

# Evolution of TennCare Yields Valuable Lessons

**The old TennCare program had many flaws and detractors. Its near collapse led to a more realistic approach to providing coverage to the uninsured in Tennessee.**

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TennCare is one of the most controversial Medicaid experiments in the recent history of state-level health care reform. Launched in 1994, this bold and ambitious health insurance initiative was designed to apply a managed care model to Tennessee's traditional Medicaid program (Mirvis, 1995, Cooper, 1996). TennCare was also to achieve two additional worthy goals: to expand insurance coverage to the uninsured and to those who were uninsurable because of pre-existing conditions and to avert a pending health care budget crisis by keeping the Medicaid budget under control (Mirvis, 1996).

In the last 13 years, the total budget of TennCare grew from the initial \$2.64 billion per year to over \$8.5 billion in fiscal year 2005 while the total enrollment remained relatively stable, hovering around 1.3 million people or 1 in every 4 Tennessee resi-

dents. In 2005, the state's inability to overcome numerous financial and legal difficulties finally led to painful cutbacks in both enrollment and medical services.

The program has undergone many structural and implementation changes, some initiated by the state and some forced on the state by litigation and court rulings (Chang, 2005).

This article traces the history of TennCare and describes the program's design. It then summarizes the root causes of the various problems that have plagued the program and discusses Gov. Phil Bredesen's current reform effort to save TennCare. The article ends with a discussion of the new state program called "Cover Tennessee" as part of a larger concerted effort initiated in May 2006 to provide insurance coverage to small businesses and uninsured workers and to mitigate the adverse effects brought on by the recent cutbacks in TennCare.

## WHAT IS TENNCARE?

TennCare was implemented on Jan. 1, 1994 as a five-year demonstration program approved by the federal Health Care Financing Administration (HCFA), which is now known as the Centers for Medicare & Medicaid Services (CMS). TennCare moved the more than 800,000 Medicaid recipients into managed care and extended the same insurance coverage

to 500,000 more people who were uninsured or uninsurable because of pre-existing conditions. The program has since received several extensions.

In July 2002, Tennessee began a new demonstration program that divided the TennCare program into two parts — TennCare Medicaid, which is for people who are eligible for Medicaid, and TennCare Standard, which is for people who are not eligible for Medicaid but have met the state's criteria for being either uninsured or uninsurable. The benefits of the two programs remain similar. However, people in TennCare Standard are required to pay premiums and copayments when receiving service.

## PROGRAM DESIGN AND RATIONALE

The design of a health plan for a large population comprises four separate yet interlocking elements, each answering a specific question about how the program is designed to work. Accordingly, the original design of TennCare and its subsequent changes will be described and discussed in four parts.

Who is eligible for coverage and what services are available? Originally, TennCare moved more than 800,000 Tennesseans who were eligible for Medicaid (the federal insurance program for low-income people) into TennCare. It also opened enrollment to another 500,000 or so people in two expansion groups: the uninsured

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**FIGURE****Significant milestones in TennCare's evolution**

<b>Date</b>	<b>Event/Milestone</b>
<b>Early 1990s</b>	Tennessee's Medicaid expenditures and the costs of caring for the uninsured rise rapidly, creating a budget crisis.
<b>Jan. 1, 1994</b>	TennCare is implemented with 12 private MCOs under contract to deliver services to 1.3 million beneficiaries. Medicaid behavioral health program continues as a state-run fee-for-service program.
<b>July 1, 1996</b>	TennCare Partners, a managed behavioral health program, begins.
<b>January 2000</b>	The Grier Consent Decree is signed. The Decree severely limits the state's ability to manage TennCare.
<b>2000–2002</b>	Some of the original MCOs go out of business and new ones are brought into the program.
<b>July 1, 2002</b>	A three-year "stabilization period" begins, with TennCare revamped and divided into two parts: TennCare Medicaid and TennCare Standard. The capitated risk arrangement between TennCare and MCOs is replaced by an administrative service organization (ASO) arrangement under which MCOs are paid an administrative fee and the costs of health care services are passed through to the state.
<b>July 1, 2003</b>	All pharmacy benefits are carved out to a pharmacy benefit manager under an ASO arrangement. MCOs no longer manage pharmacy costs.
<b>December 2003</b>	The first McKinzie report concludes that TennCare is not financially viable and is in dire need of change.
<b>January 2004</b>	The second McKinzie report offers policy options and makes recommendations for change.
<b>Early 2005</b>	Gov. Bredesen's TennCare reform plan is finalized. It reduces benefits and disenrolls 190,000 people from TennCare Standard.
<b>July 2005</b>	Disenrollment and pharmacy benefit reduction begin.
<b>August 2005</b>	The state receives court relief from the most onerous provisions of the Grier consent decree, clearing the way for reform.
<b>Late 2005–early 2006</b>	TennCare proposes to CMS and receives authorization to recruit new MCOs for the Middle Tennessee Grand Region under a new risk contract. The MCOs will deliver integrated services, including mental health and substance abuse.
<b>July 2006</b>	TennCare's 11th director in 12 years, J.D. Dickey, resigns to run a software company.
<b>December 2006</b>	TennCare officials propose a \$7.4 billion budget that is slightly greater than the year before and a far cry from the first half of this decade when TennCare funding increased by hundreds of millions of dollars per year.
<b>October 2007</b>	TennCare receives federal approval to continue operating in its current form for three more years.

