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- **SENATOR TOM HARKIN (D-IA) AND REPRESENTATIVE ROSA DELAURO (D-CT) RE-INTRODUCE PAID SICK LEAVE BILL**

Recently, Senator Tom Harkin (D-IA) and Representative Rosa DeLauro (D-CT) re-introduced a bill that would mandate that employers with more than 15 employees provide a minimum of 7 paid sick days upon oral or written request.

The bill would:

- Require employers to provide employees with one hour of paid sick time for every 30 hours worked, up to a maximum of 56 hours (7 days). Employees could carry over unused sick time, but it could not exceed 56 hours.
- Allow employees to use paid sick time for physical or mental illnesses, injuries, medical conditions, obtaining medical diagnosis or care, preventive medical care, caring for children, parents, spouses, individuals related by blood or whose close association is the equivalent of family relationships or for issues stemming from domestic violence, sexual assault or stalking.
- Exempt employers with existing paid leave policies that employees could use for the same conditions under the bill.
- Not require employers to pay employees for unused paid sick time if employers terminate them or employees resign, retire or leave for other reasons.
- Allow employees to begin to accrue leave when they are hired and to use it after 60 days. Employers could also lend paid sick time to employees in advance.
- Allow employees rehired by the same employer to keep their previous unused paid sick time.
- Prohibit employers from requiring employees to find replacements for the time

period they would use paid sick time.

- Require employees to schedule paid sick time so that it would not “unduly disrupt” employers’ operations. If the paid sick time is “foreseeable”, employees would have to provide the request 7 days in advance.
- Allow employers to request certification by health care providers or a wide variety of people including family members, psychologists, etc. based on the purpose of the paid sick time uses mentioned above for leave of 3 days or more. Employees would have to provide certification within a “timely” manner (30 days from the first day of leave). The bill would allow employees to use a wide variety of documents for certification of domestic violence, sexual assault or stalking (court order, police report, note from clergy members, attorneys, medical professionals, volunteers at victim services organizations, counselors, etc.).
- Require employers to store employees’ health information as confidential medical records in separate forms and files away from personnel information. Employers could only release these confidential medical records to their employees or with their employees’ permission.
- Not preempt state laws or collecting bargaining agreements (CBAs) that require greater paid sick leave benefits. However, it would preempt CBAs with lesser paid sick leave benefits. Existing CBAs would have to comply at the end of current CBAs or 18 months after federal regulations come out.

IMPACT ON EMPLOYERS AND EMPLOYEES: Many employers voluntarily offer paid sick leave, including for illness. Mandating paid sick leave would limit employers’ flexibility in leave provisions and raise labor costs. Employees currently without paid sick leave would obtain it, but could face lower wages or scaled back benefits to pay for mandated paid sick leave. We need to study the requirements of the Harkin-Delauro paid sick leave bill in detail, but they would add substantially to costs and reduce employers’ flexibility in managing absences to encourage speedy, appropriate return to work.

OUTLOOK: *Congress is unlikely to pass a paid sick leave bill this year.*

BACKGROUND: In 2009, the late Senator Edward Kennedy (D-MA) attempted to pass similar legislation that would have mandated that employers with at least 15 employees who work at-least 30 hours per week provide at least 7 days of “paid sick leave” a year and a pro-rated amount of paid sick leave to employees who work at least 20 hours per week.

Recently, over 18 states and cities considered bills to mandate paid leave, and there are at least 3 bills in the House to mandate paid sick leave or paid family leave. On March 31, 2010, President Obama hosted a White House Forum on Workplace Flexibility to promote the benefits of state and federal legislation on paid sick leave and both his FY 2011 and FY 2012 budgets would have provided \$23 million in State Paid Leave Fund from the Department of Labor in competitive grants to help States cover their start-up costs that choose to launch paid-leave programs.

Currently, the Family and Medical Leave Act (FMLA) requires employers with at least 50 employees to permit employees to take up to 12 weeks of unpaid leave annually for the birth or adoption of a child, the care of a spouse, child, or parent with a serious health condition, and for the employee's own serious health condition. California became the first state to provide paid leave for FMLA in 2004. San Francisco, CA; Washington State (implemented in October 2012); Washington, D.C.; and Milwaukee, WI enacted similar laws in 2006 and 2008. On May 5, 2012 Wisconsin Governor Scott Walker (R) signed a law repealing Milwaukee's 2008 paid sick leave ordinance which also bars other municipalities from enacting family and medical leave rules that differ from state-wide paid sick leave standards.

A study by George Mason University analyzing an earlier version of the Harkin-Delauro paid sick leave bill found it would directly increase employers' payroll costs by up to \$35.3 billion per year, while only saving them and their employees between \$1.6 billion and \$6.6 billion per year in lower labor turnover costs and other savings.

