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Implementing the Affordable Care Act in Virginia

Recommendations for the Governor

"Every Virginian needs access to affordable health care. The challenge is how to provide that access in an economically responsible manner. The recommendations of the [Virginia Health Reform Initiative Advisory] Council will help create an improved health system that is an economic driver for Virginia while allowing for more effective and efficient delivery of high quality health care at lower cost."

- Governor Bob McDonnell, August 2010

Part I: What is the ACA?
Implications for Virginia

A Brief Overview

The Patient Protection and Affordable Care Act (PPACA) [1] was signed into law by President Barack Obama in March 2010. A major piece of federal health reform, this legislation contains ten titles and has many implications for states. The first two titles are the most important as they deal with affordable and available coverage (Title I) and changes to Medicaid and CHIP (Title II). The ACA is modeled after the Massachusetts health reform signed into law by Governor Mitt Romney in 2006. The law established an individual mandate for health insurance, requiring all Massachusetts residents to obtain credible coverage or else pay a fee. The mandate has raised insurance coverage in Massachusetts from 87.5 percent of the non-elderly population in 2006 to over 95 percent in 2010.[1] Virginia has a considerable amount of work to do if we are to catch up to states like Massachusetts. The purpose of this report is to provide an overview of Titles I and II, analyze the current state of health care in Virginia, discuss what has been done to date to implement the ACA in the Commonwealth, and make recommendations for moving forward.

Title I: Affordable and Available Coverage

Title I of the ACA includes several immediate reforms which went into effect in 2010. Insurance companies are no longer allowed to deny health coverage based on pre-existing conditions. Young adults are allowed to stay on their parents' plans until age 26 which will provide relief for 25,800 Virginians.[2] Lifetime caps on new and existing coverage have been

[1] For readability, this legislation will be referred to as the Affordable Care Act (ACA).

removed and 81,000 early retirees in Virginia can now receive temporary insurance coverage due to $5 billion in federal funds.[3]

Title I also consists of a "three-legged stool" of long term changes including insurance market reform, an individual mandate for insurance, and premium and cost sharing subsidies which must be implemented by 2014.[4] Under the "pay or play" mandate, companies with more than 50 employees are required to offer health insurance to their workers or face penalties. To make the mandate affordable, Title I asks states to establish insurance exchanges that offer plans at lower rates as Massachusetts has done through the Commonwealth Connector. Cost-sharing for these plans is available for families between 133 to 400 percent of the federal poverty level (FPL). As of 2014, 2.6 million individuals will be eligible to purchase insurance through these exchanges. This is equal to 56 percent of the private insurance market.[5] Separate exchanges and special tax credits are available for small businesses with up to 100 employees of which there are 109,000 in Virginia. Relief for small businesses is especially important since they pay an average of 18 percent more than large employers for exactly the same coverage.[6]

Title II: Changes to Medicaid and CHIP

Under the ACA, states must expand Medicaid to cover all non-elderly adults up to 133 percent FPL which is $14,404 for an individual and $29,327 for a family of four. Prior to passage of the ACA, many low-income childless adults were not eligible for Medicaid coverage. Funding for the newly enrolled will be 100 percent federally funded from 2014 to 2016. In 2017, the funding will shift to a 95 percent/5 percent federal-state split for the newly eligible population. By 2020, states will be responsible for 10 percent of the cost of the newly eligible in Medicaid.[7]

Virginia will benefit from this expansion more than most states because its eligibility limits for Medicaid are lower than 42 other states. Virginia's current federal matching rate is 50 percent, but under the ACA, the Commonwealth will receive enhanced federal funding for all newly eligible parents between 30 and 133 percent FPL. The Commonwealth can expect a 50.6 percent reduction in the uninsured non-elderly population.[8]

The ACA also includes an extension of the Children's Health Insurance Program (CHIP) [2] until 2019. CHIP was initially signed into law by President Bill Clinton in 1997 with the goal of providing health insurance for children who did not qualify for Medicaid, but whose parents could not afford private coverage. CHIP is a joint federal-state program where the federal government provides block grants to the states which set their own eligibility levels and can disperse funds as they see fit within certain federal guidelines. In 2007, CHIP was up for reauthorization, but President George W. Bush only reauthorized it for another two years. In 2009, President Barack Obama signed the CHIP Reauthorization Act (CHIPRA) of 2009, amending Title XXI of the Social Security Act to reauthorize CHIP through FY 2013 at increased levels. CHIP is funded through increases in the federal excise tax on tobacco products, raising the tax from $0.61 per pack to $1 per pack. [9] Each state's CHIP program is structured differently. Please see Part II of this report for information about how the Virginia CHIP program operates.

