



NCLR

Healthy Choices or

Bad Medicine?



Health Tax Incentives
Roundtable Transcript

The National Council of La Raza (NCLR)—the largest national Hispanic civil rights and advocacy organization in the United States—works to improve opportunities for Hispanic Americans. Through its network of nearly 300 affiliated community-based organizations (CBOs), NCLR reaches millions of Hispanics each year in 41 states, Puerto Rico, and the District of Columbia. To achieve its mission, NCLR conducts applied research, policy analysis, and advocacy, providing a Latino perspective in five key areas—assets/ investments, civil rights/immigration, education, employment and economic status, and health. In addition, it provides capacity-building assistance to its Affiliates who work at the state and local level to advance opportunities for individuals and families.

Founded in 1968, NCLR is a private, nonprofit, nonpartisan, tax-exempt organization headquartered in Washington, DC. NCLR serves all Hispanic subgroups in all regions of the country and has operations in Atlanta, Chicago, Los Angeles, New York, Phoenix, Sacramento, San Antonio, and San Juan, Puerto Rico.

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Acknowledgments

The Health Tax Incentive Roundtable was a collaborative effort of policy staff at the National Council of La Raza to inform the policy debate on health care reform proposals that use the federal tax system to help Americans obtain health insurance coverage.

This roundtable discussion was coordinated by Kara D. Ryan, Research Analyst and overseen by Jennifer Ng'andu, Associate Director of the Latino Health Policy Project in the Office of Research, Advocacy, and Legislation (ORAL) at NCLR. Ms. Ryan conducted the preliminary research and analysis of health tax incentives with considerable guidance and substantive input from Ms. Ng'andu. Ms. Ryan also prepared the transcript for publication. Cecilia Muñoz, Senior Vice President of ORAL, Eric Rodriguez, Deputy Vice President of ORAL, and Raúl Gonzalez, Senior Legislative Director provided overall direction for the project. Finally, Jennifer Kadis, Director of Quality Control, Gregory Wersching, Copy Editor and Karen Nava, Publications Project Manager and Designer provided overall technical support and prepared the transcript for publication.

NCLR wishes to thank our funding partners for helping us carry out this project. Assessing the impact of health tax incentive proposals requires attention to many interweaving policies and systems, including health coverage, federal tax policy, and economic issues. NCLR's initial discussion paper, the subsequent roundtable discussion, and this resulting report were made possible through generous grants from the Annie E. Casey Foundation, the Nathan Cummings Foundation, and the Rockefeller Foundation. General support to the Office of Research, Advocacy, and Legislation is provided by the John D. and Catherine T. MacArthur Foundation. The views and conclusions of this paper are those of the author and NCLR alone and do not necessarily reflect the opinions of our funders.

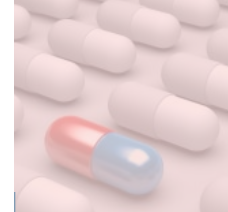
We also wish to thank the National Education Association (NEA), particularly the Minority Community Outreach division, for hosting the policy discussion at their offices in Washington, DC. NCLR is grateful to Tomás Saucedo and William Moreno III for facilitating NEA's participation and to Jacqueline Henderson for coordinating the event logistics. We are grateful to Martin G. Cerda and Lourdes Prado of Encuesta, Inc., who shared with NCLR the data from an Americanos Poll that provided insight into Latinos' tax-filing behavior. NCLR also thanks A. Mark Fendrick, who gave his permission to include his presentation on value-based insurance design in the event materials. DC Transcription & Media Repurposing recorded and transcribed the roundtable proceedings.

Finally, NCLR is grateful to the roundtable participants, whose insight, enthusiasm, and dedication to removing the barriers to health care generated the rich discussion that follows. The full roster of participants appears on page 10 and brief biographies can be found at the end of this transcript.

The insights raised in this roundtable discussion helped to shape NCLR's analysis of health tax incentives and their potential to expand coverage options for Latinos in the U.S. This issue brief, "Health Tax Incentives: Healthy Choices or Bad Medicine?" is available for download on NCLR's web site, www.nclr.org.

The content of this document is the sole responsibility of NCLR. Panelists had an opportunity to review their comments for clarification but did not materially or substantively alter them.

Executive Summary



Despite evidence that Latinos¹ have had poor access to both health coverage and care for years, few policymakers have made efforts to proactively address the barriers to the health care system that so many Latinos face. Representing nearly one-third (32.5%) of the full-year uninsured, Latinos have a substantial stake in the U.S. health care debate.² Strong workforce participation and a fairly stable economy have had little impact on reducing the Hispanic uninsurance rate over the past decade, and an increasing number of Hispanics—more than 15 million in 2006—have gone without health coverage each year. Although Hispanics are more likely to be employed than non-Hispanics, they are poorly served by the employer-based health coverage system.³ Moreover, Latinos with health insurance are more likely than non-Hispanics to be worried about losing the coverage that they already have.⁴ While public programs such as Medicaid and the State Children’s Health Insurance Program (SCHIP) insure millions of Latinos and their children, millions more low-income Latinos, such as childless adults or recently-arrived legal immigrants, do not have access this safety net. If policymakers allow this trend to go unchecked, then the coverage gap will only be exacerbated over future generations as Hispanics continue to make up a rapidly-increasing share of the U.S. population.

Public awareness of the health care system’s failure to reach millions of families that need timely care has reached critical mass and the reform movement is gaining momentum nationwide. Policymakers have begun deliberating when and how to restructure the system. The array of policy approaches is broad, ranging from coverage proposals that extend government programs to all persons living in the U.S. to narrower changes designed to make private coverage more attainable. One set of models from the latter end of this spectrum, known collectively as health tax incentives, would use the federal tax system to provide Americans with resources to purchase health insurance for themselves and their families. Health tax incentives expand conventional coverage options by encouraging participation in the direct-purchase, nongroup private market outside of the employer-based system, with which most insured Americans are most familiar. If one or more of these proposals can create new conduits to affordable coverage that improve access to quality services, then these models could potentially narrow the coverage gap. However, since health tax incentives have had limited implementation and their specific impacts on the Latino community have gone largely unstudied, their promise remains unclear.

To enhance our perspective on health tax incentives, NCLR solicited insight from a broad panel of experts and stakeholders. After conducting preliminary research on three prominent proposals—health coverage tax credits, a health insurance standard deduction, and health savings accounts—NCLR identified potential implications of these proposals for the Hispanic community. NCLR then raised these issues at an expert roundtable convened on January 28, 2008 in Washington, DC. The Health Tax Incentives Roundtable was comprised of health and tax policy specialists, as well as representatives from the business, provider, and civil rights communities.

The discussion that ensued provided many practical insights into the merits and flaws of adopting health tax incentives to reduce uninsurance in the Hispanic community. Several participants argued

¹ The terms “Hispanic” and “Latino” are used interchangeably by the U.S. Census Bureau and throughout this document to refer to persons of Mexican, Puerto Rican, Cuban, Central and South American, Dominican, Spanish, and other Hispanic descent; they may be of any race.

² NCLR calculation using data from U.S. Census Bureau, *2006 Annual Social and Economic Supplement*. “Current Population Reports”, series P-60, No. 233. Conducted by the Bureau of the Census for the Bureau of Labor Statistics, Washington, DC, 2007, http://pubdb3.census.gov/macro/032007/health/h01_000.htm (accessed June 2008).

³ In 2006, 40% of Hispanics were covered by employer-sponsored insurance, compared to 49% of non-Hispanic Blacks and 66% of non-Hispanic Whites (ibid.).

⁴ According to the Rockefeller Foundation’s *American Workers Survey*, 25% of Hispanics are “very worried” about losing their health insurance coverage, compared to 21% of non-Hispanic Blacks and 13% of non-Hispanic Whites (Elise Gould and Algeron Austin, *Health Care Insecurity Greatest Among Hispanics* [Washington, DC: Economic Policy Institute, February 20, 2008], http://www.epi.org/content.cfm/webfeatures_snapshots_20080220 [accessed June 2008]).



that some health tax incentives—generally, tax credits or Health Savings Accounts (HSAs)—would provide coverage options for Latinos who would otherwise have none, thereby improving both the affordability and accessibility of health care services. However, other panelists warn that structure is central to any of these proposals' potential to close the coverage gap; potential pitfalls include an erosion of current public and/or private systems or a reduction in newly-insured Latinos' overall consumption of care. Moreover, the ways in which the insurance market for individuals currently functions is a critical factor in any analysis. Beyond policy design, panelists recognized that culturally and linguistically appropriate outreach campaigns and educational tools would be essential to reaching vulnerable subgroups in the uninsured Latino population.

Roundtable participants raised and debated issues ranging from overarching frameworks to design details of a particular policy. Some panelists believe that health tax incentives provide opportunities for uninsured Latinos to access health coverage and care while others are concerned that the community would not be well served. Throughout the course of the conversation, key questions emerged, including:

- **Is focusing on coverage a means of improving health outcomes for Latinos?**

Ultimately, NCLR is concerned with achieving equitable health outcomes for Hispanics and other racial and ethnic minorities in the U.S. Michael Cannon (Cato Institute) questions whether providing all Americans with health insurance is best way to promote healthy outcomes for Latinos. While coverage is valuable, he says, it is not a cost-effective way to improve health outcomes. Other policy alternatives might reduce health disparities more efficiently. Leonard Burman (Tax Policy Center; Urban Institute) points out that expanding health coverage is a good solution because increasing the number of people participating in insurance pools spreads risk across a greater range of individuals, which lowers the probability that costs will spiral out of control as a result of adverse selection.⁵ Jennifer Ng'andu (NCLR) adds that while many other factors do influence health outcomes, studies demonstrate that health coverage does improve access to care, which plays a critical role in reducing health disparities.

- **Which uninsured Latinos are health tax incentives most likely to reach?**

As David Ferreira (U.S. Hispanic Chamber of Commerce) points out, uninsured Latinos are not a homogenous group. For instance, while tax credits alone might help some Latinos buy coverage, not all uninsured Latinos will be reached. "That's why we need to attract the Latino population through different types of inducements, through different angles," he explains—by offering more choices (including HSAs), working with businesses to improve the market for small employers, spreading risk through pooling, and adopting policies that remove barriers to public coverage for legal immigrants. Elena Rios (National Hispanic Medical Association) also underscores this heterogeneity. She argues that the Hispanics who are most marginalized, such as undocumented immigrants who are limited-English-proficient, would have more difficulty accessing health tax incentive programs than Latinos who are middle-class professionals.

There are a number of structural barriers that could hinder (or prevent altogether) some segments of the uninsured Latino community from participating in health tax incentive programs. For instance, Stan Dorn (Urban Institute), Mr. Ferreira, and Dr. Rios point out that the existing complex requirements regarding immigrants' eligibility for public benefits create fear and confusion in the community, a mood that is exacerbated by recent debates over comprehensive immigration reform. As a result, uninsured Latinos living in immigrant or mixed-status families may be wary of participating in

⁵ For more on this concept, see Michael Rothschild and Joseph Stiglitz, "Equilibrium in Competitive Insurance Markets: An Essay on the Economics of Imperfect Information," *Quarterly Journal of Economics* 90 (November 1976): 630-649.



federal health tax incentive programs. Linguistic and cultural barriers are also serious impediments for many of the Latinos who most need new coverage vehicle. Rea Pañares (Families USA) says that, while challenging, these barriers can be mitigated by extensive education campaigns. Both Ms. Pañares and Mr. Dorn point out that outreach strategies using the community health worker model have been shown to facilitate Latinos' awareness and enrollment in health coverage programs.

- **Is comprehensive health coverage necessary to gain access to needed care?**

Many health care advocates warn against a “something is better than nothing” approach to covering the uninsured. Yet Katherine Baicker (Harvard School of Public Health) argues that because we live in a world with limited resources, a realistic policy goal would entail giving uninsured Latinos access to basic coverage that provides some financial protections and better access to medical care. She explains that having a basic health insurance plan, even one with high cost-sharing requirements, is better than going uninsured. In addition to giving patients access to insurers' discounted rates (which lowers the out-of-pocket cost of care), Dr. Baicker says, “[Health care] providers are reluctant to take on patients who have uncapped, uncompensated liabilities associated with them.” However, Cheryl Fish-Parcham (Families USA) warns that with some plans, there have been problems monitoring whether patients are actually seeing increased access and receiving negotiated rates when they are still paying out-of-pocket to meet their deductibles. Sabrina Corlette (National Partnership for Women & Families) adds that there might be little agreement about what “basic” benefits include.

Mr. Dorn contends that while policymakers do not need to ensure that all people have the same plan, policyholders who have low incomes or chronic illnesses are at risk of experiencing poor access to care if they have plans with high levels of cost-sharing. Catherine Hoffman (Kaiser Commission on Medicaid and the Uninsured) agrees, citing research that shows that patients with high out-of-pocket costs were more likely than patients with low or no copayments to skip doctor treatments or not fill prescriptions. Mr. Cannon argues that while cost-sharing does cause people to cut back on the amount of health care that they consume, there is reason to believe that not all of that forgone care was necessary for maintaining good health. Along these lines, Dr. Baicker suggests that one approach that balances cost containment and access to care might be to structure cost-sharing in a way that encourages “high-value” care, which research demonstrates as having good health outcomes, and discourages “low-value” care that is ineffective or even harmful. Dr. Burman adds that at least some researchers have developed models for health insurance plans that vary cost-sharing levels by income, which would encourage consumer cost-consciousness but would not prevent policyholders from seeking care when they need it.

- **Will making the costs of health care transparent affect Latinos' health care consumption?**

In a related thread, Ms. Corlette argues that people should not be expected to choose the cheapest hospital or pediatrician. However, it is unlikely that newly-insured Latinos could make such a choice; she explains, “Purchasing health services or products is not like buying a toaster oven or a refrigerator...There is simply not the cost, quality, price transparency that you have when purchasing those types of products.” Sam Jammal (Mexican American Legal Defense and Education Fund (MALDEF)) believes that educational tools are fundamental for Latinos who must overcome informational barriers; without informed consumers, there cannot be a “pure” health care market. Ms. Pañares points out that if information is available but *inaccessible* to segments of the population, —such as by making cost and quality data available only on the Internet—, then some Latinos and others in vulnerable populations will remain disadvantaged. Mr. Cannon, however, argues that the famous RAND Health



Insurance Experiment⁶ showed that people are able to make decisions about their health care consumption without incurring poor health outcomes; presumably, people could do even better with decision-making resources and greater transparency. Yet Mr. Dorn warns that providing transparency might create new access problems. For example, providers seeking to improve their performance statistics could filter out high-risk or disagreeable patients.

- **How would Latinos with conventional forms of coverage fare?**

Certain health tax incentive proposals, depending on their structure, could ultimately reduce Latinos' access to health coverage if they were to decrease access to employer-based coverage and/or public coverage systems without guaranteeing access to incentive programs. With respect to public coverage, Ms. Corlette points out that there are ideological reasons for some policymakers to support replacing safety-net coverage with tax credits, and Ms. Fish-Parcham does not believe that Latinos would be as well served as they are under Medicaid and SCHIP benefit packages. For employer-based coverage, firm sponsorship has declined in recent years, and certain proposals—in particular, tax credits and the health insurance standard deduction—could hasten this erosion. For instance, Mr. Dorn explains that making tax credits available only for use in the nongroup market provides an incentive for firms to stop sponsoring coverage. Dr. Burman allows that the standard deduction might increase *overall* coverage, but the people who are likely to lose coverage are also likely to be people who have trouble obtaining coverage in the nongroup market. Yet as Dr. Baicker reiterates, Latinos are poorly served by the employer system, and continued erosion of the current employer market without any alternative mechanism is a real, current concern for the Hispanic community.

