South Carolina House of Representatives

Legislative Update & Research Reports

Robert J. Sheheen, Speaker of the House

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House Week in Review

The special order debate on H.3695, the Automobile Insurance Reform Act, took most of the House's attention last week. Only a few other bills on the calendar were dealt with, including S.202, the Taxpayer's Bill of Rights, which was enrolled for ratification. The House also gave third reading approval to H.3657, which would raise the minimum weekly payments due to the death of an employee under the state's worker compensation laws.

Auto Insurance

But most of last week was taken up in long hours of debate on automobile insurance. Although the House will return to that issue this week, a number of sections of H.3695 already have been tabled. Among these are Section 2, which would eliminate punitive damages coverage; Sections 28 on mandatory seat belts; Section 55 on non-economic loss; and Section 57 on the Reinsurance Facility servicing carriers. Section 39, which would allow banks to sell reinsurance, was ruled out of order.

Debate was adjourned on many other sections of the bill, although by Thursday afternoon, the House began to adopted some of the sections previously set aside.

H.3695 remains up for special order consideration when the House returns today.

Bills Introduced

Here is a sampling of the bills introduced in the House during the past two weeks. Not all the bills introduced are featured here. The bills are organized by the standing committees to which they were referred.

Agriculture and Natural Resources Committee

Fuel Ethanol (H.3770, House Agriculture and Natural Resources Committee). This proposed bill would add corn and its by-products to the list of feed stocks which are defined as appropriate stocks for creating the fuel ethanol. To qualify for the tax incentive, the principle feedstock from which the fuel ethanol is distilled must be grown in this state. This bill would delete the reciprocity provision which gives incentives to producers of fuel ethanol produced outside South Carolina.

State Forester (H.3841, Rep. McLeod). This bill would make the State Forester elected by the General Assembly, repeal and disband the State Forestry Commission, and have the elected State Forester take over the duties and powers of the 9-member commission. The current Forestry Commission would continue until a new State Forester is elected. The State Forester would serve a four year term.

Education and Public Works Committee

False IDs (H.3780, Rep. Corbett). This bill would make it unlawful for someone to allow another to use his personal identification documents to fraudulently obtain a driver's license or personal identification card. Anyone convicted of this offense would have his license suspended for six months.

Columbus Quincentennial (H.3782, Rep. Keyserling). This joint resolution provides for the observance of the Quincentennial of Columbus' Discovery of the New World and establishes a commission to commemorate the 500th anniversary.

Preschool Handicapped Education (H.3794, Rep. Corning). This bill would provide for the establishment of mandatory special education and related services for preschool-aged handicapped children. The State Department of Education would be responsible for developing the early intervention program to be carried out by all school districts, either through their own efforts or by contracting with another district or a public or private agency. Any handicapped child, ages three, four and five, who wants to participate in the program must be provided the transportation, if requested, by his respective school district.

Fatal Traffic Accidents and White Crosses (H.3833, Rep. Simpson). Under this bill, a four-foot white cross would be painted on the public street or highway at the approximate point where a fatal traffic accident has occurred. One cross must be painted for each fatality. This applies only to traffic accidents which occur after passage of the act.

Driver's License Renewal for the Elderly (H.3834, Rep. Simpson). Under this bill, anyone 70-years-old or older would be required to take a road test to be issued or renew their driver's license. The bill also would require that for those 70 or older, their licenses must be renewed, with a road test, every two years, instead of every four years.

Journalism to Graduate (H.3840, Rep. Blackwell). This proposed bill would add four journalism course credits to the list of credits required to graduate from a public high school in South Carolina.

Judiciary Committee

Teacher Injuries (H.3766, Rep. Nettles). This proposed legislation would provide additional penalties for a student convicted of a crime occurring on public school grounds, during which a teacher, school official or employee was injured. In addition to the punishment provided for the crime, the student would be fined no more than $200 or jailed for no more than 30 days or both.

