average of 75 organs procured per one million population; and

WHEREAS, Virginia's 18 organ donors per one million population was likewise below the national average of 21 organ donors per one million population during 1997; and

WHEREAS, the Virginia Transplant Council (VTC) is located within the State Department of Health and as such is accountable to the State Health Commissioner and to the State Board of Health; and

WHEREAS, the VTC has statutory responsibility for conducting educational and informational activities, and coordinating such activities as they relate to organ, tissue, and eye donation, procurement, and transplantation efforts within the Commonwealth; and

WHEREAS, the VTC would like to work even more closely than it has in the past with other State agencies, including DMV, in order to promote organ donation in the Commonwealth; and

WHEREAS, efficient and effective organ recovery and transplantation are vital components to the Commonwealth's overall health care delivery system; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Virginia Transplant Council be requested to develop, with the involvement of all of its member organizations including, the Virginia Hospital and Healthcare Association, a strategic plan for (i) increasing public awareness of the importance of organ donation, including improved education and outreach functions, and (ii) evaluating progress towards increased public awareness of organ donation, and towards obtaining a greater number of organ donations from potential donors. The strategic plan shall include specific actions to be taken, a timetable for implementing the plan, proposed funding sources, and periodic updates as necessary; and, be it

RESOLVED FURTHER, That the Virginia Transplant Council's strategic plan be submitted to the State Board of Health and the Joint Commission on Health Care by October 1, 1999, and shall be submitted to the Governor and the 2000 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. 454

Directing the Joint Commission on Health Care to continue its review of organ donation issues in the Commonwealth by examining the appropriate level of state oversight of organ procurement organizations and the role of the Department of Motor Vehicles within the state's overall efforts to promote organ donation.

Agreed to by the Senate, February 9, 1999
Agreed to by the House of Delegates, February 18, 1999

WHEREAS, the Joint Commission on Health Care recently completed a review of organ donation issues in the Commonwealth; and

WHEREAS, organ transplantation is an increasingly common and successful medical procedure for improving and prolonging the lives of individuals suffering from kidney, liver, heart, lung, and pancreas failure; and

WHEREAS, the demand for human organs for transplantation far exceeds the available supply such that 1,451 individuals were on transplant waiting lists at Virginia transplant centers during 1997; and

WHEREAS, the number of deaths of individuals who are awaiting an organ transplant increased by 167 percent nationally from 1988 to 1996; and

WHEREAS, 111 individuals died in Virginia during 1997 while awaiting an organ transplant; and

WHEREAS, 63 organ procurement organizations (OPOs) have been designated and certified by the United States Health Care Financing Administration (HCFA) to retrieve, preserve, and transport organs, and to maintain a system of locating prospective recipients for available organs within specified geographic regions of the United States; and

WHEREAS, five OPOs have been designated and certified by HCFA to retrieve, preserve, and transport organs, and to maintain a system of locating prospective recipients for available organs within specified geographic regions of the Commonwealth; and

WHEREAS, service areas designated by HCFA for three of the five OPOs currently operating in Virginia include significant portions of other states and the District of Columbia; and

WHEREAS, there were 121 organ donors in Virginia during 1997, representing 22 percent of the potential donors referred to OPOs; and

WHEREAS, the number of organs procured in Virginia during 1997 was 66 per one million population, which was below the national average of 75 organs procured per one million population, and likewise, Virginia's 18 organ donors per one million population was below the national average of 21 organ donors per one million population during 1997; and

WHEREAS, Virginia currently imposes no statutory or regulatory requirements on the structure or operations of OPOs; and

WHEREAS, some level of state accountability of OPOs may help to promote more accurate assessment of OPO performance in procuring organs for transplantation; and

WHEREAS, it is unclear what impact, if any, the number of OPOs operating in Virginia may have on uniformity of service, efficient use of resources, and equal access for all Virginians to organs recovered within the boundaries of the Commonwealth; and

WHEREAS, some OPOs operating in certain states have in recent years consolidated their activities with other OPOs within the state; and

WHEREAS, the Virginia Transplant Council (VTC) is located within the Virginia Department of Health and as such is accountable to the State Health Commissioner and to the State Board of Health; and

WHEREAS, the VTC has statutory responsibility for conducting educational and informational activities, and coordinating such activities as they relate to organ, tissue, and eye donation, procurement, and transplantation efforts within the Commonwealth; and

