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Implementing State-Based Healthcare Reform in Tennessee

Five Opportunities to Create Meaningful, Innovative Changes for Tennesseans

by Justin Owen

EXECUTIVE SUMMARY

For the past several months, healthcare has been at the forefront of the national political landscape. Unfortunately, the fact that states play a large role in shaping healthcare reform has been lost in the debate. It is imperative that lawmakers in Nashville seize the opportunity to implement state-based reform measures that work.

This policy brief outlines five opportunities for state lawmakers to create meaningful, innovative reform that will expand access to and reduce the costs of healthcare to Tennessee's 6.2 million residents. Lawmakers should make it a top priority to include the following five reform measures in the upcoming legislative session.

1) Give individual Tennesseans control of their healthcare decisions by moving away from employer-based insurance.

2) Allow Tennesseans to obtain health insurance from companies in other states.

3) Eliminate unnecessary mandates that require individuals to purchase coverage for certain treatments, especially for young adults.

4) Reform medical licensing laws to encourage greater competition among providers.

5) Permit public employees and TennCare recipients to utilize health savings accounts (HSAs) in lieu of conventional health insurance plans.

Each of these reforms will move Tennessee forward by driving down the cost of health insurance and increasing Tennesseans' ability to purchase and maintain effective health insurance coverage.

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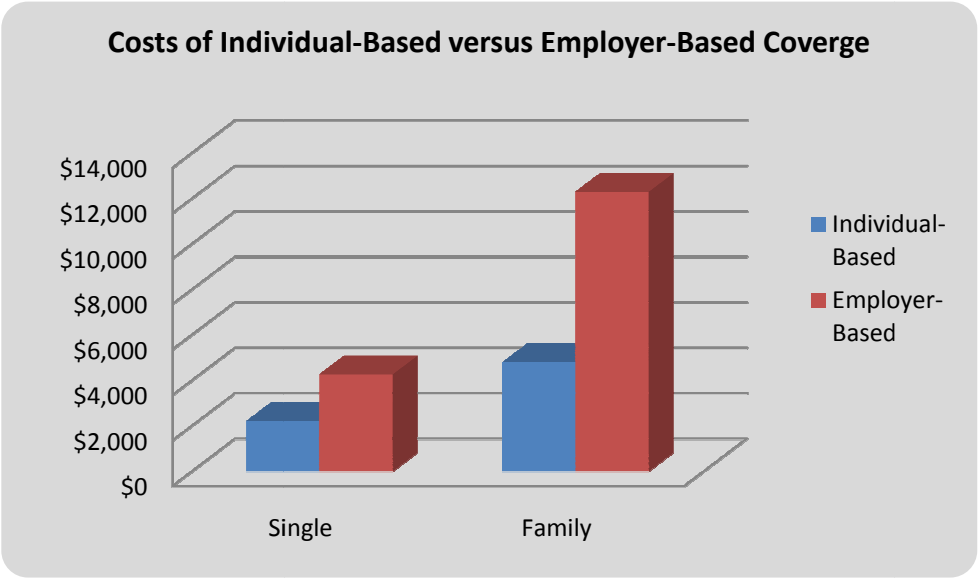
1 *Increase individual control by moving from employer-based insurance*

One of the primary reasons health insurance costs so much is that it is tied to employers. In 2007, employer-based coverage made up 58% of all private insurance in the state.[1] Despite the fact that all other insurance—car, life, property, etc.—is paid for by individuals, employers pay most healthcare premiums or take the funds out of employees' paychecks to cover the costs. Either way, individuals are rarely exposed to the true costs of health insurance. When individuals do not pay for something directly, they tend to be unconcerned with its costs. This is proven true simply by comparing the costs of individually-purchased health insurance against those of employer-based coverage.

For an individual in Tennessee, employer-based coverage costs $4,276 annually.[2] For family coverage, that cost is $12,302.[3] Conversely, plans paid for directly by individuals cost much less. The average single plan costs $2,221, nearly half that of an employer-based plan, while an individually-purchased family plan costs just $4,804 a year.[4]



While an employer may technically pay the majority of these costs, employees pay them indirectly through reduced salaries and wages. By moving health insurance costs to individuals, citizens will become more involved in healthcare cost decision-making. They will be encouraged to shop for less costly treatment and lower premiums. Further, when insurance is purchased individually rather than through employers, the plans become portable. Tennesseans would be able to take their insurance plan with them when they leave a job, for whatever reason. No longer would they be forced to stay in a job they dislike in order to remain insured or lose their insurance when they leave their job involuntarily.

One way to encourage the move away from employer-based coverage is to allow small businesses and individuals to pool together to purchase insurance like larger business can currently do. State leaders can also encourage Congress to give individuals the same federal income tax credits that employers receive for purchasing health insurance. All healthcare reform decisions made at the state level should center around transforming health insurance from an employer-based system to a more consumer-driven approach.

