

**Testimony for the Record
Submitted to the**

UNITED STATES SENATE COMMITTEE ON FINANCE

for the October 25, 2007

**Hearing on Small Business Health Insurance: Building a Gateway to
Coverage**

Dirksen Senate Office Building, Room 215

Remarks of:

Alden J. Bianchi, Esq.
Mintz, Levin, Cohn, Ferris, Glovsky and Popeo, P.C.
Boston, Massachusetts

Introduction

This testimony is being submitted to the U.S. Senate Committee on Finance in connection with its deliberations with respect to the availability of health care insurance coverage. The rising costs of health care coverage and the increasing ranks of the uninsured are well documented, and lawmakers at both the Federal and state levels are under increasing pressure to provide or at least assist with a solution. The conventional wisdom is that existing regulatory structures need to be significantly adjusted or entirely replaced in order to make health insurance coverage more widely available.

The United States is unique among industrialized nations in how it provides its citizens employment-based welfare and retirement security. More than 140 million workers are covered by employer-sponsored group health plans that are regulated by an overlapping web of sometimes conflicting Federal and state laws. Ours is a voluntary system: employers are not required to provide health care coverage to employees, nor are employees required to purchase employer-based coverage when offered. We rely instead on market forces and fiscal policy (i.e., tax breaks) to encourage employers to offer, and employees to accept, health insurance coverage.

My purpose with these remarks is to present to the Committee an overview of the nascent and emerging features of market-based health care reform mechanisms, drawing principally, though not exclusively, on the experience of the Commonwealth of Massachusetts. During 2005 and 2006, I had the privilege of serving as outside counsel to the Romney Administration in connection with the Massachusetts health care reform act, and I currently represent the Massachusetts Health Insurance Connector Authority, the health insurance clearing house established under the Massachusetts law that is central to our new law. That a single state, in this instance Massachusetts, adopted a

health care reform measure is, by itself, unremarkable. What is remarkable, however, is the extent to which key features of the Massachusetts health care reform act have been adopted by other states and included in so many other health care reform proposals at the Federal level.

The need for broad-based health care reform is generally well-accepted. Some cite the rising ranks of the uninsured and under-insured, while others focus on the rising cost of care. Whatever the reason, the conventional wisdom is that there are only two ways to accomplish health care reform. The first is a government-run, “single payer” approach, which might resemble a vastly expanded, traditional Medicare program. The second is a market-based approach, which relies on existing, private sector insurance companies to provide coverage. Whatever one’s personal views of the relative merits of these two options are, it appears clear that support for the single-payer system has not reached anything approaching critical mass. Where market-based reform proposals are concerned, the opposite appears to be the case.

Dividing the universe into “single payer” and “market-based” reform proposals is something of an oversimplification. Rather than being unique and mutually exclusive regimes, these are perhaps better understood as the opposite end-points on a continuum. It is possible to combine these approaches to produce a broad range of hybrid schemes. But of the myriad of health care reform bills and proposals currently in circulation, the ones with the most practical and immediate promise appear to be market-based, and they generally adopt many of the key design features and structures of the Massachusetts law.

Review of Available Precedent

My understanding is that your Committee is working toward a market-based health care reform proposal, but that you have not yet settled upon all of the particulars. In an effort to assist in these efforts, I have identified a handful of market-based reform features and the experience to date (if any) with respect to each. I caution, however, that these are all “early returns.” In undertaking major structural reforms aimed at expanding health care coverage nationally, the Committee is breaking much new ground. And while the experience at the state level may inform your efforts, these experiences are of relatively recent vintage. (The Massachusetts law, for example, is only a year and a half old, and many of its regulatory and oversight structures are still being developed.)

- (1) *State-based, or Multi-State, Health Insurance Connector, Gateway, or Clearinghouse*

The concept of a health insurance “connector” (alternatively known as a “gateway” or “clearinghouse”) is a flexible instrument that has worked well to date in Massachusetts. Generally, the concept of a connector is to provide a focus of health care administration efforts. They can provide access to insurance products and information and facilitate compliance.

