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HEALTH TAX INCENTIVES: HEALTHY CHOICES OR BAD MEDICINE?

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INTRODUCTION

Millions of families in the United States do not have adequate access to the medical care and services that are essential to maintaining good health. In the face of this growing problem, many Americans have come to view health care reform as essential to sustaining their families' well-being. Central to nearly all reform proposals is health insurance, and for good reason. While health coverage does not guarantee good health outcomes, research has shown that it substantially improves access to the health care system. Furthermore, mounting evidence suggests that health coverage also plays a key factor in the quality of health care that one receives.

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By any measure, the Hispanic* community, the most uninsured ethnic group in the U.S., has an enormous stake in proposals that create new conduits to obtaining health insurance. However, the broad policy changes that would restructure the health care system are unlikely to happen overnight, and 15 million uninsured Latinos† cannot afford to put their health on the line any longer. Proposals that are designed to provide health coverage options outside of the dominant systems may hold promise. One set of such proposals, known collectively as health tax incentives, would use the federal tax system to provide individuals with resources to purchase health insurance for themselves and their families. Many health tax incentive proposals expand access to the private market outside of the employer-based system to the direct-purchase, nongroup health insurance market, which remains relatively untapped by most Americans.

Previous analyses of health tax incentives have considered their potential impact on various stakeholders, such as business entities, workers, taxpayers, and health care providers. To date, however, the literature has not included an evaluation of how these models could affect the Latino community. Accordingly, this issue brief will examine whether health tax incentives could close the health coverage gap for this group by reviewing three prominent proposals—health insurance tax credits, a health insurance standard deduction, and health savings accounts—and examining how they might be designed to help Latinos and their families access new forms of coverage. This analysis should inform policymakers and advocates committed to incorporating the Latino perspective on health tax incentives into the debate.

LATINOS FACE A HEALTH COVERAGE GAP.

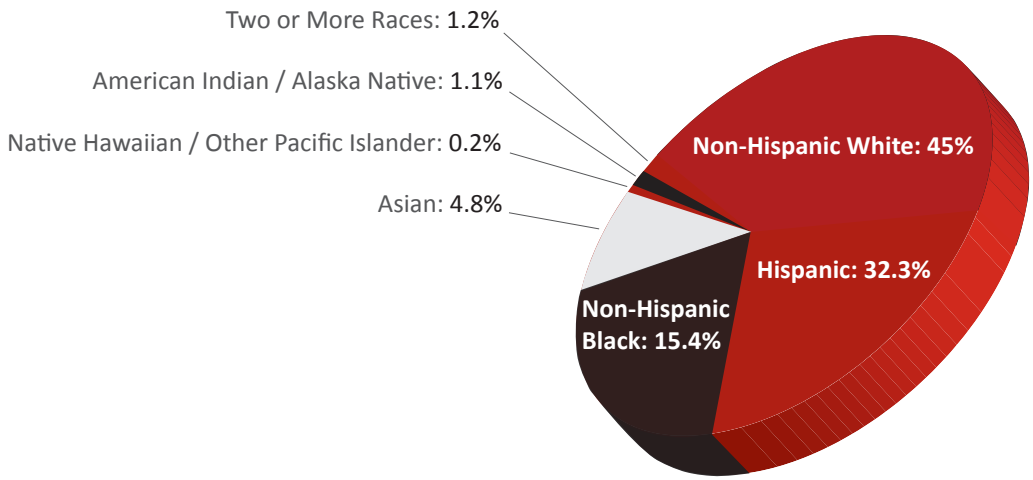
For many Latino families, health insurance is out of reach. In 2007, Hispanics composed about one in seven (15.4%) U.S. residents but nearly one in three (32.3%) uninsured individuals (see Figure 1).[1] This disproportionate representation reflects a health coverage gap between Hispanics and non-Hispanics, particularly non-Hispanic Whites (see Table 1). Overall, Hispanics were about three times more likely (32.1%) than Whites (10.4%) to be uninsured. U.S.-born Hispanics were roughly two times more likely (21.2%) than their non-Hispanic White counterparts (10.2%) to go without coverage. The gap also persists among noncitizens, who have higher rates of uninsurance than U.S. citizens across all races and ethnicities. More than half (57.6%) of Hispanic noncitizens

* 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.

† Estimates from the U.S. Bureau of the Census' *Current Population Survey* do not include the 3.9 million residents of Puerto Rico.

FIGURE 1

UNINSURED POPULATION BY RACE/ETHNICITY, 2007



Source: NCLR calculation using data from U.S. Bureau of the Census, "2007 Annual Social and Economic Supplement," *Current Population Survey.* Conducted by the Bureau of the Census for the Bureau of Labor Statistics. Washington, DC, 2008, http://www.census.gov/hhes/www/cpstc/cps_table_creator.html (accessed December 2008).

TABLE 1

UNINSURED POPULATION BY RACE/ETHNICITY AND NATIVITY, 2007

	Non-Hispanic White (%)	Non-Hispanic Black (%)	Hispanic (%)	Asian (%)
U.S.-born	10.2	18.6	21.2	13.4
Naturalized Citizen	10.5	19.2	27.1	14.1
Noncitizen	21.8	34.6	57.6	23.0
Overall	10.4	19.3	32.1	16.7

Source: NCLR calculation using data from U.S. Bureau of the Census, "2007 Annual Social and Economic Supplement," *Current Population Survey.* Conducted by the Bureau of the Census for the Bureau of Labor Statistics. Washington, DC, 2008, http://www.census.gov/hhes/www/cpstc/cps_table_creator.html (accessed December 2008).

had no health coverage at any point in the year, nearly three times the rate of White noncitizens (21.8%).[2]

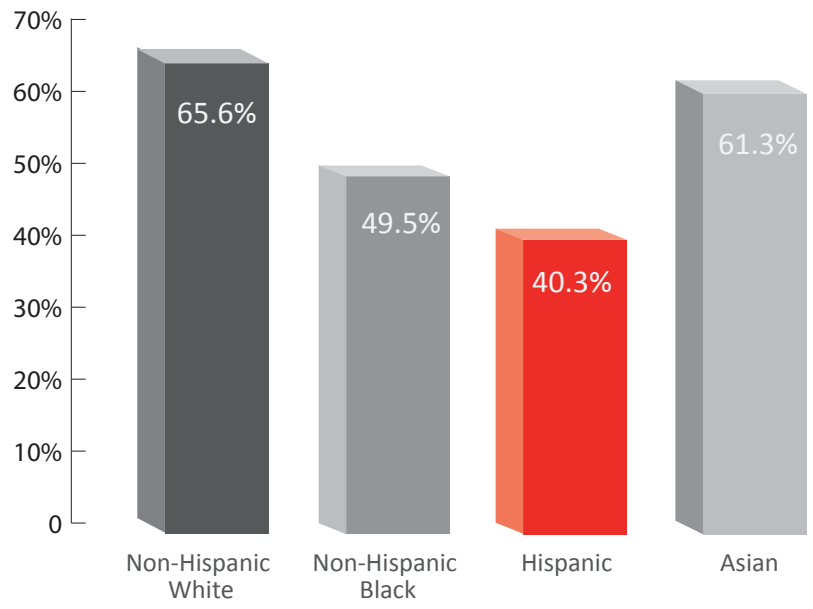
PREVAILING PRIVATE AND PUBLIC COVERAGE CHANNELS ARE CLOSED TO MANY LATINOS.

