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Hospital Association

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DISTRICT OF COLUMBIA HOSPITAL ASSOCIATION
POSITION PAPER ON UNIVERSAL PAID LEAVE

ISSUE: Paid Family and Medical Leave

EXECUTIVE SUMMARY: The District of Columbia Hospital Association (DCHA) and its members unequivocally support paid leave. We have long recognized the importance of providing our employees with access to paid leave because this leave allows them to balance their families' needs at home with their life saving work.

DCHA and its members believe that any legislation that expands the availability of paid leave must include the following provisions: 1) Employers should be allowed to control and operate the program and not have it administered by a government agency; 2) Employers should be allowed to apply an employee's leave benefit to assist in meeting the minimum requirement; 3) Any new paid leave program should start at no more than 4 weeks in order for businesses to gain experience with the effects of the program and allow the Council and the Government of the District of Columbia to analyze the impact of the program on employers, employees, and the District's economy; 4) In order to maximize the impact for employees, their wages should be protected up to 100% of their base wage; 5) The definition of "family" should be limited to no more than spouse, domestic partner, child, and parent; 6) Employees should have to work at least 1,250 hours in the preceding 12 months before the qualifying event 7) Any leave program must run concurrently with DCFMLA & FMLA and should not include intermittent leave. 8) The paid leave program must be protected from fraud and abuse.

Based on our analysis, the current 12-week proposal before the Council, could increase costs to hospitals by over **$71 million**. This is compared to an employer based paid leave program that does not exceed 4 weeks, which would cost hospitals approximately **$24 million**. For hospitals, which already contribute more than **$101 million** annually to provide care to those who do not have health insurance or are under insured and offer more than **$219 million** in community benefits, such an increased financial burden will require them to make trade-offs about which programs they will be able to support in the future.

A paid leave program must balance the relationship we have with our employees with the social compact we have with the community.

HISTORY: Over time, every individual experiences a life event that may conflict with their employment obligations. These conflicts created the necessity for legislation that attempts to establish an equilibrium between work and family. The search for this balance in the District started in 1990 with the passage of the "District of Columbia Family and Medical Leave Act of 1990;" (D.C. Law 8-181; D.C. Official Code §§ 32-501 *et seq.*) (DCFMLA) which became law on October 19, 1990. This legislation provided job protection, 16 weeks of unpaid family leave and

16 weeks of unpaid medical leave during a 24-month period after 1,000 hours worked in the 12 months preceding the request.

By the time the District passed its law, 25 states had already passed some form of job protection for absences related to family and personal needs.[i] Congress followed suit three years later by providing 12 weeks of unpaid and job protected leave for a qualifying event during a 12-month period.[ii]

In an effort to promote economic security, there is a national movement to provide employees with access to paid family and medical leave. Currently, five states have enacted paid leave laws and three are currently functioning.[iii] The programs currently operating vary on employer/employee contributions to the disability portion of the program, but uniformly the family leave portion of the program is funded by the employee only.[iv]

On October 5th of last year, Councilmembers Grosso, Nadeau, McDuffie, Silverman, Allen, May, and Cheh introduced B21-415, the "Universal Paid Leave Act of 2015" (UPLA). This bill, as introduced, would provide District residents and workers with 16 weeks of paid family and medical leave and as drafted could provide employees with 32 weeks of paid leave every 12 months for qualifying events. Under the introduced legislation, the program would be administered by the government and be funded by an up to 1% payroll tax paid for by employers and District residents employed by the federal government or outside the District. A qualifying employee would be eligible for wage replacement up to $3,000 per week depending on their salary.

On February 8th of this year, Chairman Phil Mendelson released a UPLA discussion draft for comment. According to the memo accompanying the Chairman's version, the discussion draft:

- Narrows the definition of family to legal relationships;
- Limits the scope of qualifying incidents and excludes mental health issues from serious health condition;
- Provides 90% wage replacement for employees earning less than double the minimum wage and 50% for all others up to $1,500 per week; and
- Requires the exhaustion of Accrued Sick and Safe Leave.

DCHA POSITION: The District of Columbia Hospital Association (DCHA) and its members unequivocally support paid leave. We have long recognized the importance of providing our employees with access to paid leave. This leave allows our employees to balance their families' needs at home with their life saving work. Further, our member hospitals understand the importance of wage protection for all their employees when life events occur, whether that is a sick spouse parent, child or the joy of bonding with a new child.

DCHA and our members have significant concerns about the cost and unintended consequences of the currently proposed versions of the UPLA. DCHA and its members believe that any legislation that expands the availability of paid leave must include the following provisions:

1) Employers should be allowed to control and operate the program and not have it administered by a government agency.
2) Employers should be allowed to apply an employee's leave benefit to assist in meeting the minimum requirement.
3) Any new paid leave program should start at no more than 4 weeks in order for businesses to gain experience with the effects of the program and allow the Council

and the Government of the District of Columbia to analyze the impact of the program on employers, employees, and the District's economy.

4) In order to maximize the impact for employees, their wages should be protected up to 100% of their base wage.
5) The definition of "family" should be limited to no more than spouse, domestic partner, child, and parent.
6) Employees should have to work at least 1,250 hours in the preceding 12 months before the qualifying event.
7) Any leave program must run concurrently with DCFMLA & FMLA and should not include intermittent leave.
8) The paid leave program must be protected from fraud and abuse.

