

Health Care

**Cost Versus Value –
Choice Versus Change:
Small Business Owners Consider
the Future of Health Care**

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The Small Business Perspective

What Does Small Business Want?

Fixing the System – Patient-centered, Choice-based Care

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The Small Business Perspective

Health care costs are going through the roof, and small business owners have few choices when selecting insurance coverage for their employees. The “tipping point” is here and small businesses are begging for solutions. In fact, they have discovered the whole system is broken. Policy makers who want to make sound improvements in the current system should adopt a blueprint for reform that includes changes that reflect both an understanding of the root causes of uninsurance and an appreciation of market forces that increase accessibility, coverage and choice of health options.¹

Policy makers must begin to think differently and look for solutions beyond the employment-based health insurance systems that are a relic of the World War II era. The current tax system provides tax benefits for those who purchase insurance through their employers but no incentives for people who do not have access to employment-based plans. Without reform, the increase in uninsured will continue to rise in today’s dynamic, information-driven economy that puts a premium on mobility and not lifetime service to only one employer.¹

Fundamental changes need to take place to address the unique needs of small business owners. Health care costs have been NFIB members’ number one priority since 1986. At the 2000 NFIB Congressional Small Business Summit in Washington, D.C., members began to question the effectiveness of employer-sponsored health care. A successful small business owner from New Jersey opened the discussion saying she did not want to make health care selections for her 47 employees. She said they were all different and yet the health care marketplace only offers one-size-fits-all product options, which are very expensive. She said she couldn’t afford to pay for 100 percent of their health coverage. She also said she struggled with her part-time employees, wanting to offer them some level of benefits that could be matched or offset by her employees’ other part-time employers.

During that conversation she talked about the differences between big companies and single-storefront entrepreneurs. She believed the obligation to offer health insurance was more personal than professional. She wanted the ability to provide her employees the access and leverage they need to buy health insurance and to contribute financially to the extent she was able.

Due to government subsidies and big business/big labor benefits, the health care system, especially health care financing, has become anti-competitive and economically distorted. NFIB members are typically not large enough to self-insure, so they have to share their risk with other employers through a fully insured plan. As a result, they rely on an insurance company to assign their health status to a risk pool. Theoretically this “law of large numbers” should work to contain costs. Unfortunately that approach hasn’t worked. NFIB members have experienced double-digit increases every year between 1994 and 1999, doubling the premiums they paid for coverage during this five-year period. During this same time, large companies, on average, had single-digit increases. Only recently have large companies felt the financial pressure of large premium increases. For small business owners, it has been a chronic problem.

When the Health Insurance Portability and Accountability Act (HIPAA) of 1996 was enacted, many carriers left the fully insured market. Those that stayed had less competition to contain premium costs. It is frequently said that “adverse selection” among these risk pools is a reason for premium increases and yet very little clinical or financial data exists to support this lament. In fact, insurance companies offering fully insured plans have consistently increased profitability during this time. According to the *National Underwriter* magazine, the managed care industry will have another solid year in 2003, with expanding profit margins pushing net income up 16 percent. It is projected that industry profit margins should expand through 2005. Small business owners have been amazed to learn that most of their premium increases never find their way to their doctors, local pharmacists or hospitals but somehow are absorbed by “administrative costs” that never result in greater service capabilities or more timely claims adjudication.

What small business owners know is that patient-centered, choice-based care is missing in the small group, health care marketplace. Small business health-insurance premiums were often not much better than an individual policy, nor were there sufficient market forces to help lower premiums. At the time of the 2000 Summit, Medical Savings Accounts (MSAs) had been legislated and the media began mentioning them. (MSAs are tax-favored health care accounts that are paired with high-deductible health insurance policies). MSAs were available to small business employees and the self-employed. As small business owners talked about MSAs as a way to combat high costs and minimum access, they collectively cited conversations with their insurance agents, who told them MSAs were bad. One of the reasons: there were no decent high-deductible health plans offered or allowed in their state. Business owners recognized the opportunity, but the marketplace and its agent/broker distribution impeded the deployment of MSAs and continued to do so until 2001. Innovation and competition have been absent in the small group market for too long. In terms of employee benefits, small business owners do not have a human resources department - they depend on their insurance agent and broker to guide them.

At 13.4 percent, this country leads the world in the share of GNP expenditures devoted to health care. Health care costs have risen because there are more and better treatments available for a broader range of conditions than ever before.² However; financing and distribution models have not kept pace with medical innovation or discovery.

All of these issues combined with the weakened economy have jeopardized the ability of small employers to continue to finance health care delivery.

This White Paper uses viewpoints collected via surveys regularly distributed to NFIB members. NFIB looks to its members' responses to prioritize and set its health care agenda.