Example: In the decades following the enactment of ERISA, many states were plagued with an onslaught of fraudulent health plans sponsored by

shady commercial operators, who would enter a market, collect premiums, then leave. Where health insurance products are offered through a connector, and are accompanied by a connector “seal of approval,” however, individuals and employees have the confidence that a health plan has been independently vetted.

The purpose of the Massachusetts Connector is to “furnish access by eligible individuals and eligible small groups to affordable health insurance products.” It has six main functions:

- (i) Facilitating health insurance access;
- (ii) Defining “minimum creditable coverage” for purposes of the state’s individual health insurance mandate;
- (iii) Administering the state’s low income health plan;
- (iv) Establishing “affordability” standards (also in connection with the individual mandate);
- (v) Promulgating “section 125 cafeteria plan” regulations (see discussion below); and
- (vi) Administering waivers and appeals.

More generically, connectors or gateways need not be confined to a single state (they can be multi-state), and they can be organized as governmental, quasi-governmental or private sector entities.

(2) *Small-Group Insurance Reform*

One of the Massachusetts act’s more ambitious reforms is the merger of the non-group and small-group health insurance markets. Of the two markets, the non-group market is by far the more adversely selected. The act commissioned an actuarial study of the consequences of merging the two insurance markets before the merger went live. The study, which was issued in December 2006,¹ estimates that the effect of the merger on the small group and non-group markets will result in a decrease in non-group rates of approximately 15% and an increase in small group rates of approximately 1 to 1.5%.

But small group reform need not be limited in the manner chosen by the Massachusetts legislature. Rather, it can be used to establish multi-state pools with uniform coverage requirements, in the manner proposed in connection with association health plans. States could also be permitted to vary coverage within a prescribed corridor so that they can offer less expensive, custom health insurance products. Additionally,

¹ See “Impact of Merging the Massachusetts Non-Group and Small Group Health Insurance Markets,” by Gorman Actuarial, LLC. Prepared for the Massachusetts Division of Insurance and Market Merger Special Commission, December 26, 2006..

your Committee has the option of revisiting issues such as guaranteed issue, guaranteed renewability, and portability that were first considered in a comprehensive fashion in the Health Insurance Portability and Accountability Act of 1996.

(3) *Section 125 Cafeteria Plan Mandates*

Internal Revenue Code § 125 permits employees to make pre-tax contributions under employer-sponsored group health plans. These plans are referred to as “cafeteria” plans. Cafeteria plans allow employees to make contributions toward the costs of employer-provided coverage with pre-tax dollars. The advantages accrue to both employers and the employees: Where an employee pays for health insurance on a pre-tax basis, the employer saves FICA taxes of 7.65%, and the employee saves FICA, state and federal income taxes (about 40% on average).

Under a “section 125 cafeteria plan” mandate, employers are required to offer coverage under a plan that meets the requirements of Internal Revenue Code § 125 so that employees can pay the employee portion of their health care insurance premiums with pre-tax dollars. Under the Massachusetts law, employers are required to offer access to a cafeteria plan even if they do not offer any health coverage. Connecticut and Rhode Island have also enacted cafeteria plan requirements.

A cafeteria plan requirement assumes that there is no change to the underlying income tax rules. Health care reform proposals that include structural reforms of the underlying tax rules may have no need for a cafeteria plan requirement, especially if funding is based on refundable tax credits (which I discuss below). However, a requirement that an employer reduce an employee’s salary to pay health premiums may be a key feature if tax subsidies are run through the employer.

(4) *Tax Funding Mechanisms—Limits on Employer Exclusion, Refundable Tax Credits, etc.*

Under our current income tax regime, employer contributions for employee health care coverage is deductible without limit for both income and employment tax purposes. In his 2007 State of the Union address, President Bush proposed to eliminate this deduction in its entirety in favor of a personal income tax deduction for employees. There is a middle ground, however, in which the employer’s deduction is capped instead of eliminated. Moreover, employer contributions to Health Savings Accounts (HSAs) could be counted or not counted toward the cap, as the Committee chooses.

Under current law, the cost of employer-provided health care coverage is excluded from an employee’s income. Under an alternative, this exclusion could be repealed and replaced with either an above-the-line deduction for the cost of employer-provided health coverage, or a refundable income tax credit. While the tax-credit concept for health care is currently untested, existing tax laws contain a variety of tax-credit features, with respect to which there is no shortage of date or experience (for example, the Health Care Tax Credit or Earned Income Tax Credit).

