Healthcare and Small Business: Problems and Fixes (6/23/09)

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Address to the National Economists Club

American healthcare is great, except when it's not. And when it's not, chances are it is especially bad for small business owners and their employees.

I'm Bob Graboyes, Senior Healthcare Advisor at the National Federation of Independent Business. With 350,000 members nationwide, NFIB is the voice of small business in America. For decades, our members have told us that healthcare is their most serious problem, distracting them from what they do best -- earning a living and creating most of the country's new jobs. For this reason, healthcare reform is NFIB's number one priority.

I'll begin by rattling off a list of complaints:

- **Costs:** Small business healthcare costs are high, rising, and unpredictable. Small groups pay, on average, 18 percent more than large groups do for equivalent coverage, and small-firm costs have risen 113 percent since 1999. For many small firms and for many of their employees, costs put health insurance beyond reach.
- **Market inefficiency:** Small-group insurance markets are inefficient and impose high search and administrative costs on firms and employees. Most of our members have no human resources departments, benefits counselors, insurance negotiators, onsite gymnasiums, or special expertise in healthcare or health insurance.
- **Fragmentary information:** Information on prices and outcomes and policies is hard to come by and difficult to compare, making small businesses overly dependent on the advice of brokers and dealers.
- **Lack of competition:** Firms often face a marketplace with very few carriers. It is generally impossible for a small firm to offer more than one policy to its employees – thus forcing dissimilar people into one-size-fits-all policies. Alabama is the most extreme example – with 96% of small-business policies sold by a single carrier.
- **Inadequate pooling:** Small groups often comprise small, unstable pools. Unlike self-insured plans, small group pools are restricted to the borders of a single state. A single ill family member can render coverage unaffordable or unavailable for an entire firm.
- **Tax inequities:** The tax system creates major inequities between the large-group, small-group, and individual markets.
- **Obsolete reimbursement and delivery:** Medicare and Medicaid are financially unsustainable and threaten the solvency of governments, firms, and individuals.

Now, let me discuss some potential approaches in resolving these problems.

As economists, we understand that benefits are fun, but costs aren't. Therefore much of the public debate over healthcare reform involves expanding coverage to the uninsured and improving the quality of care. Those are the fun things to talk about. Last week, the CBO tossed a bucket of cold water in our faces. In two documents, CBO reminded us that we cannot expand coverage or improve quality without dealing with costs. We either have to find funding or find ways to cut. Neither of those makes an attractive bumper sticker.

Tax policy is certainly on the table. The idea of capping the tax exclusion is discussed on both sides of the aisle. Somewhat further afield, Drs. Ezekiel Emanuel and Victor Fuchs have suggested instituting a VAT. (FYI, Dr. Emanuel is Rahm's brother.) Of course, the fact that we are in a deep recession complicates the notion of tax increases.

So I'll focus the remainder of my talk more on cost-cutting, rather than revenue-raising. A variety of experts – perhaps most famously Peter Orszag – have suggested that up to 30% of healthcare spending delivers virtually no medical good. The challenge, though, is to figure out how to cut the useless 30% while leaving the good 70%. Let me begin by listing two ideas that have considerable merit, but which are unlikely to be cost-cutters.

I. **Prevention:** For all its virtue, preventive care will mostly raise costs, not cut them. Saving one person from an expensive illness is great, but generally means testing many who aren't sick, treating some who don't need treatment, and injuring some in the process. In sum, prevention can save patients, but rarely saves money.
II. **Covering the uninsured:** Many in Massachusetts thought expanding coverage would bring in the healthy uninsured and drive costs down. The resulting "coverage now, costs later" policy has thrown the state's budget into turmoil after only two years.

Then there are two other more politically controversial ideas, and I have serious doubts as to whether either would cut costs.

III. **A public insurance option.** The best counterargument is Medicare. In 1965, President Johnson predicted Medicare would cost $500 million per year ($3.5 billion in 2009 dollars). Medicare will actually spend around $500 billion this year and suffers a $30 trillion long-term funding gap. Medicare's rigid, antiquated reimbursement structure is healthcare's single biggest cost-driver.
IV. **Tight federal controls:** However good its intentions, no national government possesses sufficient knowledge, resources, power, or flexibility to legislate cost cuts – unless you don't mind shortages, surpluses, and queues. States, providers, and consumers must have sufficient autonomy to seek, discover, and implement cost-saving measures.

Now, I'll consider some measures that just might – to use the current phrase – bend the cost curve. First let me focus on those ideas that are specific to small business.

