PRESIDENTIAL CANDIDATES' HEALTH INITIATIVES:
How Will They Affect the Hispanic Community?

Introduction

Families USA developed ***Presidential Candidates' Health Initiatives: How Will They Affect the Hispanic Community*** with input from the National Association of Latino Elected and Appointed Officials Educational Fund. This publication, designed primarily for Latino elected officials, aims to raise awareness about specific health policies, assess the impact these policies will have on the Hispanic community, and compare the health policy proposals of the 2004 Presidential candidates. By exploring several health policy topics and comparing the health policy proposals of the 2004 Presidential candidates, this publication provides insights into the strengths and weaknesses of existing health policies and programs from the perspective of

Latinos.

Racial and Ethnic Health Disparities:
Not Just a Black and White Issue

While most of the health disparities literature focuses on African Americans and non-Hispanic whites, Latinos also suffer lower rates of health care access, receive lower-quality health care, and experience worse health outcomes than non-Hispanic whites. In fact, Latinos, more so than non-Hispanic whites, are more likely to rate their health as fair or poor, to have higher rates of morbidity (illness), to have shorter life expectancies, and to have higher death rates from the nation's top killers—heart disease, cancer, and cerebrovascular diseases.

Racial and ethnic health disparities are exacerbated by several factors:

- Differences in access to health care play a fundamental role in exacerbating racial and ethnic health disparities. Because Latinos are more likely than non-Hispanic whites to lack health insurance, they are more likely to *not* have access to necessary health care services and treatments.
- Life disadvantages, including lower socioeconomic status and educational levels, greater exposure to environmental health risks, and prolonged exposure to stress due to racism, also

exacerbate racial and ethnic health disparities.

- Racial and ethnic differences in treatment within the health care system also contribute to the health disparities that Latinos experience. These differences in treatment can exist at the patient level (i.e., preferences and treatment refusal), the health care-systems level (i.e., organization and financing), and the care-process level (i.e., differences in care that result from biases, prejudices, stereotyping, lack of culturally competent care, and uncertainty in clinical communication and decisionmaking).

Factors at the health care-systems and health care-process levels account for the majority of racial and ethnic disparities in health care. Latinos are *less likely* than non-Hispanic whites with comparable conditions to receive quality care for various conditions—such as HIV/AIDS, cancer pain management, and heart disease—in settings such as intensive care. For example, Hispanic Medicare patients are about half as likely as their white counterparts to undergo bypass surgery and angioplasty.

Language barriers also interfere with Latinos' access to quality health care. Recent studies have shown that language barriers result in an increased likelihood of drug complications and unnecessary diagnostic tests, and in an increased likelihood that the patient will not adhere to the provider's advice because the patient does not understand what is being said.

Language barriers can have other detrimental effects on the health care quality and health outcomes of Latinos. For example, in health care settings, providers and administrators who cannot communicate with patients with limited English proficiency often rely on bilingual family members and other ad hoc interpreters. While this may seem harmless, or even culturally and linguistically sensitive, studies show that a lack of appropriate translation and interpretation services in health care settings results in as much as 50 percent of medical questions being incorrectly asked or answered. Furthermore, patients with limited English proficiency who could communicate with their providers because they had a skilled interpreter reported having a better understanding of their diagnosis and treatment than patients who were unable to communicate with and understand their providers.

Making health insurance available and affordable for all Americans, and ensuring that health care services are culturally and linguistically appropriate, are part of the solution to the health care disparities that affect all racial and ethnic minorities, particularly Latinos. President Bush and presidential candidate Senator John Kerry have very different plans for ensuring that all Americans have access to affordable health care coverage. However, even when Latinos have a health insurance card that helps get them into the doctor's office or the hospital, once inside, differences in treatment and challenging language barriers often leave Latinos with less-than-adequate care and poorer health outcomes. Acknowledging and addressing these critical issues must, therefore, be an important priority for our nation and the next president

The Uninsured and Employer-Sponsored Coverage

In the United States, Latinos constitute a disproportionate share of the uninsured: They represent only 14 percent of the population, but they constitute 27 percent of all people under the age of 65 who were without health insurance for all or part of 2002 and 2003.[1] Three out of five (60 percent) of non-elderly Latinos were uninsured for all or part of 2002 and 2003. Because insurance coverage facilitates access to regular monitoring and health care, uninsured individuals are less likely to receive screenings, timely diagnoses, and treatments for acute or chronic conditions.