Why Small Businesses Are Unique

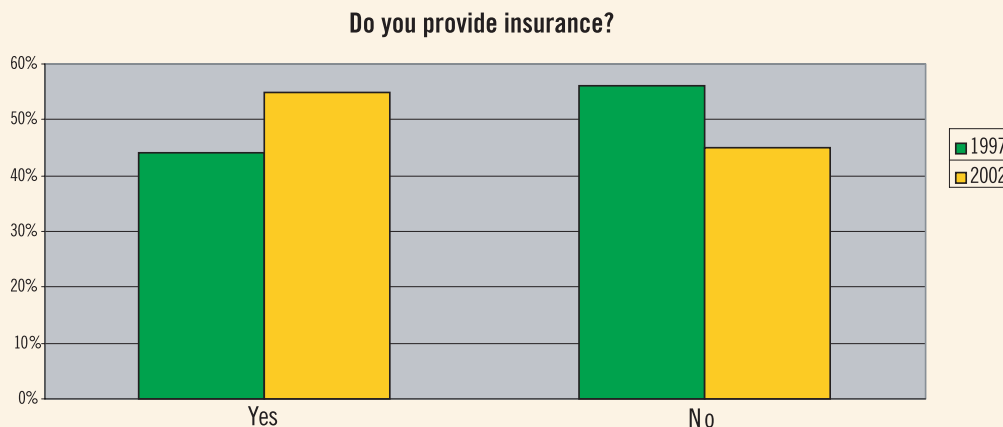
Health care coverage options, costs and quality perceptions are different for small businesses than they are for large ones.

Coverage Options

Between 1998 and 2000, the percentage of Americans with health insurance increased.³ Between 1997 and 2000, the number of small employers offering health care coverage also increased. This percentage of small firms offering health benefits increased despite rapidly rising health-care cost inflation among small firms. It is likely that the changing composition of the labor force accounted for some of the increase in employment-based coverage. For example, the percentage of self-employed workers declined between 1997 and 2000, as did the percentage of part-time workers. Because of the strong economy and low unemployment rates, more employers provided health benefits in order to attract and retain workers. These conditions may have also meant more workers were able to afford insurance.³

However, when the economy weakened and premiums escalated, the brief period of increasing employer coverage and corresponding drop in the number of uninsured Americans ended. In 2001, rising health benefits costs, coupled with the weak economy, began to affect health insurance coverage.³ In 2002, 61 percent of all small businesses (3-199 employees) offered health coverage to their workers – down from 67 percent in 2000.⁴

Coverage continued to vary substantially by firm size: 55 percent of the smallest companies (3-9 workers) offer health insurance. That rises to 74 percent for firms with 10-24 workers and 88 percent for businesses with 25-49 employees. Firms with many part-time workers are less likely to offer health insurance. Firms that employ union workers are very likely (92 percent) to offer coverage regardless of size.⁴



In 2001, 37.9 million Americans received health insurance from public programs, and an additional 16.4 million purchased it directly from an insurer. More than 28 million Americans participated in Medicaid or the State Children's Health Insurance Program (SCHIP) and 6.6 million received their health insurance through the various military dependent and other government programs designed to provide coverage for retired military members and their families. Should the uninsured population continue to increase by 0.4 percentage points per year as it did between 2000 and 2001, 46 million Americans will be uninsured by 2005 and 53 million will be uninsured by 2010.³

Coverage issues also raise the question of value. We have a health care system that promotes the idea that patients are unable to choose the coverage, doctors and treatments that are best for them. Coverage will grow if we recognize we need incentives and financing that make the patient the primary decision-maker, working in partnership with dedicated health care professionals to decide benefits and costs of care.

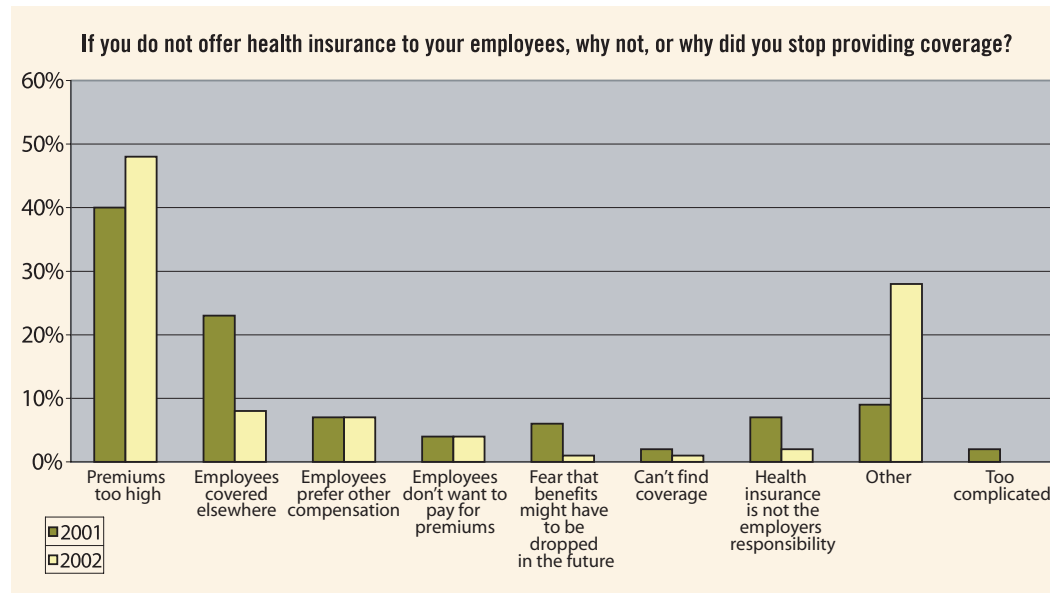
Any discussion of coverage and small business must include a discussion of the individual health insurance market. As mentioned previously, small business owners view health insurance as a personal responsibility, not a corporate one. In addition, with small group market premiums increasing dramatically in recent years, and many small group carriers having a virtual monopoly, which limits competitive choice, many small business owners have actually done better in the individual health market. The individual health insurance market served an estimated 8.6 million Americans in 2001, down 11.5 percent from 1997. Administrative costs are higher in the individual market than the group market, primarily because it costs insurers more to sell policies to individuals. The nongroup market also suffers from adverse selection, since those who seek coverage on their own are more likely to have health problems.

