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# VIRGINIA: BASELINE REPORT

**State-Level Field Network Study  
of the Implementation of the  
Affordable Care Act**

January 2015

**Rockefeller Institute of Government  
State University of New York**

**The Brookings Institution**

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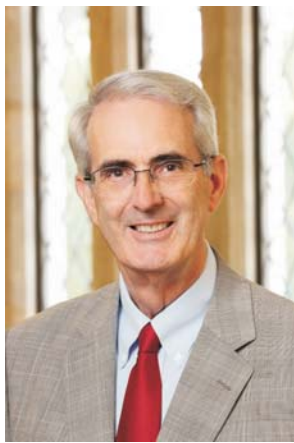


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# VIRGINIA: BASELINE REPORT

## State-Level Field Network Study of the Implementation of the Affordable Care Act

### Part 1 – Setting the State Context

#### 1.1 Decisions to Date

**H** **Health Insurance Exchange:** Virginia has a federally facilitated marketplace with the state responsible for plan management and consumer assistance, but there are active conversations about whether Virginia should move to a partnership or state-based marketplace.

With the passage of the Patient Protection and Affordable Care Act (ACA) in March 2010, discussions began about whether Virginia would have a state-based marketplace. At that time, Virginia – like most other states – was considering developing such a marketplace to ensure state control over the health insurance products sold in Virginia. To further the conversation, Virginia applied for and received a state planning grant of \$1 million in September 2010.<sup>1</sup>

However, in the spring of 2010, Virginia Attorney General Ken Cuccinelli, a Republican, filed a lawsuit challenging the constitutionality of the ACA.<sup>2</sup> Cuccinelli argued that the ACA is unconstitutional because individuals who do not purchase health insurance are not participating in commerce and therefore are not subject to the constitution's commerce clause.<sup>3</sup> Cuccinelli also argued that the individual mandate violated the Virginia Health Care Freedom Act, which passed the Virginia General Assembly with bipartisan support in 2010.<sup>4</sup> The lawsuit was dismissed in September 2010 by the United States Court of Appeals for the Fourth Circuit.<sup>5</sup>

During fall 2010, Virginia Secretary of Health and Human Resources Dr. William Hazel began convening the Virginia Health Reform Initiative (VHRI), which set out to examine a number of issues related to health care and insurance in Virginia.<sup>6</sup> In December 2010, VHRI formally recommended that “Virginia should create and operate its own health benefits exchange to preserve and enhance competition.”<sup>7</sup>

Building upon the recommendation of VHRI, Delegate Terry Kilgore, a Republican, submitted legislation for the 2011 General Assembly session expressly stating, “the intent of the General Assembly that the Commonwealth create and operate its own health benefits exchange or exchanges that meet the relevant requirements of the federal Affordable Care Act.”<sup>8</sup> The legislation was passed by both the Republican-controlled House of Delegates and Senate of Virginia. Republican Governor Bob McDonnell successfully included an amendment in the legislation, which clarified, “That nothing in this act shall be construed or implied to recognize the constitutionality of the Patient Protection and ACA.”<sup>9</sup> The governor signed the bill in April 2011.<sup>10</sup>

Following passage of the legislation, VHRI continued to meet throughout 2011 to discuss the implementation of a state-based marketplace.<sup>11</sup> Cindi Jones, director of VHRI, was designated as the lead for planning the implementation of the marketplace.<sup>12</sup> In November 2011, VHRI released an official report formally recommending that Virginia create a state-based marketplace.<sup>13</sup>

Prior to the 2012 General Assembly, Senator John Watkins and Delegate Kathy Byron, both Republicans, filed identical legislation to create a state-based marketplace in Virginia.<sup>14,15</sup> However, the bills never made it out of their respective committees. Attitudes toward implementation of the ACA in Virginia had shifted within the ranks of the Republican party. Conversations over the constitutionality of the ACA dramatically increased as the Supreme Court prepared to hear the case scheduled for late March 2012.<sup>16</sup> During this time, the Republican Party presidential primary was also dominating the news cycle and there were frequent discussions of McDonnell being a potential running mate.<sup>17</sup>

By failing to enact legislation to create a state-based marketplace during the 2012 General Assembly, Virginia effectively defaulted to a federally facilitated marketplace. Virginia has a relatively short session in the first months of the calendar year and McDonnell refused to call a special session to enact legislation to create a state-based marketplace after the Supreme Court upheld the constitutionality of the ACA in June 2012.<sup>18</sup> Consequently, no legislative action to create a state-based marketplace was taken. As a result, McDonnell indicated in December 2012 that Virginia would default to a federally facilitated marketplace.<sup>19</sup> However, the governor’s letter acknowledged the possibility of Virginia eventually moving to a partnership or state-based marketplace at a later time.

During the 2013 General Assembly, several bills were passed that directly impacted the operation of the federally facilitated marketplace in Virginia. One provision, sponsored by Kilgore, Watkins, and Senator Mark Herring, a Democrat, allows the State Corporation Commission's Bureau of Insurance, with assistance from the Department of Health, to have a role in reviewing health insurance plans that are offered through the marketplace.<sup>20</sup> Having the state conduct plan management for plans offered in the marketplace meant that Virginia was taking on one of the two major components of a partnership marketplace. McDonnell requested<sup>21</sup> and received<sup>22</sup> permission from the Centers for Medicare & Medicaid Services (CMS) for Virginia to undertake plan management despite not being a partnership marketplace. To fund the plan management functions, the state received two Level 1 Exchange Establishment grants in 2013 that totaled \$5.56 million.<sup>23</sup>

Related to the functioning of the federally facilitated marketplace in Virginia, the 2013 General Assembly passed legislation regulating navigators who would provide consumer assistance in the state.<sup>24</sup> On August 15, 2013, the U.S. Department of Health and Human Services (HHS) announced that in response to its proposals, the Virginia Poverty Law Center (VPLC) was awarded \$1,278,592 and Advanced Patient Advocacy, LLC (APA), was awarded \$483,433 to serve as navigators.<sup>25</sup>

The 2013 General Assembly also passed legislation that created a new Health Insurance Reform Commission (HIRC), which is charged with monitoring the implementation of the ACA.<sup>26</sup> Among the responsibilities of the HIRC is to consider proposals to develop a state-based marketplace for enrollment years after 2014. The HIRC is chaired by Byron, who sponsored the bill to create the commission and who has previously submitted legislation to create a state-based marketplace.<sup>27</sup> The HIRC met for the first time on August 21, 2013, and has met somewhat regularly.

