Bill as Introduced

2006 SESSION

06-2279
01/10

HOUSE BILL ***1704-FN-A***

AN ACT establishing a health care fund, continually appropriating a special fund, and requiring certain employers to report certain information to the department of health and human services.

SPONSORS: Rep. Moody, Rock 12; Rep. Walz, Merr 13; Rep. Marshall Quandt, Rock 13; Rep. Matthew Quandt, Rock 13; Rep. Harvey, Hills 21; Sen. Fuller Clark, Dist 24

COMMITTEE: Commerce

ANALYSIS

This bill requires employers with 1500 or more employees who do not spend a certain percentage of their payroll toward health care for their employees to put a certain amount into a health care fund which shall be used to support the Medicaid program. This bill grants rulemaking authority to the commissioner of the department of health and human services for the purposes of the bill.

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

06-2279
01/10

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Six

AN ACT establishing a health care fund, continually appropriating a special fund, and requiring certain employers to report certain information to the department of health and human services.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 New Subdivision; Fair Share Health Care Fund. Amend RSA 167 by inserting after section 97 the following new subdivision:

Fair Share Health Care Fund

167:98 Definitions. In this subdivision:

I. "Commissioner" means the commissioner of the department of health and human services.

II. "Employee" means all individuals employed full-time or part-time directly by an employer.

III. "Employer" means employer as defined in RSA 77-E:1, VIII. The term "employer" shall not include the federal government, the state, another state, or a political subdivision of the state or another state.

IV. "Fund" means the fair share health care fund, established in RSA 167:99.

V. "Health insurance benefits" includes payments for medical care, prescription drugs, vision care, medical savings accounts, and any other costs to provide health benefits, as defined in section 213(d) of the Internal Revenue Code.

VI. "Health insurance costs" means the amount paid by an employer to provide health care or health insurance to employees in the state to the extent the costs may be deductible by the employer under federal tax law. The term "health insurance costs" includes payments for medical care, prescription drugs, vision care, medical savings accounts, and any other costs to provide health benefits as defined in section 213(d) of the Internal Revenue Code.

VII. "Wages" mean wages as defined in RSA 281-A:2, XV.

167:99 Fair Share Health Care Fund. There is hereby established in the office of the state treasurer a fund to be known as the fair share health care fund. Moneys required under RSA 167:100 and any other money from any other source shall be deposited in the fund. Moneys in this fund shall be nonlapsing and continually appropriated to the commissioner to be used to support the operation of the Medicaid program.

167:100 Employers to Provide a Percentage of Payroll.

I. An employer which has 1,500 or more employees and which is:

(a) An employer that is organized as a nonprofit organization that does not spend up to 8.5 percent of the total wages paid to employees in the state on health insurance costs shall pay to the fund each year, an amount equal to the difference between what the employer spends for health insurance costs and an amount equal to 8.5 percent of the total wages paid to employees in the state.

(b) An employer that is organized as a for-profit organization and which does not spend up to 10.5 percent of the total wages paid to employees in the state on health insurance costs shall pay to the fund each year, an amount equal to the difference between what the employer spends for health insurance costs and an amount equal to 10.5 percent of the total wages paid to employees in the state.

II. An employer shall not deduct any payment made under subparagraph I(a) or (b) from the wages of an employee.

167:101 Reporting Guidelines.

I. An employer which has 1500 or more employees shall, commencing on January 1, 2007 and annually thereafter, submit the following information on a department-approved form to the commissioner:

(a) The number of employees of the employer in the state as of one day in the year immediately preceding the previous calendar year as determined by the employer on an annual basis.

(b) The number of employees eligible for health insurance benefits.

(c) The requirements employees and dependents must meet to qualify for health insurance benefits.

(d) The amount spent by the employer in the year immediately preceding the previous calendar year on health insurance costs in the state.

(e) The percentage of payroll that was spent by the employer in the year immediately preceding the previous calendar year on health insurance costs in the state.

II. The information required under paragraph I shall:

(a) Be designated in a report signed by the principal executive officer or an individual performing a similar function; and

(b) Include an affidavit under penalty of perjury that the information required under paragraph I of this section:

(1) Was reviewed by the signing officer; and

(2) Was based on the officer's knowledge and does not contain any untrue statement of a material fact or omit a material fact necessary to make the statement made not misleading is true to the best of the signing officer's knowledge, information, and belief.

