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Small business needs Congress to replace the Patient Protection and Affordable Care Act (PPACA) with real healthcare reform that helps address the number-one problem small businesses face – the high cost of healthcare. Here, NFIB outlines some of the components that ought to be part of a replacement strategy.

Healthcare costs have troubled small business for decades.

Why is a replacement strategy necessary for small business? For over two decades, small businesses have cited rising health insurance costs as their number-one problem. Rising healthcare costs explain why their employees' wages have stagnated. Up through 2010, NFIB advocated strongly for healthcare reform, but always insisted that meaningful reform would have to lead to lower costs. On this score, PPACA failed, as evidenced by the rapid rise in premiums following the law's enactment. Small business needs real reform that deals with costs. Here are one dozen reforms with which to begin.

#1: Equal tax treatment in the employer-sponsored and individual markets.

Tax reforms. #1: Tax breaks in the employer-sponsored market ought to be available in the individual market. The U.S. Tax Code favors employer-sponsored insurance and discourages individual purchases. Employees can only use pre-tax dollars for insurance if their employers choose, purchase and administer their insurance policies. This asymmetry generates well-documented problems. (1) The individual market is small. (2) Administering health insurance distracts employers from their core businesses. (3) The employer/insurance nexus creates "job lock," where employees cannot leave a job for fear of losing health insurance. (4) With employees unable to shop around, insurance is less competitive. (5) Differences in tax treatment should not determine whether a person secures health insurance in the workplace or on their own.

#2: Tax parity between the self-employed and other small businesses.

#2: The tax treatment of insurance purchased by the self-employed should be equivalent to the treatment of employer-sponsored coverage. Self-employed individuals do not receive the same tax treatment as individuals who receive health insurance through their employers. While the self-employed can claim a deduction for the cost of purchasing their own health insurance, the tax benefit is not equal to the tax exclusion for employer-provided coverage. Defined contribution health insurance options.

#3: Defined contribution health insurance options.

#3: Tax and insurance regulations should allow for a defined contribution option for employers. This would make health insurance simple for employers and would give employees a broad range of choices. Small businesses generally lack health insurance expertise, human resource departments and market power. They would like the option of contributing dollars to employees' health insurance without actively choosing, purchasing or managing the plans. With defined contribution health insurance, an employer could contribute pre-tax funds toward employees' insurance. (This amount should remain deductible to the employer.) Employees could then purchase their own insurance policies.

#4: Information technology to make insurance prices and quality transparent.

Insurance purchasing reforms. #4: Insurance markets need an adequate information structure for consumers to make intelligent choices; this demands transparent and easily comparable measures of cost, options and quality. Currently, comparative data are difficult or impossible to obtain. At present, neither consumers nor healthcare providers have adequate information-based tools to drive costs down. In other industries – computers, automobiles, finance, for instance – information technology allows consumers to make informed, intelligent choices. Healthcare needs to catch up with these industries in assembling comprehensive data with user-friendly interfaces.

#5: Exchanges for efficient employer and individual insurance purchases.

#5: Public and/or private exchanges should be widely available; states and other entities should have adequate flexibility to experiment with different models. Centralized portals can give consumers a seamless venue for comparison shopping, purchasing, and conducting business with insurers. It is vital that states and other entities have the ability to experiment with various exchange models. The goal should always be a purchasing environment with enough insurance carriers to unleash competitive forces.

#6: Interstate markets for health insurance.

#6: Small businesses and individuals should be able to pool risks and purchase insurance across state lines. Large businesses, labor unions and governments generally self-insure, so under the federal ERISA law, they can pool their risks across state lines. This allows them to develop larger, more stable risk pools, thereby lowering costs and reducing uncertainty. The fully-insured market (mostly small businesses and individual purchasers) has no such ability to pool risks across state lines. Another virtue of an interstate market is that it provides a check on overzealous state regulations by offering out-of-state options to purchasers.

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#7: Options for developing insurance pools.