Once again, Watkins submitted legislation to create a state-based health insurance exchange during the 2014 General Assembly. However, the main focus of the ACA debate was whether to expand Medicaid. The debate was bolstered by the gubernatorial victory of Democrat Terry McAuliffe, a champion of closing the coverage gap, and Democrats taking de facto control of the evenly divided Senate with a tie-breaking vote held by newly elected Democratic Lieutenant Governor Ralph Northam. In a bipartisan effort, Watkins's bill for a state-based health insurance exchange became the basis for the Senate's proposal to expand Medicaid — called Marketplace Virginia — and was incorporated in the Senate's version of the budget. However, through a series of events (described in more detail in the next section), the Marketplace Virginia proposal was removed from the budget, resulting in no decision to move beyond Virginia's previous posture as a federally facilitated marketplace with state-administered plan management.

In other legislative activity, the General Assembly considered and passed legislation that requires navigators to register with the State Corporation Commission (SCC). Effective July 1, 2014, navigators must register with the SCC; pay a registration fee; provide a criminal history record report; and agree to notify the SCC of any decertification, administrative actions, or convictions.<sup>28</sup>

After the General Assembly chose to continue having a federally facilitated marketplace, last year's navigators applied for and received renewed federal navigator funding. Specifically, HHS announced on September 12, 2014, that Virginia Poverty Law Center would receive \$1,274,231 and Advanced Patient Advocacy, LLC, would receive \$617,724.<sup>29</sup> The federally qualified health centers (FQHCs) also applied for and received a renewal of the Health Resources and Services Administration (HRSA) outreach and enrollment grant they received for the second open enrollment season; the grant for the second open enrollment period is \$1.3 million.<sup>30</sup>

And most recently, McAuliffe announced on October 14, 2014, that under his direction Virginia had applied for and is receiving a federal grant of \$9.3 million to hire more than 100 enrollment assistants to help state residents enroll in health insurance policies available through the federally facilitated marketplace.<sup>31</sup> The Department of Medical Assistance Services (DMAS) will administer the grant and regrant the funds to the VPLC (federally designated navigator) and the Virginia Community Healthcare Association (FQHCs) to enhance their existing enrollment efforts.

It should be noted that with this grant Virginia essentially has the two characteristics of a partnership state — a role in enrollment assistance and conducting plan management. However, the governor's announcement of the federal grant did not include any language regarding changing the state's status from federally facilitated to partnership. Accepting federal funds without acknowledging the working relationship with the federal government is in line with the previous decision to have state control of the plan management function without taking on the label of a partnership state.

**Medicaid Expansion:** The governor and the state legislature in Virginia have yet to adopt Medicaid expansion.

Leading up to the 2013 General Assembly, McDonnell removed the federal funding for Medicaid expansion that was set to begin January 1, 2014.<sup>32</sup> The funding was originally placed in the budget prior to the July 2012 Supreme Court decision that made expansion a state option.<sup>33</sup>

During the 2013 General Assembly, the legislature passed and the governor signed budget language that created either a path forward for Medicaid expansion or a firewall against expansion, depending on interpretation.<sup>34,35</sup> Medicaid expansion is contingent upon a series of reforms that must be undertaken to the satisfaction of a newly formed legislative oversight commission, the Medicaid Innovation and Reform Commission (MIRC).<sup>36</sup> The commission is comprised of five delegates and five senators. For



Medicaid expansion to move forward, a majority of members from each house must agree. The commission met in June, August, twice in October, December, and, for what appears to be the last time, in April 2014.<sup>37,38</sup>

One important issue with this deliberative process has been the delay of expansion and the timing of any future decision to expand Medicaid. DMAS, the state's Medicaid office, has suggested that it will take six to nine months after authorization to be administratively ready to expand Medicaid eligibility. This date coincided with the beginning of the next budget, which was developed during the 2014 General Assembly.

Delaying expansion has had significant implications for the state's residents and budget. It is estimated that beginning on January 1, 2014, there would be a coverage gap for nearly 191,000 uninsured Virginians who are neither eligible for Medicaid nor premium tax credits in the marketplace.<sup>39</sup> Delaying Medicaid expansion has resulted in the state foregoing hundreds of millions of dollars in federal revenue, millions in new tax revenues,<sup>40</sup> and hundreds of millions in savings from supplanting general funds with federal dollars.<sup>41</sup>

Virginia held its elections for governor, lieutenant governor, attorney general, and the House of Delegates on November 5, 2013. The Republican gubernatorial nominee and attorney general, Cuccinelli, who has been an outspoken opponent of the ACA, was defeated by McAuliffe, the Democratic nominee, who has publicly stated that he supports Medicaid expansion.<sup>42</sup> The Democratic nominee for lieutenant governor, Northam, defeated the Republican nominee, Bishop E.W. Jackson.<sup>43</sup> And after a drawn out recount of the closest statewide election in Virginia's history, Herring defeated Republican Senator Mark Obenshain for attorney general, giving Democrats control of the all three statewide offices.<sup>44</sup> In the House of Delegates, the Democrats gained a net of one seat, but that is not enough to alter the Republicans veto-proof majority of 67 seats.