Tax credits to help people buy individual or nongroup health insurance are a key part of the national debate over how to reduce the number of uninsured Americans. Reliance on the individual market has drawn sharp criticism from those who believe this market is badly flawed and is not the best way to expand coverage. Despite its shortcomings, it is estimated that the individual market works acceptably well for about 80 percent of potential buyers. These are primarily people in good health with incomes high enough to afford coverage, however, the individual market also works well for roughly 20 percent of those eligible who are in poor health and have low incomes.⁵

Efforts to force insurers to cover all applicants or to limit premiums have reduced coverage in states that have tried to enforce it. State-run high-risk pools, however, can help stabilize the rest of the individual market.⁵

The Center for Health System Change (HSC) estimates that seven percent of people with individual insurance are in fair or poor health, compared to 21 percent of the uninsured. Either those who buy individual health coverage are healthier, or the market screens out sicker ones. HSC concludes that while tax credits would indeed provide help for many healthy and younger uninsured Americans, they would need to be adjusted for age or health status if they were to help the sicker, older and poorer

uninsured.⁵ To a great extent, that was the original intent of state Medicaid programs and state high risk pools when they were originally legislated.

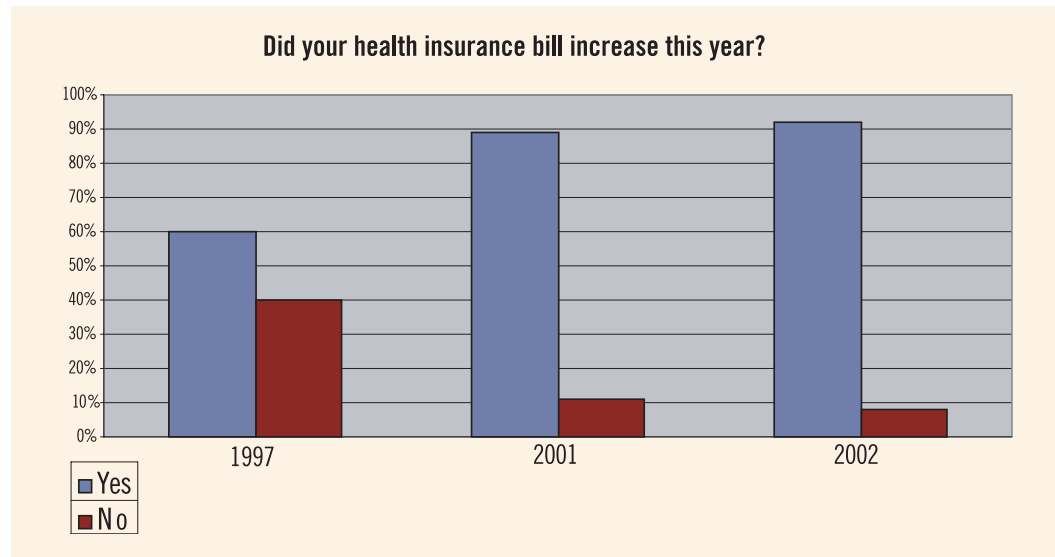


As with all small businesses, too many Hispanic Americans associated with a small business do not have access to health insurance coverage and many more are underinsured. By every measure, a lack of access to affordable health insurance disproportionately affects America's large and growing Hispanic community. According to Aetna U.S. Healthcare, the highest uninsured rate in the United States is among people of Hispanic origin. More than one-third, or 39 percent, of Hispanics were uninsured compared with only 14 percent for non-Hispanic whites. According to the Commonwealth Fund, in small- to medium-sized companies with fewer than 100 workers, 63 percent of white workers have health benefits compared with 38 percent of Hispanic workers. This data confirms recent U.S. Census Bureau findings that 34.2 percent of Hispanics are uninsured, compared with 12 percent of non-Hispanic whites.⁶

