ACA Implementation—Monitoring and Tracking

Virginia

Site Visit Report

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EXECUTIVE SUMMARY

Virginia has made significant progress in health reform implementation, despite significant political opposition in and out of the state government. Governor Robert McDonnell, despite his strong opposition to the Affordable Care Act (ACA), appointed the Health and Human Resources secretary Dr. William Hazel to lead an effort to consider federal health reform implementation and health reform initiatives for Virginia that go beyond the federal reform. Secretary Hazel developed the Virginia Health Reform Initiative (VHRI) at the request of the governor, which included an Advisory Council of key legislators and stakeholders. In December 2010 the council affirmed that Virginia should establish its own exchange. The recommendations of the council led to legislation which passed in the general assembly in April 2011 and was signed into law by the governor.

The VHRI Advisory Council continued the discussions on issues surrounding the health benefit exchange and the questions posed by the 2011 legislation. A series of public meetings (with public comments) were held, a survey of small businesses was conducted, and a report was filed in November of 2011 that contains the VHRI Advisory Council's recommendations. An exchange does not yet exist, only recommendations for one, including the recommendation to create a state-based exchange in accordance with federal law.

Health Insurance Exchange: Planning and Implementation—In addition to the VHRI Advisory Council, trade association representatives and others were included in six task forces that were developed to support and inform the council. Each task force focused on a particular topic area related to reform: Medicaid; insurance; service delivery and payment; provider capacity; technology; and purchasers. One of the task force recommendations, which was considered independent of the establishment of an exchange, has become law already—policies to expand the number of nurse practitioners and their scope of practice. In addition, the Virginia Center for Health Innovation was launched at the recommendation of the Service and Payment Delivery Reform workgroup. The nonprofit, nonpartisan group is intended to bring stakeholders together to develop and promote value-driven models for the delivery of health care in the state.

HB 2434 was enacted, stating, "that the Commonwealth create and operate its own health benefits exchange to preserve and enhance competition in the health insurance market." The VHRI Advisory Council subsequently issued an array of recommendations. Perhaps the most controversial issue of those delineated among the council's recommendations is the governance structure of the exchange. While a majority of the council recommended the exchange be established as a quasi-governmental entity, the state's dominant insurer was vocal about its preference that the exchange be housed within the State Corporation Commission (SCC). Bills taking both approaches were introduced in the last legislative session, but none was brought to a vote.

Health Insurance Exchange: Enrollment and Subsidy Determination—Virginia is actively moving ahead with plans to upgrade their information technology (IT) systems. State officials realize the need to replace their current and antiquated eligibility system for Medicaid, and are taking advantage of 90 percent federal matching payments for these system improvements. They released a Request for Proposals (RFP) in late May of 2012, which focuses primarily on modernizing and streamlining eligibility determination and enrollment for all existing social service benefits, including Medicaid, FAMIS, food stamps, and TANF. The first priority for the new system, however, will be to determine eligibility and enroll those individuals whose Medicaid eligibility will be determined using modified adjusted gross income (MAGI) beginning in 2014. The RFP will also include an optional piece for the vendor to interface the Medicaid eligibility and enrollment (ENE) system with the exchange. With the new eligibility system, Virginia hopes to streamline the process by making it web-based and hopes to move away from caseworkers filing paperwork.

Insurance Reforms—Virginia's legislation, enacted in 2011, fully adopted the ACA's insurance regulations that went into effect in 2010 and, thus, provides the Bureau of Insurance (BOI) with the authority to enforce the new requirements. Passage of these pieces of legislation was not controversial, according to informants, and the same is expected of eventual legislation conforming state law to the 2014 market reforms, although those have yet to be taken up in the legislative process. The implementation of the early market reforms, including the expansion of dependent

coverage up to age 26, prohibition of lifetime dollar limits, minimum annual dollar limits, prohibitions on rescissions, and first dollar coverage of certain preventive services, proceeded without complaint as well. The VHRI is expected to re-convene in the near future, and the choice of the EHB benchmark plan is expected to be at the top of their list of issues to address.

Medicaid Policy—If the state decides to implement the Medicaid expansion in the ACA, there will be a significant impact on coverage. The Urban Institute has estimated that there would be 400,000 new enrollees due to the ACA, roughly a 40 percent expansion of the size of the program. The cost of expansion to the state will be between \$2.1 and \$2.8 billion between 2014 and 2022, depending on assumptions about participation rates. Federal payments to the state over the same period are estimated to be between \$18.4 and \$28.2 billion.

The recession had a major impact on the state Medicaid program because of increased enrollment and declining revenues. The state largely addressed the budget problems through provider rate cuts; this has affected both hospitals and physicians, as well as managed care plans and has implications for the expansion of coverage. The state receives about \$190 million in disproportionate share hospital payments, most of which go to the University of Virginia (UVA) and the Virginia Commonwealth University (VCU) health systems. These will be scaled back as coverage expands. There is concern on the part of these institutions over the potential loss of these funds.

The state believes it has a very strong managed care program, with six plans participating in at least some parts of the state. Despite the strength of the managed care program, the state is concerned about the ability to take on large numbers of new lives. The state is not expected to adopt a Basic Health Program (BHP).

Provider and Insurance Markets—Virginia has several strong insurance plans as well as major hospital systems. The ACA provides strong incentives to become the second lowest cost plan in health insurance exchanges within geographic regions. Anthem is the largest insurer in the state and should be extremely competitive in the exchange marketplace. But provider and insurance markets differ across the state. In Northern Virginia, even Anthem has a difficult time negotiating with the INOVA hospital system. In other areas of the state, there are health plans that are aligned with major hospital systems that are likely to be quite competitive in their markets.

There is considerable concern over provider capacity in the state. It seems unlikely there will be increases in participation among privately practicing physicians because of the federal fee increase. Many large hospital systems have been purchasing physician practices and are moving to develop the primary care capacity necessary to attract new enrollees, both in Medicaid and in exchanges. The state also has a large number of community health centers which are also seen as an important part of the solution. The biggest problem will be in developing sufficient capacity in the southern and southwestern parts of the state. In these areas, enrollment increases will be the largest and provider shortages the greatest.

Conclusions—In summary, there is significant political opposition to the implementation of health reform in Virginia. The state has not indicated at this date how it will respond to the now optional expansion of Medicaid coverage or whether it will establish an exchange. But at the same time, the state has created a highly regarded process for debate on the exchange and also benefits from the extraordinary leadership of Dr. Hazel. The state experiences ongoing budget pressure because of the recession which is affecting state decision making. When the health reform law is implemented, the state could benefit from strong competition within its insurance and provider markets.

With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of the Patient Protection and Affordable Care Act of 2010. The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform in Alabama, Colorado, Maryland, Michigan, Minnesota, New Mexico, New York, Oregon, Rhode Island, and Virginia to help states, researchers, and policy-makers learn from the process as it unfolds. This report is one of 10 state case study analyses. The quantitative component of the project will produce analyses of the effects of the ACA on coverage, health expenditures, affordability, access, and premiums in the states and nationally. For more information about the Robert Wood Johnson Foundation's work on coverage, visit www.rwjf.org/coverage.

