Exhibit 6

111TH CONGRESS
2d Session

HOUSE OF REPRESENTATIVES

REPORT
111–443

THE RECONCILIATION ACT OF 2010

REPORT

OF THE

COMMITTEE ON THE BUDGET
HOUSE OF REPRESENTATIVES

TO ACCOMPANY

H.R. 4872

A BILL TO PROVIDE FOR RECONCILIATION PURSUANT TO SECTION 202 OF THE CONCURRENT RESOLUTION ON THE BUDGET FOR FISCAL YEAR 2010

together with

MINORITY VIEWS

VOLUME I
DIVISION I

MARCH 17, 2010.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

vide for the participation of non-physician providers. Non-physician providers would only be allowed to participate if they accepted the established rates as payment in full.

Reason for Change

This provision ensures that the Secretary has the tools to establish the terms and conditions for providers to participate in the public option. The provision also defines two levels of physician participation and, in order to protect consumers, establishes rules on permissible cost sharing and payment to non-participating providers who treat enrollees in the public option.

Effective Date

January 1, 2013.

Sec. 226. Application of Fraud and Abuse Provisions

Current Law

Title XVIII of the SSA, the Medicare statutes, requires activities that prevent, detect, investigate and prosecute health care fraud and abuse. In general, initiatives designed to fight fraud, waste, and abuse are considered program integrity activities. Program integrity is considered a component of the effective and efficient administration of government programs, which are entrusted with ensuring that taxpayer dollars are spent wisely. Efforts to ensure Medicare program integrity encompass a wide range of activities and require coordination among multiple private and public entities. This includes processes directed at reducing payment errors to Medicare providers, as well as activities to prevent, detect, investigate, and ultimately prosecute health care fraud and abuse.

Proposed Law

The provisions of law (other than criminal law) identified by the Secretary by regulation, in consultation with the Inspector General, that impose sanctions with respect to waste, fraud, and abuse under Medicare would also apply to the public health insurance option.

Reason for Change

Applies Medicare waste, fraud and abuse requirements in a similar manner to the public option.

Effective Date

January 1, 2013.

Subtitle C—Individual Affordability Credits

Sec. 241. Availability Through Health Insurance Exchange

Current Law

No provision.

Proposed Law

This provision would provide premium and cost-sharing credits to "affordable credit eligible individuals" (defined in Section 242) for certain individuals enrolled in coverage through the Exchange.

The Commissioner would pay each QHBP participating in the Exchange the aggregate amount of credits for all eligible individuals enrolled in that plan.

An Exchange-eligible individual could apply to the Commissioner, through the Exchange or another entity under an arrangement made with the Commissioner, in a form and manner specified by the Commissioner. The Commissioner, through the Health Insurance Exchange or through another public entity under an arrangement made with the Commissioner, would make a determination as to eligibility of an individual for affordability credits. The Commissioner would establish a process whereby, on the basis of information otherwise available, individuals may be deemed eligible for credits. The Commissioner would also establish effective methods that ensure that individuals with limited English proficiency are able to apply for affordability credits.

If the Commissioner determines that a state Medicaid agency has the capacity to make a determination of eligibility for affordability credits under the same standards as used by the Commissioner under the Medicaid memorandum of understanding (described above in Section 205), the state Medicaid agency is authorized to conduct such determinations for any Exchange-eligible individual who requests such a determination, and the Commissioner would reimburse the state Medicaid agency for the costs of conducting such determinations.

In addition, there would be a Medicaid screen-and-enroll obligation, which would ensure that individuals applying for affordability credits, may be screened for Medicaid eligibility. If they are determined eligible for Medicaid, the Commissioner, through the Medicaid memorandum of understanding, would provide for their enrollment under the state Medicaid plan, and the state would provide for the same periodic redetermination of eligibility under Medicaid as would otherwise apply.

During the first two years of implementation, credits would be allowed for coverage under a Basic plan only. Beginning in the third year, credits would be allowed for coverage under Enhanced or Premium plans by a process established by the Commissioner. Credits would continue to be based on the basic plan, the individual would be responsible for any difference between the premium for an Enhanced or Premium plan and the credit amount based on a Basic plan applicable to that enrollee.

The Commissioner would be authorized to request from the Treasury Secretary information that may be required to carry out this subtitle (regarding individual affordability credits), consistent with existing rules regarding confidentiality and disclosure of tax return information. Individuals who are eligible to receive credits would not receive them in the form of cash payments.

Reason for Change

Establishes affordability credits for those without other coverage—or an offer of affordable coverage—to assist individuals and families with the purchase of health insurance coverage. These credits are key to ensuring people affordable health coverage. It also provides for the Exchange to coordinate with state Medicaid programs to ensure people are enrolled in the appropriate program.

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MARCH 17, 2010.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

The amendment offered by Representative McKeon (R–CA) would have created a new title at the end of Division A titled Title IV—Small Business Health Fairness. This title would include rules governing association health plans; clarification of treatment of single employer arrangements; enforcement provisions related to association health plans; and other provisions related to association health plans. The amendment was defeated by a roll call vote of 21–27.

The amendment offered by Representative Castle (R–DE) would have allowed variation in cost-sharing and premiums charged by the qualified health benefits plans dependent upon participant participation in employer prevention and wellness programs. The amendment was withdrawn and no further action was taken on it.

The second amendment offered by Representative Wilson (R–SC) would add to H.R. 3200 a Sense of the House of Representatives that any members who vote in support of the public health insurance option are urged to forgo their right to participate in the FEHBP and enroll under the public option. The amendment was passed by voice vote.

The third amendment offered by Representative Price (R–GA) would have established provisions for defined contribution health plans. The amendment was defeated by a roll call vote of 19–29.

The fourth amendment offered by Representative Price (R–GA) would have struck the physician billing language in Section 225(c). The amendment was defeated by a roll call vote of 19–29.

The second amendment offered by Representative McMorris Rodgers (R–WA) would have exempted plans established and maintained by Indian tribal governments. The amendment was defeated by voice vote.

Committee on Ways & Means Mark-up of H.R. 3200

On July 16, 2009, the Committee on Ways and Means met to mark-up H.R. 3200, America's Affordable Health Choices Act and reported the bill as amended by a vote of 23–18.

