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Author

Robinson, James C

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INTERVIEW

The Best Of Times And The Worst Of Times: A Conversation With Vicky Gregg

The CEO of BlueCross BlueShield of Tennessee describes what it's like to be a profitable nonprofit in a state with a struggling Medicaid program.

by James C. Robinson

ABSTRACT: Blue Cross and Blue Shield plans have enjoyed enviable financial success, while much of the health care delivery system has faced severe financial strains. The contrast is striking in Tennessee, where BlueCross BlueShield of Tennessee dominates the commercial health insurance market and administers much of the state's Medicaid program, TennCare, while TennCare itself recently dropped hundreds of thousands of enrollees from coverage because of budgetary constraints. CEO Vicky Gregg draws lessons from the TennCare crisis for other states; describes her organization's investment in information technology, pricing policies, and management of new clinical technologies; and explains the continued political popularity of a profitable nonprofit health plan.

James Robinson: BlueCross BlueShield of Tennessee [BCBST] appears to be experiencing both the best of times and the worst of times. During the past few years, the organization has enjoyed incredible success in terms of enrollment, market share, revenues, and earnings. But when we think about Tennessee, we also think of TennCare, which for years was a leading light among state Medicaid programs, but which has been going through incredible difficulties, including, this year, the dropping of several hundred thousand enrollees. Let's start with TennCare and then move to other health insurance issues in Tennessee and for BCBST. What is TennCare, what was so special about it, and what got it into trouble?

Vicky Gregg: TennCare worked to expand coverage to both the uninsured and uninsurable population in Tennessee. It had no income

limits for eligibility. People whose incomes were 150, 200, even 250 or 300 percent of poverty still came into the program and were subsidized. The program also was different in the way that the federal match worked. Essentially there were no caps on the program; the federal dollars that were available allowed the program to grow substantially.

Robinson: Some people think that bringing federal dollars into a state is a good thing. The essence of health policy in New York, for example, is bringing federal dollars into the state. What is current enrollment in TennCare, and how much of it is with BCBST?

Gregg: Right now the program is probably down to around 1.1 million beneficiaries. We expect that BlueCross BlueShield is still in the 600,000–650,000 range.

Robinson: From your perspective, what went

James Robinson (jamie@berkeley.edu) is a professor of economics at the School of Public Health, University of California, Berkeley. Vicky Gregg is chief executive officer of BlueCross BlueShield of Tennessee, located in Chattanooga.

wrong? What got Tennessee's Medicaid program into trouble?

Gregg: First off, although TennCare is a noble experiment and certainly well-intentioned, its size was unwieldy. The state was not prepared to manage a program that encompassed bringing in two or three hundred thousand people who had not been part of traditional Medicaid. They also were not clear on how Medicaid might manage that population and not crowd out the commercial insurance market, and how to prevent people from moving from other states to Tennessee just to get coverage. TennCare was viewed more as a budget solution than a health policy solution.

Robinson: What do you mean by a "budget solution"?

Gregg: Well, in 1993, when TennCare was created, the state was seeing increasing costs in the Medicaid program. The alternatives, from the governor's perspective, were either to look at an income tax, which our state does not have, or to do something with Medicaid to stem the costs. While there was a lot of discussion about how managed care could be used to limit costs, in all reality what people bought into was the idea of the federal match—the fact that the federal government would put in extra dollars for every new dollar the state put in.

This created the ultimate moral hazard. To get the legislation passed, the advocates promised everything to everybody, and we were rewarded as a state to provide more and more care, because the more we spent, the more federal dollars we brought in.

Managing Drug Costs In Medicaid

Robinson: We hear reports about how many people are being removed from TennCare eligibility and what has happened to the benefit package. Can you summarize the current status of the program—how many people have been dropped? What has happened in response to the fiscal crisis?

Gregg: There are 191,000 people who are in the process of being dropped. Some have already been dropped; some are in an appeals process.

