The TennCare Cuts: Plunging into the Unknown

Potential consequences for the state's healthcare system and its economy

by Gordon Bonnyman

The collapse of the TennCare program has shocked Tennessee's healthcare system in a way that no other state has ever experienced. Approximately 200,000 of the program's costliest patients lost their coverage over a four-month period in late 2005. Their disenrollment, plus sharp cuts in pharmacy coverage for those remaining on the program, eliminated $1.7 billion in medical services annually for the sickest subgroup of the TennCare population. This represented the largest single increase in the number of uninsured Americans in the nation's history and the deepest cuts ever in funding for a public health program. Because the magnitude of the cuts is without precedent anywhere, it is impossible to anticipate all of their effects. What is already clear, however, is that there are serious, long-term consequences for the state's healthcare system and its economy.

TennCare's Initial Success

TennCare is Tennessee's Medicaid program (the state-federal program established in 1965 that provides health coverage for part of the low-income population). The federal government matches state contributions to the program's costs, with the match rate varying by state based on per capita income. In Tennessee, the federal match pays for 64.8 percent of the cost of Medicaid services. For more than a decade, TennCare has operated under a special waiver from the federal Centers for Medicare and Medicaid Services (C.M.S.).

In 1994, Tennessee implemented a federal waiver authorizing it to enroll the entire Medicaid population in capitated managed care. The waiver also enabled Tennessee to expand coverage to many people who were uninsured, either because their employers did not offer group coverage or because preexisting medical conditions made them uninsurable. Enrollees with

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incomes above the poverty level paid premiums on a sliding scale. The expanded coverage was also financed by savings from managed care and additional federal funding obtained through shrewd bargaining with federal officials by then Governor Ned Ray McWherter.

The program got off to a rocky start but quickly expanded coverage from 900,000 to 1.4 million participants. TennCare reduced the percentage of Tennesseans without health insurance to one of the lowest levels in the country. The program was also a financial success. It achieved one of the lowest per enrollee costs in the nation.[1] State savings over the first six years were variously estimated at $245 million to $2 billion.[2] As the Tennessee Comptroller of the Treasury summarized, "TennCare has reduced the number of uninsured persons in Tennessee and improved the quality and type of healthcare received."[3]

Although TennCare caused problems for some healthcare providers, it did not have a significantly adverse impact on the healthcare industry generally. The profitability of the Tennessee hospital industry as a whole is well ahead of the national average, and physician incomes are among the highest in the nation.[4] Quarterly reports to the Department of Commerce and Insurance by BlueCross BlueShield of Tennessee, the major TennCare managed care contractor, documented the profitability of that company's TennCare operations.

A State Uniquely Dependent on Medicaid

TennCare achieved its goal of leveraging more federal funds to address the problem of indigent care. McKinsey & Company, the corporate consulting firm hired by Governor Phil Bredesen in 2003 to study TennCare, concluded that "TennCare's broad enrollment has multiple advantages for the state, including, most important, maximizing the benefit of federal match and facilitating health coverage for as many citizens as possible."[5] Costs of the new enrollees' care would otherwise have been borne by state and local taxpayers or passed on by healthcare providers to their paying patients and those patients' insurers. TennCare succeeded in increasing the effective federal match rate to 70 percent, one of the most favorable rates of any state.

This success was achieved in part by folding almost all state and local funding of health and mental health services into the new program so those redirected dollars would qualify for federal matching funds, enabling the state to leverage more federal Medicaid revenues. Tennessee spent more on Medicaid than other states, but its total state spending on health and mental health services was actually less than that of many other states, including Georgia and North Carolina.[6] This shrewd strategy benefited the state budget, Tennessee's healthcare system, and the local communities into which the new federal money flowed.

The strategy made Tennessee uniquely dependent on its Medicaid program. Tennessee effectively put almost "all of its eggs in one basket," with an expanded Medicaid program but few services outside of Medicaid to meet health and mental health needs. Other programs atrophied, leaving little in the way of a safety net. No state had more to lose from a major Medicaid cutback.

TennCare's Demise

Although the state still calls its Medicaid program TennCare, the waiver expansion program ceased to exist in 2005. TennCare's decline began in 1999 when it became a hostage in the state income tax fight as tax opponents argued that abolishing TennCare would make increased tax revenues unnecessary. At the same time, the state fatally altered TennCare's original, successful design. State officials began to relax the cost discipline of managed care, with the state reassuming financial risk over a three-year process that culminated in 2002. Other management lapses compounded the financial problems. TennCare costs began to outstrip state revenue growth in 2001.

