

Chapter 2. Panel on Private Sector Options

DAVID WARNER: I decided since my name starts with a “W” that we ought to go in inverse alphabetical order in this panel. The first panelist who will speak, then, is Pablo Schneider. Pablo is originally from San Diego, California. He has an MBA and wrote his masters thesis on cross-border health insurance. He has worked in a private insurance agency, at Sharp Hospital, and at Community Health Group, a large, nonprofit HMO in San Diego. He is now the president of Blue Cross/Blue Shield of Mexico, which was started by Arizona, California, and Texas Blue Cross. Pablo is going to talk both about some Hispanic issues—he’s going to moderate the Hispanic panel this afternoon—and some broader issues.

The second person who will speak is Jim Rohack, who is president of the Texas Medical Association. He’s a cardiologist, and he is also the director of the Scott and White Clinic. Scott and White, where he practices medicine, gives him a unique perspective because it has a hospital, is a very large multispecialty practice, and is also an HMO. They say that where you stand depends on where you sit, and so he at one time or another can see things from the health plan, the hospital, and the clinician’s perspective. I think he’s going to speak primarily from the point of view of the physician today.

The third panelist is David Pinkus. David is a graduate of the Virginia Military Institute. He is a native Texan, and he has been president of the Texas Landscape Contractors Association. He is the president of Small Business United, which is an advocacy group for small business here in Texas, and also has tried to put together some association health plans and a number of other innovative approaches to health insurance. He participated in a White House summit on small business, and has been interested in small business health issues for a long time.

The final panelist is Diane Longley. Diane is the director of a study that has just been funded by HRSA (the Health Resources and Services Administration), on which the Texas Department of Insurance has taken the lead, and about which she’ll tell you more. A description of that study is also in your packet. Diane is a native of Wichita Falls, and she graduated from Texas A&M University. She’s been with the Texas Department of Insurance for 18 years, and has worked actively with the Blue Ribbon Task Force and with an earlier task force on the uninsured. She is also on the board of the Texas Health Care Information Council and another interstate data sharing arrangement as well as the East Texas AHEC.

So, without further ado, in the order in which I introduced them, I look forward very much to all four of your presentations.

PABLO SCHNEIDER: Thanks, Dave. A little bit about my background: I’ve worked for commercial, Medicare, and Medicaid MCOs. I was in operations in a large health system with seven hospitals and 2,300 physicians, and I also was vice president of a large regional insurance brokerage. So I’ve actually worked with payers and providers, and

worked a lot with products and customers, and distribution of health insurance products. I'm going to break my comments into several parts, and I'm going to go fast. I'm going to comment on three or four observations on this issue, and then I've got a seven-part decision framework to show you. I'm going to say what that is, and then I'm going to talk a little bit about private sector solutions to insuring uninsured people, and a little bit about Hispanic issues as well.

My observations are that it is a massive problem, and there are a dizzying array of solutions, when you start looking into this. I've identified at least 24 different types of solutions, and I've identified at least three dozen specific initiatives that package those solutions in different ways to try to solve this problem. The second observation is that we don't have a health system. What we have is really a hodgepodge. The third is that there are both structural and situational issues: structural issues such as health policy, tax policy, and so forth, and situational issues such as affordability to the consumer, or even perceived affordability or lack thereof, because there are low-income, medium-income, and high-income uninsured people. That's something we have to keep in mind in targeting solutions based on who the uninsured people are. Another issue is that there's both incremental progress and critical mass progress. Incremental progress would be these three dozen initiatives around the country with anywhere from 10 to 130,000 enrollees. A critical mass would be like a change in tax policy that affects millions. I think incremental is in the tens of thousands or even hundreds of thousands, but critical mass is in the millions. And with the associated costs, you're talking about anywhere from tens of millions on the incremental to billions on the critical mass.

The last observation is really about political will. We're the biggest health care spender in the world, and if we wanted to solve this problem, we would have already. Maybe now there's a desire to solve this problem that's strong enough to overcome inertia and to overcome opposition, and maybe now there's the political will to do something not only on the incremental level, which a lot of folks around the country are trying, but on the critical mass level. So those are some of my observations.

The second part is that I have a framework for looking at this issue, and it's in seven parts. One, what is the current situation? Two, what are the components of insurance? Three, what are the types of solutions? Four, what are specific initiatives? Five, what about implementation? Six, what is the cost? And seven, what is the benefit? In applying this framework to the situation we've talked about and heard about, there are lots of studies. There are somewhere between 42 and 44 million uninsured in the United States, and 4.7 million uninsured in Texas, and two-thirds of the uninsured people have at least one full-time, full-year worker in the family. And looking at 35.3 million Hispanics in the United States, about one-third of them are uninsured. So clearly, the situation is massive. Then there's the whole issue of our hodgepodge and how we're either treating the people or not, whether they have insurance or not. And then, every once in a while, I'll come across something and say, "Wow!" It's anecdotal, or maybe somebody has studies on it, but they say that one-third of the people who are eligible for Medicaid don't enroll. I mean, that's huge! It's amazing. So that's the situation.

The next part focuses on the components of insurance, and I'm approaching this issue by looking at products, providers, acquisition and acquisition cost, administration and administration cost, claims, reinsurance, premium taxes, and premiums. So, looking at eight components of insurance leads you to ask what are some of the types of solutions you can create that impact one or more of these eight components of insurance. I'll give you some examples. There are public solutions, private solutions, joint solutions. Some of my favorite types of solutions are MSAs, low-premium products, tweaking or changing the tax policy, premium subsidies, purchasing pools, and high risk pools. And then a couple that you may not have thought or heard of are Hispanic initiatives, specifically, and also cross-border health insurance—one of the conclusions that I came to in my masters project that I didn't expect.