The major change in TennCare on the benefit side has been in pharmacy. If there is any-

thing that really caused a problem, it was the rising cost of pharmaceuticals. As part of the reforms, a five-prescription limit was put into place for people who remain in the program [five prescriptions per enrollee at any one time]. They are eligible for two brand-name drugs and three generic drugs. And that is a hard cap. TennCare will not pay for more than that. There are also some cuts in terms of caps on hospital days and physician visits.

Robinson: To what extent does the state of Tennessee take a hard negotiating position with respect to the drug companies on the prices of drugs, as opposed to simply limiting enrollees' number of prescriptions?

Gregg: Initially, drugs were part of the managed care organization's responsibility. And we at BCBST took a very hard line, quite frankly, in terms of negotiating with the drug companies as well as trying to manage the formulary to work with physicians on prescribing habits. But there was a considerable pushback to the formulary, which ultimately led to court orders that precluded any formulary from being put into place.

Robinson: Pushback from whom?

Gregg: Pushback from the consumer advocates, from the pharmaceutical industry, from a variety of people. We had use of generics, for example, up into the high 60 percent, but after the pushback, it's now dropped to approximately 40 percent, even below what we see in our commercially insured population.

Robinson: Because they have had no cost-sharing differential between brand-name and generic drugs?

Gregg: There's been no cost sharing, and essentially no formulary. You had to give somebody a fourteen-day supply of any drug that any physician ordered, and to impose a formulary restriction, you had to show that the drug the physician ordered actually would be harmful to the patient. The state took over management, and, rather than trying to manage a tight formulary, they began to think about maximizing rebates. They could then use rebate revenue to draw a federal match. All of the incentives were perverse and led to a further explosion of pharmaceutical costs.

Lessons From TennCare's Turmoil

Robinson: The reason why everyone was taking away tools to manage costs was because the consumer advocates wanted more benefits for enrollees, the providers and pharmaceutical companies wanted unrestricted beneficiary access to their services, and the state was more interested in getting federal match dollars than in controlling the state input dollars. Is that a fair assessment?

Gregg: Yes, that's a good summary. It dates back to the origins of the program's expectations. TennCare was sold as an everything-for-everybody program. So from the perspective of the consumer advocates, there should not be any kinds of limits. The physicians and hospitals and pharmaceutical firms never envisioned anything other than being paid. No more need to provide charity care—that was the way they viewed TennCare.

It's very easy to talk about what went wrong with TennCare, but a relatively poor state did have success in reducing the number of uninsured people. We got down into the 6 or 7 percent range, which is remarkable for a state of our size and economic condition.

Robinson: If you were to give advice to other states and other health plans that work in Medicaid, what are the implications of the TennCare experience, both positive and negative, in terms of eligibility, benefit designs, formulary, and prior authorization?

Gregg: First and foremost, you have to have realistic expectations. What concerns me, when I still hear other states talking about doing expansion programs, albeit not nearly as large, is the belief that they don't need additional dollars to do it and that somehow, magically, savings can emerge through the provision of better care. What we saw with the TennCare population was that many of those people were underserved and hence that providing better care increased rather than decreased costs. So when you began to talk think about disease management programs, in many instances you are increasing the cost as opposed to decreasing the cost of care.

You also need to come to grips with the pharmaceutical programs. This is where I see a

need for political will. In Tennessee we are number one in the country in per capita consumption of medications. So you have a marketplace that uses drugs frequently, and TennCare put an unlimited pharmacy benefit into place, with no controls. We had a drug industry that lobbied like crazy in the halls of our legislature to make sure that our formularies got disrupted. When we at BCBST looked at how many pharmacies we needed in a given community, we found ourselves with an any-willing-pharmacy provision, which took away any negotiating clout. If you're going to walk into these Medicaid expansion programs, you'd better be ready to have the political will to manage that particular benefit.

Robinson: To summarize, states first need to be willing to play a bit of hardball and actually manage costs; and second, they need to recognize that if you want to deal with the uninsured, you put them either in Medicaid or somewhere else, but it's going to cost new money. Is this accurate?

