The Heritage Foundation State Backgrounder

No. 1021/S | The Heritage Foundation • 214 Massachusetts Avenue N.E. Washington, D.C. 20002 (202) 546-4400

A Policy Analysis for Decision Makers

February 28, 1995

TENNCARE: HEALTH CARE REFORM DREAM OR DISAPPOINTMENT?

INTRODUCTION

Congress last year refused to create a government-managed health care system along the lines proposed by the Clinton Administration. But legislators in Tennessee and many other states have plunged into reform of the health care system based on the principles of "managed competition," a prescription for even more government regulation of an already overregulated American health care system.[1] By examining the Tennessee plan, called TennCare, Members of Congress and legislators in other states can learn the tough lessons of adopting a reform proposal based on an expansion of government management of the health care system.

Tennessee is among the first of many states to establish a new program inspired by "managed competition" principles. State legislators have moved over a million citizens, including approximately 700,000 Medicaid beneficiaries and over 300,000 uninsured persons, into a system in which the insurance plan controls both the utilization of health care services and the doctors who offer those services and where doctors enrolled in the system are paid on the basis of a fixed fee or salary.

While TennCare is expanding health insurance coverage for the indigent and low-income workers above the poverty line, it is coupling this expansion with a new system of income-based subsidies.

1 For a discussion of the potential of managed competition to evolve into a more heavily regulated government-run health care system, see Robert E. Moffit, "Overdosing on Management: Reforming the Health Care System Through Managed Competition" Heritage Foundation *Lecture* No. 441, February 25, 1993. See also Peter J. Ferrara, "Managed Competition: Less Choice and Competition, More Costs and Government in Health Care," Heritage Foundation *Backgrounder* No. 948, June 29, 1993. For a description of "managed competition" at the federal level, see Robert E. Moffit, "A Guide To 'Clinton Lite': The Cooper-Grandy 'Managed Competition' Health Care Reform Proposal," Heritage Foundation *Talking Points*, March 28, 1994.

Under TennCare, officials have to hold down costs by using managed care. But the TennCare experiment has run into the usual problems associated with government-sponsored managed health care systems. Because of excessive paperwork and government fee schedules, for instance, there is a shortage of physicians willing to participate. In line with a long and undistinguished history of government estimates of the costs of government health care programs, financial calculations of the TennCare program have proved incorrect. In the process of "managing" care, there is a restriction of access to high quality prescription drugs. And the program already has run almost $100 million into the red, with unpaid bills likely to push TennCare deeper into deficit.

But the difficulties of the TennCare system are understood best in terms of their actual impact on doctors and patients.

ITEM: When a TennCare patient showed up at Maury County Hospital in Columbia with a broken foot, her managed-care organization first tried to refer her to a pediatrician and later to an eye doctor. And when a critically ill cancer patient on TennCare arrived at Fentress County Hospital in Jamestown in dire need of a specialist, his managed-care company supplied him with the names and telephone numbers of two doctors. When hospital personnel called the first number, they got a recording that the phone had been disconnected. When they called the second number, they got a plastic surgeon.[2]

ITEM: Brenda Truckenmiller of Hendersonville says she played by TennCare's rules. Now her 9-month-old son Shelby has a ruptured eardrum. When Shelby developed an ear infection, Mrs. Truckenmiller could not find a doctor in her area who had joined Health Net, the TennCare plan to which her son had been assigned. By the time she took her baby to a non-TennCare physician, his eardrum had ruptured. Although TennCare agreed to pay for the doctor visit, Mrs. Truckenmiller was angry and upset. The ruptured eardrum "could have been avoided if they would have just done what they were supposed to," she says. "They just moved too fast, and the kids have suffered." Dr. John E. Gore, TennCare's medical director, said that "ruptured eardrums are not uncommon among children, and that they usually heal without affecting hearing."[3]

ITEM: "Don't underestimate the seriousness of the situation across the state," said Jim Moss, CEO of Jackson-Madison County General Hospital in Jackson. "People are *not* being cared for because of the implementation of TennCare." On January 20, 1994, six-week-old Crystal Johnson died at the Jackson Hospital after her mother tried unsuccessfully for several days to find a doctor willing to see TennCare patients.[4]

These and similar stories are the direct result of the sweeping change the state of Tennessee made in the system by which it provi ies health care services to the indigent and uninsured. TennCare, launched early in 1994, was meant to replace an overburdened and costly Medicaid program and to provide access for citizens without health insurance. In-

2 Duren Cheek, "Doctoring Up TennCare," *The Tennessean*, February 8, 1994, p. 1A.

3 Bill Snyder, "Mom: I played by rules and my child suffered," *Nashville Banner*, March 30, 1994, p. A1.

4 Bill Snyder, "TennCare service irks providers," *Nashville Banner*, February 4, 1994, p. A1.

stead, the new system has been plagued with problems. These problems should be a dire warning to lawmakers in other states or on Capitol Hill who believe that managed competition is the key to overhauling health care.

WHAT IS TENNCARE?

TennCare is a comprehensive health insurance program for the state's Medicaid enrollees and uninsured, with enrollment currently capped at 1.5 million. Patients must join one of 12 private health plans (managed care organizations called "MCOs") that have contracted with the state. In most cases, they can go only to providers who have joined their health plan's network. All participants with family incomes above the poverty level are required to pay some premium costs on a sliding scale up to 200 percent of the poverty level. There are no deductibles or copayments for preventive care.

