

The Virginia NEWS LETTER

The Affordable Care Act Holds Great Promise for Virginia

by Jill A. Hanken

Introduction

Since enacted by Congress one year ago, the Patient Protection and Affordable Care Act¹ (ACA), better known as the new health care reform law, has been the subject of both wild celebration and vigorous condemnation. At the same time that many states are challenging its constitutionality and some in Congress are seeking its repeal, consumers are benefiting from many aspects of the new law, and states are receiving and using millions of federal dollars as they work to implement it.

In this atmosphere of heated debate and sometimes schizophrenic behavior by states which are both challenging and implementing the law, the problems which ACA seeks to solve have been somewhat overshadowed by the ongoing controversy. However, enormous problems in the United States' health care system do persist, and they have grown worse during the current recession. While not perfect, ACA offers sound and comprehensive approaches that will improve access to health care for millions of Americans.

This article will focus on circumstances in Virginia that demonstrate the need for national health care reform. It will describe major provisions of the ACA and steps Virginia has taken during the past year to either resist or embrace ACA requirements.



Jill A. Hanken

Private Insurance and the Uninsured

Virginia is a relatively high-income state; in 2010 its per capita personal income was 110.3 percent of the national average and the state ranked seventh in the nation.² Yet, nearly one million of her residents were uninsured in 2008-2009, including 150,900 children.³ The recession has contributed to increased poverty in Virginia. Preliminary state-level data from the Census Bureau show that in the one year time period from 2008 to 2009 Virginia's poverty rate for all people rose from 10.3 percent to 10.7 percent. Furthermore over 157,000 Virginians have joined the ranks of the poor since the recession began in 2007.⁴

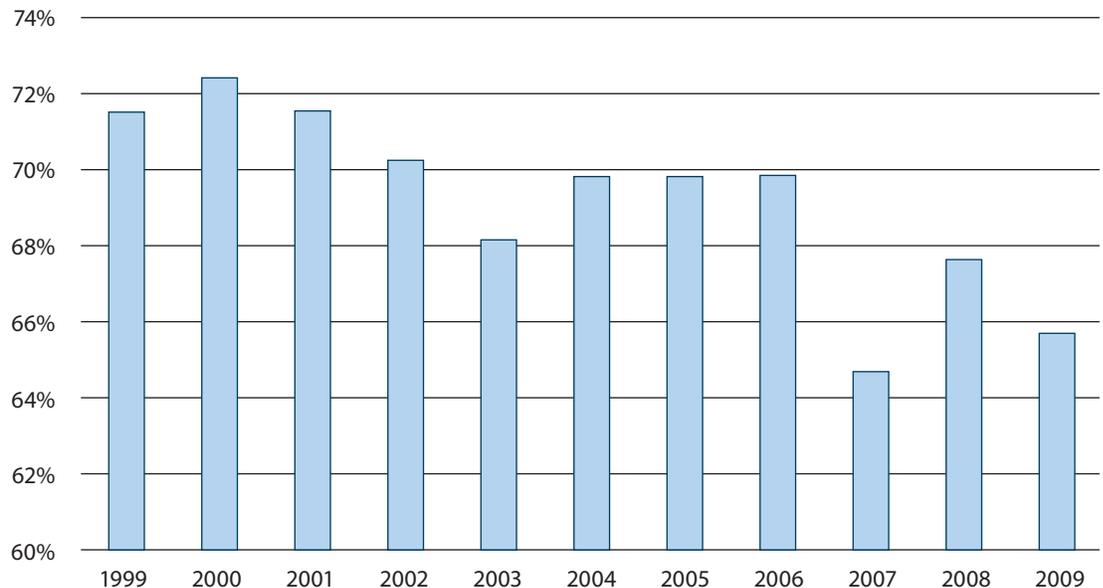
While many Virginians are fortunate to obtain health insurance from their employers, the percentage of Virginians under age 65 who get health insurance at work has declined over the last decade, dropping from 71.6 percent in 1999 to 65.7 percent in 2009 (see **Figure 1**).⁵ Moreover, the cost of that insurance has skyrocketed, and employees are shouldering more of the costs.

