Testimony of
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Before the House Education and Labor Committee

Tri-Committee Draft Proposal for Health Care Reform
Developed by the House Ways and Means, Energy and Commerce,
and Education and Labor Committees

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My name is Celia Wcislo, and I am testifying today on behalf of the Service Employees International Union. Chairman Miller and members of the committee, SEIU applauds you for the discussion draft bill released on June 19. I am a local and national officer of SEIU as well as a board member of the Commonwealth Connector Authority. This authority was set up to implement Massachusetts' healthcare reform legislation, and I have been a board member since the first meeting in 2006.

Americans are ready to fix healthcare. According to a poll conducted in April by the Kaiser Family Foundation, a solid majority of the respondents agree that the current economic crisis makes it more important that we reform healthcare now. Your discussion draft includes some essential elements that will promote coverage and access, cost containment, and improved quality and value:

A Robust Health Insurance Exchange: As a member of the Connector Board, we have found this form of exchange important for many reasons:

1) It has created a set of products, and a Web portal that, for the first time, allows consumers to compare insurance products in one place, helping them to find the information and comparisons they need to select the plan that best fits their needs.
2) The Connector has also built on top of the state's Medicaid virtual gateway, so individuals can quickly be enrolled in the appropriate subsidized plans.
3) We have established a "minimum wage" type standard for what minimum benefit coverage should look like, much as the proposed advisory committee chaired by the surgeon general would do in the discussion draft. I will speak to this more in a few minutes.

A Public Health Insurance Option: SEIU fully supports a public health insurance option as a way to keep costs down and foster price competition in the private market. While the Connector has been able to keep the cost of our subsidized plans low because of our exclusive market position and our role in defining benefits and co-pays, we have had little impact on the private market. That has meant that premiums continue to rise, and many small business owners are feeling the financial impact. In particular, in Massachusetts we have only just begun to offer plans to the small group market and it is still in the pilot stage.

One way of addressing some of the concerns of "unfair competition" that have been raised by private insurance plans is to make sure the public option pays adequate provider rates. In Massachusetts, the use of Medicaid Disproportionate Share funding to pay for coverage expansion has meant a dramatic cut in both Medicaid and DSH hospital rates that is devastating for the safety net delivery system. Currently, hospitals that are treating those on Medicaid are facing cuts that could destabilize these systems that treat low-income individuals. To avoid a cost-shift to private insurance plans, a public plan should pay above Medicare rates (and pay better for primary care services which are dramatically underpaid in Medicare).

Massachusetts has recently set up a Payment Reform Commission to solve this problem of different methods of payment. We are looking to move away from paying for volume and toward paying to promote prevention and health. Additionally, we are trying to solve the

problems of cost-shifting between Medicaid, Medicare and private coverage. A public plan could help in demonstrating how all three areas of insurance can be better moved to one playing field.

Minimum Benefit Standards: The Connector sets minimum standards for health insurance, and we applaud the House proposal for setting minimum standards. While resisted by some insurance companies, the Connector has set a floor of what health insurance should be and has allowed the Division of Insurance and attorney general's office to better police the insurance market and protect consumers. Our minimum standards are meaningful and include most, if not all, of the benefits we mandate in state law.

This has been critical in keeping the floor from dropping out of our current market and giving consumers' confidence that what they are buying provides real health protection.

Affordability: We are pleased to see that the Tri-Committee bill proposes an affordability scale that goes to 400 percent FPL, or $88,000 for a family of four. In Massachusetts one of the largest groups of residents which have received waivers from the individual mandate are those with incomes between 300 percent to 400 percent FPL, which fall outside of the Connector's authority. We still have a cliff at 300 percent, where individuals who have been buying subsidized coverage may not be able to afford even our lowest coverage level once they are no longer subsidized. In 2007 and 2008, at least 60,000 and then 51,000 individuals were ruled to be unable to afford the insurance available to them. By providing assistance for individuals and families with incomes at four times the poverty level, your legislation makes an individual requirement fairer and less burdensome for individuals and families.

Shared Responsibility: Employers, individuals, and government must all do their part to make sure we have a sustainable and affordable system that covers everybody. The journal *Health Affairs* recently published a paper by Bob Blendon and colleagues showing stronger public support for a shared responsibility approach to reform compared to an approach that relies solely on individual responsibility. Massachusetts' reform continues to be successful for many reasons, but I would say the major reason and context of our work has been the approach of shared responsibility that the House Tri-Committee bill adopts.

We have both an individual mandate and an employer mandate to provide coverage. These have both been phased in gradually and have, in fact, received very little real opposition from residents. By making government, business and individuals share in responsibility and cost, healthcare reform still receives high public support (close to 70 percent).