I was studying this big phenomenon of cross-border utilization of health services, and then it dawned on me that there are millions of people living in the border region, crossing from the United States to Mexico to pay cash for health services. Why not offer a coverage that would be 20 to 50 percent less expensive than a domestic U.S. coverage that allowed access to providers in Mexico who have the cost and culture profile that the consumers want? So of the two dozen types of solutions, that just gives you half a dozen or so of some of my favorites.

And then on the specific initiatives, as I said, I've identified at least three dozen, and I'm going to talk about three of them very briefly. One is that there's a company called WellPoint that's one of the most successful health insurance companies in the country. WellPoint is the parent company of Blue Cross of California and Unicare, and they've developed several product lines specifically targeting the uninsured. Great innovation, really impressive, and what they're focusing on is low price, medium price, and high price. They're focusing on targeted outreach—they have a Hispanic initiative, they have collateral materials aimed at small business, they have collateral materials aimed at people who are currently uninsured, and so forth. So that's a great example of a private sector initiative, and they're looking at it as a market opportunity. And when you look at it, there are numbers that say that there are over six million people in the United States who are uninsured who have household incomes over \$75,000 a year, and over six million people who are uninsured in the United States who have household income between \$50,000 and \$75,000 a year. And the remainder, still the bulk of the uninsured people, have annual household incomes of less than \$50,000. But, my point is that there are different types of solutions for each low-, mid-, and high-income segment of uninsured people.

A quick comment on WellPoint is that their approach includes all of those eight components. They're working a lot on products and on targeted outreach, and they have certain administrative policies that help facilitate uninsured people coming on board. They're leveraging the infrastructure they have that serves millions of people already, and that's another key point: there are many startups around the country that are trying to insure the uninsured. The sense that I have is that to the extent that we can leverage existing operations that have millions of enrollees already, the incremental cost for WellPoint to bring the uninsured on in their own companies is a fraction of what it would

cost for these local initiatives. For example, there is an initiative in San Diego that involves a premium subsidy and they have several thousand enrollees and a base of 70,000, so you're not going to get the kind of bang for the buck in that program that you would by leveraging a larger base.

So the WellPoint example is one option, and a second one is Community Health Group, the Medicaid HMO where I used to work. What I did there was to create a commercial group insurance product targeting the uninsured. I convinced the Medicaid provider network to extend Medicaid rates to commercial groups, and worked with them to show them that it was going to be uninsured people coming on to their practices and that they were going to get paid for that care, and that we were not going to cannibalize their commercial groups, with people shifting from commercial coverage to our product, but that we were really targeting and focusing on the uninsured. What we were able to create was a product line for the uninsured with two low, two medium, and two high options, where our premiums were at least 20 percent below market for comparable benefits. And that's where you get into the threshold of how much you can lower the premiums, and how many millions of people would be able to buy in with lower premiums.

The third private initiative that I'll talk about is cross-border. In 1995 I created a cross-border coverage called Care Mexico, and I recently worked extensively with Blue Shield of California to create a north-south HMO called Access Baja. It's a licensed HMO product in California that employer groups in California can buy, but its benefits and providers are exclusively in Mexico. We've worked extensively with credentialing, quality, and so forth to try to organize that service in a much better way than the norm, and at the same time, the premiums for that product are anywhere from 15 to 30 percent less than a U.S.-only type of benefit.

I guess the only other comment I'll make is that we're launching Blue Cross/Blue Shield de Mexico, and we would like to do cross-border coverage in the whole border region. We would be the platform on the Mexico side, and then people on the U.S. side could buy well-organized coverage where they could get benefits in Mexico. So those are some of the specific initiatives in the private sector. Then, as with everything, you need to look at implementation, cost, and benefit or impact: that is, implementation based on political viability for something huge, or implementation at the local level or at the organizational level for a private initiative; then looking at what it will cost, and what its benefit will be. Would it be an incremental benefit of tens of thousands or hundreds of thousands of enrollees, or a critical mass kind of benefit or impact of millions of enrollees? I hope you remember one or two or three things from my talk that will be of benefit to you. Thanks.

JAMES ROHACK: It is a delight to be here, because certainly we're talking about some basic principles in health care. And certainly the 1994 Rand study was very clear that 25 percent of the health care dollar that's consumed is due not to health-related reasons but to societal breakdown. Certainly the recent weapons fire in California that resulted in people being brought to the emergency room for trauma—is that due to a problem in the medical field or is that really a societal problem that we're having to deal with?

The other interesting thing was that Dean Dorn said he was delighted that we've all decided that though health care was viewed as a privilege in the past, now it's a right. And perhaps it is. But there's a misnomer. Insurance is not the same thing as health care coverage. I work at Scott and White, which was created in 1897 to provide health care for the Gulf, Colorado, and Santa Fe Railroad employees, where the employer took a dollar a month out of the employee's benefits and purchased health care. And so they created a hospital between Euless, Oklahoma, and Galveston, Texas, and called Bernard Temple, the chief engineer, to lay out the land.

So the concept of prepaid, comprehensive care provided by the employer has been around for over a 100 years at Scott and White. We are aware of the pressures of dealing with employer purchasing. But the nature of the insurance created in this country around the 1900s was based on the German model of catastrophic insurance models, just like fire or car insurance. When you purchase your car insurance, you don't expect your car insurance to buy tires, gas, and oil. But now, we expect health insurance to cover all health care costs, like drugs, like supplies, like visits. And that expectation is partially because the government got involved in 1942 to give a tax advantage to employers by providing pretax breaks, so they could provide health benefits. In the 1950s, the unions struck for first-dollar coverage of health care. So the evolution occurred.