WHEREAS, the membership of the VTC is comprised of transplant centers, OPOs, eye banks, and tissue banks, as well as

the Departments of Education, Health Professions, and Motor Vehicles; and

WHEREAS, the Department of Motor Vehicles (DMV) is required by law to establish a method by which an applicant for a driver's license or identification card may designate his or her willingness to be an organ donor, and the DMV is required to cooperate with the VTC to ensure that the method is designed to encourage organ donation with a minimum of effort; and

WHEREAS, as of November 1998, there were approximately 6.1 million individuals holding a Virginia driver's license or photo identification card issued by DMV, of which approximately 1.4 million displayed an indicator expressing a willingness to be an organ donor; and

WHEREAS, the number of individuals who have placed an organ donor indicator on their Virginia driver's licenses during transactions at DMV offices decreased from 775,561 during 1995 to 338,847 during 1997; and

WHEREAS, the VTC is not specifically authorized by the Code of Virginia to maintain a state organ donor registry; and

WHEREAS, the VTC would like to increase access to the Commonwealth's organ donor registry data maintained by DMV such that the data could be analyzed as a means of improving the coordination of VTC's educational and informational activities; and

WHEREAS, DMV performs activities to provide information intended to promote public awareness of the importance of organ donation; and

WHEREAS, it is useful to review the role of DMV, and the relationship between DMV and VTC, in order to ensure that organ donation information is being provided to Virginians in the most efficient and effective manner possible; and

WHEREAS, efficient and effective organ recovery and transplantation are vital components to the Commonwealth's overall health care delivery system; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Commission on Health Care be directed to continue its review of organ donation issues in the Commonwealth by examining the appropriate level of state oversight of organ procurement organizations and the role of the Department of Motor Vehicles within the state's overall efforts to promote organ donation. The Commission shall also consider the degree to which the number of organ procurement organizations serving the Commonwealth may affect organ recovery and allocation.

All agencies of the Commonwealth, including the Virginia Transplant Council and each of its member organizations, shall provide assistance to the Joint Commission on Health Care and its staff, upon request.

The Joint Commission on Health Care shall complete its work in time to submit its findings and recommendations to the Governor and the 2000 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. 463

Directing the Joint Legislative Audit and Review Commission to examine the Virginia Medicaid program's methodology fc determining nursing facility reimbursement.

Agreed to by the Senate, February 4, 1999
Agreed to by the House of Delegates, February 25, 1999

WHEREAS, the Virginia Medicaid program finances nearly 70 percent of the nursing facility care in the Commonwealth; and

WHEREAS, Medicaid nursing facility expenditures exceeded $400 million in FY 1998; and

WHEREAS, nursing facility expenditures account for approximately 78 percent of Medicaid long-term care expenditures; and

WHEREAS, access to quality nursing facility care is an important part of a long-term care continuum of care; and

WHEREAS, concern has been expressed about the appropriateness of both the level of Medicaid nursing facility reimbursement in the Commonwealth and the complexity of the system for determining reimbursement levels; and

WHEREAS, in 1992 the Joint Legislative Audit and Review Commission (JLARC) completed a study of Medicaid Long-Term Care; and

WHEREAS, JLARC is currently conducting a broad review of health and human resources agencies and issues, pursuant to House Joint Resolution No. 137 (1998); now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Legislative Audit and Review Commission be directed to examine the Virginia Medicaid program's methodology for determining nursing facility reimbursement. This review shall include, but not be limited to, (i) a comparison of Virginia's approach to nursing facility reimbursement with the approach of other states, (ii) the adequacy of reimbursement levels for providing quality care, (iii) options for simplifying the nursing facility reimbursement process, (iv) the extent to which patient acuity levels are factored into current and proposed reimbursement approaches, and (v) other issues as may seem appropriate.

The Department of Medical Assistance Services shall cooperate fully as requested and shall make available all records, staff, and information necessary for the completion of work by JLARC and its staff.

The Auditor of Public Accounts shall provide technical assistance, upon request.

The Joint Legislative Audit and Review Commission shall consult with interested provider organizations during this study, including the Virginia Association of Nonprofit Homes for the Aging, the Virginia Health Care Association, and the Virginia Hospital and Healthcare Association.

The Joint Legislative Audit and Review Commission shall report its findings and recommendations to the Governor and the 2000 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. 464

Directing the Joint Commission on Health Care, in cooperation with the Commonwealth's academic health centers, the State Council of Higher Education for Virginia, and the Senate Finance and House Appropriations Committees to study current and future financial and operational issues affecting the Commonwealth's academic health centers.