BACKGROUND

Virginia has made significant progress in health reform implementation, despite significant political opposition in and out of the state government. Virginia attorney general Ken Cuccinelli was the first attorney general to file a suit against the federal government over the Affordable Care Act (ACA). The suit only challenged the individual mandate, and was dismissed in the Federal Court of Appeals for the Fourth Circuit. The state was not a party to the case recently before the Supreme Court. At the same time governor Robert McDonnell, who has been consistently clear about his strong opposition to the ACA, appointed the Health and Human Resources secretary Dr. William Hazel to lead an effort to begin consideration of federal health reform implementation and health reform initiatives for Virginia that go beyond the federal reform. The McDonnell administration recognized that implementation of the law in the state warranted active attention in case the lawsuit was not successful. In addition, there is widespread awareness across the political spectrum in the state that the current health care cost trajectory is not a sustainable one, and the ACA's existence provides an opening for engendering a state-specific discussion and strategy development on those cost issues specifically.

Secretary Hazel developed the Virginia Health Reform Initiative (VHRI) at the request of the governor, which was established on May 14, 2010. As a central component of the VHRI, the governor created an Advisory Council

of 24 important and powerful stakeholders, essentially a blue-ribbon panel, which was first directed to recommend whether the state should pursue development of its own health insurance exchange. The Advisory Council, established by the governor in August 2010, consisted of key legislators, insurers, hospital and physician representatives, large and small employers, insurance brokers, and other members of the health community. The council affirmed in a report issued in December 2010 that Virginia should establish its own exchange, stating that the governor and legislature work with stakeholders on various key issues in establishing a state-based exchange in accordance with federal law. The recommendations of

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the council led to legislation which passed in the general assembly in April 2011 (House Bill 2434) and was signed into law by the governor. The law charged the secretary, in cooperation with the State Corporation Commission's Bureau of Insurance, the general assembly, relevant experts, and stakeholders to "provide recommendations for consideration by the 2012 General Assembly regarding the structure and governance of the Health Benefit Exchange." 1

The VHRI Advisory Council continued the discussions on issues surrounding the health benefit exchange and the questions posed by the 2011 legislation. A series of public meetings (with public comments) were held, analyses were done by independent consultants and research firms, and a survey of small businesses was conducted. A report was filed in November of 2011 that contains the VHRI Advisory Council's recommendations.²

An exchange does not yet exist, only recommendations for one, including the recommendation to create a state-based exchange in accordance with federal law.

In the last election, the Republicans achieved parity in the senate and, with the vote of the lieutenant governor, now control both houses except for budget matters. Most Republicans oppose the ACA. Two bills introduced in 2012 included the exchange recommendations delineated by the VHRI Advisory Council; four other bills were also introduced. The governor did not actively support any of the bills and none were brought to a vote. There is still a need to establish various provisions of the exchange through legislative action. Some officials express the view that the April 2011 legislation is sufficient to develop the exchange and to apply for a federal Level I Establishment Grant. But legislation is needed to decide the governance structure (discussed further below).

The ACA's expansion of coverage in Virginia will be much larger in Medicaid than in the exchanges if the state implements the Medicaid eligibility expansion, primarily because the state's current eligibility levels for adults are so low. Thus, Virginia could see an influx of new federal funding for new Medicaid eligibles. At the same time, there is concern over the effect of cuts in disproportionate share hospital (DSH) payments on the state's major safety net hospitals. Virginia, like other states, has been significantly affected by the recession. The state has responded to the financial pressure with cuts or freezes in provider payments,

which also affects managed care rates, threatening the program's ability to expand capacity. There are six Medicaid-managed care plans in the state, with at least two plans in each region. These plans generally believe that they have the capacity to absorb the expanded enrollment, but acknowledge that much depends on whether payment rates to doctors and hospitals can allow plans to broaden their networks.

There are several health insurance plans in the state operating in the private market. The largest and most dominant is Anthem, formerly Blue Cross Blue Shield; multiple respondents believe that Anthem's significant market share allows it to negotiate better rates with providers than other insurers can in most markets. The intensity of competition among insurers and among providers (largely hospitals) differs considerably among regions within the state. Hospital markets are quite concentrated within several areas in the state. Several hospital systems have been actively acquiring other hospitals and purchasing physician practices. This has allowed them to achieve the efficiencies of clinical integration, and also has increased their market power in local areas. Some of these systems are even moving to offer their own insurance products.

The Urban Institute estimates that in 2011, 62.9 percent of the non-elderly population had employer-sponsored insurance, 10.9 percent had Medicaid, and 14.8 percent were uninsured.³ The number of uninsured in Virginia was 1.0 million. The Urban Institute projects that, if the ACA had been fully in place that year, 400,000 people would have newly enrolled in Medicaid because of the ACA and another 100,000 would have newly gained insurance in the health insurance exchange. Over 600,000 Virginians would have obtained coverage in the health insurance exchange in total, including those who had been insured previously. The number of uninsured would have fallen to 470,000 or 6.9 percent of the population.

HEALTH INSURANCE EXCHANGE: PLANNING AND IMPLEMENTATION

As explained previously, the VHRI Advisory Council has led to the state's analysis and debate of the development of a state based exchange and its particular design. Appointments to the council, made by the governor and with input from Secretary Hazel, other agencies, and state legislators, included influential individuals from each of the stakeholder groups, but not the established organizations

that represent them. For example, representatives from particular insurance carriers selling coverage in the state were included, as opposed to the director of the Virginia Association of Health Plans. The concern was that those who represented diverse opinions of multiple entities in an organization would not be as free to express their opinions in the council. However, association representatives and

others were included in the six task forces that were developed to support and inform the VHRI Council. Each task force focused on a particular topic area related to reform: Medicaid; insurance; service delivery and payment; provider capacity; technology; and purchasers. One of the task force recommendations, which was considered independent of the establishment of an exchange, has become law already—policies to expand the number of nurse practitioners and their scope of practice (H.B. 346). In addition, the Virginia Center for Health Innovation was launched at the recommendation of the Service and Payment Delivery Reform workgroup. The nonprofit, nonpartisan group is intended to bring stakeholders together to develop and promote value-driven models for the delivery of health care in the state.

Although the council was appointed by a Republican governor, it was unified in its finding; it was clearly in the state's interest to develop its own health insurance exchange. There was also a widespread recognition that doing so would require immediate and continued planning in order to meet the federal timetable for progress in establishing an exchange. The ability to tailor the implementation of reforms to state needs and preferences to the extent possible was a driving force in the decision. During the 2011 legislative session, HB 2434 was enacted, stating, "that the Commonwealth create and operate its own health benefits exchange to preserve and enhance competition in the health insurance market." The law included language to restrict abortion coverage beyond that included in the ACA, stating that coverage sold through the state exchange "may not include abortion coverage, with exceptions only to save a woman's life or if the pregnancy is the result of rape or incest."

The law required the secretary and the BOI to work with stakeholders, the general assembly, and experts to develop recommendations for the governance and structure of an exchange that meets the requirements of the ACA. The secretary used the existing structure of the VHRI Council to fulfill the intent of the law. The state also contracted with substantive experts to provide analytic information to ensure that the process would be as evidence-based as possible. In addition to microsimulation modeling and actuarial analyses, this work included focus groups and surveys with small businesses where the exchange concept was introduced and preferences for exchange functions/roles were discussed. A number of topic-specific white papers were also prepared.

All meetings of the council and the task forces were public, and stakeholders consistently reported that the process felt open and inclusive and that various viewpoints were heard.