Committee on Energy & Commerce Mark-up of H.R. 3200

Beginning on July 16, 2009, the Committee on Energy and Commerce met to mark-up H.R. 3200, America's Affordable Health Choices Act. In addition to July 16, 2009, the Committee considered H.R. 3200 on July 17, 20, 30 and 31. The Committee reported the bill as amended by a vote of 31–28.

SENATE CONSIDERATION OF THE AFFORDABLE HEALTH CHOICES ACT

Beginning on June 17, 2009 the HELP Committee met to mark-up the Affordable Health Choices Act. The Committee reported the bill as amended on July 15, 2009 by a vote of 13–10.

III. SUMMARY OF THE BILL

America's Affordable Health Choices Act makes critical reforms to this nation's broken health care system. It will lower costs, preserve choice, and expand access to quality, affordable care. To protect families struggling with health care costs and inadequate coverage, the bill ensures that health insurance companies can no

longer compete based on risk selection. By prohibiting rate increases based on pre-existing conditions, gender and occupation, the bill requires that insurance companies instead compete based on quality and efficiency. In addition, H.R. 3200 will lower the cost of health care by eliminating co-pays and deductibles for preventive care, capping annual out-of-pocket expenses, prohibiting lifetime limits, and allowing the uninsured, part-time workers, and employees of some small businesses to obtain group rates by purchasing health care through the HIE.

H.R. 3200 will expand choice of health insurance, especially in many parts of the country where families have very limited choices because of the nature of the insurance market. The HIE will serve as an organized and transparent "marketplace for the purchase of health insurance"[7] where individuals and employees (phased-in over time) can shop and compare health insurance options. To participate in the HIE, insurers will be required to meet the insurance market reforms and consumer protections and offer the essential benefits package established by the new independent benefits advisory committee. Individuals and families under 400 percent of poverty who qualify for affordability credits will be able to use that money in the HIE to help offset the costs of their health care coverage.

One health insurance choice within the HIE will be the public health insurance option. The public option will be required to operate on the same level as private insurance companies, adhering to the same market reforms and consumer protections, and it will be required to be financed from its premiums. Rates will vary geographically just as private insurers do. The public plan option will be able to utilize payment rates similar to Medicare with provider rates at Medicare plus 5 percent. However, beginning in Y4 the Secretary will have the authority to use an administrative process to set rates (at levels that do not increase costs) in order to promote payment accuracy and the delivery of affordable and efficient care.

The inclusion of a public option in the HIE will help to rein in the costs of health insurance while preserving access. At all times, the Secretary retains the authority to utilize innovative payment mechanisms and policies to improve health outcomes, reduce health disparities, and promote quality and integrated care. Furthermore, the public option will represent choice in many communities where one insurer dominates the market. Consequently, the public health insurance option has the ability to increase competition and control costs. However, no one, including employers who put their employees into the HIE, can place or force anyone into the public option. The decision to enroll in a private plan or the public option is always left to individuals and families to decide for themselves.

H.R. 3200 is built upon the premise of shared responsibility among individuals, employers and the government, so that everyone contributes and has access to affordable, quality health care. America's Affordable Health Choices Act gives employers the choice

[7] Linda Blumberg and Karen Pollitz, Health Insurance Exchanges: Organizing Health Insurance Marketplaces to Promote Health Reform Goals, the Urban Institute & Robert Wood Johnson Foundation (April 2009).

to either offer health insurance or pay a percentage of payroll for their employees to go into the HIE.

Beginning in 2013, employers "playing" will be required to offer health coverage to all of their full-time employees and contribute 72.5 percent of the premium for an individual and 65 percent for a family premium. For part-time workers, employers will have the choice to either offer health coverage on a pro rata basis or pay the required penalty. There will be no minimum benefit requirement for existing employer-sponsored health plans until the end of 2018. At that time, employers who "play" will be required to offer coverage that is no less than the minimum benefit level within the Exchange and must include the insurance market reforms.

Employers may also choose to "pay" instead of play. A "pay" employer would be required to make a contribution equal to 8 percent of their payroll to the HIE. However, recognizing the difficulties small businesses face, the bill includes a number of provisions to help small employers. For example, H.R. 3200 exempts employers with payrolls of $250,000 or less from the pay or play requirements. For employers with payroll between $250,000 and $400,000 the contribution amount phases-up from 2 to 8 percent so that only employers with payrolls greater than $400,000 will pay the full 8 percent.

Whether obtaining coverage through an employer, a spouse or the HIE, H.R. 3200 requires that individuals either enroll in health care coverage or pay 2.5 percent of their adjusted gross income capped at the total cost of the average cost premium offered in the HIE. Recognizing that high health care costs prevent many Americans from securing health care coverage, H.R. 3200 provides for affordability credits to help eligible low- and middle-income individuals and families purchase coverage in the HIE. In addition, for those who can demonstrate that they are unable to afford health insurance, the Health Choices Commissioner (Commissioner) retains the authority to develop and grant hardship waivers.

The affordability credits provided for under the bill will be available to individuals and families with incomes between 133 to 400 percent of the federal poverty level. Medicaid will be expanded so that anyone below 133 percent of poverty will be Medicaid eligible and that expansion will be fully federally financed. Employees who are offered health insurance through an employer will be unable to go into the HIE and receive affordability credits unless that employer coverage is deemed unaffordable. An unaffordable employer offer is one where the employees' share of the premium and cost sharing are more than 11 percent of family income.

Finally, as millions of Americans gain coverage, investments in the health care workforce are critical to ensuring all Americans have access to needed care. H.R. 3200 includes significant investments to help train more primary care and public health physicians as well as nurses. It puts into place incentives to encourage more people to become doctors and nurses (particularly in rural areas). Some of the workforce provisions include: (1) increased funding for the National Health Service Corp.; (2) expanded scholarships and loans for health professionals who work in shortage professions and areas; (3) steps to increase physician training outside of the hospital and redistribute unfilled graduate medical edu-

cation residency slots so that more primary care physicians can be trained; and (4) grants through the Department of Labor to help train and retain nurses.

