Testimony before the House Committee on Health Care
HB 3163
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I am Lynn-Marie Crider, Bargaining Coordinator for SEIU Local 49, a union representing about 10,000 private sector workers in healthcare, property services, and other private sector industries.

The bill is flawed and needs work, so the purpose of this testimony is to outline the bill we'd support. It would ask hospitals and other healthcare facilities that provide services to Oregon Medicaid enrollees to provide affordable healthcare for their employees using a plan design that provides the kind of coordinated care that this state is developing for residents enrolled in Medicaid and other programs. If they don't, they could not participate in the Medicaid program.

The ACA is expected to increase the numbers of non-elderly Oregonians with insurance coverage by 190,000 from 2013 to 2014.[1] When people have insurance, they use more services and providers are paid more for them. So, healthcare employers will benefit from billions of dollars in new federal, state, employer, and individual spending.[2]

Put another way, the ACA will translate into an improved financial picture for Oregon healthcare facilities. As beneficiaries of expanded coverage, these employers should be held to a higher standard than other employers: They should provide coverage for their employees and their families with affordable premiums and a benefit structure that encourages timely access to care.

The disconnect between federal and state reform policy and healthcare employer plans

Unfortunately, right now there is a disconnect between what the Affordable Care Act is doing to make healthcare more affordable and accessible for families who qualify for Medicaid because they are very low income or can purchase subsidized coverage through the Exchange because they cannot enroll in healthcare coverage through their work and what healthcare employers are doing in the plans they offer their employees.

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[1] The total with coverage is expected to grow from 2.7 million in 2013 to 2.89 million in 2014. http://www.oregon.gov/oha/docs/affordable-care-act.pdf
[2] The Urban Institute estimates that under the ACA, the federal government will spend $1.1 billion more a year for Medicaid coverage and Exchange subsidies than in the past. www.**urban**.org/.../412310-Health-Reform-Across-the-**States**.pdf

The same healthcare facilities that will reap the benefit of massive new investment in healthcare are shifting more and more of the cost of providing healthcare for their employees to employees themselves—even though many of those workers are very low-paid. They are doing this in two ways: First, by requiring workers to pay ever-higher shares of the premium for coverage. And second, by pushing workers into high deductible plans with large and unpredictable co-pays for primary care services that mean workers cannot afford to go seek healthcare even though they work for a healthcare organization and have health insurance. Employers say they are shifting cost to workers so that workers will not over-utilize healthcare. But shifts in costs are driven by short-term bottom-line thinking, not by a careful analysis of the drivers of healthcare cost.

The ACA scheme for affordable coverage

The ACA expects all citizens under Medicare age to get coverage through a greatly expanded Medicaid program (available to the lowest individuals with family incomes up to 138% of federal poverty); through employer-sponsored plans for employees and their families; or through the Exchanges, which, thanks to federal subsidies, will provide reduced price coverage with lower-than-typical cost-sharing on a sliding fee scale based on family income.

To keep the total cost of the coverage program down, however, Congress designed the Exchange subsidy program to exclude individuals if their employer or a family member's employer offers coverage—even if the premiums and cost-sharing far exceed the levels permitted in the Exchange. Indeed, so long as the premium charged by an employer for a worker's own coverage is affordable, the worker's spouse and children have no access to subsidized coverage in the Exchange.

Employer plans often do not meet a reasonable test for affordability and access

The employer-sponsored plans that Congress is relying on as one of the three-prongs of its "everyone-gets-coverage" strategy are often not affordable for workers and their families. Many employers, even healthcare employers, pay a healthy share of the premium for their own workers but little or nothing toward coverage for their spouses and children. Moreover, too often plans are designed with such high deductibles and cost-sharing that workers forgo seeing their physicians to get basic primary care to control chronic conditions and prevent emergence of new problems.

At the same time the federal government is making individual plans more affordable for low and moderate income Americans, plans offered by many healthcare employers in Oregon have become less and less affordable.

For example, McKenzie Willamette Hospital – a for-profit hospital that earned an operating profit of 18.7% in 2011 (the last year for which we have data) – has proposed to increase premiums for workers in each of the last two years. At the same time it was increasing premiums, the hospital also proposed to increase deductibles and copays. Our union successfully resisted the increases but non-union workers and other employees are paying the increased costs.

St. Charles Medical Center in Bend, which is operated by a health system with a monopoly position in Central Oregon, plans to increase both premiums and cost-sharing for their PPO plans in 2014. The employer is steering employees toward a plan with deductibles of $1,300 for an individual ($2,600 for a family) and very high out-of-pocket maximums. Employees will no longer pay flat dollar office visit copays; instead they will pay 20% of a preferred provider's charge. The worker can't know what it will cost to go to her doctor. To avoid charges that may be very costly, workers expect to avoid seeking care except in emergencies. This plan structure is not only unaffordable for low-wage workers, it will actually discourage workers from getting the care they need to control chronic conditions that too often flare-up and cause emergency department visits and inpatient stays. In other words, the plan design interferes with timely access to care that will prevent costly hospital admissions.

PeaceHealth, the system that owns Sacred Heart in Eugene-Springfield, has implemented similar plans for many of its employees in Oregon and Washington. Like St. Charles, they are pushing employees into high deductible plans and replacing predictable flat dollar office visit co-pays with co-insurance.

Samaritan Health System, which owns the hospitals in Lebanon, Albany, Corvallis, and Newport, is moving the same direction. Indeed, the employer is steering employees toward a plan that charges workers no premiums for individual coverage but charges over $200 per month for family coverage, has a deductible of $7,500, caps medical costs at $10,500, and has no cap on prescription drugs costs. To avoid the huge deductible, a worker must pay over $300 per month for family coverage in a PPO plan.

Let's look at how that plays out for an entry level Samaritan worker with a family.

An entry level CNA at Good Samaritan Regional Medical Center works a 36-hour week and grosses less than $2,000/month. If she's married with two kids and her husband

has a $2,000/month job that doesn't offer a health benefit, their family income will be too high for Medicaid (even after the 2014 expansion). Her husband and kids won't get federal assistance to purchase through the Exchange because they can buy the Samaritan coverage. The kids might enroll in a subsidized plan under Healthy Kids program. But more than likely, the CNA will pay 15% of her gross income for family coverage under the PPO plan. If she chooses to save on premiums, she can pay 10% of her gross for the high deductible plan knowing that she will have to pay an additional 30% of her income for medical expenses before she satisfies her deductible and her insurance starts paying. With this kind of exposure for out-of-pocket costs, do you think she and her family will actually see her physician when she needs to? Or will they wait until the uncontrolled diabetes flares and they land in the hospital?

Oregon should ask healthcare facilities to lead the way in providing affordable, quality healthcare for those covered under employer-sponsored plans

There is a disconnect between the continuing profitably of healthcare facilities in this state which stand to benefit from increased societal investment in insurance coverage and the squeeze they are putting on their own employees. And there is a disconnect between the lip service they give to preventive and primary care and high deductible plan designs that discourage utilization of needed (as well as unneeded) services.

Oregon needs to ask facilities that participate in healthcare transformation in this state by contracting with CCOs or as direct Medicaid providers to provide affordable coverage to their workers under plan designs consistent with the transformation model of care delivery.

We plan to work to develop clear affordability criteria and bring you a workable bill.