

Chapter 1. Opening Discussions

KENNETH APFEL: Welcome everyone, and good morning. My name is Kenneth Apfel—I'm a faculty member at the Lyndon B. Johnson School of Public Affairs and one of the co-directors of this project, along with David Warner. My task this morning is to introduce Dean Edwin Dorn and ask him to welcome you to the LBJ School of Public Affairs.

Edwin Dorn, the dean of the LBJ School and a native Texan, was born in Crockett, Texas, and spent many of his early years east of here on a little farm in Hempstead, Texas. He attended the University of Texas and graduated Phi Beta Kappa in government. He was a second lieutenant in the army, completed his Ph.D. at Yale in political science, and spent many years in Washington, D.C., in a number of remarkable positions. He was a senior official at the Joint Center for Political Studies and at the Brookings Institution, and more recently served as the assistant secretary and then undersecretary for personnel and readiness at the Department of Defense.

Ed Dorn has been dean of the LBJ School for the past three and a half years. He's spent a lifetime developing policy and developing people. And now, at the LBJ School, he's helping to develop people to contribute to the public arena. Please join me in welcoming Edwin Dorn.

EDWIN DORN: Thank you very much, Ken. That's a very flattering introduction, especially coming from a former cabinet level official and former commissioner of social security. Ken and I, and Dean Clancy, who's also spent a lot of time in Washington, know what was omitted from that introduction. The most important thing you can say of anybody who spent twenty or so years in Washington, as Ken and I have, is that we left Washington unindicted. [Laughter] Well, I'm still counting the days until the statute of limitations runs out. [Laughter]

It's a real pleasure to welcome you and to thank you for coming to this conference on expanding health care options for the uninsured in Texas. Let me offer sort of the good news and bad news perspective. The bad news, of course, is contained in a splendid background paper that a couple of Ken Apfel's and David Warner's students, Sarah Lovering and Jeff Hamilton, wrote. Even on the first page, the evidence of the problem of the uninsured is compelling. About one in every seven Americans lacks health insurance; in Texas, it's about one in four. That's a serious problem. It's a serious problem in terms of the aggregate numbers, it's serious in terms of the cost of fixing the problem and expanding coverage.

It's a big deal in terms of the ways in which various institutions—public, private, and nonprofit—need to reorganize themselves to expand care. But it's an especially big deal in terms of the amount of human suffering and insecurity that we can avert if we can expand that coverage. That's the bad news: we've got a problem. The good news is that

we are no longer arguing about *whether* to deal with that issue, but rather *how*. That is a major change in our social values, and it is of relatively recent vintage. We can trace much of that change to the advent of Medicare and later Medicaid, and thus it's especially fitting that a conference about *how* to solve these large, remaining problems occurs at the LBJ School. President Johnson changed the nation's health care programs and more importantly, helped change our view, our social values, with regard to the delivery of health.

I'm grateful that all of you are here today, and grateful that Ken and David and their students organized this conference. I especially want to thank the many people you'll hear from today: Dean Clancy, whom I mentioned earlier, Representative Garnet Coleman of Houston, Dee Briones of El Paso, and, representing the private sector perspective, James Rohack of the Texas Medical Association, who also is affiliated with Scott and White. You'll hear from people from the private and nonprofit sectors, people who have been assessing these issues for a long time. It's going to take a rich mix of public and private and nonprofit expertise and resources to solve this problem.

We are at a point in the political life of this country where we can argue about *how* the resources of those three important sectors of American life can be combined to solve this and other significant social problems. We can argue about what the empirical evidence shows, argue from the facts, not from our ideological predispositions or our political biases. That, I think, is a healthy position to be in, even as we confront this extraordinarily serious problem.

So thanks very much for being here. This is going to be a very constructive, informative conference. Out of it will come some ideas that will point us in the right direction.