While these factors contributed to TennCare's financial woes after 2000, the more fundamental cause of its rising costs was the relentless pressure of nationwide medical inflation. For decades, medical costs have outstripped the growth of the American economy.[7] Every state struggles to maintain its Medicaid program as the cost of medical care it provides grows more rapidly than states' revenues.[8] Although many states have slowed growth by making minor cuts in eligibility or benefits or trimming provider rates, they have managed to keep their programs intact.[9] When Medicaid programs have faced budget crises, governors have averted major cuts and dislocations in the healthcare system by enlisting the aid of their congressional delegations to obtain federal financial relief.[10]

Governor Bredesen was elected in 2002, promising to use his experience as a successful former HMO entrepreneur to save TennCare through better management. In 2003, in what he hailed as a first step toward fulfilling that pledge, he negotiated a settlement involving consent decrees in four lawsuits that addressed several aspects of TennCare's administration. He announced that the settlement "puts the state

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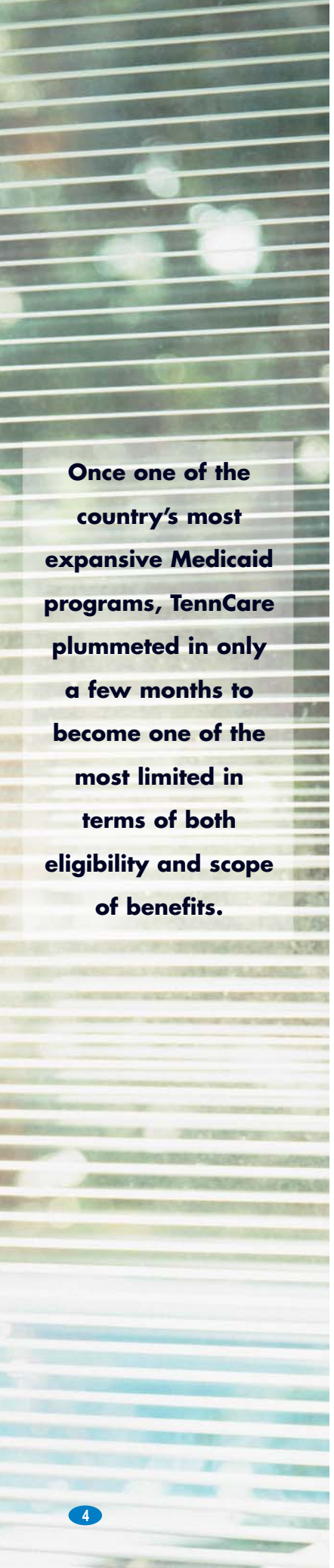

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back in the driver's seat and clears the way for some important reforms that we need to make."[11] In February 2004, he announced the state would solve its TennCare budget problems without relying on help from Washington.[12] Later that year, he repudiated the consent decrees, charging they tied his hands and prevented the state from reforming the program or getting its budget under control. In January 2005, he announced that he was returning the state to a basic Medicaid program.

By the end of 2005, the state had terminated coverage for all uninsured and uninsurable adults, with the only vestige of the original expansion being uninsured children who would be covered in other states under the State Children's Health Insurance Program (SCHIP).[13] (TennCare predated enactment of SCHIP, so Tennessee never established an SCHIP program.) Once one of the country's most expansive Medicaid programs, TennCare plummeted in only a few months to become one of the most limited in terms of both eligibility and scope of benefits.

Tennessee now is the only state that does not routinely enroll school-age children with incomes above the poverty level.[14] TennCare eligibility for elderly and disabled adults is among the most restrictive in the country.[15] For adults still on the program, TennCare has imposed the nation's sharpest pharmacy limits, something other states have avoided in order to prevent an increase in "downstream" expenditures for hospitalization and nursing home care.[16]

Winners and Losers

The federal government is a clear winner. Between FY 2005 and FY 2007, federal TennCare spending is dropping from $5.196 billion to $4.525 billion, or $670 million. By contrast, state spending is increasing by $134 million during the same period.[17]

The biggest losers are the more than 200,000 uninsured and uninsurable adults who lost TennCare coverage. Their disenrollment has especially serious implications for them and the healthcare industry; actuarial analysis showed them to be among the sickest, highest-cost TennCare enrollees.[18] Extrapolating from a 2002 analysis by the University of Tennessee Center for Health Services Research, the recent disenrollments can be expected to increase mortality by 275 deaths a year.[19]

Tennessee's healthcare industry is also a big loser. The cuts eliminated payment for $1.8 billion of medical services annually, only slightly mitigated by the expenditure of $100 million in state funds for transitional "safety net" programs that primarily funded community clinics and a discount drug program. The Tennessee Hospital Association has warned that the loss of TennCare revenues will imperil 44 hospitals, mostly in poor, rural communities that had negative margins even before the cuts.[20] The closure of such hospitals means their communities' loss of major employers and ability to recruit or retain physicians, inflicting a permanent blow to the vitality of their economies.