Part II: State of the State on Health Care

Quality of Care

[2] The Children's Health Insurance Program (CHIP) was known as the State Health Insurance Program (SCHIP) until President Obama reauthorized it in 2009. For ease of readability, the program is consistently referred to as CHIP in this paper.

The quality of health care in Virginia is average compared to the rest of the nation. Our strengths lie in cardiac care, general hospital care, and home health. Weaknesses are nursing home care, diabetes care, and child/maternal health. Virginia is 41st in the nation for breast cancer death rates, 35th for infant mortality, 27th in the percentage of children who are overweight or obese, 20th for its suicide death rate, and 17th in teen birth rate. Yet, the Commonwealth ranks 6th in median family income.[10] There is no reason why our health statistics should be this low when Virginia has the resources to ensure that all residents have quality care. We simply need to invest our dollars where they can have the greatest impact.

Intrastate variations in quality of care are of particular concern. Communities such as Fairfax County in northern Virginia, closer to Washington, DC have higher incomes per capita and correspondingly better health outcomes. In contrast, Buchannan and Emporia Counties in the southwestern and southeastern parts of the state respectively are among the poorest communities in Virginia and have the worst health outcomes. Henrico County in central Virginia which includes the state capital of Richmond is closer to the state averages. Table 1 below displays these trends for "preventable hospital care among Medicare beneficiaries" and "potential years of life lost before age 75" due to lack of care. Because of the regional discrepancies, state averages paint a misleading picture of how residents fair across the Commonwealth

Table 1: Regional Discrepancies in Quality of Care				
Statewide	Fairfax County	Henrico County	Buchannan County	Emporia County

Preventable Hospital Care Among Medicare Beneficiaries	68/1,000	49/1,000	58/1,000	224/1,000	Data not available
Potential Years of Life Lost Before Age 75	6,872/100,000*	3,693/100,000	6,667/100,000	Data not available	17,212/100,000

*1% higher than national average

Source: Report of the Advisory Council to the Chairman of the Virginia Health Reform Initiative

The Uninsured

As of December 2010, nearly 1 million Virginians including 150,000 children lack health insurance. That is 15 percent of non-elderly adults.[11] The vast majority (80 percent) of these people are employed. 46 percent work for small firms which do not offer health insurance or they are self-employed; therefore, they do not have access to affordable coverage. 81 percent are U.S. citizens and 50 percent are white, non-Hispanics. The remainder are 20 percent African American, 20 percent Hispanic, and 10 percent "other." They earn too much to qualify for Medicaid, but cannot afford to buy insurance at market rates due to the rising cost of health care. Health care costs per capita have increased 6.0 percent in Virginia during the past ten years compared to 5.5 percent nationwide, while personal income per capita has only increased 4.1 percent in the Commonwealth. [12] It is unacceptable that this many industrious, tax-paying Virginians cannot afford basic health care coverage.

The number of Virginia employers who offer health insurance to their workers is steadily declining. The problem is primarily among small employers who cannot afford premiums. Only 37 percent of small employers in Virginia offer health insurance, down from 48 percent ten years

ago. In contrast, less than 8 percent of workers in companies with 500 or more employees are uninsured. The average premium for single employee policies has increased by 8 percent for small firms compared to 7.6 percent for large firms. Premiums for family policies have increased even more at 8.2 percent for small employers compared to 7.8 percent for large employers. Most Virginians who do have access to employer-based coverage take advantage of it. Only 25 percent of the uninsured live in households where an offer of health insurance is on the table.[13]

What is the Impact of Being Uninsured?

The fact that so many Virginians are uninsured has negative consequences for the Commonwealth as a whole. People without health insurance have lower five-year survival rates from chronic illnesses, a higher likelihood of being diagnosed with late stage cancers, lower rates of screening tests such as colonoscopies and mammograms, and are more likely to have preventable hospitalizations. In addition, their immediate medical needs are unmet. Last year, approximately 60 percent of low-income uninsured adults had an unmet need for care because of the financial difficulty in paying for health care. 27 percent of uninsured children had no medical care in the past year compared to only 10 percent of children whose parents had health insurance.[14] This raises the cost of care for all residents including those with insurance and results in fewer productive employees who can contribute to the state and national economies.