Gregg: At the end of the day, the taxpayer needs to see the value and the benefits of the program. And if there is something that we failed to do as a state, it was to make the taxpayer see that.

Success Of The Blues

Robinson: Switching to BCBST, 2004 was the best year you've ever had, according to your annual report. If I could cite some statistics from the Goldman Sachs investment bank, BCBST ranks among the top not-for-profit Blues on every dimension of performance. In particular, between 2003 and 2004 your revenue increased 42 percent, compared with 13 percent for all Blues plans. Your earnings increased 12 percent, compared with 6 percent for the other Blues plans. And your enrollment increased 12 percent, compared with 2 percent for the other Blues. How do you explain your success over these past years?

Gregg: Well, good hard work, for one thing. But I will tell you that we feel the competitiveness day in, day out. There's no sense on our part that we walk in and it's a slam-dunk on any employer's health benefit account that we

bid on. We have all of the big insurers here in Tennessee. We have CIGNA, we have United. We still have some strong regional players. We have John Deere; we have some hospital-based programs such as PHP in East Tennessee. There's no market that we look at and say, "Oh, well, we just own this market."

This year in particular—2005, year to date—our rate increases to our commercial customers are around 4 percent. We're very successful, but we're also today pricing below the medical cost trend. Our medical cost trend was running closer to 10 percent, maybe even ticking up a bit. So we are giving some rate relief in the market. We are trying to make sure that people are able to keep coverage, which we believe is an important part of what we contribute as a company.

Robinson: So you are consciously pricing below your medical cost trend?

Gregg: Yes.

Robinson: That's possible, due to the fact that you've had very high financial reserves—a surplus built up from past years. If my numbers are correct, last year your reserves were at 540 percent of risk-based capital levels, which is way above the National Association of Insurance Commissioners [NAIC] minimum levels and the Blue Cross Blue Shield Association [BCBSA] guidelines.

Gregg: When we look at our company, we have to have capital. And as a not-for-profit, we do not have access to the capital markets in the sense that some of our competitors do. We look at what we need to drive our company and to be successful. And our sense is today, the most that we could say that we're, quote-unquote, over-reserved, is around \$250 million. Well, for a company of our size paying out more than \$15 billion in claims this year, is \$250 million really, quote-unquote, over-reserved? I think, again, it's capital that allows us to fuel our business and to be competitive and to do the things that we need to do to be able to deliver affordable health care to our membership.

Politics Of Profitable Nonprofits

Robinson: In some states, such as Pennsylvania, the state legislature and regulators have looked at the reserves in the not-for-profit Blues plans and wanted that money back. There have been a variety of compromises in different areas, I believe, around this. How does Tennessee look at BlueCross BlueShield, a very large, successful, and profitable not-for-profit company that is involved with the money-losing TennCare program? What kind of pressures are you under?

Gregg: The vast majority of not-for-profit Blues plans enjoy state tax exemptions—Pennsylvania is one of those. Our plan is unique in that we never had a state tax exemption. We were formed in 1945, and from day one we have paid all state taxes. In some other states, a lot of the discussion around the reserves has been a trade-off with the tax exemptions.

Robinson: You mean, the extent of community service needed to justify the tax exemption?

Gregg: Correct. But when the Tennessee legislature looks at us, there are no tax exemptions to be justified. I think, also, that the state understands that having a plan with reserves is a good thing. They understand this because TennCare has experienced a number of health plan failures, and providers have been left holding the bag. That is not something that the regulators want to see happen. Because our plan has been successful, because we have had the financial wherewithal to be able to do the things that needed to be done, we've been the backbone of the TennCare program.

I think that the state, when they look at our reserves, views them from the perspective of consumer protection. The question of adequate reserves always comes up when they begin to look at premium rates and rate filing, and we do have rate approval in our state. So when we file for approval of our individual and group products, state actuaries go through them, and a negotiation process goes back and forth—trust me, that is not an easy process.