Then the government tinkered again with Medicare, because while it covered everybody over 65, it was flawed to begin with because the government never covered the cost. They only reimbursed 85 percent of the *charge*, and you could not charge Medicare more than the private insurer, so basically it created inflation. So expanding Medicaid even more will really continue to dump onto private industry the cost of creating programs, because the funding stream that used to be individual, employer, government, is now shifting to where the government is becoming a larger payor. Take a look at Brazos County, which has the lowest unemployment rate in the State of Texas. Look at the demographics showing that government in Brazos County accounts for 42 percent of the employed. Trade is 20 percent, and services 22 percent. Take a look at the state of Texas. The state teacher retirement system, which now we want all our school systems be a part of, that's governmental. And when we take a look at the real impact, here is the problem that we have: when you are a large employer with over 1,000 employees, if you don't want to be subject to the state mandates, you go the ERISA route. As a result, you are not subject to the state premium tax, nor are you subject to any state mandates, like the ones recently passed, the "no ugly baby bill." I mean, I'm all for treatment of congenital abnormalities, but the last Legislature said any child under the age of 18 who has a congenital abnormality, trauma, or a problem as a result of injury will get cranial facial repair. So if mom doesn't like the floppy ears, it's now covered, whereas before, the insurers could say, "no, that's cosmetic, it's not a functional problem."

So again, the mandates that are unfortunately created because of anecdotes do have an impact of driving up premiums. This is where the small employer is at risk. Yes, we have guaranteed issue, but if the large employers are coming out of the system, all that's left is the small employers with increasing premiums. And the reality of insurance is that the healthy pay for the sick. So all these things we've talked about in terms of tweaking

with the system mean that as long as you allow people to opt out of the system voluntarily, we will not have enough money in the system to be able to solve the problem. As was mentioned earlier, 7 percent of those who are uninsured have incomes over \$80,000 a year. They're making the financial choice not to purchase health care coverage. When, however, they have their motor vehicle accidents and come to the emergency rooms, under the federal law of EMTALA we are forced to care for them, which we will, but where does that cost get shifted? That's the problem of the unfunded mandates, and that's the problem of these premium increases that result in uninsured people because of the small employer making the conscious decision, "I cannot afford it anymore, good luck."

We also have the high-risk pool that was created in our state, but again it is funded from the premiums of those who are insured to pay for those who can't get insurance. The funds go into a high-risk pool, which continues to drive up the cost, which goes back to "tax" those who are insured. You have those people who don't participate in purchasing health care, yet the problem is that we say, let's create managed care, managed care will be great. The problem is that that was a wonderful model in 1972 when Elwood and the Jackson Hole group came up with it, because it said let the communities take care of it. Let the doctors and the hospitals and the insurance plans that were community-based, not-for-profit, take care of it, and any dollar amounts saved would go back into the care of the community. The problem is that in 1980, under Reagan, there were incentives to take away the federal grants that were created in 1973 in the HMO law and 1974 in ERISA, and we said the government isn't going to fund this, go to the investor market. And so now we've created for-profit, investor-based insurance companies who look to quarterly profits to make their investors happy, but the investors aren't necessarily part of the system.

Health care is either a long-term benefit or it is not, and that's been the source of some of the anger that has occurred, because when you take a look at the enrollees removed from cost, it gets back to that coverage issue again: "I'll come in, and for five dollars I'll get everything I want. Give me my MRI for my headache, because I deserve it." And patients expect that we will offer the greatest technology. Again, the government, through NIH, helped to create the technological explosion. In fact, one can argue that it really doesn't cost any more to provide physician care; the real cost of care has gone up in technological advances that are obviously the result of our desire to have all the greatest, latest, wonderful stuff that we want because we saw it on "60 Minutes" last night. We also want the newest drugs. And yes, doctors, unfortunately, do continue to practice defensive medicine, because if we didn't order that MRI, two years later we're going to get sued because we didn't order the latest and greatest.

The end result is everyone wants everything. Certainly, we're in here taking a look at how can we do it, because what patients want is choice and control and service and brands and information, and I will say that I think the Internet, while it has advantages, also has tremendous disadvantages in expectations being set so that there isn't enough. When we take a look at the drug culture that we have in this country, the majority of people who are crossing from El Paso or Laredo across the border aren't getting their

coronary stents or bypasses, they are getting their pharmaceuticals. I mean, that's where I send my patients to get their drugs when they can't afford them. Why are drugs 30 percent less expensive, made by the same company, over in Mexico? Why? Direct-to-consumer advertising. Pharmaceutical manufacturers now come in with expectations. If you don't get your Allegra versus Claritin, you won't feel good. For those of us in central Texas, everybody's got allergies. The point is, should the insurance company pay for that, or should individuals decide whether or not they should maybe just take that generic Benadryl at night rather than the \$2.50 nonsedating antihistamine once a day. And all the new drugs in the pipeline are scary, because we have to decide, is it coverage, or is it insurance? And where does the consumer come in? Because really the challenge that we have is spreading risk, which means everybody has to participate. Period. End of discussion. You can't opt out.

Second, there is an individual responsibility, as was mentioned. There has to be a cost-share. Should that person who continues to smoke and who's already had their second bypass surgery be allowed to have the third bypass, when those who don't smoke are taking care of themselves? Genomics is scary, because it's going to be possible to predetermine who's at risk. But if we can't share the information with them, is that right or not? The bottom line is that we're going to have to deal with how to say no, you don't get everything. The real balance the medical profession has to achieve—just like every profession—is that between articulating what is right for our patients with the force of the state, and the power of the capitalists, the employers who are purchasing the health care, and everyone is struggling over the same aspect of how do you do what's right, knowing that there are limited dollars, and how do you shift them back and forth.