III. When calculating the percentage of payroll under paragraph I, an employer may exempt:

(a) Wages paid to any employee beyond the amount taxable for federal Social Security (FICA) purposes;

(b) Wages paid to an employee who is enrolled in or eligible for Medicare; and

(c) Wages paid to an employee who is a seasonal worker or works less than 90 days a year.

167:102 Duties of Commissioner; Rulemaking.

I. The commissioner shall, on an annual basis, based on the information reported under RSA 167:101:

(a) Verify which employers in the state have 1500 or more employees in the state.

(b) Ensure that all employers in the state with 1500 or more employees have made the report required under RSA 167:101.

(c) Pay the payroll assessment required under RSA 167:100 to the fund established in RSA 167:99.

II. The commissioner shall adopt rules, pursuant to RSA 541-A, relative to:

(a) When the payments required under RSA 167:100 shall be due.

(b) The content of any forms required under this subdivision.

(c) Further information which may be required under RSA 167:101.

167:103 Penalty. Any employer who violates the provisions of this subdivision shall be guilty of a violation if a natural person, and guilty of a misdemeanor if any other person.

167:104 Report to General Court and Governor Required. On or before March 15 of each year, the commissioner shall make a report to the general court and the governor relative to:

I. The name of each nonprofit and for profit employer with 1500 or more employees in the state.

II. The employer's definition of full-time employee and part-time employee.

III. The number of full-time employees.

IV. The number of full-time employees eligible to receive health insurance benefits.

V. The number of full-time employees receiving health insurance benefits from the employer.

VI. The source of health insurance benefits for those eligible full-time employees not receiving health insurance benefits through an employer subject to reporting under this subdivision.

VII. The number of part-time employees.

VIII. The number of part-time employees eligible to receive health insurance benefits.

IX. The number of part-time employees receiving health insurance benefits from the employer.

X. The source of health insurance benefits for those eligible part-time employees not receiving health insurance benefits through an employer subject to reporting under this subdivision.

2 New Subparagraph; Treasury. Amend RSA 6:12, I(b) by inserting after subparagraph 242 the following new subparagraph:

(243) Moneys received under RSA 167:100, which shall be credited to the fair share health care fund.

3 Effective Date. This act shall take effect January 1, 2007.

LBAO
06-2279
Revised 12/27/05

HB 1704 FISCAL NOTE

AN ACT establishing a health care fund, continually appropriating a special fund, and requiring certain employers to report certain information to the department of health and human services.

FISCAL IMPACT:

The Department of Health and Human Services states this bill will increase state revenue and expenditures by indeterminable amounts in FY 2007 and each year thereafter. The Insurance Department states this bill will have an indeterminable fiscal impact on state, county, and local revenue and expenditures.

METHODOLOGY:

The Department of Health and Human Services assumed there are relatively few employers in New Hampshire with more than 1,500 employees; and therefore subject to the provisions of this bill. The Department is unable to determine how many non-profits do not spend ~~10.5%~~ 8.5% of total wages for health care benefits or how many for-profits do not spend ~~8.5%~~ 10.5% of their total payroll for health care benefits. The Department assumed it would incur administrative costs to draft rules, receive and process the reports from employers, monitor employer's compliance and administer the fund. The Department is not able to project the administrative costs but states these costs are not eligible for federal Medicaid funds.

NHDS CORRECTION

The Insurance Department stated this bill does not have a direct impact on health insurance costs, but may impact how employers choose to design employee benefit plans. The Department assumed that employers that spend less on employee health insurance may see ~~there~~ their costs increase, and if those employers change their health benefit plans there could be an impact on premium tax revenue.

LBAO
06-2279
Revised 1/11/06

HB 1704 FISCAL NOTE

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The Insurance Department stated this bill does not have a direct impact on health insurance costs, but may impact how employers choose to design employee benefit plans. The Department assumed that employers that spend less on employee health insurance may see their costs increase, and if those employers change their health benefit plans there could be an impact on premium tax revenue.

Amendments

Rep. Moody, Rock. 12
December 30, 2005
2006-0282h
09/03

Amendment to HB 1704-FN-A

Amend RSA 167:100, I as inserted by section 1 of the bill by replacing it with the following:

I. An employer which has 1,500 or more employees and which is:

(a) An employer that is organized as a nonprofit organization that does not spend up to 6 percent of the total wages paid to employees in the state on health insurance costs shall pay to the fund each year, an amount equal to the difference between what the employer spends for health insurance costs and an amount equal to 6 percent of the total wages paid to employees in the state.

