INSURING THE UNINSURED
WHITE PAPER

Introduction

The Chamber of Commerce of Southern New Jersey created an Ad Hoc Committee on Insuring the Uninsured for the following purposes:

1. Review and assess the current landscape regarding health care for the uninsured.

2. Make recommendations with the goal of increasing the number of persons with health care coverage through a variety of potential mechanisms without shifting the burden to any one segment of society, i.e., the business community.

3. Consider issues of cost, access and quality of health care related to issues of the uninsured.

The focus of this document is on issues and recommended solutions for New Jersey. At the same time, we recognize that providing health care coverage for all Americans is a national problem that ultimately requires national solutions.

I. Whose responsibility is it to provide health insurance coverage?

A. Business. Many businesses in New Jersey (close to 96% of businesses with more than 50 employees and approximately 52% of businesses with less than 50 employees) provide health insurance to their employees, according to the Henry J. Kaiser Family Foundation Study.

B. Government: Government has a responsibility to ensure that those citizens who meet eligibility criteria, receive access to government programs that provide free or affordable health insurance. Similarly, State government should do everything in its power to make commercial health insurance premiums affordable.

C. Individuals: It is the responsibility of every individual to obtain insurance, whether it is from the employer, government or purchased on their own.

II. Who are the uninsured?

In order to solve the problem of insuring the uninsured, it is imperative to understand the population of the uninsured. Before any plan is implemented, the NJ Department of Health and Senior Services should gather all available data and conduct research on the demographics (including the who and why) of the uninsured population in New Jersey.

III. Will a government mandate work?

Requiring employers to provide health insurance coverage that meets specific dollar level requirements will not solve the problem. Such a mandate will cause companies to restructure their total compensation package and reallocate resources.

These mandates have also drawn legal scrutiny. On July 19, 2006, Federal District Court Judge J. Federal Motz, overturned the Maryland Fair Share Act (which required non-governmental employers of 10,000 or more employees to spend up to 8% of their total wages on health insurance costs or pay the State the difference), finding that the Act is pre-empted in accordance with long established Supreme Court Law that State laws which impose employee health or welfare mandates on employers are invalid under ERISA.

A. **It is a business decision on how to allocate dollars, and whether to offer health insurance to their employees.** Many companies recognize that it is in their best interest to provide a competitive, market-based total compensation package to their employees in order to avoid turnover (retain current employees), as well as to attract good employees. However, many companies simply cannot afford the cost of coverage, and understand that this decision impacts their ability to attract and retain employees.

   There are many options available to employers to reduce the cost of health insurance, many times without sacrificing benefit levels. In addition to comprehensive health plans, businesses also provide a variety of wellness benefits to help employees improve their health, thus lowering the cost of health care. Examples include Employee Assistance Programs (mental health, smoking cessation, weight control, etc.), health fairs, blood and cholesterol screening and fitness club membership reimbursements. It is important to maintain this flexibility for business. The ability of businesses to offer health insurance is a very individual, market-based decision, and flexibility allows businesses to offer plan designs that provide quality health benefits at an affordable price. Mandating that businesses spend a specific dollar level will result in artificial inflation. This will severely limit businesses' ability to allocate company resources as appropriate for their business. Additionally, an employer mandate may penalize a company that has achieved administrative and wellness efficiencies that have lowered their health benefit costs.

Any plan to insure the uninsured must not have a disparate impact on the business community as a whole, or on specific sectors within the business community. For example, proposed legislation that requires businesses that employ 1,000 or more people to provide health insurance to all employees (including part time and employees of temporary agencies) will have a severe negative impact on the home health care and temporary employment industries.

B. **Most employers that provide health insurance offer policies that are comprehensive in coverage.** Businesses view their investment in health insurance as part of their overall allocation of financial resources for their employees, including salaries, taxes, paid time off, and other types of insurance offerings. Employers approach the cost of salary and benefits for their employees by determining what is "fair."

C. **Lawmakers should consider the implications of imposing health insurance coverage requirements that would impact collective bargaining agreements, which are governed by the National Labor Relations Act (NLRA)**.

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D. **Lawmakers should also be mindful of State public policy that conflicts with ERISA.** For example as noted in Section III above, the Maryland Fair Share Act was recently overturned on the basis of a pre-emption by ERISA.

E. **The root cause for companies not offering health insurance is cost.** While this is a national issue, New Jersey specific challenges can only be addressed by the State legislature, which should do everything possible to make health insurance premiums affordable. We offer the following recommendations in the spirit of cooperation, as a partner of the State, interested in helping to solve this complex and multi-tiered problem:

1. **Expand the scope of the Mandated Health Benefits Advisory Commission (MHBAC) to include an analysis and review of all current, state-imposed mandated health benefits**. This will allow a comprehensive evaluation of the cost and relevancy of all current mandates. According to the Council for Affordable Health Insurance there are 41 mandates currently imposed in the State of New Jersey. Having such a significant number of mandates, without question, contributes to driving up the cost of premiums in our State. A thoughtful analysis of current mandates would provide policy makers with insight that will help them in developing future health care related legislative proposals. We also recommend having the MHBAC look at the impact of mandated benefits on employer-employee cost sharing, as related to rising premium costs that are directly or indirectly resulting from the various mandates. The MHBAC currently

only considers the impact on premium cost and the number of people projected to lose coverage due to the increasing premium cost associated with the mandate. It does not consider the impact on increased employer/employee cost sharing due to higher premiums.