Given these concerns, the function of the individual nongroup market is critical. John Arensmeyer (Small Business Majority) argues that the small-group and nongroup markets are not functioning well; half of small firms do not offer insurance to their employees and only a quarter of sole proprietors are insured. Mr. Cannon believes that the nongroup market works better than many people think and argues, “It’s not a question of, ‘Are we going to keep them in employer-based insurance, which works, and throw them into the nongroup market, which doesn’t work?’” Ms. Fish-Parcham points out that the function of the nongroup market varies by state, based on whether states have pooling and guaranteed-access mechanisms (which might still be ineffective). Yet panelists suggest that certain nongroup market reforms could mitigate access, quality, and affordability concerns. Dr. Baicker suggests that one such reform might ensure that people have continuous protection over their lifetime rather than face higher premiums and exclusions once they have fallen ill. Mr. Dorn suggests that states could establish comprehensive standards for benefits as well as affordability for Latinos who would like to take up new coverage in the nongroup market.

This rich discussion offers valuable insight for policymakers who are committed to closing the coverage gap for Latinos, which must be achieved if we are to eliminate health disparities in the United States. Hispanics need new policy solutions that improve the opportunity to buy affordable coverage that provides access to a wide range of health care services. Health tax incentives hold some promise of helping segments of the uninsured Latino community obtain coverage, but there are important caveats that must be addressed before any of these policies are seriously pursued.

⁶ The RAND Health Insurance experiment was an extensive study conducted between 1971 and 1982 in which participants were randomly assigned to one of five types of health insurance plans, including one nonprofit plan that offered free care, with varying levels of cost-sharing. The research found that higher levels of cost-sharing reduced participants' consumption of both necessary and unnecessary care. For a general overview of the study, see RAND Corporation, “The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate” (Washington, DC: RAND, 2006), http://www.rand.org/pubs/research_briefs/RB9174/index1.html.



Transcript: NCLR Health Tax Incentives Roundtable

Convened by the
National Council of La Raza (NCLR)
Office of Research, Advocacy,
and Legislation

9:00 a.m. – Noon

Monday, January 28, 2008



Participants

John Arensmeyer
Founder and CEO
Small Business Majority

Katherine Baicker
Professor, Health Economics
Harvard School of Public Health

Leonard Burman
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Senior Fellow, Urban Institute

Michael Cannon
Director of Health Policy Studies
Cato Institute

Sabrina Corlette
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National Partnership for Women & Families

Stan Dorn
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Catherine Hoffman
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Sam Jammal
Legislative Staff Attorney
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Rea Pañares
Director of Minority Health Initiatives
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Elena Rios
President and CEO
National Hispanic Medical Association

Kara Ryan
Research Analyst,
Latino Health and Policy Project
National Council of La Raza



JENNIFER NG'ANDU: Hi. I'm Jennifer Ng'andu with the National Council of La Raza. We're going to go ahead and get started. All panelists have arrived and I want to thank you all for attending.

Solving the problems around Latino health can be compared to the lights going out in your bedroom and groping around in the dark to find the flashlight; you might know many of the elements that are in the room, the wall, the chair, the desk in the room, but you're not quite sure where everything is. The room is not in focus and you need to dig around a little bit to find the light. There's a dearth of data out there on Latinos and health coverage, but one of the things that NCLR tried to do is pull elements together in this paper¹ to give a sense of the direction that might make sense to take with Latinos and health care reform. Really, we're trying to get to the flashlight and turn on the lights, and hoping that there's no briefcase or another obstacle that we trip on along the way.

In the past, NCLR has broken into health care issues where the light was clearly on, for instance, during the 1996 welfare reform legal immigrants were clearly cut off from critical benefits that most Americans were entitled to and the Latino population was disproportionately affected. Immigrant access to care has been a clear part of the NCLR portfolio for a very long time, but as the organization has looked at the issues surrounding new immigrants, we've also taken note of many of the issues that more broadly affect Latinos. Now we're trying to get to the core barriers of participation outside of immigration status that affect Latinos' access to health care to ensure that Latinos can be stakeholders in health care reform. In general, health care reform is not going to be successful if Latinos and their needs aren't taken into account, and that's quite frankly because they are disproportionately uninsured and more disconnected from the health care system.

This is one of the initial conversations that NCLR would like to have around health care reform. We know that Latinos are disconnected from traditional systems, so we've decided to look at what potential health care tax incentives have. We're not going to push any option based upon what people are saying about the general population. NCLR wants to hear all ideas and thoughts about health reform proposals as we move forward and respects the wealth of knowledge that is out there. Again, we're hoping that the elements that we've put together will help guide a discussion that focuses on whether this is the right move for Latinos or not. With that, I turn it over to Kara Ryan, who is going to go into a little bit of detail about the paper findings.

KARA RYAN: Thank you. Again, welcome, and thank you for coming today to provide us with your expertise. Today we want to inform the debate on health tax incentives as possible vehicles for reform. Latinos are critical stakeholders in the debate because they face significant barriers under the current system. Our hope is the forum will provide some answers to the questions and concerns that NCLR has raised about the tax incentive proposals and their potential to improve Latinos' access to health care. We think that this roundtable will provide new insight and new ideas that will shape future efforts to connect all Americans with health care.

Under the status quo, Latinos do not have equal access to health insurance coverage, which in turn limits their access to health care. Hispanics make up one in every seven U.S. residents but one in every three of the uninsured. In 2006, one-third of all Hispanics had no coverage compared to one-tenth of non-Hispanic Whites, and half of all foreign-born Hispanics went uninsured. This coverage gap is largely explained by an offer gap. Hispanics are less likely than non-Hispanics to be offered coverage in the workplace. The Kaiser Commission on Medicaid and the Uninsured showed that in 2005, 65% of Hispanics worked for a firm that offered health care benefits. That's compared to 86% of Black workers and 88% of White workers. They also found that when health insurance was offered,

¹ NCLR conducted a preliminary policy analysis of health tax incentives that was used to inform this discussion. Subsequently, NCLR has developed an issue brief based on the preliminary research and this Roundtable discussion. See Kara D. Ryan, "Health Tax Incentives: Healthy Choices or Bad Medicine?" (Washington, DC: National Council of La Raza, 2008).



Hispanics were just as likely to be eligible and take up coverage. Latinos who have limited access to health coverage at work and who also do not qualify for a public health insurance program, such as SCHIP or Medicaid, have no feasible alternative to going uninsured. The nongroup market is priced beyond the means of most Americans, and especially Latinos, because over half are low-income, living in low-income households. This means that the Hispanic community is most vulnerable to the health and economic risks that come with going uninsured. Without insurance, Latinos will often forgo care altogether or delay care until complications develop that require immediate and more expensive attention.

For all these reasons, NCLR is welcoming new health care proposals that will close the coverage gap and link Latinos to the health care system. Our preliminary analysis of health tax incentive proposals left us skeptical that they will meet affordability, accessibility, and quality concerns. Today, we want to have a deeper conversation. We'll ask you to consider both specific policy proposals, as well as the cross-cutting themes that we identified in the preliminary analysis. With that, I'd like to turn to the topics for discussion.

NCLR has had several reservations about health tax incentives' ability to close the coverage gap, based on the considerations that we've identified: affordability, accessibility, and quality. We now invite you to share your reactions to the discussion paper. Feel free to touch on any of the topics that we will discuss in later questions, but please limit your comments to five minutes.

KATHERINE BAICKER: I thought this was a really interesting discussion paper. It brought together a lot of important facts that are necessary to inform the debate, and I thought it outlined the issues that we should take on in a very clear, organized way. I found it extremely helpful in thinking through these issues. I would like to start by examining some of the assumptions that went into what the ideal solution would look like, and we may agree or we may not agree, but I think understanding what the goals are in a really crisp way will help us evaluate the potential policies on the table.

I was surprised to read the statement that something wasn't better than nothing. My perception is that something *is* better than nothing, and that having a basic insurance policy is much better than having no insurance at all for a couple of reasons. First, when you have an insurance policy, you have access to your insurer's negotiated rates, which you don't when you're on your own. So even if you're paying out-of-pocket because you're in a high deductible plan, you're paying less, because your insurer has negotiated a better set of rates with those providers and that makes a huge difference. It can be a factor or two or three in the price that you pay when you go to the doctor. That's one reason that having an insurance policy, even when you're in the deductible range, is helpful.

Second, the insurance policy provides financial protection against really high expenditures. Now, I think you're right that that may be less important to low-income people because there aren't as many financial assets to protect. Even though insurance is good to help you stay in your house or keep whatever assets you have, if you don't have a lot of assets to protect, that financial protection isn't worth as much. But I still think it's worth something because providers are reluctant to take on patients who have uncapped uncompensated liabilities associated with them. If you're a provider and you know that patient may be on the hook for the first \$10,000, but after that there's an insurance policy to cover additional costs, you may be more willing to take on that patient. Even if there's still some unfunded deductible that the patient may not be able to cover, at least the provider is not left with an uncapped liability.

So I think that having even a basic insurance policy gets people better rates and gets them access to providers that they might not otherwise have access to. I would suggest that we don't discard those as worthless, even though a lot of people are going to fall into the deductible portion of a policy with a high deductible.

I also think the goal perhaps should not be for everyone to have the same insurance coverage. Hav-



ing everyone have access to at least a basic plan would be my goal before worrying about everyone having further coverage or bells and whistles. Now, I don't mean to characterize anything beyond the very basic plan as a luxury or bells and whistles. Maybe that was the wrong turn of phrase, but the fact of the matter is that resources in the world are limited, and human needs are not, and we can't afford for everyone to have everything. We live in a world with budget constraints, and once you live in a world where everyone can't have everything at the same time, I would focus first on getting everyone access to basics before worrying about everyone having exactly the same thing. If you set out for everyone to have exactly the same coverage, I think you could set yourself up to fail, because that's not likely to happen. And if everyone had exactly the same coverage, are you preventing people with more income from getting more generous plans? How are you going to enforce that? I would start by focusing on getting people access to something, and I would focus on that something having at least basic protections so that people have access to good providers and have protection against financial risks, and then go from there.

STAN DORN: I thought the paper was terrific, at several levels. First, to see this type of engagement from NCLR is enormously important. The country may have a chance at a major coverage expansion in 2009, and no one has more at stake than the Latino community in this issue. So, to have intensive involvement could make a difference, could yield a different outcome than we had the last time a major national coverage expansion was proposed, in 1993, 1994.

And second, I found most of the conclusions of the paper to be well taken. It won't surprise you, Kate, to know that your thoughts are not necessarily universally shared around the table and neither will mine be, but I thought NCLR made a couple of excellent points in the paper. One is that a tax deduction is of very little value to low-income people. And therefore, if you're talking about tax subsidies to cover the uninsured, you have to talk about a tax credit, a refundable tax credit. Second is, if you want to provide good, affordable access to health care for low-income people, you need to provide access to comprehensive coverage. Certainly, you don't need the same benefits for everybody, but high-deductible plans don't work well with low-income people, and they don't work well with people with chronic illness. A lot of research has taken place that shows [that] high deductibles—notwithstanding the benefits that Kate rightly points to—deter people from accessing care in ways that make a difference with health outcomes. The RAND experiments are classic, when high-deductible coverage was provided to low-income people, people with chronic illness—even with the less effective medical technology that was available back in the '70s—there were serious, detectable problems with their health that resulted. And there are other studies, too, that document the adverse effects of high-deductible plans.

And I also think the notion in the paper that there's a need for a very large tax credit is absolutely on the money. If you want to help low-income people enroll in comprehensive health coverage, a \$1,000 tax credit is not going to get the job done when the average employer-based policy costs more than \$5,000 per single person. So I think that's absolutely right. And I think the paper correctly points to problems with the nongroup market. The nongroup market works beautifully for young, healthy men, but for just about everybody else there are very serious problems, including women of childbearing age who pay 30 to 40% more in their premiums in the nongroup market, even for policies that exclude routine maternity care, not to mention the problems with people who are older or who have chronic illness. So I think all of that analysis in the paper is well-taken.

One point that I would urge you to revisit is the notion that tax credits inevitably must be used in the current nongroup market or even the nongroup market at all. In addition to the problems you point out with the nongroup market, there are issues of marketing fraud that arise. We saw this with the Bentsen Child Health Tax Credits in the early 1990s. We've seen it with Medicare recently; we saw it with the arrival of Medicare managed care. Basically, whenever you give consumers the government's money and you say you can pick anybody who's licensed in your state to enroll, that becomes a magnet for the shysters to go and try to manipulate people. And with the Bentsen tax credits, it was hor-



rible in the early '90s. People who had their kids enrolled in Medicaid, and therefore didn't need other insurance, signed away their earned income tax refunds to pay for insurance policies.

Basically, tax credits, in the words of Stuart Butler, are just money the Republicans can vote for. It's a way to deliver the subsidies that's politically acceptable to some people who otherwise are troubled by voting for subsidies. Tax credits can be designed to be used only with specific types of coverage, which need not include the nongroup market.

So there's absolutely no reason why they couldn't do what HCTCs [Health Coverage Tax Credits] do, where they say that tax credits can only be used in plans that are arranged by state government and that meets certain criteria.² Now, I think the criteria used in the HCTC statute are problematic, and we can talk about that. But the long and the short of it is, there's no reason why you couldn't say, "Here's a tax credit." States need to establish comprehensive plans that meet, for example, actuarial value standards. That way, we don't have to have uniform plans in every single state in the union, but you know that every single one of those plans is going to be comprehensive. You have to make sure there are comprehensive plans that are offered, you have to make sure they meet affordability thresholds for everyone who gets the tax credit, including older adults and people who are chronically ill, and there need to be measures in place to make sure that marketing and enrollment isn't done directly by insurers because that's a recipe for marketing fraud.

So I think there is great potential for tax credits to work effectively, but they can't be your grandpa's tax credits. They have to be very generous and there have to be careful rules about where the credits are used. If you do those things, you can indeed make sure that they're a useful tool in providing low-income people, low-income Latinos and others, with access to good, affordable, comprehensive health coverage.

LEONARD BURMAN: I think I'm sort of the odd duck here because my specialty is tax policy, although I have written a fair amount about tax subsidies for health insurance. And I want to start by saying that I don't think taxes are necessarily the best solution for some reasons you mentioned in your report. A refundable credit targeted at low-income people who do not have enough money to pay for health care is a real Rube Goldberg apparatus to get money to them. They don't have tax liability. As you pointed out in the report, you can't pay them back after they've paid for their health insurance premium because they cannot afford to pay in advance. So it's got to go directly to the insurers or directly to employers, which is complicated.

A better option might very well be to just have a voucher for health insurance. Eligibility and the amount of the voucher could be means-tested, or you could provide the voucher to everyone. The benefit of the voucher could be effectively recaptured via the income tax. But that way, for the low-income people there would be a direct mechanism for getting the money to insurers or to employers. And I think it's important that any credit that's offered in the nongroup market also be available for employers, because otherwise you could be undermining the most effective way of getting health insurance to a lot of people. Most people still get their health insurance at work and there's a good reason that they do that. Large employers are a very effective pooling mechanism, and the cost of collecting the premiums from workers is relatively low, doing it through payroll. And Stan's actually done a lot of work on health care tax credits. He's pointed out some of the ways in which it doesn't work all that well, and it's complicated. People don't understand it. Basically, the goal is to make credits look like vouchers, but it's easier when you just give a voucher.

² The Health Coverage Tax Credit (HCTC) is a program is open only to production workers (i.e., workers who manufacture an "article") who lost their jobs due to foreign competition and whose companies have been certified for trade adjustment assistance. The program covers 65% of premiums for a qualified health program, including Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) coverage. States can determine which types of coverage are eligible for HCTCs.



The point is that something is better than nothing. I basically agree with Kate, except some of the things you might do in the something-is-better-than-nothing category are not necessarily better, because they could actually make things worse. One example is the standard deduction for health insurance, which might or might not increase coverage overall. The people who are likely to lose coverage are employees of small firms that would stop offering coverage and who have reasons that make it hard for them to get health insurance in the nongroup market. So if you had a plan where a lot of healthy people got insurance and a lot of unhealthy people with low incomes lost insurance, you probably wouldn't consider that to be a triumph.