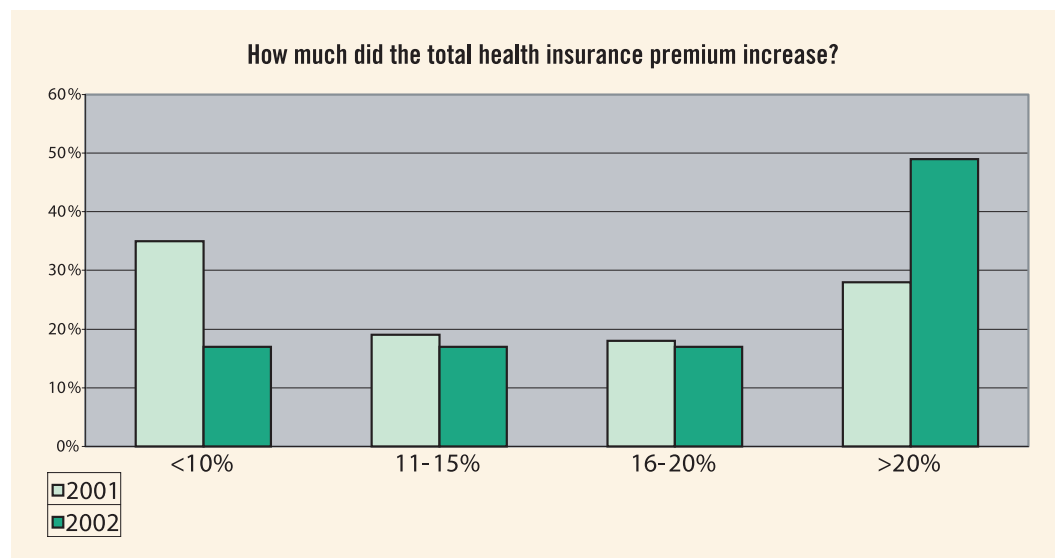
Cost

In recent surveys, the nation's small business owners identified the high cost of health insurance as their number one concern. Roughly 40 million Americans are uninsured, and more than 50 percent of those uninsured are in a family small business employs. Workers in the smallest businesses that do provide health insurance pay, on average, 17 percent more for health benefits than workers employed by large companies. This crisis is worsening as health insurance premiums for small businesses increase at double-digit rates while benefits and health plan choices diminish. A recent survey by the GAO found dangerously high levels of market concentration among large insurance companies in the state small group markets. As competition decreases, prices increase.

As providers demanded and got big increases in payments from health plans, and as plans passed those increases on to employers, group health plan costs for active employees jumped in 2002. Costs for smaller employers grew by 18.1 percent, to \$5,492 per employee.



Last year's cost increases are the highest since 1990, when they increased 17.1 percent.⁸



The last time the country experienced a comparable inflation in health care costs with annual increases in the 12-15 percent range and health care costs approaching 13 percent of the GNP was in the mid-1980s.⁷

Although employers enjoyed several years of cost stability during the mid-1990s, when managed care plans had greater leverage over medical providers and the plans competed fiercely for market share, the current situation could not be more different. Health care plan costs have increased for five consecutive years, with the increases growing each year.

Health plan costs increased by an average of \$722 per employee in 2002, compared with \$494 per employee in 2001 and \$333 in 2000.⁸

An estimated 40 percent of all NFIB members buy their health insurance from a Blue Cross-Blue Shield Plan. Many of these plans operate with a significant market share and little competition in their state markets.

Employers do not expect cost increases to abate any time soon. Next year they expect costs to rise an average of 14 percent.

Quality

A recent study published by the National Association of Manufacturers revealed that large employers focus mostly on improving the quality of health care as a way of containing costs. Since most small businesses buy their health insurance through the fully insured market, they have virtually no access to clinical outcomes or claims information. Carriers increase their rates without showing them data on how the plan performed qualitatively. Consequently, small business owners have no way to debate quality issues or medical outcomes with the carrier and are unable to provide evidence that rate increases are not justified. In addition, our litigation system encourages a medical practice environment that punishes doctors rather than rewarding them for identifying ways to deliver safe, more effective care by using uniform product standards.

The best way to improve health care quality is to create a competitive system. This system would provide incentives by giving people choices, thereby enabling them to get coverage that best meets their needs. Small business owners need to join this debate and demand quality measures for the health-care dollars they spend.

What Does Small Business Want?

Fixing America's health care system is not a partisan concern. Rather than relying on today's tax-biased system that ties coverage to employers, policy makers should make fully refundable, prepayable tax credits available so all Americans have access to health coverage.

Debate during the last six years has emphasized new litigation, more mandates and increased regulation, without addressing diminished market competition and fraudulent billing practices. Consequently, America's working families and the businesses that employ them are faced with unsustainable costs.

Health-care costs have been NFIB members' number one concern since 1986. When asked about key legislative initiatives, NFIB members have spoken against intervention and for free-market solutions.

