Report of the NYHA Modification Work Group of Labor Activists for NY Health - August, 2021

Introduction

The New York Health Act (NYHA) would create a state-funded universal single payer health care plan providing comprehensive coverage, including long-term care, to the residents and workers of New York State.

Labor Activists for New York Health is a group of union members and retirees working to build support for the NYHA among the state's labor movement. In line with that goal, over the last several months a work group has been discussing ways in which NYHA might be modified to address some of the issues the labor movement has raised with this legislation.

This report grew out of the deliberations of that work group. It discusses eight specific issues and presents some ways in which these issues might be addressed through modifications in the legislation. The ideas presented in this report are not recommendations of the group. Rather, they are suggestions for further exploration and discussion as we seek to build support for NYHA in the labor movement and among the broader public.

We welcome reactions, suggestions, and comments of any kind. Please send responses to laboractivistsfornyhealth@gmail.com.

Thank you in advance for your assistance in making this a more attractive, effective plan for the workers and residents of this state.

The questions discussed in this report are:

1. What will the plan cost workers?
2. Will out-of-state retirees benefit from the plan?
3. Will health care quality be improved?
4. Will there be equalization among hospitals?
5. Will serving as care coordinators provide continuing employment for union employees?
6. How will workers compensation and occupational health be handled under NYHA?
7. What transitional assistance will there be for displaced workers?
8. How will the Board of Trustees of the plan function?

1. How can workers be assured that they will spend less under this plan than at present, since the tax rates aren't specified in the bill?

The tax rates and brackets for the payroll and non-payroll tax are not in the bill but are left for second-stage legislation. Important issues such as these should not be left to be determined after passage of the Act. All kinds of mischief could ensue after passage on this kind of legislation, as it did in Vermont where the governor, previously a single payer supporter, decided that the state couldn't afford the plan that had been passed by the legislature. Depending upon the governor to (1) be supportive, (2) to produce legislation that will contain a truly progressive plan of the fkind we are envisioning, and upon a succeeding legislature to pass this

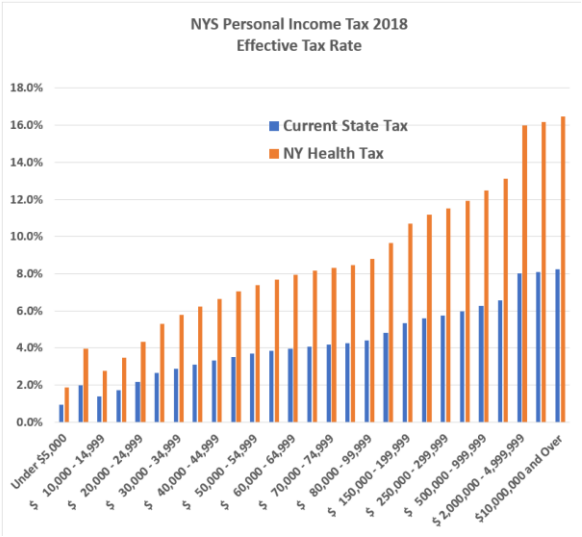
plan in the face of strenuous opposition from those who will lose their jobs, seems pressing hope too far. Further, energizing grassroots support for the bill twice seems an effort that is likely beyond the capability of any movement organization -- and unnecessary if the financing is included in the bill from the start.

So the tax details should be included in the NY Health Act, just as they are, for instance, in the national Medicare legislation. When the New York bill approaches a serious vote, we will be able to get help from the kind of reputable economic analysts who can provide the data necessary to set the rates.

For NYC workers (even non-union), the City Charter requires that the benefits be provided at no cost to the employee. The bill should include the provision that public sector workers will not have to pay a greater percentage of the tax than they are now paying of the premium. Presently, the bill *allows* for individuals to pay less than 20%, and presumably unions can negotiate those lower rates. We suggest that the status quo be preserved, at least for public sector workers where it possible to do it by state legislation, *without* the requirement that they bargain for something that was already achieved.