All health care providers are required to accept TennCare as a condition of participation in any state or state-administered health care program. The chronically mentally ill and children in state custody or at risk of state custody are enrolled in separate TennCare plans which will continue to be administered by the state. The Nursing Home Program and services to mentally retarded citizens are to continue under the present Medicaid program.

The main objectives of TennCare are to eliminate the Medicaid problem in the state budget by curbing expenditures so that they do not grow at a rate that exceeds the growth rate for tax revenues (in recent years, an average of 6 percent annually, with Medicaid expenditures growing at a rate of 20 percent) and to eliminate the indigent care problem and resultant cost shifting. The program replaced the state Hospital Service Tax.

Original estimates were that TennCare will save the state an estimated $6.5 billion by the year 2000 and the federal government $1.5 billion in the five years following implementation. Cost savings are expected to come from three sources:

❶ **The assignment of TennCare patients to primary care physicians** who, as "gatekeepers," will manage their patients' care by deciding what treatment the patients receive and from whom.

❷ **The aggressive seeking of discounts from providers,** using the buying power of a single payer.

❸ **Competition among competing health plans.**

The period between the proposal and implementation of TennCare was unusually short. Faced with a Medicaid funding crisis, Tennessee Governor Ned McWherter unveiled the plan on April 8, 1993. It was approved by the state legislature on May 5 and gave the governor broad authority to launch TennCare. On June 16, Governor McWherter submitted a request for a waiver to the Health Care Financing Administration (HCFA) and met with President Bill Clinton. On September 17, HHS Secretary Donna Shalala delayed the plan, citing unspecified but substantive concerns, among them Governor McWherter's desire to obtain additional federal monies by counting $595 million in charity care provided by hospitals and doctors as part of TennCare's share of costs.

On October 20, Governor McWherter returned to Washington to meet with Secretary Shalala and White House domestic policy advisor Carol Rasco, and then on November 8 with President Clinton. The waiver was approved on November 18 for implementation on January 1, 1994.

THE CURRENT STATUS OF THE TENNCARE PROGRAM

Many of those connected with TennCare, as well as experts analyzing the plan, agree that it had a very rocky beginning. Several start-up problems appear to have been caused by swift implementation, resulting in interruptions and dislocations in the delivery of services. Some of these initial difficulties have been smoothed out, but numerous concerns remain.

PROBLEM #1: A shortage of physicians willing to take part in TennCare burdens clinics and hospitals.

One problem appearing almost immediately was a shortage of physicians signed up to accept TennCare patients. Blue Cross and Blue Shield of Tennessee admitted that 2,220 of 7,200 doctors in its preferred provider network (PPO) dropped out when continued participation was tied to TennCare. This "cram-down" provision imposed by Blue Cross requires physicians who participate in their PPO for privately insured patients to take TennCare patients as a condition of continued participation. According to Senator Milton Hamilton, Chairman of the TennCare Oversight Committee, many state employees are upset over the loss of physicians in their Blue Cross and Blue Shield plan. Senator Hamilton remarked in a November 1994 telephone interview that the incoming governor of Tennessee has indicated that he wants to change the "cram-down" provision.

As a result of physicians' reluctance to participate, Danny Lou, a nurse supervisor for the emergency department at Maury County Hospital, complained in February 1994 that "Managed-care companies are not providing sufficient networks of physicians. We don't have anyone to refer these patients to."[5] The number of physicians signing up to treat TennCare patients did increase in the following months, but shortages remain, particularly in rural areas.

The shortage of TennCare physicians in rural areas places the burden of care on rural public health departments, which provide primary care and often are understaffed. For example, Dr. Ross Fleming, a pediatrician and district health officer for the state health department, saw a patient this spring with Parkinson's Disease who was having difficulty swallowing. "He had two doctors who wouldn't see him (unless he was referred by a primary-care doctor). I had to write a referral for him to see his own doctors."[6]

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5 Cheek, "Doctoring Up TennCare."

6 Bill Snyder, "Health Departments Shoulder Doc Shortage," *Nashville Banner*, May 20, 1994, p. A1.

The state's response to the physician shortage caused by TennCare has been to create a new rule limiting provider choice of patients. Under the new rule, physicians are not allowed to turn away any TennCare patient who appears at their office. Darrell King, an administrator with the Jackson Clinic in western Tennessee, commented in a November 1994 telephone interview that his clinic has an agreement with Blue Cross and Blue Shield that pieces together provider networks based on exactly how many patients would be covered. "This rule change may destroy that by throwing numbers out the window," King stated. "Providers are willing to see a share of TennCare patients, but not all patients who show up at their door." The rule change was slated to go into effect November 1, 1994, but has been delayed.