We'll continue to take care of patients, and that's been one of the gold markers: physicians will continue to take care of patient that need to be taken care of. But that becomes very difficult in the Medicaid population, for example. When 70 percent of your business is Medicaid, and it doesn't cover the cost of operating a business because of paperwork and administrative overload, you can't just go to the electric company and say, "I'm only going to give you 70 cents on that dollar charge, because I can't afford it." This gets back to the question of tax credits for those that are providing care. Because unless we have everybody covered by some pluralistic way—employer, individual, Medicaid for the poor, Medicare for those over 65—and then have a secondary insurer that can spread the risk amongst all, and a tax policy that can target that individual who has not opted out so the hospital and the physicians and those other caregivers can provide for them, we won't be able to fix this mess. So we've got challenges. We will have to continue to discuss how are we going to solve this issue, because we need to try to come up with a consensus, and it's one where the federal government does have a role in this because we migrate. And for Texas and the federal government, the border area is a huge issue for all of us along the border.

DAVID PINKUS: The problem that I have in being third is, am I supposed to come up with all the solutions? [Laughter] I was leaving that to Dean Clancy. I am really glad to see that a lot of the things we are looking at are also being discussed in Washington, and I think the other speakers talked about that. One of the things that I want to add is that as a

representative of small employers, we look at the whole thing a little bit differently and focus primarily on the portion of the uninsured problem that deals with employees of small employers. About 10 years ago we had a strong national dialogue during the Clinton campaign about doing something to get to the point to where we have universal insurance, or universal coverage, depending on how you defined it. But I think when that failed one thing that small business and many of the initiative's opponents did was put out the idea that although people may not have health insurance, they get health care. I think that that concept, while it was very successful in helping to kill the Clinton proposal, brought us to the point where it actually might be contributing to the number of uninsured because we sold the idea that you don't have to have health insurance but you can still get health care. I don't know if there really is a cause/effect there, but to me it's a factor in why we have so many people—particularly people in income levels that should be able to afford health insurance—that don't have it.

We as a nation have to go through a much more serious debate than we have had and really decide where we want to be. Then we have to figure out how we want to get there. I don't think we've done that. What we are doing as we go along is come up with all kinds of little patchwork solutions and deal with anecdotal problems rather than tackling systemic problems and creating solutions. I think we have gone from catastrophic-type insurance, where health insurance is supposed to cover the catastrophe which you can't cover out of your normal income, to where it is the first-dollar coverage.

I think that the concept of health maintenance organizations did a lot of good for health care, but they also did a lot of bad. The worst thing that HMOs did was bring in the concept of the \$10 and \$20 copay. They have made cost a secondary factor in many decisions for everyone—particularly those concerning which type of prescription drug to choose. Say there are two drugs, one costing \$100 a month for the prescription and the other costing \$30 a month when you look at the actual costs, but it only costs me a \$10 copay either way. Obviously I want the \$100 one. I get more for my money—I get \$100 worth of drugs rather than \$30 worth of drugs. The result, if that is carried on and on, is that the decisions that I and others like me make actually add costs to insurance, which in the long run tends to drive up the number of uninsured. We are going in the wrong direction as a result of having first-dollar—or relatively first dollar—coverage for a lot of people.

A personal anecdote: a number of months ago I had a real stiff neck and my wife offered to make an appointment with her masseuse, saying she would make my neck feel great. I asked how much that would cost and she said \$50. I said why should I pay \$50 for your masseuse when I can go to the chiropractor on my health care plan and I'll only have to pay \$20? I think a lot of people make similar kinds of decisions. In that case I didn't have time to do either one and I just endured the stiff neck until it went away. An employee who would have been eligible for a day of sick pay probably would have taken a half day or a day off and gone to the chiropractor and paid \$20.

National surveys that we've had done through Arthur Andersen indicate that roughly between 50 and 60 percent of small employers offer health insurance. This compares to

about 99 percent of large employers. Here in Texas it is significantly lower than that. The data from the Blue Ribbon Task Force indicated less than 25 percent of Texas small employers offer health insurance to their employees. So it's a much bigger problem in Texas than it is nationally.

Then we get to the question of why employers should provide health insurance. And should employers be the ones who are funding health insurance? Here in the United States what has happened is that we have a system which I think just about everybody, depending on their perspective, probably would agree is not working the way we would like it to work, but we can't all agree on how we would like it to work.

Basically we have a government-subsidized employer-based health insurance system. By government-subsidized, I mean that employers get a tax benefit for providing health insurance. They are paying with pretax dollars, which means there is about a 15 percent FICA savings and about a 20-30 percent income tax benefit, depending on the tax bracket of the employer. So for every dollar in health care costs that the employer pays, it really costs him somewhere between 60 to 80 cents for every dollar he spends, which makes insurance much more affordable for the employer.

If an individual who is not covered by a section 125 plan or something else goes out and pays with after-tax dollars, every dollar of health care he or she pays really amounts to at least \$1.15 and, depending on the person's tax bracket, can go up as high as \$1.30 or \$1.40 for every dollar. So there is a disincentive where the tax code subsidizes employers and penalizes individuals. That is why I think that the idea of coming up with some kind of tax credit, tax deduction, or something along those lines to level that playing field is a very good idea.

The other thing that we are very concerned about is the employer-based system. If you look at who is paying for insurance you've got a good percentage of the population insured by employer-based systems; here in Texas about 23-24 percent of the population is insured by employers, not counting state employees. Medicare and Medicaid cover 23 percent. So most of the people who have health insurance today have it paid for by somebody else, either the government or their employers. And thus they have very little stake in controlling health care costs, which leads to the problem of making wellness decisions. Should I smoke, or shouldn't I smoke? Doesn't make any difference if I get sick; my employer-funded or government-funded insurance plan will pay for the cost. So there is no incentive or very little incentive on the part of the employee, other than obvious, you don't want to die early, but they don't make that conscious connection from the cost standpoint or from the insurance standpoint. Driving a motorcycle without a helmet, smoking, not getting adequate exercise, all the things that go with wellness, aren't things that I really need to be concerned with because they have no impact on my pocketbook. They don't affect my ability to buy a new car or live in a bigger house, or have new clothes or go out to dinner, or go to the movies, or make those economic decisions that we make because somebody else is paying.

