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It's Not About Insurance

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RECOMMENDATIONS

- Implement sliding scale cost sharing.
- Enforce aggressive but realistic debt repayment for hospitals and other health care services.
- Increase access to care by removing restrictions on non-M.D/D.O. health care professionals.
- Provide Texans with more health insurance choices by eliminating state mandates and allowing interstate purchasing of health insurance.

One of the hottest topics during the 80th legislative session in Texas was Medicaid reform. The resulting legislation, Senate Bill 10 by Senator Jane Nelson (R-Flower Mound), was passed "with the goal of improving the Texas Medicaid program by focusing on prevention, individual choice, better planning, modernizing services, reducing Texas' rate of uninsured, and helping Texans to live longer, healthier lives."[1] From the directive of that historic legislation, the Texas Health and Human Services Commission (HHSC) submitted a waiver request to the Centers for Medicare and Medicaid (CMS) on April 16, 2008, to "transform the current system." The primary vehicle for transformation will be to create a Health Opportunity Pool (HOP), the basic goal of which is to reduce the number of uninsured in the state. The impetus of this goal is the fact that Texas has the unfortunate distinction of leading the nation in the number of uninsured citizens. A high uninsured rate is commonly assumed to be undesirable based on the theory that it not only results in excessively high emergency department and hospitalization costs but also in poorer health among the state's low-income population. Thus, providing insurance would (1) lower hospitals' uncompensated* care costs and (2) improve the health of Texans.

Therefore, the question driving today's debate on health care has become, "What can be done to insure more Texans?" But, is this the right question to ask to achieve the best public policy?

WHO ARE THE UNINSURED?

Breaking down the number of uninsured reported in the U.S. by the Census Bureau and doing a little math, creates a much different picture of the uninsured than is normally reported in the media. Statistics gleaned from the Census Bureau through the Current Population Survey (CPS) and Annual Social and Economic Supplement (ASES), should be understood in context; the numbers do not reflect:

- how long a given person remains uninsured,
- what percentage of the uninsured population remains uninsured in the following year,
- how many people obtain coverage, or
- any changes in a person's coverage within a given year.[2]

Therefore, a good analysis begins by understanding that the number of uninsured, according to the Census Bureau, includes anyone uninsured at the time the survey is taken, and as stated above, the survey does not include any changes in a person's insurance coverage within a given year. This inflates both the number and the magnitude of the problem by bringing into the total uninsured number, for example, those who lose coverage for a week or a month when they change jobs but are otherwise insured.

*Uncompensated care includes indigent care, charity care, care provided to illegal immigrants, bad debt, and Medicaid shortfall. Medicaid shortfall—costs less reimbursement—represents the largest percentage of uncompensated care.

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Even using the inflated number, Table 1 demonstrates the small percentage of the uninsured population who could be covered by a new government program designed to insure those without reasonable access to insurance, herein defined as the target population of Medicaid reform.

When determining the target population, some people must be removed from the equation. The first category listed in Table 1 is the illegal immigrant population. Regardless of one's perspective on the political issue of illegal immigration, it is not expected that taxpayers would purchase or subsidize health insurance for persons in this country illegally.† The next two populations—those eligible for but not enrolled in CHIP and Medicaid and those with incomes of more than $50,000—can be assumed to be uninsured by choice. Developing another insurance policy for those eligible for Medicaid or the Children's Health Insurance Program (CHIP) makes no sense; they are already eligible for no-cost or very low cost programs but have chosen not to enroll in spite of multiple outreach efforts by the state. Finally, there is currently no discussion in Texas of state funds going to subsidize health insurance for those making more than 200 percent of the federal poverty level (FPL), roughly $50,000 per year for a family of four. The assumption being that this population has the resources to purchase some level of coverage but chooses not to. Removing those making in excess of 200 percent of FPL, illegal immigrants, and those eligible for but not enrolled in CHIP or Medicaid, leaves only 6.4 million, or 2.1 percent, of the U.S. population in the target population, instead of the original 15.8 percent. The numbers for Texas are similar, reducing the target population from 23.4 percent down to only 5.8 percent of the state's uninsured population.

Defining the target population brings focus to the expectations of SB 10 which are to insure 600,000-700,000 by year five, roughly one-half of the target population. As with this proposal, the success of any new program must be realistic. It is difficult to ascertain whether or not insuring the entire target population would result in significantly lower hospital uncompensated care costs or a significantly healthier population. Regardless, even if the new program were extremely successful in reaching the target population, more than three times that number would still remain uninsured.

Table 1: Target Population of SB 10

	U.S. 2006 (millions)	% of U.S. Pop.	Texas 2006 (millions)	% of TX Pop.
Total Population[3]	296.8		23.5	
Total Uninsured	**47**	**15.8%**	**5.5[4]**	**23.4%**
Illegal Immigrants	11.6[5]		1.6*[6]	
Uninsured - Eligible but not enrolled for CHIP/ Medicaid	11.1[7]		0.9[8]	
Uninsured with incomes of more than $50,000	18[9]		1.6[10]	
Target Population	**6.4**	**2.1%**	**1.4**	**5.8%**

WILL THE EXPANSION OF GOVERNMENT PROGRAMS REDUCE THE NUMBER OF UNINSURED?