who were under 200% of the federal poverty level and those who were uninsurable because of pre-existing conditions. Over the next 10 years, the total enrollment remained stable, hovering around 1.3 million. In July 2005, however, budget difficulties forced the state to remove 190,000 people from the expansion group.

Services available in the original design were generous, with enrollees

required to pay low deductibles or copayments, or none at all. To emphasize primary care and prevention, financial incentives were provided for private managed care organizations (MCOs) to keep enrollees healthy and to avoid the more expensive inpatient care. In 2005, however, budget overruns and financial difficulties forced the state to cut back benefits, especially pharmacy benefits, and place

limits on services available to each enrollee.

Who administers the plan and who is at risk? TennCare services are provided by private not-for-profit or for-profit MCOs. Each enrollee has an MCO for his primary care and for medical/surgical services, and a behavioral health organization (BHO) for mental health and substance abuse services. The MCOs were orig-

inally paid on a capitated basis. Each month, they received a fixed payment from the Bureau of TennCare based on the number of enrollees and their ages. In return, the MCOs took on the total responsibility of providing all of the necessary services as stipulated in the risk contracts that they signed with the Bureau of TennCare. Since 2002, however, the risk contracts have been replaced by an administrative service contract and all MCOs today are essentially administrative service organizations, or ASOs, which process claims and administer case management programs for a fee. The BHOs have always had a different and separate financial arrangement with the state, with the state giving a global budget for the BHOs to manage and with the BHOs being allowed to keep a modest percentage of the allotted budget for expenses and profits (Chang, 1998).

Pharmacy benefits were originally provided by each individual MCO and BHO, but were later placed under the Bureau of TennCare. Currently, the pharmacy benefit is administered by a central pharmacy benefit manager and paid out of a separate budget under the control of the Bureau of TennCare.

Who provides the care and how are providers paid? Each of the MCOs and BHOs are responsible for organizing their own comprehensive networks of service providers, such as physicians, dentists, and hospitals. The payment arrangements between an MCO/BHO and a service provider are private and can take many forms. Most TennCare providers are paid on a discounted fee-for-service basis. Few receive sub-capitation payments from MCOs or BHOs.

Who pays? TennCare, like the Medicaid programs in other states, is a joint federal and state insurance program for low-income families and individuals. Under the waiver program negotiated between the state and CMS, the federal government

gives the state roughly \$2 for each dollar it contributes. Thus federal and state appropriations are the major sources of funding support for TennCare. The state collects premiums from some members in the "expansion groups" that are now in TennCare Standard. However, the premium dollars collected have been negligible relative to the total budget needs.

### **MAJOR PROBLEMS THAT HAVE PLAGUED TENNCARE**

The state originally hoped to use managed care to generate savings so as to expand services to 500,000 uninsured people. This was a worthy but exceedingly ambitious goal. To compound the problem, many of the newly formed MCOs did not have the necessary experience in managing the care of a large and unhealthy population. The lack of experience of some of the MCOs and the overly ambitious goals of covering more people while delivering generous benefits were too much for this bold public-sector managed care experiment. It could not deliver the desired outcomes.

Lawsuits that were filed on behalf of enrollees created major difficulties. Both before and after the implementation of TennCare, several lawsuits were filed against the state regarding benefits. The court rulings and consent decrees signed by the plaintiffs and the state created financial and administrative burdens, and may have delayed or even caused the cancellation of needed reforms.

One key case, *Grier v. Goetz*, dealt with procedural issues relating to the termination, denial, delay or modification of TennCare services to individual enrollees. The consent decree entered jointly by the Tennessee Justice Center and the state in 2000 stipulated, for example, that enrollees must be given 14 days of prescription supply, brand-name drugs included, while the affected enrollees appeal the denial of prescription benefits.

