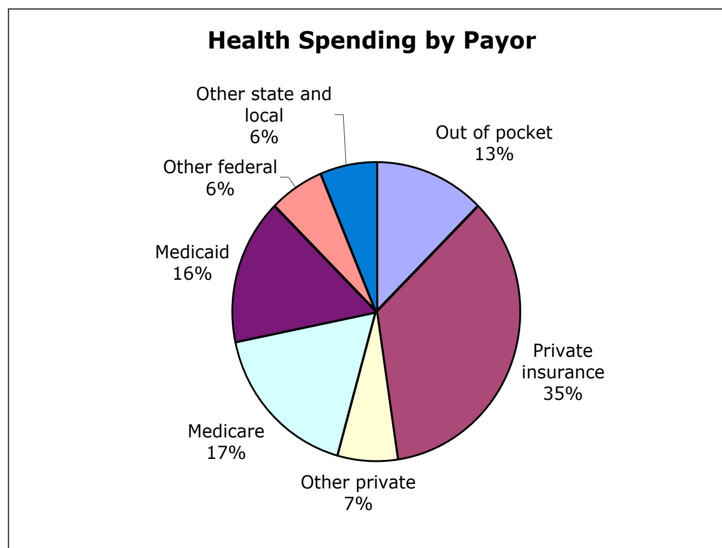
If we cannot pay for expanded coverage for the uninsured, there is no possibility of reform. Let's first identify financing obstacles and then possible solutions.

Financing through state government requires a two-thirds vote for taxes and appropriations; this gives the trump card to the minority if it opposes reform financing. Financing through the federal government requires more than 60 votes in the 100 member Senate, again giving veto power to the minority, should it oppose reform.

The potential ways to finance California health reform with a majority vote are: state ballot initiatives, mandates, fees and federal matching.

Current financing for health care is through government, private insurance and individual out of pocket spending.



Source: National Health Spending in 2005. Health Affairs (January 2007)

Financing for the insured

Right now the insured are covered by public programs (Medi-Cal, Healthy Families and Medicare), and/or private coverage (employment-based and individual insurance).

Private employment-based and individual coverage for the self-employed are subsidized with pre-tax purchasing tax advantages that offset on average, one third of the costs of such coverage.[1] Nearly, 90% of those subsidies are federal because the federal government has higher income tax brackets and collects Social Security taxes. Tax subsidies are overwhelmingly beneficial to those in higher income tax brackets.

Distribution of Federal Tax Expenditures by Family Income, 2004

	Average federal tax expenditure per household	Expenditure amount	Percent of total
Less than $10,000	$102	$1.3 billion	0.7%
$10, 000 to $20,000	$292	$5.0 billion	2.7
$20,000 to $30,000	$725	$12.2 billion	6.5%
$30,000 to $40,000	$1,231	$17.1 billion	9.1%
$40,000 to $50,000	$1,448	$17.9 billion	9.5%
$50,000 to $75,000	$2,134	$44.2 billion	23.4%
$75,000 to $100,000	$2,640	$40.8 billion	21.6%
Over $100,000	$2,780	$50.0 billion	26.5%

Source: Sheils and Haught, The Cost of Tax-Exempt Health Benefits in 2004, Health Affairs (Feb., 2004)

Employers pay for the lion's share of employment-based coverage, on average eighty percent, while employees pay for about twenty percent.[2] These percentages vary widely from employer to employer and may vary based on whether the employer offers dependent coverage and the employee has dependents.

Shares of Health Insurance Paid by California Employers and Employees, 2006

	Dollar amounts for employee only coverage	Percentage of cost of employee only coverage	Dollar amounts for family coverage	Percentage of cost of family coverage
Employees	$547	12%	$2,824	25%
Employers	$4003	88%	$9.036	75%

Source, California HealthCare Foundation, California Employer Health Benefits Survey, November 2006

