THE SYCAMORE INSTITUTE

MEDICAID REFORM 101: MORE THAN JUST BLOCK GRANTS

PART 4 OF 5 – A SUMMARY OF RECENT TENNCARE REFORM PROPOSALS

BOTTOM LINE

This brief summarizes recent TennCare reform proposals, which may provide insight into the kinds of changes that Tennessee's policymakers may consider if federal changes to Medicaid are enacted.

Bills introduced and proposals discussed over the last 2 years have proposed reforming TennCare to include a **wider range of benefit options** – including more limited or catastrophic-only benefits packages – for TennCare enrollees. These options would be coupled with **increased financial exposure for enrollees** in order to encourage healthy behaviors and lower cost care. Because of the context in which they were discussed, these proposals do not address eligibility limitations. These proposals also lack detail on at least one key program design aspect related to financing, benefits, or both. In the face of concrete changes in federal law, however, these details would likely be better defined. Our other briefs in this series explore recent federal reform proposals and the potential impact on the state.

THE SYCAMORE INSTITUTE'S "MEDICAID REFORM 101" SERIES:

PART 1: Key federal Medicaid reform design elements

PART 2: Summary of recent federal proposals

PART 3: Key TennCare reform design elements

PART 4: Summary of recent TennCare proposals

PART 5: Analysis of the potential impact on Tennessee

INTRODUCTION

The previous briefs in this series summarize federal Medicaid reform efforts and the key design choices that Tennessee state policymakers may have to address if federal changes are enacted. This brief summarizes specific TennCare reform proposals – including recent legislation introduced in the Tennessee General Assembly. Our follow-up brief summarizes the potential impact that federal reforms could have on Tennessee. This 5-part series provides a framework and context for changes to Medicaid and TennCare that may be adopted by state and federal policymakers in the coming months and years.

RECENT TENNESSEE GENERAL ASSEMBLY LEGISLATION

The following pages summarize recent proposals that would reform how TennCare delivers benefits and to whom. Because of their timing, all of the Tennessee-specific efforts presumed the current federal Medicaid financing structure under which the state would seek a waiver to either convert Tennessee's federal medical assistance percentage (FMAP) to a federal block grant or create a demonstration program with considerable new flexibilities. In many cases, the federal government may be unable to approve such changes under federal law. The features of each proposal are presented in line with the state design options laid out in Part 3 in this series.

KEY FEATURES OF RECENT TENNCARE REFORM PROPOSALS

- Recent reform efforts have all been proposed in the context of the **current uncapped federal Medicaid financing structure**.
- Most of the proposals rely on **introducing new financial responsibilities for enrollees** like paying premiums and cost-sharing – often with greater subsidization via health savings accounts for certain choices and healthy behaviors.
- Some of the proposals introduce new benefit design options into the program like **high-deductible plans**.
- Many of the proposals **lack detail on multiple key program design elements** related to TennCare eligibility, benefits, enrollee responsibilities, provider payments, or assumptions about federal financing.

Two recent efforts to expand access to TennCare – including the Governor's Insure Tennessee proposal and recent work by the Three Star Healthy Task Force – provide insights into state-specific approaches to reform.

INSURE TENNESSEE was proposed by Governor Bill Haslam in late 2014 as a mechanism for expanding eligibility for TennCare under the Affordable Care Act. Although the proposal did not pass the General Assembly, it may provide insights into how the administration might approach a reform of TennCare if given additional flexibilities. (1)

The **THREE STAR HEALTHY TASK FORCE**, appointed by Speaker Beth Harwell in 2016 to explore options for increasing access to TennCare, has not publically released a proposal on paper. In public hearings of the Task Force that staff of the Sycamore Institute have attended, however, the Task Force has indicated interest in a number of elements that would be new to TennCare with the goal of providing more cost-effective coverage under the program. Although work has largely focused on expanding eligibility to uninsured individuals with certain behavioral health diagnoses, in their most recent meeting after the election, Chairman Cameron Sexton (R-Crossville) broached the topic of applying the concepts they've discussed to more expansive TennCare reform. (2)

In addition to these efforts, 3 bills were introduced in the 109th Tennessee General Assembly (2015-2016) related to TennCare reform.

