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Richmond

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Federal Exchange Option and Indecision on Medicaid Expansion Create Uncertainty for Richmond, Va., Market

Whether Virginia will expand Medicaid, along with development of a federally run insurance exchange, has created uncertainty for Richmond health insurers and providers, according to a new Center for Studying Health System Change (HSC) study of the region's commercial and Medicaid insurance markets (see Data Source). The state has not yet decided whether to expand Medicaid eligibility, citing long-term cost concerns. In April 2013, Virginia enacted legislation outlining a series of specific reforms intended to control Medicaid costs that must be achieved before the expansion is allowed to proceed. Market observers have predicted that other factors may also contribute to delays and implementation uncertainties, including the tabling of Medicaid expansion decisions until a new gubernatorial administration is in place and delays in information concerning how the federal exchanges will operate in states like Virginia.

Key factors likely to influence how national health reform plays out in the Richmond health care market include:

- ***A relatively unregulated commercial insurance market.*** Virginia is one of two states that do not restrict premium rating in the nongroup and small-group (2-50 workers) markets. New modified community rating and guaranteed issue rules under the ACA may prompt more significant changes in insurance premiums in Richmond than in other markets.

- ***Narrow Medicaid eligibility***. Except for children and pregnant women, the state is quite restrictive with Medicaid eligibility for adults.

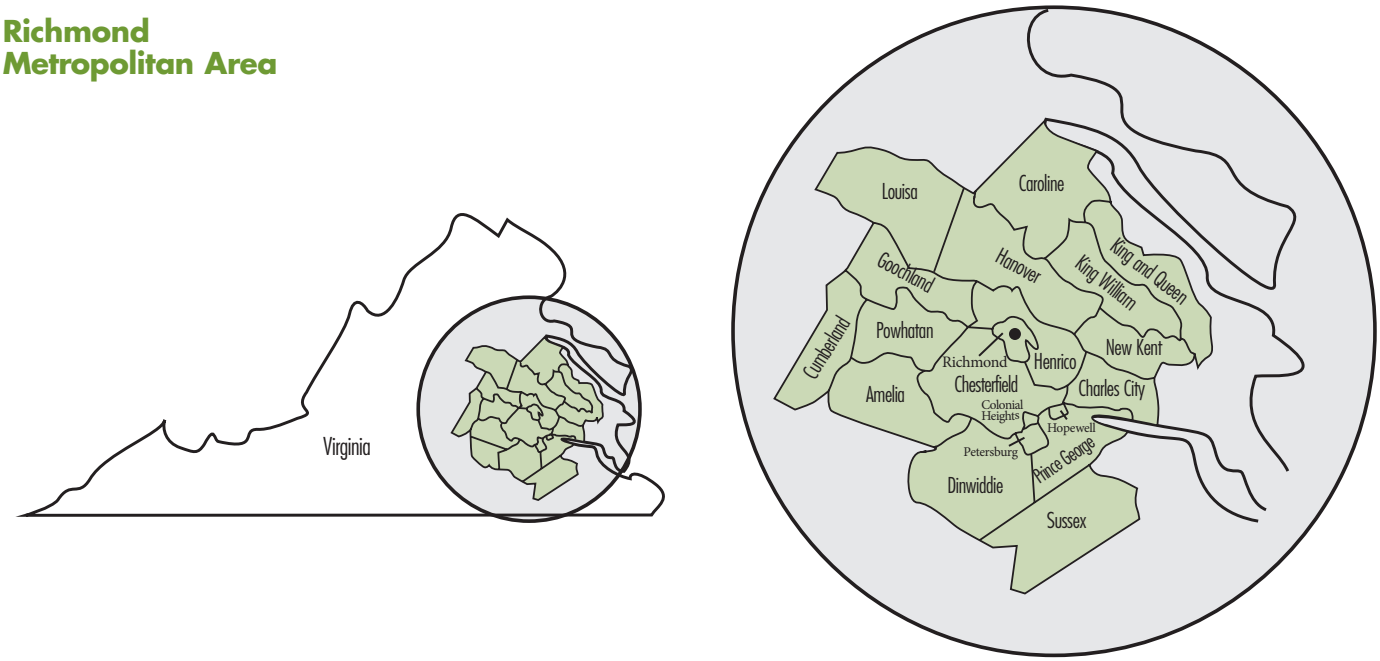
- ***Minimal health plan competition***. Anthem Blue Cross Blue Shield is considered the dominant insurance carrier in the nongroup and small-group markets, with a handful of local and national plans—Optima, Coventry/Aetna and Cigna—vying for the remaining market share. National carriers are more competitive with Anthem in the large-group market. Respondents suggested that other carriers may be gaining on Anthem.

- ***A broad array of traditional insurance products.*** Comprehensive insurance products remain popular in Richmond, whether through health maintenance organizations (HMOs), preferred provider organizations (PPOs) or point of service (POS) plans. Differences among product types have blurred, and all typically offer low cost sharing and broad provider networks. Enrollment in new products, such as high-deductible health plans (HDHPs) and limited-network products, is increasing but remains minimal.

- ***Competitive provider market.*** Three main hospital systems—state-owned Virginia Commonwealth University Health System (VCUHS), nonprofit Bon Secours and for-profit HCA—compete for patients on both sides of the James River, which divides the region. Health plans tend to contract with all three to meet consumer demand for provider choice and service-line coverage. While hospital employment of physicians has increased, many physicians avoid arrangements that limit where they can admit patients.