Agreed to by the Senate, February 4, 1999
Agreed to by the House of Delegates, February 15, 1999

WHEREAS, the Commonwealth's three academic health centers, the Medical College of Virginia of Virginia Commonwealth University, the University of Virginia, and the Eastern Virginia Medical School conduct medical research, train a variety of health professionals, provide highly specialized patient care and treat a substantial portion of the state's indigent and uninsured patients; and

WHEREAS, the Commonwealth's academic health centers face a myriad of pressures on their traditional functions, including the rising costs of uncompensated care, leveling and targeting of research funding, new demands for health professional curricula, and the financing of graduate and undergraduate medical education; and

WHEREAS, academic health centers across the country are experiencing many of the same competitive and financial pressures; and

WHEREAS, a consequence of the academic health centers' traditional functions has been that their costs of providing patient care is generally higher than those of nonteaching hospitals; and

WHEREAS, the health insurance marketplace continues to move towards managed care health insurance plans; and

WHEREAS, managed care imposes significant competitive pressures on the academic health centers to compete with nonteaching hospitals for inclusion in managed care provider networks; and

WHEREAS, a 1998 study of the academic health centers by the Joint Commission on Health Care found that in some cases managed care organizations "selectively contract" with the academic health centers, which reduces third-party reimbursement for certain services and limits the patient base for teaching purposes; and

WHEREAS, retaining Medicaid patients is critical to the academic health centers in terms of generating disproportionate share hospital payments and providing a diverse patient base for medical education; and

WHEREAS, the academic health centers continue to provide a large share of indigent care in the Commonwealth; and

WHEREAS, in fiscal year 1997, even with enhanced disproportionate share hospital payments, the University of Virginia and the Medical College of Virginia of Virginia Commonwealth University reported $30.2 million and $42.6 million respectively in unreimbursed charity care; and

WHEREAS, the State Council of Higher Education for Virginia recommended in 1997 a methodology for funding undergraduate medical education and the unreimbursed indigent care provided by the medical school faculty; and

WHEREAS, the many financial and operational issues facing the academic health centers are complex, interrelated and present significant long-term health policy implications for the Commonwealth; and

WHEREAS, a comprehensive study of the financial and operational issues facing the academic health centers would provide critical information upon which to base future budgetary and health policy decisions affecting the academic health centers; now, therefore, be it

RESOLVED, by the Senate, the House of Delegates concurring, That the Joint Commission on Health Care, in cooperation with the Commonwealth's academic health centers, the State Council of Higher Education for Virginia, and the Senate Finance and House Appropriations Committees, be directed to study current and future financial and operational issues affecting the Commonwealth's academic health centers. The study shall include, but not be limited to: (i) identifying key financial and operational issues that impact the short-term and long-term viability of the academic health centers; (ii) identifying the actions taken by the academic health centers to respond to these financial and operational issues; (iii) examining the financial and operational conditions of the Commonwealth's academic health centers relative to that of academic health centers in other states; and (iv) identifying key policy decisions and other actions that the academic health centers and the Commonwealth can take to ensure the long-term viability of the centers.

The services of a consultant, estimated to cost $50,000, will be required for the Joint Commission on Health Care to complete the study. Such expenses shall be funded by a separate appropriation from the General Assembly.

The Joint Commission on Health Care shall submit its findings and recommendations to the Governor, the Senate Finance and House Appropriations Committees, and the 2000 General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

SENATE JOINT RESOLUTION NO. 489

Directing the Joint Commission on Health Care, in cooperation with the Bureau of Insurance, to develop a pooled purchasing model for health insurance to determine if such a pooled purchasing arrangement could improve the affordability and availability of insurance for small employers in the Commonwealth.

Agreed to by the Senate, February 4, 1999
Agreed to by the House of Delegates, February 15, 1999

WHEREAS, a 1996 survey of the insurance status of Virginians found that approximately 13 percent, or 858,000 persons, are uninsured; and

WHEREAS, the percentage of Virginia's uninsured adults who are employed full time has increased from 41 percent in 1993 to 57 percent in 1996; and

WHEREAS, small employers have a significantly higher percentage of employees who are uninsured than larger employers; and

WHEREAS, when purchasing health insurance, small employers generally are more price-sensitive than larger employers, pay higher administrative costs, have less negotiating power with insurance carriers, often experience wide fluctuations in premiums from year to year, and generally are able to offer less of a choice of benefit plans to their employees; and

WHEREAS, pooled purchasing arrangements enable small employers to "pool" their purchasing power, a practice which provides them with many of the same purchasing advantages of larger employers; and

