

HB 667

EXHIBIT 9  
DATE 2.16.05  
HB 667

## Talking Points

### Small Business Health Insurance Tax Credits

The legislation was found under HB200 but now changed and expanded in HB667 to include purchasing pools. The tax credit is reviewed here, the purchasing pools are reviewed in another report.

The intent of the bill is to move several thousand Montanans from being "uninsured" to "insured." There are two ways to achieve that end:

1. Let the private sector do it free by eliminating government regulation and taxation of medical insurance and reducing the cost of care/insurance.
2. Have the government use taxpayer funds to "bribe" the uninsured with tax credits and other subsidies.
3. Expand government provided coverage through tax funded SCHIP and MEDCAID turning consumers into recipients.

The new Montana state administration is taking the last two approaches. The legislation discussed here is #2—the "bribe."

#### ***The "bribe"***

The general idea of the legislation is to provide two tax credits for the uninsured and a state run insurance purchasing pool for small business (under 10 employees).

1. The first tax credit (about 40% of the program) would go to small businesses that already offer group insurance to employees.
2. The second (60% of funds) would go to small businesses that have not offered group medical insurance during the past two years.

Both tax credits would be limited to \$100-125 per employee per month for employees with annual incomes below cap (around \$75K per year). The second credit could only be used to purchase insurance from a state created "purchasing pool" or private pools/associations.

The first credit would be offered on a first-come-first-serve basis; the second would have to be approved by a state appointed board.

Because these individuals and businesses have voluntarily opted out of an insurance purchase, they have said, "the cost of insurance does not equal its value to me." This \$1,000+ per year subsidy attempts to change their mind without changing the cost or value of insurance. That is a bribe.

additional costs born by these plans. Fund “public” programs (MCHA, “auditing” carriers, etc.) from general taxation, not by taxing insurance consumers. (This would be a better—but not long-term—use of the new cigarette tax).

4. **Eliminate all mandates.** This would reduce premiums and, if more choice of coverage were provided, increase the value of insurance to consumers. These are key to bringing consumers back into the market.
5. **Eliminate underwriting restrictions**—begin by eliminating “unisex.” Then, permit group insurance carriers to base individual premiums on underwriting factors—create risk bands. It is only through underwriting that insurance will be able to design and price policies for everyone.

Premium tax note: (Needs checking) All insurance carriers pay 2.75% tax. On top of that tax, health, life and disability carriers (including HMOs, HSCs, etc.) pay 1%. Total annual revenues are about \$60 million.

JR Chipman  
Jan. 31, 2005.

The value of this public purpose is dramatically over-stated. The National Center For Policy Analysis calculated that:

- $\frac{3}{4}$  of all uncompensated medical cost was attributed to Medicare and Medicaid. The un-insureds only contributed  $\frac{1}{4}$  of the total.
- “Prices” charged the un-insured may be multiples of that charged others. Cost shifting from M & M has been compounded by “managed care” (PPOs and HMOs)—the un-insured are at the end of all the cost shifts.
- Un-insured pay higher taxes because they do not have the income exclusion granted group insurance plans and their employers pay high taxes. The insured and their employers save about 40% (combined) of the cost of premiums—the uninsured’s don’t.
- The CBO estimated that uncompensated care for the un-insured was only 2.9% of the national health care bill (1995). When that estimate was made, “bad debts for the economy as a whole [were] 2.4 percent of sales.” (NCPA).

Even if we consider this a large problem, the return to the tax payers from this expensive program will only be pennies on the dollar. Less than 5% of the participants will have a catastrophic event (requiring hospitalization). If 10% would have failed to pay an average bill of \$20,000, the cost would be \$100 per participant. The subsidy (not including overhead) is \$1,200; probably \$1,600+ with overhead.

A program that provides the taxpayers \$1 in benefits for \$16 in tax funds spent would not be considered a good “investment.”

### ***What should rational insurance consumers do?***

Take the non-political approach and urge all legislators to vote “NO” to more punishing taxes and medical insurance premiums inflating at an even faster pace.

But, if politics demand that some program be implemented, do as little harm to the market as possible and as much good for low-income consumers.

Here are some ideas:

1. Provide tax credits for low-income individuals (as envisioned in the cigarette tax initiative)—but only on an individual basis. Have it applied to their share of group coverage at their place of employment. Only permit its application to the purchase of individual coverage, if no group coverage is available. Such a program could be linked to the proposed Medicaid waiver to permit recipients to purchase private insurance (see Sen. Cobb).
2. **Eliminate the purchasing pool.** Employers can establish associations now—there is no need to subtract thousands of Montanans from the insurance marketplace to create an inefficient state pool that will be tempted to “fix” insurance premiums and inflate insurance costs for the rest of Montana.
3. **Eliminate all premium taxes on group medical insurance.** This would actually reduce the cost of insurance. Under HIPAA, group insurers must guarantee issue their policies. The elimination of the premium tax would help offset the