Not surprisingly, the problem is particularly acute for small businesses—defined here as those with under 50 workers. In 2009, only 37 percent of such small businesses offered health coverage to their workers. This was a significant drop from just



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Figure 1: Percentage of Virginians Under 65 with Employer-Based Health Insurance, 1999 to 2009



Source: U.S. Bureau of the Census, “Health Insurance Historical Tables,” Table HIA-6 “Health Insurance Coverage Status and Type of Coverage by States—Persons Under 65: 1999 to 2009” <http://www.census.gov/hhes/www/hlthins/data/historical/index.html>

one year earlier. In 2008, insurance was offered by 44 percent of such small businesses. The current percentage in Virginia is below the national average for the first time since 1998.⁶

The reduction in employer-based coverage can largely be traced to the rising cost of health insurance premiums. The average yearly employer health insurance premium for an individual with no dependents working in a small business was \$4,652 in 2009—almost \$400 more than two years previous and more than double the cost in 2000.⁷ The average annual employer cost of a family plan was just under \$12,500 a year in 2009.⁸

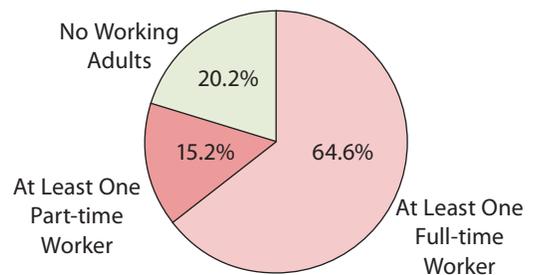
The growth in the costs of health care services in Virginia has exceeded per capita personal income growth by over 35 percent in the past ten years, and premium increases have been even higher, “outstripping economic growth in general” according to the Virginia Health Reform Initiative Advisory Council.⁹ Thus, Virginia workers must cope with relatively lower income to pay for higher premium costs and increased cost sharing at the point of service.¹⁰

As is true for the entire nation, the majority of uninsured in Virginia are working people. Nearly two-thirds of the uninsured live in families with at least one person in the household working full time (see **Figure 2**).¹¹ Yet 35.2 percent of the nonelderly uninsured have incomes at or below the federal poverty level and an additional 26.8 percent have incomes 101 to 200 percent of the poverty level (see **Figure 3**).¹² Even if they are offered insurance at their jobs, many workers are unable to afford the required employee premiums.

Public Insurance

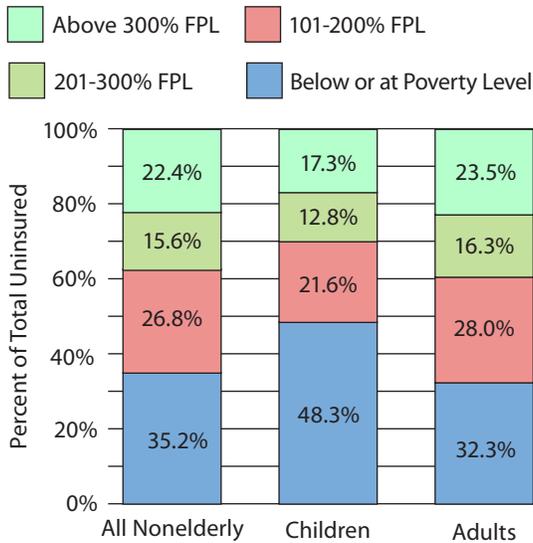
When people are unable to secure health insurance through their employment, they may seek assistance from the government. In this regard, Virginia’s public health insurance programs fail to assist large segments of the uninsured, even individuals who are extremely poor. Medicaid is the largest public health insurance program for certain low-income people. The state government and the federal government jointly fund the program, with Virginia usually paying 50 percent of the costs. A comparison of Medicaid expenditures by state ranked Virginia forty-seventh in per-capita Medicaid expenditures in federal fiscal year 2008.¹³ This low ranking is largely attributable to restrictive eligibility rules and low payments to providers. For example, in 2010 Virginia’s Medicaid program ranked 46th nationally in income

Figure 2: Virginia Nonelderly Uninsured by Type, 2008-2009^a



Source: Allison Cook, Genevieve Kenny, and Emily Lawton, *Profile of Virginia’s Uninsured and Trends in Health Insurance Coverage, 2000-2008*. (Prepared for the Virginia Health Care Foundation by the Urban Institute.) (Washington DC: Urban Institute, January 2010) p. 28. http://www.vhcf.org/wp-content/uploads/2010/10/Profile-of-Uninsured-in-VA_final_Jan2010.pdf

^a Average for 2008 and 2009.

Figure 3: Share of Virginia Nonelderly Uninsured by Federal Poverty Level, 2008-2009^a

Source: Allison Cook, Genevieve Kenny, and Emily Lawton, *Profile of Virginia's Uninsured and Trends in Health Insurance Coverage, 2000-2008*, p. 27.

^a Average for 2008 and 2009.

eligibility for parents.¹⁴ For low-income working parents, the Virginia's Medicaid income eligibility level is set at under \$7,000 per year for a family of four.¹⁵ Only truly impoverished parents qualify for Medicaid assistance in the commonwealth.

