Miscellaneous Writings and Interviews

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Business and Health Care Reform (2/12)

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Interview with Cobank

Few issues in recent years have been as heavily debated or as highly contentious as health care reform. And for good reason. The issue affects every American, and its impact on the economy is huge. U.S. health spending in 2010 totaled $2.6 trillion, or almost 18 percent of the total economy. That same year Congress approved, and President Obama signed, a massive overhaul of the U.S. health care system, setting off a firestorm that's still roiling today.

Only a small portion of the law, officially known as the Patient Protection and Affordable Care Act, has gone into effect, but businesses of all sizes are trying to understand and comply with its requirements. Meanwhile, all of the Republican candidates running for president this year have vowed to repeal the law if elected. And those who want to see all, or most, of the law rolled back have limited time: Its major components don't kick in until January 1, 2014.

Besides political opposition on the right, the law is facing legal hurdles as well. Next month, the U.S. Supreme Court will hear a key challenge to the law's constitutionality, which could partially or entirely upend the law.

One of the plaintiffs in the Supreme Court case is the National Federation for Independent Business, an association representing small businesses throughout the country. The NFIB supported health care reform but eventually opposed the Affordable Care Act; NFIB argued that the law failed to address high and rising costs and that it imposed burdensome monetary and administrative costs on businesses.

For this month's Outlook, we interviewed economist Robert Graboyes, senior fellow for health and economics at the NFIB Research Foundation. A fierce critic of the legislation, he says Americans are only beginning to understand the profound impacts it will have on business and the health care delivery system in this country.

Editor's note: In order to provide readers with a balance of perspectives, next month's edition of Outlook will feature an interview on health care reform with economist Henry J. Aaron, a supporter of the law and a senior fellow at the Brookings Institution.

OUTLOOK: Take us through a timeline – what's happened already with health care implementation, and what's yet to happen?

Robert F. Graboyes: In 2010, a small-business tax credit kicked in, along with the tax on tanning parlors, and a provision that all insurance policies had to allow coverage of children of policy holders up to age 26 if other employer coverage isn't available. In 2011, there was a new tax on drugs, and people were told they could no longer buy over-the-counter medications with a flex plan or health savings account – unless they have a doctor's prescription. Not much that impacts small businesses kicks in this year. But there's a flurry of regulation writing going on. Next year, there are a bunch of new taxes, such as those on medical devices; some 1040 deductions go away; and some additional limits on flex plans kick in. Many small business owners will face new surtaxes on household wages and salaries and on investments; these taxes are officially called "Medicare" taxes, though their proceeds will not actually go to Medicare. But 2014 is the big year — the individual mandate goes into effect, as does the employer

mandate, the individual subsidies, the small-business health insurance tax, the exchanges, the benefit mandates, and the Medicaid expansion. And for the rest of the decade, there's about one big change a year, plus endless regulation writing.

OUTLOOK: Remind us: what are the most significant changes Americans will see due to the health care law?

RG: First, there's the individual mandate, which is a requirement that every American, with a few minor exceptions, must have health insurance. It is an unprecedented mandate, as the federal government has never told all Americans they must buy a product or a service. The second part is a recognition that some people can't afford to purchase insurance, especially given the premium increases we expect to see, so there are subsidies for people who meet some fairly generous criteria. Third, there's an employer mandate that says if you are an employer of 50 or more people, and if even one of your employees qualifies for a subsidy, then you will likely be financially penalized through a complicated formula.

OUTLOOK: There are also a number of changes to how health insurance is sold.

RG: The idea is to construct exchanges or centralized marketplaces where consumers can compare insurance plans across prices and other features. They'll be run at the state level, though some states are currently inclined to leave the task to the federal government; exchanges are supposed to serve small businesses and individuals buying insurance on the private market. If you want to think of a model, Travelocity is sort of an exchange, but there are all sorts of different visions about what an exchange should look like. Some have much more of an activist role than others. I should mention that NFIB has supported the idea of exchanges, though not necessarily in the form laid out in this law.

There is also a massive expansion of Medicaid. If forecasts hold up, an extra 30 million people would gain health insurance coverage; and about half of them would move into Medicaid, which is a program most of us don't want to be in -- for good reason.

Another key change is the regulatory definition of "essential health benefits." In order to require everyone to buy health insurance, you have to first define what health insurance is. So the Secretary of Health and Human Services is supposed to compile a list of things that every insurance policy purchased in the fully-insured market must cover; but the rules do not apply to the self-insured market. That means the policies small businesses must buy will have all sorts of requirements as to what has to be in them – and those requirements can expand at the flick of the Secretary's pen. But this is not true of governments, big business and labor unions, by and large, because most are self-insured. That is one of the reasons we at NFIB tend not to like it.

And insurance policies can no longer include annual or lifetime maximum payouts. There is also a long list of preventive services that must be provided free of charge.

OUTLOOK: How does the employer mandate and its penalties work?

RG: The mandate requires companies with 50 or more full-time-equivalent employees to provide a health insurance plan that meets certain minimum standards or to pay a penalty in lieu of coverage.

The penalties are very complicated. If a business does not provide insurance and if at least one of its employees receives federal insurance subsidies in a health insurance exchange, the business will have to pay $2,000 per employee above 30 employees. As an example, a business with 50 employees, two of whom are subsidized, would pay $40,000 per year -- 50 minus 30 times $2,000.

If a business does provide insurance, and if at least one employee receives insurance subsidies, the business will pay $3,000 per subsidized employee or $2,000 per employee minus the first 30, whichever is less. So a 50-person firm with two subsidized employees would be fined $6,000 per year. If the number of subsidized employees at the firm rose to 14 or more, the tipping point for the formula would kick in and the penalty would be $40,000 per year.

OUTLOOK: Who qualifies for the subsidy?

RG: The employee qualifies for a subsidy if two conditions are met. First, household income must be less than four times the poverty level, which is a function of income and your family size. Today, a family of four would have to earn less than about $89,000 a year. That's not rich, but it's not low income. Second, the family's insurance premium has to cost them more than 9.5 percent of household income. So if you meet those two criteria, you can apply for a subsidy starting in 2014.

What makes it very difficult for businesses is that the penalties involve so much that is outside of their control or even outside of their view. Let's say you're married with two children and you and your wife together earn $100,000. Now your wife's income drops a bit, and you're below $89,000. Your employer and your wife's employer will both be slammed with a fine. I have jokingly referred to this as the "employee's spouse's uncle tax," because it is literally true that an employer could be fined because one if its employees has a spouse who has an elderly uncle who moves into their spare bedroom, thereby increasing family size. The employer is not entitled to ask, "Why are you suddenly entitled to a subsidy?"And so you can conceive of a situation where an employee falsely tells the government, "My uncle moved in." The employer has little recourse other than challenging the employee's honesty before the Internal Revenue Service It puts the employer in a very awkward position. By the way, the IRS has acknowledged that this is a problem and is seeking a solution. I'm skeptical that a good fix can be devised.

OUTLOOK: How are small businesses reacting to this provision of the law?

RG: It certainly discourages job growth. We've already had a number of our members say something like, "I'm already at 45 employees, I've got a contract offer that will allow me to expand, but I'm not going to even contemplate it until I figure out whether I'll be subject to these penalties." The mandate provides a tremendous motive to stay below 50 employees. The mandate also encourages employers to avoid the penalties by firing full-timers and replacing them with part-timers.