- ***Stable Medicaid managed care program.*** In an effort to control costs, Virginia has been a strong proponent of placing Medicaid enrollees in risk-based managed care. In the Richmond market, three of the four largest Medicaid plans are subsidiaries of commercial carriers. Anthem's HealthKeepers Plus plan has long held the

Richmond Metropolitan Area



largest share of Medicaid enrollees, with three other plans—Optima, Virginia Premier Health Plan (owned by VCUHS) and CoventryCares of Virginia—dividing the rest.

- ***Federal exchange decisions.*** The state opted for a federally run health insurance exchange but will maintain some role in plan management for the exchange. Brokers expect to play a key role in selling exchange products.
- ***Uncertain Medicaid preparations.*** State agencies, health plans and other organizations involved in Medicaid are on alert for what could be a significant increase in Medicaid enrollees if the state ultimately decides to expand the program to include all eligible residents with incomes up to 138 percent of the federal poverty level. If the state forgoes expansion, many people will remain uninsured, and providers could face challenges caring for the uninsured with diminished financial resources.

Market Background

The sprawling Richmond metropolitan area includes 16 counties and four incorporated cities (see map).[1] Although the city of Richmond serves as the state capital, much of the metropolitan area is sparsely populated—with a total of 1.3 million residents, the region is the third largest in the state. However, the area is growing: Richmond's population increased 7.4 percent over the past five years, compared with 4.6 percent for metropolitan areas overall (see Table 1). The region is home to a larger proportion of black residents than other metropolitan areas—30 percent compared to the metropolitan average of 14 percent—but other minority groups make up only about 10 percent of the population compared with 30 percent in metropolitan areas as a whole.

The Richmond economy is anchored by a large government presence and several large private employers, including the HCA and Bon Secours hospital systems. More than 18 percent of workers are employed by the public sector, including Virginia Commonwealth University and its health system.[2] And, the area is home to Capital One Financial Corp.; Dominion Resources, the local power and energy provider; and Altria, a major tobacco company.

The area's stable employment base has contributed to well-paying jobs that typically offer health coverage. Compared to the average metropolitan area, Richmond has lower unemployment, higher incomes and higher levels of private health coverage. The region also has a lower rate of uninsured people compared to the average metropolitan area—13.3 percent vs. 17.0 percent. However, Richmond-area residents are more likely to smoke, be

obese, and have heart disease or diabetes. Even so, residents are less likely to consider themselves in fair or poor health than residents in other metropolitan communities.

Still, socioeconomic status varies across the region. Residents to the west of Richmond—including the counties of Hanover, Chesterfield, Powhatan and Goochland—enjoy some of the highest incomes and health outcomes in the state, while residents in Richmond and some of the southeastern areas—the cities of Hopewell and Petersburg and Sussex County—have much lower incomes and more health problems.[3]

Limited Insurance Regulation and Public Coverage

Virginia has a relatively unregulated commercial insurance market, resembling southern states more than other Mid-Atlantic states. One commercial health plan respondent described the market as "more insurance friendly [than markets in nearby states]." In key examples, Virginia is one of two states—Hawaii is the other—that does not impose any rate restrictions in the nongroup or small-group markets; plans can vary rates according to many factors, including an enrollee's age, health status and gender (see Table 2).

Virginia requires Anthem Blue Cross Blue Shield, a WellPoint subsidiary, to offer coverage to any individual with a pre-existing condition or who is otherwise unable to obtain other commercial insurance, yet rates can be high, and the state does not provide subsidized coverage through a high-risk pool.[4] Nongroup rate increases are subject to approval by the Virginia Department of Insurance, and small-group plans must file rate increases with the state for informational purposes.

Through Medicaid and the state Children's Health Insurance Program (CHIP), Virginia offers coverage to children and pregnant women at income-eligibility thresholds that are on par with many other states. Virginia Medicaid covers pregnant women and children 5 and younger with incomes up to 133 percent of poverty—or $31,322 for a family of four in 2013—but covers children aged 6 to 19 only up to the poverty level. CHIP, referred to as Family Access to Medical Insurance Security in Virginia, extends coverage to children and pregnant women up to 200 percent of poverty.