Donations of Food to Charitable Organizations (H.3774, Rep. Kirsh). This bill would limit the civil liability of a food facility donating food to a non-profit charitable organization. With the exception of injury from negligence or a wilful act in the preparation or handling of the donated food, no food facility is liable for any damage or injury resulting from the consumption of the food. This also would be true for the non-profit charitable organization.

Uniform Law for Forfeited Substances and Property (H.3797, Rep. Tucker). This bill would require SLED to develop uniform procedures for the seizure, inventory, reporting, handling, auditing, testing, storage and preservation for evidentiary purposes, or destruction of controlled, forfeited or seized substances. All law enforcement officers in the state would be required to transfer to SLED the substances and property forfeited, to be handled according to the regulations established.

Legislative Audit Council Changes (H.3811, Rep. Blackwell). This bill would allow the legislative members of the Legislative Audit Council to appoint designees to serve in their place on the council. The bill also spells out what must be included in an audit done by the council. From whom the Audit Council takes requests for investigations and in what priority order these requests are completed is also revised in the bill.

Court Interpreter for the Deaf (H.3830, Rep. Hearn). The position of Court Interpreter for the Deaf -- an appointment made by the Chief Justice -- would be created by this bill. The bill further states that whenever a deaf person is a party or a witness in a legal proceeding or confined to any institution, the court will provide a qualified interpreter to interpret the proceedings to, and the testimony of, the deaf person. The Court Interpreter's functions, duties and qualifications are outlined in the bill.

Labor, Commerce and Industry Committee

Outdoor Advertising (H.3768, Rep. Altman). This bill would make a number of changes in the existing outdoor advertising law. It would reduce the permissible size of signs by about 30 to 45 percent. Permit fees for signs also would be increased. The legislation further defines and makes stricter the regulations dealing with size, location, spacing and lighting of signs along interstate and federal-aid primary highway systems. Also clarified and made more restrictive is what constitutes zoned or unzoned industrial and commercial areas where signs are permitted.

Co-ops and PSC (H.3826, Rep. Klapman). Under this legislation, the rates and service areas of electric co-operatives would be subject to the same review, assignment or approval by the State Public Service Commission as are electric utility companies.

Pari-mutuel Betting Bill (H.3796, Rep. Cork). This bill, a companion to S.432, outlines the provisions of the South Carolina Pari-mutuel Sports Act, which proponents contend would enhance the economic development and tourism of the state. The bill would create an 8-member South Carolina Racing Commission to oversee pari-mutuel wagering activities in the state. The bill goes into great detail regarding the governing of horse and greyhound racing in South Carolina, including the duties of stewards at the tracks, how the races themselves should be conducted, licensing provisions, how the proceeds of the races should be divided, and the collection and dividing of an admissions tax. How the betting itself must be conducted is also outlined in detail in the bill. County and state fairs would be allowed to conduct one race a year under this legislation. The bill includes the criminal penalities resulting from violations of the act.

The final section of the bill requires that a statewide referendum be conducted at the next general election to determine whether the voters favor pari-mutuel betting in connection with horse and greyhound races if the state receives a portion of the proceeds. The bill must receive a favorable referendum vote in order for it to go into effect.

Medical, Military, Public and Municipal Affairs Committee

Blood Giving Bill (H.3757, Rep. Fair). This bill would prohibit a practicing homosexual or a user of illegal intravenous drugs from giving blood now and up to ten years after halting the practice. A person who violates the provision would be guilty of a felony and subject to a fine of no more than $10,000 or jail time for not more than a year. The bill states no part of the sentence can be suspended and the person convicted could not be paroled until he had served his entire sentence.

Ways and Means Committee

Bond Bills in Odd-Numbered Years (H.3792, Rep. McLellan). The State Bond Bill would be authorized in odd-numbered, instead of even-numbered, years beginning in 1991, under this bill.