#7. Employers should be able to voluntarily join with other employers to form larger risk pools and purchasing arrangements. Properly crafted, Small Business Health Plans legislation would enable groups of employers to band together to form larger, more stable risk pools.

#8: Access to insurance for those with pre-existing conditions.

#8. Health insurance reform ought to enable individuals with pre-existing conditions to obtain and maintain health insurance. People with pre-existing conditions often have difficulty obtaining affordable insurance. The individual market can be a difficult place to secure health insurance if an individual has a pre-existing condition or illness. Reforms should be in place to mitigate these practices. Whichever means is adopted should not discourage employers from hiring individuals with pre-existing conditions.

#9: Insurance portability for individuals who maintain coverage.

#9. People should be able to move from one job to another, between a job and no job, and from state to state without losing insurance coverage or encountering excessive cost increases for changing. Insurance portability has always been a problem in a system dominated by employer-sponsored insurance. Changing jobs or moving sometimes entailed lapses in coverage or, potentially, loss of coverage altogether. Insurance laws should make it possible for those who maintain their coverage to continue doing so after changing jobs or stopping work altogether.

#10: Insurance that fits individuals' needs.

#10. Laws should permit individuals broad latitude in using consumer-driven tools such as high-deductible policies, HSAs, HRAs and FSAs. For many consumers and small businesses, a high-deductible policy can be an attractive way of managing risks and holding down costs. Premiums are less expensive because insurers deal with less paper flow and because high-deductible policies give patients incentive to reduce unnecessary procedures. Pre-tax accounts, such as HSAs, HRAs and FSAs help prepare consumers for expected and unexpected expenditures before the insurance kicks in. These tools encourage consumers to take an active role in managing their expenses and risks.

#11: Wellness options.

#11. Employers and insurers ought to be able to offer consumers price breaks and other incentives to encourage them to maintain their health. Companies like Safeway have made headlines by incentivizing their employees to engage in healthy lifestyles and prudent preventive and wellness care. Incentives could include price breaks on health insurance for those who engage in healthy behaviors or participate in company-endorsed wellness programs. Most importantly, businesses should be free to tailor such incentives to their specific workforces.

#12: Malpractice reform.

Tort reform. #12. Medical liability laws should limit non-economic damages, rationalize economic penalties for malpractice, and offer options for arbitration and no-fault malpractice insurance. Through excessive malpractice judgments, we penalize good doctors practicing good medicine, when their patients happen to experience bad outcomes. At the same time, most patients who suffer actual acts of malpractice are never compensated. This incoherent system raises costs and damages doctor-patient relationships.

Reform will also have to tackle entitlements and delivery systems.

What other vital elements are we not discussing in this document? Small business desperately needs healthcare reforms that lead to lower costs. This document has outlined some private health insurance market reforms. It has not touched on two other areas that should be part of any meaningful reform – entitlements and medical delivery systems.

Excessive or arbitrary malpractice judgments penalize good doctors who are practicing good medicine, simply because their patients happen to experience bad outcomes. At the same time, most patients who suffer actual acts of malpractice are never compensated. This incoherent system raises costs and damages doctor-patient relationships. Medical liability reform should rationalize economic penalties for malpractice, limit non-economic damages, and offer options for arbitration and no-fault malpractice insurance.

Malpractice reform is important to small business.

Small businesses are both consumers and producers of healthcare. Today's irrational malpractice laws harm small businesses whose employees consume healthcare services and small businesses that produce healthcare services. Well-crafted reforms could benefit both healthcare consumers and producers.

Consumers could reap financial savings.

For decades, small businesses have said their biggest problem is the high cost of health insurance coverage for their employees. Malpractice-induced litigation and defensive medicine contribute to this cost, and reforms can reduce both. Small businesses would see these savings reflected in their insurance premiums.

Small healthcare providers could also benefit.