The subject of individual responsibility has been mentioned a couple of times today and I think that there is where we are. We believe that we need to put more of a focus on

individual responsibility and bring the individual back into the equation. Back into the paying equation—not to pay the whole amount, but to get the individual to where they have a stake in the decisions that are made. The analogy to having employer-paid health insurance that I use a lot is that if employers paid your grocery bill, nobody would buy hamburger. And that is where we are—if somebody else is paying the bill, we want the best drug, we want the MRI or the CAT scan or whatever. We're entitled to it whether it is indicated or not. I've been in meetings where doctors have said they have patients who come in with injured knees or joints, mainly just as a result of excessive exercise or whatever, and rather than putting an icepack, taking an aspirin, and calling them in the morning, now they want an MRI or CAT scan—\$1,500 for something that should have cost very little, rather than waiting a day or two. Those kinds of things are driving up health care costs, because the individual has no stake in the cost. So somehow we have to get the individual into the equation.

What are we looking to do? A number of proposals are out there and I wish I could say these are the ones we think are really the best. There have been a lot of studies done and there are a lot of task forces working on this issue, but I don't think it is enough. It needs to be ongoing, where not only the policy experts but all the stakeholders are continually involved, and the public must become much more involved and aware of what is going on. The only way that will happen is if the employee starts to feel the bite a little bit. Because right now, it's the providers and the employers and the government who are feeling the bite. It hasn't gotten to the point where taxpayers and employees really understand that there is a bite or that they have a stake in the issue, other than just getting care that they pay very little for. When you talk about individual responsibility, one of the things that we have talked about is that there needs to be some kind of a way—and “require” may not be the exact word—to get people, individuals who don't have insurance, to know that they need to have it and to go out and get it. If it is offered to them, if it is available to them, and if they can afford it, they should buy it.

During the early 1990s and during the Clinton health care era, when the Clintons had an employer mandate, they would have required all employers to provide health insurance, and I think that that was really the issue. I think the members of Congress will tell you that was the thing that really killed the whole program. It was an employer-mandate-based issue. Senator Gramm and a number of other members of Congress had an individual mandate proposal which would have had government subsidies for people who couldn't afford health insurance, but if you could afford it, you paid for it. I'm not sure if that is the right way to go, but I think that if people understood that if they don't have health insurance and they could afford it, and they went in for health care procedures, they were going to have to pay the full cost. We may approach people who don't pay their hospital or doctor bills for services that the medical providers have to provide by law in most cases. The public policy says to the provider, “you have to provide care,” but the public doesn't do anything to make sure that the provider gets compensated for that care. Maybe we could do something like we do with bad checks where the District Attorney is empowered to collect bad checks, where medical providers could turn bad debts over to the local District Attorney. Some people say that clearly that is called “criminalizing,” not paying your doctor bill, but if people can afford to pay and don't

have insurance, there should be some individual consequences. I'm not sure where that would take us, but there needs to be some way. Having the IRS enforce health policy doesn't sound like a real good way to go either. Especially when there are a lot of people who would like to do away with the IRS altogether.

I want to quickly talk about the areas that we looked at and that have already been discussed today. We talked about earned income tax credit for low-income individuals that would help get them there. There are a lot of changes needed in the area of medical savings accounts. Right now with an MSA, you have a choice—the employer puts money into the savings account or the employee puts money in, but it can't be both. It should be both, if an employer is willing to. When we do surveys of employers, we ask how much they can afford to pay for health insurance for their employees. Some say less than \$50 per month, some say \$50 to \$100 a month, some say \$100 to \$150 and so on. Depending on the business and the type of business and the wage scale and who they are competing with, it varies from employer to employer. We need to come up with a system where an employer could contribute what he can afford, and the employee can match that; then we could put in some reasonable government tax subsidies, such as being able to put pretax dollars into an MSA, being able to pay with pretax dollars into a section 125 plan, or some sort of equivalent. Basically, what you would end up having is a variety of ways that you can have “defined contribution” plans where employers and employees put in money. There also should be a financial incentive to the employee to not spend the money. Life insurance is an example. You pay premiums every month or every quarter or every year for your life insurance, depending on the kind of policy. If you want to you can buy a policy that at some point develops cash value and you know that you have been making an investment. With health insurance, you don't do that. If you don't use it, you lose it. Maybe we should have some kind of insurance where you get individuals putting money in, and if they don't use it, they keep it or it carries forward, or it rolls over. That is one of the changes that needs to be made to Section 125 plans because when employees contribute to a Section 125 plan they lose the money if they don't use it by the end of the year. There needs to be a roll-over provision so that they can keep it. I think employees would put a lot more money into Section 125 plans if they knew that the money would roll over and be there when a catastrophe happens. We need to get the individual involved in planning for the catastrophe and having money available to handle the bigger medical expenses of the year.

The last thing that I want to mention that we've talked about is one of the things that we looked at in group insurance. We should consider whether to have a provision that allows variable copays. For somebody who makes \$75,000 a year, a \$20 copay is nothing. For somebody who makes \$7 an hour, a \$20 copay is a lot of money. So we should allow insurance companies or HMOs or providers to have copays that go up as the individual's income goes up, so they have to make a conscious decision about their expense. Those are just some of the proposals that we've talked about.

The last one that I haven't mentioned that we've been working on a lot is cooperative purchasing arrangements. The Jackson Hole group and everybody else have for a long time been talking about our need for purchasing cooperatives. I think if you look around

the country, including Texas, in just about every place where we've had them, purchasing cooperatives have failed for a variety of reasons. But we need to revisit that whole issue, however, because I think that there has to be a way to bring in small purchasers of health insurance, whether they be individuals or small employers. We have to find a way to allow them to pool their buying resources and get the same kind of deal on health care that large employers do. That is basically what I wanted to cover.

