50 Million Uninsured: The Faces Behind the Headlines

Alliance for Health Reform
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ED HOWARD: I guess we're two minutes late. My name's Ed Howard with the Alliance for Health Reform. We want to welcome you to this program to look at the newest official estimates of the number of uninsured Americans and I hope to look behind those numbers at the meaning -- at their meaning for the economy, for the health of the country and not least, for the lives of the people who are in fact uninsured. I extend that welcome on behalf of our Board of Directors, Senator Rockefeller and the entire Alliance staff as well.

Now the Census Bureau announced the results of the current population survey estimates of the uninsured last month and found that 49.9 million people lacked insurance in 2010. Up almost a million from 2009. Now some people raise probably legitimate questions about the absolute accuracy of the Census Bureau numbers. After all another government survey issued recently found only 46 million people are uninsured. But here are some thoughts that I'd like you to keep in mind as you listen to the experts up here really discuss these numbers.

First, and this is particularly true over time, no matter what survey you consult, the number of uninsured in this country is rising inexorably. Diane Rowland and I were on the staff of the Pepper Commission more than 20 years ago. A commission that made recommendations to deal with the crisis

that in 1988, 32 million Americans were without insurance. It's a small consolation that the percentage of the population without coverage hasn't grown that much from just under 15-percent back then to 16.3-percent last year, but the actual number is 50-percent higher. So that's one.

Second, coverage matters. The Institute of Medicine concluded a couple of years ago that the lack of insurance impairs not only the health of the uninsured but the health of those with insurance in those communities where the un-insurance rate is high. And you'll hear fairly dramatic evidence today of the impact of the health of people who are uninsured when they enroll in Medicaid.

Third, the uninsured can't and don't get the care they need in emergency departments. Hospitals can stabilize patients who present in those departments, and in fact they are required to under federal law, but then they can discharge them. And they very often do that too.

Now the Patient Protection and Affordable Care Act has its detractors. And on a briefing that we held Tuesday, we heard some predications that to keep coverage expansions in that act might be postponed because of fiscal concerns. But whether one agrees with how the reform law pursues its goals, we can't lose sight of why anyone was interested in passing reform legislation in the first place. That is, primarily

anyway, to address the unconscionable fact that 1 out of 6 Americans lacks health coverage.

Now our partner and co-sponsor in this briefing is the Kaiser Commission on Medicaid and the Uninsured. A major project of the Kaiser Family Foundation. Both the Family and the Commission -- the Foundation and the Commission are among the most respected voices and sources of information about the uninsured in this country and we're very pleased to have representing both of those institutions, Diane Rowland, executive vice president of the Foundation, executive director of the Commission, and I should note, chairman of the newly created Medicaid and CHIP Payment and Access Commission. Not to mention her checkered history as a former staffer of the Pepper Commission.

Diane, thank you for being with us.

DIANE ROWLAND: Thank you, Ed, and thank you all for coming out on a dreary day to hear about the uninsured which can be a dreary topic, but I know today it's going to be one in which we see a lot of faces and hear a lot of the human stories as well as the trends behind the uninsured numbers. And I think that's the most important thing. We sometimes as we talk about Healthcare Reform get so caught up in talking about exchanges and about all the ways in which Medicaid expansion will occur and FMAP and blended rates that we lose sight of

what Ed has pointed out is a fundamental part of what health reform was all about, which is trying to provide health insurance coverage to some of the 50 million uninsured and the nature, the profile of the uninsured population lends to different strategies within the health reform legislation. And I think today we'll be providing you with some very important background on who the uninsured are, why their uninsured, what's been happening over time to the uninsured population, and what some of the consequences of that are for their access to care and for the providers and safety net facilities that are caring for them today.

So I welcome the discussion and I'm glad that we continue to do this, though I hope the next time we track the uninsured down the road, we can go from 50 back down. Not because census change the way they calculated a few numbers, but because we have a real decline in the number of Americans without insurance. Thanks.

ED HOWARD: Thanks, Diane. A little bit of housekeeping. There's a lot of material in your kits. All of it and additional material that wouldn't fit in those kits is at all health.org. On Monday, you'll be able to watch a web cast of this briefing on KFF.org thanks to our friends at the Kaiser Family Foundation. There's a green question card in your kits that you can use once we get to that part of the

program and a blue evaluation form that my cousin Veto will insist that you fill out and hand in before you leave.

Now, let's get to what I believe will be a -- one of the more interesting programs that we've ever had. And we're going to start off with Rachel Garfield, a senior researcher and an associate director at the Kaiser Commission on Medicaid and the Uninsured. She is in charge of the Foundation's work and the Commission's work on the impact of health reform on coverage and access of care, and a number of related topics.

She holds a doctorate in health policy from Harvard and came to the Commission from the faculty of the University of Pittsburgh. So we're pleased to have you, Rachael. Go right ahead.

RACHEL GARFIELD: Thanks so much. I'm happy to be here. So my role today is to lay out some of the numbers that we're going to try to get behind on the panels, specifically with some of our other panelists who are going to dig into what are the consequences of having a large uninsured population, but someone has to be the data geek who lays out all of the facts and figures and today that person is me.

But I'm going to try not to bombard you with too many charts and numbers, just provide enough information so that

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you can understand why it is that people lack insurance coverage, who's at risk for being uninsured, and what the uninsured population looks like today. Now, the first step in trying to figure out, well, why is it that people don't have health insurance coverage is to actually look at the health insurance coverage system that does provide coverage to people and think about what some of the gaps in that system are.

And so what you see here in Figure 1, is how coverage is distributed among the non-elderly who we focus on because by and large, the elderly are covered by the Medicare program. And what you can see is that a majority, about 56 percent of the non-elderly receive health insurance coverage through either their own job or through a family member's job, but what you can also see in this figure is that the employer-based system does not reach everyone.

So obviously, if you're not connected to the work force, you're not going to have access to that kind of coverage. In addition, many people are working, but not all employers offer coverage, so it's simply not available to some people. A small slice of the population, about five and a half percent purchase coverage in what we call the none-group market. This is when someone goes directly to the insurance company, either themselves or through a broker to

purchase coverage.

This has been consistently a small slice of the market because coverage purchased in this way is often very expensive. It can be quite limited and there are also some administrative challenges to getting coverage in this manner. Just under 20-percent of the non-elderly population is covered by the Medicaid program. And here, we're also including the children's health insurance program in this slice of the pie and this program is targeted to low-income individuals, but it doesn't reach everyone who's low income and we'll talk about that in a little bit.

But that leaves about 18 and a half percent of the non-elderly population without any source of coverage in 2010. Now, the major coverage provisions of the affordable care act do target a large majority of this uninsured population, and you can see how they layout on the right-hand side there according to the general eligibility for the Medicaid expansion, up to a 139-percent of poverty and then the available of subsidies for people up to four times the poverty level.

