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Health Reform and the Medicaid Expansion: Planning for Tennessee's Fiscal Future

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In March 2010, Congress approved large changes for the health care industry, including an expansion of the existing Medicaid program. This paper explores the potential fiscal impacts of this Medicaid expansion for the state of Tennessee. First, the development of Medicaid and TennCare, the current recession, and the broader health reform law are outlined to contextualize the Medicaid expansion. Second, the population to be covered by the expansion is characterized to understand cost implication and reveal strategies for cost containment and health improvement. Next, the costs of the program are estimated under set assumptions and the strength of the impact of two main variables – inflation and enrollment – are analyzed. Additionally, this section looks at savings the state may realize as well as some corollary consequences of the increased federal funding to the state.

Introduction

Spring 2010 in D.C. saw both the bloom of cherry blossoms and the passage of the first national bills that address the entirety of the American health system. Rife with political contention and questionable negotiations, the past year of debate was intensely emotional. Facts about the legislation were often misconstrued amidst framing of the many issues involved in the debates. Even now after its passage, many groups and politicians continue to fight both the legislation as a whole and individual provisions within the bills. At the same time, administrators in all levels of government and throughout the private sector are expected to prudently implement the bill.

The purpose of this report is to aid in this implementation by exploring the costs and factors involved in the Medicaid expansion. The aim is objectivity in considering how these portions of the bill will unfold on the ground. As such, facts are blatantly presented; these goals are expensive. Their effectiveness, however, will be determined in the coming years.

In light of the recent passage of the *Patient Protection and Affordable Care Act* and the *Health Care and Education Reconciliation Act* (subsequently referred to collectively as PPACA) as well as the lack of Tennessee-based analysis, my paper focuses on interactions between the new law and Tennessee operations, including the budget and current policies on Medicaid and children's coverage. I attempt to characterize how health reform *may* affect Tennessee government by comparing analysis of the bills, national and state data on budget and health indicators, and analysis of state programs and policies. By comparing, combining, and analyzing information from these sources, a picture of the fiscal impact begins to emerge.

Many factors will alter the course of the Medicaid program in the future; this paper highlights major unknowns that administrators should consider and account for in planning. Since Tennessee has unique public programs and legislation regarding insurance regulation, federal reforms will impact Tennessee in distinctive ways.

In the coming years and months, the Center for Medicare and Medicaid Services (CMS) and the Tennessee Office of Finance and Administration will release their own analysis that will include more comprehensive information on implementation. My goal is to inform the numbers with history and an understanding of the expansion population. I make no attempts to be exhaustive in my work but rather to add to existing discourse.

Part 1 explores the context of the Medicaid expansion, including the development of Medicaid and TennCare, the current recession, and the broader health reform law. Part 2 explores an estimated net cost of \$2.3 billion. First, I work to characterize the population to be covered by the expansion. While the ultimate goal of this exercise is to understand the impacts on the cost of the program, it reveals several strategies for cost containment and health improvement. Second, I broadly estimate the costs of the program under set assumptions. Finally, I analyze the strength of the impact of two main variables – inflation and enrollment. Moreover, this section looks at savings the state may realize as well as some corollary consequences of the increased federal funding to the state.

Part 1: Context

The context of this Medicaid expansion is crucially important. Medicaid has been expanded numerous times in the past, but events do not occur in vacuums. Current economic and political situations differ at this moment. Accordingly, in this section, I outline the history of Medicaid and TennCare, look at the current structure of TennCare, and explore the goals and provisions of health reform as a whole.

TennCare History

Those who cannot learn from history are doomed to repeat it.
—George Santayana¹

Beginning of Medicaid

Medicaid and Medicare, passed under the Social Security Amendments of 1965, provided health insurance for the elderly, the poor, the blind, and the disabled. While both are entitlement programs, unlike the categorical State Children's Health Insurance Program, these two programs differ in several key ways. First, Medicare provides coverage for elderly

Americans; Medicaid provides care for the poor. Second, Medicare is operated from the federal level while Medicaid, which does receive federal funding, is administered at the state level. Third, each program was designed for a different purpose. Medicare was deemed necessary because the “elderly had unique health needs which could never be addressed by the private sector, and thus required specific government remedy.”² In contrast, Medicaid worked in conjunction with other period initiatives to fight the “War on Poverty.” Unlike its cousin, Medicare “drew little opposition from organized medicine” since the program was seen as a “mere expansion of existing welfare programs.”³

Within five years of the creation of the Medicaid, all states – except Arizona – established Medicaid programs to expand care to the population targeted by the new program.⁴ They covered a portion of the poor, as well as the blind and the disabled. Eligibility was based on welfare guidelines already in place under Aid to Families with Dependent Children (AFDC, now Temporary Assistance for Needy Families, TANF) and administered through existing state welfare departments.⁵ In the beginning, Medicaid “effectively prohibited” cost-sharing, deductibles, and co-payments.⁶ By providing health insurance for the disenfranchised, program planners wanted to make care from private providers accessible to all patients, who up to this point had been treated in public clinics and hospitals. The program aimed to merge a two-tiered medical care system.

Medicaid was only one part of the Johnson Administration’s War on Poverty which created programs that ranged from youth and work training to neighborhood health centers. This “three-pronged approach drew on research indicating that the poor were disproportionately undereducated, undertrained, sick, ignorant, and isolated.”⁷ Still, the attack on medical disparities did not follow the general community-focused theme of other poverty programs because of political pressures. Instead, Medicaid left the traditional private infrastructure in place without addressing the design and coordination of the medical and hospital systems. According to liberals at the time, “federal policy overemphasized hospital constructing, while ambulatory care was neglected.”⁸ In other words, Medicaid policy continued the emphasis on hospital care set in 1946 with the Hill-Burton Act that funded hospital construction.⁹

As such, Medicaid worked to integrate the low-income population into mainstream private hospitals that provided a higher quality of care than public clinics. Since the program needed to change the way this population received care, administrators had difficulties enrolling those eligible in the program.¹⁰ In addition, states saw almost immediate budget problems from their generous hospital-based programs and began scaling back.

Two lessons can be gleaned from the early Medicaid years that are important when considering what methods will contain health costs. First, simply expanding coverage does not solve all problems in the health system and specifically does not help combat rising costs. Second, cost issues are compounded by undue emphasis on the benefits of hospital and acute care.

Medicaid Expansions in the 1980s

Medicaid enrollment has ebbed and flowed over the past two decades. Expansions in the late 1980s, however, put much financial stress on states, which in addition to failed national reforms in 1993 caused many of the state-level reforms seen in the ‘90s, including the TennCare waiver, to fail. Table 1.1 identifies both federal and Tennessee cuts and expansions in eligibility since 1981 and serves as a reference for the following discussion.

Table 1.1: Tennessee Medicaid Coverage: State and Federal Changes, 1981 – 2014

Year	Cuts or Expansions in eligible Medicaid Population	Bill
1981, 1982	Federal Cuts	Omnibus Budget Reconciliation Act of 1981 Tax Equity and Fiscal Responsibility Act of 1982
1984 – 1989	Federal Expansion	Deficit Reduction Act of 1984 Consolidated Omnibus Reconciliation Act of 1985 Medicare Catastrophic Coverage Act of 1988 Family Support Act of 1988 Omnibus Budget Reconciliation Act of 1989
1994	Tennessee Expansion	TennCare Section 1115 Waiver
2005	Tennessee Cuts	Waiver Amendments
2010	Tennessee Cuts	Waiver Amendments
2014	Federal Expansion	Patient Protection and Affordable Care Act of 2010

Source: Kaiser Medicaid History¹¹; Jonathan Engel¹²

The parallels between the Medicaid expansion of the 1980s and the planned expansion are obvious, but several differences are worth noting. First, the expansion of the 1980s came through a series of eligibility expansions.¹³ These began in 1984 with AFDC children under 5 and select AFDC-eligible pregnant women. Omnibus budget legislation in 1990 then extended Medicaid to all children and pregnant women under 133 percent of Federal Poverty Level (FPL)¹⁴ and added the Medicare cost-sharing of dual eligibles to Medicaid's responsibilities. In contrast, all new PPACA-eligible beneficiaries will qualify for the program on January 1, 2014. Second, the federal government provided no financial help during the 1980s; matching rates remained the same.¹⁵ More money was pumped into states by the federal arm, but states were also more fully responsible for cost increases, which brought on an increase in the number enrolled. In contrast, the federal government will share a significant portion of costs of upcoming expansions; instead of phasing-in coverage, they phase in cost-sharing, initially covering all expenses and the gradually reducing reimbursement levels that ultimately remain higher for newly eligibles. Third, the scope of these mandates differ by significant amounts. Coverage twenty years ago doubled (which represents a 100 percent increase in enrollment) whereas researchers predict a 25-33 percent increase under recent legislation.^{16 17} In other words, the number of enrollees jumped from 500,000 to 1,000,000 between 1987 and 1993; projected increases put the next expansion from approximately 1,200,000 to 1,450,000. Both the raw numbers affected and the percentage change under PPACA will be smaller. Fourth, each expansion (or set of expansions) was passed under different political environments. The expansions of the 1980s were passed through Omnibus Budget bills which were not health-specific; the recent expansion was passed through a comprehensive piece of health reform legislation.¹⁸ The impact of these additional reforms is addressed later.