- NFIB members would like to see legislation that would allow small employers to provide health insurance for their employees without state mandates.
- Individuals who contribute to a tax-free savings account for health care should be allowed to carry over any unused portion to the next year.
- In either attempting to provide coverage or making it more affordable, NFIB members would like their employees to be able to shop for coverage. The employer would reimburse (up to a previously set amount) the employee when presented with a receipt verifying health care coverage.
- NFIB members do not believe Congress should expand the scope of mental health parity requirements to include a broader definition of mental illness while also requiring more small businesses to offer such coverage.
- Overwhelmingly, NFIB members believe Congress should work to expedite the delivery of generic drugs to the market.
- Congress should not enact a universal health care program with the government as the sole provider of health care.
- NFIB should support cost testing of all proposed health insurance mandates and proposals.
- Congress should pass medical malpractice reforms that cap non-economic damages.
- NFIB should oppose all public/private initiatives that seek funding through a tax on employers.
- NFIB should not support the adoption of a government-subsidized health insurance program for qualified working poor.
- NFIB members do not believe any public/private initiatives have saved money. In fact, they believe many state and federal programs have led to cost shifting back to small employers and to fully insured health care plans.
- Attempts to use entitlement programs as an insurance option for small businesses have not affected NFIB members' decisions to offer health insurance.
- Employers should not be required to either purchase health insurance for their employees or pay a tax that funds a public/private health-insurance program.
- A very small number of NFIB employers are enrolled in a state-sponsored health-insurance programs.
- Tax incentives should be available to help small employers pay for their own health insurance.
- Individuals should have the option of using a health care tax credit as a tool to purchase health insurance.

Considering the above opinions, the question becomes, "What is the government's role in providing a health-care solution?"

NFIB members believe the government's primary role should be to improve the health care market. The government can do this by providing information and incentives so that doctors and patients are making the best use of resources available. Where needed, regulation should be targeted to address some limited failure of the market.

Other appropriate roles of government include:

- Promoting research
- Providing financial support for those with low incomes and significant health care needs so they too can participate in the same kind of mainstream health care coverage other Americans enjoy
- Supporting biomedical research

Fixing the System – Patient-centered, Choice-based Care

Rapidly increasing premiums have generated speculation that employers may move to new types of health insurance arrangements to control future costs. One such option is a defined contribution approach, where, in the extreme, employees are given cash to buy health insurance on their own, rather than selecting among plans with which the employer contracts.⁴

PPOs continued to be the most preferred health plan in 2002, enrolling just over half of all employees with health coverage. Ninety-three (93 percent) of small firms that provide coverage offer just one plan compared to 40 percent of larger businesses.⁴

Health care reform almost certainly will return to center stage in American politics in 2003 and small businesses should be ready to take a lead role in that debate. Health care premiums and cost increases are out of control, rising 20 percent and more in an economy that is otherwise almost deflationary.⁹ If the government really wants to fix the problem it needs to impose less bureaucracy on providers (doing its part to bring down costs and encourage competition) and also give small businesses some serious new incentives to purchase coverage.⁹

A person's source of health insurance coverage is related to his or her income.³ Other factors influencing the status of health insurance coverage include geographic location, citizenship, employment, industry, firm size, race and ethnic origin, family type and age and family size.³

Ultimately, the challenge is how to substantially reduce the number and percentage of uninsured and maintain such reductions through economic and other cycles. Employers offer health insurance as an employee benefit to promote health and increase worker productivity as well as to provide financial security. The "business case" for health benefits is the ability for employers to offer a compensation package, comprised of both wages and health benefits, that is more profitable than providing wages alone. In general, the availability of health insurance allows consumers to avoid unnecessary pain and suffering and improves the quality of life in that it has a positive impact on worker recruitment, retention, health status and productivity.

Mitigating unlimited employer risk in the form of consistently high premium increases has been a key issue to small business owners who are not able to self-insure. Four recent trends are worth noting in the quest for solutions in the small group market. They are:

1. The emerging popularity of Medical Savings Accounts (MSAs)
2. The creation of health reimbursement accounts (HRAs)
3. Entitlement programs are no substitute for a free market solution
4. Hope for financing long-term care options

The Emerging Popularity of Medical Saving Accounts

HIPAA legislation included a pilot program allowing MSAs. Despite a slow start, MSAs are gaining ground as a viable alternative for individuals and small employers who have not found an acceptable product match in the fully insured market. The program is slated to expire December 31, 2003, but has many proponents, including NFIB members, who would like to see Congress make MSAs permanent.

HIPAA created a four-year demonstration project allowing the establishment of 750,000 MSAs. Economic stimulus legislation (Pub. L. No. 107-147) signed into law in March 2002 included MSA extension.

MSAs' increasing popularity and positive impact on the uninsured should help arguments to expand the MSA program and make it permanent. In addition, it does not make sense to limit MSA participation to the self-employed and small business employees. MSAs will be more effective if the 108th Congress makes them permanent and also:

- Lifts the 750,000 MSA enrollment cap;
- Removes thresholds for deductibles on health policies that accompany MSAs;
- Allows MSA contributions from both employers and employees in the same year;
- Allows MSA holders to fund their MSAs up to 100 percent of the deductible;
- Allows MSAs to be offered as part of a cafeteria plan; and
- Reduces the tax penalty for MSA withdrawals that are not for qualified medical expenses from 15 percent to 10 percent.

MSAs stirred controversy in congressional debates prior to and following HIPAA's establishment of the current pilot program. MSA detractors contend that, if MSAs become available to everyone and are offered with lower deductibles and fewer restrictions, the insurance market will be segmented and those with less money and more health problems will have to pay disproportionately high health insurance rates.