Complaints from public health clinics about their treatment under state reform programs such as TennCare prompted the recent filing of a lawsuit by the National Association of Community Health Centers. The clinics are concerned that state reforms spread health spending so thin that Medicaid recipients get less care than in the past. The suit contends that five Medicaid waivers for Tennessee, Oregon, Hawaii, Rhode Island, and Kentucky will "jeopardize critical health services to America's poor" by allowing participating HMOs to pay public clinics and other providers rates below their costs.[7]

One major reason for the physician shortage is the payment schedule. Doctors, particularly those in rural areas, complain about low payment rates. Provider reimbursement under TennCare is left to be determined primarily through negotiations with the MCOs. MCOs have overall spending targets, and if they exceed these targets, provider reimbursement may be reduced across the board.

A lawsuit filed by the Tennessee Medical Association (TMA) contends that inadequate funding of TennCare means that care for the poor is being financed on the backs of doctors. Adding several hundred thousand uninsured to those already in the Medicaid program without significantly increasing funding will result in cuts in services or payments to providers. TMA General Counsel Marc Overlock says that "after managed care organizations skim off administration fees averaging 15 percent of billings, there will be less money than ever to pay providers."[8]

Dr. Ted Taylor, a pediatrician in rural Elizabethton, is troubled by the low payment rates. In a May 1994 telephone interview, he complained that "TennCare will look successful because doctors are not getting paid for a lot of care they are dispensing. How long will they do this? In the short run TennCare will look like it is saving money.... The problems will come in the long run." Taylor says that only 20 percent to 50 percent of rural physicians are taking TennCare patients and that some are quitting while others are almost bankrupt. He was not paid for the first three months of treating TennCare patients and had to rely on his private paying patients for income. Taylor also complains that the MCOs are downcoding to reduce reimbursement amounts to doctors.[9] Senator Hamilton stated that in August 1994 Governor McWherter used ex-

7 *Health Care Reform Week* (United Communications Group, Washington, D.C.), June 20, 1994, p. 3.

8 Brian McCormick, "Tennessee Reform Tempest," *American Medical News*, January 24/31, 1994, p. 2.

9 Downcoding means altering the diagnosis or treatment description to one with a lower reimbursement rate.

tra monies from a surplus of funds (due to non-capacity enrollment) to raise reimbursement rates to physicians.

Some physicians also are upset with the increased paperwork under TennCare. Dr. Taylor commented that "the paperwork is worse than Medicaid, probably quadruple, and costs more than Medicaid to bill." He also said that the program was confusing due to constant changes from the MCOs and that extra physician time was needed to deal with the ever-changing paperwork. Taylor was concerned that the system was slowing down and that waiting lines were developing due to increased paperwork and delays in procedures.

State Representative Steve McDaniel, in a November 1994 telephone interview, remarked that physicians are unhappy with the TennCare program: provider areas are still not adequate, and specialists are lacking. Representative McDaniel mentioned that the incoming governor was concerned about the problems with TennCare and was planning to appoint a committee of providers that would suggest improvements in the program.

PROBLEM #2: Low payment rates are burdening hospitals.

Hospitals are worried about the effects of TennCare on their financial stability. They face losses because of a disparity between TennCare rates and previous Medicaid payments and subsidies. TennCare's relatively low capitation rates mean that hospitals are getting 20 percent to 50 percent less than they were getting under Medicaid. And because some patients experience difficulties in finding physicians who will treat them, many recipients end up in hospital emergency rooms, exacerbating indigent care costs. Charlotte Collins of the Regional Medical Center at Memphis urged soon after TennCare was implemented that the state begin funneling money soon to hospitals like hers. Medicaid patients make up 30 percent to 40 percent of Regional's caseload, and Collins estimated the 525-bed hospital would lose about $6 million a month in Medicaid subsidies for hospitals with a disproportionate share of poor patients.

To make up for these discounted capitation rates and resulting low provider payments, the state established two supplemental pools for provider payments. According to some hospital and physician groups, the state has not been forthcoming with information about the value and disposition of these pools. Payments were made promptly to some high risk essential providers but not to others, and there has been little guarantee of future payment or of a reliable quantifiable formula or payment mechanism. Moreover, according to the National Association of Public Hospitals, "given the design of the program, and the cap on federal reimbursement, it is by no means clear that there will always be adequate funds available in the supplemental pools."[10] Ken Renner, a press official with the governor's office, related in a recent telephone interview that payments have been made to hospitals for indigent care. Discussions have taken place with the U.S. Department of Health and Human Services about using the supplemental pools to compensate other providers, such as physician groups, for their uncompensated care costs, but no funds have been distributed.

10 "Assessing the Design and Implementation of TennCare: Executive Summary," a National Health Reform Briefing Paper prepared by the National Association of Public Hospitals, April 27, 1994, p. 12.

A recent study completed for the Tennessee Hospital Association indicates that 35 state hospitals spent $47 million more to treat TennCare enrollees than they received from the program. Among the hospitals facing the severest shortfalls are the state's two teaching facilities. The state has also broken Medicaid waiver conditions requiring the program to reimburse public hospitals adequately for TennCare enrollees.[11]

PROBLEM #3: The program appears to be significantly underfunded.