The use of a payroll tax to fund the plan also has a number of problems, including the familiar one that it will discourage the hiring of additional full-time employees (the kind who will be likely to earn more than $25,000). Further, it is a regressive way to raise revenue in a period when wages, as a percentage of national income, have been declining. More emphasis should be plan on taxing non-wage personal income and business or corporate income. The current tax on a worker's wages also puts a focus on the current insurance premium, a portional of which is frequently deducted from a worker's wages, whereas the deductibles and copays in union plans are often a greater problem, and these aren't as visible.

Alternatives should be considered. For example, one possibility, instead of taxing employees and employers, would be to tax businesses with a 2.4% gross receipts tax and individuals and families with a personal income tax that would be double the personal income tax that New York State now imposes. (The idea of a gross receipts tax is taken from studies conducted by the Political Economy Research Institute UMass/Amherst, led by Robert Pollin). Small businesses having fewer than 10 (or 25) employees could be exempted from the tax, or could pay at a smaller tax rate than larger businesses. Public employers would not pay the tax at all and could be required to give their savings to employees. The following figure shows the effective tax rate for this tax by income.



2. Will out-of-state retirees have benefits under NYHA?

We need a provision which takes care of everyone who retires, under appropriate conditions, whether or not they are union members, public sector workers, or any other type of worker.

Under NYHA as it is currently written, retired New York residents who move out of state, as well as out-of-state residents who retire after working full-time in New York State, would not be covered. Many today receive health benefits from their employer or through a union-negotiated plan, but under NYHA those plans might drop coverage since most of their risk pool would have moved to NYHA.

We recognize that the State could see that whatever health benefit obligations public employers currently provide for out-of-state coverage would continue (§ 5101(c),). However, that would not help employees of private sector employers or others (e.g., stay-at-home spouses) who didn't receive their benefits through employers, so there might be strong objections to such a proposal.

What NYHA does now for those working full-time in New York State is to define them as residents of the State for purposes of coverage under NYHA so that, even if they live out-of-state, they are covered. This approach could be extended to retirees and others so that, for instance, anyone who has lived or worked full-time in New York for ten years would be considered, for purposes of NYHA benefits, to be a resident of the State. This limits the population to be covered so that, for instance, someone who comes to New York for just two or three years and then retires would not be covered. With such a condition, this extension of NYHA should not place an undue financial burden upon the program.

If an out-of-state retiree is covered by the program and has (or wants to have) a NY Health card (which would presumably denote membership in the plan), should that person also be subject to the NY Health tax? Retirees are subject to the tax if they receive non-payroll income (or possibly even payroll income from another job). If the person is eligible for the benefit, shouldn't they also be subject to the tax? If they lived in-state, they would. If they are being treated by NYHA as a "resident", then they should also.

3. Will the quality of care be uniform and improved across the system?

Quality of care will be <u>more</u> uniform under NYHA than it is now, because there will be no uninsured or underinsured NYS residents and because payments to providers by a single payer will tend to be more uniform than it is presently. However, no health care system anywhere has been able to ensure uniformity across different geographies, socio-economic conditions, and racial/ethnic situations. Even countries with long-established universal system have difficulties providing sufficient medical practitioners and facilities in rural and low-income areas, even when there are financial incentives that encourage them to locate in underserved areas. New York will have to continue using such incentives to reduce these inequities, as it and the federal government do now.

4. Will there be the kind of equalization among hospitals that has long been sought by health care activists?

Will hospital care in different neighborhoods become more equal? There is strong evidence that the current quality of service differs widely based not just on income but also on race and ethnicity. In a single-payer system, health care cannot be provided in a discriminatory manner, so how do we transition away from divergent care and ensure that everyone receives the same high quality of care regardless of income, race, gender, or zip code?