Tennessee business in general loses in several respects. Employers can expect to see their group insurance premiums rise as healthcare providers shift to private patients the costs of caring for former TennCare patients who now have no means of paying for their own care. Hospitals were expected to raise their rates by 17 percent in the first year to offset the effects of the TennCare cuts.[21]

The consequences are being felt by urban taxpayers, who are spending more to support facilities like Nashville General Hospital. Local governments must absorb additional law enforcement costs for dealing with untreated severely mentally ill patients.[22]

Job loss caused by the reduction in federal funds will occur throughout the entire state economy.[23] The number of jobs lost due to TennCare cuts offsets most of the state's gains in new job development over the year.[24] Because a disproportionate share of lost federal funds would have been spent in poorer communities with high TennCare enrollment, the loss will be felt most in counties that already have the weakest economies.

Strikingly, state government appears to be a loser. McKinsey & Company warned in 2004 that returning to Medicaid would involve a loss of the federal funding advantages associated with TennCare's broadened coverage: "A move to Medicaid would therefore require Tennessee to contribute additional money from state funds, largely offsetting the savings from reducing enrollment."[25] That has been vindicated: the cuts relieved immediate state budget pressures but did not address the underlying inflation.

The cuts did not even eliminate increases in state TennCare expenditures because the massive savings accrued to the federal government, not the state. Total state spending on TennCare in 2004–2005, prior to the cuts, was $2.539 billion. Despite the cuts, state spending will rise by $110 million in the current fiscal year. The governor's budget projects growth next year to $2.673 billion.[26]

The state has eliminated almost all Medicaid benefits and eligibility categories not either required by federal law or, like nursing home and prescription drug coverage, impractical to eliminate. Worrying projections of medical

inflation create the specter of the state's facing new pressures within the next few years—without much left to cut and without the aid of the massive federal funds returned to Medicaid.[27] ■

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Notes

1. Kaiser StateHealthFacts, Medicaid Spending per Enrollee, 2002, available at www.statehealthfacts.org.

2. Tennessee Comptroller of the Treasury, *TennCare: A Closer Look*, p. 1 (October 2001), www.comptroller.state.tn.us/orea/reports/tenncarebrief.pdf; C. Conover & H. Davies, *The Role of TennCare in Health Policy for Low-Income People in Tennessee,* p. 9 (Urban Institute, 2000), www.urban.org/uploadedPDF/occa33.pdf.

3. Comptroller of the Treasury, *Seeking a Way Out: Services and Challenges Affecting Tennessee's Poor*, p. 56 (April 2004), www.comptroller.state.tn.us/orea/reports/safetynet.pdf; see also C. Conover et al., supra n. 2, pp. 7–8; L. Moreno and S. Hoag, "Covering the Uninsured through TennCare: Does It Make a Difference?" 20 *Health Affairs* 231 (February 2001).

4. Aon Consulting, *Actuarial Review of the TennCare and TennCare Partners Program: Development of Fiscal Year 2006 Per Capita Costs* (May 2005), p. 28, available at www.comptroller.state.tn.us/orea/reports/FY_2006_Actuarial_Report.pdf; American Medical Association, *Physician Socioeconomic Statistics*.

5. McKinsey & Co., *Achieving a Critical Mission in Difficult Times—Illustrative Strategic Options for TennCare* (February 11, 2004), p. 18, available at www.tenncare.org.

6. In fiscal year 2003, combined health expenditures, excluding federal funds, accounted for 37.2 percent of state spending in Georgia, 26.9 percent in North Carolina, and 25.1 percent in Tennessee. See National Association of State Budget Officers, Milbank Memorial Fund and Reforming States Group, *2002-2003 State Health Expenditures Report (June 2005),* Table 46, p. 59: Total State Expenditures—Capital Inclusive, Fiscal 2003; Table 14, p. 25: Total State Health Expenditures—Fiscal 2003.

7. Smith, C., et al., "Health Spending Growth Slows in 2004." *Health Affairs* 25:1 (2006): 186–196, Exhibit 1; see also www.nchc.org/facts/cost.shtml.

8. National Association of State Budget Officers, *2003 State Expenditure Report*, p. 46 (November 2004), www.nasbo.org/Publications/PDFs/2003ExpendReport.pdf.

9. Kaiser Commission on Medicaid and the Uninsured, *States Respond to Fiscal Pressure: A 50-State Update of State Medicaid Spending Growth and Cost Containment Actions*, p. iii (Jan. 2004), www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=3045.