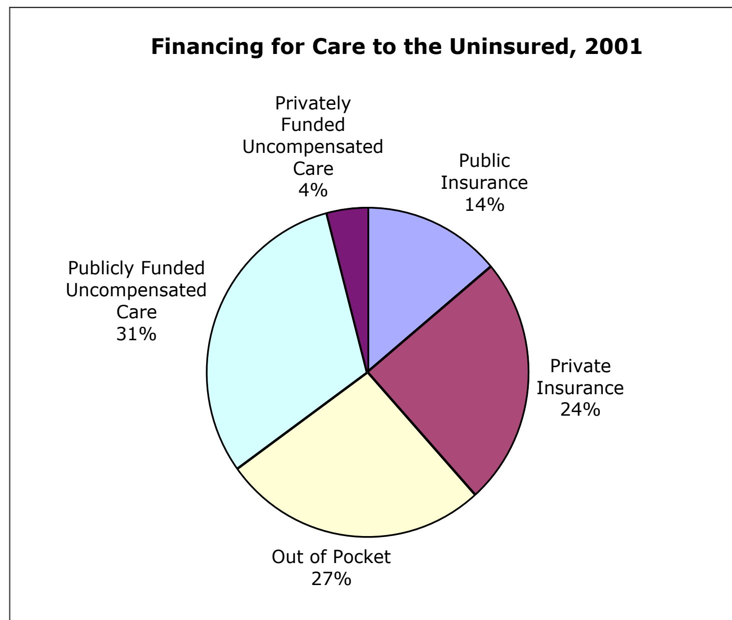
Public coverage is primarily financed through the federal government as well: fifty percent of Medi-Cal, two thirds of Healthy Families and one hundred percent of Medicare. State government and, to a limited degree, California's county governments pay the state match. At a given point in time, 7.5 million Californians are enrolled in either Medi-Cal or Healthy Families and 4.4 million in Medicare.

Individuals pay out of pocket for health costs, pay federal, state and county taxes, and pay shares of their own premiums, ranging from one hundred percent for individual coverage to zero percent for those with the most generous employer plans.

Employers, employees, individuals and government share a common goal of moderating the sizable health care and coverage cost increases and improving the quality of covered services.

Financing for care to the uninsured

The uninsured receive roughly half as much care as the insured,[3] too often too late to be as effective as it should be.[4] Funding for that care comes from the uninsured themselves, from the federal, state and county governments, and from the cost shift of uncompensated care for private providers to the privately insured.[5] Delivery of services to the uninsured occurs in community and county clinics, in public and private hospitals and in private doctors' offices.[6]



Source: Hadley and Holahan, Who Pays for Care and How Much: the Cost of Caring for the Uninsured (Urban Institute, February 2003)

Financing proposals under health reform (current status)

The proposals from the Governor and the state legislative leaders call for shared responsibility: from employers, employees, individuals, federal, state and county government, doctors and hospitals. Most would agree with the concept of shared responsibility for others but would prefer an exception for themselves.

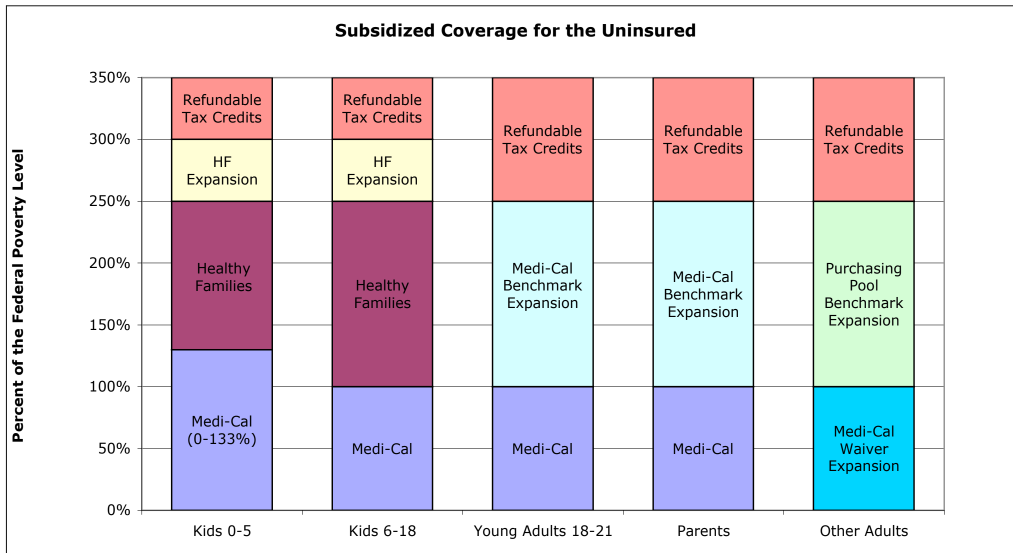
After lengthy negotiations, hospitals have agreed to pay half the costs of a major increase in their Medi-Cal reimbursement rates. Doctors have refused.

