CHAPTER 3
HEALTH CARE DELIVERY AND FINANCING

INVENTORY OF HEALTH CARE FACILITIES AND SERVICES

Adequate and accessible health care personnel, services, and facilities are essential in providing quality health care to all of West Virginia's residents. In 1998, 50 of the state's 55 counties were designated by the federal government as Medically Underserved Areas (MUAs).

Rural Health Care. Rural health care represents one of the most fragile aspects of the state's health care system. One way in which the state has addressed this problem is through the development of rural health alliances, or integrated health care delivery systems, referred to as rural health networks (RHNs). The formation of RHNs can improve the health of rural residents through the ability of the networks to link data systems, i.e., improve communication among segments of the health care industry, decrease duplication of services, recruit health personnel, address the needs of special populations, and improve access to care. Integration falls into three major categories: (1) physicians only, (2) physicians with provider organizations (hospitals, primary care centers, and ancillary sites), and (3) physicians, providers, and insurance entities. RHN development has proceeded at different paces along the continuum of integration in different parts of the state; to date, however, the majority of work in RHN development in West Virginia has focused on the integration of providers to more cost effectively deliver health services. Networks hold the potential to improve the delivery and financing of rural health care by maintaining local access to care and supporting the implementation of managed care in rural areas.

Hospitals. As of 1998, 54 acute care hospitals in 41 counties were providing 10,239 beds for inpatient services. Residents in the state's remaining 14 counties access hospital-based services through facilities in neighboring counties. There are four Veterans Health Administration facilities located in Beckley, Clarksburg, Huntington, and Martinsburg that serve the state's estimated 1998 veteran population of 190,999.

Thirty-one (31) of the state's 54 acute care hospitals are designated as "small rural hospitals," i.e., acute care facilities with fewer than 100 beds, fewer than 5,000 admissions annually, and located in a rural community with a population of fewer than 10,000 persons. Of these, seven are designated as Critical Access Hospitals (CAHs), and others are considering such a conversion. An important part of a regionalized health care system, CAHs are acute care facilities that provide outpatient, emergency, and limited inpatient services created under the Medicare Rural Hospital Flexibility Program (RHFP) authorized by Congress in 1997 (and eligible for Medicare reimbursement). Small, rural hospitals are often the only providers of obstetrics services, emergency care, primary care, and short-term inpatient care in the areas they serve. Increasingly, these hospitals are converting excess capacity to long-term care in response to a growing elderly population.

With the importance of rural hospital viability in mind, the West Virginia Legislature established the Rural Health Systems Program (RHSP) under WV Code 16-2D-5, to be jointly administered by the West Virginia Health Care Authority and the Office of Community and Rural Health Services (OCRHS) located within the Bureau for Public Health. The program was developed to assist financially vulnerable health care facilities located in underserved areas and to collaborate with other facilities to provide cost-effective services. To avoid potential crisis or collapse of essential rural health care services, the RHSP encourages

the restructuring of the rural health care system through early intervention.

The principles of the RHSP are as follows: The program is to be driven by community-based decisions and is designed to reduce excess capacity and duplication of services. The intent is to assure that essential local health care services are provided. Linkages to secondary and tertiary services and facilities must be considered. Through technical assistance, grants, and loans, the program helps rural communities to integrate and strengthen their health care delivery systems to assure access, as well as to prevent the loss of essential services in crisis situations. Since the inception of the RHSP, all certified CAHs in the state have received funds.

Hospital Utilization. According to a report by the RHFP, total inpatient utilization decreased by almost half during the 1980s, from approximately 480,000 days in 1983 to 262,000 in 1988. Utilization increased again in the 1990s, to an approximate 394,000 days in 1995. During that same period, the utilization of outpatient services increased 29%, from 738,000 visits to more than 1,000,000 visits. In addition, long-term care admissions doubled between 1990 and 1995. The following table compares hospital admissions, inpatient days, and emergency room outpatient visits for West Virginia and the South Atlantic Region for the years 1992 through 1996. As can be seen, the utilization of both inpatient and outpatient hospital services by West Virginians was consistently higher over the time period than that reported in the region as a whole. Studies by researchers at Dartmouth Medical College, in conjunction with the American Hospital Association (AHA), have indicated that the use of hospital services by a population is strongly affected by local practice patterns and the supply of resources, rather than the age and health of the population.