A coverage gap exists because the dominant health coverage systems—employer-based private coverage and public safety-net programs—are inaccessible to many Latinos. The most common way that Americans obtain health insurance is through their jobs; however, Hispanic workers and their families are much less likely than non-Hispanics to be covered by employer-sponsored insurance (ESI). Likewise, while federal programs such as Medicaid and the State Children's Health Insurance Program (SCHIP) provide safety-net coverage for millions of Latinos, not all uninsured Latinos qualify for public health insurance. With virtually no reasonable alternatives available, many Latino families go uncovered.

Despite their robust participation in the workforce, Hispanics are less likely than non-Hispanics to have employer-based health coverage. In 2007, just 40.3% of

FIGURE 2

INDIVIDUALS WITH EMPLOYER-SPONSORED INSURANCE BY RACE/ETHNICITY, 2007



Source: NCLR calculation using data from U.S. Bureau of the Census, "2007 Annual Social and Economic Supplement," *Current Population Survey.* Conducted by the Bureau of the Census for the Bureau of Labor Statistics. Washington, DC, 2008, http://www.census.gov/hhes/www/cpstc/cps_table_creator.html (accessed December 2008).

all Hispanics—including both workers and dependent family members—had workplace coverage, compared to 65.6% of non-Hispanic Whites, 61.3% of Asians, and 49.5% of non-Hispanic Blacks (see Figure 2).[3] Narrowing the focus to employed persons (covered by their own ESI policies or those of others) reveals that coverage rates differ by race/ethnicity and nativity (see Table 2). Overall, just more than half (51%) of employed Hispanics were covered by ESI, compared to about three-quarters of Whites (76.6%) and Asians (71.2%) and about two-thirds (67.5%) of Blacks. Yet while 64.1% of U.S.-born Hispanic citizens and 61.8% of naturalized citizens were covered by ESI—rates that are still lower than those of their non-Hispanic peers—only 31.3% of Hispanic noncitizens had employer coverage, compared to 64.6% of White, 54.7% of Black, and 66.8% of Asian noncitizens. The ESI disparity seems to be largely explained by an employer offer gap. For example, Hispanics are more likely to be employed than Blacks or Whites,* but they are less likely to work in firms that offer ESI to employees. In a study by the Kaiser Commission on Medicaid and the Uninsured, researchers found that in 2005, 64.9% of Hispanics worked for an employer that offered ESI, compared to 85.9% of non-Hispanic Black and 87.7% of non-Hispanic White workers.[4] Yet when employers did offer ESI, Hispanics were as likely as non-Hispanic workers to be eligible for the benefit and they took up coverage at similar rates (see Table 3).[5] Moreover, research indicates that Hispanic workers were disproportionately affected by recent declines in employer sponsorship. Between 2001 and 2005, the percentage of workers whose employers offered ESI dropped by 2.3%. The

TABLE 2

EMPLOYED INDIVIDUALS COVERED BY EMPLOYER-SPONSORED INSURANCE BY RACE/ETHNICITY AND NATIVITY, 2007

	Non-Hispanic White (%)	Non-Hispanic Black (%)	Hispanic (%)	Asian (%)
U.S.-born	76.9	68.0	64.1	73.0
Naturalized Citizen	71.7	72.6	61.8	73.9
Noncitizen	64.6	54.7	31.3	66.8
Overall	76.6	67.5	51.0	71.2

Source: NCLR calculation using data from U.S. Bureau of the Census, "2007 Annual Social and Economic Supplement," *Current Population Survey.* Conducted by the Bureau of the Census for the Bureau of Labor Statistics. Washington, DC, 2008, http://www.census.gov/hhes/www/cpstc/cps_table_creator.html (accessed December 2008).

* In 2007, the Hispanic workforce participation rate was 68.8%, compared to 66.4% for non-Hispanic Whites and 63.7% for non-Hispanic Blacks. Among Hispanics, the foreign-born were even more likely to participate in the labor force (71.3%) than native citizens (66%). See U.S. Bureau of the Census, *Current Population Survey,* Table 3, "Employment status of the civilian noninstitutional population by age, sex, and race," and Table 4, "Employment status of the Hispanic or Latino population by age and sex." Conducted by the Bureau of the Census for the Bureau of Labor Statistics. Washington, DC, 2008. See also U.S. Department of Labor, "Foreign-Born Workers: Labor Force Characteristics in 2007," Table 1, news release, March 26, 2008, http://www.bls.gov/news.release/pdf/forbrn.pdf (accessed December 2008).

TABLE 3

EMPLOYER-SPONSORED INSURANCE OFFER, ELIGIBILITY, TAKE-UP, AND COVERAGE RATES BY RACE/ETHNICITY OF WORKERS, 2005				
	Workers whose employers offer ESI (%)	Workers eligible for ESI when firms offer coverage (%)	Workers who take up ESI when eligible (%)	Workers with ESI coverage (own or dependent) (%)
Non-Hispanic White	87.7	93.6	83.9	82.8
Non-Hispanic Black	85.9	92.9	82.8	72.7
Hispanic	64.9	92.6	78.7	54.0
Other, non-Hispanic	82.9	93.7	83.6	76.5

Source: Lisa Clemans-Cope and Bowen Garrett, *Changes in Employer-Sponsored Health Insurance Sponsorship, Eligibility, and Participation: 2001 to 2005* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2006), Table 12.

decline for Hispanic workers (4.4%) was more than twice the decline for White (1.8%) and Black (1.2%) workers, a statistically significant difference.[6]

Although employment patterns and household income are factors that correlate with having health insurance, coverage disparities persist between comparable non-Hispanic White and Hispanic families. Experts have posited that one reason for Latinos' low ESI rate may be attributed to their employment in small businesses that cannot afford to extend health coverage offers to their employees.[7] However, in 2007, similar shares of Hispanic and non-Hispanic White workers were employed in firms with fewer than 25 employees (36.2% and 29.1%, respectively).[8] Despite this, 57.8% of Hispanic workers in firms of that size went uninsured, about two-and-a-half times (21.9%) the rate of White workers.[9] Moreover, Hispanic workers are more likely than non-Hispanic White, Black, and Asian workers to go uninsured at every firm size (see Table 4).[10]

TABLE 4

UNINSURED WORKERS (AGES 18–64) BY FIRM SIZE AND RACE/ETHNICITY, 2007				
	Non-Hispanic White (%)	Non-Hispanic Black (%)	Hispanic (%)	Asian (%)
Fewer than 25 employees	21.9	40.7	57.8	33.1
25 to 99 employees	13.0	28.0	42.6	18.9
100 to 499 employees	9.0	21.0	33.9	13.0
500 to 999 employees	7.2	22.1	26.0	10.1
1,000 or more employees	7.8	15.5	21.6	9.2
Total	12.7	23.4	39.8	17.8

Source: NCLR calculation using data from U.S. Bureau of the Census, "2007 Annual Social and Economic Supplement," *Current Population Survey* . Conducted by the Bureau of the Census for the Bureau of Labor Statistics. Washington, DC, 2008, Table HI01, http://pubdb3.census.gov/macro/032008/health/h01_000.htm (accessed December 2008).

Many Latinos without access to ESI are covered by public safety-net programs, but not all are able to participate in them. According to U.S. Census estimates, more than one-fifth (22.5%) of all Latinos had coverage through Medicaid or SCHIP in 2007.[11] Yet because Medicaid and SCHIP are designed to reach only certain populations (such as children, the disabled, pregnant women, and the elderly), Hispanics who do not fall under these categories—such as childless adults—are less likely to have public coverage.[12] Furthermore, Hispanic noncitizens without ESI often do not have access to safety-net programs, as evidenced by the fact that 47.9% of U.S.-born Hispanics without ESI were covered by Medicaid or SCHIP in 2007,* compared to 15.7% of Hispanic noncitizens without employer coverage (see Table 5).[13] These data reflect the significant restrictions to federal health coverage programs for both legal and undocumented immigrants.[14] For example, researchers estimate that more than 400,000 legal immigrant children in the U.S. live in income-eligible families but do not qualify for coverage due to a five-year bar that prevents recently arrived legal immigrants from enrolling in Medicaid and SCHIP.[15] Moreover, since the use of health care benefits is often perceived by immigrants to threaten the pathway to permanent residence and citizenship, families with mixed-status households—where at least one parent is a noncitizen—often feel deterred from enrolling eligible members in public programs.