In the health care context, one of the most well-developed tax-credit proposals was put forth by the Heritage Foundation in or about 2005.² The Heritage Foundation proposal called for a refundable, advancable and assignable tax credit. A “refundable” health care tax credit ensures that an individual is eligible for the credit even if he or she owes little or no taxes. It is, effectively, a direct subsidy for the purchase of health care coverage. To say that a credit is “advancable” simply means that the credit can be claimed “up front” when insurance premiums are due rather than having to wait until the end of the year for reimbursement. Lastly, an “assignable” tax credit is one that could be forwarded directly and automatically to the insurer.

At bottom, in any market-based health care reform, dollars must flow from individuals, employers and the government to the health insurance issuer that provides the insurance. Under the Massachusetts approach, governmental dollars originate with government subsidies that flow through a government agency on their way to the insurance companies. Where market-based reforms are financed with tax mechanisms, dollars from the government flow through the tax system to the insurance companies. The end result is the same; what differs is the policy mechanism whereby the ends are achieved.

(5) *The Individual Mandate*

Perhaps the most novel feature of the Massachusetts health care reform act is its “individual mandate,” under which all residents of the Commonwealth must obtain and maintain a minimum level of health insurance coverage—referred to as “minimum creditable coverage”—based on an annually published premium schedule. The individual mandate is controversial, and it has not been widely embraced by other reformers. It does, however, solve some intractable problems relating to underwriting, and it also ensures that the risks are spread over as large of cohort as possible.

Tax Considerations

The proposal floated by President Bush in his State of the Union address was both innovative and novel. The President’s plan had two parts: Under the first part, the current system (based on a tax exclusion for employer-provided health insurance premiums, with a corresponding employer deduction) is replaced with a standard tax deduction for health insurance for families and individuals with private coverage. The rationale for this is that the current system penalizes individuals who obtain coverage other than through their employer. Under the second part of the Bush proposal, States are encouraged to pursue their own, independent efforts to expand access to affordable coverage. To encourage this, the Secretary of HHS would be given the power to redirect Federal payments in support of state efforts to help low-income individuals purchase private health insurance.

It is possible to envision tax-based reforms that are not as radical as the Bush proposal. Rather than eliminate the exclusions, they can be capped, with the resulting tax

² See “Health Care Tax Credits: Designing an Alternative to Employer-Based Coverage,” by Nina Owachenko at <http://www.heritage.org/Research/HealthCare/bg1895.cfm> (Nov. 8, 2005).

savings applied to tax credits or other relief. Alternatively, the tax benefits of the current system can be replaced with tax credits in an effort to encourage employers to make coverage more widely available. The availability and use of tax credits can also be tied to state reform efforts.

Conclusion

I hope that this overview has been helpful to the Committee in understanding something of the course that health care reform is currently following. Some of these concepts are new and untested or little tested, while others are old concepts that are being put to new uses. Each has its defenders and detractors, though, in the end, the purpose is the same, namely, to expand the availability of health care coverage in these United States and to reign in the rapidly increasing costs of that coverage.

Appendix

**U.S. SENATE COMMITTEE ON FINANCE
Hearing on Small Business Health Insurance:
Building a Gateway to Coverage**

October 25, 2007

**Summary of Key Features of Existing and Proposed,
Market-Based Health Care Reform Features**

Item	Design Component or Feature	Comments
1.	State-based, or multi-state, health insurance connector, gateway, or clearinghouse	First adopted under the Massachusetts health care reform act, this approach appears both flexible and promising.
2.	State or multi-state insurance pooling arrangement	State high risk pools are already common. Multi state pooling arrangements (i.e., association health plans) were proposed, but never enacted into law. (<i>See, e.g., S. 1955, the Health Insurance Marketplace Modernization and Affordability Act</i>).
3.	Small-group insurance reform—individual and small group merger	Adopted under the Massachusetts health care reform act in the form of a merger of the individual and small group health insurance markets. Early indications are that this approach has brought significant downward pressure on individual rates without any marked increase in group rates.
4.	Small-group insurance reform—combine small groups for underwriting purposes	Not yet tested, but the larger the pool, the more diverse the risk, and the more stable and predictable the rates.

