

*Investing in Texas: Financing Health Coverage Expansion  
Conference Proceedings*

**Panel Discussion: Financing Health Coverage Expansion**

*David Warner:* We are very fortunate this afternoon to have on this panel several people from different perspectives who are very knowledgeable about these issues to address some of these options that have been laid out today, and also, perhaps, to identify problems that they can see with cooperation and coordination, and what they think the next steps might be. Also, at the end of this panel session, I will call on both former Representative Sherri Greenberg and Representative Glen Maxey for their perspectives as well, and then we will open it up to questions. Today we are very lucky to have five people who between them have a lot perspective and I won't even try to guess how many years of experience.

Our first panelist is former Senator Chet Brooks. Senator Brooks served four years in the Texas House and 26 years in the Texas Senate. For 20 years, he was the chairman of the Senate Health and Human Services Committee. I mentioned to him this morning that when I did the math I realized that he voted for Texas to participate in Medicaid back in 1967. So he has been continuously involved with this program even before it began, and he was also involved in the interim before Senate Bill 10 in laying out some of the issues in 1993. Since retiring from the senate he has been working at the Health and Human Services Commission. He remains active in the Texas State Guard, and is also a student at the LBJ School. He was a member of this class and is close to graduating.

Our next commentator is Dr. Jim Walton, who is a physician in Dallas. He works both in Waxahachie, where he has an internal medicine practice, and since 1996 he has served as the medical director in the office of community health at the Baylor Health System in Dallas. He has developed a comprehensive community-based health care delivery system for medically underserved residents of a six-zip-code area in Central Dallas. He is active both in Dallas County and statewide with the medical society with regard to Medicaid programs. He also, in his spare time, works on coaching Little League Baseball with his four sons. He also participates in international mission programs and other programs.

Our third commentator is John Guest. Since 2000, he has been the CEO of Harris County Hospital District. He formerly was the CEO of Bexar County Hospital District in San Antonio, where he served for 16 years. He is a graduate of the University of Texas and Trinity University's Hospital Administration Program where he was recognized as an outstanding graduate. He has been Chairman of the Texas Hospital Association and currently serves as Chairman of the Texas Association of Public and Community Hospitals.

Our next panelist is Ron Luke. Ron is a graduate of Harvard University and has a Ph.D. from the Kennedy School as well as a law degree from the University of Texas. He is the

principal owner and also president of both Research and Planning Consultants and of Forté, which is a health consulting and management company. He has 80 employees, both in Austin and in Florida. He serves on the Texas Association of Businesses and Chambers of Commerce board of directors. He has served as the vice chairman of the Texas Healthcare Information Council, and has been appointed to a number of other entities including the Texas Department of Insurance's utilization review advisory committee.

And the final panelist is Anne Dunkelberg. Anne is a native Austinite who is a graduate of the University of Texas and the LBJ School. She has worked for the Texas Research League where she did a lot of good work on Medicaid and health care generally. She also worked at the Health and Human Services Commission where she was principal author of the notorious "pink book" on Medicaid that is still updated and used as a main source for Medicaid information, and since 1994 she has been with the Center for Public Policy Priorities. She is generally seen as the person who has the most definitive figures and is most up on many health and human services programs and issues in the state.

These panelists have been given the charge to examine what they have heard today, both in terms of feasibility and whether it can work. And, if they think it does make sense to try to draw down an extra billion dollars with cooperation and/or collusion, how that might happen. And finally, any other thoughts that they might have about some of the concessions that might be required on a HIFA waiver and some of the concessions and arrangements that might have to happen in terms of drawing upon local money or imposing some of these other taxes.

**Chet Brooks:** I'll speak briefly because there are some much more knowledgeable and experienced people on the panel with me. I want to leave the bulk of the time for them, so I want to make just a couple of quick points. Historically, Congress passed Medicaid in 1965 and Texas implemented it in the next legislative session in 1967. As all of you in this room probably already know, it started as a very limited program just for very poor women and children. It has expanded over the years. We have now encompassed other populations and we continue to try to move farther along and cover those who are uninsured and have no other way right now to get health care services other than showing up to the emergency room, which is probably the worst entry point into the health care system.

Another big change that occurred during the years that we were working on it at the legislature was that then-U.S. Senator Lloyd Bentsen made a major breakthrough when he, as Chairman of the Senate Finance Committee, managed to get the Congress of United States to recognize that preventive services will work. That there is a payday for spending upfront for prevention services and early detection of diseases or illness. In 1989 and 1990, I was privileged to serve on the National Conference of State Legislatures program and to represent that organization before the U.S. Congress and specifically before Senator Bentsen's Senate Finance Committee, endorsing and urging Congress to act on preventive services. That was one of the biggest breakthroughs we ever had. It has paid many dividends and I continue to be very thankful that we were able

to be a part of that. I am also very glad to see that it is now becoming more of an accepted fact with very few people still arguing about it.

In the beginning critics said how can you prove that you saved any money when you do not spend the money; it was a real battle. It was kind of interesting, and some you in this room were a part of that effort, and frankly it was fortunate that it worked. Now, today's conference is not our first brush with creative financing, because that was the order of the day in the legislature for the 30 years when I was there. You have to find a way to sell your program and sometimes you have to be a little sneaky. I slipped some things through in interesting ways and so did many of my colleagues, but you do have to prove your case. Many times you have to start with a pilot program and see if that works, and we have been modestly successful through the years doing exactly that. Starting a demonstration or pilot program proving that it will save money or it will deliver services better and more safely, that it has the potential to serve your people better. After that, it is much easier to expand it or take it statewide. To some extent, I think, the expansion ideas that we are talking about in this conference today are in that same or similar category.

