

### NFIB Healthcare Bulletin

Periodic email blast

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- The Day After: Health Care Reform After NFIB v Sebelius: (6/20/12): NFIB's guide to restarting healthcare reform after the Supreme Court rules.
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- The Majestic Equality of the Healthcare Law (4/19/10): The 1099 provision's special burdens on small business.
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## Small Business under PPACA: Behind the Eight-ball (8/22/12) NFIB Healthcare Bulletin

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NFIB v. Sebelius is history. The Patient Protection and Affordable Care Act (PPACA) lives on -1,000 pages of law and 10,000 pages (so far) of regulations. Small businesses ask what lies ahead, and the job-killing answer comes from the Magic 8 Ball®: "REPLY HAZY. ASK AGAIN LATER."

For decades, the high and erratically increasing costs of health insurance have throttled the capacity of small business to plan and grow. The Great Recession compounded that uncertainty. Now, a Supreme Court-altered PPACA thickens the haze.

An exchange-based health insurance market is scheduled to open on January 1, 2014. The exchanges are essential to other provisions that kick in the same day – <u>individual mandate tax</u>, <u>employer mandate</u>, <u>health insurance tax (HIT)</u>, essential health benefits, health insurance premium tax credits (i.e., subsidies), guaranteed issue, modified community rating, etc.

It's not hard to find descriptions and forecasts of where small businesses will buy health insurance after January 1, 2014, or how much that insurance will cost, or how many Americans will be covered. But for now, no forecast is worth the pixels it's written with. PPACA will make life worse for small business, but there are big reasons why no one can say how much worse or worse in what ways. This is because every small business has to ask the following baker's dozen of questions:

- [1] Will PPACA's key institutions be up and running by 2014? The exchanges and other provisions will require a massive new information technology infrastructure that merges individual-level data (on all 310,000,000 Americans) from the U.S. Departments of Health and Human Services (HHS), Labor, Justice, Homeland Security, Treasury (and the Internal Revenue Service), plus Social Security, Medicare, Medicaid, 50 states, exchanges, and hundreds of insurers. Governors of both parties reported a year ago that HHS was missing crucial deadlines related to the construction of this IT infrastructure. Indeed, some skeptics (I am one) question whether this unparalleled IT integration will ever be feasible.
- [2] Who will establish my state's exchanges? Most states have not yet decided whether to establish health insurance exchanges or whether to leave the task to HHS. Is HHS capable of running a multi-state array of exchanges? A recent paper has raised questions about whether individual subsidies and employer mandate penalties are applicable in states that have HHS-operated exchanges. Only time and courts will tell.
- **[3] Will my state expand Medicaid?** In the original forecasts, half of those gaining insurance coverage would do so through Medicaid, partly thanks to heavy-handed federal incentives. NFIB v Sebelius, however, diminished the federal government's power to force states into complying. Some states are declining the expansion and others are thinking about doing so. This new question gives a small business yet another uncertainty: how many employees will be on Medicaid and not on its group plan or in the exchanges?



- [4] How many Americans will pay the individual mandate tax rather than purchase coverage? Before NFIB v Sebelius, PPACA ordered Americans to purchase insurance and threatened them with penalties if they did not. After the ruling, PPACA offers Americans a choice: buy insurance or pay a tax. Choosing the latter no longer implies a violation of the law. If a large percentage of Americans choose to pay the tax, health insurance premiums will spike, thanks to adverse selection.
- [5] How will the individual mandate affect wages? Whether or not a business offers coverage, many or most of its employees will now be required to either purchase health insurance or pay the individual mandate tax. A business will have to pay sufficient wages for employees to meet this obligation. But until we know how many states expand Medicaid and how many opt for the individual mandate tax, we can't estimate the impact on wages with any confidence.
- [6] How many employers will choose to pay the employer mandate penalty rather than provide coverage? For any small business, bottom line calculations will be complicated by how their competitors react to PPACA. Will a large percentage of businesses offer employees insurance coverage, or will they send employees instead into the exchanges (when and if the exchanges open)? Both employees and employers stand to gain financially from the exchange-based individual subsidies.
- [7] Which services must my insurance policy cover, and who decides? Every insurance policy purchased in the small-group and individual markets must cover PPACA's Essential Health Benefits (EHB) package a menu of mandates. An expansive EHB package will increase the cost of insurance. PPACA stipulated that the U.S. Secretary of HHS would define EHB, but this role was shifted to the states, at least temporarily.
- [8] Will I be able to self-insure? Some small businesses find they can control costs better by self-insuring, rather than by purchasing a commercial policy in the fully-insured market. But some in Congress and in state legislatures would like to deny small businesses this option. (See the 5/31/10 entry here.)
- [9] Is my businesses "small" or "large" with respect to the employer mandate? When and if the exchanges open, businesses with 50 or more full-time employees (FTs) or full-time equivalents (FTEs) will be subject to potentially massive employer mandate <u>penalties</u> each year. Calculating FTs and FTEs is not simple; the employee count will depend on whether a particular individual is considered full-time, part-time, seasonal, or temporary, and the distinctions are not always clear. In addition, multiple businesses with a common owner even unrelated businesses may be interpreted by the IRS as a single business.
- [10] How expensive and time-consuming will PPACA's paperwork requirements be? Some businesses are already experiencing a cascade of paperwork thanks to the Medical Loss Ratio (MLR) provision. MLR sets a benchmark for when an insurer has "overcharged" a business. When this occurs, the insurer sends the employer a rebate check which the employer may have to refund, in turn, to employees who received health insurance during the previous plan year. This can entail complex calculations and may require the employer to track down former employees and send them checks, often for trivial amounts of money.
- [11] Which insurers will still be around once the exchanges open? Some insurers have already been driven out of certain markets. It is already true, for example, that insurers cannot refuse to cover children. The result has been the virtual disappearance of child-only policies nationally. Similarly, the



market for student health insurance plans at colleges is also drying up. Other insurers in other markets may follow.

[12] Will provider shortages drive up costs? PPACA supposedly brings complete insurance coverage to perhaps 35 million Americans. It promises free services to just about all 310,000,000 Americans. Yet there is no near-term increase in the number of doctors, nurses, hospitals. The result will be shortages, and the response should be higher costs. Here's a back-of-the-envelope calculation: Suppose the new provisions lead Americans to spend one extra hour a year with a doctor. With just under 1 million doctors, that's around 300 extra hours of demand per year for each doctor.

To make this a baker's dozen, we can add one more element.

[13] Will the U.S. head over the "fiscal cliff" in 2013? If all of these issues were not complicated enough, decisions on most of these provisions will have to be made in 2013 – a year when the American economy may be heading over the fiscal cliff and potential disaster.

### What To Do

Summing up, a business owner planning for the next year has to think the following: "Will the exchanges be ready in 2014? Will my state open one? How many of my employees will be on Medicaid? How many of my employees will opt out of insurance? What will PPACA do to wages? Will my competitors offer coverage? How generous will my health insurance policy have to be to attract employees? Will I be able to self-insure? Am I 'large?' How much paperwork will I have? Will my insurer still be around? How much will doctors charge for their services? And will the U.S. economy lie in a heap at the bottom of the fiscal cliff?" This mash-up of questions is not a strong incentive to create jobs.

To operate a small business in the PPACA era, the owner has no choice other than to become something of an expert in health care law. This means spending large amounts of time reading circulars from the IRS, other federal agencies, insurers, and other entities. But no owner can possibly grasp all the ways that PPACA will affect a business and its employees. Those of us who spend every working hour poring over this law discover new mysteries every week.

However, any business that tries to be its own health care consultant is likely to miss important requirements, impacts and opportunities. Trolling the Internet for advice will likely yield plenty of misinformation. Perhaps a small business owner should add an extra bedroom on his house. Going forward, he'll want his accountant available 24/7, and perhaps an insurance broker and tax attorney close by as well.

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# The Day After: Health Care Reform After NFIB v Sebelius (6/20/12) NFIB Healthcare Bulletin

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The long process of health care reform will begin the day after the U.S. Supreme Court rules in the case of NFIB v Sebelius. No matter how the Court rules, we will still face the big problems that predated The Patient Protection and Affordable Care Act (PPACA) – high and rising costs, gaps in coverage, uneven quality and heavy red-tape burdens for individuals, providers and businesses. The Court may throw out all of PPACA, part of it, or none of it; but no matter which, health care spending will remain the single greatest fiscal threat to the federal government, state governments, businesses and individuals. Congress and the 50 state legislatures will have little choice but to revisit the topic.

What will be the elements of post-Supreme Court reform debates? In the text below, I'll outline two areas: small business issues and entitlement issues.

#### Small business health care solutions

Small business is the logical starting point for health care reform. In the lead-up to PPACA's passage in 2010, it was often said by parties on all sides of the debate that reform had to address the health care problems faced by small business. With no human resources departments, small businesses have great difficulty dealing with the administrative side of health care. The laws governing small-group insurance create special obstacles to purchasing coverage for employees. But most importantly, insurance costs are at their worst – high and volatile – in the small business sector.

In 2008, NFIB said, "When it's fixed for small business, it's fixed for America." Unfortunately, PPACA did not fix the problems for either small business or for America. Since the challenges have not lessened for small business, it's time, once again, to address the issues.

If the Court upholds all or part of PPACA: It's essential to deal with some of the law's provisions that are especially troubling to small business. Congress could start by repealing the health insurance tax and the employer mandate. Following those, there are some harmful taxes that discourage employers from hiring: the so-called Medicare wage and investment taxes, the medical device tax, the drug tax and so forth. (NFIB led the successful effort to repeal the infamous 1099 provision.) Of course, if the Court strikes down PPACA in its entirety, these questions will be moot.

Regardless of how the Court rules: NFIB has proposed a set of twelve health care solutions that would benefit small businesses. These include: (1) Equal tax treatment in the employer-sponsored and individual markets; (2) Tax parity between the self-employed and other small businesses; (3) Changes in tax and insurance laws so employers may offer insurance on a defined-contribution basis; (4) Information technology to make insurance prices and quality transparent; (5) Insurance exchanges to expedite insurance purchases by both employers and individuals; (6) Interstate health insurance markets for small business; (7) Options for developing larger insurance pools; (8) Access to insurance for those with pre-existing conditions; (9) Insurance portability for those whose residence or job situation changes; (10) Broader range of consumer-driven health insurance products (e.g., improvements in HSAs,



FSAs); (11) Wellness and preventive options; (12) Medical malpractice reform. NFIB's website provides more information on this starter set of health care solutions.

On #3 (defined contribution), I'll note that while opposing PPACA in late 2009, NFIB avidly supported a bipartisan amendment, introduced by Sen. Ron Wyden (D-OR) and Sen. Susan Collins (R-Maine) that would have enabled small businesses to offer health insurance on a defined-contribution basis. Unfortunately, the amendment was defeated. The basic framework of Wyden-Collins is a good starting point for new discussions, as is the Utah health insurance exchange, which includes a defined-contribution capability.

Solutions #8 (concerning pre-existing conditions) and #9 (concerning portability) are perhaps the most daunting challenges on the list. The individual mandate, the subject of NFIB's constitutional challenge, was meant to address these problems. The mandate, however, is not essential for these goals. By 2009, ways to achieve these goals without a mandate were already under discussion. <a href="Editable-Identity-Editable-Identity-Ide

#### **Entitlements**

NFIB focuses on issues that are of direct concern to small business. However, the "NFIB Healthcare Solutions" document acknowledges "meaningful reform" must also deal with entitlements.

**Entitlement reforms:** The most difficult long-term financial problem facing the federal government is how to make Medicare efficient and financially sustainable. For states, the biggest problems are Medicaid and CHIP (the Children's Health Insurance Program).

Medicare's reimbursement system is nearly 50 years old and fails to reflect underlying economic realities. There is a chain of arguments that goes something like this: (1) Medicare's reimbursement formulae overcompensate specialists and undercompensate primary care doctors; (2) thus, we have an overabundance of specialists and a shortage of primary care physicians; (3) Because Medicare is so big, the overcompensation and overabundance of specialists spills over into the private health insurance markets for people under 65 years of age; (4) The end result is to skew health care toward treating disease rather than toward preventing it.

Medicaid is a heavy financial burden on the states, as well as on the federal government. And, as with Medicare, part of the problem involves nearly-50-year-old financing formulae. In particular, the structure of Medicaid financing arguably rewards states that are profligate and punishes states that are prudent.

How should we change entitlements? That's the \$60-trillion-dollar question. And we'll need answers in order to keep the federal government solvent and in order to deliver better care less expensively and more efficiently.

We can start the conversation on entitlements the day after the Supreme Court rules on NFIB v Sebelius. And Congress can begin pursuing those small business health care solutions that same day.

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# Self-insurance and Small Business (5/31/12) NFIB Healthcare Bulletin

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Some small businesses find it advantageous to provide health insurance coverage via self-insured plans rather than through the fully-insured market. Now, some state and federal policy-makers are moving to deny small businesses the self-insurance option by limiting the stop-loss insurance policies that make self-insured plans safe and viable.

A business that self-insures makes a conscious choice – to accept more risk in exchange for higher return. Businesses face tradeoffs between risk and return every day; that is the essence of owning a business. Government should not arbitrarily deny small business the right to self-insure while allowing big business to do so.

The proposed limits are motivated in part by a desire to ramp up usage of the insurance exchanges established under the Patient Protection and Affordable Care Act (PPACA). This effectively requires small business to serve PPACA, rather than the other way around.