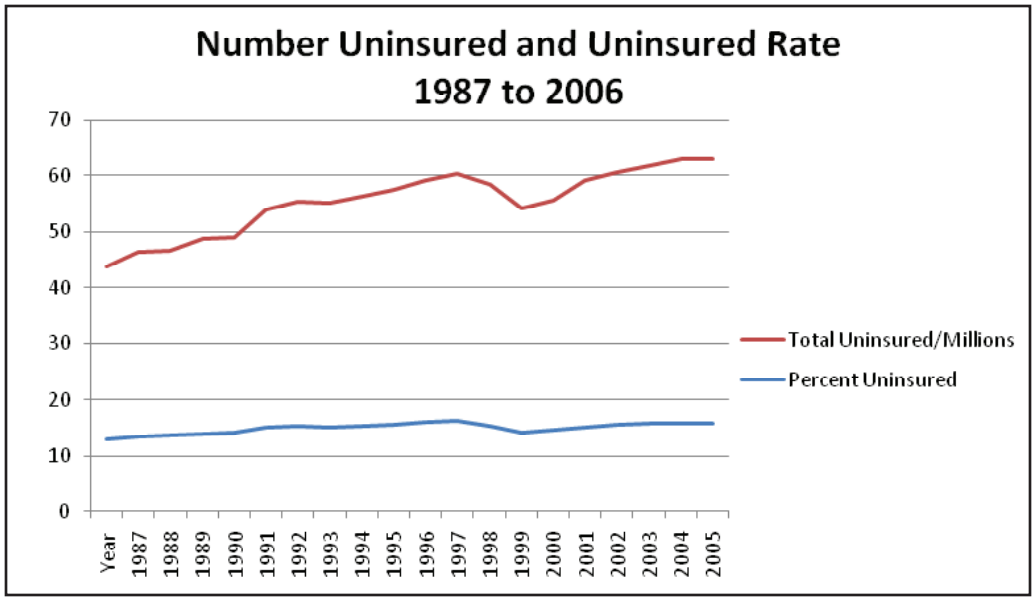
U.S. Census Bureau reports reveal that while the number of uninsured has increased over the past 20 years, the percentage of people who are uninsured has been relatively constant, hovering around 15 percent.

It becomes particularly interesting when that data is placed alongside well-funded, government programs that were designed to reduce the number of uninsured, such as the Children's Health Insurance Program, referred to in Texas as CHIP and nationally as SCHIP. Created by Congress in the *Balanced Budget Act of 1997*, the law au-

* The statistic on the number of illegal immigrants covered by insurance policies is not available and, therefore, not deducted from this number; however, it is assumed by the author to be a very small number. It is unreasonable to assume that the numbers involved could skew the results of this calculation enough to offset the inflation of total uninsured numbers caused by the inclusion of those without insurance for a week or a month.

† This is not to say that persons in this country illegally do not receive health care at taxpayer expense. For example, emergency care hospitals are compensated for care provided to non-citizens through the Emergency Medicaid program, Texas' CHIP Perinatal Program provides standard prenatal coverage regardless of immigration status, and there are also county level programs for primary and preventative care that are funded by hospital district taxpayers. But with rare exception, government does not provide a health insurance policy for illegal immigrants.

Figure 1



Source: U.S. Census Bureau, Current Population Survey, 1988 to 2007 Annual Social and Economic Supplements.

thorized states to provide health care coverage to low-income children who were not eligible for Medicaid and who were uninsured. States were given a particularly generous federal match of three to one as an incentive to participate. By 2000, more than three million children were enrolled nationwide to which one might optimistically attribute the 2 percent drop in the number of uninsured that year. Even that, however, was short lived. Six years later with almost seven million enrolled, the percent of uninsured in the nation exceeded the pre-CHIP number. Increasing the number of people on government-provided insurance was the target that was actually hit—not the intended target of reducing the number of uninsured. That conclusion is confirmed by both the Texas experience and the Congressional Budget Office (CBO).

The Texas Experience

Participation in SCHIP began in some states as early as 1998, but the program was not passed by the Texas Legislature until 1999. Aggressive outreach was in full swing by January 2000, and over the next three years, approximately 600,000 children were enrolled in CHIP and another 300,000 were enrolled in Medicaid through CHIP outreach efforts. At the time the Legislature was considering the legislation, there were a reported 1.2 million uninsured children in the state. Logic would presume that adding 900,000 children to government provided insurance would lead to a dramatic drop in that number; however, 36 months later, the number still stood at 1.2 million uninsured children.[11]