OUTLOOK: Proponents of the law said the penalty provision was there to incent employers to provide health care for their employees, rather than having the employees rely on the government.

RG: Whatever the intent, the actual incentives are quite perverse. We feel quite strongly that a lot of employers are going to shift the burden to the government because of the mandates. Employers will be able to say, "I'm going to forget about providing insurance. I'm going to throw my employees into the government subsidies and split the difference with them." Come 2014, an employer will be able to sit

down with his employees and say, “You know, guys, I always bought you insurance, but they’ve got these new rules. What I can do is drop all of you; you get your subsidy and buy your insurance in these new exchanges. Then, I’ll use some of the money I save to give you a raise. I’ll have more to take home and you’ll have more to take home, and the taxpayers will pick up the difference.” One of the analysts at the Employee Benefits Research Institute, a nonpartisan group, recently argued that companies would be crazy if they don’t do that. And the impact on the federal budget could be enormous.

OUTLOOK: Can’t the law be amended if it ends up creating too many problems for businesses?

RG: It has been already amended, but that’s not necessarily reason for comfort. There was going to be a horrifically onerous onslaught of paperwork called the 1099 requirement; it would have mandated the filing of an IRS form any time a business made purchases of $600 or more to a vendor over a year. Business owners could not believe the extent to which it was going to disrupt their lives and operations – sorting and collating thousands and thousands of receipts. The day after the 2010 elections, the president said the 1099 requirement had to go, the leaders of the House and Senate of both parties agreed it had to go, and business leaders agreed it had to go. Yet it took six months of battling to strip around 170 words out of the law.

OUTLOOK: Beyond the penalties you’ve described, how challenging will it be for businesses to comply with the law from an administrative standpoint?

RG: The red-tape and administrative tasks involved in all these mandates are going to be enormous. I have strong doubts as to whether many of them will even be manageable.

Gene Steuerle of the Urban Institute wrote in 2009 that the interactions between the individual mandate, the subsidies and the employer mandate are so complicated and wholly dependent on extreme amounts of data flow that he doubted that it would work. In February 2011, two scholars who support the law, Benjamin Sommers and Sara Rosenbaum, warned the way they’ve structured the math of the subsidies and Medicaid qualification means people will bounce back and forth repeatedly from Medicaid to their employer’s plan then to the subsidized plan, on and on.

OUTLOOK: What about government administration of the law?

In 2011, two scholars who oppose the law, Paul Howard and Steve Parente, warned that managing the subsidies and penalties would require ongoing, real-time merger of the data flows from the Department of Labor, the Department of Health and Human Services, the U.S. Treasury, the Department of Homeland Security, the Internal Revenue Service, Medicare, Medicaid, CHIP, Social Security, 50 state exchanges, and private insurers. They argue that there is no history of these agencies ever bringing their data together at this scale and that it would qualify as the largest IT integration project in U.S. history.

The National Governors’ Association sent out a scream in September that effectively said, “This thing isn’t working. The federal government is missing all of its deadlines. And even if they made their deadlines we’re not sure this would be doable by Jan. 1, 2014. Help!” This is going to be a nightmare.

OUTLOOK: Does the law adequately address the problem of the rising costs of health care?

RG: That’s easy: No. It sets into motion some long-term experiments that they hope will hold costs

down; but there's no evidence that they will. NFIB very, very, very strongly supported health-care reform, and when I began at NFIB in 2007, most of the criticism I heard was from the political right saying, "Why are you guys going up to Ted Kennedy's office and talking to these people and working with them?" And we said we need to get health care reformed, and our interest is cost, cost, cost, cost, cost. In the end, the law was sold on the argument that it would be able to get costs down, but by late 2009, it was obvious to NFIB that it would do no such thing. And we're now seeing torrents of evidence that we were right.

OUTLOOK: What have various courts ruled in relation to the law?

RG: A federal court in Virginia said the individual mandate should go, but the rest could stay; a court in the Midwest that said it could all stay. But I can tell you the most about the case in which the NFIB is a plaintiff, along with 26 states and two individuals, in the federal district court in Florida. The district court judge ruled the individual mandate is unconstitutional, and because the law did not include a severability clause the entire law must fall. A severability clause essentially says, "If any part of this law is struck down by a court, the rest remains intact."

Then it was up to the Obama Administration to appeal, because they lost everything in that ruling. They continued implementing the law and assumed the judge wasn't telling them to stop. They sent a request for clarification. I'm told judges don't like people saying "Would you clarify what you meant?" He issued a very strong clarification saying, essentially, "I've ruled it's unconstitutional, so it has to stop, unless you file an appeal." So it went to the 11th Circuit Court of Appeals, where three judges were chosen randomly. One was clearly a Republican appointee, one a Democratic appointee, and one who'd received appointments under both but was considered more of a Democratic appointee. Ultimately, that court ruled to throw out the individual mandate, and that was viewed as a striking finding because it was the first time Democratic-appointed judges had ruled the individual mandate was unconstitutional and must go. But the appeals court said it would let the rest of the law stand, treating it as if there were a severability clause. I'll stress that I'm an economist, not an attorney, so I'm out of my environment here.

Earlier drafts of the legislation had the severability clause, but for whatever reasons, it was removed by the final draft. One of the theories is it was done to make it an all-or-nothing proposition, to say to a judge if you throw out one comma the whole thing implodes. So the appeals court said, with some precedent, we will void the individual mandate but let the rest of the law stand. But that created a volatile situation, since both sides are quick to say if you simply remove the individual mandate, the law begins caving in on itself. It is the glue that holds it all together.

Since each side had a partial loss in the decision, either side could appeal, and we appealed the severability part of it. And the government stepped in and appealed the individual mandate part of it. The Supreme Court will hear the case.

OUTLOOK: What, specifically, are the issues that will be considered by the U.S. Supreme Court?

RG: The first is whether the individual mandate is constitutional. The second, assuming it's not constitutional, is whether the law is severable — whether they must strike down the whole law. The third issue refers to what's called the Tax Anti-Injunction Act, which dates back to the 1860s. With the employer mandates, there's a legal question as to whether the penalties are penalties or taxes. Prior to

the law's passage, supporters said they were penalties, not taxes, and nowhere in the law did it say they were taxes. From the president on down, they said, "It's not a tax increase -- it's penalties for people who don't meet certain criteria on insurance." But once it became apparent a constitutional challenge would be a serious thing, there was a reversal in those arguments. As I understand it, courts are very hesitant to strike down tax provisions, taking the view it's the government's bailiwick. And the Anti-Injunction Act says the court can't consider the constitutionality of a tax until it's actually collected, which in this case would be 2014. The argument that we endorsed is that it doesn't say anywhere it's a tax, it says it's a penalty, they said it was a penalty, it looks like a penalty, it quacks like a penalty, so there's no reason to think it's a tax — and therefore no problem for the court to look at it now.

And the fourth issue is that this is going to foist enormous costs onto states through Medicaid. Certain states with large Medicaid populations are just going to be demolished by the financial implications of this. Medicaid has always been an allegedly voluntary program, part federal and state funding, with the understanding if a state doesn't want to be in it, it can always leave. However, this law makes states lose vast amounts of money if they leave Medicaid, so the question came up of whether the federal government was exerting coercion to keep the state in. I don't think most observers expected the Supreme Court to look at that issue, but they made it one of the four.