Beach Management Trust Fund and Oversight Committee (H.3795, Rep. Sturkie). Earlier in the session, H.3084, was introduced to establish the Beach Management Trust Fund. This bill, reported out of the House Agriculture and Natural Resources Committee, is now on the House second reading contested calendar. H.3795 repeats those sections of H.3084 dealing with the creation of the 7-member oversight committee for the fund and the levying of an additional one cent accommodations tax in Beaufort, Charleston, Colleton, Georgetown and Horry counties. H.3795 also duplicates how the proceeds will be divided: 75 percent going to the Trust Fund and 25 percent to the county where collected.

State Refund Filing Extension (H.3818, Rep. Winstead). This bill would allow those federal retirees, affected by the recent U.S. Supreme Court decision in Davis v. Michigan Department of Treasury, to have until July 15 to file a claim for a state income tax refund for the 1985 tax year. The recent Supreme Court decision struck down a Michigan law that exempted the pensions of state and local government retirees from state income tax, but taxed the pensions of federal retirees. South Carolina is one of 14 other states that have tax laws similar to Michigan's.

State Audits for Local Capital Improvement Projects (H.3838, Rep. Mattos). This proposed bill would require that the State Auditor audit the use of state funds of $20,000 or more appropriated for local capital improvement projects. The bill provides remedies for reimbursing the state if the audit determines that the funds were not used for the purpose for which they were appropriated.

African Development Bank (S.574, Senate Banking and Insurance Committee). The African Development Bank would be added to the International Bank for Reconstruction and Development and the Asian Development Bank as financial institutions issuing securities in which state funds and funds from political subdivisions may be invested.

Without Reference

Obscene Bumper Stickers (S.65, Sen. Land). This is the Senate-passed version of the obscene bumper sticker bill. This bill defines the offensive sticker as "containing patently obscene words, photographs or depictions that are displayed to the members of the public not occupying the vehicle." Penalty: a misdemeanor punishable by a fine of not more than $200.

Research Report: Rural Health Care Crisis

The crisis facing rural health care is an issue that is growing on a number of fronts: the financial crisis confronting rural hospitals, the recruitment of doctors and other health professionals to serve rural hospitals and communities, and the availability of emergency medical services in isolated, rural areas.

The Health Care Planning and Oversight Committee has studied the problems facing rural health care and approved the following report March 16. At that time, the committee also adopted 14 recommendations, which appear at the conclusion of this report. Work already has begun on some of the recommendations.

Many thanks to Dr. David E. Murday, research director for the Health Care Planning and Oversight Committee, who drafted this report and the charts that follow.

An Overview of Rural Hospitals in South Carolina

In 1944, the Commission on Hospital Care conducted the first thorough study of U.S. hospitals. To provide 4.5 hospital beds for every 1,000 people, the Commission recommended 195,000 more beds. The Hill-Burton program was passed in 1946 to meet this goal. The program also tried to spread hospitals more evenly between rural and urban areas. Almost half of the Hill-Burton projects were in towns with less than 10,000 people.

But the goal of 4.5 hospital beds per 1000 people now appears too high. Changes in health care have led to the lowest hospital occupancy rates in over ten years. More than 30 percent of the nation's hospital beds are now empty.

This is a bad time for many rural hospitals. Lack of patients and low government payments mean less income. Competition for doctors, nurses, and other staff and rising insurance costs mean higher costs. Aging buildings and equipment do not attract modern patients.

Rural hospitals differ from larger urban hospitals. There are not enough patients to support many specialists and special equipment. Other concerns include:

-- More poor patients;
-- More older patients;
-- Larger distances and no public transportation;
-- Less private pay patients, and
-- Effects of changes in the local economy.

Poor, elderly, and very sick rural patients have strong ties to the community. Often, they cannot travel to or afford an urban hospital. But other rural patients are attracted to urban hospitals. In South Carolina, these hospitals are often close to home. Rural patients sent to urban hospitals for special care are rarely sent back to their local hospital once their special needs are met.

Yet even patients going to the city for health care still have strong ties to their local hospital. For many, generations of their families have used the local hospital. They may not use it, but do not want to see it closed.