Table 1
Demographics and Health System Characteristics

	Richmond	Metro Areas (800,000+ Pop.)
Population Statistics, 2010	1,260,396	
Population Growth, 10 Year	14.9%	10.9%
Population Growth, 5 Year	7.4%	4.6%
Age		
Persons Under 5 Years Old	6.3%	6.6%
Persons Under 18 Years Old	23.2%	24.3%
Persons 18 to 64 Years Old	64.7%	63.7%
Persons 65 Years and Older	12.1%	12.0%
Race/Ethnicity		
White	59.7%	55.6%
Black	29.9%	14.1%
Latino	5.0%	20.6%
Asian	3.0%	6.8%
Other Race or Multiple Races	2.3%	2.9%
Foreign Born	7.2%	17.8%
Limited/No English	3.8%	11.7%
Education		
High School or Higher	86.0%	85.9%
Bachelor's Degree or Higher	31.7%	32.4%
Health Status		
Asthma	12.0%	13.7%
Diabetes	9.8%	8.7%
Angina or Coronary Heart Disease	5.7%	3.7%
Overweight or Obese	67.2%	62.1%
Adult Smoker	19.6%	15.2%
Health Status Fair or Poor	9.9%	14.7%
Economic Indicators		
Less than 100% of Federal Poverty Level (FPL)	11.6%	14.2%
Less than 200% of FPL	27.6%	31.9%
Household Income Above $100,000	23.4%	24.4%
Unemployment Rate 2011	6.9%	9.0%
Health Insurance		
Uninsured	13.3%	17.0%
Medicaid/Other Public	8.6%	12.5%
Privately Insured	62.6%	56.3%
Medicare	10.1%	10.0%
Other Combinations	5.3%	4.3%
Hospitals		
Hospital Beds Set Up and Staffed per 1,000 Population	3.5	2.8
Average Length of Stay, 2010 (Days)	6.3	5.7
Health Professional Supply		
Physicians per 100,000 Population	204	207
Primary Care Physicians per 100,000 Population	82	82
Specialist Physicians per 100,000 Population	122	125

Sources: U.S. Census Bureau, 2010; American Community Survey, 2010; Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2010; Bureau of Labor Statistics, 2011; American Hospital Association, 2010; Area Resource File, 2011

Richmond's commercial health insurance market is largely stable, with limited competition among carriers. Anthem Blue Cross Blue Shield, formerly Trigon Blue Cross Blue Shield, is the long-standing dominant insurer.

However, Virginia Medicaid covers relatively few other adults. Parents earning up to 25 percent or 31 percent of poverty, depending on employment status, can receive Medicaid coverage, but nondisabled, childless adults at any income level are ineligible.

Stable Commercial Insurance Market

Richmond's commercial health insurance market is largely stable, with limited competition among carriers. Anthem Blue Cross Blue Shield, formerly Trigon Blue Cross Blue Shield, is the long-standing dominant insurer. According to some market observers, the long history of the Blue plan's dominance and Richmond's relatively small size have made the region a less compelling target for national competitors, allowing smaller, regional insurers to play a more significant role than in some communities. A handful of carriers divide the rest of the market, including Optima Health, owned by Sentara Healthcare, a dominant southeastern Virginia health system, as well as national players Coventry Health Care, now part of Aetna, UnitedHealth Group and Cigna. The merger of Trigon with Anthem in 2002, and Anthem's merger with WellPoint in 2004, reportedly has had little impact on the Blue plan.

Respondent estimates of Anthem's market share ranged from about 40 percent to 60 percent. Its presence is largest in the nongroup sector, where it has around three-quarters of the market, and the small-group sector, where it has about half of the market. With brokers playing a large role in the sales of small-group and nongroup products—albeit a smaller role for nongroup—one respondent suggested that Anthem's market share is buttressed by a cadre of loyal brokers who once worked for Anthem. United and Coventry divide the rest of the nongroup market. These three plans, plus Optima, serve the small-group market. In contrast, the large-group market is a more balanced mix of Anthem, Aetna, United, Cigna and Optima; respondents indicated that the large-group market is competitive enough that large employers have some ability to obtain lower premiums and customized products from carriers.

Some respondents reported that Anthem's hold on the Richmond insurance market may be eroding. Respondents predicted that Aetna's acquisition of Coventry will provide entry into the nongroup market and more fully insured small-group clients. Also, Sentara, Optima's owner, has purchased hospitals in other major Virginia cities, including Fredericksburg, about 60 miles from Richmond, but outside the study area. These developments may affect Anthem's ability to negotiate discounts with providers across the state and impact premiums for Richmond employers whose reach extends beyond the metropolitan area.

Traditional Plan Offerings

Overall, respondents characterized the Richmond commercial insurance market as conservative, comprised of traditional product designs, broad provider networks, mid-range levels of patient cost sharing, and few payment innovations. While Anthem still sells many primary care-gatekeeper HMO products based on its ability to gain discounts with a core set of providers, other carriers have migrated to open-access POS products to respond to consumer demand for more flexible networks.

Still, differences among product types have blurred in recent years. For example, Anthem's HMO network was described by a health plan executive as "a subset of the PPO network but a close subset." As costs increased, many HMO products have adopted deductibles and coinsurance requirements to keep premiums more affordable. Respondents reported that deductibles for single coverage varied widely—from $350 to $2,000 across all market segments—although smaller groups tend to have larger deductibles.

Enrollment in high-deductible health plans eligible for tax-advantaged savings accounts for medical expenses reportedly has grown, but these products are not as prevalent in Richmond as in some markets. Respondents' estimates of current HDHP penetration ranged from 10 per-

Table 2
How Do Virginia State Laws Compare to Major Provisions in the Affordable Care Act (ACA)?