According to a recent <u>RAND study</u> of businesses that offer insurance coverage, 8% of those with 3-49 employees self-insure, as do 20% of those with 50-199 employees. In 2010, PPACA's framers promised, "If you like the insurance you have, you can keep it." For that 8% and 20% representing hundreds of thousands of businesses and millions of employees, limits on self-insurance could break that promise.

**SELF-INSURANCE DEFINED:** With a self-insured plan (before adding in a stop-loss policy), the employer bears the financial risk of employees' healthcare. If employees collectively spend a great deal on healthcare, the business loses money — paying the bills out of its profits or savings. In the fully-insured market, a business purchases a policy from an insurance carrier (Blue Cross, Aetna, etc.), for a fixed premium. If some employee suffers, say, a \$150,000 illness, the carrier, not the employer, foots the bill.

Few self-insured employers, however, can or wish to bear all of the financial risk from employees' healthcare. One or two catastrophically ill employees could potentially wipe out the health plan or even the business. That's where stop-loss insurance comes in.

**STOP-LOSS INSURANCE DEFINED:** Stop-loss insurance allows self-insured employers to modulate their risk; by using the policies intelligently, they can bear more risk than with a fully-insured policy, but less than with a purely self-insured plan. In this way, a stop-loss policy protects both the employer and the employees.

A stop-loss policy might, for example, limit the employer's liability to \$20,000 for any individual employee and \$100,000 for all of the business's employees combined; here, \$20,000 is the policy's "attachment point" and \$100,000 is the "aggregate attachment point." If an employee suffers a \$500,000 illness, the employer only loses \$20,000. If six employees suffer \$500,000 illnesses, the employer only loses \$100,000.



**ADVANTAGES OF SELF-INSURANCE:** With self-insurance, certain businesses save money in most years, losing money in the scattered years when some employees suffer major illnesses. For these businesses, self-insurance costs less over the long-run than do fully-insured products. So some, but not all, businesses will find it advantageous to self-insure.

Self-insurance also offers employers wider latitude in designing coverage. Under the federal law known as ERISA, self-insured plans are immune from costly state benefit mandates. Importantly, the option to self-insure offers employers an emergency exit in case the fully-insured market becomes problematic. Given the uncertainties surrounding PPACA, that is an important option.

**PROPOSED RESTRICTIONS:** Some state policymakers would like to prohibit small businesses from self-insuring. Oregon and New York already prohibit self-insurance outright for businesses with fewer than 50 employees.

In California, Amended Senate Bill 1431 would limit the sale of stop-loss insurance to businesses with fewer than 50 employees. Specifically, small employers could not purchase a stop-loss policy with an attachment point of less than \$95,000 per individual and an aggregate attachment point of less than the greatest of (a) \$19,000 x the number of covered employees and family members, (b) 125% of expected claims, or (c) \$95,000. For some employers, this would effectively eliminate the self-insurance option; others might continue to self-insure, but also to carry considerably more risk than they currently have.

In Washington, D.C., it appears that the Administration is <u>considering regulations</u> that would similarly restrict the ability of small businesses across the nation to self-insure and to safeguard their plans by using stop-loss insurance.

**QUESTIONABLE MOTIVATIONS:** The policymakers seeking to limit stop-loss insurance and self-insured small-group plans worry that self-insurance will lead to segmented markets, higher rates of claims denials, and lighter benefit packages, but the evidence supporting these fears is weak. They worry, too, that self-insurance will weaken the SHOP exchanges, but this argument, once again, is speculative.. The federal government understands that these worries are overblown.

Proponents' fears about self-insurance do not hold up to scrutiny. The <u>RAND study</u> cited above challenges concerns that businesses with healthy employees will tend to self-insure, leaving a sicker, more expensive-to-treat employee base in the fully-insured market and, in particular, in the Small Business Health Options Program (SHOP) exchanges set to open in 2014. "Our results do not point to major differences in benefit generosity between self-insured and fully-insured plans or to a major threat of adverse selection in the small-group market after [PPACA] is fully implemented."

The RAND reports also dispute concerns that employees in self-insured plans may experience higher rates of claim denials or skimpier benefit packages: "Although data are limited, we found no evidence that claims denial rates are higher for self-insured firms." And even if one believed those charges, it raises the question of why self-insurance is fine for employees of large entities, but not of small businesses.

The federal government bulletin cited above includes wording that suggests how weak the argument against self-insurance is: "The Departments have little data on the incidence or terms of stop loss insurance among self-insured employers' group health plans." ... "The limited available information suggests that stop loss insurance is perhaps becoming more common among smaller self-insured plans



but information is not available on the type of stop loss coverage purchased by plans of various sizes." ... etc. etc.

**SUMMARY:** The drive to limit small-group self-insurance is one of many examples of PPACA-inspired micromanagement of healthcare. This means more time and effort devoted to paper-shuffling and less time devoted to developing and growing businesses. A better solution in this case is for states and the federal government to allow markets to function properly. Let employers and employees determine what is too risky and what is not. If the government wishes employers to insure their employees through the SHOP exchanges, then make the SHOP exchanges attractive places to do business. That means well-functioning services, simple forms, competent administrators, well-designed websites, and telephones that don't go straight into voicemail; it also means adding attractive and innovative features like defined-contribution capabilities.



### Cashews on the Hindenburg (2/24/12)

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The Patient Protection and Affordable Care Act (PPACA) has a thousand pages of moving parts, and the relatively few that have rolled out are shedding sprockets across the landscape. This is deeply worrying, given that the stability of the nation's health care system depends on the successful construction and launch of a vast fleet of new institutions before New Year's Day, 2014.

### Number-one selling point

Consider the small business health insurance tax credit. For two years, PPACA supporters have trumpeted this small piece of the law as their <u>number-one talking point toward small business</u>. For some businesses, they note, the credit can offset up to 35 percent of employee health insurance costs and 50 percent beginning in 2014. "This year, up to 4 million small businesses may be eligible for tax credits, making it easier for them to provide coverage to their workers," says the <u>White House website</u>. "Health care reform saves small business owners money immediately through tax credits," proclaims <u>another site</u>. The credit is a "<u>huge boon</u> to small businesses," declares a recent newspaper column.

This is equivalent to the statement, "Unlimited cashews offer huge boon to Hindenburg passengers."

A bowl of cashews is a tempting snack, but it's relatively unimportant to someone riding five million cubic feet of hydrogen toward an electrical source. Likewise, the incessantly-touted credit is a modest little windfall for a relatively few small businesses. It's not a bad thing in and of itself. But the credit is miniscule next to the <a href="heavy load">heavy load</a> of financial costs, red-tape, and uncertainty generated by PPACA. And the credit provides a cautionary tale for the rest of the law.

### The record

The National Federation of Independent Business noted all along (see  $\frac{4/3/11 \text{ and } 5/13/10}{13/10}$ ) that far fewer than 4 million businesses would qualify. Our warnings were greeted with rolling eyes, but even our most pessimistic forecasts weren't as bad as the actual numbers.

The U.S. Treasury Inspector General for Tax Administration said only 309,000 businesses claimed the credit for 2010—8 percent of that theoretical 4,000,000. Those 309,000 received, on average, only \$1,346. Spread across the mythical 4,000,000 "potential" recipients, that's \$103 apiece. To put this in perspective, in 2011 small-group insurance premiums averaged \$5,328 for an individual employee and \$14,098 for a family. So \$1,346 per employer (not per employee) is not much of an inducement to offer insurance.

But as insignificant as the credit is for most businesses, it did cost the government \$416,000,000 in 2010.



Buried within a trillion-dollar deficit, something just under half-a-billion dollars isn't huge, but as the federal debt floats toward crisis, neither is it trivial.

The <u>real reasons</u> for the credit's failure were obvious from the start. It was terribly designed, relatively few businesses qualified, and many who did only qualified for a pittance. The 35 percent credit shrinks to nothing as a business grows beyond 10 employees, raises wages beyond \$25,000, employs the owner's relatives, uses part-time labor, or offers more-generous-than-average insurance. Once the exchanges open in 2014, the credit expires within two years. Some accountants have told business owners to forget about claiming the credit—that it costs more to calculate than it will pay out. (For the record, NFIB always suggested that employers take advantage of the credit if it were in their financial interests.)

#### The excuse

Why this failure? PPACA supporters give a troubling response. They did a survey purporting to show that 57 percent of business owners had never heard of the credit. Let's suppose they're correct and consider what that claim implies.

Advocates, from President Barack Obama on down, have continuously touted the credit. In 2010, the <a href="White House">White House</a> launched a "nationwide educational campaign for small businesses and tax preparers." According to the official website, this campaign included a special page on WhiteHouse.gov, millions of postcards mailed by the IRS to businesses, over 1,000 tax workshops and small business forums, email blasts to 175,000 tax professionals, and a special section on IRS.gov.

And yet after two years of this massive information campaign, PPACA supporters complain that a majority of business owners (and by extension, their accountants) remain unaware of a <u>tax form</u> that could potentially save an individual business thousands of dollars per year. Keep in mind that these are business owners who constantly navigate the more cumbersome and arcane corners of the U.S. Tax Code. If we believe the survey, in two years, all the resources of the federal government could not reach a small, targeted, well-educated, easily-identified segment of society.

Now, the same government has less than two years to acquaint 300 million Americans with the impenetrably complex workings of PPACA's individual mandate, premium credits, cost-sharing subsidies, exchange and non-exchange markets, employer mandate, essential health benefits, Medicaid qualification, actuarial values, myriad tax-code changes, benefit tiers, preventive service coverage and on and on.

### Beyond the credit

PPACA's failures do not end with the credit. PPACA created high-risk pools so that Americans with preexisting medical conditions could immediately gain access to insurance. The Congressional Budget Office estimated that perhaps 4 million Americans would be eligible. The Chief Actuary of Medicare and Medicaid <u>estimated</u> that 375,000 people would enroll by the end of 2010. By October 2011, only 41,000 had signed up nationwide—an 89 percent underperformance.



PPACA was sold as a way of lowering the cost of health insurance. And yet health insurance premiums rose 9 percent in the year following enactment, versus a 3 percent increase in the year before (and 5 percent between 2005 and 2010).

As the states scramble to establish the exchanges that must be operative by January 1, 2012, governors of both parties are warning that the law is a logistical nightmare (scroll to 9/28/11).

The list goes on.

The <u>Supreme Court will decide</u> in early 2012 whether to throw PPACA out. Whatever the court decides, it is time to rethink health care reform and to do it right this time. Here's a small starter set of ideas – <u>twelve ways</u> to begin genuine reform.

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A thick volcanic plume is flowing over the 2010 healthcare law. Rumbles are heard from the U.S. Supreme Court which, in 2012, will issue a fourfold constitutional judgment. To one centrist scholar, the law's constitutional frailty suggests chambers of operational dysfunction beneath the surface. An NFIB study estimates how that dysfunction will waft over small business and the rest of the economy. And a Treasury Inspector General's report indicates that the law's overhyped tax credit provides little shelter. As the law sags beneath the ash, NFIB suggests twelve ways that Congress could begin to replace the law with real reform that improves healthcare and cuts costs.

The constitutional challenge: The U.S. Supreme Court announced on November 14 that in 2012, it will decide the fate of the Patient Protection and Affordable Care Act (PPACA). From the many cases wending their way through the federal courts, the Supreme Court selected NFIB v Sebelius as the centerpiece of its deliberations. In March, the Court will hear arguments on four questions: (1) Is the unprecedented individual mandate constitutional? (2) If the Court strikes down the individual mandate, must it also strike down the entire law? (3) Does the Anti-Injunction Act require courts to wait until 2014 to consider constitutional challenges, since no penalties will be paid on the mandate until then? (4) Does PPACA's massive increase in Medicaid unlawfully coerce the states into participating? A ruling is likely to come in June.

In 2010, the National Federation of Independent Business (NFIB) joined with 26 of the 50 states to challenge the healthcare law's constitutionality. A Florida federal court ruled that the individual mandate was unconstitutional and ordered the entire law struck down, since it lacked a severability clause. The Eleventh Court of Appeals agreed that the mandate was unconstitutional but allowed the rest of the law to stand. NFIB appealed the second part of that ruling, arguing that without a severability clause, the entire law must fall. More information on NFIB's lawsuit is available at <a href="https://www.nfib.com/lawsuit">www.nfib.com/lawsuit</a>.

**Operational dysfunction:** In a penetrating column, <u>Walter Russell Mead</u> (Bard College) explored the deeper significance of the lawsuit: "Writing a bill that passes constitutional muster should be easy in a Congress so rich in lawyers and legislation writers. Writing a bill that successfully improves American healthcare delivery while controlling costs, on the other hand, is hard. Very, very hard. ... If they did so poorly at the easy part of their task, the part where we can actually measure and monitor their success, what kind of mess have they made of the hard and murky parts that nobody, including the authors of the bill, really understands?"

**Job losses:** NFIB has supported healthcare reform for decades but strongly opposed PPACA because it failed to do what Professor Mead suggested was important: improving healthcare delivery while controlling costs. As an example, the NFIB Research Foundation has just released a **job-loss study** enumerating the damage that PPACA's higher costs will do to small business. "Effects of the PPACA Health Insurance Premium Tax on Small Businesses and Their Employees," by Michael J. Chow,



estimates the job losses that will result from just one provision of the law – PPACA's health insurance premium tax. Chow estimates that this tax "will reduce private sector employment by 125,000 to 249,000 jobs in 2021, with 59 percent of those losses falling on small business." This tax falls heavily on small business while bypassing big business, labor unions, and governments; and it is only one of a constellation of cost-increasers that small business faces in PPACA. NFIB is spearheading a repeal coalition aimed at dropping this tax; toward this end, H.R. 1370 and S. 1880 have been introduced in the House of Representatives and Senate.