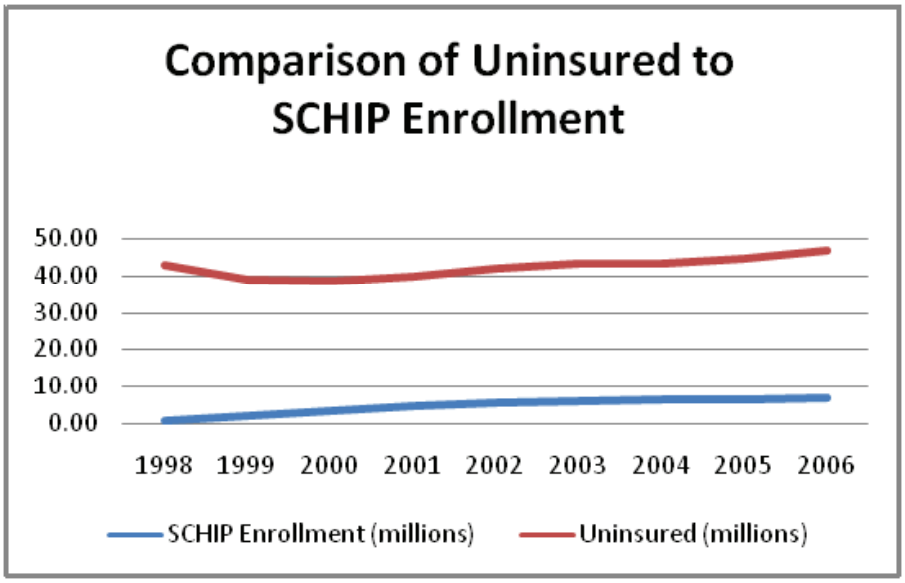
The National Experience

The research of Jonathan Gruber and Kosali Simon issued last year in a working paper[12] for the National Bureau of Economic Research reported, "[T]he number of privately insured falls by about 60 percent as much as the number of publicly insured rises." The largest programs for public insurance are Medicaid and SCHIP, and there is no evidence to suggest that this number does not apply to SCHIP. In fact, a Congressional Budget Office study referenced the findings stating, "According to one study, 60 percent of the children who became eligible for SCHIP had private coverage in the year before the program was established."[13] Other studies lower that estimate and the results vary by state; however, one can conclude that between 25 and 50 percent of the children enrolled in SCHIP had private coverage the year before enrolling, which further validates the conclusion that the intended target was missed.

Downward Spiral

Such instances of government-provided insurance supplanting previously held private insurance is referred to as crowd-out. The impact of crowd-out has often been pointed out when discussing the effectiveness of SCHIP during the re-authorization debate, especially concern-

Figure 2



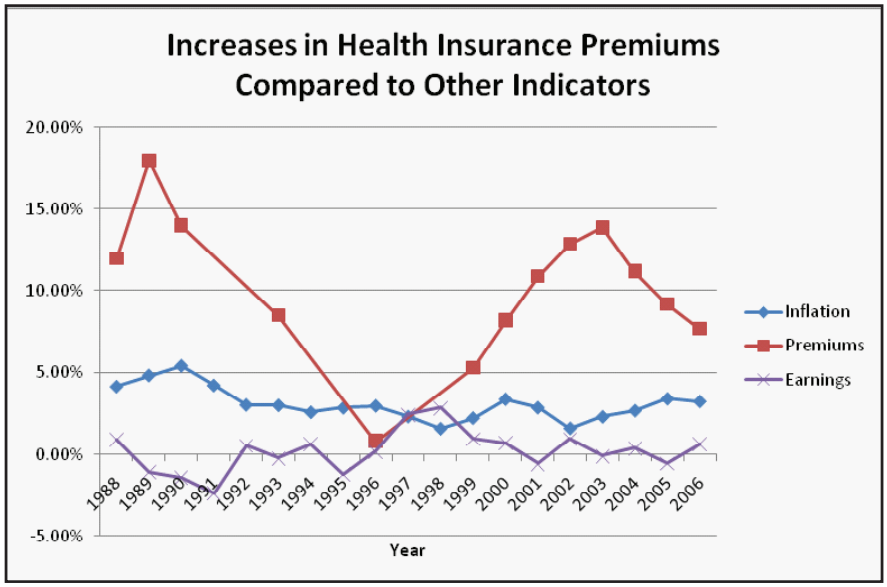
Source: U.S. Census Bureau, Current Population Survey, 1988 to 2007 Annual Social and Economic Supplements.

ing expansion of eligibility to higher income levels where crowd-out is even more pronounced, since higher income families are more likely to be able to afford private insurance for their children. The impact that government-funded insurance programs have on the insurance premium rates for private insurance also warrants discussion. An actuarial table demonstrates that the healthiest segment of the population is the children. This begs the question, does taking 25 to 50 percent of seven million healthy individuals out of the private sector market increase health insurance premiums for those remaining? While a direct cause and effect is not demonstrable, a look at the percentage of annual increases in the cost of health insurance premiums (Figure 2) shows that it certainly has not helped. Reducing the number of uninsured children should have reduced the much-reported cost shifting by providers to private insurance, whereby profits from private insurance are used to balance losses from uncompensated care, resulting in higher premiums. That cost shifting is estimated at $1,500 per policy per year. Instead of less cost shifting reducing premiums, premiums have continued to increase dramatically.