Latinos are uninsured for many reasons, including ineligibility for employer-based coverage, the inability to enroll in employer-based coverage, the loss of a job, and falling through the holes in the health care safety net. When employed, Latinos are more likely than non-Hispanic whites to work in low-wage or part-time jobs that do not provide health insurance benefits. What's more, even when they work for firms that offer health insurance coverage, some Hispanic workers are unable to afford the premiums. In 2003, only 42 percent of Latinos had employer-based coverage, compared to 66 percent of non-Hispanic whites and 50 percent of African Americans (Note: This is based on 2003 Census Table C-1).

Recent proposals to expand health coverage, such as tax credits for the purchase of health insurance in the individual market, Health Savings Accounts (HSAs—tax exempt accounts established to pay for qualified medical expenses of beneficiaries who are enrolled in high-deductible health plans), and Association Health Plans (AHPs), may not necessarily improve every Latinos' ability to obtain health insurance.

As proposed, individual tax credits can only be used in the individual health insurance market. This market has fewer consumer protections, and many individuals in less-than-perfect health will be able to buy only coverage that *excludes* care for their health problems or will not be able to buy coverage at all. Furthermore, the amount of the tax credit is not large enough to cover the cost of decent health insurance coverage, especially for sicker and older people. Finally, some employers who do offer health insurance coverage to low-income workers may view the tax credit as a reason to no longer provide this important benefit to any of their employees.

Health Savings Accounts (HSAs) may not help Latinos, many of whom may not able to afford the costs associated with enrolling in high-deductible plans. About one third (36 percent) of uninsured Americans have incomes that are too low to owe taxes and therefore would receive no benefit from either tax credits or HSAs. So, many Latinos would not be able to take advantage of the tax incentives offered by HSAs.

In addition, HSAs may have a negative effect on some Latinos and others with employer-based health coverage. This is because HSAs will likely appeal to younger and healthier people who anticipate having few health care expenses (and whose lower health care expenses balance the risk pool and help defray rising costs). If healthier

people enroll in HSAs, this will likely cause a change in the composition of the risk pool for the traditional, employer-sponsored health insurance plans. Those remaining in traditional PPO and HMO plans will likely be older beneficiaries and those with health problems, and these beneficiaries will face increases in health care costs. For the Latinos who are not likely to enroll in HSAs, these changes in the risk pool could result in higher health care premiums.

Association Health Plans (AHPs) could also have a negative effect on Latinos. AHPs would exempt insurers from state laws that were enacted to provide consumer safeguards (e.g., prevent discrimination based on health status, ensure solvency, require that core services [such as maternity care] be covered, and provide appeal rights when care is denied). Thus, AHPs could offer less expensive health coverage with fewer benefits— the kinds of plans that would be more attractive to healthier workers. Since many Latinos, like other racial and ethnic minorities, are less healthy overall, AHPs may be unattractive because they have the potential to actually raise premium costs. Furthermore, because Hispanic communities are concentrated in certain geographic areas, AHP insurers could exclude them from coverage by "redlining" selected neighborhoods.

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[1] Most of the elderly in the United States receive health insurance coverage through the Medicare program.

The Uninsured: A Comparison
President Bush vs. Senator Kerry

(Note: This includes Expanding Employer Sponsored Health Insurance and Expanding Medicaid.)

President Bush

The Bush plan would cover *2.1 million people*, cost $90.5 billion over 10 years, and use the following:

✓ **Health Savings Accounts (HSAs)**

- These tax free accounts, to be used with high-deductible health insurance plans, have significant tax advantages for those who qualify.
- One-third of the uninsured have incomes that are too low to owe federal income taxes, so they do not benefit from the tax break.
- Another large segment of the uninsured would get equal or less than a 10 cent tax subsidy for each dollar they would spend on health insurance premiums, an amount that is not enough for adequate health care coverage.

✓ **A Tax Credit For Non-Group Insurance**

- The proposed value of the tax credit ($1,000 per person) is too small to provide meaningful coverage.
- To use this tax credit, an individual would have to purchase insurance in the individual market and would likely face much higher premiums and many more coverage exclusions.
- Employers may cut back health coverage or drop it altogether if they think their employees will be able to purchase coverage on their own.

✓ **Association Health Plans (AHPs)**

- AHPs encourage small businesses and the self-employed to ban together to plan and purchase health insurance coverage
- Typically, this type of coverage is not subject to important state consumer protection laws or appeal rights.
- AHPs can be designed such that only small businesses with the healthiest employees are in the plans and businesses with less healthy workers pay even higher premiums.

Senator Kerry

The Kerry plan would cover *27 million people* and cost $653 billion over 10 years. Kerry would finance this plan by repealing tax cuts for people who earn more than $200,000 per year.