The economic analysis of NYHA performed by the RAND Corporation and others assumes that overall levels of spending for hospital and other health care services will change little, except for the removal of excess administrative and billing-related costs. So there need not be any diminution in overall spending, and eventually the spending by different hospitals should tend to become more equal.

However, just as it is currently, hospital funding will be a terrain of political struggle, even after passage of NYHA, though the terrain should be much more favorable to those advocating for equity than is currently the case. The issue will be out in the open, because information on health care finance will be more publicly available and subject to political struggle and popular influence. Thus NYHA advocates can credibly claim that health care will become more equitable under the NYHA, but only active, continuing public pressure will make this happen.

How will we fund hospitals to overcome the persistent disparities? The current system relies on a patchwork of funding from federal, state and city sources that often disproportionately benefit private and more affluent non-private hospitals. Under NYHA, it is unlikely that there will be equal payments, at least initially. What is more likely is that there will be a continuing political struggle to equalize payments -- think of the ten-or-more year continuing struggle over allocation of the Indigent Care Pool -- but with conditions much better than today since all the funds will be coming from a single public source rather than the disparate unequal sources they draw on today.

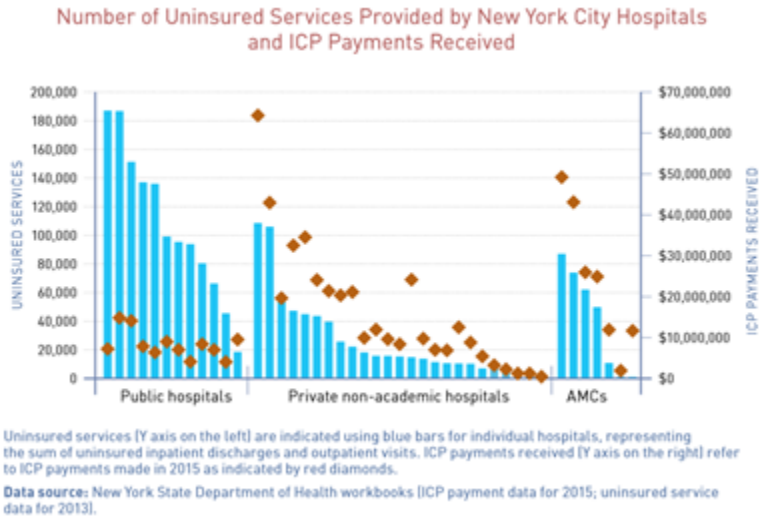
NYHA will provide a supportive environment for efforts to equalize hospital distribution and other sources of health care access across disparate racial, ethnic, and socio-economic areas. It provides criteria for the funding of health care providers designed to ensure that all New Yorkers have access to care: NYHA provision § 5104.4.((a)(ii) states that “All payment methodologies and rates under the program shall be reasonable and reasonably related to the cost of efficiently providing the health care service and assuring an adequate and accessible supply of the health care service.”

However, this will not automatically guarantee that the services will be uniformly accessible and of high quality everywhere. The great inequalities created and perpetuated by a profit-oriented, market-driven system has allowed individual hospitals and hospital systems to negotiate favorable rates with private insurers. Further, the wealthier, better-endowed hospitals have had greater political influence, so that even public Medicaid reimburses these facilities at higher rates than the so-called “safety net” hospitals which serve lower-income communities.

One likely outcome of the passage of NYHA is that, initially, reimbursement rates will approximate the <u>average</u> rates currently received by each hospital, and there may be improved access to capital funds. The public and safety net hospitals will be reimbursed for nearly all their patients, because those who are resident in New York will be covered, but the reimbursement rates for these hospitals may well be lower than those of the more prominent, expensive

hospitals. Over time, there will be public pressure to equalize these rates, but this change will not come easily or automatically.