What they see through that, though, is that we're a responsible partner. Several years ago we did a premium payback when we saw that

we were actually having some huge cost savings from some of our pharmacy programs that had more savings that we could have ever imagined.

Information Technology

Robinson: Let's switch gears to another subject. What has your company done toward fulfilling the information technology [IT] demands that inevitably arise in today's health care environment?

Gregg: I'm quite proud of what we have been able to do in the area of data management. We bit the bullet back in 1999 and went to a single platform. It allowed us to build a data warehouse and have information, so that we could begin to understand the population and where the opportunities were for better management. It's ironic to me, but TennCare gave us the impetus and opportunity to hone our skills. We are trying to help drive the information infrastructure in our state, because we believe that it can't be proprietary. This is a radical stance for a company like ours to take.

Our focus on information grew out of what happened in TennCare, as the traditional tools were being taken away—

Robinson: The managed care tools?

Gregg: Right. We asked ourselves whether there were other ways to bring about structural changes in the way health care was delivered. It was very clear that having better information at the point of care would be really helpful to physicians and hospitals. So we looked at what we had just within our own database and realized that we had, for our TennCare population in particular, pharmacy data that were updated every night—we had diagnoses, we had patients' claims and utilization histories. So we began to look at how we could leverage that information to be helpful. And that is what led to the formation of Shared Health, a new subsidiary of BCBST. The first product rolling out is Community Connection, which takes all of those data and populates a health record for TennCare beneficiaries, a record that's available via the Web to authorized clinicians at the point of care.

Robinson: This is a personal health record for

the enrollee?

Gregg: The person does not have access to it yet, but the intent is that over time they will. We were recognizing the fragmentation and the lack of information available to physicians; the idea was to provide that information to them at the point of care. Today it's for the 700,000 TennCare enrollees. We will go to over a million when we bring on the other managed care organizations' membership. Our intent is to expand that into our own commercially insured population over time.

Robinson: And so right now, individual physicians treating an individual TennCare patient could, through the Internet, look up a person's record, including drug use and lab values?

Gregg: It shows the lab tests they've had, the lab values, and the norms. Because today there's no standardization out there between labs, interestingly. It shows the physicians whom the patient has seen over time, their diagnoses, any procedures they've had, and their prescription drug use history. The drug history has been by far the best tool in terms of a physician looking at a new patient and trying to understand what's going on.

Robinson: And for the enrollees in the other health plans, are equivalent data fed into the Shared Health system?

Gregg: Yes.

Robinson: So if an enrollee were to switch from BCBST to one of the other health plans, or vice versa, the data would follow, so to speak?

Gregg: Yes. It's one of the things that can't be owned by any one entity. You've got to be able to follow that patient over time. If the patients move between managed care organizations, if they move between clinicians, all the data need to follow.

Robinson: How would that principle translate into the commercially insured population, where you're competing against other health plans and where enrollees do frequently switch health plans? How would the data be aggregated, where would they be aggregated, and who would have access to them?

Gregg: Our sense is that ultimately we're going to need state oversight. I don't know if it's a

commission, but there's going to have to be an understanding of who controls the data and how, and who has access to them and how.

Prevention And Disease Management

Robinson: Tell us about your diversification into behavioral health, disease management, and into Gordian Health Solutions.

Gregg: We recently acquired a company called Gordian, which is in the health risk appraisal as well as health coaching business. As we looked at our population, the first thing we figured out was there is a need to stratify from day one. And employers emphasized to us that understanding populations at risk is important not only as it relates to medical care costs, but also as it relates to productivity and absenteeism. So we decided to enter the business of risk assessment, to be able to look at a population that today is healthy but perhaps has risks sitting out there.

Robinson: You find that doing risk assessment and then presumably disease management internally is better than outsourcing to outside firms, some based in Nashville, some based elsewhere, that would be happy to do that for you on a contract basis?