Beginning of TennCare

As seen, the 1980s brought a gradual increase in the population states were required to cover through their Medicaid programs. Implemented with no federal fiscal support, states were tasked with accommodating these new enrollees; Tennessee was no exception. In five years, enrollment doubled and expenditures tripled, leaving the state with few options.¹⁹ While enrollment likely was not the only cause of increased costs, Tennessee's budget could not sustain this rate of increase. The Blue Ribbon Task Force, commissioned by

then Governor Ned McWherter and chaired by Dr. William Frist, who later became Senate Majority Leader, gave legislators three options: 1) Increases taxes, a politically infeasible move; 2) Reduce Medicaid services, a move counter to McWherter's vision for the state; or 3) Reform the delivery and financing of the current system.

Threatened with the insolvency of Tennessee's Medicaid program in 1994, Governor Ned McWherter led a drastic overhaul to implement a new managed care system to be dubbed TennCare.²⁰ The state successfully petitioned a Section 1115 demonstration waiver to transition 800,000 enrollees to managed care in order to save costs. Additional savings, realized by reallocating Disproportionate Share Hospital (DSH) payments, allowed the program to expand its eligibility requirements to two additional groups – those uninsured and the uninsurable (now referred to as “medically eligible”).

Disproportionate Share Hospital (DSH) payments were designed to sustain hospitals that provide more care to Medicaid-eligible populations than other hospitals.²¹ States and the federal government share these costs in the Medicaid program. Each state sets different requirements to identify eligible hospitals but must follow minimum federal guidelines. In the late 1980s, states used funding from provider taxes and local governments to increase the amount of DSH money the state received from this uncapped source. The rapid growth in these funds led to the passage of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L. 102-234) that reduced the amount of donated funds eligible for a federal match and capped DSH payments at 12 percent of the Medicaid budget. This bill also locked in state contributions at 1992 levels; Tennessee was classified as a state with “high” DSH spending since this consumed 17.6 percent of its total Medicaid spending.²² The new law went into effect in 1993 and Tennessee faced losses of \$494 million in Medicaid payments.²³ TennCare began the next year and worked with CMS to reallocate these funds into its managed care program.

In 2005, the budget once again led Tennessee Governor Phil Bredesen to advocate drastic action. This time, the Democratic governor and one-time health insurance executive borrowed solutions from the private sector. TennCare dropped coverage for optional groups, including those who would be otherwise uninsured because of a pre-existing condition. Bredesen replaced the federally-matched program with a high-risk program and with a less-expensive state-subsidized insurance program for small businesses called CoverTN. Ample savings were possible through premium cost-sharing; the state, the business, and the beneficiary each paid one-third of the costs. In 2009, this program covered approximately 22,000 people at a cost of \$20 million, which still left many without coverage.²⁴ This cost equals \$910 per capita for the state, in contrast with the \$4,106 per capita spent on TennCare Services. AccessTN creates a high-risk pool in which individuals can purchase coverage. The state spends \$3,841 to cover each high-risk individual compared to the estimated \$7,500 spent on elderly and high-risk individuals in 2006.²⁵

Despite these overarching changes in public programs, Tennessee saw no change in DSH funding through its dealings with CMS. Still operating under a waiver because of the continued reliance on managed care, federal payments for DSH hospitals were still redirected to insurers. However, the *Tax Relief and Health Care Act of 2006* granted the state DSH funds in 2007, the *Children's Health Insurance Program Reauthorization Act* (CHIPRA) extended these funds through 2012, and the *American Recovery and Reinvestment Act* (ARRA) allocated additional DSH payments. Together, DSH funds are set to expire in 2013, just before the enactment of the Medicaid enrollment.

Recent Recession and 2010 Cuts

Economic dips have a unique impact on public programs that serve low-income populations: while the need for the programs increase, government revenues decrease. As a result of the current recession, most states are facing budget shortfalls. The federal government intervened in 2009 with a stimulus bill known as the American Recovery and Reinvestment Act (ARRA). The bill included an increase in federal matching funds for Medicaid programs, which allowed many states to lessen or delay cuts while stimulus funds were available. Tennessee also received a nine percentage point increase in its Federal Matching Assistance Percentage (FMAP), the reimbursement rate for its Medicaid spending.

Despite stimulus funds, Tennessee's continual decrease in sales tax revenue compounded with a continual increase in TennCare expenditures led Governor Bredesen to propose benefit cuts in the 2010-2011 budget.²⁶ These changes would cut therapy services and drastically limit hospital and office care for non-institutionalized adults in order to save \$99.4 million to help address an estimated \$1 billion budget shortfall. A recent decision by CMS to return a portion of the federal share of the Medicaid drug rebate allowed the state to postpone most of these cuts for one year.²⁷

Current TennCare Landscape

Below, a table displays current TennCare eligibility for major categories. Like many other states, Tennessee does not cover low-income adults who do not have dependent children. As noted before, these eligibility levels differ drastically from the TennCare of five years ago since they do not include Tennesseans who are uninsured due to lack of employer-sponsored group insurance or because of pre-existing conditions.²⁸ PPACA expands coverage for all individuals to 133 percent FPL, which will cover previously excluded childless adults as well as more parents. The reference income threshold column is for a family of four.

Given its dynamic history over the past twenty years, TennCare is in a unique position to absorb this next round of mandates. Some aspects – our reduced Medicaid rolls and lack of DSH payments – may actually sustain Tennessee when the Medicaid expansion is implemented. For example, I show that the reductions over the past five years open Tennessee to more federal dollars. Since Tennessee will have more “newly eligible” Medicaid enrollees because our current eligibility is lower, Tennessee receives a higher match for these individuals. In addition, I examine the roll of uncompensated care and DSH payment reductions that Tennessee largely avoids in absence of these funds. Uncompensated care is expected to decrease since fewer individuals will be uninsured and unable to pay their hospitals bills. Additionally, PPACA will gradually reduce DSH

Table 1.2: Current TennCare Eligibility

Category	Eligibility (As % of FPL)	Income Threshold (For a family of 4)
Infant	185%	\$40,792
Child Age 1 – 5	133%	\$29,326
Child Age 6 – 19	100%	\$22,050
Pregnant Woman	185%	\$40,792
Parent Working	80%	\$17,640
Non-Working	70%	\$15,435
<i>Income for a Full-Time Minimum Wage Worker: \$15,080</i>		

Source: Tennessee Center for Policy Research ²⁹; FPL Levels ³⁰

payments to 25 percent of their current rates. Since Tennessee receives only temporary DSH payments, Tennessee hospitals will not receive these fiscal cuts. These ideas are further expanded in Part 2.

Health Reform

As previously referenced, the pending Medicaid expansion comes as part of comprehensive health reform. Other provisions will impact the implementation of these new Medicaid requirements. Outlining major components of the full bill further contextualizes the Medicaid expansion, allowing a more complete understanding of potential impacts of the remainder of the bill. As such, before expanding on details of the expansion, I outline general goals of the bill and highlight two specific components – Health Insurance Exchanges and the employer and individual mandates – that will impact the expansion most directly.