So we are going to have to look for creative ways to raise the money or utilize the money we are already spending in order to get the match. I need to make one more comment—I think tobacco tax is a possibility. It is an existing tax. Tobacco is now in great disfavor with a portion of the public who now understand what the health consequences are, and I think that a modest increase there—Texas is only about in the low average, low mid-average compared to the other states—has a real potential to get that seriously considered and perhaps passed. Alcohol taxes: alcohol has an awfully powerful lobby, but there has not been an increase in quite some time, so if it is a modest increase, I think that is a doable thing. A soda tax has worked in one state, but I can see the lobby effort now: “the people there in Austin are trying to tax my kid's soda pop.” This is a tax against kids. It'll work, that argument will work. I would like very much now to hear from others guests.

**Jim Walton:** Thank you. All that I can say about traveling internationally is that working in the inner city of Dallas has prepared me well for working in Bulgaria. Bulgaria, you know, came out from behind the Iron Curtain in 1989. I had the privilege of traveling there about five times and interfacing not only with their medical schools but also with their medical delivery system. My hope in working with them was to help them avoid repeating some of the mistakes that we have made in the United States. I am going back in June, and we will see what we can do to help move them closer or further away from where we are.

I see patients who are uninsured, and principally, I care for people that are immigrants and are undocumented. In Dallas, probably like in other major metropolitan areas like El Paso and Harris County, our public health care system has a capacity currently physically able to see half of those who need to be seen, those who are considered medically underserved. That means the physical plants can only hold so many patients per 24-hour period, shortages of beds, you know the story. So, when you have a

conference about financing—and I appreciate being invited—I want to add that. I think it is incredibly important if you want this to actually have some legs to connect financing with delivery.

So the very next conference you ought to have should be the delivery side of the equation because short of that, you have a very expensive program. I think we are seeing the fruits in Dallas. I think we see some examples of that since the recent rollout of Medicaid managed care and our MSA. The gentleman from Oregon said something that was very, very important in that the policy that they based their program on would serve us well, which is health care is on a continuum of other human services. So I want to applaud the work that was done to move Medicaid managed care out of TDH and into Health and Human Services because it makes more sense there. When I take care of patients, as a physician I provide about 10 percent of what they really need with their health care problems, like the complex diabetic or hypertensive. The other 90 percent are other social services, and if we do not get that message, we are going to throw good money after bad money at a rather rapid rate with this waiver.

I am not raining on this parade of a waiver. I think drawing down a billion or \$12 billion of federal dollars would be great. I send a lot of my money up there. I would like to see some of that come back to Dallas to work for people that I really care about, which happens to be the uninsured working poor, which happens to be a lot of undocumented immigrants, by the way. They clean the tables and take care of the beds and do a lot of the things that make life really comfortable for me when I live in Dallas.

There are two messages. I work for a health care system and I am a physician. The health care system I work for perceives itself to be sick. Perception is reality whether or not you would think they were sick financially. I debate with them all the time since I am in the area of community health, but they perceive themselves to be financially strapped, and they anticipate the marketplace handing them another financial challenge to make ends meet next year, and so they are contracting. There is a hiring freeze as a result. So, there is a capacity issue just in the private sector in the health care system. On the physicians' side of the equation, it is probably even worse, in that managed care has taken the joy out of practicing medicine, and it is not your fault because we were late to the party, so to speak. Commercial managed care has absolutely hassled the physicians to the point where they do their very best just to get through the day, and I think all of you have seen doctors and had to deal with your insurance company well enough to know that it is not a fun experience to go to the doctor, let alone have an illness. So layering in another group of people who have this product that you call Medicaid or CHIP through some waiver creates a dilemma for the provider community that just staggers my imagination, because I do not know where you are going to find the people to see the patients that you now are going to pay for.

What I know to be true instinctively is where my patients are going to get care or their neighbors are going to get care and that is the emergency department. We know looking at data internally in the inner city of Dallas that people are going to the emergency room in larger numbers with more complex problems. They are being admitted to the hospital

with more complexity, and they are having the tendency to be less likely to be insured. So, what that means to the delivery community, and I have a lot of interface with a lot of physicians who are trying to deliver care, is that when they are on call they have to take care of these patients. They do not have a choice at the emergency department, but they do have a choice when you offer them the opportunity to be part of the Medicaid managed care network in Dallas, and they choose with all due respect to say no thank you. They prefer to do indigent care in a limited capacity every so often at their own call. So, once you put more people into this system, there will be folks who do not have care. They do not have primary care, and they are going to have more complex problems.

Health care is on a continuum, and so we have to find out what we can do on the delivery side of the equation to incentivize the provider community to play with this increased number of folks in the system. The good news, if I can find some, is that the provider community is so dissatisfied with their experience of being physicians that they are willing to look at new models of care that are less hassle. I am working on a program in Dallas that we've been developing for the last two years called Project Access. Project Access gives physicians an opportunity to donate a certain number of visits per year to see patients who are uninsured. It is very little. We understand the amount of lift that it is going to give. Parkland, our public hospital, is carrying the piano and we are going to be carrying the piano bench pad, if you will, to try and help lift the problem of the uninsured and the medically underserved in Dallas.