Businesses that do not provide coverage face two types of penalties: a per-worker "play-or-pay" payment, as well as potential penalty assessed for the cost of care if their worker needs government help with healthcare costs. This was designed into the bill to avoid "crowd out," or the action of companies to drop coverage and pass the cost onto government programs. A play-or-pay mechanism based on the size of payroll, such as your bill proposes, is a better approach than a per-worker fee because it is more reflective of the employers' ability to pay and less regressive.

To date, these two combined approaches appear to have worked better in Massachusetts than most predicted. The Division of Healthcare Financing and Policy reports that 438,000 residents are newly insured since reform started, of which 150,000 have purchased insurance through employer-sponsored insurance, and 41,000 have bought through the individual market. So while there may have been some small number of employers who have dropped coverage, fully 44 percent of the newly insured have bought coverage in the private market with no subsidies.

Additionally, from 2003 until 2007, the number of employers which offer health insurance has risen from 68 percent to 72 percent, heading in a better direction than the national trend, which continues to see the erosion of ESI. However, Massachusetts is not representative of the nation in this regard. We had a higher rate of employer-sponsored coverage than the national average when we began our reforms.

Opponents of the play-or-pay proposal say that it will result in massive job losses and high costs to employers. This is not the case. Two recent studies, one by Philip Cryan at Berkeley and the other by Ken Jacobs and Jacob Hacker, using the proposed play-or-pay requirement—with the "pay" being between 6 percent and 8 percent of payroll—found that the net effect of such a policy would result in minimal job losses—between one-tenth of 1 percent and .03 percent. Minimal job losses likely to be offset by other impacts of healthcare reform including improved efficiency and productivity of the labor market. Nearly 75 percent of the 45 million uninsured could gain coverage through an employer mandate. Under the play-or-pay proposal, the studies indicate that the increase in payroll costs from the employer requirement is likely to again be offset through declines in the cost of coverage and increased productivity.[i]

Reform has fundamentally improved coverage for Massachusetts' residents. But it has not solved all of our problems. Close to 3 percent remain uninsured, with many others underinsured. Large employers, while providing generous benefits for their full-time employees, still have many employees whose work status as part time, temporary, or not eligible for coverage means they are eligible to receive subsidized care. The House draft proposal would require employers to either contribute a pro rata share for part-time employees or pay into a fund, an important provision of the bill that Massachusetts could have benefited from.

If Congress were only to adopt a "fair share" approach for employers who do not provide affordable coverage, there could be some serious consequences:

- The proposal would have a much greater effect on employers not offering coverage who have employees with lower family incomes than employers not offering coverage who have higher income employees.
- Employers would have incentives to tilt hiring toward people who have health coverage through a family member, who have a spouse who has a good income, teenagers whose parents make a decent living, and people without children (since the income limits for Medicaid and subsidies rise with family size). Poor parents with children in one-earner families would be particularly disadvantaged.
- Employees (or prospective employees) who know their employer would be charged might be discouraged from applying for Medicaid or subsidies even though they are eligible, and might forgo healthcare that they need as a consequence. And this could

discourage employers from hiring persons with disabilities since they are often enrolled in Medicaid programs.

I would also make several suggestions about how the employer mandate should be structured:

- Base the required payment on the size of an employer's payroll rather than the number or type of employees. A per-employee requirement would disproportionately affect firms with larger numbers of low-wage workers, as compared with firms with smaller numbers of highly compensated individuals. The House proposal contains a flat 8% of payroll penalty, which is reasonable and fair, and will take into account firms with a significant numbers of low-wage workers. In Massachusetts, we considered taking similar steps, but was dropped because of concerns from our state leaders of an ERISA challenge.

- To protect small firms with low-wage workers, exempt a specified dollar amount from the amount of payroll subject to tax. The amount of payroll exempted from tax should be kept small, however, so that as many firms as possible are subject to the play-or-pay requirement.

It is critical that reform mandates both businesses and individuals to contribute to the cost of insuring everyone, along with the government. We must build a safety net for those individuals and small businesses that do not have adequate access to affordable insurance. We need a public plan to provide needed competition and continuity in the market. And we have to make sure we set a floor on what essential insurance is, so that we truly make available coverage that is as good as what you all receive as Members of Congress.

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[i] Philip Cryan, June 2009. "Will A Play-or-pay Policy for Healthcare Cause Job Losses? Goldman School, University of California, Berkeley For the Institute for America's Future and the Economic Policy Institute, And Ken Jacobs and Jacob Hacker June 2009 " How to structure a play-or-pay requirement for employers: lessons from California for national healthcare reform." Advancing National Healthcare Reform: Policy Brief.