OUTLOOK: When will the case be decided?

RG: The court will hear the arguments in March and will probably rule by the end of June 2012.

OUTLOOK: What will happen if the Supreme Court strikes down the law? Will everything simply return to the way it was before?

RG: Some things have already changed. Some insurance companies have stopped writing some kinds of policies. You haven't scrambled all the eggs yet, but the fork has swirled through several of them. The longer it goes, the more it's irreversible. But it's early enough that most of it is still reversible.

OUTLOOK: If the Supreme Court upholds the law, what do you expect to happen then?

RG: Part of it depends on how bad you think this thing is going to be; I think it has the potential to be disastrous I think the Congressional Budget Office has grossly underestimated the number of employers who are going to chuck it and pay penalties and walk away. If that happens, the federal deficit swells rapidly. And that might have been OK 10 years ago, but with the current fiscal situation, you start bleeding the federal treasury, and you've got a problem.

OUTLOOK: NFIB supported the idea of health care reform. If you get your wish and the law is repealed or struck down in court, what would you like to see happen next to address the problem of health care costs?

RG: Our website has a list of 12 things that could be done to reform health insurance markets. That's one area of needed change. We're also going to need entitlement reform. The Medicare payment system, fee-for-service reimbursement, is the source of a vast percentage of our problems. It skews resources badly, diverting them to the wrong places. It probably undercompensates general practitioners and overcompensates specialists, distorting practice patterns. And Medicaid's revenue formula rewards states that are profligate and punishes states that are careful.

Finally, we're going to have to change many things about the health-care delivery system. That's a large set of smaller issues and questions. If you're getting a particular service, do you have to get it from a doctor, or can you get it from a nurse practitioner? Can a pharmacist write a prescription? Can you start a specialty hospital, or do they all have to be big general hospitals? This is not going to be something where you'll have a neat bumper sticker that's "the solution." It'll be a long hard slog through an awful lot of experiments.

OUTLOOK: That doesn't sound like something that can easily be achieved.

RG: In the early to mid-1990s, when I was in my late 30s or early 40s, my wife suggested that I shift into health-care economics. After thinking about it, I told her, "I think I'll do it because it will keep me occupied for the rest of my working life. And given what I know about Social Security and Medicare, it's going to be a very long working life." So far, that prediction is coming true.

Job Stagnation: Lost Years' Legacy (12/1/10)

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Adapted from speech to Urban Institute

The U.S. Labor Department reported unemployment at 9.0% for January 2011. Include the underemployed (part-timers seeking full-time work) and the discouraged (those who have ceased looking for jobs), and unemployment is 16.1%.

Private-sector job creation has been weak throughout the Great Recession. The federal government has gunned the nation's economic motor for two years with the Stimulus pedal, so why are the wheels still spinning deep in the mud? Since 65 percent of new jobs normally arise from the small-business sector, that's a good place to look, and the top answers are consumer demand, real estate, taxes, and healthcare. The hulking new healthcare law also reinforced the demand and real estate and tax problems, too.

Low Demand: The proximate cause of the recession was a decline in consumer spending. Small business hoped for a payroll tax holiday, leaving funds in consumers' pockets so they could start spending again. Instead, Congress opted for $800 million in debt-financed government spending (much of it long-term). Sales remained depressed, and small business had little incentive to hire new workers or invest in new equipment.

Lost Collateral: Much small business expansion is financed by borrowing on entrepreneurs' real estate equity – in residences, workplaces, and investment properties. Plunging values wiped out much of this equity, leaving limited alternative means of financing expansion. Adding extra damage, start-ups are especially hard-hit by the property crunch.

Tax Uncertainty: The outgoing Congress generated profound uncertainty over future tax liabilities. Even businesses with the ability to spend and hire and to obtain credit may have chosen not to do so because of uncertainty over future taxes. With only days left in 2010, businesses and the customers on whom they depend had no idea of whether income tax increases would reverse the Bush-era rates and whether the estate tax would be 0% or 55% or somewhere in-between.

Healthcare Law: The healthcare law (PPACA) crushes expansion ideas under layer-upon-layer of costs, red-tape, and years of uncertainty. If a business owner's wife gets a salary increase, PPACA may claim 0.9% of her increase. If they sell their beach house, there may be a 3.8% tax on the profit. If these taxes lead to acid reflux, there's a new tax on Nexium. If that elevates blood pressure, there's a 2.3% tax on the pressure meter. Small-business health insurance plans face a tax that big businesses and labor unions don't. Companies with 50 or more full-time employees face large penalties if even a single employee qualifies for a subsidy. The list goes on, as does the list of new administrative burdens – most notoriously the impossible-to-manage 1099 provision. The extent of these burdens depends on regulations that won't be written for years to come.

The healthcare debate carried a double-wallop. In late 2008, America and the world faced the most severe financial crisis in two generations. The economy stumbled and unemployment grew. Congress and the White House could have focused on stabilizing consumer demand, finance and real estate, and taxes but chose, instead, to turn their attention to a chronic, but non-crisis, issue – healthcare. (I say all

of this as someone who always viewed healthcare reform as essential to business and whose employer feels likewise.)

They clumsily reinvented one-sixth of the economy on the fly, neglecting the deepening real estate crisis, allowing it to fester and weigh down small business's net worth and, therefore, access to credit. PPACA committed the country to enormous long-term financial obligations of uncertain magnitude. (The CLASS Act, written from Day One in red ink, is a perfect example.) The struggle to fund PPACA delayed efforts to reform Medicare and Medicaid, turning conversation to new tax burdens, like a Value-Added Tax (an especially onerous tax for small business.) PPACA was sold as a path to long-term financial stability – but even the federal government has punted that claim.

The struggle over PPACA did not end on 3/23/10. With each passing week, another piece falls off of the law. Precious time that could be devoted to the housing and entitlement crises is funneled back into scotch-taping PPACA back together again. The civil war sparked by the healthcare debate makes bipartisan efforts on housing and taxes exceedingly difficult.

How do we get business and jobs growing again? How do we get the government's eye back on the ball? Great questions, but they've barely been asked. Not by an assortment of federally micro-managed micro-incentives. Repealing PPACA (followed by more constructive reforms) would be a start. But we will never get back the lost years of 2009-2011, which Congress frittered away on its hobbies.

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.

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

Dr. Robert F. Graboyes / rfgraboyes@gmail.com / www.robertgraboyes.com

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.

Small Business and Healthcare Reform (5/28/09)

Dr. Robert F. Graboyes / rfgraboyes@gmail.com / www.robertgraboyes.com

Address to the American Benefits Council

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.

We appreciate the eloquent, admirable statement that the American Benefits Council sent to Senators Baucus and Grassley. NFIB could comfortably adopt verbatim many of the sentiments you expressed. We especially appreciate your clear and repeated comments that health insurance is an especially tough obstacle course for small businesses and their employees.