But a couple of things to keep in mind: The affordable care act is expected to make a big dent in the number of uninsured, but not to capture everyone so people will remain uninsured even after it's implemented. In

addition, these coverage provisions don't go into effect until 2014. Which, for policy makers seems like it's just around the corner, but for uninsured people, it seems like it's still quite a ways off.

Now, the major reason that people are uninsured is affordability. So it's not surprising to see that insurance coverage varies by income. And what you can see here in Figure 2, is that -- starting on the right-hand side -- for those who are in the highest income group, that is four times the poverty level, the vast majority are covered by either employer based or other private coverage and just five percent lack insurance coverage.

In contrast when you move to the lower end of the income spectrum, you see a much more limited role for employer coverage in these income groups and there are a few reasons for this. As I mentioned before, not all employers offer coverage and we know that certain types of industries, such as the service industry, the agriculture industry are less likely to offer coverage to their workers.

In addition, certain types of firms, specifically small firms or firms with many low-wage workers are also less likely to offer coverage. And you can see that here in, again, the limited role that employer base coverage plays for people who are low income. Medicaid and CHIP fill in some of

the gaps for that population, but not all and so the low income have a very high rate of uninsurance. For people who are poor, it's 34-percent, and for those who are up to twice the poverty level, who we've considered to be low income, it's almost 30-percent.

Now, the main reason that Medicaid doesn't reach all of the poor and low income is because of the way that eligibility for that program is structured right now, and here in Figure 3, you can see some examples of that. So in comparison to children for whom eligibility levels in most states target most low-income children, eligibility for adults is much more limited and in particular, for adults who don't have dependent children, in most states, you are ineligible for coverage no matter what your income. And this is one of the reasons the differences in the availability of the safety net that we see adults at much higher risk of being uninsured than children.

Now, the last piece of the puzzle to think about in understanding why people don't have insurance coverage is what's going on with insurance itself. And here, I'm presenting some data from our annual survey of employer health benefits and what we found was that in 2011, the average annual premium for family coverage, that's coverage for a family of four, was over 15 thousand dollars. And this

has increased a 113-percent over the last decade. In addition, you can see that employees are covering a significant share of that cost, over 4000 dollars, and in addition, the cost to employees has increased over time as well.

And so obviously, the increasing cost of health services and correspondingly of health insurance coverage has implications for the availability and the accessibility of coverage. So when you're thinking about why people are uninsured today and what these reasons, you really see that when you're looking at the profile of the uninsured. So you see, for example, the implications of the inability to afford coverage, the lack of access to employer-sponsored covering, and limits in the safety net.

Most of the uninsured are in working families. 84-percent have at least one worker in the family and nearly 60-percent have a full-time worker in the family. So these are people who through their employer, either are not offered coverage, or if they are offered coverage, is prohibitively expensive for them and they can't take it up. Most of the uninsured are low income, and in fact, 41-percent are living below the poverty level.

And in addition, most of the uninsured are adults and within adults, adults who don't have dependent children, who

as I mentioned, are not eligible for this safety net coverage. Now, these three factors that I'm talking about, also vary geographically. And so you see variation across the nation in the percent of people who are uninsured, and again, this is linked to those same three factors. The distribution of poverty across the county. So areas with a higher share of the population living in poverty tend to have higher uninsured rates.

The nature of the industry in the region matters because, as we talked about before, whether or not a firm offers coverage is related to the nature of that industry, and then of course the availability of the safety net since states set eligibility levels for Medicaid, whether or not you're eligible for that coverage is going to depend on where you live. Now, in closing, I want to just loop back and give a little preview of some of the comments later by saying the reason we care about this is not because we care where someone falls in one of the slices in one of my pie charts.

The reason we care is because we know from many, many years of research, that having health insurance matters for how you interact with the health system. Survey after survey has shown that people who don't have insurance coverage have a harder time accessing services, whether they're kids or adults, whether they're trying to get preventative services

or they're already sick and trying to get services to treat something that they need and Kate will present some really compelling evidence to update our understanding of this point.

In closing, I just want to remind everyone that of course the main reason we care about this issue isn't because of these numbers at all. It's because each number on my chart represents a real person who is uninsured and struggling today. This is a bit of a preview from a project we're working on called, The Faces of the Uninsured, in which we are interviewing people who don't have insurance coverage to try to understand what their lives are like.

And so I would like you to just bear in mind throughout the rest of the section today that there are people like Will Wilson, who is living with H.I.V. AIDS, and is working, but has been uninsured for 10 years. People like Margie Barlow whose children are covered by Medicaid. She herself is unemployed and has racked up about $30,000 in medical debt for services for her and her husband.

And Stephanie Simco, who is a teacher and a grad student, who's trying to work to get herself to a better place but she has to spend four hundred dollars a month out of pocket for drugs to treat her Type 1 Diabetes. And so I hope that we can keep these people in mind throughout the

rest of the panel.

ED HOWARD: Great. Rachel, that's one of the least nerdy numbers presentations I have ever heard. Thank you very much.

[Interposing]

ED HOWARD: Now we're going to turn to John Holahan who's the director of the Health Policy Research Center at the Urban Institute. He's one of the most respected analysts in the county in all things Medicaid for sure. He's also published research on the reasons for the growth in the uninsured over the past decade and he has a new paper on the Urban Institute website. If you haven't taken a look at it, you really should, on ways to contain growth in health spending, which is not unrelated to this topic. John, thank you for being with us and go right ahead.

JOHN HOLAHAN: Okay, thanks. Yeah, this is from a paper that I'm writing with Vicki Chen who's here and it should be out in a few weeks, I hope. What I want to do today is to make a few comments about what happened in the last year when -- since this release date in September, then take a broader look at the past decade and then focus a bit more on the 2007-2010 period which, for all intensive purposes, has been the great recession, even though it's

officially, apparently over, but we all know it really isn't. So what happened in the past year?

The uninsured increased by eight hundred thousand. The rate of employers sponsoring insurance declined for both adults and children by 0.7 percentage points. And in this presentation I'm going to mention percentage points a lot. Keep in mind that overall when we're talking about the whole population, one percentage point is 2.7 million people. So if you move something by a percentage point, it's a lot.

Obviously, it's less if you break it up and look at adults, or children, or low-income people, or whatever, but anyway, it's a significant move. At the same time, Medicaid and CHIP coverage increased for children, but not for adults. So this meant that the expansion of Medicaid and Chip offset the decline in employer coverage among children, but not for adults. Thus the number one insured increased for adults, but not children. Adult uninsured went up by nine hundred thousand. Kids fell by one hundred thousand.