ACA PROVISION (EFFECTIVE DATES)	VIRGINIA LAW BEFORE THE ACA
Making Coverage Available and Affordable	
High-Risk Pool (2010-2014): States must have in place a federally financed, temporary high-risk pool that provides coverage to individuals with pre-existing conditions who have been uninsured for at least six months.	Virginia does not have a state high-risk pool. Anthem Blue Cross Blue Shield serves as the insurer of last resort for the nongroup market and must offer coverage to anyone who is unable to obtain other commercial insurance.
Medicaid Expansion (2014): States have the option to expand Medicaid coverage to 138% of the federal poverty level (FPL) for individuals (U.S. citizens and legal immigrants residing in the country at least five years) under age 65. Coverage of newly eligible individuals will be fully funded by the federal government until 2016, with support gradually declining to 90% of cost by 2020.	Virginia's CHIP and Medicaid programs cover children up to 133% of FPL, pregnant women up to 200% of FPL, working parents up to 31% of FPL and unemployed parents up to 25% of FPL. Childless adults are not covered under these programs. One estimate predicts a 51% increase in Virginia's Medicaid enrollment under the ACA expansion of eligibility to 138% FPL.[1]
Regulating the Private Insurance Market	
Guaranteed Issue (2014): Carriers must offer a policy to everyone who applies for coverage. (Prior to the ACA, federal law required that guaranteed issue apply to small-group plans and that guaranteed renewability apply to both small-group and nongroup plans.)	Virginia does not require guaranteed issue in the nongroup market.
Modified Community Rating (2014): Carriers cannot base insurance premiums on an individual's health status but can base premiums on age (limited to a 3 to 1 ratio); geographic area; family composition (single vs. family coverage); and tobacco use (limited to a 1.5 to 1 ratio).	Virginia does not impose any restrictions on factors commercial insurers use to vary rates.
Review of Premium Rate Increases (2010): Carriers must justify particularly large premium rate increases to the federal government and state.	All rate increases in the nongroup market are subject to prior approval at the state level. Nongroup HMOs and small-group plans in Virginia must file any rate increase over 10% with the federal government.
Medical Loss Ratios (2010 and 2011): Since 2010, carriers must report the share of premium dollars spent on clinical services, quality initiatives, administrative and other costs, and since 2011, provide rebates to consumers or reduce premiums if the share of premiums spent on health care services and quality initiatives is less than 85% for large-group plans or 80% for nongroup and small-group plans.	Virginia had a medical loss ratio requirement in the nongroup market prior to the ACA, but it was not as stringent as ACA requirements. There were no medical loss ratio requirements in the group markets.

[1] Kenney, Genevieve M., et al., *State and Local Coverage Changes Under Full Implementation of the Affordable Care Act*, prepared by the Urban Institute for the Kaiser Commission on Medicaid and the Uninsured, Washington, D.C. (July 2013).

Sources: Authors' analysis of existing state regulations and ACA provisions; Kaiser Family Foundation State Health Facts, Virginia: Health Insurance & Managed Care, http://kff.org/state-category/health-insurance-managed-care/?state=VA, *(accessed Sept. 15, 2013); Kaiser Family Foundation,* State Exchange Profiles: Virginia, http://kff.org/health-reform/state-profile/state-exchange-profiles-virginia/, *(accessed Sept. 15, 2013); Kaiser Family Foundation,* Summary of the Affordable Care Act, *Menlo Park, Calif. (April 23, 2013)*

cent to 20 percent of commercial enrollees, reportedly up from about 5 percent a few years ago. Respondents attributed the increase in HDHP enrollment to rising premiums across other product types, which over the past few years reportedly have reached the point where "the math makes sense" to switch, according to one respondent. Employers do not typically provide HDHPs as full-replacement products, instead offering enrollees at least one other plan choice.

Market observers generally reported that the major plans' product offerings and networks are similar enough that employers regularly shift workers to different carriers to obtain lower premiums. Yet other respondents noted some differentiating characteristics among carriers: Anthem was reported to have the broadest networks and deepest provider discounts, while Cigna has the most publicly promoted wellness programs, and United is known for using claims data to analyze enrollees' care-seeking patterns.

Providers Compete on Both Sides of the River

Three main hospital systems serve the market: nonprofit Bon Secours Richmond Health System, part of the national Catholic Bon Secours system; for-profit HCA Virginia, an affiliate of the national HCA chain; and VCUHS, a part of the state university system.

To varying degrees, these systems serve both sides of the James River, which divides the region; residents tend to seek care on the side of the river where they live. Three of Bon Secours' four Richmond hospitals are on the north side of the river and one is on the south side. HCA's six Richmond hospitals are split, with three south of the river and three on the north side. VCUHS's hospital and outpatient facilities are concentrated just north of the river in downtown Richmond, while maintaining some outpatient diagnostic and specialty physician services south of the river. Perhaps related to the demand for facilities on a specified side of the river, the Richmond market has more hospital beds and longer lengths of stay than the average metropolitan area.

Given consumer demand for broad provider choice and physicians' referral patterns, employer and health plan efforts to limit choice of providers to help control costs have gained little traction in the Richmond market.

In addition to needing broad geographic coverage, health plans reportedly need all three hospital systems in their networks to provide adequate access to different services. As an academic medical center, Level 1 trauma center and provider of other subspecialty services, VCUHS draws patients from across the city and is vital to insurers' networks.

Both HCA and Bon Secours have expanded into more affluent suburban areas, with both systems opening free-standing emergency departments to draw patients. Bon Secours recently opened a facility near its St. Francis hospital south of the river, and HCA opened a facility in Richmond's northwestern suburbs.