IV. COMMITTEE VIEWS

The Committee on Education and Labor of the 111th Congress is committed to containing the cost of health care and ensuring that every American has access to affordable, quality health care coverage. H.R. 3200 includes critical reforms to the health care system that are needed to reduce surging premium and health care costs that families, businesses and governments are struggling to afford. The bill cuts over a half trillion dollars from the health care system, ensures that no one is ever one illness away from bankruptcy and creates a system where 97 percent of Americans will have health care coverage by 2015.

OVERVIEW

Health care reform is a critical issue in this country. There are 47 million people in the United States without health care coverage and almost nine million of them are children.[8] Meanwhile, health care costs are rising for nearly everyone. The United States spends over $2.4 trillion—more than 18 percent of GDP—on health care services and products—far more than other industrialized countries.[9] In addition, health care costs continue to grow faster than the economy as a whole, and individuals and families are burdened by the weight of these escalating expenses. Yet, for all this spending, the United States' scores are average or worse on many key indicators of health care quality. Health care reform is critical to restoring prosperity for our nation's families and H.R. 3200 will ensure that coverage is truly affordable and dependable for hard-working Americans.

The Uninsured

The number of uninsured persons in the United States continues to grow, from 44.8 million in 2005 to 47.0 million in 2006. The percentage of uninsured is also rising, from 15.3 percent of the total population in 2005 to 15.8 percent in 2006.[10]

More than two-thirds of the uninsured live in a household with one full-time worker. These increasing numbers can be attributed to the rising cost of health care, a decline in manufacturing jobs and an increase in workers employed in the service industries and small businesses, which are less likely to provide insurance.[11] Roughly two-thirds of Americans without health insurance have incomes 200 percent below the federal poverty level—or approximately $44,000 for a family of four.[12] Not surprisingly, those in households with annual incomes below $25,000 are even less likely

[8] Supra note 2.
[9] National Coalition on Health Care, "Facts on the Cost of Health Insurance and Health Care," (2007), available at: *http:www.nchc.org/facts/cost.shtml*
[10] U.S. Census Bureau, "Health Insurance Coverage: 2006—Highlights." (Aug. 27, 2007), available at: *http:www.census.gov/hhes/www/hlthins/hlthin06/hlth06asc.html*
[11] Robert Pear. "Without Health Benefits, a Good Life Turns Fragile," N.Y. Times (Mar. 5, 2007).
[12] Kaiser Family Foundation, "The Uninsured: A Primer," (Oct. 2008). *http:www.kff.org/uninsured/upload/7451–04.pdf.*

to be insured. In 2006, twenty-five percent of these Americans were uninsured in comparison to 16 percent of the total population.[13]

Approximately 162 million non-elderly workers and their dependents received health coverage through their employment-based health plans.[14] However, millions of other working Americans are unable to participate in an employer-sponsored plan, either because the employer does not offer coverage or the employee is not eligible under the plan. In 2005, 20 percent of "wage and salary" workers had an employer that did not offer any coverage to their workers. And 18 percent were not eligible for the health plan that was offered by their employer.[15] For example, some firms do not offer coverage to part-time employees and some do not offer coverage to workers who have been employed for less than a specific amount of time.

While employer-sponsored plans still remain the dominant source of health coverage for most Americans, the percentage of people obtaining health coverage through these plans has been steadily shrinking. For example, 60 percent of employers offered benefits in 2007, compared with 69 percent in 2000. Most of this decline can be attributed to the decline in small businesses (less than 200 workers) offering coverage.[16] Among firms with less than 10 workers, the offer rate dropped from 57 percent in 2000 to 45 percent in 2007.[17] For employers who have stopped offering coverage, almost three out of four say that premiums are too expensive.[18]

Unaffordable Health Care Coverage

Employers and workers alike are increasingly concerned about the rising costs of health care and insurance. Premiums for employer-sponsored health coverage are rising much faster than workers' earnings and inflation. Between spring 2006 and spring 2007, premiums for coverage offered by employers across the United States increased by 6.1 percent—more than twice the growth in the Consumer Price Index (CPI). The average annual cost of employer-sponsored health insurance was nearing $13,000 in 2008. In response to these steady premium hikes, many companies are asking their employees to cover some of the new costs. For instance, workers taking single coverage through an employer paid 12 percent more for their coverage in 2007 than in 2006. Premiums for a family of four paid by workers increased by 10 percent from 2006 to 2007.[19]

These increases are of great concern, and more and more workers believe that they may not be able to afford their share of the cost

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[13] Carmen DeNavas-Walt, Bernadette D. Proctor and Jessica Smith, "Income, Poverty, and Health Insurance Coverage in the United States: 2006" Current Population Reports (2006) at 60–233. See also, U.S. Department of Commerce, Economics and Statistics Administration, August 2007.

[14] Elise Gould, "The Erosion of Employer-Sponsored Health Insurance," Economic Policy Institute (Oct. 8, 2008).

[15] Supra note 9.

[16] Kaiser Commission on Medicaid and the Uninsured, "2007 Employer Health Benefits Survey—Summary of Findings," (Sept. 2007) at 29, available at: *http:www.kff.org/insurance/7672/index.cfm*

[17] Paul Fronstin. "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2007 Current Population Survey." Employee Benefit Research Institute, October 2007.

[18] Kaiser Family Foundation/HRET, "Employer Health Benefits 2007 Annual Survey." (Sept. 2007).

[19] Id.

of coverage. In a recent poll by the Pew Research Center,[20] forty-four percent of workers surveyed say that affording health insurance is difficult or very difficult. In addition, almost three out of four uninsured workers who chose not to participate in their employer's health plan in 2002 said the plan was too costly. Workers also know that if they lose their job, they are likely to lose access to affordable health care coverage.