I think the most interesting thing probably that we saw this census -- because those trends are consistent with what we've seen in other years -- is what happened to young adults ages 19 to 25. As I'm sure you know, there's a requirement in the ACA that claims that often dependent coverage has to offer and make that coverage available to

those up through age 25. And here, I think we see that it already has had an effect. We saw significant increases in private coverage for young adults and uninsured rate declines from 31.7 to 30-percent.

We don't see this for other age groups so it seems likely that it is an ACA fact and it's shown here in this chart -- if you look at the left side -- age 19 to 25, increases in private coverage of 1.5 percentage points, pretty much translated into a drop in the uninsured by 1.7 percent points. There was no statistically significant change for those 26 to 34, but there were significant changes for the two older age groups and in the opposite direction.

The lowest employer coverage and had increases in their own insurance rates, so that the uninsured fell among young adults by four hundred thousand and increased for the other age groups. Pretty hard to see any other explanation other than the Affordable Care Act. We went back and looked at the year before. Everybody's losing private covering and uninsured rates are going up for everyone. So I think that's the most interesting thing that came out of it. This year's release -- let's go back and look over the last decade.

We began the decade with the recession. Unemployment rates increased, incomes fell, particularly adjusted for inflation. State revenues declined up until about 2004.

Then we had a modest recovery where there's slight increases in incomes and the unemployment rate went down. And then we had a rapid deterioration in the economy and unemployment rates went up to over nine percent where they still are today. This chart shows changes in real median household incomes and real per-capita incomes.

As you can see, they decline in the first four years during that recession, although we go at it, a little bit beyond the official dating of that recession, and then start to increase modestly, but they never get back by 2007 to where they were in 2000, in inflation adjusted terms, and then fall over quite a lot between 2007 and 2010. The drop in real median household income is about ten percent. Real per-capita, about 6-percent.

So clearly, we had a sharp jolt to the economy. This looks at the net change in the population over that period, looking at under 200, 200 to 400, and 400 percent of poverty, and the net growth in population is all kinds of things happening. Births, deaths, people moving above the age of 65, because this is just a non-elderly, in and out migration from the -- into the county and out of the county and then up and down the income ladder. So it's the net change.

What you see on the left-hand side is that all of the growth in the net growth in the U.S. population is among

those below 200-percent of poverty. It went from 80.6 million people to 105.1. In the other two groups, over the decade they both declined. Over and above the economic problems caused by this, people are moving down to an income strata where they're much less likely to have employer coverage and much more likely to be uninsured. So we'll look at that in a bit more detail.

The change in coverage for adults between 2000 and 2010, employer coverage over the entire period fell by 10 percentage points. It fell sharply in the early recession of this decade and then still continued to fall a bit even as the economy was improving and then has fallen again. So employer coverage declines for lots of reasons. The main one is that we see faster growth in premiums relative to wages and it becomes unaffordable either for employers or for employees to take up employer offers, but there are other things going on.

We're having movements in the work force from what we call high ESI industries or high employer -- high industries with high levels of employer-sponsored insurance to low. Think about moving from manufacturing or unionizing manufacturing to service industries, shifts from the North and Midwest to the South and the West where there's much lower levels of employer coverage and much higher rates of

uninsured. And then we're just having a loss of income.

People lose jobs, they take jobs that don't pay as well, and along with that, are less likely to offer employer coverage. So along with the drop in employer coverage, you see some increases in Medicaid and state coverage for -- for adults, but not enough to offset the drop in employer coverage. So as a result then, the uninsured rates increased. They increased over the decade from 16.5-percent to 22-percent, and number of uninsured adults went up from 27.8 to 41.2-percent.

For children, the pictures are pretty different. The changes in employer coverage are almost identical. A big drop during both recessions and a smaller drop during the recovery, but Medicaid and CHIP expansions were enormous increasing from 16.5-percent of the population to 29. So the number of uninsured -- the uninsured rate fell and the number of uninsured declined as well. In the next few slides, just look at the last three years, the period of the recession and make some of the same points. It's just a different way of looking at it.

It's like looking at the change in various kinds of coverage. What's missing here is non-group coverage. Medicare and Tri-care. If I had every type of coverage in there, the numbers that are below the line would have to be

offset by numbers above the line. So if the rate of employer coverage is falling, some other form of coverage or the uninsured has to increase by a comparable amount so you get back to a hundred percent of the population.

So what you see among adults is a drop of 4.8-percent, percentage points in the likelihood of having employer coverage. Medicaid offset it, offset that a bit, increasing 1.4-percent, but the uninsured rate went up by 3-percent. The overall growth in population was 3.9 million so it's the combination of the growth in the population and the increase likelihood of being uninsured that gets you to the 6.3 million more adults who are uninsured. For kids, the rate of employer sponsored insurance, the loss of that is the same, but the rate of increase in Medicaid and CHIP more than offsets it so the uninsured rate comes down.

There's a small increase in the child population, but that's dominated by the drop in the likelihood of it being uninsured so the number of uninsured kids falls. The next chart looks at the low income slice of that population. And it's important to look at that because that's where most of the action is. Low income adults and children are less likely to have ESI and to become uninsured, but at the same time, we're really growing that low income population.

So as you can see there, employer sponsored insurance

falls by 3.4-percent, a little bit of increase in Medicaid, and an increase in the uninsured rate. But if you look below, the low income population increased by 10.1 million people. So taken together, the increased size of the low income population and the increased likelihood of being uninsured, you get to 5.6 million more uninsured. For kids, you get a very different story. Pretty much the same decline in employer coverage, but the big increase in Medicaid and Chip, decline in the uninsured rate, and that decline was enough to pretty much offset the growth in the population and so you end up with a small increase or small decline in the number of uninsured kids.

The next chart looked at is something really related to the recession. What happens to people who are working and this shifts from work to non-work. What you can see there is that if you were still working, or if you were in a household with two full-time workers or one full-time worker, you get a loss of employer-sponsored insurance, but it's not great. It's by and large offset by increases in public coverages and there's only small changes in uninsured. But what you see there is down at the bottom, that the number of people living in a household with two full-time workers falls by 7.2 million. One full-time worker, by 3.8 million. So there's not much change overall in the number of uninsured.

Where you're seeing it is in people who are moving to a family with just a part-time worker or to no workers. The size of those populations increase a lot. They are less likely to have employer coverage, had higher uninsured rates. So between the change in their uninsured rates and how many more people were moving into that status, really explains a lot of what we've seen in terms of the change in the uninsured.

A few more points: About 60 percent of the increase in the uninsured is among whites, about 85-percent was among native citizens, actually the number of non-citizens in this period actually declined a little bit and they only accounted for a hundred thousand of the 5.7 million uninsured. The increase in the uninsured is distributed across all regions, all regions lost employer coverage, and all had increases in their own insured rate. The South probably did a bit worse but not by a lot.