In another strategy to gain patient referrals, hospitals increasingly are employing or otherwise aligning with more primary care and specialty practitioners. Bon Secours employs almost 300 physicians through two groups and affiliates with physicians through inHEALTH, a physician hospital organization owned by large physician groups and health systems in Virginia that helps affiliated practices establish patient-centered medical homes and provides other practice and patient management activities. VCUHS employs more than 600 physicians through Medical College of Virginia Physicians, which admits patients primarily to VCUHS. Still, respondents suggested that many physicians remain independent and shun employment or other arrangements that limit where they can admit or refer patients.

Given consumer demand for broad provider choice and physicians' referral patterns, employer and health plan efforts to limit choice of providers to help control costs have gained little traction in the Richmond market. Tiered-network arrangements, where enrollees face lower cost sharing if they use a provider in the preferred tier, are not actively promoted by health plans, though reportedly they are available to large, self-insured employers that request them. With no health plan dominating the large-group market and having sufficient leverage over providers, past attempts at creating narrow networks—that give members access to a significantly smaller subset of the carrier's standard provider network—proved unsuccessful, and these products are largely nonexistent in the market today.

Respondent views differed as to whether hospital-physician alignment is extensive enough to facilitate significant development of accountable care organizations (ACOs) where groups of providers take responsibility for the cost and quality of care of a defined patient population. Bon Secours has entered an ACO agreement with Aetna in five states, including Virginia,[5] and Cigna has developed the "Collaborative Accountable Care" initiative with the Bon Secours physician group.[6] The market has no Medicare Pioneer ACOs, but Bon Secours and Aetna recently formed a Medicare shared-savings ACO called Good Help.

Stable Medicaid Managed Care

Approximately two-thirds of Virginia's Medicaid enrollees are in risk-based managed care arrangements.[7] Managed care for aged, blind or disabled enrollees, as well as pregnant women and children, was implemented on a geographic basis; Richmond adopted managed care in the late-1990s, while the southwest region of the state was the last to transition to managed care in mid-2012. Also, Richmond recently piloted a program for moving children in foster care and adoption assistance into managed care, and this program is now being implemented statewide. As one plan executive said, "The state may be dead set against expanding Medicaid, but they are very interested in managing the populations that are currently in Medicaid."

Richmond's mature Medicaid managed care market has been served by the same four health plans holding "exceptionally static" market shares, in the words of one plan executive, over the past 15 years. With approximately 40 percent market share, Anthem's HealthKeepers Plus product is the largest player in Medicaid. Two provider-sponsored plans—Optima Family Care and Virginia Premier Health Plan, which is owned by VCUHS and only covers Medicaid enrollees—follow in membership, with 22 percent and 20 percent market share, respectively. For-profit CoventryCares of Virginia is the smallest plan, with 17 percent of enrollees.[8]

While additional plans could enter and compete in the Richmond Medicaid market, the four plans' favorable reputations and symbiotic relationships with the state reportedly have served as an entry barrier. The state places high value on strong quality scores; Virginia was the first state—there are now 11—to require Medicaid plans to be accredited by the National Committee for Quality Assurance. Also, state payments to plans are adjusted according to the risk profile of plans' enrollees and their overall financial status, ensuring that plans earn a profit but only a small one.

Respondents varied in their perceptions of differences among Richmond-area Medicaid plans. A market observer described "distinguishable cultures and identities" among the plans that are important to the state and enrollees—for example, Virginia Premier's close relationship with VCUHS providers and Anthem and Coventry's favorable reputations as commercial plans. A plan executive noted differences in enhanced benefits—for example, eyeglass discounts—while another discussed different care and utilization management programs. However, another Medicaid plan executive noted little differentiation among plans, saying, "The state assigns most Medicaid enrollees randomly to a health plan because most enrollees do not choose one themselves or switch plans, because there is no difference between [plans] at all. We have the same network, same services and approach things the same way."

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Indeed, the Medicaid plan networks include a common set of safety net providers. VCUHS is the main safety net hospital and key provider of both inpatient and outpatient care, especially specialty services, and certain Bon Secours and HCA facilities, depending on location, reportedly also serve many Medicaid enrollees. Medicaid plans are required to contract with the federally qualified health centers, with Capital Area Health Network and Daily Planet serving as the main centers in Richmond. Respondents also pointed to small minority physician practices in Richmond that serve many low-income people. At approximately 80 percent of Medicare physician payment rates, Virginia's Medicaid rates are relatively higher than many states', which may help ensure provider participation.[9] Richmond Medicaid plans largely still pay providers on a traditional fee-for-service basis, with little in the way of innovative payment arrangements.

Rocky Road to Reform

Political wrangling and delays at the state level have made the path to reform a tumultuous one in Richmond. Virginia's minimally regulated commercial health insurance market and limited Medicaid eligibility mean that the scope of changes required to fully implement the ACA is

Virginia's minimally regulated commercial health insurance market and limited Medicaid eligibility mean that the scope of changes required to fully implement the ACA is larger than in many other states.

larger than in many other states (see Table 3). This uncertain environment and the extent of required changes make it difficult to predict the impacts on the commercial and Medicaid insurance markets.

