Appendix D - UNIVERSITY HONORS PROGRAM
SENIOR PROJECT - APPROVAL

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I have reviewed this completed senior honors thesis with this student and certify that it is a project commensurate with honors level undergraduate research in this field.

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Tenn who Care's?

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Tenn who Cares?

Preface

Let me begin by giving the purpose of my project. I began researching TennCare as an innovative Tennessee program. One which attempted to solve ever increasing Medicaid costs, while at the same time extending health care opportunities to groups that were not covered by Medicaid, but still could be classified as poor. This basic framework has remained constant, and in light of recent developments my goal is as follows.

An informed populace is vital to making a democracy work, even a representative democracy. Citizens need to be well informed to make the best decisions (relative to their own beliefs). We seem to live in an age of apathy, when barely one half of eligible voters exercise that right during a Presidential election and even fewer people vote at other times. In the 2000 Presidential Election, only 51.3% of the voting age population exercised their right to vote. Furthermore, almost 50 million people old enough to vote are not registered ("Voter Registration and Turnout 2000"). And this was actually higher than expected. Attempts to influence elected leaders are few as well on an individual level, leading one to believe that few people really care about public policy anymore. Yet, there are still a great many of our citizens who vote, realize how policies effect them, want to shape policy, etc. Surely being fully informed about the issues enables an individual to support the appropriate position. But also, if we take a pluralistic view of the world (and it is understandable that pluralism can be true, at least in part), then this belief would seem to work on an even larger scale. As individuals form groups to

achieve specific goals, any lack of, or distorted, information would cause inefficiency in the political process. But with high levels of information, individuals are able to intelligently support policies and programs that effect them, joining groups to enhance their political power in support of those goals. This prevents an individual from supporting one side of an issue, only to change his or her position often upon the receipt of any new information.

TennCare is one program area that, in general, the public is not adequately informed about. A perfect example was given by our local news media recently. One individual, when asked how to rectify Tennessee's current budget problems responded by castigating TennCare and making references to the elderly who, it was claimed, were a drain on the state's resources. This person, who will remain anonymous, is typical of many, though certainly not all, Tennesseeans. While some of the state's citizens are well informed concerning TennCare, this case proves that others are not. This individual and all others like him are my target audience. They apparently lack even the basic knowledge to make a decision regarding TennCare, and all the public opinion polls regarding anything relating to TennCare are not very useful as more than a very short-term guide to public opinion. Hopefully, by the end of this paper it will be understood just how incorrect this man is. My secondary audience is the group of people who are already informed about TennCare. I hope to add to their knowledge if possible, and perhaps bring a fresh perspective to the opinions of that group.

Let me continue to introduce my topic with the idea that the budget should be a reflection of the state's values. Important programs, projects, etc., will get adequate funding as the state's goals are furthered. If we assume that the populace is informed and

that legislators are responsive to public opinion, then the budget should reflect, though perhaps not with perfect accuracy, the views of the people. I say this because I hope to achieve the first assumption with this document. And now, more than ever, does the budget need to reflect the informed preferences of the people.

Tennessee is in a budget crisis. The state faces a structural deficit that will not correct itself. Revenues are not adequate to meet expenses, and the future looks even bleaker (Wade, 2002). The legislators of this state may or may not take steps to secure adequate funding for the future. Nevertheless, there is an appropriate size of government in the minds of its citizens, and Tennesseans are no different than other peoples. Though not often stated in dollar terms or population served, this appropriate size usually takes the form of "The government should do this" or "The government should stay out of that."

If we return to our previous assumption of an informed populace, we get an overall, appropriate size of government. In our budget crisis, money is lacking for many programs, and funding cuts have been proposed for future years. That is where a state's values begin to be revealed. And with our assumption in place, these values are less transient as opinions, attitudes, and beliefs change less than if people are not well informed.

Introduction

With this in mind, attention must be given to one of the least understood, yet most expensive programs the State of Tennessee undertakes. TennCare was first introduced on April 8, 1993 as the capstone to Governor Ned McWherter's administration. He saw it as a solution to the problems of Medicaid, one of which was up to twenty percent inflation per year. In its first year, the TennCare program was projected to spend $2.9 billion to insure almost 1.5 million people (Humphrey, "Governor offers sub", 1993, p. A1). Most of these people were already on Medicaid, but hundreds of thousands of people would now have access to health insurance for only an additional $100 million over the previous fiscal year. Future benefits were expected to be even greater as the governor expected savings to exceed $6.5 billion over its first five years. Considering that in the fiscal year before TennCare was enacted the State of Tennessee posted a $150 million surplus, spending a slightly greater amount in the present to bring about future savings seemed not only possible, but the appropriate course of action (Humphrey, "Governor offers sub", 1993, p. A1).

Medicaid is the federal government's attempt to grant health care coverage to the indigent. The Health Care Financing Agency (HCFA), parent organization to Medicaid, Medicare, and other programs, establishes broad goals for the program. Individual states then set their own goals and requirements within the HCFA's broad goals and must have approval from the HCFA for these state goals. The majority of the funding comes from the federal government. In the past, most states treated Medicaid as a fee-for-service system. If someone on Medicaid goes to the doctor, any tests, treatments, etc., are paid for by the state according to the doctor's predetermined rate ("Overview of the Medicaid

Program"). By observing the plan, one could see that Medicaid would make the poor healthier. But there was no attempt made on controlling costs, and it will be seen just how bad this problem is.

Medicaid in Tennessee was seen as mismanaged. According to the governor, "the existing system amounts to 'an elaborate hocus-pocus program of hospital provider fees in order to feed our addiction to federal matching funds'" (Humphrey, "Governor offers sub", 1993, p. A1). Abandoning it for TennCare and its managed care policies, would lead to both massive savings and better health in Tennessee (A1).