2. **The State should consider creative options for smaller employers that increase the number of covered lives.** One such option could be a State-regulated, flexible plan design product that mirrors benefit design options currently available to larger employer groups under federal law (ERISA). Such a law would encourage and empower health insurance carriers to develop affordable product designs that could be attractive to smaller employers.

3. **Impose a moratorium on legislative proposals, including mandates, which would increase health insurance premiums and/or the costs associated with wellness initiatives** (i.e. extension of the 7% sales tax on <u>all</u> health club memberships).

F. **The state should examine all options that impact access to care and the delivery of health services**. CCSNJ supports initiatives to expand the number of Federally Qualified Health Centers (FQHCs). These facilities offer lower cost, more efficient care – primary care, urgent care, and in many cases specialty care – than hospital emergency rooms can provide. Further, these acute care facilities should be eligible for charity care reimbursement from the State.

Federal laws and regulations prohibit hospitals from turning away any patient presenting at the emergency department. Therefore, the Chamber supports educational efforts to change the behavior of the uninsured to rely upon the services of the FQHCs rather than hospital emergency rooms.

Furthermore, the Chamber urges State government to encourage additional health insurance companies to enter the market in New Jersey thus increasing competition.

G. **State government should mirror the private sector in seeking lower cost options to providing health insurance benefits to their employees. The Chamber's Board Council on Responsible Government Spending has recommended that the State make structural reforms to its health care benefits,** including requiring all employees and retirees to contribute to their health insurance premiums, offering a PPO as an option and requiring higher copays and deductibles for doctor visits, hospitalization and prescription drug benefits.

While State employees are now required to contribute 1.5% of their salary toward their health insurance premiums (a step in the right direction), retirees may still qualify for free medical benefits if they enroll in a wellness program. The PPO plan that will be offered has been set in statute, including copays, deductibles, out of pocket maximums, and the services that must be covered by a plan. This will make any future changes to the plan subject to action by the State legislature, therefore, highly politicizing a benefit that should be subject to collective bargaining. Any cost savings realized from the changes made contractually and legislatively should be used to fund programs that offer health insurance to the uninsured.

H. **Utilizing taxpayer dollars to support government programs, such as Family Care, KidCare, and charity care is appropriate**. However, there should be greater accountability to ensure that taxpayer dollars are utilized efficiently and appropriately, and that those eligible for these government funded programs receive the benefit.

In the FY 2008 State budget, expenses for Charity Care total $716 million (with half coming from the State and the other half coming from the federal government).

The Chamber supports initiatives to collect demographic information on the users of charity care and marry it to the claims made in order to assess who the charity care population is and how to better manage it.

The Chamber also supports recent New Jersey initiatives to expand Family Care (which now incorporates Kid Care) and simplify the enrollment process. New Jersey Family Care is a federal and state funded health insurance program created to help New Jersey's uninsured children and certain low income parents and guardians to have affordable health coverage. More needs to be done to identify and reach eligible recipients. The State FY 2007 budget appropriates $190 million of State funds and $261 million of Federal funds for this program.

IV. Conclusion

Intrigued by Massachusetts health care reform law, the Chamber believes New Jersey policymakers should adopt a wait-and-see approach and carefully evaluate the Massachusetts model before considering a similar reform effort in New Jersey. With the implementation of Massachusetts law only in the beginning stages, there is much still to learn from that State's experience.

The differences between New Jersey and Massachusetts are striking and cannot be ignored when reviewing this issue. First and foremost is the wide variation in the number of uninsured. In 2006, Massachusetts had approximately 372,000 uninsured residents compared to New Jersey, which has 1.4 million uninsured residents – nearly four times the number of uninsured in Massachusetts.

While Massachusetts' health care reform legislation has put significant pressure on other states to follow its lead, it is unknown how this "reform effort" will impact accessibility and affordability. The Massachusetts Health Care Reform, which became law on April 12, 2006 attempts to increase the number of insured through a combination of individual and business mandates, as well as through governmental initiatives. Currently, the Massachusetts Division of Health Care Finance and Policy (DHCFP) is holding public hearings on emergency regulations pertaining to several key components of the law. Therefore, it will be difficult to draw any conclusions about the Massachusetts plan until it is fully implemented.

In addition to Massachusetts, Vermont passed a law in 2006 to achieve universal coverage which includes access to lower cost insurance and relies on voluntary participation. Both Illinois and Pennsylvania have created programs to increase the number of insured children, while states such as Oklahoma and Rhode Island have adopted new laws and programs to assist small employers in obtaining affordable health insurance for their employees. A number of states that have not yet enacted reform legislation have created commissions to evaluate this problem and seek viable solutions.

Given the magnitude of this issue, the Chamber of Commerce Southern New Jersey believes that the State should not rush forward with untested models. As Garden State policy leaders consider health care reform for New Jersey, we believe the process should be inclusive, bringing all stakeholders to the table. Employers have much experience in the employee benefits business, and, as was the case in Massachusetts, they must be included in the reform process. This collaborative process must balance the responsibility of employers, government and individuals to solving the issues involved with achieving insuring the uninsured.

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