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Table 10
Hospital Utilization Indicators, West Virginia and the South Atlantic Region (SAR)*, 1992-1996

Year	Hospital Admissions per 1,000		Inpatient Days per 1,000		ER Outpatient Visits per 1,000	
	WV	SAR	WV	SAR	WV	SAR
1992	154.1	123.3	1064.6	864	559.5	376.1
1993	153.1	121.8	1035.4	833.4	568.2	386.5
1994	149.4	121.1	993.6	795.8	563.4	383.2
1995	148.2	121.5	974.5	763.9	569.5	379.9
1996	148.4	122	946.8	749.5	565	372

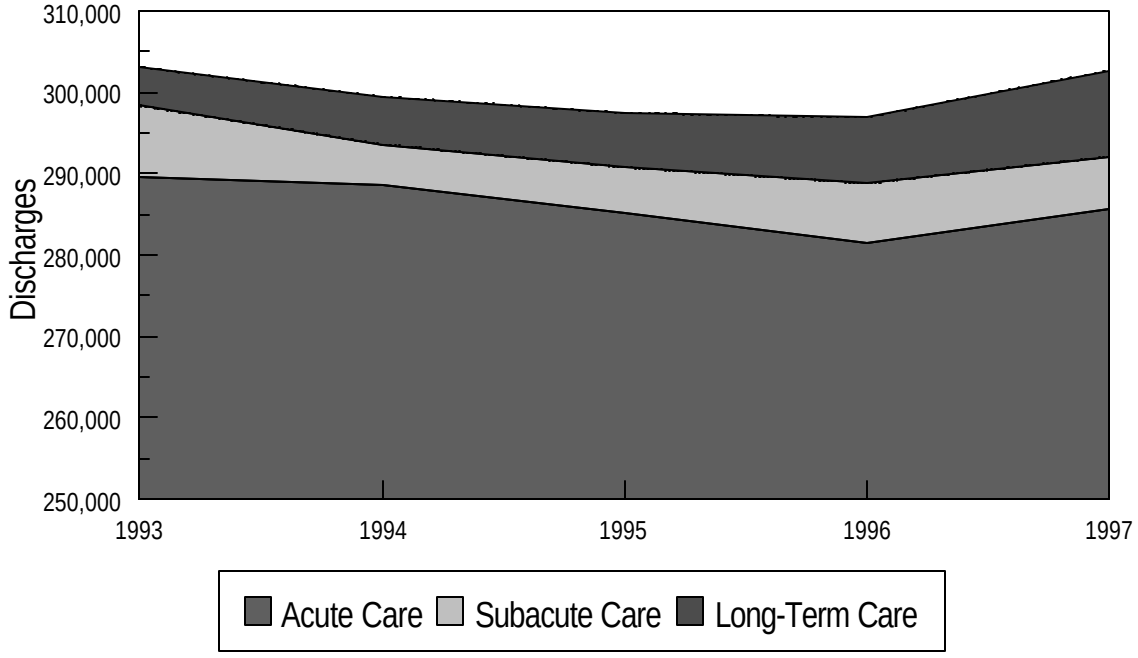
*Delaware, D.C., Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia
Source: AHA 1998 Hospital Statistics

Hospital Discharges. Figure 9 illustrates the proportions of hospital inpatient discharges from FY 1993 through FY 1997. As can be seen, the proportion represented by acute care discharges has decreased overall, even with a slight upswing in 1997. Subacute care, which includes chemical dependency and medical rehabilitation units in general hospitals as well as in freestanding rehabilitation hospitals, has remained fairly constant. Long-term care utilization, however, has steadily increased over the period. Hospital discharge data is found in Appendix C.

The top eight reasons for hospitalization in 1997 were, in rank order, childbirth; heart failure and shock; chronic obstructive pulmonary disease (COPD); psychoses; simple pneumonia and pleurisy; specific cerebrovascular disorders except transient ischemic attacks (TIAs); esophagitis, gastroenteritis, and miscellaneous digestive disorders; and chest pain.

Figure 9

Hospital Discharges by Type of Care
West Virginia, FY 1993-1997



West Virginia Health Care Authority, 1999

The top diagnoses in terms of gross charges in 1997 were, in rank order, coronary bypass with cardiac catherization; tracheostomy except for face, mouth, and neck diagnoses; heart failure and shock; major joint and limb reattachment; psychoses; COPD; simple pneumonia (age >17); coronary bypass without cardiac catherization; major small and large bowel procedures; and percutaneous cardiovascular procedures.