Link to the study:

<http://www.consad.com/content/reports/Potential%20Economic%20Impact%20of%20HF%20A.pdf>

NATIONAL BUSINESS GROUP ON HEALTH VIEW AND ACTION ON THESE ISSUES: The Business Group believes that mandating paid sick leave is unnecessary and may adversely impact employment if it adds to labor costs. Many Business Group members voluntarily offer generous sick leave benefits—paid and unpaid. A mandate would limit employers' flexibility in designing benefit packages that meet the needs of their unique workforces within the constraints of their labor market, increasing costs for employers. Some employers could scale back existing benefits for current employees in order to comply with any new paid sick leave mandate for employees.

Link to the Business Group's Position Statement on mandated paid sick leave:

<http://www.businessgrouphealth.org/pdfs/National%20Business%20Group%20on%20Health%20Position%20Statement%20on%20Mandated%20Paid%20Sick%20Leave.pdf>

➤ **SENATOR JON KYL'S (R-AZ) BILL WOULD REPEAL HEALTH CARE LAW'S EMPLOYER MANDATE**

This week, Senator Jon Kyl (R-AZ) introduced a bill that would repeal a number of provisions in the health care law affecting employers; allow current high-deductible health plans (HDHP) offered with health savings accounts (HSAs) to qualify as exchange plans; and permit current grandfathered plans to maintain their status regardless of any future plan changes (contribution rates, cost sharing or covered benefits).

The bill would repeal the following general provisions in the health care law impacting employers:

- The employer mandate (free rider assessment) or "shared responsibility" provision that requires employers to pay a penalty if coverage is not comprehensive (they contribute at least 60%) or affordable (costs exceed

employees' household incomes by 9.5%) and employees qualify for federal tax credits for exchange coverage (below 400% of federal poverty), beginning in 2014;

- The requirement to have a prescription to purchase over-the-counter (OTC) drugs (except for insulin) with health accounts, beginning in 2011; and
- The requirement capping the annual maximum election for Flexible Spending Accounts (FSAs) at \$2,500 (adjusted for inflation), beginning in 2013.

IMPACT ON EMPLOYERS AND EMPLOYEES: Repealing the employer mandate would encourage some employers to continue offering coverage instead of considering paying penalties; keep other employers from considering adjusting their workforces by eliminating jobs, moving more jobs offshore, keeping unfilled positions open, or reducing wages or other benefits; and other employers from raising consumer prices to comply with the mandate.

Removing the requirement for people with health accounts to get a prescription before purchasing OTC drugs would remove a burden purchasing OTC drugs with these accounts and lower their health care costs. Similarly, removing the FSA cap and the prescription requirement for health account OTC drug purchases would allow more employers to offer health accounts to their employees and lower employees' out-of-pocket costs.

OUTLOOK: *Senator Kyl's bill will not pass the Senate, but Congress may include some changes to the health care law in upcoming negotiations to raise the U.S. debt limit.*

BACKGROUND: The U.S. Chamber of Commerce and the National Federation for Independent Business (NFIB) both support Senator Kyl's bill.

Beginning January 1, 2011, under the Affordable Care Act, people can no longer use FSAs, Health Reimbursement Arrangements (HRAs) or HSAs to pay for OTC medications, unless prescribed by physicians. Beginning, on January 1, 2013, the Affordable Care Act limits the annual maximum employee elections for FSAs to \$2,500 (adjusted for inflation beginning in 2014).

NATIONAL BUSINESS GROUP ON HEALTH VIEW AND ACTION ON THIS ISSUE: The Business Group opposes mandating that employers offer coverage or requiring them to pay the government because it is very harmful to working families and our economy. Given the health care law, the Business Group is working with regulators to assure that implementation goes as smoothly and with as minimal a burden as possible for employers.

The Business Group supports eliminating the barriers to using health accounts to offer affordable, effective benefits that help to lower employees' out-of-pocket health care costs.

The Business Group previously supported legislation from Senator Kay Bailey Hutchison (R-TX) to remove the health care law's FSA cap and prescription requirement for OTC drugs: We also plan on supporting a similar bill, recently introduced by Ranking Finance

Committee member Senator Orrin Hatch (R-UT), that would also repeal these requirements and implement other measures to expand the use of health accounts including allowing a roll over of \$500 in unused FSA account funds.

Link to our previous support letter:

<http://www.businessgrouphealth.org/pdfs/021611%20Support%20Letter%20to%20Senator%20Hutchison%20and%20Rep%20Paulsen.pdf>

➤ **REPUBLICAN SENATORS ASK HHS TO REWRITE ACCOUNTABLE CARE ORGANIZATION RULE**

This week, Senator Tom Coburn (OK), along with six Republicans, in a [letter](#) to Health and Human Services (HHS) Secretary Kathleen Sebelius and Centers for Medicare and Medicaid Services (CMS) Administrator Don Berwick, asked them to withdraw the proposed Accountable Care Organization (ACO) rule and write a new version that addresses concerns raised by providers—mainly that the current proposal includes too much financial risk.