WHEREAS, a number of states have enacted laws to establish state-sponsored health insurance purchasing pools or encourage the development of private pools; and

WHEREAS, the purchasing pools in other states have produced mixed results with some being successful in making coverage more affordable for small employers while others have been disbanded; and

WHEREAS, the Joint Commission on Health Care studied the feasibility of implementing a pooled purchasing arrangement in the Commonwealth pursuant to Senate Joint Resolution 124 and House Joint Resolution 202 of the 1998 Session of the General Assembly; and

WHEREAS, there continues to be disagreement between interested parties as to the ability of pooled purchasing arrangements to lower premium costs and make insurance coverage more affordable for small employers; and

WHEREAS, actuarial analysis is needed to develop a specific pooled purchasing model that would identify alternative benefit designs and estimated costs that can be compared to the level and cost of coverage that can be purchased in the marketplace without such a pooled purchasing arrangement; and

WHEREAS, without such an actuarial analysis there will continue to be unanswered questions regarding the potential benefits of such a purchasing arrangement for small employers; 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, be directed to develop a pooled purchasing model for health insurance to determine if such a pooled purchasing arrangement could improve the affordability and availability of insurance for small employers in the Commonwealth. As part of its deliberations, the joint commission shall hire an actuary to develop a specific model of pooled purchasing which shall: (i) identify any insurance market reforms or other statutory or regulatory changes necessary to support a pooled purchasing arrangement; (ii) include alternative benefit designs which could be offered through the purchasing arrangement; (iii) calculate estimated costs of the alternative benefit designs; and (iv) compare the estimated costs for small employers to purchase coverage through the pooled purchasing arrangement with the costs of purchasing similar coverage in the marketplace; and, be it

RESOLVED FURTHER, That the Joint Commission on Health Care shall form a panel of experts from the insurance, business, provider, consumer, and insurance agent communities to review and respond to the actuary's pooled purchasing model in terms of the potential for a pooled purchasing arrangement to increase the affordability and availability of coverage for small employers. In its review of the pooled purchasing model, the panel also shall make recommendations on other possible actions to improve the affordability and availability of coverage for small employers.

All agencies of the Commonwealth shall provide assistance to the Joint Commission on Health Care and its staff, upon request. Actuarial work, estimated to cost $75,000, will be required for the Joint Commission on Health Care to complete the study. Such expenses shall be funded by a separate appropriation from the General Assembly.

The Joint Commission on Health Care shall complete its work in time to submit its findings and recommendations to the Governor and the 2000 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

HOUSE JOINT RESOLUTION NO. 644

Directing the Joint Commission on Health Care, in cooperation with the State Department of Health, the Department of Medical Assistance Services, the Virginia Dental Association, the Virginia Dental Hygienists' Association, the Virginia Commonwealth University School of Dentistry, the Virginia Board of Dentistry, the Virginia Association of Free Clinics, and the Virginia Health Care Foundation, to study ways to increase access to dental care throughout the Commonwealth.

Agreed to by the House of Delegates, February 4, 1999
Agreed to by the Senate, February 18, 1999

WHEREAS, a 1996 survey of the insurance status of Virginians found that approximately 13 percent, or 858,000 persons, are uninsured; and

WHEREAS, research has shown that uninsured persons are half as likely as insured individuals to visit a dentist regularly; and

WHEREAS, the 1996 Health Access Survey sponsored by the Virginia Health Care Foundation found that less than one-half of all Virginia households used dental insurance to pay for at least part of their dental care; and

WHEREAS, the 1996 Health Access Survey also found that 11 percent of survey respondents had not seen a dentist in over four years, and six percent reported they had never seen a dentist; and

WHEREAS, the lack of preventive and other dental care often can lead to serious, costly health conditions; and

WHEREAS, a recent report by the Division of Dental Health within the State Department of Health noted that there are dental care shortage areas in the Commonwealth; and

WHEREAS, there is limited data regarding the number and location of practicing dentists throughout the Commonwealth, which hampers dental workforce planning efforts; and

WHEREAS, a significant shortage of dentists participating in the Medicaid program adversely affects the dental health services available to Medicaid recipients; and

WHEREAS, the cost of tuition for dental school has risen significantly in recent years, causing an adverse impact on the recruitment of dental students, especially those from disadvantaged backgrounds; and

WHEREAS, concern has been raised regarding the adequacy of the number and dollar amount of dental scholarships currently available to dental students; and