Some employer groups have indicated a willingness to pay for some portion of the reform if others contribute as well, while others have not. Labor groups have agreed to the principle that employees pay a share; they seek to cap that contribution at 5% of income. Labor and some consumer groups have sought to cap the contributions of individuals who are not employees at 5% of income as well.

The federal government has in principle agreed to pay for the match to expand eligibility for eligible individuals and increase public program provider rates in California. Some counties have indicated a willingness to help finance the reform; others have not.

What financing reforms would make sense? Starting principles

1. Use public programs to cover the low wage/low income uninsured since the federal government will pay a significant share of these costs and the financial burdens of covering them through the private sector are far too high.[7]



2. Use existing public funding for care of the uninsured to pay for their coverage; otherwise the federal, state and county governments and some providers receive a large budget windfall. Funding must be transitioned so the funds follow the patients as they enroll in coverage.

3. Use all available federal and state tax advantages for private coverage of the higher income uninsured workers and the self employed.

4. Tie employer, employee and individual contributions to affordability – a percent of wages for employers and employees or in the case of individuals a percent of income serves as a measure of affordability. As the following chart demonstrates those facing the greatest affordability challenges are families and older workers; this can be mitigated with public subsidies, tax credits or with tighter benefit packages or a combination.

Table: Individual Plan Monthly Premiums – January 2007

Los Angeles

	25 year-old single	***35 year-old single***	***55 year-old single***	***25 year-old married couple, two children***	***35 year-old married couple, children***	***55 year-old married couple, children***
			HMO Products			
Kaiser-$25 Copayment Plan	$202	$242	$394	$704	$797	$895
Premium as a percent of monthly income for an individual or family of four with income at 300% of FPL	8%	10%	16%	14%	16%	18%

5. Mirror new funding and coverage with existing public and private coverage to reduce incentives "crowd-out or crowd-in" which occurs when individuals and employers drop their coverage to avail themselves of better subsidies.

6. Universal coverage makes sense to improve health outcomes, health system efficiency and eliminate uncompensated care and a system where it is possible to capitalize on the coverage of others by using health system services to which some do not contribute.

7. Lastly, and most controversially for some of you I would expect, a mixed system of public and private financing makes the most sense because it is far too expensive to buy out the existing financial contributions of the public and private sectors for the mixed system we have today.[8]

These are the basic outlines of agreement on financing reform principles.

Where are the hang-ups and what can be done?

In the first place, all stakeholders understandably want to improve their standing from the current system. Employers, employees and individuals want to pay less and/or get better results from the health system. Providers and plans want to make more money (some will say lose less money) for the health services and coverage they provide. These conflicts cannot be reconciled, but they could be balanced. Covering more of the uninsured reduces providers' bad debt and uncompensated care and increases plans and providers' incomes; this could and should be used to reduce cost shifting and thus the rise in premiums of the privately insured. Whether the magnitude of this decrease is large or small, the savings should be measured, captured and passed back to the private payors.[9] Improving quality and efficiency of the system benefits most participants but does not translate to coverage of the uninsured.

Employer, employee and individual shares

Unions want employers to pay for a greater share of coverage while employers prefer that individuals take on greater financial responsibility.

- The Governor's initial proposal exempts employers with 10 or fewer employees, mandates participation of the self-employed and sets the uninsuring employer share at 4%.
- The Speaker and Senate President's AB 8 exempts the self-employed, applies to all sizes of employers and sets the uninsuring employer share at 7.5%. The Speaker's measure applies to insuring employers as well and thus sets a minimum-spending threshold for those who do offer coverage.
- The Governor's initial proposal sets employees' cost share at 3-6% of wages, while the Speaker's bill sets employees' cost share at 2-5% of wages.
- The latest draft of the reform measure from the Governor proposes employer shares, ranging from 0-4% of payroll for very small employers and 4% for employers of more than 10 employees.
    - Uninsured workers under 150% of FPL ($15,000 annually for an individual) will not pay premiums, and uninsured individuals up to 250%

of FPL ($50,000 annually for a family of four) will pay premiums capped at 4% of income for those between 150 and 200% of FPL and capped at 5% of incomes for those between 200 and 250% of FPL. Individuals with incomes between 250 and 350% of FPL will receive advanceable, refundable tax credits such that their premium contributions do not exceed 5% of their incomes as well.