What this is doing is planting a seed back into the physician community of Dallas that civic engagement is really important. That civic engagement and community service makes your life worth living, that it really adds to who we are as people and feeling like we now come to the table with something to give. It is very valuable and it probably opens the door a little bit to increasing the number of providers who are going to participate in the network of Medicaid managed care. But, we are going to have to figure out a way to make it worth their while to participate by reducing the number of regulatory hassles that are inside the delivery of care. One example would be when I see a Medicaid patient; I use a different form in my office to send the bill in than I would any other insurance company. Now, what is up with that? That is a regulatory problem that doesn't cost any money to change, does it? Other than the investment of time it takes to actually change the form. That is going to resonate with the physicians if someone really starts to spend the amount of time that these good students have spent in understanding the financing, and if they will actually take the same amount of energy and intellectual capital and invest it in the simplification side. Not people getting into the program but how you actually run the program, for the provider community, I think, will actually have some magic. Short of that, I think that you are going to have a whole bunch of people insured, and you are going to pay for that in the emergency departments with a lot of complex problems, and you are going to go bankrupt, and you are going to basically cap the program, and we will be having this conversation in about five years. I do not want to be controversial, so I am going to stop and let my new good friend here speak.

**John Guest:** As I was hoping that I would be bookended by some uplifting talk, let me start with the positive part. I really do appreciate the presentations that were given today.

I thought all of you did a wonderful job, and I learned a lot. I feel refreshed by the great excitement and enthusiasm that you expressed today, and I want to thank you for that. In trying to comment, I thought I would try to start from the negative and work my way to the positive, and as I looked at the list, I realized that it started negative, and it just sort of stayed there. So, I apologize for that. I would not be doing what I do if I didn't have a basic optimistic view of the world and the future and our ability to change things for the better. You talked about it. I live with it.

This is a fragmented state. We talked earlier today in the breakout session about how we learned in Texas history that Texas had the ability at one time, and may be it still does, to break up into five different states, if we should ever choose to do that, and one of the dilemmas with the whole waiver as I understand it, is this premise that whatever we do has to be done statewide. There are some local option waivers that are available, and we ought to be thinking about some opportunities to pilot or do some things differently in different parts of the state. To the extent that we might be able to understand our regional differences, I think that will be very helpful. When you begin to identify different ways of doing things, it becomes a problem of dealing with the legislature and getting a singular bill passed that would allow for that to happen, but I think that is a real challenge that we have.

The other fragmentation in this whole issue is that the stakeholders are fragmented. The nine public hospitals, of which my organization is one, have a pretty hard time agreeing on just about anything, and we are put into a card game in which we are asked to make contributions to the state's match. Obviously, it is in my best interest to make sure my contribution is less, and theirs is more, and so we spend lots and lots of time haggling about those kinds of issues. That is our problem, and the more stakeholders we get to make contributions the more difficult it is going to be. One of our members decided that they would drop their contribution. It was in their individual best interest to reduce their contribution by a couple of million dollars, and as a result, they benefited, and everybody else had to pick up the slack. That kind of individualistic behavior in a group environment can be deadly. So, that is a problem we have to understand. I am a part of the public sector of the hospital industry. There was talk about Senate Bill 10, and I think we need to understand that the hospital industry as a whole viewed the notion of a provider tax about like popular opinion views the income tax in the state of Texas. It is offensive to the lion's share of my colleagues who were in hospital leadership roles, and I will come back to that issue when I get a little more positive towards the end.

We talked a lot about our perspective on federal matching. I do not want to appear sexist, but I am reminded of how every time my wife tells me that she bought an outfit on sale and saved 20 percent, my comment to her is where we are going to spend all that money we saved. The problem with federal matching is there is a state commitment that is required and in spite of the fact that we have benefits that can come to us from the federal match, there still is a revenue problem so in the state's budget urgency, it is sometimes very difficult for them to see the benefit of this federal matching program. The public hospitals' view, our stated policy, is that we would prefer not to have to contribute anything to federal match—that this is really a state responsibility and that if the state

would step up to the plate and meet that responsibility, it would be better for all of us. And so we have some battling that goes on about this whole issue, and we also need to appreciate that our colleagues at the federal level faced with this gambit that calls for the state to put money up and then requires the federal treasury to unleash a billion dollars of additional federal dollars, is viewed quite candidly by many people in leadership in the federal government as a scam. So there is strong effort at the federal level—we read about it through UPL limits and efforts to try to reduce DSH funding—there is a strong effort in many quarters of the federal government to try to bring this mechanism to some close.

The recent discussions that I have heard at the federal level would indicate that the governors would like to get more authority, more flexibility, with Medicaid, and the federal government will give them that flexibility, but there won't be any money associated with it, and we will see the responsibility for funding Medicaid perhaps revert down to the local level. So there may be change and that is why I mentioned that. This is not original with me, but I believe it to be true. I read a book called *Beginnings Count* a couple of years ago, I think written by David Rothman. He talks about how nothing in American health policy changes unless it affects the middle class, and his examples are the iron lung in the polio days, renal dialysis, the implementation of social security itself, and the implementation of Medicare—nothing changes unless it affects the middle class. It is a cruel but real reality that the problems of the uninsured are really not very important for the middle class unless the middle class becomes uninsured. And I believe we are beginning to see evidence that the middle class is beginning to be affected by the problem of uninsurance. There is probably not a person in this room that either has not had some experience or knows someone who has had difficulty gaining access to health care because of an insurance problem or lack of insurance coverage. And that gives us an opportunity politically to be on the watch for when political sentiment will begin to change and give us a more positive opportunity to change public policy both in Texas and elsewhere.

