

TennCare: Tennessee's Answer to Runaway Medicaid Costs

Managed Care Quarterly

TennCare's uniqueness lies in its coverage of uninsured and uninsurable Tennesseans, in addition to traditional Medicaid recipients. When implemented in 1993, an overall enrollment cap of 1.775 million was set for budgetary reasons; there were no limits on enrollment of Medicaid eligibles or uninsurables, only on the numbers of uninsured. Eligibility to the uninsured group was opened on January 1, 1994 and closed on January 1, 1995, but enrollment for uninsured children was reopened in 1997. Traditional managed care arrangements were used to control costs, but a significant feature was continuous enrollee coverage in the program. The most controversial part of the program was the TennCare Partners Program, which consolidated mental health and substance abuse services for TennCare members. Capitation rates to the 12 contracting managed care organizations originally averaged \$100 per member per month (based on age/sex distribution of members), with cost sharing provisions based on income. The state's uninsured rate has declined to 5.9%-one of the lowest in the country. Satisfaction levels are high among enrollees; medical services utilization continues to decline, with a particularly sharp decline in emergency service use; in 1997, only seven percent of respondents indicated that they sought care at hospital emergency rooms as an initial contact point-a 14% decline from 1993. Average well child visits for children ages 3 to 6 exceeded national averages as well as the state's 1993 Medicaid rate. Nonetheless, most TennCare MCOs are losing money on the program. A survey by the Tennessee chapter of the American College of Physicians found a majority of physicians in the state limiting their participation in the program because of low reimbursements and complex rules.-P. Baggett, J. Harkey, and J. Alexander, Spring 1999, pp. 6-14, \$35

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Note: At a May 10 briefing, TennCare's director, Brian Lapps, told lawmakers that the program, with 1.3 million enrollees or almost one quarter of the state's population, needed an immediate \$190 million infusion to keep doctors from leaving the program. To salvage the program, Lapps outlined further reforms including a temporary freeze on uninsurable enrollment, raising premiums and levying copays, and modifying benefits to pre-1993 Medicaid levels.

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An Evaluation of Health Insurance Market Reforms

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A seven-state study (Colorado, Florida, New York, Iowa, North Carolina, Ohio and Vermont) of insurance reforms in the small business and individual markets found such reforms to have met with mixed success. Small group reforms were more successful than reforms in the individual market, but reforms have done little to substantially change the percentage of small-group employees with private health insurance. Small group

reforms were most successful in aiding very small "micro" groups of five or fewer workers to obtain group coverage; however, most insurers still resist sales to these groups because of high administrative costs and adverse selection. The small group market remains highly competitive in terms of price and product offerings; there is little indication of product design decisions being driven by risk selection strategies. Reforms to the individual market have created an individual market that "resembles a large high risk pool," with widespread and substantial enrollment, but where it is difficult for younger, healthier workers to obtain affordable coverage. Rating restrictions have caused insurers to leave markets fearing a loss of profitable business. Where pure community rating laws have been introduced, insurers have adopted a number of strategies to avoid higher risk subscribers. State efforts to standardize products have not been very successful and such products have sold poorly; agents and insurers perceive them as inferior.-M. Hall, February 1999, 6 pages (summary).

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