While facing common problems, each rural hospital's concerns and choices differ. But few of them can survive if no changes are made.

A subcommittee of the Joint Legislative Health Care Planning and Oversight Committee studied 43 small or rural hospitals. One hospital closed during the study. Eight public hearings were held across the state. National studies and articles were reviewed. Data from Medicare, Medicaid, hospitals, doctors, and nurses was studied. Concerns fall into four basic areas: payments, health professionals, access to health care, and economic concerns.

Payments from Government Programs

Government health programs are important to South Carolina's rural hospitals. Medicare, Medicaid, and Medically Indigent Assistance Fund patients are over half of their business (60 percent of the patient days and 55 percent of the total charges).

Medicare

Federal figures show nearly half the nation's hospitals lost money on Medicare patients in 1987. The average Medicare profit for urban hospitals fell to 7.6%. The average Medicare profit for rural hospitals fell to 0.14%. Medicare pays rural hospitals less than urban hospitals for the same care. (National studies show that rural hospitals have lower costs for goods and services.)

Due to our state's size, these national figures do not make sense. Most of our "Medicare rural" hospitals are 40 miles or less from an "urban" hospital. Rural patients, nurses, and other health workers commute to these hospitals. Rural hospitals must pay staff more to compete.

The 36 "Medicare rural" hospitals in South Carolina lost over $19 million in FY 1988 due to this Medicare policy. This is very hard on rural hospitals since more of their patients are on Medicare. Based on Medicare's planned rates for FY 1989 this loss would have grown. But after much debate, the final rates for FY 1989 will reduce the losses by 7 percent over FY 1988.

In each state, Medicare hires a Peer Review Organization (PRO) to make sure patients receive proper hospital care. PRO staff review medical records to see if the care was needed and of good quality. If PRO doctors have questions, they consult with the patient's doctor. If they still believe the care was not needed, Medicare payment is denied.

Most doctors and hospitals agree that some means of assuring quality care is needed. However, the South Carolina PRO's methods have created problems. In 1987, SCPRO denied Medicare payment for hospital care almost three times more often than the national average. Most denials are based on SCPRO's belief that the patient should not have been in the hospital. Patients, doctors, and hospitals are sent a form letter with a brief reason for the denial inserted. Then letters are exchanged until the SCPRO is satisfied.

The second guessing and focus on fewer admissions forces doctors to practice defensive or "cookbook" medicine. Of special concern to doctors is that Medicare PRO staff review charts after the fact. Often, doctors must make crucial decisions before all facts are known.

In making these decisions, doctors respond to two opposing forces. They are challenged by Medicare PRO if they put patients in the hospital. But patients want, and will sue if they think they did not get, "the best." This creates a natural tension between the SCPRO and our doctors and hospitals. Poor communication has made it much worse.

Medicaid

Medicaid pays hospitals much less than the actual cost of care. Hospitals say that about 50 percent of charges, 60-70 percent of costs, are paid. This is a real problem for those hospitals which care for many Medicaid patients. To help, our Medicaid program has set aside $1.5 million for "disproportionate share" hospitals. About $453,000 will go to the 13 rural hospitals which qualify.

Payments to doctors also do not cover the cost of care. As a result, many doctors in rural areas will not take new Medicaid patients. The problem is worse for patients seeking obstetrical (OB) care.

Medicaid's method for paying for nursing home care makes it hard to place very sick patients. This and the lack of Medicaid nursing home beds forces hospitals to keep Medicaid patients longer. Medicaid does not pay for these longer hospital stays.

Federal rules allow small hospitals to use acute care beds as long term care beds if needed. These "swing" beds are good for patients waiting to enter nursing homes. They also help persons needing a little extra care before going home. Swing beds are good for hospitals. They allow hospitals to increase their patient census and keep staff. Medicaid payments for swing beds are limited by federal rules to the average nursing home rate. This is much less than the actual cost of care.