Long-Term Care Facilities. As noted in Chapter 1, in 1998 West Virginia's population aged 65 and older made up 15% of the state's population, compared to 12.7% nationally. The graying of West Virginia is expected to continue to increase, along with life expectancies for both men and women. As this happens, the prevalence of chronic disease will also rise, increasing the need and demand for long-term care facilities in the state. The long-term care system must be prepared to provide a continuum of services that includes community-based in-home services as well as institutional and nursing home care. Figure 10 shows the percentage of total long-term care beds by county in 1999. See Appendix C for corresponding data.

Intermediate and Skilled Nursing Facilities. Based on Office of Health Facility Licensure and Certification (OHFLAC) information, there were 106 freestanding licensed nursing homes in the state in 1999. These nursing homes have a total of 9,969 licensed beds. There are an additional 1,055 skilled nursing beds licenced among 34 hospitals. In addition, five state-owned long-term care facilities have a total of 536 licensed beds. The total number of Medicaid-certified long-term care beds in West Virginia is 10,884.

Home Health Services. Home health services comprise an array of professional health and other related services to West Virginia individuals and families in their homes. These services include skilled nursing services and may include physical therapy, speech therapy, occupational therapy, nutritional services, homemaker and home health aide services, and/or other special medical services. In 1997, 103 West Virginia CON-approved home health agencies provided care to 39,946 state residents. Gross patient revenue in that year totaled nearly $173 million for 1,932,494 visits.

Personal Care/Residential Board and Care Facilities. Personal care homes provide alternative, community-based care for individuals who require limited and intermittent nursing care. Such care and treatment requires a living environment that approximates a normal home environment. Current regulations, as implemented by OHFLAC, stipulate that all health care facilities providing care to four to ten residents must be licensed by the West Virginia Bureau for Public Health.

According to OHFLAC, in 1999 there were 2,398 personal care beds in 58 open personal care homes in the state. Twenty-two (22) personal care homes (711 beds) are currently licensed by OHFLAC. These include personal care beds licensed and operated as a distinct unit by acute care hospitals. In addition, there are 842 (95 licensed) beds in 69 open residential board and care facilities, 12 of which were licensed in 1999.

Hospice Care. Hospice services provide in-home care to the terminally ill. Currently there are 25 hospice agencies providing services in 53 of West Virginia's 55 counties. According to the Hospice 1997 Report of Facilities (provisional), there were 3,082 patients receiving hospice services in 1997. Additionally, 99 patients were served in nursing homes. Volunteers provided 45,648 hours of services to the hospice agencies.

Respite Care. Respite care provides temporary relief to a primary caregiver usually responsible for the care of an impaired person needing constant care and supervision. Respite services are intended to prevent caregiver exhaustion and to prevent nursing home or institutional placement. Respite care is provided by six hospitals, with 28 total respite beds licensed and staffed; 6,379 total respite inpatient days were reported for 1997.

Alternative Care Services. Communities have increased the availability of alternative care services, which can be offered in the outpatient setting for disabled individuals and the growing elderly population. The provision of such services can extend an individual's independence and postpone the need for long-term care.

Figure 10 can be viewed from the Appendix.

Behavioral Health Facilities. Public and private behavioral health care facilities and programs in West Virginia provide a continuum of prevention, treatment, and rehabilitation services to individuals who have or risk developing mental illness, developmental disabilities, or chemical dependency. The public behavioral health system includes 18 comprehensive behavioral health centers and two state-operated psychiatric hospitals (240 beds). The public behavioral health system currently serves about 65,000 individuals annually. In addition, there are two private freestanding psychiatric hospitals and 14 acute care hospitals with 561 beds.

The Office of Behavioral Health Services states that West Virginia has 84 intermediate care facilities with 1,339 beds for people with mental retardation. All 84 of these facilities are located in community settings. In April 1998, the Department of Health and Human Resources officially closed the Colin Anderson Center. There are only five other states that have attained the goal of closing all institutions for persons who have developmental disabilities.

Primary Care Services and Centers. A primary care center (PCC) is a not-for-profit organization that provides services to all state residents, regardless of their ability to pay. PCCs are expected to meet all the requirements for federally qualified health centers, including being community owned and operated. Community-based PCCs were first developed in West Virginia in 1972; since then, more than 100 such centers have been established. These centers serve as the principal source of primary medical services in rural medically underserved areas of West Virginia, and they are often the only source of medical care in many isolated rural communities. In 1998, West Virginia PCCs served 127,230 residents who had no health insurance.