In addition, unlike many states, Virginia offers no Medicaid or other public coverage to childless adults who are not disabled, over 65 years of age, or pregnant. Thus, even if totally destitute, such adults are ineligible for publicly funded health insurance. There are approximately 565,000 uninsured non-elderly adults in Virginia who fall into this category.¹⁶

While Virginia's public health insurance programs for children are more generous, they still fail to reach many low-income, uninsured children. Virginia's Children's Health Insurance Program, funded through Title XXI of the Social Security Act, is called Family Access to Medical Insurance Security (FAMIS). This program covers uninsured children whose family income exceeds Medicaid eligibility. FAMIS limits coverage to families with gross income under 200 percent of the federal poverty line. This income eligibility level is lower than for 42 other states.¹⁷

Consequences of Being Uninsured and Underinsured

The consequences of being uninsured can be dangerous and even life threatening. In addition to decreased or delayed access to primary and preventive medical care, the uninsured have increased rates of undiagnosed chronic conditions that

often lead to hospitalizations for otherwise avoidable conditions.¹⁸

Virginians who cannot afford the costs of treatment either forgo necessary health care or seek health care from overburdened health clinics and hospital emergency rooms. These gaps in coverage contribute to an annual burden of uncompensated care that amounts to \$43 billion nationwide.¹⁹ In 2009 Virginia hospitals admitted 106,000 uninsured patients. The hospitals provided \$491 million in charity care services and experienced \$376 million in bad debt expenses.²⁰ For 29 Virginia hospitals, charity care (uncompensated care, bad debt and taxes) constituted over 15 percent of their overall expenses.²¹ Three Virginia hospital systems provide over 25 percent of their inpatient care to Medicaid patients and the uninsured: 42.9 percent at VCU Health System; 28.5 percent at the University of Virginia Medical Center; and 27.3 percent at the Carilion Medical Center.²²

When a patient fails to pay a medical provider, the patient incurs medical debts that the provider usually seeks to collect. Medical debt affects both the uninsured and the "underinsured"—consumers who have health insurance but their coverage does not cover all necessary care or costs because of preexisting condition restrictions, limits on services, caps on coverage, and out-of-pocket expenses.

For the underinsured, the harm from exclusions for pre-existing conditions cuts across the entire U.S. population. An estimated 57.2 million Americans under the age of 65 suffer from a pre-existing condition.²³ A Congressional investigation conducted after passage of the ACA found that the four largest U.S. for-profit health insurers denied policies to one out of every seven applicants based on their prior medical history.²⁴ Diagnoses that usually led to coverage denials included common conditions, such as pregnancy, diabetes, and heart disease.²⁵

The medical debt incurred by the uninsured and underinsured can quickly become a part of the secondary markets for consumer credit and debt financing. Throughout the United States, about 29 million adults have medical debt, and even relatively small levels of medical debt can have major consequences on financial security.²⁶ Overall, 20 percent of indebted low- and middle-income households reported having a major medical expense in the previous three years, with those medical expenses contributing to their current level of credit card debt.²⁷ One study estimates that 62 percent of all bankruptcies have a medical cause, and the share of bankruptcies attributable to such causes increased by 50 percent between

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2001 and 2007.²⁸ In 2009, there were 35,338 non-business bankruptcy filings in Virginia.²⁹ If Virginia conformed to the national pattern than approximately 21,900 of those bankruptcies had a medical cause.

The Affordable Care Act

The ACA addresses all of the above problems: the high cost of health care and health insurance premiums, the private insurance practices that leave many insured people without coverage when they need it, and the uninsured. The primary components of ACA include private insurance reforms, an expansion of Medicaid, and a Health Benefit Exchange to serve as a marketplace for affordable coverage through public insurance or private insurance with federal subsidies.

Several important insurance reforms are already in effect and provide significant protections to consumers. Since July 2010, the federal government has operated a high-risk pool plan for Virginia residents who have preexisting conditions and who have been uninsured for six months or more. This “Preexisting Condition Insurance Plan” (PCIP) includes a broad range of services, and there are no waiting periods for coverage. Premiums for a standard policy for Virginia residents range from \$156 per month for an individual from 19-34 years of age to \$498 for those over age 55.³⁰

A very popular provision under the act that took effect in September 2010 allows young adults to stay on their parents’ health insurance plans until they reach age 26. It is estimated that 54,000 young adults in Virginia will benefit from this provision.³¹ Previously, this population often remained uninsured for months or even years after losing coverage from their parents’ plans.

Under ACA, insurance companies can no longer deny coverage to children with pre-existing health conditions, reversing a practice that has plagued families for decades. It is estimated that 123,000 Virginia children will benefit from this new prohibition.³² Moreover, in 2014, preexisting condition restrictions will be prohibited for adults as well.³³

ACA prohibits lifetime limits on all new insurance plans issued after March 23, 2010, and annual limits on specific coverage must be totally eliminated by 2014.³⁴ These are essential protections for very sick people such as cancer patients and premature infants who, before ACA, could quickly hit caps in their policies, losing coverage just when they needed it the most.