The fact that conservatives like the idea of high-deductible health plans creates a possibility to craft an option that could win some bipartisan support. The challenge is that a \$5,000 deductible for people sitting around this table is maybe no big deal; but a \$5,000 deductible for somebody earning \$15,000 might as well be infinite. Marty Feldstein and Jon Gruber have proposed high-deductible plans where the deductible varied with income. It would be complicated, but you could get the advantages of high-deductible plans: they encourage cost-consciousness; they encourage people to pay attention to what they're spending on health care. You can argue about how well people are suited to doing that, but there's definitely a point that health insurance encourages people to get more health care than they would if their own money were at stake.

But the trick would be to have the amount of money be meaningful, given your income, and not prohibit you from getting the care that you really need. So it might be that the appropriate high deductible for a low-income person might be \$100, and for somebody earning \$200,000, it might be \$20,000, and it varies by income. Actually, the simulations that Feldstein and Gruber did suggested that for the amount of money that's being spent on the current tax exclusions, you can actually pay for such a plan, with the deductible that scaled up with income for everybody. And that would be the basic health insurance. And you could craft a voucher that would pay for that kind of a thing, make sure that it was available for everybody, and guarantee that low-income people would get something meaningful and still address the concerns of people like Mr. Cannon, who want to encourage cost-consciousness. I think I'll let you [Mr. Cannon] respond to whether you actually think that idea works.

MICHAEL CANNON: I'm in favor of cost-consciousness. But if you're done, yes, I'll take that opening and I'll go ahead and jump in.

I want to start with what I think is a threshold question that I would urge NCLR, and really everyone, to examine when thinking about health policy. The goal of this paper—and it was very well put together, very informative—and of most discussions about health policy is, how do we provide the health insurance to everyone?

Health insurance is certainly valuable; it certainly does have an impact on health. It's not the only thing, however, that has an impact on health. And actually, health insurance is very expensive. Some of the other things that have an impact on health are things like nutrition. There's a relationship between income and health, education and health outcomes. And so economists have looked at the cost-effectiveness of health insurance and improving health outcomes and tried to compare that to other policy options for improving health outcomes, and they have found no evidence that health insurance is a cost-effective way of improving health outcomes.

So what that means is that for the same money that we would spend to expand health insurance coverage, we might be able to improve health more if we invested in other things, even things that appear to be unrelated to health, such as education. The scholars who have looked at this have suggested things like educational campaigns to promote good nutrition or public clinics or so forth. So if there is no evidence that health insurance is going to get us the most health for the money that we spend, I think we have to ask then, why are we focused on providing everyone with health insurance? We don't



know that that's the best way to promote health with whatever resources we have available. And what it suggests is that if we don't know that health insurance is the most cost-effective way, well, then maybe we don't want to pursue a policy where we're trying to insure everyone. Maybe what we want to do is to generate some of that evidence, pursue that policy of universal coverage in some states, whereas in other states we pursue other things. So I raise that question because I think that one of the premises of most debates on health care and health care reform needs reevaluation.

And a couple of other items. The document speaks about pooling in the group market and in the nongroup market. It mentions that in the individual market, people with chronic conditions are individually underwritten, and they are often turned down for health insurance, and that's certainly true. I think, though, that the nongroup market probably performs better than most people think it does, especially when compared to the group market. For example, Len mentioned that under the president's proposal for a standard health insurance deduction, a lot of people who are high cost and in small groups would lose their insurance. The estimates are that, on net, more people would have health insurance under that proposal, but there's some movement underneath that net number, and some people with high-cost conditions would probably lose their coverage because their employer might drop coverage. I think that that is a very real concern, but we have to ask what's already happening in those markets. Those same small groups are already dropping coverage, they're already letting those high-cost people go, and it's probably precisely the firms with those high-cost people that can't hold onto the coverage that they're offering.

So it's not a question of, "Are we going to keep them in employer-based insurance, which works, and throw them into the nongroup market, which doesn't work?" It appears that employer-based insurance isn't working that well, and actually the nongroup market, I think, works better than most people give it credit for. I'd encourage you to look at some of the research that's done by Mark Pauly and some of his colleagues, and Susan Marquis and some of hers, that have looked at how much pooling actually happens in the group market in the employer-based system, and how much pooling of risk happens in the nongroup market. And what they find is that there's less in the former and more in the latter than people think. Susan Marquis and her colleagues had a study in *Health Affairs* recently of the individual market in California that found that a lot of people with chronic conditions not only get insurance through the individual market, but also pay standard rates rather than appear to be individually underwritten.³

And finally, though, having questioned the whole idea of using tax policy to expand health insurance, I do actually dabble in tax policy and have put forward proposals to try to reform the tax treatment of health insurance in a more sensible way, in a way that I think would increase insurance coverage. I think one thing that's missing from most of those discussions, and that I didn't see in this document, is that tax credits for health insurance are great—if you can get health insurance. Even though I think the nongroup market works better than most people think, there are still some people who cannot afford insurance and they're not going to get insurance in the nongroup market. And if all you do is create a tax break for health insurance, those people get nothing. When you're required to buy an insurance policy—whether it's a tax credit and standard deduction or Health Savings Accounts—if you cannot afford insurance, then these tax breaks do nothing for you. So I think that, if possible, tax reforms should try to do something for the uninsurable as well as those who can't afford insurance.

ELENA RIOS: Yes. I just wanted to comment that I took a different spin on this paper. I'm not a tax expert, okay, but I think that in addition to looking at the differences of the policies presented, the

³ M. Susan Marquis, Melinda B. Buntin, Jose J. Escarce, Kanika Kapur, Thomas A. Louis, and Jill M. Yegian, "Consumer Decision-Making in the Individual Health Insurance Market" *Health Affairs* Web Exclusive (May 2, 2006), <http://content.healthaffairs.org/cgi/eletters/hlthaff.25.w226v1#941>.



National Council of La Raza deserves credit for looking at this from a Latino perspective, as it should.

I think that one of the most important things for the Latino community is that it is the largest group without insurance. It is by far, across the board, across the life span. Any insurance product, there's always been a question: why is it that it's so hard to reach the Latino community? And the system needs to be changed in more ways than have been addressed by this paper, but I think this paper goes a long way to bring up language, culture, enrollment, automatic enrollment—different things have been brought up. And I do think the employer-sponsored insurance for Latinos is something that needs to be beefed up in the paper, that we just shouldn't drop it and say, "Let's have tax credits and go to individual markets." I think that for Latinos, we do work, and there's a very strong work ethic and there's a very strong connection to the employers' trust. And whether you're migrant farmworkers or working in temporary positions, I think the Latino worker is critical to this policy perspective that we need to advance the insured. The other thing is, I think that this paper doesn't have the goal of the insured, and maybe because you're looking at ways to cut and compare the tax policies that you're looking at, I think maybe you just lost sight of the real goal: to increase the number of insured for Latinos.⁴ So that's one criticism I have.

The other thing is that I do think the issue of the Hispanic subgroups is brought up in the paper; it's alluded to, but it's not brought up enough.⁵ I'd say [there are] three different types of Hispanics: the native-born Hispanics, the naturalized Hispanics—my grandparents and a lot of us have come from generations of generations of people who were immigrants who are now naturalized citizens—and then there's the immigrant and the undocumented immigrant, and I think that there are studies that have been shown that take a brief—and it did look at the EITC [Earned Income Tax Credit] study—that take a—(inaudible)—varies by the class or the subgroup of Hispanics, and this paper doesn't say that. It says, "Oh, Hispanics have a hard time." There's a generalization, I think, that's not fair to the Latino community and to policies that we're trying to add input to, and the value added to this paper is that we're looking at the Latino community and the responsiveness of the system. So the most marginalized group, the Spanish-speaking the undocumented immigrant, has worse problems and issues with any of these policies than the U.S.-born Hispanics who are middle-class professionals, and there's a variety of outreach and enrollment that can happen.

And also, I think the issue of the quality of coverage. I know you need to have comprehensive coverage, but I tend to agree with the person who said, "Well, maybe, we don't want to talk about giving everything all at once." And maybe the quality needs to be staged, or somehow, we need to talk about what quality is and how we measure it in terms of good health care outcomes. A good health status is what we're looking for, not necessarily just having insurance. But I know insurance is very important, and I just disagree with you on the terms of the importance of health insurance for our communities because we only—(inaudible)—have it and how important it is for us to have it, at least to be at level playing field with the rest of the country.

MS. RYAN: Thank you. John?

JOHN ARENSMEYER: I thought I'd give a small business perspective on this. And by the way, I think this is a great paper, and I agree with a lot of the conclusions. I'd agree with Michael that the small-group market isn't really working that well, but we might disagree on whether the nongroup market works well either.

⁴ The preliminary discussion paper stated that proposals' effectiveness should ultimately be measured by whether they eliminated the health coverage gap.

⁵ When possible, NCLR breaks down its analysis of Latinos by country-of-origin subgroups and by citizenship status. This information is not consistently collected and reported.



A couple of statistics: for firms of under 200 employees, 41% don't offer insurance, and for firms of 10 employees or less, nationally, 55% don't offer insurance, and that's actually 70% when it comes to Latinos, in terms of how many are not covered by their company. So clearly, the nongroup market is critically important not only in general, but to small business owners and to their employees. Also, we should keep in mind the majority of small businesses are sole proprietors, which represents 9% of the private-sector workforce in this country and is actually 1% higher than the number of unionized employees in the private sector in this country. And 7% of the private-sector workforce of Latinos work in small businesses as well. And of course, sole proprietors don't qualify for the small-group market in most states. And so they're forced into the individual market, which, again, in most states is not community-rated or guaranteed-issue. So in fact, you've got a majority of small business owners having to deal with the nongroup market as it stands now. So what we can do for the nongroup market is absolutely critical, particularly in the Latino community.

I should also mention that the reason I'm not sure that the nongroup market is working all that well is that 26% of all sole proprietors don't have insurance, and for Latinos that share is much higher. So we've really got a significant problem, particularly because the self-employed is a growing segment of the economy. Again, the reason all this is particularly relevant to Latinos is that the fastest-growing segments of small business ownership in this country are women and people of color, and there are now 1.5 million total Latino-owned small businesses in this country.

A couple of other specific statistics related to Latinos: over a million are self-employed. On a percentage basis, Latino small business owners are more likely to be self-employed, yet the mean wage of self-employed Latinos is 60% that of non-Hispanic Whites. So the needs of the small business market, and particularly small business owners and sole proprietors, are remarkably similar to the needs of the consumer market in general. I hate to say that tax credits, tax deductions, et cetera is really just nibbling at the edges. Where I think we need to be focusing our energy is on some sort of comprehensive solution, and that can take a variety of different forms. I know it's not the forum to go into that here.

So I think the paper did a really good job of pointing out why certainly tax deductions and HSAs [Health Savings Accounts] probably really are not particularly relevant for lower-income people for all the reasons that we've talked about, for all the reasons that were in the paper. Obviously, fully refundable tax credits might be more effective, but you still have the problem, as has been mentioned a couple of times, of access to the market. Sure, you might be able to get tax credit, and sure, it might be large enough, but if you're still talking about a system without guaranteed issue or community rating, it's not going to help people who are going to have trouble getting insurance whether you give them a tax credit or not.

And the fact of the matter is that I think all the studies have shown that the take-up rate is going to be miniscule. First of all, you've got the cash flow issues, which I thought were really well done in the paper, about people putting money in up front and having to wait a year to get paid back. Someone who's living paycheck to paycheck is not going to be able to do that. They're just not going to do it. And if they're looking at a high-deductible policy, I think all the studies have shown that the take-up rate is going to be pretty miniscule as well. So while yes, fully refundable large tax credits in theory might work, I don't think they really go far enough toward solving the problem.

MS. RYAN: Thanks, John. Sabrina?

SABRINA CORLETTE: First of all, I just want to say this was a terrific paper, and I think it did a really great job of dissecting a lot of the issues as they are particular to the Hispanic population. As I was reading it, I had sort of a threshold question: is this paper the first in a series, in the sense that there are other approaches to health care reform, whether it's the expansion of government programs



or shoring up the employer-based system or an amalgamation of all three? And it wasn't really clear whether you picked this topic because it may be the most politically feasible, or whether it was sort of just the beginning of a conversation. Maybe at some point, we can talk about that, but overall I thought the paper was great.

I guess I was also sort of looking at this from the perspective of a taxpayer. I think tax incentives can be good, but I think as a taxpayer we want to know that we're getting value for our tax dollars. And a lot of people have already mentioned this, but quite frankly, particularly in the nongroup market, there is a lot of crap out there. And I don't need to repeat what folks have already said, but guaranteed issue, community rating, and particularly issues relating to benefit packages—I come from an organization that represents women's and families' issues, including maternity care. Katherine, you talked about the basics. I think there are a lot of differences of opinion as to what exactly the basics might be, particularly if you're sick. There are insurance policies out there that say, "If you've had cancer before, we'll cover you for everything but cancer care." So I think there's a lot of devil in the details as to what the basics are. You can't do the tax policy stuff without coupling it with market reforms. I'll leave it at that.

DAVID FERREIRA: I think it's fantastic, Dr. Rios and Mr. Arensmeyer, to hear other perspectives of the Hispanic and small business community. The United States Hispanic Chamber of Commerce represents 2.5 million Hispanic businesses in this country; it's frankly a million more than the numbers that have been heard before. And it is not only women and people of color that are growing the most—it's primarily Hispanic businesses, and Latinas in particular, outpacing all other sectors.

Small businesses and entrepreneurs are a growing part of the workforce. The GAO [Government Accountability Office] estimates that 30% of the American workforce in 2000 was made up of freelancers, independent contractors, and temporary employees. Small businesses account, we know, for a little bit over a half of the uninsured number for small business owners and small business workers and self-employed. We also know that over one-third of the uninsured are Hispanics. Therefore, as an organization that represents both Hispanics and small business issues, we see a convergence of those demographics of the uninsured that compel the interest of the Hispanic small business community. We are thankful that NCLR is bringing up this discussion. Thank you, Jennifer.

We believe it's not mutually exclusive, but we believe that the employer-sponsored insurance system is working, for the most part, even if there are big problems within the small- and nongroup markets. The numbers have been relatively stable since the mid-1990s. Employers have found ways how to adjust, when it comes to cost, because of the double-digit premium increases that they saw for many years and over 120% increase in premiums that they saw over the past five or six years. So they found ways to adjust. And we believe these high-deductible/Health Savings Account-linked processes are some of the ways that happened; for instance, we've seen a slowdown in the rate of growth of premiums. For as much as we understand that there are critiques of HDHPs [High Deductible Health Plans], we think of them from the concept of the rate of growth of premiums, and the rate of growth may not necessarily slow down much further as economic pressures are building. So we are concerned with not only whether the trend can continue, but also what else can be done to capture the uninsured and what new innovations will arise to ease costs and therefore improve affordability.

When it comes to small businesses, we know that it's actually the smaller businesses that are the most affected. We've all heard the numbers and we've seen them from the Kaiser Family Foundation reports. The numbers that say that 8% of the loss between '99 and '07 were those businesses between three and 24 employees, and 5% were those between 25 and 49 employees, and that constitutes virtually the entire bulk of loss of coverage between 1999 and 2007. And we know that 23% of these small businesses between three and 24 employees that stopped providing the coverage actually did provide coverage within the last five years. That's a whole quarter of them, and that corresponds with 72% of them that say that it's the premiums that are sagging them, and the trend has continued downwards for



small businesses while it's stabilized for all the other size categories for businesses.

So we believe that the problem with the small-group market is actually one of the main focuses by which we can address the issue of the uninsured. The incentives proposals out there, including the Administration's, say that they can only address three to five million—other studies say 9.2, 9.5 million or so through their proposals. That still leaves 40 million people not taken care of. That's why we believe a small-group market is one of the most efficient means by which to try to address the coverage issue, especially among Hispanics, where you have a high labor participation rate and a high rate of loyalty to their employers. And when it comes to the small-group market, we obviously are concerned that the challenges are not only administrative costs, but also the issue of adverse selection. Toward that end, then, what are the solutions? Is it risk shifting, which is what we talked with the high deductible issue, and in linking to a Health Savings Account? Or is it risk spreading—which we find promising—the concept of trying to promote the use of pools, so that the small-group market can be promoted in a more efficient way, where the insurers and the selling process are taken out of the way and the administrative costs are more efficiently managed?