Many healthcare providers, such as standalone medical practices, are small businesses. The negative consequences of today's malpractice law may hit these smaller providers harder, since they lack the in-house legal talent to combat frivolous cases. Reforms, then, could benefit smaller providers.

Malpractice implies negligence and preventability.

What is malpractice? Medical malpractice is an event where (1) an injury or death results from medical treatment; (2) the injury or death was preventable; and (3) the provider's action (or failure to act) was negligent – deviating from accepted standards of medical practice.

Most adverse events are not malpractice.

Most medical injuries do not qualify as malpractice. Injuries can be preventable but non-negligent; the provider could have made a less harmful choice but followed accepted procedures. Non-negligent, non-preventable injuries are unfortunate, but not malpractice. These types of injuries are not the object of malpractice laws.

Malpractice laws have multiple purposes.

What are the benefits of malpractice laws? Malpractice laws serve multiple purposes, including: (1) reimbursing wrongfully injured patients for the costs of treating the injuries; (2) compensating patients for pain and emotional suffering resulting from acts of malpractice; (3) giving healthcare providers a strong incentive to avoid acts of malpractice; and (4) punishing providers who have committed such acts.

Judgments have economic and non-economic parts.

Malpractice judgments generally have two components. Economic damages reimburse patients for the financial cost of dealing with a malpractice injury – medical expenses, lost income, etc. Non-economic damages compensate patients for the pain and suffering of the medical injury.

Our malpractice system has costly side effects.

What are the costs of malpractice laws? America's malpractice system generates costly side effects. Providers defensively order excessive tests and procedures that cost money and sometimes result in medical side effects. Fear of legal action complicates the relationship between providers and patients.

Estimating malpractice costs is an inexact science.

It is difficult to estimate the malpractice system-induced costs of litigation, defensive medicine, patients harmed by defensive medicine, and so forth. In addition, fear of the malpractice system leads some providers to retire or relocate to less-litigious localities, creating shortages in some places.

Unintended consequences may increase healthcare costs by 2%- 10%.

According to numerous estimates, the cost of litigation and defensive medicine increases national healthcare spending by something in the neighborhood of 2%. A 2006 Price Waterhouse study put that figure at 10%. National health expenditures should total $2.8 trillion in 2012. Using the 2% and 10% figures would put the cost of malpractice litigation and defensive medicine at between $56 billion and $280 billion per year.

Excessive or arbitrary malpractice judgments penalize good doctors who are practicing good medicine, simply because their patients happen to experience bad outcomes. At the same time, most patients who suffer actual acts of malpractice are never compensated. This incoherent system raises costs and damages doctor-patient relationships. Medical liability reform should rationalize economic penalties for malpractice, limit non-economic damages, and offer options for arbitration and no-fault malpractice insurance.

Many defendants are innocent.

How effective are malpractice laws? According to a 2007 RAND study, "There is only about a 37-percent chance that a medical episode leading to a payment actually involved medical malpractice." Countless providers settle out of court in order to avoid litigation costs.

Few victims are compensated.

One estimate holds that only 2% of malpractice victims file lawsuits. An even smaller number receive any remuneration. However, an unknown number are compensated through out-of-court settlements.

The goals of malpractice reform are twofold.

What are the goals of malpractice reform? The goal of malpractice reform is to reduce the negative side effects of the laws as much as possible while reducing the benefits as little as possible. Unfortunately, there are tradeoffs between these two goals.

Malpractice reform can reduce the federal deficit.

In 2009, Sen. Orrin Hatch (R-UT) asked the Congressional Budget Office (CBO) to estimate the effects of malpractice reform on the federal budget. Assuming changes such as limits on non-economic and punitive damages, a statute of limitations, and a shift from joint-and-several liability to fair-share liability, CBO estimated $54 billion in budgetary savings over a ten-year period.

Below are several reform proposals.

What are some specific reform proposals? There are many different approaches to malpractice reform, some of which are listed below. Each has its positives and negatives. This document is not ranking the relative desirability of the different approaches.

Non-economic damage caps.