**Credit oversold:** At the same time, the most heavily-touted cost-decreasing measure in the law turns out to be a dud. PPACA supporters have argued that over 4 million businesses would benefit from a tax credit of up to 35% of the businesses' health insurance costs (50% beginning in 2014). NFIB consistently said that the credit is fine for those who can make use of it, but that relatively few businesses would get much out of it. The preliminary figures are in now, and they are worse than NFIB's pessimistic estimates were. The Treasury Inspector General for Tax Administration <u>reported</u> that as of mid-October, only 309,000 businesses had claimed the credit for 2010 and that the average credit per business was around \$1,346 – not much of inducement to offer insurance.

Twelve doable reforms: Whichever way the Supreme Court rules, the country will need real healthcare reform that improves healthcare delivery and moderates costs. Toward this end, NFIB has posted a set of twelve NFIB Healthcare Solutions that could begin the task of replacing PPACA. The proposals include (1) Tax parity between the group and individual markets; (2) Tax parity between insurance purchased by the self-employed and groups insurance; (3) Defined contribution health insurance; (4) More transparent measures of cost, options, and quality; (5) Public and/or private exchanges; (6) Interstate insurance purchasing. (7) More risk-pooling options for small businesses and individuals; (8) Mechanisms to get insurance for those with pre-existing conditions; (9) Greater insurance portability; (10) Greater latitude for consumer-driven health insurance products; (11) Wellness incentives; and (12) Malpractice reform. These reforms are just a start and did not touch on two big areas where reform is needed: healthcare delivery systems and entitlements.

### Conclusion

Those who wrote this law ought to go to bed each night fearing two things. Their lesser fear should be that the Supreme Court overturns PPACA, leaving their vision of healthcare reform as dead as Pompeii. Their greater fear should be that the Supreme Court doesn't overturn the law, for then they will spend the next generation explaining the destruction they brought upon American healthcare and the American economy.



## PPACA: Five Layers of Uncertainty (9/28/11) NFIB Healthcare Bulletin

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The Patient Protection and Affordable Care Act (PPACA) discourages small businesses from hiring and expanding by smothering them under multiple layers of uncertainty. This essay will describe five sources of uncertainty, with a lengthier focus on the less-discussed fifth source.

#### **Four Uncertainties**

- (1) Can we afford PPACA? PPACA supporters claimed that the law would help control healthcare costs, but that claim now lies in shreds. Probable cost increases were discussed in "Costs and The Law that Shall Not Be Named" (10/4/10). Just this week, a Kaiser survey showed a stunning increase in health insurance premiums since the law passed. Premiums rose 3% in 2010, but then leaped by 9% in 2011. Also this week, there were indications that the Administration had abandoned the fiscally unstable CLASS Act portion of PPACA.
- (2) What are the rules? Much of PPACA was written in general terms; regulators will spend years writing the specifics. Example: a business with 50 or more employees will owe tens or hundreds of thousands of dollars a year in insurance premiums and/or penalties. But whether or not a firm is under, over, or at 50 depends on as-yet-unwritten definitions of part-timers, temps, and seasonal workers. Another still-unwritten regulation was described in "Essential health Benefits: The Secretary's Joystick" (5/3/11).
- (3) Who must follow the rules? PPACA invests officials with power to exempt specific businesses from certain provisions. The Department of Health and Human Services has granted some, but not all, businesses "mini-med waivers," but has never explained the criteria by which waiver requests are granted or refused. See "Small Business in Waiver World" (3/9/11).
- (4) **How will markets respond to the rules?** The many changes in PPACA greatly increase the vagaries of economic forecasting. How high will physicians' charges rise as 30 million people gain insurance? How many insurers will continue to write policies? Will employers dump their employees into subsidized exchanges? What will happen to the cost of insurance premiums? **The HIT Hit: PPACA's Health Insurance Tax (6/14/11)** describes uncertainty over the size of the Health insurance Tax.

### **One More Uncertainty**

- (5) **Will the rules work?** PPACA is a complex piece of clockwork. Aside from rules, exemptions, and market responses, there's another gaping maw of uncertainty: can the gears of the clockwork mesh?
- (a) In October 2010, **Gene Steuerle (Urban Institute)** asked, "Can the new health subsidies be administered?" The new exchanges promise subsidies to tens of millions of households, with subsidies based on a household's income, family size, insurance costs, and other variables. Under PPACA's rules, millions will float in and out of eligibility for Medicaid and exchange subsidies. Steuerle asked whether it



is feasible to track these flows: "For some reason, health reformers think they can do better than the welfare and tax systems and set up what is essentially a whole new transfer and tax system based on past annual rather than current income and then adjusted for changes during the current year."

- (b) In February 2011, <u>Benjamin Sommers (Harvard) and Sara Rosenbaum (GWU)</u> warned that PPACA's eligibility rules for Medicaid and for the new exchanges would results in millions of people bounced back and forth between different insurance coverage as their incomes fluctuate. They voiced concern that this bouncing between markets would drive some people to give up on health insurance altogether.
- (c) In June 2011, <u>Paul Howard (Manhattan Institute) and Stephen Parente (University of Minnesota)</u> examined the information technologies required to manage the flows described by Steuerle and Sommers/Rosenbaum. Managing these information flows is critical to the health insurance exchanges that are supposed to form the heart of the small business health insurance market:

"For the first time, secure data feeds from the Departments of Homeland Security (establishing legal immigrant or US citizen status), Justice (for felon history), Treasury (for tax return information to impute income) and the Social Security Administration (establishing that the recipient is not deceased) would have to be combined. These data feeds would then have to be securely coordinated by the Department of Health and Human Services. There is no history of these agencies ever bringing their data together at this scale. It would qualify as the largest IT integration project in U.S. history. ... Next, all 50 states would have to integrate this data into 50 different versions of a Travelocity.com for health insurance – all while seamlessly shifting millions of recipients back and forth between private insurance and public programs like Medicaid and CHIP; allocating subsides; and collecting insurance premiums."

- (d) In September 2011, <u>the Internal Revenue Service (IRS)</u> requested comments on its attempt to fix a serious flaw in PPACA. <u>"Premium Credits + Free Rider Provision = Mystery Tax" (6/7/10)</u> noted that PPACA's employer mandate subjected businesses to a "mystery tax" large penalties based on private employee data that is irrelevant to and unobservable by the employer. To its credit, the IRS is striving to cope with a provision that may be impossible to administer but which is critical to PPACA's operation.
- (e) Also in September 2011, the <u>National Governors Association (NGA)</u> warned that time was running out to fix a range of difficulties in implementing the health insurance exchanges. The report reiterated the problems described above: "[T]he requirements for interconnected, automated systems to determine Medicaid and subsidy eligibility, pose major challenges. Tight deadlines, severely strained budgets, and human resources shortages further complicate implementation in nearly every state."

The reported noted that "Federal guidance has yet to be released or finalized on many issues, confronting states with a lack of clarity on many issues – a problem frequently compounded both by insufficient detail and efforts to preserve apparently broad flexibility." Other concerns included "uncertain and challenging timelines," "a lack of clarity and detail," and "concerns about costs."

The NGA report discusses the practical information technology challenges presented by these eligibility determinations. Because of federal officials' lack of clarity, state procurement rules, and normal problems of IT implementation, states are worried that they cannot get their systems up and running in time for the 2014 opening of the exchanges. The report specifically mentioned how these shortcomings could impact small business health insurance markets.



### Conclusion

PPACA adds an extra measure of drag on an already-sputtering economy. For more than two decades, health insurance has been the biggest concern of small business. With the passage of PPACA, small businesses have to say, "I don't know what this law will cost me. I don't know what the rules will be. I don't know how they'll be enforced. I don't know what the insurance markets will look like during the next enrollment cycle. And it's not clear that the new small business insurance market will be functional." Many owners reluctantly conclude, "I won't hire or expand until I know more."



# PPACA and the Jobless Recovery (8/9/11) NFIB Healthcare Bulletin

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Small-business owners are deeply concerned that the 2010 health-care law (PPACA) will prolong what has been described as America's "jobless recovery." Recent <u>Congressional testimony</u> and <u>a new study by the NFIB Research Foundation</u> (my employer) shed some additional light on this concern. It is worth noting that small businesses normally create around 65 percent of the country's net new jobs, but the sector has been shedding jobs almost continuously since early 2007.

Obviously, job-creation anemia did not begin with PPACA. But if small-business owners are correct, PPACA could prolong a situation that, in August 2011, is dire. For context: In June, the overall unemployment rate was 9.2%; add in discouraged and underemployed workers and the real rate is 16.2%. Since the second quarter of 2007, the small-business sector – normally the engine of job creation – has lost, not added, jobs in all but one quarter. Pre-PPACA, we can cite at least three contributory factors: Weak economic growth stripped businesses of the incentive to expand or hire. (The latest official data show 0.4% in the first quarter of 2011 and 1.3% in the second quarter.) Uncertainty over tax rates made it difficult for businesses to do even relatively short-term business planning. (2011's marginal income tax rates and estate tax rates were not known, after all, until days before the year began.) And the real estate collapse obliterated the collateral that many small businesses would have used to fund expansion and hiring. (Business owners own a lot of homes, offices, and investment properties.)

But recent information adds to the perception that PPACA has joined these other three anchors in discouraging growth and job creation. In late July, a panel of business owners expressed their fears before a subcommittee of the U.S. House Oversight Committee. One of the panelists, with 450 mostly blue-collar employees, was an NFIB member whose written and oral testimony walked members of Congress through the mechanics of his business and the options PPACA imposes on it in 2014. In his words, "this law will cost our company \$1,000,000 or more no matter which option we choose. ... Today, these estimates are more than the company makes. ... These forecasts do not even consider the significant additional administrative costs we are incurring and will continue to incur managing the program, preparing mandated government reports, and tracking all [employees'] household dependents and earnings." He added, "[O]ur thirty-year business and the jobs of 450 employees are at risk of being legislated out of existence. ... Our goals turn from 'hire-and-grow' to 'cut-and-survive.' "Other panelists expressed similar fears about the impact on their businesses. For those interested in a flesh-and-bones look at the law, their testimony is worth reading.

The panelists' testimony accorded with the new NFIB Research Foundation. In the study, by William J. Dennis, Jr., majorities of business owners familiar with the law said PPACA:

- won't reduce paperwork or simplify the provision of healthcare (79%);
- will increase taxes (77%);
- will increase federal budget deficits (71%);



- will infringe on the rights of Americans (65%);
- won't slow the rate of health insurance cost increases (65%);
- won't improve the overall health of the American public (59%);
- will lead to a government takeover of healthcare (58%); and
- will separate doctors and patients (50%).

In general, the negative sentiments were more widely held by those businesses currently offering insurance than by those who do not offer – similar to the findings in the McKinsey and Company report that made headlines recently by predicting that, "Overall, 30 percent of employers will definitely or probably stop offering insurance coverage in the years after 2014."

The Foundation study was based on a survey of 750 small businesses, chosen at random from Dun and Bradstreet. The survey of these companies was conducted by the nonpartisan Mason-Dixon polling organization.

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# The HIT Hit: PPACA's Health Insurance Tax (6/14/11) NFIB Healthcare Bulletin

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The 2010 health care law, the Patient Protection and Affordable Care Act (PPACA), hits small business with a barrage of inequities. Among the most egregious is the health insurance tax (HIT) launched by the law's Section 9010. Ostensibly a tax on insurers, its real effect will be hundreds of billions of dollars of taxation on people who purchase coverage in the fully-insured market – mostly small business employers and employees and the self-employed. These are the people who usually generate around two-thirds of America's new jobs.

In contrast, the HIT bypasses those who have coverage through self-insured plans – mostly big business, labor unions, and governments. Like PPACA's essential health benefits and longstanding state benefit mandates, the HIT puts an anchor around the neck of small business while leaving larger organizations free to swim unburdened. And the anchor is a heavy one.

Over the first decade, the HIT will hit the fully-insured market with an estimated \$87.4 billion tab, but that figure greatly understates the long-run financial impact. The tax is not implemented until the fourth year of the decade (2014) and is only fully implemented in 2018. The tax rises from \$8 billion in 2014 to \$14.3 billion in 2018 and in later years, even higher according to a complex (and at this point opaque) index, discussed below.

To put this in perspective, that \$14.3 billion equals around 15 percent of the total small business expenditures on employee benefits in 2007. According to IRS data, proprietorships, partnerships, and corporations with up to \$10 million in annual receipts deducted \$96.8 billion that year for Employee Benefit Programs. An extra 15 percent or so constitutes an enormous blow to the ability of small businesses to compete against larger entities.

The HIT's full magnitude will only become apparent in the second decade (2021-2030), when businesses and consumers experience 10 years of a premium-indexed, fully-implemented HIT. The second-decade cost is difficult to forecast, but may exceed \$200 billion or even \$300 billion. It all depends on how rapidly the law's arcane index lifts the HIT beyond its \$14.3 billion base in later years. There are two major sources of uncertainty in that index.

