HOUSTON GALVESTON BRAZORIA CONSOLIDATED METROPOLITAN STATISTICAL AREA HEALTH NEEDS ASSESSMENT PROJECT

Health Reform and Policy Needs in the Houston Area: Policy

INTRODUCTION

Health reform is on the political agenda and whatever the result, there will be an enormous change in the coming decade in the provision of health care. Overall it is likely to impact positively on the unmet needs of Houston area residents in the future. This major reform trend will be examined in this report, as will the predicted consequences for specific sectors of the population and the various institutional providers. Resource planning decisions in the health sector will be affected by reform, and these decisions are best made by careful consideration of the possible outcomes.

Several health system reform options are under consideration in Congress. A brief examination of each option will be given. The Clinton Health Security Act, the most elaborate, has not been the only focus of committee and subcommittee study in the House and the Senate. Other important health reform proposals are (1) another managed competition plan, H.R. 3222/S1579 proposed by Cooper and Breaux, (2) Phil Gramm's Comprehensive Family Health Access and Savings Act (S-1105), (3) the McDermott-Wellstone single-payor proposal entitled the American Health Security Act of 1993 (S. 491 and H.R. 1200), and (4) Chafee/Mitchells's Health Equity and Access Reform Today Bill (H.R.3704/S.1757). Each of these, if enacted, would carry different implications for primary, preventive, and hospital care as would the Stark, Dingell, and Hoagland bills reported out of subcommittees in the House of Representatives in April 1994.

Highlights of some of the main health reform proposals follow.

HEALTH CARE REFORM PROPOSALS

1) A Single-Payer Plan (McDermott-Wellstone)

If a single-payer form of health care reform were implemented, it would mean that "a single public entity, the federal government, would be responsible for collecting and distributing to the states all funds needed to pay for covered health care services in the United States" (New England Journal of Medicine, May 20, 1993: 1489). Adoption of a single-payer system would reduce administrative costs and provide universal access (Woolhandler and Himmelstein, New England Journal of Medicine, 1991(324):1253-58). As proposed by McDermott and Wellstone, this reform would provide a full range of benefits, including hospital services, available to all legal U.S. residents. Preventive care and primary care are both covered, as are physician fees, prescription medications, and mental health care. No co-payments are envisioned, and thus no financial obstacles to access would exist.

Because of the administrative simplicity, providers would not have to worry about unpaid bills, reducing the costs of billing. Providers could dramatically reduce administrative personnel costs. A national Health Security Board would establish global budget limits on health care costs and set prices for covered services. The impact on health services is hard to determine in advance. States would structure the plans for health services, ensuring that these plans conformed to federal requirements.

The single-payer plan has the advantage of simplifying access. All except the undocumented immigrants would find health care without the obstacles of administrative or bureaucratic complexity. This would encourage preventive treatment and facilitate early diagnosis of disease. It would mean far

fewer individuals requiring expensive emergency care would be expected to present themselves at hospitals.

2) The Health Security Act - Clinton's Proposal

The Clinton proposal with its 1300 to 1400 pages of text is the most detailed plan, and the impact for provision of health services seems clear. Legal residents of the United States would be entitled to a fairly adequate, basic benefits package of preventive and primary care, complete hospital coverage, doctors fees, and prescription drugs. This package is similar to that now offered to employees of the Fortune 500 through private insurance plans. Limited mental care and dental benefits are expected to be brought into the package over a period of several years. Employers would pay 80% of the costs, and employees would pay 20%. Federal government subsidies would be offered to low-income employees and small, low-wage businesses. Consumers would choose between HMOs, fee-for-service, and a combination. Large corporations could administer and negotiate directly with providers for services for their employees. No co-payments would be charged for preventive services, with a maximum of $3000 per family in co-payments for other health services. A National Health Board could modify what is covered in the basic health package, limit insurance costs increases, and establish national and regional health expenditure budgets.

Some sectors of the population, including many in poverty and the uninsured working poor, would benefit from the adoption of the Health Security Act (HSA) or similarly drafted health reform legislation. The elderly, those with serious disabilities and/or very large health bills would be better off (New York Times, Sept 27, 1993). Unlike Medicare, the HSA does not cover preventive care. People currently without insurance and those with pre-existing conditions would gain if the Health Security Act is adopted. The plan would remove financial barriers of access and reduce restriction to private sector services. Insurance will be "portable" and would not be discontinued if an individual is suddenly unemployed. Incentives are provided to ensure availability of medical care in both urban and rural underserved areas.