Despite initially enacting legislation declaring the state's intention to develop a state-run exchange, Virginia in December 2012 announced that it would instead default to a federally facilitated exchange.[10]

Although Virginia's exchange will be federally run, the state intends to retain responsibility for certain plan management functions, including collecting and analyzing data from health plans on premiums, cost sharing and benefits, recommending plans for qualified health plan certification, recertification or decertification, and transmitting data to the federally facilitated eligibility and enrollment platform. The federal government will review the state's recommendations, establish and maintain the exchange website, conduct eligibility and enrollment activities, and operate the risk-adjustment program. Virginia has opted not to perform consumer assistance functions, such as handling complaints and assisting consumers with issues related to tax credits, which will instead fall to the federal government.[11] Virginia selected the largest small-group plan, an Anthem PPO, as the benchmark for essential health benefits. Respondents generally regarded this plan as offering an average level of coverage.

Still, in Richmond, as across the country, insurance carriers expressed similar questions and concerns about setting premiums for products offered in the exchange, including:

- Risk pools—how sick will the newly insured be compared to the currently insured? Will the young and healthy not enroll because of higher rates and instead pay the tax penalty? Which small groups will drop coverage and how will this affect the risk pool?
- Pent-up demand—will the newly insured make up months and years of forgone care by using large amounts of medical care?
- Expanded benefits—how much utilization will occur, and how much will premiums increase because ACA minimums exceed benefits of many existing plans, especially in the nongroup market?
- Risk adjustment—how will the health status of enrollees be measured, and how will funds be redistributed among carriers? Will this process adequately account for differences in risk profiles of plan members?

Given Virginia's current lack of rating restrictions for nongroup and small-group coverage, new ACA requirements likely will compress premiums more than in other states, potentially generating premium spikes for younger, healthier people and more affordable rates for older, sicker people. Along with these broader concerns, there are some ways these issues could play out more specifically in the Richmond market.

Plan participation in the exchange. The state recommended several nongroup and small-group products for the federal exchange, with the actual number of choices varying by locality. In the core Richmond market, Aetna, Coventry, Anthem and Optima are offering products in the nongroup exchange,[12] and Anthem and Optima will offer in the small-group exchange. United and Cigna have opted not to participate in 2014.

Changes in product design. Although Richmond historically has had little appetite for limited-network products, some respondents predicted that such products would grow incrementally in the exchange environment. This prediction is related to respondents' belief that currently uninsured individuals purchasing coverage through the exchange will be more receptive to trading provider choice for a lower premium, particularly when state health exchanges make the trade-off between network breadth and cost more transparent. In preparation, Anthem is developing a product that tiers hospitals and physicians as well as a narrow-network option. And, Cigna plans to offer a

Table 3
Implementing the Affordable Care Act (ACA): Virginia's Key Decisions

ACA PROVISION	VIRGINIA'S DECISION
Insurance Exchanges: By 2014, states must have in operation insurance exchanges selling products to individuals and small groups. States may operate their own exchanges, partner with the federal government to operate their exchanges, or allow the federal government to operate and administer their exchanges. Federally operated exchanges will offer one small-group plan in 2014; states choosing to operate their own small-group exchanges now have until 2015.	The federal government will operate Virginia's health insurance exchange and perform consumer assistance functions, though the state intends to retain responsibility for certain plan management functions, such as collecting and analyzing data from health plans, recommending plans for qualified health plan certification, recertification or decertification, and transmitting data to the federally facilitated eligibility and enrollment platform.
Nongroup and Small-Group Markets & Exchanges: States have the option to merge the risk pools of the nongroup and small-group markets; they also may operate a combined small-group and nongroup exchange, provided the exchange has adequate resources to assist both small employers and individuals in purchasing coverage.	Virginia will not merge the nongroup and small-group markets or risk pools.
Passive vs. Active Purchaser: States will decide the degree to which their exchanges will regulate health insurance products. States may allow any insurance product that meets the minimum federal requirements to be sold through the exchange, referred to as a clearinghouse model. Or, states may select plans to be offered in the exchanges based on additional requirements, referred to as an active purchasing model.	The federally facilitated exchange will use the clearinghouse model in 2014.
Tools to Reduce Adverse Selection: States must adopt a risk-adjustment model for nongroup and small-group health plans, in which they collect payments from plans with relatively healthier enrollees and redistribute these funds to plans with relatively sicker enrollees.	Federal government will administer risk adjustment until December 2015
Essential Health Benefits Package: States must select a health benefits package that establishes a benchmark level of minimum coverage for plans sold in the exchange (and non-grandfathered plans sold outside the exchange). For this essential health benefits package, states may choose: 1) one of the three largest (based on enrollment) small-group insurance products; 2) one of the three largest state employee health plans; 3) one of three largest Federal Employee Health Benefit Program plan options; or 4) the largest insured commercial health maintenance organization.	Small-group plan (Anthem Preferred Provider Organization)

Sources: Authors' analysis of existing state regulations and ACA provisions; Kaiser Family Foundation State Health Facts, Virginia: Health Insurance & Managed Care, http://kff.org/state-category/health-insurance-managed-care/?state=VA, *(accessed Sept. 15, 2013); Kaiser Family Foundation,* State Exchange Profiles: Virginia, http://kff.org/health-reform/state-profile/state-exchange-profiles-virginia/, *(accessed Sept. 15, 2013); Kaiser Family Foundation,* Summary of the Affordable Care Act, *Menlo Park, Calif. (April 23, 2013)*

narrow-network product in the nongroup market. Still, these efforts appear modest in scope compared with some other markets.