The last thing I wanted to say is that the middle class will not only be affected by the issue of uninsurance, but what is going on in health care in that there is not enough capacity to do what we all need to have done. In San Antonio, the wife of a former board chairman of the public hospital waited for almost a day in the emergency room to get access to an ICU bed. She had insurance and she was obviously very important. In McAllen, Texas, a well-to-do gentleman fell off a ladder and bumped his head. He went to the hospital and they did not have a neurosurgeon. They called every hospital up the road until they made it to Houston, and just by accident, our hospital was not on diversion and we were able to accept him. He was flown by airplane to Houston from McAllen, and he died in our hospital shortly after his arrival. He could have been saved if there had been adequate access to trauma services available for him within five hours of his injury. It took him a day to get to us. We are in a situation today, where from the capacity standpoint there is not any and it is affecting all of us. It may be that reality that will have much more influence on the politics of this issue about how do we get insurance improvement or improved access to care.

So in a perhaps depressing kind of way, there may be an opportunity in this tragedy that I believe is occurring every day and it is going to continue to occur, for something to be changed in a meaningful way. This is very important for how we set public policy, and it also creates a very important obligation among public policymakers because if we tip the scale in the wrong way, if we pick a solution in the wrong way in a system which does not have any slack or capacity left, we are at risk of making the problem worse rather than better. So we have to be even more careful about what we decide to do when we understand finally that we have to act and do something about the situation.

**Ronald Luke:** I usually get to be the storm cloud but John has taken that role. So let me deal with a couple of things from the perspective of having looked at this for business. I want to go back to the notion that the problem we are discussing is obtaining appropriate health care for the uninsured. What I think we've got to look at is that there is probably no silver bullet, umbrella solution short of universal national health insurance coverage—which is probably not going to happen this year or next. So we are talking about a continuation of the incremental changes that we have been engaged in for many, many years. One of the questions is who are our uninsured. Some of the materials in our packets showed quite a few of those folks are not likely to be enrolled in any government-sponsored health care program for the obvious reason that they are not only not U.S. citizens but they are not here legally. To me, health care for illegal immigrants is pretty much a separate issue that is not going to be helped by expanding Medicaid coverage or CHIP coverage. I am not trying to say that expansion of those programs could not have a beneficial affect indirectly.

Second, I think we have a problem here of manufacturing new uninsured and having the percentage of uninsured rise. Unfortunately, it may go back to the middle class that John was speaking of. We still hold the record for more health care insurance mandates than any other state. You can have many studies and enormous debates about those mandates, but at the end of the day, there is no question that they raise health care costs and that there is some economic relationship where at the margin, by imposing those mandates, we create more uninsured. We have a choice that will cost us zero general revenue dollars to reduce the number of uninsured by going back and thinking carefully in an Oregonian sense about the costs and benefits of those mandates.

Thirdly, we passed beginning in 1997, both in Texas and nationally what I would generally characterize as anti-managed-care laws, or in other words a patient's bill of rights. We saw beginning in 1993 major growth in HMO coverage of the population. Were there some screw-ups by HMO managers and administrators? You bet. More screw-ups than by-fee-for-service doctors? We do not know because we do not count all those screw-ups. You can find horror stories in either system, but we had inconvenience. I think I would not be out of bounds in saying that health care providers, generally speaking, did not like the additional structure that managed care plans were providing for their lives. They petitioned their legislators for redress of grievances, and they have generally been quite successful because they were able to tap into the issue of choice and convenience and why do I need this guy's approval to see a specialist I really need to see?

But guess what—the for-profit entities that are providing HMOs basically say fine, you want choice, I will give you choice, no problem! So now what we have is almost all-inclusive networks which do not direct volume, so therefore cannot command discounts, and which therefore are inhibited from taking the physicians with the most cost-effective practice patterns. So health insurance costs and health insurance premiums began rising again like they did before 1993 by double digits. Following what a good economist would expect, at the margin, the percentage of people who are uninsured also began to rise. So we have more uninsured

The Aetnas and the Cignas and the PacifiCares basically say, “I am not in business to lose money. I am not in business to subject myself and my shareholders to the liability risk of being sued, and so if you want to pay higher premiums, I am here to pay the bills and pass it through in higher premiums.” And that is exactly what is happening. The latest CMS projections project that by 2011 the percentage GDP spent on health care will rise from 14 percent to 17 percent—that is about a 6 percent per year increase in health care expenditures per capita. CMS projects as part of that for the percentage of the uninsured to rise.

You have an interesting question not about quality because there is no peer-reviewed study that exists that shows that HMOs deliver less good care as measured by outcomes than fee-for-service medicine, and that it does it cheaper and it is better from the preventive standpoint. What we have is an issue that the middle class doesn't like the hassle and the providers do not like the hassle. As long as we keep insurance premiums tax deductible, so that you can buy a more expensive policy and the federal government is paying 15 percent or 39 percent of whatever your bracket is of that incremental cost, you have a lot less incentive to buy smart on health insurance policy than you do on a car or house, it's simple economics. So one of the questions is when do we get to the point where we decide to stop creating higher and higher percentages of uninsured because it is a result of mutually exclusive policy choices. As I am fond of saying, a patient's bill of rights does not apply to the people without health insurance.

Part of the problem is not how do we get more people on Medicaid. Part of this problem is how do we make private health insurance more affordable until we decide to go to some sort of national baseline policy, British-style, if ever. The second thing is the cost of Medicaid. Some states have pursued Medicaid HMOs and effective approaches to Medicaid cost control. Texas has for the most part stopped development of Medicaid HMOs. Once again there is no question we can provide care cheaper and better through an HMO structure that gives every patient a medical home than we can through a fee-for-service system where you got your Medicaid card and you get out your telephone directory and start calling providers until you find one that will take you. We have a situation with higher costs and less access because politically we are not willing or able to impose a managed care model on our health care providers. There is no question that the providers do not want one.