Goals of Health Reform

Our country ranks 37th in a report released by the World Health Organization because of the gaps in insurance coverage and the resulting gaps in health care access of our population as a whole.³¹ Financial considerations remain at the core of many inadequacies in our system. Since health care costs increase at a higher rate than base inflation, health care costs have steadily eaten up a larger portion of our nation's Gross Domestic Product and accordingly have gradually priced more and more Americans out of health coverage. In addition, health insurance companies, as logical businesses, seek to minimize loss to maximize profits. These business techniques, however, often result in practices that block high-risk individuals from the market and seek only the healthy to insure. In other words, increasing costs and business awareness of bottom lines have left many uninsured. While other factors, including lifestyle, contribute to the overall health of Americans, high inflation and incomplete insurance coverage represent core problems that Congress addressed in recent legislation; below I outline these goals in more detail.

Advocacy groups have pushed strongly for their issues to be included in this round of discussion. Still, PPACA, while expansive, has a limited scope. The problem of 47 million uninsured Americans has remained in the spotlight throughout, but the underinsured population, a large subset of those insured but at risk of bankruptcy if they face a major health crisis because of inadequate insurance coverage, have received much less attention. Additionally, the bills put much effort into reforming the individual and small group health insurance markets that boast exorbitant prices and discriminatory selection of customers, but ignore job-lock problems created by employer-sponsored insurance. Additionally, Congress has given much attention to the inflation in health care, which outgrows base inflation, since it is making health care inaccessible for more and more people. But public health concerns are not being adequately addressed, in spite of increasing obesity and the need for prevention. In short, PPACA makes large strides in some areas but provides inadequate solutions for other problems.

Moreover, the rhetoric and the extent of reform has shifted over the past year as conversations have clarified what issues will be addressed in the current bills. Public health concerns have become less important to Congress, as the focus has increasingly shifted to reforming the insurance system. Even delivery system reforms in the bills take a financial form – changing reimbursements – as opposed to true organizational changes. As Gail Wilensky, senior fellow at Project HOPE and former Medicare administrator, emphasizes, tensions exist between finding quick money for financing reform and implementing long-lasting health care savings and quality improvements.³² Unfortunately, she said, encouraging integrated delivery systems, management of chronic disease, and reducing

inappropriate admissions do not show savings when scored by the Congressional Budget Office. “The ways you get money quickly are not the ways that produce the kind of changes you need for quality,” she told reporters.

As stated in early versions of both the House and Senate versions, the Patient Protection and Affordable Care Act (PPACA) aim is “to provide affordable, quality health care for all Americans and reduce the growth in health care spending.”³³ Of particular interest, this statement of purpose specifies accessibility of health care as the ultimate goal. While many in the health community acknowledge the need for a wider range of reforms, PPACA was designed with this specific goal. Major objectives can also be seen in the President’s September 2009 address to a Joint Session,³⁴ which identified four specific areas of concern that clarify the purpose statement of the bill, which I summarize as: 1. Regulating the insurance industry, 2. Covering the uninsured, 3. Reducing the growth rate of health care inflation,³⁵ and 4. Responsibly sustaining current public programs. Again, all areas are insurance reforms.

More specifically, PPACA addresses the inaccessibility of insurance due to risk selection and costs. Insurers institute many risk selection factors in order to maintain a healthy bottom line.³⁶ Often, this translates to denying coverage to those with pre-existing conditions, to retroactively denying coverage, to demanding drastically higher premiums for those in higher risk groups, and to capping total payouts for individuals. Because of these business strategies, many Americans cannot obtain health insurance. Legislation attempts to resolve this problem, either by providing alternative coverage or by regulating these aspects of insurance coverage. Additionally, legislation mandates coverage for individuals and employers and provides increased government assistance to meet this goal, through subsidies and Medicaid expansions. Moreover, costs of health care are climbing at exorbitant rates and must be controlled.³⁷ Legislation aims to do its part to control costs, with the understanding that the private sector needs to implement its own cost controls as well.³⁸

Other concerns with the bill, including the proper role of government in regards to health and health care, have become a factor in debate. Still, reform addresses concerns with insurance *coverage* of Americans and *costs* to individuals and government. As such, the success of these proposals is defined both by how well they achieve goals of coverage and cost-control and by their political viability.

Provisions in PPACA

Among many other provisions, PPACA creates a Health Insurance Exchanges in the states (or regions), institutes mandates that could increase enrollment, and raises Medicaid eligibility. Below, I outline these three major provisions of the health reform law, each chosen for its scope and contribution to major reform goals. Not coincidentally, these provisions will create the most changes in public programs offered by Tennessee.

Health Insurance Exchange

Creating new health insurance exchanges, originally one of the less controversial provisions in the bill, forms the cornerstone of the reform law. The exchanges aim to make the small group and individual insurance market more consumer-friendly to enhance competition while reducing unethical practices. The exchanges could be compared to comparison shopping websites like Priceline³⁹; an online interface would allow consumers to compare rates for similar plan. Benefit plans will contain standardized benefits and provide information in an easy-to-compare format. The bill outlines four benefits categories of plans that

would be offered that vary based on the cost amount the plan covers.⁴⁰ Funding would also be available to start health cooperatives. Subsidies would be offered within the exchange to assist families up to 400 percent of the Federal Poverty Level (FPL) in purchasing the plans such that their costs would not exceed 2 – 9.5 percent of their income, based on a graduated scale. Importantly, plans in the exchange must guarantee issue and renewal to all enrollees so no one could be denied coverage for a pre-existing condition.

Advocates of the health insurance exchanges argue they will cut costs by improving competition. They create more uniform plans and bring them together in a more open marketplace. The offered subsidies improve the affordability, thereby increasing the consumer base. Opponents argue that increasing the number of consumers will subsequently drive up the costs of care; more demand translates into higher costs and counters the positive impact of the subsidy.

In light of a federally subsidized health insurance plan, Tennessee's CoverTN subsidized insurance program becomes redundant, as will be explored in Part 2 on "Program Cuts and Reductions" in more depth.

Mandates

In order to reach the goal of universal coverage, the bill includes both employer and individual mandates. The employer mandate requires large- and medium-sized employers, those with over 50 employees, to provide insurance for their employees. In some cases, they would face a fine if they failed to cover their workers. Similarly, the individual mandate requires individuals to purchase or enroll in insurance or face a fine; in most cases, provisions are made to ensure affordability of the insurance or to exempt those who cannot afford the premiums (See Table 1.3). Supporters insist that both mandates must be instituted together as a critical component in ensuring that health reform as a whole is successful. Opponents argue that mandates are simply another tax that will punish those who cannot afford insurance.

In addition to noting that mandates are a way towards universal coverage, supporters point to the cost-shifting that now occurs when people are uninsured. Their uncompensated care is absorbed by the hospital and the government and passed along to others via higher premiums or higher taxes. As such, all have a "shared responsibility" to obtain insurance coverage to avoid unpaid bills. Opponents question the Constitutionality of the mandates as well as their unintended consequences. They argue that Congress does not

Table 1.3: Summary of Mandate Penalties

Patient Protection and Affordable Care Act (P.L. 111-148) as amended by the Health Care and Education Reconciliation Act of 2010	
Individual Mandate	Penalty: The greater of \$695 ind (\$2085/family), or 2.5% of household income Exemptions: Financial hardships, religious objections, those without insurance for less than 3 months, if the lowest plan exceeds 8% of income, or if income is below filing threshold or \$9,350 (in which case you'd qualify for Medicaid)
Employer Mandate	Penalty: For companies that do not offer insurance - \$2,000 / employee Do offer insurance, but have people using subsidies in the exchange, the lesser of - \$3000 / person getting subsidy OR \$2,000 / employee Exemptions: Employers with under 50 employees

Source: Kaiser Health Reform Side-by-Side⁴²

have the authority to impose such a requirement on individual citizens.⁴¹ Further, they see the mandates as simply a hidden tax that punishes individuals for personal decisions.

As a point of comparison, mandated car insurance receives little political fanfare. Most states require drivers to obtain liability insurance for their vehicles to protect others in the case of an accident. Proponents compare the health insurance mandate to car insurance mandates since both serve to protect the financial well being of others. In a car accident, the responsible party contributes to the damages. If someone needs extensive medical care, their insurance will help them cover the costs; otherwise, the hospital incurs cost and arguably passes these costs along to private insurance companies. Opponents point to substantive differences between the two mandates.⁴³ A health insurance mandate, they argue, impacts everyone, regardless of their choice to obtain specific types of property, such as a car, so the mandate is an overreach of federal authority.