First, after 2018, the size of the tax depends on how fast health insurance premiums rise, and no one can forecast that rate of increase with any confidence. In <a href="Essential Health Benefits: The Secretary's">Essential Health Benefits: The Secretary's</a> <a href="Joystick">Joystick</a>, I explained the uncertainty that the essential health benefits structure poses for premium forecasts. PPACA was supposed to moderate the increase in health insurance premiums, but that talking point has been killed by pronouncements from the Congressional Budget Office, the Chief Actuary of Medicare and Medicaid, and a rash of private forecasters. Even a White House-sponsored teleconference in summer 2010 warned participants to stop arguing that PPACA would reduce costs. There are few reasons to think that premiums will rise more slowly, but many reasons to think they will increase more rapidly – the essential health benefits package, the health insurance tax, the slew of other



new taxes imbedded in the premiums, elimination of coverage limits, mandatory preventive services, giving more people insurance while creating no new doctors or nurses, and demographic trends.

**Second, the precise mathematical structure of the index is uncertain.** The index consists of a complex set of equations that incorporate not only premium increases, but also each year's number of policyholders, size of U.S. gross domestic product, Consumer Price Index, and certain tax credits contained in PPACA. The provision says of the index (PPACA, Section 9010):

"In the case of any calendar year beginning after 2018, the applicable amount shall be the applicable amount for the preceding calendar year increased by the rate of premium growth (within the meaning of section 36B(b)(3)(A)(ii) of the Internal Revenue Code of 1986) for such preceding calendar year."

For readers who enjoy solving puzzles, I suggest that they turn to Section 36B(b)(3)(A)(ii) of the Internal Revenue Code and try to figure out how the IRS will calculate the post-2018 tax increases. With the help of some taxation and insurance industry experts, I think I have it figured out. But we'll see. Meaningful forecasts will have to await future IRS rulings and other regulatory interpretations.

**Nevertheless, we can explore some plausible scenarios.** Health insurance premiums for the average family grew by around 5 percent between 2005 and 2010 (see Exhibit 1.1 <a href="here">here</a>.). If the HIT were to rise by 5 percent per year after 2018, the tax would total \$208 billion between 2021 and 2030. Family premiums rose by over 10 percent between 2000 and 2005. If the HIT were to rise by 10 percent per year, the second-decade cost would be \$303 billion.

**In addition, the HIT will cascade on itself.** Insurers will pass the HIT along to purchasers in the form of higher premiums. In turn, those premium increases will enter into the index and raise the tax in later years, and insurers will have to pass those increases along to purchasers, as well. So the HIT violates a common principle of fairness in taxation – that one should not be taxed on a tax.

And interactions between the HIT and the corporate income tax will augment the total effect by over 50 percent. Former Congressional Budget Office Director Douglas Holtz-Eakin explained how the first-decade costs will actually be \$134.6 billion, rather than \$87.4 billion ("Higher Costs and the Affordable Care Act: The Case of the Premium Tax," available on the web.) By the same logic, a \$208 billion second-decade HIT would really mean a \$320 billion impact on health insurance consumers.

**Finally, the impact on those in the fully-insured market is likely to be even worse because of the peculiar structure of the HIT.** If some businesses switch from the fully-insured market to self-insured plans, those remaining in the fully-insured market will have to pick up the tax bill for those who have switched to self-insurance. And because of the inequity of the tax, it will certainly drive some businesses to self-insure – even if such a switch may be imprudent from a risk standpoint.

In short, this tax will bludgeon small business.

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# Essential Health Benefits: The Secretary's Joystick (5/3/11) NFIB Healthcare Bulletin

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Beginning in 2014, the Patient Protection and Affordable Care Act (PPACA) hands the Secretary of the U.S. Department of Health and Human Services a joystick – the Essential Health Benefits package – with the potential to rocket small-business health insurance premiums skyward. EHB is the menu of goods and services that must be covered under all exchange-purchased insurance plans and nongrandfathered small-group and individual insurance plans. By vesting one set of hands with control over EHB, small business faces permanent administrative uncertainty. At the same time, the brunt of EHB appears largely to bypass big business, unions, and governments.

### EHB, Ban on Limits, Actuarial Value

Beginning in 2014, PPACA (§1302) makes EHB a mandatory feature of most insurance plans purchased by America's 6 million small businesses and 15 million self-employed individuals. Exceptions initially include businesses with more than 100 employees and those with grandfathered policies. The EHB requirements apply to policies purchased both in exchanges and in non-exchange small-group or individual markets.

In the small-group and individual markets, annual or lifetime coverage limits on all EHB items are forbidden. And plans must have an actuarial value (AV) of at least 60 percent, meaning the plan's total reimbursements must be at least 60 percent of the total qualifying health care costs incurred.

Section 1302 empowers the Secretary of HHS to define EHB, but gives little specificity beyond requiring that EHB include 10 general categories (e.g., ambulatory patient services) and "the items and services covered within the categories;" the Secretary is to also assure that EHB includes "benefits typically covered" by a "typical employer plan." The meaning of these words in quotation marks is left to the Secretary (and future Secretaries) to define and redefine. The fluid definitions and concentrated discretion mean uncertainty, which carries a financial cost for small business.

### **State Mandates as Precedent**

The Council for Affordable Health Insurance lists <u>2,156 state mandates</u> in 2010. These included benefit mandates (e.g., reimbursement for smoking cessation), provider mandates (e.g., reimbursement for services provided by acupuncturists), and covered-person mandates (e.g., inclusion of stepchildren under family policies).

Some mandates are less controversial than others. But every mandate benefits some patients. The problem is that mandates, no matter how well-intentioned, mean higher costs.

At least with state mandates, the legislative process restrains proliferation. Typically, a new mandate has to wend its way through a state legislature, with attendant impact estimates, public hearings,



recorded votes, and so forth. Disease groups and provider groups can lobby for additional covered benefits, but so can groups representing consumers and taxpayers. In the end, legislators have to weigh both costs and benefits of mandates or else incur the wrath of financially pressed voters. Importantly, with state mandates, cross-state comparisons provide evidence of how the mandates affect costs and health outcomes. One can measure the difference in costs between Rhode Island's 69 mandates and Idaho's 13 mandates.

For small business, a perpetual irritation is the fact that state mandates apply mostly to small businesses and individuals (including the self-employed). Most big businesses, labor unions, and governments are self-insured, and, therefore, exempt under ERISA. EHB appears to compound this inequity.

#### **Federal Mandates under PPACA**

Effectively, §1302 creates national benefit mandates. Most small-group and individual policies must cover the entire EHB package, with no coverage limits and an AV of 60 percent or higher. States will still have the discretion to add additional mandates on top of the EHB package. In contrast, plans obtained in the self-insured and fully-insured large-group (over 100) markets apparently do not have to include all EHB items. They can't impose annual or lifetime coverage limits on any EHB services that they do cover, but it appears that they can omit EHB items from their coverage. This would seem to create a powerful motive to omit EHB items that are rare, but terribly expensive – a luxury small business will not share.

Unlike most state benefit and provider mandates, designing and altering the EHB package will require no legislative action. PPACA specifies simply that the Secretary of HHS "shall define the essential health benefits" after commissioning some data collection from the Labor Department. (In the current process, HHS also turned to the Institute of Medicine for advice in crafting the EHB.) Since EHB is national, there will be no cross-state comparisons of costs and health effects of the actual EHB with any other design. According to the law:

"The Secretary shall ensure that the scope of the [EHB] is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary. To inform this determination, the Secretary of Labor shall conduct a survey of employer-sponsored coverage to determine the benefits typically covered by employers, including multiemployer plans, and provide a report on such survey to the Secretary." ... In defining [EHB], the Secretary shall ... ensure that such essential health benefits reflect an appropriate balance among the categories ... so that benefits are not unduly weighted toward any category."

The Labor Department's <u>survey</u> of April 2011 cites problems with employer plan data. The document notes, for example, variation in how plans define items such as "infertility treatments." The report warns: "Unfortunately, this review indicated that it is not possible to produce reliable data for many of the services due to the lack of detail that characterizes many plan documents. Services may or may not be covered when they are not mentioned in plan documents." Hence, the Secretary will have to layer subjective judgment on top of inadequate data.

But even if the data were adequate, the vagueness of PPACA's instructions creates considerable uncertainty for small business. How is the Secretary to define a "typical employer?" Should a shoe store's employee plan depend on the "typical" coverage offered by an investment bank, a white-shoe law firm, a federal agency, or a union shipyard? Or, since EHB affects small businesses most directly,



should the shoe store's requirements square with other small firms in the fully insured market? The Secretary's thoughts apparently carry the day.

What are "benefits typically covered?" Suppose 1/3 of the employers surveyed offer "Cadillac" coverage (high-end), while 1/3 offer what we can call "Corolla" coverage (middle-of-the-road), and 1/3 offer "Kia" coverage (bare-bones, but decent). Does the Secretary decide that since 2/3 of employers offer Corolla coverage or better, then that should define the EHB? Businesses with Cadillac or Corolla plans will be relatively unaffected. Only those companies with the Kia policies will see their premiums rise, and it's likely that these will include many small businesses and perhaps especially start-ups. In other words, those hardest hit will be the incubators of America's job growth.

How finely will the Secretary define the required benefits? The Secretary's wide discretion is described in a bulletin from the American Cancer Society:

"While it requires coverage for each of [ten] categories of benefits, the law does not name the specific services that must be covered or the amount, duration, and scope of covered services. The Secretary will define the specific benefits within each of the categories and will update the package to address gaps or to respond to changing medical practices. ... [W]ill the Secretary determine how many counseling sessions are covered for smoking cessation, or whether medications are included, and which ones? Or will a plan be permitted to decide the number of covered sessions and medications? The Secretary will need to make critical decisions about the level of discretion to leave to health plans. ... While the law enumerates certain considerations that must be taken into account, the Secretary retains wide authority in making determinations on covered services. And while the law requires an opportunity for public comment, it does not define a procedure for involving stakeholders like cancer patients, clinicians, or experts in cancer care. Advocates, therefore, will need to seek out opportunities to weigh in to make sure important benefits are included."

As an example of the lobbying to come, a Cancer Society spokesman wrote, "If a patient requires chemotherapy every week for a year... they should not be hindered by an arbitrary rule about only getting 35 visits." In contrast, America's Health Insurance Plans <u>urged</u> HHS not to get into "the details of each category of care" and suggested that HHS permit restrictions on the number of visits in certain situations to hold down costs. Medical merits aside, these two policies have very different cost impacts. And small business shares the Cancer Society's concern that the law defines no procedure to involve stakeholders – including small business.

Section 1302 also requires the Secretary to update the EHB at least annually. When a new benefit is added, will outstanding insurance contracts have to comply immediately? If so, then insurers are going to have to build extra margins of safety into their premiums, and costs will rise.

### Conclusion

The Essential Health Benefits package is a ganglion of uncertainty for small business. Disease and provider lobbies, with admirable intent, will tout the benefits of expanded coverage and ignore the costs. Small business will wonder how "typical coverage" is defined and who the "typical employers" are against whom they are measured. The jobs and the wages of their employees will depend on the whims



of whoever happens to be Secretary of HHS at the time. They will look with envy as big business, labor unions, and governments go unscathed. And with certainty, their premiums will rise.

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# The Incredible Shrinking Small Business Tax Credit (4/3/11) NFIB Healthcare Bulletin

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It's tax time, and some small businesses will at last file for the endlessly-touted health insurance tax credit included in the health-care law. Most will be disappointed. Since PPACA passed a year ago, its supporters have said, "[S]mall businesses need the benefits the Affordable Care Act provides, such as small business tax credits ..." As April 18 approaches, it's important to remember why the credit does not deserve any lavish praise.

Relatively few will qualify for the credit: To qualify for the credit, a business has to jump through a series of hoops. Very likely, no more than 1 to 2 million out of the country's 6 million small businesses would qualify for any credit at all. Self-employed individuals (another xx million or so) do not qualify at all.

**Fewer still will get the full percentage advertised:** Many or most businesses who qualify will get less (maybe far less) than the maximum 35% of the employer's portion of the premiums. The percentage shrinks if you increase your workforce; if you give them raises; if you employ a broad range of family members; if you're more generous with your insurance than other firms are; or if you have some part-timers. The theoretical maximum rises from 35% to 50% in 2014, but only if you drop your current policy, move over into the new exchange, and buy a policy that probably costs more – maybe a lot more.

The credit discourages businesses from hiring or rewarding employees for success: If a business goes beyond 10 employees, the credit percentage begins to decline. As the average wage goes from \$25,000 to \$50,000, the percentage begins to drop off, as well. With 10 employees at \$25,000 apiece, the business might get a 35% credit. If it hires 9 more employees and raises wages to \$35,000, the credit is entirely gone.

The whole thing goes away fairly soon: The credit is effectively self-repealing. Congress built in an expiration date of 2016, after which the credit vanishes entirely for everyone. So no matter how much good the credit does a business, it isn't going to do it for very long. This is ironic, since the law weighs small business down with loads of new taxes and other costs that go on forever.

Calculating the credit may cost more than the credit itself: It takes a good tax accountant to figure out how much, if anything, the credit is worth to a particular business. This NFIB calculator gives a first impression of the credit's complexity. But there are many more questions an accountant has to help the business to answer: How many full-time employees can the business claim over the previous year? How many part-time hours were there? Which employees are considered family members? What were the average wages? How much were the business's insurance premium costs – not including those that were paid for owners or family members? Some NFIB members have reported their accountants advising against trying for the credit -- the accountants' fees would exceed any possible credit.