The Health & Human Service Finance Commission sets Medicaid payment rates based on available funds. Higher rates depend on more funds.

Medically Indigent Assistance Fund (MIAF)

The Medically Indigent Assistance Fund helps people too poor to pay for hospital care but not eligible for other programs. It will only pay for in-patient care. Doctors who care for patients before, during, and after their hospital stay are not paid. The MIAF does not help patients who need other types of care.

The MIAF covers so little and yet falls short of even that demand. The money runs out several months before the end of the year. This leaves many hospitals scrambling to recover their costs for indigent care.

For all its flaws, the MIAF has served its basic purpose. In two and one half years, hospitals have been paid to care for almost 20,000 poor patients. Most all of these patients cannot get help from any other government program. Rural hospitals report less trouble transferring patients to urban hospitals.

There are many suggestions to improve the MIAF: increase funding, expand services, reserve it for rural patients, or use the funds to expand Medicaid. The pros and cons of these ideas need to be studied.

The Rural Need for Health Professionals

There are few reasons for doctors, nurses, or other health workers to locate in rural areas. Rural areas have more poor people and fewer staff to share the burden. Spouses may fear limited career and social options. Urban hospitals can offer better work hours and advanced work settings. A rural hospital must offer as much if not more money to draw health workers.

Doctors

Half of all medical students educated in South Carolina leave the state to practice. But the main concern is not how many doctors stay in the state. It is where they choose to practice in the state. Recruiting and keeping doctors is becoming harder for rural communities. They are always searching for doctors. Most have some general or family doctors, not enough other primary care doctors, and few if any other specialists. Of the 46 counties, 19 whole counties and parts of 13 others are "health manpower shortage areas". OB care in some rural areas has been reduced or lost due to the lack of doctors. Many specialists need a large number of patients to support their practice. They generally locate in urban areas.

The link between a local hospital and the supply of doctors is strong but simple. A hospital cannot stay open without enough local doctors to admit patients. It is very hard for a community to attract doctors without a modern hospital.

Nurses

Doctors are needed to admit patients. Nurses must give the constant care a hospital patient needs. There are not enough nurses in either urban or rural areas. In four years, South Carolina will need 2,000 more registered nurses (RNs) that it will have.

Demand for RNs will increase as health care changes. Less severe cases are treated as out-patients. In-patients are sicker and need more nursing care. Rural hospitals must compete for nurses with urban hospitals, doctors' offices, clinics, and other new health care settings. Often these other settings offer better hours and pay.

Other careers also offer better hours and pay. More female college freshman want to become doctors than nurses. Since 1983, enrollment in RN nursing programs has shrunk nationwide by more than 25 percent. In South Carolina, enrollment in the four year nursing (RN) program at MUSC has declined. But over 400 hundred students are on waiting lists for the two year nursing (RN) programs at the technical colleges.

Technical colleges are funded based on the prior year's enrollment. This forces them to seek start up funds from private sources. Hospitals are asked to put up the money for new nursing classes, but rural hospitals often cannot afford the cost. Due to standards set by the State Board of Nursing, it costs the state $5,000 per FTE nursing student.

Physician assistants, nurse midwives, and nurse practitioners are not encouraged in South Carolina. As a result, fewer work in our state than in nearby states.

State Incentives

To encourage doctors to locate in rural areas, South Carolina offers a loan forgiveness program. Funds are loaned to students to help pay for medical school. These loans are forgiven in exchange for three years of practice in a rural area. Of the 83 doctors who have completed their commitment, about 20 percent continue to practice in the rural area. Forty-four doctors are now serving their commitment. And there are 39 more in medical school or in residency programs.

However, funds for the loan program have been cut. In both FY 1981 and FY 1982, the Department of Health and Environmental Control received $403,000 in state funds for loans. From FY 1983 through FY 1987, this fell to $279,000 per year. In FY 1988, the $279,000 was vetoed. For FY 1989, DHEC received $112,000 in state funds for loans. Due to the FY 1988 veto and the FY 1989 cuts, DHEC has not offered any loans for the past two years.

