Healthcare Reform and Small Business (7/20/09)

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Address to the National Conference of State Legislatures

Good afternoon. With 350,000 members nationwide, NFIB is America's Voice of Small Business. For decades, our members have said healthcare is their most serious problem, distracting them from earning a living and creating most of the country's new jobs. For this reason, NFIB is committed to reform. But not just any bill will do. Reform must make small business owners and employees better off. We'd like everyone covered, but costs can't continue to rise as they have.

Our 50 state organizations are honored to work with your legislatures. Both federal and state governments have unique roles to play in healthcare reform. Neither can go it alone. Today, I'll cover four broad areas: Complaints. Solutions. Federal legislation. And Costs!

Complaints

- **Costs:** Small groups pay 18% more than large groups for equivalent coverage, and their costs have risen 113% since 1999. For many small firms and many of their employees, high, rising, unpredictable costs put health insurance beyond reach.
- **Inefficient purchasing:** Small-group insurance markets are inefficient, prone to churning, and impose high search and administrative costs on firms and employees.
- **Fragmentary information:** Insurance price and outcome information is hard to find and compare, making small business overly dependent on brokers and dealers.
- **Lack of competition:** Firms face concentrated insurance markets. 96% of Alabama policies are sold by a single carrier. Small firms can rarely offer employees more than one policy.
- **Inadequate pooling:** Many small group pools are small and unstable. Unlike self-insured plans, they can't pool across state lines.
- **Tax inequities:** There are 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. Medicare's fee-for-service structure drives other public and private insurance markets.

Solutions

The catch-phrase this year is "bending the cost curve." and that means changing insurance markets, the practice of medicine, Medicare, and Medicaid.

Private insurance markets: Insurance market reform is a top NFIB priority. It's important, and it's an area where NFIB can have an impact. Our wish list is extensive and includes:

- Health insurance exchanges to increase transparency and expedite transactions.
- Better information technology for transparent cost and outcomes data.
- Voluntary defined contributions by employers.
- Greater portability.
- Larger, more stable risk pools.
- Federal market rules, with adequate state discretion.

- Guaranteed issue and renewal and ending excessive rating on health status.
- Reasonable definitions of minimum creditable coverage.
- Greater consumer involvement through HSAs and CDHPs.

Practice of medicine: NFIB spends most of its time on insurance market reform. But serious cost restraint also requires us to alter the underlying clinical costs. NFIB's views on clinical reform aren't as well-defined as those on insurance market reform, but we're interested in exploring the following:

- Better use of IT, including more transparent cost and outcomes data
- Comparative effectiveness applications, but not government micromanagement.
- Malpractice reform (Non-economic damage caps? Arbitration? Health courts? No-fault insurance? Safe harbors for self-reporting?)
- Greater leeway to substitute GPs for specialists and non-physicians for physicians.
- Increased capacity to coordinate care, as Mayo, Geisinger, and Kaiser do.
- Consumer-friendly venues like Minute Clinics
- Drug reimportation.
- Medical tourism (more capacity to reimburse, legal protections)

Medicare: Medicare offers a devastating warning about the risks of a public plan option.

- Medicare's antiquated reimbursement rules reward doctors for poking, prodding, and cutting, but not for getting patients healthy or keeping them that way.
- Some estimates place fraud at 12% of Medicare payments; Google "Medicare" and "fraud" together and you get 7,270,000 hits.
- In 1965, President Johnson predicted Medicare would cost $500 million per year ($3.5 billion in 2009 dollars). This year, Medicare will actually spend around $500 billion – 143 times as large. Medicare's $30 trillion long-term funding gap is on course to consume the entire federal budget by mid-century.

Medicaid: State legislatures understand better than anyone how urgently we must fix Medicaid's $300 billion + in annual spending.

- To reform Medicaid, we have to reform Medicare.
- The federal-state revenue-sharing arrangement that rewards high spending and punishes frugality.
- 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 – and those in this room have to pick up the bill.

Federal Legislation

So how are the bills shaping up in Washington? There are two overarching problems. So far, the bills don't do enough to bring costs down. And they do some really risky and expensive things to spread coverage around.

Everyone agrees with President Obama's view that the rapid rise in healthcare costs is "a threat to our economy" and a "ticking time bomb for the federal budget." Yet, most proposed legislation begins by asking "Where can we find an extra trillion or two to spend?"

House Tri-Committee Bill: NFIB opposes the House Tri-Committee Bill. There are many things wrong with it. It includes a public plan that would demolish private insurance markets. It centralizes both the

business of insurance and the practice of medicine to an unacceptable degree. It extends subsidies and government programs to far too many people. But its biggest fault, and our greatest disappointment, is that it does not deal with costs.