Some, however, voiced displeasure that a professional consumer advocate was not included as a member of the council. The perspective of state officials is that all members of the council are consumers, and are thus able to represent the interests of consumers. In addition, state officials noted that a board member of the Virginia Health Care Foundation was also on the council, and that the Foundation's mission is focused on increasing access to care for uninsured and underserved Virginians. There was extensive public commenting, which members of the VHRI found informative and enriching to the discussions. Some informants remarked, however, that the diversity of backgrounds among members of the council and the task forces was not always positive. Some found that the lack of an understanding of insurance and other health policy related issues was sufficiently great that much time was spent on educating some members on fundamentals, thus limiting how much could be accomplished and how fast it could be accomplished.

The VHRI Advisory Council issued an array of recommendations in a report released in November 2011. While these recommendations were not all unanimously supported by council members, there was a sense of substantial cohesion around them. The recommendations included:

- Create the exchange as a quasi-governmental agency with a governing board of 11 to 15 people, serving staggered terms of two years;
- Utilize existing administrative structures in the Medicaid agency (e.g., Medicaid eligibility and enrollment) and the Bureau of Insurance (e.g., functions consistent with its current mission) whenever possible to avoid duplication;
- Maintain two separate risk pools for the small group and nongroup markets, while establishing one administrative structure for the exchange;
- Create a role for both agents and navigators within the exchange and allow agents to be navigators. Nonagent navigators would be required to have training and certification:
- Have the exchange utilize a "passive purchaser" model, which will allow all qualified health plans to participate.
 The recommendations do suggest enabling the governor and the exchange board to take temporary steps to stabilize the market if extreme adverse selection should occur; and
- Sustain the non-exchange small group and nongroup markets, but have consistent insurance mandates apply inside and outside the exchange.

Many involved in the process believed that these recommendations would be put forward as legislation and voted on during the 2012 session, which took place over the first few months of the year. While a number of laws were indeed introduced, including one that closely mimicked the council's recommendations, none were brought to a vote. Many informants noted that the governor made it clear that he did not want to address legislation on the exchange until the Supreme Court decision was made. A number of informants from different stakeholder perspectives expressed disappointment in this turn of events, as they felt it would make it harder and perhaps impossible for the state to develop its own exchange within the federal time requirements.

Perhaps the most controversial issue of those delineated among the council's recommendations is the governance structure of the exchange. As indicated above, the majority of the council felt quasi-governmental governance was the best option, but Anthem Blue Cross Blue Shield was very vocal about its preference that the exchange be housed within the State Corporation Commission (SCC), which is the judicial entity that includes the state BOI. As is the case with all courts in Virginia, the SCC's judges are appointed by the state legislature, and it has no policymaking authority and does not make recommendations. Instead, in matters of policy, the SCC and its divisions can, at legislative request, provide the legislature with information about options and the SCC's analyses of the implications of the options. As such, an array of informants believed that placing the exchange under the auspices of the SCC would make the exchange slow to respond to changes in markets and identified needs, particularly since the state legislature works on a part-time calendar (they normally sit only during the first three months of the year). Some of the insurance companies clearly believe that the SCC would be more market-friendly than a quasi-governmental entity and that effective control by the state legislature is likely to be a more industry-friendly approach, while at least some nonprofit carriers prefer the quasi-governmental approach. A bill (S.B. 496) was introduced during the 2012 legislative session which would place the exchange in the SCC, but this bill did not advance either. This bill is the one exchangerelated bill that will carry-over to the next legislative session

for consideration, although others could be re-introduced or new bills written and introduced as alternatives.

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Another area of contention on the council was the composition of an exchange governing board, should the exchange be created using the quasi-governmental approach, as the SCC approach would not permit a governing board. There was considerable discussion as to whether insurers should be represented on the board or whether they should be excluded along with others posing a possible conflict of interest. While even those supporting the inclusion of insurers agreed that they should not comprise a majority of board positions, the council could not come to agreement on this issue and the recommendations did not include specification of board membership.

A number of other issues were not decided upon by the time of our site visit but were expected to be considered in summer 2012. Among these issues is that of funding for the exchange. It seemed clear that general state funds would not be used for this purpose and that in some manner plans would have to generate revenue to support the exchange administrative functions. In addition, since agents might assist Medicaid-eligible individuals to enroll in Medicaid-managed care plans under the reforms, it was considered worth exploring whether those plans might also contribute toward exchange administrative costs in some way. In addition, there has been considerable discussion within the council about the consequences of adverse selection if different rules apply to insurers operating inside and outside the exchange. However, the inclination is to default to the free-market approach with insurer flexibility within an ACA context. Some informants, however, feel that inconsistent market rules and the potential adverse selection implications are the biggest concern for developing a successful exchange.

HEALTH INSURANCE EXCHANGE: ENROLLMENT AND SUBSIDY DETERMINATION

Modernization of the State's Information Technology Systems

While many decisions had been on hold until the Supreme Court decision, Virginia is actively moving ahead with plans to upgrade their information technology (IT) systems. State officials realize the need to replace the Application Benefit Delivery Automation Project (ADAPT), their current and antiquated eligibility system for Medicaid, and are taking advantage of 90 percent federal matching payments for these system improvements. They released a Request for Proposals (RFP) in late May of 2012, which focuses primarily on modernizing and streamlining eligibility determination and enrollment for all existing social service benefits, including Medicaid, FAMIS, food stamps, and TANF. The first priority for the new system, however, will be to determine eligibility and enroll those individuals whose Medicaid eligibility will be determined using modified adjusted gross income (MAGI) beginning in 2014. The RFP will also include an optional piece for the vendor to interface the Medicaid ENE system with the exchange. State officials mentioned several ways they see this unfolding: the vendor could be responsible for interfacing and operating the exchange; the vendor could subcontract with a partner to operate the exchange; or the vendor could interface the ENE portion with an exchange system that will be purchased by the state at a later time. The RFP option does not cover all the exchange functions, nor is it particularly prescriptive of how the state envisions the exchange will work. Many informants emphasized the desire to avoid building an exchange IT system; as one informant said, "Let the vendor propose the idea and their model. We want them to bring the model to us, essentially." The state plans to add the exchange piece if needed, and state officials have noted that the upgraded system for the existing programs will be a good investment.

With the new eligibility system, Virginia hopes to streamline the process by making it web-based and hopes to move away from caseworkers filing paperwork. Caseworkers will continue to assist enrollment for complex cases, but the state would like to accommodate the large influx of cases in 2014 by increasing automation and not by new hiring. The current system, ADAPT, is only able to determine eligibility for the nonelderly, non-disabled population, and it is not web-based. Although children and pregnant women are able to file and sign applications electronically, which

prepopulates the determination information into ADAPT, a caseworker is still required to supervise the process. Once a case is deemed eligible, ADAPT is able to send enrollment information to the federal Medicaid Management Information System (MMIS) for these groups.

Currently, for the populations that ADAPT is not equipped to handle, such as long term care, the disabled, and the elderly, caseworkers both determine eligibility and enter the case into MMIS manually. However, state officials envision the new system reducing the paperwork load and caseworker involvement for all standard cases, including these.