Proponents contend that MSAs are helping to address the problem of the uninsured. They cite Internal Revenue Service figures (IRS Announcement 2002-90) released in September 2002 to support their position. In the announcement, the IRS said that of 78,913 tax returns reporting an excludable or

deductible contribution to an MSA for the 2001 taxable year, 57,834 of the returns (73 percent) were for taxpayers reported as being previously uninsured.

The Creation of Health Reimbursement Accounts (HRAs)

HRAs also provide small employers some hope.

Unveiled by the U.S. Treasury in June 2002, HRAs are accounts that accumulate monies for medical expenses. When combined with high-deductible health plans (HDHPs), they reduce health insurance premiums while giving employers and employees freedom to make health care decisions. And, HRAs are available to any group size, so even the smallest businesses can take advantage of them.

What's more, employers don't prefund HRA accounts, meaning they do not deposit money into an account until there's a medical claim. More importantly, their exposure for the claim is only as much as their portion of the employees' deductibles.

HRAs combined with HDHPs are consumer-driven, so employees must spend some of their own money to pay health care expenses.

Entitlement programs are no substitute for a free market solution

Senate Democrats have introduced the Health Care Coverage Expansion and Quality Improvement Act. The proposal would expand the State Children's Health Insurance Programs (SCHIP) to include coverage for parents, pregnant women and legal immigrants. It also includes a tax credit provision for small employers who offer health insurance coverage to employees, mental health parity and patients' rights provisions. While this initiative sounds admirable, we have not seen public/private initiatives have a great impact on small business insurability.

Small business owners are skeptical of subsidized initiatives and do not view Medicare or Medicaid-type programs as alternatives to their health care financing needs.

Hope for Financing Long-Term Care Options

The President has proposed a tax deduction for long-term care insurance premiums that will make these options significantly cheaper for people who are considering whether to save or set aside resources for their long term health care needs. The President also proposed a tax exemption for people who receive care in their own homes. This exemption illustrates the benefit to the government and the person involved who is able to stay out of a Medicaid-financed institution.

The NFIB Health Care Agenda

Multiple recent years of accelerating premium growth and a weakened economy may have begun to erode the coverage improvements of the previous few years. Despite concerns over increasing costs, however, less than one percent of NFIB members report they are likely to stop offering health benefits in the near future.

NFIB knows no one solution will help the more than 40 million uninsured, but a multi-faceted approach will help these people receive affordable health care. On behalf of its 600,000 small-business owner members, NFIB actively supports enacting Association Health Plans (AHPs) legislation into law, and expanding MSAs, Flexible Spending Accounts (FSAs) and tax credits.

Finding and affording quality health insurance is a top concern of small business owners. The debate boils down to access and cost. In several states, small business owners have only one or two insurance companies from which to choose — a monopolistic situation producing out-of-sight prices. Of the 43 million Americans with no health insurance, more than 60 percent are small business owners, their dependents or their employees, and employee dependents.

The following six-point plan is a summary of action on Capitol Hill taken by NFIB advocates on behalf of small business.

Association Health Plans (AHPs)

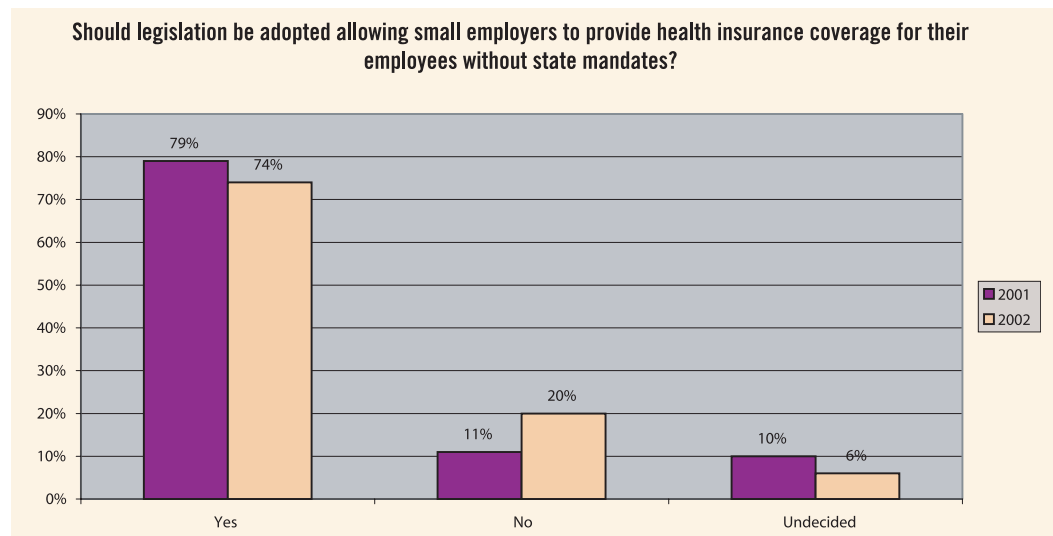
AHPs can help reduce the number of uninsured and ease the burden of small business by giving them the same accessibility, affordability, and choice in health care that big business now enjoys. Currently, labor unions, medium-sized businesses and Fortune 500 companies like Ford, Chrysler and Wal-Mart have the ability to offer health benefits to their employees under one uniform federal statute known as ERISA, the Employee Retirement Income Security Act of 1974. This saves such companies from the cumbersome task of having to comply with the different rules, regulations and benefit mandates in each of the 50 states. Small business, however, has no such opportunity—that is why AHPs are a necessity.