One illustration of the difficulty of accomplishing this equalization is the way the state-managed Indigent Care Pool has been handled. These funds are intended to reimburse hospitals for care of the uninsured, but for more than a decade advocates have been trying to have these disbursements match the actual expenses that hospitals incur for treating the uninsured. They have continued to fail to achieve this, as shown in the figure below.



The move toward lessened disparities would be facilitated by greater openness on the financing of health care services. NYHA could include provisions requiring that reimbursement rates and expenditure data should be publicly available; this is not generally the case at present. It (or companion legislation) could establish a health care planning and analysis body that would be charged with carrying out analyses of this data. These would also help assure that the large sums of money involved in the health care system are being properly spent in accordance with agreed-upon public priorities.

5. Will serving as care coordinators provide employment for significant number of union staff?

The care coordination provisions of NYHA could provide some funds to unions, but they may not be enough to support existing benefit staffs. Most people will probably choose their primary care provider, or someone associated with them, to provide that coordinating and advisory function. Nevertheless, unions can advocate for workers within the NYHA framework by establishing themselves as care coordinators. The legislative language establishes a continuing role for the care coordinator in facilitating access to care, quite a different role from what union benefit departments currently play. This seems a useful way for unions to continue to play a role in a health plan that will now be run by the state.

It should be helpful for a group of professional experts, including union reps, to examine this and develop a detailed model of how care coordination would work under the NYHA plan. Connecticut replaced its Medicaid managed care program with a direct-payment plan and funded a separate non-profit agency to provide care coordination for those with complex needs. NYHA prescribes a different, universal, individualized model. Other models, such as services provided by many community health centers, could be examined as well.

6. Should workers comp and occupational health regulations be specified in NYHA?

Workers Compensation medical expenses, while only a small fraction of overall health care costs, are among the most contentious and costly issues in the workers comp system. Substantial cost savings could occur through integrating worker's comp medical costs into NYHA. The following recommendations are adapted from proposals developed by the AFL-CIO in the 1980s and introduced during discussion of the Clinton plan in the 1990s. Their length reflects the detailed discussion that went into developing them at that time,

Recommendation #1: Include the medical portion of workers comp in NYHA. Current arrangements involve private workers compensation insurers which cover the medical portion of workers compensation. These should be preempted by NYHA. Integrating workers comp medical into the general health care system should improve the ability of health care providers to recognize and treat occupational disease and injuries and initiate interventions to help prevent such incidents in the future. Maintaining a separate medical delivery system for workers comp will simply encourage medical providers, insurers, employers, claimants, and attorneys to continue behaviors that exacerbate current problems.

Inclusion of workers comp in NYHA should preserve essential philosophical principles of the system which should not be jeopardized. These include:

- The principle of full employer liability for all the costs associated with medical treatment for occupational injuries and illnesses. This includes full medical coverage and wage replacement as established by state or federal law.
- The principle of employee control in the selection of medical providers. The reliance upon medical determinations to resolve disputes over causation and extent of impairment is critical in workers compensation. Disputes in this area are at the root of concern over the issue of choice of physicians.
- The collection of information concerning occupational injuries and illness and the reporting of that data to government agencies responsible for the enforcement of safety and health laws and oversight of workers comp systems. This information is also essential for financial assessments on prospective and retrospective bases, and for estimation of necessary reserves.
- The provision of medical services which may be unique to occupational injuries and illnesses.
- The absence of limitations on appropriate medical treatment. This includes, for example, referral and treatment by specialists, the provision or replacement of prosthetic devices, chiropractic treatment, nursing care, and physical therapy.

Recommendation #2: Employers should pay annually for workers comp medical coverage directly to the Department of Health administering NYHA. Such payments should be community rated and adjusted from time-to-time based upon group experience. All employers should participate, regardless of their current method of insuring workers compensation coverage. Rates should be based on estimates for employers in similarly situated categories to cover costs for medical treatment that cannot be assessed against a specific employer.