Senator Coburn’s letter cites several concerns from a variety of provider groups to the CMS’ initial proposed ACO rule.

The [American Medical Group Association](#) also sent a letter to CMS criticizing the proposed rule as operationally burdensome for providers, stating that 95% of their members would not enroll as ACOs under the current regulatory framework.

IMPACT ON EMPLOYERS AND EMPLOYEES: While employers and employees stand to benefit if the ACOs succeed in redesigning the health care delivery system to coordinate care and lower costs, they could face increased prices if the ACOs exert undue market leverage and shift costs to patients and private payers. If ACOs do not truly reorient care or integrate delivery, employees and their families may not see any improvement in quality of care.

OUTLOOK: *CMS will likely ease some of the ACO requirements and deadlines to accommodate providers in the final ACO rule and may create additional, separate shared savings pilot programs through its innovation center.*

BACKGROUND: The Affordable Care Act creates ACOs, entities where networks of doctors and hospitals, emphasizing primary care, take responsibility for coordinating the care of a minimum of 5,000 Medicare beneficiaries for at least 3 years and offer bonuses or “shared savings” when providers keep costs down and meet specific quality benchmarks.

On May 17, the Center for Medicare and Medicaid Innovation (CMMI) announced a separate pioneer ACO model, an advanced ACO track for providers already experienced in coordinating care across patient settings, that will allow up to 30 advanced ACO models that care for a minimum of 15,000 Medicare beneficiaries to have both higher levels of shared savings (70% vs. 60%) and risk (15% vs. 7.5% in losses) in the first 2 years and transition to a population based payment or a per-beneficiary per month payment, in place of Medicare’s traditional fee-for-service (FFS) payments in year 3.

NATIONAL BUSINESS GROUP ON HEALTH VIEW AND ACTION ON THESE ISSUES: The Business Group believes that if CMS implements ACOs correctly they have the potential to truly reform health care by incentivizing and rewarding networks of providers (hospitals, primary care physicians, specialists and potentially other health care professionals) who succeed in coordinating patients' care, controlling costs and improving quality and move towards an effective and efficient health care delivery system. However, they could also be a wasted opportunity if they merely repackage or re-label existing provider arrangements and ways of delivering care and pose risks if they exert undue market leverage to increase prices or shift costs to patients and private payers.

The Business Group plans on submitting comments/recommendations to CMS on if the proposed ACO rule's quality measures and eligibility criteria for shared savings truly integrate, organize and coordinate care delivery rather than repackage the existing ineffective and inefficient delivery models. We will also recommend that ACOs monitor and address any potential cost-shifting to private payers. We also plan on submitting separate comments on the Department of Justice/Federal Trade Commission's (FTC) joint statement on enforcing ACO anti-trust issues.

Link to the Business Group's Position Statement on ACOs:

http://www.businessgrouphealth.org/pdfs/Position%20Statement%20-%20National%20Business%20Group%20on%20Health%20Position%20Statement%20Accountable%20Care%20Organizations%20_ACOs_%20Final%20Draft.pdf

➤ **SENATE REJECTS HOUSE-PASSED REPUBLICAN VOUCHER PLAN, CONGRESS CONTINUES FEDERAL DEBT NEGOTIATIONS WITH THE WHITE HOUSE**

This week, the Senate rejected Representative Paul Ryan's (R-WI) House-passed budget bill that would cut about \$4 trillion in federal spending over 10 years and convert Medicare into a health insurance subsidy program (\$8,000 for individuals; \$11,000 for families) with a choice of plans for people who are currently 55 or younger, beginning in 2022.

Senate Democrats did not introduce any alternatives, but argued that the bill would cut Medicare funding and require seniors to pay more, citing a recent Congressional Budget Office [report](#). Senate Republicans countered that Medicare must reduce costs or go bankrupt in 2024, citing a Medicare trustees' [report](#).

The Senate also rejected other bills that would have:

- Cut approximately \$2 trillion over 10 years and repealed the tax cuts for people who earn at least \$250,000/year; and
- Repealed the so-called free rider assessment in the new health care law and implemented comprehensive medical liability reform.

The stalemate continues over what to do about the federal debt, government spending, and entitlement programs.

Next week, in a symbolic vote, the House is likely to reject a bill that would raise the debt ceiling by the \$2.4 trillion requested by the President because it does not include any spending cuts.

