



Small Business Health Care Reform A Long-Term Solution for All

In attempting to create positive health care reform for small businesses, one quickly bumps up against the reality that the small business problems cannot be solved in isolation from the rest of the system. Since small businesses purchase insurance as part of the overall small group (2 to 50 employees), the decisions of others directly affect what a small business must pay and the terms on which insurance is available to them. It has become clear to NSBA that, to bring meaningful affordability, access, and equity in health care to small businesses and their employees, a broad reform of the health care and health insurance systems is called for. This reform must reduce health care costs while improving quality, bring about a fair sharing of health care costs, and focus on the empowerment and responsibility of individual health care consumers.

The Realities of the Insurance Market

Small employers who purchase insurance face significantly higher premiums from at least two sources that have nothing to do with the underlying cost of health care. The first is the cost of “uncompensated care.” These are the expenses health care providers incur for providing care to individuals without coverage; these costs get divided-up and passed on as increased costs to those who have insurance. It is estimated that this practice, known as “cost-shifting”, adds another 8.5 percent to the cost of health care for those who purchase insurance. Second is the fact that millions of relatively healthy Americans choose not to purchase insurance (at least until they get older or sicker) due to cost. Almost four million individuals aged 18-34 making more than \$50,000 per year are uninsured. The absence of these individuals from the insurance pool means that premiums are higher for the rest of the pool than they would be otherwise. Moving these two groups of individuals onto the insurance rolls would bring consequential reductions to current small business premiums.

Implicit in the concept of insurance is that those who use it are subsidized by those who do not. In most arenas, voluntary insurance is most efficient since the actions of those outside the insurance pool do not directly affect those within. If the home of someone without fire insurance burns down, those who are insured are not expected to finance a new house. Not so in the health arena. Any individual with injuries or illnesses will receive care from an emergency room, regardless of whether or not the individual is insured. It is simply sound business sense that the hospital will then look to other avenues to ensure the cost for that uninsured injury or illness is recouped. Moreover, individuals’ ability to assess their own risk is somewhat unique regarding health insurance. People have a good sense of their own health, and healthier individuals are less likely to purchase insurance until they perceive they need it. As insurance becomes more expensive, this proclivity is further increased, which, of course, further decreases the likelihood of the healthy purchasing insurance.

Individual Responsibility

There is no hope of correcting these inequities until we have something close to universal participation of all individuals in some form of health care coverage. NSBA’s plan for ensuring that all Americans have health coverage can be simply summarized: 1) require everyone to have a basic level of coverage; 2) reform the insurance system so no one can be denied coverage and so costs are fairly spread; and 3)



institute a system of subsidies, based upon family income, so that everyone can afford coverage.

Required Coverage

Of course, the decision to require coverage would mean that there must be some definition of the insurance package that would satisfy this requirement, as well as a system of penalties for those who chose not to comply. Such a package must be truly basic to ensure both affordability and choice are inherent in the overall system. The required basic package would include only evidence-based, scientifically sound benefits that would be determined on a federal level. The process for defining the basic package must be nonpolitical and incorporate an appropriate array of stakeholder involvement including state insurance commissioners, state legislative representatives (governors or legislators), insurers, actuaries, small and large businesses, consumer groups, providers, and those insured. This group shall be responsible for not only defining the initial package offering, but also for evaluating, on an ongoing basis, a broad cost-benefit analysis of benefits offered, as well as evaluating such analysis of any proposed additional benefits.

Fair Sharing of Costs/Market Reforms

Incumbent on any requirement to obtain coverage is the need to ensure that coverage is available and affordable to all. In coordination with the requirement that all individuals have coverage, insurance companies would operate on a guaranteed issue basis—the requirement to provide coverage to all seekers. A coverage requirement on individuals would make insurers less risk averse by broadening the make-up of their covered individuals, thus bringing to fruition the goal of health insurance being paid for through fair-sharing rather than through cost-shifting. The importance of a penalty for individuals who seek not to purchase health insurance is imperative in preventing individuals who only purchase health insurance when they get sick. The guaranteed issue requirement on insurers must be accompanied by safeguards in the form of an individual mandate and penalty systems that prevent such behavior.