2 *Allow Tennesseans to purchase insurance from out-of-state companies*

Legislators should allow health insurance companies from other states to sell policies in Tennessee. This will drastically expand the health insurance options of Tennesseans and increase competition among insurance companies, thereby reducing the costs of premiums. Currently, Tennessee ranks worse than numerous states in insurance premium costs. The competition that comes with allowing Tennesseans to shop for insurance in other states will drive these costs down to the level of those other states or potentially even lower.

Simply allowing Tennessee residents or their employers to purchase insurance from bordering states would significantly reduce their costs. Of the eight states that border Tennessee, seven have a lower annual premium rate. Only North Carolinians pay more for employer-based coverage than do Tennesseans.[5]

Single Premium by State

	State	*Premium*
1.	North Carolina	$4,460
2.	Tennessee	$4,276
3.	Virginia	$4,202
4.	Georgia	$4,160
5.	Alabama	$4,139
6.	Missouri	$4,124
7.	Mississippi	$4,124
8.	Kentucky	$4,009
9.	Arkansas	$3,923

Family Premium by State

	State	*Premium*
1.	North Carolina	$12,308
2.	Tennessee	$12,302
3.	Virginia	$11,935
4.	Georgia	$11,659
5.	Missouri	$11,557
6.	Kentucky	$11,506
7.	Mississippi	$11,363
8.	Arkansas	$11,220
9.	Alabama	$11,119

Allowing out-of-state insurers to sell policies to Tennesseans would provide the state's citizens with numerous options that they presently lack. There are currently 127 private insurance plans offered to Tennesseans.[6] If their options were expanded just to bordering states, Tennesseans would have access to more than 1,200 insurance plans.[7] If insurance companies nationwide were permitted to sell insurance in Tennessee, that number would increase to 5,305 plans.[8]

Further, allowing insurance companies to sell insurance across state lines would expand their risk pool. This alone would drive down costs to consumers, as risks could be spread out over a wider population rather than being limited to one single state. Finally, if lawmakers worked in conjunction with their colleagues in other states to allow Tennessee-based insurance companies to sell policies to their citizens, Tennessee insurers would also benefit by broadening their markets.

3 *Eliminate unnecessary government-imposed coverage mandates*

The state should reduce the number of coverage mandates forced upon insurance companies, especially for low-risk policies sold to young, healthy adults. Health insurance mandates drive up costs unnecessarily, and those costs are always passed on to consumers.

Tennessee state law imposes 41 different health insurance mandates on its citizens.[9] These mandates force individuals to obtain coverage for treatment that they might not want or need. As a result, they pay higher premiums. Paying for additional coverage should be at the discretion of each individual, not dictated by government mandate.

The mandates imposed in Tennessee drive health insurance premiums up by more than 20 percent.

Among the treatments that Tennesseans must pay for, regardless of their lifestyle or risk factors, include alcohol/substance abuse, autism, breast reconstruction, cervical cancer, Chlamydia, and prostate cancer screening.[10] Mandates also require insurers to cover—and individuals to pay for—certain providers, such as chiropractors, nurse midwives, psychologists, social workers, and speech therapists, even if the individual will never use the services of these providers.[11]

Research shows that every single mandate "adds roughly one half to one percent to the costs of a health insurance plan."[12] Certain mandates can tack on as much as four percent to an insurance plan.[13] Based on this research, the mandates imposed in Tennessee drive health insurance premiums up by more than 20 percent.[14]

Not only do mandates raise costs, they lead to reductions in quality of care. As insurance companies attempt to keep down costs and shift the risks of providing the litany of mandated treatment, fewer resources are directed at truly necessary treatment.

Legislators should eliminate the myriad of mandates imposed upon Tennesseans. At the very least, legislators should permit insurance companies to offer a mandate-free or "mandate light" plan for young adults that are less likely to need or want the mandated coverage. The General Assembly could follow the lead of lawmakers in Washington State who filed a bill to do just that.

Young adults between the ages of 19 to 24 are the least likely to be insured, with nearly 30 percent of the age group living without insurance.[15] Similarly, 26 percent of those between the ages of 25 to 34 are uninsured. There are several explanations for this. Most young people are not in stable long-term jobs, and since insurance is employer-based, they are less likely to have continuous coverage. Similarly, young people's earnings are lower, making them more likely to opt against purchasing costly health insurance, especially since they are the healthiest members of society and often do not view health insurance as a necessity.

People of all ages, but especially those age 19 to 34 should be free to purchase insurance plans that do not contain the 41 mandates imposed by state law. Because young people are far less likely to utilize the numerous treatments that are mandatory, this would significantly reduce their insurance costs. These "mandate light" plans would "entice 19 to 34-year-olds to purchase low priced, basic health insurance, rather than go with no coverage at all."[16] This simple solution would be a step toward insuring the thousands of adults in Tennessee without coverage.

4 *Reform medical licensing laws to encourage competition*

Medical licensing laws—while intended to protect patients and consumers—actually harm them by driving up costs and limiting their ability to seek treatment. State law should be reformed to allow nurse practitioners, physician assistants, midwives, and other non-physician practitioners greater ability to treat patients. This will increase accessibility to treatment and reduce costs by allowing patients to visit less expensive practitioners that are still qualified to treat them.