So to wrap this up, we see a longstanding secular decline in employer-sponsored insurance exacerbated tremendously by economic downturns, went through the reasons for that so I won't repeat it. We saw increases in public coverage for adults that were modest that help offset some of that decline, a much greater increase in public coverage for children which definitely, limited and really fully offset so

there was no change in the uninsured for kids.

All of the increase in the uninsured was constipated therefore among adults and among those losing full time work, or an attachment to a household with a full-time worker. Young adults seem to have benefited from the health reforms that were introduced in 2010 seeing gains in private coverage, while other age groups saw declines.

It's important to hear that say, you know, in the future whether health reform, assuming it's implemented, it will end this link, or at least weaken it greatly, the link between employer-sponsored insured and uninsured because people will have many more avenues to get coverage as their incomes fall or they lose employment. So I'll stop at that. Sorry for going over a little bit.

ED HOWARD: Great, John. Thank you very much. We're going to turn now to Dr. Kirk Calhoun who is president of the University of Texas Health Science Center in Tyler. He's been there for about nine years. He served on the Texas Task Force on Medical Indigent Care among other committees. He also is the chairman of the Executive Committee of the National Association Public Hospitals. And Dr. Calhoun, I guess the numbers that you have been hearing might indicate that the uninsured are only statistics for him, their patients. So we're very anxious to hear from you about this

question, Dr. Calhoun.

KIRK CALHOUN: Well, thank you very much. And I want to thank the Alliance Health Reform and the Kaiser Family Foundation for putting on this session this afternoon. It's a very important topic. Just quickly, a little bit about the University of Texas. It's a large organization. Our annual budget is approximately 13 billion dollars. We're made up of 15 institutions and because of football, everybody knows about UT Austin, but there are actually nine academic institutions and six health institutions.

The six health institutions make up a substantial part of that budget. In fact, the majority of that budget belongs to the six health institutions. The largest being M.D. Anderson Cancer Center in Houston, and we're the smallest. We're the -- we're in Tyler, Texas, which is in the piney woods of deep east Texas. We were the former Tuberculosis sanitarium for the state, and in the 70s, the facility was turned over to University of Texas and an academic medical center was created to focus on rural health issues in our part of the state. So we've been involved very closely with this issue.

The University of Texas trains about 70-percent of the health professionals for the state of Texas and we provide a very substantial amount of uncompensated care

throughout the entire state. Texas is an interesting place. We're a large state. 25 million people who have been counted. We may have a few more that have not been counted. And I'm sure all of you are aware that we have about six million uninsured people. And unfortunately, it wound up on the cutting room floor as I was getting ready to prepare this talk, but I have a really great slide where we take all of New England including New York and we neatly tuck it away in the Southeast corner of Texas leaving about two thirds of the state uncovered.

And the point of that slide would have been that maybe solutions that work well in Massachusetts, won't work very well in a state like Texas with regard to care and health care reform. I haven't had a chance to verify the veracity of this statement, but someone told me just a few days ago that even if the affordable care act moves forward as planned and we have many more people with some degree of coverage, that Texas will still have more uninsured people than there are people in the state of Massachusetts. So it creates a very special challenge for us as we try to deal with these issues.

Just briefly, the National Association of Public Hospitals is an association that's made up of a lot of university centers as well as the big public hospitals all

over the county. So L.A. General, the New York Health and Hospital System, other large public hospitals all are part of this and my presentation today will discuss some of the issues we're confronted with. When you run a public entity as I do, or some of these large public hospitals, we feel a little bit like this donkey that we're carrying this huge burden of what to do with the uninsured and it's a little difficult to even get your feet on the ground to deal with it.

And certainly as we all enter into this new era with the Affordable Care Act, trying to understand what's going to happen, how it's going to work, how it's going to affect us just added to some of our frustration and some of the challenges that we're going to have to deal with.

I served on a panel in Texas a few years ago called Code Red – Critical Condition of Healthcare in Texas, and we attempted to look at our problems in terms of dealing with the uninsured, come up with a set of solutions and then share those solutions with our elected leadership. And in preparation for my work there -- and what I frequently wind up teaching my students -- is first of all a recognition that the United States does not have a single healthcare system. We have multiple healthcare systems. We have a military healthcare system that has active duty people in it, VA, CHAMPUS and so

forth. And if you look at that system it has very distinct characteristics about it that don't quite fit what we do in other areas.

We have a government healthcare system that's Medicaid and Medicare predominantly. How does that fall in and what are the characteristics of that system.

Most of those in the audience today, we belong to the employed insured, middle income system. And frequently when I hear leaders talk about the United States has the best healthcare system in the world, this is the system that they're talking about. It has an absence of formality about it, although with managed care it can become a little bit more formal. Physicians carry a lot of weight in terms of what occurs to the individual patient. How much money is spent and so on and so forth. It's paid for by consumers, by employers, and it's even paid for by our taxes in that premiums for health insurance are deductible and thus deprives the Federal Government of significant sums of money.

So it too is subsidized. And what we're talking about today is the unemployed, uninsured or under-insured system. It's the indigent or the medically indigent. They tend to not have continuous coverage. The emergency room is frequently the point that they access care. The burden of carrying for these people is borne in large part by public hospitals and academic

health centers, community clinics and so forth around the country. And it's paid for by taxes or charity.

One of the large areas of debate in Texas is responsibility. And I want you to think a little bit differently about healthcare when I talk about responsibility. Who has responsibility for the uninsured? First of all what is the individual accountability and responsibility. What is the individual's responsibility for their own health? What is an appropriate amount for them to pay for their own health insurance? What do you do for those who -- some young people who maybe can't afford health insurance of one kind or another but choose not to participate in an employee sponsored plan or to obtain health insurance on their own and they're in a motorcycle accident and they show up in the emergency room? So what is the individual responsibility?

What is the responsibility of the healthcare profession? In Texas we subsidize the training of our doctors to the tune of about $200,000 to train a physician. That's taxpayer money. So when a physician graduates, goes out and practice, what is their responsibility to provide charity care? For not for profit hospitals? What is their responsibility in providing care to the uninsured?

And finally the government, what is the government's responsibility for providing care to the uninsured, and at what

level? Is it at the Federal level, is it at the state level, or as in Texas, that has been the responsibility of local government, of counties to be responsible for the uninsured. So as we debate these issues in Texas, it is one of responsibility.

So what is the impact of having an uninsured population? Well in looking at our state, we believe that an unhealthy, poorly educated workforce, will result in decreased productivity and hurts the nations production as a whole. That community institutions are thrown into jeopardy when our emergency rooms don't function, or hospital rooms become financially impaired as a result of caring for large numbers of uninsured. And we believe that having large numbers of uninsured actually decrease the quality of care for all of us in terms of receiving medical care.