✓ **Give small businesses, individuals, and the unemployed access to the same health insurance that members of Congress receive, without regard to health conditions.**

- Small businesses would receive a tax credit to pay up to 50% of the costs for low-income workers.
- Unemployed people would receive a 75 percent subsidy to help them pay for health coverage.
- Individuals would also receive a subsidy to make health coverage more affordable.

✓ **Expand the health care safety net for low-income Americans.**

- Ensure that the federal government continues to help states pay for health coverage for low-income Americans by providing fiscal relief to states.
- The federal government would pick up *all* the costs of covering children currently enrolled in Medicaid. In exchange, states would pay to expand coverage for kids with family incomes up to 300 percent of poverty, parents with incomes up to 200 percent of poverty, and adults without children who live below poverty.
- Allow working families with children with special needs who are currently above Medicaid income limits to buy into Medicaid.

✓ **Make health care coverage more affordable by subsidizing high cost claims.**

- The federal government would reimburse employers for 75 percent of medical bills over $50,000 that any worker may incur in a year.

Medicaid Restructuring

Medicaid, the nation's health care program for low-income seniors, people with disabilities, children, and working families, provides comprehensive health care services to more than 51 million people. While Latinos constitute nearly 14 percent of the total U.S. population, they represent more than 20 percent of all Medicaid beneficiaries. This is partly because, of all population groups, Latino workers are the least likely to have employer-sponsored health insurance coverage, either because their employers do not offer it or because workers do not qualify to receive it. High rates of uninsurance, coupled with disproportionately greater poverty rates, make Medicaid a crucial source of health insurance coverage for the Hispanic community.

Medicaid is financed jointly by the states and the federal government, with a guarantee that the federal government will pay at least half (more in states with low per-capita incomes) of the cost of the program. For every $1 that a state invests in Medicaid, the federal government pays between $1 and $3.36. In fact, Medicaid is the largest source of federal grant funds to states, providing some 43 percent of all federal funds to states. Despite this considerable federal funding for Medicaid, states have significant flexibility in designing their programs and, thus, in controlling program costs.

Many states are in the process of, or have already developed, proposals to restructure their Medicaid programs. Such proposals include replacing the current entitlement program (i.e., a program in which all eligible people can enroll to receive benefits) with a block grant. Under these Medicaid block grant proposals, the federal government would give each state a *fixed sum* of money as a match for the amount the state would be mandated to spend on health insurance and services for their low-income population.

Because this would require states to estimate health care expenditures in advance, a block grant would degrade states' ability to respond to the changing health care needs of their residents. While the current system guarantees a state additional federal funds if costs increase, under a block grant, states would be left entirely on their own to pay for any unexpected increases in Medicaid costs (for example, due to a downturn in the economy that causes more people to become uninsured, cost increases that mount as the population ages, public health threats or natural disasters, advances in costly medical technology, or new medicines). Replacing the current system—in which states are reimbursed for actual Medicaid expenditures—with one under which states receive an estimated, fixed amount of funding, would likely put access to health insurance coverage and services for program beneficiaries, including Latinos, at risk.

Other factors affect Latinos' ability to obtain Medicaid coverage, despite its importance to the health and well-being of many in the community. Federal civil rights law requires that application forms and procedures be accessible for people with limited English proficiency, but translated forms and procedures may still be unavailable,

inaccurate, or culturally inappropriate. Federal law also prohibits states from inquiring about the immigration status of other household members who are not applying for Medicaid. Unfortunately, the reality is that in some areas, state and local agencies may still ask inappropriate questions. Improving compliance with federal laws would help improve access to health insurance for Latinos.

In addition, since 1996, recent legal immigrants have been barred from receiving federal Medicaid benefits during their first five years in the U.S. Some states have chosen to cover limited groups of legal immigrants using state-only funds, but many legal immigrants remain uninsured because of this law. The Immigrant Children's Health Improvement Act (ICHIA), a bill that has been introduced in Congress, would restore access to Medicaid for legal immigrant children and pregnant women. This bill has received bipartisan support in Congress, but it has yet to become law.

Medicaid: A Comparison
President Bush vs. Senator Kerry

President Bush

President Bush proposed a restructuring of the Medicaid program in 2003 that would:

- ✓ Cap federal funding for Medicaid.
- ✓ Eliminate entitlement to Medicaid by establishing a block grant.
- ✓ Allow states to establish waiting lists and cap or freeze enrollment in Medicaid.
- ✓ Allow states to raise cost-sharing amounts and cut covered health care services without federal oversight or approval.
- ✓ Allow states to treat people in Medicaid differently from one another, depending on where they live or other factors (for example, by age, health status, or whether they participate in other programs such as Medicare or TANF)

Senator Kerry

Senator Kerry proposes to expand Medicaid and the health care safety net.