Non-physician practitioners receive a high degree of education and experience, yet they are considerably limited as to what types of services they can offer patients. If patients are comfortable with a midwife carrying them through child birth or a nurse practitioner ordering certain tests, they should be allowed to save the money from lower-cost services while receiving quality care.

Further, doctors, and indeed other health professionals, should also be allowed to take their licenses state to state. This would reduce the bureaucratic costs associated with becoming licensed in every state where they wish to treat patients. Tennessee could lead the charge by making it easier for nonresident physicians to practice in the state, thereby expanding the number of doctors and other health professionals that can treat patients. The additional competition would lower costs and increase access to care.

Finally, walk-in facilities, cash-only clinics, and minute clinics are innovative healthcare options that should be encouraged. In conjunction with reforming the licensing schemes,

the state should make it easier to open a clinic outside the traditional model. These alternative clinics provide consumers with more choice at reduced expenses.

These reforms would not impact those that still wish to pay more for a licensed physician or attend a traditional clinic. However, for the thousands of Tennesseans that cannot currently afford treatment under the traditional healthcare model, these options provide a refreshing opportunity to receive quality, affordable healthcare.

5 *Embrace the use of health savings accounts*

Another reform opportunity lies in providing health savings accounts (HSAs) to public employees and TennCare enrollees. This will give public employees and TennCare recipients more control over their health insurance choices and eventually reduce the healthcare costs to the state.

Individuals use HSAs in conjunction with inexpensive, high-deductible insurance plans. Basic medical expenses are paid with the HSA, which functions as a checking account (that earns interest) for health-related purchases. An insurance plan then kicks in to cover costs in excess of the deductible. These funds are portable, so it will be easier for people to retain their insurance if they leave or lose their job. HSAs permit individuals to take control of their healthcare decisions and tackle high costs. Because of their attractiveness, 8 million Americans now use HSAs for their health insurance needs.[17]

HSAs provide several unique advantages over traditional health benefits packages. They give employees direct control over money saved for healthcare, permitting employees to tailor their health services to their own needs and the needs of their families. Unlike traditional health benefits, HSAs belong directly to employees and can move with them if they change jobs. HSAs can also be used to supplement retirement income or even to purchase long-term care insurance at retirement.[18]

Because of their attractiveness, 8 million Americans now use HSAs for their heath insurance needs.

In 2004, the federal government began allowing its employees to choose HSAs as a way to receive their health benefits.[19] Thousands of federal workers already take advantage of these flexible plans.[20] As of 2006, seven states also offer HSA options to their employees.[21] Tennessee should join these states in allowing its 43,000 employees to utilize HSAs.[22]

Not only would the HSA option be beneficial to state employees, it could save the government millions in tax dollars. According to the Washington Policy Center, HSAs "help control costs by encouraging better utilization of healthcare services and by promoting price competition among providers."[23] Further, the billing of routine healthcare is handled by a financial institution chosen by the employee rather than state administrators,

lowering the state's administrative and record-keeping costs.[24] So not only do state employees benefit from having more control and flexibility over their healthcare savings, the taxpayers win as well.

HSAs could also help the state tackle the enormous costs of TennCare, by far the most expensive single program funded by state taxpayers. During the current 2009-2010 fiscal year, TennCare, the state's Medicaid program, will cost taxpayers an estimated $7.6 billion in state and federal money.[25] That amounts to 26 percent of the entire state budget.[26]

There is no mechanism within the system that encourages the 1.2 million Tennesseans that receive services through TennCare to work toward independence.[27] In fact, by cutting off benefits after enrollees reach a certain arbitrary income, the program discourages work and job improvement.

The General Assembly could learn from South Carolina's reform efforts. Under its proposed Medicaid waiver plan, beneficiaries receive their own personal HSA that can be used to "fund their own health care in a variety of ways—either through [HSAs], by purchasing a managed care plan, by purchasing health insurance from their employer, or by joining a medical home network."[28] Such a waiver empowers "beneficiaries to tailor their own health care dollars to their own health care needs."[29] By providing TennCare enrollees with choices and personal responsibility for their own health care dollars, they will be encouraged to become self-sufficient and independent, eventually falling off the TennCare rolls and opting for private coverage. Then, TennCare enrollees will be able to get the same high-quality healthcare coverage as other citizens, and taxpayers will become free of the enormous burden of TennCare funding.

Like the reduction in employer-based healthcare, the expansion of HSAs is one slice in the larger pie of consumer-driven healthcare. As more Tennesseans begin to take control of their healthcare decisions, including those on government-funded health insurance rolls, costs will subside. This in turn will encourage many uninsured Tennesseans to obtain healthcare coverage, since it will become more affordable and accessible.

Conclusion

These five options present state lawmakers with an opportunity to reduce the costs of, and thereby expand access to, healthcare in Tennessee. Rather than waiting on Washington to dictate reform measures down to the states, the Tennessee General Assembly should pass serious, meaningful reform as soon as it resumes business in January. In the meantime, lawmakers should work to prepare legislation that will effectuate the reform laid out in this brief.

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