In another example, *John B. v. Goetz*, the plaintiff alleged that TennCare failed to provide federally-mandated screening, diagnosis, and treatment services to children. In 1998, the state agreed to set a timetable to comply with federal laws that set minimum health care standards for children, known as Early and Periodic Screening, Diagnosis, and Treatment (EPDST). In late 2001, the federal court found that the state had failed to honor its promises. It appointed a special master to help the state develop a system that meets minimal standards. In 2003, the state again pledged to comply with the federal law and the original 1998 order, but in October 2004, the court found a lack of progress and ruled that the children were due further relief and imposed a proposed plan by the special master and his medical experts. In response, the state filed a flurry of motions against the special master and his experts. The case remains open although it has been inactive in the last few years.

### **RECENT CHANGES**

In his successful campaign to become governor, Phil Bredesen promised to fix TennCare. Soon after taking office in 2003, he retained an international consultant, McKinzie & Co., to provide a comprehensive assessment of the financial sustainability of TennCare and to provide a range of options for reform.

The first report, delivered in late 2003, unequivocally declared that TennCare as it was then structured was not viable and, if unchecked, would threaten the fiscal health of the entire state.

The second report, delivered in January 2004, made several specific recommendations ranging from returning to the original Medicaid program by dropping those in the expansion group to setting limits on enrollment and benefits to save costs.

In early 2005, a TennCare reform plan was finalized that included re-

removal of 170,000 people from TennCare Standard and reduction of benefits based on a new, more restrictive definition of a reimbursable service that would be considered a medical necessity. It also limited the number of prescriptions and refills to five per member per month.

An advocate for patients, the Tennessee Justice Center, immediately challenged the cutback plan but a federal appeals court ruled in the state's favor, clearing the way for a major reform of TennCare. In July 2005, disenrollment and benefit reduction began.

To assist those who lost TennCare coverage, Gov. Bredesen appointed a task force to make recommendations on how to create a health care safety net for people coming off TennCare. The Tennessee General Assembly subsequently made available \$100 million to provide health care for the uninsured in June 2005, and the assistance program was later extended to December 2006.

A second recent change to TennCare was the return of a capitated model with two new MCOs that have now begun to serve middle Tennessee. In contrast to the no-risk contracts between the state and the MCOs that are currently serving the east and west, the new model shifts most of the risk to the newly recruited MCOs, with the state assuming partial risk for catastrophic outliers. A third major change was the integration of behavioral and physical health services under a single contractor.

Through competitive bidding, the state has chosen two managed care companies, AmeriChoice and Amerigroup Community Care, each to serve approximately 170,000 middle Tennessee TennCare enrollees. AmeriChoice is a subsidiary of United-Health Group, a national health service company that serves more than 1.3 million beneficiaries of government health care programs in 16 states from Rhode Island to California.

Amerigroup Community Care is a unit of Amerigroup Corp., a national managed care company that serves 1.3 million people in 9 states and the District of Columbia. The new service model is expected to be expanded to the east and west regions in a few years.

### **"COVER TENNESSEE"**

In June 2006, Gov. Bredesen signed into law the Cover Tennessee Act, a new, multi-pronged health care initiative for the uninsured and for those who cannot afford prescription drugs. It has five components:

CoverTN is a low-cost, limited benefits health insurance program for up to 100,000 workers in small businesses and the self-employed. Launched in March 2007, this \$300 million initiative provides basic major medical coverage up to \$25,000 for health expenses to uninsured workers for \$150 a month per person. The premium is shared equally between the state, the employer, and the individual. This is in contrast to the reform plans of Massachusetts and California that require participating individuals to pay a monthly premium ranging from \$250 to almost nothing depending on family income.

Cover Kids is Tennessee's new SCHIP program that creates a partnership between the state and the federal government to extend health coverage to uninsured children under age 18 and to pregnant women under the federal State Children's Health Insurance Program.

AccessTN is a high-risk pool that provides health insurance benefits to seriously ill adults who have not been able to obtain private coverage. This is guaranteed comprehensive health coverage for uninsurable adults who meet eligibility conditions that include proof of U.S. citizenship or legal alien status and at least six months of "going bare" (no insurance). Its benefits are similar to those offered to state employees. The premiums are

estimated to range from \$273 to \$1,156 per month and vary according to the benefit level selected, as well as the individual's age, weight, and tobacco use. AccessTN also includes premium assistance for low-income participants.