Even though the Senate was not up for election in 2013, the election had major implications for the Senate because the Democratic candidate for lieutenant governor and both candidates for attorney general were current state senators. As a result, there were two special elections to fill the seats vacated by Northam and Herring. Through special elections, both vacated seats were filled by Democrats, maintaining the Senate's twenty-twenty split.<sup>45,46</sup> However, because the lieutenant governor serves as the president of the Senate and has a tie-breaking vote on the Senate floor, the Democrats took control of the Senate in late January.<sup>47</sup> However, that authority of the lieutenant governor does not include votes relating to budget or tax matters.<sup>48</sup>

In the last weeks of his term, McDonnell — as is tradition in Virginia — submitted his new biennial budget on December 16, 2013. His budget did not include any form of Medicaid expansion, such as the private option that has been discussed by members of

the Medicaid Innovation and Reform Commission.<sup>49</sup> In early January, the new chairman of the House Appropriations Committee, Republican Delegate Chris Jones, announced that he would not allow McAuliffe to submit any budget amendments, arguing that this was consistent with actions taken by outgoing Chairman Lacey Putney, an independent.<sup>50</sup> However, with Medicaid expansion as one of McAuliffe's key priorities, Chris Jones's decision was seen as a strategy to prevent McAuliffe from raising the issue of Medicaid expansion.

Once Democrats officially took control of the Senate in late January, there emerged a bipartisan effort led by Watkins to move forward his private market-based Medicaid expansion proposal, Marketplace Virginia.<sup>51</sup> After a series of procedural moves, the senator's bill, which was originally limited to converting the federally facilitated marketplace to a state-based marketplace, was incorporated into the Senate's version of the budget. The Senate then passed a budget that included Marketplace Virginia, but the Republican leadership of the House of Delegates used its uncontested majority to remove the provision from the budget.<sup>52</sup> In turn, the Senate refused to accept the budget passed by the House, and the General Assembly reached the end of its regularly scheduled session without passing a budget.<sup>53</sup>

After the General Assembly failed to reach a compromise during the regular session, McAuliffe called lawmakers back in late March for a special session that dragged on without significant progress until the week of June 9th, when a series of events culminated with a newly Republican-controlled Senate, which agreed with the House of Delegates to a budget that did not include Medicaid expansion. The first key event was the surprise resignation of Democratic Senator Phillip Puckett, which tipped control of the Senate to Republicans.<sup>54</sup> (Note: The circumstances under which Puckett resigned are a matter of federal investigation.<sup>55</sup>) Then, a few days after Puckett's resignation, David Brat upset former House Majority Leader Eric Cantor for the Republican nomination for the seventh U.S. House district.<sup>56</sup> Brat's victory emboldened the tea party element of the General Assembly. Lawmakers returned to Richmond two days later, and the House and Senate passed a budget that not only did not expand Medicaid but also prevented the governor from taking administrative action to increase coverage on his own.<sup>57</sup> Moreover, the budget as passed by the General Assembly and signed by the governor eliminated the authority of the Medicaid Innovation and Reform Commission to expand Medicaid.

Unable to expand Medicaid on his own because of constitutional limitations and statutory preclusions, McAuliffe directed his secretary of Health and Human Resources, Hazel, to develop a plan that would allow him to cover more Virginians through executive action. The governor's plan, A Healthy Virginia, was released on September 8, 2014, and includes ten steps to expand health care services to more than 200,000 vulnerable Virginians.<sup>58</sup>

However, the plan does not raise Medicaid eligibility or draw down the 100 percent federal funding for closing the coverage gap.

The General Assembly convened on September 18, 2014, for a special session to debate Medicaid expansion. The Republican House leadership agreed to the special session as a way to fulfill their promise of debating the issue separately once they passed a “clean budget” earlier in the year.<sup>59</sup> However, the special session, which was originally set for two days, ended after just one day with the nearly party-line defeat of Republican Delegate Glenn Rust’s compromise bill to close the coverage gap.

Most recently, Governor McAuliffe introduced his budget amendments, which included language that would lift Medicaid eligibility as called for in the ACA. The governor’s announcement on December 17, 2014, shows that this issue remains unresolved and will be a topic of debate during the 2015 General Assembly, which will consider the governor’s budget amendment and any potentially other related legislation.

## 1.2. Goal Alignment

The federal policy goals encompassed in the Affordable Care Act have been opposed by Virginia Republicans since the act’s passage. Republicans in the commonwealth have taken a decidedly oppositional response to the ACA. Cuccinelli was the first attorney general to take the federal government to court to oppose the ACA. McDonnell, thought in 2012 to be a potential vice presidential hopeful, also vigorously opposed the ACA, making it clear that no overt actions of the state could be construed as facilitating implementation. The position of the commonwealth was to wait for the Supreme Court to overturn the ACA. Consequently, the commonwealth did very little to prepare for implementation of the ACA and was largely unprepared for implementation.

While Cuccinelli never wavered in his opposition to the ACA, McDonnell seemed to take a more pragmatic approach after it became clear that his national ambitions would not be realized. In a political deal with Senate Democrats to assure passage of his transportation package in 2013, McDonnell agreed to the creation of [the Medicaid Innovation and Reform Commission \(MIRC\)](#). The MIRC was charged with overseeing three phases of reforms and was authorized to expand Medicaid once the conditions of the reforms had been met. Some claimed that this would allow the state to take steps towards the approval of Medicaid expansion, a move that most agree would save the commonwealth substantial sums of money and provide health care coverage to hundreds of thousands of Virginians. In a [March 5, 2013, letter to the HHS secretary](#), however, McDonnell insisted that “the language of the budget actually places a firewall against expansion consideration, unless real, sustainable, cost savings reforms are implemented at the state and federal level.” The appointment of [oppositional House of Delegates members](#) to the commission greatly lowered the odds

that the commission will be a change agent on behalf of Medicaid expansion.

The November 5, 2013, election of McAuliffe as governor, as well as the election of Northam and Herring as lieutenant governor and attorney general, respectively, signaled a major change in the executive branch's position. The difference can be seen in how Cuccinelli called on voters to make the 2013 election a "referendum on Obamacare" while McAuliffe made expanding Medicaid one of his key platform issues. During his first year in office, McAuliffe, with support from Northam and Herring, has pushed for Medicaid expansion, proposing a number of compromises.<sup>60</sup> And McAuliffe's administration has worked to more actively promote outreach, education, and enrollment efforts in the federally facilitated marketplace.