DIANNE LONGLEY: As is noted in your packet, the Texas Department of Insurance applied for a federal grant last year and was pleasantly surprised to find out not too long ago that we were one of the states included in the second round of awards. It became effective March 1, 2001, and I'm going to be directing that project for the next year. The project abstract is in your packet, if you are interested in finding out exactly what we will be doing. I'll go over the highlights in a few minutes. If it sounds a little bit ambitious to accomplish what we've laid out in a 12-month period, it is. And I've got to confess that this is the first time I've ever applied for a federal grant, and the requirements were fairly rigorous in that you had to meet a lot of different requirements to prove that you would come up with comprehensive recommendations. You couldn't limit your study to a particular group of uninsured people, such as the Hispanic population or low-income adults. It had to be comprehensive and include the entire state and the project has to be completed within a 12-month period.

Unlike many of the states that were awarded these grants, Texas has to comply with all the requirements under state laws that have to do with contracting, purchasing, and everything. So we are really pushing the clock to get this finished, but I was told that I was going to be last on this panel because they wanted to end on an optimistic note. So I'm going to try and be optimistic, and I can assure you that we will do what we have laid out in our project that we are going to do.

Just briefly, there are about four big pieces of this study that we will be doing over the next year. One of the first things we are working on is drafting a request for proposals right now to do a statewide study of the uninsured. This is not to duplicate information that we already have (we are not looking at demographic information), but we are trying to find out why people who are uninsured don't have insurance. We've heard some discussions here today about the fact that a lot of these people have incomes that suggest that they could afford health insurance. We know that about one-fourth of the population that is uninsured in Texas, maybe more, have insurance available that is offered through an employer and they have elected not to take it. We assume that is because they couldn't afford the premium payment that was required by the employer. But we don't know that for a fact.

Clearly we know that there are a lot of low-income uninsured people who could not afford even a minimal premium contribution, but what is minimal to those of us in this room? We would think that paying \$100 a month for full family coverage would be a bargain, but for a family that is panicking over increased utility bills right now in Texas, asking them to pay \$100 a month for health insurance is unreasonable. If we come up with a plan that will require payments that are beyond their means then it is not going to

do us a bit of good. Trying to find out what you can afford, what you think is reasonable, why you don't purchase insurance, do you want insurance? If you are not enrolled in Medicaid and you are eligible for it, why are you not enrolled? Is it because you have never had a health condition that needed care and so you've never gone to the trouble of enrolling, or do you feel that there is a stigma attached to it and you are not going to enroll under any circumstances? These are the types of things we will look at in our survey.

At the same time that's going on—all of these projects will be going on simultaneously—we will examine the small employer reforms that were enacted in Texas in 1993 and 1995 and sort out what we did that was right and what we did that was wrong. There have been several legislative groups that have looked at this issue over the past couple of years. There is the Joint Interim Committee on Mandated Benefits that sort of touched on this issue. There is a separate working group that David Pinkus and a number of other people worked on. We know that the number of small employers with insurance has gone up dramatically since 1993, and in 1998 we had about 86,000 small employers in Texas that had health insurance, about 24 percent. But that percentage went down in 1999, although the number of lives covered has actually gone up. What this suggests is that even though the number of employers offering coverage has gone down, the employers offering coverage are probably the larger employers.

When we talk about small employers, we're talking about groups of 2-50 employees. So most likely, the larger employers with 25-50 employees are continuing to offer coverage and perhaps more of them are entering the system and the smaller groups are dropping out. The good news is that the number of lives covered has gone up, although the total number of employers providing insurance has gone down. When you look at the reforms, however, a number of people have suggested specific reasons why those numbers initially went up and why they are going down, but we don't know for sure. We haven't heard from the small employers themselves exactly what it is that encourages them to purchase insurance or why they don't purchase it. And again, the question is affordability—how much are they willing to spend? What is too much? There are probably some employers who, because of the administrative burdens, will never offer insurance to their employees. So these are the types of issues we will examine through our small employer survey.

As long as I'm talking about small employers, under state law there are two standard policy forms that must be offered. One is called the basic plan and one is the catastrophic plan. The basic plan offers a standard level of benefits and is designed to cover the everyday types of illnesses that most people incur. The catastrophic plan has a much higher deductible and is designed more for those expensive hospital stays or lingering illnesses that can truly be catastrophic. Neither of those plans have sold well in Texas at all. Last year, less than 30 of the employers who purchased health insurance purchased those two policies. Even though the premiums are lower than those for other plans, they are not cheap. They are, however, considerably lower than what you would consider to be the full coverage standard plan that is normally offered. Some of the mandated benefits that are required in Texas are not included in these two plans. I know that

mandated benefits are a contentious subject under the best of circumstances, and I don't really want to get off into that debate, but if we design a policy that people don't want, it's not going to do us a bit of good, no matter what it costs, if they are not going to buy it. And if we start stripping out benefits that, even though they cost money are desirable to the public, we're going to be back exactly where we are right now, with people choosing not to buy health insurance because they figure it is not going to do them a bit of good.

I totally agree that we have not done a very good job in terms of educating people about why health insurance is important to them. I have a daughter who is a sophomore at A&M right now and I've asked her whether any of her high school classes did anything to educate the students about the "real world"—once you are outside of high school. Half of those kids are going to go get jobs and half of them are going to go to college and eventually get jobs, and there is virtually no education at the high school level that is telling these kids what they will need or what their expenses are going to be when they get out in the real world. Certainly nothing about health insurance or why it is important. And I think that is where we have to start in terms of educating people, and it is not going to be an easy process. It's going to take years, but 10 years from now we are going to have a group of students in the workplace who understand that health insurance is valuable. When employees go to apply for a first job, most of them aren't even going to know to ask about health insurance—only if their parents have suggested that you need to sign up for it or that you need to at least ask if it's offered. These young employees, many of them single, in that 18-25 age group that is one of the biggest problem populations in terms of the uninsured, have no clue why health insurance is even necessary. So I think that that is also one of the challenges we have to face. It will require the cooperation of a lot of different people, but it is certainly something that we can overcome.