So with that, we'd like to just again give kudos at the discussions taking place, and we would encourage that the report take a stronger focus on the small business community and the convergence of demographics of the uninsured being mainly composed both of Hispanics and the small-business community. Addressing that factor is the most efficient means by which to target both the Hispanic and general uninsured.

CHERYL FISH-PARCHAM: I thought it was also a terrific paper. I thought you did a really great job of capturing lots of issues.

Just to respond to a few things that have been said—I think what we're seeing in high-deductible plans is that it's very hard to monitor what goes on during the deductible period. It would be nice if providers would really take people, especially low-income people, and assume that they would eventually pay their deductible even if they did not have money at the time of service. But by and large, that is not actually the case. You can see the harm especially when you think of someone who has, for example, juvenile diabetes. They need their medicines. Well, you really can't find a drug-store that will give you your medicines until you reach your deductible on the theory that the plan will eventually pay them something.

We also have found that consumers have different abilities to really make sure that they get the discounted rate when they're in the high-deductible period; there are a lot of ambiguities about who's an in-network provider [and] who's an out-of-network provider, and that creates problems. And then there are problems with monitoring generally whether people get their discounted rates. So for those reasons, as well as this problem that people just can't afford to meet a deductible, I really would discourage the use of high-deductible plans as a first step to coverage.

We have seen a couple of examples of states that are looking at variable deductibles based on income in different ways. Massachusetts, for example: in their new health reform plan, the lower- to moderate-income people below 300% of poverty are in plans that do not have as high a deductible, and then the high deductibles become available, once you get over that [income bracket]. And the same with Maine. So those would be examples to explore.

I agree that the individual market is a mess, the biggest mess, and the small-group market comes closely following thereafter. And it really depends on what state you're in, how much pooling takes place and how much guarantee of access takes place. In a number of states, there still is not a guaranteed-access mechanism at all for individuals, and in many states, the guaranteed-access mechanism is meaningless because you can be charged up to twice as much based on your health alone.



And then when you look at all the factors that insurers can charge more or less on, sometimes it's a 17-times spread in insurance. The small-group market is barely better in many states.

So I agree that a lot of pooling needs to take place to fix that problem, and also, if we do go to any sort of tax credit process, there needs to be a real look at what people are getting for their credit. Are they getting some kind of a negotiated rate as well as a pooled rate? Are they getting something that's going to control the administrative costs of health insurance and the profits that insurers are making? We [Families USA] did a thought piece about what a good tax credit would look like.⁶ Besides having it be refundable, advanceable, and based on income, you'd want to make sure that any kind of credit did not erode public coverage, and so it should only be available at income levels where Medicaid and SCHIP and other public coverage are not available. It should be targeted to the employer-based market, not to the individual market. Then, people who weren't able to get employer-based coverage might be able to get coverage through a tax credit, through a state fallback plan that was a pooled mechanism with guaranteed-issue and heavily regulated prices. But having said those things, I do agree that that's a cumbersome way to get there and that looking at other health reforms would make a lot of sense.

REA PAÑARES: Let me just touch on a couple of things; we're kind of tag-teaming here. I thought the paper was great as well. It was great to see such a compilation of analysis of the different proposals in one paper, and I just want to thank NCLR for taking the lead on this. And I think we do have a chance of making meaningful steps towards comprehensive health care reform in the next year, and it's likely that some form of tax incentive policies will be part of that. So I just want to echo Sabrina's question of whether NCLR has weighed in on this issue. I would encourage you to weigh in on other big pieces that are being considered for health care reform, like expansion of public programs and the regulation of private insurance market.

Just one point that I want to touch on that you had in the paper was that tax incentive proposals require consumers to be active consumers. It can be particularly problematic in low-income, and particularly minority, communities because it requires individuals to have equal access to information on appropriate health plans, on cost, on quality of care. And if that information is not readily available, particularly to communities of color, and in this case, Latinos, then it could be especially problematic. We saw this in Medicare Part D, where much of the information about the various health care plans and the different offerings was found online. And if Latinos in the low-income communities aren't given equal access to information, if we see a digital divide in access to a lot of the information sources, then consumer-directed care isn't something that people can equally take a part in. So I just wanted to touch base on that particular point.

CATHERINE HOFFMAN: This is a very good panel here. I've already told Kara that I thought this was a great report and I spend a lot of my time editing and writing these types of papers, so I know the challenge in tackling this level of analysis and distilling it into a concise document. So thanks for doing a good job. Your framework is useful, and I had the exact same thoughts Sabrina did, that the report needs to be part of a set of papers. And I would even caution you that if you put this out as your first paper in this area, it may appear to be imbalanced and reactive to single out tax credits rather than examining all the other proposals being discussed right now with equal rigor. It's very clear from this example that your organization has the analytic ability to examine other kinds of health reform proposals relative to the population that you care about.

Dr. Rios, your comment about subpopulations—as a person who studies insurance coverage, I'm always trying to dig down below subpopulations. I was looking for that too, and I know that data is

⁶ Families USA, "What Would a Good Health Care Tax Credit look like?" (Washington, DC: Families USA, 2007).



very hard to come by. And so I would say that whenever you can, try to flush out the impact on subgroups. And when you can't say anything because you don't have the data, be sure and say that, because that identifies what data need to be collected in the future.

SAM JAMMAL: Sam Jammal with the Mexican American Legal Defense and Educational Fund. I thought this was a great paper. It's really interesting to read. I guess reflecting on the same subpopulation aspect, I'm definitely curious as far as the breakouts of some of the different issues you raised throughout this. I know there was some mention on the immigrant workforce with the tax issues, as far as some of the—just the relation of the tax—(unintelligible)—specifics in terms of the employer-based. And that would have been helpful, as well as hashing out a little more of the employer-based insurance pickups, an interesting discussion in and of itself, and specifically targeting the Latino community: where have changes been, what improvements might be helpful, and whatnot. I would imagine that whatever happens in the longer, comprehensive debate, that seems its own discussion in and of itself, whether the government programs might replace that.

MS. RYAN: Thank you.

MS. NG'ANDU: I just want to answer, or attempt to answer, a few of the questions that the panelists have put out there with respect to the direction that NCLR's work is heading in. First of all, this is one of our first excursions into a broader health reform conversation, but we have been doing other health work for quite a while. NCLR has a better sense of what is going on in the employer-based system, as well as the public health system, with respect to Latinos. Our focus on incentives for this conversation came down to a need for lead time to explore health tax incentives. This is the first of one of many discussions that we hope to have with respect to health care reform. NCLR hopes to touch upon all aspects of health reform as vigorously.

With respect to health coverage being a universal goal, there are a couple of things I have to say. NCLR's goal is to make sure that Latinos have optimal health status, and by what mechanism that comes, that just depends. But we do know that Latinos aren't getting access to health care, and despite having the highest presence in the workforce, they have low rates of employer-based coverage. Take a population like the Latino foreign-born population. They have among the highest rates of workforce participation, and they don't get offered coverage by their employers. And we also know that they aren't using health care at the same rates as the U.S.-born. Finally, when they are able to use health care, it's often reactionary. It's reactionary because they had an injury in the workplace, or because their child is very, very sick and develops an asthma attack, rather than treating the symptoms of the asthma with an inhaler. We do know that health coverage is one of the mechanisms by which we achieve optimal health status within the Latino community. We're not disregarding other factors that lead to optimal health status, but we are recognizing that health coverage is one of the main issues.

MS. RYAN: Thank you for providing more context.

A few of you brought up the potential impact of health tax incentive proposals on other types of coverage that exist: the employer-based market and the public health insurance programs. The employer-based market is really the only option for some working Latino families that don't qualify for Medicaid and SCHIP. Buying health coverage in the nongroup market is often beyond their means. What impact do we think that these tax incentives could have on access to traditional channels? Will they erode ESI [employer-sponsored insurance] without giving low-income Latinos another source of coverage?

DR. BURMAN: I think one answer is that if you don't reform the nongroup market, that you face the threat of that, especially for some of the proposals that are only for tax credits for nongroup health



insurance. That gives especially small employers, who already are having a hard time providing insurance, a strong incentive to drop their coverage. Their employees would say, “Increase my wage and I’ll buy the insurance myself if I want it and get the credit.” Employers might say to employees, “If you want to get the subsidy, you buy in the nongroup market.” Also, one reason why the small employers have the strong incentive to offer health insurance to their workers is because that’s the way they can get the tax break themselves. And if the tax break is available in the nongroup market, they lose that incentive as well.

It’s certainly true that the small-group market isn’t working perfectly, but still—I think according to the statistics that John gave, almost half of small, very small employers are offering health insurance. So it’s a big concern, and trying to figure out what to do in the nongroup market is a real challenge. It has to be some kind of pooling mechanism that can substitute for what’s offered, particularly among large- and medium-sized firms.

MS. RYAN: John?

MR. ARENSMEYER: Yes. I guess glass half-full, glass half-empty; 55% of employees of firms with fewer than ten workers are not getting their health coverage from their firms. It’s much higher among Latino employees. So, yes, I think you have to do both. I think you have to reform everything, but putting that aside, yes, you need to reform the small-group market and you need to also reform the nongroup market, absolutely.

DR. HOFFMAN: But if you didn’t reform the nongroup market and tax credits were available to the individual employee, would small business owners still feel they no longer had the responsibility to offer health benefits?

MR. ARENSMEYER: You’re saying if the small-group market—

DR. HOFFMAN: Or nongroup market is not reformed, but yet, tax credits are out there, some kind of mechanism to subsidize workers from small employers, would small employers say, “Well, it’s not ideal out there, but I still feel like they’re getting something and I don’t need to then provide it.”

MR. ARENSMEYER: You might find some small business owners who conclude that it’s going to be cheaper to buy something in the nongroup market if I’m getting a tax credit versus the tax deduction I get by providing health insurance through my small-group. But I think for all the reasons that the paper talked about, the situation is not going to change a lot. It would have to be a huge refundable tax credit and then maybe—but then again, you’re undermining the benefits for the small-group employees.

MS. CORLETTE: Can I ask a clarifying question? Are we talking about a tax credit to the employer or to the employee to go out on the nongroup market?

DR. HOFFMAN: To the individual, yes. It’s the latter.

MR. ARENSMEYER: So you’re suggesting that the small business owner would say, “Gee, I can get a tax credit in the nongroup market now, so therefore, it’s better—”

DR. HOFFMAN: My employee can get it.

MR. ARENSMEYER: Yes, but I think that for all the reasons we talked about, the take-up is going to be really low for employees. I thought what you were saying was would the employers say, “Well, gee, it’s going to be better for me to get a tax credit in the nongroup market than it is for me to get my own



insurance through the group market, and I get a tax deduction.” I haven’t really thought the math on that, but I don’t think for the employees this is going to make a big difference. First of all, you have a greater number of states where you have community rating, guaranteed-issue in the small-group market than you do in the nongroup market. So in many states, you’re going to be kicking out people out of a guaranteed issue, community-rating situation into an unregulated situation. So that, in and of itself, is going to be a problem in those states.

DR. BURMAN: But the thing is that the employees effectively pay for their health insurance through their wages, and the healthy employees who qualify for credit are going to say, “I’m not willing to pay much in terms of lower wages for my employer offering me health insurance, particularly if I can get a credit myself.” I think there would be pressure on employers, even if they wanted to offer health insurance. Basically, their employees wouldn’t be willing to pay for it. And that’s the concern, that you have this kind of adverse selection of the healthiest employees no longer wanting to work at small firms that offer health insurance because they pay lower wages.

MR. ARENSMEYER: Logically, that makes sense, but the studies show that, actually, benefits rank incredibly high among employees’ attraction to work at firms, and most employees don’t do that calculation. Again, you’re talking about a nongroup market where, if it’s not a guaranteed-issue or community-rated, your rates can go way up if you get sick. So you still have the benefit of more security getting your insurance from the small group market. Secondly, the studies show that employees don’t make that calculation of “oh, I could get more wages if I’m not getting insurance.” Even if the math does work out that way, that’s not how employees tend to look at the situation.

DR. BURMAN: That might not be the way they’re thinking about it, but then with competing job offers, they’ve probably noticed they get offered higher wages at firms that don’t offer health insurance.

DR. HOFFMAN: Do they? Did the data bear that out?

MR. CANNON: Yes.

MR. ARENSMEYER: I’m not sure about that, because the firms that are more likely to offer insurance are higher-wage firms.

(Cross talk.)

MR. CANNON: But if you had two job options and one of them was paying—they’re equal in all ways except for this. One of them pays \$50,000 and has no health benefits and the other pays \$50,000 and does offer health benefits. You go with the one that offers health benefits because that would be more stuff. So how does the other—the first firm has to compete for your labor. They have to increase their compensation.

MR. ARENSMEYER: The studies show they’re more likely to go with the health insurance, that they—

DR. BURMAN: But right now, that’s the way—why they get the tax break is—

MR. CANNON: But the first firm has to increase their wages, so that—

MS. CORLETTE: I think what John is saying, though, is even the firm that pays the higher wages without the benefits, the employee is going to go with the benefits.

(Cross talk.)



MR. ARENSMEYER: I think it's all in the salary—maybe not, but—

MR. CANNON: But this discussion is predicated on the fact that there's a huge population that doesn't choose those jobs.

MR. ARENSMEYER: Doesn't choose what?

MR. CANNON: That chooses the jobs without health insurance.

(Cross talk.)

MR. ARENSMEYER: There's a huge correlation between firms that offer health insurance and firms that tend to have higher-wage jobs, higher margins. So an employee with a given skill set, who's going to work in a given industry, is rarely faced with a choice of a significantly bigger salary and no health insurance versus a lower salary with health insurance. Just because the way the industries are structured, the better jobs, the higher-paying jobs, tend to also offer health insurance. They tend to be a higher margin, et cetera, et cetera. So it's rare that you get that kind of apples-to-apples.

MR. DORN: I think the concern is that this would change if there were tax credits available. I agree with you 100% about permeability and the mismatch between worker perceptions and economists' descriptions, but the fear is if there are tax credits available, the healthy employees could say, "You know what? If I take this other job that pays me more and then I have this tax credit, I can get better coverage on my own and still wind up with more money in my pocket." Now, people aren't always so rational, people aren't willing to invest time and figure things out in a way that a lot of economists think they will, but still, some people would and so you get serious risks posed to employer-sponsored insurance.

MR. ARENSMEYER: Perhaps, but you have the security issue of—

MR. DORN: If I could, I think it's a mistake to paint with too broad a brush; that is, some tax proposals could have a tremendous eroding effect on employee-sponsored insurance. In particular, proposals that would say "let's create a uniform tax deduction that applies identically to the employer market and to other markets" would have a huge corrosive effect.

On the other hand, tax credits could either have a corrosive effect or not, depending on the details. For example, if you said that the tax credits are going to be structured to cover a percentage of premiums and that you can use them for employer-sponsored insurance to cover the workers' share of premiums, that means it's to each employee's benefit, financially, to take up the employer insurance. Alternatively, this issue of crowd-out is something that the SCHIP program has grappled with.⁷ And lots of states have been effective—the evidence is mixed, but in my view, the best read of the literature suggests overall effectiveness—in having eligibility restrictions that prevent crowd-out from taking place. So a lot of these things, whether it's crowd-out or whether it's accessing comprehensive benefits at an affordable price, it's all a function of the details of policy design, mind you.

DR. BAICKER: There's clearly a big difference between credits that apply only to the nongroup market versus credits that apply to the nongroup market and the employer market. I think that we all agree that a policy is much more likely to erode the employer market if it gives a bigger benefit for being in the nongroup market than if it gives a uniform benefit to both. And then, of course, a benefit that disproportionately accrues to people in the employer market is the least likely to erode the employer market.