We see states facing budgetary crisis, particularly in these economic times and as I mentioned local governments bear -- in many states bear a high responsibility through their county hospitals for medical care and how are they going to deal with these increased costs, particularly if there are cutback in Federal Government, if FMAP is cut and some of these other issues come forward.

And we believe in talking with our leadership, that the problems with the uninsured can actually hurt our state

economically if we don't identify ways to deal with it and it will hurt investment in some key areas.

With regard to the challenges facing public hospitals, as the Affordable Care Act moves forward, we may lose our disproportionate share of funding, or large portions of it. And will that have an impact on our public hospitals? There's a concern that if reimbursement rates are improved, that private hospitals will become more attractive to the patients than our public hospitals around the country. We've seen this in states where the reimbursement for deliveries is substantially better than other types of medical care and we've seen public hospitals lose these deliveries to private institutions and thus hurting their financial status.

There's a concern that public hospitals may see an increase in the number of undocumented patients and that will have its own impact. One of those impacts possible being the lose of a local tax support as there may be some resentment against undocumented people receiving medical care at the taxpayer's expense. And many of the hospitals are concerned that they may be predominantly caregivers to the undocumented and what will be the effects of that?

So with all that being said, we believe that public hospitals will still, even if the Affordable Care Act is fully implemented and moves forward as planned, will still remain a

vital force, even after the ACA will have 25 million or so people who are uninsured. We believe that the elected leadership will likely realize that public hospitals are still going to be a critical lynchpin in delivering healthcare to the uninsured and the under-insured. And we believe that as seen in Massachusetts that even if there is Medicaid expansion, it will put a tremendous strain on the supply of physicians and caregivers and these patients are going to need every asset available in order to have access to care, particularly primary care, and may find it difficult to access care otherwise.

So we believe that we're sort of in a Code Red condition now as in our emergency room, but it's something that's these public hospitals have a tradition of dealing with and I believe that as we have forums like this and opportunity to discuss these issues, we can come up with some unique solutions. Thank you.

ED HOWARD: Thank you. Thanks very much Dr. Calhoun. Let me rescue your clicker from you. We need a left clicker and a right clicker I guess. Our final speakers is Katherine Baicker. Kate is a Professor of Health Economics at Harvard School of Public Health. From 2005-2007 she was a member of the president's council of economic advisors which my wife, who is also a Harvard trained economist says is the highest aspiration an economist can have. She obviously did it at a very young

age. She currently serves on a slew of important boards and commissions. In fact she has swooped in on us from a meeting of MEDPAC of which she is a member and more immediately relevant, she has been leading a research program investigating the effects of expanding health insurance coverage in the context of a Medicaid expansion -- a randomized Medicaid expansion in the state of Oregon, going to the question of how much coverage matters.

Kate, thank you very much for taking time out of a very busy schedule to be with us today.

KATE BAICKER: Well I'm sorry I missed the beginning, but I'm glad to get here for the tail end. And I'm very excited to tell you about this research project that's the work of very many people including state officials in Oregon, public funding, private funding from foundations and collaboration across a lot of institutions.

What we're investigating is the effect of expanding access to Medicaid to low income adults on their healthcare use, on their health outcomes, on their financial well being. Now we may all have thought, not me I knew but you might have thought that we knew the answers to those questions ahead of time. Surely people have been asking this question since the dawn of the Medicaid Program. And people from different

vantage points are all very sure of what the answer is. They're just not all sure of the same answer.

There are reasons to think that Medicaid changes care a lot because people get access to health insurance that lowers the price for them and therefore they're able to consume more care. Or that it doesn't change it by so much because Medicaid doesn't pay providers very much. People have trouble getting access to the primary care that they need even with the Medicaid card. And so they don't do that much better. And the uninsured find access to care through community health centers and emergency rooms.

They are arguments on both sides that make it really just a question about the data. What do we know from looking at the experiences of people who are on Medicaid verses the uninsured? Now the first pass at that would be to look at the experiences of the people who are on Medicaid verses the uninsured. But the problem is that people who are on Medicaid are different from the uninsured in lots of different ways.

There are these income criteria for gaining eligibility. There are demographic criteria. It varies from state to state. You may think that these groups differ in lots of other ways that affect their health outcomes besides just being on Medicaid. If there are differences in education

attainment, in poverty, in underlying health status, you might get a very wrong picture from just comparing those groups.

For example, suppose people who have health concerns are more likely to take up Medicaid when it's offered to them and to find a way to get into the program. Then if you just looked at the health status of people who are on Medicaid relative to the uninsured, you would say Medicaid kills people. They're sicker. [Laughter] They have worse outcomes.

Well it's not that Medicaid caused those outcomes in that scenario. It's that those outcomes changed people's likelihood of being on Medicaid. So there's that reverse causality that's possible. There are all sorts of other things going on in addition to income and the like that might muddy the waters. So what you would really like to do is have a randomized controlled trial for some people had insurance and some people didn't. And it was just a matter of chance.

And that's what we do in scientific experiments. When we're testing a new drug, we don't say hey, you stopped sneezing. The allergy medication must have worked. We compare people who take the medication and people who are on a placebo and see what the difference is. We don't just look at people who are taking allergy medicine out in the world and say those people seem kind of sneezy. Well that's why they're taking the

allergy medication in the first place. You need a randomized controlled trial to control for all of those other factors.

In social sciences, unlike medicine and other sciences, we rarely have the opportunity to do that because it's not normally ethical to randomize people in that way. Do you want to know what the effect of education is on children? Let's lock half of them in the basement. [Laughter] It turns out we're not allowed to do that anymore. [Laughter] So, you need some alternative strategy for gauging the affect of these really important social insurance programs that you can't put to the scientific test in the same way.

Until our study came along and we had this unprecedented opportunity to study the effects on expanding Medicaid to low income adults in the context on a randomized controlled trial. Well I just finished telling you that that is not ethical, what happened? Well this expansion in a randomized way wasn't done for the sake of doing research. It was a byproduct of a particular set of policy environments and budget constraints in the State of Oregon.

Now Medicaid is different in every state. States have the option of covering able bodied, low income adults but most don't. And that will change in 2014 as the Affordable Care Act is implemented. This is a very similar target population. Oregon had chosen to cover adults below 100-percent of federal

poverty level in its program until 2004. And then it ran out of money. And it said we're not going to let any new enrollees into this program. We're going to maintain the program but close it to new enrollment.

Then in 2008, they decided they had enough money because of attrition from the program and a change in their tax schedule to enroll 10,000 more people in that Medicaid expansion program. And they knew that there was demand by more than 10,000 people in the State of Oregon for the program. So they decided the most fair thing to do would be to draw straws.

