



## Employers Association of New Jersey

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### **Statement to the N.J. Senate Committees on Commerce and Health**

My name is John Sarno, president of the Employers Association of New Jersey (EANJ), a nonprofit trade association comprised of New Jersey employers. I have been asked to share my views with the Committee on the implementation of the Affordable Care Act, specifically on an insurance exchange, and I am happy to do so.

EANJ does not engage in lobbying. Since 1916, it has provided advice, counsel and training to employers on labor, employment and health care issues. I am a labor lawyer by background and also teach labor and health care law at Fairleigh Dickinson University.

We continue to make an extensive study of the Affordable Care Act and to translate the law to employers in practical ways. New Jersey's economy continues to feel the sharp aftermath of the two year-plus recession and even though the economic decline may be statistically over, the state's employers are still wary about hiring. And while February's small employer hiring numbers are cause for tempered optimism, one of the biggest concerns for small employers is the escalating costs of health care.

From March through October 2010, EANJ convened ten groups of employers in five regions of the state. 458 private sector employers that employ 41,200 employees in New Jersey attended, about a third of the EANJ's membership. The meetings resulted in a real time cross section of the state's employers.

Among the top concerns expressed by these employers were increased health care costs (78%); maintaining the productivity of the existing workforce (62%); the mismatch of skills of current and future workers (39%); and finding the money to make capital investments (32%). Most employers are continuing the cost cutting measures that got them through the recession. Many jobs remain vacant, although as noted there appears to have been some rehiring in February. However, Increasing health care premiums have eaten into whatever wage savings employers have been able to muster.

Increasing health care costs have also eaten into paychecks. Employers passed health-insurance costs onto employees at a sharply higher rate in 2010, reflecting an acceleration of a trend that has been on the rise for years. As firms struggle to remain competitive, more of them are reducing benefits they offer workers or making workers pay more for them.

The cost of health care premiums in New Jersey have already rose nearly five times faster than wages since 1998, according to Families USA, a Washington-based nonprofit group. Their report issued in 2008, found premiums in New Jersey rose 71 percent while earnings increased just 15 percent between 2000 and 2007. New Jersey is ranked 28th among states in the rate of growth in premiums compared with earnings.

The number of individuals insured by small employer plans peaked in 1999 at 937,784 but has since declined to about 800,000. Layoffs are the major cause of this decline, but regardless of how business friendly New Jersey becomes, fewer employers are going to provide workers with health care coverage under the strain of increasing premiums.

In fact, during EANJ's meetings, slightly more than one in ten employers stated that they will consider discontinuing coverage this year because of costs.

Recently, President Obama acknowledged during a meeting with state governors at the White House that states might need more flexibility in implementing the Affordable Care Act. He highlighted a part of the law that would allow states to tailor their own solutions to healthcare reform in 2017 if they fulfilled the same goals as the federal law. He supported a measure put forward in Congress to move that date up to 2014.

"If your state can create a plan that covers as many people as affordably and comprehensively as the Affordable Care Act does - without increasing the deficit - you can implement that plan," Obama told the governors. "And we'll work with you to do it," he added.

States are charged with carrying out many of the reforms, including establishing exchanges where individuals and small employers can buy health insurance in 2014.

To date, New Jersey has accepted all of the federal money that has been offered to implement the law.

For example, New Jersey received federal money to set up a reinsurance program that covers individuals who are not eligible for Medicare but who cannot otherwise get insurance. The program has been reimbursed over \$30 million by the federal government the first year.

New Jersey has also accepted funds to plan for the creation of an exchange, which under federal law must be a self-sustaining enterprise.

The Affordable Care Act enables a state insurance exchange can accomplish at least four important goals:

**1. Offering consumers a choice of health plans and focusing competition on price.** Exchanges offer enrollees a choice of private health insurance plans. Covered services and cost sharing (i.e., deductibles, coinsurance or copayments, and out-of-pocket limits) would be organized or standardized in ways that make comparisons across plans easier for consumers. The aim is to focus competition among plans on the price of coverage and minimize the tendency for plans to vary benefits in order to attract healthier than average enrollees.

**2. Providing information to consumers.** In conjunction with offering a choice of plans, an exchange is intended to provide consumers with transparent information about plan provisions such as premium costs and covered benefits, as well as a plan's performance in encouraging wellness, managing chronic illnesses, and improving consumer satisfaction. The exchange could also serve a customer assistance function—typical for large employers—to assist consumers who encounter billing or access problems with their plans.