Nevertheless, islands of uninsured will remain even if the HSA is adopted. The HSA does not provide care for undocumented immigrants. The homeless and mentally impaired, though formally insured, would find it very difficult to navigate through the administrative apparatus of alliances and plans envisioned. Removal of financial barriers to service alone will not eliminate the difference in health status between the rich and the poor.

The Houston-Galveston Consolidated Metropolitan Statistical Area, under the terms of the HSA, could constitute a single Alliance (Section 1202 b). The law requires that "the entire portion of a metropolitan statistical area located in a State" be in the same alliance area. Gerrymandering alliance boundaries to discriminate on the basis of "race, ethnicity, language, religion, national origin, socioeconomic status, disability, or perceived health status" will be prohibited (Section 1202 b, 4). This means that the healthier and wealthier sections of the city will not be separated off into a separate Alliance. The health insurance premiums paid by individuals in the Houston-Galveston area would thus be uniform.

While the Health Security Act mandates employers to pay 80% of health insurance premiums, the net result is likely to impact very little on business but may negatively effect workers. First, government subsidies to small business will be provided, and percentage of payroll caps on premiums will be in force to protect the viability of businesses. Second, according to the New York Times "Economic Scene" published Sept. 30, 1993, 75% of mandated labor benefits have, in recent U.S. history, been "passed back to workers with the rest passed forward to consumers. So employers will not pay." Will

this situation result in a reduction of living standards for the working disadvantaged? How will this effect health status?

Traditional, neighborhood, nonprofit, community-organized, citizen-initiated health care service providers to vulnerable groups will be largely "orphan providers" after the transitional five year period. There is no provision in the proposed legislation to structurally integrate the providers into the Health Security Act's Alliance and Plans. Since the Health Security Act groups providers into private, for-profit plans, this special group of community-based providers may be required to convert to private-provider status, but at the risk of abandoning their mission statements and their special character.

If the HSA is implemented, those who previously received their care from public, neighborhood clinics will move to the private-sector providers who have contracted with a plan. Vulnerable populations will have a health security card and in theory be able to obtain care from any of the basic plans. But the populations these neighborhood, non-profit providers would serve may not make the transition to the new health system easily and may have considerable difficulty navigating through the new system despite guarantees of universality. They may not choose to enroll in a plan though obliged to by law.

The newly organized plans in the private sector may also have trouble meeting the needs of the vulnerable populations. Providers whose customary clientele are middle class may not be able to cope with differences in language and culture. Providers willing to set up business in less desirable neighborhoods may be hard to find. There is a worry that some providers will use what might be termed "geographical adverse selection". These providers would choose to locate in neighborhoods far from the populations that are thought in advance to be the sickest and most costly to care for, in the hope that these individuals would not travel a long distance to find a provider. Transportation, in any case, in terms of time, costs, and distance may discourage some sectors of the population from obtaining prompt care. Habitual behavior patterns may also contribute to making it difficult for some individuals to find care within the system established by the Health Security Act. The plight of the homeless, a heterogeneous collection of disadvantaged groups, is unlikely to be improved by the adoption of the Health Security Act and may not effectively serve them.

Even if the Health Security Act is adopted without amendment, a group of individuals still likely to be without medical care is undocumented immigrants (New York Times, Sept 20, 1993). These individuals will seek uncompensated care, and either adequate provision needs to be planned so that the undocumented can be integrated into the health system, or arrangements need to be made for alternatives to the standard plans and Alliances. Such arrangements could parallel the Community and Migrant Health Centers to be established under Section 3401 of the HSA. The state of Texas has a higher proportion of undocumented immigrants than most other states. If the states are required to cover the health care costs of these individuals, without federal assistance, the requirement could be an unfair burden.

Because plans are required to offer three choices of health insurance arrangements to consumers, HMOs, fee-for-service, or a combination, there is a possibility that people in different plans would reflect differences in ability to pay. The fear remains that a two- or three-tiered health system would evolve, with those in the least expensive plans receiving less preventive treatment, fewer referrals to specialists, etc.

The opportunity to implement a single-payer health care system in Texas remains an option under the terms of the Clinton HSA. Evidence from health services research, outlined above, suggests that it would improve efficacy and effectiveness at the local level, especially with regard to preventive health services and medical care, with a goal to improving health status and decreasing unmet needs. Because the single-payer system simplifies administration, it facilitates access. At the same time, it may also contain costs through global budgets.