Gregg: What we see is the need to be able to get the information and to integrate it in relationship to all of our other claims, cost, and utilization data. We also see here a new business opportunity—Gordian is a company that works with employers across the country, and in fact only about 4 percent of its clients are in Tennessee today. Gordian has nine years of experience in this. It can demonstrate a \$1.60 return for every dollar invested in risk appraisals and health coaching, and having that kind of data to show employers gets their attention.

We also see this as an important product for consumers. Employers want to provide incentives to employees to stay healthy. So we can do the health risk appraisal to support this. If there are risks that are identified and the employees agree to participate in a health coaching program, then they may get a discount on their premium contribution, they may get a higher amount of money put into

their HSAs [health savings accounts]. We view it from the perspective of, first, something that makes sense as we look at our population. And from our perspective as a poor state, we look at this as something that can drive revenue and profits back into our state.

Cost-Effectiveness Of New Clinical Technology

Robinson: Let's turn to medical technology. The long-term trends in health care cost inflation are driven heavily by new drugs, new devices—clinical innovations that often are quality-increasing but certainly are cost-increasing. What sorts of programs do you see in Tennessee to manage the appropriateness of, and the expenditure on, new technologies?

Gregg: The governor has put a stake in the ground with TennCare with his definition of *medical necessity*, which essentially says that the program will cover the least costly effective treatment for a given condition. This “least costly” clause introduces a new element into the debate over new technologies.

Today, for the most part, when the FDA [Food and Drug Administration] staff look at approving new drugs or devices, they don't look at something in terms of how it performs versus existing interventions, they look at it as to how it performs against a placebo. The question in Tennessee now becomes whether this particular treatment, although it may be effective, performs well against other treatments in terms of cost-effectiveness. If you have equal outcomes, let's defer to the one that is least costly. That's a whole new way to think in our industry.

Robinson: Focusing on your commercially insured enrollees and not on TennCare, how are you managing the costs and use of specialty drugs, biologics, and medical devices?

Gregg: We are looking at prescribing patterns for biologics and devices. Just like you do with pharmacy, you can look at how physicians use these new technologies. If you are looking at orthopedists, for example, and you're looking at how they use MRI [magnetic resonance imaging] scans in given situations, and you're profiling them against their peers, then you

can ask some questions as to why. That's where you get into the interface with physicians and show them information [on practice patterns] and try to understand why they are using a technology the way they're using it.

In our state we have a very strong certificate-of-need [CON] program. But physicians have been able to get into these things [ownership of specialty facilities] without going through the full-blown CON. The physician-ownership issue is one that we really have begun to look at, to ask whether we include those in the network or not, whether we impose cost differentials on them.

Robinson: Do you face pressure to have an "any-willing-provider" approach to ambulatory surgery and diagnostic capabilities and other physician-owned enterprises?

Gregg: It's a quandary right now. To the extent that physician-ownership drives overutilization, then we have to question the convenience-versus-cost trade-off. What we are trying to do as a plan, particularly on the commercial side, is to understand what's going on, to communicate information on physician-ownership to consumers, and to design benefit plans that drive people to act in their own best interest. It's been quite interesting to watch.

Consumer-Driven Health Plans?

Robinson: The buzz at the moment in health care is all about consumer-driven product designs. What is the trend in your commercial population in terms of copays, coinsurance, deductibles, and the product mix?

Gregg: We had several years, starting in early 2000s, of high double-digit inflation in medical care costs. And we saw our commercial employer customers begin to ask, "How do we engage our employees?" They did it in a number of ways.

First, we saw them begin pushing some of the premium costs over to employees. This was to wake them up, in terms of what health care really costs. The second element of employer strategies was to put deductibles and coinsurance back into place, after having taken them out during the managed care era. And now it is not unusual to see \$500 and \$1,000 deduct-

ibles and 20 percent coinsurance. That is the primary tool that most of our commercial customers use. It's very prevalent in the small-group market, maybe a little less among larger groups.

We have also seen a big increase in the HSA products in our individual market. People want to have a little more flexibility there. We have seen some HSA penetration now in our group market.

Robinson: Do you see any potential in new product designs to bring some of the uninsured into insurance coverage—people who are not indigent but who are the working uninsured, who work for small firms?