**3. Creating an administrative mechanism for enrollment.** For people who obtain private insurance coverage through work, the employer typically facilitates enrollment in a plan and the payment of the premium. This is especially true in larger businesses. An exchange could serve a similar function for people without access to that kind of assistance, including people buying insurance on their own or who work for small businesses. The exchange could also be used to determine eligibility for and administer income-related subsidies.

**4. Moving towards portability of coverage.** Coverage through an exchange can be de-linked from employment, helping to make health insurance more portable for people moving from job to job. Exchanges also could coordinate enrollment shifts between Medicaid and subsidized private coverage for people with very low and potentially changing incomes.

Another function of an exchange could also be to facilitate changes in the rules governing how insurers sell coverage. Although these types of changes can be implemented simply by changing insurance laws and do not necessarily require the creation of exchanges, some argue that exchanges can make these insurance market reforms more effective by monitoring marketing practices and administering a uniform system for enrolling in a health insurance plan.

In important ways, New Jersey already has a small employer health benefits law that tracks the federal law. Like the Affordable Care Act, state law requires guaranteed issued policies

regardless of pre-existing conditions. Basic coverage must be provided on a modified community rated basis, meaning that everyone within a band can purchase insurance for the same price regardless of medical condition. In return, the law requires employers to cover 75% of all eligible employees and carriers must meet medical loss ratios. To increase rates, an insurance carrier must submit a certified actuarial report but premium increases are automatic if the basic criteria are met.

Assuming that New Jersey will have flexibility in implementing the Affordable Care Act, what would a reformed small employer market look like? A key feature would be the insurance exchange or some other pooling arrangement, the success of which would be dependent upon insuring as many people as possible to leverage purchasing power. Private carriers will sell within the exchange. People who cannot afford to buy insurance will receive a subsidy. Employers who do not offer insurance to their employees will contribute to the subsidy either directly or indirectly, with exemptions for small business.

New Jersey employers have stated that the primary reason for offering coverage is to attract and retain qualified workers. *Rutgers Center for State Health Policy (2004)*. Most employers that do not offer health insurance indicate that the cost is too high. *Id.* Research indicates that even a 30% reduction in premiums would cause only about 15% of currently uninsured small employers to offer coverage. *See The Commonwealth Fund, Task Force for the Future of Health Insurance (2002)*.

The mechanics of the exchange are not controversial and since New Jersey already has in place a regulatory infrastructure, the physical creation of the exchange can be accomplished efficiently. But as noted, the success of the exchange depends on enrolling sufficient critical mass. The Affordable Care Act relies, in part, on the personal mandate to accomplish this end. Massachusetts has also enacted a personal mandate so we may look to that state for an example of the perils of implementing health care reform.

Massachusetts enacted its reform in 2006. Its insurance regulations were similar to New Jersey's and the 2006 law was, in many ways, the model for the Affordable Care Act, including the personal mandate to purchase insurance and the creation of an insurance exchange. Coverage increased from about 88% to 96% the first year but the cost of insurance still increased, more so for small employers. When insurance companies announced premium increases in 2010 up to 30%, Governor Deval Patrick authorized a price-fixing inquiry.

Carriers in Massachusetts argued that hospitals and big medical practices held too much bargaining power and therefore they had no choice but to pay them monopoly rates for medical care. The premium increases were necessary to stay in business, they said. In January, 2011, the Patrick administration introduced a bill to create an 18-member board to regulate how much providers should be paid for what service. Some have called this an attempt to impose price controls, a regulatory strategy to mitigate price inflation.

The Massachusetts health care law, like the Affordable Care Act relies on tax breaks, subsidies, penalties, the personal mandate and the insurance exchange to expand care and create consumer purchasing power. Two federal courts have found the Affordable Care Act unconstitutional, although three courts have upheld the law. But whether the Supreme Court of the United States upholds or invalidates the law, New Jersey will still have a health insurance system that is unsustainable over the long haul.

The Affordable Care Act has many complex moving parts, each dependent on the other. Should the personal mandate be invalidated, the challenge for New Jersey will be deciding how to develop the critical mass of employers for a viable insurance exchange. If the mandate is upheld, the Act's incentives will encourage smaller employers to discontinue insurance coverage for employees.

This is a critical time for New Jersey's economy. Employers are weighing whether to hire next year or buy new equipment, or both. Projected health care increases could be as high as 25% in a run up to the reforms under the Affordable Care Act that become law next year. Without productivity gains, many businesses, particularly smaller business, are highly vulnerable.

The state has about 250,000 small employers (defined as 500 or less employees) and 8 of 10 New Jersey residents work for a small employer. About three of four New Jersey residents are covered under an employer-sponsored health care plan, although only about half by a small employer.