The RHFP reported that, in 1999, West Virginia had a system of 47 nonprofit community health center corporations operating 81 primary care practices. These 47 organizations operate 79 comprehensive clinic sites, 30 school-based health centers, five clinics for women, two children's clinics, three migrant clinics, and one homeless clinic. In 1998, this network was the entry point for 290,673 state residents. The state also funds two rural health clinic comprehensive primary care centers and one freestanding site for women and children. There are seven free clinics in the state that serve approximately 45,000 residents annually.

Emergency Medical Services. The West Virginia Emergency Medical Services (EMS) System is patterned after the Federal Emergency Medical Services Systems Act of 1973, which provides guidelines and funding for development of regional EMS systems. The law established 15 components of the emergency medical services system. The state system is organized through the Office of Emergency Medical Services as the lead EMS agency within the Office of Community and Rural Health Services.

The RHFP reports that as of June 1997 there were 180 EMS agencies certified by the state EMS office, with 8,596 personnel certified as Emergency Medical Services Personnel to staff over 788 EMS vehicles and to provide out-of-hospital care. More than 82% of the EMS agencies were staffed by advanced life support personnel, while the remaining agencies operate at the basic life support level. Often, basic life support squads are located in the more rural areas of the state, giving those residents more access to advanced life support services.

Local Health Departments. There are 54 local health departments in West Virginia (Wetzel and Tyler County health departments are combined), with 48 administrative centers. Each health department functions under the direction of a board of health, whose members are appointed by the county commissioner. The exceptions are those counties with combined boards of health whose members may be

appointed by municipalities or several county commissioners.

There are approximately 655 full-time personnel employed by local health departments to provide public health services. Since local health departments receive only about 25% of their revenue from state and local governments, they provide some services for which they can generate fees.

Through the "Public Health Transitions Project," a new program being implemented by the OCHRS, local health departments are networking more with other providers and reevaluating their role and work force. The new program is an effort to improve public health functions by addressing public health from the perspective of the health care delivery system. An additional $4.3 million was included in the state's budget for this project.