Economic growth in 1993 was anticipated as three to four percent. Mark Greene, President of the Tennessee Medical Association, stated in regards to this revenue growth, "That's way behind medical inflation" (Ferrar, "Caution, enthusiasm", 1993, p. A7). Few groups were more skeptical than Greene's association of doctors, but even the TMA had to admit TennCare might prove to be more successful than Medicaid. Of course those who stood to benefit most favored the plan, while those like the TMA who may actually lose somewhat questioned its future funding. Overall, response to the newly introduced program could be summed up in two words: enthusiasm and caution. Everyone experienced either one or both of these emotions regarding TennCare. Superficially, it appeared to achieve important state goals of controlling expenses and increasing public health. But despite this, questions abounded, especially concerning state funding of TennCare as well as the roles of insurance companies and health care providers (A7).

In 1993, President Clinton was making an attempt at creating a national health care system. TennCare was designed to bridge the gap between Medicaid and this new system, and hopefully serve as a national model along the same lines as any national

health care system. In light of futile attempts to reform Medicaid in other states, this new plan would in effect start from scratch with a new program designed specifically to correct Medicaid's problems. The governor summed his proposal by saying that it, "'...is essentially bringing management to a health care system that now has unmanageable growth'" (Humphrey, "Health reform", 1993, A1).

Obstacles

Three hurdles needed to be cleared for TennCare to be enacted. First, the governor needed support from within the state. The politicians as well as the public as a whole would have to endorse TennCare. Next, the governor needed support from those who would participate in the program: insurance companies, doctors, and hospitals. Finally, after everything else has fallen into place, federal approval would be necessary for TennCare to replace Medicaid.

Affordable health care for all Tennesseans. That was the governor's rallying cry for TennCare. With TennCare he hoped to achieve this and fulfill a promise he made upon taking office. Coupled with the uncontrollable financial costs Medicaid would produce if left unchecked, this attempt at fulfilling his promise brought in support from many sectors.

As previously mentioned, extended health coverage was expected with only a minimal increase in expenses. The public overwhelmingly supported it. The General Assembly followed suit. Little opposition was offered from them. Only Randy McNally publicly criticized the program. The legislature overwhelmingly approved TennCare

legislation: the Senate by a margin of 30-1 and the House 91-4 (Ferrar, "TennCare passed by Senate, 1993, p. A1). The first obstacle was easily cleared.

However, TennCare still faced opposition, primarily from doctors and hospitals. Insurance agencies saw TennCare as a new opportunity to make money. They offered no objection, only widespread support (Ferrar, "Caution, enthusiasm", 1993, p. A7). The Tennessee Medical Association (TMA), representing more than 6,000 doctors, expressed concern over TennCare (Womack, "Doctors question", 1993, p. A1). Most doctors accepted the proposal as inevitable (some still opposed it), but the Tennessee Hospital Association (THA) lobbied extensively against it until the state reached compromises over several issues pertaining to the hospitals.

First, the state agreed to allow a 6.75% hospital tax expire. Hospitals had been lobbying unsuccessfully for years to remove that tax. Now, to gain their support the governor was willing to give it up. Lost revenue for TennCare was to be replaced with local money and federal matching funds. Second, the design for TennCare was clarified. Much of the opposition was due to the lack of disclosed information about the new program. The state would award contracts to Managed Care Organizations (MCOs - run by the insurers), which would then, "negotiate rates with hospitals, doctors, pharmacists and other health care providers to offer care through the PPOs and HMOs" (Ferrar, "TennCare passed by Senate", 1993, A1). Given these concessions, the THA withdrew opposition to TennCare, which was subsequently passed by the legislature. The insurers were satisfied, the hospitals were pacified, and at least some of the doctors supported it. Enough support from the participants in the program was now acquired. The first two obstacles had been cleared, now only one remained.

Any divergence from the basic Medicaid system or any proposed changes to it must be approved from the federal government: the HCFA and its cabinet-level department the Department of Health and Human Services (DHHS). With little comment, the DHHS followed up Tennessee's waiver request slowly. There were still disagreements over TennCare's funding. However, to speed the process along Gov. McWherter met with President Clinton privately. According to the governor, President Clinton supported the proposal (Ferrar, "McWherter says Clinton", 1993, p. A1). Shortly after this private meeting, and with the final stipulation that $185 million more be allocated to TennCare, a five year trial period was granted to try out this new program. On November 18, 1993, Tennessee was granted a waiver by DHHS, allowing TennCare to replace Medicaid within the state (Ferrar, "TennCare gets Washington's OK", 1993, A1). TennCare received this approval from the federal government a mere six weeks before it was to take effect. However, with all three obstacles cleared, TennCare became the new health program for the indigent. However, just because all the pre-implementation problems were mitigated did not mean that TennCare would have no others. Problems were soon to emerge once more.

On January 1, only one thing was certain regarding TennCare: confusion. A large number of specialists did not join TennCare. Eligibility had to be determined every time a TennCare patient came into a doctor's office (Keim, 1994, p. A1). Many of the doctors did not know the changes in the rules, as many regulations were vastly different from Medicaid. Worst of all, a large number of the approximately 1.3 million people on TennCare were unsure what doctor(s) and what hospital(s) were compatible with their

MCO. The TennCare hotline was overwhelmed with telephone calls from both doctors and patients (Keim, 1994, p. A1).

One might expect confusion with a program this large, but the level of confusion was staggering. Perhaps the focus had been on obtaining support and approval for TennCare. While the need for informing recipients was not entirely ignored, a less than adequate amount of attention was spent on informing those effected by the new program. Despite the early confusion, people adapted to TennCare. Confusion was eventually corrected as people became more accustomed to the program.

But that only gives a glimpse of the formation of TennCare. The program has been altered a few times since its inception over eight years ago. Most of these changes have pertained to eligibility requirements or MCOs. Few other changes have been made, since the original waiver has determined the state of TennCare for its first eight years. Such changes have been the closing of TennCare to some people or the addition of new MCOs. These changes have been made to reinforce the state's goals believed accomplished with TennCare. The basic format, though, remains the same.