State officials also anticipate more efficient data sharing within the state and a decreased reliance on obtaining documentation from applicants to verify eligibility. The state currently is able to do data matches with the state Social Security database, with SSI eligibility, and with immigration status. Virginia also subscribes to a database called Work Number, where some large employers, such as Wal-Mart, report their employees' income and insurance information. Beyond these, the accessible data is limited; for example, the social services department cannot access the state tax department data. To facilitate information exchange further, Virginia is working on an enterprise-level data sharing agreement within the state. Eventually, the system will also connect to the federal data hub, which will assist with citizenship, immigration, and IRS information on household composition and income. Both these developments will simplify eligibility verification and subsidy determination once the system is coordinated with the exchange and other social services.

Caseworkers will continue to assist enrollment for complex cases, but the state would like to accommodate the large influx of cases in 2014 by increasing automation and not by new hiring.

State officials cite the timeline as the biggest challenge. They expect to award the contract by October 2012 and will need Centers for Medicare and Medicaid Services (CMS) to certify

the system by October 2013. This leaves very little time to build a system that typically, according to one official, would take 4 to 5 years. Getting the new system up and running for Medicaid and Childeren's Health Insurance Program (CHIP) Modified Adjusted Gross Income (MAGI) populations is the number one priority. Because the MAGI population requires a new rules engine and no system exists currently for the non-MAGI populations, the state would have no ability to determine eligibility for anyone except by hand without the new system. In anticipation of 400,000 new Medicaid applications, the state needs to have the new IT system in place ahead of time. Once the Medicaid eligibility portion is up and running, the state plans to begin integrating the other social service programs and removing all legacy systems.

There are still many unknowns regarding the detailed workings of the system. State officials envision a unified system that would simultaneously determine eligibility for Medicaid, exchange plans and subsidies, and other programs. But they do not know how many of the consumer-side functions will work, such as plan shopping, network comparisons, and premium collection. For these, state officials hope to rely on their vendor for ideas or follow the example of other states.

Consumer Outreach and Education

Most informants acknowledged that consumer outreach and public education have yet to become high priorities in

the state. The challenges in moving exchange development forward have usurped outreach plans, even among advocates. The state's primary focus for implementation has been the IT system up to this point. However, the Virginia Healthcare Foundation has plans to mount a substantial outreach effort, building upon their experience with other state programs, including FAMIS. The foundation has a strong relationship with the Department of Medical Assistance in this regard, and they expect it to continue and are optimistic that the administration will be open to an outreach partnership in the future.

Using their federal Consumer Assistance Program grant, the Virginia Bureau of Insurance has developed a booklet that outlines the immediate provisions of the ACA, and has updated the state's health insurance guide to delineate the changes up to 2014 and to explain the future role of exchanges. These booklets have been distributed to 800 sites across the state (community colleges, hospitals, libraries, etc.), along with postcards that can be mailed in for additional information. An additional booklet has been developed and distributed explaining the preexisting condition insurance plan, which is federally run in Virginia. However, advocates still sense that public awareness of the early implementation reforms remains low.

INSURANCE REFORMS

Virginia's legislation H.B. 1958, enacted in 2011 as Article 6 of Chapter 34 of the Code of Virginia (§38.2-3438 et seq.), fully adopted the ACA's insurance regulations that went into effect in 2010 and, thus, provides the BOI with the authority to enforce these new requirements. The new state insurance article created by this legislation, "Federal Market Reforms," included all of the ACA's early market reforms with the exception of those relating to internal appeal and external review, which were adopted separately through H.B. 1928 (enacted in 2011 as Chapter 35.1 of the Code of Virginia §§38.2-3556 et seq). The legislation was also careful to include language amending other sections of Virginia code that might be in conflict with the ACA's early market reforms. Although H.B. 1958 included a provision that would cause these new protections to expire in 2014, a Republican state legislator who sponsored the bill has indicated that the reforms may not be allowed to expire

because of their popularity, as they have already been written into consumer policies.⁴

Passage of these pieces of legislation was not controversial, according to informants, and the same is expected of eventual legislation conforming state law to the 2014 market reforms, although those have yet to be taken up in the legislative process. The BOI provided additional guidance to carriers beyond that provided by the federal government, developing a checklist of things that the BOI would be looking for in form reviews. BOI also held a training session for carriers on the new appeals process, along with distributing a letter explaining the changes expected of the carriers in the internal appeal and external review processes.

The relationship between the BOI and the health plans appears to be a cooperative one. This positive environment may be related, at least in part, to the fact that the BOI is

not a policy-making body and is not part of the executive branch of state government, which is considerably different than the situation in other states. The BOI is part of the State Corporation Commission (SCC), an entity that operates as a court. The General Assembly appoints three judges to oversee the SCC, each of whom serves a six year term (with the terms of the judges staggered), the same as other state judges. The judges, in turn, appoint the commissioner of insurance. The BOI thus serves as technical advisor, not a voting member on the VHRI, researching insurance laws, regulations, processes, and procedures, in order to anticipate any changes that might be necessitated by the ACA and the timing on those changes.

Early Market Reforms

The implementation of the early market reforms, including the expansion of dependent coverage up to age 26, prohibition of lifetime dollar limits, minimum annual dollar limits, prohibitions on rescissions, and first dollar coverage of certain preventive services, were implemented without controversy. For example, the removal of lifetime limits had no noticeable effect in the nongroup market, since the lifetime limit for a number of policies there was already a minimum of five million dollars. As far as the BOI can tell, the carriers made all of the appropriate adjustments. The BOI estimates that perhaps a 1.5 to two percent premium increase in group market premiums might be attributable to the early reforms. In the individual market, the thinking is that the provision for first dollar coverage preventive care probably had the biggest impact on premiums, but that the effect was not more than a three percent increase. Industry insiders report that carriers had to hire staff to respond to the early reforms in general, but there have not been real problems associated with them. "If anyone knows how to deal with regulation," one industry informant said, "it's us."

Virginia did include provisions in its early market reform legislation, 2011 H.B. 1958, intended to ensure the availability of child-only policies once the prohibitions against declining coverage or imposing preexisting condition exclusion periods for children was put in place. The legislation allows insurers who offer child-only coverage to offer such coverage continuously or during two standardized open enrollment periods, but does not require insurers to sell child-only policies. Some carriers that were offering child-only policies in the nongroup market did withdraw from selling those products, although the BOI thought that one company might have re-entered that product line. By all accounts, however, this line of business was always perceived as very small in the state, and there has been no formal tracking of it.

The small employer tax credit is perceived as too difficult to qualify for, due to the wage requirement being so low (average salary must be \$25,000 or less). The process for determining eligibility was also thought to be complex.

Medical Loss Ratio Requirements and Premium Rate Review

Medical Loss Ratio (MLR) refers to the share of a health insurance premium the insurer spends on health care services and improving the quality of care, as opposed to administrative costs and profit. Virginia did not have a MLR requirement in place in its group markets prior to the ACA. The state does, however, require individual accident and sickness insurers to submit an actuarial memorandum which includes their loss ratio when submitting policy forms for approval, although the calculation is not the same as for the federal MLR. Most nongroup coverage in the state had to meet a minimum loss ratio standard of 60 percent, as compared to the 80 percent federal standard under the ACA.

The state did not request a waiver or adjustment to the federal MLR standard. There is a perception that carriers have modified their broker compensation schedules as a result of the new rules, but there is no data available to assess the actual impact. The state has not interacted with carriers significantly regarding MLR or possible rebates, since the carriers realize that the authority in this area lies at the federal level. However, at least one carrier did report that they made changes to their small group rates in order to avoid rebates.

Informants indicated that agents found it more difficult to obtain information and reimbursement from at least one of the state's major carriers.

