Conversations with Robb Mandelbaum (late 2007-early 2008)

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

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

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

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

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

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

PART I

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PART II

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PART III

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

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

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

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

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

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

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

PART IV

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

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

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

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

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

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

PART V

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

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

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

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

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

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

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

PART VI

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

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

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

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

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

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

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

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