The year 2006 had the highest ever enrollment numbers for children at 6.6 million plus another 700,000 adults enrolled in SCHIP expansion programs; at the same time private insurance premiums increased 7.7 percent. In fact, the lowest percent increase occurred during the five years prior to the enactment of SCHIP. The spiral goes from more children enrolled in government-funded health insurance, which leads to higher insurance premiums causing more people at higher income levels to become uninsured because now they can no longer afford to purchase health insurance. Then concern grows over the high number of uninsured which leads to more expansion of government-funded health insurance. At the same time, taxes will also have increased to pay for all the government-provided health insurance leaving the marginal-income family with fewer resources with which to buy their own insurance.

Answer: To the question of will expansion of government programs reduce the number of uninsured, the data proves the answer to be no. The conclusion drawn from the SCHIP experience is that expansion of government-provided health insurance does not lead to a corresponding reduction in the number of uninsured. And it is not a way to save money—either for taxpayers or for purchasers of private insurance. Instead, government will continually be trying to cover an increasing number of people at a growing cost to taxpayers and health insurance consumers.

Figure 3



Source: U.S. Census Bureau, Current Population Survey, 1988 to 2007 Annual Social and Economic Supplements.

WILL PROVIDING AN AFFORDABLE INSURANCE OPTION TO THE UNINSURED IMPROVE PATIENT HEALTH OR CUT COSTS?

The thrust of the Medicaid Reform proposal in Texas is to create a Health Opportunity Pool (HOP) trust fund that will provide premium subsidies to low-income adults for private sector insurance. The goals as explained on the Health and Human Services Commission (HHSC) website are "…to provide more people with insurance, reduce reliance on expensive emergency room visits for basic care, and make it easier for the working poor to buy into employer-sponsored health coverage." The funding for the subsidies is to come through a waiver which will allow federal upper payment limit (UPL) and disproportionate-share hospital (DSH) dollars to go into the HOP. UPL and DSH were designed to allow additional Medicaid funding to certain facilities (primarily public hospitals) to compensate for higher operating costs due to patient populations that are sicker and more likely to have no health care coverage at all. The presumption is that more people with health insurance will seek care from primary care physicians at an earlier, therefore less severe, stage in their illness thereby lowering both the cost of uncompensated care in emergency departments and the overall cost of treatment. At least three factors will be at play in determining the success of the program: improved health status of the uninsured, fewer emergency department visits for less than an emergency, and the number of uninsured who consider the insurance to be of value and purchase it.

Health Status

First, will having health insurance result in better health status? To answer this question, Helen Levy and David Meltzer published a study, "The Impact of Health Insurance on Health," in the *Annual Review of Public Health 2008*. One of the conclusions reached "…found very little convincing evidence to demonstrate that having health insurance improves population health on average." Another interesting conclusion was "Medicare increases consumption of medical care and may modestly improve self reported health but has no effect on mortality, at least in the short run. Whether there are long-term effects remains an open question…"[14]

Answer: At best, it is uncertain that having health insurance results in better health.

Emergency Department Visits

Second, will having health insurance, particularly government-provided insurance, reduce the number of emer-

gency department visits? A new study published in the *Annals of Emergency Medicine*, the official journal of the American College of Emergency Physicians, comparing emergency department visits from 1996 to 2004 found that the proportion of visits by uninsured actually went down slightly over the decade—from 15.5 to 14.5 percent.[15] Additionally, the study discovered:

> …a significant increase in the proportion of ED visits by those whose usual source of care was a private physician's office. Together, these findings suggest that the rise in ED use is disproportionately due to non-poor individuals who have a usual source of health care. These findings have significant implications for current policy discussions because they suggest that the provision of health insurance will not, in and of itself, address issues of ED crowding or the more general issues of access to, and appropriateness of, health care services.[16]

This chart (Figure 4) from the Centers for Disease Control and Prevention (CDC) shows that Medicaid, SCHIP, and Medicare are more of a problem for emergency departments in the number of visits than the uninsured and certainly more than those covered by private insurance.