What is TennCare

The need for TennCare was due to a market failure. There were people who went without health insurance because they could not afford what was available. However, TennCare was an attempt to create a government-supported market solution. The government (federal, state, and local) provided the additional funds needed for these people to acquire health insurance. The money was not a direct subsidy, but paid on behalf of recipients to the MCOs, who privately made arrangements with doctors and

hospitals. It was not a pure market solution, but the state still could maintain control over the system with TennCare.

The theory behind TennCare was managed care. It is the same principle that made HMOs so popular. The key to managed care is preventative medicine. Going to the doctor regularly, immunizations, and in general maintaining one's health is expected to significantly reduce the more costly medical expenses associated with curing diseases, which is what Medicaid pays for. Everyone on TennCare is allowed to choose between a variety of plans designed with the goal of maintaining one's health. It is important to note that the recipients themselves decided what options they needed rather than being lumped together under one generic health plan, strongly mirroring the private sector, rather than following the often used public sector ideal of a bureaucratic impersonality.

As of the end of the last federal fiscal year, thirty states, the District of Columbia, and the Commonwealth of Puerto Rico have at least part of their Medicaid population on managed care ("2001 Enrollment", 2001). It appears to be the wave of the future, as well a viable solution to rising costs in the present.

An important question still remains. Who then is eligible for TennCare? Recipients are usually divided into three categories: Medicaid eligible, the uninsurable, and the uninsured. The first group is comprised of those whom every state must cover, regardless of their preferences. Federal mandates provide for their health coverage, and the U.S. government pays for approximately two-thirds of the health costs of the Medicaid eligible. Generally, these people have incomes below the poverty line (though they may not be the only ones), and often receive other government benefits designed to assist the poor. Concerning this group, the state was trying to control financial costs by

changing the way in which health care was provided to them. For more on the official poverty level see Appendix D.

To be classified as uninsurable, and be a member of the second group, one must provide an official letter of rejection from a private insurance agency. The uninsurable generally have chronic illnesses making them a poor financial risk for the private insurance companies. This is the first group the state tries to assist in its attempt to provide "affordable health care to all Tennesseans."

The third group, the uninsured, is simply composed of those people who cannot afford health insurance. Included in this group are displaced workers whose COBRA coverage has expired. The State of Tennessee does not have to provide coverage to this group, and a large number of states do not.

A fourth group can be carved out of these three. Children under the age of nineteen with no access to health insurance can obtain coverage under TennCare. However, they are not usually grouped together, since they fall into one of these three main categories.

Benefits for TennCare recipients are designed to approximate those in the private market. TennCare pays for basic services like hospital care, prescription drugs, and doctors visits with co-payments being required of the beneficiaries of the program. The myriad of plans includes options for dental care, extensive rehabilitation services, and mental health services. In most cases TennCare benefits are typical of private insurance companies. There are caps on out-of-pocket expenses and preventative services are exempt from co-payments (Appendix A). Only for the Medicaid eligible are the services

beyond what the private market would provide, particularly in the area of nursing home care.

But what is the state of these three groups today? Those people eligible for Medicaid cannot be excluded from TennCare, nor can any of them be dropped from the program as long as they remain Medicaid eligible. They cannot pay premiums nor do they have co-payments for their health coverage. They are entitled to free coverage by federal law and cannot be asked to bear any of the financial responsibility ("Eligibility for Copay", 2001).

Currently, all uninsured and uninsurable who have incomes of less than the poverty line are also exempt from co-payments and premiums. In addition to these people, everyone institutionalized (as in a nursing home) is exempt from premiums and co-pays. These people have very low abilities to pay and are assumed to be unable to pay their health expenses ("Eligibility for Copay", 2001).

Everyone else in both the uninsured and uninsurable categories must follow a strict schedule of co-payments and premiums. This schedule is based entirely upon income. Those who are not excluded from co-payments are divided into two groups: those with incomes greater than the poverty line but under 200% of poverty, and those with incomes greater than 200% of poverty. The schedule for premiums is divided into eleven categories above the poverty line, all based upon family income. For example, the lowest bracket in this case lists family income as between 101% and 119% of poverty (see Appendices A and B for more on co-pays and premiums).

Both co-payments and premiums are cheaper than could be obtained for these people in the private market as one would expect since the goal is to enable them to have

access to affordable health insurance. Health coverage was for the most part inaccessible or too expensive in the private market for the people on TennCare. Thus, the state in effect subsidizes health insurance with TennCare.

But why is TennCare so important to Tennessee? Currently it serves approximately 1.4 million people, about one-fourth of the state's population. This number has increased only slightly since the program began in 1994. A year after it began, the state closed TennCare to adults in the uninsured category. The financial burden was increasing because of the uninsured population. Since TennCare's lowest priority was to assist the uninsured, it made sense for the state to close the program to them and remain open to the ones who really needed help in obtaining health coverage: the Medicaid population and uninsurable (Ferrar, "TennCare accepting no more", 1995, p. A4).

Only for a few months in 1997 has the program been reopened to the uninsured, but has remained open to the uninsurable since it began. In October of 2001, Governor Don Sundquist attempted to close TennCare to the uninsurable in an attempt to reduce the program's growth and save money in light of budgetary concerns. However, U.S. District Judge William Haynes issued a court order preventing the closing of TennCare to the uninsurable, citing the need to follow federal regulations in altering TennCare policy ("Judge orders TennCare", 2001).

Again, currently the total population on TennCare is about 1.4 million. Of this, approximately 818,000 recipients are classified as Medicaid eligible. About 125,000 people receive TennCare under the uninsurable class. Nearly 458,000 of the rest are categorized as uninsured. The federal government pays approximately two-thirds of the cost of TennCare, even for those not eligible for Medicaid. However, this applies only

when the program's enrollment is less than 1.5 million. When the program reaches this cap, the state must pay for any additional TennCare recipients (Locker, 1993).