In addition, among those employers that offer benefits, a large percentage of firms report that in the next year not only are they very or somewhat likely to increase the amount workers contribute to premiums (45 percent), but they will also increase deductible amounts (37 percent), office visit cost sharing (42 percent) or the amount that employees have to pay for prescription drugs (41 percent).[21]

The problem of being "underinsured" has also become increasingly relevant. One recent study estimated that 29 percent of individuals who have insurance are "underinsured" and have coverage that is inadequate to secure them access to needed care or protect again catastrophic medical bills.[22]

The Commonwealth Fund found that 25 million adults who had health coverage in 2007 were underinsured[23]—a 60 percent increase from the 16 million Americans who were underinsured in 2003.[24] Another study found that while 16 percent of adults spent more than 10 percent of their family income on health care service in 1996. By 2003 the proportion of adults bearing these health-related "catastrophic financial burdens" had increased to 19 percent to about 49 million individuals.[25] Another study found that financial burdens had increased to the point that private health insurance coverage no longer provided adequate financial protection for low-income families.[26]

In addition, many families have little room within their family budgets for large or unexpected out-of-pocket health care expenses. In 2003, an estimated 77 million Americans—nearly two out of five adults—had difficulty paying medical bills.[27] Even working age adults who were continually insured had problems paying their medical bills and carried medical debt as a result. Nearly half of all bankruptcies in the United States are related, in part, to health care expenses. And of those facing medical bankruptcies, roughly

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[20] Pew Research Center for the People and the Press poll, conducted January 9–13, 2008, available at: *http:people-press.org/reports/dispaly.php3?ReportID=* 395.

[21] Supra note 16.

[22] Consumer Reports, "Health Insurance: CR Investigates Health Care," September 2007, available at: *http:www.consumerreports.org/cro/health-fitness/health-care/health-insurance–9–07/overview/0709__[illegible]__[illegible]*

[23] According to the Commonwealth Fund study, families are identified as underinsured if they had out-of-pocket medical spending that absorbed at least 10 percent of family income, or for low-income adults (200 percent below the federal poverty level), medical spending consumed at least 5 percent of family income.

[24] Cathy Schoen et al, "How Many are Underinsured? Trends Among U.S. Adults, 2003 and 2007," Health Affairs 27 no. 4 (2008).

[25] J. Banthin and D. Bernard, "Changes in Financial Burdens for Health Care: National Estimates for the Population Younger than 65 Years, 1996 to 2003," JAMA (2006).

[26] J. Banthin, P. Cunningham and D. Bernard. "Financial Burdens of Health Care, 2001–2004," Health Affairs 27, no.1 (2008) at 188–195.

[27] Michelle M. Doty, Jennifer N. Edwards, and Alyssa L. Holmgren, "Seeing Red: Americans Driven into Debt by Medical Bills," The Commonwealth Fund (Aug. 2005).

three-quarters had health insurance at the onset of their bankrupting illness.[28]

The risk of being underinsured or experiencing financial problems due to health spending varies not only by family income, but also by health status. According to Judy Feder, Senior Fellow at the Center for American Progress, "health care affordability is particularly elusive for individuals with chronic illness and other conditions that require on-going, often costly, medical care."[29] Individuals who are older and have chronic conditions such as diabetes, heart disease, or arthritis, or have experienced a stroke, are more likely to spend a high proportion of their income on health expenses. If these individuals do not have an employer-sponsored health plan, or if they lose this coverage, their ability to purchase coverage in the non-group market is limited at best. The non-group market systematically denies coverage, limits benefits, and charges excessive premiums to individuals with pre-existing conditions or those who are perceived to be at high-risk. Ironically, the people who are more likely to become sick—the very population that insurance is supposed to protect—are also more likely to be underinsured and face grave financial problems.

The Consequences of being Uninsured or Underinsured

Being uninsured makes it more likely that a person will not receive adequate medical care. Individuals without insurance often go without or delay care, and the care they do receive is likely to be lower quality than the care received by insured individuals. An estimated 18,000 to 22,000 Americans die each year because they do not have health coverage.[30] The length of time a person goes without health insurance also makes a difference—people who are uninsured for at least a year report being in worse health than those uninsured for a shorter period of time.[31] Finally, lack of coverage and coverage stability is particularly burdensome on the seriously and chronically ill, whose care is often delayed or denied when they cannot pay.[32]

HEALTH CARE COSTS AND SPENDING: THE COST OF DOING NOTHING

H.R. 3200 ensures quality and affordable health care choices for all Americans while also controlling costs in a system in which costs have spiraled out of control. The United States spends over $2.4 trillion on health care each year.[33] As noted earlier, health care expenditures in the United States constitute approximately 18 percent of the current Gross Domestic Product (GDP).[34] If health care costs continue to grow at historical rates, the share of GDP

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[28] David Himmelstein, Elizabeth Warren, D. Thorne, and S. Woolhandler, "Illness and Injury as Contributors to Bankruptcy," Health Affairs (2005).

[29] Judy Feder, Testimony before the Committee on Energy and Commerce Committee (hereinafter Feder) (Mar. 17, 2009).

[30] "Insuring America's Health: Principles and Recommendations," Institute of Medicine (Jan. 14, 2004).

[31] Id.

[32] Institute of Medicine, "Care Without Coverage: Too Little, Too Late" (May 2002), available at: *http:www.iom.edu/Object.File/Master/4/160/Uninsured2FINAL.pdf*

[33] Supra note 9.

[34] Executive Office of the President, Council of Economic Advisors, "The Economic Case for Health Care Reform," available at *http:www.whitehouse.gov/administration/eop/cea/TheEconomicCaseforHealthCareReform/ (June 2009).*

devoted to health care in the United States is projected to reach 34 percent by 2040.[35]

International Comparisons

The United States devotes a far larger share of GDP to health care spending more than two times per person on health care than any other OECD (Organization for Economic Co-operation and Development) country.[36] While health care expenditures in the United States are about 18 percent of GDP[37] the OECD reports that the next highest country was Switzerland—with 11.3 percent—and in most other high-income countries, the share was less than 10 percent.[38]

Despite outpacing other countries with investments in health care, the U.S. fails to produce better health outcomes in fundamental ways. OECD data shows that life expectancy in the United States is lower than in any other high-income country, as well as in many middle-income countries.[39] Similarly, the infant mortality rate in the United States is substantially higher than that of other developed countries. While many factors other than health care expenditures may affect life expectancy and infant mortality rates—for example, demographics, lifestyle behaviors, income inequality, non-health disparities, and measurement differences across countries[40]—the Council of Economic Advisors (CEA) has concluded that "the fact that the United States lags behind lower spending countries is strongly suggestive of substantial inefficiency in our current system."[41] Indeed, according to estimates by the CEA based on the spending and outcomes in other countries, efficiency improvements in the U.S. health care system potentially could free up resources equal to 5 percent of U.S. GDP.[42]