In 1988, the General Assembly created a Policy Council for Nurse Recruitment and Retention. The council's goal is to establish, with private funds, a program to help recruit and retain nurses. State support for the council will be phased out over three years.

The Public's Access to Health Care

Rural hospitals play a key role in providing access to health care. This is due to both direct services and through attracting doctors. The loss of the only hospital in a rural county would limit access to care by older and poorer patients.

Lack of prenatal and Obstetric care is a real problem in rural areas. In South Carolina, all county health departments offer prenatal care. When the health department provides care, hospital staff caring for the mother in labor may have no medical history. Too often, a mother has had no prenatal care. Then hospital staff must care for her, with no medical records and more chance of complications.

Emergency care is one of the most important services offered by rural hospitals. Rural workers have more on the job injuries. If a rural hospital closes, the travel time to another hospital could be fatal. Local emergency care can keep a patient alive for later transfer to a large hospital.

Impact on Local Economies

Rural areas are concerned about their hospitals for health and financial reasons. Rural hospitals are important to local economies. Often the hospital is one of the largest employers and purchasers. There is a huge impact on the local economy in terms of number of jobs and money.

Florida studied the indirect jobs and income created by rural hospitals. Rural hospitals create an extra 58.7 fulltime jobs for every 100 hospital workers. Every $100 hospitals spend on wages creates $47.90 in wages for these other jobs.

In FY 1987, South Carolina rural hospitals reported 8,107 FTE workers and $142,643,413 in wages. The indirect impact, using Florida's figures, is another 4,758 jobs and $68,326,195 in wages. The combined economic impact of rural hospitals in 1987 was about 12,865 jobs and $211 million.

Twenty six rural hospitals lost money during 1987. They employed 3,858 FTE workers, with $70 million in wages. Not all of these hospitals are at risk of closing. But the economic impact of a closing cannot be taken lightly.

Loss of a local hospital may also reduce chances of new industry coming to the area. A town seeking new industry will cite the hospital and its services. Employers value easy access to health care.

Planning and Paying for Change

The health care industry has changed rapidly over the past five years. An industry which seemed shielded from competitive, "free market" forces is now driven by them. The Hill-Burton program goal of more rural hospital beds seems to be a mistake. If left alone, market forces will continue to reshape the hospital industry. Those forces respond to the needs of the majority and those who have money.

Even if health care were just another product or service, government would have a role. In many rural areas, factories and rail service are important to the economy. So, too, are doctors and hospitals. Losing one risks losing the other and hurts efforts to recruit more industry. Losing both risks disaster. So state and local governments must work hard to keep them.

But health care is not just another product or service. Poor quality, shortages, and poor distribution only cause resigned grumbling for most services. But they can be fatal in health care. State and local governments must help shape the health care system.

In South Carolina, no agency worries constructively and regularly about rural health care. Good rural health care will not happen without planning and support for new ideas. The health needs of each community and rural hospital differ. Some hospitals want a larger role for state and local governments. Others just want governments to pay for health care for the poor and elderly as promised and to be freed from government restraints.

Experts often urge rural hospitals to consider changes in management, financing, legal structure, and services. But when they try to change, hospitals may find their options limited by state laws or lack of funds. Some states have increased the ability of rural hospitals to adjust to the changing environment. New laws in some states allow rural hospitals more flexibility in the services offered. Some states have created special capital funds to help hospitals which need access to low cost capital loans. Unless a rural hospital has ties with a larger organization, funds for construction can be hard to get. Rural hospitals often have very poor credit ratings. Local governments often do not, or cannot, assist with bond issues.

Committee Recommendations

The following recommendations, adopted by the Health Care Planning and Oversight Committee last month, focus on two basic roles of state and federal government. One is to cover the costs of health care for the poor and elderly. Another is to support local efforts to change the health care system. But it falls to local leaders, public and private, to identify their own needs and solutions.