The Medicaid eligible population has increased and is expected to increase even more as the state's population grows over the next few years ("Overview of the Medicaid Program"). The number of uninsurables in the system has increased only slightly over TennCare's eight years though it remained open for the entire time. The number of uninsured on TennCare has also changed very little, but the reason is precisely because the program has not admitted many new uninsured since it has been closed to them for nearly seven of its eight years. Considering how close the number of TennCare recipients is to the 1.5 million cap, enrollment is a concern. It is also the reason Governor Sundquist attempted to close TennCare to the uninsurable, and is a pressing concern for the future.

Positive and Negatives of TennCare

TennCare has both its critics and supporters. The supporters cite statistics that put TennCare in a favorable light, while, of course, its critics cite problems with the program. Neither group has to be wrong; TennCare may have both positive and negative consequences. But which is greater? Do the pros outweigh the cons? Attention will now be turned to these issues.

Problems - Fraud and Abuse

A persistent belief, even among Tennessee's political leadership, about TennCare is that it is riddled with fraud, abuse, and waste that can be eliminated to save a great deal of money. Van Hilleary, candidate for governor, estimated that as many as 200,000

people on TennCare are ineligible (Sharp, "Hilleary says", 2002). However, this high number might be the result of political rhetoric. A state audit found the number currently improperly receiving benefits less than 20,000 after the recent removal of almost 60,000 from the TennCare rolls ("Audit finds", 2002). Far lower than the political response, this audit still indicates fraud and abuse of the program still exists. There are ways to abuse any government program. Some people will find a way to take advantage of humanity's sense of fairness. The only way to eliminate the chances of this happening is to spend so much money on administration and enforcement that the state eventually loses more money than it saves by implementing measures to reduce fraud.

Though it is not economically beneficial to pursue all possible sources of fraud, measures can be taken to reduce waste in TennCare and save money. In fact the state of Tennessee has undertaken efforts to reduce fraud and abuse within the system. It began with the Fraud and Abuse Hotline, which by August of 1999, had saved, "'Tennessee taxpayers over a million dollars by disenrolling people who were not eligible for TennCare, 'said TennCare Director Brian Lapps, Sr." ("TennCare Beefs Up", 1999). This effort has continued with a website designed to facilitate the reporting of suspected abuse of TennCare ("Fraud and Abuse"). Both the hotline and the website have made an impact in reducing fraud and abuse by relying on recipients and doctors to report possible violations. The total amount of money saved is uncertain, but the estimated one million dollars saved by August 1999 has surely been increased.

Further attempts at mitigating abuse have only been made within the past two years. On May 31, 2000, Governor Sundquist signed into law Public Chapter 853 (of the 101st General Assembly) which classified fraudulent receipt of TennCare services as a

felony. Furthermore, TennCare recipients were to report any changes in their eligibility immediately.

The *Rosen* settlement was entered on March 12, 2001 and provided for, "substantial review and enhancement of TennCare eligibility determination" ("TennCare Update: Quarterly Report", 2001). Included in this plan was the provision for periodic monitoring of the eligibility of TennCare recipients (2001).

Combining the *Rosen* settlement with Public Chapter 853, the state has an effective means of both terminating the coverage of those not eligible for TennCare as well as deterring others from fraudulently obtaining that health coverage with the threat of a felony sentence. In theory both might prove very effective with but a slight increase in administrative cost.

Though exact data on possible monetary savings have not been published, for the fiscal year ending June 30, 2001, over 2600 recipients were recommended for termination, with the vast majority coming in the fourth quarter, when both the *Rosen* settlement and PC 853 were in place ("TennCare Quarterly Report", 2001).

It is a fair assumption that both have lead to lower rates of fraud in the system. While this trend may continue in the short run, there is only so much fraud in the system that can be eliminated with only these current efforts. Also, though fraud is a problem, and will likely remain one, the extent to which it pervades TennCare has been often overstated and perceived to be much more widespread than it is due to a few isolated instances (Humphrey, "Sundquist's TennCare", 2001). And, as stated earlier, stronger efforts at reducing abuse in the system may actually cost more than they save especially if pursued to the extinction of all fraud.

Problems - MCOs

Some of the program's worst problems have been with the Managed Care Organizations (MCOs) involved with TennCare. For example, a year ago BlueCross/BlueShield threatened to pull out of TennCare, citing a lack of profitability. However, the state reached an agreement with the MCO to scale back to a maximum of 300,000 patients in East Tennessee only and remain in the program ("Governor announces agreement", 2001).

A much worse and more visible example happened less than six months ago. Access MedPlus, the largest of TennCare's ten MCOs, revealed it did not meet the state's required net worth of $12.5 million dollars. In fact its net worth was reported as negative $54 million. Following this revelation, Chancellor Ellen Lyle declared the MCO insolvent and ordered the liquidation of its assets on November 2, 2001. Access MedPlus's response was that the state assigned a large number of patients with expensive medical conditions to the MCO and that adequate compensation was not provided by the state (Associated Press, 2001).

However, only a year earlier, four new MCOs joined TennCare after the state accepted their bids. A much more likely scenario involves the mismanagement of funds by the leadership of Access MedPlus. Most of the other MCOs have not had any problems with their profitability, nor has a judge ordered their liquidation. Most of the complaints concerning the MCOs involve the less than prompt payment of medical expenses for TennCare enrollees, a concern for doctors.

Positive Aspects – Better Health

Despite its problems past and present, TennCare has been credited with many positive results. In 1996, the infant mortality rate for babies covered by TennCare had dropped to 10.0 from 12.2 in 1995 ("Decline in Infant Mortality", 2001). This was a significant decline for only one year, and came just two years after TennCare began. In that same time period, the infant mortality rate rose for non-TennCare babies from 6.4 to 6.9. Furthermore, the Bureau of TennCare cited a First Health study showing improvements among TennCare enrollees for the five indicators measured: pre-term births, low birth weights, prenatal care, infant case fatality, and infant mortality. Health Commissioner Nancy Menke said, "We're definitely seeing a downward trend in the overall infant mortality rate, and a majority of that decrease appears to be attributable to the TennCare population" ("Decline in Infant Mortality", 2001).