They opened a waiting list. They let everybody who wanted to sign up. About 90,000 people put their names on the list. And then the state drew names from that list by lottery. They didn't want to do first come, first serve because that would advantage populations that were the most tapped into the system with higher education, with more computer access. They wanted a level playing field so they had an open sign up period. And then they drew names.

The fact that the only thing that affected whether you got the opportunity to apply for the program from that group was a random lottery number gives us a randomized control trial. The people whose names were drawn by chance are a treatment group. The people whose names were not drawn are the control group. It's important to note that they drew 30,000

names to get 10,000 people enrolled. Because signing up on the list was really easy.

You just put your name down, your date of birth, your address. That didn't mean you were eligible. If your name was selected, you were mailed an application. Only about 60-percent of the people who were mailed at application sent it back. And only about 50-percent of the applications received were actually deemed eligible. So this is a 10,000 – a group of 10,000 who were actually enrolled. But the treatment group, the names who were drawn were 30,000 people.

So we used this opportunity to gauge the effects on healthcare utilization which I'm labeling as a cost. And I think that's right but I think we forget in the debate that the goal isn't for people to consume healthcare. The goal's for people to get healthy. And the way you get healthy is you use healthcare resources. But that's not the target, that's the input to getting the health that we want people to have.

So, one of the things that might change is healthcare use. And I gave you some arguments at the beginning for why it's not obvious how big an effect that would be that Medicaid might not give as much expanded access as private insurance or as a differently designed program. We're just not sure.

The first benefit that we're going to look at is improvements in financial stability. Now that's not the first

improvement I think you think of when you think about health insurance. You think about health. And we're going to get to that. But I think it's under appreciated that insurance is about risk. It's not just about getting access to healthcare. It's protecting you from financial ruin if you have a bad health outcome.

So we want to look at people's financial stability. And then of course, we want to look at their health outcomes. And we do this through a variety of data collection. We have the lottery list data. We have administrative data that includes hospital discharge data. So we know everything about everyone on the list who went to the hospital. We have credit report data so we know all of the former access to credit that everyone on the list has. And we have mortality records which is fortunately very small in this prime age population.

That's not all the outcomes you'd want to know though. So we added survey information to that. We sent out a mail survey. And that's what I'm going to tell you about today in addition to the administrative data where we asked people about their healthcare use and their health outcomes and their use of informal financial instruments like borrowing from friends that wouldn't show up in credit reports.

We're going to have in the coming years a much more intensive data set of in person metrics where we went to

people, measured their blood pressure, got blood samples, collected diabetic blood sugar control, cholesterol, exposure to infection, obesity. So we're going to have some hard objective measures to add to that. But I'm not going to tell you about those today because that data collection happened a year after the data that I'm telling you about today.

So that's Oregon. You'll see it's a rectangle. Let's get right to the results. Healthcare use. For utilization, we have that hospital discharge data. We saw a 30-percent increase in the use of hospitals for people who gained access to Medicaid relative to those who didn't.

Now ahead of time that might not be clear. You might think oh, people get more primary care so they don't have to go to the hospital. Well these hospitalizations are the change in hospitalizations. It's concentrated in admissions that occurred not through the emergency department but through scheduled procedures. So there's no change in showing up in the emergency department. That's also a surprise to some people. We're going to get better data on that. That's a fairly noisy variable here.

But there's a big change in hospitalizations that occur not through the ER but through your doctor admitting you to the hospital or setting up an appointment for you at the hospital. And we saw a big increase in the probability of outpatient use,

35-percent more likely to use outpatient use, 15-percent more likely to have prescription drugs, much more likely to comply with recommended care – mammograms, pap smears, diabetic blood sugar monitoring and cholesterol monitoring, mammograms I mentioned. All of those included.

That total increase in utilization translates to about 25-percent more use. So people who are on Medicaid use about 25-percent more healthcare resources than people who aren't. That's a smaller number than some people might have thought I think. But it's not zero; it comes at a cost. For that cost, what do you get?

Well benefits; let's look first at financial strain. There's a 25-percent decline in the probability of having a bill sent to collections. And those are primarily medical bills that are sent to collection. All the activity there is focused there when people gain access to insure. And that benefit really accrues not just to the individual whose credit is not now hurt by having a bill sent to collections but also by the providers or the patients to whom they pass those costs on to because only about 2-percent of bills sent to collections are ever collected upon. So it's more like a marker of bad debt than of the collection agency really extracting any more resources.

There's also a big reduction in financial strain through those mechanisms that wouldn't show up in credit reports. A reduction in borrowing from friends, a reduction in being turned away from medical care because of previous bills being unpaid, a reduction in not being able to pay other bills like utility bills or rent or things like that.

But what about health; I think that's the punch line that you are all waiting for. You were waiting for a punch line, right? You're with me. There are big improvements in self reported health both physical health and mental health. And this is a population with a high health burden. More than 50-percent of the population reported having a diagnosis of depression at baseline, 40-percent reported heart problems, 18-percent reported diabetes, asthma. There were really high rates of health among – health problems among this population which is probably why they signed up for the lottery in the first place but is indicative of lots of low income, uninsured populations.

They reported improvements across a range of outcomes both mental health and physical health. And this is consistent with their improved access and with their improved reported quality of healthcare. They were much more likely to have a provider they saw regularly to go to a regular place of care rather than patchwork urgent care clinics. But I think this is

open to some interpretation. Because those improvements in self reported health show up before the improve – the increased utilization of care. Even before people start using more care, they report that they are in better physical health.

What this suggests to me is that they're reporting not only their physical conditions as a doctor would measure them but also the stress of being uninsured and the financial strain. And this is consistent with what people report in interviews and focus groups that it is really a very bad thing in their lives to be uninsured. So they report that they're better off in lots of ways. And some of that creeps in to the physical health reports that I think we can't take as a pure measure of physiological health.

And that's why we're so excited in addition to these results to have physical health measures to show you to help interpret that. That doesn't mean that I discount those improvements. If people are reporting that they're under less strain and better off, that's a benefit. But we, as policy makers – you, as policy makers, need to decide how to weigh those benefits against the cost of the program. The program costs money. When you expand Medicaid, you know you're paying something like $5,000 or $6,000 for people in this population per year. They're getting these benefits.

You need to decide whether that tradeoff is worth it. And what I think our study has done is demonstrate decisively that people on Medicaid are better off than people who are uninsured. But we can't then tell you therefore here's the right level of Medicaid benefits. You have to weigh the costs against the benefits. And the physical measures will help a lot with that.