A third perspective offered by Leonard Burman of the Urban Institute compares the mandate to tax credits for owning a home, having a dependent child, or making a charitable contribution. These tax breaks could save a married couple \$7,000 for home ownership or \$1,300 for a having a child.⁴⁴ Thus, he argues, the mandate represents a mere rhetorical difference aimed at increasing the number of Americans who buy insurance.

In light of varying explanations and opinions on the individual mandate, Tennessee residents may or may not respond to this mandate. If they do, enrollment numbers for Medicaid may increase even though many who are Medicaid-eligible are not at risk of incurring the penalty. This “culture of insurance” is covered in more depth later.

Medicaid Expansion

In addition, the bill will expand Medicaid eligibility to 133 percent of Federal Poverty Level as another method to achieve universal coverage. As you may recall, current law prohibits coverage of large portions of the population that may otherwise be eligible by income level since many states only cover adults with children, children, and the disabled. The new legislation would greatly expand the number of those eligible for this state coverage by including all who meet the income requirement. Table 1.4 shows the updated TennCare eligibility that will go into effect in 2014.

Once the expansion takes effect, federal funding will divide Medicaid enrollees into two groups – those eligible before reforms and those eligible after reforms. To assist states with the increase in enrollees, the federal matching rate will be higher for those newly eligible.

These two provisions – the individual mandate to obtain health insurance and the expansion of Medicaid – have caught the attention of those concerned with state budgets. Governor Phil Bredesen’s office reported that an earlier version of the Senate bill would cost the state \$735 million between 2014 and 2019 (Part 2 on the “Cost Estimate” includes

Table 1.4: Reformed TennCare Eligibility, 2014 (Changes in Bold)

Category	Current Eligibility (As % of FPL)	New Eligibility (As % of FPL)	Income Threshold (For a family of 4)
Infant	185%	185%	\$40,792
Child Age 1 – 5	133%	133%	\$29,326
Child Age 6 – 19	100%	133%	\$29,326
ALL Adults under 65	80% working parents 70 non-working parents	133%	\$29,326

Source: Kaiser Health Reform Side-by-Side⁴⁵

a break-down of this estimate). This large figure is particularly troubling in light of decreased state revenues and spending cuts in the existing TennCare plan. As Bredesen states in his letter:

[B]y 2013, we expect to have returned to our 2008 levels of revenue and will have already cut programs dramatically – over a billion dollars. At that point, we have to start digging out – we will not have given raises to state employees or teachers for five years, our pension plans will need shoring up, our cash reserves (“rainy day funds”) will have been considerably depleted and in need of restoration, and we will not have made any substantial new investments for years. There will have been major cuts to areas such as Children’s Services that we really need to restore. On top of these, there are all the usual obligations that need to be met – Medicaid, for example, will continue to grow at rates in excess of the economy and our tax revenues. It’s going to take at least a full decade to dig our way out and back to where we were prior to the recession ... These are hard dollars – we can’t borrow them ...

I would point out that the problem is entirely recession-related. If our revenues had grown from the 2008 base at the normal average rates we have experienced over the years – good times and bad – we would have well over \$2 billion of additional revenue in 2019 (and smaller obligations in the pension area) and would definitely be prepared to accommodate reform.

As Governor Bredesen aptly states, the recession will force our state to make difficult spending choices over the coming years.

Moreover, organizations and leaders from both sides of the aisle, both nationally and locally, have voiced concern with increasing federal control as well as the fiscal obligations that will be handed down to states. In one article, the Heritage Foundation correctly reminds readers that state participation in the Medicaid program is optional⁴⁶; Arizona, for example, did not join the program until 1982, seventeen years after its inception.⁴⁷ Ending Medicaid in the state would, however, be a drastic move that would gravely endanger both Tennessee hospitals who have become dependent on federal matching funds to cover their costs as well as Tennessee residents who would still be required to purchase insurance but have no affordable option to do so. Newt Gingrich, in an American Enterprise Institute article, argued for state-control, harkening to age-old federalist debates about the power of the states versus the federal government.⁴⁸ The National Governor’s Association, in multiple statements, emphasizes the ability of states to more accurately understand their own fiscal limitations. As NGA Executive Director Ray Scheppach explains,

Just as no state is offering the maximum of all possible options; neither does any state cover only the bare minimum mandates. Every state makes political and fiscal calculations with regard to how expansive they can afford their Medicaid program to be. Therefore, imposing broad new unfunded mandates upon states could force them to reduce spending on optional categories.⁴⁹

Accordingly, Bredesen’s cost estimate included reducing the coverage of optional groups. Further expansion, they argue, would reduce funding for other programs. The remainder of this paper explores these concerns and outlines what the state should expect in regards to the cost of the expansion.

Summary and Conclusions

The Medicaid program was born of necessity and has undergone many changes in the past four decades. Today's Medicaid expansion occurs alongside insurance mandates, the opening of Health Insurance Exchanges, and an on-going recession. Many predictions have been made and yet we still know little about how the public, the providers, and the payers will respond to these changes. On top of the unknowns, unique conditions in Tennessee, namely our lack of a state income tax, decreased enrollment, absence of DSH payments, and our managed care program will interact with these new changes in distinctive ways. We do know that Medicaid rolls have been previously both expanded and reduced. New funds were allocated for the program or savings were realized from program changes in order to expand. Through these experiences, we also know that expanding coverage alone does not address the problem of rising costs. In other words, the Medicaid expansion will increase costs. Many interpretations of the impact of the provisions are available; as such the next section describes factors that could impact the ultimate cost of the expansion and provides a vague estimate.

Costs and Savings

The following section explores factors that must be considered when working with a cost estimate of the Medicaid expansion. In order to understand fully the components of this estimate, I first draw on existing research to identify potential qualities of the population the program would impact. From this discussion, I estimate that full enrollment is unlikely and represents an upper bound. Thus, the upper bound net costs to implement the expansion of Medicaid is \$2.3 billion, assuming full enrollment and health care inflation held constant at its current high rate. The following conversation further explores parameters of this estimate, including a sensitivity analysis of parameter assumptions.

Considerations

Before quantifying potential costs of expanding Medicaid, I outline factors that will influence the implementation – and consequently the costs – of the bill. This type of cost estimate requires sweeping assumptions about the behavior of people in order to reach any useful estimate. Understanding these assumptions will allow this estimate to evolve as factors become known. I have divided confounding factors into two groups: access and utilization factors and health factors. Each set depends on human behavior as well as how the bill is implemented, which depends largely on decisions made by the state and by the Department of Health and Human Services.

As such, my first task was to characterize the population that would be affected by the Medicaid expansion and by the individual mandate. As previously noted, two groups will enroll in Medicaid after the expansion – those currently eligible but unenrolled and those newly eligible. Before making an estimate, it is important to understand the health and habits of these people since the nature of this population will impact the success and costs of this program.

The following example clarifies these types of consequences. Estimating costs requires using data on the currently enrolled Medicaid population in place of unknowns about the newly affected populations. For example, my estimate uses the current rate of expenditures for the currently enrolled population to estimate costs for the newly enrolled populations assuming that covering these different populations will cost the state the same amount. In contrast, these populations may have different types of health needs that require differing amounts of health services.

The following discussion draws from the work of previous researchers in order to better understand how these factors will alter the projection that I outline later in this section. Much of this work is based on national studies, so some generalizations apply nationally; also, this analysis is not comprehensive. I examine the likelihood that this population enrolls in Medicaid, the likelihood that they subsequently utilize health services, and the health of this population.

Enrollment

Traditionally, public programs – health care related and non-health care related – are not fully utilized by the eligible population. For example, the Food Stamp program reached 31 percent of its target group two years into the program; after recent outreach efforts, the program reached 67 percent of its target but still does not enroll all eligible persons.⁵⁰ Five years after its inception, the Children's Health Insurance Program (CHIP) enrolled 60 percent of eligible children; likewise, the Medicare Savings Program only reached 33 percent of intended recipients ten years after creation. Accordingly, TennCare does not reach the whole of its currently eligible population; an estimated 200,000 individuals who may be eligible are not enrolled in this program.⁵¹ If the current Medicaid expansion follows this pattern, only a fraction of those eligible will enroll; consequently, the state would spend less than projected on Medicaid assuming full enrollment.