Some outside experts and many of those working with TennCare are concerned about the actuarial soundness of the program. According to *Health Care Reform Week*, "At least two months before TennCare was approved, HHS was alerted to a state consultant's opinion that the rates weren't actuarially solid." Phoenix HealthCare Corp., a Tennessee HMO, hired Peat Marwick to analyze TennCare's proposed rates. Peat Marwick found that proposed payments did "not appear to be developed on an actuarially sound basis" and "would not produce an adequate revenue level for most HMOs to provide the desired TennCare benefits."[12]

Recent pretrial testimony in a Tennessee state court suit indicates that state officials may have disregarded HHS rules by ignoring Peat Marwick's recommendations in setting TennCare's payment rates. A May 1993 KPMG Peat Marwick report to Tennessee's health department analyzing the actuarial soundness of TennCare's proposed rates recommended that state officials recalculate them based on Medicaid "eligible months" rather than on annual Medicaid eligible figures (Medicaid recipients rarely remain in the program throughout the year). TennCare Director Manny Martins conceded in a pretrial deposition that using the 8.7 eligible months figure recommended by Peat Marwick would have raised TennCare's payment rates significantly—possibly by 26 percent to 28 percent. "I have never contended that the annual cost [estimate] was actuarially sound," Martins testified. Complaints about low payment rates and the money woes they have caused for public health clinics are among the chief reasons for the recent lawsuit that seeks to revoke HHS Medicaid waivers for TennCare.[13]

Another consultant firm engaged by the Tennessee General Assembly prior to TennCare's implementation[14] emphasized the inadequacy of capitation rates, concluding that they were not based upon sound actuarial principals.

First, the rates were based upon an underestimate of the prior cost of providing services to a Medicaid patient.

Second, the MCOs would have to achieve medical cost reductions of about 35 percent in order to operate within the capitation levels, a reduction the consultants predicted would be very difficult to achieve.[15]

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11 *Health Care Reform Week*, February 6, 1995, p. 2.
12 *Health Care Reform Week*, June 20, 1994, p. 1.
13 *Ibid.*, pp. 2, 3.
14 Schubert Associates and Milliman and Robertson.
15 "Assessing the Design and Implementation of TennCare: Executive Summary," p. 7.

The capitation rate initially determined to be actuarially warranted was $1,641 per enrollee, but the discounted rate actually being paid is $1,230 per enrollee. Capitation payments to MCOs thus are discounted 30 percent to 40 percent below rates the state determined to be actuarially correct. This compares with capitation rates of $2,500 in California and over $2,500 in Arizona.

TennCare has an enrollment cap of 1.3 million persons for 1994 and 1.5 million thereafter. The purpose of this cap is to curb the cost of the program and allow it to grow at a predictable rate. According to Governor McWherter's office, those who are uninsurable or who would have been Medicaid-eligible under the old system will not be affected. The cap limits those served to uninsured persons enrolled on a first-come, first-served basis, within the state funds available to pay for their coverage. The state believes that there are sufficient funds to cover the total number of uninsured. However, experience has shown that government programs typically underestimate both costs and numbers of people demanding to be served. If this proves to be the case with TennCare, it soon will find itself exceeding its enrollment cap, at which point it must deny coverage to some citizens—or else enroll them and exceed its budget.

For most TennCare recipients (those who previously were on Medicaid) there will be no deductibles or copayments. Experience has shown that plans instituting no cost-sharing encourage greater utilization and patient overuse, contributing to higher program costs. This higher utilization rate overloads physician schedules and may cause doctors to ration care by limiting their time with patients or even refusing to see TennCare recipients.

The Schubert Associates study, commissioned by the Tennessee legislature, expressed concern that TennCare would experience a budget shortfall and recommended dipping into state unemployment trust funds and demanding interest income from managed care organizations to cover the difference. The firm warned that the reform program's $3.4 billion budget is likely to be short of the amount needed to provide health care to eligible recipients.

The Schubert study also questioned whether Tennessee added enough money to MCO capitation rates to pay for mental health. State officials insist that mental health services were calculated into their annual approximately $1,200 capitation rate. But Schubert said they did not factor in about $59 million extra that will be needed to pay for inpatient psychiatric services for TennCare enrollees who were not Medicaid-eligible. Schubert and others noted that Tennessee originally sought to establish a separate capitation rate for mental health. When it decided instead to include mental health in the overall capitation rate, it did not add money to pay for the change.[16]

The U.S. House Energy and Commerce Oversight and Investigations Subcommittee plans to air the results of a General Accounting Office investigation of TennCare operations next year, according to an article in the November 7, 1994, issue of *Health Care Reform Week*. Letters from the HCFA to various TennCare officials in the months prior to the January 1, 1994, start-up date indicate that HCFA agreed with Ten-

16 *Health Care Reform Week*, February 21, 1994, pp. 3, 4.

nessee providers who felt that proposed capitation rates were too low. A September 1, 1993, letter indicates that HCFA chief Bruce Vladeck was concerned that TennCare's proposed rates could lead to the same problems that arose in Arizona's Medicaid managed care program. In the early 1980s, one of Arizona's managed care contractors suffered severe financial problems, and nearly all of the program's plans were criticized for low provider reimbursement.

The second-largest of TennCare's managed care organizations, Access Med-Plus, is already in trouble. The plan recently was notified by at least two participating hospitals that their TennCare contracts would not be renewed next year because of mounting unpaid claims. One of the facilities, Baptist Hospital of Cocke County, is the sole provider in Newport, a rural eastern community. Administrator Wayne Buckner says emergency room use at the hospital has jumped 40 percent since TennCare began. Many Access Med-Plus patients have arrived seeking treatment because they cannot find TennCare primary care providers. Others come because they want to avoid copayments demanded by other providers but not by the hospital.