I think they're clearly implications for the Affordable Care Act population but I would give – leave you with some caveats about extrapolating. This is 10,000 people. Something very different might happen when you expand 40 million people at the same time. There might be different provider effects. What I've shown you here is effects after one year. Eventually we're going to have effects after two years.

It doesn't tell you effects after 10 years. It also doesn't tell you what would happen to different demographic populations. Oregon looks a lot like the rest of the U.S. in many ways. But it's only about 2-percent black; the population which is much lower than national averages so we can't do a lot of demographic breakdowns. That said; I think we've given you a lot more information than we used to have about the real causal cost and benefits of expanding Medicaid to this population.

ED HOWARD: Terrific. Thank you very much Kate. Can I just ask a follow-up question? Something you said right at the end about the financial cost of this coverage at $5,000 to $6,000 a person. How does that compare with the rest of the Oregon Medicaid population?

KATE BAICKER: Oh, I was using that – actually that number was a benchmark from the Oregon Medicaid population. We don't directly measure the total cost of spending on this population in this data set.

ED HOWARD: I see.

KATE BAICKER: We have hospital use data but then we just have to ask people about their doctor's office visits. And we couldn't say how much did that cost. We could really say did you go to the doctor. How many times? Did you stay in the hospital? How many days?

So that's not a good way to produce an aggregate number for how much the program costs. We asked Oregon what's your budget and how many people do you cover. And that's where I'm giving you that number. And it's a little fuzzy because this group is 19 to 64 year old nondisabled adults. A lot of people on Medicaid don't fall into that category.

They're children. They're dual eligibles. They're disabled people. And so the total cost of the program, we can't take the total cost of the program divide it by the total

number of people and get the right cost for this group. So that's why I was a little squishy on what the number was.

ED HOWARD: Very good. Thank you. You have questions too. And if you have a green card with a question written on it and hold it up, someone will come and bring it forward so that the panel can address it. There are microphones that you can use to ask questions as well. And if you do that, please identify yourself and make the question as distinct as possible.

I'd invite comments from the panel and Diane, of course, asking any questions that you would like. Let me, I have – ask a question of Dr. Calhoun if I can. You were talking about how providing coverage for people would avoid the degradation in the access of – accessibility of healthcare for all. And I wondered what you would say to those who would argue that broadening coverage is going to actually harm access for people who already have it while the new – newly covered people compete for doctors' appointments and slots in the ER.

KIRK CALHOUN: Well I – you know I – it's a concern. There are stresses and strains on the system. On my last visit to Washington, I was – I'm a state official so I can't lobby. I educate. So I was [laughter] I was educating some of our local delegation about indirect medical education. And, in the

President's budget there's a reduction in funding for indirect medical education of about 10-percent.

MedPAC had, I believe, initially recommended somewhere around 50-percent. They – I believe they backed off from that now. But it was sort of inconceivable to me that you would do anything that would hurt the pipeline of physicians on the eve of dramatically expanding – hopefully dramatically expanding access to care.

But the point of my talk was also that we're all in this together. And some of you may remember the debate about whether Texas would continue to participate in the Medicaid Program that came up. It was in the newspapers. It was – some of that talk was exaggerated a little bit. But I do have an opportunity to talk to a number of folks in Texas. I talked to a number of political groups, what you would maybe call Tea Party groups.

And, you know, one of the things I point out to them that Medicaid in Texas, a lot of it is sent on dual eligibles in nursing homes – an awful lot of it. And if there are cuts to that system, you know, your man cave may become your mother-in-law suite. So you know these kinds [laughter] these kinds of concepts really resonate with people. And so we have tried to make this argument that the system needs to be improved. And that access to care, that issue needs to be resolved one

way or another. And, it needs to be done carefully in a way that we can both afford and maintain access for all of us.

ED HOWARD: Very good.

DR. CAROLINE POPLIN: I'm Dr. Caroline Poplin. I'm a primary care physician. I'm tempted to ask what a man cave is but [laughter] I — my question really is for Miss Garfield and the Affordable Care Act. The insurance companies keep saying that once everyone is required to buy insurance they will pick up what they think is a large group of young invincibles; healthy young people between 26 and 35, who are currently out of the pool. And once they're in the pool that will make the pool much better. My sense is that the pool of uninsured is — tends to be sicker and poorer than the people who are insured. And I wonder if the insurance companies have a good idea of who they're going to pick up.

RACHEL GARFIELD: That's a great question. Thanks for asking. And I'm going to loop in John for a little bit of the second half of your question about the health status issue with respect to the first part of your question about this young invincible group that has received a lot of attention.

It is true that people in that age group have higher uninsured rates than people in other uninsured — excuse me — in other age groups. When you look at the composition of the uninsured population as a total, they don't make up the vast

majority because their numbers are smaller. But it is something that people have been paying a lot of attention too.

And I'm going to actually loop in John because he's done some analysis to look at the health status issues. And so I think he can speak a little bit better to that topic.

JOHN HOLAHAN: Yeah, we looked at the – used the Medical Expenditure Panel Survey to look at who are – who would – what do these new eligibles look like in terms of health status and looked at a lot of different health status measures. Basically they are much healthier than the Medicaid disabled population and much healthier than the nondisabled population.

I mean they are – there's – but within that, there is a broad mix of people. I mean they – just like any other slice of the population, there's some who are quite sick and – but predominantly, they're – it's going to bring in a relatively healthy population. They are I think, if I remember right, somewhat less healthy than people who are now covered by employer plans. But compared to the people we're already covering through public programs, we're bringing in a pretty healthy slice of people.

DR. CAROLINE POPLIN: Thanks.

DEREK CHRISTOPHERSON: Derek Christopherson, worked on uninsured, underinsured about the same time that Ed has in terms of maybe about 35 years. Affordable Care Act is very

good in a sense of bringing in a lot more of the uninsured in. The tricky part of all of this, of affordable care, of course, is that the underinsured is a very large population out there as well. About to get under – a lot – somewhat larger because company insurance policy people will be picking up under the Affordable Care Act who will be not terribly strong policies in terms of that.

If you look and talk to people, the faces of the underinsured cost is a very large issue. And some of the issues pop up a little bit, Kate, in your – the work you've done with Oregon as well. And you see it in Texas big time, obviously, there as well.

So if you could speak to a few minutes of the issue of what's likely to happen with the underinsured who are really not going to have their affordability improved probably at all or at least very minimally in terms of that. And there's going to be addition people who are underinsured who are going to move from the uninsured into the underinsured category.

KIRK CALHOUN: Yeah, I'll start off with that. You know that's one of the issues for example that's surrounding some of the supplements that have been available to hospitals to help cover people like DSH and UPL. Which some will argue that those plans were put in place to actually make up for the short fall in the cost of providing care to Medicaid patients

and the underinsured and you know weren't initially intended at all to be a provider of healthcare to the totally uninsured but to help make up that difference.