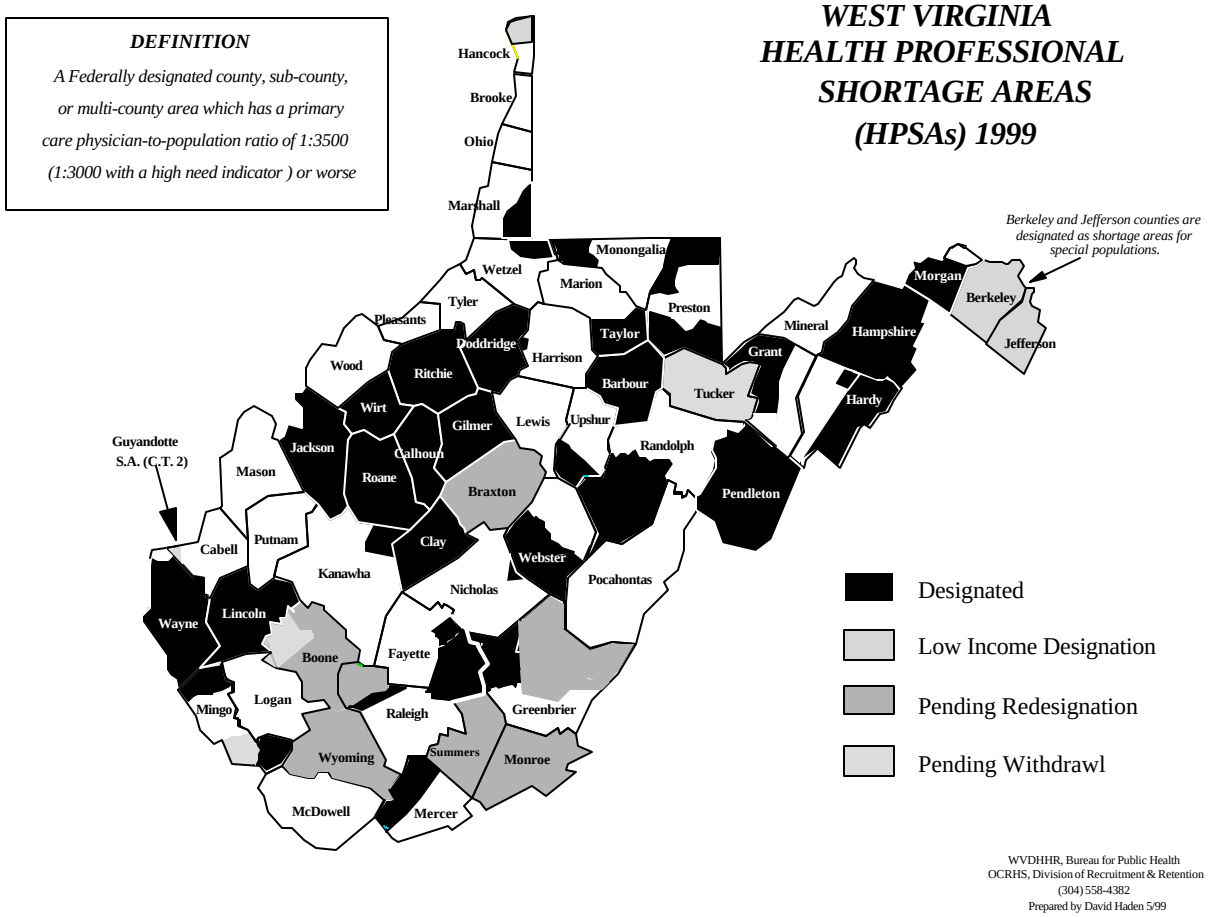
HEALTH PROFESSIONALS

Health Professional Shortage Areas. The federal Division of Shortage Designation (DSD), Bureau of Primary Health Care, Health and Human Resources and Services Administration, Department of Health and Human Services determines Health Professional Shortage Areas (HPSAs). This designation refers to a geographical area consisting of a county or subcounty area and is based on the ratio of primary care physician providers to the population. There are currently 26 HPSAs in West Virginia that include all or part of 40 counties (see Figure 11). The state also provides data to the DSD for the purpose of designating dental and mental health HPSAs. The Rural Hospital Flexibility Program reports that in 1999 there were seven dental HPSAs and six mental health HPSAs.

Physician shortages in rural areas have troubled West Virginia for years. The Division of Recruitment within OCRHS has worked with other state agencies and provider organizations to assist community efforts in alleviating health care provider shortages. The RHFP reports that at present there are requests for 134 primary care physicians for rural underserved areas of the state: 61 family practitioners, 30 internists, 22 pediatricians, and 21 obstetricians/gynecologists. In addition, there are requests for 65 nonphysician providers, i.e., nurse practitioners, physicians, and certified nurse midwives.

Physicians. In 1998, the latest year for which data are available from the WVBPH, there were 5,076 MDs with active licenses, 3,395 of whom were actively practicing in West Virginia. The specialties most frequently listed by MDs were internal medicine and family practice. Monongalia, Cabell, and Kanawha counties reported the highest percentages of specialists. However, when adjusted for population, Monongalia, Cabell, and Ohio were the counties with the highest percentages of specialists. Figure 12 illustrates the number of physicians per county, in addition to the percentage of total state population living in each county. In 1999, there were 799 osteopathic physicians licensed in West Virginia. Of these, 459 were actively practicing in the state in that year.

Figure 11
WEST VIRGINIA HEALTH PROFESSIONAL SHORTAGE AREAS (HPSAs) 1999



Other Health Professions. In addition to physicians, the following counts were obtained for other health professions practicing in the state. In all cases, the numbers represent the most recent year of collection by the respective licensing boards.

Dentists	811	Basic EMT staff	4,657
Dental hygienists	597	Ambulance EMTs	825
Pharmacists	1,672	Nonaffiliated EMTs	418
Chiropractors	199	Mining EMTs	2,338
Psychologists	583	Paramedic EMTs	1,300
Registered nurses (See Figure 13)	15,000	Registered CNAs	15,589
		Physician assistants	321
LPNs	5,696	Radiologic technicians	2,500

Licensing Boards and the Internet. Licensing boards for health care personnel have limited staff, yet their data are critical to health care delivery. It would be advantageous to have this information on the Internet, where it would be easily accessible to all health care entities. (The board licensing radiology technicians is currently in the process of publishing their data on the Internet.)

Figures 12 and 13 are available in the Appendix

HEALTH CARE FINANCING

While hospital costs in West Virginia rank 47th lowest in the country, overall health care spending per capita ranks among the highest in the nation relative to the gross state product. Containing the rising cost of health care and stretching the state's resources are of the utmost priority. West Virginia must continue to develop sources to fund accessible and affordable essential services for the residents of the state. The state's ability to integrate federally funded and federally controlled programs into the state health care system will determine how the system will continue to grow and change. The table below illustrates the overall financial health of West Virginia's hospitals.