The recession has taken a toll on employer-sponsored health care in the state. In the first quarter of 2010, the small employer group market had about 775,000 covered lives, down 16.5% from 2000, as small employers have dropped coverage.

Other responses from the EANJ focus employer groups were:

- Percentage that will consider changing health care coverage within the next year: 68%
- Percentage that will consider eliminating health care coverage next year: 12%
- Percentage that will consider paying penalty in 2014 rather than offer health care coverage: 48%
- Percentage that will invest in employee wellness in 2014: 22%
- Percentage that think the Affordable Care Act will reduce health care premiums: 8%
- Percentage that think the Affordable Care Act will be amended within the next 2 years: 38%

As noted above, slightly more than one in ten employers state that they will consider discontinuing coverage next year because of costs. Almost half state that they would consider paying the penalty for employers with 50 or more employees that discontinue coverage.

As one participant, a senior manager at an optical instrument manufacturer employing 90 employees put it:

“Pension and health benefits traditionally have been annoying distractions from core business functions and increasingly have become very expensive cost centers. I don’t think that I will lose much sleep about shifting my employee benefits obligations, as long as employees can get decent coverage in the exchange, at reasonable cost and I save money after paying federal penalties.”

The participant above is commenting on a cost-benefit simulation that shows the cost of continuing to pay 80% of health care premiums for employees against discontinuing coverage and paying an annual penalty based on full-time headcount, minus the first 30, when at least one employee receives a subsidy to purchase their own insurance. In the simulation, the employer reaps a substantial savings for discontinuing coverage.

Moreover, standardized coverage will be available on the insurance exchange. Consumer protection requirements and coverage mandates will ensure that employees will be able to receive basic coverage equivalent to most employer-sponsored plans.

On October 21, 2010, Philip Bredesen, the governor of Tennessee published an op-ed in the *Wall Street Journal* entitled “ObamaCare’s Incentive to Drop Insurance” which was discussed by several of the groups. In the piece, the governor concluded that “the economics of dropping coverage is about to become very attractive to many employers” by conducting a simulation substantial similar to the one referenced above. Letters that followed reflected opinions in the offered in the groups.

As noted above, slightly more than half (52%) of employers implicitly stated that they would *not* consider discontinuing coverage in 2014. This comports with a 2010 Towers Watson report that notes that 57% of employers are confident that they will be offering health care benefits five years for now. However, it is clear that employers assume that competitive pressures will result in both voluntary and involuntary terminations of older workers with replacement by younger, cheaper and relatively healthier employees who are expected not to be big consumers of health care in the short term. Should there not be a return to a “normal” replacement rate, as another participant noted, “it’s hard to see how the status quo is sustainable.”

In any event, in 2014 both current and new employees will be subject to the personal mandate. Thus, to the extent that most employers are more or less equal in their ability to hire new talent, the playing field becomes more equal regarding health care. In other words, employer sponsored health care may not be as an important inducement in recruiting and hiring when all

new hires are legally obliged to carry their own insurance. This is particularly true with entry level jobs and certainly the case in a “buyers market.”

Many participants explained that their current health care programs are “legacy costs.” Many began providing health care insurance to remain union free, when insurance was inexpensive and when proprietary knowledge to perform firm-specific jobs required a generous benefits package to recruit and retain employees. Over the last decade, technology has de-skilled some jobs and has diluted the importance of proprietary knowledge for others. Labor unions are no longer a threat for most firms and as noted above, health care costs have skyrocketed.

Policy makers have often opined that employers will continue to offer coverage to compete for talent. However, the transformation of jobs and work over the last two decades, together with immigration and wage patterns, has created a more fungible job market. Thus, some participants reported that they anticipated recruiting and retention costs to be less expensive, which would include less generous benefits packages or, in the case of health care, none at all.

In short, New Jersey must plan for the migration of insured individuals from the small group market to the individual market. Indeed, the insurance may want to encourage this outcome. As employers get out of the health and welfare business they can focus more intensely on their core competencies. Employees can buy their own portable insurance in the exchange. Employers can choose to offset the costs with a free choice voucher or with some other tax exempt plan or employees will receive a subsidy. In either case, portable health care would be de-coupled from employment – a win-win.

Finally, with a critical mass of participants, the exchange must decide whether and how it will use its purchasing power. A large corporation with thousands of employees pays far less in insurance premiums than a small employer. The reason is because of purchasing power. I would suggest that the New Jersey Insurance Exchange have the authority to drive a hard bargain with the insurance carriers for the benefit of participants.

Thank you. I will be happy to take any questions that you might have.