Analyzing health care spending over time, the CEA also notes that while health care spending has increased in other countries as well, the spending by the U.S. has not yielded the same outcomes as other countries. In 1970, the United States devoted only a moderately higher fraction of GDP to health care than other high-income countries, whereas in 2009 the United States spends dramatically more.[43] Yet, during that same period, life expectancy has actually risen less in the United States than in other countries.[44] This data suggests that much of the increased U.S. spending is inefficient.[45]

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[35] Id.
[36] Marcia Angell Testimony before the Committee on Education and Labor Committee (hereinafter Angell) (Jun. 10, 2009).
[37] Supra note 34.
[38] Id.
[39] Id.
[40] Robert Wood Johnson Foundation, Commission to Build a Healthier America, "Beyond Health Care: New Directions to a Healthier America" (Apr. 2009).
[41] Supra note 34.
[42] Id.
[43] Id.
[44] Garber, Alan M., and J. Skinner, "Is American Health Care Uniquely Inefficient?" Journal of Economic Perspectives (2008) at 27–50.
[45] Supra note 34.

Cost of the Uninsured

While the U.S. health care system currently leaves 47 million Americans uninsured[46] and approximately 25 million underinsured,[47] the CEA projects that the number of uninsured could increase to 72 million by 2040.[48] Such increases in the numbers of uninsured people will create additional uncompensated care costs, which include costs incurred by hospitals and physicians for the charity care they provide to the uninsured as well as bad debt such as unpaid bills.[49] Both the federal government and state governments use tax revenues to pay health care providers for a portion of these costs through programs such as Disproportionate Share Hospital (DSH) payments and grants to Community Health Centers.[50] In 2008, total government spending to reimburse uncompensated care costs incurred by medical providers was approximately $42.9 billion.[51] The CEA projects that if the U.S. does not slow the real growth rate of health spending and a subsequent rise in the uninsured, the real annual tax burden of uncompensated care for an average family of four will rise from $627 in 2008 to $1,652 (in 2008 dollars) by 2030.[52]

Costs to Individuals and Families

As the cost of health care skyrockets, families and employers offering health insurance struggle to absorb the increased costs. In 2008, employer-based premiums increased by 5 percent. That growth was even greater for small firms. On average, they incurred a premium increase of 5.5 percent, and, for those with 24 or fewer workers, their respective increase was 6.8 percent.[53] Much of the increase in health care costs has been shifted onto workers. In 2008, the average annual premium for a family of four was $12,700, and workers contributed approximately $3,400 of that total which was 12 percent more than the year before. Workers are now paying $1,600 more for family coverage than they did 10 years ago.[54] Over the last decade, health care costs have risen on average four times faster than workers' earnings.[55]

These dramatic increases in health care costs have serious implications for American households. Some economists believe that, over the long run, workers pay for the rising cost of health insurance through lower wages.[56] To illustrate this relationship, the CEA has analyzed historical and projected average annual total compensation (measured in 2008 dollars), which includes wages as

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[46] National Coalition on Health Care, available at: *www.nchc.org/facts/cost.shtml (2009).*
[47] "How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007," Commonwealth Fund (2008)
[48] Supra note 34.
[49] American Hospital Association, "Uncompensated Hospital Care Fact Sheet" (Nov. 2005), available at *http:www.aha.org/aha/content/2005/pdf/0511 UncompensatedCareFactSheet.pdf.*
[50] Hadley, Jack, J. Holahan, T. Coughlin, and D. Miller. "Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs," Health Affairs (2008).
[51] Id.
[52] Supra note 34.
[53] The Henry J. Kaiser Family Foundation. Employee Health Benefits: 2008 Annual Survey, (Sept. 2008).
[54] Angell.
[55] See, National Coalition on Health Care, available at: *www.nchc.org/facts/cost.shtml* (2009).
[56] Pauly, Mark V., "Health Benefits at Work: An Economic and Political Analysis of Employment-Based Health Insurance" (1998).

well as non-wage benefits such as health insurance.[57] Their analysis indicates that health insurance premiums are growing more rapidly than total compensation in percentage terms, and as a result, an increasing share of total compensation that a worker receives goes to cover health insurance premiums.[58] Moreover, the CEA notes that households with employer-sponsored health insurance could also be affected by rapid cost growth as employers shift to less generous plans with higher annual deductibles.[59] It is important to note, however, that the wage stagnation experienced by workers over recent decades cannot be attributed solely to rising health care costs. For example, low-wage workers have experienced real wage declines in recent years despite few such workers having access to or participating in employment-based health insurance coverage.[60] More economic dynamics are at work in the wage squeeze on workers, but rising health costs contribute to the downward pressure.

H.R. 3200 Will Increase Standards of Living and Create New Jobs

By slowing the growth in health care costs, standards of living will improve and resources will be freed to improve and expand the health care system. The CEA projects that slowing growth by 1.5 percentage points per year will save a family $2,600 by 2020.[61] By 2030 that savings would be increased to nearly $10,000.[62]

Furthermore, the CEA estimates that the coverage expansions that will result from health reform will produce a net benefit of approximately $100 billion a year, or about two-thirds of a percent of GDP.[63] According to its analysis, health care reform will lower the unemployment rate in the United States and could add as many as 500,000 jobs on an annual basis.[64] By producing a more healthy and productive workforce, health care reform will improve standards of living and help strengthen the U.S. economy.

Shared Responsibility & Employment-Based Health Care Insurance

In order to control costs and expand access to quality affordable health care, everyone must be covered and employers, individuals and the government must share in this responsibility. Consistent with the minimum wage and overtime laws, H.R. 3200 creates a fundamental right to a minimum level of health care contribution and/or coverage through an employer. As noted earlier, two-thirds of Americans receive health coverage through an employer, and H.R. 3200 builds upon the current employer-based system by implementing a 'pay or play' requirement.