In contrast to existing programs, the current expansion is accompanied by an individual mandate to obtain the product it provides. Because the mandate will impose fines on individuals who fail to obtain coverage, Medicaid most likely will see an increase in currently eligibles and in newly eligibles. Still, while the exact impact is unknown, 2004 Massachusetts reforms provide an informative case study. Similarly to national health reform, Massachusetts' reforms included both a mandate for individual coverage as well as an expansion of public programs. Also like national efforts, the penalty for those not covered by insurance did not impact those at the lowest income levels, who are also the target of Medicaid programs. Even though this population would not face a fine, they often enrolled in the program. According to analysis by Stan Dorn, Massachusetts' reforms, along with the accompanying public education campaigns, made it easy for people to enroll in new state health coverage programs.⁵² As a result of this phenomenon – as well as a host of other innovative enrollment techniques – 97 percent of Massachusetts' residents have health coverage. The Massachusetts example suggests that a combination of public education and enrollment modifications can drastically raise the rate of Medicaid enrollment. Consequently, if Tennessee employs these techniques, the state should expect higher rates and, consequently, higher costs.

Access and Utilization

Once this population has health *coverage*, other factors will impede their ability to obtain this coverage. These factors, accordingly, have both fiscal and public health impacts. Both access and utilization will impact the extent to which this new population will utilize its new insurance coverage. Access, or the ease with which an individual can obtain health care, is a concern often associated with current Medicaid programs. Several factors impact access to care, including the number of Medicaid doctors and the location of health services. First, since Medicaid reimbursements are well below those of Medicare and private companies, providers are reluctant to see patients with this coverage. In addition, health care facilities are often located in more wealthy, more populated areas. As a result, those in lower-income communities have to travel farther to find needed physicians; a lack of access to transportation compounds this problem. Due to these and other barriers to care, patients may not receive the treatments they need, not because of inability to pay, but because of confounding factors that impede access.

Furthermore, we cannot assume that having coverage will automatically compel people to seek health care. Different cultures have different views on the benefits of health care that may change their utilization rates of this care. For example, women of color often delay prenatal care; this trend could in part be explained by different cultural views.⁵³ Some groups even have negative views of health care as a profession. Negative stigmas may have prevented certain groups from pursuing coverage on their own; likewise, compulsory coverage would not be likely to compel them to see a physician even for serious conditions. If rates of use differ, costs for the currently uninsured population could also differ.

In addition, this expansion of coverage may have a minimal additional cost because those within that income bracket already *spend-down*, or spend their assets so they meet the qualifying levels of the program. Thus, the new bill allows these sick patients to maintain their assets while receiving medical care without drastically increasing costs for TennCare. In contrast, however, Tennessee hospitals saw major increases in uncompensated care following the TennCare cuts in 2005.

A report by Thomas Miller finds an increased utilization of the emergency room by those enrolled on Medicaid. If this new population follows this trend for ER use, which seems the easiest way for new enrollees to develop a relationship with the health system, then expenditures will increase. This trend also represents an area for cost control; if the program can connect enrollees to the health care system at other points, the state can reduce the use of expensive emergency care.

Another interesting story hints at the potential savings that may be seen as a result of fully covering this population. This report, published in the *New England Journal of Medicine*, compared the Medicare expenditures of those who were insured or uninsured from ages 50 – 64 before becoming Medicare-eligible. Once of Medicaid age, the consumption of health services by those newly insured is significantly greater than the usage by their previously-insured counterparts.⁵⁴ This study supports the notion that expanding Medicaid, at least for this population, will decrease program costs for Medicare. According to the authors, “the costs of expanding health insurance coverage for uninsured adults before they reach the age of 65 years may be partially offset by subsequent reductions in health care use and spending for these adults after the age of 65, particularly if they have cardiovascular disease or diabetes before the age of 65 years.” Unfortunately, these particular savings would be felt at the federal level since states are not fiscally responsible for Medicare unless the state sees similar savings across age groups.

Health

Understanding the health and health needs of the population of newly eligibles is another way to estimate the potential rate at which this population will use health services. For example, if this population is generally healthier than the current Medicaid population, then the Medicaid expansion would cost less for the state. Current research presents conflicting pictures of the health of this population.

A 2001 study by the Urban Institute found that uninsured eligibles are in better health than Medicaid-enrolled counterparts but still have unmet needs.⁵⁵ This suggests that expanding coverage would cost less per capita since these patients would need less care; at the same time, expanding their coverage would enable this population to obtain needed care. This study focused on the currently Medicaid-eligible population to determine health differences between adults enrolled in the program, those privately insured, and those uninsured. The study did not, however, examine the health of the total population that meets the income criteria for Medicaid. As such, significant portions of the population were not included in this study, including childless adults and those between current

income thresholds and the new federal flat rate at 133 percent. Consequently, this report offers no conclusive information on the health of the entire population that will be affected by the expansion. Still the study suggests that the cost of covering those currently eligible but unenrolled will be less than current expenditures.

According to Thomas Miller of the American Enterprise Institute, uninsured individuals are more likely to report their health as “good to excellent,” which may suggest that people do not buy insurance unless they are sick or at risk and need insurance coverage.⁵⁶ Other studies, however, have contradictory findings. A Health Affairs paper finds that uninsured individuals have a greater chance to go with undiagnosed hypertension, diabetes, and elevated cholesterol; these conditions are best treated early and cause greater health expenditures when discovered later.⁵⁷ Undiagnosed conditions that have yet to exhibit symptoms would not prompt survey participants to characterize their health as “fair” or “poor.” Additionally, a joint study by RAND and Price Waterhouse found that patients do not shift medical treatments to periods in which they are insured.⁵⁸ This surprising finding supports another point made by Miller; those uninsured for just part of the year spend 75 percent of what those with insurance do on health care. Consequently, if patients do not shift care, access less care, and go without needed diagnoses, one can infer that the uninsured go without necessary care, regardless of how they self-report their own health. Whether these patients would have received this care if they were insured is quite another matter.

Based on the above-cited reports, we are no closer to categorizing the health and potential service utilization of those who would be newly eligible for Medicaid. In the absence of directed studies to answer this specific question, we must extrapolate from existing research that often yields contradictory results. The Medicaid expansion assumes that this population has conditions that need treatment, but we cannot definitively predict whether they will access said treatments. TennCare should carefully monitor usage changes in this new population in order to develop targeted cost reduction plans.

Cost Estimate

As a result of the variability of the implementation process and the unknowns about the expansion group, reaching an exact estimate of the cost impact of the Medicaid expansion is not possible. Governor Phil Bredesen released an estimate of \$735 million from 2014 – 2019 in October 2009 based on the language of the Senate Finance bill (See Table 2.1).⁵⁹ His calculations are below for reference. My estimate of \$2.3 billion over this same five-year time period incorporates the language of the final version of the bill. Below, I explain the assumptions and methods used to reach this estimate. Since I was not able to obtain the governor’s assumptions, I cannot comment directly on the large difference between the two estimates. A different set of assumptions or use of a different data set would easily alter any estimate. Further, my work provides a high-end estimate, while the governor seeks middle ground. Still, my work should allow open conversation on how the state can address these costs in a way that also benefits the health of Tennesseans.

Governor Bredesen’s estimate does present a few interesting findings. First, the state would spend much more to cover those already eligible for coverage. In other words, the primary fiscal concern is increased demand for a product already offered. This assumes Medicaid eligible parents will obtain free coverage from the state instead of incur a fiscal penalty, which also assumes that this population makes economically rational decisions. As discussed above, neither of these assumptions is absolute. Secondly, Bredesen includes elimination of optional groups above the new threshold as a source of savings. While it is possible that the next governor will follow this trend, I do not include such cuts in my estimate.