Laws can limit the level of non-economic damages that a court may order. In 2003, Texas limited non-economic damages to $250,000. Malpractice payouts dropped dramatically, and there was an influx of physicians.

No-fault medical injury insurance.

No-fault insurance could compensate those suffering adverse medical events, regardless of whether the injuries resulted from malpractice. This is similar to no-fault auto insurance, which pays regardless of whose fault and requires no litigation. New Zealand has a system of no-fault medical injury insurance.

Loser pays expenses.

Under the British legal system, the loser in litigation pays the winner's legal expenses. While discouraging frivolous suits, this system also discourages some patients with legitimate complaints from filing legal actions.

Malpractice courts.

Lay juries, lacking medical expertise, arguably turn malpractice litigation into a game of chance. An alternative is to establish malpractice courts whose judgments are rendered by healthcare experts. Sen. Mike Enzi (R-WY) has introduced legislation creating such courts on a test basis.

Limit on contingency fees.

Plaintiffs' attorneys typically receive 1/3 of any judgment, but also cover 100% of the expenses associated with the case. Some argue that this high-stakes incentive scheme encourages "fishing expeditions" by attorneys. In some countries, attorneys' compensation is limited.

Encourage arbitration.

Laws could encourage injured parties and providers to engage in arbitration. One such incentive would limit non-economic damages if the provider alerts the patient to the problem and admits culpability.

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Healthcare Solutions: Defined Contribution Plans

Tax and insurance regulations should allow for a defined contribution health insurance option for employers. This would make health insurance simple for employers and would give employees a broad range of choices. Small businesses generally lack health insurance expertise, human resource departments and market power. They would like the option of contributing dollars to employees' health insurance without actively choosing, purchasing or managing the plans. With defined contribution health insurance, an employer could contribute pre-tax funds toward employees' insurance. (This amount should remain deductible to the employer.) Employees could then purchase their own insurance policies.

Most group plans today are defined benefit (DB) arrangements.

Defined benefit (DB) and defined contribution (DC) plans are different. Since employer-sponsored insurance (ESI) became common in the 1940s, DB plans have dominated the market. With a DB plan, the employer offers employees an insurance policy (or several policies) with a specific range of healthcare benefits. With DB, the employer is an active participant, and the employee is mostly passive.

Defined contribution (DC) is a newer model.

With DB, the employer chooses and administers the insurance plan. In contrast, with a DC plan, the employer provides the employee with a fixed quantity of money; the employee uses these funds to purchase a health insurance policy of his or her own choice.

Post WWII policies led to DB health plans.

World War II-era policies led to today's DB dominance. Wartime and postwar price controls made it unlawful to give raises to employees. Employers discovered that they could circumvent these controls by providing insurance rather than additional money. Later tax and labor regulations cemented this scheme into place.

Employers and employees have few choices.

Employers have little bargaining power in the small-group market and usually have a narrow range of plans from which to choose. Among firms with 1-199 workers, 86 percent of those who offer coverage can only offer one plan. DC would introduce a new element of contribution into this market.

DC is a way to reduce employers' red-tape.

DC health insurance could benefit employers significantly. DC can free employers from a heavy load of administrative time. Employers would no longer have to choose their employees' insurance plans. Nor would the employer have to manage the plan or at least play a large role in its management. Less red-tape means more time to build the business.

DC means financial predictability.

With DC, an employer can determine up-front how much to contribute to employees' health insurance. This gives financial predictability, making it easier to plan and grow the business.

DC can improve relations with employees.

Done correctly, DC can improve employer-employee relations by offering employees more choices and better choices than they currently have. Employees would no longer be limited to their employer's one-size-fits-all insurance choice. The portability of DC plans removes a source of tension between employers and employees.

Small businesses aren't health insurance experts.

DC would be especially valuable to small businesses. In general, small businesses have no special expertise in the area of health insurance. There is little reason to believe that the small-business owner can make better insurance choices for his employees than the employees can make for themselves.