The employer responsibility to provide and/or contribute to the health care of its workers will stabilize the employer-based health care system. Because the Employee Retirement Income Security Act of 1974 (ERISA) currently contains no requirement that an em-

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[57] Supra note 34 (relying on the 1996 to 2006 Medical Expenditure Panel Survey-Insurance Component).
[58] Id.
[59] Id.
[60] Economic Policy Institute, "Increasing Health Costs Can't Explain Earnings Dip for Low-Wage Workers," Economic Snapshot (April 12, 2006).
[61] Supra note 34.
[62] Id.
[63] Id.
[64] Id.

ployer offer employee benefits, employers who do not offer health insurance to their workers gain an unfair economic advantage relative to those employers who do provide coverage, and millions of hard-working Americans and their families are left without health insurance. It is a vicious cycle because these uninsured workers turn to emergency rooms for health care which in turn increases costs for employers and families with health insurance. It is estimated that in 2008 premiums were about 8 percent or $1,100 higher due to this hidden cost shift.[65]

Strengthening the Employer-Based System

Millions of employers voluntarily decide to offer health benefits because it is in their economic interest. Employers are not taxed on their contributions to employees' health care, and these costs are deductible as a business expense.[66] In addition, large employers can offer health care coverage at a much lower cost because they can negotiate with insurers and have a larger pool of employees to spread the risk. Furthermore, employers recognize that investments in health care can produce gains in employee health which means fewer missed days, higher productivity and better overall job satisfaction.

Despite the incentives to offer health coverage, skyrocketing health care costs make it difficult for employers, particularly small businesses, to offer comprehensive health insurance. As noted earlier, while approximately 63 percent of the under–65 population and their dependents have insurance through employment,[67] the number of employers offering health care coverage has been declining over the last decade. The number of people getting health coverage through an employer dropped by 3 million between 2000 and 2007,[68] largely due to increasing costs. In addition, the Center for American Progress projects that as a result of layoffs, approximately 14,000 Americans lose their employer-sponsored coverage each day.[69] Overall, since 1999 premiums have increased 120 percent and at a rate that is on average four times faster than workers' earnings.[70]

However, even without an employer shared responsibility requirement, 86 percent of employers surveyed report that they will continue offering health care despite increasing costs.[71] Many of these employers are large ones who use health care benefits as a means to recruit and retain employees. Health care benefits are "highly valued by employees, and risk-averse employers may be reluctant to take advantage of the option of dropping coverage" even though they can currently do so.[72]

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[65] Ben Furnas and Peter Harbage, "The Cost Shift from the Uninsured," The Center for American Progress (Mar. 2009).
[66] Paul Ginsburg, "Employment-Based Health Benefits Under Universal Coverage," Health Affairs (May/June 2008) at 675.
[67] Supra note 10.
[68] Id.
[69] Center for American Progress (Feb. 2009), available at: *http:www.americanprogressaction.org/issues/2009/03/health—losses.html.*
[70] National Coalition on Health Care, "Health Insurance Costs," (2009), available at: *www.nchc.org/facts/cost.shtml*
[71] Supra note 61.
[72] Hacker at 10.

H.R. 3200 generally will not change what many employers are already doing. Beginning in 2013, the bill requires employers already offering health insurance to make an offer to all full-time employees and contribute 72.5 percent of the cost toward an individual policy and 65 percent toward a family policy. Today, employers on average contribute 83 percent toward the coverage of individual premiums and 71 percent toward the coverage of family premiums.[73]

The second phase of requirements under H.R. 3200 for existing employer health plans does not take effect until the end of 2018. At that time, in addition to making the required contribution amount, every employer-sponsored health plan will have to, at a minimum meet the essential benefit standards defined by the benefits committee, as well as satisfy the insurance reform standards specified in the bill. Employer health insurance plans will be required to be equivalent to no less than 70 percent of the actuarial value minus the cost sharing components of the essential benefit package. The majority of employers already meet this standard. According to the Congressional Research Service, the typical employer-sponsored PPO has an estimated actuarial value between 80–84 percent, while the typical employer-sponsored health savings account (HSA) and a qualified high deductible health plan (HDHP) has an estimated actuarial value of 76 percent, excluding contributions by an employer.[74]

While many employer plans already meet the bill's requirements, there are some notable omissions. For example, 10 percent of employer plans do not offer mental health and substance use disorder benefits and many include caps on lifetime limits and out of pocket expenses. In these cases, employers will have over 8 years to modify their plans and meet the requirements. Finally, H.R. 3200 extends the same benefit and insurance reform standards in all new employer and HIE plans, so that individuals and families have access in either case to affordable quality health coverage.

Protecting Small Business

For small business, health reform "is their number one need." [75] Forty-percent report that high costs have a "negative effect on other parts of their business, such as high employee turnover or preventing business growth." [76] According to the Small Business Majority, a non-profit independent group representing 27 million small businesses, small businesses spend 18 percent more than large employers for health care coverage.[77] The result is that in 2008, the percent of firms offering health insurance with three to nine employees dropped from 57 percent to 49 percent.[78]

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[73] "Employee Benefits in the United States, March 2008," Bureau of Labor Statistics (Aug. 7, 2008).

[74] Chris Peterson, "Setting and Valuing Health Insurance Benefits," Congressional Research Service (May 29, 2009) at 3–4.

[75] John Arensmeyer, Testimony before the Committee on Education and Labor Committee, "The Tri-Committee Draft for Health Care Reform," (hereinafter Arensmeyer)(Jun. 23, 2009) at 1.

[76] Taking the Pulse on Main Street, "Small Businesses, Health Insurance and Priorities for Reform (Jan. 2009).

[77] Arensmeyer at 2.

[78] Id.

Small businesses have small purchasing pools and one of the biggest obstacles they face in securing affordable health coverage is the lack of bargaining power they have against the insurance companies. In addition, the administrative costs paid by small businesses can be up to 27 percent of premiums to pay for marketing and paperwork costs and underwriting.[79]

LaShonda Young, a small business owner, testified to the Committee about the problems she has had in seeking coverage for her forty employees. She received eight bids and each was from the same insurance company. She testified her experience isn't unique, as there are only one or two health insurers in her area.[80] She went on to testify that, "it's been years since we've been able to afford group health insurance . . . we got quotes from a couple of different places, [the] quotes came in at about 13 percent of payroll. [We're] willing to pay our fair share but we just couldn't afford 13 percent . . . "[81] Even if she was able to afford the coverage, she knew that it wouldn't cover the pre-existing conditions of her employees for up to 18 months and there was no guarantee the costs would remain stable.[82] As a result, small employers like Young are looking to other ways to help their employees find coverage on their own. Young testified that her company offers small stipends to employees to buy insurance on their own.