The BOI conducted a carrier survey to assess nongroup carriers' concerns and expected response to the new rules.⁵ Four carriers of the 33 responding to the survey replied that they would "discontinue new sales in the individual accident and sickness market in Virginia" due to the new requirement; no carriers anticipated leaving the Virginia market entirely; and 25 replied that they were not sure yet. Industry experts predict that carriers in the state will pay rebates only once. They will then make the necessary adjustments in order to preclude the need for future payments.

The Department of Health and Human Services (HHS) found Virginia's premium rate review process to be only partially effective. The state currently only reviews rates for non-HMO products in the nongroup market where it has the authority to approve rates. HHS reviews rates for HMO products and association products in the nongroup market

and all products in the small group market. The reason the state's process was not found effective for products in these markets is because the BOI does not review those rates and there was no established standard to which they were held. Rates were only filed for informational purposes. The BOI is exploring the changes that would be required to make the state's process fully effective and will develop a plan for doing so.

As the BOI is not a policy-making body, making the necessary changes to the rate review process to move it to being fully effective from a federal perspective will have to be a legislative decision, and that is expected to be considered in the 2013 session. According to informants, carriers in Virginia would prefer to have the state regulating rates, as opposed to having it done by the federal government. In addition, in order for the state to have the option to enter into a partnership with the federal government for running its exchange, the state may need to take responsibility for rate review. It is felt that taking over this responsibility would be very resource intensive, requiring significant new hiring.

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A particular concern is the BOI's ability to review rates of association health plans and out-of-state trusts. Much of the association coverage sold to state residents is sold by carriers headquartered outside of Virginia, so their regulation prior to 2014 is the purview of other states. Clarifying language provided by Center for Consumer Information and Insurance Oversight has made clear that an effective rate review program requires a state to have rate review authority over association products sold to its residents.

The BOI is working to increase the transparency of rate and form filings for consumers. They have engaged in a website enhancement project related to this effort using a Cycle I rate review grant, including a mechanism for consumers to comment. They also used Cycle I funding to do a targeted intense financial and actuarial review of rate filings from two insurance companies. They reviewed underlying data and audited data in the filing on rates that had already been reviewed and approved as part of their existing rate review process. This was done as a self-audit to identify whether the original review process was correct and sufficient. The process took eight months to review two companies, and

was considered a positive experience that identified areas for company improvement, primarily in the estimation of trend.

There is a perception that the new rate review regulations and the 10 percent premium increase threshold have had an impact on carrier behavior, but since the rate of increase in medical costs has slowed recently as well, it is difficult to determine precisely how much of an impact it has had. At least one company included a statement in their public filing that all their rate increases would now fall just below the 10 percent review threshold.

The remainder of the Cycle 1 funds are being used to create a rate review procedure manual and for an analysis of premium trends in the small group market. The BOI does not anticipate applying for a Cycle 2 grant.

2014 Market Reforms

CCIIO issued a bulletin in December 2011 that delineated 10 state options for a benchmark plan delineating essential health benefits (EHB) in the small group and nongroup markets beginning in 2014.⁶ These are:

- The largest plan by enrollment in any of the three largest small group insurance products in the State's small group market;
- (2) Any of the largest three state employee health benefit plans by enrollment;
- (3) Any of the largest three national FEHBP plan options by enrollment; or
- (4) The largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the State.

The VHRI is expected to re-convene in the near future, and the choice of the EHB benchmark plan is expected to be at the top of their list of issues to address. They have had a study done by a consulting firm to compare three of the four general categories of benchmark options as to how they relate to Virginia's insurance benefit mandates, and that will be used as a resource. Some of Virginia's mandates do not fit easily into the 10 benefit categories delineated in the ACA, and it is not clear how that will be dealt with. There are also remaining questions about the definitions of the categories in general, which will complicate the choice to some degree. The cost of the EHB package is expected to be a major factor in the state's choice. But policy-makers expect the EHB to be based upon either an Anthem or Optima small employer plan.

There appears to be discomfort within the state legislature, however, in moving forward with policy decision-making based upon a federal bulletin, as opposed to actual rule-making. The state does not currently collect the detailed data at the plan level that will be necessary to assess and compare the 10 EHB options; consequently, the BOI will need to do a "data call" to carriers to obtain it. While the BOI does have complete policy forms for benchmark options, they do not have enrollment data attached to them. Until they obtain that data, it is not possible to identify with certainty which plans have the largest enrollment. While HHS collected data on what the agency believes are the three largest small group plans in the state, the BOI does not know how they arrived at that list, since the necessary information does not appear available to the state.

Aside from the EHB determinations, two other policy changes are expected to pose some challenges. First is the move to modified community rating, allowing a maximum of three to one age bands and tobacco use rating bands of 1.5 to one. CCIIO has not yet released regulations clarifying the specifics of how these limits will be implemented, and the state is awaiting answers to questions such as how the age and tobacco rating bands as well as new wellness requirements might interact, whether children will have their own rating band, and other issues. Defining the geographic premium rating areas also poses a challenge for both the BOI and the carriers. The modified community rating reforms will create an incentive for smaller employers to self-insure, since stop-loss coverage is regulated in only a limited way in Virginia. Only general insurance requirements apply

to these policies, as opposed to more extensive regulation of small group and nongroup health insurance policies. At this time, however, the state does not have a mechanism for monitoring potential movement of small employers into self-insurance and stop-loss coverage.

The second concern is with potential rate effects associated with moving the small group size definition to 100 from 50, since the 51 to 100 market is currently an experience-rated market. Another concern is the expected impact on nongroup policy-holders. One informant predicted that the rate shock (increase) for individuals currently obtaining coverage in the nongroup market would be "stunning" once medical underwriting is removed and age rating limits are imposed in 2014. In addition, maternity benefits are currently not available in the products sold in the state's nongroup market with the exception of Kaiser Permanente coverage, so that change alone could increase rates for current enrollees to some degree. Informants acknowledge that risk adjustment and reinsurance are vital and will help with rate shock, but such approaches are not perfect.

There is an expectation that the BOI will need to increase its staff in form and rate reviews, plan management and qualification issues, and in actuarial expertise to meet the demands of the 2014 reforms. Given the uncertainty with the direction of exchange development in the state, however, it is difficult to plan specifically, and staff have not yet moved forward with hiring. Depending upon the exchange's needs for BOI expertise, one possibility is to develop an interagency agreement to help to fund some of the increase in BOI activities.

MEDICAID POLICY

The Medicaid expansion in the ACA will have a significant effect in Virginia if the state decides to implement it.

Currently the state covers 591,000 children, 179,000 non-disabled adults and 290,000 elderly and disabled. Children are covered up to 200 percent of the federal poverty level (FPL) under a combination of Medicaid and CHIP. Children living in families with incomes above 138 percent of the FPL are likely to eventually migrate to exchanges if CHIP's federal funding is not renewed. But Virginia would see a major expansion in coverage for adults under the ACA expansion. Parents are currently covered up to 29 percent of the FPL (on average) and childless adults are not covered at all unless disabled. Based on Urban Institute estimates, the state expects 400,000 new enrollees in Medicaid due to the ACA (based on the simulation of full reform implementation

in 2011), roughly a 40 percent expansion in the size of the program.⁸ Thus, it is expected that the Medicaid expansion would be large, mostly due to enrollment by new eligibles but also due to some increases in coverage among current eligibles. The state share of Medicaid is funded almost entirely through general revenues, aside from a small provider tax on intermediate care facilities for the mentally retarded (ICFMRs). There are no hospital taxes. Another non-general revenue source of funds is from the Tobacco and other Tobacco Product Tax Revenue Master Settlement Agreement (MSA).