- We think it makes most sense to require all employers, their employees and the self-employed to contribute. It puts all employers, employees and the self-employed on a more level playing field. It eliminates gaming opportunities and incentives such that today's employees would become tomorrow's independent contractors or today's employer of 25 employees could be broken up into three separate entities of less than 10 employees.
- It is hard to recommend as a matter of policy what is the correct formula for uninsured employee, individual and uninsuring employer affordability.
    - The economists maintain that determining respective employer and employee shares makes little difference as it is all part of the total compensation package involving trade-offs between wages and benefits. While this may be an accepted economic certainty, it is counter-intuitive for real life employers and employees concerned with their individual and businesses' bottom lines.
    - Supporters of a higher figure for uninsuring employers are partially concerned with preventing crowd out – the possibility that insuring employers will drop coverage and pay into the purchasing pool for coverage.
    - Supporters of a lower figure for uninsuring employers are partially concerned with mitigating any economic impacts of health reform on job creation.
    - While both arguments are correct to a degree, in our view it is far more important that the Governor and legislative leaders negotiate a fair agreement on respective employer, employee and individual shares of financing that has the support of business and labor leaders and will be supported by the voting public.

Hospitals and doctors

Most hospitals and doctors are paid less for their care to Medi-Cal patients than they are paid for their care to Medicare patients and to commercial, privately insured patients.[10] The federal government would match an increase in those payment rates to Medicare levels, but the state of California lacks the state funds to pay the state match for that increase.

The Governor had proposed that private hospitals and doctors pay the match through a mechanism, variously described as a fee, assessment or tax. Public hospital counties already have such a mechanism in place and pay their own match in a form known as CPEs (Certified Public Expenditures) for both rate increases and care to the uninsured. Minnesota and Washington State both have had a provider tax in place for over fifteen years to finance coverage for the uninsured.

The Governor's proposal includes both rate increases and provider assessments. The Speaker's bill did not include either the provider assessments or their rate increase.

Hospitals recently overcame their historic opposition to this form of financing and negotiated an agreement with the Governor to pay a tax/assessment of 4% of revenues. Under the most recent draft of the reform proposed by the Governor, hospitals' Medi-Cal rates would be increased to Medicare levels and the state would pay the heretofore-county share of public hospitals' Medi-Cal rates.

An increase in Medi-Cal rates for doctors is warranted, as most types of practitioners have seen no increase in their payment rates since the early 1980s; however doctors have not yet come to an agreement to help finance an increase due to the distribution of benefits and burdens. Relatively few physicians see very high shares of Medi-Cal patients while the majority sees comparatively few. The physician assessment could entail the majority of practitioners heavily subsidizing increased payment rates for a comparative few; therefore, reaching agreement among physicians is quite difficult. Under the most recent draft of the reform proposed by the Governor, physicians would pay no fee, nor would their Medi-Cal reimbursement rates be increased.

Governments: federal, state and county

The **federal** role in financing is split between mandatory and discretionary programs. For example, the federal administration must provide federal matching funds (FFP) for an increase in Medi-Cal eligibility levels for low wage working parents and their children to 250% of poverty ($50,000 for a family of four) or for an increase in payment rates for hospitals to Medicare levels. It cannot deny the advantages of pre-tax purchasing to employers, employees and the self-employed. These are mandatory forms of federal financing.

The federal administration can authorize federal matching funds for coverage of "medically indigent adults" (MIAs), the working poor now in the care of county governments, through a mechanism known as an 1115 waiver, but it is not required to do so. The federal government can negotiate with the state the conditions under which it would be willing do so. The Governor's proposal included a request for such a waiver in the amount of $250 million.[11] The Speaker's bill did not include a waiver. The Governor's recent draft proposal seeks federal waivers to maximize federal support of California's reform efforts.

In a form of "Catch 22", the federal government can recapture from local public and private hospitals DSH and other federal payments for uncompensated care (bad debts, charity care to the uninsured and Medi-Cal underpayments) that are eliminated or reduced by the state health reform package covering the uninsured. The Governor's proposal shifted some current funds into coverage to avoid federal recapture. The Speaker's bill did not. The current reform proposal envisages steps to shift funds to avoid federal recapture, but gives no specifics.