For small business, the House Bill is deadly. An onerous pay-or-play requirement features an 8% payroll tax that would hobble the capacity of businesses to create and retain jobs. The biggest brunt would fall on low-income workers who would either lose their jobs or see their wages depressed. Payroll taxes are recipes for replacing full-time workers with part-timers, machines, and foreign outsourcing. A recent NFIB study examined the impact of employer mandates and estimated 1.6 million jobs lost over five years.

For minimum creditable coverage, the bill mimics a gold-plated Federal Employees' Plan. The Congressional Budget Office warned that little in the bill would contain long-term cost increases. It would, however, open up an immediate funding gap, and the House is considering a surtax on the "wealthiest Americans" to fill that gap. "Wealthiest Americans" is in quotes, because this tax relies on a spurious definition of who is wealthy. Seventy-five percent of small business owners report business earnings on their individual income taxes. These businesses reinvest lots of their after-tax portion back into their firms to expand markets, hire employees, build facilities and buy supplies. For many, the surtax would sap the firms' biggest funding source, choking business growth and job creation. This tax most severely damages those firms experiencing the greatest success and producing the most new jobs. This bill effectively tells them, "Slow down. Don't grow. Don't create so many jobs." Bad idea in good times; terrible idea in a deep recession. Even if an owner takes home very little and plows the lion's share into new jobs, this bill treats him as if he's the guy on the Monopoly board – cash flying out of tuxedo pockets.

Senate Bills: NFIB has been much more deeply involved in the process that produced the two major Senate bills. Senators Kennedy and Enzi involved NFIB deeply in the deliberations leading up the HELP Committee's bill, and Senators Baucus and Grassley did likewise in the Finance Committee process.

The HELP bill shares some of the negative aspects of the House Bill. It suffered a blow when CBO estimated a $1 trillion funding gap to cover only one-third of the uninsured. A later score reduced the gap and increased estimated coverage, but this is still a bill with serious problems. Like the House Bill, the subsidies are excessive, there's a public plan, and minimum coverage imitates the federal employees' plan. Again, NFIB appreciates the input we were accorded, but we're less happy with the end result.

The Finance Committee bill is very much on the table. Some of its features trouble us, but it could become palatable to small business. There's no public plan. At least one version eliminates pay-or-play. We'll see where the process takes us over the next few weeks.

There are other bills. The Republicans have offered a more market-oriented substitute. Senators Wyden and Bennett have offered a bipartisan plan that essentially blows up the employer-sponsored insurance and starts over again.

Costs!

Benefits are fun. Costs are not. “Cover the Uninsured!” makes a great bumper sticker. So does “Better Care for All!” But “Let’s All Cut Costs!” doesn’t show up on many bumpers. The rhetoric of reform revolves around benefits, but our ability to deliver those benefits depends entirely on whether we can get costs under control. With 90 million baby-boomers heading toward the healthcare system, we need that bumper sticker – in a large, bold font.

Now, when I ask folks how we’re going to get costs under control – and believe me, I ask it a lot – a funny thing happens. Whomever I’m talking to tells me about his favorite benefit and concludes with, “And that’ll bring down costs!” “Get all the uninsured people covered – and that’ll bring down costs!” “Improve the quality of medical education – and that’ll bring down costs!” “Practice more preventive care – and that’ll bring down costs!” Problem is, those benefits usually don’t bring down the costs. Here are two cases:

Prevention: I like prevention. So does small business, as long as programs are voluntary. But while prevention may be good for health, it generally pushes costs up, not down. There’s little hard evidence that company prevention programs actually improve health. Even less so for small business. And, truth be told, prevention’s not always good for health.

How can prevention not cut costs? An ounce of prevention is worth a pound of cure. A stitch in time saves nine. Yadda-yadda. Problem is, you can’t just compare how expensive Mr. Smith’s illness is and how cheap prevention would have been. Prevention isn’t just “Brush, floss, exercise, eat broccoli, look both ways before crossing.” It’s tests, pills, surgery, therapy, consultation. Preventing Smith’s costly illness means screening lots of people, treating the sick ones, treating some well ones who SEEM sick but aren’t, and undoing side effects of testing and treatment. (Add some lawyers to the mix.) Plus, prevention helps people live longer, so they have more time to get REALLY expensive illnesses. That’s good, but doesn’t cut costs. This isn’t fun to hear, but the weight of evidence is really strong.

Coverage: I can say many good things about the 2006 Massachusetts reforms. But they made one grave error, and it’s one that other states and Congress are in danger of repeating. They said, “Let’s expand coverage – and that’ll bring down costs!” But it didn’t. This coverage-before-cost gambit imperils the state's fiscal stability and the long-term success of the healthcare reform itself. They’re dropping dental coverage for the poor and medical coverage for legal immigrants. Even though the statistics say there are very few uninsured, there’s evidence that people are drifting in and out of coverage under the radar.

The lesson? When anyone says, “And that’ll bring down costs!” You ask a simple question: “How?” And when they say, “I don’t exactly know,” you say, “Find out. Get back to me on it.” And while you’re at it, give them a bumper sticker.