For the 1.1 million Medicare beneficiaries in Virginia, cost-sharing for preventive health services, such as mammograms for breast cancer, colonoscopies for colon cancer, and PSA testing

for prostate cancer have been eliminated.³⁵ In 2010 around 80,000 Virginia Medicare beneficiaries with high prescription drug expenses reached the Medicare Part D “doughnut hole,” which requires full payment for over \$3,600 in annual prescription costs until catastrophic coverage is available. ACA provided each person in the doughnut hole a \$250 rebate check in 2010.³⁶ Beginning in 2011, ACA will phase out the Part D doughnut hole until its complete elimination in 2020.³⁷

Another direct benefit of ACA that is already in place is the tax credit for small businesses that do provide health insurance to their employees. Small employers with fewer than 25 full-time-equivalent employees³⁸ who have average annual wages less than \$50,000 can receive a tax credit for up to 35 percent of the cost of employee insurance.³⁹ At least 14,000 small businesses in Virginia should qualify for this tax credit.⁴⁰

Over 130 government entities and companies in Virginia have signed up for ACA’s Early Retiree Re-Insurance Program. This program provides federal subsidies for individuals who retire before they are eligible for Medicare at age 65. The approved employers include the City of Richmond, Dominion Resources, Colonial Williamsburg Foundation, the Commonwealth of Virginia, and Washington and Lee University.⁴¹

In 2011, ACA requires new accountability in premium pricing by health insurance companies. Increases in insurance premiums will be subject to additional review and oversight,⁴² and stringent Medical-Loss Ratio (MLR) standards will take effect. Insurers are required to spend at least 80 percent of premium dollars on medical care and qualifying improvement activities. The MLR ratio for large group policies is 85 percent. Companies that fail to meet the MLR criteria will be required to provide rebates to their policyholders beginning in 2012.⁴³ The rate review and MLR requirements are critical efforts to rein in skyrocketing premium costs and establish efficiencies. Until ACA, the premiums, expenditures and profits of Virginia health insurance companies were subject to very little, if any oversight.

Beyond the above provisions which provide direct assistance to consumers, the Commonwealth of Virginia is also benefiting from over \$50 million in federal grants and projects which are designed to help the state plan for future changes and/or evaluate additional health system reform.⁴⁴ For example, the State Corporation Commission’s Bureau of Insurance has received \$1.8 million to develop its rate review and consumer assistance programs. The commonwealth was awarded a \$1 million planning grant related

to its Health Benefit Exchange. Over \$7 million is now available for various projects to improve Virginia's health care workforce, such as expanding opportunities for primary care residencies and advanced nursing education. Nearly \$30 million will allow Virginia to expand and increase capacity in its network of federally supported health centers, which serve over 250,000 lower income patients each year. Federal funding will also support 90 percent of the cost of developing technology for a new web-based system for determining eligibility for Medicaid and other Virginia public benefits.

All this preparation is necessary to have systems in place for the three major ACA provisions that take effect in 2014. First, the Health Benefits Exchange will begin operation in 2014, providing a "one-stop shop" to compare, select and purchase private health insurance. The exchange will not only calculate and help to administer the tax credit subsidies designed to make products sold on the exchange affordable, but it will also determine eligibility and facilitate enrollment for Medicaid, the FAMIS program for uninsured children, and other public benefit programs.

The exchange will also be essential to accommodate the second major 2014 provision—the requirement that certain employers provide, and nearly all individuals have, health insurance.⁴⁵ The "minimum essential coverage provision," also called the "individual mandate" has been the most controversial of all of ACA's requirements. Yet, many health economists agree that the private health insurance reforms, such as prohibiting preexisting condition restrictions and eliminating lifetime and annual coverage limits would not be possible without it.⁴⁶ By adding millions of currently uninsured people and their premiums into the insurance risk pools, the insurance companies will be able to pay for the additional costs of ACA's more generous coverage provisions.

Many opponents of the mandates are not aware that the employer mandate only applies to larger businesses (with over fifty employees), and there are several important exceptions to the individual mandate, such as exemptions for some lower income people, individuals with certain religious objections, and people uninsured for a short period of time.⁴⁷ Moreover, the penalties that apply to non-compliant individuals are modest, typically falling well below what it would cost to purchase insurance.⁴⁸

The third major reform in 2014 is the required increase in Medicaid income eligibility. As described earlier, Virginia's Medicaid eligibility income limits for adults are among the very lowest in the country. ACA establishes new

income limits for Medicaid set at 133 percent of the federal poverty line.⁴⁹ In 2011, this level is \$14,484 per year for an individual and \$29,726 for a family of four. This change has enormous implications for Virginia, since anywhere from 270,000 to 425,000 individuals may newly qualify for Medicaid coverage, including very poor adults who have never had insurance.⁵⁰ The federal government will cover 100 percent of the Medicaid cost of this newly eligible population for three years. The federal share reduces to 95 percent in 2017 and continues to decline until 2020, when it is set at 90 percent.⁵¹ This component of ACA will bring billions of dollars to Virginia to support our health care infrastructure, physicians and other medical providers, patients, and the commonwealth's overall economy.⁵²