The Center for Business and Economic Research (CBER) and the Social Science Research Institute at the University of Tennessee conducted a survey near the end of 1997. One important fact about TennCare states that the percentage of TennCare recipients who went to emergency rooms has declined by half since the program began. The key to this statistic is a twenty- percent increase in regular doctor visits for TennCare recipients compared to 1993, before the program began. The rate for doctor visits among children also increased in the same time period ("Most TennCare Enrollees", 1998).

The Bureau of TennCare issued another press release in October 2000, adding further support for TennCare's effectiveness. The stated conclusion was simply that TennCare has improved health care. A TennCare study that was cited described how children with asthma have received better preventative care under TennCare. Other

surveys by the CBER, conducted annually, elaborated upon the decreased usage of ERs and the increased importance of regular doctor's visits ("TennCare has Improved Health Care", 2000). TennCare studies have shown increases in immunizations, prenatal care, and mammography under TennCare. An Urban Institute study from 2000 confirmed the increased use of preventative services ("TennCare has Improved Health Care", 2000). Facing the combined weight of these studies, it can be concluded that TennCare has been effective in improving the health care of Tennesseans.

Positive Aspects – Possible Monetary Savings

However, better health may increase costs. Has TennCare achieved its other goal of saving the state money? In 1998, Tennessee had the third lowest capitation payment per recipient in the country ("TennCare Has Saved Money", 1999). The capitation payment is simply, "The basic average cost of payments per covered person" for an entire year (Humphrey, "TennCare has", 1993, p. A1). Third lowest in the country is an important gain for a state that had supposedly faced skyrocketing Medicaid costs. And after only four years, this gain occurred. By lowering the average cost per recipient, more people could be served with the same amount of money, which is exactly what TennCare is designed to accomplish.

Furthermore, the estimate of Medicaid expenses for Tennessee based upon the average growth rate of other southern states was $1.3 billion dollars in state money for 1998. TennCare's budget for that year was only $1.1 billion from the state, covering everyone on TennCare, not just the Medicaid eligible. More people had better health coverage for less money. "In terms of cost management and budget management,

TennCare has really been very successful for us," according to State Comptroller John Morgan ("TennCare Has Saved Money", 1999).

TennCare supporters cite even more recent statistics that claim that the state has saved more than $2 billion since it began (Miller, 2001). Even if this statistic was dismissed because of its source, expenses mandated by Medicaid have been contained at the very least. TennCare has been shown to be effective in both saving money and improving health within the state.

The Current Budget Crisis and its Impact on the Future of TennCare

But in light of the recent budget crisis, can the state really afford it? Not all monies ascribed to TennCare pay for the Medicaid population. And even though other recipients pay part of their costs and the federal government funds two-thirds of the program's expenses, the state still pays health coverage costs for which it is not obligated.

The budget for the current fiscal year ending June 30, 2001, is approximately $350 million or more out of balance. The state needs at least, but probably more than, $350 million in additional revenue just to follow the state constitution's requirement for a balanced budget. There are no changes in TennCare that will fix this year's problem, but the problem will still exist next year. Next year the budget is expected to be short on revenues by nearly $1.2 billion dollars (Wade, 2002).

That number is a worst case scenario, yet even conservative estimates place next year's shortfall at more than $700 million. However, the shortfall is expected to continue to grow. The state faces a structural deficit. Revenues do not grow as fast the desired size of government, which usually mirrors economic growth. There are three solutions to

a structural deficit: cut spending, increase the tax rate, or change the tax structure. The first two are short-term solutions and the last is hopefully a long-term solution. Unfortunately, the legislature has not come to an agreement on which plan to choose. If the people of Tennessee decide that TennCare is a program that does not deserve to be cut and that it must remain, either the second or third option must be taken. However, the latter two will not be discussed in detail here, but in light of the preferences of many who favor cutting services (including TennCare), the first must be discussed.

Of course TennCare's original waiver expired at the end of 1998. After the waiver expired, it was renewed for three years. At the end of the last calendar year, the state was granted an extension of the current waiver. There were no problems with a straight renewal of TennCare's original waiver at either point in time. The federal government simply acquiesced to the continuance of the status quo. Now the state awaits federal approval of a new waiver for the next three years. Despite the ease with which the state can renew the waiver, any change to the system would require the state going through the approval process again, and most likely could not be achieved quickly.

Future – Return to Medicaid

One possible option to change the system is to eliminate TennCare altogether and return to the old Medicaid system. About $1 billion in funding would be cut from Tennessee's health system under this plan and of course everyone who receives health coverage under TennCare, and is not classified as Medicaid eligible, would no longer have health coverage (Wade, 2002). This proposal is popular for some politicians. The

people who would actually lose their coverage are not politically powerful and the argument is that with TennCare gone, no tax solution need be taken.

Hundreds of thousands of Tennesseans would be forced to purchase private insurance or go without. Considering the vast majority of these people either were denied health coverage or could not afford it, they most likely will go without. Who then will pay for them to go to the hospital? Who will pay for their medication?

Furthermore, since TennCare has been shown to save money over Medicaid, it is possible that costs will actually rise if the state reverts to Medicaid. Even if the state maintains the managed care philosophy, and savings are proportionally similar to that under TennCare, not very much state money will be saved. The people who would lose their coverage pay a part of their expenses, as opposed to the Medicaid population, which pays none of their expenses and is often granted more extensive services. Furthermore, two-thirds of the costs of the program are borne by the federal government. The total amount in state funds that could be saved certainly would not be enough to correct next year's deficit, nor any future deficits. Tennessee made a statement by extending health coverage to those who were believed to be unable to obtain it on their own. How equitable is it for the state to now declare that it is just not worth it to help these people? Does the state have a moral responsibility to take care of these people if they cannot take care of their own medical costs, or does the state owe them nothing more than the average taxpayer?

Future – The Most Likely Scenario

Yet there is a budget problem, and hope remains that "reforming" TennCare can save some money. Anticipating problems with the budget, in January of 2000, Governor Sundquist formed the Commission on the Future of TennCare, which notably included former Governor Ned McWherter, the architect of TennCare. A year after the Commission's report to the governor, Governor Sundquist announced a plan to restructure TennCare based upon the Commission's recommendations.