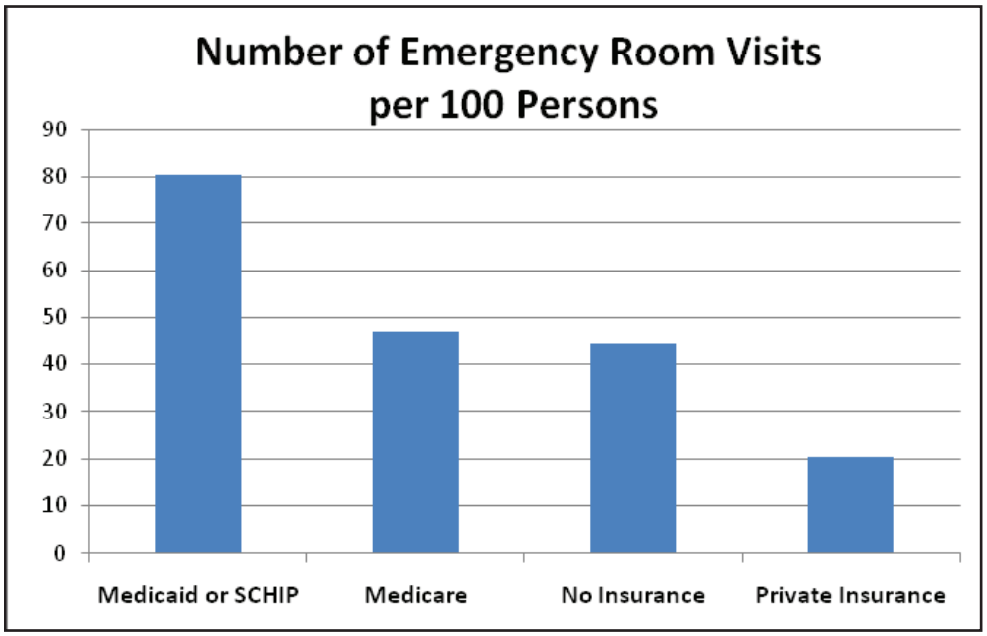
Answer: Evidence demonstrates that a government-provided program would likely increase the number of costly emergency department visits. The fact that the HOP is intended to rely on private sector insurance adds hope. Having a well-structured personal responsibility provision for unnecessary use of the emergency department as a part of the plan design will be of utmost importance in achieving lower utilization.

Perceived Value

And third, will those currently uninsured find value in becoming insured? If those who are uninsured do not purchase the insurance, regardless of the amount of subsidy received, the uninsured rate will not decline. The decision to purchase health insurance depends on the perceived value of insurance coverage and the understood consequences for not participating.

Massachusetts attempted to change the value proposition and increase participation by mandating individual coverage with penalties for non-participation. The current penalty for not having health insurance is up to one-half of a standardized premium cost and is collected through the state's income tax system. Penalties for 2008 are expected to quadruple, but it is still unlikely that the state

Figure 4



Source: Linda F. McCaig, M.P.H., and Eric W. Nawar, M.H.S., Centers for Disease Control and Prevention, National Hospital Ambulatory Medical Care Survey: 2004 Emergency Department Summary, June 23, 2006.

will achieve its goal of universal coverage, as it has been undermined by the expected exemption of 60,000 individuals who could not find affordable health insurance as defined by the Connector's board.[17]

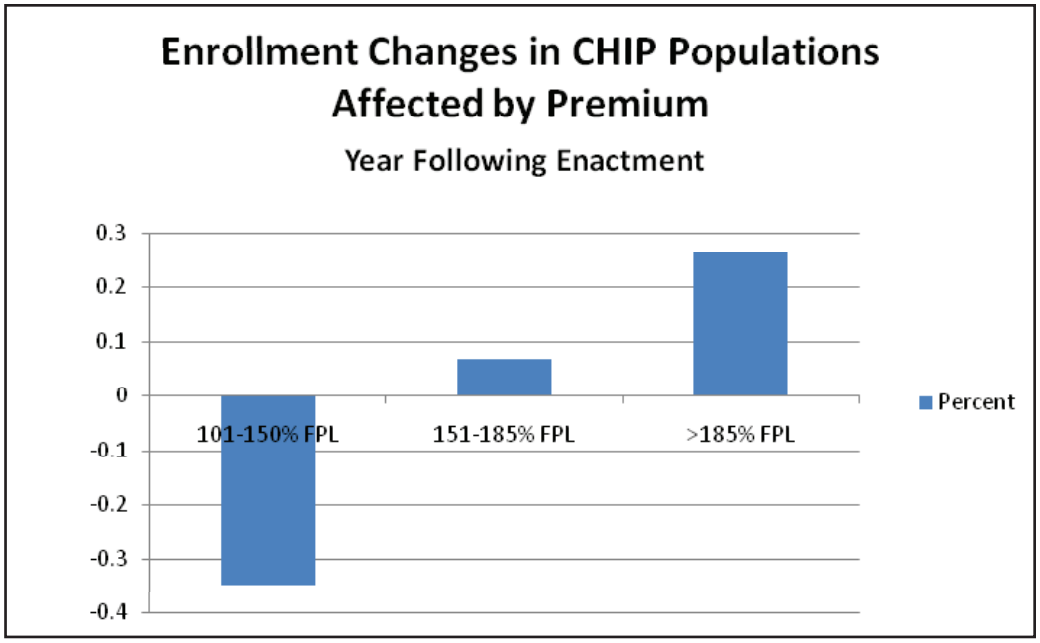
If the real objective of the HOP is to reduce the number of uninsured, what will be the incentive? Texas does not have a tax structure that lends itself to collecting a fine, nor does a truly valuable product require a tax penalty to incentivize individuals to purchase it. Furthermore, the federal mandate (the *Emergency Medical Treatment and Active Labor Act*, or EMTALA) that requires hospitals to treat anyone regardless of insurance status, provides a disincentive to purchase private insurance. Why buy insurance, at any cost, when treatment is free at the emergency department?