Let me begin by rattling off a list of complaints:

- **Costs:** Small business healthcare costs are sky-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 119 percent since 1999. For many small firms and for many of their employees, costs put health insurance beyond reach.
- **Uninsurance:** A majority of America's uninsured are in families headed by a small business owner or employee.
- **Market inefficiency:** Small group insurance markets are inefficient and impose high search and administrative costs on the firms and their employees. Most of our members have no human resources departments, no benefits counselors, no insurance negotiators, no onsite gymnasiums, and most of all, no special expertise in healthcare or health insurance.
- **Fragmentary information:** Information 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.
- **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 rest on antiquated reimbursement systems that lock obsolete delivery systems into place. The programs are financially unsustainable and threaten the solvency of governments, firms, and individuals.

Now, likewise, I'll list some of NFIB's favored approaches in resolving these problems:

- **Market reform:** The small group and individual markets need major overhauls.
- **Consistent rating rules:** We need national rating rules with some state discretion.

- **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.
- **Unified small-group market:** The small group market should not be split into multiple markets, such as separate markets for micro (1-10) groups and larger small groups.
- **Individual/small group merger:** To maximize the benefits of pooling, the small group and individual markets should be merged under consistent rules over a prudent timeline.
- **Exchanges:** Health insurance exchanges/portals should be present in every state to expedite the gathering of information, comparison of plans, and enactment of transactions. An exchange could encompass a multi-state region. 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.
- **Tax credits:** Small business and low-income tax credits are essential if an individual mandate is enacted. It is important to structure credits so that they benefit those who need financial help in securing insurance, rather than those who do not.
- **Stabilize Medicare:** Medicare's financial balance must be restored. The financial hole in Medicare amounts to an unfunded debt of $124,000 for every adult and child in America. In addition, Medicaid and SCHIP pose similar risks.
- **Medicare microeconomic effects:** The current reimbursement system rewards medical treatments rather than medical outcomes and wellness.
- **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.
- **Easier Medicaid enrollment:** 25% of today's uninsured are Medicaid-eligible, so enrollment must be made easier.
- **Maintain private markets:** Market reforms and private insurance are preferable to a public plan or to early Medicare buy-in.
- **Plan flexibility:** Rules on minimum creditable coverage must not squelch innovation or preclude flexible benefit design. Like NFIB, you endorse quality high-deductible plans, for example.

You correctly note the "hidden tax" that uncompensated care imposes on taxpayers and private insurance purchasers. But without cost-reduction measures, reform may simply replace this hidden tax with an even larger, explicit, out-in-the-open tax. Employer mandates or pay-or-play schemes would have just that effect, plus the sort of perverse responses that you mentioned.

We agree that large and small employers care about their employees' health which, in turn affects firms' profitability. You mentioned some of the tools at your members' disposal: "innovative health coaching and healthy lifestyle programs, cost and quality transparency initiatives, pharmaceutical management programs, and value-based health plan designs." It is much more difficult, if not impossible, for small businesses to use such tools to steer their employees toward good health.

We appreciate your comment that, "the solutions to expanding coverage among smaller employers will critically depend on the ability to make this highly valued benefit more affordable and sustainable for

all." In this, you mirror NFIB's contention that expanded coverage and improved quality cannot occur without ratcheting down costs.

I've provided you today with NFIB's recently expanded Small Business Principles for Healthcare Reform. I've also brought four recent studies that NFIB either conducted or commissioned. Lots more information is on our healthcare website: www.FixedForAmerica.com.

In sum, I think we agree that there's a lot of good in America's healthcare system. And there are substantial problems, many of which are centered on the families, employees, and owners of small businesses. As we move forward in the coming weeks and months, it is vital that we remember both of these facts.

Easing the Healthcare Burden on Small Businesses (2/2/09)

Dr. Robert F. Graboyes / rfgraboyes@gmail.com / www.robertgraboyes.com

Radio interview with Dr. Janet Wright

You are listening to ReachMD, The Channel for Medical Professionals. Welcome to Heart Matters where leading cardiology experts explore the latest trends, technologies, and clinical developments in cardiology practice. Your host for Heart Matters is Dr. Janet Wright, Senior Vice President for Science and Quality for the American College of Cardiology. New proposals for restructuring healthcare comes into roles these days. These organizations work to secure their voice at the table of healthcare reforms. In the small business sector, which in some states is a collective employer for upwards of half of the uninsured population, meaningful healthcare legislation would be welcome news. How do their efforts shape today's healthcare discussions. Our guest today is Dr. Bob Graboyes, Senior Health Care Advisor for the National Federation of Independent Business, an association representing the interest of small businesses in today's healthcare debate.

DR. JANET WRIGHT: Welcome Dr. Graboyes.

DR. BOB GRABOYES: Glad to be here.

DR. JANET WRIGHT: Well, we are delighted to have you. May be you could share with our audience the special problems faced these days by small businesses.

DR. BOB GRABOYES: You could say that just about everything that is wrong with healthcare and everything that people complain about is worse in small business sector. For our guys, we represent 350,000 businesses and we would like to thank that we represent the broader small business community beyond that. Their costs are higher. Most of the uninsured in America work for or own small businesses or members of their families. They face what is ineffective dysfunctional market for health insurance and these combined are threat to the viability of the small businesses to the jobs to the employers, so forth.

DR. JANET WRIGHT: This really affects, I know we have heard a lot about Wall Street and Main Street, but this, you are at the heart of Main Street, are you not?

DR. BOB GRABOYES: Absolutely.

DR. JANET WRIGHT: I come from a small town in Arkansas and lived through years when the downtown sector, which was really 3 or 4 blocks, was a ghost town, so I have a special place in my heart for the health of small businesses.

DR. BOB GRABOYES: I come from a similar background, small southern town. My parents were small business people, so me too.

DR. JANET WRIGHT: As we are all optimistic about a new administration and all the problems that we face we are feeling, I guess, there is a greater sense of hope about succeeding in the next 3 or 4 years. What's the outlook for healthcare reform from the small business perspective?

DR. BOB GRABOYES: First of all, I don't know if I being anything the status quo is unacceptable, it's just not viable. The numbers have gotten worse and they are set to get considerably worse in coming years. The cost of healthcare, the problems with availability of insurance for other workers threatens to kill off small business, which is the engine of job growth in America. This is really where the new jobs come from where wherein often a lot of people busy with healthcare reform in the city now and all over the country, and by the way, we have offices in every state capital because a lot of what's going to happen is going to be the state level as well, but we have process now where associations all over Washington are busy forming coalitions and if IB is part of a number of fairly in usual coalitions of nontraditional partners you have a process just to cross a street here at the capital with Senator Kennedy, Senator Baucus. There is an interesting bill out there by part is an effort by Senator Widen. We have obviously a new President who is coming in with a deep interest in this, who has named his health and human services secretary and also I think importantly a budget director who has a long-standing interest and expertise in healthcare. I am cautiously optimistic, and I say cautiously because you can get to these points where everyone agrees that something has to be done, but everyone's second choice is the status quo and we were hoping that that won't be the case this time.

DR. JANET WRIGHT: We would all like to have a revolution in healthcare as opposed to some sort of incremental change at this point.

DR. BOB GRABOYES: Well, I guess we could have little over what that means I think certainly some aspects of it need considerable change, even drastic change. On the other hand, there is not a lot of good about the American Healthcare System that we want to preserve, and it would be easy to pass reforms that can kind of sweep that a side.

DR. JANET WRIGHT: What would you most desire and then what you think realistically will happen, what kind of reform?

