

NFIB Blogs, Speeches and Interviews

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Health Care Law Subsidies (10/11/11)

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The 2010 health care law will conjure up a strange brew of inequities as it comes to a boil in 2014. The mechanistic, one-size-fits-all health insurance subsidies, for example, will generate serious questions about the law's fairness. By ignoring the enormous regional disparities in cost of living, the subsidies effectively penalize those in more expensive localities and reward those in lower-cost areas. Additionally, the law biases the subsidies toward those with larger families.

This inequity arises because of a three-part structure at the core of the Patient Protection and Affordable Care Act (PPACA). First, PPACA requires individuals to purchase health insurance (or to pay penalties for not doing so). Second, another provision draws a mathematical line between those households with access to "affordable" insurance and those without such access. Third, the law offers premium tax credits (subsidies) to households lacking options meeting the affordability standards. To qualify for subsidies, the household's income must be below 400 percent of the [Federal Poverty Level](#) (FPL), and insurance premiums that the household pays must exceed 9.5 percent of the employee's income. A household meeting these two standards can obtain the subsidies and purchase insurance in the exchanges set to open in 2014.

To understand the problem, let's focus on two siblings – one in New York City and one in Abilene, Texas. Both own small businesses.

New York sister, Texas brother

The New Yorker is single and has a new business that earns her \$45,000 in its first year of operation. To put this in perspective, this amount is almost exactly what a beginning schoolteacher earns in New York. With high taxes, food prices, and apartment rents, \$45,000 in New York City only buys a Spartan life in a cramped apartment.

The Texan is married, has three children, and earns \$100,000 a year at his 15-year-old business. He and his family live in a roomy house with a swimming pool. In Abilene, \$100,000 buys a very cozy life. An unscientific Google search suggests that most of Abilene's attorneys earn less than our business owner.

In 2014, sitting at the Thanksgiving table, the sister complains to her brother about the heavy burden of health insurance. The brother mentions that he bought insurance in the new exchange and received federal subsidies because the law deems health insurance unaffordable for him and his family. The sister is surprised – and irritated – since she was told that her income is too high to qualify for subsidies.

Here's the explanation. To get a health insurance subsidy, a household's income must be less than 400% of FPL for a given size of household. The guidelines have separate dollar figures for Alaska and Hawaii, but no regional variation within the 48 contiguous states. In those 48 states, 400% of FPL for a household of one person is currently \$43,560; for a household of five people, the figure is \$104,680. The

sister earns more than \$43,560, so she cannot receive subsidies. Her brother earns less than \$104,680, so he may qualify.

To obtain the subsidies, the Texan's insurance would have to cost more than 9.5 percent of household income – \$9,500 in this case. An October 2011 [Kaiser Family Foundation survey](#) reported that, across the U.S., average 2011 individual and family policies cost, respectively, \$5,429 (up 8 percent from 2010) and \$15,073 (up 9 percent from 2010). We can say with near certainty that the New Yorker's individual policy will cost more than 9.5 percent of her income (\$4,275). It's not important to this blog piece, but given the high cost of health care in New York, the sister's unsubsidized individual policy might even cost more than her wealthier brother's subsidized family policy.

In a different context, [New York Senator Charles Schumer recently declared](#) a proposed income tax provision to be unacceptable because it effectively treats households across America as "rich" if they earn more than \$250,000 a year. Schumer said, "\$250,000 makes you really rich in Mississippi but it doesn't make you rich at all in New York and there ought to be some kind of scale based on the cost of living on how much you pay." One can apply Schumer's logic to PPACA's subsidies. Doing so, however, would open quite a few new cans of worms.

When families gather in 2014, PPACA's fairness will be questioned around many a dinner table. In that year, members of Congress from high cost-of-living areas are likely to hear quite a few of those questions from displeased constituents.

Small Business Health Care Wish List: Repeal and Replace (2/8/11)

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For small business to flourish the Patient Protection and Affordable Care Act (PPACA) must go away, and—equally importantly—the status quo that preceded it must never return. The laws of physics do not limit American health care to those two unacceptable choices. And, unfortunately, productive discussion of health care reform ends whenever a PPACA supporter begins a sentence with, “Does that mean you want to go back to the days when... ?” The answer is almost certainly “No,” and the question itself distracts us from more fruitful discussion.

To start a real dialogue that leads to real reform, here’s the small business position: The past was awful, the present lies somewhere between no-better and much-worse, and the future can be bright if sensible replace follows blessed repeal.