HEALTH TAX INCENTIVE PROPOSALS WOULD OPEN THE DOOR TO THE NONGROUP HEALTH COVERAGE MARKET.

With conventional channels closed to so many, it is important to consider the merits of policy proposals that would facilitate Latinos' ability to buy health insurance on

TABLE 5

INDIVIDUALS WITHOUT EMPLOYER-SPONSORED INSURANCE COVERED BY MEDICAID/SCHIP BY RACE/ETHNICITY AND NATIVITY, 2007

	Non-Hispanic White (%)	Non-Hispanic Black (%)	Hispanic (%)	Asian (%)
U.S.-born	21.3	41.8	47.9	32.9
Naturalized Citizen	16.8	25.7	21.5	23.8
Noncitizen	19.9	29.7	15.7	23.1
Overall	21.1	40.8	34.2	26.5

Source: NCLR calculation using data from U.S. Bureau of the Census, "2007 Annual Social and Economic Supplement," *Current Population Survey.* Conducted by the Bureau of the Census for the Bureau of Labor Statistics. Washington, DC, 2008, http://www.census.gov/hhes/www/cpstc/cps_table_creator.html (accessed December 2008).

* These figures likely reflect the large number of Hispanic children who are covered by these programs; in 2007, nearly two-thirds (64.6%) of Hispanics covered by Medicaid or SCHIP were children under age 18. See U.S. Bureau of the Census, "2007 Annual Social and Economic Supplement," *Current Population Survey.* Conducted by the Bureau of the Census for the Bureau of Labor Statistics. Washington, DC, 2008, http://www.census.gov/hhes/www/cpstc/cps_table_creator.html (accessed December 2008).

their own. Health tax incentives encourage greater participation in the direct-purchase "nongroup" market. This experience is different from buying employer-based coverage in the "group" market, where workers join a risk pool and insurers assess the risk (and determine the price) for the overall group. In the nongroup market, individuals and family members are evaluated on their potential to incur future medical claims ("risk") and priced accordingly.[16] Another difference between the markets is the cost burden of premiums. Employers often contribute a share—sometimes sizeable—to employees' health insurance premiums, while nongroup policyholders bear 100% of their premium costs.

Few Americans currently participate in the nongroup health insurance market—just 7% of the total nonelderly population and 3.9% of all nonelderly Hispanics had direct-purchase coverage in 2007.[17] A RAND Corporation study found that people who are self-employed (whose premiums are tax-deductible) or who have higher incomes are more likely to purchase individual coverage.[18] Currently, Hispanics are less likely than non-Hispanics to have nongroup coverage, regardless of nativity. Table 6 shows that among the nonelderly population, Hispanic citizens—both U.S.-born (4.5%) and naturalized (5%)—were more likely than Hispanic noncitizens (2.8%) to have direct-purchase coverage in 2007. Hispanic noncitizens were also less likely than non-Hispanic noncitizens—particularly Whites and Asians—to have nongroup health insurance.

To evaluate whether health tax incentives are appropriate solutions for the Latino community, it is useful to understand the common characteristics of the nongroup market and how its structure affects access to health coverage. Under practices called "individual underwriting," insurers in the nongroup market assess the financial risk of insuring each individual through application processes, sometimes requiring medical exams or other evidence of health status.[19] Factors that play a role in determining policy prices include age, sex, and health status. Insurers may exclude coverage for preexisting

TABLE 6

NONELDERLY PERSONS COVERED BY DIRECT-PURCHASE HEALTH INSURANCE BY RACE/ETHNICITY AND NATIVITY, 2007

	Non-Hispanic White (%)	Non-Hispanic Black (%)	Hispanic (%)	Asian (%)
U.S.-born	8.0	4.1	4.5	6.6
Naturalized Citizen	12.2	5.0	5.0	9.6
Noncitizen	10.2	5.8	2.8	8.3
Overall	8.2	4.2	3.9	8.4

Source: NCLR calculation using data from the U.S. Bureau of the Census, "2007 Annual Social and Economic Supplement," *Current Population Survey.* Conducted by the Bureau of the Census for the Bureau of Labor Statistics. Washington, DC, 2008, http://www.census.gov/hhes/www/cpstc/cps_table_creator.html (accessed December 2008).

health conditions or refuse to issue coverage altogether. People without health problems at the time that they apply for coverage might be considered by underwriters to be "good" risks because they are less likely to file expensive medical claims. If they become chronically ill while insured, then they may face higher premiums when they renew their policies. People who are considered relatively "poor" risks will pay more for their coverage and may be subject to exclusions for certain services.

The nongroup market is regulated on a state-by-state basis, meaning that Latinos entering the market could have different experiences based on where they live. For example, some states have imposed regulations, such as "guaranteed issue" and "community rating" provisions, which are designed to increase access to coverage for people who would otherwise have trouble obtaining coverage under individual underwriting processes. While these regulations often expand access, opponents warn that they involve tradeoffs such as increased premiums for all policyholders, including the populations they are designed to assist.[20] Given these factors, some uninsured Latinos may find nongroup coverage unaffordable even if financial subsidies are available under a health tax incentive program.

Policymakers should also be aware that opening up the nongroup market with health tax incentives could affect access to other forms of coverage, depending on how the incentives are designed and implemented and in which markets they are made available.* To be effective, health tax incentives should address the potential disadvantages of buying insurance in the nongroup market.

TABLE 7

U.S. HISPANICS BY SOURCE OF HEALTH INSURANCE COVERAGE, 2007

	Number (in thousands)	Percent
Total	46,026	100%
Employer-Sponsored Insurance	18,551	40.3%
Medicaid/SCHIP	10,348	22.5%
Direct-Purchase	1,804	3.9%
Other	553	1.2%
Uninsured	14,770	32.1%

Source: NCLR calculation using data from U.S. Bureau of the Census, "2007 Annual Social and Economic Supplement," *Current Population Survey.* Conducted by the Bureau of the Census for the Bureau of Labor Statistics. Washington, DC, 2008, http://www.census.gov/hhes/www/cpstc/cps_table_creator.html (accessed December 2008).

* For more discussion on the impact of how the structure of health tax incentives might affect Latinos' access to coverage, see National Council of La Raza, "Healthy Choices or Bad Medicine? Health Tax Incentives Roundtable Transcript" (Washington, DC: National Council of La Raza, 2008).

TABLE 8

UNINSURED U.S. HISPANICS BY NATIVITY AND AGE, 2007		
	Number (in thousands)	Percent*
U.S-born		
Children (under 18)	2,479	16.8%
Nonelderly adults (18–64)	3,466	23.5%
Elderly adults (over 65)	24	0.2%
Total U.S.-born	5,968	40.4%
Naturalized Citizens		
Children (under 18)	42	0.3%
Nonelderly adults (18–64)	1,232	8.3%
Elderly adults (over 65)	42	0.3%
Total Naturalized Citizens	1,316	8.9%
Noncitizens		
Children (under 18)	635	4.3%
Nonelderly adults (18–64)	6,705	45.4%
Elderly adults (over 65)	146	1.0%
Total Noncitizens	7,486	50.7%
All Nativities		
Children (under 18)	3,156	21.4%
Nonelderly adults (18–64)	11,402	77.2%
Elderly adults (over 65)	212	1.4%
Grand Total	14,770	100%

* In some cases, percentages do not equal 100% due to rounding.