DR. BOB GRABOYES: First of all, things have to be made affordable. I cite the budget director who is well known around town presiding a statistic that probably 30% of the expenditure is on healthcare in United States do know good medically. Now, that said, if you just say well let's stop doing that that 30%, but that's the problem of how do you actually read out those procedures, those items medical practice that aren't actually doing people good, and I am not going to say it's easy and I don't think anyone would, but we need to make healthcare more affordable. We need to make it more portable. It's a serious problem when a person can't change jobs. In retrospect here, we were very interested in the fact that a lot of people working for big companies have the American dream, they want to start a new company. They have a brilliant idea, but they don't do it because they say if I leave my job I might lose my health insurance, maybe I have a sick child, which again is indicative of our dysfunctional market for insurance. Thus, we have to get portability into it and I think we can do that. There are number of different ways. We think it is important to preserve a system with lots of private providers and private insurers who think competition is the best way to go at it. Things have to be made more transparent. Transparent

both from the consumer, the patient's perspective, but also from the provider. Such as interesting circumstance of dealing with an emergency room where I got immediate answers on what were the costs going to be, what were the likely outcomes, dazzling amount of information immediately happened to be veterinarian's office and certain admirable aspects of the way business have done there, it can't get in standard human medical practice.

DR. JANET WRIGHT: I was actually going to ask you if your own vacation in the Netherlands or Denmark.

DR. BOB GRABOYES: No, it wasn't, just for the dog. You raise an excellent point, though, I think lot of people tend to ask well which system out there in the world can we kind of take off the rack and hang _____ to me, that's not the way to go at it. There is no other system on earth I would want that exists today that would fit comfortably with America that would do well here. The other systems have problems at least as severe as our own. I spent a lot of time looking at other countries systems, there are some admirable things to see overseas and there are some not so admirable aspects to those.

DR. JANET WRIGHT: If you are just joining us, you are listening to Heart Matters on ReachMD, The Channel for Medical Professionals. I am you host, Dr. Janet Wright. Our guest today is Dr. Bob Graboyes, Senior Health Care Advisor for the National Federation of Independent Business. We are discussing the influences of small businesses on today's healthcare reform debate. Clearly, as the reform train gets rolling, there will be an impact on medicine, and as you pointed out medical practices are also small businesses. In fact, I think in cardiology the predominance of practices are the one of these than two of these. We do have some large groups and clearly in primary care small groups are still the predominant models. What would you say would be the impact on both the business aspects of medicine and the practice aspects?

DR. BOB GRABOYES: I wear a couple of hats when I am not identified _____ professor in couple of medical centers in 3 universities and lot of my students are physicians and a lot of cardiologists who go through my classes they are small businesses, they are struggling in the same way other small businesses are. I frankly was surprised to learn that some of them can no longer afford to supply health insurance to their employes, and I am in the business, I know that's kind of a staggering fact when the healthcare provider can't afford the health insurance and these are clearly people who want to do so, who feel compelled to do so, and yet their bottom line says, "If I try to do that, I am going out of business." Again, how do you get things affordable. One thing, I think we want to avoid is likely having the government coming in with treatment algorithms that say, "this is how you must do your practice and you must not stray from the way folks in the bureaus have determined you out of practice medicine. So, we think it's absolutely crucial that the doctors have sufficient leeway. I think it's going to take unit with the revolution in medicine. I think the revolution really must come in first of all in health IT. We have a really adequated system of information technology. The information flows probably 30-40 years behind a lot of other industries, and again, that is one of those things that are not unique to United States. I think we are going to see increased reliance on electronic medical records, more transferrable information from one provider to another, and again, the doctors are going to have to be in the position to do just as our veterinarian did, which was to say at the snap of a finger. This is how much this procedure costs, this is how much good it will do you, these are the risks, so that today's very enlightened patients and consumers can make a judgment and inform judgment. One of the other changes that we have seen in medicine is I think there is a sharp financial shift 30 years ago. A medical license was a piece of security for the rest of your life. You really didn't have to worry about the money, today you do, and so as reform progresses, we have to make sure the doctors, in fact, can earn a decent

living, a competitive living, and frankly that means enough of living that they don't abandon the practices and go off to law school or go fishing or something else.

DR. JANET WRIGHT: Or retire prematurely, which is a frightening concept that we are losing some of our most experienced practitioners because of the, both financial and just a burden of trying to care for people in such fragmented system.

DR. BOB GRABOYES: You have to be really careful. I had a young, fourth year medical student speak to a class of mine. He was a kid, really kind of up from the streets, I think first kid to go to college in his family and going to medicine had been his lifelong dream. He made a comment that kind of floored me. He said he thinks at least 50% of the other students in his class no longer view medicine as a profession. They view it as a job, something they will do 9 to 5, and at that point they click the lights off and go home, and he was deeply worried that the changes in just the economics and the finance of medicine are going to fundamentally change the way doctors feel about what they do.

DR. JANET WRIGHT: And probably who is the type of person who is attracted to, to go into medicine.

DR. BOB GRABOYES: Absolutely.

DR. JANET WRIGHT: May be you could speak to our listeners about what an individual person, one of the nurses or the physicians listening, what role could they play in supporting small business and in small businesses perspective on healthcare reform.

DR. BOB GRABOYES: Actually we have a dedicated website, www.fixedforamerica.com where we outline and of a lot of this and of lot of division that we think that ought to go into healthcare reform, the problems we have, the needs that we have. I think it is absolutely crucial that doctors who are coming along now understand the business side as well as the medical side. I don't think that a doctor 10-15 years from now is going to be able to function without a good working knowledge of the business side of it and I know that's not a reason that a lot of the people in the profession went into the field, but it is one of these time to settle up because that is going to be part of life.

DR. JANET WRIGHT: And would you say the professional organization, societies, and associations have a role in helping educate their members about the business aspects of their career?

DR. BOB GRABOYES: Absolutely. I think they do, and again, when I went at the universities that's where I get students, a lot of them come because they are aspiring to fill those administrative positions to understand how to run the business of medicine and it is business and I know that _____, there are lot of doctors, but that really is something they have to recognize. If we are ready to get this costs down and it is not just about dollars and cents, getting costs down means making insurance and healthcare affordable to people who cannot afford it today. So, the dollars and cents are really lives in healing.

DR. JANET WRIGHT: Well, and it's also employment for people in communities around the country who work in these offices.

DR. BOB GRABOYES: Absolutely, and one of the things I tell students all the time is they have to be alert, the structure of healthcare is going to change. We have seen lots of changes over the last couple of decades. We have had nurse practitioners as a substitute for certain services for doctors. The

introduction of international medical graduates into the healthcare system to fill gaps, and certainly with primary care physicians now we have some serious problematic gaps, and right there if thought that a been a single problem, I think that's the one because the PCPs serves such absolutely critical role in healthcare system, and we are short and there is something where if you look at some of our neighbors, the Canadian system whatever, it is even more severe than the problem we face, so it's a worldwide problem.

DR. JANET WRIGHT: We have challenges ahead.

DR. BOB GRABOYES: Hmm Hmm.

DR. JANET WRIGHT: We have been talking about current efforts of small businesses towards healthcare reforms with Dr. Bob Graboyes. Dr. Graboyes, thank you for being our guest today.

DR. BOB GRABOYES: Thank you.

You have been listening to Heart Matters on ReachMD, The Channel for Medical Professionals. For more information on this week's show or to download a podcast of this segment, please visit us at reachmd.com. Thank you for listening.