This plan is estimated to save approximately $150 million per year over the next ten years and forego slightly more than twice that amount in federal money. The savings would come by reducing benefits to some recipients and dropping about 179,000 enrollees from the system. Of this number 4,000 are children in families with incomes at least 200 percent of the poverty line. Of the adults 40,000 are eligible for both Medicaid and Medicare. The other 135,000 adults are reported to have incomes over the poverty level (Miller, 2001).

In addition to dropping these people from TennCare, the governor's proposal would divide the program into three pieces. TennCare Medicaid would serve an estimated 950,000 Medicaid eligible people when implemented. Benefits would be similar to those in other states, except that optional Medicaid benefits, like private duty nurses, would not be included (Miller, 2001).

TennCare Standard would be the primary extension of health coverage to the indigent not on Medicaid. Benefits would be similar to commercial plans for small businesses. The approximately 300,000 people who are expected to qualify would not have access to group health insurance and must either be adults living under the poverty

line, or children living under 200 percent of poverty. The uninsurable would be primarily included in this category, however, simply being denied coverage by a private firm would not be enough to guarantee one eligibility for TennCare. This population would pay premiums on a sliding scale according to their incomes, much like they do now under TennCare (Miller 2001).

The last piece of the TennCare puzzle would be named TennCare Assist. The number of people served by this part of TennCare is uncertain, but the state would not provide health coverage to them. Instead, the state would give a direct subsidy to families with lower incomes to purchase private insurance through their employers (Miller, 2001).

The governor's plan would reinforce certain principles of TennCare. It is a program of last resort, assisting someone when there is no other help available. In addition to this, the state continues its goal of affordable health care to all Tennesseans. But not only would all Tennesseans have access to health coverage, children would especially be taken care of, considering they have less ability to earn a living than adults do ("TennCare Program Design", 2002). But this new program would also attempt to encourage a private market solution through TennCare Assist.

Some minor changes have been made to this plan between the time it was presented to Tennesseans and the time it was submitted to the federal government. However, the basic outline remains the same. Only minor details have changed. For example, one of the four groups of TennCare Standard offers eligibility to someone at 250% of poverty, rather than 200%, without access to group health insurance. See Appendix C for the timeline from the governor's submitted proposal ("TennCare

Program Design", 2002). Governor Sundquist has obtained some legislative support and praise from his possible successors concerning this plan. However, he does not need it. He only needs approval from the Centers for Medicare and Medicaid Services in the HCFA in the DHHS ("Miller, "Governor splits TennCare", 2001). Thus, the new TennCare plan will go into effect pending federal approval, which is slow in coming once again.

This is an intriguing proposal. It appears to save the state money by dropping certain Tennesseans who might be able to purchase private insurance rather than relying on the state. Furthermore, it would continue the recent tradition of the state to extend health coverage to those who are least able to afford it. However, any attempt at maintaining TennCare would not save very much money. One hundred fifty million will certainly not be enough to solve Tennessee's budget problem. A new tax option, like an income tax, increase in the sales tax, or a tax on services will be necessary to "save" TennCare and many other programs.

Conclusion

While TennCare is not the only target of criticism, nor of proposed budget cuts, it does draw much of the blame for Tennessee's budget crisis. Thus, it boils down to a simple question for all taxpayers to answer. Is TennCare worth it? We cannot just stick our heads in the sand. The state has to do something for these people. We have no choice but to pay for the Medicaid population. But should the state be responsible for the other people covered by TennCare? Does the state owe them anything if they are unable to help themselves? It will cost money to pay for their health coverage, so where will

that money come from? The main criticism of TennCare is that it costs a lot of money, often unnecessarily (fraud and abuse), but the result is quite often poor a poor argument. Tennessee has historically had a low tax burden, but to save TennCare that may need to change. With some people arguing for equity and the continuance of TennCare, and with others arguing for the elimination of TennCare and for low taxes, conflict is certain. But which side is right? What is best for Tennessee?

Though the question is simple, the answer is very complex considering all the issues before taxpayers. However, for the government to work appropriately, the people of Tennessee must understand all the issues and their preferences involving government. Remaining ignorant about pertinent issues facing all citizens will certainly lead to more confusion in the future, if that is possible.

Bibliography

2001 Enrollment Fact Sheet. (2001, June 30). *Health Care Financing Agency*. Available: http://www.hcfa.gov/medicaid/fctsht01.pdf

2002 Federal Poverty Guidelines. (2002, April 24). U.S. Department of Health and Human Services. Available: http://aspe.hhs.gov/poverty/02poverty.htm

Associated Press. (2001, November 3). Judge orders liquidation, ending stormy life of largest TennCare MCO. *Knoxville News-Sentinel* online. Available: http://www.knoxnews.com/kns/state/article/0,1406,KNS_348_867327,00.html

Audit finds millions improperly spent by TennCare. (2002, April 25). *Knoxville News-Sentinel* online. Available: http://www.knoxnews.com/kns/state/article/0,1406,KNS_348_1110566,00.html

Decline in Infant Mortality Rate Attributed to TennCare. (1998, January 9). *Bureau of TennCare*. Available: http://www.state.tn.us/tenncare/news-rel/pr010798.htm

Eligibility for Copay. (2001, March 7). *Bureau of TennCare*. Available: http://www.state.tn.us/tenncare/copayimp.html

Ferrar, R. (1993, April 9). Caution, enthusiasm greet health-care proposal for state. *Knoxville News-Sentinel*, p. A7.

Ferrar, R. (1993, November 10). McWherter says Clinton 'on my side'. *Knoxville News-Sentinel*, p. A1

Ferrar, R. (1995, January 5). TennCare accepting no more uninsured in '95. *Knoxville News-Sentinel*, p. A4.

Ferrar, R. (1993, November 19). TennCare gets Washington's OK. *Knoxville News-Sentinel*, p. A1.