## Part 2 — Implementation Tasks

### 2.1. Exchange Priorities

Virginia defaulted to a federally facilitated marketplace in December 2012, and as a result has largely relied upon the federal government to implement many of the major components of the ACA. However, the state government has been involved in several distinct exchange priorities to varying degrees, including plan management, systems compatibility, and consumer assistance.

During the 2013 General Assembly, legislation was passed that called for the State Corporation Commission's Bureau of Insurance (BOI) and the Virginia Department of Health (VDH) to manage the plans being submitted by health insurance carriers for the new marketplace.<sup>61</sup> Eight insurance carriers submitted individual health plans and six submitted small business health plans for BOI and VDH to review.<sup>62</sup> BOI and VDH worked with the plans, and then transferred the applications with their recommendations to CMS for final certification. CMS certified the plans and publicly released initial plan information on September 25, 2013.<sup>63</sup> In Virginia, consumers are directed to the federally facilitated marketplace at HealthCare.gov. Using [HealthCare.gov](http://HealthCare.gov), some consumers in Virginia have been able to create accounts, find out what financial assistance they can get, and shop for plans available in their part of the state. However, it has been well documented that the functionality and performance of HealthCare.gov has not been sufficient.<sup>64</sup> As a result, many consumers in Virginia struggled to complete the process.

Virginia consumers have also been able to access the federal call center and submit applications through the mail. However, there have been issues with the call center's capacity to enroll people.<sup>65</sup> It was also reported by navigators in Virginia that the mailing address for the initial draft of the paper application was a nonexistent address. To date, significant questions remain about these alternate modes of application.<sup>66</sup>

As part of the HealthCare.gov application process, consumers are screened for eligibility using Modified Adjusted Gross Income (MAGI). In Virginia, consumers with incomes below 100 percent of the federal poverty level (FPL) have their applications directed to the state Department of Medical Assistance Services to be screened for Medicaid eligibility.

To prepare for the transition to MAGI, Virginia developed a new case management system (VaCMS) to determine Medicaid eligibility using the Internal Revenue Service methodology. VaCMS is connected with the federal marketplace, and applications are to be transferred from the marketplace to VaCMS electronically.<sup>67</sup> Virginia's systems were expected to be operational on October 1, 2013, but it remains unclear what the true level of interoperability is between VaCMS and the marketplace. (Note: Virginia applied for and received a waiver from CMS to begin determining Medicaid eligibility using MAGI starting October 1, 2013, instead of January 1, 2014, to avoid having to operate two eligibility systems.<sup>68</sup>)

Despite having a federally facilitated marketplace, the state has also developed a website, [CoverVA.org](http://CoverVA.org), and a call center to connect Virginians with coverage. The website helps consumers understand if they qualify for Medicaid or premium tax credits in the marketplace and it directs consumers to either [commonhelp.virginia.gov](http://commonhelp.virginia.gov) for the state's online Medicaid enrollment portal or HealthCare.gov for enrollment in the marketplace.<sup>69</sup> It is currently unclear why the state developed the website or the call center or to what extent either resource has been used by consumers. During the McDonnell administration, the state did not promote CoverVA.org or the call center, and as a result utilization of those resources was minimal. Indeed, some would argue that the creation of these access points caused more confusion than clarity. However, part of McAuliffe's A Healthy Virginia plan includes re-vamping CoverVA.org and actively increasing official outreach and education of the site and the ACA.

Beyond CoverVA.org and the associated call center, the state had not officially promoted the marketplace or enabled consumer assistance prior to the election of McAuliffe. The state relied exclusively on federal navigator grants and the Health Resources and Services Administration Health Center Outreach and Enrollment Assistance Funding during the first open enrollment. However, McAuliffe has made it an initiative of his administration to promote greater access to consumer assistance, which includes utilizing federal funding for education, outreach, and enrollment.

The navigator funding for 2013 and 2014 was awarded to the same two applicants — the Virginia Poverty Law Center and Advanced Patient Advocacy, LLC. VPLC was awarded \$1,278,592 for 2013 and slightly less in 2014 to hire and train 13.3 navigators located at nine legal aid groups across the state.<sup>70</sup> The amount awarded to VPLC also included funding for two navigators to operate through the Young Invincible program. Those navigators are

working with Northern Virginia Community College to enroll individuals under thirty. As a part of VPLC's outreach and enrollment efforts, it created [Enroll-Virginia.com](http://Enroll-Virginia.com), which helps consumers find in-person consumer assistance in their area. Advanced Patient Advocacy, LLC, is a for-profit entity that was awarded \$483,433 in 2013 and more than \$600,000 in 2014 to place approximately five navigators in hospitals primarily in the central region of the state. APA has a history of working with hospitals to help their patients enroll in the benefits that they qualify for, helping the hospitals mitigate uncompensated care. The grant funds are augmenting their current services.

In addition to the navigator funding, twenty-two out of twenty-three of Virginia's federally qualified health centers received approximately \$2.5 million in 2013 and \$1.3 million in 2014 from HRSA to fund outreach and enrollment.<sup>71</sup> The grants will fund about eighty assistors, according to the Virginia Community Healthcare Association, which represents the FQHCs.

On October 14, 2014, McAuliffe announced that Virginia had received a federal grant of \$9.3 million for marketplace enrollment assistance. In partnership with the VPLC and the FQHCs, the grant will employ over 100 in-person assistors to help connect consumers with coverage.

## 2.2. Leadership – Who Governs?

Virginia's 2013 gubernatorial election featured two candidates with diametrically opposed positions on the Affordable Care Act. The Republican nominee, Cuccinelli, framed the election as a referendum on Obamacare. As attorney general, Cuccinelli had sued to prevent implementation of the ACA. McAuliffe supported the ACA and used his \$15 million fund-raising advantage to frame Cuccinelli as an extremist. While he enjoyed a double-digit lead in the polls, McAuliffe won the election by three percentage points. McAuliffe's victory rested largely on the basis of a hefty advantage in northern Virginia, likely helped by a federal workforce with extra time to vote because of a government shutdown.