The Past: Unmourned

Small business holds little nostalgia for the status quo that went on life support March 23, 2010, and is now drawing to an unmourned close. For a full generation, the rising financial costs of health insurance have strained the capacity of small business to grow and create jobs. The administrative burdens of purchasing and managing policies are a serious distraction. The small-group insurance market is inefficient, and in many states, there is little competition or choice. (Several states have near-monopolies in the small-group market.) Tiny risk pools mean that small-group premiums can go through the roof if a single employee becomes ill.

Small businesses generally don’t have human resources departments, so the burden of decisions usually falls on the owner who, in most cases, has no special understanding of insurance. Between renewals, problems with employees’ coverage fall on the employer, distracting attention from running the business.

The small-business market is dynamic and depends heavily on the ability to find and hire good employees when the time is right. The old status quo limits this ability. A prospective employee may refuse an offer because changing jobs means leaving a trusted family doctor or giving up an important benefit in the prospect’s current policy.

In answer to the question (hopefully unasked): Small business does not wish to return to the days when (fill in the blank).

The Present: Unaffordable

The hopes of small business were dashed when PPACA headed from the Capitol to the White House. The past year has shredded claims that the new law would rein in health care costs—especially for small

business. New administrative burdens (e.g., 1099s, employer mandated documentation, etc.) are suffocating. Competition and choice in the insurance markets began to decline almost immediately.

Portability will remain limited for most small-business employees purchasing in the group market—impacting the employers’ ability to hire the employees they need. In 2014, they’ll have access to coverage, but a change of jobs may still mean changing doctors, hospitals, etc. For people with pre-existing conditions, the good news is that they’ll have access to coverage; the bad news is that they may not be able to afford that coverage, and their employers may not be able to afford them.

The idea that PPACA will cut costs is dead. A month after the bill became law, the Congressional Budget Office issued caveats about pre-passage forecasts. Soon thereafter, the Centers for Medicare and Medicaid Services warned that: (1) Supposed Medicare savings were double-counted; (2) The long-term finances of the Community Living Assistance Services and Supports Act (CLASS Act) were financially unstable from the outset; and (3) Another round of “doc-fix” is likely to overturn implied Medicare savings. In January 2011, the CMS Actuary reiterated and amplified these concerns.

PPACA drops new costs directly or indirectly on small business. Multi-billion-dollar brand-name drug tax. A 2.3 percent medical-device tax. A 0.9 percent “Medicare” payroll tax. A 3.8 percent “Medicare” investment tax. A 10 percent tanning tax. An undetermined number of new federal benefit mandates are overlaid on existing state mandates (estimated at 2,156 in 2010). Perhaps 80 percent of small businesses (by administration calculations) will lose their current coverage because of hair-trigger grandfathering regulations. And nothing in the bill touches our ineffective, inefficient, intrusive malpractice system.

The infamous 1099 provision has now been decried by business owners, the IRS Tax Advocate, Republican members of Congress, Democratic members of Congress, and the President. The employer mandate even penalizes some employers who provide coverage. All Americans face the unprecedented individual mandate. Employee subsidies will trigger employer penalties and in the process, violate the financial privacy of both.

The fabled small business tax credit can, as advertised, offset “up to 35 percent” of a small firm’s insurance costs. But only the smallest, lowest-paying businesses will get 35 percent. Most will get nothing. Those who get something will likely get less—perhaps much less—than 35 percent. The percentage erodes if a company hires more employees, pays more generous wages, uses part-timers, hires family members, or offers more- generous-than-average coverage. (e.g., 18 employees, average wage + average wage of \$38,000 = zero credit.) Most importantly, the credit automatically repeals itself by 2016.

Together, these shortcomings encourage businesses to downsize, to lay off employees, to shift from full-timers to part-timers, and to avoid hiring individuals who are likely to obtain subsidies and trigger penalties on the employer (a single mother for example?). Repeal is a necessity.

The Future: Undeterred

So how do we begin to make things better? We could start with items that small business asked for in the years leading up to PPACA and then add some new ones.

Begin by leveling the tax treatment of people buying insurance in the group and individual markets. The current tax code effectively locks individuals into employer-based plans, limits their portability, and disadvantages them when they become unemployed. It lessens the incentive for individuals to become smart, well-informed shoppers in insurance and provider markets.

Reduce the benefit mandates that drive up the cost of insurance. PPACA makes the problem worse by empowering the federal Department of Health and Human Services to lay an extra layer of mandates on top of the state-level mandates.