AHPs will allow small business owners to band together across state lines through their membership in bona fide trade associations, like NFIB, to purchase health coverage for their families and employees. For example, many small business owners may have memberships in several associations like NFIB, the U.S. Chamber or the National Restaurant Association. If AHPs became law, a small business owner could purchase health benefits through any one of these entities that would, in turn, act much as the human resources department of a large company. The Department of Labor will oversee AHPs, writing the rules and regulations that will govern AHPs.

Through AHPs, small business owners and employees would benefit from the same economies of scale, purchasing clout, and administrative efficiencies their big business counterparts already enjoy. This

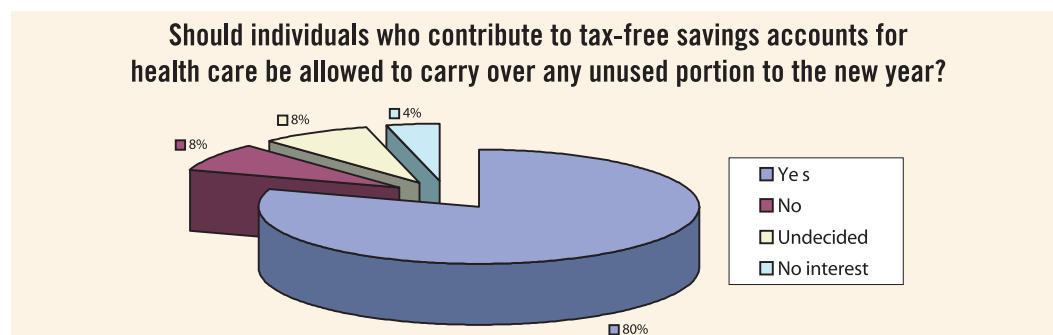
would result in lower health care costs and new coverage options for the working uninsured, whose only current choices are the high-priced, over-regulated plans that may exist in their individual states.

According to the Congressional Budget Office (CBO), AHPs would save small-business owners and their employees as much as 25 percent on their health insurance. The savings would come from basic economies of scale. Just like buying a case of soda at a supermarket costs less per can than buying 24 individual cans at a vending machine, AHPs would allow groups like NFIB to buy thousands of health-insurance policies at a lower per-policy cost.



Flexible Spending Accounts (FSAs)

Flexible spending accounts allow for up to \$4,000 (pre-tax) to be used for medical expenses such as co-pays, deductibles and services not covered under the base insurance plan. However, if these funds are not used by the end of the year, the money is returned to the employer. There is no rollover provision to allow individuals to keep the money for future expenses or for the funds to be distributed to the individual after taxes have been paid on the remaining funds. These limitations need to be changed to allow workers to take control of health care costs and prepare for the future.



Medical Savings Accounts (MSAs)

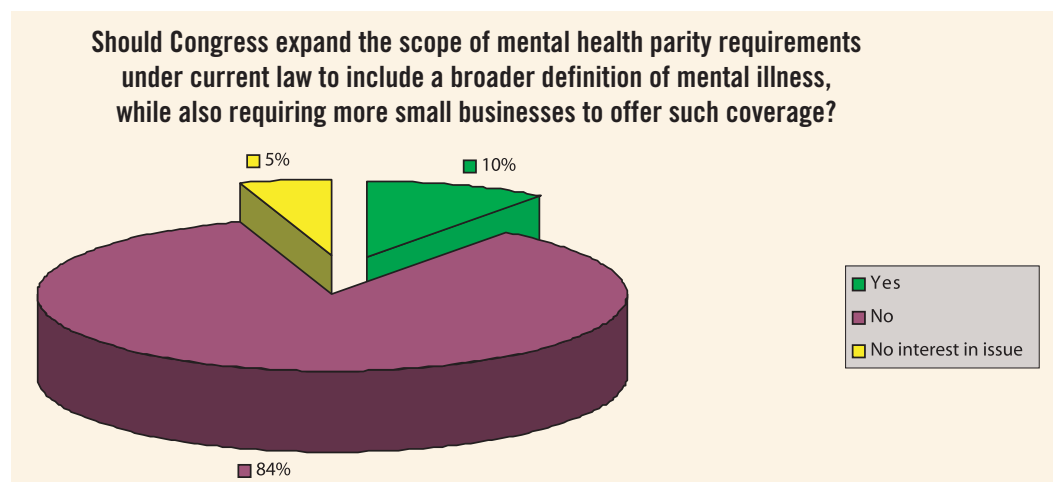
MSAs allow workers a low-cost, high deductible, private health insurance policy coupled with a tax-preferred, personal medical savings account for out-of-pocket expenses. In fact, 73 percent of all MSA purchasers previously had no health insurance. Under current law, MSAs have too many restrictions and families cannot rely on them for their future health care needs. NFIB advocates:

- Expanding MSAs to include all individuals and families.
- Increasing contribution limits to cover 100 percent of deductible costs.
- Lowering deductible requirements for high deductible plans from \$1,650 to \$1,000 for individuals and from \$3,300 to \$2,000 for families.
- Allowing employers and employees to make contributions.