Source: NCLR calculation using data from U.S. Bureau of the Census, "2007 Annual Social and Economic Supplement," *Current Population Survey.* Conducted by the Bureau of the Census for the Bureau of Labor Statistics. Washington, DC, 2008, http://www.census.gov/hhes/www/cpstc/cps_table_creator.html (accessed December 2008).

A PROFILE OF UNINSURED LATINOS PROVIDES A NEW PERSPECTIVE ON HEALTH TAX INCENTIVES.

Health tax incentives may offer resources to a number of Latino families, including those that have insurance. Yet in order to evaluate these models' potential to truly narrow the coverage gap, one must take a closer look at the characteristics of the uninsured Latino community. As Table 7 shows and Table 8 further details, 14.8 million Hispanics had no form of health insurance in 2007. About half (7.5 million) were noncitizens, 40% (six million) were U.S.-born, and 9% (1.3 million) were naturalized citizens. While nonelderly adults make up the bulk of the uninsured Latino community, children also represent a substantial share. To identify how a tax incentive proposal might reach the widest number of uninsured Latinos, one should consider these and other relevant factors that would affect the proposal's ability to target these families.

Family Characteristics and Age

When Latino workers have limited access to workplace coverage, their families are also less likely to be covered by ESI. As a result, uninsured Latinos are overwhelmingly concentrated in families (see Table 9). More

TABLE 9

UNINSURED HISPANICS BY FAMILY TYPE, 2007			
	Example	Number (in thousands)	Percent*
Primary Family: Two or more related persons residing together	Married couple and children living together	12,163	82.3%
Primary Individual: Householder residing alone	Single man living alone	918	6.2%
Unrelated Subfamily: Two or more related persons residing with but not related to householder	Married couple living as roommates of householder	95	0.6%
Secondary Individual: Individual residing with but not related to householder	Single man living as roommate of householder	1,594	10.8%
Total		14,770	100%

* In some cases, percentages do not equal 100% due to rounding.

Source: NCLR calculation using data from U.S. Bureau of the Census, "2007 Annual Social and Economic Supplement," *Current Population Survey.* Conducted by the Bureau of the Census for the Bureau of Labor Statistics. Washington, DC, 2008, http://www.census.gov/hhes/www/cpstc/cps_table_creator.html (accessed December 2008).

TABLE 10

UNINSURED INDIVIDUALS BY AGE AND RACE/ETHNICITY, 2007				
	Non-Hispanic White (%)	Non-Hispanic Black (%)	Hispanic (%)	Asian (%)
Ages 0–17	7.3	12.2	20.0	11.5
Ages 18–64	13.7	25.0	41.1	19.7
Ages 65 and over	1.0	2.9	8.3	7.8
Overall	10.4	19.3	32.1	16.7

Source: NCLR calculation using data from U.S. Bureau of the Census, "2007 Annual Social and Economic Supplement," *Current Population Survey.* Conducted by the Bureau of the Census for the Bureau of Labor Statistics. Washington, DC, 2008, http://www.census.gov/hhes/www/cpstc/cps_table_creator.html (accessed December 2008).

than four in five (82%) uninsured Hispanics live in primary families, with two or more related people living in the same household. Moreover, the average size of an Hispanic household (3.34 people) is larger than that of a non-Hispanic White household (2.41 people).[21] Therefore, proposals that facilitate the ability of people to obtain coverage for their whole families show the most promise in effectively reducing Latinos' uninsurance.

Hispanics are more likely than non-Hispanics to be uninsured in every major age group (see Table 10). Among nonelderly adults, Hispanics are more than eight times more likely (8.3%) to be uninsured than non-Hispanic Whites (1%). Hispanic children are also considerably more likely to go without health coverage for the full year than non-Hispanic children; one in five Hispanic children (20%) was uninsured in 2007, compared to about one in thirteen (7.3%) White children. Among adults over age 65—who generally have very low levels of uninsurance due to their eligibility for Medicare—Hispanics are more than eight times more likely (8.3%) to be uninsured than non-Hispanic Whites (1%). While it is critical for health tax incentives to target working-age Hispanics who are less likely than their non-Hispanic peers to have employer-based coverage, proposals must also reach their family members and dependents. More than one in five (21.4%) of all uninsured Hispanics are children.[22] Health tax incentive proposals will be ineffective at closing the coverage gap if the families of uninsured dependents are unable to access the benefit.

Work and Income

Uninsured Latinos are likely to live in working families with low-to-moderate levels of income. Of the total 14.8 million uninsured Hispanics in 2007, 2.5 million were minors under age 15, and of the remaining 12.2 million, 8.5 million (70%) were employed during the year (see Table 11). Nearly half (47.7%) of uninsured Latinos worked full-time for all or part of the year. In fact, full-time, year-round workers made up the largest portion of uninsured Latinos (36.6%). Although uninsured Latinos are working, most are living in low-income households (see Table 12). More than one-quarter (27.4%) of uninsured Hispanics have household incomes below the federal poverty level (FPL). Nearly

TABLE 11

UNINSURED HISPANICS BY WORK EXPERIENCE, 2007		
Work Experience	Number (in thousands)	Percent
Worked full-time, year-round	5,418	36.7%
Worked full-time, part-year	1,622	11.0%
Worked part-time, year-round	812	5.5%
Worked part-time, part-year	707	4.8%
Did not work	3,669	24.8%
Not of working age (under 15)	2,542	17.2%
Total	14,770	100%

Source: NCLR calculation using data from U.S. Bureau of the Census, "2007 Annual Social and Economic Supplement," *Current Population Survey.* Conducted by the Bureau of the Census for the Bureau of Labor Statistics. Washington, DC, 2008, http://www.census.gov/hhes/www/cpstc/cps_table_creator.html (accessed December 2008).

TABLE 12

UNINSURED HISPANICS BY INCOME-TO-POVERTY RATIO, 2007			
Household Income as Percent of Federal Poverty Level (FPL)	2007 Income Threshold (for a family of three)	Number (in thousands)	Percent
Below 100% of FPL	Below $17,170	4,037	27.4%
Between 100% and 200% of FPL	$17,171–34,340	5,425	36.8%
Between 200% and 300% of FPL	$34,341–51,510	2,926	19.9%
Over 300% of FPL	Over $51,510	2,352	16.0%
Total		14,740*	100%

* In this calculation, the U.S. Bureau of the Census omits unrelated individuals under the age of 15. Thus, this total differs slightly from other totals given.

Source: NCLR calculation using data from U.S. Bureau of the Census, "2007 Annual Social and Economic Supplement," *Current Population Survey.* Washington, DC, 2008, http://www.census.gov/hhes/www/cpstc/cps_table_creator.html (accessed December 2008).

two-thirds (64.2%) live below 200% of the FPL, the common definition for low-income households.[23]

Because uninsured Hispanics are likely to hail from low-income households, they are also likely to need more than a nominal subsidy to purchase and maintain coverage under health tax incentive proposals. There are different ways to think about whether health tax incentives are making coverage affordable for the target group. One important factor is the value of the benefit in relation to the price of a policy in the nongroup market. Another is timing—a delay between the date that one purchases health coverage and the date one receives the subsidy would create a barrier for families without the financial means to purchase coverage up front and wait for reimbursement. Finally, an evaluation of affordability should consider the out-of-pocket health care expenses

of newly insured families. One study defines people with health coverage as "underinsured" if their health care out-of-pocket expenses exceed 10% of household income (or 5% of income for families living below 200% the FPL).[24] Health tax incentive proposals that target the needs of low- and moderate-income families will have greater impact on reducing uninsurance in the Latino community.