Enable employers to shift from defined-benefit to defined-contribution health insurance—similar to the shift from traditional pensions to 401(k)'s. Under a defined-contribution plan, employers could contribute tax-free toward their employees' health insurance purchases on the new health insurance exchanges. This would give employees the motive and power to apply competitive pressures on insurers.

Allow individuals to purchase health insurance across state lines, forcing insurers and regulators to compete against other states. Opponents of this idea fret about a "race to the bottom." Those making this argument assume, rather than demonstrate, that people will opt to save a penny rather at the expense of their health. And they can't cite any state that represents the dreaded bottom to which reckless consumers will race. Idaho and Utah have few benefit mandates but excellent health care.

Fix medical liability laws. Our tort system fails to punish doctors who truly commit malpractice, and it punishes many who practice excellent medicine on patients who happen to suffer adverse events. This increases costs, pushes doctors into defensive mode, and frays doctor-patient trust.

Enable those who depend on the individual market (the self-employed, for example) to get insurance, even when they have pre-existing conditions. The PPACA accomplishes this by bludgeoning employers and individuals with mandates. There are less intrusive ways to accomplish this goal.

These ideas are just a start. We just saw Democrats and Republicans seated together at the State of the Union. Perhaps it's time that they do the same with health care.

Conclusion

The wheels began to fall off of PPACA as soon as it left Union Station in Washington. Big companies prepared for billions in new costs and revealed drawing-board plans to drop coverage. CBO and CMS undermined the law's numbers. Grandfathering became moot for most small businesses. Child-only policies vanished. A White House teleconference was warned "Don't ... say the law will reduce costs and deficit." Some providers began layoffs. It is in the interest of both political parties now to devise a better choice than either PPACA or the pre-PPACA status quo. The challenge is to get it done—and soon.

Health Reform — New Burdens for Small Business (4/27/10)

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Health care reform is now the law of the land, and the rollout has begun. If the law stands without major revision, only time will tell how it ultimately affects health care costs, coverage, and quality. Like everyone else, I have my own thoughts, but opinion and forecast must give way to reality. Congressional Budget Office and Centers for Medicare & Medicaid Services scores prepared before the reform legislation passed are now museum pieces. Without a doubt, however, the new law radically alters the environment for small business, and some firms will struggle to survive the changes.

The new law complicates small firms' administrative burdens, their access to capital, and their capacity to estimate input costs. Few of the smallest firms have human resources, accounting, or legal departments to help them adapt. Hence, they rely heavily on outside advisors: brokers, CPAs, attorneys, and others. Time will also tell whether this network of outside advisors is up to the task at a price that small businesses can afford. If not, this shortcoming will have serious macroeconomic ramifications given the immense role that small business plays in job creation.

Like all firms, small businesses will face a heavy dose of new reporting requirements. But again, most will do so without the benefit of specialized departments to handle the load. The best example concerns Internal Revenue Service Form 1099. At present, if a firm pays \$600 or more for services from an unincorporated vendor in a year, it must mail the vendor and the IRS a Form 1099. At present, purchases from corporations are exempt from this requirement; in 2012, the new law drops the exemption.

So, if Sue's Flower Shop pays \$25 for supplies from two locations of a chain hardware store every other week ($\$25 \times 26 = \650), Sue has to obtain a taxpayer ID number, aggregate her purchases over a year, and mail the store and the IRS the 1099. But what if the hardware store fails to send her their taxpayer ID? What if the ID number is typed incorrectly? If the two locations are franchises, are they still considered part of the same corporation? How much time must she devote to tracking down this information from her many vendors? How difficult will it be to aggregate hundreds, even thousands of payments each year by vendor? Who is at risk when errors are made? These and hundreds of other questions will be subject to years of regulation writing, interpretation, education, and enforcement. Those who have not worked in a small business may not adequately understand how disruptive and expensive these microscopic reporting requirements will be.

The new law also exacerbates the difficulty that small firms are encountering in accessing credit. Small firms have relied heavily on real property equity for collateral, and much of that equity has been consumed by declining property values. Beginning in 2013, individual filers earning more than \$200,000, and joint filers earning more than \$250,000, will be subject to an additional 3.8 percent tax on investment income (such as dividends from the business or gains on the sale of capital assets). This additional tax will induce an indeterminate number of potential investors to place their capital elsewhere.