Table 2.1: Governor's Estimate: October 5, 2009

Projected Tennessee Net New Costs of Senate Finance Reform 2014-2019 \$ millions			
	Best Estimate	Optimistic	Pessimistic
New Medicaid Members			
1. Newly Eligible Members	\$175	434	175
2. Already Eligible Not Enrolled	911	488	1361
3. Total New Membership	\$1086	922	1537
Cost Savings Offsets			
4. Elimination of Optional Groups >133%	\$(78)	(78)	(78)
5. Additional Drug Rebates (net)	(191)	(191)	(191)
6. TN-CoverTN Elimination	(91)	(91)	(91)
7. TN-AccessTN Savings	(31)	(31)	(31)
8. TN-CoverRX Savings	(6)	(6)	(6)
9.	\$(397)	\$(397)	\$(397)
Additional Costs			
10. Mandated Pharmacy Extensions	\$30	30	30
11. Presumptive Eligibility Net Costs	16	16	16
	\$46	46	46
12. Total State Costs of Reform	\$735	571	1186

Source: Governor's Letter to Corker⁶⁰

Methods

In light of incomplete information regarding the process of implementation and the characteristics of the expansion population, assumptions were necessary for the purpose of a cost estimate. Once these assumptions were made, calculating an estimate of the cost of the Medicaid expansion was straightforward. The methods for choosing inflation rate, costs per capita of new enrollees, federal reimbursement rate, and the numbers of new enrollees are explained below. Again, given the unknowns and dynamic nature of this expansion, any of these measures is subject to change. As such, I will later explore the sensitivity of costs to two variables – inflation and enrollment.

Inflation was based on the figure used in the governor's estimate to approximate future TennCare expenses.⁶¹ This number consequently reflects the rate expected by government analysts. While the bill aims to reduce inflation, the amount to which this occurs is unknown. Sensitivity analyses later, however, explore the impact of alternate parameter assumptions.

All cost calculations began with the amount spent per capita on health services for current enrollees in TennCare in 2009. (The costs for new enrollees were assumed to be the same as costs for current enrollees.)

Table 2.2: Assumptions in Cost Estimate

Inflation	6.7%
Costs per Capita	\$4,106
FMAP* for currently eligible	64% (2008 rate)
Newly Eligible	261,970
Currently Eligible but not enrolled	198,130

Federal Matching Assistance Percentage

Equation 1

$$2009 \text{ Per Capita Spending} = \text{Total Health Services Expenditures} / \text{Total Enrollees}$$

Cost per capita were calculated from figures in the 2009 – 2010 state budget. The amount spent on health care *services* was divided by corresponding enrollment. Long-term care was not included. Consequently, this assumes that the majority of new enrollees will not be disabled or elderly, groups that consume the largest amount of care. Also, no difference was made in the amount spent on children and adults even though this amount has been shown to differ greatly. The most recent break down by status, based on 2006 data, showed a sizeable difference in children's and adults' costs (See Table 2.3). A more significant difference was found between these amounts and the average spent in 2009, excluding long-term care and home-based services used mainly for the population that is developmentally delayed. This figure indicated a sizeable increase in services rendered to mainly adults and children. In short, available data did not allow further differentiation for those disabled and those who have elderly status in the cost analysis.

Two separate reimbursement rates (FMAP) were used – one for currently eligibles and one for newly eligible. I assumed a return to the pre-stimulus FMAP – the 2008 rate of 64 percent, which historically has held constant. Under the new law, the state receives higher federal contributions for those newly eligible (See Table 2.4).

As a result of these higher matching rates, the state pays significantly less per capita for these new participants. If the state unilaterally decided to expand coverage to this same population, the state would spend an additional \$816 per person (See Table 2.5).

In other words, since Tennessee will see increased matching rates for its expansion population, Tennessee receives a more cost-effective method of increasing Medicaid eligibility levels. If the state had undertaken reform on its own, the state would pay significantly more per capita to cover more people on Medicaid since this increased rate would not have

Table 2.3: Medicaid Payments per Enrollee, FY 2006

Medicaid Payments per Enrollee, FY 2006	
Children	\$1,681
Adults	\$2,941
Elderly	\$7,214
Disabled	\$8,453
Total, 2006	\$3,975
Total, 2009, excluding long-term and home care	\$4,106

Source: StateHealthFacts.org ⁶²

Table 2.4: FMAP for Newly Eligible Medicaid Participants

FMAP for Newly Eligible Medicaid Participants	
Year	Rate
2014 – 2016	100%
2017	95%
2018	94%
2019	93%
2020	90%

Source: Kaiser Health Reform Side-by-Side ⁶³

been available. As shown in Table 2.6, Tennessee will spend significantly less per new enrollee, over \$2,000 in savings in 2020. Granted, the state is still required to cover this new population.

I used data available from StateHealthFacts.org to estimate the number of Tennesseans eligible for TennCare (See Table 2.7). Various sources do estimate the number of uninsured at different levels because they use different methods. For example, the Center for Business and Economic Research at the University of Tennessee estimated that 616,967 or 10 percent of the population was uninsured in 2009.⁶⁴ FamiliesUSA, in contrast, places that number at 1,722,000 or 32.4 percent for of the population for 2007-2008 since it includes anyone who went without insurance at any point during the year.⁶⁵ StateHealthFacts.org is in the middle with a 2008 estimate of 904,100 uninsured Tennesseans.⁶⁶ Consequently, estimates based on different data may easily differ from those outlined below. Still, the given estimates fall into ranges given by Heritage (250,000) and the TennCare office (200,000) for the expansion population.⁶⁷ My estimates found that approximately 260,000 will become newly eligible for TennCare and approximately 200,000 are currently eligible but unenrolled.

Table 2.5 State Medicaid Costs Per Capita

Total Costs per Enrollee	\$4106
Current State Contributions	\$1030
Projected State Contributions for new enrollees	\$218
State Savings Under Reform	\$816

Table 2.6: Per Capita TennCare Costs

	Per capita Medicaid costs at 6.7% inflation	Costs to state at 64% FMAP - Current eligibles	Costs to state for newly eligibles
2014	\$5,322.02	\$1,915.93	\$0.00
2015	\$5,678.60	\$2,044.29	\$0.00
2016	\$6,059.06	\$2,181.26	\$0.00
2017	\$6,465.02	\$2,327.41	\$323.25
2018	\$6,898.18	\$2,483.34	\$413.89
2019	\$7,360.35	\$2,649.73	\$515.22
2020	\$7,853.50	\$2,827.26	\$785.35

Table 2.7: Enrollment, broken out from Population Parameters

Total	460,100
Children	69,100
Adults	391,100
Parents	258,060
Under 80%	129,030
Over 80%	129,030
Childless	132,940
Currently Eligible <i>Children and Parents under 80%</i>	198,130
Newly Eligible <i>Parents over 80% and Childless Adults</i>	261,970

Source: StateHealthFacts.org ⁶⁸

To carry out the calculations, costs per capita were indexed to inflation then multiplied by the projected number of newly enrolled and newly eligibles, respectively (See Table 2.8). Total costs are estimated at \$3 billion over five years, from 2014 – 2019. (The year 2020 was included in the Table since the federal matching rate will continue to change through 2020, but was not included in the cost estimate.) Savings and projected net costs of \$2.3 billion over the five-year period are discussed later. Beyond this estimate, the state could be spending an additional \$660 million a year by 2020.

Table 2.8: Estimated Costs of Medicaid Expansion and Increased Enrollment, 2014 - 2019

	Per capita Medicaid costs at 6.7% inflation	Costs to state at 64% FMAP - Current eligibles	Total Costs to State for currently eligible but not enrolled	FMAP for newly eligibles	Costs to state for newly eligibles	Total Costs to state for newly eligibles	
2010	\$4,106	\$1,109					
2011	\$4,381	\$1,577					
2012	\$4,675	\$1,683					
2013	\$4,988	\$1,796					
2014	\$5,322	\$1,916	\$379,000,000	1.00	\$0		
2015	\$5,679	\$2,044	\$405,000,000	1.00	\$0		
2016	\$6,059	\$2,181	\$432,200,000	1.00	\$0		
2017	\$6,465	\$2,327	\$461,100,000	0.95	\$323	\$84,700,000	
2018	\$6,898	\$2,483	\$492,000,000	0.94	\$414	\$108,400,000	
2019	\$7,360	\$2,650	\$525,000,000	0.93	\$515	\$135,000,000	
2020	\$7,853	\$2,827	\$560,200,000	0.90	\$785	\$206,000,000	
			\$2.7 billion			\$328 million	~\$3 billion

Savings

The legislation will also provide savings for the state. For the sake of scope, I focus only on the savings that result from changing the public insurance coverage structure, or those savings related to the Medicaid Expansion. Additional savings may be seen if inflation is altered, if the general health of the population improves, or if the system becomes more efficient. Savings may also be seen if the amount of uncompensated care provided by hospitals decreases; the impact of uncompensated care is discussed later.