Table 11
Composite Balance Sheet for All Hospitals

FY 1996-97			
Category	**1997**	**1996**	**% Change**
Total current assets	$707,134,157	$726,979,746	-2.73
Other assets	829,947,607	740,482,535	12.08
Net property, plant, and equipment	1,176,990,890	1,123,781,432	4.73
Total Assets	**2,714,072,654**	**2,591,243,713**	**4.74**
Total current liabilities	356,886,732	357,821,098	-0.26
Long term debt	639,196,108	531,165,786	20.34
Capital lease obligations	2,798,906	55,167,959	-94.93
Other liabilities	31,996,913	120,265,350	-73.39
Total Liabilities	**1,030,878,659**	**1,064,420,193**	**-3.15**
Total Fund Balance	1,683,193,995	1,526,823,491	10.24
Total Liabilities and Fund Balance	**$2,714,072,654**	**$2,519,243,684**	**4.74**

Source: WVHCA Annual Report to the Legislature, 1998

Rural Health Care Financing. The face of rural health care financing has changed during the last several years. In recent years, in an effort to slow the rate of cost increases, there have been significant changes in Medicare and Medicaid reimbursement practices. Private businesses strive for the same cost containment measures through contracts with managed care organizations.

These changes can be critical for rural providers. Many small rural hospitals are currently financially vulnerable to decreases in utilization and increases in costs. Shifting financial mechanisms may impact the hospitals' ability to continue to provide services. According to the American Hospital Association's Survey of Hospitals Profit/Loss Comparison 1994-1998, during the survey period small rural hospitals in West Virginia realized a significant decline in total profits, from $5,387,673 in 1994 to a total loss of $3,162,985 in 1998. Twenty (20) of 31 small rural hospitals had a negative margin in 1998. By 2002, the Balanced Budget Act may reduce the Medicare revenues for these hospitals by $50 million.

State Agency Health Care Funding. The state funds health care through the state agencies that are listed in Table 12.

Table 12 West Virginia State Agency Health Care Funding		
	1997	1998
Department of Health and Human Resources (1)		
Bureau for Behavioral Health and Behavioral Health Facilities	$135,849,091	$108,335,521
Office of Aging *	9,696,725	**9,867,253
Bureau for Medical Services	1,316,440,545	1,364,421,129
Bureau for Public Health		
Epidemiology and Health Promotion	12,456,327	13,639,914
Environmental Health Services	4,422,420	5,216,557
Community and Rural Health Services	20,666,012	21,377,000
Laboratory Services	2,670,460	2,289,004
Health Facility Licensure and Certification	3,564,904	4,072,512
Maternal and Child Health	24,040,969	25,370,097
Nutrition Services	31,192,682	27,272,574
DHHR Total	1,560,000,135	1,571,994,308
Workers' Compensation (2)	202,810,800	198,947,045
PEIA (3)	250,170,564	250,540,989
West Virginia Rehabilitation Hospital (4)	2,155,789	2,378,426
Totals	$2,015,137,288	$2,023,860,768
* More than $8,000,000 was transferred during each of these two years to the Bureau of Medical Services for the provision of Title XIX waiver and health care services.		
** The Office of Aging was transferred to the Bureau for Senior Services in 1998.		
Sources: (1) DHHR Budget Office; (2) Office of Medical Services, Workers' Compensation Division; (3) Public Employees Insurance Agency; (4) West Virginia Rehabilitation Office		
Note: Some funding may be reported twice. For example, the Bureau for Medical Services pays for EPSDT services through Maternal and Child Health; these dollars would therefore be reported for both the Bureau for Medical Services and Maternal and Child Health.		

PAYORS IN WEST VIRGINIA

Table 13 below provides a breakdown of gross patient revenue by payors for hospitals and nursing homes in FY 1997.

Table 13 - All Payor Gross Patient Revenue for Hospitals and Nursing Homes, FY 1997						
	Medicare	Medicaid	PEIA	Other Gov't	Non-Gov't	Total
Hospitals	$1,833,147,104	$541,247,314	$147,611,301	$133,082,496	$1,137,942,576	$3,793,030,791
Nursing Homes	$77,708,696	$259,945,881	$30,192	$4,045,956	$68,319,459	$410,050,184

Source: WVHCA Annual Report to the Legislature, 1998

Principal Sources of Non-Government, Private Insurance Coverage. According to Current Population Survey data from the Bureau of the Census, the percentage of the population under the age of 65 covered by employer-provided insurance in 1995 was 60.9%, with an additional 5.1% covered by other private insurance. This compares to national averages of 63.7% and 6.9%, respectively . The top 20 private insurers in West Virginia as of December 1998 are listed in Table 14.