Medicaid in Virginia Today

The Virginia Medicaid Program served over 1 million beneficiaries in 2010. At a cost of $6.6 billion, Medicaid is the second largest budget item in the Commonwealth, but is still a lean program in terms of eligibility levels and provider payments. Virginia currently offers Medicaid for all children up to 133 percent FPL, but only covers parents up to 30 percent FPL and offers no coverage for childless adults. As explained in Part I of this report, under the ACA, Virginia will be required to cover all low-income residents up to 133 percent FPL regardless of family status. Medicaid enrollment in Virginia is expected to increase by more than 275,000 new enrollees by 2022 at a cost to the Commonwealth of more than $1.5 billion.[15] As Part III will illustrate, the cost of this Medicaid expansion is considerable, but not overwhelming when dispersed over the next ten years.

CHIP in Virginia Today

In 2001, the Family Access to Medical Insurance Security (FAMIS) Program was established as Virginia's Title XXI CHIP program, replacing the Children's Medical Insurance Security Plan (CMISP) which had previously provided health insurance to some low-income children in the Commonwealth. CMISP was eliminated in 2003 and all children ages 6 to 18 in families between 100 to 133 percent FPL were enrolled in Medicaid in order to eliminate the need for two programs. While these children were being transitioned into Medicaid, Virginia continued to receive federal funds for CHIP.[16]

Today, Virginia's CHIP program is funded through a combination of FAMIS funds, state general funds, and federal funds. Virginia's federal match rate for CHIP is 65 percent and its allotment for FFY 2010 was $184.4 million with $54 million of carry-over funds. Under

CHIPRA, all carry-over funds must be used by year's end. In SFY 2010, enrollment in the Virginia CHIP program increased from 96,163 in January to $99,433 in December, but increases were limited to the Medicaid expansion program. Enrollment in FAMIS has decreased because more families have moved into Medicaid.[17]

Base Health Care System

The base health care system in Virginia is comprised of those with private insurance. Today, 4.7 million Virginians have private health insurance coverage and most of them receive coverage through employers. The ACA will not affect coverage for these residents. People who are satisfied with their existing coverage may keep it as long as their plans are at least as comprehensive as the ones that will be offered through the federal insurance exchanges.[18]

Part III: Key Issues and Choices: What Has Been Done and Where We Are Going

Costs of Medicaid Expansion in Virginia

Between 2014 and 2019, Virginia is expected to spend $500 million on the Medicaid expansion and the federal government will spend $9.6 billion. In FY 2011, Virginia will spend $3 billion on Medicaid and $50 billion over the next twelve years. Spread out over time and supplemented by federal funds, these costs are manageable, especially considering that the above numbers only anticipate a 10 percent reduction in uncompensated care payments and do not account for savings in mental health. Experiences in Massachusetts suggest that savings could be as high as 38 percent. 95 percent of the cost of the Medicaid expansion under the ACA will be financed by the federal government, so this is a good deal for Virginia. While Medicaid expansion will increase state government spending, it will also bring more federal resources to

the Commonwealth and cover a large percentage of the low-income uninsured adult population at a manageable increase in total program spending and a reduction in the cost of uncompensated care.[19]

Health Insurance Benefit Exchange Legislation

Under the ACA, states are required to either establish their own Health Benefits Insurance Exchanges or participate in a federal exchange program. On April 4, 2011 the Virginia Legislature passed *VA H2434* stating that it is "the intention of the General Assembly that the Commonwealth create and operate its own health insurance exchanges that meet ACA requirements." Under the legislation, the "Governor is requested to provide recommendations for consideration by the 2012 Session of the General Assembly regarding the structure and governance of the Virginia exchange."[20] Given that SFY 2011 is well underway, the time for action is now. Since Virginia has chosen to create its own exchanges, we should make every effort to go above and beyond ACA requirements, serving as a model for other states in how we implement federal health reform.

Governor's Commission on Government Reform and Restructuring

In April 2011, Governor McDonnell signed Executive Order 32, establishing the Governor's Commission on Government Reform and Restructuring. The ACA is closely aligned with many of the Governor's goals in this Order and provides ways to make good on campaign promises while fulfilling federal mandates. Some of the pertinent sections of the Order are listed below:

- Identify opportunities for creating efficiencies in state government, including streamlining, consolidating, or eliminating redundant and unnecessary agency services,

governing bodies, regulations and programs.