Few small businesses have HR departments.

Few small businesses have human resources departments. The time burden of comparing policies, talking with brokers, dealing with complaints, and managing the plan fall on the business owner. The owner's time is diverted away from the business and into something in which he has no special expertise.

Small businesses have little market power.

A common argument for DB health insurance is that a business can use its size to negotiate better rates and better coverage for its employees. Small businesses are by definition small, and they have little capacity to exert such market power.

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DC will create portability.

DC would improve life for employee, as well. DC can give employees portability. If an employee moves from one employer to another, he can keep his current policy. This reduces the likelihood that the employee will have to change doctors, will be stuck in an undesirable job, or will be left uninsured during transition periods.

DC will lower costs.

A central idea behind DC health insurance is to promote competition among insurers. DC allows employees to vote with their feet – to change insurers when they find a better price or are dissatisfied with the service they are receiving.

DC could help part-timers obtain health insurance.

Utah's health insurance exchange offers a desirable benefit for employees working for employers who provide DC insurance. Different members of the household can combine their employers' contributions into a single pool of funds. In addition, they can aggregate funds from multiple part-time employers.

The current legal environment discourages DC.

Current laws and regulations discourage DC today. Today, a business can use a Section 125 cafeteria plan to provide employees with DC coverage, but it is easy for a small business to trip over the intricacies of 125s. The business must take steps to avoid violating anti-discrimination privileges as related to highly-compensated employees or high-cost health coverage. Also, Section 125 plans cannot be used to purchase insurance offered through an exchange or if the employer is exchange-eligible under PPACA. Also, 125 plans are restricted to employees; business owners cannot obtain coverage through these plans.

New laws are needed to encourage DC.

Other than the Section 125 option, there are currently no tailored vehicles that allow DC health insurance coverage. The 2010 healthcare law does allow a limited DC capability in the SHOP exchanges. However, the choices will be limited, and the employee will not be able to carry these policies from one employer to another. To make DC truly viable, Congress and state legislatures must create new vehicles. DC is also inhibited by today's feeble individual market, a situation arising from the unequal tax treatment of group and individual markets.

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Differences in tax treatment should not determine whether a person secures health insurance in the workplace or on their own. The current tax treatment of insurance premiums disproportionately tips the scale in favor of employer-based coverage. This tax inequity reflects an ad hoc reaction to World War II-era price controls.

Tax laws favor group over individual health insurance.

Tax laws have hobbled health insurance markets for decades. Since just after World War II, our tax laws have riddled the health insurance market with inefficiencies. Employees can purchase group health insurance with pre-tax dollars. But if employees or self-employed individuals purchase policies in the individual market, they lose some or all of these tax benefits.

This bias distorts health insurance markets.

This tax distortion, not economic efficiency, artificially herds businesses and workers into employer-sponsored insurance (ESI). As a result, small employers and employees typically have few choices.

The bias creates many serious problems.

This bias causes or contributes to some of the biggest problems in healthcare. Many of the biggest complaints about health insurance derive from this tax bias toward group insurance.

This distortion limits competition and consumer control.

Thanks to this tax distortion and some related factor, the individual health insurance market is small and relatively uncompetitive. Employees with group insurance have little or no motive to compare policies and to shift their purchases toward policies that best fit their families' wishes. With employees unable to shop around, insurers have less of a motive to provide the insurance people want at prices they can afford.

The tax bias diminishes portability.

The employer/insurance nexus leads to "job lock." With today's group policies, employees can't carry their insurance from one employer to another. They can lose coverage altogether if they become unemployed. Or they face high costs of extending group coverage through the COBRA law.

It diverts small businesses from their core business.

To compete for labor, many employers must offer group insurance coverage. This requires the business owners to choose their employees' policies and to administer the plans. Most small business owners have no special expertise in health insurance. Assuming this role occupies their time and diverts them from building their businesses.

There should be tax parity for different purchasers.