DAVID WARNER: I'm Dave Warner, co-director of this project along with Ken Apfel. Mark McClellan and Chris Britton had both planned to be here until yesterday, when a change of schedule in the White House prevented Mark from making it and illness prevented Chris from joining us. Both of them told me yesterday that one of the main things they would have said is that both President Bush and Governor Perry are committed to figuring out some way to reduce the number of uninsured in Texas, and that they felt that Tommy Thompson, the Secretary of Health and Human Services, would work with the state to try some innovative measures, but at the same time, solutions would have to be developed with all of the stakeholders, including those who would pay.

I want to say one other thing at the beginning, and that is that when I read the Blue Ribbon Task Force Report for the first time, I saw a consensus that the legislature no longer has a philosophical problem with extending Medicaid coverage for adults up to the poverty level, as long as very little additional general revenue is required. Now, as we all know, an extra \$800 million will be required this year in the state budget to just keep the status quo going. There are a number of ways that you could do it. In fact, I could come up with 15 or 20 ideas right now, but they would all require, in one form or another, changing who pays—in other words, local taxes, a provider tax, or copays. In conjunction with the financing arrangements you could increase reimbursement rates or

coverage rates so most of those who contribute can come out ahead since each extra dollar raised in principle can draw down an extra \$1.50 from the federal government.

The other issue we discovered in this policy research project was the need to find initiatives to help the private insurance market work better for people above the poverty level. And that is the second theme we will be addressing today. The five breakout sessions are related to one or both of these themes. Two of them will examine options for simplification and expansion of Medicaid and SCHIP. One looks at options for the high-risk pool, which may seem like a very arcane topic, but actually, that enrollment is growing, and if we're going to depend more on individual health insurance, either through tax credits or enhanced deductibility, the high-risk pool will become very important. The fourth session, on small group insurance—how it's regulated and methods to try to expand coverage—is also going to be significant. Finally, since nearly half of those who are uninsured in Texas are Hispanic, a breakout group will look at some of the reasons why Hispanics are so disproportionately uninsured and discuss approaches to increase coverage. The students in the policy research project have prepared background papers for each of the breakout sessions and these will be provided to you.

For our first speaker today, we're very lucky to have Dean Clancy. Ken Apfel called around Washington last fall to find out the best person to give a general idea of what was likely to happen in this Congress, and Dean Clancy's name came up. Dean Clancy lived in his youth in Hawaii and Bell County, Texas, then in El Paso, and then he went to high school in Colorado. He's a graduate of the Georgetown Foreign Service School. He has a masters degree in journalism from Columbia. He started out in the mail room in the Reagan White House, and then became a speech writer for Dan Quayle, and also for Jack Kemp. Since 1993, he's been a health adviser for Dick Arney, who's been majority leader since 1995. Dean is intimately involved in a lot of the initiatives that are being developed, and can give us a good view of what's likely to make it through Congress and through the White House.

DEAN CLANCY: Thank you very much. This is far too formal a setting for me. I feel like I'm in "Dr. Strangelove," pointing to the big map of Russia. [Laughter]

This is quite an honor and a pleasure for me, and I want to thank Kenneth Apfel and David Warner and Nicole Sherbert and all the good students and faculty who have helped put this on. I met some new friends last night and saw some old ones this morning, so this is really neat for me. I'm also happy that I'm the only person giving the Washington perspective. It means that I can speak without fear of being contradicted. [Laughter] I'm not sure that I'm necessarily the best source, but I'll give it a try.

I think that this conference is well-framed. Focusing on the uninsured in Texas is a good way to go. It's very practical, because, as I realized when talking with Ken last night, the uninsured problem is really not one problem, but many different ones, many local problems. The problem of the uninsured in Vermont is not the same as the problem in the south part of Texas, so it needs to be solved at the local level. We who work on the

national level can only add so much, but of course we have a role, too, and that's why I'm happy to be here.

I also think 2001 is a very promising year for legislation in this area because we have a slowly congealing consensus around what to do about the uninsured at the national level: measures to take, not necessarily total solutions. And 2001 is an odd-numbered year. We're just past an election, so some of the fevers and heats of election time have abated for a while, so we can get something done.

I will be so bold as to predict that we will legislate on the topic of the uninsured in this session of Congress. I want to talk very briefly about what we may do, and then take your questions.