CoverRx is a statewide pharmacy assistance program that has provided coverage to more than 21,000 low-income uninsured people since Jan. 1, 2007. It is not an insurance program, but is designed to assist those who have no pharmacy coverage and have a critical need for medication. It offers affordable access to about 250 medications (mostly generic) and restricts the number of prescriptions to five per month per person with the exception of insulin and diabetic supplies.

Project Diabetes is a school health program that expands an educational pilot project to K-8 schools across the state to teach healthy lifestyles and eating habits. It has launched a grant program to expand treatment options focusing on reducing Type 2 diabetes and obesity.

It is important to note that Cover Tennessee is a market-based health insurance program for targeted groups such as low-income workers in small businesses, uninsured children, and the uninsurable. It is not an entitled program and therefore can be terminated legally at the state's discretion. It will not be administered by the state. Instead, private insurance companies meeting certain conditions and criteria will bid for the program and propose to the state how much coverage they will offer and how they will administer the program.

### **LESSONS LEARNED**

The original TennCare program was bold and visionary. It was ambitiously envisioned to provide better coverage to more people than traditional Medicaid while solving the state's chronic crisis in its health care budget. It has provided access to

health care to many otherwise uninsured people, including many who have chronic conditions that made them ineligible for private health insurance (Moreno, 2001). It has also increased preventive screenings for women and immunization rates in children. (Cooper, 1999, Narramore, 2001).

But as time went on, the program experienced numerous financial and administrative difficulties which, in the end, forced the state to cut benefits and enrollment to avoid another budgetary crisis that loomed even bigger than the fiscal crisis that it first sought to avoid.

A first lesson of TennCare is that states that outsource health care services to private contractors must manage them effectively to harness the benefits of competition. TennCare was put in place too quickly at the beginning, resulting in the state's accepting many "home grown" MCOs that were not experienced in managing the care for the Medicaid and uninsured population that they were given responsibility for. Overwhelmed by the day-to-day responsibility of providing basic services to their enrollees, many of the MCOs could never develop the necessary managed care practices and protocols to deliver care in an economical way. The more successful and efficient MCOs, on the other hand, led the way to demand that the state resume the financial risk. The state gave in to this demand and lost the very cost-control mechanism on which it relied to produce savings.

TennCare also suffered from unstable leadership. Over the last 12 years, TennCare has had 12 directors. Each new director had to climb the steep learning curve and each director had his or her own perspective on the program. With so many directors in so short a period, many program and policy changes were inconsistent and contradictory.

Fundamentally, a deeper health reform lesson may be that it is exceed-

ingly difficult, if not impossible, to simultaneously expand coverage to a large population, offer a generous package of benefits and still check the excessive growth of total budget. The state government cannot match the efficiency of a well-managed private business such as Federal Express. In addition, Tennessee was behind many states in developing managed care practices and participation when it introduced TennCare.

The sudden introduction of a statewide public sector managed care reform and simultaneous expansion of enrollment in a state that did not have a managed care tradition proved too ambitious for a relatively poor state to manage.

The new Cover Tennessee program is a far more modest and realistic reform than the mammoth TennCare program. There are still many unanswered questions relative to the future of this new market-based program and it is difficult to predict how much difference it will make in attacking the problem of the uninsured in Tennessee. However, Cover Tennessee is a step in the right direction and reflects the many lessons that the state has learned.

For example, by setting strict budget limits and adjusting enrollment according to a realistic state revenue forecast, the Cover Tennessee program is not likely to cause the same financial difficulties experienced by TennCare. Further, by focusing on benefits that most eligible people care about, such as low copayments, deductibles, and monthly premiums, the program appeals to the target populations. Enrollees, as part of a large insurance group, benefit from the deep discounts that Blue Cross & Blue Shield and other contracted plan administrators can extract from doctors, hospitals, and drug companies.

### HOPEFUL SIGNS

In January 2007, TennCare officials proposed a \$7.4 billion budget to Gov. Phil Bredesen for the 2008 fiscal

year. This was a slight increase year and a far cry from the first 10 years of TennCare history when funding increased year after year by hundreds of millions of dollars. A major source of cost savings came from the reduction in pharmacy costs, from \$2.44 billion in 2005 to \$1.2 billion in 2006, a whopping 50 percent decline in a year (Mooradian 2007). The state plans to use the savings for preventive care such as weight-loss and anti-smoking programs and for supporting the Cover Tennessee initiative for helping uninsured workers and those who lost TennCare coverage.

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