While all three statewide offices were won by Democrats, the House of Delegates remained firmly in Republican hands. The Republicans enjoy a sixty-seven to thirty-three advantage in the House of Delegates, partly a result of superior party building at the local level and district gerrymandering that maximizes the party's various advantages. The Senate was twenty-twenty after the November 2013 elections. Control of the Senate rested with the Democrats as a result of the election of Northam as lieutenant governor. McAuliffe's hopes for fuller Virginia participation in the ACA rested on leveraging the slim Senate majority for a compromise to the budget that included some form of Medicaid expansion. Those hopes were short-lived. Control of the Senate shifted to the Republicans in June 2014 when Puckett abruptly resigned in June 2014, giving Republicans a twenty-nineteen majority. With both chambers of the legislature in Republican hands, a budget

without Medicaid expansion was passed on June 13th. Adding insult to injury, language was added to the budget limiting the governor's ability to take administrative efforts to expand Medicaid. The Medicaid expansion portion of the ACA appears unlikely under current conditions.

While Medicaid expansion has been a nonstarter, the exchange portion of the ACA has enjoyed some successes. From a leadership standpoint, McAuliffe decided to retain two key actors from the Republican administration of McDonnell. Hazel, McDonnell's secretary of Health and Human Resources, was retained both for his knowledge and expertise and in the hope that Hazel could find common ground with Republican legislators. Administrative continuity was also a factor in the reappointment of Cindi Jones, the director of Virginia's Department of Medical Assistance Services. Jones, with twenty-five years of service at DMAS, provides needed expertise in navigating Medicaid's labyrinthine rules and regulations. Virginia's best hope for leveraging available Medicaid opportunities may come from the effective and creative use of the Medicaid waiver process, as DMAS is the fiscal agent for the Medicaid funds received for Virginia's implementation of the federally facilitated marketplace.

Another Virginia administrative actor under the ACA is the State Corporation Commission. The SCC is theoretically independent of the political process as its three members have six-year rotating terms. Commissioners are politically savvy, however. Commissioner Mark Christie served as Republican George Allen's policy director. Judith Williams Jagdmann was selected to serve as attorney general of Virginia (2005-2006) to fill the term of Republican Jerry Kilgore, who resigned to run for governor. James C. Dimitri has served in various positions, including staff attorney of the VPLC, which represents the interests of low-income Virginians. The SCC's Bureau of Insurance receives proposed plans and ensures that they are compliant with the ten essential ACA benefits, the age component, and other factors. The line workers of the Bureau of Insurance are administrators who objectively assess and forward eligible plans to HHS for certification.

### **2.3. Staffing**

Because Virginia has a federally facilitated marketplace, exchange staff members are federal employees of HHS.

### **2.4. Outreach and Consumer Education**

Official outreach and consumer education by the state was nearly nonexistent during the McDonnell administration, but has increased since the election of McAuliffe. The state's minimal involvement stemmed from the decisions by McDonnell and the Republican-controlled General Assembly to have a federally facilitated marketplace and reject resources for outreach and consumer education.<sup>72</sup>

The extent of the state's education effort has been limited to the website CoverVA.org, which provides basic information on Virginia's Medicaid program.<sup>73</sup> Cover Virginia, which rolled out in fall 2013, is intended to connect Virginians to affordable health insurance. However, it only provides a few sentences about the federal marketplace or the premium tax credits available to help make the plans more affordable.<sup>74</sup> Moreover, field researchers are not aware of a coordinated effort to drive people to CoverVA.org as an educational resource. Under McAuliffe's plan to connect more Virginians with coverage, he has promised to overhaul CoverVA.org and actively promote the site.

In an attempt to fill the informational vacuum created by the state's limited efforts, many nonprofit advocacy organizations have deployed their own outreach, education, and enrollment campaigns. Among the organizations conducting outreach and education work are the various legal aid groups that received navigator funding through VPLC; Northern Virginia Family Services (NVFS), which created a network of organizations capable of reaching out to Spanish and Korean communities; and Virginia Consumer Voices for Healthcare (VCV). VCV conducted outreach and education activities in central Virginia and regranted \$25,000 to four different organizations around the state to support their activities. The subgrantees included NVFS and organizations in the southeastern and southwestern portions of the state.

Virginia's posture in relation to outreach and consumer education for the marketplace and the ACA in general has taken a different tone since the election of McAuliffe. He has begun to use his executive authority to change the approach taken by the relevant executive branch agencies. For example, the state's Medicaid office has hired Christina Nuckols, formerly an opinion editor at the *Roanoke Times*, to be a communications advisor.<sup>75</sup> The governor has also directed that \$4.3 million in unspent federal funds for establishing a state-based marketplace be granted to the VPLC to hire outreach and education staff.<sup>76</sup> However, the authority of the governor to fully alter the state's posture on implementing the ACA is limited. For example, one of the most significant state agencies involved — the State Corporation Commission — is an independent agency, exempt from the governor's authority.<sup>77</sup>

## 2.5. Navigational Assistance

### Funding for Enrollment Assistance

By defaulting to a federally facilitated marketplace, Virginia has had limited funding for in-person assistance. Specifically, the only funding that has been made available to connect consumers with coverage are federal grants. No state funds have been allocated for this important component of successfully implementing the ACA.

There are two federally designated navigator organizations in Virginia — Virginia Poverty Law Center and Advanced Patient



Advocacy, LLC. VPLC was awarded \$1,278,592 for 2013 and \$1,274,231 in 2014 to hire and train 13.3 navigators located at nine legal aid groups across the state.<sup>78</sup> The amount awarded to VPLC also included funding for two navigators to operate through the Young Invincible program. Those navigators are working with the Northern Virginia Community College to enroll individuals under thirty. Advanced Patient Advocacy, LLC, is a for-profit entity that was awarded \$483,433 in 2013 and \$617,724 in 2014 to place approximately five navigators in hospitals primarily in the central region of the state. APA has a history of working with hospitals to help their patients enroll in the benefits that they qualify for, helping the hospitals mitigate uncompensated care. The grant funds are augmenting their current services.