Drug Rebate Change

TennCare provides coverage for outpatient drugs. The state pays the full sticker price upfront and is subsequently reimbursed by the pharmaceutical companies. States are allowed to negotiate these rates with insurance companies and many states receive reimbursements greater than the 15.1 percent minimum set by CMS. The new legislation raises this minimum threshold to raise revenue for the federal costs of the bill; consequently, the funds from this increase will be paid to the federal government. Some reports indicate that Tennessee will lose funds as it hands over its extra rebates; others indicate Tennessee will in fact save money from increased rebates. In light of these conflicts, I simply leave the impact of these changes at \$0.

Program Cuts and Reductions — CoverTN

Tennessee currently operates a subsidized insurance plan called CoverTN that targets small businesses and self-employed individuals who are uninsured. In 2014, this demographic will either be able to enroll in Medicaid or to purchase insurance in a new Health Insurance Exchange; many will qualify for federal subsidies for their purchases. As such, CoverTN will become a redundant program and can be eliminated. Governor Bredesen also identified this program for elimination in his cost estimate. Below are estimated savings based on 2009 CoverTN levels and indexed to a 6.7 percent inflation rate (See Table 2.9). Eliminating this program will save the state \$160 million.

Program Cuts and Reductions — AccessTN

Tennessee currently operates a high-risk insurance program called AccessTN to cover Tennesseans who cannot obtain insurance because of a pre-existing condition.⁶⁹ Since AccessTN is not an entitlement program, Tennessee capped the program in December 2009 because of budget pressures.⁷⁰ The state should see significant funding and savings from legislation focused on high-risk and often “uninsurable” patients.

First, the bill required the implementation of a high-risk pool by June 1, 2010. Tennessee received \$97 million in federal funds for the operation of the temporary high-risk pool required by the health bill.⁷¹ Over the next four years, Tennessee had the option to expand AccessTN or create a new high-risk pool to operate concurrently. Tennessee opted to allow the federal government to run the new high-risk pool in the state.⁷² Requirements

Table 2.9: CoverTN Elimination

Years	
2014 - 2015	\$27,830,104
2015 - 2016	\$29,694,721
2016 - 2017	\$31,684,267
2017 - 2018	\$33,807,113
2018 - 2019	\$36,072,189
2014 - 2019 TOTAL	(\$159,088,393)

Table 2.10: AccessTN Elimination

Years	
2014 - 2015	\$31,877,037.51
2015 - 2016	\$34,012,799.02
2016 - 2017	\$36,291,656.56
2017 - 2018	\$38,723,197.55
2018 - 2019	\$41,317,651.78
2014 - 2019 TOTAL	\$226,308,276.86

for AccessTN are actually more stringent than those required for the new or expanded program: AccessTN premiums cannot exceed an age rating of 2:1 such that premiums for older members cannot surpass twice the premiums of younger members; premiums that meet federal requirements cannot exceed 4:1.⁷³ However, many are concerned that limited funds to administer the new plans would leave state-run plans to foot the remainder of the bill. This federal program will end at the beginning of 2014 when the Health Insurance Exchanges (HIE) become operational.

In addition, PPACA requires all plans in an HIE to cover all patients, regardless of pre-existing conditions. Consequently, Tennessee will have the option to phase-out AccessTN and transition enrollees to the Health Insurance Exchange. Before Tennessee makes this decision, it should assess the ability of this population to afford insurance in the HIE with subsidies before ending AccessTN. In my estimate, I assume program elimination.

Program Cuts and Reductions — CoverRX

CoverRX is a prescription assistance program that provides medications at affordable co-pays to those without insurance coverage.⁷⁴ As the population reaches larger insurance rates, need for this program will decline. I use Governor Bredesen's estimate of a savings of \$6 million for this program.

Increased CHIP Contributions

PPACA includes an increase in federal funding for the Children's Health Insurance Program. Matching rates increase by 23 percent beginning in 2015, raising federal contributions for CHIP to 99 percent of costs. Savings of \$262 million because of a 23 percent-age point increase in FMAP.

Net Costs

When these costs and savings are summed, the net costs are \$2.3 billion (See Table 2.11). Because of the nature of my assumptions, this represents a high-end figure.

Sensitivity Analysis of Parameter Assumptions

Below I carry out several calculations to compare the impact of two factors – inflation and enrollment, two factors that face the most variance during bill implementation. In order to fully understand the impact of inflation and enrollment rates, I conducted experiments to test the strength of each variable. Inflation varies in tests 1 – 3, from 4.7 percent as low inflation to 8.7 percent as high inflation; enrollment is held constant. Enrollment varies in tests 4 – 6, as a percentage of the full enrollment assumed in the cost estimate. Low enrollment is arbitrarily considered to be 33 percent, medium as 66 percent, and high enrollment as 100 percent; inflation is held constant (See Table 2.12).

Table 2.11: Net Costs

Increase in Coverage	+ \$3 billion
Additional Drug Rebates	0
CoverTN Elimination	- \$ 159 million
High-Risk Pool Allotment	- \$ 97 million
AccessTN Elimination	- \$226 million
CoverRX Savings	- \$6 million
Increased CHIP Contributions	- \$262 million
Net Costs	+ 2.3 billion

Table 2.12: Test Parameters

		Inflation Rate	Enrollment (% of full enrollment)
1.	Test for Decreasing Inflation Rate	4.7%	100%
2.	Test for Constant Inflation Rate	6.7%	100%
3.	Test for Increasing Inflation Rate	8.7%	100%
4.	Test for Low Enrollment	6.7%	33%
5.	Test for Medium Enrollment	6.7%	66%
6.	Test for High Enrollment	6.7%	100%

Table 2.13: Test Results for Inflation

		Cost, 2014 - 2019	Difference*	Percent difference*
1.	Decreased Inflation	\$2.66 billion	-\$363 million	-12%
2.	Constant Inflation	\$3.02 billion	\$0 billion	0%
3.	Increased Inflation	\$3.43 billion	+\$412 million	+14%

*from cost estimate

Table 2.14: Test Results for Enrollment

		Cost, 2014 - 2019	Difference*	Percent difference*
4.	Low Enrollment	\$1.03 billion	-\$1.99 billion	-66%
5.	Medium Enrollment	\$2 billion	-\$1.2 billion	-33%
6.	High Enrollment	\$3.02 billion	\$0 billion	0%

*from cost estimate

As expected, decreases in the inflation rate create savings, while increases in inflation increase costs. As a consequence, a 2 percentage point decrease in inflation would save the state \$363 million over a five-year period. Similarly, a 2 percentage point increase in inflation would cost the state an additional \$412 million (See Table 2.13).

Likewise, changes in enrollment have expected results. Enrollment rates, however, have greater influence over the amount spent on the expansions since enrollment can vary to a greater extent than inflation. For every percent change in enrollment, cost would change by \$30 million (See Table 2.14). These findings are consistent with a recent report published in Health Affairs that attributed the bulk of increases in Medicaid spending to increases in enrollment.⁷⁵

Indirect Savings: Uncompensated Care

Under the current health system, providers, other patients, and government entities incur the burden for uncompensated care received by uninsured persons. Some argue that expanding health insurance coverage will correspondingly reduce the amount lost from these medical services that are provided to uninsured persons for which they do not pay themselves. Theoretically, if everyone who receives medical services has health insurance, providers would receive reimbursements for all procedures, hospitals would no longer incur uncompensated care, and governments could reduce payments to hospitals that cover these losses.