- Explore innovative ways to deliver state services at the lowest cost and best value to Virginia taxpayers.

- Examine ways for state government to be more transparent, user friendly and accountable to the citizens of the Commonwealth.[21]

By expanding eligibility for Medicaid and making health insurance available through exchanges, the ACA will help to reduce uncompensated care, especially the use of emergency rooms for primary care services which will save money across the system. These changes will ensure that state services are delivered "at the lowest cost and best value" as well as "create efficiencies in state government." In the long run, it is not efficient for people to use the emergency room to get a throat culture when the same service can be performed in a physician's office for less than half the cost. With more Virginians able to afford insurance, uncompensated care funds can be used to cover services for those with the most limited financial resources. As the Commonwealth creates its own exchange, state government can be "more transparent, user friendly and accountable" by posting updates on the process of implementation on a new website dedicated to health reform, including how state and federal dollars are being spent. Such a website could also provide links to health plans that residents can purchase through the exchange.

Governor's Health Reform Initiative

On May 14, 2010, Governor McDonnell announced the creation of the Virginia Health Reform Initiative to oversee the implementation of the ACA in Virginia. The purpose of the Initiative is to serve as a liaison between the Governor's office and affected agencies; lead the development of a Health Insurance Exchange; identify and coordinate grants to fund reform; make findings and recommendations on reforms related to Medicaid, insurance, and health care

delivery; and develop an advisory group of stakeholders.[22] Upon appointing members of the Advisory Council for the Initiative in August, the Governor said, "Every Virginian needs access to affordable health care. The challenge is how to provide that access in an economically responsible manner. The recommendations of the Council will help create an improved health system that is an economic driver for Virginia while allowing for more effective and efficient delivery of high quality health care at lower cost."[23] The Council made its recommendations in December 2010. Points related to Medicaid and private insurance are discussed below.

Recommendations from Initiative

The Advisory Council made several recommendations for the Virginia Department of Medical Assistance which administers Medicaid in the Commonwealth. First, the Department should pursue care coordination models. Second, the Department should work with nursing facilities, hospitals, and physicians on strategies for caring for nursing facility residents. Third, the Department should evaluate and pursue potential federal reforms for chronic disease management and care coordination. Fourth, providers should be required to submit claims and receive payments electronically. Fifth, cost sharing opportunities should be explored for the expanded Medicaid population. Finally, the Department should fund and implement a streamlined eligibility system across all publicly funded health and human services.[24]

Overall, these actions are consistent with the Governor's goals outlined in Executive Order 32; however, we disagree with the Council's recommendation that cost-sharing opportunities should be explored for Medicaid. If Medicaid is administered correctly, it would only provide health coverage for residents with extremely low incomes who cannot afford to pay any portion of any premium. All other low-income residents should be required to purchase

subsidized insurance through an exchange if they do not have access to coverage through an employer. By limiting Medicaid to those who truly need it, Virginia can save a considerable amount of money on entitlements, some of which can go toward implementing federal health reform.

Regarding insurance reform, the Council suggested that Virginia establish a state Health Insurance Benefit Exchange, not a federal one, in order to preserve and enhance competition. This recommendation is consistent with the aforementioned legislation that stated the intention of the General Assembly to not participate in a federal exchange. The Council also recommended that the Virginia Bureau of Insurance be given statutory authority to implement the ACA. For the sake of preventing unnecessary bureaucracy and expansion of government, the regulation of insurance should remain with the Bureau and not be transferred to new exchanges. In addition, the Council raised some questions concerning the structure of the new exchanges.

For example,

- Will the exchanges be government or non-profit?
- If government, will they be delegated to a new or existing agency?
- Will individual and small group markets be combined or separate?
- Will Virginia have one statewide exchange or several smaller ones?[25]

Recommendations to address these issues and others are offered here.