WHEREAS, a comprehensive study of various issues regarding access to dental care in Virginia is needed to ensure that the greatest number of Virginians receive quality dental care; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Commission on Health Care, in cooperation with the State Department of Health, the Department of Medical Assistance Services, the Virginia Dental Association, the Virginia Dental Hygienists' Association, the Virginia Commonwealth University School of Dentistry, the Virginia Board of Dentistry, the Virginia Association of Free Clinics, and the Virginia Health Care Foundation, be directed to study ways to increase access to dental care throughout the Commonwealth. The study shall include, but not be limited to, an analysis of: (i) the need for practitioner data for dental workforce planning purposes; (ii) the financial, structural and other barriers to accessing dental care throughout the Commonwealth; (iii) dental practitioner shortage areas and ways to increase the number of dentists practicing in these shortage areas; (iv) the number of dentists participating in the Medicaid program and actions that would increase the number of participating dentists; (v) the current dental scholarship program and potential revisions to the program that may increase the number of dentists establishing practices in underserved areas; (vi) the actions taken in other states to increase access to dental care and to increase the number of dentists participating in Medicaid and practicing in underserved areas; and (vii) other appropriate issues which will increase access to dental care.

The Joint Commission shall submit its findings and recommendations to the Governor and the 2000 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

HOUSE JOINT RESOLUTION NO. 646

Directing the Joint Commission on Health Care, with the assistance of the Department of Health Professions and the State Department of Health, to examine the advisability of legalizing the practice of direct-entry midwifery in the Commonwealth.

Agreed to by the House of Delegates, February 8, 1999
Agreed to by the Senate, February 18, 1999

WHEREAS, direct-entry midwives are not currently allowed to practice in Virginia unless registered with the State Department of Health prior to 1977; and

WHEREAS, only six direct-entry midwives are currently registered under these statutory provisions, most of whom are not actively practicing; and

WHEREAS, some direct-entry midwives are currently practicing in Virginia outside of state law; and

WHEREAS, most states currently permit the practice of direct-entry midwifery in some form; and

WHEREAS, significant variation exists among states that have legalized direct-entry midwifery regarding whether and how the practice is regulated; and

WHEREAS, notwithstanding the prohibition on the practice of direct-entry midwifery in the Code of Virginia, at least 199 births in Virginia during 1996 were attended by direct-entry midwives; and

WHEREAS, access to competent care is important in both in-hospital and out-of-hospital birth settings; and

WHEREAS, at the request of the House Rules Committee, the Joint Commission on Health Care recently completed a study on issues regarding midwifery, issues originally raised by Senate Joint Resolution No. 196 (1998); and

WHEREAS, further study is necessary to examine the experiences of other states that have legalized direct-entry midwifery as well as to further examine scientific studies on birth outcomes in different settings; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Commission on Health Care, with the assistance of the Department of Health Professions and the State Department of Health, be directed to examine the advisability of legalizing the practice of direct-entry midwifery in the Commonwealth. The study shall include, but not be limited to, analysis of (i) advantages and disadvantages of legalizing direct-entry midwifery, (ii) experiences of other states that have legalized direct-entry midwifery, (iii) options for effectively regulating the practice of direct-entry midwifery to ensure, to the extent possible, the health and safety of women and infants receiving direct-entry midwifery services, and (iv) other issues as may seem appropriate.

The Joint Commission shall report its findings and recommendations to the Governor and the 2000 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

HOUSE JOINT RESOLUTION NO. 647

Requesting the State Health Commissioner to establish a task force to review and examine health-related data sets as part of further analysis of the health status of African Americans.

Agreed to by the House of Delegates, February 4, 1999
Agreed to by the Senate, February 18, 1999

WHEREAS, the State Department of Health's Office of Minority Health recently completed a study of the health status and conditions of African Americans pursuant to Senate Joint Resolution No. 355 (1997); and

WHEREAS, based on available health data, there are a number of significant disparities in the health status and conditions of African Americans and Caucasians, including life expectancy, heart disease mortality, stroke mortality, diabetes, infant mortality, low birth weight, and teenage pregnancy; and

WHEREAS, heart disease, cancer, stroke, unintentional and intentional injury, and HIV/AIDS are among the most significant health concerns for African Americans; and

WHEREAS, 20 percent of African Americans lack health insurance compared to 14 percent of all Virginians; and

WHEREAS, the Department study concluded that Virginians as a whole are generally making progress towards the Healthy People 2000 objectives but that in most cases these objectives will not be achieved by African Americans; and