Ferrar, R. (1993, May 6). TennCare passed by Senate after tax deal with hospitals. *Knoxville News-Sentinel*, p. A1.

Fraud and Abuse. *Bureau of TennCare*. Available: http://www.state.tn.us/tenncare/fraudabuse.html

Governor announces agreement to keep BlueCross in Tennessee. (2001, February 21). *Office of Governor Don Sundquist*. Available: http://www.state.tn.us/tenncare/news-rel/pr22301.htm

Humphrey, T. (1993, April 9). Governor offers sub for Medicaid. *Knoxville News-Sentinel*, p. A1.

Humphrey, T. (1993, April 11). Health reform seen as 'bullet-proof'. *Knoxville News-Sentinel*, p. A1.

Humphrey, T. (2001, October 7). Sundquist's TennCare overhaul met with praise by candidates. *Knoxville News-Sentinel* online. Available: http://www.knoxnews.com/kns/state/article/0,1406,KNS_348_841301,00.html

Humphrey, T. (1993, October 29). TennCare has $185 million snag. *Knoxville News-Sentinel*, p. A1.

Judge orders TennCare to stay open to uninsurables. (2001, October 27). *Knoxville News-Sentinel* online. Available: http://www.knoxnews.com/kns/politics/article/0,1406,KNS_356_861336,00.html

Keim, D. (1994, January 6). Many report TennCare confusion. *Knoxville News-Sentinel*, p. A1.

Locker, R. (2001, September 28). Sundquist to bare TennCare plan. *Knoxville News Sentinel* online. Available: http://www.knoxnews.com/kns/state/article/0,1406,KNS_348_834384,00.html

Miller, K. (2001, September 29). Governor splits TennCare into three pieces. *Knoxville News-Sentinel* online. Available: http://www.knoxnews.com/kns/state/article/0,1406,KNS_348_835424,00.html

Most TennCare Enrollees Say Quality of Care Excellent. (1998, March 11). *Bureau of TennCare*. Available: http://www.state.tn.us/tenncare/news-rel/pr031198.htm

New TennCare Co-Pay Schedule for Uninsureds and Uninsurables. (2001, April 23). *Bureau of TennCare*. Available: http://www.state.tn.us/tenncare/copay.html

Overview of the Medicaid Program. *Health Care Financing Agency*. Available: http://www.hcfa.gov/medicaid/mover.htm

Premium Schedule. (2001, April 23). *Bureau of TennCare*. Available: http://www.state.tn.us/tenncare/povprem/htm

Public Chapter 853. (2000, May 31). *101st Tennessee General Assembly*. Available: http://www.state.tn.us/sos/acts/101pub/pc853.pdf

Sharp, T. (2002, April 22). Hilleary says restructuring TennCare should solve budget woes. *Knoxville News Sentinel* online. Available: http://www.knoxnews.com/kns/politics/article/0,1406,KNS_356_1103775,00.html

TennCare Beefs Up Anti-Fraud and Abuse Effort. (1999, August 26). *Bureau of TennCare*. Available: http://www.state.tn.us/tenncare/news-rel/pr082699.htm

TennCare Has Improved Health Care. (2000, October 19). *Bureau of TennCare*. Available: http://www.state.tn.us/tenncare/news-rel/pr101900.htm

TennCare Program Design and Waiver Modifications. (2002, February 12). *Office of Governor Don Sundquist*. Available: http://www.state.tn.us/tenncare/waiver2-11.pdf

TennCare Quarterly Report. (2001, July 18). *Bureau of TennCare*. Available: http://www.state.tn.us/tenncare/July2001.html

TennCare Update: Quarterly report to the Tennessee General Assembly. (2001, April 12). *Bureau of TennCare*. Available: http://www.state.tn.us/tenncare/April2001.html

Voter Registration and Turnout 2000. *Federal Election Commission*. Available: http://www.fec.gov/pages/2000turnout/reg&to00.htm

Wade, P. (2002, April 15). Legislators do nothing while fund woes grow. *Knoxville News-Sentinel* online. Available: http://www.knoxnews.com/kns/politics/article/0,1406,KNS_356_1088258,00.html

Womack, B. (1993, April 18). Doctors question TennCare viability. *Knoxville News-Sentinel*, p. A1.

Appendix A:

Schedule of Co-payments



NEW TENNCARE CO-PAY SCHEDULE FOR UNINSUREDS AND UNINSURABLES

***Note**: Medicaid eligibles are exempt from co-pays.*

Poverty levels	**Co-pays**
At or below 100% poverty	0
101%-200% poverty	• $25 for emergency room use (waived if admitted) • $5 for PCP and Community Mental Health Agency services other than preventive services and mental health case management • $15 for specialists • $5 for prescription drugs • $100 for hospital stay
200% poverty and above	• $50 for emergency room use (waived if admitted) • $10 for PCP and Community Mental Health Agency services other than preventive services and mental health case management • $25 for specialists • $10 for prescription drugs • $200 for hospital stay
Preventive services are exempt from co-pay obligations. Deductibles are eliminated. Maximum out-of-pocket expenses are limited as follows: 100%-200% poverty $1,000 individual; $2,000 family 200% poverty and above $2,000 individual; $4,000 family	



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Appendix B:

Schedule of Premiums

Individual Premium	$0.00	$15.11	$18.55	$24.91	$34.71	$77.91	$85.33	$93.02	$104.68	$116.34
Family Premium	$0.00	$25.97	$34.19	$50.35	$74.73	$194.51	$212.80	$232.41	$261.56	$290.44
Percentage of Poverty	0% -100%	101% -119%	120% -139%	140%-169%	170% -199%	200% -209%	210% -219%	220% -239%	240% -269%	270% -299%
Family Size										
1	0 – 687	688 – 818	819 – 955	956 – 1,161	1,162 –1,374	1.375 –1,436	1,437 – 1,505	1,506 – 1,642	1,643 – 1,848	1,849 – 2,060
2	0 – 922	923 – 1,097	1 098 – 1,282	1,283 – 1,558	1,559 – 1,844	1,845 – 1,927	1,928 – 2,021	2,022 – 2,204	2,205 – 2,480	2,481 – 2,765
3	0 – 1,157	1,158 – 1,377	1,378 – 1,608	1,609 – 1,955	1,956 – 2,314	2,315 – 2,418	2,419 – 2,536	2,537 – 2,765	2,766 – 3,112	3,113 – 3,470
4	0 – 1,392	1,393 – 1,656	1,657 – 1,935	1,936 – 2,352	2,353 – 2,784	2,785 – 2,909	2,910 – 3,051	3,052 – 3,327	3,328 – 3,744	3,745 – 4,175
5	0 – 1,627	1,628 – 1,936	1,937 – 2,262	2,263 – 2,750	2,751 – 3,254	3,255 – 3,400	3,401 – 3,565	3,566 – 3,889	3,890 – 4,377	4,378 – 4,880
6	0 – 1,862	1,863 – 2,216	2,217 – 2,588	2,589 – 3,147	3,148 – 3,724	3,725 – 3,892	3,893 – 4,080	4,081 – 4,450	4,451 – 5,009	5,010 – 5,585
7	0 – 2,097	2,098 – 2,495	2,496 – 2,915	2,916 – 3,544	3,545 – 4,194	4,195 – 4,383	4,384 – 4,595	4,596 – 5,012	5,013 – 5,641	5,642 – 6,290
8	0 – 2,332	2,333 – 2,775	2,776 – 3,241	3,242 – 3,941	3,942 – 4,664	4,665 – 4,874	4,875 – 5,109	5,110 – 5,573	5,574 – 6,273	6,274 – 6,995
9	0 – 2,567	2,568 – 3,055	3,056 – 3,568	3,569 – 4,338	4,339 – 5,134	5,135 – 5,365	5,366 – 5,624	5,625 – 6,135	6,136 – 6,905	6,906 – 7,700
10*	0 – 2,802	2,803 – 3,334	3,335 – 3,895	3,896 – 4,735	4,736 – 5,604	5,605 – 5,856	5,857 – 6,139	6,140 – 6,697	6,698 – 7,537	7,538 – 8,405
*For each additional family member over 10, add per month:	0 – 234	235 – 278	279 – 325	326 – 395	396 – 469	470 – 489	490 – 515	516 – 559	560 – 629	630 – 704

Monthly Premiums for Uninsured Enrollees with Income Above 400% of Poverty **Monthly Premium for Uninsurable Enrollees with Income Above 400% of Poverty**

Individual Premium	$195.84		$201.67		Individual Premium	$238.50	
Family Premium	$489.19		$504.03		Family Premium	$595.72	
Percentage Of Poverty	400% - 749%		750% - Over		Percentage of Poverty	400% - 749%	
Family Size					Family Size		
1	2,748 – 5,153		5,154 – Over		1	2,748 – 5,153	
2	3,688 – 6,915		6,916 – Over		2	3,688 – 6,915	
3	4,628 – 8,678		8,679 – Over		3	4,628 – 8,678	
4	5,568 – 10,440		10,441 – Over		4	5,568 – 10,440	
5	6,508 – 12,203		12,204 – Over		5	6,508 – 12,203	
6	7,448 – 13,965		13,966 – Over		6	7,448 – 13,965	
7	8,388 – 15,728		15,729 – Over		7	8,388 – 15,728	
8	9,328 – 17,490		17,491 – Over		8	9,328 – 17,490	
9	10,268 – 19,253		19,254 – Over		9	10,268 – 19,253	
10*	11,208 – 21,015		21,016 - Over		10	11,208 – 21,015	
*For each additional family member over 10, add per month	940 – 1,755		1,756 – Over			940 – 1,755	

Appendix C:

Proposed Timeline from the Governor's Submitted Proposal

Attachment E

Proposed Timeline

NOTE: The following dates are proposed for planning purposes only. These dates are subject to change depending upon CMS approval, operational factors, etc.

January 2002	Extension of existing TennCare waiver begins
January-June 2002	State will begin notifying entire TennCare population about the proposed new program and will begin classifying enrollees according to new eligibility criteria
July 2002	New eligibility criteria go into effect; current enrollees who meet the new eligibility criteria will remain on TennCare
	State will begin disenrolling current TennCare members who do not meet new eligibility criteria
Fall 2002	Subject to legislative appropriation, state will conduct an open enrollment period for potential new eligibles, using income thresholds for TennCare Standard approved by the General Assembly in its spring 2002 session; a continuous open enrollment period may also be authorized for subgroups of the demonstration populations, subject to availability of funds
January 2003	Modified TennCare Medicaid program begins
	TennCare Standard begins
	Coverage begins for new TennCare members identified during the fall open enrollment period
	Benefit changes go into effect
Spring 2003	Subject to appropriation, state will conduct an open enrollment period for potential new eligibles, using income thresholds for TennCare Standard approved by the General Assembly in its spring 2002 session; a continuous open enrollment period may also be authorized for certain subgroups of the demonstration population, subject to availability of funds

January-June 2003	Enrollment procedure used for TennCare Standard to be evaluated
Fall 2003	Subject to appropriation, state will conduct an open enrollment period for potential new eligibles, using income thresholds for TennCare Standard and TennCare Assist approved by the General Assembly in its spring 2003 session; a continuous open enrollment period may also be authorized for certain subgroups of the demonstration population, subject to availability of funds
January 2004	TennCare Assist begins
	Coverage begins for new TennCare members identified during the fall open enrollment period

Appendix D:

Official DHHS Poverty Standards -2002

2002 HHS Poverty Guidelines

Size of Family Unit	48 Contiguous States and D.C.	Alaska	Hawaii
1	$ 8,860	$11,080	$10,200
2	11,940	14,930	13,740
3	15,020	18,780	17,280
4	18,100	22,630	20,820
5	21,180	26,480	24,360
6	24,260	30,330	27,900
7	27,340	34,180	31,440
8	30,420	38,030	34,980
For each additional person, add	3,080	3,850	3,540