Part of the way you create additional capacity is by using the resources you have more efficiently. Delivery system capacity and cost and efficiency and quality and access are

all bundled together. One of the things that bothers me about expanding public insurance programs is that it is a “let’s throw more money at it” plan, which if we were a lean, mean nation when it came to health care, I would say you are right, we are underfunding health care, let us throw more money at it. But we are spending 14 percent of GDP to cover 80 percent of our population. The European countries are spending median 8 percent of a lower GDP to cover 100 percent of their population and the health outcomes are the same. Now, we can import cars to force our manufacturers domestically to learn who Deming was and to improve their product and improve their cost and all that, but we cannot really import health care. So we have a basic problem because the things that force change in other American industries are not going to be the same things that force change in the health care industry.

Speaking from a business and economic perspective, in the short run, I know some businesses will be opposed to raising the sin taxes. I am okay with that. If you can figure out a gimmick to get more federal money back from Washington, I am okay with that. But I think it is a Band-Aid as opposed to a solution. I think that John is exactly right: that it will only be when the middle class is impacted when there are 25 percent uninsured, or maybe 30 percent. But at some point you say, “hey, this system cannot produce equitable efficient health care like it has.”

The interesting question is how many incremental changes do you go through before folks say, “you know what, we are the only industrialized country without a single payer of basic health care.” Some countries allow you to buy more, some do not, but we are the only country without a basic single-payer system. What is it we think we know that all the people in the rest the industrialized world do not know? We are not there yet. We are not going to be there in the next legislative session or the session after that.

I guess the thing you need to understand is now that the tools to do cost-effective managed care have in effect been taken away from the private sector, the next time somebody proposes a single-payer system, you will see the business community reject it. In the early 1990s not only did they not like Hillary Clinton, but you had managed care as an alternative, and in 1993, managed care took off and worked. But now if you tell business, well, no, I am sorry, you cannot do tightly managed care programs. You may get sued. So the next time Congress says okay, how would you like us to take you out of the health care insurance business, I think you are going to find a large number of businesses saying, “Look, as long as you let me supplement whatever the government buys for my key employees and people I am trying to recruit, go for it.” You provide the base; we will provide the second tier, which is the way the British seem to be going. So, I would not count on business being the salvation of the private health care system, and I say that to the doctors and the hospitals. I do not think they are necessarily going to stand in the way of going to a federal health care finance system. I appreciate the opportunity to visit with you.

**Anne Dunkelberg:** Well, I am not sure if you intended that to be an optimistic note but it sounded like one to me. If the message is that the ground is becoming more and more fertile for universal care in this country and perhaps moving away from the employer-

provided model as the best way to do it, maybe that is good news. I think one of the reasons that they asked me to sit up here was because I made the mistake on another panel on this same stage about a year ago alluding to the trade-off that advocates would have to consider—the concept that the HIFA waiver presents—about whether it is better for more people to get covered for fewer benefits, and whether that is something we are willing to advocate for. So I am going to force myself to first address that rather than the more global topic of how we get to universal access to health care in this country. I guess in terms of the assignment to talk about feasibility and barriers it is clear to me that an expansion similar to the one that we've heard laid out today that would cover parents up to 200 percent of poverty in the state and perhaps childless adults up to some lower income level would clearly be of significant benefit to those families. There is absolutely no doubt about that, and I am glad that we're in a room where there is not a whole lot of controversy over the evidence before us about the absolute cost of health insurance. The cost of health insurance is high that we know that only about 17 percent of Americans below poverty actually get health insurance through somebody's job, whether it is their own or a family member's. No matter how many things we fix about the marketplace, that population is not the one that is going to get the bang out of that. It is going to be higher-income folks who benefit from any market improvements. So I think we can insure the people below the poverty level, but the income is getting higher and higher at which people are still finding it difficult to access health insurance. So if we do not have a public solution or at least a public partnership in this solution for low-income people to access health insurance, it is simply not going to happen.

I do not feel like I can make some kind of definitive statement about what the acceptable trade-off is in terms of reduction of benefits. I think it was really clear from Leah Kegler's presentation that the actuarial work you would have to do to figure out what kind of benefit package you really could tease out is critical to how a lot of people would approach that. Obviously, there are a lot of ways you could do that analysis before you make a decision about the income levels you are going to cover that would give you some ability to make sure that you still have a fairly comprehensive package. But, I think one of the things that we know going in is that if it is going to be worthwhile, it is going to have to include a prescription drug benefit. We all are growing more and more aware of the fact that Medicare seems less and less valuable to people because of the fact that it does not include prescription drugs, which seem to be the biggest component of medical treatment these days. The one thing that people really need, they are not getting.

We had a discussion in the breakout session that I attended about the value that might come to us from a major expansion of Community Health Centers, federally qualified health centers. One of the observations that many folks in the room made was that one of the problems with that approach is that it provides a good base for the provision of primary care and preventive care, but so many people, when they are through that process, are diagnosed as having some kind of chronic condition or serious condition that requires specialty care, and there is nowhere to refer them. There is a terrible struggle to find providers outside the FQHC structure that are willing to take on those people's care and so it is an important contribution, but it's not the whole solution, we need more. I do not want to see us move in a direction where people will get to where they are in a good

position to have their conditions diagnosed, but then there is no treatment available for them.