Eligibility and Participation

The opportunities and challenges that existing federal tax-based programs hold for Latinos are good indicators of the features that would be relevant for health tax incentive models. Although the Internal Revenue Service (IRS) does not collect data on filers' race or ethnicity, anecdotal evidence and polling data reveal some insight into Latinos' tax filing behaviors. For example, Latinos report filing their income tax returns at similar rates as non-Hispanics. One recent poll by Encuesta, Inc. asked a nationally representative sample of individuals about their experiences in filing tax returns and found that Hispanics and non-Hispanics were just as likely to report filing or intending to file their returns for that year. In fact, the vast majority of Hispanics (86.9%) and non-Hispanics (93.2%) reported filing returns for the previous year.[25] These data suggest that Hispanics are as likely as non-Hispanics to be engaged with the federal tax system.

One of the most salient questions for these proposals is whether Latinos living in immigrant families will be able to participate. Half (7.5 million) of uninsured Latinos are noncitizens, which means that any exclusions applied to this population would greatly decrease Hispanic participation in a tax benefit program. Excluding noncitizens from participation shrinks the potential to reach Latinos by half—from the 14.8 million total uninsured to the 7.3 million citizens who were either born in the U.S. or naturalized.[26] Yet this estimate is conservative, since Hispanics are likely to live in households with mixed immigration status in addition to mixed work authorization status. For some tax-based programs, such as the Earned Income Tax Credit (EITC), an entire household may be deemed ineligible for the benefit if one family member is restricted from participation. For instance, in a household where a legal immigrant without work authorization is married to a U.S. citizen, the household cannot claim the EITC. In addition to excluding non-work-authorized adults, this requirement disqualifies any family member in the household from receiving the benefit—including citizen and noncitizen children. The effect of such an eligibility standard is potentially devastating. In 2007, Jeffrey Passel of the Pew Hispanic Center estimated that there were 2.7 million mixed-status families living in the U.S.,[27] and it is reasonable to assume that many of these families are Hispanic. If health tax incentives were to adopt similar eligibility standards, then only a fraction of uninsured Latinos would have access to new coverage options.

For these reasons, it is critically important that eligibility for participation in any health tax incentives program be designed with eligibility standards that ensure the greatest opportunity for individuals to purchase health coverage. Without this consideration, the program's impact would be severely limited.

English Proficiency

Latinos who stand to benefit from a new health tax incentive program must be notified that the option is available to them, and they must understand their rights and responsibilities as participants. Limited-English-proficient (LEP) Latinos—as well as some bilingual Latinos who are competent in English but more comfortable speaking Spanish—require outreach and information that are linguistically appropriate. The Census Bureau estimates that of the 40.5 million U.S. Latinos age five and over in 2007, about 31.5 million (77.6%) spoke Spanish at home.[28] Of these Latinos, only about 15.8 million (50.1%) spoke English "very well."[29] The remainder, an estimated 15.7 million, spoke English "less than very well," the generally accepted measure of limited English proficiency.[30]

While it is difficult to estimate the portion of uninsured Latinos with limited English proficiency, there is reason to believe that the uninsured population includes a substantial number of LEP individuals. Research shows that LEP Latinos are more likely than English-proficient Latinos to experience uninsurance. A nationally representative study using data from the most recent Medical Expenditure Panel Survey (MEPS) found that in 2004, LEP Hispanics were about twice as likely (59.6%) to be uninsured as English-proficient Hispanics (29.4%).[31] Given that a large share of uninsured Latinos are likely to be LEP, policies that do not include linguistically appropriate outreach and information will have limited impact. For example, in a study of parents who were applying for Medicaid for their eligible children, nearly half (46%) of the Spanish-speaking parents did not complete the application process because materials were only available in English.[32] The effectiveness of health tax incentives for the Latino community depends on the extent to which policymakers and administrators provide bilingual resources that present information in an accessible way.

HEALTH TAX INCENTIVES PRESENT OPPORTUNITIES AND CHALLENGES FOR COVERING LATINOS.

As noted above, there are 14.8 million uninsured Hispanics in the U.S. They are likely to live in low-income, working households, and they are just as likely to be noncitizens as citizens (by birth or naturalization). They tend to live in families, with working-age adults most likely to lack coverage but children and elderly family members also going uninsured. Finally, while many uninsured Latinos are English-proficient, a number may be assumed to be LEP. These characteristics are important considerations for the analysis of health tax incentive proposals that follows.

Health Insurance Tax Credits

Health insurance tax credits would subsidize an individual's purchase of self or family health insurance, primarily in the nongroup market. Claiming the credit on one's tax return would reduce the amount of tax that the filer owes to the government, leaving the filer with more income and offsetting some portion of the cost of his or her insurance premium. Yet tax credits would be little help for Latinos who have low or no tax liability, meaning that they owe little or no income tax under a progressive tax system. This issue could be resolved by making the tax

credits refundable. A refundable credit allows a filer to receive the entire credit amount, even if his or her tax liability is lower than the credit value; the filer receives the remainder as a refund. If credits are not refundable, the probability of reaching the majority of Hispanics in the target group is low.

The potential of a refundable tax credit to help uninsured Latinos also depends substantially on the price range for nongroup policies based on the current market structure. The credit value could be a flat dollar amount or a portion of the filer's health coverage premiums, and one cannot know which value is greater to the filer without knowing the price of the plan. For example, as one analysis explains, if policies were to range from $1,200 to $2,500, then a tax credit for $1,000 will provide greater assistance than a credit that pays 50% of the premium.[33] In the nongroup market, premiums are based on individual assessments of risk based on factors such as age, sex, and health status. Currently, people who already suffer from chronic illness at the time they seek nongroup health insurance are more likely to pay much higher premiums (if they can obtain coverage at all) than people without a history of illness.[34] Tax credits need to be tied to the true costs of health care plans. However credits are structured—as a set dollar amount or as a proportional rate of premiums—they will not reduce uninsurance in the Latino community if they ultimately fail to make premiums affordable. The time at which Latinos would collect the subsidy is also important. If a tax credit were structured like the EITC, then the credit amount for the tax year would be refunded after tax returns have been filed within the first four months of the following year.* With lower incomes and fewer assets, most uninsured Latinos are likely to need cash assistance at the time of purchase.

When looking at some of the current offerings for health tax credits, one can make rough estimates about tax credits' potential to make nongroup premiums affordable to uninsured Latinos, particularly those who are low-income, using the measure for underinsurance put forth earlier. A recent survey published by America's Health Insurance Plans (AHIP), a trade association for the health insurance industry, reports that the nationwide average for nongroup market premiums during 2006–2007 was $2,613 for single coverage and $5,799 for a family policy annually.[35] In 2007, 200% of the FPL was $34,340 for a family of three; for a household with these earnings, an average policy in the nongroup market would cost 16.9% of that family's income. If the family were to receive a $3,000 credit—one set value that has been proposed for family policies—then the premium for the same policy would be

* If a household expects to qualify for the EITC at the end of the tax year and has at least one qualifying child, then the family may be eligible for the advance EITC program. The advance program allows the taxpayer to receive the EITC incrementally throughout the year in his or her paycheck. Self-employed taxpayers are not eligible. During the tax year, if household income changes and the family is no longer eligible for EITC, the worker must notify his or her employer and stop the advance payments. For more information, see Internal Revenue Service, "Advance Earned Income Tax Credit Questions and Answers," http://www.irs.gov/individuals/article/0,,id=96515,00.html#QA1 (accessed December 2008).