Part of the savings envisioned by the Clinton Administration to finance the costs of the Health Security Act involve phasing out the Disproportionate Share Funds now available to hospitals that serve vulnerable populations. Newspaper analysis by journals suggests that hospitals with many Medicaid and Medicare program participants will be "at risk" (NYT Oct 9, 1993). A five- year transition period of funding is currently included in the HSA (Section 3481). The fiscal impact of the HSA on Houston Disproportionate Share Medicaid hospitals is unclear. Hospitals that offer highly specialized care are also said to be in jeopardy. Some predict that no matter what scenario plays out, layoffs of personnel can be expected. This trend is already becoming common in some major U.S. cities as hospital managers seek to reorganize in anticipation of the highly charged competition that is expected to develop if the HSA is adopted (New York Times, October 3, 1993).

Hospitals may receive antitrust relief as part of the Clinton health care reform. The broad lines of the revisions suggest that cooperation among hospitals as to services provided will be permitted. Joint purchase and management of equipment and technology may be encouraged. A division of labor may be proposed for specialized high technology, including coordination at the community level among hospitals. This could reduce hospital costs and make services more accessible to those whose health needs remained unmet in the past.

3. The Chafee Plan

Chafee's plan requires individuals to obtain health insurance. It would be applied universally by the year 2000 and would impose a 20% penalty to individuals who fail to comply. Two plans would be made available. One would cover the full range of benefits, and the other would only cover catastrophic health care costs. Community rating would be obligatory. Vouchers would be available to the poor to assist them in paying for health insurance. State-organized, voluntary, employer-purchased insurance would remain as well as state-coordinated, voluntary participation in health insurance purchasing cooperatives. Savings could be expected from administrative simplification, broad tort reform, Medicaid and Medicare program revisions, and competition among insurance companies offering different plans. Both Medicaid and Medicare would be folded into a purchasing cooperative in the long term. Medicaid recipients might also be turned over to a managed care program, or other such arrangements. Federal government Medicaid payments to states would continue. Antitrust legislation would permit hospitals and physicians to share the costs of expensive technology and would encourage more regional coordination. Federal government block grants to the states would continue so as to encourage provision of health services in underserved areas.

Primary care would be encouraged by using demonstration consortia, and Medicare graduate medical education funds. More money would be made available for National Health Service Corps and Public Health Service primary care providers educational activities. Hospital services would probably be better coordinated at the regional level, given anticipated anti-trust revisions.

Preventive services would not be included in the catastrophic benefits package, and the level of coverage in the basic benefits full-coverage option are uncertain. The underserved and vulnerable populations would still be in need of uncompensated care. Cost shifting between those with the full benefits package and those with only catastrophic care might remain a problem.

4. Cooper's Managed Competition

Cooper's health care reform proposal is a form of managed competition. Employers would **not** be required to provide health insurance to their employees. Competition and administrative simplification are expected to yield savings. Standardized health forms (electronic) would be required. Insurance

companies would offer standard Accountable Health Plans (AHP). AHPs would not be allowed to use experience ratings. But a six-month waiting period on pre-existing conditions would be permitted. Insurance costs for the very poor would be government subsidized on a sliding scale. Responsibility for long-term care costs of the Cooper program would eventually be transferred entirely to the states. Cooper's plan would establish purchasing cooperatives. A National Health Board would be set up to determine benefits, and the nature of these remain unknown at present. This makes it very difficult to assess the impact on any special populations or on primary, preventive or hospital care. Medicare would remain much as it is presently with preventive care expanded. Medicaid would be replaced by a federal program to help vulnerable populations purchase health insurance from an AHP. Antitrust law revision would facilitate cooperation among hospitals to share costs and increase the efficiency of high technology use. Funding for primary and preventive medical care education would be increased. So would funds for public health activities, including vaccinations, screening for lead poisoning and cancer, as well as AIDS-related work according to HCFA/OLP assessment of this proposal (Oct. 25, 1993).

5. Gramm's IRA Plan

The proposal by Phil Gramm is unique in the emphasis it places on a Medical IRA to address the cost of health care by leaving the decision to the individual consumer. States would set up health insurance purchasing cooperatives, but participation would be voluntary. Vulnerable populations would not be likely to have the financial resources to participate. Their care would continue to be covered by Medicaid or it would be uncompensated, as is so often the case at the moment. This plan does not outline a specific benefits package. But it does include a rather extensive tort reform project. It requires mediation and/or alternative dispute resolution. To discourage trivial and unfounded cases from coming to court, the loser would be required to pay the winner's legal costs. Limits on pain and suffering compensation would be set at $50,000, and lawyers could charge a maximum of 20% for contingency fees.