WHEREAS, the Department study concluded that there is no consistent method for determining the extent to which health promotion activities target African Americans and whether those activities that do so are effective; and

WHEREAS, the adequate portrayal of the distinct health outcomes of African Americans is difficult because much of the state's health data is not collected or reported by racial classifications; and

WHEREAS, state health data has historically been collected under the race categories of "White" and "non-White," with "non-White" including African Americans as well as other racial and ethnic groups; and

WHEREAS, the Department study concluded that disaggregation of these health data by racial and ethnic population groups is critical if a true picture of African-American health, and the health of other minority groups, is to be accurately portrayed; and

WHEREAS, the Department study also concluded that further analysis is needed to develop a more accurate depiction of efforts to reduce health disparities between African Americans and Caucasians, and to establish a baseline for analyzing and evaluating health data and health promotion activities; and

WHEREAS, the Department study recommended that a methodology be developed for estimating the state's population by race, geographic area, and gender in order to allow for a uniform method of analyzing health data sets; and

WHEREAS, the Department study further recommended establishment of a task force to focus on African-American health in Virginia: now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the State Health Commissioner be requested to establish a task force comprised of representatives of appropriate state agencies and private health-related entities to (i) review and examine health-related data sets in Virginia as part of further analysis of the health status of African Americans, (ii) develop reporting processes to generate more reliable estimates of minority populations, and (iii) examine how state agencies and private health organizations can assist by collecting and reporting data classified by race and ethnicity.

The Commissioner shall submit the findings and recommendations of the task force to the State Board of Health and the Joint Commission on Health Care by October 1, 1999, and to the Governor and the 2000 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

HOUSE JOINT RESOLUTION NO. 648

Requesting the State Department of Health to cosponsor a forum with other public and private sector organizations on African-American health care access issues.

Agreed to by the House of Delegates, February 5, 1999
Agreed to by the Senate, February 18, 1999

WHEREAS, the State Department of Health's Office of Minority Health recently completed a study of the health status and conditions of African Americans pursuant to Senate Joint Resolution No. 355 (1997); and

WHEREAS, based on available health data, there are a number of significant disparities in the health status and conditions of African Americans and Caucasians, including life expectancy, heart disease mortality, stroke mortality, diabetes, infant mortality, low birth weight, and teenage pregnancy; and

WHEREAS, heart disease, cancer, stroke, unintentional and intentional injury, and HIV/AIDS are among the most significant health concerns for African Americans; and

WHEREAS, 20 percent of African Americans lack health insurance compared to 14 percent of all Virginians; and

WHEREAS, the Department study concluded that Virginians as a whole are generally making progress towards the Healthy People 2000 objectives established by the United States Department of Health and Human Services but that, in most cases, these objectives will not be achieved for African Americans; and

WHEREAS, the Department study concluded that there is no consistent method for determining the extent to which health promotion activities target African Americans and whether those activities that do so are effective; and

WHEREAS, the Department study further concluded that eliminating the health disparities currently faced by African Americans would benefit the Commonwealth economically by increasing the number of people who are fit to work and thereby contribute to Virginia's productivity and competitiveness; and

WHEREAS, the Department study also proposed additional discussion of strategies to strengthen the African-American family through improvements in access to health care and improvements in behaviors; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the State Department of Health be requested to cosponsor a forum with other public and private sector organizations on African-American health care access issues. The Department shall also develop public and private partnerships with appropriate state and local government agencies and private health-related organizations in conducting the forum. The forum shall address topics such as (i) providing care to African Americans in public and private settings, (ii) developing strategies to enroll African Americans in private and public health insurance programs, (iii) recruiting and retaining African-American physicians in Virginia, (iv) developing culturally competent health care services, (v) managed care, (vi) public and private partnerships that increase access to care for African Americans, and (vii) identifying key health issues related to African-American families.

The Department shall report the results and recommendations of the forum on African-American health care access to the State Board of Health and the Joint Commission on Health Care by September 1, 1999, and to the Governor and the 2000 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

HOUSE JOINT RESOLUTION NO. 675

Requesting the Technical Advisory Panel of the Virginia Indigent Health Care Trust Fund to examine the feasibility of establishing a pilot pharmacy program for the indigent.