The new health insurance exchanges will offer firms opportunities and risks. Their subsidy structures are complex and, in a number of ways, will make it difficult to predict the cost of labor inputs. Here's an example: When a firm goes from 50 to 51 employees, it runs up against the law's employer mandate and its arcane rules. Suppose a firm with 80 employees does not offer health insurance but instead sends its employees into the new health insurance exchanges to purchase coverage. As long as none of the employees' household income falls below 400 percent of the federal poverty level, the company incurs no fines. Now suppose one employee's wife loses her job at another firm, so the family's combined income drops below that roughly \$88,000 mark. At that moment, the company incurs a \$100,000-per-year fine (\$2,000 x 50 of the 80 employees). This employer's annual profit will now depend heavily on the employment and wage decisions of some other firm and on whether an employee is married. (The potential employee privacy issues are troubling. In effect, your employer now gains the right and need to know personal information about your family status and your spouse's income.) One way for a firm to avoid these complications is to simply avoid growing past the 50-employee mark—not a useful incentive for hiring given today's high unemployment.

The 1099, the payroll and investment taxes, and the subsidy structure are only a few of the myriad complications that the health care law brings to the life of a small-business owner. Notice that the potentially disruptive changes described here have little or nothing to do with improving health care or business efficiency. At the very least, small businesses will need a whole new information infrastructure to deal with all of these issues. For some, the cost will be too much; they and the jobs that they provide will simply be lost.

Finally, it's worth noting that many physician offices, laboratories, and other health care providers are themselves small businesses. The increase in administration, taxation, and uncertainty will affect these businesses as well. Like other small businesses, some will not survive the changes. And that will occur at the very moment that an estimated 30 million people gain health insurance and, hence, access to health care. Supply-side constraints could push costs upward; for small businesses, high costs were the problem in the first place.

Small businesses can be fragile things. For many of our least advantaged residents, they are the entry point into the American economy. These firms will be severely tested as the new health reform law unfurls.

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

Adapted from speech to Urban Institute

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

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

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

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

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

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

The healthcare debate carried a double-whammy. In late 2008, America and the world faced the most severe financial crisis in two generations. The economy stumbled and unemployment grew. Congress and the White House could have focused on stabilizing consumer demand, finance and real estate, and taxes but chose, instead, to turn their attention to a chronic, but non-crisis, issue – healthcare. (I say all of this as someone who always viewed healthcare reform as essential to business and whose employer feels likewise.)

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

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

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

Healthcare Reform and Small Business (7/20/09)
Address to the National Conference of State Legislatures

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

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

Complaints

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

Solutions

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

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

- Health insurance exchanges to increase transparency and expedite transactions.
- Better information technology for transparent cost and outcomes data.
- Voluntary defined contributions by employers.

- Greater portability.
- Larger, more stable risk pools.
- Federal market rules, with adequate state discretion.
- Guaranteed issue and renewal and ending excessive rating on health status.
- Reasonable definitions of minimum creditable coverage.
- Greater consumer involvement through HSAs and CDHPs.

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

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

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

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

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

- To reform Medicaid, we have to reform Medicare.
- The federal-state revenue-sharing arrangement that rewards high spending and punishes frugality.
- Complex qualification requirements and enrollment procedures mean that 12 million Medicaid-eligible people go uninsured and, often, seek medical care in emergency rooms, hospitals, and other high-cost venues – and those in this room have to pick up the bill.

Federal Legislation

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

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

House Tri-Committee Bill: NFIB opposes the House Tri-Committee Bill. There are many things wrong with it. It includes a public plan that would demolish private insurance markets. It centralizes both the business of insurance and the practice of medicine to an unacceptable degree. It extends subsidies and government programs to far too many people. But its biggest fault, and our greatest disappointment, is that it does not deal with costs.

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

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

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

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

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

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

Costs!

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

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

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

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

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

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

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

Address to the National Economists Club

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

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

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

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

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

As economists, we understand that benefits are fun, but costs aren't. Therefore much of the public debate over healthcare reform involves expanding coverage to the uninsured and improving the quality of care. Those are the fun things to talk about. Last week, the CBO tossed a bucket of cold water in our

faces. In two documents, CBO reminded us that we cannot expand coverage or improve quality without dealing with costs. We either have to find funding or find ways to cut. Neither of those makes an attractive bumper sticker.

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

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

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

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

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

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

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

to minimize adverse selection. With well-crafted rules, insurers can make good returns in ways other than by health underwriting.