In addition to the federal navigator funding, twenty-two of twenty-three of Virginia's federally qualified health centers received approximately \$2.5 million in 2013 and \$1.3 million in 2014 from HRSA to fund outreach and enrollment.<sup>79</sup> The grants will fund about eighty in-person assistors, according to the Virginia Community Healthcare Association, which represents the FQHCs.

And in an October 2014 announcement that reflects the state's shifting approach to the ACA, McAuliffe announced that Virginia had applied for and received a federal grant of \$9.3 million for marketplace enrollment assistance. The federal grant will allow for an additional 100 in-person assistors to help connect consumers with coverage. The state's Medicaid office will receive the grant and has arranged to regrant the funds to VPLC and the FQHCs, which will then be responsible for hiring and managing the in-person assistors.

The other set of official groups that have provided in-person assistance are the federally designated Certified Application Counselors (CACs). Although CACs have federal designation, there is no federal funding for these organizations to provide enrollment assistance. There is also no state funding for CACs, so the more than 100 organizations that have been designated as CACs in Virginia have been solely responsible for funding their own work.<sup>80</sup>

### **Adequacy of Consumer Assistance**

The decision to default to a federally facilitated marketplace severely limited the amount of funding for in-person consumer assistance available for the first open enrollment. In total, there was only slightly more than \$4 million available to provide in-person consumer assistance for as many as 624,000 people projected to be eligible for advanced premium tax credits on the marketplace.<sup>81</sup>

Most regions of the state had access to in-person assistance, but the capacity appears to have been insufficient to meet demand. The largest federal navigator grant was awarded to VPLC, in part because it submitted a statewide application that included nine legal aid offices throughout the state. In combination with

the twenty-two FQHCs, which are located in Medically Underserved Areas (MUAs) of the state, in-person assistance was present in most regions. However, the capacity of the in-person assistance was insufficient, especially in the first few months of the open enrollment period when the federal enrollment website, HealthCare.gov, was not functioning properly. In practical terms, most of the legal aid offices only had one navigator, and when they had to revert to using paper applications they struggled to assist everyone who requested help.<sup>82</sup>

Although the resources for enrollment assistance appeared to have been inadequate, the number of Virginians enrolled in Qualified Health Plans (QHPs) far exceeded federal forecasts. By the end of the first open enrollment period, more than 216,000 Virginians had enrolled in new health plans through the federally facilitated marketplace. For reference, the final enrollment count is more than twice the federal projection for the first year.<sup>83</sup> As of October 2014, the field team is unaware of any detailed analysis that attempts to reconcile the apparent inadequate resources with the higher-than-expected enrollment and will continue to research this issue.

Adequacy of in-person assistance is expected to improve. With the \$9.3 million federal grant that was announced in early October 2014, there will be 100 additional assistors to help connect consumers with coverage. The state is partnering with VPLC and the FQHCs to add these 100 assistors, and in doing so there will be greater capacity to help consumers.

### **Organizational Classification**

The various organizations and entities providing in-person assistance in Virginia include nonprofit and for-profit entities, although nonprofit entities appear to far outnumber for-profit groups. Based on a review of the entities listed on HealthCare.gov, there are more than 100 nonprofits providing assistance, including the primary navigator group VPLC (listed as EnrollVirginia!) and the various federally qualified health centers. The secondary navigator grantee, Advanced Patient Advocacy, LLC, and the twenty-three brokers/agents listed on HealthCare.gov are among the for-profit entities providing navigational assistance.

As it is understood by the field research team, most of the organizations providing consumer assistance were established to aid low-income families, but may have slightly modified their structure when undertaking this new role. For example, VPLC and the legal aid groups providing navigational assistance have historically provided assistance to low-income families, but the organization EnrollVirginia!, which is the legal name of the group providing assistance through the legal aid offices, is newly established. Other organizations such as Northern Virginia Family Services have also expanded their traditional assistance to low-income families to provide help enrolling in marketplace plans.

Organizations in Virginia are typically taking on all three responsibilities of outreach, education, and enrollment. The navigators, the assistors from the FQHCs, and CACs have undertaken all three responsibilities. However, in an effort to most effectively use limited resources, there has been some coordination among different organizations to have navigators focus on enrollment, while other organizations, including some that are not certified to provide enrollment assistance, conduct outreach and education activities.

## **2.6. Interagency and Intergovernmental Relations**

**2.6(a) Interagency Relations.** Interagency relations between Virginia's Department of Medical Assistance Services and the federal Centers for Medicare & Medicaid Services are functional. McAuliffe's retention of health care leaders has promoted administrative continuity. In addition, Marilyn Tavenner, the administrator for CMS, has Virginia roots. Tavenner served as Governor Tim Kaine's secretary of Health and Human Resources. During that time, Cindi Jones was Virginia's DMAS director. At the administrative level, intergovernmental relations between federal and state actors are good. State agencies under McAuliffe are more receptive to federal efforts to implement the ACA than they were under the McDonnell administration. Even though the DMAS-CMS relationship may be largely unchanged, the tone of the federal-state relationship has generally improved.

**2.6(b) Intergovernmental Relations.** Virginia's state-directed, locally administered departments of social services are not structured for rapid response to initiatives as substantial as the ACA. This has been especially true when the state response has included lawsuits by the former attorney general and the General Assembly's preemptive restrictions on anticipated initiatives of a governor committed to expanding medical services for underserved populations. Intergovernmental communications are also somewhat hampered by computer systems that do not operate seamlessly between the state and federal governments or even between Virginia state agencies. However, Virginia's "no wrong door" approach has promoted more successful local-state-federal cooperation.