Mental Health Parity

Small business owners want to and do offer health plans that cover a wide variety of benefits, including mental health benefits. Providing mental health benefits, like medical and surgical benefits, is important to the productivity of NFIB members and their employees.

Nevertheless, NFIB is greatly concerned by government-imposed mandates that increase costs for employers who voluntarily offer health benefit plans. Mental health benefits have proven to be the most unpredictable of health benefits because of their potential to increase costs. Plus, mandates prevent employers from offering more affordable and flexible plans that meet their employees' needs. NFIB opposes the mental health parity legislation Congress is considering.



Patients' Bill of Rights

The legislation Congress is considering would impose a so-called "Patients' Bill of Rights." This legislation is bad for small business, because it would impose numerous new federal mandates on

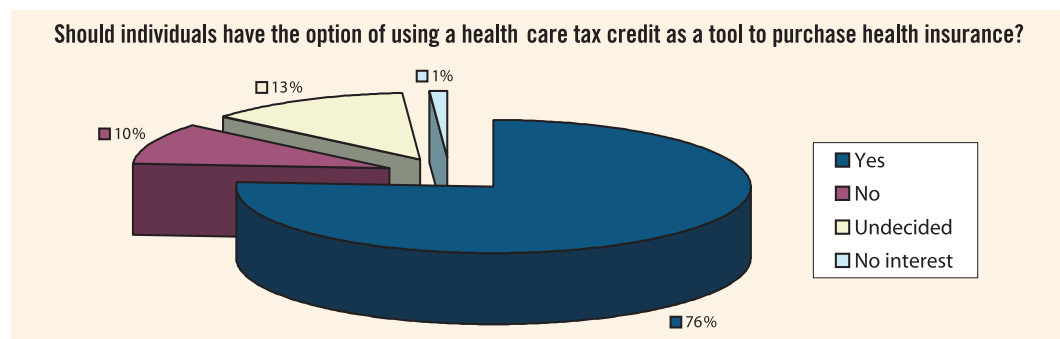
health plans and would subject small business owners to potential lawsuits caused by disputes with employees over health-insurance claims.

However, if a Patients’ Bill of Rights is introduced with a cap on punitive damages or with a tort reform provision that will protect both consumers and providers but limit awards for frivolous lawsuits, NFIB members’ position on this type of legislation could change. Liability provisions will do nothing to improve the quality of care or ensure that patients receive treatment in the event that an HMO doesn’t honor its obligations. NFIB will continue to fight against any liability provisions that will keep small businesses from being able to offer affordable coverage for their employees.

Tax Credits

Members of Congress from both parties support legislative proposals to expand private health insurance coverage to millions of Americans through a system of tax credits. Some of the proposals would allow small business employees to use a tax credit to purchase their own individual policy.

With tax credits, small business owners and employees without insurance would be more likely to purchase coverage, leaving fewer people uninsured. Certain pieces of proposed legislation would allow the credit to be used toward either an individual policy or an employer-sponsored policy. Health insurance policies purchased with the proposed tax credit would also be portable, meaning employees could carry the policy with them to another job and keep the same care providers for many years, rather than changing providers with each new job. Essentially, tax credit provisions would provide a way to insure more people without creating a new government bureaucracy.



Conclusion

NFIB surveys show that the nation’s small business owners identify high health insurance costs as their number one concern. Roughly 40 million Americans are uninsured, and more than 50 percent reside in a family employed by a small business. Workers in the smallest businesses that do provide health insurance pay 17 percent more on average for health benefits than workers at large companies. Alarmingly, this crisis is worsening as health insurance premiums for small businesses increase at double-digit rates while benefits and health plan choices diminish. A recent survey by the GAO found

dangerously high levels of market concentration among large insurance companies in the state small group markets. As competition decreases, prices increase.

Patient-centered, choice-based care is missing from the small group marketplace. Action must be taken to begin to allow the consumer, not the employer, to influence health spending. New options are needed to encourage operating efficiencies that will:

- Give tax incentives for more employees to participate in employer-sponsored health care
- Increase economies of scale and bargaining clout for small employers
- Allow administrative savings through one uniform set of rules across state lines
- Maximize flexibility in benefit plan designs to meet the diverse needs of working families
- Provide the ability to self-fund like health plans sponsored by Fortune 500 companies

Small business owners need to join with other stakeholders interested in understanding what solutions might exist for the small business market. A great deal of data exists on where health care costs have been going. Solutions need to address new ways to simplify and stabilize health service purchases going forward. Small business owners need to take a lead role in this debate.

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