I also think that some of the huge issues for all of us to work out are what kind of trade-off are we willing to accept in the area of freedom of choice—there is a whole set of issues that go along with that. They are really issues more for providers than perhaps they are immediately for the consumers, and I want to talk about those in just a second. As one individual advocate, I am willing to consider the possibility that I do not necessarily have to have access to every single physician in town—that might be an acceptable trade-off. But unfortunately, just as with the benefits, in doing that sensitivity analysis and figuring out what it would really mean, you do have to start slogging into that detailed level before you are willing to say “yes, I will buy into this, this is better than no access,” or not.

I think that both Mr. Guest and Mr. Luke raised the real important issue of “who is going to support this?” Obviously, it is a benefit to low-income people. If we are talking of 200 percent of poverty, it is important to remember that half the children in the state of Texas are at or below 200 percent of poverty, so it is not a minority of people. They may not be the most politically empowered and active segment of our population, but they compose a very significant number of people in our state. So, it is not like the affected population would not have any voice. I think the folks who are out there in the community working with families on CHIP almost immediately started hearing parents saying, “this is great, now, where can we get insurance for ourselves?” I myself have heard that from several people asking “where is the insurance for single mothers?” So I think there is a constituency there.

But the bottom line is whether this could be of considerable benefit to the county government structure in the state of Texas. I understand all of the incredible difficulties that Mr. Guest laid out: that the counties are not just dying to embark on this, but I do think that it could be crafted in a way that will take a lot of burden off of the counties and their current health care financing. I am not sure if that is enough to get us there in terms of the political will, which is perhaps the biggest component of feasibility. I think in practical terms we could arrive at a program that will be enormously beneficial to the local taxpayers across the board. But if our county governments, our hospital districts, and significant components of the provider community, are not behind it, it is certainly not going to happen. That constituency has to be there. I think one of the things that we hear loud and clear are the concerns among both the hospitals and the physicians about administrative hassles and the adequacy of reimbursement. While the discussion of the different taxing options may have been distasteful to a lot of people, I think that for a package like this to become real it must include financing that could create a guaranteed annual inflation factor for every aspect of Texas Medicaid reimbursement, which we currently do not have. We have a very uneven situation where some methodologies get increases, others do not, and those that have gotten increases are currently threatened with losing those. We are never going to have a viable program if rates are constantly frozen and slipping decades behind the private sector.

I understand what Senator Ellis was saying about how Medicaid and CHIP do not have to compete with the private sector, and I think that is true. I do not think that the inflation in Medicaid necessarily needs to be as good as what is expected in the private sector but neither can it be a severely money-losing proposition. There are a lot of inequities that come to the forefront when you are talking about regions of the state geographically, or of the provider community, where you are drawing most of your revenue from that program and you simply cannot afford to participate if the rates are not good enough.

I think the rate issues have to somehow be built into a viable proposition, and in that way we can begin to address the capacity issue that we were hearing about all over the state in response to CHIP—I think El Paso is the place where we heard the most complaints. Clearly, if you have a state where one out of four people have been uninsured for a long time, and if you are going to flip a switch overnight and give them all insurance, unless there has been a lot of doctors and clinics and hospitals sitting around with nothing to do, we are going to have a capacity problem and we do have to deal with that. I do not know what the solution is other than if you fund it, the capacity will slowly grow. In terms of a quick fix that you would lay alongside an eligibility expansion to somehow ease the capacity issues at start-up, I do not know what that is. I think it is something that we need to have a lot more discussion about.

To move from these more specific responses from the point of view of somebody who is supposed to be advocating for low-income people, when we were first looking at a more aggressive roll-out of Medicaid managed care, a lot of us were drawn to the process that Oregon went through because of the articulation of principles that were laid out first before they started counting the dollars and making the decisions. Part of the problem that cripples us here—not just here in this room, but in Texas—is the fact that we avoid having that discussion of what is the principle that is driving our decision. Mark Gibson laid out that Oregon had made the decision that it was better for everyone to have a basic level of care than to have a really good level of care for something less than the substantial majority of the people, and I am not sure we are there yet in Texas. I am not sure that every one necessarily agrees to that, and I think we have to accommodate the fact that we have influential people in the discussion in Texas who in fact not only do not agree with that but they actually believe that it is better for significant numbers of people to go on uninsured than it is for significant investments to be made in public programs to provide health care. They are going to be part of any discussion, so it is a significant issue to deal with. And finally to wrap up my comments, I think all of us have to go through a private experiment with ourselves of “walking the walk” and saying “if I want universal health care or even just an expansion of Medicaid in Texas to cover folks up to 200 percent of poverty, how do I think that should be paid for?” I think that question is probably enough for a whole day of discussion right there, and I think it is a good exercise for us all to embark on.

**David Warner:** We would like to hear now from Representatives Maxey and Greenberg if they have any questions or comments for the panel.

**Glen Maxey:** Thank you. I have a comment that is a little bit off the topic, but I think it is one of the more instructive comments of the day. I am retiring from the Texas Legislature in December 2002. I believe that while we have talked today and we see how complex this issue is, it doesn't seem to have any consensus about where we go with it, what we do with it, and in this room are some of the best minds on this issue. You have to think who is going to make the final decisions about what we do on this, and it is my colleagues in the pink building down the street, and I will say this since I am leaving the legislature: the majority of them are about as dumb as dirt on this topic. There is not a lot of institutional will to deal with health and human services in the legislature, and we are about to go into probably a little more unsettling political situation than has been there since after the Sharpstown scandal back in the '70s, as far as how the legislature and policy makers are going to be very unsure.