The third part of our study is going to be a survey of insurers and HMOs to get some data that we don't have right now on rates, on areas of the state where they are offering coverage, and some of the benefits that are most often selected, just to find out what is going on in the marketplace. People are always surprised to discover how very little data we really have on the insurance market in Texas and that is because it is not something that in Texas is regulated. Rates are totally unregulated, except for the small employer market where there are some rating requirements, but in general health insurance rates are not regulated and so we don't have much data. That is something that we hope to collect in the next year as well. And then once we have all this information, we are going to be putting together some plans that consider the data that we've collected and we'll craft some recommendations that have detailed plans that address the different populations, whether low-income, or Hispanic, or middle-income single parents who choose not to purchase insurance because they don't think that it is a valuable or a worthwhile expense for them. I expect that we will have a number of different proposals.

None of these proposals are going to be comprehensive in the sense that they will address the problem for everyone, but I think, again, as everyone has said here today, it will be one of those things where we have an assortment of recommendations that will hopefully

address, if not everyone, a significant percentage of the uninsured in Texas. We are going to be consulting with actuaries to develop some cost estimates on each of these plans, and we hope to come up with some funding recommendations. I think that is probably going to be our biggest challenge. Everyone here knows that there is not a big bucket of money sitting over there in the Capitol for us to spend, and so what we really want to do is develop some reasonable recommendations that are also feasible. We don't want to propose a bunch of great recommendations that don't stand a chance of being enacted. So within those limits we hope to come up with a good package and then sometime either next November, or January—we are still trying to figure out the timelines on this—we will hold a conference where we ask people to come in and review the project findings and recommendations and then give us comments. Under the grant proposal we have to demonstrate to HRSA that we have received input from a variety of different types of groups all across the state, and report their reactions to our recommendations. That is just a way of proving that some things will work and some things won't. So that will be the last part of the study. I'm guessing it will be January of 2002, and that's about it in terms of this study.

DAVID WARNER: One other thing that Chris Britton said to me last night was that the governor's office is eager to promote private/public collaboration. I haven't heard much discussion of that yet, but I thought in fairness I ought to mention it. The other thing I should have mentioned is that Ken Apfel and I are going to do a policy research project again next year and we hope to use some of the findings from this afternoon and the conference as the basis of what we should be looking at, and we want that effort to be not competitive with but complementary to Dianne's study. Let's take questions now.

CARL RUSH: I'm from the Family Health Foundation in San Antonio. A lot of comments in this panel and also earlier have been about individual responsibility, making choices. It occurred to me as I was listening to this that if we are talking about incentives to obtain coverage, what we are talking about is incentives to put more money into a system that is already costing more or is increasing in cost faster than other elements of cost in this country. And I haven't heard much talk about incentives to encourage more appropriate use of care, incentives to more helpful behaviors. Is there some way that we can combine those incentives? In other words, we don't want just incentives not to use care, we want incentives to use care more appropriately, to seek care at an earlier level of acuity, and so on. To use primary care appropriately. And we already have occurrences where people will delay seeking care until the situation becomes more serious and more costly. It seems to me that we haven't dealt with that set of incentives.

This is related to whether people sign up for Medicaid, for example—if they don't have immediate needs, then they don't feel a lot of incentive to apply for coverage. But it's more than just incentives not to seek care. Does anyone care to respond to that?

JAMES ROHACK: Certainly I think that when you take a look at what was mentioned before, such as when a patient comes in to see a cardiologist and their coronary arteries are all clogged up, and the doctors says you can go on an exercise program and diet, or we can do a bypass operation. They say "I want the bypass because insurance pays for

it.” And that is the individual responsibility of trying to say how can proactive care be incentivized? So if we created a package where the coinsurance to get preventative care was less than that for certain specialists, that may be appropriate.

At one time if you were a specialist, you were allowed to charge a higher rate than you were if you were a primary care physician, but then the federal government got rid of that and said everybody gets paid the same. So while we talk about what can we do in the state to incentivize, we also have to realize that because of the federal policy, even though Medicare is supposed to be just for Medicare, most insurers now tie reimbursement to a percentage of Medicare. And so the Medicare RBRVS that was created really as a model is now tying the private industry back to that federal system and so your percentage basis goes back. To the individual, the MSA account was supposed to be part of that. That you should be incentivized to get appropriate care so you don't necessarily have to see an allergist to get Claritin, you can go ahead and get some Benadryl over the counter and not have to pay the out-of-pocket expense.

I think it is going to be the challenge of how do we articulate as a society when it is okay to say no for certain catastrophic illnesses? Again, that is the huge problem that we deal with in our health plan where we have 170,000 patients that we care for. Last year, \$76 million were consumed by 1,700 of them. Or another way to say that, 1 percent consumed 26 percent of the resources. I'm sure other insurance companies have that model, so if people are opting out of the system, or a part of the system, and then have unhealthy behaviors, then they are often the catastrophic cases that show up in the emergency room that we all have to care for. So I think it has to be a universal system as far as coverage with pluralistic models of being able to deliver that, and the only insurer that is large enough to spread the risk has to be some federal intervention as the secondary insurer for the catastrophic.