The credit is unlikely to offset insurance cost increases: Before PPACA, businesses already experienced high rates of cost increase. The new law adds to cost growth, via a substantial tax on the insurance policies purchased by small businesses and individuals (but not by most big businesses and governments). There are new taxes on drugs and medical devices. Premiums have to pay for a range of mandatory bells and whistles. In addition to these financial costs, PPACA also brings a heavy dose of new red-tape.

A year after PPACA became law, small business is incessantly asked, "Don't you realize that you'll lose this credit if PPACA is overturned or repealed?" So it's only fair that small business ask a few questions in return: If the credit is so vital, why do so few small businesses qualify? Why do even fewer qualify for anything near that 35% level? Why does the credit penalize a business for hiring new employees or giving raises? And why does the whole thing go away in a few short years, while the costs of healthcare go on forever?



# Small Business in Waiver World (3/9/11) NFIB Healthcare Bulletin

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Small business suffers when regulations are vaguely stated, poorly advertised, and inscrutably administered. HHS's process for granting waivers for limited-benefit health insurance plans ("minimeds") is an excellent example. The rules governing applications have been hazy and communications with employers spotty. Such shortcomings fall especially hard on small businesses that lack HR departments and internal insurance expertise. The onus falls on small-business owners to navigate news stories and bureaucratic labyrinths – an unaffordable time burden, especially in today's troubled business environment.

Mini-meds are inexpensive health insurance policies whose benefits are typically capped at \$25,000—\$100,000 per year. PPACA banned the sale and renewal of mini-meds as of September 23, 2010 — over three years before exchanges and subsidies are supposed to facilitate insurance purchases by those with modest incomes. This three-year-plus gap meant that in the interim, mini-med subscribers and employers would have to shift to costly comprehensive policies or drop coverage altogether.

In September 2010, with employers threatening to drop coverage, HHS granted waivers to 30 employers and labor unions – freeing them, but not others, from the mini-med ban for one year. More followed, so that by March 6, 2010, 1,040 waivers exempted 2.6 million people from the ban for one year. A federal government website lists the following (vague) criterion for judging waiver applications: "[W]aivers last for one year and are available only if the plan certifies that a waiver is necessary to prevent either a significant increase in premiums or a decrease in access to coverage."

At best, the waiver process has been inadequately communicated. Consider this chronology:

- [1] 9/3/10: HHS listed documents required of waiver applicants. To qualify, the employer had to show that "compliance with the interim final regulations would result in a significant decrease in access to benefits or a significant increase in premiums."
- [2] <u>9/30/10</u>: The Wall Street Journal reported that without a waiver, McDonald's might drop coverage for 29,500 employees. Timing was left vague, however: "Federal officials say there's no guarantee they can grant mini-med carriers a waiver. They say the answer may not come by November, when many employers require employees to sign up for the coming year's benefits."
- [3] <u>10/1/10</u>: The *Journal* reported that, "[The Secretary of HHS] will 'exercise her discretion' in enforcing a new health-law requirement, a move that could help McDonald's Corp. and other employers from disrupting their health-care policies for hourly workers."
- [4] 10/7/10: USA Today reported that waivers had been granted to 30 employers and unions. Note that this was only a week after "the answer may not come by November."
- [5] <u>11/9/11</u>: The New York Times wrote, "Concerned about the potential disruption that would be created by enforcing the new rules, the administration has granted dozens of additional waivers and also made clear that it would modify other rules affecting these policies."
- [6]  $\frac{11/5/10}{1}$ : HHS listed general criteria for assessing waiver applications, but not explicit rules.



- [7] <u>12/9/10</u>: HHS specified two exceptions to the rule that no new mini-med policies could be sold after 9/23/10.
- [8] 2/10/11: FOX Business reported "just over 50 applications had been denied [waivers] as of the end of December." The article quoted Sen. Orrin Hatch: "My home state of Utah has numerous small businesses and I have heard from many of them asking why they were not able to get waivers like the 700 plus entities who were able to receive them. Many of these businesses had not even heard there was a waiver process."
- [9] <u>2/16/11</u>: The New York Times reported that 4 of the 50 states had been granted waivers, adding, "Lawmakers said that many other states, insurers and employers needed similar exemptions from some of the law's requirements and would seek waivers if they knew of the option."
- [10] <u>3/7/11</u>: *The Hill* reported that HHS had granted 126 more waivers, bringing the total to 1,040 and covering 2.6 million enrollees.

Regardless of what one thinks about mini-meds or waivers in general, small businesses have a severe disadvantage in tracking vague, shifting rules and timetables. Also, the process of applying for waivers is laborious and must be done each year. For the sake of small business, some general principles would have improved the process:

- Rules for granting and denying waivers could have been explicit and objectively determined.
- Rules could have been crafted well enough to remain stable over time.
- Notifications and clarifications should have been more efficient.
- Steps could have been taken to avoid suspicion of favoritism.
- Waivers could have lasted through 2014, rather than requiring annual renewals.
- A universal waiver could have been granted to all mini-med holders.
- Best of all would have been to leave the ban out of the law entirely until the exchanges and subsidies began in 2014.

The ban on mini-meds constitutes only one tiny piece of PPACA, and yet it has given rise to a great deal of confusion and rancor for nearly six months. As the rest of the decade ticks away, countless other pieces of PPACA are scheduled to fall into place. The uncertainties that the waiver process generated should serve as a cautionary tale for future regulatory roll-outs.



# Caught in the Middle (1/6/11) NFIB Healthcare Bulletin

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For those who savor perverse policy incentives, the Patient Protection and Affordable Care Act (PPACA) is a gift that keeps on giving. Today's surprise is a counterintuitive tax that, under certain circumstances, is small for low- to middle-income families, bigger for high-income families, but biggest of all for those caught in the middle. This tax is especially bad news for small businesses and for people in high cost-of-living parts of the country.

For many years, most of us have paid a Medicare payroll tax of 1.45% on wages and salaries. But in 2013, the PPACA adds two new "Medicare" taxes. ("Medicare" is in quotes because the two new taxes really have nothing to do with Medicare and simply fund the PPACA's huge insurance expansion.)

#### Gift of The MAGI

The first new tax is a payroll surtax — an extra 0.9% on wage and salary income over \$200,000 for single filers or \$250,000 for joint filers. The second is a new 3.8% tax on some or all investment income of taxpayers with modified adjusted gross income (MAGI) over \$200,000 for single filers or \$250,000 for joint filers.

What are the implications of these taxes? Let's run some numbers. Consider three couples, whom we'll call the Lows (lower-income), the Middles (middle-income), and the Highs (higher-income). Each has \$30,000 in investment income, but the Lows have \$100,000 in wage income, the Middles have \$230,000 in wage income, and the Highs have \$260,000 in wage income. Thus, their MAGIs (wages + investments) are \$130,000, \$260,000, and \$290,000, respectively.

Suppose one spouse in each couple is offered a more exhausting job for a \$10,000 wage increase. The Lows' wages and MAGI will both remain below the \$250,000 cutoff, so their taxes rise only by the existing payroll tax (\$145). The Highs are already well over the threshold for both wages and MAGI. With a \$10,000 wage increase, their tax increase will include both the regular payroll tax (\$145) and the new surtax (\$90), for a total of \$235.

With a progressive taxation system, one would imagine that the Middles' tax increase would lie somewhere between \$145 and the \$235. In fact, their taxes rise by \$525 — more than twice the Highs' increase and more than three times the Lows' increase. This is because the new investment tax falls on either investment income (\$30,000 for the Middles) or the difference between MAGI and the \$250,000 threshold, whichever is less. After the \$10,000 wage increase, the Middles' MAGI-minus-\$250,000 rises by \$10,000 — from \$10,000 to \$20,000. Thus, the new taxes produce both an additional payroll tax of \$145 and an increase in the investment tax of \$380 — a total of \$525 — even though the Middles' investment income has not changed.

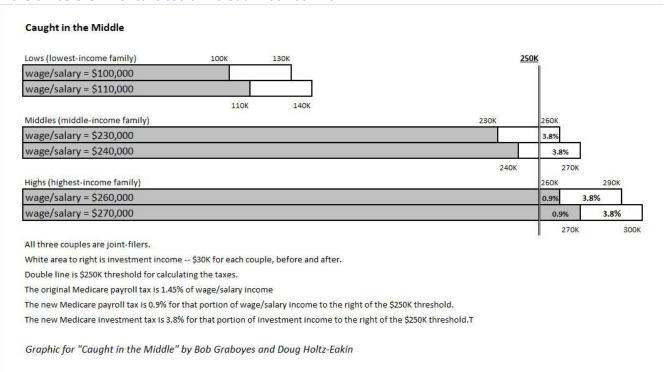


This regressive result hits households where wages are below the \$200,000/ \$250,000 threshold but where MAGI is above that threshold. Under these circumstances, the investment tax formula effectively misinterprets a wage or salary increase as an investment income increase.

### **Cracking Nest Eggs**

This effect is likely to hit a substantial number of small-business owners — particularly those who report their business earnings on their personal income tax. The tax would also hit, for example, a couple that has saved a modest nest egg for retirement and in which each spouse's salary is around \$100,000 (not a huge amount in high cost-of-living areas).

This problem matters for two reasons. First, this adds another 5.25% tax disincentive against taking initiative and working harder — on top of federal and state income taxes and Social Security taxes. Second, this tax is irrational and is buried invisibly in the PPACA. It reminds us that Congress had to pass the bill before Americans could find out what was in it.



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# No sales tax on home sales, BUT ... (10/20/10) NFIB Healthcare Bulletin

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Does the 2010 healthcare law (the PPACA) actually impose a 3.8% sales tax on home sales? Despite the scary email zipping around the Internet, this claim isn't entirely true. It is an exaggeration based on one of a troubling pair of new Medicare taxes.

**The viral email says, in part:** "Did you know that if you sell your house after 2012 you will pay a 3.8% sales tax on it? ... That's \$3,800 on a \$100,000 home etc. ... When did this happen? It's in the healthcare bill. Just thought you should know."

**To repeat - this claim is not true (at least not entirely).** However, the law does contain a 3.8% tax, and an accompanying 0.9% tax.

- Medicare Payroll Tax: There is currently a 1.45% payroll tax that funds a portion of Medicare. The PPACA adds a 0.9% surtax on wage/salary income that exceeds \$200,000 for single filers and \$250,000 for joint filers. This tax has several troubling features. It hits both personal and business income for entrepreneurs job creators who report both on their Form 1040s. It applies not only to the individual's income, but also to that of spouses and other household members. (Yet another marriage penalty.) And despite the name, the funds will be used the pay for the new healthcare law and not Medicare.
- Medicare Net Investment Tax: This is the 3.8% tax, and it applies to a portion of investment income according to a complex formula (explained below). Someone who sells a primary residence will only pay the 3.8% on the profits of the sale above and beyond a threshold of \$250,000 for a single filer or \$500,000 for joint filers. (Actually, the formula is more complex than that.) The \$250,000/\$500,000 thresholds only apply to the sale of a primary residence, so the tax will hit other property sales harder. This tax provides a sizable disincentive for businesses to grow It marks the first time that non-wage income is designated to fund Medicare; but again, despite the designation, these funds will not actually go to Medicare.

For those who dislike math, you can stop here. For those who want to understand the mechanics of these taxes, there's a fuller explanation below. One caveat: we believe the following explanation is correct, but the wording in the law is confusing, and you can find conflicting interpretations on the Internet. And of course, businesses need to check the facts with their own accountants to be sure. ... The math follows here, and you may wish to listen to this recording while working through the equations:

STEP ONE: Collect the raw data. We'll look at the example of a couple, filing jointly. They have:

- \$270,000 in wage/salary income,
- \$27,000 in investment income (rents, dividends, interest, royalties, capital gains on property sales other than primary residence, etc.), and



• \$305,000 in capital gains on the sale of their primary residence.

STEP TWO: Calculate Modified Adjusted Gross Income (MAGI).

- A single filer can exclude \$250,000 from the sale of a primary residence, and joint filers can exclude \$500,000. In this case, since \$305,000 is less than \$500,000, the capital gains on their home sale is completely exempt. No "sales tax" at all on this sale.
- With the home sale proceeds excluded, MAGI is simply \$270,000+\$27,000=\$297,000.

**STEP THREE:** Decide whether these taxes are applicable.

• These two taxes are only applicable if MAGI is greater than \$200,000 for a single filer or \$250,000 for joint filers. Since MAGI=\$297,000 and these are joint filers, the taxes are applicable in this case.

**STEP FOUR:** Calculate the taxes.

- The new payroll tax equals 0.9% of the amount of **household** wage/salary income above the threshold described in Step Three. So, here, it's 0.9% x (\$270,000 \$250,000) = \$180.
- The new investment tax equals 3.8% times the LESSER of net investment income (\$27,000 in this case) OR the difference between MAGI and the Step-Three threshold (\$55,000 here). So in this case, it would equal 3.8% of \$27,000 which is \$1,026.
- So the two new taxes add \$1,206 (= \$1,026 + \$180) on top of the old Medicare payroll tax.

**STEP FIVE:** Calculate how much of this tax will actually go to Medicare.

• \$0. Remember? Though the law refers to these two new taxes as "Medicare" taxes, none of the proceeds actually go to Medicare. Instead, these new funds mostly go toward health insurance for people who are NOT on Medicare.

Summing up: Contrary to the claims in the viral email, the sale of your home will not automatically face this new tax. But there is a new tax. It might hit part of the gains on your home sale. It's even more likely to hit the sale of property other than your primary residence. And, like much else in the PPACA, it is all very, very confusing.