The first piece of legislation I predict that we will sign into law in this session is the patients' bill of rights. The five-year-long stalemate likely will come to an end because the two sides have slugged it out to exhaustion, and because we have elected a new president who has said he will veto a bill that contains an unlimited right to sue an employer health plan, and because there is not a two-thirds majority in either house of Congress for that idea, so it is effectively off the table for the next two years. I think both sides are ready for a compromise that will enable us to move forward. The right to sue, which as you know is the stickiest issue in the whole legislation, will probably have some constraints on it: requiring people to use external review except where it would be futile to do so, and probably imposing some kind of damage caps on awards received in the course of litigation. Then there are the federalism questions that must be sorted out. Is it state court, or federal court, or both? Do we have a federal regime of regulation, or a state regime of regulation, or some combination? Where do you draw the line? I won't try to predict where we're going to draw that line, it's so complicated. Sometimes, when I listen to people discuss it, I'm reminded of Lady Macbeth. I just feel like standing up and screaming, "Out, damned ERISA, out!" [Laughter] But, this is what you've got to deal with.

Whatever we do on the patients' bill of rights, I think it's safe to say it will probably have the effect of driving up premiums. Who knows by how much? That's a contested question. But I think it will, and I think that means more uninsured people. As part of that legislation, therefore, the House certainly will try to attach measures designed to reduce the number of uninsured.

The first of these measures, which is supported mostly by Republicans and a few Democrats, is legislation to improve the Medical Savings Accounts program, the one we created four years ago, and which has only attracted a small number of participants. We'd like to change it to make it permanent, more workable, and more available. Permanent so that insurance companies will be willing to offer MSAs. Workable so that MSAs will be more attractive to consumers. And more available because we think it will help the uninsured. One of the interesting things we've learned from the MSA program to date is that at least a third of those buying MSAs have been people who had no health insurance for at least six months previous. So the uninsured (at least a certain segment of

them) are attracted to it, and while MSAs are not a panacea and not the only solution, we think they should be part of the solution.

Another area we're going to address is tax equity for the uninsured. This will be either in the form of deductions or of credits for the purchase of health insurance. There are a lot of questions we need to answer. The first question is: deductions, credits, or both? On the Republican side of the aisle, we have a consensus in favor of deductions. In fact, in the last Congress we passed a package of access provisions that included \$50 billion over 10 years' worth of deductions for the uninsured. You have to pay at least half of the premiums yourself to be eligible for it, and you can use it whether you're buying employer-provided coverage or coverage outside the workplace. That provision did not become law, however; it got caught up in the patients' bill of rights logjam. People like my boss, Dick Armey, come down on the left side of that debate. We're for refundable tax credits. Some of our Republican colleagues say that's not very good tax policy, and our response is, "well, perhaps not, but it's pretty good health policy, given where we are at the moment," and it's worth doing. Unlike the employer exclusion, the tax credits are progressive. They also have a lot of bang for the buck, we think, particularly if you do a fixed-dollar-amount credit.

That's the next question we'd have to answer if we do credits: is it a fixed-dollar-amount credit or is it a percentage credit? My boss favors the fixed-dollar amount, because for some people, they'll be able to get 100 percent of the premium covered; not everybody, but at least some. How generous should the credit be? Should it cover 100 percent of the premium, half, a third? There are arguments about that. My own view is that if you cover at least 30-40 percent of the premium cost you will induce a lot of people to use the credit, although not everyone. You won't necessarily buy the richest policy, but it's a start. Should the credit be useable for workplace coverage, or should it be just for people who don't have access to workplace coverage? My boss's view would be that, consistent with budgetary constraints, we ought to allow people to use it in the workplace. Should it be means-tested, or should it be a universal entitlement? Here again, Dick Armey is a leftist; he's for a universal entitlement in this area.