**2.6(c) Federal Coordination.** Federal coordination is a work in progress, as stated in previous sections. The problematic national ACA roll out, coupled with Virginia's oppositional stance from 2011 to 2013, were expected to result in far lower ACA enrollments than were actually realized. It is possible that Virginia's proximity to Washington yielded some administrative coordination advantages. It is also possible that the centrality of the ACA/Obamacare debate to the 2013 Virginia gubernatorial election had the unintended consequence of elevating citizen awareness about the ACA and led to more individual proactivity. This will be an area of interest by the state team as implementation proceeds.

## 2.7. QHP Availability and Program Articulation

**2.7(a) Qualified Health Plans (QHPs).** Virginia has benefited from robust participation from health plans in the federally facilitated marketplace. Eight health plans offered QHPs on the marketplace for 2014. During the first open enrollment, more than 216,000 people enrolled in QHPs. The majority of marketplace enrollees (64 percent) chose a silver-level plan.<sup>84</sup> The second most popular choice was a bronze plan (22 percent) followed by a gold plan (11 percent). Very few chose platinum (1 percent) or catastrophic (3 percent) plans.

Looking forward to the second open enrollment, an additional health plan has entered the market, increasing the number to nine.<sup>85</sup> Of the nine issuers in the market for 2015, four are preferred provider organizations (PPOs) and five are health maintenance organizations (HMOs). In total, the nine issuers are offering ninety-six plans for individuals on the marketplace.<sup>86</sup>

The benefits of plans offered in the federally facilitated marketplace appear to be more comprehensive than plans offered in the individual market prior to national health reform. This is largely because in Virginia, like many other states, certain benefits such as maternity coverage were not frequently offered as part of individual health insurance policies.

In addition, Virginia has a lower than average cost for its benchmark health plan. According to an analysis by the Kaiser Family Foundation, the benchmark health plan in Richmond costs \$253 per month, which is the twenty-second lowest among a major city in each state.<sup>87</sup>

**2.7(b) Clearinghouse or Active Purchaser Exchange.** Virginia does not operate its own exchange. Instead, the state relies on the federal marketplace while maintaining the health insurance plan management function currently performed by the State Corporation Commission's Bureau of Insurance.

**2.7(c) Program Articulation.** While Virginia defaulted to a federally facilitated marketplace, it also set up CoverVA.org as a nominal state portal to help steer low- and moderate-income applicants to the most appropriate programs. The screening tool employed by CoverVA.org uses several questions to determine household size, distribution by age, income, and foster care status.<sup>88</sup> These questions are used as a preliminary eligibility determination tool for members of a household to steer applicants to the most appropriate online application, whether that is the state's Medicaid, FAMIS health insurance for children, or Plan First programs or the federal marketplace. However, given the limited number of questions used in the screening tool, there seems to have been an explicit choice favoring ease of completion over completeness and accuracy. This choice is defensible given that the eligibility determination processes for the programs favor completeness and accuracy over ease of completion, but it does mean that people may be initially led to the wrong program application. Moreover, as previously mentioned, it is unclear how

frequently people use CoverVA.org since there has been no coordinated effort to promote the site.

In addition to CoverVA.org, the state's multiprogram online enrollment portal is [CommonHelp](#). People who applied for health coverage through CommonHelp or their local departments of social services and were found to have incomes of 100 percent of the FPL or more had their applications forwarded to the federally facilitated marketplace. Hazel, the state's secretary of Health and Human Resources, reported that there were approximately 40,000 applications forwarded to the federally facilitated marketplace. He also noted that once an application is transferred to the marketplace, Virginia loses access into the status of the application. From the state's perspective, this raised a customer service concern that was brought to the attention of former HHS secretary Kathleen Sebelius.<sup>89</sup>

The other major issue is the capacity of the federally facilitated marketplace to transfer applications submitted with incomes below 100 percent of the FPL to the state. There were initial reports that the federally facilitated marketplace struggled to identify and properly transfer applicants with incomes below 100 percent of the FPL to the state for Medicaid eligibility determination. And when the federally facilitated marketplace began transferring applicants on February 18, 2014, the state reports that there were errors in the data stemming from issues with HealthCare.gov. The state Department of Social Services is working to address the application issues, which often requires directly contacting the applicant, and then passing on the application to the appropriate local department of social services. (Note: In Virginia, the local departments of social services are responsible for the eligibility determination.) As of April 7, 2014, there were 43,773 applications pending on the federally facilitated marketplace to be transferred to the state.<sup>90</sup>

The state and local departments of social services were ill-equipped to handle the large number of applications, many of which had errors. In particular, Medicaid applications went up 51 percent from October 1, 2013 to April 2014 while resources had not changed, creating a backlog of applications. Combined with the pending applications on the federally facilitated marketplace, employees of the state and local departments of social services have been overwhelmed.

Contributing to this backlog also appears to be multiple or erroneous applications. In particular, by April 2014, 70 percent of the applications that had been transferred to the state were denied. This is, in part, because of Virginia's low Medicaid eligibility thresholds (e.g., the highest eligibility for parents is 51 percent of the FPL in Northern Virginia), but also because as many as one-third of the applicants were already enrolled in Medicaid.<sup>91</sup>

While the state made progress on the backlog through the spring and summer, the backlog was sufficient to draw the attention of CMS, which issued a written request for more information on the issue on June 27, 2014.<sup>92</sup>

**2.7(d) States That Did Not Expand Medicaid.** Virginia has not expanded its Medicaid program as of January 2015. There remain efforts to raise the Medicaid eligibility threshold to 133 percent of the FPL as described within the ACA. However, the controlling majorities of the Virginia House of Delegates and Senate remain steadfast in their opposition to expanding Medicaid.

The state's Medicaid office estimates that approximately 277,000 uninsured Virginians who would have been eligible for Medicaid if the eligibility threshold had been raised are now in the coverage gap. The coverage gap is defined as the income levels between current Medicaid eligibility (0 percent of the FPL for childless, nondisabled, nonpregnant adults and about 40 percent for nondisabled, nonpregnant adults with children) and 100 percent FPL.