The state estimated the impact of the ACA Medicaid expansion as well as increased participation by current eligibles. They made estimates of the new federal payments

along with new state expenditures. The estimated cost of the expansion to the state is between \$2.1 and \$2.8 billion for the 2014 and 2022 period, depending upon assumptions about participation rates. Federal payments over the same period are estimated to be between \$18.4 billion and \$28.2 billion. The estimated savings from DSH reductions, pharmacy rebates, and the CHIP matching rate increase are \$625 million over the same period. The state's analysis did not include potential savings elsewhere in the state budget, such as other state payments to hospitals or clinics or savings on community mental health services that would shift into Medicaid.

The Recession

The recession has had a major effect on the state with increased Medicaid enrollment and declining revenues. Most of the budget problems caused by the recession have been addressed through provider rate cuts, but this has left the state in a difficult position for expanding coverage under health reform. Several provider groups, primarily nursing homes and hospitals, were accustomed to getting automatic inflation adjustments each fiscal year, but these have now been deferred for the past several years. These payment rate freezes have translated into the state's managed care rates. Physicians do not get an automatic inflation adjustment; instead they occasionally get across the board rate increases, and rates are also periodically adjusted for particular specialties (e.g., obstetricians).

Provider Participation

Large numbers of physicians in the state do not participate in Medicaid. Although physician fees are relatively high in Virginia compared with Medicaid programs across the country, they are only 83 percent of Medicare rates and their level dissuades physician participation in the program.¹¹ There has not been a Medicaid reimbursement rate increase in three years. Rate increases in the ACA are not expected to bring many new physicians into Medicaid, given that these rate increases are temporary and the state may have difficulty sustaining them. Medicaid-managed care rates are considered low in Virginia, reflecting budget pressures in the state attributable (to a considerable extent) to Medicaid; the response has been a tightening of budgets which ultimately has affected provider payment rates, and in turn, managed care rates. Medicaid-managed care rates are set such that plans have limited ability to pay more than fee-for-service payment levels, though they do pay more for some specialists and sometimes for primary care (e.g., pediatricians).

Hospital rates are also a problem, as hospitals have been able to avoid cuts in Medicaid rates, but there have been no increases for the past three years. Medicaid fee-for-service rates for hospitals are currently at about 68 percent of costs according to respondents. Hospitals generally do not sign contracts with Medicaid-managed care plans unless they pay at least the amounts in the fee-for-service rate schedule. Hospital rates in managed care are slightly above the fee-for-service rates but this varies across markets, depending on the relative market power of plans and hospitals. Thus, payment adequacy is a huge issue for hospitals with the possible expansion of coverage. There is a real concern among hospital representatives about the effects of the Affordable Care Act, especially those hospitals that rely heavily on Medicaid.

Disproportionate Share Hospital Payments

Virginia hospitals receive about \$190 million in disproportionate share hospital (DSH) payments annually. The bulk of the DSH payments go to the University of Virginia (UVA) and the Virginia Commonwealth University (VCU) health systems to help, along with graduate medical education payments, bring their reimbursement for Medicaid services up to the cost of care. These systems are also the largest providers of care to the uninsured in the state; DSH payments also contribute to the indigent care (up to 200 percent of FPL) provided by these hospitals. However, they are not the only hospitals in the state that serve the uninsured; many other hospitals also receive small (relative to UVA and VCU) amounts of DSH payments. When the DSH reduction under the ACA occurs, UVA and VCU could experience significant cuts. Currently, Medicaid pays hospitals at rates that are about 68 percent of costs. There have been discussions of using the forthcoming state savings on DSH to increase hospital reimbursement rates. But unless much of these savings are directed to UVA and VCU, they could experience losses relative to current payments for current Medicaid patients. Of course, they will be receiving Medicaid payments for people for whom they are currently not being reimbursed if the state expands eligibility under the ACA. If the state savings on DSH payments are used for across the board rate increases, all other hospitals will do better on Medicaid than they do today and be reimbursed for the majority of the costs of providing care to those uninsured who gain coverage.

Medicaid-Managed Care

Unlike the Medicaid program in general, Medicaid-managed care is popular among many state legislators. The state has six health plans participating in Medicaid-managed care, which provides care to children, pregnant women,

and the aged and disabled without long-term care. By July 1, 2012, managed care expanded to the deep southwest of Virginia, making Medicaid-managed care fully statewide. There are two to four managed care plans in all areas with managed care currently, and some may expand to other areas by 2014. The same plans are expected to take on the expanded Medicaid population. Though the state is concerned about the system's ability to take on large numbers of new lives, the plans believe that they can do so.

The six Medicaid plans are Anthem, Virginia Premier, Optima, MajestaCare, CareNet/Coventry and Amerigroup. Anthem serves most regions in the state, except for part of northern Virginia. Anthem has introduced a large HMO product called Health Keepers that it offers through Medicaid. The Health Keepers product has a more limited provider network than Anthem's commercial product and providers are paid at lower rates, a necessity given the state's managed care rates. CareNet is a commercial carrier that has a small Medicaid business. Amerigroup is a national for-profit chain that has a presence in northern Virginia and is expanding in the south and southwest regions. Optima is the managed care plan of the Sentara hospital system. It is based in the Tidewater area but has been expanding throughout the state. Virginia Premier is a plan of the VCU system. It too has been expanding throughout the state, contracting with providers outside the Richmond area. MajestaCare is an Aetna/Carilion product; the Carilion hospital system is at risk but Aetna manages the product. Carilion is a large hospital system based in Roanoke that has purchased many hospital and physician groups in southern and western Virginia.

Managed care struggled in Virginia when it was first introduced and was not popular, but it is now believed to be a major improvement upon the fee-for-service system. Plans must offer case management, chronic care management, and enhanced pre-natal care, which are not offered in fee-for-service. Managed care plans in Virginia

must obtain National Committee for Quality Assurance accreditation. Managed care has increased physician participation, resulting in better specialty and primary care networks than those for Medicaid fee-for-service. Many plans offer physicians per member per month fees of \$3 to \$5 that help pay for the administrative costs.

Plans are limited in their ability to negotiate rates for Medicaid products because of the market power held by large hospital systems—in particular, these are INOVA in northern Virginia, UVA in Charlottesville, the Carilion system in Roanoke, and the Sentara system based largely in the Tidewater area. Even rural areas have must-have hospitals with a form of market power. Anthem has more market power than other plans and seems to be able to negotiate better rates, though evidence on this is not solid. It is believed that most plans pay more than fee-for-service rates for primary care services. This is discussed in further detail below.

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Basic Health Program

There has been a limited interest in Virginia in adopting a BHP. It is recognized that a BHP would mean lower health care costs for beneficiaries and would reduce churning. The concerns that are raised are that a BHP would mean an expansion of a public program—Medicaid is not politically popular in the state—and would result in an even smaller exchange. Further, there is a risk to the state that federal payments would not cover the full cost of a BHP. Providers have raised concerns about being paid Medicaid rates for even more people. The general conclusion is that the state would not adopt a BHP.