A warning sign was given on perceived value with Texas' experience with SCHIP in 2003. A sliding scale premium payment was enacted for those families making over 100 percent Federal Poverty Level (FPL). A modest $15 per month premium purchased insurance for all children, whether that be 1 or 15, in a family earning between 100-150 percent FPL, $20 per month for families earning 151-185 percent FPL, and $25 per month for 186-200 percent FPL. The number of enrollees below 150 percent FPL dropped dramatically (Figure 5). Interestingly, the number increased in the higher income levels even though the premiums increased by 1/3 and by 2/3 over the lower income premium. Perhaps those making 101-150 percent FPL weighed the cost and found even $15 per month an unvaluable investment when they would likely qualify for free care at the hospital.

A BETTER QUESTION

SB 10 was built on laudable goals—protecting the state's UPL and DSH funding by transforming it into a federal block grant, boosting the individual insurance market, and modernizing services. But healthy skepticism, informed by the results of previous efforts, certainly raises questions about the likelihood of significantly reducing the uninsured. In this case, since such a large portion of the uninsured population will not or cannot be covered by the reform measures, it is unlikely that the program can reduce the rate of uninsured by more than 5 or 6 percent, leaving almost 20 percent of Texas' population a burden to Texas taxpayers.

Figure 5



Source: Texas Health and Human Services Commission, http://www.hhsc.state.tx.us/research/CHIP/CHIPEnrollIncomeGroup.html.

Those seeking to obtain universal health insurance coverage have yet to find a workable plan. The full-scale socialized medicine model employed by Canada and so admired by those pushing for a single-payer system in the U.S. is being abandoned. As reported last month in the *Investor Business Daily*, "the godfather of Canada's health care system, Claude Castonguay, has concluded that four decades after it began, the system now is in crisis" and has advocated that private insurance be legalized.[18] The less inclusive Massachusetts plan is already more than 30 percent over the original $472 million budgeted for the current year. For the fiscal year just begun, the *New York Times* reported that the governor "has requested $869 million for Commonwealth Care, but his aides have already conceded that will not be enough as enrollment continues to grow,"[19] and projections range up to $1.1 billion. Even less ambitious programs that expand government coverage only to a specific population, such as SCHIP, fail to deliver one hundred percent of those eligible into the program.

Rather than continuing to chase after an unattainable answer to the question, "How can we reduce the number of uninsured?" perhaps it would be better to ask, "How do we improve access to care without increasing reliance on government or increasing the cost to taxpayers?"

CARE, NOT INSURANCE—IN THE PRIVATE MARKET

Free enterprise solutions for primary care are already beginning to surface. These market responses should be allowed to evolve and barriers to innovation removed.

One response is the increasing number of family practice physicians who have transformed their practices into cash-only businesses. Weary of all the red tape, practice restrictions, and low reimbursements from managed care arrangements, many physicians have returned to the old model of cash payment at the time of service. Reviving this business model and eliminating the administrative burden of insurance claims processing and patient billing has allowed physicians to discount their fees by 30-50 percent.[20]

For patients with insurance, a completed insurance form (the standardized CMS-1500) is provided for them to send to the insurance company for reimbursement. This model of payment is particularly admirable in that it restores the proper financial relationship between the patient and the doctor. The insurance policy belongs to the patient, not the doctor, yet, it is the doctor who bears the administrative responsibility and associated costs. Physicians want to practice medicine—not accounting, and neither party in the transaction has an incentive for controlling costs since the patient is not the direct payer for the care received and neither patient nor doctor is rewarded for controlling costs. Cash-only practices eliminate the middle man who stands in the way, keeping prices artificially high.

The second free-market solution is the emergence of convenient care clinics. Located in discount stores and high-volume pharmacies, convenient care clinics are primarily staffed by nurse practitioners and live up to their name by delivering basic primary care at a time and place convenient to the patient. Prices are posted and the patient is seen without an appointment, generally within 15 minutes. Convenient care clinics provide access to health care, including many uninsured, at very reasonable prices and give consumers an alternative to the highest cost provider, which they are traditionally limited to.

Combining either of these options with an inexpensive, high-deductible insurance policy provides affordable primary care and protection for major illnesses or accidents.

CARE, NOT INSURANCE—IN THE PUBLIC SECTOR

No doubt the state still faces a large number of individuals who cannot afford health care at today's prices. The partnership between the University Health System (UHS) and the San Antonio Metropolitan Health District, Bexar County's mental health and mental retardation agency, non-profit clinics and local private providers has incorporated operating provisions that should be explored by the state as it looks to tackle the cost of providing indigent health care.

Innovations began in 1997 with the creation of CareLink—a new approach to combating uncompensated costs. Bexar County residents with an income of 200 percent FPL, treated in the hospital and incurring debt are enrolled in CareLink, University Health System's care program for the uninsured. Texas counties are required by state law only to cover indigent care costs up to 21 percent of poverty, so it was attention grab-

bing that UHS covered up to 200 percent and was, at the time, the only hospital district in the state that was in the black. CareLink is not an insurance offering, but the program offers the best advantages of insurance—a medical home and negotiated rates. But unlike Medicaid HMOs, CareLink requires a monthly debt repayment based on a realistic sliding scale, which requires everyone to pay something and UHS is serious about collecting.