It follows, then, that the methods by which insurance companies price or “rate” their product could reasonably withstand more rigorous standards. The rating for the basic package would be based on a modified community rating system with defined rate bands and only limited allowable actuarially-sound rating characteristics, including defined geographic regions. In addition, insurance companies would be allowed to provide certain, limited discounts or benefit enhancements to individuals or companies, or both (depending on who pays for the cost of the plan) who implement a certified, evidence-based and actuarially-sound wellness programs. Insurance companies would operate within narrow rate-bands and no additional charges or discounts could be given outside that band.

Modified community rating would apply only to the federally-defined basic package, any additional services purchased above the federal package would be subject to market-based rating rules and would not be eligible for preferred tax treatment. Although not subject to the modified community rating rules, those additional services should not be used as a means to game the system.

While the onus should no longer reside with employers to provide health insurance, the option ought to remain open to those employers who chose to carry out the administrative work for individuals in securing health insurance. All market rules and regulations would apply equally to the insurance plan regardless of who does the administrative work.

As another method to balance the market and infuse a greater level of choice, higher deductibles for those able to afford them would be implemented. The shape of the package would help return a greater share of health insurance to its role as a financial backstop, rather than a reimbursement mechanism for



all expenses. More robust consumer behavior will surely follow

Subsidies

Due to the requirement that individuals purchase health insurance, without exemption for low-income individuals, there would be available federal financial assistance for individuals and families based upon income.

Finally, it should be clear that coverage could come from any source. Employer-based insurance, individual insurance, or an existing public program would all be acceptable means of demonstrating coverage.

Reshaping Incentives

There currently is an open-ended tax exclusion for employer-provided health coverage for both the employer and employee. This tax status has made health insurance preferable to other forms of compensation, leading many Americans to be “over-insured.” This over-insurance leads to a lack of consumer behavior, increased utilization of the system, and significant increases in the aggregate cost of health care. Insurance now frequently covers (on a tax-free basis) non-medically necessary services, which would otherwise be highly responsive to market forces.

The health insurance tax exclusion also creates equity concerns for small employers and their employees. Since larger firms experience less volatile rate increases, and have greater bargaining power than a small firm, their health insurance packages are typically richer than what a small business can afford. Therefore, a large firm can build very rich benefit packages which are tax exempt for the business and are considered a piece of the employees’ compensation package. This gives large employers a significant competitive edge over small businesses with regards to both their tax treatment as well as their ability to recruit employees. Furthermore, many small business employees are currently in the individual insurance market, where only those premiums that exceed 7.5% of income are deductible.

For these reasons, the individual tax exclusion for health insurance coverage should be limited to the value of the basic benefits package. But this exclusion (deduction) should also be extended to individuals purchasing insurance on their own. Moreover, the tax treatment of both health insurance premiums and actual health care expenses should be the same. These changes would bring equity to small employers and their employees, eliminate the federal subsidy for over-insurance, induce much greater consumer behavior, and reduce overall health care expenses.

Reducing Costs by Increasing Quality and Accountability

While the above steps alone would create a much more rational health insurance system, a more fair financing structure, and clear incentives for consumer-based accountability, much more must be done to rein-in the greatest drivers of unnecessary health care costs: waste and inefficiency. More accountable consumer behavior can help reduce utilization at the front end, but most health care costs are consumed in hospitals and by chronic conditions whose individual costs far exceed what any normal deductible level is likely to be.

Health care quality is enormously important, not only for its own sake, but because medical mistakes, waste and inefficiency add billions to our annual health care costs. Medical errors, hospital-acquired infections, and other forms of waste and inefficiency cause additional hospital re-admissions, longer recovery times, missed work and compensation, increased strain on family budgets and, in the most severe cases, death. In fact, medical errors are the eighth leading cause of death in the United States. The



medical costs alone probably total into the hundreds of billions of dollars.

What financial pressures are we bringing to bear on the provider community to improve quality and reduce waste? Almost none. In fact, we may be doing the opposite, since providers make yet more money from re-admissions and longer-term treatments. It is imperative to reduce costs through improved health care quality. Rather than continuing to pay billions for care that actually hurts people and leads to more costs, we should pay more for quality care and less (or nothing) when egregious mistakes occur.