The complaints about Access Med-Plus are primarily that its reimbursements are haphazard or nonexistent and that its provider networks are often inadequate. Buckner says his hospital's total TennCare payments in 1994 are about $2 million below the amount previously received under traditional Medicaid.

The financial problem for MCOs is so severe that in January 1995 the state used a maneuver avoiding public comment to divert dollars from hospitals and physicians to the most cash-strapped MCOs. This cash crisis is due in part to the state's failure to collect millions of dollars in premiums.[17]

Representative McDaniel complained that the TennCare Oversight Committee has not met since May 1994 and that, as a member, he has many questions about the program he would like the committee to investigate. One of his concerns is the financial status of the program. When the program reaches 85 percent of capacity, only those below 200 percent of poverty will qualify. McDaniel is concerned because they already have reached that 85 percent cap. He says that information on the financial status of the program is difficult to obtain.

Aides to newly elected Republican Governor Don Sundquist are now assessing TennCare's dismal financial picture. According to a January 23, 1995, memorandum from Finance Commissioner Bob Corker, TennCare chalked up a $99 million deficit last year—two-thirds of the state's entire deficit anticipated for FY 1995. Moreover, warns Coker, claims yet to be received likely will add more red ink.[18]

PROBLEM #4: TennCare restricts access to new drugs.

TennCare could have a major impact on the quality of patient care because of its limitations on pharmaceuticals. Eight of the 12 TennCare MCOs have a contract with Rx Care, a statewide network of about 1,600 pharmacies, to dispense drugs and pre-

17 *Health Care Reform Week*, January 23, 1995.
18 *Health Care Reform Week*, February 6, 1995, p. 1.

scriptions. RxCare uses a formulary (a list of approved drugs that physicians may prescribe) assembled by a small company in Rhode Island called Promark. Some physicians and pharmacists are upset with the Promark formulary, considering it very restrictive and, in some cases, favoring older drugs over newer, more expensive pharmaceuticals. For example, since 1991, although the Food and Drug Administration (FDA) has approved 81 new drugs, only one is on RxCare's formulary (see appendix).

Many physicians believe the restrictive formulary pits doctors against pharmacists, as druggists must refuse some doctors' choices of medications. The restrictive formulary sometimes forces doctors to hospitalize patients so they may have greater access to drugs that are prohibited outside the hospital.

Another criticism of the formulary is that restricting the use of certain costlier drugs can turn out to be more expensive in the long run. Newer, more effective drug treatments may cost more at the outset, but over the long run they achieve cures in less time and with lower dosages, actually saving money. But Rx Care's formulary is based on acquisition costs only, not on the long-term cost of drug use.

In addition, individual patients may react better to some drugs than to others. If a physician is restricted to using only one type or brand of drug and barred from prescribing a slightly different but more expensive alternative, some patients may have to endure unpleasant side effects or longer usage of a particular medication. Under a restrictive formulary such as that developed by Rx Care, the possibility exists for higher mortality rates, more drug complications, and higher costs for TennCare in the long run.

Dr. Taylor complained that "the drug formulary has changed three times since the first of the year," resulting in confusion for physicians, patients, and pharmacists since no one is quite sure which medicines are prescribable and which are not. "Patients are not getting the medicine needed as prescribed by the doctor," added Taylor. According to *Health Care Reform Week*, "pharmacists are also unhappy with the widely varying formularies and drug utilization reviews employed by TennCare MCOs. State pharmacists aren't any happier about TennCare's payment rates—which on average are at least 20 percent below Medicaid rates."[19]

Senator Hamilton commented that the new governor wants to tackle problems with the formulary. He remarked that changes would likely be made in the formularies but did not know what those changes would be.

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19 *Health Care Reform Week*, January 24, 1994, p. 5.

IS TENNCARE THE RIGHT SOLUTION FOR TENNESSEE AND A MODEL FOR OTHER STATES?

Is Tennessee on the right track with TennCare? Or is there a better method for increasing access to health insurance coverage and treating the indigent? While some of the difficulties discussed above, such as physician shortage and program confusion, have been alleviated somewhat with time, the issue with TennCare is not really whether the state bureaucracy can fine-tune specific problems. The overriding concern is that TennCare illustrates the inherent defects found in any government-sponsored managed care/managed competition program.

These deficiencies in design, with TennCare or with any other managed competition approach, eventually will trigger the same short-term and long-term economic problems.[20] Offering health insurance coverage to people without some patient responsibility for cost-sharing inevitably increases demand and costs, presenting state governments with the choices of budget-busting, tax increases, or rationing of care. Artificial price-setting, through capitated rates and low reimbursements, injects false price signals into the marketplace, skewing incentives and causing physician drop-outs, hospital bankruptcies, and patients unable to find care.

The initial popularity of the managed competition approach to health care reform captured the attention not only of Congress, but also of many state governments looking to curb rising health care costs, particularly within their Medicaid programs.