This problem is solvable. These pathologies can be eliminated by treating all purchases of health insurance – group, self-employed, and individual the same under tax laws. This would allow economic efficiency to determine how and where Americans buy insurance.

This document is not advocating any particular version of tax parity.

Various versions of tax parity have been proposed, and this document is not advocating any particular version. Some would allow all insurance purchasers – group, self-employed, or individual -- to pay their premiums with pre-tax dollars. Other proposals would eliminate the tax exclusion altogether and replace it with a tax credit that all Americans could use to buy insurance.

Group insurance became the norm thanks to WWII wage-price controls.

The tax bias is a World War II-era accident. During and immediately after World War II, the federal government imposed wage and price controls. There were limits on when or whether employers could give their employees raises. Employers realized that giving benefits, such as health insurance, would not violate the restrictions on wage increases.

The bias was augmented by later laws and regulations.

As ESI became more common, tax law changes reinforced it by allowing employees to exclude group insurance premiums from their taxable income. The law did not extend this exclusion to individually-purchased insurance. Later on, labor regulations added health insurance to collective bargaining arrangements, further cementing the bias toward ESI.

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Healthcare Solutions: Portability

An important goal of healthcare reform should be portability. People should be able to change jobs, addresses, family status, and health status with minimal disruption to their health insurance coverage, their healthcare, and their financial condition. America's system of employer-sponsored insurance has long impeded portability.

Portability has no single, simple definition.

Portability is a goal along a continuum. There is no single, simple definition of portability, but here's a workable description of the concept: As a goal, portability means that the health insurance market is structured so that a change of job, address, family status, or health status has the least possible negative impact on one's insurance coverage, healthcare, or insurance premiums.

There will always be some limits to portability.

A cross-country move obviously means changing one's network of healthcare providers, so portability has its limits. Similarly, if a couple gets insurance through one spouse's employer, a divorce probably means that one spouse will have to change coverage.

But better laws and regulations can greatly improve portability.

While portability has its limits, changes in a few laws and regulations could greatly increase the continuity of coverage and care as Americans go through changes in their lives. Portability would be especially enhanced by changes in tax laws, more flexible insurance pools, and increased consumer options.

COBRA and HIPAA allow some portability.

Current laws provide limited portability. Under current law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) allows an employee to keep his ESI after leaving a job. However, purchasing coverage through COBRA is time-limited and costly. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides similar guarantees.

PPACA allows limited portability.

For all of its severe failings, the Patient Protection and Affordable Care Act (PPACA) does increase portability though its guaranteed issue and rating restrictions. To a large extent, however, PPACA reinforces the shortcomings of today's employer-sponsored insurance (ESI). After 2014, while an individual will have some guarantee of being able to purchase an insurance policy, they may not be able to carry a policy they like from one employer to another.

Employer-sponsored insurance (ESI) limits portability.

Tax law changes would be the most essential catalyst for portability. Today's fragmented market for employer-sponsored insurance (ESI) is single biggest impediment to portability. This includes prohibitions on interstate purchase of insurance. An employee who changes jobs generally has to change insurance coverage. This, in turn, can entail changing healthcare providers and frequently means a change in the cost of the insurance.

Current tax laws bias markets toward ESI.

The Tax Code is a major reason for the pervasiveness and rigidity of ESI. Since the 1940s, employees with ESI have been able to buy insurance with pre-tax dollars. People with individual policies have to pay their premiums with after-tax dollars.

A change in family status is also risky.

Portability is currently a problem for those changing family status. Take, for example, an individual who gets insurance through an employer's ESI. If the two divorce, the spouse will probably have to change coverage.

Tax parity would provide the strongest boost to portability.

The most incentive for portable insurance would be tax parity between the individual, group, and self-employed buyers. One option is to allow all insurance purchasers to pay premiums with pre-tax dollars. Others propose to eliminate the tax exclusion and replace it with an equal tax credit for all Americans. Either way, individuals could base insurance choices on their personal needs rather than on arcane tax laws.