⁷ "Crowd-out" refers to the potential that families that have access to employer-sponsored insurance are enrolling in public coverage programs.



An evaluation of those policies should be flavored by the fact that Latinos are the least well-served by the employer market. Any acceleration of employer withdrawal from the health insurance market I think is likely to be relatively small compared to the existing trend of employers stopping offering health insurance. And who does that most affect? People who aren't getting access to that employer insurance need some help getting insurance in the nongroup market, especially low-income groups, which, again, are disproportionately represented in the Latino community. We might want to think about getting people who don't now have access to a subsidized employment-based insurance plan some subsidy to help them out.

I think the biggest problem that you've highlighted in the nongroup market is the fact that people get re-underwritten when they go to get a new individual insurance policy. If you have gotten sick in the interim, your premiums may go up or your new policy may exclude a preexisting condition—both of which we don't think of as real insurance. Insurance is not just about protecting you against financial risk this period, but protecting you against higher expenditures over your lifetime. So an ideal insurance system gets people covered when they're healthy and then their premiums never go up because of their illness status and there are no exclusions of conditions that develop while they're continuously insured. There are a lot of transition problems getting from here to there, and we need to take those seriously. But when you're thinking about designing an ideal system, I would think you'd want a system that gets people in when they're healthy, and then protects them against any premium increases because of their subsequent health status. And that does involve some small- and nongroup market reforms, but focusing entirely on making sure that you preserve the existing employer system does a disservice to the people who just aren't in that system, including a disproportionate share of Latinos.

MR. ARENSMEYER: Plus, underlying all that is whether reforming the insurance system is going to do a lot more to affect the coverage than whether you have a tax credit, and how big it is in the nongroup versus the group. It's exactly the security you talked about. People know that if they have employer-based coverage, it's going to be more secure, in general, than if they're in the nongroup market.

DR. BAICKER: That's an especially big issue for groups of people who change jobs more often.

MR. ARENSMEYER: Right, which is a bigger and bigger trend in society.

DR. BAICKER: So again, focusing on ensuring that people's premiums don't go up because of their health status, as long as they're continuously insured, helps with a lot of those selection issues.

MS. NG'ANDU: Right. I think David has been holding a thought for a while.

MR. FERREIRA: A lot of discussion was taking place about, first, the small-group market, and then we moved into nongroup market. But I guess when it comes to tax credits, the question is: what does the previous research show? Is it effective? Our impression of the research is that the ability of a tax credit to reduce the uninsured population depends heavily on design, like the size of the tax credit relative to income and income levels overall. Research by Thorpe in 1999 showed that for single workers with income at 150% of the federal poverty level, only 48% would gain coverage even if the tax credit was set to 79% of the premium. A tax credit equal to the full amount of the premium would yield 75% of the population of single workers at 150% of the poverty level receiving coverage.

Now, the Robert Wood Johnson Foundation had also done some research through their Health Care for Uninsured Program in the 1980s where they were able to do an experiment, and they were able to get reduced premiums for self-employed workers at small firms, despite premium reductions



ranging from 9% to 60%, with most in the 25% and 50% range. Nevertheless, they had trouble reaching a reasonably large segment of the target market, so even very generous tax credits may not be large enough for a significant portion of the low-income population to purchase health insurance and will primarily benefit particular segments of workers.

So that's the reason why when we're talking about tax incentives versus polling we do not think of the uninsured as one homogeneous group. It is an entire different subset of single self-employed and small-group market folks that need additional tax incentives. Therefore, we should try to attract them from different angles to be able to expand coverage.

MS. NG'ANDU: Do you have any thoughts on that, specifically as it relates to Latinos and how you think that would play out?

MR. FERREIRA: Only to Latinos?

MS. NG'ANDU: Yes.

MR. FERREIRA: We believe that when it comes to tax credits, Latinos have a higher level of skepticism of participating in government programs or availing themselves of sophisticated tax benefits. Latinos are also—they're more likely, among the uninsured, to possibly be workers that are not necessarily here under legal status. They might be undocumented. We see that a lot of the industries where you have lack of ESI coverage are many of those industries where you have a lot of Latino workers, where the attraction has to be very key and tailored: agriculture, 59%; construction at 59%; retail, 38%; service, 59%. Those are the lowest industry sectors, so how can we bolster ESI to be able to cover them? And while tax credits may be able to induce some Latinos—wealthier Latinos who are, say, web developers, freelance workers, or the self-employed—it doesn't apply to everybody. That's why we need to attract the Latino population from different types of inducements through different angles.

And there was a small reference, by the way, to SCHIP, and we wanted to make sure that when it comes to coverage issues—nearly 22% of Latino children are uninsured. So if we have to assume that there is a very large portion of the uninsured that would be taken care of immediately through ICHIA, the Immigrant Children's Health Improvement Act.⁸ So there are different approaches to being able to take care of this, and SCHIP works when it is able to work. There's a small business tie-in through SCHIP language. It was controversial and it was fought over, but it would allow the small employers to work towards linking their employees with SCHIP. So the abilities are there. I think this conversation is more hopeful than pessimistic.

MS. NG'ANDU: Just one more clarifying question, or to expand your question and address it to the room: Medicaid and SCHIP cover about a quarter of the Latino population (if you just look at the raw numbers). Will incentives provide an alternative that is equally as viable as these programs, and provide quality of care? Will incentives ensure that children are covered like the seven million Latino children of approximately the 11 or 12 million Latinos who are covered in Medicaid and SCHIP programs?⁹

MS. FISH-PARCHAM: Well, that's easy: no. Medicaid and SCHIP have a much better benefit pack-

⁸ Legislation passed in 1996 (the Personal Responsibility and Work Opportunity Reconciliation Act, also known as welfare reform) subjects recently arrived immigrants to a five-year bar from date of entry before they may qualify for coverage through Medicaid or SCHIP. Passage of the Legal Immigrant Children's Health Improvement Act (ICHIA) would remove the five-year bar for lawfully residing immigrant children and pregnant women. At this time, nearly half of the states choose to cover this population through state-only dollars.

⁹ For the most recent year available, fiscal year 2004, about 12.8 million Hispanics were eligible for coverage through Medicaid or SCHIP and 10.8 million Hispanics were enrolled in these programs. See "Medicaid Statistical Information System State Summary, Fiscal Year 2004 National MSIS Tables." Conducted by the Center for Medicaid and Medicare Services. Washington, DC, June 2007, <http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/msistables2004.pdf> (accessed March 10, 2008).



age than private insurance. They do negotiate rates with the government. They do have enrollment systems and marketing controls and lots of other things that are really helpful to people.

I wanted to just go back and mention there are two other state experiments that might be useful for you to look at, and I don't know a lot about them. One is Montana, which gives both tax credits to employers who offer new coverage and a tax incentive to employers who agree to maintain the coverage. It's not a large program. It has improved insurance a tiny bit, but in terms of looking at the cost-effectiveness of tax incentives and whether they're geared towards employers, that might be one place to look. The other state is Arizona, which has a community-rated product for small businesses; it would be interesting to know how many Latino small businesses have taken that up. Initially, there was a state subsidy attached to that product. Then the administrators thought by marketing high-deductible plans and other things, they could just deal with this through the market and they didn't need the state subsidy anymore. They tried that for a few years and found that it wasn't working for them, and I believe they went back to a state subsidy last year, at least temporarily.

MR. ARENSMEYER: How is that working in Arizona? And the reason I ask is [that] the one in California did not work well because of adverse selection.

MS. FISH-PARCHAM: Right. When I talked to them probably a year and a half ago, they were having fewer adverse selection problems than the other states that used those pools.

MR. ARENSMEYER: Is that because of subsidy?

MS. FISH-PARCHAM: I think so, but I don't know what's happened in the last year.

MS. RYAN: Before we break, I just want to follow up on the discussion about Medicaid and SCHIP. We don't have a complete understanding of how these health tax incentive proposals would interact with these public health insurance programs, especially if they are tailored to a low-income population. Are the incentives only for people who don't qualify for these programs—for example, someone who makes slightly more income than the eligibility limit, or someone who is a recently arrived immigrant who, as David pointed out, does not qualify for coverage due to the five-year bar imposed by the 1996 welfare reform legislation? What impact might these proposals have on public coverage that has been so important to Latinos?

MS. CORLETTE: I just have a general comment, and I think you're sort of getting at the very heart of what I think the political debate is shaping up to be. And we saw this with SCHIP when there was an effort to expand SCHIP to cover all eligible children. Folks who did not want to see that happen were pushing a tax approach and tried to stop efforts to expand SCHIP. So I think when you're looking at limited federal dollars, if it's an either/or type of scenario, my view is that there is a problem for populations that are eligible for programs like SCHIP and Medicaid because there are folks who have different views about how to spend their federal tax dollars. So that's just a general comment about the political dynamics.

MR. CANNON: Can I make a comment about the attractiveness of a tax-based approach versus a Medicaid or SCHIP-based approach? It seems that the biggest barrier to Latinos getting health insurance, from what I've been able to glean from this paper, is that they have low incomes, and that's really the biggest problem here. So I think that any approach that you take toward trying to improve access to health care, whatever approach that is, you should be very careful about any disincentives you might create for Latinos to increase their incomes.

One of the difficulties with Medicaid and SCHIP is that they do create that disincentive. If you look at a single mother of two living in New Mexico—say she's earning \$15,000 a year—and look at all



the government programs she's eligible for—not just Medicaid and SCHIP for her children, but also a housing subsidy, food stamps, child care, and so forth—if by some miracle she was able to increase her earnings from \$15,000 a year to \$45,000, effectively tripling it, you'd think that she'd be a lot better off because she was getting \$30,000 in additional income. But in fact, she would be paying \$4,000 more in taxes and losing \$26,000 of government benefits. So in effect, every additional dollar of earnings she loses either to taxes or government benefits. That means she faces what economists call a marginal effective tax rate of 100%. So financially, she's no better off after having exerted all of that work effort. And that's a problem that can arise, depending on how you structure something like a tax credit. If you phase out a subsidy, then you can exacerbate that low-wage trap that already exists. I think that's something that the other tax-based approaches—or, I guess, a problem that a level tax credit—does not create, even if it is refundable. So I think that's just something that you keep in mind.

MR. DORN: In terms of thinking about public programs versus tax credits, I think you'd need to be very wary of constructing a tax credit so that it could encourage undermining public programs. There's a lot of evidence that these public programs provide good access to care and improve health outcomes, certainly in comparison to similar populations that are uninsured. There are issues about provider participation and reimbursement rates, so it's not an unmixed picture, but by and large for low-income people, these public programs have worked pretty well.

Tax credits, by contrast, have been tried twice—with Bentsen Child Health Tax Credits in the early '90s and now HCTCs—and they failed both times. While the earlier failure was much more severe than the more recent HCTC program, no one can plausibly call HCTC an overall success. Tax credits are thus zero for two. Now, as you all have heard, I believe that you could do it right. I believe you could get the details of a tax credit right so that it could provide affordable access to comprehensive health coverage, but I think it would be a horrendous risk to create tax credits in a way that could unravel public coverage. So I think it's very important, as Cheryl was indicating, that you have a bright line that excludes eligibility for tax credits for people who qualify for public benefits, in the same way that SCHIP is available only for people who were ineligible for Medicaid, as existed at the date of SCHIP's enactment.

But that said, I think you need to also think about the public program side of the picture. It's not simply a question of having income above the thresholds. If you're an adult who's not a parent—or is not pregnant, severely disabled, or elderly—you are ineligible for Medicaid no matter how poor you are. So I would think about if you wanted to go to the tax credit route for political reasons—and that in my view is the reason to do it—you want to think, “Do we strengthen public programs for the very poorest Americans? And do we layer on top of that tax credits for people who are not quite as poor, but still encumbered in their ability to purchase coverage?”

And I wanted to echo something David said, which I think was extremely important, which is coupling pooling with tax credits. Rather than thinking about using tax credits in the nongroup market, which I think is problematic for lots of reasons, I think it's a much more exciting model to say, “Let's help states set up health insurance exchanges or purchasing pools where there's a variety of health insurance plans that are available and offer tax credits.” And let's say that the place that you use the tax credits is either with your employer or with these pools. And at the same time, you open up the pools to employers and say, “If you want to provide coverage to your worker through these pools, go ahead and do it.” There's a lot of design issues you have to think about. How do you make sure you keep employer dollars in the system? How do you avoid adverse selection? Any time you think about health reform, there are nasty, detailed issues you have to grapple with, but I think in terms of an overall direction, that's a much more promising approach in my view than tax credits for the nongroup market.

MS. RYAN: Thanks. Another issue that NCLR wants to address is whether HSAs have any potential if they were de-linked from high-deductible health plans.



MR. BURMAN: I'm not sure I see the point.

MS. RYAN: Okay—

MR. BURMAN: I thought the whole idea of HSAs was that people are paying money themselves out of their accounts. Without the high deductible, the rationale for HSAs pretty much disappears.

MR. CANNON: Actually, as a supporter of HSAs, I always thought that the point was related to something that you said earlier, which was that the worker pays for their employer-sponsored health insurance in the form of lower wages, even if it's the employer that's actually writing the check for those premiums. And so the value of HSAs, from my perspective, has always been that by leveling the tax treatment of the money deposited in the Health Savings Account, giving it the same tax treatment as the employer part of the premium, it actually gives what is really part of the worker's compensation to the worker and eliminates a tax penalty on the worker's control of that part of their compensation. So while I generally think that high-deductible health plans are a better option than a lot of the critics that do—and we can talk about what the health effects of high-deductible health plans are—I'm not dogmatic about them like some HSA supporters are. In fact, I think that they're just one option that workers should be able to choose.

And so I think about what sorts of tax reforms would be beneficial to workers, to expanding coverage, but more importantly, to creating the type of health care sector where health care gets better and cheaper, so that it's available to more and more people over time. I think that the way to approach it is actually to build on Health Savings Accounts. One way of doing that would be to turn the Health Savings Account from what it is right now—which is a very prescriptive, small account that lets you control some of your money, but you're required to have this health plan that Congress assigned—into a vehicle that really lets the worker control all of their health benefits dollars. And I think that a way of doing that would be to expand the amount of money that a worker can put into their Health Savings Account, so that they can put the employer portion of the premium into that account and then let the worker purchase whatever kind of insurance they want with it. Because certainly, there's a lot that managed care, that integrated health systems like Kaiser have to offer—a lot of innovations and benefit design that Health Savings Accounts, as they exist now, do not allow workers to benefit from.

But also, I think it gets at another problem that I brought up earlier. Most of these tax breaks for health insurance are just that: tax breaks for health insurance. If you are uninsurable, then you don't get any tax benefit from them. Expanding Health Savings Accounts in the way that I mentioned would actually provide some tax relief for the uninsurable because the money that's put into the Health Savings Account is tax-free. And then, if there's no requirement to purchase health insurance, then the uninsurable can effectively get a tax break on their out-of-pocket medical expenses. So I think that's another option that NCLR might want to look at because—well, and for other reasons that we can get into.

DR. HOFFMAN: Well, ironically though, the uninsurable are the people who often are the least likely to be able to save for a rainy day because they are needing medical care and accumulating medical bills.

DR. BURMAN: They also don't get the—

DR. HOFFMAN: The population of low-income Latinos is another group that's not likely to be able to save much at all, despite the fact that the savings would come from pre-tax dollars.

MR. CANNON: But it's not about saving. Take that uninsurable person right now. They don't have



health insurance. If they have a stream of income, then they're probably paying payroll taxes on it. So if they have a stream of income, they have medical expenses, then they put that money into the Health Savings Account. Then they're able to purchase medical care directly and they would be able to do that with pre-tax dollars, whereas now they have to do it with money that has already been subject to payroll tax. So for those people who have high medical bills, it's essentially a tax break on their out-of-pocket spending.