Several of these states, seeing the popularity of the managed care approach on the national level, are watching the implementation of the TennCare program to see whether it would be effective for them. But Jim Blumstein, a law professor at Vanderbilt who sat on the governor's committee that examined ways to improve the Medicaid program, has a warning for both the states and Congress: "There are tremendous bureaucracy problems, start-up problems, transition problems" with TennCare. "If this happened throughout the whole country for everybody, I think that might really be a disaster. I think healthcare reform on the national basis has to be done on an incremental basis. You cannot do this kind of thing nationwide. The circuits will just blow out."[21]

A primary concern with any managed care/managed competition approach to reform, whether on the state or national level, is that it limits freedom of choice by forcing everyone into a managed care plan. Proponents say this is necessary if people are to obtain an adequate level of care. But forcing people into a plan even against their wishes in order to achieve expanded access and contain costs is not necessary. There are several market-based reforms that could be undertaken by the states and Congress that would increase access to health insurance coverage and contain rising costs while actually expanding freedom of choice, particularly for those currently on Medicaid or in state-run managed-care plans.

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20 See Ferrara, "Managed Competition."

21 Lacrisha Butler, "D.C. Giving TennCare Mixed Reviews," *The Tennessean*, May 16, 1994, p. 1B.

❶ Establish tax credits for personalized health insurance.

A first step toward expanding access and containing costs would be to allow federal tax credits for premiums on individual tax returns. People then would be able to choose a health insurance policy tailored to individual and family needs and to keep that plan from job to job and between jobs. This would mean a large reduction in the number of uninsured Americans. Allowing all individuals a tax credit for health insurance premiums would correct a long-standing bias that has allowed those with employer-provided health insurance to receive coverage while the self-employed and those working for small businesses often could not afford it.

These changes in the tax code would expand the availability of health insurance beyond those who work for large companies that offer benefits purchased with pre-tax dollars (money removed from their paychecks for health benefits and not included in taxable income). Those who are self-employed or who work for small companies that cannot afford health benefits must pay for their health insurance with after-tax monies.

Offering tax credits would subdue the traditional opposition to eliminating the tax incentives available to employees for employer-provided insurance. Many fear that the loss of employer tax incentives would increase workers' tax liability, but this concern would be removed by offering the incentives on the personal side of the tax code.[22]

By purchasing insurance themselves, consumers would become more cost conscious and would shop for the best coverage at the most reasonable price. In addition, they could tailor their coverage to their individual needs. Often, workers find that they must choose from the few medical plans offered by their company, with none fitting their needs. Workers for small businesses frequently find their choices even more restricted than those available to workers at large corporations.

Another advantage of individually purchased health insurance is that workers could take their coverage with them as they change jobs. Changing or eliminating health care coverage can seriously limit job mobility. A worker changing from a large corporation to a small employer may find his coverage reduced or even eliminated, and someone with a family member who has a pre-existing condition may not be able to change jobs at all for fear of losing all coverage. Individually purchased insurance would eliminate that problem.

A refundable tax credit could be offered for those whose income tax liability was less than the value of the credit. In that case, the consumer would receive money back from the government, helping to offset some of the payroll taxes paid by lower-income families. The credit would be equal to a percentage of premium costs and would be phased out as income surpassed the poverty level. In effect this would be a voucher for lower-income citizens to buy health insurance. Additional deductions or credits could be allowed for those whose medical bills exceed a certain amount of income during the year.[23]

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22 As an illustration of how tax relief would be affected in one proposal, see Stuart M. Butler, "Reforming Health Insurance: Analyzing Objections to the Nickles-Stearns Bill," Heritage Foundation *Issue Bulletin* No. 193, June 14, 1994, pp. 14-16.

23 For additional information on tax credits for health care insurance, see Edmund F. Haislmaier, "Health Care for Workers

❷ Establish Medicaid vouchers.

Another option for the very poor would be to give Medicaid recipients a voucher with which to purchase their medical care. They would receive an amount based on family size and income and would be free to purchase health insurance or to enroll in an HMO or managed care plan. Although they would be required to show that they did in fact purchase some kind of health coverage, they could pocket any unused amount. This would encourage recipients to shop for the best coverage at the lowest price.

States could introduce refundable deductibles in capitation plans for the poor. Under a refundable deductible system, a state could enroll beneficiaries in a capitation plan that included deductibles similar to those used in normal insurance. The difference would be that the state would prepay the deductible and then refund any unused portion to the beneficiary at the end of the year. In this way, the poor would have an incentive to avoid unnecessary or overly costly care.

This incentive is important because Medicaid patients tend to use costly and inappropriate care, such as unnecessary hospital emergency room visits rather than seeing a family doctor. This has added considerably to Medicaid budgets in the past, and some have suggested that Medicaid patients be charged deductibles and copayments. However, the difficulty with this proposal is that the very poor often cannot afford the copayments and deductibles. If the patient had a refundable deductible, the cost would be paid for him, but he would have some incentive to seek the most cost-effective treatment as he would receive any savings at the end of the year. Such a system could reduce overutilization and excessive treatment significantly, lowering program costs and making more efficient use of every dollar spent.

❸ Consider high-risk insurance pools.

Health insurance risk pools, like auto insurance risk pools, are a mechanism for assuring that insurance is available to high-risk persons now considered uninsurable. Costs either are borne entirely by those in the risk pool or are subsidized by government or by premiums of nonrisk-pool policies.