Section 125 is a mechanism to extend the advantages of pre-tax purchasing to employees' premium contributions. The self-employed already have tax deductibility to offset some of the costs of their premiums. Individuals not connected to the workforce are not able to receive a federal or state subsidy to offset their premiums. Tax deductibility for individuals has been proposed by President Bush, but has not had much support in Congress because the bulk of the tax benefits inure to higher income insured individuals and there is little impact in extending coverage for the uninsured.[12] The Governor's proposal, the Speaker's bill and the most recent Governor proposal all require employers to offer the Section 125 option for any employee who seeks to tax-shelter their premium contributions.

The Governor's recent reform proposal also includes an advanceable, refundable tax credit to assure premium affordability for individuals purchasing individual coverage through the state purchasing pool. The tax credit is proposed for individuals with incomes between 250 and 350% of FPL ($50,000 to $75,000 for a family of four). The level of the tax credit will be calculated such that premiums of basic coverage for individuals in this income bracket do not exceed 5% of their income.[13] Credits will be most useful for individuals over the age of fifty and for families that face the most severe affordability challenges in the individual market.[14]

The federal administration could also contest the legitimacy of the state match for Medi-Cal coverage expansions. Provider taxes/fees/assessments and employee/employer premiums/fees/taxes/assessments could face federal scrutiny as to whether they meet federal matching requirements, and therefore they need to be designed consistent with federal rules.

State government has a series of programs that pay for care of the uninsured with particular diseases or at certain providers. These include AIM and other programs for uninsured pregnant women, MRMIP for the medically uninsurable uninsured, CCS and GHPP for the uninsured with designated diseases, EAPC for clinics, SB 12 for emergency room physicians, TB coverage, Family PACT, and Breast Cervical and Prostate Cancer Screening and Treatment programs for the uninsured.[15]

The Governor's proposal proposes to integrate some of these programs and their funding into expanded coverage for the uninsured. The Speaker's bill does not. The latest reform proposal is unclear to what degree existing programs will be consolidated.

County government provides care to uninsured adults (MIAs) with a mix of state, federal and county government funds.[16] The Governor's proposal would take half the state funds realigned to counties and use them to pay for state coverage for the uninsured adults, heretofore a county responsibility. The Speaker's bill covers only the working adult portion of the MIAs and leaves all the state funding in place with the counties.[17] The draft of the latest reform package includes provisions that counties will pay for 40% of the costs of coverage for those MIAs with incomes up to 150% of FPL who enroll in state coverage. Each county's obligation is capped but without yet specifying the level of the cap. This is a vast improvement for counties now paying 100% of these costs and precludes a county windfall from expanding coverage. There should be opportunities for successful transitions of strong local safety net delivery models into managed care through Medi-Cal and the pool and opportunities to coordinate residual county programs for the uninsured with state and federal financing and programs for the uninsured.[18]

Other financing options

The most recent proposal from the Governor involves leasing the state lottery and devoting the projected $2 billion in annual revenues from the lease to a trust fund to help pay for his reform proposal.

The state can increase taxes with a two-thirds vote of the state legislature or a majority vote of state voters, and all taxes are very difficult to pass. We think that any new voter-approved financing should be deposited into a special health care trust fund that can only be used for the designated purposes.

One option is to increase consumption taxes (such as a sales tax).[19] This could be an increase in the rate of sales taxes or an application of the sales tax to some or all services. These increases could be very small, one percent or less, because they touch such a broad range of economic activity. Sales taxes are less regressive than advertised as they exempt food and rent that make up a large percentage of household expenses.

Another option is to increase special fund taxes such as the Unemployment Insurance tax or the State Disability Insurance tax to pay for health coverage for special populations of uninsured such as the disabled or unemployed.[20] This could be a very small increase such as one tenth of one percent (or the state could increase the caps on these taxes) to pay for coverage for these special populations.

A third option is to increase taxes on products contributing to poor health and higher health costs such as tobacco or hard liquor.[21] Some have suggested snack taxes.

A fourth option is to increase taxes or assessments on health plans. Assessments on health plans to pay for the medically uninsurable enrolled in MRMIP are under consideration.[22] Another option not under discussion is tax equity for health insurers and health plans.