Implementing the ACA in Virginia

On March 23, 2010, the same day that the ACA was signed by President Obama, Virginia Attorney General Kenneth Cuccinelli filed the first lawsuit in the nation to challenge ACA's individual mandate. In December 2010, Judge Henry Hudson, federal judge in the Eastern District of Virginia, ruled the individual mandate was unconstitutional because it exceeded congressional powers.⁵³ Judge Hudson did not find the entire ACA unconstitutional, and he did not enter any kind of injunction.

It is less well known that a second case challenging aspects of the ACA was filed in the U.S. District Court in Lynchburg, Virginia. That case was filed by Liberty University and a number of individuals who objected to several parts of the law, including the individual mandate. In that case, U.S. District Court Judge Norman Moon ruled the individual mandate was a constitutional exercise of congressional authority under the commerce clause.⁵⁴

Both of these cases are now pending in the 4th Circuit Court of Appeals in Richmond, and they will be argued on the same day in May 2011. Many other challenges to the ACA have been filed in and by other states. Notably, in a Florida case brought by governors and/or attorneys general from twenty-six states, the court found the individual mandate was unconstitutional.⁵⁵ That case is now on appeal in the 11th Circuit Court of Appeals. The United States Supreme Court will ultimately resolve the constitutional question. Because the Supreme Court has declined to expedite review, as requested by Attorney General Cuccinelli, its decision is not expected until 2012.⁵⁶

Beyond the litigation, there are efforts in Congress to repeal all or parts of ACA and/or

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defund parts of it. On January 19, 2011, the U.S. House of Representatives passed H.R. 2 by a vote of 245 to 189, to repeal the ACA,⁵⁷ but, to date, the Senate has not taken up the bill. The Congressional Budget Office issued a report on February 18, 2011 finding repeal of the law would add \$210 billion to the nation’s deficit over the next decade and would leave 57 million non-elderly people uninsured.⁵⁸

Meanwhile, Virginia is actively engaged in evaluating ways to improve the commonwealth’s system of health care and taking important steps to comply with ACA’s legal requirements. In August of 2010, Governor Bob McDonnell appointed twenty-four political, health system, civic, and business leaders to a new Virginia Health Reform Initiative (“VHRI”) Advisory Council. In appointing this group, the governor said:

The recommendations of the Council will help create an improved health system that is an economic driver for Virginia while allowing for more effective and efficient delivery of high quality health care at lower cost. . . Every Virginian needs access to affordable health care. The challenge is how to provide that access in an economically responsible manner. . .⁵⁹

The advisory council is chaired and led by Virginia’s Secretary of Health and Human Resources, Dr. William Hazel. VHRI was directed to develop recommendations about implementing health reform in Virginia and to seek innovative solutions that meet the needs of Virginia’s citizens and its government in 2011 and beyond.

The governor also created six task forces to focus on the following areas: Medicaid reform, capacity, service delivery and payment reform, technology, insurance reform, and purchaser perspectives. In December 2010, after very comprehensive study, analysis and deliberations, the advisory council issued its report.⁶⁰ In an overall assessment of Virginia’s health care system, the report states:

Surprising to some and embarrassing to all, Virginia’s overall health system performance is actually quite mediocre. To be sure, there are excellent hospitals, physicians, health centers, and innovative health plans that are working hard to effectuate local and statewide improvement. Still, it is hard to be proud of a system in which nearly one million Virginians—and 150,000 children—lack health insurance and timely access to quality care that only it can ensure. Something is wrong with a system in

which only 37 percent of small employers offer health insurance to their workers, down from 48 percent ten years ago. Virginia’s overall quality of care is average, with strengths in cardiac care, hospital care generally, and home health. Weaknesses in Virginia’s quality rankings include nursing home care, diabetes care, and maternal and child health. Specifically, Virginia ranks 41st in the nation in breast cancer death rates, and 35th in infant mortality. None of these statistics measure up to Virginia ranking sixth, nationwide, in median family income.⁶¹

In addition to a careful review and analysis of data and information in the six substantive areas, the advisory council adopted 28 specific recommendations.⁶² Most of recommendations are independent of ACA requirements. This reflects the VHRI’s focus on improving Virginia’s health system, with or without national health reform. The key recommendations that serve consumer interests include the following:

- Identify, pilot, test, and spread effective models of service delivery and payment reform for use in both public and private health programs.
- Protect the existing health care safety net to ensure its continued existence up to and after 2014. This recommendation very importantly acknowledges that there still will be uninsured people after 2014, and safety net providers will be essential in the delivery of services to the large population of newly eligible for coverage through Medicaid and the Exchange.
- Improve use of health information technology, such as electronic health records and telemedicine in areas where there are underserved populations. In this area, the council emphasizes the necessity of expanding broadband access throughout the commonwealth.
- Increase health workforce capacity and improve distribution of health professionals around Virginia. In addition to graduating more health professionals, there must be better use of multi-disciplinary health teams and an examination of scope of practice restrictions for non-physicians.
- Support additional care coordination for different populations served in Virginia’s Medicaid program and evaluate cost-sharing options. The 2011 General Assembly endorsed expanded care coordination and managed care in its budget.⁶³
- Automate eligibility systems for Virginia’s health and human services programs. This

Virginia Gateway project will serve as a platform for the Health Benefit Exchange.

- Create and operate a consumer-friendly Virginia Health Benefits Exchange to preserve and enhance competition. Focus on value, quality and transparency. Explore how the Exchange can reduce costs. The 2011 General Assembly adopted legislation that authorizes the Exchange.⁶⁴ With its planning grant, the VHRI will develop specific recommendations for the Exchange by October 2011.
- Amend Virginia laws to allow the State Corporation Commission's Bureau of Insurance to implement and enforce the insurance market reforms and other applicable provisions of the ACA. The 2011 General Assembly adopted legislation to do this.⁶⁵

With the valuable work of the VHRI, Virginia is well positioned to move forward. The VHRI Advisory Council will continue to serve through 2011 to act as a fact-finder and sounding board for the secretary as he works with the governor and the legislature to implement the recommended steps and develop additional proposals.

Conclusion

In 1912, when Theodore Roosevelt was running for re-election, his party's platform advocated for national health insurance. Since then, significant steps have been taken to improve access to health care, and legislators from both political parties have presented ideas such as mandatory insurance for all individuals.⁶⁶ Yet, affordable coverage for all Americans remained elusive. With health insurance costs spiraling higher each year, the ranks of the uninsured growing, and the U.S. per capita costs for health care being higher than all other industrialized nations,⁶⁷ the need for the key provisions of the Affordable Care Act is compelling. While currently the subject of intense debate and controversy, the Affordable Care Act offers great promise in Virginia and throughout the United States. When fully **implemented and understood** by more people, the law will be accepted as an essential component of the country's health care system.

ABOUT THE AUTHOR:

Jill Hanken is a staff attorney at the Virginia Poverty Law Center (VPLC), where she specializes in health issues. She earned a B.A. in urban studies at Georgia State University and a law degree from Boston College Law School. Jill worked with Legal Services in Charleston, South Carolina, before coming to Virginia and the Poverty

Law Center. During a hiatus from VPLC, she worked as an Administrative Law Judge for the Virginia Department of Medical Assistance Services. At VPLC, Jill provides technical assistance and training and also handles legislative and administrative advocacy. She has been one of the key advocates promoting the development and improvement of public health insurance programs for low-income Virginians. In 2006 she received the Virginia State Bar Legal Aid Award and in 2009 she received the Outstanding Partner Award from the Virginia Department of Medical Assistance Services "in recognition of outstanding service and contributions to Virginia's Medicaid and FAMIS programs."

End Notes

Editor's note: When available, web links for sources are shown. At the time of publication all of the links worked. However, some links may be unstable and may not work with certain browsers or they may have been modified or withdrawn. If you cannot open a link with your default browser, then try another. For example, if you cannot open the link with Microsoft Internet Explorer, try Firefox, Chrome, or Safari.

- 1 Public Law 111-148, as amended by the Health Care and Education Reconciliation Act, Public Law 111-152.
- 2 Bureau of Economic Analysis, U.S. Department of Commerce, "State Personal Income 2010," News Release BEA 11-12 (March 23, 2011). <http://www.bea.gov/newsreleases/regional/spi/2011/pdf/spi0311.pdf>
- 3 The Henry J. Kaiser Family Foundation, *StateHealthFacts.org*. Note: the estimates are an average for 2008 and 2009. <http://www.state-healthfacts.org/profileglance.jsp?rgn=48>
- 4 The Commonwealth Institute, "Poverty Rises in Virginia, Nation." Press release issued September 16, 2010. <http://thecommonwealthinstitute.org/Portals/16/Labor%20and%20Wage/100916tcipovertyday.pdf>
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- 6 The Commonwealth Institute, *Aftersbock: The State of Working Virginia* (Richmond: The Commonwealth Institute, November 2010), p. 26. http://thecommonwealthinstitute.org/Portals/16/Labor%20and%20Wage/stateofworkingva10_web.pdf
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- 9 Virginia Health Reform Initiative Advisory Council, *Report of the Virginia Health Reform Initiative Advisory Council*. (Richmond: Virginia Health Reform Initiative Advisory Council, December 20, 2011), p.4. <http://www.hhr.virginia.gov/Initiatives/HealthReform/docs/VHRIFINAL122010>
- 10 *Ibid.*
- 11 Allison Cook, Genevieve Kenney, and Emily Lawton, *Profile of Virginia's Uninsured and Trends in Health Insurance Coverage, 2000-2008*. (Prepared for the Virginia Health Care Foundation by the Urban Institute.) (Washington DC: Urban Institute, January 2010) p. 3. http://www.vhcf.org/wp-content/uploads/2010/10/Profile-of-Uninsured-in-VA_final_Jan2010.pdf
- 12 In 2011 the federal poverty line is \$22,350 per year for a family of four; 200 percent of that figure is \$44,700. <http://aspe.hhs.gov/poverty/11poverty.shtml>