DR. BURMAN: I'd be surprised if many uninsured Latinos would use HSAs. First of all, they get no income tax benefit. If your income is low—and your study showed that most Latino people have very low incomes—you generally do not owe income tax. So you don't get the income tax benefit. HSAs actually combine two things: one is effectively a deduction for medical services and the other is this kind of supercharged IRA. You not only get an income tax exclusion, but also you save payroll taxes on the money going in. And if you use it to pay for health care at any point—health care is fairly broadly defined—it can include Medicare Part D premiums and retirement; my guess is it's going to include all kinds of long-term care services and I think it's actually going to be a nightmare determining where the line is between retirement living facilities and medical services, when people start taking the money out of these things. It's a hugely favorable tax subsidy that's most valuable to very high-income people who don't really need any help. You can say, "Well, they save payroll taxes," but for most people saving payroll taxes is a good deal because you don't get much back in exchange for the money that you put in Social Security. But for low-income people, that's not true. Social Security is a very progressive system, particularly if you're lifetime low-income. The money you put in translates into higher benefits. It can make the difference between being poor in retirement and not being poor in retirement.

MR. CANNON: But that's a feature of the exclusion as it exists right now. All the low-income people who do get employer-sponsored health insurance deduct those payments from payroll taxes and, therefore, have lower Social Security benefits. So it's not—

DR. BURMAN: But if you're talking about uninsured people, who you imagine will put money into a Health Savings Account, the only tax benefit they're going to get is to save payroll taxes and that's really not worth anything to them over the long term.

MR. CANNON: I'm not sure that that's the case. But it does bring up another question that I had. I wish that I had been visited when I was 12 years old by a kindly demographer who said, "I know that your brothers took French, and I know that you think it's easier to learn than Spanish is, but listen to me. You're going to wish you took Spanish in about 20 years." Because I don't know a lot about the Latino community. Most of what I know about their relationship to health insurance comes from this paper, but it seems to me, from what I've read there, that income is just one obstacle to getting Latinos health insurance. There appears to be another, and it crops up when talking—you mentioned that even when you control for income, Latinos are less likely to be insured. And so I'm wondering: are there cultural factors that make Latinos less likely to value health insurance?

DR. RIOS: Yes. One is fatalism, having this attitude that "if I'm going to get cancer, well, that's my death sentence and so be it because that's what God wanted—why bother?" Health insurance is looking ahead and planning ahead, and how can you plan ahead when the very people who are working—poor Latinos especially—who are very conscious of the family first; the culture is so ingrained with taking care of the family and the people around you. And usually it's multiple families and extended families, lots of children, so you don't buy something like a health insurance product because you're never going to use it. You've got to have food and clothing and take care of the family first.

The whole idea of insurance is based on something that's foreign to most people, because the Latino communities, they're immigrants, especially if they come from countries where they don't have to go



buy insurance. Pharmacies, pharmacy care, are more important than medical care, and it's because pharmacies are at every corner of East L.A. [Los Angeles], of the Bronx. In this country, we have an underground system of medical care that's free, that's charitable. There is no such thing as insurance in our communities. And for a long time, generation after generation, living in the United States, nobody talks about it because it hasn't been studied. And it's not the community health centers. It's clinics that are private businesses by foreign doctors, mainly Spanish-speaking doctors, who have started gold mines in communities that offer care that's trusted, that has an attraction to the local neighborhoods to provide care when needed. And it's not an emergency room. It could be an emergency room, but it's more the local mom-and-pop clinic that's really a private business.

MR. CANNON: So I guess the reason I asked that question—and I'll just ask a further question and then shut up—but given that that barrier exists, how much more difficult is it going to be then to cover more Latinos if they just don't value health insurance? And would it be beneficial to create a tax break that gives them another option, which is: you don't have to pay all that money in insurance premiums but we will let you save what you are able to, tax-free, dedicated for medical expenses?

MS. NG'ANDU: I just want to interject and respond to that because while I think there may be some cultural barriers, Latinos can overcome them. And I'll just point to employer-based health insurance, because when employer-based health insurance is offered to Latinos, they do take it up. Employer-based coverage is just not offered to Latinos. So while there may be unfamiliarity with the system, when the opportunity to have coverage is presented to Latinos, they take up insurance. And so therefore, I would propose that we need to look at mechanisms of making them aware of the opportunities that are available to get into existing health coverage systems, or come up with new systems that do work within Latinos communities. Put Latinos in a space where health coverage is more accessible.

DR. HOFFMAN: I'm always impressed when you look at take-up rates across income groups. I always expect to see a really big drop-off in the low-income groups. As high as 70% of low-income groups participate in health benefits when they are offered. That tells you that most people understand the value of it.

DR. RIOS: Yes.

MS. PAÑARES: And I would just add to Jennifer's point. With regard to public programs, when you see things like community health workers going to communities and informing communities about the availability of public programs like Medicaid and SCHIP, you do see uptake rates increasing with outreach and enrollment. So, yes, there are cultural and linguistic barriers to enrolling in health insurance coverage. And I can't speak to cultural barriers to the idea of valuing health insurance coverage, but I will say that there are cultural and linguistic barriers to enrolling in insurance programs, whether it's employer-sponsored care or public programs, but when that is addressed through things like community health workers or education or increased outreach and enrollment, you do see uptake levels increasing.

DR. BURMAN: I just want to respond to one thing Michael said about the HSAs. I think you made a good point about leveling the playing field between different ways of controlling health care cost, but I actually want to make a pitch for a proposal that Kate worked on when she was in the Administration, which is the idea of providing a subsidy for getting health insurance, whatever kind it is, and not having it depend on the amount you're spending on health insurance.

You said you're not so sure that having people get health insurance is the best policy, but I think it actually is, because it deals with problems of adverse selection when you get more people in the



market to solve these inherent market failures. If you take that as a given—that a subsidy is actually tied to having insurance, but not the amount you’re spending on health insurance—it makes a lot of sense. There are problems with the standard deduction, because just like Health Savings Accounts, the benefits are largest for people with high incomes who have high marginal rates, but that could be fixed by taking that approach and turning it into a refundable tax credit instead. I think that if you’re concerned about leveling the playing field, giving people incentives to find inexpensive health insurance wherever they can, and dealing with problems with the nongroup markets, it’s actually possible to use a tax credit to get reasonable, affordable insurance that’s fairly comprehensive. And not tying the credit value to the amount you’re spending is the best approach.

DR. BAICKER: And there’s nothing magic about a high-deductible policy, per se.

DR. BURMAN: Right.

DR. BAICKER: I think the appeal is that the policy aimed to get incentives lined up so that people seek higher value care. The goal is to stretch our dollars further by having people consume more of the high-value stuff and less of lower-value stuff. And the high-deductible policy is one way to try to get at that, but there are lots of other things that insurers can do to bring down premiums, like limiting the doctors who are available in a network panel, having lower copayments for in-network providers, or having tiered formularies. There are all sorts of different strategies, and there’s no reason, I think, that we should particularly favor one strategy over another. And in fact, there’s a little hint of that in HSAs, in that preventive care can be covered without being subject to the deductible. There’s a safe harbor for preventive care. There’s mixed data on how much that’s utilized, but I could imagine a system in which if I were an insurer (and there was nothing interfering with setting up what I thought was the optimal insurance) I might pay people to go get flu shots. “Here’s \$100 if you get a flu shot.” And I might charge a lot of money for things that I thought of as elective, or of very low value, for the typical person. There are some procedures that are done that are really of very low benefit, and may be even harmful, but the insurance system fosters that kind of care.

So in a perfect world, I think we’d see lots of different insurance products that might subsidize some kind of care and charge more for other kinds of care. And all that would be laid out ahead of time so people would know what they were getting themselves into, and they would choose the policy with the premium that they felt delivered the best value for them. And insurers would compete on designing a product that really delivered high value. There are a lot of things that interfere with us being there now, but I think that should be the goal, not a particular insurance design.

MS. RYAN: I think that we are getting into the subject of health and tax literacy within the Latino community. You’re talking about designing different insurance products that the consumer would have to have a lot of information about in order to consume health care wisely. And we know some things about Latinos’ health and tax literacy that are relevant to these proposals. We know that they’re less likely to know about big tax credits, such as their income tax credits, or what they have to do to qualify for them. We also know that Latinos who are in mixed-status families have some fear and anxiety about taking up benefits that are linked to the government. Additionally, both Rea and Jennifer mentioned the importance of culturally competent and linguistically appropriate outreach to these communities. Given all these things that we know about these barriers, what do you think would be the largest obstacle of connecting the Hispanic community to health tax incentives and what would be the steps for overtaking it?

MR. DORN: It’s not just a question of literacy. It’s also a question of a real basis for fear. Yes, thankfully, in the closing days of the Clinton administration, they came out with a policy that said that utilization of publicly funded health care should not be taken into account in making immigration status decisions, but how universally is that applied? I’m not so sure. And what about issues like sponsor



deeming? If I take up health coverage, does that mean that the family member who sponsored me is going to have to pay back the amount that gets paid for my health insurance? So I think one issue is to really lay to rest the legitimate basis that people have for fearing involvement in publicly funded coverage. I think that's not a question of literacy.

In terms of literacy, it seems to me it's worth investing in community-based intensive consumer assistance programs. A couple of examples: one, there was a study in *Pediatrics* in December of 2005 where they looked at standard Medicaid and SCHIP outreach versus community-based case managers who were empowered to help the families fill out forms, advocate on their behalf when there were problems in the application process, educate them about how to use services, and so forth.¹⁰ The standard outreach procedure—these are low-income Latino communities in Boston—resulted in something on the order of 50, 60% take-up, which is not bad. The community-based case managers had 96% take-up.

MS. NG'ANDU: Yes. Glenn Flores.

MR. DORN: Yes, exactly, yes. Another example is OERU [Outreach, Enrollment, Retention, and Utilization] in California. I'm not sure I'm pronouncing it correctly. There's this very interesting model of community-based outreach, where it's outreach, enrollment, retention, and utilization, the idea being, "Let's have community-based folks—a *promotores* model to some degree—help people apply, stay enrolled, and actually know how to use services appropriately." There are other examples too.

DR. HOFFMAN: Highly effective type of project.

MR. DORN: Yes. The basic health program in Washington State has this thing called Sponsored Enrollment, where essentially, community-based clinics can pay people's premiums, help them pick a health plan, and educate them about how to use services. And it's just startling, the difference that it makes for people who are low-income, people who don't speak English, people who aren't well-educated. The take-up rate differential is just extraordinary. So I think that's an area where a significant investment could yield significant benefits.

MS. RYAN: Thanks, Stan. David?

MR. FERREIRA: Well, I think Mr. Dorn brought up the issue of obviously trying to ease the fears of participation in government programs, which is a very big fear we're dealing with. There are scores of amendments in any given year in Congress on sponsor responsibility and we are probably not seeing the end of that. Obviously, there are concerns in everything...[such as] participation with just getting Stafford Act assistance [for] disaster relief, where the Department of Homeland Security and FEMA used to not report undocumented disaster victims to Immigration Enforcement. Now they do. There are scores of examples where mixed-status families may have concerns for participating in government programs. And that is one of the main aspects to be tackled, since such a high percentage of the Hispanic population may be part of mixed-status families.

When it comes to the issue of health and tax literacy and how we address that—I wanted to touch on what Dr. Rios had said before—the impediment is educational and not really as much cultural. It can be redefined as an educational impediment. The accessibility and the use of tax credits, whether it's EITC or whether it's for health care, and participation in sophisticated programs has a diminishing value for folks that already have a high level of skepticism of participating in government programs. So obviously while we're not necessarily trying to paint the entire uninsured community

¹⁰ Glenn Flores et al., "A Randomized, Controlled Trial of the Effectiveness of Community Based Case Management in Insuring Uninsured Children." *Pediatrics* 116 No. 6 (December 2005): 1433-1441.



with a broad brush, we have to talk about what are the segments, the large segments. If you can isolate and compartmentalize them, you can start talking about what are solutions that affect large portions of that underserved community. And when it comes to, for instance, with Hispanics, because of the significant labor participation rate, the health literacy would be very much more promoted if it's done through an employer, for instance, where the employer becomes the sponsor, the health advocate. For instance, the Montana Small Business Health Care Affordability Act, they have a funding stream from the tobacco tax or settlement for that, but there are no federal funding streams for similar programs independent of that.

So if we can find ways how to be able to address those large segments and compartmentalize them and start talking about how there is no one politically feasible magic bullet solution—that it's not just about income and wages—and not about being able to address the issue of Hispanics using better use of their dollars, then we can talk about how we can actually start promoting those practical and politically achievable solutions to deliver coverage to large segments of the uninsured population, instead of focusing on big and politically troubled solutions to address the needs of the entire group.

MS. RYAN: Thank you.

DR. RIOS: I think just maybe a positive spin on all this is needed, maybe a little bit more proactive thought. Let's say the day comes when we have immigration reform and we don't have to deal so much with all this fear. I think what's important is that in order to increase the take-up rates for health insurance, our community needs to understand the importance of prevention and preventive health and having health insurance to be able to get the screenings and the access. It's not just about having diabetes as a death sentence or cancer as a death sentence. It's about changing the paradigm through education. I agree with David that it's education, but it's also changing that paradigm now. This is a perfect opportunity with health reform to start thinking in terms of public health or in terms of health prevention. And so the community interventions, the school interventions, the family interventions, the home interventions, the things that the Latino community would really resonate with, those messages, I think, are what are important.

MR. FERREIRA: Community-based care is also a very big aspect of this. A lot of Hispanics rely on community-based care. While none of us in this room necessarily think about going to a community clinic, we very much know that there's a lot of innovative work being done at these places for cost containment and being able to provide the best bang for the buck on that service and that plays along with this.

MS. RYAN: A number of speakers have touched on cost containment. Many people believe that one of the benefits of health tax incentives is that they're generally paired with higher cost-sharing levels that will, over time, contain costs and lower aggregate spending on health care. As Michael mentioned, the idea is that will lower the cost of health insurance premiums so that coverage is available to more people.

Yet NCLR is concerned that this emphasis on spending loses sight of the real goal, which is improving health outcomes. Given the way that Americans make health care choices—for instance, as John was saying, if we have an offer with a health benefits package from one firm and we have another offer with higher income but no benefits, people tend to choose the job with the employer benefits package, even if they can theoretically purchase coverage on their own. Given what we know about the Latino community and the way that people make health care choices, which might not be completely rational [from an economic point of view], is higher cost-sharing the best solution for Latinos?

MS. CORLETTE: I think a number of things have been said about high-deductible health plans and cost-shifting onto consumers, and I would echo many of those things, including the deterrents to



getting primary care. Even if you offer preventive care and screenings separate from the deductible, there is a significant disincentive to access primary care. And then the other piece I'd like to say is that purchasing health services or products is not like buying a toaster oven or a refrigerator. Consumers do not enter into the same decision making process. There is simply not the cost, quality, price transparency that you have when you're purchasing those types of products. There's complete opacity in the health care marketplace. And we cannot, simply cannot, ask consumers to go out and choose the cheapest pediatrician or the cheapest hospital. People are not making decisions in that way.

MR. DORN: I agree. The United States spends more per capita on health care than any developed country by a significant margin, even taking into account the fact that we're an unusually wealthy country on average. Some folks will say the reason why health care costs in the U.S. are out of control is that there's just too much third-party reimbursement; there's not enough "skin in the game" on the part of consumers. But all the other developed countries have less skin in the game than we have in the U.S. We have by far the highest proportion of health care costs that's paid by consumers.

So how have these other countries done it? Well, they've done it through managing health care costs. And so I would argue that if you really want to get costs under control in a way that helps Latinos and other communities, you would want to think about things like managing the cost of chronic illness. Seventy-five percent of the health care dollars are spent on chronic illness. And there are certain kinds of interventions we can do that will bring down costs a lot.