Some state and federal organizations help reduce premiums by providing reinsurance for losses beyond a certain level. The reinsurance pool is essentially insurance for the risk pool and is funded by the government or by assessments levied against insurance companies.

Several states have enacted laws establishing health insurance risk pools. States generally operate the pool by forming an association of all health insurance companies doing business in the state. One insurance organization normally is selected to administer the plan under specific guidelines for benefits, premiums, and deductibles.

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and Their Families," in Stuart M. Butler and Edmund F. Haislmaier, eds., *A National Health System for America* (Washington, D.C.: The Heritage Foundation, 1989), chapter 3, p. 59; Terree P. Wasley, *What Has Government Done to Our Health Care?* (Washington, D.C.: Cato Institute, 1992), chapter 5; and John C. Goodman and Gerald Musgrave, *Patient Power* (Washington, D.C.: Cato Institute, 1992). These ideas have been incorporated into several legislative proposals before Congress, including those sponsored by Senators Don Nickles (R-OK) and Phil Gramm (R-TX).

Insurance obviously is more expensive for high-risk individuals than for standard risks. But in a risk pool, premiums are set at a level affordable to those enrolled in the pool. This means that enrollees pay less in premiums than the cost of the services they use. Since all states cap the price of risk pool insurance, risk pools almost always lose money. The most common approach to covering losses incurred by the pool is to require insurance companies to contribute in proportion to their share of the state health insurance market. Some states offset this assessment partly through some form of tax credit against premium taxes or other state taxes. While the establishment of a state-subsidized risk pool is often attractive to policymakers trying to cope with the problem of uninsured persons, some conservative economists are understandably concerned over the potential of such pools to grow into another large government program with all of the regulatory apparatus entailed in setting up such a system.[24] Policymakers should be extremely cautious in designing such risk pools, given the potential impact of such programs on doctors, who already are struggling with the cumbersome rules and regulations of the Medicare and Medicaid systems, and the potential extra financial burdens on the taxpayers if such programs should expand beyond initial projections.

A market-oriented alternative to state risk-pools would be to allow insurers, on their own or in combination with other insurers, to provide federally qualified high-risk insurance. Such plans would be confined to catastrophic insurance policies. Individuals who purchase high-risk insurance should be permitted deductions on their federal income taxes up to twice the level of a premium limit adjusted for age and family size.[25]

❹ Consider medical savings accounts.

An added tax incentive could be given to individuals to help with out-of-pocket medical costs. This incentive would complement the purchase of health insurance covering catastrophic events. Individuals could make annual deposits to individual Medisave accounts (with a tax deduction or credit) and use these funds for routine medical expenses. These accounts would eliminate the need for individuals to purchase expensive first-dollar coverage, would give individuals control over their health care dollars, and would accumulate over time, allowing for lifetime and retirement health care planning.

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24 See, for example, Butler, "Reforming Health Insurance," pp. 14-16.

25 See John C. Goodman, "Mandating Health Insurance," National Center for Policy Analysis *Policy Report* No. 136, February 1989, pp. 20-21.

CONCLUSION

Members of Congress have become painfully aware of the enormity and complexity of reforming the American health care system. Many now realize that failing to reform health care the right way can result in explosions in costs and even higher rates of uninsurance, a series of unforeseen and unintended consequences. Real reform of the health care system will not be accomplished unless and until Members of Congress and state legislators realize that they must make necessary and precise changes in the federal tax code and in the current insurance rules that govern the system, ensuring personal ownership of health insurance policies, guaranteeing Americans real consumer choice, and promoting genuine competition.

The formidable task of health care reform becomes even more difficult if legislators insist on trying to micromanage this complex and intricate sector of the American economy. The Clinton Administration's huge bill, with its various congressional incarnations, was an ambitious attempt to do precisely that.[26] Remarkably, much of what has proven too confusing and complex for Members of Congress on Capitol Hill has been recklessly adopted by many state legislators around the country who wish to reform the health care system through government sponsorship of managed care in a fashion broadly similar to the health care delivery model proposed by the Clinton Administration. The state of Tennessee is among the first to initiate these experiments in "managed competition."

States should avoid managed competition programs, including those which place the uninsured and indigent in a lower tier of health care compared to the insured population. Instead, individual states and Congress should adopt health care policies that incorporate choice for all citizens. Such reforms would eliminate many of the problems faced by those states, including Tennessee, that already have adopted government-sponsored managed care programs. Market-based reforms not only would expand choice and access while lowering health care costs for state governments and the overall economy, but also would preserve access to high quality care and the traditional doctor-patient relationship.

Prepared for The Heritage Foundation by
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26 The Clinton Administration's health proposal includes many features that have been promoted or adopted by several state legislatures. For a detailed discussion of the Clinton plan, see Robert E. Moffit, "A Guide to the Clinton Health Plan," Heritage Foundation *Talking Points*, November 19, 1993.

27 Terree P. Wasley is the author of *What Has Government Done to Our Health Care?* (Washington, D.C.: Cato Institute, 1992). Since completing this study, she joined the Tempe, Arizona, office of Representative Matt Salmon (R-AZ) as District Director.