Practically, however, the absence of a uniform and comprehensive data collection system limits our ability to accurately demonstrate these savings. A 2007 Comptroller's paper explores federal, state, and local expenses that cover "indigent care" within the state

of Tennessee. The difficulties and inaccuracies in determining these exact costs can be summarized as two major impediments. First, hospital finances for this purpose are self-reported and based on a variety of accounting practices. Losses based on the gross amounts charged to every patient even though only a fraction of these costs are actually reimbursed by insurers; an estimation technique is then used to determine actual costs of indigent care from these often exaggerated figures. Second, “government expenditures are rarely earmarked explicitly for indigent care, though many government programs likely treat individuals who are indigent.”⁷⁶ In other words, identifying exact amounts spent on indigent care is complicated since few programs solely treat this population. A more complete discussion is available in that report.

Despite these inaccuracies, I have included a series of tables to approximate and identify funds that could be impacted by coming changes in our health system. Estimate 1 provides estimates of losses incurred by Federally Qualified Health Centers, Health Departments, and Hospitals (See Table 2.15). While the accounting and reporting systems differ within each category, this estimate highlights the dramatic revenue streams that each organization foregoes in a single year.

This amount – \$562.2 million – offers one incomplete estimate of the amount spent in Tennessee on uncompensated care. The estimate, however, fails to include all providers and all sources of uncompensated care. Physician practices not directly associated with hospitals, freestanding clinics that do not receive federal funds, and charity clinics that also forego federal funds are excluded from this total.

The Urban Institute has also released estimates of uncompensated care that offer a more complete estimate of these costs (See Table 2.16).

Without reform, the Urban Institute estimates that the amount spent on uncompensated care in Tennessee could double in the next ten years, based on health care inflation and an increase in the number of uninsured individuals. Under recent reforms, however, the total amount spent will decrease according to its model. Above I copy a table provided by Urban Institute that comprises these estimates on a national level (See Table 2.17). These calculations show an estimated decrease in the amount spent nationally despite accounting

Table 2.15: Costs of Uncompensated Care in Tennessee – Estimate 1

Publically and Privately Funded Health Providers		
Federally Qualified Health Centers, 2005	Uncompensated Indigent Care Provided to Self-Pay Patients	\$23.5 million
Tennessee Rural County Health Departments, 2006	Uncompensated Indigent Care Provided to Self-Pay Patients	\$24.2 million
Tennessee Metro County Health Departments, 2006	Uncompensated Indigent Care Provided to Self-Pay Patients	\$23.9 million
Hospitals, Joint Annual Report, 2005	Uncompensated Average Costs (Not Gross Charges)	\$491 million
	Total:	\$562.2 million

Table 2.16: Costs of Uncompensated Care in Tennessee – Estimate 2⁷⁷

Urban Institute		
Number of Uninsured Tennesseans (2008)	Uncompensated Care Costs (Per Capita)	Total Uncompensated Care Costs for Tennesseans (2008)
900,000	\$1,264	\$1.13 Billion

Sources: statehealthfacts.org; “The Costs of Failure to Enact Health Reform: Implications for States”, Urban Institute

Table 2.17: Costs of Uncompensated Care Under Reform– Estimate 3*

Urban Institute			
	Number of uninsured (millions)	Cost per uninsured person	Spending on Uncompensated care (billions)
Nationally			
2009	49.1	\$1,264	\$62.1
2014	34.0	\$1,588	\$54.0
2019	23.0	\$2,026	\$46.6
Tennessee			
2019	.45	\$2,026	\$.9

*Note: Reflects Senate bill

Source: “The Cost of Uncompensated Care with and Without Health Reform,” Urban Institute

Table 2.18: Costs of Uncompensated Care in Tennessee – Estimate 4 - Savings

Urban Institute		
No Reform – Spending in 2019	With Reform – Spending in 2019	Savings under Reform
\$2.5 billion	\$.9 billion	\$1.6 billion

Sources: statehealthfacts.org; “The Costs of Failure to Enact Health Reform: Implications for States,” Urban Institute

for inflation in health care costs. The Tennessee estimate presented in Estimate 3 assumes that health reform cuts the number of uninsured Tennesseans in half and projects that \$900 million will be spent on uncompensated care in 2019. This total is compared with projections assuming no changes in the system in Estimate 4 and show net savings of \$1.6 billion in a single year.

The savings demonstrated – \$1.6 billion – represent savings to service providers. In order for the state budget to realize any portion of these savings, the General Assembly must directly decrease current allocations, a task which presents fiscal and political difficulties. As previously mentioned, the budget rarely allocates funds to cover specifically uncompensated care; as such, preemptively identifying cuts requires sophisticated guesses. And since these funds are not earmarked for these costs, legislators face backlash from affected parties.

Such action is taken in the national reform bill. The federal law initially reduces Disproportionate Share Hospitals (DSH) payments by 75 percent; subsequent increases will be based on the number of uninsured and the amount of uncompensated care.⁷⁸ Tennessee hospitals fortunately will not shoulder these reductions in DSH payment since Tennessee does not receive these allotments per its TennCare waiver. At the same time, hospitals should see a reduction in the amount of uncompensated care they provide.

Federal Spending in Tennessee

The nature of the Medicaid program requires state fiscal contributions in order to receive federal matching funds. Tennessee will be responsible for finding the additional funds to expand this program to the federally-mandated levels. This report would be remiss, however, if federal contributions were ignored. The table above identifies federal spending available to the state under the assumptions used to calculate the costs to the state (See Table 2.19). Combined with the state contributions for Medicaid enrollees, health providers in Tennessee will receive an estimated revenue increase of \$13 billion.

Table 2.19: New Federal Spending in Tennessee – Medicaid (2014 – 2019)

New Federal Spending in Tennessee – Medicaid (2014 – 2019)		
Currently Eligible	Newly Eligible	Total
\$4.9 Billion	\$5 Billion	\$9.9 Billion

Summary and Findings

In other words, this section serves to clarify a vague cost estimate of \$2.3 billion. First, the research on characteristics of the population is contradictory at best. Enrollment in most public programs is relatively low, yet Massachusetts has seen almost full enrollment. Moreover, various cultural differences may exist within this population that naturally reduce their likelihood of pursuing care or signing up for coverage. Finally, contradictory research on this population's health finds them to have both better and worse health. Taken in sum, we can only generalize about the enrollment, usage, and expenses that will be incurred from the expansion population.

As such, assumptions were made that assumed full enrollment with a constant high inflation rate of 6.7 percent. Costs for five years are estimated at \$3 billion. Savings from eliminating redundant programs and increased federal funding are estimated at \$0.7 billion, leaving nets costs at approximately \$2.3 billion. The severity of impact of enrollment is much greater. In other words, most variation in cost will come from the number of people who sign up as opposed to from inflation.

Conclusion

From its beginning days through recent cuts, Medicaid and TennCare have grappled with health care costs and attempted to balance increased enrollment with the necessary increased costs. This struggle will continue when Medicaid enrollment increase in 2014 but will do so in a rapidly changing health care environment. Corresponding changes that result from PPACA will create a dynamic market that is difficult to predict. Similarly, the fiscal implications to the Tennessee state budget are nearly impossible to accurately predict. The figures presented by this paper should not be used as exact sums but rather as starting points.

As Health and Human Services unveils more details on reform implementation, Tennessee should remain responsive to changes. During the first years of the new changes, Tennessee would be well served to collect as much data as fiscally and feasibly possible in order to uncover trends that will aid in planning.

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Dr. Michael R. Fitzgerald is the chair of the American Studies Program, the Senior Teaching Fellow at the Howard H. Baker, Jr. Center for Public Policy, and a professor of Political Science at the University of Tennessee. Dr. Fitzgerald is an active scholar who has published several books and research monographs, numerous research articles and book chapters, and more than forty conference papers, including studies devoted to Tennessee politics and government and federal agencies. He has received countless awards for his contributions to student life, meritorious university service, and outstanding contributions in graduate and undergraduate courses in American politics, public administration and policy, the mass media, and political philosophy. He received his Master's and Ph.D. degrees in Political Science at the University of Oklahoma. A native of Kalamazoo, Michigan, Dr. Fitzgerald received his B.A. degree from the Honors College of Western Michigan University in 1969 and subsequently served for two years in the U.S. Army, completing one tour of duty as a Non-commissioned Officer with the 25th Infantry Division in Vietnam.