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Conversations with Robb Mandelbaum (late 2007-early 2008)

Dr. Robert F. Graboyes / rfgraboyes@gmail.com / www.robertgraboyes.com

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Back in December, the National Federation of Independent Business made what at first sounded like a sweeping statement on health care, and perhaps even a reappraisal. The NFIB called its "Small Business Principles For Health Care Reform" "a foundation to address the No. 1 issue plaguing small-business owners" and "the culmination of more than 20 years of research." It sounded like a grand project, indeed.

On second glance, though, the Entrepreneurial Agenda was not impressed. The principles struck me as little more than a recapitulation of long-standing policy proposals that would gut the group health market, topped off with a new call for a health care system that is "universal." I wrote that the proposal read pretty vaguely and wanted things not just both ways, but all ways -- -universal coverage that was somehow affordable but with as little government intervention as possible.

The NFIB, in turn, thought my post was unfair. The organization's senior health care advisor, Bob Graboyes, wrote a point-by-point rebuttal. That turned out to be the beginning of a dialogue: Graboyes recently answered 19 of my questions in an extensive interview by email. It may be the most comprehensive discussion yet published about the NFIB's position on health care.

So who's right? Now you can be the judge -- and, more importantly, you can weigh in. The NFIB claims to represent you (or at least entrepreneurs like you) -- what do you think of its positions? What questions do you have for the organization? For my part, I found our virtual conversation problematic. Graboyes' answers, in my mind, raise as many questions as they settle. However, when I put some of those follow-ups to him, Graboyes declined to respond, citing the constraints of his schedule and the time he had already committed to the project. But he said he'd reconsider if our conversation generated enough interest among our readers. Fair enough: now it's in your hands.

At the end of his comment, Graboyes wrote, "It would help to know where Mr. Mandelbaum's criticisms originate. Is he a single-payer enthusiast? A libertarian? A staunch defender of the status quo? How would he reform American health care -- if at all? Since he provides no alternative vision whatsoever, it's much harder than necessary to engage in a productive conversation." In the interest of productive conversation, I'll report that my views on health care are simple: we are a wealthy country, and we can afford -- and we are obligated -- to provide decent health care to everyone, and we're better off as a society, and as an economy, if we do. As to how we go about it, I'm much less certain. I can say, though, that I don't have much faith that unregulated private enterprise will effect these changes on its own; as I've written before, if the market could figure it out, it would have done so already.

But enough about me. Let's talk about the NFIB. That conversation starts tomorrow.

PART I

INC.COM: You've commented that the health care debate has long centered on the question: "Which is more important -- coverage, cost, or quality?" What do you mean exactly, and where did NFIB historically come down on that question?

GRABOYES: Health care reform entails several admirable goals: Holding down costs, getting people covered by private or public insurance, and improving the quality of treatments (including the range and availability of those treatments). In a world of limited resources, no country can achieve the maximum along every dimension. Choice is inescapable in health care, as in all economic markets. Interest groups disagree on which goals to sacrifice in the course of reform. Historically, NFIB's membership has been most concerned with cost, both for affordability and as a means of expanding coverage.

INC.COM: How has the NFIB's stance in that debate evolved in the last year, and what brought about the change?

GRABOYES: In 2007, NFIB broadly defined its Small Business Principles for Health Care Reform. In 2008 and 2009, we'll further define these principles. High and rising costs remain the paramount concern of small business. The soaring costs are driven by rapid advances in technology, incentive structures that reward medical procedures rather than outcomes and prevention, insufficient competition among insurers and providers, lack of transparency on costs and outcomes, and vagaries of malpractice law. We're an aging population, plus we're richer and demand more. These problems are all worsening, but are fixable.

However, it's increasingly difficult to disentangle cost and coverage. Why? According to a Kaiser/HRET Employer Health Benefits Survey, health insurance premiums for small businesses have increased 129 percent over the last eight years, leading to more people without coverage. In addition, cost and coverage both impact the quality of care and the rate of medical innovation. In NFIB's view, cost/coverage/quality is not a multiple-choice question.

A majority of America's uninsured work for or own small businesses and the numbers are worsening. Relatively few existing small businesses -- including NFIB members -- drop coverage. The problem is that new small businesses, opening their doors for the first time, are less likely than in the past to provide health insurance for employees. These new firms make the excruciating choice of jobs over health insurance. In addition, fear of losing insurance coverage deters countless Americans from pursuing their dreams of owning their own businesses. That's bad for them, bad for our economy, bad for America.

INC.COM: You warn Americans not to expect "unlimited access to the highest quality care at bottom-dollar prices whenever they want." Where would NFIB propose to draw the line with its universal coverage? What kind, and how much, care could every American expect?

GRABOYES: NFIB has endorsed universal access to quality affordable health care, which means insurance coverage must be within the reach of all Americans, including those who are sick or poor. But that does not mean limitless expenditures for all. Every health care system on earth limits access -- the word "universal" does not allow any system to escape the need to deny some people care that they want and that would help them. The difficult questions are: Who is denied care? Which care? Why? When? Where? Health care reform doesn't eliminate the questions, but only alters the answers.

Neither NFIB nor any other organization has the cognitive power or moral authority to dictate exactly how much and what sort of care 300 million Americans ought to have. We need a system that allows individuals to make their own choices or to delegate them as they see fit. It's important to remember that guaranteed benefits are meaningless without guaranteed availability. A few years ago, the Canadian Supreme Court slammed Quebec's single-payer system, with the Chief Justice declaring, "Access to a waiting list is not access to health care."

INC.COM: How much would NFIB's vision of universal access cost? Who would pay for it, and how?

GRABOYES: It's not clear that universal access has to cost more than we currently spend. Our health care system is not at maximum efficiency by anyone's standards. Peter Orszag, director of the Congressional Budget Office, was quoted recently as saying that evidence "suggests you can take costs out of the system without harming health and maybe even slightly improving it." This notion that we can reduce spending without harming health comes from economists across the political spectrum.

We need to create incentives for consumers, providers, and insurers to increase wellness and prevention efforts. We need transparency from providers and insurers -- clear, understandable, easily obtainable information on costs and outcomes of different medical interventions. Consumer Reports and similar publications and databases have made it possible for ordinary people to make sensible decisions about highly complex products in which they have no expertise. The health care industry needs do the same, and they're not likely to do so out of altruism. They need to be rewarded for doing the right thing, and currently they're not.

INC.COM: Apart from malpractice reform, what measures could we take to lower the cost of health insurance, or the underlying health care?

GRABOYES: We can't really get a handle on the numbers without solving a big mystery lurking within the cost structure of American medicine. Within the United States, per capita health care costs vary tremendously across geographic regions, across insurers, and across providers; Utah, for example, spends 40 percent less per person on health care than Massachusetts. We know some of the difference results from differences in cost of living and differences in age and health of the populations. But most of the variation is unexplained. Some parts of the country spend way less on health care for some reason and -- this is the real news -- the patients seem to do just as well there as in the high-spending areas.

So a big policy question is whether and how we might bring down spending in the high-cost areas without reducing the quality of care. If we can find the key that unlocks this mystery, we then have the potential to free up resources and cover some or all of the uninsured. Lots of economists are working on these questions, the Congressional Budget Office included.