If anybody in this room right now could raise their hands and tell me who is going to be the leaders on this issue in the next legislative session, I want to talk to you. Keep in mind, we may have a new governor or we have a governor who sort of stumbled on some of these topics in his first term. The governor's office is the bully pulpit. We do not know what is there. We will definitely have a new lieutenant governor. Even though there is not going to be a great shift in membership in the senate, we are losing some strong members like Mike Moncrief who was a great advocate on health and human services. But even though there is not a big turnover in the senate, you are going to have new shuffling of committees, definitely different people in different committee roles. We have no clue who those are going to be or what those committees are going to look like. Then we move to the house, where we may or may not have a different speaker. We probably will have a different party majority. With that probably comes a rewriting of the rules of procedure in the house and/or the senate, it could change how we do business. There are at least 12 committee chairs who are retiring, a huge amount of institutional memory. When those 12 committee chairs move, that means even if we have Pete Laney as speaker and he puts back every other committee chair, people off appropriations will move to committee chairmanships, and we'll lose knowledge on appropriations. It is going to be a nightmare.

If I was telling somebody today to pick a house sponsor on a bill, I would say wait until the second week of the session because you do not know who is going to be on what committee or who is going to be the pressure points. So I guess my point here today is that as much as we want to come together and try to find what the solution is to talk to public policymakers, in this legislative session, we are going to have very short time to get people up to speed. We just went through a primary election, and the most depth I heard in a candidate in primaries at the state level or for state representative or state senator say about health care is, "I am for affordable health care." That is the depth we have gotten to in this public policy debate. I doubt that we will get much deeper than that in November, so the people who are coming here are not coming here with an agenda to reform the health care system in Texas, and I leave you with that.

**Sherri Greenberg:** Well, this is an issue that I dealt with for many years as an undergraduate student here at UT Austin. Also, when I went to graduate school at the

London School of Economics, I was the recipient of the British health care system. Finally, when I worked at the Texas Research League, we did a study of what in those days was called “de-institutionalization,” bringing people from the hospitals and schools for the mentally ill and retarded to community care. We visited all of the state facilities and I was assigned to speak with the directors, walk the wards, and look at the continuum of care. I came up with this idea that the funds needed to follow the clients. Wow! Now, there is a brilliant idea. However, this was a report we were doing for the Texas Legislature. What I learned after we submitted our report is, it is all fine and well to say that the funds need to follow the clients, but there were legislators who represented rural areas whose constituents depended on these institutions to help them with their livelihoods. Change is possible but it does not happen overnight.

While I was in the Texas Legislature, this discussion was still ongoing. How do we fund this continuum of care and move some people to the community? Much to my disbelief, it actually happened. Some schools for the mentally retarded, including one right here in Austin, Travis State School, were closed. So, what did I learn from this? Well, I learned that change is possible but it takes time. I have learned that you have to have the political will. And yes, it does have to hit the middle class. Various people used to ask me, “what will it take to change our system of taxation?” I would tell them, “when an angry mob of citizens storms the capital.” This is really what you are talking about when you allude to the middle class, but do I perceive that we are seeing change? When I first started in the legislature, I was discussing “how do we fund affordable childcare?” and I was not getting very far. Then what happened—welfare reform. You would not believe the allies that I suddenly had in this particular area. Change is occurring and I was able to get funding and legislation.

**David Warner:** Now let’s open it up for questions. Does anyone else have questions or comments for the panel?

**Stuart Greenfield:** The two medical speakers had a real interesting point. As an economist by training, I’ve noticed that everybody has been focusing on demand. If you increase demand, what do you do to price? You are going to increase it and I think the point is how do you increase the supply? It would seem to me as an economist that if you increase supply, I do not think that will force down pricing and so basically all this is going to do is increase prices for everyone. Are there government programs to increase the capacity?

**John Guest:** I do not think health care follows the normal economic model of increased supply at increased price, and that is unfortunate and that is part of the challenge we are facing. On the capacity problem, I would tell you things that you already know, but I would underscore that we have a nursing shortage that is huge and is probably very long term. That problem is going to take a long, long time to solve. There may be some opportunity in the nation’s focus on homeland security as it relates to health care capacity. It is clear that if we were to have a major disaster in any of our communities, in Texas or elsewhere, there would not be adequate health care capacity to respond to that disaster, so because that is sort of the hot topic of the day, there is some possibility that

federal funds might find their way down to local communities to help assist with expanding hospital capability or emergency room capacity or first responder capability and those kinds of things, so there may be some opportunity in that arena.

**David Warner:** I suspect that at least half of the care that would be demanded is being delivered now on a free basis mostly at the hospital districts, community hospitals, and to a limited extent, by community physicians. If they got paid for it instead, and theoretically, you could reduce taxes a little bit, at least at the county and hospital district level. In principle, it is not all just moving demand, especially if you have something of a managed care aspect to it.

**Ronald Luke:** Just one other thing to add to that: if you go to a leaner benefit package as you cover more people, it's like a length times width equation and so you are not necessarily talking about a proportionate increase in demand.

**Ron Cookston:** My comment would be that I hope that as folks are looking at this from a policy standpoint, particularly recognizing the difficult political situation we may have in the next session, that they think of looking at some alternatives that may allow for some regional pilots to take place. For example, with the waiver for women's health, the potential there is so significant if we were allowed to do some local pilots in Houston, and Harris County—it does have something to do with the ability to come together in a geographic area. I talk to Jim Walton in Dallas all the time, but boy, I would hate to have to come to the same conclusions for Harris County or for Dallas County, but let me work in Harris County. I believe I can give you some things that we could move forward on, so I would hope that as you are looking at this, you seriously consider letting us look at some regional alternatives.