Now, that said, there is a room for cost-sharing. And although it sort of goes against the grain for me to admit it, I think we've seen slowdowns in the acceleration of employer-based insurance premiums in recent years. And I have to wonder whether part of that isn't due to new cost-sharing structures like tiered pharmaceutical copayments and so forth. So I think there's a role for cost-sharing, but cost-sharing has to be greatly limited for low-income populations to be able to retain access to health care. Lots of evidence shows teeny little copays, five to ten dollar copays, have a dramatic difference in terms of people's utilization of essential services. And then the other thought is there are other ways to approach the cost issue than to raise consumers' out-of-pocket costs.

DR. HOFFMAN: There's not a lot of research just on the impact of the deductible, but I think one that's the easiest to digest and might be useful to reference in the paper—I think it's called *Squeezed*. Yes, from Sara Collins, the Commonwealth Fund.¹¹ You really see the impact, to a large degree, on these decisions that people make about filling prescriptions, seeing a doctor when they're sick, skipping medical treatments, and just those kinds of general access problems when you have a higher deductible. There isn't a lot of research out there, but I suggest that you try to pull together what's available. The evidence is clear.

MR. CANNON: I'm not sure whether greater cost-sharing is the solution. I think that there are different ways of containing health care costs. By that, I mean reducing the consumption of low-value care, and one way is by making the consumer more cost-conscious at the moment they're trying to decide whether they go to the doctor, get this test, or get this procedure. Another way is for the consumer to hire an agent who will help them make these decisions, and this could be Kaiser. Kaiser Permanente collects lots of data and figures out what works and what doesn't and through what [services] they cover and maybe the tiers in their pharmacy benefit. They can convey the information they have on what works and what's cost-effective through cost-sharing or with blunt we-won't-cover-that-sort-of-thing coverage decisions. I don't know which of those approaches is best and I

¹¹ Sara R. Collins et al., *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families* (Washington, DC: The Commonwealth Fund, September 2006), http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=402531.



don't know that anyone knows. So I think that NCLR might want to look at ways of giving consumers the option of choosing between different approaches for containing costs. I think that most of these tax reform proposals do that. And that also lets consumers who are very concerned about someone else telling them what kind of health care they can get go to Joe's high-deductible health plan that will give them more discretion in what kind of care they get than they would get with Kaiser. Or people who don't value that could do the opposite.

With regard to what effect high-deductible health plans are going to have on health outcomes, I think there are two things to keep in mind. One is that access to care is not the same as health outcomes. There are a lot of studies that show that when people have a high deductible, have a lot of cost-sharing, they don't go to the doctor as much. And that just means their demand curve slopes downward. As the price goes up, people consume less of something. Now, we don't know whether that's good or bad on its own. That could just mean that they're getting a lot less low-value care. What you want to look at is what kind of impact...that [has] on their health.

The best research that is available on health outcomes and cost-sharing comes from the RAND Health Insurance Experiment—and here my interpretation is different from Stan's, which he mentioned at the beginning—which shows that there are no adverse health outcomes when you have high-deductible insurance compared to insurance with lower forms of cost-sharing. Compared to insurance that's completely free, you can find some areas where some people with high deductibles have worse health outcomes. They are very narrow areas, and unless you're saying that everyone should have access to free care, that's not really an option for most people, especially people who are struggling to pay for health insurance right now. So that's just my pitch that high-deductible health plans aren't as bad for health outcomes as a lot of people think.

DR. HOFFMAN: I think it's a serious problem we have in health services research that we rely on the RAND Health Insurance Experiment that is so many years old now. It is not the same world of health care delivery now nor anywhere near the level of health care costs. And yet some feel it's all we've got to inform us about cost-sharing consequences on access to care. Isn't that just painful?

MR. CANNON: Yes.

MR. DORN: Yes.

DR. BURMAN: That's why we need the Kaiser Health Insurance Experiment. (Laughter.)

DR. HOFFMAN: You know, one of the reasons why we don't have it is what it took to mount the RAND Health Insurance Experiment, the investment. So we just do little pieces of that research and we never really get to the core of it. And I worry when we continue to pull from that study that we're not informing the health policy debate well by trying to apply the RAND Health Insurance Experiment to 2008.

MR. CANNON: I think you just said that it's the best that we've got and that we shouldn't use it.

DR. HOFFMAN: There just comes a point of diminishing return, when you're so many years out from that reality of health care, and the system—

MR. CANNON: Well, and we can talk about what has changed and what hasn't, but I'm not aware of anything that has changed that would necessarily call into question those conclusions.

DR. HOFFMAN: The cost of health care?

MR. CANNON: Well, right, but that doesn't—that said, that's the—



DR. HOFFMAN: That's the center of the—

MR. DORN: And the effectiveness of health care. Health care is a lot more effective now than it was in the '70s.

MR. CANNON: The question is—

MR. DORN: And even then, low-income populations and people with chronic illness did have problems in their outcomes. Other populations—I agree with you, they weren't able to find differences, but there was a panel of clinicians that said, "These folks who were exposed to high cost-sharing decreased their utilization of both necessary and unnecessary care." Is that really the best way to go?

MR. CANNON: A couple of important points, though. What's essential is not whether health care has gotten better. Undoubtedly, it has. We can do a lot more stuff now than we could have done back in the '70s and '80s when the RAND experiment was conducted. The question is the mix of the health care that people actually get because a lot of it is productive, a lot of it is not productive, and a lot of it is harmful. So what's important is what are the different levels of cost-sharing for the mix of services that people get, and when consumers had to weigh for themselves without any information about what was good and wasn't good, they appeared to cut back on helpful and unhelpful care in equal amounts, but it still didn't harm their health. So I think that what's important is, hence, whether the mix of services that people would get with free care versus cost-sharing have changed, and therefore...the effect on the health outcomes.

DR. BURMAN: Can I make a very small comment, which is that the way you framed the question was about the value of cost containment, and then, are high deductibles a good thing? Those are different questions. I think it's absolutely essential that we do find ways to manipulate the growth of health care costs, because that's a threat to everybody. Part of the reason why people don't have health insurance is that it's really expensive.

I think there are a lot of reasons to be skeptical, particularly for low-income populations, about high deductibles as an effective way to restrain cost. And Michael and Kate and others are right that there are a lot of different ways to do that, but you need to find some options that lower the rate of growth of health care costs or else, as a nation, we're in big trouble because the biggest long-term fiscal problem is how much we're going to be spending on medical care 20, 30, 40 years down the road.

MS. NG'ANDU: The one thing that I want to say about costs of health care is that we definitely agree that there's a larger health care cost issue at hand, but when people start to talk about containing cost, Latinos are often within the population that is left behind without health care. If we're addressing cost containment, does that mean that it reaches into the Latino community? That's an answer that's really important to NCLR. We want to make sure that whatever cost-containment methods are put into place don't prevent Latinos from accessing health care services.

TRAPPER MICHAEL¹²: I don't know if I'm allowed to make a comment, but to your question, as HDHPs increase, might we be able to revisit this question? I saw a study in *JAMA [Journal of the American Medical Association]* in the spring that said people with HDHPs are less likely to use emergency department services.¹³ Will we have opportunities to do empirical research?

¹² Mr. Michael was an invited observer of the roundtable proceedings.

¹³ Corita R. Grudzen and Robert H. Brook, "High-Deductible Health Plans and Emergency Department Use," *JAMA* 297 (2007): 1126-1127, <http://jama.ama-assn.org/cgi/content/extract/297/10/1126>.



DR. BURMAN: The problem is that you don't have a controlled experiment. People who are taking up HDHPs have higher incomes and are healthier than others. What you'd like is a health insurance experiment with random assignment—you give people money and say, "You're in a high-deductible plan, and you're in the aggressively managed care plan, and you're in the plan that covers everything in the world," and see what happens. We don't have that information. The best information we have is from a 20-year-old experiment.

MS. FISH-PARCHAM: I think people forget how little of cost-sharing is really within the consumer's control. There was an actual call I got two days ago—or actually it was four days ago—from a woman who had bought a \$10,000 deductible policy. She called me because she had been in a car accident, had [been in] a coma, and had been transported by helicopter to the nearest health facility, which was not in her insurance plan's network. This was not anything she had control over. And she ended up with a \$50,000 debt that she can't do anything about. While that may be an extreme example, there's certainly a lot of cost-sharing that's not within people's control, partly because of these out-of-network problems. Also, whether the most cost-effective service actually exists in their community is really beyond consumers' control. And so I think, especially looking at the Latino population, you have to think about the availability of services, not just how much they cost.

MR. FERREIRA: [And] also to make sure that we don't talk about the Latino population homogeneously. While we know that they fall proportionally into certain economic groups, we also understand that high-deductible plans may be useful for many that would otherwise not be able to afford employer-sponsored coverage. And it has also helped a lot of employers retain that coverage for their workers. And we know that deceleration in the growth of premiums has been, in part, due to high-deductible plans.

But the question that we have to be able to consider is that high deductibles do actually have a role, and they actually have a role for a lot of segments in the small business community and hence, to a lot of Latino workers. Whether it provides the best benefit and care or not is another question. I am approaching this discussion from the coverage angle and not quality of care—I do not know enough about that subject.

MS. FISH-PARCHAM: And then just one other thing is that it may also be useful to look at the area of medical error and reduction of that as a way outside of the health insurance system to make a big difference to cost.

MS. CORLETTE: Yes. I don't know how old this data is, but another RAND study has shown that, I think, 30% of our spending on health care is spent on unnecessary, wasted care, low-value care. So maybe if we can tamp down that 30%, we'd be a long way along.

MR. CANNON: Insurance would be a lot more affordable.

MR. ARENSMEYER: Does that include rectifying medical errors?

MS. CORLETTE: Yes.

MR. ARENSMEYER: Okay.

DR. HOFFMAN: And the majority of that savings wouldn't be something that the consumer would be able to really control.

MS. CORLETTE: No. You're looking at fundamental payment reforms.



MR. ARENSMEYER: Yes. As a layperson on this—because I’m not an expert—but I’m listening to all of this and I’m trying to think of my own experience, my own family’s experience, and we do have stories that kind of relate to this. And I don’t know one time when really I would have ever had the ability to have any control over the cost, and even in making judgments about whether to spend money. We did have a high-deductible plan for a while. I don’t see how—and obviously, I’m probably better educated than most people out there—how I could possibly have made that judgment.

MR. CANNON: Consumers did in RAND, even without those tools.

MR. ARENSMEYER: Did they have better medical—were there the same medical outcomes versus cost?

MR. CANNON: The high-deductible insurance is much more cost-effective if you consider that the free-care users spent 43% more and got no better health outcomes.

MR. ARENSMEYER: I’m not an expert on this. I’m just passing it on, but literally, just to step out of my expert role—I can’t even think of a situation where I would have been able to make that type of decision.

MR. CANNON: Your point is well taken. It’s just [that] I don’t want to give the poor consumers such short shrift, treat them like they’re that bad at this, because we have evidence that they did okay, even without any tools. And so consumers, presumably, could do even better if they had more decision tools to help them.

MR. FERREIRA: And towards the decision tools, transparency in health care cost is a very important tool, especially to small-business employees that are much more likely to be in these high-deductible plans. If we are moving towards consumer-directed health care, we have to consider the importance of not only having the education, but easy access to the costs and comparisons for actual shopping.

MR. DORN: But nobody should be under the illusion that this stuff is easy—for example, making quality data available. Well, do you adjust for the risk characteristics of the patient population? If not, then you’re telling providers, “You treat risky people at your peril, because it will hurt your statistics.” Suppose you do risk adjustment. What do you do about a town where there are two doctors and everybody knows Mrs. Jones is a difficult person? They’re not going to take Mrs. Jones. Cost data, making it transparent, well, that’s very nice, but one of the things that happens when you make cost data available is [that] providers look around and say, “Oh, he’s charging that? I’m not charging enough.” So this stuff is not so easy to do.

MS. NG’ANDU: So why don’t we let Sam make the last comment on that and then we’ll move on.

MR. JAMMAL: It just goes back to when we were talking about the cultural competence issues. There are certain barriers in the Latino community as far as you can’t have this completely consumer system without bringing the educational tools in there, because then you’re going to go back to the same thing where we have this great tax incentive system that no one is going to be using because of the fact there are informational barriers there. It’s not going to be a pure market in any sense just because of the low information levels to the consumers.

MS. RYAN: I think that we have covered a lot of ground here today. We’ve talked about a lot of different ways that maybe we can improve upon tax incentives to get people to have ultimately access to the health care system, whether that takes the form of HSAs de-linked from HDHPs or a very large tax credit that is to be used in a very limited sense for folks who don’t qualify for public



coverage or combining proposals with nongroup and small-group market reforms.

If possible, let go of the political implications for a moment. How could you design a health tax incentive policy that could close the coverage gap for Latinos and still make sure that they have the quality and affordable access to coverage and care? If there any proposals that NCLR should be considering, but we haven't yet, please, let us know.

MR. FERREIRA: I'll just start off by echoing the same comment from the very beginning and say it over. Solutions must be broad. We can think about incentives, we can think about risk-spreading and risk-shifting. And more often, it's going to be a combination of all of them. And the best way to be able to get efficiencies is through integrations of them, like integrations of tax credits and pooling through risk-spreading, and [it is] the best way that we can try to approach that very large segment of the uninsured, more than half of which are small businesses, self-employed, and a third of which are Hispanics. And then the [integration of the] public benefits issue, which is outside of the scope of ESI, which takes care of uninsured children and uninsured that have limited income and rely more on public and community health programs.

MS. RYAN: Thanks, David. Sam?

MR. JAMMAL: I guess I actually have more of a question for the group in here that would fall on looking at what plans work. I guess the viability of state approaches versus the federal approach, where you have states such as California and Massachusetts, [is a proposal to consider]. And definitely in the Latino community, the dynamics going into different types of pockets of the community are going to be different in different states. If there's going to be a tax incentive system, does it build more on benefits for a federal approach versus the states and maybe on—(inaudible)—you guys can look at, because we don't know where the health care debate is going to go. But just knowing California and Massachusetts are in the process of—Massachusetts more than California at this point—but—(inaudible).

MS. NG'ANDU: And there is something good and bad to say for that, which is: ...many of the states where health care reform is being pushed forward are states where the density of Latinos is. The health reform efforts in California and Massachusetts and Illinois are fairly inclusive thus far...But we have also seen what happens with limited federal coverage for Latinos, which is inherent in the issues surrounding legal immigrants. Currently, some states cover legal immigrants and some states don't, and when you head into economic recessions, states really don't. So there can be both value and drawbacks when taking that approach.

Michael, I want to call you out for a second because you've been addressing one of the different aspects of health reform today, which is that NCLR is trying to get people to health care services and we consider health coverage a conduit to those services. You seem to be bringing up ideas about moving around the health coverage system. I just wanted to know if you would speak about that a little bit.

MR. CANNON: I wonder if some people might think that I was against health insurance by questioning whether health insurance is the best way to improve health of Latinos, or, I should say, the most cost-effective way of improving the health of Latinos—and that's not the point at all. The point is actually one that has been brought up by others, which is there are so many other things that contribute to health. And if the goal is to improve the health of Latinos, I think you would want to make sure that you were doing that in the most effective way with the money involved. And since there is no evidence that health insurance is the best way to do that with the money involved, and since the resources are scarce, I would just suggest that you take that into account, and that NCLR takes that finding seriously and considers other options that might help us figure out what is the best way to improve the health of Latinos. I'll just leave it at that.



MS. NG'ANDU: Okay. Thank you.

DR. BURMAN: Now, Michael made a comment earlier, which I found intriguing, which was suggesting that you try different approaches in different states. One problem with the state reform plans now is that they're pretty under-funded, so they've got to scrape together money from various resources. One option would be to basically say that the goal is to cover everybody and the goal is to limit the growth of health care costs. We're going to set up a grant program for states that want to do this. You can compete for different ideas and then see which things work the best.

(Cross talk.)