Table 14 Top Twenty Private Insurers in West Virginia in 1998	
Insurer	Market Share (%)
Mountain State BCBS	20.19
Health Plan (WV only)	9.60
Carelink	9.07
United Healthcare Insurance Company	6.47
Optimum Choice (WV only)	4.36
PrimeOne	3.00
Coventry Health & Life Insurance Company	2.57
Continental Assurance Company	2.03
Advantage Health Plan (WV only)	1.73
Guardian Life Insurance Company of America	1.52
MAMSI Life and Health Insurance Company	1.26
Mutual of Omaha Insurance Company	1.14
Combined Insurance Company of America	1.13
Bankers Life & Casualty Company	1.11
Conseco Health Insurance company	1.09
Health Assurance	1.04
American Family Life ASR company	1.04
John Alden Life Insurance company	0.98
United American Insurance company	0.96
Continental Casualty Company	0.96

Source: West Virginia Insurance Commission

Managed Care in West Virginia. The development of health maintenance organizations (HMOs) in West Virginia has proceeded slowly. The first HMO to operate in the state was The Health Plan of the Upper Ohio Valley, which was licensed in 1979. There are currently seven HMOs operating in West Virginia, six licensed since 1994. HMO enrollment has increased from 13,667 in 1980 to 72,295 in 1990 to a total of 191,754 West Virginians as of December 1998.

A significant factor in the increase in HMO growth in West Virginia has been the enrollment of Public Employees Insurance Agency (PEIA) beneficiaries. Health benefits through HMOs have been available to PEIA enrollees since 1994. Another factor driving the increasing penetration of managed care plans is

enrollment of Medicaid recipients. The Bureau for Medical Services received a waiver from the federal government in 1996 to allow the mandatory enrollment of Medicaid beneficiaries in HMOs. The waiver was limited to 12 counties.

Nationally, the financial performance among HMOs has been marginal. HMOs in smaller MSAs (<250,000) across the U.S. had medical loss ratios averaging 90% in 1996. Total operating margins (administrative costs and medical losses/ premiums written) for HMOs in West Virginia as well as those in small MSAs were negative in 1996. According to InterStudy, national operating margins for small MSAs were (6.6%) in 1996, up from (7.2%)in 1995. In the Charleston MSA, the operating margin in 1996 was (25.5%).

Table 15 presents HMO enrollments by county for 1998. Figure 14 shows 1998 HMO enrollment by percent by county and these same data normalized by county population. Using this method, it can be seen that increasing enrollment is "creeping outward" from Kanawha County and spreading southward from the Northern Panhandle into Wetzel and Marion counties.

Table 15
HMO Enrollment in West Virginia, December 1998

County	Total Enrollment	Market Penetration (%)	County	Total Enrollment	Market Penetration (%)
Barbour	216	1.38	Mineral	1,348	5.05
Berkeley	1,279	2.16	Mingo	132	0.39
Boone	4,631	17.9	Monongalia	10,673	14.13
Braxton	603	4.64	Monroe	182	1.47
Brooke	5,079	18.82	Morgan	367	3.03
Cabell	3,238	3.34	Nicholas	604	2.26
Calhoun	363	4.6	Ohio	22,417	44.07
Clay	2,371	23.75	Pendleton	58	0.72
Doddridge	117	1.67	Pleasants	182	2.41
Fayette	3,533	7.37	Pocahontas	122	1.35
Gilmer	146	1.9	Preston	2,602	8.96
Grant	209	2	Putnam	7,153	16.7
Greenbrier	972	2.8	Raleigh	3,049	3.97
Hampshire	248	1.5	Randolph	442	1.59
Hancock	5,123	14.54	Ritchie	218	2.13
Hardy	121	1.1	Roane	1,221	8.08
Harrison	8,624	12.43	Summers	280	1.97
Jackson	1,925	7.42	Taylor	1,998	13.19
Jefferson	1,194	3.32	Tucker	122	1.58
Kanawha	52,722	25.39	Tyler	1,666	17.01
Lewis	474	2.75	Upshur	637	2.79
Lincoln	1,072	5.01	Wayne	443	1.06
Logan	990	2.3	Webster	195	1.82
Marion	10,868	18.98	Wetzel	4,263	22.14
Marshall	12,712	34.03	Wirt	152	2.93
Mason	1,577	6.26	Wood	3,787	4.36
McDowell	388	1.1	Wyoming	437	1.51
Mercer	2,336	3.59	Other	3,873	
			Total	**191,754**	10.65%*