Jim Jeffords has introduced a tax-credit bill in the Senate. Dick Armey is going to introduce one, probably next week. The Jeffords bill is cosponsored by Senators Breaux and Frist. Their credit would be \$1,000 for an individual and \$2,500 for a family. There would be a second credit alongside it that would be half that size, that you could use inside the workplace, and the larger credit outside the workplace. It would be means tested. The Armey credit, by contrast (we call it Fair Care), would be \$1,000 for an individual, \$3,000 for a family. It would not be means tested, and you could use it only if your employer did not offer coverage. To deal with the problem of employers possibly ceasing to offer coverage, we would ask employers to continue to offer coverage for five years after enactment, and if they dropped their coverage before then, they would pay a tax penalty for doing so. We also would require the states to set up risk pools, and these would be funded by assessments on the insurers, which they could pass along to all insureds through premiums. In these ways, we would try to deal with the employer dumping and making sure the higher-risk folks get covered. Our main cosponsor on this

bill is Bill Lipinsky, and we've just learned that we have Harold Ford, Jr., as a cosponsor as well. They are both Democrats, so we're pretty excited about this. But, as I said before, there's not a consensus on the Republican side in favor of this. Republicans tend to prefer deductions, so we're going to work on that.

Finally, the last thing I'll say before we go to questions and answers is that we do expect, and are more than happy to look at, expansions of Medicaid and SCHIP. And let me stop here for a moment to inform you all that it is a violation of federal law to call it merely "CHIP." [Laughter] Believe it or not, there is actually a provision of law that says that federal and state officers must always refer to it as "SCHIP," to keep the states in there. Anyway, some people want to expand these programs, either the eligible population or the amount of funding available, or want to give greater flexibility. The Jeffords tax credit bill includes provisions designed to improve and streamline Medicaid and SCHIP enrollment and outreach. Jocelyn from the Center of Budget and Policy Priorities, I believe you may have helped draft some of those provisions.

That brings me to the end of my prepared remarks. I just want to thank you again for having me here, and I'm excited to learn from you, and I am now ready for you to let me have it. [Laughter]

JAMES ROHACK: The tax incentives and credits: you seem to be moving toward the IRS to be the enforcer for health policy for the nation. The question comes up, for those in places like Texas—we have a large border area—where we have people coming across our borders who may not be employed, whom physicians are obligated to care for, whom hospitals under EMTALA (The Emergency Medical Treatment and Active Labor Act) are obligated to care for. Is there any discussion of allowing hospitals and physicians to have tax credits for caring for those who are not insured, since you are not mandating that everybody be insured?

DEAN CLANCY: That's a good question, and you put your finger on a serious issue. Kenneth Apfel last night was pointing out that in some parts of Texas, some people don't see the benefits of paying monthly premiums for insurance, because there are so few doctors or hospitals available. There are free health clinics, perhaps, or emergency rooms, where the free care that's delivered there is ultimately underwritten by state and federal taxpayers. And of course many of these Texans have few assets to protect, and are healthy and don't see any value from being insured. So yes, a tax credit policy is not a panacea—it won't reach everybody and it won't help everybody in their situation. I started out by saying, as you recall, the problem of the uninsured is many different problems, each of which has its own unique, local flavor. But we think that's part of the solution. As for the folks you're talking about, I think the important thing is to make sure that hospitals and doctors get compensation for having provided free care to the indigent, and we have a number of federal programs now that are designed to provide those kinds of subsidies. Whether they are adequate or properly structured is another question.

PABLO SCHNEIDER: A couple of things. One is on the border issue—of 174 million counted border crossings, we estimate there are more than 7 million crossings for health services, and that the proportion of north-south versus south-north is 5-1.

American residents are invading the Mexico side of the border region to purchase health services. So that's a little different. And then the other thing is I've seen studies on uncompensated care on the border that show that 85 to 90 percent are U.S. citizens. So the concept of people coming across the border, unemployed, and getting care, yes, it happens, there's anecdotal evidence and you can point to cases of it, but if you start looking at what's happening in the border region dynamic, there's a lot more to it than just that.

I'm really interested in hearing more about medical savings accounts, and what you view as the difference between a medical savings account and doing something like extending Section 125 tax deductibility of premiums paid by employees, that is, premiums with pretax dollars. What's the difference between going through the logistical exercise of expanding MSAs versus just doing some kind of an edict that says that any premiums are pretax, and you don't have to be a large enough employer to implement a Section 125 program to pay your premiums with pretax dollars?