PROVIDER AND INSURANCE MARKETS

It is generally expected that under the ACA, competition on price and quality in the insurance market will increase due to the elimination of opportunities to avoid high cost individuals (due to guaranteed issue, prohibitions of medical underwriting, risk adjustment, etc.), and increased numbers of individuals attracted to the nongroup insurance market (due to subsidized coverage for those with modest incomes and reforms of insurance market rules). The new structure of products within the exchange, e.g., gold, silver, bronze, etc., and consistent accessible information to allow consumers

to compare exchange-based plan options on benefits, price, and quality will also enhance competition.

Understanding the current structure of insurance industry competition is important as it will affect the extent to which these reforms will change the nature of the markets with which people are familiar, the extent to which the reforms will change the cost of plans in the group and nongroup markets, and the consumer choices that are likely to be available. In addition, the characteristics of insurance

markets and the actual level of competition engendered by the reforms will, in turn, determine the level of federal subsidy costs.

How health reform will affect health insurer competition in Virginia is uncertain. There is likely to be some increase in competition between insurers for the reasons described above, but much depends on which plans will be available among the lowest cost options in each geographic area. Enrollees in higher cost plans will face the full marginal cost of higher premiums above that of the second lowest cost plan, thus the competition to be a low cost competitor. In most markets it will be difficult for plans to be competitive with Anthem, which—together with Carefirst Blue Cross in northern Virginia¹²—is clearly the dominant insurer in the state. With its large market share and expansive networks, Anthem does better at negotiating with providers on rates and thus is able to offer products at a lower premium than other insurers.

The other insurers in the state are smaller and include Cigna, Coventry, and UnitedHealthcare. All lack the market clout of Anthem. Kaiser could be a strong competitor, but only in northern Virginia. A Medicaid-only plan such as Virginia Premier may be competitive with Anthem in some markets if they choose to participate in exchanges.

Optima, the insurance plan of the Sentara hospital system, is based in the Hampton Roads and Tidewater areas but is becoming important elsewhere in the state. Sentara has been buying hospitals in other parts of the state which allows Optima to compete elsewhere for covered lives. The Aetna/Carilion system now participates only in Medicaid but could be a strong competitor in the commercial and exchange markets in the Roanoke area and in the southwest with its large hospital system and physician networks. The Carilion hospital system has expanded provider capacity aggressively and is working with Aetna to develop insurance products that could be offered in markets well beyond Roanoke. In both cases, the connection to major hospital systems enhances their competitive positions.

In the current non-group market, Anthem also has the largest market share. Competing with Anthem are small out-of-state association trusts, such as Golden Rule and John Deere with about 25 percent of the market. Currently, they are not subject to Virginia state regulations but will have to comply with state and federal rules under the ACA. Many other health plans in Virginia are likely to participate in the individual market in exchanges.

Exchange markets and the premium pricing associated with them are expected to be local once all the ACA market reforms are in place, perhaps organized by the seven Medicaid regions. Anthem's market dominance and ability to negotiate rates is counterbalanced to some degree by the dominance of large health systems in their region. In areas that are more competitive on the provider side, Anthem has the upper hand in setting rates with hospitals. Generally, this is only in Richmond and central Virginia, where there is no single large dominant hospital, with VCU, the Hospital Corporation of America (HCA), and Bon Secours all having a significant presence.

In both concentrated and less concentrated hospital markets, however, hospital systems need to negotiate contracts with Anthem because of its substantial market share. Even insurers associated with large hospital systems such as Optima (Sentara) and Aetna (Carilion) need to offer at least some products that provide access to providers outside their systems, limiting their use of market power.

A major driving factor in the hospitalphysician integration is the growing acceptance from physicians that the future will be defined by electronic medical records, bundled payments, controls over readmissions, and that they need to be part of the system.

All insurers, including Anthem, have difficulty contracting with large hospitals for lower rates in other parts of the state, particularly in northern Virginia. Insurer competition on price is constrained by a high degree of concentration in the hospital markets. INOVA is close to being a monopoly in northern Virginia. Anthem, CareFirst and other insurers do not have significant market power vis-à-vis INOVA. The Carilion hospital system has substantial market power in the Roanoke area, as does Sentara system in the Tidewater area, though there is some competition with HCA in the Roanoke area and Bon Secours in the Tidewater area. Charlottesville is largely dominated by the UVA system, with some competition from the Sentara system, which has purchased hospital capacity in that area. It also is common for small hospitals to have substantial market power in rural areas. But despite the existence of some competition outside of northern Virginia, concentration is thought to be a substantial driver of health insurance costs in many areas of the state.

While the presence of large hospital systems constrains cost-containment efforts, at the same time these systems are clearly moving to expand clinical capacity and increase efficiencies. There has been a large increase in clinical integration throughout the state over the last decade. It is estimated that about half of actively practicing physicians are in some kind of employer arrangements with a health system. This varies regionally—it is less the case in northern Virginia where independent physicians continue to practice successfully. But in the southern part of the state, Carilion has been aggressively buying hospitals and hiring and contracting with physicians. Much of this is oriented toward expanding their primary care capacity in order to compete for new covered lives that will come with the ACA. Similar efforts are being made by Sentara. There are also efforts to move to clinical integration without entering into employer arrangements. This model is used by VCU, which tends to contract but not purchase physician practices.

A major driving factor in the hospital-physician integration is the growing acceptance from physicians that the future will be defined by electronic medical records, bundled payments, controls over readmissions, and that they need to be part of a system. Thus, physicians are more open to going into these arrangements than they have been in the past. The large hospital systems are convinced that they need to engage in greater care coordination and bundling, and to do so they will need more primary care capacity. The power of insurers over physicians in setting rates has been another factor in their decision to partner with hospitals. Various delivery system reforms are making it increasingly difficult to practice as an independent physician. The heightened scrutiny from government programs and insurers drives the trend toward integration.

Provider Capacity

Many stakeholders, including state officials, are worried about capacity and access, particularly in Roanoke and southwest areas. If Medicaid eligibility expands, enrollees will join one of the state's managed care plans. The state requires managed care plans to have strong networks. The issue is whether providers will participate more heavily in Medicaid at the rates the plans are able to pay. A key question is whether the state will accommodate the higher rates likely to be demanded by hospitals and doctors; the increase in some physician fees that is part of the ACA is not expected in itself to make much difference.

A major source of capacity to serve newly enrolled populations, both in Medicaid and in exchanges, is likely to come from hospital systems. Several of these systems, including but not limited to Carilion and Sentara, are expanding the purchase of physician practices. They use these physician practices as well as integrate ancillary personnel into their systems to increase capacity. They see the expansion of primary care capacity as a way to market products that provide a full range of services. Some are developing primary care medical homes and are taking steps to become accountable care organizations. These efforts are speeding the end of independent physician practices, as well as increasing the use of nurse practitioners, physician assistants, and other ancillary personnel in delivery of care.

The federally qualified health centers (FQHCs) are also likely to become a major source of care for the newly insured. Most managed care plans contract with FQHCs. The state has over 200 community health centers, including many in rural parts of the state. Community health centers get paid full cost under Medicaid, so it is more costly for the state which must pay the difference between the rates negotiated with managed care plans and full costs. Community health centers are attempting to expand capacity and are contracting with non-physician personnel to expand primary care capacity.