5.	Small-group insurance reform—multi-state uniform coverage requirements based on NAIC-developed standards, with options to vary coverage within a prescribed corridor that permits states to craft less expensive, custom products	<p>Not yet tested, but would appear to have a salutary effect.</p> <p>NOTE: This is similar to a codification of current practice, under which there is a good deal of uniformity among the mainstream group health insurance products, but it would furnish protection from what appears to be an explosive growth in non-standard products.</p>
6.	Section 125 cafeteria plan mandate.	<p>Massachusetts, Connecticut and Rhode Island have adopted some form of a “section 125 cafeteria plan” requirement for the purpose of ensuring that employees get the benefit of pre-tax treatment on their employee-paid health care premiums.</p> <p>NOTE: Proposals that rely on income tax-credits or other tax-based financing mechanisms generally have no need for a cafeteria plan requirement, unless the tax subsidies are run through the employer.</p>
7.	Individual market reforms—guaranteed issue, guaranteed renewability, limitations on pre-existing condition exclusions, etc.	These have been successfully tested, for the most part, under the HIPAA.
8.	Cap on income tax exclusion for employer-provided health coverage—with HSA contributions counting toward the cap.	Not yet tested, but is not too different from current rules.

9.	<p>Include cost of employer-provided health coverage in employee's income. Employee is provided with an above-the-line deduction for the cost of employer-provided health coverage (up to the amount of the cap described in item (8) above).</p> <p>NOTE: See item (10) below for an alternative.</p>	<p>This approach has not yet been tested, but think tanks on both the left and right contemplate similar changes in the tax treatment of health insurance.</p>
10.	<p>Refundable income tax credit to the employee for health insurance (reduced by payments made on the employee's behalf).</p> <p>NOTE: The credit would be revenue neutral and indexed for medical care cost inflation.</p>	<p>Not yet tested. An advanceable, refundable, assignable health insurance tax credit was previously proposed by the Heritage Foundation.</p>
10.	<p>Individual coverage mandate</p>	<p>Adopted in Massachusetts, but not generally gaining traction in most other states or proposals.</p>

About the Author

Alden J. Bianchi is a Member in the Boston office of Mintz, Levin, Cohn, Ferris, Glovsky and Popeo, P.C., where he leads the employee benefits and executive compensation practice group.

Mr. Bianchi advises corporate, not-for-profit, governmental and individual clients on a broad range of executive compensation and employee benefits issues, including qualified and non-qualified retirement plans, stock and stock-based compensation arrangements, ERISA fiduciary and prohibited transaction issues, benefit-related aspects of mergers and acquisitions, and health and welfare plans. He represented the Romney administration in connection with the ground-breaking Massachusetts health care reform act, and he currently advises the Massachusetts Health Insurance Connector Authority, the state agency established to facilitate the purchase of affordable health insurance by individuals and small groups. He is also currently advising a handful of other states with respect to health reform issues.

Mr. Bianchi has written and lectured extensively on employee benefits issues. He is the author of three books, *Employee Benefits for the Contingent Workforce* and *Plan Disqualification and ERISA Litigation* (both published by Tax Management, Inc.), and *Benefits Compliance* (published by World-at-Work), and over 50 benefits-related articles. He has also published a comprehensive summary of the Massachusetts health care reform act, entitled *An Employer's Guide to the 2006 Health Care Reform Act*. His speaking engagements include presentations to the ALI-ABA, American Bar Association, American Insurance Group, Deloitte & Touche, PricewaterhouseCoopers, Smith Barney, UBS, ING Financial Services and the Risk Insurance Management Society, as well as a host of bar groups and professional, educational and civic organizations.

Mr. Bianchi is a graduate of Worcester Polytechnic Institute and the Suffolk and Georgetown Law Schools, and he holds an LL.M. in taxation from the Boston University Law School. He is listed in Woodward & White's *The Best Lawyers in America*, and Marquis' *Who's Who in American Law*, and he is a Fellow of the American College of Employee Benefits Counsel.