# Costs and The Law that Shall Not Be Named (10/4/10) NFIB Healthcare Bulletin

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Judging from the year's political advertisements, those who supported the healthcare law now view it as The Law that Shall Not Be Named (or, for the less squeamish, the Voldemort Act of 2010). The law (officially, the PPACA) is now politically toxic in part because event after event has shown that a central selling point – cost-containment – was and is transparently false.

For years, small business argued that America desperately needed healthcare reform and that any such reform had to relieve the cost burden that was crushing small business and its employees. Last fall, NFIB and others in the small business community warned that the PPACA offered no such relief. Still, supporters promised that the law would "bend the cost curve down," and that argument helped ram the bill through over the objections of a majority of Americans.

Now, six months after passage, there is no longer any credible, coherent argument that the law will make healthcare more affordable for small business – now, next year, or anytime in the foreseeable future. The evidence runs strongly in the other direction – that passage of the law will increase the costs for small business. The PPACA creates a maze of new costs – direct and indirect – as well as layer-upon-layer of uncertainty.

By the time the PPACA began to approach its final form last fall, its new costs were obvious to small business: new benefit mandates, mandatory coverage of preventive services, elimination of annual and lifetime coverage limits, drug tax, medical device tax, Medicare payroll and investment taxes, small business health insurance tax, the individual mandate, the employer mandate (free-rider provision), the Cadillac Tax. Several additional cost increases came into view at the time of passage: the tanning tax and the notorious 1099 provision, for example. Since passage, each month has brought more bad news for those who hoped or argued that the law would bring down costs. The list of unpleasant post-passage cost surprises is endless, but here's a chronology of picks-of-the-month:

March: Just days after the law's passage, Caterpillar, Verizon, John Deere and other companies announced that they were setting aside funds to protect against anticipated losses resulting from the law. A House of Representatives committee demanded that CEOs appear before the committee, but canceled the hearing after it became clear that (1) The companies' actions were clearly required by law and (2) The law's new costs had led all the companies to examine the possibility of dropping health insurance coverage altogether.

**April:** The top healthcare forecaster in the federal government, **Rick Foster, the Chief Actuary for Medicare and Medicaid**, issued a breathtakingly critical <u>analysis</u> of the law. Among many other points, Foster wrote that healthcare costs will rise faster with the law than without it, that imbedded taxes will push premiums up faster, and that the Class Act (the long-term care program created by the PPACA) is financially unsound from the outset.



May: In his blog, Congressional Budget Office Director Doug Elmendorf wrote that "The rising costs of health care will put tremendous pressure on the federal budget during the next few decades and beyond, ... In CBO's judgment, the health legislation enacted earlier this year does not substantially diminish that pressure." CBO, of course, produced the official numbers on which the PPACA was sold just two months earlier.

**June:** After endless promises that businesses could keep their insurance policies if they wished to, **the Department of Health and Human Services issued "grandfathering" <u>regulations</u> that will cause up to 80% of small businesses to lose their current plans. Instead, those 80% will have to purchase new, more expensive bells-and-whistles-laden policies in the health insurance exchanges to be established by 2014. According to the new regulations, even minute changes to existing policies would render them ineligible for grandfathering.** 

**July:** Massachusetts passed PPACA-like reforms several years ago, so problems in that state may foreshadow things to come for the national legislation. In July, several ominous cost-related stories hit for Massachusetts. One noteworthy story was that <a href="mailto:emergency room">emergency room</a> visits have increased, not decreased, since the state's reforms were adopted. Like the national law, the state law was supposed to shift patients out of expensive emergency rooms and into cheaper primary care facilities. But the opposite happened because reforms expanded coverage and increased demand without also increasing the supply of healthcare providers. The result is a scarcity of primary care physicians and more patients than ever heading to the ERs.

**August:** In a **conference call**, <u>prominent pollsters</u> outlined a new messaging strategy to defend the PPACA. The PowerPoint used on the call noted that "Voters are concerned about rising health care costs and believe costs will continue to rise," and that "Many don't believe health reform will help the economy." The pollsters explicitly told PPACA supporters on the call: "Don't ... say the law will reduce costs and deficit" – the exact opposite of the claims on which the law was sold just five months earlier.

**September:** At a press conference, **President Obama** said that costs would not be contained anytime soon. "I said at the time, it wasn't going to happen tomorrow, it wasn't going to happen next year. ... as a consequence of us getting 30 million additional people health care, at the margins that's going to increase our costs, we knew that." In the same month as the president's comment, insurers in several states <u>suspended</u> offering **child-only plans** because the PPACA adds the risk of potentially huge and unexpected costs to these policies. In particular, the law provides incentives for parents to leave children uninsured until and unless they have a major illness. In Minnesota, several large insurers suspended their sale of individual policies because of PPACA-related uncertainty.

The list goes on. And will continue to go on. Now and then, a stray "healthcare reform will help small business" study comes over the transom. But thus far, the underlying assumptions of such studies have always been contradicted by the unpleasant facts rolling out each month. Looking forward, there's every reason to believe that small business will see an environment of higher premiums, greater administrative burdens, vanishing options, and endless surprises.



## 1099 Collation Calamity (8/31/10) NFIB Healthcare Bulletin

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2012: You Are Warned. The 2,000-page healthcare law passed in March harms small business in many ways. But arguably, its least defensible provision is the innocuous-looking, 162-word, Sec. 9006 ("Expansion of Information Reporting Requirements"). Starting in 2012, Sec. 9006 drowns small business under an ocean of IRS Form 1099s.

**Sec. 9006** is part of the healthcare law, yet it has nothing whatsoever to do with healthcare. It aims to increase federal revenues, yet there's little evidence that it will. It vastly expands the flow of paperwork that businesses must file with the IRS, yet the IRS already says it cannot manage this flow. It guarantees that business will shift purchases from small vendors to big-box stores. It forces employees and employers to devote fewer hours to productive work and more hours to mind-numbing recordkeeping.

The 1099 today: Pre-2012, the 1099 is a sort of W-2 for contractors – people who do work for a business but are not employees of that business. Both the W-2 and the 1099 are tax compliance tools, informing the IRS that a business has paid someone to do some work. Today, two limitations keep the flow of 1099s to a manageable level. First, businesses only have to send 1099s to unincorporated contractors, not to corporations. Second, 1099s only reflect the purchase of services, not goods. In 2012, Sec. 9006 erases both of these limitations, and the flood begins.

The 1099 in 2012: Beginning in 2012, every business-to-business relationship exceeding \$600 in a given year must generate a pair of 1099s – one for the vendor and the other for the IRS. Suppose a business has 20 truck drivers, each of whom purchases gas and turns in receipts for reimbursement. Somehow, the business owner will have to take hundreds or thousands of receipts from all the drivers and collate them by gas station. (Perhaps we should call this the "1099 Collation Calamity.") Then they'll have to seek a taxpayer ID number or social security number from each gas station where the receipts exceed \$600. Actually, it's even worse; if, say, two gas stations are part of the same corporate entity, the business owner will have to somehow determine that.

But wait, there's more. If one gas station fails to provide the taxpayer ID, the business will have to send an amount equivalent to 28% of the purchases to the IRS as withholding; except that the money has already been spent, so it's not clear where the business is supposed to come up with the 28%. Add to this the fact that the business owner will have to do the same thing for all of the hundreds of business vendors from whom he purchases – gasoline, stationery, automotive parts, computer services, utilities, coffee shops, hotels, etc.

The IRS Advocate has already indicated that the IRS cannot handle the paper flow that would result from this provision. So there are some possible partial solutions. One is to exempt credit card purchases, but this creates several new problems. First, credit card transactions carry a fee, so using this method instead of cash or checks would raise the cost of doing business. Second, if the company purchases some goods using cards and others using cash, separating these transactions will be a major headache.

Best of all, no one is actually certain whether this whole mess will actually bring in any substantial amount of government revenue. And no study has been done to determine how much compliance will cost business and whether those costs will exceed the incremental revenue raised by the federal government.

Sec. 9006 gives every business in America a good reason to stop buying goods and services from small businesses and purchase from the fewest possible vendors. Why chase down a hundred small businesses at tax



time when you can simply buy all of your gas, food, stationery, hardware, computers, and so forth from one big-box retailer? One 1099 instead of hundreds.

Representative Dan Lungren has introduced <u>H.R. 5141</u>, The Small Business Paperwork Mandate Elimination Act, to repeal Sec. 9006. Senator Mike Johanns has introduced <u>S. 3578</u> to do the same. The efforts of Rep. Lungren and Sen. Johanns to stave off this disaster face strong opposition in Congress; opponents have introduced <u>"alternative" bills that are subterfuges that only provide political cover</u>.

Until and unless this provision is repealed, companies have no choice other than to prepare for this onslaught. Preparations will have to be in place and ready to go sometime in 2011.



### The Healthcare Law: Pulling the Plug on Grandfather (6/29/10) NFIB Healthcare Bulletin

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No, we're not talking about your grandfather or anyone else's grandfather. We're talking about so-called "grandfathered" health insurance plans. During the debate over the new healthcare law (the PPACA), supporters endlessly repeated that, "If you like your current health insurance plan, you can keep it." Now, however, an interim final rule from the Obama administration largely voided that promise. For small business, the message has effectively become, "If you like your current health insurance plan, there's around a 1-in-5 chance you can keep it past 2012."

The PPACA requires all new policies to include expensive new features. Businesses were told during the debate that if they already offered insurance, they could keep their old plans — without most of the bells and whistles required for new policies. However, even old plans would have to include some of the new features at higher cost. For small businesses, many of whom operate on very thin margins, these costs could mean financial trouble. Normally, a business owner would ask his insurance agent how to trim the policy back to keep costs within budget. With advice in hand, the owner and his employees might agree that the best solution is, for example, to increase co-pays by a few dollars or to switch to an equivalent plan offered by a different insurer. Businesses generally revise their policies in this fashion whenever it's time for a new contract. Having been told that they could keep their current plans, most assumed that, as in prior years, they could make such small adjustments to hit budgetary targets. Wrong.

The PPACA specified that "significant" changes would void a company's ability to grandfather its old policy, but the definition of "significant" was left undefined. The interim final rule released by the Secretaries of Labor and HHS defines significant changes as practically any changes. So, for example, the business loses grandfathered status if it does any of the following: Drops some significant treatment from the plan. Raises coinsurance (e.g., patient's portion of surgical bills) from 15% to 20%. Raises copayments by more than medical inflation + 15% (e.g., increases office visit co-pay from \$30 to \$45). Raises deductibles by more than medical inflation + 15%. Reduces the employer contribution by more than 5 percentage points (e.g., 75% to 65%). Changes insurance companies ... period.

In other words, the interim final rule leaves most businesses with three choices: (1) keep the old policy, virtually unchanged, at a considerably higher price than it would have cost without the PPACA; (2) drop the old policy and buy one of the new, even more expensive policies; or (3) drop the coverage altogether.

However virtuous the bells and whistles might be from a medical standpoint (and one can debate that), there is no longer any doubt – the changes will be expensive. For many businesses, and especially small businesses, losing the old plans will mean severe, job-killing financial stress. By the White House's own estimates, by 2013, between 49% and 80% (mid-range 66%) of small businesses will lose their grandfathered policies. For large businesses, the equivalent percentages are 34% and 64%



(mid-range of 49%). Notice that, as with other post-enactment surprises, this one hits small business much harder than big business.

The discovery that they can't keep the policies they like is one more guarantee that small business will experience higher healthcare costs and greater uncertainty. The cost will be measured in terms of growth forgone and jobs lost. For small business, it's looking like PPACA stands for "Pull the Plug on Affordable Care Act."



### Premium Credits + Free Rider Provision = Mystery Tax (6/7/10) NFIB Healthcare Bulletin

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The previous *Healthcare Bulletin* (read it here) explored how the new healthcare law's free rider provision (FRP) exposes an employee's private financial information (and that of his family) to the eyes of his employer. Today's *Bulletin* describes the flip side of this problem - how the FRP penalty exposes a business owner's income to the private affairs of his employees' families. This then constitutes a sort of "mystery tax," since the employer may not know exactly which private events trigger his tax bill increases. (The FRP begins in 2014 and applies to businesses with more than 50 full-time employees or full-time equivalents.)

Summarizing the previous Bulletin's argument, the FRP's strange, complex penalty structure gives an employer a powerful interest in an employee's private affairs. When an employee becomes eligible for a premium credit (insurance subsidy), this can raise the employer's annual tax bill by \$0, \$2,000, \$3,000, or in unusual cases, tens of thousands of dollars per year. Since credit eligibility depends on household size and household income, the employer's tax penalty can be triggered if, say, the employee's spouse's income declines or if the spouse's elderly aunt moves into their house. Even if the employer respects the employee's privacy, monthly government reports will indirectly reveal this private data to the employer.

Now to the flip side. To understand the mystery tax, let's start with a brief introduction to the premium credits and the free-rider provision. (Click here for a comprehensive one-page description with examples.)

**Premium Credits:** Health insurance is expensive, and the new law presumes that no household should pay an excessive amount for coverage. So for eligible families, the law provides offsetting credits that can be quite small or can range upward from \$10,000 (giving the employee a strong motive to seek the credit.)

