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Just what is Marketplace Virginia?

By Michael Martz

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The Medicaid Innovation and Reform Commission heard encouraging words last week from a national health care consultant about Virginia's options in fashioning its own commercial insurance program for hundreds of thousands of uninsured Virginians.

Deborah Bachrach, a former New York Medicaid director who has consulted with members of the state commission before, used examples of new programs in Arkansas, Iowa, Michigan and, still pending, New Hampshire that have federal permission for different approaches to expanding health insurance coverage.

"I do not think your hands are tied on new products," Bachrach told the commission Monday. "You won't know until you ask."

The next day, Del. R. Steven Landes, R-Augusta, the commission's vice chairman, disagreed in a speech on the House floor that assailed the Senate's proposed alternative to Medicaid expansion.

Landes asserted that the Marketplace Virginia plan is nothing more than Medicaid expansion and includes cost-sharing requirements and work incentives that the federal government never has approved before.

"If it looks like a duck, walks like a duck, and talks like a duck — it's a duck," he said.

But like the waterfowl kingdom, there are many variations on state programs to expand health coverage with federal funds reserved under the Affordable Care Act for expansion of state Medicaid programs.

Here are some of the questions that sharply divide Senate supporters and House opponents of Marketplace Virginia in a continuing stalemate over adoption of a state budget for the next two years:

Would Marketplace Virginia simply expand Medicaid?

Sen. Walter A. Stosch, R-Henrico, co-chairman of the Finance Committee, insists the answer is no. The Senate plan would draw down an estimated $1.7 billion each year in federal funds generated by taxes paid by Virginians and businesses under the ACA.

“I do not view that money — the new taxes — as Medicaid dollars,” Stosch said at last week’s meeting of the MIRC, as the Medicaid commission is known.

Bachrach said that is correct, but she said the money for insurance premiums under the program would be paid under Title XIX of the Social Security Act — the Medicaid program. “That is the authorization for your money,” she said.

Under Marketplace Virginia, the money would be held in the Virginia Taxpayer Recovery Fund, which would pay insurers for coverage of newly eligible people. However, state oversight of the funds would be provided by the Department of Medical Assistance Services, the state Medicaid agency, which already administers a separate, non-Medicaid program for children and adolescents.

The Senate plan would rely on private insurance companies that already provide managed care — at their risk — to more than 700,000 people in the state Medicaid program, mostly children, pregnant women and extremely low-income parents.

The state relies on a private insurance broker to enroll recipients in the seven private managed care plans offered to eligible Medicaid recipients.

“It’s completely privatized today,” said Doug Gray, executive director of the Virginia Association of Health Plans, which supports the Senate plan.

How is Medicaid managed care different from traditional Medicaid?

The state directly administers benefits for the aged, blind and disabled in programs that account for about one-third of the Medicaid population and two-thirds of the $8 billion annual cost.

In these fee-for-service programs, providers directly bill the state, which pays them but does not coordinate care for recipients. In managed care, the state pays insurers a fixed, per-person monthly rate and they pay providers under negotiated rates. The insurers have an incentive to lower their costs — and raise their profit margins — by managing the care provided.

At the same time, the companies compete against one another for customers, based on provider networks and access to care, which depend on the rates the companies negotiate with health care providers.

New Hampshire recently approved legislation to expand its Medicaid managed care network on July 1 as a step toward an insurance premium assistance program through its health insurance exchange. The law provides for a higher state payment to insurers to pay for wider provider networks and access.

Under the Marketplace Virginia proposal, the state would use federal funds to pay the premiums of an estimated 247,000 to 400,000 uninsured people, depending on how many choose to enroll. Nationally, the average takeup rate is 69 percent, which represents the lower end of the Virginia estimate.

As it does now for its Medicaid managed care program, the state would rely on a private broker to enroll people in health plans and negotiate contracts. It also would negotiate fixed per-person monthly rates with insurers to deliver and pay for benefits.

Marketplace Virginia would not rely on operation of an insurance exchange at the State Corporation Commission, as Sen. John Watkins, R-Powhatan, its principal author, originally proposed. "The (insurance) companies are doing most of the work," Watkins said last week.

Would recipients be required to share in the cost of premiums and services?

Yes, but the amounts depend on their income. Currently, Virginia does not provide any benefits to childless adults, parents who make more than 31 percent of the federal poverty level, and disabled adults who make more than 80 percent of the poverty level. (The federal poverty level is $11,670 a year for an individual and $23,850 for a family of four.)

Under current Medicaid guidelines, people with income between 100 and 138 percent of the poverty level could be required to share in the costs of their care up to 5 percent of their household income on a quarterly basis.

They could be charged up to 10 percent of the cost for a service, $8 for every non-emergency visit to a hospital emergency room, and $4 to $8 for medications, depending on whether the drug is on a preferred list.