DEAN CLANCY: Are you saying, for people who buy on the individual market, their premiums would be pretax somehow?

PABLO SCHNEIDER: Yes.

DEAN CLANCY: How would you structure that? I mean, when they file their taxes, they would—

PABLO SCHNEIDER: Well, it's a good question. I mean, you're the experts. I'm asking you.

DEAN CLANCY: No, no, no! [Laughter] Don't leave it up to me!

PABLO SCHNEIDER: If you could just expand a little bit on MSAs, just talk a little bit about what you're thinking about MSAs. The idea occurred to me that basically a Section 125 program, as you know, allows companies that implement it to have their employees set aside pretax dollars to pay their health premiums.

DEAN CLANCY: Sure, right.

PABLO SCHNEIDER: Most of the time, the small companies don't implement that Section 125. So it's really a two-part question. One is MSAs, and the other is what do you think about figuring out a way essentially to extend the Section 125 type of a situation to all premiums, whether individual, small group, and so forth?

DEAN CLANCY: Well, I'm about to answer, but it looks like David Pinkus has the answer.

DAVID PINKUS: I don't have the answer, but I just want to point out that the difference between a straight tax deduction, which you've already talked about, and a 125 plan is when an employee participates in a 125 plan, not only is it pre-income tax dollars,

it's also pre-FICA tax dollars. So if the employee is paying with the deduction he's already paid the FICA which is a total of about 15 percent. So that's really much more of a subsidy without it really being a subsidy.

DEAN CLANCY: I'll try to be brief. I would say that from our perspective, the goal in tax health policy ought to be level playing fields wherever possible so that people have a chance to get health coverage in whatever way is best for them: workplace, outside the workplace, group market, individual market, etc. So consistent with workability, your idea sounds okay to me.

As for medical savings accounts, the idea behind them has been to encourage people to get economically affordable insurance, high-deductible insurance, but also give them a chance to cover first-dollar expenses with the subsidy for the account. It also has the benefit of encouraging people to think of their insurance as their own, and to think about the price of things before they make purchases. It's not for everybody, as I said, but we think it's a good idea worth trying. We feel that it really hasn't been tried.

CONNIE BERRY: I'm from the Texas Department of Health, Community Health Provider Resources. One observation I made was that when the Legislature was addressing Medicaid issues in an editorial in the *Austin American-Statesman*, they talked about federal dollars almost as if they were manna from heaven, without the realization or recognition of where those dollars come from, and the process by which those dollars shrink from the time they come out of our income taxes until the time that they actually pay for one dollar of health care service. One of my concerns is how we can address that, or turn around the perception that this money is free, and also reduce the shrinkage from the time that it disappears to the time that it actually purchases health care services.

DEAN CLANCY: I don't know how to answer your question. I've never thought of it before, but I think you're on to something there. Let me ask you, do you have an idea yourself of what you would do to reduce that shrinkage?

CONNIE BERRY: I think those dollars staying in the community rather than going into the income tax process and into the federal budget and through many hands, and then coming back to the states, passing through many hands, would really increase the value of that dollar.

DEAN CLANCY: Right. Well, if what you're saying is tax cuts, amen. [Laughter] You know, our idea is that it doesn't make sense to fly the dollars to Washington and then fly them back with some of them gone. Republicans generally think it would be better just to leave them in the community, and then if the state wants to set taxes to fund programs they can do that, and then these taxes, as you say, stay within the borders of the state. And of course we're working on the tax cut issue. And to the extent that leaves more money in individuals' pockets, that's more money that can be used for health insurance and health services.

CONNIE BERRY: Or perhaps those dollars could come directly back from the treasury to the states for health care programs.

DEAN CLANCY: Is the money being sifted through somebody else? Isn't it coming directly from Washington to the states?

CONNIE BERRY: Well, after it goes through HHS and HCFA and all of the programs. Each of these agencies requires administrative costs for handling the dollars as they pass through the agency.

DEAN CLANCY: Well, sure. That's right, if you're going to administer, you've got to pay for administration.