I'll conclude by noting that one of NFIB's reform principles is "realistic." We'd like to proceed rapidly, but not so rapidly that some Americans' care suffers as reform takes hold.

PART II

INC.COM: In its principles, the NFIB opposes rules that would force business to either provide their own coverage or pay into a national pool, yet you've insisted that the organization wouldn't "let anyone off the hook in financing health care." What do you think is small business' fair share, and how should they pay it?

GRABOYES: "Fair share" is easier to declare than to implement. Failing to recognize this yields unpleasant unanticipated results. In the 1980s, Congress imposed a stiff tax on luxury goods such as yachts. The rich should pay their fair share, went the argument. In practice, the tax barely touched the wallets of the rich but deeply slashed the modest incomes of boat-builders and boat-sellers. Yacht-buyers simply passed the tax along to the suppliers, making a hash of the fair share idea.

So if Congress imposes a payroll tax to create some "fair share" burden on small businesses, the question is whose wallet suffers. Will a payroll tax to buy health insurance come out of the profits of the business or out of the wages of the employees? In industries or regions with tight labor markets, the tax probably hits companies' profits a lot and employees' wages only a little. With looser labor markets, wages, not profits, get slammed. The noble idea of a fair share turns into a lottery for both firms and workers.

Even worse, a payroll tax skews markets in some predictable and unfortunate ways. It's based on wages paid in the U.S., not on other business costs, so a payroll tax penalizes firms that hire American workers and rewards firms that replace them with machines or overseas facilities. Many small businesses, and some large ones, have thin profit margins. An attempt to allocate a "fair share" to these businesses may drive them out of the market. Fair share becomes no share, and more workers and their families go on the dole. Besides, small business is not the primary cause of the broken health care system, so we can't ask small business to bear all or most of the cost of the repairs.

INC.COM: Why does NFIB place such importance on a universal tax deduction for health insurance costs? Who would it benefit, since the self-employed can already deduct health insurance as a business expense, and at least 80 percent of the uninsured don't pay any taxes anyway? Does NFIB envision replacing the tax deduction for businesses with the deduction for individuals, or two deductions side by side, one for employers and one for individuals?

GRABOYES: The tax code has a major impact on the health care market, so you can't try to fix the health care system and ignore federal tax laws. The current tax treatment of health insurance benefits creates a bias for providing health care through employers and, in some cases, encourages businesses to purchase lavish plans because the benefits are not taxed as ordinary income would be. At the same time, the owner of a small business may not be able to cover himself under the same plan as the rest of his employees and has to shop for a separate plan in the individual market. While the self-employed are allowed an individual deduction for those costs, the deduction is not as rich as the deduction at the business level because the deduction does not apply to payroll taxes.

To treat entrepreneurs differently than those who receive their health care from a corporation punishes them simply because they are self-employed. Fixing this inequality in the tax code is a critical step in helping entrepreneurs gain access to more affordable health care options. Those who are self-employed

should be on equal footing with their larger counterparts by permitting health insurance premiums to be deducted from both their income and payroll taxes.

These are just a few of the issues in the tax code that impact different health care consumers in different ways. Our goal should be to find incentives that can create a level playing field and ensure that affordable, quality health care coverage can be purchased no matter who is purchasing it.

INC.COM: Would a tax deduction make individually purchased insurance cheaper for most consumers than getting it through their employers? If not, what might prod employees to buy their own coverage?

GRABOYES: A more level market ought to lower the price for individual policies and for employer-based policies. The difference between costs of individual and employer-based policies would almost certainly narrow. How they ultimately compare is an unanswerable until we do it. Right now, consumers have little incentive to shop around, because the purchasing decisions are made by employers. Firms have little incentive to shop around, because switching policies tends to generate ill will among employees, and prices aren't much better when switching plans. The result is that insurers and providers are not subject to the competitive pressures that exist in other markets. A more competitive insurance market would almost certainly generate more innovative policies -- rewards for wellness and prevention, longer-term consumer-insurer-provider relationships, special policies tailored for people with specific health conditions.

INC.COM: Let's talk about another measure that the NFIB has always supported as a way to lower costs: interstate health associations. Are most states too small to support internal health associations in NFIB's view? Or is the cross-border provision really about avoiding onerous regulations?

GRABOYES: It is exceedingly difficult to achieve sufficient small business pools within the confines of a single state -- even a large state. And, we do see multi-state arrangements as a way to create more uniformity in the regulatory structure. It is very difficult for a small business to deal with 50 different sets of state regs, and uniformity would go a long way to easing the administrative burden and may well help drive down the administrative costs facing those in the small group market. For decades, ERISA has allowed large firms to pool risks across state lines and to avoid onerous state regulations. Their employees receive excellent care and coverage. NFIB isn't asking anyone to exempt small businesses from prudent regulation and oversight; we only want small businesses to enjoy the same opportunities and to bear the same burdens as large firms. That's not the case today, and the fixes aren't all that difficult.

INC.COM: Help me distinguish between "less government oversight" (my words) and eliminating "misguided or obsolete regulation," as you more or less put it -- what current regulations strike NFIB as particularly misguided or obsolete?

GRABOYES: Again, state regulations play a vital role in guaranteeing the safety and quality of health care. But small businesses are subject to thousands of regulations that do not apply to big companies regulated under ERISA. If these thousands of regulations aren't necessary for the health and safety of big-company employees, then it's difficult to argue that they're necessary for small-business employees. Monitoring and regulating insurers and providers is a good thing, but small business should face the requirements as big business, and that's not the case today.

PART III

INC.COM: You wrote in your comment to my original post that "our goal is not to 'push people away from employer coverage.' " However, the NFIB's principles state "Health care and tax laws should not push Americans into employer-provided or government-provided insurance programs and hobble the market for individually purchased policies" and "to the greatest extent possible, Americans should receive their health insurance through the private sector." (My emphasis.) Why isn't it reasonable to assume that NFIB would prefer to see more people trade employer coverage for their own insurance?

GRABOYES: We're getting hung up on semantics here and may be talking past one another. Since the 1940s, price controls, tax laws, and labor regulations have artificially boosted the penetration of employer-based policies and desiccated the individual market. Your employer can deduct the cost of health insurance on its taxes, whereas the individual doesn't get the same kind of deduction. Without this tax-induced distortion, we would certainly have a larger, more vibrant, more competitive market for individual policies, and there would probably be a shift in that direction.

With regard to your comments about the individual market, it is worth noting that it is not a matter of "pushing" them there, as you said. In fact, there are a lot of small business owners already in the individual market, particularly among the self-employed. The goal ought to be to transform the individual market so that the bias that exists today between large-employer, small-employer and individual markets no longer exists. Tax equity would be an example of how we can achieve that equity across all markets.

All in all, greater control over health insurance by individuals would probably be a good thing. But if firms want to continue providing insurance and individuals want to get insurance through their employers, NFIB isn't opposed.

INC.COM: But a small business, as marginal revenue to a large insurer, is thought to lack leverage when buying insurance in the competitive market. Wouldn't an individual consumer have even less leverage -- not just purchasing power but also in appealing claims decisions? (Daniel Gross makes this argument in a column for Slate, the online magazine.)

GRABOYES: If this is true with respect to health insurance, then why isn't it true with respect to every other kind of insurance or every other kind of good? If you work for a large employer, would you want that employer to purchase your auto insurance and your homeowners insurance? How about your groceries or your housing? The same argument ought to hold.