Source: State of West Virginia Insurance Commission Financial Conditions
*West Virginia's population is approximately 1.8 million

Figure 14 is available in the Appendix

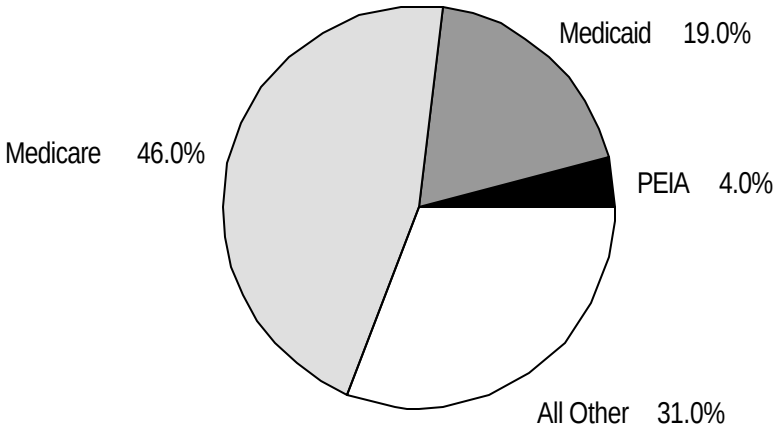
Government Health Care Coverage. Government programs continue to increase their coverage of health care expenditures, both statewide and nationally.

Public Employees Insurance Agency. The Public Employees Insurance Agency is the agency of the State of West Virginia that is charged with the administration of health, prescription drugs, and life insurance benefits for approximately 205,000 members, i.e., state employees, teachers and school personnel, and some city or municipal groups.

Medicaid. Medicaid was begun in 1966 as a joint federal-state program designed to cover health care costs for certain low-income families, as well as aged and disabled persons who meet federal and state specific guidelines. Across the nation, the number of Medicaid recipients increased 33% between 1990 and 1997, according to data from the Health Care Financing Administration (HCFA). Over that same time period, the number of Medicaid recipients in West Virginia increased by 43.5%. In 1997, West Virginia ranked 3rd among the 50 states and the District of Columbia in the percent of population receiving Medicaid. Nearly one-fifth (19.8%) of the state's residents received Medicaid benefits in that year, compared to 12.5% of the population nationwide.

Medicare. Medicare was also begun in 1966 to cover health care costs for the elderly and the disabled. According to unpublished 1998 data from HCFA , West Virginia ranked 1st among all the states and the District of Columbia in percentage of the population enrolled in Medicare. In that year, 18.4% of the state's residents were enrolled in Medicare, surpassing even Florida, which had 18.3%. The 1998 national average was 13.9%. Given the projections on the continuing aging of the state's population, West Virginia is unlikely to lose its number one ranking in the near future. Figure 15 illustrates the unequal distribution of hospital discharges by payor class, showing that the largest share is borne by Medicare (46%), followed by Medicaid (19%).

Figure 15
Hospital Discharges by Payor Class
West Virginia, FY 1997



West Virginia Health Care Authority, 1999

Uncompensated Care. The amount of uncompensated care in West Virginia continues to be an issue. In FY 1997, the WVHCA reported to the state legislature that there was $131,200,711 in bad debt and $99,969,480 in charity care for a total of $231,170,191 in uncompensated care. This constituted 6.1% of gross patient revenue in that year.

The Uninsured in West Virginia. The U.S. Bureau of the Census reports in "Health Insurance Coverage: 1997" that 17.2% of the state's total population was uninsured in 1997, compared to 16.1% of persons nationwide. West Virginia's uninsured population increased by 8.3% between 1992 and 1997, according to the same report, while the national numbers increased by 12.4%.

West Virginia Children's Health Insurance Program. The West Virginia Children's Health Insurance Program (CHIP) was signed into law on April 9, 1998. CHIP is part of a national effort to improve children's health by providing comprehensive health insurance. Covered services include doctor's office visits, check-ups, immunizations, prescriptions, vision care, dental and mental health services, and hospital inpatient, outpatient, and emergency services. CHIP is being implemented in two phases. Phase I, begun in 1998, provides coverage to children aged through five years whose household incomes do not exceed 150% of the federal poverty level but do not qualify for Medicaid. Phase II, begun in 1999, covers children aged six through eighteen and will have the same income guidelines. It is estimated that approximately 20,000 children are eligible for CHIP, with perhaps another 20,000 who qualify but are not enrolled in Medicaid.