Concerns that employers will sidestep regulations. Richmond respondents voiced concerns about employers taking steps to avoid triggering certain ACA requirements. Earlier this year, Virginia passed a budget amendment stipulating that hourly wage employees of state agencies may not work more than 29 hours per week.[13] The rule ensures state employers will be in compliance with the ACA without incurring the costs of expanding coverage to additional classes of employees. Respondents expected some private employers with a high concentration of variable-hour or seasonal workers—particularly those in the retail and hospitality industries—to similarly limit employees' hours to reduce the number of employees deemed full-time workers under the ACA.

Richmond respondents also noted interest among smaller employers in self-insurance as a way to circumvent excise taxes on insurance carriers, community rating and essential health benefits requirements under the ACA. Reportedly

health plans are willing to administer self-funded contracts for increasingly smaller employers in recent years. Virginia does not have any restrictions on stop-loss insurance—secondary coverage an employer buys that covers the cost of medical claims beyond a certain threshold—and respondents were not aware of any plans for the state to enact regulations to restrict self-insurance.

Ongoing role for brokers. Brokers typically felt secure about having a role on the exchange, and some even expected additional opportunities under reform. Brokers predicted significant demand for their services as individuals and small groups move into the exchange environment and need information about new product offerings and subsidies. Similar to some states, Virginia has passed legislation prohibiting navigators on the health exchange from engaging in activities requiring a broker license or acting as intermediaries between employers and insurers, thereby distinguishing the role of brokers as distinct from navigators.[14] Moreover, brokers expected that a large portion of small-group business will remain off the exchange, meaning the market—and their role in it—will continue to operate largely as it does today.

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Addressing churn. With both Medicaid and commercial lines of business, many health plans in Richmond could readily compete on the exchange for a slice of the subsidized population and minimize the impact of "churn"—that is, movement of individuals between Medicaid and subsidized private coverage if their incomes fluctuate. Virginia Premier—the only Medicaid plan without a commercial license—is not entering the exchange in 2014, related in part to concerns that minimal individual-mandate penalties will lead to major adverse selection among the subsidized population.

Uncertain Medicaid expansion. The governor's bill to control costs in the Medicaid program as a condition of expanding eligibility outlines 19 initiatives, with many centered on tightening managed care practices and covering more populations through managed care.[15] The bill also created a new bipartisan commission, the Medicaid Innovation and Reform Commission, charged with reviewing, implementing and monitoring the progress of reform proposals. The commission will meet periodically and, by the end of the year, advise the state Legislature whether to proceed with the Medicaid expansion for July 2014.

However, some respondents viewed the push for Medicaid reforms as mainly political posturing, claiming that the state's Medicaid program is already quite efficient. Many predicted that Medicaid expansion largely will depend upon the outcome of the November 2013 gubernatorial election.

Given the stringent eligibility rules currently in place in Virginia, an expansion of Medicaid could mean a significant increase in program enrollment. According to one estimate, full implementation of the Medicaid expansion would increase Medicaid/CHIP enrollment in Virginia by 51 percent, with 401,000 new enrollees.[16] The state is planning to implement a streamlined eligibility and enrollment portal, called CommonHealth, in late 2013. The system will be linked to the federal exchange, as well as six other state benefit programs, but would be useful to the existing Medicaid program even if the state does not expand eligibility. And at least one private group, the Virginia Health Care Foundation, is preparing to launch a large-scale outreach campaign if Medicaid eligibility expands.

While health plans would welcome the new Medicaid business, a large expansion would create some pressures as well. At least one Medicaid plan executive expected more plans to enter the market if the Medicaid expansion occurs and if the federal government approves the state's application to transition people dually eligible for Medicaid and Medicare into managed care. Respondents also expressed concern about pent-up demand for services and whether the market has sufficient provider capacity, especially because many physicians caring for low-income people in downtown Richmond are approaching retirement age.

In the absence of Medicaid expansion, adults earning between 100 percent and 138 percent of poverty will be eligible for subsidies to purchase health insurance on the fed-

erally facilitated exchange. However, those who fall above the state's current eligibility level but below 100 percent of poverty would not eligible for subsidies under the ACA and likely would remain uninsured. Also, safety net hospitals—primarily VCUHS—could face considerable financial challenges if supplemental Medicaid disproportionate share hospital (DSH) payments that support the costs of caring for the uninsured are reduced but many patients remain uninsured.

Issues to Track

- Will the state ultimately expand Medicaid eligibility?
- How smoothly will the state and federal government interact on the health insurance exchange? How extensive will the choice of products be for consumers?
- To what extent will new ACA requirements affect affordability of coverage for individuals in this market that historically has allowed premiums to vary widely according to a person's risk factors?
- Will Anthem maintain dominance in the nongroup and small-group markets, or will other plans make significant inroads through innovative product designs, effective marketing or lower premiums?
- How much traction will limited-network products and other innovative benefit designs gain in the health insurance exchange?
- To what extent would a Medicaid expansion shake up the currently static Medicaid managed care market as plans compete over newly insured people?
- Can the Richmond provider market adequately handle patient demand stemming from a potentially significant Medicaid expansion and new private coverage options?