Vice President Joe Biden leads bipartisan talks between House and Senate members to reduce spending by \$1-\$4 trillion, potentially including “triggers” that would force automatic deficit reductions, and increase the current \$14.3 trillion debt ceiling. Vice-President Biden and House Majority Leader Eric Cantor (R-VA) remain at odds over including tax increases as a part of any potential deal. However, they have reportedly agreed to approximately \$150 billion in additional budget cuts over 10 years, likely through Medicare and Medicaid payments to hospitals, skilled nursing facilities and home health care agencies.

Another group, including Senators Richard Durbin (D-IL), Kent Conrad (D-ND), Mark Warner (D-VA), Mike Crapo (R-ID) and Saxby Chambliss (R-GA) working on a deficit reduction plan, faced a major setback last week when one of its members, Senator Tom Coburn (R-Ok), left because the group could not agree on immediate cuts to Medicare.

Anticipating future cuts in Medicare hospital payments, the American Hospital Association recently suggested that Congress consider alternatives to increase revenues and reduce the federal deficit including enacting medical liability reform, taxing junk food, increasing cost sharing under Medicare, taxing employer-provided coverage and increasing the eligibility age for Medicare.

IMPACT ON EMPLOYERS AND EMPLOYEES: Congress and the President need to come to an agreement to reform our nation’s expensive entitlement programs (Medicare and Social Security) and the state-federal Medicaid program to save the federal government from fiscal ruin and our economy too, before the Medicaid expansion begins in 2014, and both Medicare and Social Security run out of money, respectively, beginning in [2020](#) and 2036.

Hospitals may respond to cuts in Medicare payments by raising rates for employers and other private payers.

Taxing employers’ contributions toward employees’ health care benefits would reduce employees’ incomes overall; would have a disproportionate impact on older workers, employees covered by small employers and employees residing in states with comparatively high health costs or less efficient health care systems and would likely reduce or eliminate benefits, and some employers may discontinue their coverage.

OUTLOOK: *The rejection of the House-budget plan in the Senate increases the pressure on the Vice President and members of Congress to reach a deal to cut federal spending in order to increase the debt ceiling. Hospitals, skilled nursing facilities and home health care agencies will likely face additional cuts in the final agreement.*

BACKGROUND: This week, voters elected Representative Kathy Hochul (D-NY) over her Republican opponent Jane Corwin in a special election which Democrats attribute to the public’s rebuke of Corwin’s support for Representative Ryan’s Medicare proposal.

The federal government reached the debt ceiling on May 16, 2011 and has taken administrative measures to delay a default until August 2 when the federal government will exhaust its borrowing authority. Defaulting on the U.S. debt would cause interest rates to increase dramatically and damage America's economic recovery.

The current debt owed by the federal government stands at \$13.5 trillion and is rising. The U.S. currently borrows \$125 billion per month to pay for all of commitments, including Medicare. In January, the CBO raised its estimate for the annual deficit (spending more than it takes in on revenues) from \$1.1 trillion to \$1.5 trillion. Spending on the government's major mandatory health care programs—Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), and future health insurance subsidies provided through the insurance exchanges in 2014—along with Social Security will increase from roughly 10% of Gross Domestic Product (GDP) in 2011 to about 16% over the next 25 years. Medicare, Medicaid, and SCHIP together account for 21% of total federal spending.

In April, the President signed legislation that cut \$41 billion across a variety of government programs while funding the federal government for the rest of the congressional fiscal year (September 30, 2011). The President also made a [speech](#) calling for up to \$4 trillion in savings over 12 years, but did not release many details.

In December 2010, the bipartisan Fiscal Commission Co-Chairs released [recommendations](#) to balance the federal budget in November that included a number of items to shore up Social Security and Medicare, including taxing (fully or partially) employer-sponsored coverage.

NATIONAL BUSINESS GROUP ON HEALTH VIEW AND ACTION ON THESE ISSUES: The Business Group believes that we need a long term solution to the country's unsustainable entitlement spending. We need to put our government's fiscal house in order and invest in high value services and programs in order to strengthen our economy.

The Business Group opposes hospitals' shifting costs onto employers and private payers to make up for any shortfall caused by additional federal payment cuts to the hospitals.

The Business Group believes that maintaining the current tax treatment of employer-sponsored health coverage is essential to the ability of employers to continue offering affordable health coverage to employees.

If you would like more details on these or other issues or would like a phone briefing on legislation, or want to express concerns about specific issues, please contact Steven Wojcik, Vice President, Public Policy at wojcik@businessgrouphealth.org or 202-558-3012. **Also, as part of our "Ask a Benefits Question" service, we are happy to respond within 24 hours to any health benefits question on policy, regulations or legislation.**

This material is provided for information purposes only and is not a substitute for legal advice.

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