CONNIE BERRY: Right, and maybe direct-lining that rather than taking out the administrative costs at each different level would increase the value of those dollars.

DEAN CLANCY: Sounds like the principle of block grants is what you're describing.

CONNIE BERRY: Right.

DEAN CLANCY: Yes. We're strongly for that, too. Thank you.

GAIL BELLAMY: I work for Scott and White in Bell County. The question that I have has to do with the MSAs and whichever tax Congressman Arney supports, and the problems of the chronically ill and those who are low-income employees of small employers. A high deductible plan certainly doesn't benefit either of these two populations. They have more need for health care than the healthy population. MSAs almost suffer from the same criticism as health maintenance organizations. It kind of cherry-picks those who are healthy. Its greatest benefit, from a business standpoint, is for those who are healthy, not for those who have health problems. How do you address those concerns, or do those fall back to the risk pools, or does that fall back to some other kind of subsidy or support?

DEAN CLANCY: In the case of our fair care tax credit, we try to deal with that with the risk pools. We want to make sure that those who are uninsurable, in a sense, or those who have risks that are just too expensive to ensure affordably, get a subsidy, get charity, if you will, get help, so that they can buy into the ordinary insurance market with that help. So that's the point of risk pools.

There are other ideas floating around in Washington which I haven't mentioned yet, so I'll do so briefly, such as the association health plans idea, which NFIB and small businesses are really in favor of, allowing a bona fide membership association to offer health plans to their members, some of which would be free of state benefit mandates that would make them cheaper for people. This idea is controversial with the state insurance regulators, and with the insurers, particularly the Blue Cross/Blue Shield plans. That's the main idea that comes to mind at the moment. But yes, you're right, you have to deal with the question of the chronically ill in health policy.

BILL JONES: I'm president of Materials Transportation Company, a manufacturer with about 180 employees in Temple, Texas, so I'm coming at this from an employer's perspective, but as someone who's been working on health care for several years.

The tax credit proposals seem to address those who are employed or seemingly paying taxes.

DEAN CLANCY: No—these would be fully refundable tax credits. You could owe nothing in federal income tax and still get the benefit.

BILL JONES: That was the first part of my question. You get the credit regardless of whether you're in a tax-paying position. All right, the second part addresses those uninsured who are unemployed. I guess they're covered by Medicaid and SCHIP, but are those insurance programs, or are they just paid-for healthcare proposals; on that point, why could those dollars not be used for purchasing insurance for all and almost have a universal health insurance program? When there's more money going into the insurance pool, it puts more people into that insurance pool to spread that risk, and then you don't have such an adverse selection process with the uninsureds who are high utilizers of health care. There will still be some type of care provided by hospitals, but there's an insurance policy for them that's basically an umbrella that, when it gets to a certain point, would reimburse those hospitals.

DEAN CLANCY: Well, I'm not sure what to think about it. My guess is you wouldn't get the votes for it, even if it were a sound idea. I mean, there are a lot of ideas out there. I'll just mention one of the most radical. Bill Thomas, the chairman of the Ways and Means Committee, has proposed getting rid of the employer exclusion, Medicare, Medicaid—remember, I'm just the messenger here, I'm not advocating—and using all of this money to fund a universal system of credits and vouchers for people to get health insurance. He would advocate that the insurance be community rated, and guaranteed issue, and he would also require everybody in the country to participate. That's a big, bold idea, but it doesn't have the votes, and he knows that. But I would say that with any idea in Washington, you move forward most easily when you don't create any losers. If you can find a policy that only creates winners, then you're more likely to move forward. I'm afraid that with what you described, some people might feel that it was creating losers.

BILL JONES: Who's the loser? And how does it create them?

DEAN CLANCY: Well, you talked about getting rid of Medicaid, is that right? Did I misunderstand you?

BILL JONES: No, I didn't say get rid of Medicaid. It's just something for the provider, so that if they're still providing health care for indigents, there's a way to have a cap on the amount that they provide, and then through a universal service program, there's a way for them to get some kind of reimbursement from a universal health insurance pool.