**David Warner:** I want to say one thing about your point about the next stage. This conference was organized by a class. This class is over on May 1st. We've done the research we can, and we are going to lay it out. The proceedings and papers are going to be on the website, and we will also have hard copies in time, but our goal was to try to lay out some choices for people and policymakers who are interested. We are not trying to shove anything down anybody's throat, and we expect you in the audience to carry the torch if you find it a torch worth carrying.

Our view is that this is a way to possibly generate maybe another billion dollars, maybe cover everybody under 200 percent of poverty with a limited package, maybe have some buy-in to private health insurance, maybe lead to some investment in Texas and in rural areas and in the city. We are not allowed to lobby—we are an educational institution and we have done our best. But now it is up to you in the audience, and I strongly say that.

One other issue I do want to mention is that the Bush administration is saying okay, you can apply for a HIFA waiver online for the whole state. I have not heard them say you can have a different Medicaid system in give different parts of the state, and I think what I would like to strongly stress is to make sure that you have it greased in Washington before this is the only thing we do at the legislative level. I think you can tear apart a proposal that could be statewide by getting into a balkanized situation and even getting it

through the legislature and getting the governor to bless it, but it still has to be blessed by HHS and by OMB, where the HIFA waivers are just rolling right through right now.

**Jim Walton:** My comment was that with all due respect, that we actually make these recommendations to your class, because we can end up as a footnote on the recommendations.

The proceedings are a footnote that actually could have some influence on a piece of academic work that has been done and could really make a statement. And to that end I think, underscoring Ron's and others comments, that autonomy is a cherished resource in our state and in certain professions may be more significant than others. Certainly in mine it is, and also for patients and individuals, and so I would like it to be noted that what we are speaking about when we regionalize this is that we could actually make some recommendations at a federal level, and coming together and massaging these ideas would give us the opportunity to actually create a context for the next discussion, which is I think where Anne was taking us, so regional autonomy is a powerful motivator to bring people who are disenfranchised from this particular solution to the table for the next meeting. I would encourage us to take your body of work and applaud it, and not let it sit on a shelf somewhere, but move forward. I am reticent to send it to Washington as an application pretty soon, because I think it has some issues that we've got to deal with, so I don't mean to send it to Washington too quickly.

**David Warner:** What we will promise is we will make public the proceedings. They will be on the website for at least through the next legislative session, but then it's up to all of you and everybody else to move forward. A few people in the class may continue working on it on an individual basis. But as a group, I think, even the laws of the state of Texas say we are not allowed to get involved in lobbying.

**Lisa McGiffert:** I have been here most of the afternoon, and I want to say one thing. Broad pooling of risks is very important and that broad financing in my opinion is very important to create a fair system. If, for example, you went to some kind of regional approach and tried to collect the financing on a regional basis, it does not take much to figure out which regions would come out ahead and which ones would not in Texas. So I hope that as we go forward and think about financing, we think about how we can build on the big pools we have now and how we can move away from fragmentation by not carving out people by population, by location, by body part, by sex, by whatever, and figuring out how to fix one little problem and creating more and more of a fragmented system. So, I hope that we all can go forward thinking of it more as a big picture.

**Camille Miller:** When Anne said a while ago that she and I worked on this in 1992, I sat down and thought when was the first time in my career like some of these other folks have talked about study-sharing and so forth and I was shocked. I have been working on this for 32 years, and I am more excited today than I have ever been in those entire 32 years, and there were some pretty exciting years in there, Chet. We did some great stuff, with Senator Bentsen,

**Chet Brooks:** We actually won something.

**Camille Miller:** Absolutely, and it was fun. But what I see happening is, to quote Churchill, “Americans will finally do the right thing after they have tried everything else.” And by golly, we just about have, but we have not done the right things yet, right? So that has got to be next, but I am excited because unlike our president, I am very excited about our boomer generation. I was at the University of Texas when we were out raising hell, but I came from a small town, so I was not as brave as some of the big-town people to get out there and actually stick flowers in the guns. I was a little bit more afraid that the guns might go off, but I was out there marching and I was listening and I was trying to study and understand, and then I saw my most radical friends go join the Air Force and now they are retiring. And they are going back to where they were with those values and that is really exciting because the boomers were the people that brought you McDonald’s and lots of other fast things, we are not going to tolerate these 8 to 5 hours by physicians and hospitals and everybody else.

A revolution is coming folks, and we are going to be there. I am so excited, I am at an institute trying to get ready for that revolution because we have to have data and we have to have it at the local level. We have to make good, informed decisions. Community collaborations, Jim Walton, Ron Cookston; I was not in Ron’s session, but I bet you Ron wasn’t real quiet in that session. These local community folks get it, and they see the interconnections and they are putting it together and they are excited and that is fabulous, and then the institute is trying to help keep the big picture, Anne, always the big picture out there and bringing it down to apply to the stuff is coming up from the local level. This is really, really fun, and it is going to happen. It is going to be the best we have ever had. It is going to be different in different parts of the state and nation and so forth, but Texas is going to be a leader in this.

We need leaders with courage; as Glen said, legislators do not like to get into this. It is a lose-lose situation and it is too damn complicated. It’s too hard to understand. You have to be there 26 years like Chet Brooks to understand it and know what to do with it. We do not have people who will make that kind of commitment. You need out-of-the-box thinking, and David and these students have made a great contribution to get us all thinking about some things. We need to remember our past and not repeat those mistakes. We need to use the experience that is available. This state is full of experience, including the local level, and we need to embrace that new generation to help them be the leaders to get out there and carry this forward. I am really excited, because this is going to happen, and we have a chance to be a part of it.

**Chet Brooks:** That is very good.

**David Warner:** Is there is anyone else who wants to say something in closing? Please fill out your feedback forms, and thank you very much for coming.