PABLO SCHNEIDER: On that issue of individual responsibility with health care and health insurance: it's really quite irrational in its behavior, and we are pretty irrational in a lot of ways in that we want more and more for less and less until we get everything for nothing. And obviously that is impossible, so three points on individual responsibility: one is the responsibility to participate in the first place. In America, we don't like people to force us to do anything. But we need the individual responsibility to participate, to enroll in Medicaid if you are eligible, to buy health insurance if you can. So one is participation, and two is product design. That is where you get into the individual financial responsibility for paying a copay, a coinsurance, a premium, and so forth. The third point is utilization decisions: the decision to use the \$20 option versus the \$100 choice. I think those three things are linked.

You've got somebody who is participating, who is in a product design that makes them cost-conscious, not thinking that somebody is going to give me everything for nothing, but cost-conscious. That influences their utilization decisions. The other day I went to the doctor and said I've got this problem, and he said okay, I would like you to have this, but let me look. He whipped out his Palm Pilot and he said I've got the formulary here, and your problem and your diagnosis, and there are two different things I could give you,

but one of them your insurance company won't pay for (it's more expensive), and the other one they will pay for (it's less expensive). So I asked about the difference in effectiveness of the two medications. If the expensive one is a lot more effective, either ask for an exception or I'll pay the difference, but if it is not, then I'll take what is on the formulary if you think that it works comparably. But that is a good example of those three things. I participate, I have coverage with a product design, and I make a utilization decision based on that.

JAMES ROHACK: That's one of the concerns of physicians—we're trying to be professionals and we don't necessarily want to get too much into your insurance coverage. That's where it gets into the fine lines of the administrative hassle that the doctor has to mess with in filling out a bunch of forms to get the formulary exception. Should it be the patient's responsibility to have the coverage or should it go back to the doctor?

PABLO SCHNEIDER: Yes, the use of technology is a key issue there. And that was one of my favorites that I forgot to mention on strategies and approaches to solving the problem. If you could do a health plan that is 100 percent on the Internet, you could save literally truckloads of money on all the administrative activities, and there are lots of people trying to do that.

DAVID WARNER: We only have five minutes left, so let's try to take one more question and get a quick response.

ANNE DUNKELBERG: I'm with the Center for Public Policy Priorities. If Dr. Rohack's figures are correct then you've made the point that you think somewhere in the neighborhood of a quarter of health expenditures fall in that category of things that could be avoided if people made better choices, but that means 75 percent of health expenditures have to do with things that people can't do anything about, so I guess I get a little concerned when we get too focused on that. I think it is something the system needs to address, but it's not going to fix the whole problem.

One of the problems that I can offer as an example for you is that at my office we are currently paying for small-group coverage of \$900 a month for family coverage. The State of Texas, with its many employees, gets a very good rate—about \$625 a month on average for family coverage. We've all seen the discussions about trying to get health insurance for more of our teachers and school district employees and their families in this state, and we've seen that there are districts that have 10 times as many employees as my little 12-person office paying premiums of \$1,000 to \$1,300 a month for family coverage. So what I'd like to hear from you folks is what suggestions you have on private sector solutions that help the folks that are well above the poverty line. I'm wondering what kind of private-sector solutions you see that can help the folks out here in Texas who are having to pay anywhere from \$7,500 to \$12,000 a year for family coverage. And in most cases, the employer is only paying the employee's share of the premium. Thank you.

DAVID PINKUS: I own a company in East Texas. I think we are paying less than \$600 a month for family coverage but we have a fairly high deductible and a fairly high copay

in order to get those costs down. As an example, a lot of these plans, particularly the state plans, used to have a \$10 copay. But I think that most employers are starting to try to look at ways to get the employee more involved in sharing in the cost and reducing the benefits so that there is more cost-sharing. I think that has to be done and if that is done, you can get the premiums down. If you have real rich benefit plans, you are going to pay \$900 or \$1,000 a month for insurance. But that doesn't get to the problem; I mean that is part of the problem of the uninsured. One of the things that has happened as a result, particularly in small-employer reforms, is that prior to 1993 individual policies were more expensive than group policies. If you had a small group, it didn't matter if you had 10 employees, you could go out and buy insurance and because it was a group it was going to be cheaper than if everybody went out and bought individually. As a result of guaranteed issue and portability and the "good things" that we did back in the early 1990s and that are now part of HIPAA, it's exactly the opposite. Individual policies, which are medically underwritten, are much cheaper in most cases than comparable group plans.

ANNE DUNKELBERG: If you are a healthy guy.

DAVID PINKUS: If you are healthy. What has happened, though, is as a result we have adverse selection against group plans. Because in many cases, in putting together a real small group, if you are healthy, everybody goes out and buys individual policies and saves money, and the employer pays for it. In my case, I have a company, and my wife is on an individual policy because we save about \$75 a month compared to if I put her on our group plan, and the coverage is about the same. That is an economic decision that I made. But if she had a preexisting medical condition and she explored the individual market and it was more expensive, then I'd put her on the group plan, and that is why group plans are more expensive. So that is one thing that we definitely have to revisit—what we have done with the group plans. The other thing is, on the individual market, if you smoke, you are going to pay a higher premium as a smoker buying an individual policy, but in a group policy, particularly in a small group, you can't differentiate. It doesn't matter whether employees are smokers or not. We have it in the law, and large corporations like Texas Instruments all have wellness programs. They know it pays and they get their employees involved. Under state law, we have a premium discount provision in the small employer plan if the company has a wellness plan. There may be somebody who can educate me on this: I don't know of a single small employer, even a medium-size employer, that has a company wellness program and has taken advantage of that provision. It just hasn't happened, and there is already an economic incentive there. But part of it is because the employees don't have the incentive. The employees have got to get into it and I think a lot of it is education. We need to change the way people do things.

DAVID WARNER: We are going to have to cut it off at this point, but if you have deep questions on this, remember there are five breakout groups, two of which are on private health insurance, and you can also ask questions after the next panel.