DEAN CLANCY: Hmm. I guess I'm either not understanding it. Show of hands, is that a good idea? No, just kidding. [Laughter]

BILL JONES: A universal insurance concept.

DEAN CLANCY: In other words, using federal resources rather than government programs to help more people into the insurance market.

BILL JONES: Another whole perspective that I come from is more personal responsibility on the insurance side, that people care and take responsibility to get health insurance, to take responsibility for their wellness care. I think that's a whole issue on the uninsured side and that's an issue that I don't see addressed in any of the papers. So it's still a continuation of welfare, even if it's a tax credit. It's still welfare, and it's not driving the responsibility for individuals to take responsibility for their health care.

STEPHANIE TABONE: I'm from the Texas Nurses Association, and I'm confused a little bit about distinctions when you talk about either credits or refunds. Who would not be in the workplace? If you're a self-employed person, how is that defined? I guess I don't understand how you would be defining someone who would get a full credit versus someone who would get that half-credit.

DEAN CLANCY: Let's say you work in a company that offers health insurance, but you feel it's too expensive, so you don't join. The Jeffords half-credit would now be available to help you pay to participate in that employer plan. The full credit would be available if your employer doesn't offer health coverage.

STEPHANIE TABONE: And if you were self-employed? Those are persons who often opt for no insurance.

DEAN CLANCY: Right. Under all of the bills, generally the self-employed are given an option. They can choose the existing deduction for health insurance that the self-employed already have, or they could take the credit and buy health insurance with it.

STEPHANIE TABONE: And would they have the full credit, or would they then be the employer?

DEAN CLANCY: I think they would have the full credit.

STEPHANIE TABONE: The other question I have is about medical savings accounts. How do persons who advocate medical savings accounts envision what would constitute an adequate medical savings account? I guess when I think about serious illness, like the person before was talking about chronic illness, what is the thought of legislators as to what an adequate medical savings account would look like?

DEAN CLANCY: I believe the current law says you have to keep as much money in there as some fraction of your deductible. Or you have to keep at least the amount of your deductible. Do you know the answer to this question? I get confused.

AME YATES [from the Texas Medical Association]: The current provisions are that you can only contribute in any given year 75 percent of your deductible, or 65 percent of your family deductible (or maybe it's the other way around), but the people who propose expansions propose that you should be able to put 100 percent of the deductible in your medical savings account every single year.

DEAN CLANCY: Right, that's it.

DAVID WARNER: Let's take one more question, because I think there's a very good chance we will have some tax credits proposed, so it's worth taking a little extra time on this.

CHUCK BEGLEY: I'm from the School of Public Health in Houston. I have more of a global question. In Texas, we have allegedly the highest uninsured population in the country. Besides the obvious adverse effects on those people, it seems to be becoming a palpable problem for our whole population, and our business community is getting a bad rap politically. My question is, have you all, with your policies, expanding MSAs and the tax equity strategies, gotten to the point of trying to estimate how much of the problem of the uninsured in Texas and other states this might address, and how much is going to be left up to us to try to fix with our state-level activities?

DEAN CLANCY: That's a great question—I should have mentioned that. The bill that President Bush is about to come out with, which is based on a bill that Dick Arme and Jim Jeffords did together last Congress, was estimated by an outside estimator to cover 8.8 million people, of which 3.2 million would be uninsured. That again, as I say, was a small credit. It was a means-tested credit, and you could only use it if your employer didn't offer you coverage, and so you're talking in the millions but not in the tens of millions. But of course the more generous and the bigger you make it, the more you get covered.

CHUCK BEGLEY: So that's about 10 percent of the 40 million person problem, the 3.2 million. So we have to work on 90 percent of the problem here at the state level.

DEAN CLANCY: Well, I told you, we're talking about Medicaid and SCHIP and other programs. I guess I don't want you to look at it as if we're leaving you a big problem. We're trying to help with a problem that everybody shares. It turns out there's no solution that gets you all the way there, without creating a lot of people who are opposed to what you're trying to do, so we're trying to make forward progress.

DAVID WARNER: Thank you very much, Dean.