Gregg: Yes. We have a number of products, and we've done a lot of focus groups around what products and price points are attractive to at least some of the uninsured. For the population that we're talking about—and it tends to be low income but working—we heard a couple things. First, the price point is somewhere around \$60 per month for a premium. So what can you buy for \$60? The second point, which really made us sit back and say, "Wow, we need to think about this," is that they indicated that if they're going to pay \$60, they don't want just catastrophic protection. They're paying \$60, and they want to know what they're going to get back for that. So in the focus groups they want dental benefits, they want vision benefits, and they want all these different things. So we have designed products. We have one called Simply Blue that's targeted to that market and provides skinny benefits but does have some front-end first-dollar coverage [for preventive care].

Robinson: The consumer's question is, What have you done for me lately?

Gregg: You're right.

Robinson: That's what the employee asks the employer.

Gregg: That's not been the way that our industry has historically thought about our products. We have thought of them more as insurance, as financial protection, as opposed to something that provides financial benefits now for people who are not severely ill. We see that younger people, if they're going to pay

money out, want to know what they're going to get in return.

The Price Of Health Care Services

Robinson: Let's talk a little about price information. With all these deductibles, people care now about the price of health care services more than they did in the past. What kind of price information do you provide, now or in the foreseeable future? How can this information be provided to consumers in a way that doesn't overwhelm them, avoiding the thousands of micro-prices for each particular test and service, and yet allowing them access to the information that's actually influencing their physicians' and their own health care decisions?

Gregg: Let me say, there is nothing rational today about health care pricing. This has been driven in a vacuum around negotiations between health plans and providers. The currently available information, for the consumer, is total nonsense.

Robinson: It's the Tower of Babel.

Gregg: Yes, they cannot understand it. Inpatient care, to some degree, has been subsidized by outpatient care in terms of how providers have priced their services. But when hospitals began to compete with ambulatory surgical centers and freestanding diagnostic centers that are owned by physicians, entities that are able to price lower than the hospitals, and if the consumer has 20 percent out-of-pocket coinsurance, the hospitals are really at a competitive disadvantage. It's going to be a radical change in the marketplace, though, in terms of pricing. And that has to happen before you can really get a rational, transparent pricing system for consumers.

Robinson: Before you can have a rational, informed consumer, you have to have something rational for them to be informed about.

Gregg: That's exactly right.

Robinson: In some markets I've heard reference to treatment cost estimators, and to comparative cost data on hospitals for procedures. Where are you going, as the largest health plan in your state, in pushing the visibility of pricing data?

Gregg: We are trying to work collaboratively with the providers to make sure the information is accurate and that people can use it. Some of this is still in the pilot phase for us, so we're not ready to tout it and yell from the ceilings and say it's been a tremendous success. But we are working on getting it in ways that people can really use it.

Robinson: Tennessee is, like many other states, evolving toward becoming a very consolidated health care market, on both the hospital side and the insurance side. Blues plans are dominant in each region—and in each region one or a few hospital systems are dominant. So instead of a textbook economic market with lots of buyers and lots of sellers, you have a dominant buyer—that's you—and then one seller or a few sellers on the hospital side. How does that affect the market-oriented approach to managing cost, to managing choice, and to managing performance?

Gregg: I like to use the term "shared destiny." Our state is the poor state. We are forty-seventh in overall health status in the country. We have an uninsurance rate now that will be pushing toward 20 percent, from a low of about 6 percent. Another 20 percent are still on Medicaid, and another 15 percent are in Medicare. So you're looking at 55 percent of the market either unfunded or underfunded, from the perspective of the actual costs of providing and financing care.

I don't think any one entity, whether it's Blue Cross or anybody else, can win at the expense of everyone else. Because ultimately all we're doing is driving more people out of the market. I tell people that our biggest, toughest competitor is "nonconsumption." It's people who choose not to buy. And when you're in a state where the average income is less than the U.S. average, people's ability to buy health insurance is compromised.