"With health insurance costs spiraling higher each year, the ranks of the uninsured growing, and the U.S. per capita costs for health care being higher than all other industrialized nations, the need for the key provisions of the Affordable Care Act is compelling."

- 13 Joint Legislative Audit and Review Commission, *Virginia Compared to Other States, 2010 Edition*, Table 23, available at <http://jlarc.state.va.us/states/t23.pdf>
- 14 Kaiser Family Foundation, *State Health Facts*. Table showing income eligibility limits for working adults at application as a percent of the federal poverty level by scope of benefit package, January 2011. <http://www.statehealthfacts.org/comparereport.jsp?rep=54&cat=4&sortc=1&o=a>
- 15 *Ibid.*
- 16 Kaiser Family Foundation, *State Health Facts*. Table showing Virginia distribution of adults without dependent children. <http://www.statehealthfacts.org/profileind.jsp?cmprgn=1&cat=3&rgn=48&ind=645&sub=39>
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- 18 Institute of Medicine. *America's Uninsured Crisis, Consequences for Health and Health Care*. (Washington, DC: National Academies Press, February 2009.) <http://www.iom.edu/Reports/2009/Americas-Uninsured-Crisis-Consequences-for-Health-and-Health-Care.aspx>. See also Kaiser Commission on Medicaid and the Uninsured, *The Uninsured A Primer, Key Facts About Americans Without Health Insurance*, (December 2010), pp 10-11. <http://www.kff.org/uninsured/upload/7451-06.pdf>
- 19 Congress made this specific finding within the ACA. See 42 U.S.C.A. § 18091(a)(2)(F). See also, Families U.S.A., *Hidden Health Tax, Americans Pay a Premium* (Washington DC: Families USA, 2009), pp. 2, 6. <http://familiesusa2.org/assets/pdfs/hidden-health-tax.pdf>
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- 21 Virginia Health Information, *2010 Industry Report*. http://www.vhi.org/industry_reports.asp. The taxes included in the charity care calculation reflect taxes paid by for-profit hospitals—an accounting convention used by Virginia Health Information.
- 22 Sheldon M. Retchin, CEO, VCU Health System, Presentation to Virginia Senate Finance Subcommittee on Health and Human Resources: Impact of Health Care Reform on Virginia's Academic Medical Centers, slide 11 (Aug. 24, 2010), <http://sfc.virginia.gov/pdf/health/2010%20Session/August24%20Jt%20Mtg/No5VCU.pdf>, slide 11.
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- 27 *Ibid.*
- 28 David U. Himmelstein et al., *Medical Bankruptcy in the United States, 2007: Results of a National Study*, 122 Am. J. of Med. 741, 742 (2007). http://www.pnhp.org/new_bankruptcy_study/Bankruptcy-2009.pdf
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- 32 *Ibid.*
- 33 PPACA §2704
- 34 PPACA, §1001, Part A, Sec. 2711.
- 35 Kaiser Family Foundation, Estimate of Total Number of Medicare Beneficiaries, 2010, <http://www.statehealthfacts.org/comparemtable.jsp?ind=290&car=6>.
- 36 US Department of Health and Human Services, <http://www.healthcare.gov/center/reports/medicare03222011a.html>.
- 37 Recon. Act §1101
- 38 ACA defines full-time work as 40 hours/week. So two 20/hr/wk workers = 1 FTE. Four 10/hr/wk workers = 1 FTE.
- 39 PPACA §1421
- 40 Joanne Corte Grossi, MIPP, Regional Director, US Department of Health and Human Services, Region III, "Affordable Care Act. The One Year Anniversary: What Implementation Means for Virginia", Richmond Health Care Forum, March 22, 2011, Slide 7.
- 41 *Ibid.*, Slide 8.
- 42 PPACA §§1003, 10101
- 43 PPACA §1001, Part A, Sec. 2718
- 44 Office of Senator Mark Warner, Update on the Affordable Care Act, email dated March 23, 2011.
- 45 PPACA §§1501, 1513
- 46 Jonathan Gruber, *Getting the Facts Straight on Health Care Reform*, 361 *New England Journal of Medicine*, 2497, 2498 (2009), at <http://healthcarereform.nejm.org/?p=2473>. In Congressional hearings, testimony on behalf of the National Association of Insurance Commissioners also noted that due to the severe adverse selection resulting from the elimination of preexisting condition exclusions for individuals, state regulators can support these reforms to the extent they are coupled with an effective and enforceable individual purchase mandate and appropriate income-sensitive subsidies to make coverage affordable. *Roundtable Discussion on Expanding Health Care Coverage: Hearing Before the Senate Finance Committee*, 111th Cong. 3 (2009) (statement of Sandy Praeger, Chair of the Health Insurance and Managed Care Committee, National Association of Insurance Commissioners).
- 47 Exceptions to the individual mandate include individuals not lawfully residing in the US, religious objectors, incarcerated populations, native American tribes, taxpayers with incomes below the filing threshold, recipients of hardship waivers, and people uninsured for less than three months. PPACA §1501, Recon. §1002.
- 48 Failure to maintain minimum coverage will result in a penalty of the greater of \$95 per adult (\$48 per child) or 1% of family income in 2014, \$325 per adult (\$163 per child) or 2% of family income in 2015, and \$695 per adult (\$398 per child) or 2.5% of family income in 2016 up to certain family maximums. PPACA §1501, Recon. §1002.
- 49 PPACA §2001.
- 50 Virginia Health Reform Initiative Advisory Council, *Report of the Virginia Health Reform Initiative Advisory Council*, (Richmond: Virginia Health Reform Initiative Advisory Council, December 20, 2011), p.43 <http://www.hhr.virginia.gov/Initiatives/HealthReform/docs/VHRIFINAL122010.pdf>
- 51 Recon. Act, §1201.
- 52 John Holahan and Irene Headen, *Medicaid Coverage and Spending in Health Reform: National and State-By-State Results for Adults at or Below 133% FP* (Washington DC: The Urban Institute, May 2010), Table 12. The study was prepared for Kaiser Commission on Medicaid and the Uninsured. <http://www.kff.org/healthreform/8076.cfm>
- 53 *Commonwealth ex rel. Cuccinelli v. Sebelius*, 728 F. Supp. 2d 768 (E.D.Va. 2010)
- 54 *Liberty Univ., Inc. v. Geithner*, 2010 U.S. Dist. LEXIS 125922 (W.D. Va. 2010)
- 55 *Florida v. U.S. Department of Health and Human Services*, 2011 U.S. Dist. LEXIS 8822 (N.D. FL 2011)