109TH GENERAL ASSEMBLY – SB 742/HB 1116 was introduced in 2015 by Senator Brian Kelsey (R-Germantown) and Representative Jerry Sexton (R-Bean Station). The bill was not acted on. (3)

109TH GENERAL ASSEMBLY - SB 1351/HB 1271 was introduced in 2015 by Senator Randy McNally (R-Oak Ridge) and Representative Eddie Smith (R-Knoxville). The bill was not acted on. (4)

109TH GENERAL ASSEMBLY - SJR 88 was introduced in 2015 by Senator Mark Green (R-Clarksville). The resolution was passed and signed into law in May of 2015. Joint resolutions, however, express the views or sentiments of the Legislature and cannot require Executive action. (5) (6)

ALEC'S MEDICAID BLOCK GRANT ACT is a model law drafted for states' use in 2014 by the American Legislative Exchange Council (ALEC), an organization of state legislators across the country that advocate for limited government and free markets. The model law has not been specifically introduced in the Tennessee General Assembly, but it might provide some detail on how Tennessee might approach TennCare reform under a capped federal contribution. (7)

INSURE TENNESSEE				
Eligibility	**Covered Benefits**	**Enrollee Responsibilities**	**Provider Payments**	**Assumptions about Federal Reform**
Expands eligibility to individuals up to 138% of the federal poverty level as allowed under the Affordable Care Act under a 2-year pilot.	Under the "Volunteer Plan," newly eligible employed enrollees would receive a subsidy to purchase employer-sponsored insurance (ESI) with benefits defined by the employer. Other newly eligible enrollees would receive the Healthy Incentives Plan, which would cover the same benefits covered under TennCare currently.	Volunteer Plan enrollees would be responsible for any difference between the subsidy and the premium and any cost-sharing like deductibles and co-pays. Healthy Incentives Plan enrollees would receive a Healthy Incentives for Tennesseans (HIT) account to pay premiums (depending on their income) and certain co-pays. The amounts in the accounts would vary based on specific enrollee choices (e.g. participation in an annual health assessment) and healthy behaviors. Enrollees would be responsible for any difference between the amount in their account and actual costs for premiums and cost-sharing. Some of these responsibilities would be enforceable - either by disenrolling individuals or by allowing providers to deny services for failure to pay co-pays.	Does not include specific information about provider payments, but was billed as building on the state's payment and delivery system reform initiative already underway.	Based on the enhanced FMAP financing structure provided for under the ACA's eligiblity expansion. Includes an opt-out provision in the event that state costs associated with the expansion are more than expected.
THREE STAR HEALTHY TASK FORCE				
Eligibility	**Covered Benefits**	**Enrollee Responsibilities**	**Provider Payments**	**Assumptions about Federal Reform**
Expands eligibility to uninsured individuals with certain behavioral health diagnoses.	Specific covered benefit changes have not been publically discussed.	Provides enrollees with accounts to pay out-of-pocket costs. Enrollees would be responsible for any difference between the amount in the account and actual out-of-pocket costs. Includes work or job training requirements. Some or all enrollee responsibilities would be enforceable by barring individuals from reenrolling for some defined period of time.	With the exception of expanded access to telehealth, specific provider payment reforms have not been publically discussed.	At the time many of the details were publically discussed, assumed the current FMAP financing structure.

SB 742 (KELSEY) / HB 1116 (SEXTON)				
Eligibility	**Covered Benefits**	**Enrollee Responsibilities**	**Provider Payments**	**Assumptions about Federal Reform**
Retains current TennCare eligibility	Covered benefits would vary by plan chosen by enrollee. Plans would represent a range of TennCare-approved options competing for enrollment. Options would reflect "a broad continuum of consumer flexibility" – including "limited-benefit" plans, "full-service" managed care plans, "self-directed plans," and "medical home networks." "	Provides all current enrollees with risk-adjusted subsidies to pay for health plan premiums and cost-sharing via Personal Health Accounts. Cost-sharing structure would vary by plan chosen by enrollee. Enrollees would be responsible for any difference between the amount in the Personal Health Account and actual costs for premiums and cost-sharing.	Allows medical home networks to serve as a health plan option, but is otherwise silent on changes to provider payments.	Does not include specific assumptions about federal financing, but given the context, is likely based on the current FMAP financing structure.
SB 1351 (McNALLY) / HB 1271 (SMITH)				
Eligibility	**Covered Benefits**	**Enrollee Responsibilities**	**Provider Payments**	**Assumptions about Federal Reform**
Retains current TennCare eligibility and expands eligibility to all individuals under 138% of the federal poverty level.	Does not include specific provisions related to covered benefits, enrollee responsibilities, or provider payments, but notes that a block grant would allow Tennessee to innovate and expand TennCare eligibility with the same amount of funding as is currently spent.			Assumes a conversion of current federal medical assistance funding to a block grant. Does not include explicit assumptions about how federal contributions under a block grant waiver would grow annually.
SJR 88 (GREEN)				
Eligibility	**Covered Benefits**	**Enrollee Responsibilities**	**Provider Payments**	**Assumptions about Federal Reform**
Retains current TennCare eligibility and allows voluntary participation in the "TennCare Opt Out" pilot by any current TennCare enrollees. The fiscal note estimates that the pilot program would service an estimated 17,200 males age 21-44 eligible for Temporary Assistance for Needy Families (TANF).	Participants in the pilot project would receive catastrophic-only coverage with a high deductible paired with an electronic benefits transfer (EBT) card.	Provides all participating enrollees with an EBT card to pay premiums and out-of-pocket expenses. Enrollees would be responsible for any difference between the amount on the EBT card and the deductible - including the direct purchase of primary care services and medications. According to the fiscal note, the deductible would be $6,350 and the EBT card contribution would be $1,576.	Participating enrollees would directly pay for primary care services, which would allow for faster payment and lower claims processing costs for providers incentivizing them to offer enrollees lower prices.	Does not include specific assumptions about federal financing of the pilot, but given the context, is likely based on the current FMAP financing structure.