Agreed to by the House of Delegates, February 1, 1999
Agreed to by the Senate, February 18, 1999

WHEREAS, access to necessary prescription medications is critical to the prevention and treatment of a wide range of health conditions and diseases; and

WHEREAS, the cost of prescription medications has increased substantially in recent years; and

WHEREAS, the 1996 Health Access Survey of Virginians found that approximately 13 percent, or 858,000 persons, are uninsured; and

WHEREAS, the 1996 survey found that when compared to persons with insurance coverage, the uninsured are three times more likely not to get a prescription filled because of the high cost of prescription medications; and

WHEREAS, the 1996 survey found that 13 percent of the respondents were unable to purchase needed prescriptions due to costs; and

WHEREAS, the Virginia Association of Free Clinics and the Virginia Primary Care Association report that access to prescription medications is the most critical health care need of their indigent and uninsured patients; and

WHEREAS, the Indigent Health Care Trust Fund receives moneys appropriated by the Commonwealth and contributions from certain hospitals for the purpose of reimbursing hospitals for unreimbursed inpatient and outpatient medical care provided to certain indigent persons; and

WHEREAS, the Technical Advisory Panel established in §32.1-335 of the Code of Virginia assists the Board of Medical Assistance Services in the administration of the Indigent Health Care Trust Fund; and

WHEREAS, one of the responsibilities of the Technical Advisory Panel is to establish pilot health care projects for the uninsured and administer any money voluntarily contributed or donated to the fund by private or public sources for the purpose of subsidizing pilot health care projects for the uninsured; and

WHEREAS, in a 1998 study conducted by the State Department of Health regarding ways the Commonwealth can support Free Clinics and Community Health Centers, the Department found that improving access to pharmaceuticals is one of the most pressing needs of the Free Clinics and Community Health Centers in serving their respective indigent and uninsured patients; and

WHEREAS, one of the core options for supporting the Free Clinics and Community Health Centers identified by the 1998 State Department of Health study was to request the Technical Advisory Panel of the Indigent Health Care Trust Fund to consider establishing a pilot pharmacy program for the indigent as a means of increasing access to pharmaceuticals for the indigent and uninsured; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Technical Advisory Panel of the Indigent Health Care Trust Fund be requested to examine the feasibility of establishing a pilot pharmacy program for the indigent as a means of improving access to prescription medications for the indigent and uninsured. The feasibility study shall include, but not be limited to, examining (i) alternative program designs, (ii) necessary administrative systems, (iii) scope, duration, location, and estimated costs of the pilot, and (iv) potential funding sources.

The Technical Advisory Panel of the Indigent Health Care Trust Fund shall submit its findings and recommendations to the Board of Medical Assistance Services and the Joint Commission on Health Care by September 1, 1999, and to the Governor and the 2000 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

HOUSE JOINT RESOLUTION NO. 683

Requesting the Secretary of Technology, in cooperation with the Secretary of Health and Human Resources and other affected state agencies and entities, to develop guidelines for ensuring compatibility among telemedicine equipment operat… by state agencies and other affected entities.

Agreed to by the House of Delegates, February 7, 1999
Agreed to by the Senate, February 23, 1999

WHEREAS, telemedicine is defined as the use of telecommunications technology to deliver health care services and health professions education to sites that are distant from the host site or educator; and

WHEREAS, telemedicine has increased access to health care, particularly for residents of remote areas requiring subspecialty services; and

WHEREAS, a number of state agencies and teaching hospitals are now involved in telemedicine initiatives including, but not limited to, the Department of Corrections, the Eastern Virginia Medical School, the Medical College of Hampton Roads, the Medical College of Virginia, the University of Virginia Health Sciences Center, the Department of Mental Health, Mental Retardation and Substance Abuse Services, and the State Department of Health; and

WHEREAS, the technology for telemedicine services is changing rapidly; and

WHEREAS, the equipment purchased for telemedicine represents a significant investment; and

WHEREAS, telemedicine offers the opportunity for cooperation among a number of state agencies in serving the health care and health professions education needs of Virginians; and

WHEREAS, the Governor has recently appointed a Secretary of Technology; now, therefore, be it

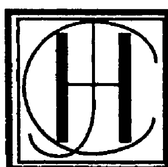
RESOLVED by the House of Delegates, the Senate concurring, That the Secretary of Technology, in cooperation with the Secretary of Health and Human Resources and other affected state agencies and entities, be requested to develop guideline… ensure compatibility, to the extent feasible, among the telemedicine equipment purchased by state agencies and entities involved in telemedicine.

All agencies of the Commonwealth shall provide assistance to the Secretary of Technology, upon request.