- 56 <http://www.thenewamerican.com/usnews/health-care/7256-supreme-court-rejects-fast-track-request-for-obamacare-challenge>
- 57 <http://thomas.loc.gov/cgi-bin/bdquery/z?d112:HR00002:@@@R>
- 58 Letter from Congressional Budget Office to The Honorable John Boehner, Speaker of the U.S. House of Representatives, February 18, 2011. <http://www.cbo.gov/ftpdocs/120xx/doc12069/hr2.pdf>
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- 60 Report of the Virginia Health Reform Initiative Advisory Council, December 20, 2011, <http://www.hhr.virginia.gov/Initiatives/HealthReform/docs/VHRIFINAL122010.pdf>
- 61 *Ibid.*, p. ii.
- 62 *Ibid.*, Appendix D.
- 63 HB 1500, Conference Report, Item 297 #21c. <http://leg2.state.va.us/WebData/11amend.nsf/ebea1c0863d2f61b8525689e00349981/b967211d823d39b085257844005a02ee?OpenDocument>
- 64 HB 2434, patroned by Delegate Terry G. Kilgore. <http://leg1.state.va.us/cgi-bin/legp504.exe?111+sum+HB2434>
- 65 HB 1928, patroned by Delegate Daniel Marshall, III. <http://leg1.state.va.us/cgi-bin/legp504.exe?ses=111&typ=bil&val=hb1928>; HB 1958, patroned by Delegate Thomas D. Rust. <http://leg1.state.va.us/cgi-bin/legp504.exe?ses=111&typ=bil&val=hb1958>
- 66 The concept of the individual health insurance mandate originated in 1989 at the conservative Heritage Foundation. Stuart M Butler, *Assuring Affordable Health Care for all Americans, The Heritage Lectures #218*, Oct. 2, 1989. In 1993, Republicans twice introduced health care bills that contained an individual health insurance mandate. Consumer Choice Health Security Act (SB 1743), Health Equity and Access Reform Today Act (SB 1770). *History of the Individual Health Insurance Mandate, 1989-2010*. <http://healthcarereform.procon.org/view.resource.php?resourceID=004182>
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