Here's the bottom line: We have a 60-year accumulation of legislation that hands leverage to large employers and denies it to small businesses and individuals. Then, we tout the large-group leverage as a reason to further shrivel the small-group and individual markets. It's circular reasoning.

PART IV

INC.COM: The NFIB appears to put a lot of emphasis on controlling health expenses by turning patients into smart shoppers making cost-benefit calculations. But when the choices are between sickness and health, or even life and death, don't they often defy rationality? How successful can such an approach be?

GRABOYES: I'll answer this one circuitously by talking first about a house.

Last year, I bought a house built in 1955. It has a gas heater, some carbon monoxide detectors, and lots of electrical wiring. I don't know any more about how those work or when they are malfunctioning than I do about my heart and lungs. I know that gas goes through the burner and blood goes through my heart, but not much more than that. And yet both can mean the difference between sickness and health, life and death. In the case of the heater, proper functioning also determines my family's life and health, whereas my heart is pretty much just me. The bottom line is that I do not have the skills or knowledge to guide the proper maintenance of either the heater or my heart. And if a malfunction in either leaves me gasping for breath, I won't be in much of a position to make calm, collected decisions.

In the case of my house, however, there is an information infrastructure that is partially missing in our health care system. When I bought the house, a skilled inspector examined the house and issued a report. There is a database of problems associated with the history of my home. The bank that holds my mortgage, the insurer who indemnifies the property, the city in which I live, and other assorted characters form a latticework of checks and balances to minimize the chance that the heater will turn lethal. In the case of health care and health insurance, the equivalent network is stunted and the information flows far less effective at providing information.

Two themes pop up constantly in discussions about health care. One theme portrays health care as uniquely important to one's sickness and health, life and death. But HVAC technicians, pilots, electricians, auto mechanics, architects, inspectors, food handlers, bus drivers, bridge engineers, and countless others also hold our lives in their hands. The other theme is that in most endeavors, people are really smart and capable of decisions, but somehow in the case of health care, they're dumb as paperweights.

But even in our information-constricted health care system, there's ample evidence that people are pretty smart and capable of controlling their destinies. Some clever health economists have examined the differences in health care treatments and outcomes in families headed by physicians and families headed by ordinary laymen. If the people-are-dim-but-doctors-are-smart hypothesis holds true, doctors' family members ought to do much better in medical situations than ordinary folks' family members. But they don't. Somehow, ordinary folks delegate the information-gathering in myriad ways -- by consulting with multiple doctors, by asking friends, neighbors, and clergymen, by consulting books and websites. And they do this even in a health care system where information is notoriously hard to acquire. That said, I'm quite sure that the decisions made by laymen and by physicians are not as good as they could be.

PART V

INC.COM: What does NFIB think of the "managed competition" proposals that the Democratic candidates have proposed, where subsidized government-run coverage competes with private insurance?

GRABOYES: I'm not going to critique the proposals of candidates from either party. We're proactively and positively reaching out to all the campaigns, engaging them in conversation about the needs of small business. We're working as an organization to help shape policies that benefit small business and the country as a whole.

INC.COM: Why is the NFIB so reluctant to embrace a government role in providing health insurance, especially considering that in the NFIB's vision the government would guarantee a minimum of coverage and presumably help pay for it?

GRABOYES: As I mentioned in my answer to another question, NFIB has endorsed guaranteed access, as opposed to a particular guaranteed level of coverage. But NFIB is certainly not opposed to a government role in providing health insurance. Medicare, Medicaid, SCHIP, the Indian Health Service, Hill-Burton, EMTALA, and a slew of other programs exist and we're not opposed.

INC.COM: Why isn't a more expansive government-based system good for small businesses -- after all, it would keep their employees healthy and it wouldn't cost them nearly as much as those who provide coverage now pay?

GRABOYES: I disagree vehemently with your premises on both health and costs. Single-payer systems do some things better than we do, but we do some things better than they do -- and on balance, I think the latter is more frequently the case, though that's partially subjective. American health care may deny someone a transplant because she has no insurance, whereas that might not be an issue in some country with universal coverage. On the other hand, America treats and saves extreme low-birth weight infants who would never be treated in some countries who proudly proclaim "health care for all." Americans expect rapid treatment of illness, while Canadians and others expect longer wait times for treatment -- and sometimes waiting kills. Some nationalized systems place rigid age limits on who is eligible for treatments such as kidney transplants.

International data suggest that government-run health care would not be cheaper than our current private insurance. Compare the original estimates of Medicare's costs (recalibrated into current dollars) with the actual costs. Look at the growth of health care costs in Canada and other single-payer countries. Explore the hidden costs implicit in single-payer system: the job-killing tax rates necessary to finance Canadian health care, for example. The humorist P. J. O'Rourke said it best: "If you think health care is expensive now, wait until you see what it costs when it's free."

PART VI

INC.COM: For those who can't afford health insurance now, what specifically would NFIB propose to make it available to them?

GRABOYES: There's no single, simple cure to the problem, but the best tool will be to restrain and even diminish the cost of care. And as for that goal, government-issued price controls won't do the job. Automobiles and computers didn't sweep the American economy because of complex tax schemes and government programs. The market expanded because the products became cheap, understandable, and clearly useful. In health care, the opposite is true.

Subsidies for the poor and sick will be a part of any expansion in coverage, and better pooling arrangements are vital. The current system is tilted toward large-group employer-based policies: small businesses pay around 18% more for their employees' coverage than do larger employers. And a big reason is that small employers and individuals are denied access to the efficient pooling arrangements that large employers enjoy.

INC.COM: You wrote that the current system's inability to accommodate people with pre-existing conditions is one of the motives behind NFIB's principles. In NFIB's estimation, how should a reformed system ensure that sick people do find insurance that is "affordable and obtainable"?

GRABOYES: There are many possible mechanisms for enabling sick people to obtain insurance. We could begin quickly by developing better pooling arrangements for individuals and small businesses. Perhaps the biggest cause of our system's dysfunction is the inability to forge long-term contracts between insurers and consumers. Your insurer has little motive to keep you healthy because he's nearly certain that you'll switch insurers before too many years pass. Why should your insurer help you to get your blood pressure or weight under control when some other insurer will be the financial beneficiary of your good health?

INC.COM: In NFIB's view, what is a "realistic" target date for fully implementing health care reform?

GRABOYES: This depends entirely upon what kinds of reforms are eventually enacted. Too much discussion today revolves around arguments over which off-the-rack health care system ought to be plopped down on the country to cure all our ills. What we need is a carefully tailored, uniquely American system that draws good ideas from different states, countries, ideologies, and theories.

NFIB's take on health care is, "When it's fixed for small business, it's fixed for America." We sincerely believe that, which is why we place such importance on the needs and wishes of small business. At this very early stage, we're laying the groundwork for future discussions by engaging organizations across the political spectrum in open, honest dialogue. Notably, NFIB joined AARP, the Business Roundtable, and the Service Employees International Union in the Divided We Fail coalition. NFIB is engaged in friendly discussions with health care experts from across the partisan/ideological spectrum. We believe that finding real solutions requires the cooperation of diverse, bipartisan groups willing to work together for change. And that is what NFIB and our members intend to do.