Notes

1. The 16 counties are Amelia, Caroline, Charles City, Chesterfield, Cumberland, Dinwiddie, Goochland, Hanover, Henrico, King and Queen, King William, Louisa, New Kent, Powhatan, Prince George and Sussex; the four independent cities are Richmond, Petersburg, Hopewell and Colonial Heights.
2. Authors' calculation. U.S. Bureau of Labor Statistics, *Economy at a Glance: Richmond, VA* (Dec 2012), *http://www.bls.gov/eag/eag.va_richmond_msa.htm* (accessed Aug. 26, 2013).
3. Robert Wood Johnson Foundation, *County Health Rankings & Roadmaps*, *http://www.countyhealthrankings.org/* (accessed Aug. 26, 2013).
4. Virginia did not operate a high-risk pool prior to 2010; however, under the ACA the state was required to have a federally financed temporary high-risk pool in operation for individuals with pre-existing medical conditions who have been uninsured for at least six months. Virginia opted to have the federal government administer the program. Enrollment in these federally run programs was suspended in March 2013 and the programs will be operational through 2013. As of June 30, 2013, roughly 2,900 state residents were enrolled in Virginia's temporary high-risk pool.
5. McCann, Erin, "Bon Secours, Aetna Ink Big ACO Deal," *Healthcare IT News*, (June 25, 2013), *http://www.healthcareitnews.com/news/bon-secours-aetna-ink-big-aco-deal* (accessed Aug. 26, 2013).
6. Cigna, "Cigna and Bon Secours Medical Group Bring Accountable Care to Greater Richmond," News Release (April 9, 2012), *http://newsroom.cigna.com/NewsReleases/cignaandbonsecoursmedicalgroupbringaccountablecaretogreaterrichmond.htm* (accessed Aug. 26, 2013).
7. Virginia Department of Medical Assistance Services, *The Virgnia Medicaid Program at a Glance*, Richmond, Va. (January 2013).
8. Authors' calculations based on March 2013 enrollment data provided by a managed care organization. Also, INTotal Health (formerly Amerigroup Virginia) serves Louisa County in the market, but for Medicaid contracting purposes, is considered part of the Charlottesville market.
9. Kaiser Family Foundation, *Medicaid-to-Medicare Fee Index*, *http://kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/* (accessed Aug. 26, 2013).
10. Office of the Governor, Commonwealth of Virginia, Letter to U.S. Department of Health and Human Services Secretary Kathleen Sebelius (Dec. 14, 2012), *http://www.governor.virginia.gov/utility/docs/HealthcareExchangeLetter.pdf* (accessed Aug. 26, 2013)
11. Mosquera, Mary, "Michigan, Virginia Active Participants in Fed-Run Exchanges," *Heatlhcare Payer News* (July 8, 2013) *http://www.healthcarepayernews.com/content/michigan-virginia-active-participants-fed-run-exchanges* (accessed Aug. 26,

2013).

12. Martz, Michael, "Healthcare Marketplace Opens," *Richmond Times-Dispatch* (Oct. 2, 2013).

13. Somashekhar, Sandhya, "Health-Care Law is Tied to New Caps on Work Hours for Part-Timers," *The Washington Post* (July 23, 2013).

14. Virginia Code, Chapter 751, Article 38.2-3448, Sections A and B.

15. For a full list of the 19 initiatives, see Virginia Department of Medical Assistance Services, *Medicaid Reform: HHR-DMAS Project Matrix-Public Document 052113*, Richmond, Va., *http://www.hhr.virginia.gov/Initiatives/HealthReform/docs/MedicaidReformMatrixforPublicComment.pdf* (accessed Aug. 26, 2013).

16. Kenney, Genevieve M., et al., *State and Local Coverage Changes Under Full Implementation of the Affordable Care Act*, prepared by the Urban Institute for the Kaiser Commission on Medicaid and the Uninsured, Washington, D.C. (July 2013).

Richmond is one of eight metropolitan communities studied by the Center for Studying Health System Change on behalf of The Robert Wood Johnson Foundation.

Data Source

As part of the Robert Wood Johnson Foundation's (RWJF) State Health Reform Assistance Network initiative, the Center for Studying Health System Change (HSC) examined commercial and Medicaid health insurance markets in eight U.S. metropolitan areas: Baltimore; Portland, Ore.; Denver; Long Island, N.Y.; Minneapolis/St. Paul; Birmingham, Ala.; Richmond, Va.; and Albuquerque, N.M. The study examined both how these markets function currently and are changing over time, especially in preparation for national health reform as outlined under the Patient Protection and Affordable Care Act of 2010. In particular, the study included a focus on the impact of state regulation on insurance markets, commercial health plans' market positions and product designs, factors contributing to employers' and other purchasers' decisions about health insurance, and Medicaid/state Children's Health Insurance Program (CHIP) outreach/enrollment strategies and managed care. The study also provides early insights on the impact of new insurance regulations, plan participation in health insurance exchanges, and potential changes in the types, levels and costs of insurance coverage.

This primarily qualitative study consisted of interviews with commercial health plan executives, brokers and benefits consultants, Medicaid health plan executives, Medicaid/CHIP outreach organizations, and other respondents—for example, academics and consultants—with a vantage perspective of the commercial or Medicaid market. Researchers conducted 16 interviews in the Richmond market between March and June 2013. Additionally, the study incorporated quantitative data to illustrate how the Richmond market compares to the other study markets and the nation. In addition to a Community Report on each of the eight markets, key findings from the eight sites will also be analyzed in two publications, one on commercial insurance markets and the other on Medicaid managed care.

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