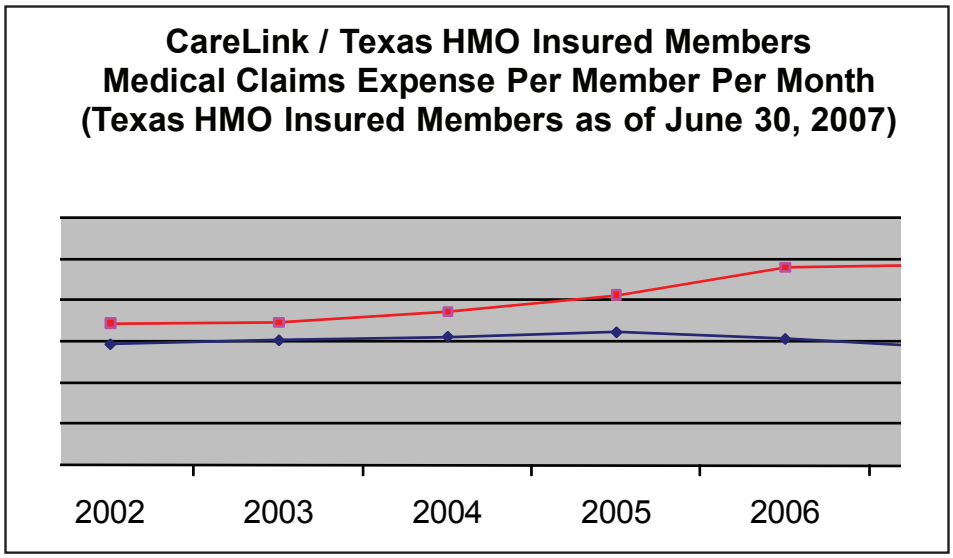
An additional benefit for the enrollee is 340(b) pricing[21] for pharmaceuticals, the lowest price in the nation, plus an aggressive system of maximizing free medications from pharmaceutical companies. The savings go to the patient, but a co-pay, based on the individual's ability to pay, is required. A recent interview with George Hernandez, Jr., President and CEO of UHS, revealed that the innovations do not stop with the CareLink program.

- A new financial software program was purchased allowing electronic scheduling, billing, and collection for patients.
- Providers are now paid on a fee for service basis at the Medicare rate, instead of an FTE basis.
    - This method is much more cost effective in that the system pays only for services rendered.
    - Allows UHS to utilize community providers willing to contract rather than building additional brick and mortar infrastructure.
    - Also allows CareLink enrollees access to more specialists.
    - Provides the system with more encounter data to better analyze services provided to enrollees.
- Community partnerships have been forged.
    - The Center for Health Care Services (CHCS), the county's mental health and mental retardation agency, was one of the first partnerships formed. By enrolling qualified residents into CareLink, mental health clients now had access to comprehensive primary and specialty medical care. Moreover because its clients were now CareLink members, CHCS was able to save $1.2M of its pharmaceutical budget. While these costs shifted to CareLink, the CareLink expense was significantly less because of 340(b)* pricing for prescription medications and the Health System's well developed drug vendor medication assistance program. CHCS's pharmaceutical savings were then used to serve other mental health needs in the community including clinics for milder mental health conditions and a jail diversion program that focuses on proper identification and continuity of care.
    - CareLink contracts with existing clinics serving primarily underserved populations.
- The latest change has been the addition of the CareLink Plus program for uninsured with incomes between 200 and 300 percent FPL.
    - This program does not include the sliding scale for repayment, but it does allow those persons to take advantage of CareLink's negotiated rates and access to the CareLink provider network.
- One of the most impressive advantages to the CareLink program has been the case management initiatives. Hernandez attributes aggressive management of high cost cases for an 80 percent reduction in the number of hospitalizations and a similar reduction in total estimated cost of both hospitalizations and ER visits.

The result of all these innovations is clearly measurable and evident in Figure 6.

* "Established by a 1992 law, the 340B program allows qualifying providers to purchase drugs for outpatient use at significantly reduced rates: approximately 20 percent below the Medicaid price. Eligible providers include federally qualified health centers, 'disproportionate share' hospitals, and certain clinics that focus on specific diseases such as AIDS or hemophilia." (Mertz)

Figure 6



Source: George Hernandez Jr., University Health Systems, Testimony to the Senate State Affairs Committee meeting on the uninsured, March 26, 2008.

RECOMMENDATIONS

Promote the principles of CareLink, such as:

- Use of a sliding scale in every program possible,
- Aggressive but realistic debt repayment for hospital and other services,
- Maximize community resources, and
- Implement case management, where proven improvement in health outcomes resulting in cost savings can be demonstrated.

Using a realistic sliding scale does not trap people in a low income type of "glass ceiling." The all-or-nothing eligibility for Medicaid strongly discourages recipients from earning a higher income. It also teaches personal responsibility and reinforces the expectation of paying for one's own health care needs.