6. Stark Plan

Coming late to the health care reform debate, the Stark plan made its appearance during the hearings of the subcommittee on Health of the House Ways and Means Committee. The Stark plan includes employer-mandated insurance. It expands Medicare to cover the poor, the uninsured, and those businesses with only a few employees. ***Because Medicare does not include prevention in most cases, this may be a problem with the Stark plan as well***.

The Stark plan would require that states continue to pay for Medicare patients. State and local government employees would pay Medicare taxes. Individuals with insurance now could keep it as is. No provision is made for purchasing Alliances. Community ratings of health insurance are required by law. A $350,000 limit is included on pain and suffering malpractice awards. Medical teaching universities would be required to graduate a minimum of 53% primary care physicians. The benefits package would be similar to Medicare benefits.

Proposed funding for the Stark plan comes from several sources, including increased tobacco taxes. A one-percent payroll tax on employers with more than 1000 employees that choose the self-insured option as part of this plan will be used to pay for the plan.

7. Dingell Plan (Dem - Mich)

John Dingell, Chairman of the House Energy and Commerce Committee, has proposed a plan that includes universal access. It protects small businesses by making provision for those with fewer than 10 employees to be exempt from providing health insurance. It mandates individuals to pay 25% of health insurance premiums, which is more than required by other plans, while 75% would be paid by employers. It provides for higher deductibles and copayments than the other plans. There are no health insurance purchasing alliance structures in the Dingell plan, which has been called a scaled-back version of the Clinton plan.

8. Hoagland (D-Neb.) Proposal for Discussion

This bill includes a phased-in employer mandate for small businesses and voluntary health alliance purchasing cooperatives. It includes insurance reform mandating community rating within alliance areas. Health Plans could sell insurance outside the geographic Health Alliance boundaries but they would be subject to conditions regarding performance and cost. Low-wage and low- salaried employees would receive subsidies for health insurance from the government. Tort and antitrust reforms are included. More detailed information will become available as this bill makes its way thought the House Ways and Means Committee.

ONGOING HEALTH SYSTEM CHANGES PRIOR TO CONGRESSIONAL LEGISLATION

The health sector has already begun to respond to changes expected as a result of legislation that might be adopted by Congress in the near future.

Institutional Reorganization and Cost Containment

The anticipation of health care reform, especially in the form of managed competition, is already having an impact on the organization of health care services in Houston, and this affects the unmet needs of our citizens. It has brought mergers and self-imposed cost-containment measures in advance of any legislation in the Houston area ("A Hospital Giant Comes to Town, Bringing Change," New York Times Nov. 21, 1993). Cost-containment efforts will probably have substantial effects on our geographical area, because the managed care costs here are higher than those in other areas. There may also be an excess of health care resources. Prices have already started to decline in the Houston area (down 4% between November 1993 and February 1994). The estimated "excess" could be absorbed in the process of health care reform, but much depends on the character of the final legislation adopted by Congress. (Houston Chronicle - 29 March 1994 - report of Michael Cadger, a principle with A. Foster Higgins & Co. Inc.)

Health reform will affect health care providers and patients broadly. While considerable uncertainty remains, the possibilities for organization alignments among providers are likely to be improved since most reform plans include incentives for providers to work together in groups even though these groups will be encouraged to compete. The most complete reform plans provide for regulatory policies governing the quality of care, performance, confidentiality of patient records, etc. Experts tend to agree that the final legislation is unlikely to provide close monitoring of providers because performance standards and guidelines are controversial and would be expensive to develop and implement. Changes in antitrust policies are already being made parallel to the ongoing reform efforts to encourage provider cooperation where it makes for more effective use of expensive technology and a reduction in overall health system waste.

The form of payment that Congress employs for health reform may affect both provider institutions and citizens as well. For example, Disproportionate Share Funds are scheduled to disappear under some reform plans. This would mean a substantial loss of revenue for some hospitals in the Houston area. In theory, these hospitals would be compensated for the burden of uncompensated care of the poor since health insurance is extended to all citizens in the United States.

Tobacco taxes might be markedly increased to generate revenue to pay for health reform. This price increase is expected to reduce the number of smokers and the quantity of tobacco consumed. If these things occur, the revenue generated by such a tax might be smaller than anticipated. On the other hand, the health of those who quit smoking will improve over time.