They would not be required to share in the cost of monthly insurance premiums under straight Medicaid expansion, but the federal government has given waivers to two states to require recipients to pay a portion of their premiums as part of a private insurance program.

In Iowa, no one would pay a premium in the first year but, in the second, they would pay $5 a month if they earned between 50 and 100 percent of the poverty level and $10 a month if they earned more than 100 percent. The premiums could be waived if recipients participate in wellness and prevention programs that reduce their need for care.

The state says it would disenroll people earning above 100 percent if they did not pay their share of the premium. People with lower incomes would be subject to debt collection, but would not be disenrolled unless they still had not paid at the time of their annual contract renewal.

Michigan expanded coverage through its existing Medicaid managed care program, but received a federal waiver that would allow the state to require people earning up to 138 percent of the poverty level to pay monthly premiums up to 2 percent of their household income.

In both states, the premium share would be subject to a cap on all cost-sharing of 5 percent of quarterly household income.

Arkansas does not have a Medicaid managed care program, so its plan pays the premiums of newly eligible recipients on health plans purchased on the state's insurance marketplace or exchange.

It does not require recipients to share in the premium cost, but people who earn more than the federal poverty level would be subject to a $150 deductible, as well as co-payments for visits to doctors and specialists, medications and medical equipment, again up to 5 percent of quarterly household income.

Arkansas also plans to ask federal permission to require cost-sharing for people who earn between 50 and 100 percent of the poverty level, but the state has not yet submitted a waiver request.

The Marketplace Virginia plan would require recipients to share in the cost of services up to 5 percent of household income to "encourage use of primary care and prevention and discourage inappropriate use of emergency room care."

But the proposal does not specify what cost-sharing requirements the state would seek beyond those already allowed by the federal Medicaid program.

Would Virginia have to get a federal waiver for permission to carry out the Senate plan?

It depends on what the state ultimately would choose to include in the plan.

Virginia would not require a waiver to expand insurance coverage under its managed care program to a new population. Instead, it would seek a state plan amendment to its current managed care waiver under Section 1815 (b) of the Social Security Act. The state has had the waiver for nearly 20 years.

"Waivers are by definition time-limited, but most of them are routinely extended," Bachrach said.

Virginia would have to seek a waiver under Section 1115 of the act if it wants federal permission to require the expansion population to share in the cost of monthly premiums, as Iowa and Michigan have done.

The state also would require a waiver for permission not to provide non-emergency transportation for recipients — as required under its current program. CMS gave Iowa permission to exclude non-emergency transportation as a benefit.

The Marketplace Virginia plan would "require incentives for job search and work activities."

Critics point out correctly that Pennsylvania sought to tie benefits to a work requirement but withdrew the request after CMS said it would not approve it.

Virginia would need a waiver to offer incentives for people to work or seek a job. An estimated 70 percent of those who would be eligible for insurance under expansion live in a household where someone works full time or part time.

But Bachrach said the state might not need a waiver to encourage jobless recipients to seek work. "They don't need a waiver if they do what New Hampshire is doing," she said. "Unemployed recipients will be referred to worker-assistance programs for training."

If Virginia expands insurance coverage under the ACA, can it withdraw from the program later?

This question goes to the heart of the political battle over Marketplace Virginia because opponents contend the federal government cannot be trusted to fulfill the law's promise of 100 percent federal support through 2016 and no less than 90 percent thereafter.

Legally, the answer appears to be yes, but politically the prospect of ending coverage for hundreds of thousands of people is harder to divine.

The Senate plan would require notification of recipients "up front" that their insurance contract is contingent on federal funds and would end the program if the government does not meet its commitment. It also would require insurers to notify participants of any contract changes.

"I see this whole thing as a contract," Watkins said. "It's a contract with the individual, but it's also a contract with the federal government."

Opponents say the federal government simply cannot afford to pay its promised share of the cost.

Michael L. Cannon, a senior health policy analyst at the Cato Institute, told the MIRC last week that there is no pot of federal money reserved for Medicaid expansion in Virginia and the government would borrow to pay for it.

"We do not want to increase the federal debt to expand Medicaid in Virginia," said Cannon, who added that "it would be more fair to expand Medicaid paid for entirely by the state."

Cannon said the federal government potentially could penalize states for withdrawing from the program and added that pulling out would require "$10 of political pain for every $1 of budget savings."

But Bachrach said the ruling of the U.S. Supreme Court in 2012 explicitly forbids the government from "coercing" states to expand their Medicaid programs by withholding existing Medicaid funds.

“It seems to me to follow inexorably that if expansion is optional, the state has the option to get out at any time,” she said.

As for political pain, people who lose coverage would be “no worse off” than they are now, she said.