- Any services considered to be in addition to or beyond the covered services generally offered under NYHA should be billed to the NYS Workers Compensation Board and, in turn, recovered by the Board from the employer.
- Experience rating shall provide a safety incentive for employers covered by the current New York State Workers Compensation system and can be retained through a retrospective assessment levied on employers based on actual experience.

Recommendation #3: The Workers Comp Board shall assess payments from employers for the medical portion of workers compensation. Payments should be based on "community rating," adjusted by group and individual company experience. The agencies activities should include:

- Collecting information on medical treatments that are work-related. The data will be reported to relevant government agencies responsible for enforcement of safety and health and workers compensation laws.
- Ensuring that the complete range of medical services necessary to treat work-related injuries and illnesses is available.
- Supervising and monitoring such service to ensure the same controls on quality and cost as exist on benefits provided under NYHA.
- Establishing a procedure and process for retrospective experience rating.
- Conducting quality control reviews to ensure that providers are properly treating, categorizing, and reporting occupational injuries and illnesses. Similar reviews shall be instituted to ensure that non-occupational medical treatments are not being designated as work-related.
- Establishing a dispute resolution process to settle disputes over causation and extent of permanent and partial impairment and disputes over appropriate medical treatments.

Recommendation #4: Determinations as to the work-relatedness of the condition being treated should be made at the point of initial care, if possible. Procedures for assigning the determination of work-relatedness at a later point should be established. Quality control measures must be instituted by the agency administering NYHA to engender trust and confidence by workers and employers in determinations of treatments, causality, and extent of impairment.

Recommendation #5: The NYS Workers Compensation Board must institute procedures to ensure that all employers licensed for business within the State carry indemnity insurance for wage loss due to work-related injuries and illness. It will be responsible for all dispute resolutions involving indemnity benefits. Where disputes involve questions of causality or extent of impairment, the decision of the agency administering NYHA shall govern.

Occupational Safety and Health

Federal OSHA law sets national standards for health and safety in private workplaces, and establishes a national inspectorate to monitor workplace compliance with these standards. Upon federal approval, states may establish programs to protect state and local government employees which are "at least as effective" as federal standards. They may also monitor OSHA compliance for private sector employees. New York is one of five states which have mixed

jurisdictions, i.e. a State program for state and local governmental employees alongside federal enforcement for private sector employees. The agency administering health and safety for state and local employees in New York is PESH, the Public Employees Safety and Health Administration.

Most functions of the state and federal OSHA jurisdictions, in particular the workplace inspection and penalty program, will not be affected by passage of the NYHA. However, there are a number of exposure standards which involve medical surveillance and testing. The surveillance and testing required for affected employees does not involve the delivery of health care as it is generally defined – for example, the drawing of blood and/or collection of urine are medical tasks, but are not usually considered health care delivery. Under OSHA and PESH, the employer pays for these costs.

However, some OSHA functions, such as implementation of the lead standard, require annual medical exams and medical removal protection in cases of overexposure. These examinations and medical assessments are mandated by federal OSHA and conducted by physicians of the worker's and employer's choices. Bills for these tasks should ordinarily go to whatever body handles ordinary medical reimbursements. There is one exception: If the physician conducting these activities is an employee of the company or hired under contract by the employer, the employer's medical payment goes directly to the employed physician as salary without outside mediation. Under NYHA, for those services conducted under outside auspices, NYHA should establish a procedure to bill the employer.

7. What transitional help will there be for people working in union benefit and other insurance-related offices?

We need to guarantee that any displaced workers will get jobs in the new system or elsewhere that provide comparable income or, for older workers, some kind of income protection for an extended period ─ not just job training. It will be important to be specific about these jobs and allay the fears of affected workers and their union leaders. There should be a concrete plan for income maintenance and job placement during and after the transition, with unions involved in developing it.