Availability of Recently Approved Drugs on TennCare ProMark Formulary

Bold Type — Available on TennCare ProMark Formulary without restriction.
Italic Type — Available on TennCare ProMark Formulary with prior authorization only.
Plain Type — Not available on TennCare ProMark Formulary.
Asterisk * — Product given special review status by FDA: such as High Priority for AIDS; Orphan Drug (grave disorders in limited patient populations); Expedited Review (used for treatment of severe medical conditions for which there are currently inadequate treatments).

Brand	Generic	Use	Year
Accupril	quinapril	Hypertension	1991
Aceon	perindopril erbumine	Hypertension	1993
Actinex	masoprocol	Cancer	1992
Almoide*	lodoxamine	Eye disorders	1993
Altace	ramipril	Hypertension	1991
Ambien	zolpidem	Hypnotic (sleep aid)	1992
Aredia	pamidronate	Hypercalcemia	1991
Betapace	sotalol	Arrythmias	1992
Biaxin	clarithromycin	Infections	1991
Cefazil	cefprozil	Infections	1991
Ceredase*	alglucerase	Enzyme Deficiency	1991
Chemet*	succimer	Heavy metal poisioning	1991
Claritin	loratadine	Allergies (Seasonal)	1993
Cognex	tacrine	Alzheimer's Disease	1993
Daypro	oxaproxin	Arthritis	1992
Demadex	torsemide	Hypertension	1993
Desogen	desogestrel/ethinyl estradiol	Contraceptive	1992
Dovonex	calciprotriene	Psoriasis	1993
Effexor	venlafaxine HCl	Depression	1993
Fascovir*	foscarnet	Cancer	1991
*Felbatol**	*felbamate*	*Seizures*	*1993*
Fludara	fludarabine	Cancer	1991
Flumadine	rimantidine HCl	Infections	1993
Ganite	galliumintrate	Diagnostic	1991
Halfan*	halofantrine	Malaria	1992
Histrelin*	supprelin	Precocious puberty	1991
*Hivid**	*zalcitabine*	*HIV Infection*	*1992*
Imagent GI	perflubron	Diagnostic	1993

Imitrex	*sumatriptan*	*Migraine headaches*	*1992*
ISMO	isosorbide monhydrate	Angina	1991
Kytril	granisetron HCl	Nausea/vomiting (Cancer therapy)	1993
Lamisil*	terbinafine	Infection (Fungal)	1992
Lescol	fluvastatin	Lipid lowering	1993
Leustatin*	cladribine	Cancer	1993
Lipidil	fenofibratae	Lipid lowering	1993
Livostin	levocabastine HCl	Allergies	1993
Lodine	etodolac	Arthritis	1991
Lorabid	ioracarbef	Infections	1991
Lotensin	**Fenzperil**	**Hypertension**	**1991**
Lovenox	enoxaparin	Blood clots	1993
Manoplax	flosequinan	Hypertension	1992
Maxaquin	*lomefloxacin*	*Infection*	*1992*
Mazicon	flumazen	Anesthetic adjunct	1991
Mepron	atovaquone	Infection	1992
Metastron	strontium Sr-89	Cancer pain	1993
Mivacron	mivacurium	Anesthetic adjunct	1992
Monopril	fosinopri	Hypertension	1991
Mycobutin*	rifabutin	Infection (Tuberculosis)	1992
Neurontin	gabapentin	Seizures	1993
Neutrexin*	trimetrexate glucuronate	Infections	1993
Nipent*	pentostatin	Infections (AIDS related)	1991
Norvasc	amoldipine	Hypertension	1992
Nuromax	doxacurium	Anesthetic adjunct	1991
Omniflox	temafloxacin	Infection	1992
Omniscan	gadodiamide	Diagnostic	1993
Orlaam	levomethadyl acetate	Narcotic dependence	1993
Paxil	paroxetine	Depression	1992
Penetrex	enoxacin	Infection	1991
Plendil	felodipine	Hypertension	1991
Pravachol	*pravastatin*	*Lipid lowering*	*1991*
ProHance	gadoteridol	Diagnostic	1992
Propulsid	cisapride	Gastric stimulant	1993
Proscar	finasteride	Enlarged prostate	1992
Relafen	nambumetone	Arthritis	1991
Risperdal	risperidone	Psychosis	1993
Sporanox	itraconazole	Infection (fungal)	1992

Suprane	desflurane	Anesthetic	1992
Survanta	beractant	Infant respiratory distress syndrone	1991
Taxol	paclitaxel	Cancer	1992
Ticlid	*ticlopidine*	*Stroke prevention*	*1991*
Tilade	nedocromil	Asthma	1992
Trasylol*	aprotinin	Blood loss	1993
Vantin	cefpodoxime	Infection	1992
*Videx**	*didanoxine*	*HIV Infection*	*1991*
Vumon	teniposide	Cancer	1992
Zebeta	bisoprolol	Hypertension	1992
Zithromax	arithromycin	Infection	1991
Zocor	simvastatin	Lipid lowering	1991
Zofran	ondansetron	Nausea/vomiting (Cancer therapy)	1991
Zoloft	sertraline	Depression	1991
Zosyn	piperacillin sodium/taxobactam sodium	Infection	1993