Interstate insurance markets would provide more options.

More flexible small-group markets would also enhance portability. Large businesses, labor unions and governments generally self-insure, so under the federal ERISA law, they can pool their risks across state lines. Hence, an employee who changes addresses or moves from one of his employer's locations to another experiences minimal disruption. The fully-insured market (mostly small businesses and individual purchasers) has no such ability to pool risks across state lines. Small businesses and individuals should also be able to pool risks and purchase insurance across state lines.

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An important goal of healthcare reform should be portability. People should be able to change jobs, addresses, family status, and health status with minimal disruption to their health insurance coverage, their healthcare, and their financial condition. America's system of employer-sponsored insurance has long impeded portability.

Similarly, employers should be able to voluntarily join with other employers to form larger risk pools and purchasing arrangements. Properly crafted, **multi-employer risk pools** legislation would enable groups of employers to band together to form larger, more stable risk pools. Thus, an employee in a particular industry could move from one employer to another without changing coverage or care.

Broader pooling arrangements would also provide options.

More consumer options would also help. Small businesses generally lack health insurance expertise, human resource departments and market power. They would like the option of contributing dollars to employees' health insurance without actively choosing, purchasing or managing the plans. With **defined contribution** health insurance, an employer could contribute pre-tax funds toward employees' insurance. (This amount should remain deductible to the employer.) Employees could then purchase their own insurance policies and carry them from one job to another when they change employers.

Defined contribution health insurance gives individuals choices.

The small-group and individual insurance markets have long been fragmented and relatively uncompetitive. Public and/or private exchanges are an attractive innovation, potentially giving consumers a seamless venue for comparison shopping, purchasing, and conducting business with insurers. Importantly, exchanges can allow individuals to purchase policies that they can carry from one job to another. It is vital that states and other entities have the ability to experiment with various exchange models. The goal should always be a purchasing environment with enough insurance carriers to unleash competitive forces. PPACA creates exchanges, but it remains to be seen whether they will be viable or flexible enough to permit competition to flourish.

Insurance exchanges provide a venue for portability.

Small businesses and individuals should be able to purchase insurance across state lines. This would allow small businesses to form broader, interstate risk pools – an option already available to big businesses, labor unions, and governments. A nationwide market would augment competition among insurers, providers, and regulators. Regional markets would help to a lesser extent.

Risk-pool limits raise small business costs.

Current laws artificially restrict small business risk pools. Limiting risk pools to individual businesses within the confines of a single state helps make insurance costs the single biggest problem for small business. These limits do not typically apply to big businesses, labor unions, or governments, most of which self-insure.

Pooling limits put small business at a disadvantage.

The stability of an insurance pool depends in part on its number of covered lives. With larger pools, the "Law of Large Numbers" makes overall costs of an insurance plan highly predictable. With smaller pools, costs vary more and, hence, businesses have less ability to predict their employees' healthcare costs.

Fully-insured vs. self-insured is the key.

To understand why current risk-pool limits hurt small business, it is important to understand the distinction between the fully-insured market and self-insured plans.

Fully-insured employers hire outside insurers.

In the fully-insured market, a business purchases a policy from an insurance carrier (e.g., Blue Cross, Aetna, Cigna). The employer pays a fixed premium and the insurer assumes the financial risk (after deductibles and co-pays are met). In general, if some employee suffers, say, a $15,000 illness, the insurer, not the employer, experiences a $15,000 financial loss.

Fully-insured risk pools are limited.

Most small businesses are fully-insured, as are buyers in the individual market. Fully-insured markets are regulated by state officials. Employers and individuals can only purchase insurance within their state of residence and are largely banned from joining together to form larger risk pools.

A self-insured employer acts as its own insurer.