High health care costs also present an enormous obstacle for those trying to start or maintain a new business. While small businesses have traditionally played an essential role during prior economic recoveries, the high cost of health care is deterring entrepreneurs from starting a business in the first place. Louise Hardaway started her own business near Nashville, Tennessee. When attempting to get health care insurance she was quoted $12,800 a month to cover herself, her husband, business partner, and her business partner's spouse and child. Due to her inability to find affordable health care coverage Ms. Hardaway went out of business and went to work for another company where she could get health care.[83]

Recognizing the economic reality for many small businesses, in addition to driving down health care costs overall, H.R. 3200 contains numerous provisions such as tax credits and access to the HIE to help these employers provide coverage and alleviate their costs. In addition, the bill exempts employers from the pay or play requirement if they have payrolls of $250,000 or less. For employers with payrolls above $250,000 who choose not to offer coverage and would rather pay a penalty, that penalty is phased-up so that only employers with payrolls over $400,000 must pay the 8 percent penalty.

The Small Business Majority reports that small businesses, workers and the economy stand to save billions of dollars with the

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[79] "The Economic Impact of Healthcare Reform on Small Business," Small Business Majority (Jun. 11, 2009) .

[80] LaShonda Young, Testimony before the Committee on Education and Labor Committee, "The Tri-Committee Draft for Health Care Reform," (hereinafter Young)(Jun. 23, 2009) at 2.

[81] Young at 2.

[82] Id.

[83] Simona Covel, "Sick and Getting Sicker," Wall St. Journal (Jul. 23, 2009).

enactment of health care reform.[84] Absent health care reform small businesses will spend $2.4 trillion in health care costs over the next ten years. With health reform, small businesses will save 36 percent of those costs, as much as $855 billion. Without health reform, small businesses stand to lose $52.1 billion in profits due to high health care costs over the next ten years. Health reform will decrease these losses and save $29.2 billion. Reduced health care costs will allow employers to reinvest in their business and their workers. Without health reform, individuals working for small businesses could lose up to $834 billion in lost wages as employers pass increased health care costs onto their employees over the next ten years. Health reform could save workers over $300 billion over the next ten years.[85] Reduced health care costs will allow employers to reinvest in their business and their workers.

THE HEALTH INSURANCE EXCHANGE WILL HELP SMALL EMPLOYERS

H.R. 3200 creates a health insurance exchange (HIE) for the uninsured and employees of small businesses to purchase health insurance in the initial years after enactment. Due to the disadvantages small businesses face when trying to purchase health care coverage on their own, both proponents and opponents of the bill believe that a health insurance exchange is essential for small business: "a broad, well-functioning marketplace offering consistency, fairness and healthy competition will vastly improve the availability and affordability of coverage to small businesses and the self-employed."[86] Furthermore, it "can be a vehicle that facilitates and monitors the movement of the system toward achievements of many national health care reform goals." Eighty-percent of small business owners in a recent state survey stated they favor a health insurance pool that they can put their employees into to buy coverage.[87]

A health insurance exchange is an organized marketplace where individuals and some employers can go to purchase health insurance. The HIE is advantageous to those looking to purchase insurance because it provides transparency when individuals and families shop for their health insurance. Currently, insurers are regulated by a patchwork of state laws. Beyond licensing requirements to sell insurance, private health insurance companies and health maintenance organizations (HMO) operate with considerable autonomy. The result is that policies can vary greatly and many policies leave people underinsured.

The robust HIE will not only organize the marketplace but also include insurance reforms and consumer protections, administer affordability credits, and provide people with choice of plans. The HIE will require that insurers, both private and public, adhere to the same rules. To help consumers make educated decisions the Commissioner will conduct outreach and provide assistance to consumers. The Commissioner will ensure that information is readily available in plain language and is provided in a culturally and linguistically appropriate manner. Furthermore, qualified health ben-

[84] Supra note 76.
[85] Id.
[86] Arensmeyer at 4.
[87] Id.

efits plans (QHBP) including those participating in the HIE will be required to comply with transparency requirements established by the Commissioner, including the accurate and timely disclosure of plan documents, plan terms and conditions, as well as information on cost-sharing and payments with respect to out-of-network coverage, claims denials and other information to help educate consumers.

In addition to monitoring and streamlining the insurance industry, the HIE will play a significant role in containing health care costs. Health care costs are comprised of both the underlying costs of providing health care services as well as the administrative costs related to the provisions of coverage.[88] The HIE will require participating plans to offer standardized benefit packages which will increase the ability to compare plans and "reinforce incentives for insurers to price premiums as competitively as possible."[89] Lower cost plans in the HIE will help those employers who "play" by putting their employees into HIE because they will be responsible for a set contribution amount regardless of the plan an employee choose.[90] Furthermore, the affordability credits available to individuals in the HIE who do not enter the exchange with an employer contribution are tied to the average of the lowest three plans which will then incentivize individuals to choose low-cost plans. By the same token, insurers will be incentivized to offer low-cost plans in order to get more business.[91]

Access & Cost Containment Through A Public Health Insurance Option

The inclusion of a strong public health insurance option in the HIE will save over one hundred billion dollars and provide choice to millions of consumers who currently have little or no choice when looking for a health plan. Its inclusion in the HIE will promote value and innovation in the private health insurance industry by increasing competition. The result is that the public option will lower costs for consumers across the private market.

The public health insurance option will provide access to meaningful choice, something many Americans have never had when searching for a health plan. Many areas only have one or two dominant insurance options that control the market and thus have no downward pressure on costs.[92] Furthermore, "it is often in [these insurers'] interest to pay higher rates to key doctors and hospitals because they can pass on these costs to individuals and employers."[93] For insurers trying to enter a market, this practice makes it difficult for them to compete and reduce costs.