According to Gerald Friedman, there are about 300,000 workers employed in health care administration in New York. Health insurers would employ 26,000 additional workers. He estimates that as many as half of the 300,000 and most of the health insurance workers would be displaced by the New York Health Act – resulting in as many as 150,000 new unemployed workers. This displacement would be balanced, at least in part, by the creation of additional jobs due to the increased demand for health care workers coming with the expansion in coverage and increased utilization of health care. Also, expansion of the economy through the shift to progressive taxation will create demand for new jobs throughout the economy.

Even though monthly turnover of jobs in New York State is comparable with the scale of this displacement, the prospect of a disruption in the labor market of such a magnitude has already led to significant political opposition. This has already been by those within the health care industry who oppose the bill. The opposition will also use the disappointing history of job training programs designed to deal with previous dislocations to criticize this one, unless it becomes more concrete with greater guarantees of continuing income. Unions, in this context, have a responsibility to represent their members' interests and will oppose legislation that results

in hardship or disruption of the lives of their members and their families, as well as their own employees.

These are all formidable concerns. Can we design a program that will overcome them? It is likely to require dedicated State funds (The Jayapal bill provides that 1% of its funds be used to facilitate the transition of displaced workers).

Consequently, a just transition program must provide a robust safety net for all workers, with particular emphasis on workers over the age of 50. (See, If You're Over 50, Chances Are the Decision to Leave a Job Won't be Yours, Dec. 28, 2018)

The elements of a Just Transition program should include, but not be limited to, the following.

1. A wage guarantee for up to 5 years and possibly a pension based on previous salary.

2. Job placement assistance, including training for a different career path, as well as free tuition for a four-year public college education or vocational job training with living expenses.

3. Preferential hiring in the health care field for those whose jobs have been eliminated.

4. Housing assistance if relocation is necessary

5. Incentives for employers to hire transitional employees

These proposals should be included in the draft legislation with the understanding that further discussions with potential dislocated workers, their unions, and community representatives will be held to discuss additional or supplemental benefits.

8. Will the Board of Trustees function effectively to run the plan, or will it just be a tool of the Governor?

The legislation establishes a Board which consists of 31 people, appointed by the governor and leaders of the legislature. It includes some labor representatives, representatives of various types of providers, health finance experts, consumer advocates, etc. Members of the Board, as currently written, will serve without compensation. It may be desirable to compensate them so they can devote more time to the job and take more responsibility for how this complex health care system functions.

The larger question is whether it will really be an independent decisionmaking board or simply a tool of the governor (e.g., will it operate like the MTA?). Because of the importance, to every New Yorker, of the work of this Board, perhaps it should have more independence of the governor and, as a result, be more responsible for the work it is doing to the general public. Members could serve for fixed terms and be removable only for cause, not simply at the discretion of the governor or legislative head. The terms might also be staggered to provide continuity in operation of the overall system.

The question may not be who is on the board, or what powers it will have, but how it will make decisions about how the NY Health plan operates. Clearly, a board made up of 31 people, most of whom have other jobs and are not paid to spend very much time on board activities, is not going to be the body that makes decisions. It might simply ratify decisions presented to it by others. So creating a Board that is structured to be more politically independent, and perhaps with requirements for expanded transparency on the operation of the overall NY Health plan, will ensure that it operates more consistently in the public interest.

It may be desirable to have a small working Board that would have a specified term, with dismissal only for cause and substantial independence from political interference. It would be compensated and would have a professional staff capable of providing it with knowledgeable analytical advice. Perhaps, as one example, it might be a five-person Board with members appointed by the Governor, Majority Leader of the State Senate, Speaker of the Assembly, the Business Council of NYS, and the State AFL-CIO. Other models could be suggested that would ensure a Board that has the capability of overseeing a complex and very important financing system.

One other suggestion for giving a continuing voice to labor would be to create a standing Labor Advisory Board within the Department of Health This would give labor a more prominent, though not decisionmaking, voice in the operation of the NY Health plan.