8.2% of their total household income. This proportion is higher than the threshold experts have suggested as affordable for low-income families (5%), but it suggests that a more generous credit that accounts for more of the premiums and takes additional out-of-pocket costs into consideration could help to drive the cost below that affordability standard. For the median household income for Latinos in 2007—$38,679[36]—a $3,000 credit would bring the premium down to 7.2% of household income. While other factors must be taken into consideration,* this simple analysis shows that a generous and refundable credit could help make health coverage affordable for uninsured Latinos.

One can also examine health insurance tax credits that have already been implemented (on a small scale) for empirical evidence of any impact on uninsurance. The Health Coverage Tax Credit (HCTC) is one such program, although it is limited both in scope and in how closely the target population for this benefit resembles the uninsured Latino population.† The credit, available to displaced workers who lose their health insurance coverage, is refundable and covers 65% of premiums for a qualified health plan. To assess participation, the Government Accountability Office (GAO) evaluated displaced workers at five sites and found that the highest HCTC participation rate at any location was 12%.[37] Similarly, the Urban Institute calculated that between 13% and 21% of eligible individuals took up the credit in 2005.[38] This low take-up rate, researchers believe, is likely attributable to problems with affordability or liquidity (having enough money readily available to pay premiums when they are due). The credit is proportional so that policyholders pay the remaining 35% of premiums; the affordability of this cost-sharing level depends on the cost of the policy purchased. Families must also foot the entire bill for the first several months of coverage before the IRS begins payment, unless their states have programs in place to fill the gap.[39] The HCTC experience suggests that providing low-income Latino families with the subsidy amount up front would be critical to tax credits' effectiveness.

Assuming that health tax incentives would have broad eligibility criteria, informational barriers must still be overcome. For example, if Latinos' experiences with the EITC are any indication of health tax incentives' potential to reach eligible Latinos, then any proposal's impact will be limited without significant outreach efforts. In 2006, according to Census data, 21.9% of Hispanics were eligible for the EITC, compared to 29.3% of Blacks and 15.6% of non-Hispanic Whites.[40] While we do not know how many families claimed the credit,

* For instance, there is wide variation in plans according to the location and demographic makeup of the policyholder. Additionally, these premiums only reflect the cost of policies that have been written, which may or may not incorporate costs of premiums for plans that are not taken up. Based on this fact, the actual average may skew lower or higher.

† The Health Coverage Tax Credit is restricted 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. Qualifying plans include Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) coverage.

there is reason to believe that the take-up rates among Hispanics are lower than among non-Hispanic taxpayers. A 2001 study by the Urban Institute found that Hispanic workers were much less likely than their non-Hispanic peers to be aware of and report having received the EITC. Among Hispanics, 32% knew of the program and 18.4% had reported receiving the credit at one time, compared to 64.2% of non-Hispanics who were aware of the EITC and 43.2% who reported claiming it on their returns in the past.[41] These information barriers are likely to impede program participation to some degree among the target population. Extensive outreach in the Latino community could raise awareness of tax-based programs, and a natural partner in this effort may be the tax preparer who works within the Latino community. Encuesta, Inc. found that about one in ten (10.9%) Hispanics reported that they would prepare their tax return on their own, compared to about one in four (25.6%) non-Hispanics, and that Hispanics were nearly twice as likely (19.9%) as non-Hispanics (11%) to report planning to use an organization that would prepare their returns for free.[42] However, lay tax preparers who offer their services at low or no cost may need additional resources to stay up-to-date with the tax codes.[43]

Finally, any of these proposals should include an aggressive education component that is culturally competent, linguistically appropriate, and well-funded. Campaigns should not only raise awareness of the program's existence but also demystify these federal benefits and dispel any fear and confusion that Latinos—particularly immigrant and mixed-status families—may have about program eligibility and participation.

With appropriate design and implementation, such as the factors outlined above, health coverage tax credits could help a substantial share of the 14.8 million Latinos who are currently uninsured.

Health Insurance Standard Deduction

The employer-based system remains the dominant means of providing health insurance in part because the government heavily subsidizes it—employers' contributions to health insurance premiums are exempt from payroll and income taxes. Employers' subsidized premium contributions are not counted as taxable income for employees. In contrast, most tax filers without ESI cannot deduct their health insurance premiums from their taxable income, even if they are bearing the entire premium for a nongroup policy.[44] This structure advantages people with employer-based coverage over people who purchase coverage in the nongroup market.

Some policymakers believe that all people who buy health coverage should receive a tax benefit rather than just participants in the employer-based market. One way to accomplish this goal is to eliminate the employer tax exemption for premium contributions, count them toward employees' taxable income, and offer a standard deduction to individuals to offset the cost of their health coverage. Under this proposal, all people who purchase insurance would be able to claim a standard deduction from their taxable income. Most employees with ESI

would see their taxes reduced (leaving them with more take-home pay) if the nominal value of the deduction were set higher than the cost of most employer premiums.

While the deduction reduces a household's tax bill, the amount of the subsidy will depend on the tax bracket (and therefore the income) of the filer. The current ESI subsidy is regressive, meaning that it provides more tax benefits to the highest earners (who are taxed at a higher rate) and less to low-wage workers.[45] By the same token, a standard tax deduction is regressive because it provides the greater dollar value as earnings increase. The deduction would likely increase some Latinos' net income by reducing the amount that is subject to taxation, but it is difficult to know the amount by which disposable income increases as a result of the tax deduction, since it is dependent upon income and other components of the tax filing. Thus, it is difficult to assess how much of the cost of a nongroup policy the tax deduction would ultimately defray. For Latinos who can expect a tax refund to offset the cost of coverage, the subsidy amount in relation to the cost of premiums and medical expenses (both in the group and nongroup markets) is uncertain.

Finally, and most significantly, in many deduction proposals, tax filers must purchase health coverage before claiming the deduction on their returns. This feature raises significant concerns about affordability and liquidity for the target population. Because the leading proposal would have the deduction applied at the point at which one files his or her taxes, it could be administratively difficult to advance subsidies to Latinos who do not have enough cash on hand to pay premiums when they are due. To serve the target population, policymakers may have to design a mechanism to advance the subsidy to those who wish to purchase coverage and claim the deduction on their tax returns at a later date.

Given these considerations, the health insurance standard deduction is unlikely to make coverage accessible to Latinos who are currently uninsured, and it is more likely to affect the 18 million Latinos who are already covered by employer-based insurance.

Health Savings Accounts

Health savings accounts (HSAs) are accounts in which people can deposit pretax dollars to be later withdrawn to pay for qualified medical expenses. Currently, HSAs—as required under the Medicare Modernization Act—can only be used with certain insurance policies called high deductible health plans (HDHPs). HDHPs have lower premiums than traditional health insurance plans but higher out-of-pocket costs for policyholders, a deliberate design known as "consumer-directed care" that is structured to make policyholders more aware and potentially more accountable for the true cost of medical services. HSAs allow participants to save for the expected expenses that are not covered by their health coverage plan. HSA balances roll over, accumulating over time. They are also portable, meaning that participants can keep contributing to and using their accounts if they change jobs, as long as they continue to be enrolled in an HDHP. Employers can also contribute to employees' HSAs as a fringe benefit. Contributions are not taxed and withdrawals for qualified medical

expenses are also tax-free; withdrawals for other purposes are taxed at a 10% rate. To be eligible for an HSA, participants must purchase an HDHP that carries a minimum deductible of $1,100 for single coverage or $2,200 for family coverage and out-of-pocket maximums of $5,600 (self-only) or $11,200 (family).[46]

At this time, there is not yet enough evidence to conclude whether or not HSAs could help uninsured Latinos afford coverage. In 2006, GAO analyzed workers' participation in federal health plans shortly after HSAs were authorized and found that HSA holders were generally younger and more affluent than participants with conventional plans. Forty-three percent of HSA participants earned incomes of $75,000 or more, compared to 23% of conventional plan participants.[47] GAO confirmed this trend in a follow-up study. According to the report, "Among tax filers between the ages of 19 and 64, the average adjusted gross income for those reporting HSA activity in 2005 was about $139,000, compared with about $57,000 for other filers."[48] These data indicate that HSAs may easily reach the highest-earning uninsured Latinos but are likely to prove unaffordable for uninsured low- and moderate-income Latinos. In fact, using the 10% of income measure of affordability discussed previously, for a Latino family making the median household income in 2007—$38,679—the minimum deducible for a family policy ($2,200) would represent 5.7% of its income, but the out-of-pocket maximum ($11,200) would be nearly one-third (29%) of that income.