1. **Exchanges:** Health insurance exchanges/portals should be present in every state to expedite the gathering of information, comparison of plans, and enactment of transactions. In other words, transparency. Conceivably, some areas of the country could have multiple, competing exchanges, as long as all exchanges in a state or region are subject to identical market rules.
2. **Increase portability:** Apply consistent, national rating rules with some state discretion, guaranteed issue, and guaranteed renewability.
3. **No health status rating:** Health status rating should be abandoned in the small group and individual markets. An illness should not put health insurance beyond reach of anyone. Rating on age, geography, and behavior is more defensible. Adequate risk-adjustment mechanisms will be needed to minimize adverse selection. With well-crafted rules, insurers can make good returns in ways other than by health underwriting.

4. **Move to larger, more stable risk pools:** To maximize the benefits of pooling, the small group and individual markets could be merged under consistent rules. Multi-state pooling is a worthy possibility.
5. **Taxes:** Consider capping or eliminating the tax exclusion or providing a means for tax equity between those with individual policies and those with employer-sponsored plans. Current law creates a wall that gives rise to job lock and restricts the capacity of enrollees to vote with their feet.
6. **No employer mandates or pay-or-play:** NFIB strongly opposes employer mandates or pay-or-play schemes. Our recent study suggests that an employer mandate with a minimum 50% contribution would cost the country 1.6 million jobs over 5 years. A pay-or-play scheme would result in perverse incentives. It is a recipe for replacing full-time workers with part-timers, machines, and foreign outsourcing. It is vital to remember that the cost of employer mandates and pay-or-play ultimately falls on employees, not employers. Employer contributions should remain voluntary.
7. **Minimize benefit mandates:** Some states mandate that all policies cover items like in-vitro fertilization and hair transplants (plus many far-less-controversial mandates). Rules on minimum creditable coverage must not squelch innovation or preclude flexible benefit design. The impact of these mandates fall primarily on small business.

Now, I'll look at some broader reforms, not specific to small business, but which will have tremendous spillover effects on small business.

8. **Reform Medicare:** Medicare is the single largest cost-driver in the system, largely due to its fee-for-service reimbursement. A managed care, outcomes-based approach could solve a lot of cost problems. Currently, Medicare has separate segments for physicians, hospitals, and pharmaceuticals – three classes of inputs. In a recent NFIB publication, Dr. Lou Rossiter suggested restructuring payments according to four classes of outputs – medically necessary, lifestyle, experimental, and long-term. Because Medicare is so big, Medicaid and private insurers tend to mimic its reimbursement system.
9. **Reform Medicaid:** Medicare is pressing on the federal budget, and at $300 billion + per year, Medicaid is doing likewise on state budgets. Part of the problem is the federal-state revenue-sharing arrangement that rewards high spending and punishes frugality. Another problem is that complex qualification requirements and enrollment procedures mean that 12 million Medicaid-eligible people go uninsured and, often, seek medical care in emergency rooms, hospitals, and other high-cost venues.
10. **Coordinated care:** Use grants and regulatory leeway to encourage providers like Mayo, Geisinger, Kaiser, and Intermountain to expand and experiment, particularly with Accountable Care organization structures and with chronic care and disease management. Apply pay-for-performance bonuses at the organizational rather than individual level. But when tempted to mandate coordinated care, remember that these high-quality models are notoriously hard to transplant, and no one knows why.
11. **Clinical effectiveness:** Assemble institutions inside and outside the government to assess the relative value of different medical approaches. But don't turn this research into rigid, centralized micromanagement.
12. **Information technology:** Devise standardized language, medical records, and payment procedures, but don't micromanage the process. Use pay-for-performance funds to encourage process goals and where possible, build on existing systems such as credit card platforms.
13. **Malpractice:** Cap settlements. Establish health courts, and substitute arbitration and insurance for torts. Enact safe harbor protections for providers who voluntarily reveal their own medical errors.

14. **Medical workforce:** Encourage prudent substitution of non-physician providers for physicians, and substitution of primary care physicians for specialists. Lower barriers for interstate provider mobility. Eliminate legal biases that artificially increase the number of specialists and reduce the number of primary care physicians.
15. **Consumer involvement:** Encourage Health Savings Accounts, Consumer-Driven Health Plans and similar instruments to involve consumers directly in managing their own health.
16. **Low-cost alternative venues:** Encourage low-cost community based options – clinics, existing retail drug outlets, etc.
17. **Medical tourism:** Promote, or at least do not discourage, medical tourism. Don't limit or prohibit reimbursement for interstate or international medical tourism. Develop legal protections (malpractice, fraud indemnification) for medical tourists.
18. **Permit drug reimportation:** Permit reimport of drugs, as long as adequate safety standards are in place.

I've brought you NFIB's Small Business Principles for Healthcare Reform. Our research and other information are on NFIB's healthcare website: www.FixedForAmerica.com.