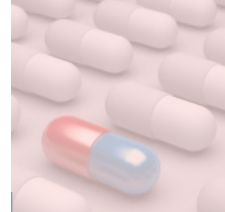
MR. CANNON: I find it extremely odd, the idea that those state programs are under-funded, because with Medicaid, and someone said with SCHIP, states can at least double their money by expanding those programs, and so that's not exactly my idea of state experimentation with these different approaches to improve health. SCHIP and Medicaid are more of an experiment to find out who can best raid the Federal Treasury. States expand their Medicaid and SCHIP programs without regard to whether these interventions are really cost-effective because the states themselves, at margin, aren't bearing all the costs. They will pass it on to the other states. So again, I think if what you want is to find out how to get the most health for the money, I don't think that Medicaid and SCHIP, as currently financed by the federal government, are going to get you there.

MR. DORN: But keep in mind that you don't get that two-for-one tradeoff when it comes to childless adults, and low-income childless adults are by far the largest group of uninsured right now. There's no additional federal money that comes to states for that. That's one issue. And then the other issue is ERISA [Employee Retirement Income Security Act]. ERISA is a huge obstacle to states moving forward and saying anything at all about employer-based coverage. So the kind of thing you were talking about, Len, makes a lot of sense as long as you can say, "Give the states the flexibility to leave ERISA behind and make sure states can access federal matching funds for all low-income populations, not just those who fit within narrowly defined household categories."

MS. RYAN: Any last words? Thank you all for participating. This conversation has been very productive, and I know it will be valuable as we continue the health care reform discussion.

(END)

Participant Biographies



John Arensmeyer

John Arensmeyer is Founder and CEO of Small Business Majority (SBM), a national small business advocacy organization. SBM promotes progressive 21st century solutions to small business needs and ensures that entrepreneurial values are a central part of our national political debate. SBM has identified the lack of affordable health care as the single most pressing problem facing small businesses in America—one that creates a significant disincentive for those who wish to start small businesses and a significant competitive disadvantage for those who do. SBM has launched Small Business for Affordable Healthcare, a national coalition of small businesses that support comprehensive health care reform, and has successfully organized small business owners, communicated successfully through the media, and reached out to business leaders, policymakers, and political advocates across the country.

Previously, John spent 12 years as Founder and CEO of ACI Interactive, where he built and managed a 35-person company that developed and licensed successful, award-winning e-commerce and multimedia products for over 80 national and international Fortune 500 clients. Earlier, he was COO of a pioneering international multimedia company, an attorney in New York City, an aide to Mayor Bill Green of Philadelphia, and worked in a variety of positions on Capitol Hill. He received his J.D. from Rutgers University, where he was a member of the law review, and his B.A. in political science from the University of Pennsylvania. He has written numerous articles and is a frequent speaker on small business policy issues.

Katherine Baicker

Katherine Baicker is Professor of Health Economics in the Department of Health Policy and Management at the Harvard School of Public Health. She received her B.A. in economics from Yale in 1993 and her Ph.D. in economics from Harvard in 1998. She is a research associate at the National Bureau of Economic Research. She has served on the faculty of the Economics Department at Dartmouth College, the Center for the Evaluative Clinical Sciences and the Department of Community and Family Medicine at Dartmouth Medical School, and in the Harris School of Public Policy at the University of Chicago. From 2005 to 2007, Professor Baicker served as a Senate-confirmed member of the President's Council of Economic Advisers.

Professor Baicker's research interests include health economics, welfare, and public finance, with a particular focus on the financing of health insurance, spending on public programs, and fiscal federalism. Her research has been published in journals such as the *American Economic Review*, *Health Affairs*, the *Journal of Public Economics*, and the *Quarterly Journal of Economics*, and has been featured in the *New York Times*, the *Wall Street Journal*, *Business Week*, and on National Public Radio.

Leonard Burman

Leonard Burman is a Senior Fellow at the Urban Institute and Director of the Tax Policy Center. He is an expert in public finance and modeling the effects of government policies on individuals' and firms' decisions. He has held high-level positions in both the executive and legislative branches of government, serving as Deputy Assistant Secretary for Tax Analysis at the Treasury from 1998 to 2000 and as Senior Analyst at the Congressional Budget Office. Dr. Burman is also a Visiting Professor at Georgetown University's Public Policy Institute and has previously taught economics at The George Washington University and Bates College.

Dr. Burman is the author of *The Labyrinth of Capital Gains Tax Policy: A Guide for the Perplexed* and numerous articles, studies, and reports. Dr. Burman's current research is focused on the changing role of taxation in social policy, pension and retirement policy, estate taxation, the alternative minimum tax,



and tax policy with respect to health insurance. He holds a Ph.D. from the University of Minnesota and a B.A. from Wesleyan University.

Michael F. Cannon

Michael F. Cannon is the Cato Institute's Director of Health Policy Studies. Previously, he served as a domestic policy analyst for the U.S. Senate Republican Policy Committee under Chairman Larry E. Craig, where he advised Senate leadership on health, education, labor, welfare, and the Second Amendment. Cannon has appeared on ABC, CBS, CNN, CNBC, C-SPAN, the Fox News Channel, and National Public Radio. His articles have been featured in *USA Today*, the *Los Angeles Times*, the *New York Post*, the *Chicago Tribune*, the *Chicago Sun-Times*, the *San Francisco Chronicle*, and the *Yale Journal of Health Policy, Law, and Ethics*. Cannon is coauthor of *Healthy Competition: What's Holding Back Health Care and How to Free It*. He holds a B.A. in American government from the University of Virginia and an M.A. in economics and a J.M. in law and economics from George Mason University.

Sabrina Corlette

Sabrina Corlette is Director of Health Policy Programs at the National Partnership for Women & Families. As such, Ms. Corlette leads the organization's efforts to promote access to quality, affordable health care and protect women's access to reproductive rights. Before joining the National Partnership, Ms. Corlette was an attorney with the law firm of Hogan & Hartson LLP, advising clients on health care issues relating to Medicare, Medicaid, health information technology, health privacy, and medical research laws and policies. Prior to joining Hogan & Hartson, Ms. Corlette served on the U.S. Senate Health, Education, Labor and Pensions Committee. There, she served as Senior Health Policy Advisor to Senator Tom Harkin (D-IA), providing guidance on short- and long-term legislative strategy, drafting legislation, and building and maintaining coalitions on health care issues. Before her tenure on Capitol Hill, Ms. Corlette served as a research assistant and speechwriter to former First Lady Hillary Rodham Clinton.

Ms. Corlette received her law degree with high honors from the University of Texas at Austin and her B.A. cum laude from Harvard University. Before law school, she spent a year in Nairobi, Kenya assisting efforts at the United States International University to develop an HIV/AIDS prevention program. She is the mother of two daughters and enjoys cooking for friends, traveling, and spending time with family.

Stan Dorn

A Senior Research Associate at the Urban Institute since July 2006, Stan Dorn is one of the nation's leading experts on Health Coverage Tax Credits, Medicaid, SCHIP, and the uninsured. Before coming to the Urban Institute, Mr. Dorn was Senior Policy Analyst at the Economic and Social Research Institute, where he focused on bipartisan strategies to cover the uninsured, including tax credit mechanisms; Director of the Health Consumer Alliance, a consortium of legal services groups that help low-income Californians obtain health care; Health Division Director at the Children's Defense Fund, where he led the organization's health policy team in a national campaign that helped pass SCHIP in 1997; Managing Attorney of the National Health Law Program's (NHeLP) Washington office, where he played a leadership role in a consumer/provider coalition that helped stop proposals in 1995-96 to repeal Medicaid and convert the program into a block grant; and Staff Attorney at NHeLP's Los Angeles office, where he helped lead litigation and legislative efforts to preserve health care services for low-income immigrants during the late 1980s.



David D. Ferreira

David Ferreira joined the United States Hispanic Chamber of Commerce (USHCC) on August 15, 2006 and serves as Vice President for Government Affairs. In this role, he has overseen the policy and legislative operations of the USHCC, worked as the principal staff lead for the 17th National Legislative Conference, and helped formulate an aggressive legislative agenda for the 110th Congress that will help align USHCC's strategic policy objectives with the current and future needs of the organization's membership.

Mr. Ferreira is an accomplished government affairs and legislative specialist with an expertise on anti-hunger/nutrition policy, federal appropriations law, authorization of infrastructure projects, city-municipal appropriations, and legislative procedure in the House of Representatives. Mr. Ferreira served the Clinton Administration as an appointee at the U.S. Department of Energy. Mr. Ferreira has also held other positions in Congress and the private sector. A native of Santurce, Puerto Rico, Mr. Ferreira received his degree in international economics/affairs from The George Washington University. He serves on the board of directors of the Hispanic Lobbyists Association and is a member of various civic groups.

Cheryl Fish-Parcham

Cheryl Fish-Parcham is Deputy Director of Health Policy at Families USA, a national organization for health care consumers. Her current areas of focus are private insurance and state initiatives to cover the uninsured. Previously, she helped to form a national support center for consumer health assistance programs and provided technical assistance on Medicaid issues. She is the author of numerous reports on designing consumer health assistance programs, the plight of the uninsured, and on Medicaid and private insurance.

In addition to her national work, Cheryl is active in health care advocacy in the District of Columbia. She helped draft Washington DC's Health Care Member Bill of Rights Law and the DC Health Care Ombudsman Law, and she provides training to local groups on various health insurance issues. Earlier in her career, Ms. Fish-Parcham worked as an advocate at AARP's Legal Counsel for the Elderly and as a social worker in various community organizations in the District of Columbia. She holds an M.S.W. from Howard University.

Catherine Hoffman

Catherine Hoffman is Senior Researcher and Associate Director of the Kaiser Commission on Medicaid and the Uninsured, based in Washington, DC. Most of her current research, writing, and public speaking focus on health insurance disparities. She has published on topics spanning health insurance disparities in access to care, racial and ethnic health disparities and their causes, the prevalence and costs of chronic conditions in the United States, and nursing reimbursement policies, as well as created numerous chart books on health insurance coverage in America.

Dr. Hoffman builds her policy research on a foundation of 14 years in nursing, largely spent as a clinical nurse specialist in cardiac care. During this time, her volunteer work led to a number of local, state, and national leadership positions within the profession, and she has been awarded for her contributions both at the state and national level. Serving on the founding board of the Napa County Children's Health Initiative and now as its Vice President, Dr. Hoffman's recent volunteer work focuses on the health insurance coverage of children.



Sam Jammal

Sam Jammal is a Legislative Staff Attorney with the Mexican American Legal Defense and Educational Fund (MALDEF) in Washington, DC. Mr. Jammal has been with MALDEF since August 2007. His current policy focus is on health care, language access, juvenile justice, and employment. Mr. Jammal received his J.D. from The George Washington University Law School in 2007 and graduated from the University of Southern California with a B.A. in Political Science in 2004.

Prior to joining MALDEF, Mr. Jammal clerked at a law firm in Washington, DC and on Capitol Hill. He also sat on the board of the American Bar Association (ABA) Law Student Division as Division Delegate to the ABA House of Delegates. In law school, Mr. Jammal served as President of the Student Bar Association (SBA) and was awarded SBA President of the Year by the ABA in August 2007. Mr. Jammal was also a member of the Oxford Press International Law in Domestic Courts online journal.

Jennifer Ng'andu

Jennifer Ng'andu joined the National Council of La Raza in 2004. In her capacity as Associate Director of the Latino Health Policy Project, Ms. Ng'andu leads efforts to improve the health status of Latinos. She does this by advancing federal health proposals that address injustices in health care for Latinos. Specifically, Ms. Ng'andu concentrates on achieving parity in health care by increasing health coverage in the Latino community and improving access to quality health care.

As part of her work to enhance public health, Ms. Ng'andu strengthens antipoverty initiatives and federal nutrition programs. In December 2006, she coauthored *Sin Provecho: Latinos and Food Insecurity*, raising the profile of hunger in the Latino community. Ms. Ng'andu's media credits include a broad spectrum on radio, print, and television media, including *The New York Times*, BBC, and *The Washington Post*.

Outside of her work at NCLR, Ms. Ng'andu also engages in other activities to strengthen health care in the U.S. Currently, she sits on the National Physicians Alliance Board of Directors and Council of Consumers to encourage service, integrity, and advocacy among the medical professions. She is also a board member of the Herndon Alliance, an organization dedicated to the dissemination of information that ensures that advocates can pursue strategies to make health care affordable and accessible for all Americans.

Prior to joining NCLR, Ms. Ng'andu worked at the National Immigration Law Center and helped to advance legislation that improved health and social services for low-income immigrants and increased educational opportunities for immigrant students. Ms. Ng'andu holds a B.S. in psychology from Duke University.

Rea Pañares

Rea Pañares is Director of Minority Health Initiatives at Families USA, a national nonprofit organization dedicated to the achievement of high-quality, affordable health care for all Americans. In this role, she analyzes the impact of health policies and proposals on racial and ethnic minorities' access to health care, develops tools and resources to build institutional capacity within communities of color, and raises awareness about minority health policy issues among key stakeholders, including members of the media and elected officials.

Prior to this position, she was a program associate at Grantmakers In Health (GIH), a nonprofit educational organization dedicated to helping foundations and corporate giving programs improve the



nation's health. Ms. Pañares was responsible for leading GIH's work in the areas of racial and ethnic health disparities, including language access, immigrant health, and the social determinants of health. She was also involved with projects related to foundation support for public policy and advocacy, public health, and environmental health. Prior to joining GIH, Ms. Pañares served as Manager at the Washington Business Group on Health (now the National Business Group on Health), the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services), and the Women and Children's Health Policy Center at the Johns Hopkins School of Public Health.

Ms. Pañares holds an M.A. in health policy and management from the Johns Hopkins School of Public Health and a B.A. in molecular and cell biology from the University of California, Berkeley.

Elena V. Rios

Elena Rios serves as President and CEO of the National Hispanic Medical Association (NHMA), representing Hispanic physicians in the United States. The mission of the organization is to improve the health of Hispanics. Dr. Rios also serves as President of NHMA's National Hispanic Health Foundation, affiliated with the Robert F. Wagner Graduate School of Public Service, New York University, to direct educational and research activities. Dr. Rios also serves on the National Hispanic Leadership Agenda and the Partnerships for Prevention boards of directors and is chair of the National Coalition on Hispanic Health. Dr. Rios has lectured, published articles, and received several leadership awards.

Prior to her current positions, Dr. Rios served as Advisor for Regional and Minority Women's Health at the U.S. Department of Health and Human Services Office on Women's Health, Coordinator of Outreach Groups for the National Health Care Reform Task Force for the White House, and President of the Chicano/Latino Medical Association of California. Dr. Rios earned her B.A. in human biology and public administration at Stanford University in 1977, M.S.P.H. at the University of California School of Public Health in 1980, and M.D. at the UCLA School of Medicine in 1987.

Kara D. Ryan

Kara Ryan is Research Analyst for the Latino Health Policy Project at the National Council of La Raza. Since joining NCLR in 2007, Ms. Ryan has worked to eliminate health disparities in the U.S., particularly the unequal access to health coverage and care that ultimately places working Latino families at greater risk for poor health outcomes and financial instability. Through research and analysis, she supports NCLR's efforts to advance federal health proposals that provide Hispanics with equitable access to quality care.

Prior to joining NCLR, Ms. Ryan worked in both the policy and legal fields on tax, health, and insurance matters. As Research Associate with the Campaign Finance Institute, she coauthored a discussion paper, "Nonprofit Interest Groups' Election Activities and Federal Campaign Finance Policy," which was published in the *Exempt Organization Tax Review*. In 2006, she published a policy analysis, "Uniformly Protecting U.S. Workers from the Risks of Second-Hand Smoke Exposure," in *Policy Perspectives*, a journal of the School of Public Policy and Public Administration at The George Washington University. Ms. Ryan also worked as a paralegal in reinsurance law for a large firm in Washington, DC. In this capacity, she acted as an authorized representative for HIV positive clients of the Whitman-Walker Clinic's legal services program.

Ms. Ryan holds a Master of Public Policy from The George Washington University in Washington, DC and a B.A. in political science from Wheaton College in Norton, Massachusetts.