- ✓ Opposes a Medicaid block grant.
- ✓ Proposes the following changes to expand Medicaid:
  - Provide federal fiscal relief for state Medicaid programs.
  - Eliminate the five-year waiting period for Medicaid and SCHIP eligibility for legal immigrants.
  - Allow working families with disabled children to buy into Medicaid if they earn too much to qualify otherwise.
  - Build on Medicaid to expand coverage to uninsured children, and low-income families and adults (see "The Uninsured" on page 3 for more detail).

Medicare and Prescription Drugs

Medicare is the federal health insurance program for the elderly and people with disabilities. It currently provides insurance for hospital and outpatient services, and it will add an outpatient prescription drug benefit in 2006. Between now and 2006, a Medicare Drug Discount Card is available. Recent changes to the Medicare program (in 2003) have threatened its projected future solvency, an issue for all current and future beneficiaries, but especially for Latinos who, as a group, are unlikely to have employer-based health insurance as retirees and less likely to be able to afford out-of-pocket health care expenses.

Rapid price increases for prescription drugs mean that most in Medicare need help with drug costs—prices of the brand-name drugs most frequently prescribed to seniors increased by 4.3 times the rate of inflation in 2003. But for Latinos, this need is particularly acute. That is because Latinos, compared to non-Hispanic whites, have a higher incidence of heart disease, cancer, diabetes, and HIV/AIDS, and therefore are more likely to be dependent on prescription drugs as they age. In addition, their lower socioeconomic status sometimes makes it more difficult for some older Latinos to afford high, and rising, drug prices.

Both the Medicare Drug Discount Card and the Medicare drug benefit that will begin in 2006 provide added help for low-income individuals. Unfortunately, a variety of factors may limit Latinos' ability to take advantage of this added help. For example, the Medicare Drug Discount Card offers $600 a year in assistance to low-income individuals. However, language barriers, a lack of translation and interpretation services, and the difficulty individuals have trying to determine which card provides the best discount on needed pharmaceuticals, as well as problems accessing pharmacies that accept the card, limit the card's usefulness and pose a barrier to Latinos who might qualify for the $600 assistance.

Similar barriers will likely be associated with the drug benefit once it begins. What's more, for those who do not qualify for added help, the Medicare drug benefit offers less-than-comprehensive coverage. The benefit comes with high up-front costs—in 2006, premiums are estimated at $420, and the deductible will be $250; both will increase annually. In addition, once coverage begins, beneficiaries must pay 25 percent of their drug costs until those costs reach a certain level (set at $2,250 in 2006) and then pay their drug costs in full until they reach that year's catastrophic limit ($5,100 in 2006). This gap is known as the "doughnut hole."

Lastly, although the drug benefit will provide added assistance for low-income individuals, many such beneficiaries will not be eligible for that help. That's because eligibility for this added help will be based not just on income, but on both income and assets, such as savings accounts and life insurance policies. Many with low incomes will therefore continue to pay for high drug expenses out of their own pockets even after the drug benefit starts.

Medicare and Prescription Drugs: A Comparison
President Bush vs. Senator Kerry

President Bush

President Bush signed into law legislation that adds a drug benefit to Medicare in 2006. Major features of this legislation and his agenda include:

- ✓ Prohibiting the importation of lower-cost medicines from Canada.
- ✓ Prohibiting Medicare from negotiating with drug companies for lower prices.
- ✓ Seniors must rely on private companies (pharmacy benefit managers [PBMs], insurance companies, and HMOs) to negotiate the prices that will be the basis for their drug benefit. These companies have minimal requirements to make their contracts with drug companies "transparent."
- ✓ The Administration opposes states' efforts to extend Medicaid discounts to the uninsured.

Senator Kerry

Senator Kerry would make the following changes to the recently enacted Medicare prescription drug law:

- ✓ Allow the importation of lower-cost drugs from Canada.
- ✓ Allow the federal government to negotiate directly with drug companies to get the lowest prices possible for seniors and others who rely on Medicare.
- ✓ Medicare would operate the drug benefit plan. Pharmacy benefit managers that contract with the federal government would be required to disclose their financial arrangements with drug manufacturers.
- ✓ Federal support would be provided for state efforts to extend Medicaid purchasing discounts to the uninsured and to develop bulk purchasing plans to reduce drug prices to consumers.
- ✓ Allow adults 55-64 years of age to buy into the program.

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