Quality of Care

Quality of care will also be influenced by health reform legislation, and unmet needs will be affected. HMOs, which have shown they can conserve health care resources, are likely to be encouraged under managed competition, but with greater risk of undertreating. This is because some HMOs reward doctors for "ordering fewer tests and referrals" (New York Times Sept. 20, 1993). Fee-for-service medical care encourages overly generous utilization of health resources (see Houston Chronicle April 3, 1994). Health reform at its best could help locate the point at which treatment and intervention are most appropriate. To achieve this reform, legislation adopted by Congress needs to ensure that quality of medical care is monitored at the same time that price competition is encouraged. Without such protection health reform may simply ensure access to poor quality, substandard health care in the form of low cost HMOs. If this occurs, some of the health needs of the population will remain neglected.

Impact of More Than One Health Insurance Option

If health care reform mandates two or three different levels of health insurance, unmet needs might remain a problem. Universal access to a minimum catastrophic health insurance plan is ensured by most reform proposals. But if reform legislation also provides for a better, more expensive package that is voluntary, a two-tiered health care system might evolve (New York Times, Sept. 11, 1993). The portion of the population able to afford only the cheapest, minimum catastrophic care option would still face substantial unmet needs, especially with regard to preventive care. This is likely to be a problem for those reform proposals that involve Medicare expansion since they may not cover much in the way of preventive care.

Who Will Benefit from Reform?

Who benefits from health reform depends in part on the exact nature of the health care reform proposal adopted by Congress. In general, the disadvantaged, the elderly, and those with serious disabilities and/or very large health bills are likely to be better off after health care reform (New York Times, Sept 27, 1993). None of the health care reform proposals, however, adequately provides for long-term care for the elderly (Commerce Clearing House's Health Care Reform Newsletter, April 1, 1994). Those with pre-existing conditions will be able to obtain insurance under most reform proposals before Congress. In Texas, those with low incomes "stand to gain the most from the universal coverage provisions" of the Clinton proposal (B. Weinstein in the Houston Chronicle Sept 26, 1993). Those

currently without insurance and those with pre-existing conditions will gain under almost any form of health reform.

Obviously, those without insurance should benefit from health reform. This group includes a broad range of individuals including many employed, the unemployed, and the homeless. Those with part-time employment, young people, and the very poor are most likely not to have health insurance (Journal of American Health Policy, Nov/Dec 1993). The health needs of the uninsured are not being met despite emergency room care and public programs to assist them. Uninsured patients " are more likely to die prematurely." They go to the doctor less often, ignore serious medical disease symptoms, and obtain lower quality care when it is available (Research Activities, AHCPR Oct 1993). Health reform that ensures universal access to medical care will help meet the health needs of this group.

Even those who already have health insurance might benefit in some cases (according to Families USA Foundation, see Houston Chronicle March 31, 1994). Eight to ten million Texans are estimated to gain dental benefits, more mental health and substance abuse coverage, and vision benefits if the Clinton health reform proposal is adopted. This is because their coverage, though poor at the moment, would improve after reform legislation (Houston Chronicle March 31, 1994).

The workforce would be better off in Texas, a state having the highest percentage of workers with no health insurance (New York Times, October 10, 1993). Proposals differ as to incentives provided to ensure improved availability of medical care in both urban and rural underserved areas. Nevertheless, islands of uninsured will remain, even if the most generous plan is adopted because few reform packages (the single-payer excepted) offer care for undocumented immigrants. This could seriously affect Texas. (Time Sept. 20, 1993). Nevertheless, the removal of financial barriers to service will not in itself, eliminate the difference in health status between the rich and the poor based on the experience of other countries. This problem will need to be followed on a continuing basis over the long run.

Health reform is likely to include an employer mandate. Evidence suggests that companies that already provide health insurance would pay between $57 and $923 per worker depending on the size of the firm involved. Employers who do not now offer their employees health insurance would see their costs increase between $640 and $905 per worker per year. Many Texas employers do not offer insurance to their workers, but because so many of the employers operate small, low-wage operations, substantial subsidies are expected to compensate for increased costs under most health care reform packages (Weinstein, Houston Chronicle, Sept 26, 1993). "Economists predict that the [Clinton] plan would funnel tens of billions of dollars from the high-wage North to the low-wage South by the year 2000" (New York Times Oct. 10, 1994). Overall, the Clinton administration estimated that Texas would save $3,300,000 by the year 2000 if the Health Security Act is implemented (New York Times, March 2nd 1994).