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

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

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

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

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

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

Address to the American Benefits Council

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

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

Let me begin by rattling off a list of complaints:

- **Costs:** Small business healthcare costs are sky-high, rising, and unpredictable. Small groups pay, on average, 18 percent more than large groups do for equivalent coverage, and small-firm costs have risen 119 percent since 1999. For many small firms and for many of their employees, costs put health insurance beyond reach.
- **Uninsurance:** A majority of America's uninsured are in families headed by a small business owner or employee.
- **Market inefficiency:** Small group insurance markets are inefficient and impose high search and administrative costs on the firms and their employees. Most of our members have no human resources departments, no benefits counselors, no insurance negotiators, no onsite gymnasiums, and most of all, no special expertise in healthcare or health insurance.
- **Fragmentary information:** Information is hard to come by and difficult to compare, making small businesses overly dependent on the advice of brokers and dealers.
- **Lack of competition:** Firms often face a marketplace with very few carriers. It is generally impossible for a small firm to offer more than one policy to its employees -- thus forcing dissimilar people into one-size-fits-all policies.
- **Inadequate pooling:** Small groups often comprise small, unstable pools. Unlike self-insured plans, small group pools are restricted to the borders of a single state. A single ill family member can render coverage unaffordable or unavailable for an entire firm.
- **Tax inequities:** The tax system creates major inequities between the large-group, small-group, and individual markets.
- **Obsolete reimbursement and delivery:** Medicare and Medicaid rest on antiquated reimbursement systems that lock obsolete delivery systems into place. The programs are financially unsustainable and threaten the solvency of governments, firms, and individuals.

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

- **Market reform:** The small group and individual markets need major overhauls.
- **Consistent rating rules:** We need national rating rules with some state discretion.
- **No health status rating:** Health status rating should be abandoned in the small group and individual markets. An illness should not put health insurance beyond reach of anyone.
- **Unified small-group market:** The small group market should not be split into multiple markets, such as separate markets for micro (1-10) groups and larger small groups.
- **Individual/small group merger:** To maximize the benefits of pooling, the small group and individual markets should be merged under consistent rules over a prudent timeline.
- **Exchanges:** Health insurance exchanges/portals should be present in every state to expedite the gathering of information, comparison of plans, and enactment of transactions. An exchange could encompass a multi-state region. Conceivably, some areas of the country could have multiple, competing exchanges, as long as all exchanges in a state or region are subject to identical market rules.
- **Tax credits:** Small business and low-income tax credits are essential if an individual mandate is enacted. It is important to structure credits so that they benefit those who need financial help in securing insurance, rather than those who do not.
- **Stabilize Medicare:** Medicare's financial balance must be restored. The financial hole in Medicare amounts to an unfunded debt of \$124,000 for every adult and child in America. In addition, Medicaid and SCHIP pose similar risks.
- **Medicare microeconomic effects:** The current reimbursement system rewards medical treatments rather than medical outcomes and wellness.
- **No employer mandates or pay-or-play:** NFIB strongly opposes employer mandates or pay-or-play schemes. Our recent study suggests that an employer mandate with a minimum 50% contribution would cost the country 1.6 million jobs over 5 years. A pay-or-play scheme would result in perverse incentives. It is a recipe for replacing full-time workers with part-timers, machines, and foreign outsourcing. It is vital to remember that the cost of employer mandates and pay-or-play ultimately falls on employees, not employers. Employer contributions should remain voluntary.
- **Easier Medicaid enrollment:** 25% of today's uninsured are Medicaid-eligible, so enrollment must be made easier.
- **Maintain private markets:** Market reforms and private insurance are preferable to a public plan or to early Medicare buy-in.
- **Plan flexibility:** Rules on minimum creditable coverage must not squelch innovation or preclude flexible benefit design. Like NFIB, you endorse quality high-deductible plans, for example.

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

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

We appreciate your comment that, “the solutions to expanding coverage among smaller employers will critically depend on the ability to make this highly valued benefit more affordable and sustainable for all.” In this, you mirror NFIB’s contention that expanded coverage and improved quality cannot occur without ratcheting down costs.

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

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

Conversations with Robb Mandelbaum (late 2007-early 2008)

Inc.com

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

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

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

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

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

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

PART I

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PART II

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PART III

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

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

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

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

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

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

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

PART IV

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

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

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

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

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

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

PART V

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

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

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

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

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

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

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

PART VI

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

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

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

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

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

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

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

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