The access workgroup that was part of the VHRI process proposed expanding Virginia scope of practice laws, which would affect the range of services that could be provided by nurse practitioners and other ancillary personnel. Legislation was passed in 2012 expanding the range of responsibilities of nurse practitioners. There has been some resistance on the part of physicians to using mid-level practitioners. It is hoped that this will diminish as demand expands. There is also an increased use of nurse practitioners and physician assistants in free clinics, community health centers, and nursing homes.

There is concern that areas with provider shortages will remain such, given that mid-level practitioners seem to be locating in areas that have a plentiful supply of physicians. How much movement there will be into underserved areas is unknown. While there will be more money available to providers in more remote areas, this could simply mean that people with insurance cards will have to travel for medical care. There is some discussion that the larger systems, e.g., Sentara and VCU, will develop mechanisms, such as telemedicine and transport services, to bring individuals to their facilities for care rather than vice-versa. The state

has many free clinics, but these are staffed by physician volunteers and thus they tend to be located in areas with adequate physician supply. There is some talk that some free clinics will apply to become FQHCs as Medicaid expands.

Business

The business response to health reform has been generally negative, though state officials are starting to see signs of support as the law is better understood. Respondents have suggested that many meetings of the business community have not been balanced; they largely have stigmatized the ACA as bad for small businesses and driving up health care costs. On the other hand, small businesses have been extremely frustrated with the growth in health care costs, having experienced years of double-digit premium increases. However, they do not trust that government programs will do better or that the ACA will lead to more competition in the insurance market. Many respondents believed that small employers have a very limited understanding of the

ACA. Much of the opposition seems to be related to the individual mandate provision. It is believed that businesses will be more receptive to the ACA as they learn more about it, especially as they come to understand exchanges.

Large businesses are also worried about costs and want the system to become more efficient, but at the same time, they are worried about higher taxes and cost-shifting from low payment rates by public programs. Many continue to think that they cut a better deal with insurers on their own than they could by joining with others.

Secretary Hazel has pushed hard to engage the business community with the Virginia Center for Health Innovation, which is housed at the Chamber of Commerce. The Center is supported with funds from the hospital association, health plans, the medical society, and some law firms. The goal is to develop models of payment and delivery system reforms that would save money, increase quality, and improve health and worker productivity.

CONCLUSIONS

Thoughtful planning and stakeholder involvement has characterized the state's approach to reform, despite political controversy. The establishment of the Virginia Health Reform Initiative has allowed key legislators, insurers, hospital and physician representatives, employers, and others to engage in thoughtful discussion regarding the best reform options available under the ACA from the Virginia perspective. Engagement by stakeholders and others has been high, by all accounts, and the Exchange Council has developed a clear set of recommendations for exchange design. However, controversies remain over governance of the exchange, and the failure to actively consider legislation during the 2012 session has raised concerns as to whether the state will be able to accomplish all of the necessary tasks within the required federal timeframe.

The VHRI Advisory Council has taken Virginiaspecific preferences into account in developing a set of recommendations that are likely to be the least disruptive to current markets. These recommendations include: keeping the small group and nongroup markets distinct; delaying the expansion of small group size to firms of 100 or fewer workers until 2016; having the exchange act as a "passive purchaser"; and creating roles for both brokers and navigators in the exchange and allowing brokers to act as navigators. The Council's most controversial recommendation is to create a quasi-governmental entity to operate the exchange.

The state is taking advantage of federal funds to update their antiquated public insurance IT system.

State officials recognize that the current IT system needs substantial streamlining, and that web-based systems should replace the current system which relies heavily on caseworkers filing paperwork. They expect to release an RFP in the summer of 2012 for revamping the system. Integration with an IT system for a new exchange is not explicitly a part of the work being solicited; however, provisions for a potential add-on to do that will be included in the RFP, a sign of political reluctance to fully engage in exchange development. The short time for developing a system and having it up and running before a large number of people gain program eligibility in January 2014 is considered a tremendous challenge facing the state.

The state efficiently passed legislation to conform state insurance regulations for the ACA's early implementation reforms. Both industry and regulatory sources suggest that the implementation of the reforms that went into effect in 2010 went smoothly. Any premium effects appear to have been modest. There is an expectation, however that the Bureau of Insurance will need to increase its staff in form and rate reviews, plan management and qualification issues, and actuarial expertise to meet the demands of the 2014 reforms.

Virginia could have an expansion of about 400,000 new enrollees in Medicaid in 2014, if the state adopts the ACA's Medicaid expansion. This represents a 40 percent increase in the number of enrollees in the program. The state expects significant new costs because of the expansion but acknowledges savings from reductions in state DSH payments, pharmacy rebates, and the increase in CHIP matching rates. There is significant concern in the state over the impact of federal DSH reductions on the state's major safety net hospitals.

The recession has had a major impact on the state's Medicaid program. Medicaid enrollment has increased, but at the same time state revenues have declined. The state's response to budget pressures was cuts and freezes in provider payment rates. Physician fees are relatively high by standards of other state Medicaid programs, but considered inadequate by physicians. As a result, large numbers of physicians do not participate in the program. It is not expected that the physician fee increase in the ACA will bring many new physicians into Medicaid, given prevailing attitudes.

Medicaid-managed care is strong in Virginia. The largest of six managed care organizations is Anthem's Health Keepers Plan, which has a more limited network than its commercial product. Major competitors to Anthem are Virginia Premier, the Medicaid-managed care plan of the VCU hospital system; Optima, the health plan of the Sentara hospital system; and Aetna, particularly in the Roanoke area where it has an allegiance with the Carilion hospital system. All plans are expanding into the southern and southwestern parts of the state where much of the eligibility expansion is likely to occur.

Competition among insurers will intensify with health reform. Currently, Anthem is the dominant insurer in the state. With the largest market share in both individual and group markets, Anthem does better than most insurers in negotiating provider payment rates. There are a large number of other insurers in the state, including Aetna, Cigna, UnitedHealthcare, and Kaiser; they all currently face difficulties in competing with Anthem. The managed competition structure of exchanges places a premium on becoming one of the two lowest cost plans in an area. This is likely to include Anthem because of its current market power vis-à-vis providers, but much depends on which other plans compete in the market. For example, if Virginia Premier offers its network and competes in exchanges, it is likely to be a formidable competitor. Similarly, the Optima/Sentara and Aetna/Carilion systems could also be strong competitors in the Tidewater and Roanoke areas, respectively.

There is considerable concern over provider capacity in the state. It is not expected that increases in participation among privately practicing physicians will contribute much to solving the capacity problem. Rather, many expect that large hospital systems that have been purchasing physician practices are moving to develop the primary care capacity necessary to attract new enrollees. The state also has a large number of community health centers, which are also seen as a major part of the solution. The state has been increasing its efforts to expand the role that nurse practitioners play in providing primary care. A major problem is providing additional capacity in the southern and southwestern parts of the state, where sizable enrollment increases will occur. Even mid-level professionals seem to resist locating in these areas, therefore expanding capacity in the rural areas will be a substantial challenge for the state. There is also hope that telemedicine initiatives will expand capacity in these areas.

About the Authors and Acknowledgements

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The Urban Institute is a nonprofit, nonpartisan policy research and educational organization that examines the social, economic and governance problems facing the nation. For more information, visit www.urban.org.

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- 12. By charter, Blue Cross Blue Shield plans cannot compete against each other. In Virginia, Carefirst is the BCBS plan in the northernmost part of the state, while Anthem is the BCBS plan covering the remainder of the state.