The Secretary of Technology's findings and recommendations shall be submitted to the Joint Commission on Health Care prior to October 1, 1999, and shall be submitted to the Governor and the 2000 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

APPENDIX B:

1999 Workplan



JOINT COMMISSION ON HEALTH CARE

Proposed 1999 Meeting Schedule and Workplan

(Shaded Areas Represent JCHC Issue Briefs)

April 9

* Status of 1999 Legislation
* 1999 Workplan
* Lyme Disease *(SJR 347, Senator Mims)*
* Organ Donation Issues *(SJR 454, Senator Gartlan)* and Medicaid Organ Transplant Coverage *(Budget Language)*
* Acupuncture *(SJR 493, Senator Woods)*

May 18

* "A Pocket Guide to Health Care in Virginia" (Update)
* 1998 Annual Report
    - Ancillary Services Report
* Asthma Study *(HJR 729, Delegate Baskerville)*
* Prenatal & Obstetrical Medical Education Study *(HJR 656, Delegate Bryant)*
* Update on Virginia Children's Medical Security Insurance Plan

June 29

* Licensure Issues in Long-Term Care *(SB 1172, Senator Woods; SB 1173, Senator Woods; and HJR 527, Delegate Parrish)*
* Health Workforce Data *(HJR 682, Delegate Brink)*
* Cancer Registry *(HJR 524, Delegate Deeds; SB 942, Senator Mims)*

July 27

* Assisted Living and Services for Vulnerable Adults Issues in Long-Term Care *(SJR 485, Senator Walker; SJR 486, Senator Walker; HJR 689, Delegate Croshaw; HJR 751, Delegate Diamonstein)*
* Dental Study *(HJR 644, Delegate Davies)*
* Status Report On Managed Care Oversight And Regulation: Bureau of Insurance and Department of Health
* Update on Virginia Children's Medical Security Insurance Plan

September 15

* Midwifery Study *(HJR 646, Delegate Hamilton)*
* Health Workforce Study *(Budget Language)*
* Mammography/Renal Dialysis Study *(HJR 642, Delegate Rhodes and HJR 556, Delegate Puller)*
* Update on Virginia Children's Medical Security Insurance Plan
* Virginia Health Quality Center Activities and Functions

October 13

* Therapeutic Interchange of Chemically Dissimilar Drugs Study *(HJR 734, Delegate Davies)*
* Advanced Directives Study *(HJR 603, Delegate Brink)*
* Status Report on "Turning Point" Initiative
* Telemedicine Reports
    - Secretary of Technology *(HJR 683, Delegate Brink)*
    - Virginia Department of Health *(SB 1214*, Senator Martin)*
    - Department of Medical Assistance Services *(Budget Language)*
* Summary of Other Reports
    - Virginia Transplant Council Strategic Plan *(SJR 453, Senator Gartlan)*
    - African-American Health Status Task Force *(HJR 647, Delegate Melvin)* and Health Forum *(HJR 648, Delegate Melvin)*

* *Pending action by the Governor*

November 16

* Academic Health Centers *(SJR 464, Senator Bolling)*
* Health Insurance Issues: *(SJR 489, Senator Walker; SB 1235/HB 871, Senator Williams/Delegate Griffith; HJR 555, Delegate Puller; HJR 601, Delegate Marshall; HB 2708, Delegate Cantor)*
* Update on Virginia Children's Medical Security Insurance Plan
* State Health Commissioner's Annual Review of COPN Program *(1997; HB 2477, Delegate Melvin)*
* Status Report On Virginia Health Information's Strategic Plan for Health Care Cost and Quality Initiatives *(1996, HB 1307, Delegate DeBoer)*
* Summary of Other Reports
    - Free Clinics'/Community Health Centers' Purchase of Pharmaceuticals *(Budget Language)*
    - Center For Pediatric Research Development of Reporting Mechanism for Pediatric Care *(Budget Language)*

December 1

* Decision Matrix, Final Recommendations

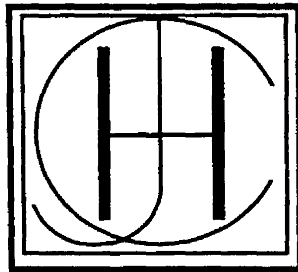
December 7

* Decision Matrix, Final Recommendations

January 6

* Approve Legislative Package

Note: The Long-Term Care Subcommittee will receive and review the following reports: DMAS Report on LTC Financing Issues *(Budget Language)*; JLARC Report on Medicaid Reimbursement Methodology for Nursing Homes *(SJR 463, Senator Bolling)*; and DMAS Report on Proposed Revisions to its Assisted Living Waiver *(Budget Language)*



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