ALEC's MEDICAID BLOCK GRANT ACT				
Eligibility	**Covered Benefits**	**Enrollee Responsibilities**	**Provider Payments**	**Assumptions about Federal Reform**
Sets up a state commission that would be responsible for filling in many of the details within the broad structure laid out in the model law. Sets up a task force to advise the commission. It would be made up of 12 members – including 8 appointed by the Governor, the Lt Governor, the Speaker of the House, and the Chairs of the Senate and House Finance Committees, the Senate Health & Welfare Committee, and the House Health Committee.				
Eligibility of acute care benefits would be limited to existing Medicaid enrollees and individuals under age 19 in foster care and receiving supplemental security income (SSI).	Benefits would be administered "through the most cost-effective means" as determined by the commission, including using different benefit delivery models for different populations or different parts of the state. Does not address specific covered benefits beyond a requirement for maternity benefits.	Provides sliding scale subsidies for health plan premiums and cost-sharing via health savings accounts. Subsidies would also vary based on specific enrollee choices (e.g. enrollment in a high deductible plan) and behaviors. Cost-sharing structure would vary by plan chosen by enrollee. Enrollees would be responsible for any difference between the subsidy and actual costs for premiums and cost-sharing.	Does not include any specific provisions related to provider payments.	Does not include specific assumptions about the structure of federal reforms.
Addresses long-term services and supports (LTSS) and home and community-based services (HCBS) separately. LTSS eligibility would be restricted to a state-defined income threshold and individuals under age 19 in foster care and receiving supplemental security income (SSI). The model law does not specifically address HCBS eligibility.	Does not address the coverage of specific LTSS benefits. Allows the commission to develop home- and community-based services (HCBS) packages "designed to prevent the overutilization of services."	Provides sliding scale subsidies, which would vary by disability and functional status, for the purchase of LTSS from authorized providers. Enrollees would be responsible for any difference between the subsidy and actual costs for LTSS. The commission could establish maximum subsidy amounts or other cost-containment measures to ensure that support for LTSS does not exceed a state's desired budget. Requires that the parents/guardians of children receiving institutional long-term care or HCBS pay a fee; although failure to pay the fee could not affect the child's eligibility. Similarly, requires adult children of individuals receiving institutional long-term care services or HCBS help pay for their parent's care. Failure to pay could not affect the parent's eligibility.	Does not include any specific provisions related to LTSS/HCBS provider payments.	

PARTING WORDS

If the U.S. Congress and President Trump act to make concrete changes to federal Medicaid law, Tennessee's policymakers may have an opportunity to make significant reforms to TennCare. Although proposals and legislation put forward in the 2015-2016 sessions of the Tennessee General Assembly were done in a much different federal context than is expected this year, they share some common elements. Namely, instead of offering enrollees a standard benefit plan, they would be provided with additional options – including high-deductible or catastrophic-only coverage – coupled with funds to help offset out-of-pocket costs. These benefit designs are aimed at generating savings by more directly involving enrollees in health care spending.

Depending on the key features of any final federal reforms, it is likely that additional program design elements would need to be defined by Tennessee policymakers. For example, federal financing reforms could require further TennCare design changes beyond those recently introduced in order to offset the potential loss of federal dollars without increasing state spending. This could necessitate decisions about how these changes would apply to different TennCare eligibility groups.

THE SYCAMORE INSTITUTE

Written by
Mandy Pellegrin
Director of Health Policy
mpellegrin@sycamoreinstituteTN.org

Other TSI staff
Laura Berlind
Executive Director

Courtnee Melton, PhD
Policy Analyst

Sign up for email alerts at:
www.sycamoreinstituteTN.org

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