The law sets two criteria to determine whether the cost is excessive for a given family: (1) Does the household earn less than 400% of the Federal Poverty Level (FPL)? (2) Do insurance premiums cost the household more than 9.5% of household income. If the answer to both questions is "yes," then the household can purchase insurance in the new exchanges, and the government will offset a portion of the cost with a premium credit. Notice that we're dealing with three variables here - household income (the combined salaries and investment income of all members of the household), the FPL, and the employee's share of his insurance premium. Therefore, three types of events can shift the employee's family from "not entitled to a credit" to "entitled." [1] Taxable household income declines because some member of the family experiences a decrease in compensation. [2] FPL (which is based on family size) rises because the number of people in the household increases. [3] The family's insurance premiums rise.

**Free Rider Provision:** The law also assumes that employers with more than 50 full-time employees are obliged to cover a large portion of their employees' insurance costs. The FRP reflects a belief that if



Company A's employees receive premium credits toward the purchase of health insurance and Company B's employees do not, then Company A is free-riding (directly or indirectly) on Company B. The FRP penalizes Company A in order to even things up. When an employer is hit with a penalty, the government informs him, in effect, that: "Employee John Smith now qualifies for a subsidy, so you, as his employer must pay a \$3,000 penalty."

Mystery tax: John Smith's boss now faces the possibility of thousands of dollars in annual penalties because of things that have nothing to do with him or his business or his employees' relationship with the business. The Smith's household income can decline because John's wife leaves him, because she suffers a pay cut at her job, or because their daughter quits her part-time job; household income can also decline because of a downturn in the family's investments or because they buy a house and increase their itemized deductions. 400% FPL for the Smiths can rise because the Smiths adopt a new child or move Mrs. Smith's elderly aunt into the house as a dependent. And the family's insurance premiums can rise for reasons unrelated to John's employer. John's boss merely receives a notice saying that he owes \$3,000 in new taxes because of some unknowable change in the Smith household - hence the mystery.

The provision also raises some troubling prospects for employer-employee relationships. What if, for example, the employer believes that John's wife earns far more than 400% FPL but is masking that fact from the government? What if he doesn't believe that the employee actually has an elderly aunt living with him? The new law mentions an appeal process for the employer, but it also suggests limits on the employer's access to the employee's information. Should the employer challenge the employee's honesty or simply accept an annual \$3,000 penalty that he does not believe he owes?

**Unintended Consequences:** Recapping, the interactions of the premium credit and the free rider provision subject an employer to large tax liabilities that depend on factors totally unrelated to the employee's job and which may be invisible to the employer. An employer can minimize his exposure to the mystery tax by pursuing a strategies that are otherwise economically undesirable:

- -- He can offer such a rich insurance policy that no employees qualify for subsidies. This directly conflicts with the goal of reducing the costs of healthcare.
- -- He can avoid creating new jobs, thereby keeping his business at 50 employees or fewer.
- -- He can get rid of his lower-income employees and outsource their work to companies that are not susceptible to the FRP.
- -- He can replace full-time employees with part-timers who work less than 120 hours per month. The FRP does not apply to these part-timers.
- -- He can seek private data on employees and prospective employees and avoid those who seem likely to qualify for subsidies.
- -- He can shatter the bonds of trust with an employee by challenging the employee's eligibility for a premium credit. The law also appears to allow employees to waive their right to confidentiality in case of such a challenge.

None of these strategies is good for employers or for employees.



### Healthcare Law vs. Employee Privacy (5/25/10) NFIB Healthcare Bulletin

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The new healthcare law will likely compromise the privacy of employees and their families. The free-rider provision will inadvertently reveal to employers some personal, even embarrassing, financial details about the family of any employee who receives premium credits (government health insurance subsidies).

Beginning in 2014, the new law will give certain middle- and lower-middle class households premium credits to help defray insurance costs. But when an employee receives a credit, this triggers a penalty that his employer must pay. (This is true for businesses with more than 50 employees.) Each subsidized employee can cost the employer thousands of dollars in penalties, so, the government will inform the employer which specific employees are receiving credits. With this information in hand, an employer can easily infer quite a bit about the earnings of the employee's spouse and other household members. Effectively, the free-rider structure forces the employee to choose between his privacy and the credit, which can amount to thousands of dollars per year. And it forces the employer's eyes into affairs that should be none of his concern.

Credits are only available to families whose household income is below 400% of the Federal Poverty Level and for whom a particular benchmark insurance plan in the new insurance exchanges costs more than 9.5% of household income. (That percentage drops as household income drops, but let's avoid that complexity here.) The employer knows how much his employee earns, and he can easily obtain the cost of the benchmark insurance policy. Find out how many people live in the employee's household, and he can also calculate 400% FPL for that family. With these data in hand, the employer already knows a great deal about how much the rest of the employee's family earns. Take for example, a mid-level manager married to a doctor. When this employee obtains a credit, his boss will now see clearly that the wife's medical salary has disappeared from the household. Maybe she was fired. Maybe there's an impending divorce and she has left. Maybe she is ill. Whatever has happened, the boss knows that all is not well in the employee's home. The employee may be deeply embarrassed that his diminished circumstances are known to the employer. And the employer may be equally embarrassed that he is privy to his employee's private life. (For those scratching their heads, I've provided a numerical example at the bottom.)

The structure of the free-rider provision will make it virtually impossible for an employer to avoid the intimate details of his employees' lives. Those details now impact his bottom line. Some analysts suggest that the problem goes even farther. The free-rider provision may give employers a financial motive to avoid hiring people who are likely to qualify for premium credits; some businesses might prefer, for example, to hire the wives of attorneys and investment bankers rather than single mothers. If so, the free-rider provision could have a disparate impact by race, age, gender, nationality, and other socioeconomic factors that have no relationship to the job.



An employee's pay and working relationships should depend on the quality of service that he provides to his employer - - not on extraneous details of his home life and on the perverse incentives of a badly designed subsidy mechanism. The free-rider provision has the potential to shatter bonds of trust between employers and employee s.

\* \* \* \* \* \* \*

Numerical example: Take an employee who earns \$68,000 per year, whose wife is a physician, and who has two dependent children. For a family of four, 400% FPL equals \$88,200. Let's suppose the benchmark family policy costs \$10,000. One day, the government notifies the business that this employee is now receiving a credit. \$10,000 is 9.5% of \$105,263, so the family can't be earning more than that. The employee earns \$68,000, so his wife can't be earning more than \$37,263. Adding precision, the employer knows the family's income is below \$88,200 (400% FPL), so the wife can't be bringing in more than \$20,200 (\$88,200 minus \$68,000). Clearly, her medical income is gone from the household. The government's letter does not explicitly announce whether the doctor was fired or whether she has moved away in the course of a divorce. But her husband's employer can surmise that her income has vanished from his employee's home. This should be none of the employer's business, except that thanks to the free-rider provision, now it is.



### Small Business Tax Credit: Less Than Meets the Eye (5/13/10) NFIB Healthcare Bulletin

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The new Small Business Health Insurance Tax Credit probably won't induce many businesses to offer insurance to their employees. Firms that qualify for the credit ought to take it, but most who do will be firms who were going to offer coverage anyway.... People who use NFIB's online tax credit calculator tend to say, "I didn't know the credits were so small." At most, a credit offsets 35% of the business's portion of the insurance premium. But that maximum only applies to firms (and not all firms) with 10 or fewer employees whose average wages are no more than \$25,000 per year. For such micro-firms, the other 65% of the cost may still be difficult or impossible to cover. Plus, there are at least eight other factors that can make the credit less valuable than that 35%:

- (1) INSUFFICIENT CONTRIBUTION, NO CREDIT: If the business pays less than 50% of the cost of the insurance premiums, then it is not eligible for any credit at all.
- **(2) MORE EMPLOYEES, SMALLER CREDIT:** As the firm adds more employees, the credit shrinks as a percentage of insurance cost. With 10 employees at \$25,000 per year, the credit covers 35% of the premium costs. Increase that to 15 employees, and it drops to 23%. At 20 employees, it's just under 12%, and at 25 employees, there is no credit at all.
- (3) HIGHER WAGES, SMALLER CREDIT: As the firm raises wages, the credit percentage shrinks. With 10 employees at \$25,000, the credit is 35%. At \$35,000, it's down to 21%. At \$50,000, no credit. (Note: when firm size and wages both rise, the credit drops faster. Example: with 19 employees earning \$35,000 on average, the credit is gone.)
- **(4) BETTER INSURANCE, SMALLER CREDIT:** The credit percentage is applied either to the business's premium contribution or to the "average" firm's contribution (determined by the Department of Health and Human Services), whichever is smaller. So if the firm is more generous than other firms with its insurance, its percentage is smaller than what the calculator suggests.
- **(5) MORE PART-TIMERS, SMALLER CREDIT:** Part-time workers are combined into full-time equivalents for the credit calculation. So every 40 hours per week of part-time labor counts the same as one additional full-time employee.
- **(6) CREDITS TODAY, INSURANCE FOREVER:** The credit lasts at most six years, whereas health insurance costs last forever. On the up side, the credit percentages will increase in 2014, with the maximum rising from 35% to 50%.
- (7) FOUR YEARS, NEW PLAN: Beginning in 2014, businesses will only be able to receive the credit on insurance plans sold through the new exchange. So businesses using grandfathered plans up to that point will have to change plans in order to receive the credit for the full six years.
- **(8) FAMILY MEMBERS, NO CREDITS:** Members of the business owner's family are excluded from the credit calculation and are ineligible for the credit itself. For many small family enterprises, this will dramatically reduce the available credit, especially since "family" includes children, parents, grandparents, siblings, aunts, uncles, in-laws, and others.

Again, any business that qualifies for the tax credit should take it. But it's hard to imagine that this fairly small, time-limited, multi-caveat credit will affect offer rates very much.



# The Majestic Equality of the Healthcare Law (4/19/10) NFIB Healthcare Bulletin

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-"The Law, in its majestic equality, forbids the rich, as well as the poor, to sleep under bridges, to beg in the streets, and to steal bread." - Anatole France (1894)

I don't care for Anatole France's fin-de-siècle politics, but his quote is classic. Let me update it:

- "The Healthcare Law, in its majestic equality, requires big business, as well as small business, to file an IRS Form 1099 for every business-to-business purchase of \$600 or more." - Bob Graboyes (2010)

OK. Anatole wins on lyricism. But the analogy's the thing. The new healthcare law peppers firms of all sizes with new obligations, many of which will mildly inconvenience big business but oppressively burden small business. Some small businesses, unable to bear the burdens, will vanish, along with the jobs they had generated or would have generated later.

The problem is that a small business is not just a miniature big business. (Example: It's tougher to provide wellness activities at a small business. A dry cleaner can't build an in-house gym. A boutique with three thin employees and one obese employee can't offer weight-loss brochures without risking hurt feelings or a lawsuit.) Because of the intrinsic differences between big and small firms, rules applied to both can have radically different effects - more often to the disadvantage of small business. Consider the Form 1099 provision, plus a few other majestic-equality provisions in the new law:

**FORM 1099:** The healthcare law requires vast amounts of revenue and conjures up a feast of new taxes to sate its appetite. Congress feared that compliance would be challenging. So the law commands business to generate vast new paper trails, and thousands of newly hired IRS agents will trek along these trails. Starting in 2012, businesses will have to file a Form 1099 covering every business-to-business transaction (or series of transactions) of \$600 or more. If a firm buys a new laptop, copier, ergonomic chair, or some shipments of stationery, each transaction must be reported on a 1099. For a big firm, this is a minor annoyance. The IT department programs a new line of code into the accounting system; henceforth, the computer spits out a 1099 every time it encounters a \$600+ transaction. No sweat. In contrast, the small firm typically has no IT or accounting departments. The owner may bear 100% of the responsibility of tracking transactions, determining which ones require 1099s, and filling in the forms. Add to this the small firm's lack of big-firm double-checks and, you add compliance fear to the paperwork requirements.

**SMALL BUSINESS HEALTH INSURANCE TAX:** Then there's the tax on health insurance policies that, in the manner of Anatole France, applies equally to big and small firms. The tax applies only to fully insured plans (where the insurer bears the financial risk), and not to self-insured plans (where the employer bears the financial risk), regardless of whether the plan is offered by a big business or a small one. But most big businesses (and big labor unions) self-insure, and most small firms fully insure. So the law is majestically equal, but its impact is not.

**BENEFIT MANDATES:** Big business thought it would be great for the Department of Health and Human Services to mandate hugely generous and expensive benefit packages in every insurance policy. This isn't a problem for Microsoft. It is for the corner grocery.

EMPLOYER MANDATE MATH: The employer mandate digs a mathematical minefield that small businesses will



have to navigate. A mid-sized restaurant that goes from 50 to 51 employees suddenly crashes into an employer mandate that, at minimum, adds \$42,000 to its annual expenses. An 80-employee firm may suddenly feel the blow of a \$100,000 fine because one employee's SPOUSE loses his or her job at ANOTHER firm. For big firms, these issues are mostly irrelevant; where they're relevant, the big firm has HR specialists to handle the issue. Most small businesses do not.

By weighing small firms down with financial and administrative time obligations and by handing competitive advantages to big business, the new law imperils the job-creating capacity of small business. Frankly, the cumulative effect of all of these majestic-equality provisions will drive some firms to close the doors and shutter their businesses. This a problem in an economy that has lost over 8 million jobs since late 2007 and where small business generates 70% of the new jobs.



### To Congress: Three Proverbs for Healthcare Reform (3/18/10) NFIB Healthcare Bulletin

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#### Proverb #1: "The road to ruin is paved with good intentions."

The Senate healthcare bill is filled with good intentions. And yet, as proverb #1 warns, the bill could ruin the cause of healthcare reform for years or decades.