The state can apply user fees with a majority vote, but not to exceed the cost of the services. For example, an annual user fee of $100 for all persons using publicly funded health services would raise over $1 billion in revenues, albeit in a regressive fashion.[23]

At the other end of the spectrum is an increase in tax brackets for high-income persons.[24] This may be warranted to correct the imbalance of an economy producing large income gains at the very top while incomes stagnate at middle and lower incomes.[25]

The state can also apply mandates with a majority vote: such as a parental mandate to enroll children in available coverage, an individual mandate to enroll in available public or private coverage, a mandate on schools and institutions of higher education to assure their students are enrolled or an employer mandate. The caveats are that coverage needs to be available and affordable, or the mandate will be ignored.

The state can also apply increased fines and forfeitures on those convicted of illegal activity by the courts with a majority vote.[26] This could help pay for interim coverage for uninsured children in local Children's Health Initiatives.

ERISA[27]
Congress enacted the Employee Retirement Income Security Act (ERISA) in the early 1970s to assure the solvency of pension funds for employees. It included a section pre-empting states from regulating employers' self-insured plans and shifted that responsibility to the federal Department of Labor. The goal was to avoid 50 separate state rules on large employers operating in states across the country. States were allowed to maintain their traditional roles of regulating insurance. The federal courts have interpreted this section of ERISA as barring states from mandating specific levels of employer benefits. Any aspects of the reform governing employers must be very carefully designed to withstand an ERISA challenge that would halt California's reform efforts.

VATs and Global Competitiveness[28]
As we all have been reminded from the recently concluded GM/UAW pact, American employment-based health costs are one factor impairing the global competitiveness of American companies. Adding too great a financial burden on payrolls to pay for health care does impair job creation. At a national level, it is time to revisit financing of health coverage, and one issue that should be considered is shifting in whole or in part to a value added tax (VAT), personal income tax surcharge or some other form of financing that increases the global competitiveness of American companies and American workers. States cannot afford to make that large financial leap as they are tethered by the large federal tax and funding advantages to employment-based coverage and public program expansions within allowable federal strictures.

Prepared by: Lucien Wulsin October 10, 2007

[1] Sheils and Haught, The Cost of Tax-Exempt Health Benefits in 2004, Health Affairs (Feb., 2004)

[2] California HealthCare Foundation, California Employer Health Benefits Survey, November 2006 and California HealthCare Foundation, Snapshot, Employer-Based Insurance: Coverage and Cost (2006). The average employer cost is about 7.7% of payroll; however for one fourth of employers, it exceeds 15% and for a quarter it is 4% or less; the highest share of premiums is associated with small low wage businesses offering family coverage. Ibid. Ninety percent of California's workers are employed by a business that offers health coverage which is not to say that all workers for those offering employers are covered by their employers as some (such as new workers, part-time workers and particular classes of employees) are ineligible and some cannot afford their share of premiums and are therefore uninsured. Ibid.

[3] See Hadley, Sicker and Poorer, the Consequences of Being Uninsured (May 2002) at www.kff.org; Institute of Medicine, Care without Coverage (National Academies Press, 2002), and Haley and Zuckerman, Health Insurance, Access and Use: California (Urban Institute July 2000) at www.urban.org

[4] See Strunk & Cunningham, Treading Water: Americans' Access to Needed Medical Care, 1997-2001. Center for Studying Health System Change, 2002; Cunningham, Declining Employer-Sponsored Coverage: The Role of Public Programs and Implications for Access to Care. Medical Care Research and Review, Vol. 59, Issue 1, March 2002; Hoffman & Gaskin, The Cost of Preventable Hospitalizations among Uninsured and Medicaid Adults. Kaiser Family Foundation, 2001; Ayanian et al., The Relation between Health Insurance Coverage and Clinical Outcomes among Women with Breast Cancer. The New England Journal of Medicine, Vol. 329, 1993; Roetzheim et al., Effects of Health Insurance and Race on Colorectal Cancer Treatments and Outcomes. American Journal of Public Health, Volume 90 Issue 11, 2000; Families USA, Getting Less Care: The Uninsured with Chronic Health Conditions. 2001; Moy, Bartman, Weir, Access to Hypertensive Care: Effects of Income, Insurance, and Source of Care. Archives of Internal Medicine, Vol. 155 No. 14, 1995; Ayanian et al., Unmet Health Needs of Uninsured Adults in the United States. JAMA, Vol. 284 No. 16, 2000; and Obrador et al., Level of Renal Function at the Initiation of Dialysis in the US End-stage Renal Disease Population. Kidney International, Vol. 56 No. 6, 1999.