POSITION BACKGROUND: In order to obtain the best possible picture of the current leave structure, DCHA surveyed its members on the current status of leave benefits offered to employees. As a result of this work, we have confirmed that all hospitals comply with the Accrued Sick and Safe Act, and that FMLA and DCFMLA polices are in place and allow the use of available leave to receive pay during this leave. According to our survey, over 4,600 employees took some form of FMLA leave last fiscal year. In addition to paid time off and sick leave programs, all hospitals provide employees access to disability insurance policies.

On average, District hospitals allow employees in their first year to accrue an average of 4.6 weeks of paid leave. This combines paid leave and sick leave for those facilities that have both types of leave programs. Employees with longer longevity at the hospitals can accrue an average maximum of 13.6 weeks of paid leave. **Hospitals provided employees over 390,000 days of paid leave last fiscal year at a cost totaling over $125 million.**

We are concerned that the current proposal does not take into account the leave policies that are currently in place within the business community. Moreover, our human resource professionals have significant concerns with a government administered program because it will be difficult for a government agency to process the necessary paperwork and provide adequate notice to the employee and employer. In the hospital environment, time is of the essence and any delays could potentially harm employees and operations. Finally, the human resource departments at our hospitals already have challenges with employees providing the necessary documentation in a timely manner to substantiate a DCFMLA claim; operation by an outside government agency could further exacerbate the issues. These documentation issues are especially problematic for employees taking intermittent leave because of the potential for abuse, and the need to protect an employee's rights under the law. Unfortunately, this can lead to coverage problems, as well as delays in the recruitment to fill the positions of employees found to be fraudulently claiming FMLA protection during intermittent leave.

The importance of the ability to apply existing accrued leave to any paid leave benefit cannot be overstated. Even under current leave programs hospitals may have to temporarily shutter a surgery program if a surgeon is on extended leave. In other cases, hospitals may have to reschedule, or delay procedures because certain specialty staff are unavailable. The ability to stack paid leave and paid time off would exacerbate the difficulty in finding replacement physicians, nurses or technologists in specialty fields, which are already experiencing significant shortages across the country. Failure to take the existence of accrued leave into account could limit access for patients to important services.

Hospitals believe that the increased cost in the proposed leave program could have unintended consequences and lead to reduced benefits to offset costs. This could mean elimination of employer contributions to short term disability programs, life insurance and other benefits that employees currently receive. While we may be large employers, it does not necessarily follow that hospitals have large margins to absorb additional costs. Our members are also concerned about the treatment of hospital employees primarily based in Maryland or Virginia because they would be treated differently and have access to fewer benefits than those on main campuses in the District of Columbia.

IMPACT:

Based on our analysis, the current 12-week proposal before the Council could increase cost to hospitals by over $71 million dollars. This estimated cost includes a 1% tax on payroll for DC based employees and estimates replacement costs for a 16% take-up rate. There are no reductions to current paid leave accrual programs because we are not convinced that a rollback of these programs is a viable option, especially with multiple union contracts, so this figure would be on top of the over $125 million in paid leave we already provide to our employees. The employee replacement cost for hospitals is the largest cost driver because the premiums for temporary labor can be up to 200%. Foregone revenue based on the temporary closure of a program could not be estimated, and therefore is not included in this estimate.

We believe an up to four-week employer mandate model would cost hospitals more than $24 million, inclusive of replacement costs. This model also assumes a 16% take-up rate and offsets the additional cost by deducting accrued leave. Again, the employee replacement cost for hospitals is the largest cost driver because the pay premiums for temporary labor can be up to 200%. Foregone revenue based on the temporary closure of a program could not be estimated, and therefore is not included in this estimate.

Each additional week of paid leave would cost hospitals another estimated **$8 million**. We should also note that this increase in personnel costs would result in additional expenditures by the District through increased Medicaid rates based on facility Medicaid Cost Reports. This increased burden on the District Medicaid program raises the specter of further attempts to reduce reimbursement rates, which the District hospitals are already holding off by supporting rates with $16.8 million in provider fees. The same would likely be true for the District's skilled nursing facilities, whose rate rebasings are often up to six years behind.

The nature of hospitals is fundamentally different than most other industries. We must fully staff our facilities **24 hours a day, 7 days a week** to maintain access to vital services. Hospitals already contribute more than **$101 million** annually to provide care to those who do not have health insurance or are under insured and offer more than **$219 million** in community benefits, such an increased financial burden will require them to make trade-offs about which programs they will be able to support in the future.

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[i] Report on the "District of Columbia Family and Medical Leave Act of 1990" Bill 8-82 (Rep. No. B8-82). (9).
[ii] Mayer, G. (2012). *The Family Medical Leave Act (FMLA): An overview*. Washington, DC: Congressional Research Service, Library of Congress. (4).
[iii] State Paid Family Leave Insurance Laws. (2016, April). Retrieved October 13, 2016, from http://www.nationalpartnership.org/research-library/work-family/paid-leave/state-paid-family-leave-laws.pdf
[iv] ibid.