With a self-insured plan, the employer is effectively its own insurance company. The employer sets aside a pool of funds and bears a substantial portion of the financial risk of employees' healthcare. If some employee suffers, say, a $15,000 illness, the employer loses $15,000. (Typically, a self-insured employer will also buy an additional stop-loss insurance plan to limit losses from any individual employee or from all employees in the aggregate. Read the 5/31/12 entry **here** to learn more.)

ERISA gives self-insured plans artificial advantages.

Risk-pool limits disadvantage small business. Most big businesses, labor unions, and governments are self-insured. Their health insurance plans are federally regulated under the Employee Retirement Income Security Act (ERISA). Self-insured plans are free to pool risks across state lines and are also exempt from almost all benefit mandates that small businesses must pay for.

Pooling limits give insurers excessive leeway.

The smaller pools and single-state limits also discourage competition among insurers in the fully-insured market. Some states have only one or two significant insurers. This lack of competition leads to higher costs and fewer choices for employers, employees, and individuals.

Pooling limits give regulators excessive leeway.

Overzealous regulation contributes to high health insurance costs. Some states require all fully-insured policies to cover extensive lists of benefits and provider types. Some estimate that these mandates add 30% to 50% to the cost of an insurance policy. Even the lowest-end estimates suggest a 5% layer of extra costs.

Interstate markets would help small business.

Interstate markets would help level the playing field. Allowing groups and individuals to purchase health insurance across state lines would help level the playing field between small business and big business. This would mean lower costs and a greater range of insurance options for small-business purchasers.

Insurers and regulators would face out-of-state competitors.

Interstate purchasing would inject an element of competition into those states with few competing health insurance carriers. Employers dissatisfied with in-state insurers would have out-of-state options. Perhaps more importantly, even the possibility of entry by out-of-state competitors would spur in-state insurers to better serve their markets. Interstate markets would also restrain states from piling on excessive regulatory burdens and costs.

Small businesses and individuals should be able to purchase insurance across state lines. This would allow small businesses to form broader, interstate risk pools – an option already available to big businesses, labor unions, and governments. A nationwide market would augment competition among insurers, providers, and regulators. Regional markets would help to a lesser extent.

Healthcare providers would have to seek greater efficiency.

Most of the increase in healthcare costs comes from rising payments for healthcare services. Interstate competition would give insurers stronger motives to bargain aggressively with healthcare providers – to bring costs down and to improve quality.

Nationwide purchasing would be ideal.

Ideally, laws could allow groups and individuals to purchase insurance from sellers in any state – creating a national market for health insurance. Regulation could largely remain a state function, but a nationwide market would effectively create competition among those state regulators.

Regional compacts would help somewhat.

A less expansive option would be to create regional markets. This has always been a legal possibility under the Compact Clause of the U.S. Constitution, but this option was never exercised by states. Very recently, Georgia initiated a highly limited experiment in regional insurance purchases. The Patient Protection and Affordable Care Act (PPACA) reinforces the availability of regional compacts.

Interstate markets are not a panacea.

Interstate markets should be part of a larger package of reforms. Interstate purchasing can help to moderate costs and expand purchasers' choices, but the effects are likely to be moderate. Entering a state market is a major undertaking for an insurer. A new competitor has to develop networks of healthcare providers – not an easy task. The development of interstate markets would likely be a long, slow process, with border regions being the first to see effects. However, the threat of future competition would have beneficial effects.

Interstate markets are not a "race to the bottom."

Opponents of interstate purchasing warn of a "race to the bottom" – the notion that consumers would instinctively flock to states with cheap insurance and ominously lax regulations. There is little reason to buy this argument. Thousands of other products are sold across state lines, with no observable ill effects. Consumers care about quality as well price.

Multiemployer plans offer a complementary way to broaden risk pools.

Multi-employer pools would complement interstate purchases. Employers should also be allowed to voluntarily join with other employers to form larger risk pools and purchasing arrangements. Properly crafted, such legislation would enable groups of employers to band together to form larger, more stable risk pools. Combined with interstate purchasing, multi-employer pools would move small business toward a more level playing field with larger entities.

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