Insurers should reimburse providers based upon actual health outcomes and standards, rather than procedures. Evidence-based indicators and protocols should be developed to help insurers, employers, and individuals hold providers accountable. These protocols—if followed—could also provide a level of provider defense against malpractice claims.

Through digital prescription writing, individual electronic medical records, and universal physician IDs, technology can reduce unnecessary procedures, reduce medical errors, increase efficiency, and improve the quality of care. This data also can form the basis for publicly-available health information about each health care provider, helping patients make informed choices. The implementation of electronic patient records played a significant role in the seismic shift in the Veterans Health Administration from being a highly criticized system to being one of the best around today—receiving a 67 percent rating for overall quality as compared with the 51 percent ranking for a sampling of non-government health care providers in a recent report from the *Annals of Internal Medicine*.

The U.S. medical system can also benefit from thinking outside the box. While traditional doctors' offices and hospitals remain the primary mechanism of health care delivery, creative and effective alternatives should also be taken into consideration. There are myriad programs in existence today, such as Volunteers in Medicine, community and retail clinics, urgent-care and 24-hour clinics, that can offer near-term relief to many individuals in underserved communities, and to uninsured individuals.

Availability of Information

Small businesses are particularly disadvantaged when it comes to being able to access information. While large businesses that self-insure conduct quality studies and compile provider information, small businesses are at the mercy of their insurance carrier to provide them with such data. As a result, little to no provider information with regards to cost or quality is made widely available. This disadvantage will be a heavy burden on individuals as well, if they are not armed the information needed to make important health care decisions.

Insurance companies and health care providers should take the lead of the Centers for Medicare & Medicaid Services (CMS) in compiling provider information and quality rankings, and making them publicly available, easily accessed and understandable. Also included in these rankings should be common-sense pricing lists. Increased information flow to consumers will ensure better decision making and improve the long-term health status of Americans by empowering them as a partner, with their primary care provider, in their own health. Engaging consumers in their own care requires accurate and abundant information that will help individuals evaluate the options and make their own best decision.

With the increased attention many health providers are paying to prevention and wellness programs, quality measurements must be a key part to ensure their success and scientifically-proven benefit. Prevention and wellness programs ought to be held to the same high standards regarding the tracking and reporting of outcomes. Additionally, health care providers should carefully track chronic disease



management and report on the risk-adjusted outcomes of such programs. Tracking this data should enable doctors nation-wide to share best-practices and adjust treatments for optimum outcomes in their patients.

NSBA calls on hospitals and doctor's offices to make publicly available, a plain-language list of the top 20 in-patient and out-patient procedures' costs and risk-adjusted outcomes. This information should be updated at least annually and the number of procedures included incrementally over time until all procedures' cost and outcomes are publicly listed. Under the lead of CMS, all health care providers will compile the data in universal forms enabling the consumer to easily compare providers against each other.

Reform Medical Liability

There is an enormous array of financial pressures and incentives that act upon the health-care provider community. Too often, the incentive for keeping patients healthy is not one of them. Our medical malpractice system is at least partly to blame. While some believe these laws improve health care quality by severely punishing those who make mistakes that harm patients, the reality is that they simply lead to those mistakes—and much more—being hidden.

In addition to instituting reasonable limits on medical liability awards, NSBA supports the creation of so-called "health courts." Health courts would serve as administrative courts to handle medical injury disputes. Judges would be health-care trained professionals assisted by independent experts to settle malpractice disputes between patients and health care providers.

Plaintiffs would receive full economic damages, as well as non-economic damages based on a compensation schedule. This new process for medical liability would also provide the injured party with an avenue to appeal with further review in the traditional court system. In addition to easing the medical liability burden, health courts would establish a mechanism that clear and consistent standards be developed based on cases and the opinions of the judges.

Conclusion

The small business community needs substantial relief from escalating health insurance premiums. This level of relief can only be achieved through a broad reform of the health care system with a goal of universal coverage, focus on individual responsibility and empowerment, the creation of the right market-based incentives, and a relentless focus on improving quality while driving out unnecessary, wasteful, and harmful care.