There is also speculation about whether delinking HSAs from HDHPs could help uninsured Latinos afford health care.[49] Delinked from HDHPs, HSAs could likely help Latino families save for expected out-of-pocket medical costs, acting as portable flexible spending accounts for use with or without conventional insurance. The tax benefits, regardless of insurance status, would help families that have the ability to save for health care expenses. However, HSAs alone cannot address the increasing affordability issues that are indicative of a broken health care system. They are insufficient by themselves to help Latinos obtain and pay for health insurance that substantially lowers the cost of medical care through both covered benefits and negotiated rates. If HSAs are implemented, they must also be paired with reforms that make insurance more affordable and accessible for Latino families.

Thus far, information about HSAs has generally come from a population that was already insured, making it difficult to estimate their impact on the uninsured Latino population. Uninsured Latinos from moderate- to high-income families, such as the 5.3 million in households earning over 200% of FPL, are more likely than poor or low-income Latinos to realize a tax benefit from their HSA and afford the cost-sharing of their HDHP. If all of these Latinos are able to become insured through HSAs, nearly ten million low-income, uninsured Latinos are likely to remain uncovered.

HIGH DEDUCTIBLE HEALTH PLANS AND ACCESS TO NEEDED CARE

High Deductible Health Plans are emerging as an alternative source of health coverage for a number of Americans. Although HDHPs continue to be associated with individual health savings accounts, these plans are increasingly promoted in many markets. In fact, GAO found that between 2005 and 2007, 42–47% of people with HSA-eligible HDHPs did not open HSAs.[50] Part of the attraction to HDHPs is the promise of affordable premiums, which may be appealing to people who cannot afford premiums for conventional plans. For this reason, uninsured Latinos might find HDHPs to be a good option under any of the health tax incentive proposals. Yet a number of health policy analysts have raised questions regarding the quality of coverage that HDHPs provide, as well as the financial burden on families who take them up.

Preliminary studies by GAO found that HDHPs have for the most part covered the same preventative services as traditional plans, including routine physical examinations and well-child visits; copayments for these services were also about the same as with traditional plans after the deductibles had been met.[51] This evidence indicates that these plans could save money for people in good health. However, there is also evidence of gaps in covered services when compared to conventional plans. For instance, in a survey of nongroup market plans, only 40.3% of HSA/MSA* family coverage plans included normal childbirth services, compared to 59.5% of family PPO/POS† plans.[52] Furthermore, recent evidence bears out a concern that coverage for HDHP holders may still not meet affordability thresholds to ensure access to necessary care; a nationally representative survey found that people enrolled in HDHPs (without HSAs) and consumer-directed health plans (HDHPs with HSAs) were more likely to skip needed care due to cost than people with conventional health care plans.[53] It is hard to measure the consistency of coverage benefits because private plans are proprietary; insurers do not have to make them available for review.

If HDHPs limit access to care and services, they may offer a false sense of security for participants. A major medical event could leave families with much higher bills than they anticipated. For example, childbirth is a common, expensive event for millions of families. One study examined the extent to which various high deductible health plans—some HSA-qualified and some not, with policies offered in group, small-group, and nongroup markets—covered maternity costs from routine prenatal care to complications related to delivery.[54] Researchers found that there was no consistency in maternity coverage offered by HDHP plans. Family out-of-pocket estimates varied depending on factors such as whether a pregnancy spanned more than one calendar year, whether an in- or out-of-network provider was used, the type of delivery (vaginal or Caesarian), and complications arising for mother or baby requiring hospitalization. Unless families are fully aware of specifics of the HDHP policy and the medical procedures covered, such discrepancies in coverage could leave families liable for substantial medical expenses and lead to debt.

* The Medical Savings Account (MSA) is a plan similar to the HSA, but one that differs in some respects, including in its requirement that individuals and employers cannot both contribute to an employee's MSA in the same year. For more information, see Internal Revenue Service, *Health Savings Accounts and Other Tax-Favored Health Plans.* Department of the Treasury. Washington, DC, 2007.

† The Preferred Provider Organization (PPO) and Point-of-Service (POS) plans are both types of conventional managed care health insurance plans.

CONCLUSION

Widespread implementation of health tax incentives would represent a sea change in the way Americans buy health insurance. Tax incentives, in theory, have the potential to expand health coverage outside of the employer-based coverage and safety-net systems, a development that could benefit Latinos who need the improved access that health insurance often brings.

The promise of health tax incentives depends on policymakers' willingness to address the nongroup market. Proactively addressing the factors that would disadvantage Latinos purchasing insurance in the nongroup market should be a requirement before any of these proposals are seriously considered. For proposals to be effective in reducing uninsurance within the Latino community, they must take into consideration the unique characteristics that play out in Latino families, such as household size, income barriers, language, and eligibility rules. For instance, due to the information gaps that could naturally rise from the implementation of relatively nascent models, with specific focus on the concerns of noncitizen communities, policymakers must plan an aggressive and extensive outreach component before any of these proposals are implemented. Furthermore, the proposals' power to reduce uninsurance in the Latino community will be hamstrung if policymakers make arbitrary exclusions that have little to do with an individual's need for health coverage. Exclusions based on a person's work authorization status or immigration status could be highly problematic, keeping Latinos from taking up health tax incentives.

Health tax incentives are one set of policies that may offer new options to Latinos who face limitations under the current health care system. However, to achieve measurable results, the incentives must be thoughtfully crafted to eliminate barriers to insurance that many in the Hispanic community already face. Without these considerations, health tax incentives could prove ineffective. In order to eliminate the coverage gap in the United States, policymakers must ensure that all Americans have equitable access to health insurance.