While the public option will be subject to the same standards as private plans, the public option can use administrative efficiencies to control costs. On average, private insurance overhead was about 11.7 percent of premiums which is significantly higher when com-

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[88] Linda Bloomberg and Karen Pollitz, "Health Insurance Exchanges: Organizing Health Insurance Marketplaces to Promote Health Reform Goals" (Apr. 2009).
[89] *Id.*
[90] However, an employer is always permitted to contribute an amount greater than the minimum should it choose.
[91] *Id.*
[92] Hacker at 5.
[93] *Id.*

pared to public insurers (Medicare is estimated at 3.6 percent and Medicaid at 6.8 percent).[94] In addition, because the public option is a health plan available nationwide it will have a broad reach and be able to obtain larger volume discounts and will not operate for profit.[95] Accordingly, the public option in H.R. 3200 will serve as a "benchmark for private plans, a backup to allow consumers access to a good plan with broad access to providers in all parts of the country, and to serve as a cost-control backstop."[96]

Ultimately, it will be up to consumers in the HIE to decide whether to enroll in the public option or a private plan. H.R. 3200 intends to create a level playing field for both to compete. Consumers will be able to compare what each plan offers—private plans or the public option—and decide which plan serves them and their families best.[97]

Ensuring Access to Health Care Through Insurance Market Reforms

Comprehensive insurance reforms are another critical element of health reform. Guaranteeing access to health care and protecting against medical debt largely depends on implementing comprehensive insurance reforms. About "20 percent of the population accounts for 80 percent of health spending;" the "sickest one-percent accounting for nearly one-quarter of health expenditures."[98] This uneven distribution of medical care creates incentives for insurance companies to avoid risk altogether rather than trying to spread it among the insured population.[99] As a result, health insurers—particularly in the individual market—have adopted discriminatory, but not illegal, practices to cherry-pick healthy people and to weed out those who are not as healthy.[100] These practices include: denying health coverage based on pre-existing conditions or medical history,[101] even minor ones; charging higher, and often unaffordable, rates based on one's health; excluding pre-existing medical conditions from coverage; charging different premiums based on gender;[102] and rescinding policies after claims are made based on an assertion that an insured's original application was incomplete.[103] In addition, while "state and federal laws give individuals the right

[94] John Holahan and Linda Blumberg, "Can a Public Insurance Plan Increase Competition and Lower the Costs of Health Reform," Urban Institute (2009).
[95] Hacker at 7.
[96] *Id.*
[97] *Id.*
[98] Karen Pollitz, testimony before the Committee on Energy and Commerce, Subcommittee on Health (hereinafter Pollitz) (Mar. 17, 2009).
[99] Linda Blumberg, testimony before the Committee on Ways And Means (April 22, 2009).
[100] Mila Kofman, testimony before the Committee on Energy and Commerce, Subcommittee on ealth (hereinafter Koffman)(Mar. 17, 2009); Blumberg, *supra* 94.
[101] *See* Fran Visco, testimony before the Committee on Education and Labor (June 22, 2009). Ms Visco testifying on behalf of the National Breast Coalition, stressed how no insurance or inadequate insurance has had a devastating effect on women diagnosed with breast cancer.
[102] A 2008 report by the National Women's Law Center examined individual insurance policies in 47 states and the District of Columbia and found that most of the states engage in a practice called "gender rating" where insurance companies arbitrarily charge women and men different rates for individual insurance premiums. Specifically, they found that women under 55 are charged more for health insurance than men (at age 25, 4% to 45% more; at age 40, 4 to 48% more). In addition, the report discovered that the vast majority of individual policies do not cover maternity leave, and in 9 states and the District of Columbia, insurers can reject survivors of domestic violence and those who have had C-sections. *See: Nowhere to Turn: How the Individual Insurance Market Fails Women*, National Women's Law Center (2008).
[103] *Id*, Pollitz, supra 98.

to renew their health insurance coverage, guaranteed renewability provides no protection against rate increases."[104]

Discrimination based on health, gender and other factors has severe economic consequences for those who have been unable to find affordable health coverage and for those who have coverage, but are under-insured.[105] As noted earlier, these practices have resulted in about 57 million Americans having debt because of medical bills,[106] and over 42 million of that number has some sort of medical coverage.[107] Medical debt is now the leading cause of personal bankruptcy.[108]

A key element to health reform is to prohibit risk selection practices and to support those factors based on quality and efficiency. Where states have prohibited these discriminatory practices, consumers have benefitted. For example, since 1993, Maine requires insurers to provide health insurance to individuals or small businesses on a "guarantee issue" basis. In addition, it also has an "adjusted community rating" so that prices for policies are set based on "the collective claims experience of anyone with a policy" and not on any one individual's medical history.[109]

H.R. 3200 includes insurance market reforms ending discriminatory practices conducted by insurance companies. These reforms will apply both inside and outside the HIE to end the discriminatory practices currently practiced by insurance companies. The bill requires that all policies be sold on a guaranteed issue basis; prohibits insurers from excluding coverage based on pre-existing conditions; and prohibits insurers from charging higher rates based on health status, gender, or other factors. It would allow premiums to vary based only on age (no more than 2:1),[110] geography and family size. In addition, the bill prohibits lifetime and annual limits on benefits so that families no longer face bankruptcy as a result of a serious medical illness.

STRENGTHENING THE HEALTH CARE WORKFORCE

As millions of new people gain access to health care coverage, H.R. 3200 recognizes that significant investments in the health care workforce are needed. There is mounting evidence that the nationwide healthcare workforce shortage is accelerating. The Health Resources and Services Administration, within the Department of Health and Human Services, reported in January of this year that twenty states were experiencing scarcities of physicians and

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[104] *Id.*

[105] *Id*; Pollitz, *supra* 98. While 47 million Americans have no health insurance at all, almost as many are underinsured.

[106] Pollitz, *supra* 98, testified that "when out-of-pocket spending for medical bills (not including premiums) exceeds just 2.5% of family income, patients become burdened by medical debt, face barriers to accessing care, and have problems paying other bills."

[107] Pollitz, *supra* 98.

[108] David U. Himmelstein, Deborah Thorne, Elizabeth Warren, Steffie Woolhandler, *Medical Bankruptcy in the United States, 2007*, The American Journal of Medicine (2009) at 3, finding that in 2007, 62.1% of all bankruptcies in the United States were medical, compared with 8 percent in 2001. *See also:* Pollitz, *supra* 98; Kofman, *supra* 100, both of whom testified that most medical bankruptcies are filed by insured people.

[109] Kofman, *supra* 100.

[110] Pollitz, *supra* 98, testified that age is "a strong proxy for health status."