10. For example, in the months preceding Tennessee's implementation of cuts precipitated by a projected $650 million shortfall in TennCare's budget, Louisiana received $775 million in federal relief, Alabama received $900 million, and New York State received $1.5 billion. See J. Moller and B. Walsh, "774 Million in Medicaid Approved—Decision Averts 'Catastrophe,' Breaux says," *Times-Picayune* (April 21, 2004); K. Chandler, "Medicaid Chief Says Huge Increase Needed," *Birmingham News* (Dec. 28, 2004); "HHS Agrees to Give New York More Medicaid Funds if It Implements Changes to Program." Kaiser Daily Health Policy Report (March 17, 2005) available at kaisernetwork.org.

11. R. Locker, "TennCare Deal 'Step Forward,'" *Commercial Appeal*, (August 27, 2003).

12. Governor Phil Bredesen, "Saving TennCare: Address to the Tennessee General Assembly," February 17, 2004, www.tennesseeanytime.org/governor/viewArticleContent.do?id=77&page=1.

13. SCHIP provides matching federal funds for state programs that cover uninsured children who do not satisfy traditional Medicaid eligibility rules. SCHIP was established in 1997 by Title XXI of the Social Security Act.

14. Kaiser Commission on Medicaid and the Uninsured, "State Income Eligibility Guidelines for Children's Regular Medicaid, Children's SCHIP-Funded Medicaid Expansions, and Separate SCHIP Programs (Percent of the Federal Poverty Line), July 2005."

15. Kaiser Family Foundation, "Income Eligibility Levels for Other Medicaid Enrollment Groups as a Percent of Federal Poverty Level," www.statehealthfacts.org; "Total Number of Aged and Aged/Disabled Medicaid 1215(c) HCBS Waiver Participants, 2002," www.statehealthfacts.org.

16. See D. Goldman et al., "Pharmacy Benefits and the Use of Drugs by the Chronically Ill," *JAMA* 291: 2344–2350 (May 19, 2004); M. Heisler, "The Health Effects of Restricting Prescription Medication Use Because of Cost," *Medical Care* 42(7): 626–634 (July 2004).

17. State of Tennessee Budget, Fiscal Year 2006–2007, p. B-139, www.state.tn.us/finance/bud/bud0607/0607Document.pdf.

18. Aon Consulting, *Actuarial Review*, supra n. 4, p. 36.

19. UTCHSR, *Special Bulletin: The Impact of Reducing TennCare Enrollment on Mortality Rates* (March 2002), available at www.tenncare.org.

20. Tennessee Hospital Association, "Tennessee Hospital Reimbursement and the Impact of the Proposed TennCare Waiver Amendment, January 19, 2005."

21. Tennessee Hospital Association, "THA Comments on the Proposed TennCare Waiver Amendment September 24, 2004, Submission and January 19, 2005, Proposal," (2/15/05), p. 6.

22. T. Pack, "Cash-Strapped General Needs a Savior," *Tennessean,* February 19, 2006; J. Tackett, "TennCare Turns Jail into Ward," *City Paper*, September 16, 2005.

23. UTCHSR, *Special Bulletin: Economic Impacts of a Cut in State Expenditures on TennCare: The Role of the Federal Match* (September 2005), available at www.tenncare.org, estimated that cuts of $1.7 billion would result in a loss of 16,000 jobs statewide in addition to other adverse economic consequences. The state's $1.8 billion projection of reduced spending included $650 million state and $1.15 billion federal expenditures that would have been incurred, given medical inflation, had eligibility and benefits been maintained at 2004 levels. Thus, part of the job loss is in existing jobs, and part is in new jobs that would have been created but now will not be. Disregarding inflation, the annualized loss in federal funding is $670 million, resulting in the loss of 10,160 existing jobs. See also L. Ku, "Will the New TennCare Cutbacks Help Tennessee's Economy?" (Center on Budget and Policy Priorities, July 8, 2004), available at www.cbpp.org/7-8-04health.htm, which projects a loss of 20,000 jobs.

24. According to the Tennessee Department of Community and Economic Development, 14,345 new jobs were created in Tennessee through the first three quarters of 2004, for an annual rate of growth of 19,126 jobs statewide. See www.state.tn.us/ecd/pdf/new_jobs04.pdf.

25. McKinsey & Co., *Achieving a Critical Mission in Difficult Times—Illustrative Strategic Options for TennCare,* supra n. 5, p. 84.

26. See n. 17 above.

27. C. Borger et al., "Health Spending Projections through 2015: Changes on the Horizon," *Health Affairs* 25(2), (March/April 2006):w61–w73.

Extrapolating from a 2002 analysis by the University of Tennessee Center for Health Services Research, the recent disenrollments can be expected to increase mortality by 275 deaths a year.