And so as those funding mechanisms under the Affordable Care Act that funding gets rolled into expansion, what are we going to do? How are we going to make up those short falls in the cost of care for those who are in groups that are considered underinsured or for which the compensation is not adequate?

I think the answer to that is that they – they, the government – is demanding that the healthcare system in and of itself identify ways to cut costs. And they are both using carrots and sticks to try to force us to identify ways to bring the costs down so that even those who do not have the best of insurance coverage that that care becomes much more affordable.

I think lowering healthcare costs has been the goal of this nation for the last 50 years. We still struggle mightily at it. I'm not sure how successful we're going to be in the future even with all these efforts to get our costs under control. I think we're going to have to get it under control or the country will go bankrupt. But I don't know if what's happening right now is adequate to take that on.

DIANE ROWLAND: This question relates to the health status again of the uninsured population but really focuses on

what percentage or how many of the uninsured in 2014 are likely to have mental health conditions that may require additional resources to treat.

ED HOWARD: John.

JOHN HOLAHAN: That's in our paper. And I do not remember the answer to the question. [Laughter] But, the title of the page is something like the health status of new Medicaid eligibles under health reform. And it's on the Urban Institute website. And, so the answer'll be there.

DIANE ROWLAND: Alright Kate, maybe you could speak a little to – [interposing]

KATE BAICKER: Yeah. One thing I know that I mentioned that the population that signed up for the Oregon lottery but I think it was about 56-percent reported depression at baseline. And that may be an under report in that the question asked if they'd ever been diagnosed or told by a healthcare professional. Now that is probably higher than the people who didn't sign up for the lottery. And I mention this because you might wonder when there's this expansion in 2014 will everyone who's eligible take up or will it be a selected group.

Now in Oregon there was no mandate whereas under the Affordable Care Act there is. But there's basically no penalties for low income people who failed to comply with the mandate. So the mandate may exert some moral swaytion. It may

change the landscape such that it looks like a higher take up rate than we're getting for Medicaid now.

But you have to think that there's still going to be selective into taking up Medicaid, complying with the mandate, based on how strongly people want insurance. And that's got to be driven by underlying health conditions. So among the eligible pool, you have to think that people with greater health needs are more likely to take up.

JOHN HOLAHAN: Could I just [interposing] say I totally agree with that. And in that paper, we talk about that selection issue and participation rates quite a lot. And, you know if there – if Medi – if the participation rates are down around 50 - 60-percent range which I don't expect then the population you'll bring into Medicaid will be relatively sick.

And, but what we try to do is to look at well what if we get everyone – what do – what kind of – what are we looking at in terms of the population. So, you know and I think one of the reasons insurance companies bring this up a lot for the people – those that are going to participate as managed care plans in Medicaid or – and states worry about it is that they fear that they'll have relatively low participation rates and get adverse selective. And, you know, it's a concern that it really does depend on participation.

DIANE ROWLAND: Rach.

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RACHEL GARFIELD: Yeah, I just wanted to add I actually did a little bit work on this issue with some colleagues at the University of Pittsburgh. And we tried to look at mental health status of the currently uninsured population in the context of the Affordable Care Act. And a couple things to keep in mind here when you're thinking about this specific illness or set of illnesses is there is some people believe that everyone with very serious mental illness is already covered by the Medicaid Program which is untrue. There is a population of people who have very serious and persistent mental illness who are currently uninsured. And so, a lot of them have low incomes because there's correlation between having this illness and having low incomes. So it's expected a lot of them will come into the Medicaid Program.

But in addition, there are a much larger number of people who are living with what we would call more moderate illnesses, different levels of severity, less acute illnesses. And one thing that's tricky to tease out with the data is how many people are living with these illnesses and what's going to happen to their utilization once they gain coverage because we know from a long history of research about the demand for medical care that these types of services tend to be very sensitive to price. And so having insurance may make a big difference in whether or not you are using the system.

KIRK CALHOUN: Oh, I just want to comment. If you know you look at many of the root causes of the utilization in our emergency room, it goes back to mental illness of personality disorders, of drug addictions, of various kinds. And it's a huge driver of the semantic healthcare costs that we encounter.

And you know it just brings to mind, you know I have a black sheep member of the family. Every single one of us has one. He was committed to my hospital last nigh when he came in with an exacerbation of HIV infection, pneumonia, severe anemia. Over the last decade, he's probably cost the Texas Medicaid system a small fortune. And it all — all — all goes back to his drug addiction problem. It's the root cause of all his medical illnesses.

And if we're going to get a handle on the cost of our healthcare system, it's going to require, in my opinion, a much more aggressive approach to how we deal with mental illness and drug addiction.

DIANE ROWLAND: And that was a great question. It inspired the entire panel. This is a question aimed first at you, Dr. Calhoun, in terms of your statement that the population counting has some issues in Texas. The questioner wants to know is that related to the number of undocumented immigrants or what can you tell us about the likelihood of the right estimate for the population?

KIRK CALHOUN: The right estimate –

DIANE ROWLAND: The right estimate.

KIRK CALHOUN: – of the undocumented population. You know I don't know that the – the answer to that. What I will say and I don't want to give this impression because a lot of people have it that the – either in Texas or nationwide that the sole issue of the uninsured is an undocumented problem. It is not.

And I think somebody in their presentation, you know, sort of pointed out that the undocument and the growth of the uninsured that there was slight growth in the undocumented population. But that was not where the bulk of growth was coming from. I believe it was said it was the white population. That's where they've seen – with the economy and so forth where they've seen the biggest jump.

So one of the things that I deal with a lot as I go around the state and talk to people is convincing them that the uninsured problem is not solely a problem of the undocumented.

DIANE ROWLAND: Okay. And the other part of this question was about the U.S. Territories. Do they have Medicaid and how will they be affected by these expansions? And the territories do in fact have Medicaid. Porto Rico and the other territories but it's capped and there's sort of a unique way in which the funding will work for those areas. So the

territories are Medicaid programs but they're structured financially in a very different way. Other questions?

Well I think we must have answered every question then.

ED HOWARD: That's right. And –

DIANE ROWLAND: And now the evaluation.

ED HOWARD: – we would appreciate you filling out those blue evaluation forms. It will be very helpful to us to improve these programs. Let me point out that John Holahan's slides we didn't get in time to put into your packets but they'll be on the Web site.

And, failing any other pieces of new business, let me thank our colleagues at the Kaiser Family Foundation and the Commission on Medicaid and the Uninsured for their participation in and support of this briefing. Thank you for being interested in a topic that not enough people are interested in these days. And ask you to join me in thanking our panel for explaining an awful lot of very difficult questions to us. [Applause]

[END RECORDING]