Recommendations on Federal Issues

#1) Through our Congressional delegation, the legislature should attempt to:
   a. Do away with Medicare's lower payment rates for rural hospitals; and
   b. Change federal rules to allow Medicaid payments for swing beds to be based on the average rate for hospital based nursing homes ($49.09/day). The rate is now limited to the average rate for all nursing homes ($43.82/day).

Members of the Health Care Planning and Oversight Committee have met with the state congressional delegation, who have indicated they will work toward the solutions recommended by the committee. Regarding the elimination of lower payments for rural hospitals, the delegation indicated that this can be resolved but it may take some time to work out. The change allowing the use of the hospital-based average rate for Medicaid swing beds is imminent.

#2) A State Medicare Forum should be convened by the Joint Legislative Health Care Planning & Oversight Committee. Members should represent the Medicare regional office, the Medicare fiscal intermediary (Blue Cross/Blue Shield), the Medicare review organization, members of Congress, the Governor, the General Assembly, the state Hospital Association, Medical Association, AARP and others, as needed

The Medicare Forum would meet at least twice a year to:
-- Review problems with Medicare or SCPRO;
-- Discuss changes in the Medicare program; and
-- Recommend changes to state and federal officials, including Medicare contractors.

Recommendations on State Issues

#3) The Legislature required the Health and Human Services Finance Commission to study payments to doctors and hospitals. The report was submitted in January. Based on the study, the Legislature should provide funds for adequate rates.

In the House-passed Appropriations Bill, a $24 million increase in state funding for Medicaid will bring in $70 million in federal matching money. Of this, $18.7 million will be used to bring rural hospital rates up to cost. An additional $17.4 million will raise all provider costs to the rate of inflation.

#4) Medicaid pays higher rates to hospitals which see more (a disproportionate share of) Medicaid patients. Doctors who treat more Medicaid patients should also be paid higher rates.

#5) The Medicaid swing bed program should include larger hospitals and intermediate care patients.

As of July 1, the Heath and Human Service Finance Commission will include larger hospitals and probably ICF patients in this program.

#6) The Health Care Planning & Oversight Committee should study the Medically Indigent Assistance Fund and recommend changes if needed.

Recommendations to use MIAF for Medicaid services currently are being reviewed by the committee and the Senate Finance subcommittee on Medicaid.

#7) The current loan forgiveness program should be changed. Loans should be made to senior medical students or residents committed to serving in rural areas. Loans would cover prior as well as current tuition and fees. The program should be funded at $403,000, as it was in 1982.

#8) The loan forgiveness program should include nurse midwives, nurse practitioners, and physician assistants.

#9) The Medical University, the USC School of Medicine, and the Consortium of Community Teaching Hospitals should give students and residents opportunities to practice in rural settings. The status of these efforts should be included in the Office of Rural Health's annual report.

#10) Enrollment in nursing (RN) programs at the state's technical colleges should be increased by an additional 100 FTE students each year until the state's nursing shortage is relieved. This will require an additional $500,000 over the previous year's appropriation.

#11) The state should create a $250,000 rural health project matching grant fund. Run by the Office of Rural Health, the fund should support innovative proposals for health care in rural areas.

#12) **An** Office of Rural Health should be created within the **Department** of Health & Environmental Control. The office **will**:

a. Run the loan forgiveness program (see Recommendation #7);
b. Help local efforts to recruit health professionals;
c. Run the rural health project matching grant fund (see Recommendation #11); and
d. Report on rural health issues to the Governor, General Assembly, the Development Board, and state institutions which educate health professionals.

#13) To increase flexibility, a rural hospital should be exempt from the state Certificate of Need process if it has less than 76 beds and:

a. It is the only acute care hospital in the county; or
b. It is the only acute care hospital within 25 miles.

The state currently is addressing this issue.

#14) The state should develop a pool of funds, supported by state bonds, to be used for low cost loans to rural hospitals for construction and purchase of equipment. This pool should be run by the Jobs-Economic Development Authority.