Other Recommendations

In response to the questions posed by the Council, we suggest that Virginia establish a statewide Health Insurance Benefit Exchange as Massachusetts has done. By having one exchange instead of several smaller ones, we can limit bureaucracy and facilitate efficient communication and administrative efficiency. As in Massachusetts, this exchange should be government-run through a new independent agency and should separate individual and small group markets. A government exchange makes the most sense because it will be easier for the state to oversee the exchange if the state is operating it. While establishing a separate agency may appear to be a source of government expansion, we believe it is important for the exchange to operate under its own leadership to prevent the missions of other agencies and secretariats from interfering with it. This will make the exchange more effective and efficient in the long run. Having separate markets for individual and group insurance is essential considering that private citizens and small businesses have different needs and priorities when shopping for coverage. Since the Massachusetts model is tried and tested, there is no reason to reinvent the wheel when there is hard evidence that this model can be successful.

Unlike in Massachusetts, we recommend that the Governor appoint regional directors for the Virginia exchange. This will help control costs since these directors can report back on cost-containment issues in their communities and changes can be made as needed. The presence of regional directors will also help to address the discrepancies in health status across the Commonwealth discussed earlier in this report. Regional directors would meet monthly with the statewide director of the exchange and raise any issues or concerns about how the ACA is being implemented in their part of the Commonwealth. They can also serve as voices for residents who

have "checked out" of state government and may not feel that anyone in Richmond is listening to their views.

In addition to appointing regional directors for the insurance exchange, we urge the Governor to further address disparities in health status by taking advantage of funding from the National Health Service Corps to repay services for doctors and nurses who choose to work in areas with a shortage of health professionals. This funding provided under the ACA could help the 9 percent of Virginians who live in underserved areas. Increased funding for the Commonwealth's 146 community health centers could nearly double the number of patients seen.[26] Special attention should be paid to the poorest counties in the southern part of the Commonwealth since individuals in those areas stand to benefit the most from federal health reform.

We suggest that Virginia use Massachusetts as a model for providing access to care, but not for controlling costs. Massachusetts has done an outstanding job of making health insurance affordable through the Commonwealth Connector, but has not been as successful in finding ways to fund this subsidized coverage. While the ACA is modeled after Massachusetts, Virginia has an opportunity to also be a leader in health reform by finding ways to make the individual mandate sustainable for the long term, a goal Massachusetts is struggling to achieve.

One way to control costs is by focusing on wellness and prevention which has the positive externality of improving the quality of life for residents of the Commonwealth. As Virginia begins to offer Medicaid to more people and insurance becomes available through the exchanges, it will become more important than ever that preventable causes of illness are

addressed. A healthier population results in less expensive claims which in turn create lower premiums and less cost-sharing for policy holders. The Healthy Virginians Initiative which "works to promote healthy lifestyles in workplaces, schools, and among families who receive health care through Medicaid"[27] is a good starting point. This initiative can be expanded to include residents who receive health care through the new Health Insurance Benefit Exchange. The Healthy Virginians website is currently not very interactive and could be modeled after the "Mass in Motion" website which includes regular blogs and updates for Massachusetts residents. Healthy Virginians should emphasize the federal Healthy People 2020 goals of attaining high quality, longer lives free of preventable disease, disability, injury, and premature death; achieving health equity, eliminating disparities, and improving the health of all groups; creating social and physical environments that promote good health for all; and promoting quality of life, healthy development, and healthy behaviors across all life stages.[28]

In order to ensure that Virginia residents take full advantage of the health plans offered through the new exchange, the Commonwealth should take steps to improve access to primary care physicians (PCPs) before 2014. The American Association of Medical Colleges reports that by 2020 there will be a shortage of 1,500 PCPs in Virginia. Physician retention is the primary reason for this shortage with only 36 percent of doctors remaining in the Commonwealth after completing medical school. By 2030, 25 percent of Virginia's population will be over age 60, increasing the frequency of necessary doctor's visits. Unless the shortage is addressed, many Virginians will continue to go without care even though they have comprehensive coverage. The Commonwealth needs to increase the class size of medical schools, especially the University of Virginia, and provide incentives for doctors to stay in Virginia.[29]

Overall, we recommend that Virginia take immediate action to implement the ACA so that the Commonwealth is ahead of the curve by 2014. We need to begin laying the foundation for a Health Insurance Benefits Exchange and give the Department of Medical Assistance the necessary authority to carry it out. Otherwise, thousands of individuals and small businesses will be subject to fines and penalties when the federal law fully comes into effect. Virginia has the leadership and financial resources to successfully implement federal health reform and to even solve some problems that Massachusetts has yet to address. To do so, we must maintain an equilibrium between fiscal responsibility and providing affordable access to quality care for all residents.

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