Endnotes

1. NCLR calculation using U.S. Bureau of the Census, "2007 Annual Social and Economic Supplement," *Current Population Survey*. Conducted by the Bureau of the Census for the Bureau of Labor Statistics. Washington, DC, 2008, http://www.census.gov/hhes/www/cpstc/cps_table_creator.html (accessed December 2008).
2. Ibid.
3. Ibid.
4. Lisa Clemans-Cope and Bowen Garrett, *Changes in Employer-Sponsored Health Insurance Sponsorship Eligibility, and Participation: 2001 to 2005* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2006), Table 12.
5. Ibid. The authors found that, when offered and eligible for ESI coverage, 87.4% of White workers, 87% of Black workers, and 85.7% of Hispanic workers took up coverage. Of the Hispanic workers, 86.6% of U.S.-born workers, 89.8% of naturalized citizen workers, and 81.4% of noncitizen workers took up coverage when offered.
6. Ibid. As a result of declines in sponsorship, eligibility, and take-up between 2001 and 2005, the share of Hispanic workers with ESI coverage dropped by 6.4%, compared to 6.3% for Black workers and 2.6% for White workers. Changes in employer sponsorship resulted in a 3.3% decrease in Hispanic workers' ESI coverage, a larger share than among Black (1%) and White (1.4%) workers. Worker take-up explained most of the remaining change (2.6%) in Hispanic workers' ESI coverage.
7. Several members of NCLR's Health Tax Incentives Roundtable suggested that NCLR should analyze Latinos' uninsurance rates by firm size, positing that Hispanic workers' concentration in the small business sector could be responsible for disparate access to ESI. See National Council of La Raza, "Healthy Choices or Bad Medicine? Health Tax Incentives Roundtable Transcript" (Washington, DC: National Council of La Raza, 2008).
8. NCLR calculation using data from "2007 Annual Social and Economic Supplement."
9. Ibid.
10. Ibid.
11. Ibid. For Medicaid statistics in this analysis, NCLR uses Census data because it provides detailed information about the Medicaid population. Medicaid Statistical Information Services (MSIS) has more accurate information about the number of eligible and enrolled Latinos. 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 Centers for Medicare and Medicaid Services, *Fiscal Year 2004 National MSIS Tables* (Washington, DC: Centers for Medicare and Medicaid Services, 2007).
12. Adults without child dependents are excluded from Medicaid programs, even if they are low-income. Thus, states that wish to cover this population must apply for a waiver and reduce federal Medicaid spending for every additional dollar spent on this coverage group or use state-only funds to provide coverage. Consequently, few states cover childless adults. See Stan Dorn et al., *Medicaid and Other Public Programs for Low-Income Childless Adults: An Overview of Coverage in Eight States* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2004).
13. NCLR calculation using U.S. Bureau of the Census, "2007 Annual Social and Economic Supplement."
14. Not all poor families are eligible for public coverage. Undocumented immigrants are ineligible for traditional Medicaid benefits, but they may qualify for emergency Medicaid services if they otherwise meet eligibility requirements. Although certain legal immigrants qualify for public coverage, federal law imposes additional eligibility barriers on this population. Legislation passed in 1996 (the Personal Responsibility and Work Opportunity Reconciliation Act) subjects recently arrived immigrants to a five-year bar from their date of entry before they may qualify for coverage through Medicaid or SCHIP. For more information, see *The Truth about Health Care Use among Immigrants* (Washington, DC: National Council of La Raza, 2007).
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16. Mark Merlis, *Fundamentals of Underwriting in the Nongroup Health Insurance Market: Access to Coverage and Options for Reform* (Washington, DC: National Health Policy Forum, 2005).
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20. Scott Harrington and Tom Miller, "Perspective: Competitive Markets for Individual Health Insurance," *Health Affairs* web exclusive (October 23, 2002): w359–w362, http://content.healthaffairs.org/cgi/reprint/hlthaff.w2.359v1.pdf (accessed December 2008).
21. U.S. Bureau of the Census, "2007 Annual Social and Economic Supplement."
22. NCLR calculation using U.S. Bureau of the Census, "2007 Annual Social and Economic Supplement."
23. Ibid.

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25. Encuesta, Inc., "Americanos Poll: Hispanics and Non-Hispanics Equally Likely to File a Federal Tax Return, but More Refunds and Fewer Audits for Hispanics, Survey Says," news release, April 2006. Encuesta, Inc. conducted this Americanos Poll by telephone between April 6 and April 13, 2006 among a representative national sample of 321 Hispanic and 305 non-Hispanic adults. The margin of error for the entire sample is approximately +/-4%, with a higher margin of error for subgroups.
26. NCLR calculation using U.S. Bureau of the Census, "2007 Annual Social and Economic Supplement."
27. Jessie Mangaliman, "Immigration Crackdowns Hurt Mixed-status Families," *The Oakland Tribune*, April 2, 2008.
28. U.S. Bureau of the Census, *2007 American Community Survey.* Conducted by the Bureau of the Census, American Community Survey Office. Washington, DC, 2008, Table C16006. The margins of error for these estimates are +/-11,290 and +/-71,677, respectively. Another estimated 149,471 (+/-8,199) Hispanics speak a language other than English and Spanish in the home.
29. Ibid. The margin of error for this estimate is +/-68,851.
30. Ibid. The margin of error for this estimate is +/-77,660.
31. Cindy Brach and Frances M. Chevarley, *Demographics and Health Care Access and Utilization of Limited-English-Proficient and English-Proficient Hispanics* (Rockville, MD: Agency for Healthcare Research and Quality, 2008). For this study, researchers defined LEP Hispanics as those respondents who reported speaking English "not well" or "not at all."
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33. Mark Pauly and Bradley Herring, "Expanding Coverage Via Tax Credits: Trade-Offs and Outcomes," *Health Affairs* 20, no. 1 (2001): 9–26.
34. Mark Merlis, *Fundamentals of Underwriting.* To show the effects of medical underwriting in this market, the author used a simplified model to analyze nationally representative data from the Medical Expenditures Panel Survey. After adjusting for age and sex, people with a history of cancer, diabetes, or heart disease at the beginning of the plan year were charged premiums that were five times higher than people who had no history of any of these diseases.
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37. U.S. Government Accountability Office, *Trade Adjustment Assistance: Most Workers in Five Layoffs Received Services, but Better Outreach Needed on New Benefits* (Washington, DC: Government Printing Office, 2006).
38. Stan Dorn, *Take-Up of Health Coverage Tax Credits: Examples of Success in a Program with Low Enrollment* (Washington, DC: Urban Institute, 2006). The research excluded individuals who would qualify for the program but have another form of health coverage such as Medicare.
39. Ibid.
40. U.S. Bureau of the Census, "2007 Annual Social and Economic Supplement," *Current Population Survey,* Alternative Measures of Income and Poverty (R&D), Table 2: "Percent of People in Poverty, by Definition of Income and Selected Characteristics: 2006."
41. Katherin Ross Phillips, *Who Knows About the Earned Income Tax Credit?* (Washington, DC: The Urban Institute, 2001).
42. Encuesta, Inc., "Hispanics and Non-Hispanics Equally Likely to File a Federal Tax Return."
43. "Making Your Taxes Work for You" (National Council of La Raza Annual Conference workshop, Los Angeles, CA, July 2006).
44. People who are self-employed or have proportionally high out-of-pocket medical costs are the exception to this rule. Beginning in 2003, self-employed filers could deduct the entire cost of their health coverage premiums. Additionally, if medical expenses incurred during the tax year exceed 7.5% of adjusted gross income, filers can deduct these costs (including, with some exceptions, health insurance premium payments) on their income tax returns. See Sandra Block, "Individual Insurance Buyers Should Check IRS Deductions," *USA Today*, October 14, 2003.
45. Claudia Williams, *Tax Subsidies for Private Health Insurance: Who Currently Benefits and What Are the Implications for New Policies?* (Princeton, NJ: Robert Wood Johnson Foundation, 2003). According to this analysis, for a family making more than $200,000 in 1998 and receiving ESI, the subsidy is worth one-third of the total premium (including both employer and employee contributions). That family pays 2% of household income for coverage. For the poorest family, however, the subsidy is much less generous; for a family making less than $10,000, the subsidy is worth about 10% of the premium, with the family contributing 40% of its income toward ESI.
46. U.S. Department of the Treasury, *2008 HSA Index Amounts* (Washington, DC: Government Printing Office, 2007), http://www.ustreas.gov/offices/public-affairs/hsa/pdf/rp-2007-36.pdf (accessed December 2008). These requirements are adjusted annually for inflation.

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