**2.7(e) Government and Markets.** The ACA has meant substantial reforms of the insurance market in Virginia, especially as it relates to consumer protections in the individual market. First and foremost, the establishment of the federally facilitated marketplace has created a more centralized market than previously existed. As mentioned, there are nine carriers offering plans in the marketplace for 2015, which engenders competition. However, that competition is less apparent at the local level where there are often only a few issuers in the market. That said, there are at least two carriers offering plans in every locality.<sup>93</sup>

Other reforms include the requirement that health plans must now cover all ten essential health benefits and make an offer of coverage to everyone who applies during the open enrollment period or during a qualifying special enrollment period. Another substantial change is that health plans can no longer exclude pre-existing conditions or deny treatment based on a preexisting condition. And underwriting in the individual and small business markets is now constrained by the federal limitations placed on age (3:1), tobacco (1.5:1), and geography (12 ratings areas), thus resulting in a relative compression of premiums offered in the individual market.<sup>94</sup>

There is one way in which the interaction between the government and the markets has not been fundamentally altered. Rather than interacting with a new set of federal regulators, Virginia health plans worked with lawmakers to enact legislation giving the state's Bureau of Insurance the authority to regulate plans offered on the federally facilitated marketplace. This arrangement maintains the longstanding relationship between BOI and the health plans, and, while there are not substantiated claims to this effect, the continuance of this relationship could be to the detriment of full health reform.<sup>95</sup>

## 2.8. Data Systems and Reporting

The state team has no report on data systems and reporting at this time.

## Part 3 — Supplement on Small Business Exchanges

### 3.1. Organization of Small Business Exchanges

As with other states that have relied on the federal government to establish marketplaces, there was no small business exchange for 2014. That said, agents and brokers were allowed to sell small business policies for 2014, and six insurance carriers offered policies. For the 2015 open enrollment period, the small business exchange — or SHOP — is expected to be operational through the federal website HealthCare.gov. There are six carriers, two PPOs and four HMOs, offering a total of eighty-nine policies.

One interesting development resulting at least in part from the federal government's postponed rollout of the small business exchange is the announcement in June 2014 by the Virginia Chamber of Commerce that it is going to develop a small business health insurance exchange, the Virginia Benefits Market.<sup>96</sup> It will be a partnership of an existing exchange for sixty local chambers and the state chamber. The impact of this exchange is unclear given the preexisting small business exchange for sixty local chambers and the federal exchange, which is set to come online for 2015. Thus, while the Virginia Chamber president, Barry DuVal, remarked that this effort is meant to fill a niche, the rollout and full implementation of this new exchange does not appear to be a game changer.

## Part 4 – Summary Analysis

### 4.1 Policy Implications

By and large, Virginia opponents of the Affordable Care Act have been able to thwart full implementation at the state level. This can be seen in Virginia's decision to default to a federally facilitated marketplace and refusal to close the coverage gap. Having control of the executive branch and legislature until 2014 allowed lawmakers to minimize the impacts of the ACA, implementing only what was legally required of them and ignoring calls from advocates for low-income people who called for fuller implementation.

While opponents of the ACA controlled the executive and legislative branches, powerful interest groups were able to secure specific actions that benefited their industry. Specifically, the insurance industry was able to convince lawmakers to enact legislation that allowed health carriers to maintain their established relationships with the State Corporation Commission's Bureau of Insurance rather than dealing with new federal regulators. Some interest groups with highly concentrated benefits at stake were able to move lawmakers in ways that others have been unsuccessful. However, other highly influential lobbies, such as the Virginia Hospital and Healthcare Association, were

unsuccessful in overcoming ideological opposition to key components of the ACA.

Advocacy groups representing low-income people have been largely unsuccessful. Groups representing thousands of people have been calling on Virginia lawmakers to close the coverage gap and engage more actively in outreach, education, and enrollment in the marketplace. However, to many observers it would appear that these calls, often coming from people who are directly affected, have been largely dismissed.

The election of McAuliffe, who supports the ACA, has allowed for some administrative progress in implementation of the ACA, but the structure of Virginia's government has constrained action. While McAuliffe has been successful in bringing federal funding for consumer assistance to the state, he has been unable to close the coverage gap, an action that would have far greater benefits for low-income people. Taking action on Medicaid expansion is a prerogative that has been reserved by the legislature through its power of the purse. And the fact that the State Corporation Commission is an independent agency that favors bureaucratic restraint lends itself to less dramatic shifts in posture.

External politics and groups can have large and potentially overpowering effects on state policy decisions. The controlling majorities of the House of Delegates and Senate have fully embraced the "anti-Obamacare" sentiment espoused nationally by conservative groups such as Americans for Prosperity and the Foundation for Government Accountability as well as the National Federation of Independent Businesses. This disposition has framed much of the debate around implementation of the ACA. Countering these groups are a variety of Virginia-based organizations that advocate on behalf of low-income Virginians.

#### **4.2. Possible Management Changes and Their Policy Consequences**

Looking forward, there remains the possibility for significant changes, including the structure and functioning of the marketplace as well as closing the coverage gap that would alter the state and national policy landscape.

There remains serious debate about if and how Virginia will close the coverage gap. If Virginia moved forward, nearly 400,000 Virginians could get access to quality, affordable health care. Moreover, some advocates have asserted that Virginia could be the linchpin in opening up the South to Medicaid expansion.

The debate around officially transitioning to a partnership or state-based marketplace is less robust. Given the failings of HealthCare.gov and the overall lack of approval of the ACA, there is little interest in taking on this task at the state level. Moreover, some opponents of the ACA continue to hold on to the notion that



the Supreme Court will rule that the advanced premium tax credits are only available in states with their own marketplace, and thereby reversing the implementation of the ACA in states with federally facilitated marketplaces. However, as we have seen, McAuliffe has been working to increase the federal funding available for outreach, education, and enrollment in the marketplace. This has been done without declaring Virginia a partnership state, an issue that is likely to be picked up during the 2015 General Assembly. And finally, there continues to be work around how to best process and transfer applications between the state and federal government. This issue will like require process and management changes to improve the system.

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