The Senate bill shares many of the weaknesses of state-level reforms that failed catastrophically in recent years. Congressional members who ignore these warnings and vote "yes" put at risk the hopes and dreams of sincere and principled advocates of healthcare reform. The state-level disasters demonstrate that failure can come rapidly, massively, and irrevocably. Once that happens, legislators lose their appetite for healthcare reform.

The pattern generally looks something like this: The state enacts reforms designed primarily to expand coverage. The reforms do little to push costs down, yet supporters assume that savings will materialize at some unspecified future date. The coverage expansion alters incentives, in turn undermining the stability of private insurance pools and pushing people into public programs. As a result, private insurance markets crumble and the government's financial burden soars. Unable to bear this burden, the state government eventually repeals the reforms and renounces its earlier promises. Some individuals lose their insurance coverage. The system never fully recovers. Thereafter, legislators are hesitant to revisit healthcare. Here are some dramatic examples:

In 1994, TENNESSEE <u>created</u> <u>TennCare</u> to expand coverage to the uninsured. The idea? Use managed care to cut Medicaid costs, and use the savings to expand coverage. The result? People lost their private coverage and were forced into the public program. Hospitals closed, and doctors moved away. The state treasury hemorrhaged, and legislators desperately sought to stanch the bleeding by raising old taxes and passing new ones. The state threw 200.000 people out of the failing plan and reduced coverage for others

KENTUCKY also enacted reforms in 1994. Like the Senate bill, the state imposed guaranteed issue, guaranteed renewal, and the elimination of premium rating on gender, health status, or claims experience. These reforms, were not accompanied by incentives to hold the risk pools together. Rapidly, almost all the states' insurers closed their doors, forcing people into <a href="Kentucky Kare">Kentucky Kare</a>, a state-run plan. The remaining ones bled financially until the reforms were repealed. The competitive insurance market that existed before is gone.

In 2009, HAWAII created <u>Keiki Care</u> to provide coverage for the state's uninsured children. But thousands of families whose children already had insurance dropped that coverage and dumped their children into the state-financed program. Within seven months, Keiki Care was broke, and the state effectively dismantled the program.



In 2003, MAINE sought to cover its uninsured by expanding Medicaid and launching <u>DirigoChoice</u>. The plan was designed to fund the coverage expansion through savings from greater efficiency. In the end, the program added very few people to the insurance rolls but spent vast sums of money.

In 2006, MASSACHUSETTS adopted the most ambitious reforms of any state, and these reforms strongly resemble the Senate bill's provisions. The Bay State decided to expand coverage immediately and cut costs later. The plan included employer and individual mandates. The result so far? Soaring premiums. Longer waits for medical services. People <u>drifting in and out</u> of coverage under the radar. The current state <u>Treasurer</u> said this week that the reforms have failed and are draining the state's treasury.

#### Proverb #2 (from Mark Twain): "History doesn't repeat itself, but it rhymes."

The Senate Bill is not exactly like any of these state bills, but the resemblance (especially to Massachusetts) is strong - it rhymes. Its focus is coverage, not cost containment. The market reforms may drive private insurers out. A massive Medicaid expansion threatens the financial stability of the states. Some have begun to fear that the bill may force states to <u>abandon Medicaid</u> and throw the burden on the federal government.

NFIB, a strong advocate of healthcare reform, has warned that the is Senate bill could badly damage small business by raising costs, sending taxes soaring, discouraging job creation, and tampering with the relationship between employers and employees. If the reforms fail as badly as their state-level predecessors - a legitimate worry - the regrets of small business may be matched by the regrets of those who most strongly supported the Senate bill at its inception.

Proverb #3: "Be careful what you wish for."



## Health Insurance Exchanges (10/15/09) NFIB Healthcare Bulletin

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Health insurance costs are killing small business. Lawmakers and insurers have long relegated small-firm owners and employees to markets where costs are high, pools are small, and shopping is a pain. Insurance exchanges can be a market-based approach for alleviating these problems. To understand why, let's look at airlines and scalpers around 15 years ago.

Pre-Internet, booking flights meant calling multiple airlines, listening to Muzak, asking questions on fares and availability, and repeating the process when the initial itinerary didn't work. Alternatively, a booking agent might find you a less-than-ideal flight at a higher-than-ideal price. Today, go to Orbitz or Travelocity, compare options from multiple airlines, and book the flights. Little pain. Lower fares. Roughly speaking, a model for a health insurance exchange?

Another metaphor: In 1995, Phoenix worried about scalpers selling sports and concert tickets on the streets. They charged high prices, sold counterfeit tickets, menaced passers-by, and (I'll bet) falsely claimed, "These are the last tickets in town." If you wanted a scalper, it wasn't always easy to find one. They were scattered, so comparison shopping was impractical. Some cities banned scalpers, licensed them, limited their prices, or sent police to monitor them. Phoenix, in contrast, took a market approach, setting aside an empty lot near the arena, where scalpers could scalp with no licenses needed. Immediately, customers knew where to find second-hand tickets. Prices plunged. Counterfeit tickets and scuffles vanished. A small bit of government intervention (restricting sales to the parking lot) unleashed market forces and benefited consumers.

Today, small-businesses health insurance markets resemble 1980s airlines or 1990s scalping. The owner calls a broker, and he and his employees fill out lengthy forms. Going to other brokers for comparison means a lot more time and effort. Brokers don't necessarily mention cost-saving products like HSAs because customers may never hear of them from competitors. Shopping around is a paperwork nightmare, so sticking "with the devil you know" might not be cheaper, but requires less time and effort than getting alternative quotes. In recent years, NFIB has supported proposals to boost competition, among them Association Health Plans, Small Business Health Plans, and interstate purchasing options. The insurance lobby and lawmakers friendly to the industry did not support them, so good policy was trampled by bad politics.

Exchanges have the potential to give small-business what the Phoenix parking lot and Orbitz gave ticket-seekers -- markets where private insurers compete fiercely. It is important that exchanges be done right. California's exchange, <a href="Pac Advantage">Pac Advantage</a>, not only acted as a marketplace but also as a purchaser of insurance, a factor that contributed to its failure. (If the Phoenix City Council had bought and sold tickets in the parking lot, they probably would have either failed or wrecked the private market.) Massachusetts established its <a href="Connector">Connector</a>, whose large cost increases are due, in part, to the exchange's excessive regulatory powers. Utah is establishing an exchange that, at least initially, sounds more market-friendly than the California and Massachusetts exchanges.



All the major bills circulating in Congress include provisions to establish exchanges. It's important to learn from history and design exchanges that can encourage, rather than stifle, the market.



### Healthcare Reform and Wages (8/19/09) NFIB Healthcare Bulletin

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Healthcare reform must lead to slower growth of healthcare costs, or wages could stagnate or decline for decades - especially for low-income workers. This comes from a must-read <u>paper</u> by Steven Nyce and Sylvester Schieber of Watson Wyatt. (<u>Summary here.</u>) Schieber is chairman of the <u>Social Security Advisory Board</u>. The authors divide the workforce into 10 income ranges and estimate the wages of each through 2030 under the following baseline scenario [B] and 5 alternatives:

- [B] Some employees uninsured. Employer health benefit costs grow more slowly. RESULT: Healthy wage growth for all income ranges, but slower in the middle-income range.
- [1] All employees insured. Employer health benefit costs grow more slowly. RESULT: High-earners do fine. The bottom 20% see wage declines through 2015 and moderate increases through 2030.
- [2] All employees have insurance. Employer health benefit costs grow at present rate. RESULT: Wage growth is lower for everyone. The bottom 20% see their wages decline at least through 2030.
- [3] All employees insured. Employer health benefit costs grow more rapidly. This wider coverage/higher-cost scenario resembles what happened after Medicare was implemented in 1965. RESULT: 90% of see their wages decline through 2030. The lowest income range's wage is devastated.
- [4] All employees insured. Employer health benefit costs grow more rapidly. Entitlements reformed, taxes added. RESULT: Wages decline for the bottom 40% and rise slowly for others through 2030.
- [5] Some employees uninsured. Employer health benefit costs grow more rapidly. RESULT: Lethargic wage growth through 2030.

Nyce and Schieber say: "[U]nless we can reel in health costs, the outlook for increasing returns on labor and higher productivity is bleak." They see solutions in reducing the practice variation seen in the **Dartmouth Atlas** data and explored in Atul Gawande's New Yorker **article**. Like Gawande, they suggest lower costs may come from coordinated care providers like **Mayo**, **Geisinger**, and **Intermountain**. The history of these and other successes provide clear messages: Innovation emerges unpredictably in unlikely places. It often arises from small businesses. Inside-the-Beltway micromanagement doesn't create them. Innovators can be not-for-profits or for-profits. What works one place may not elsewhere. In **The New York Times**, Gawande and three other authors describe 10 regions that have scored considerable success in controlling costs while maintaining quality. A recent book, "**The Innovator's Prescription: A Disruptive Solution for Health Care**," explores the importance of innovation.

Mayo went from frontier clinic to world-class system. No one in DC decided that this would happen in Rochester, MN, or told the Mayos how to do it. Mayo has successfully branched into Arizona and Florida, defying a frustrating rule -- in a country as large and varied as the U.S., success is often difficult to transplant to other localities. Healthcare reform can't succeed if it stifles diversity and the spirit of enterprise. Bottom line: Nyce and Schieber say our wallets depend on innovation. I'll add, so do our lives.



## The Problem with Prevention (7/24/09) NFIB Healthcare Bulletin

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Healthcare costs consume the resources of small business and wages of their employees. The solution? Many folks suggest, "More prevention and wellness programs!" That's a problem. I like prevention. So does small business, as long as programs are voluntary. But while prevention may be good for health, it generally <u>pushes costs up</u>, not <u>down</u>. And honestly, there's <u>scant evidence</u> that company prevention programs actually improve health. Even less so for small business. And, truth be told, <u>prevention's not always good for health</u>.

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 Joe's illness is and how cheap prevention would have been. Prevention isn't just "B rush, floss, exercise, eat broccoli, look both ways." It's tests, pills, surgery, therapy, consultation. Preventing Joe'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.

Companies like <u>Safeway</u> use prevention to cut employee healthcare costs. That's admirable, but I can't tell whether this cuts America's total spending or just pushes some costs to the next employer or Medicare. I recently heard a long, description of another company's elaborate wellness program, my economist brain wondered, "Does it work? Does it cut spending?" To my surprise, the speaker concluded with (paraphrasing), "We're not sure any of this works, but our company decided it's the right thing to do." So the gyms, screenings and counseling are a form of philanthropy, similar in spirit to corporate contributions to the arts. Perfectly fine, and I hope the employees appreciate it.

Insurance policies should generously cover some preventive services. But Congress shouldn't require insurers to cover every imaginable preventive procedure, giving rise to unnecessary medication, cost, and <u>iatrogenesis</u>. They shouldn't require companies, especially small businesses, to offer prevention and wellness programs. The gas station or pizza parlor can't build a gym or hire a dietician, psychological counselor or physical therapist. On the other hand parity might be good. Big companies can write off employee gyms and therapists on their taxes. Why not let the gas station or machine shop deduct its employees' gym memberships? Worth considering.



### Healthcare lesson from Massachusetts: Deal with costs from Day One (7/14/09) NFIB Healthcare Bulletin

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In 2006, Massachusetts instituted the most ambitious healthcare reform of any state. Today, the program's expenses are strangling the state's budget and threaten to undo the reform itself. As we work on national healthcare reform, the big lesson is: "Deal with costs from Day One."

In the Bay State, a Republican governor and Democratic legislature together rebuilt the health insurance market in pursuit of universal coverage. But to complete the deal, Massachusetts took a huge calculated risk - seek broader coverage now and deal with costs at an unspecified date in the future. Rather than repair the payment system to give consumers and providers incentives to economize, they established commissions to study how to do that in the future. Jon Kingsdale, who runs the Connector, presented a reasoned defense of this "sequenced" approach in <u>Health Affairs</u> (5/28/09) and suggested that policymakers consider a similar path at the national level.

Unfortunately, this coverage-before-cost gambit now imperils the state's fiscal stability and the long-term success of the healthcare reform itself. The *Boston Globe* (6/24/09) reports state officials have cut 12% from the budget of Commonwealth Care, which subsidizes premiums for needy residents. This seems to mean cutting dental coverage for the poor and perhaps insurance for legal immigrants. As they note in <u>another article</u> (6/28/09), "Massachusetts doesn't have enough money to pay for the coverage envisioned by the law." A <u>Rasmussen poll</u> (6/29/09) in Massachusetts suggests profound skepticism about the state's healthcare reforms. Twenty-six percent (26%) say the effort is a success, while 37% call it a failure. Ten percent (10%) say quality has improved, while 29% say it's worse. Twenty-one percent (21%) see coverage as more affordable today, and 27% find it less affordable. Keep in mind that all this spending hasn't bought bliss. Some people are still uninsured, and there 's evidence (6/22/09) and 6/29/09) that others are only insured intermittently. Patients are also experiencing long <u>wait times</u> (6/9/09) to get a doctor's appointment.

But the big lesson is this: Lawmakers must deal with costs on Day One. They can't underestimate the costs of reform or assume funds will just show up on their doorstep later. They can't rely on quick revenue grabs, like employer pay-or-play, that kill off long-term funding sources. And they must enable patients and providers to reinvent the way we purchase and deliver healthcare. That requires reimbursement, delivery and information systems that have not yet been imagined, and neither Boston nor Washington alone can develop them.