SB 10 is on the right track in promoting the development of Health Savings Accounts that promote competition and efficiency by allowing consumers to decide where to spend available health care dollars and promote personal responsibility by deciding which services they need. More opportunities for HSAs should be allowed. Other initiatives that could be explored are:

- Allow interstate purchasing of insurance so that Texans are not held captive by insurance mandates that increase costs, making a basic policy either unattainable or unaffordable.
- Increase access to care and increase competition by increasing the pool of qualified, primary care providers by removing restrictions on non-MD/DO independent health care professionals.
- Explore alternative payment methods that would encourage more efficient treatment procedures. Harvard Business School professor Regina Herzlinger suggests in her book, *Who Killed Health Care*, the bundling of treatment payments whereby providers create their own network to treat all aspects of a condition and receive a single payment for total care. For example, a provider group might be given one fee for the care of a diabetic patient and would bear the responsibility for payment of all aspects related to diabetes by contracting with a "team"—a dietician for educating on the proper diet, a pharmacist for medication management, an optometrist for monitoring retinal health, an internist for treating circulation, and so on. In that model, keeping the patient well would produce profits rather than treating illness. Because the provider team's single fee would cover expensive hospitalizations as well, consulting and case management would become profitable in an effort to keep patients out of the hospital and at the primary care level as long as possible. Providers would be willing to invest in the patient's health because they would not fear that a change

in insurance would send the patient to someone else the next year who would receive the financial benefit from the wellness of the patient. The team leader would not supervise the other team members but would instead be responsible for case management.

CONCLUSION

It is not a shortage of ideas that has created our health care problem; rather it is a lack of freedom to try out the ideas and a tendency to rely on government assistance to cure the problem. In the name of protecting the public, statutory restrictions and the resulting regulatory maze have created a system so complex that innovations in health care are almost impossible to achieve, making health care unaffordable and inaccessible for too many Texans.

Rather than looking for ways to expand government sponsored health coverage, allowing the free market principles that encourage innovation and competition in every other sector of our economy to govern the health care market is a better way of ensuring that more Texans have access to the health care they need without putting an unnecessary burden on taxpayers. By incorporating free market principles to make private insurance more affordable and pushing government programs toward efficient models of care rather than insurance, Texas can lead the way in hitting the right target—a healthy state with a healthy economy. ★

ENDNOTES

[1] Senate Bill 10 (80-R) Bill Analysis, http://www.capitol.state.tx.us/tlodocs/80R/analysis/html/SB00010F.htm.

[2] Bureau, U. C. (5 Oct. 2005). Overview, Survey of Income and Program Participation (SIPP) (retrieved 10 July 2008, from Health Insurance) http://www.census.gov/hhes/www/hlthins/overview.html; Turner, G.M. (27 June 2008) Galen Institute (retrieved 9 July 2008, from Newsletters, Single Payer Redux) http://www.galen.org/component,8/action,show_content/id,14/category_id,0/blog_id,1057/type,33/.

[3] U.S. Census Bureau, "Current Population Survey (CPS)" (1 July 2006) http://pubdb3.census.gov/macro/032007/health/h01_001.htm (accessed 17 June 2008).

[4] Carmen DeNavas-Walt, Bernadette D. Proctor, Jessica Smith. "Income, Poverty, and Health Insurance Coverage in the United States: 2006," U.S. Census Bureau (27 Aug. 2007) http://www.census.gov/hhes/www/hlthins/hlthin06.html (accessed 17 June 2008).

[5] Michael Hoefer, Nancy Rytina, and Christopher Cambell, "Estimates of the Unauthorized Immigrant Population Residing in the United States: January 2006," US Department of Homeland Security (Aug. 2007) www.dhs.gov/xlibrary/assets/statistics/publications/Ill_Report_1211.pdf.

[6] Ibid.

[7] Lisa Dubay, John Holahan, and Allison Cook, "The Uninsured and the Affordability of Health Insurance Coverage," *Health Affairs*, 2006: W27.

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About the Author

Arlene Wohlgemuth is a visiting research fellow at the Texas Public Policy Foundation's Center for Health Care Policy. Prior to joining the Foundation, she served for 10 years as state representative for district 58.

During the 77th legislative session, Wohlgemuth served as chairman of Appropriations Article II Subcommittee (Health and Human Services), vice-chairman of Calendars, CBO for Human Services, and member of the Select Committee for Health Care Expenditures. Wohlgemuth authored HB 2292, the sweeping reform of Health and Human Services which improved service delivery for the recipients and will save taxpayers more than $3.7B during its first five years. The reform included consolidating twelve HHS agencies into five and is the largest government reform bill ever passed in the state. Organizational changes led to the early discovery of problems within Child and Adult Protective Services. The creation of the Office of Inspector General and the additional authority and funding given to the Office of the Attorney General led to Texas being recognized for fraud prevention/prosecution and was given the nation's top fraud-fighting award last September by the U.S. Department of Health and Human Services.

Wohlgemuth served as president of the Texas Conservative Coalition, chairman of the TCCRI Health and Human Services Task Force, and chairman of the TCCRI State Finance Task Force. She was twice named to *Texas Monthly's* "Ten Best" List.

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