The impact of health reform by employer mandate is complex. While it may place a hardship on small manufacturers depending on the extent of subsidies available, there is evidence that business may pass the cost on to workers. "Overall, researchers believe that about three-quarters of mandated labor benefits are passed back to workers, and the rest passed forward to consumers". (New York Times, Sept. 30 1993)

Impact on Small Hospitals

Various changes in the status of small hospitals and their role in the developing networks have been observed in some U.S. cities (New York Times April 4, 1994) and can be anticipated in the Houston area as a result of health reform and the evolution toward managed competition. A new relationship has been observed between larger urban hospitals and outlying smaller hospitals. While it was feared that large hospitals might be so efficient that smaller hospitals, unable to compete with them, would be

forced to close, a very different pattern is emerging. Large hospitals in some locales are eagerly seeking smaller affiliates to incorporate into their network. Larger hospitals can benefit from having referrals for tertiary care and for specialized (costly) procedures that are not performed at the smaller institutions. Larger hospitals broaden their patient base through affiliations with smaller hospitals by offering continuing education, access to world famous specialists for consultations etc. In addition, smaller hospitals in the community generally have a middle-class clientele that has insurance. The small hospitals that are not being aggressively pursued by larger hospitals for affiliation are those whose clientele is largely Medicaid-based patients (New York Times October 6, 1994). This pattern may be transitory if Congress legislates universal care. Under these circumstances even the smaller hospitals with a Medicaid patient base may become more attractive to large hospitals for purposes of affiliation.

WHAT WILL HEALTH CARE REFORM LEGISLATION LOOK LIKE?

While it is impossible to anticipate the exact character of the legislation that might be adopted, it is possible to describe the major contenders in general terms and to anticipate some of the elements that will be included in the final package. Any health care reform bill produced by Congress may well be a combination of elements drawn from several different proposals. No matter which form of health reform is adopted, Congressional modification designed to reduce costs to the federal government, will transfer the financing to states and result in larger co-payments by users than was envisioned by the initial proposals put forward by individual members of Congress. Universal access, at some specifically designated time in the future, is likely to be a part of the bill adopted. But universal access does not mean that everyone will benefit from the same level of health care.

Health reform in the United States in 1994 will probably include community rating for health insurance. This means that many of those without insurance will be insured. Portability, the ability to move insurance from one job to another, might well be included, though how this would be implemented outside of a comprehensive government sponsored program is difficult to predict. As many as 20% of all Americans have turned down a job or stayed in a position to retain health insurance (Houston Post 1/27/94). Health insurance purchasing cooperatives may play a role in the future health system in the U.S. At a minimum, they would be voluntary alliances, but they are required by several health reform proposals. Employer mandates to cover health insurance are also a possibility though there is strong opposition to them in some economic sectors. Universal access via government provision of insurance for the poor, perhaps through Medicare expansion is also a possibility even if employer mandates are not implemented. Medicare entitlement will be maintained in theory but is likely to be reduced indirectly by increasing co-payment and/or deductible. This could mean that providers would have to bill Medicare patients for increased amounts in the future. Simplification of administrative paperwork may also result from health reform, but it may be limited to the mandated use of a standardized form. Funding for universal access is also likely to mean that the Disproportionate Share Funds program for hospitals will disappear. This is balanced, it is assumed, by the fact that uncompensated care will no longer be a problem once everyone has health insurance. However, none of the health reform packages under consideration offers insurance to undocumented immigrants. The cost of unpaid care in this population is estimated to be quite high, and it will be an important consideration in Texas.

CONCLUSION

Policies can constrain or facilitate meeting the health needs of a population. National health care reform legislation will have a similar impact as it implements policy across the whole health care sector. But even if no legislation is enacted by Congress, which is highly unlikely, health policy has been

dramatically influenced by the very possibility that such legislation might be forthcoming. The problem is that anticipatory institutional and organizational change takes place in the absence of any protective legislation or of any transition mechanisms to ease the transformation. Its overall impact is to provide services for an already existing market without paying attention to unmet needs. Absence of attention to preventive services for those who cannot pay continues to be a problem. With "uncontrolled" managed competition such as that found in Houston's health sector, unintended consequences are always possible. For example, the danger of a resulting monopoly resulting from hospital mergers could make for higher costs in the long run, even though prices would be temporarily reduced ("A Hospital Giant Comes to Town, Bringing Change," New York Times Nov. 21, 1993.) This scenario suggests that the shorter the period of national health reform, the better. Once legislation is enacted, change is likely to take place at a more rational pace and it is likely to be less disruptive of the services already in place.