[5] Hadley and Holahan, Who Pays for Care and How Much: the Cost of Caring for the Uninsured (Urban Institute (February 2003) and Harbage and Nichols, A Premium Price: The Hidden Costs All Californians Pay in our Fragmented Health Care System (December 2006 at www.newamerica.net

[6] Nearly half of uninsured adults and one third of uninsured children have no usual source of care; those with a usual source of care and lower incomes commonly use community clinics and county clinics; the uninsured with higher incomes typically use private doctors. Haley and Zuckerman, Health Insurance, Access and Use: California (Urban Institute July 2000) at www.urban.org and Brown at al, The State of Health Insurance in California (July 2007) at www.healthpolicy.ucla.edu

[7] Family coverage for a minimum wage working family costs roughly 70% of their annual salary.

[8] For example, many support a single payor system; this involves buying out all private insurance premiums and most patient out of pocket costs at a cost of over $95 billion. Others support reliance on an individual mandate and individual private insurance; this also involves buying out private employment-based insurance that accounts for 30% of current spending and is attached to a large federal tax subsidy.

[9] See n. 3. Harbage and Nichols believe the cost shift accounts for nearly 10% of private premiums. ITUP believes the cost for bad debt and charity care for the uninsured is much less -- closer to 2% of private premiums. See Wulsin, ITUP Discussion of Reform Opportunities (February 2007) at www.itup.org

[10] California HealthCare Foundation, Medi-Cal Facts and Figures (May 2007) and The Financial Health of California Hospitals (June 2007) at www.chcf.org According to these studies, physicians are paid by Medi-Cal at 59% of Medicare rates while hospitals are paid by Medi-Cal at 74% of Medicare for inpatient care and 81% for outpatient services. This does not include the substantial Medi-Cal DSH and other payment supplements.

[11] Many other states already have such waivers, including our neighboring states of Oregon and Arizona and the pioneering states of Massachusetts and Vermont. See Wulsin, Safety Nets and Coverage Expansions: ITUP Recommendations (July 2007 at www.itup.org

[12] See Burman, et al, The President' Health Insurance Proposal – A First Look, Urban Institute, January 2007. http://www.urban.org/publications/411412.html

[13] Five percent of a family of four's income of $60,000 (300% of FPL) is $3000 or $250 a month for family coverage; five percent of an individual's income of $30,000 (300% of FPL) is $1500 or $125 a month for individual coverage.

[14] See Wulsin, Thoughts on an Individual Mandate (ITUP, September 4, 2007) at www.itup.org

[15] See Botelho, A Summary of Health Care Financing for Low Income Californians 1998-2007 (ITUP, August 2007) at www.itup.org

[16] Ibid. See also Safety Nets and Coverage Expansions: ITUP Recommendations (July 2007 at www.itup.org

[17] The Governor's initial proposal would have saved county government between $471 and $928 million, roughly double the savings projected for AB 8. Newman and McMahon, The Financial Impact of Health Care Reform on California Counties (2007) at www.blueskyconsultingGroup.com or www.chcf.org.

[18] See Safety Nets and Coverage Expansions: ITUP Recommendations.

[19] Raising selective sales taxes to the national average raises $3.3 billion while braidening the sales tax to include some services raises $2 billion. Rueben and Gordon, Financing Health Coverage: California's Tax Structure and Options (2007) at www.newamerica.net

[20] A payroll tax like SDI set at 0.6% raises $3.1 billion. Ibid. See also Wulsin, California at the Crossroads: Choices for Health Care Reform (Center for Governmental Studies, 2004)

[21] Doubling the cigarette tax to $1.74 a pack, raises $1.1 billion. Ibid.

[22] AB 2 (Dymally) of 2007

[23] Under the reform proposals, most Californians will have access to coverage subsidized by state programs or federal and state tax advantages.

[24] Doubling the millionaire's tax approved by the voters in Prop 63 raises less than $1 billion. Rueben and Gordon, Financing Health Coverage: California's Tax Structure and Options

[25] California Budget Project, A Generation of Widening Inequality 1979-2006 (August 2007) at www.cbp.org

[26] See e.g. SB 12 (Maddy)

[27] Butler, ERISA Implications of State Pay or Play Laws (July 23, 2007) at www.chcf.org

[28] See Kominski, Financing a System of Universal Health, prepared for Transforming the Organization and Financing of the US Health System (September 5-7, 2007)