(b) An employer that is organized as a for-profit organization and which does not spend up to 8 percent of the total wages paid to employees in the state on health insurance costs shall pay to the fund each year, an amount equal to the difference between what the employer spends for health insurance costs and an amount equal to 8 percent of the total wages paid to employees in the state.

ADOPTED

Speakers

SIGN UP SHEET

To Register Opinion If Not Speaking

Bill # HB 1704-FN-A Date 1-11-06

Committee Commerce

** Please Print All Information **

Name	Address	Phone	Representing	(check one) Pro	Con
Matt Quandt	Exeter	772 3417	Rock 13	✓	
TOM LANGLAIS	EPSOM	736-6040	MERRIMACK	✓	
Carol McGuire	Manchester		self		X
Eileen Flockhart	Rock. Co	978-0647	#13	✓	
Lawrence D Brown	Milton	652-4306	Strafford 3	X	
Rep. M.E. Morton	Nashua			X	
REP JEAN JEWETT	134 CALEF RD	645-5290		✓	
Rep. Neal Kurk					✓
REP JAMES POWERS	PORTSMOUTH	436-7846		X	
JAY PHINIZY	SULLIVAN DIST 5	ACWORTH.		✓	
Rep. Randall Pitt	Holderness Hills	Dist 2	Republican	✓	
LESLIE MELBY	125 AIRPORT RD CONCORD	225-0900	NHHA	✓	
Jeanne Rousseau	138 Hampstead Rd Derry	NH		✓	
Deborah Wheeler	38 Bay St Northfield	NH		✓	
Jerry Daigle	21 Whitehall Rd Hooksett	NH.		✓	
Rep Frank Tupper	Carroll County	Merr Dist 6		✓	
DAVID LUDLOW	1279 CHOCORUA RD	TAMWORTH		✓	
Jason Bruce	4 Park St. Concord	225-2097	NHCA	✓	
Andrew Sylvia	28 MERRIMACK	MERRIMACK		✓	
Rep. Pam Mauney					✓
Mary Frost	101 Old Lakeshore Rd	Gilford	524 2974	✓	
Rep John Gibson	Hills Dist 19	Republican		✓	
Benjamin J. Clifford	33 Myrtle St	Manchester	714 8376	✓	

Hearing Minutes

HOUSE COMMITTEE ON COMMERCE

PUBLIC HEARING ON PH 1704-FN-A

BILL TITLE: establishing a health care fund, continually appropriating a special fund, and requiring certain employers to report certain information to the department of health and human services.

DATE: January 11, 2006

LOB ROOM: 302 **Time Public Hearing Called to Order:** 3:11 pm

Time Adjourned: {4:10 pm}

(please circle if present)

Committee Members: Reps. S. Francoeur, Stepanek, Belanger, Langley, D. Flanders, Marshall Quandt, Matthew Quandt, C. Clark, S. Scamman, Headd, Kidder, J. Martin, Pelkey, Kathleen Taylor, Reardon, DeStefano, Kopka, DeVries, Egbers, McLeod and Mitchell.

Bill Sponsors: Reps. Moody, Walz, Marshall Quandt, Matthew Quandt, Harvey and Sen. Fuller Clark

TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.

Rep. Marcia Moody, prime sponsor – Testified in support of the bill

Rep. Suzanne Harvey, co-sponsor – For the bill

Rep. Mary Beth Walz, co-sponsor – Supports the bill.

Q: Rep. Martha McLeod – Cost shift to medicaid not reasonable.

Q: Rep. Bonnie Mitchell –

Q: Rep. Stephen Stepanek – 1500 employees? Why? Subjective judgment; companion bill HB 1703/500 exemption. Model legislation- Maryland. "NH for healthcare."

Sen. Martha Fuller Clark – Co-sponsor – Supports the bill. Fair share bill. Company funded insurance; 90's recommendation. Highly progressive income tax; 90% health benefit tax deduction.

***Rep. Marshall Quandt, co-sponsor** – Supports the bill. See written testimony.

***Rep. H.C. Dickinson** – Supports the bill. See written testimony.

Rep. Pam Manley – Opposes the bill; Wal-Mart employee.

John Thyng, NH For Healthcare – Supports the bill; ERISA compliant.

*Curtis Barry & Nancy Kyle, Retail Merchants Association of NH – Opposes the bill. Submitted written testimony.

Q: Rep. Stepanek – Part time help? Affect? Negative.

*Susan Bruce, NH Citizens Alliance – Supports the bill. Submitted written testimony.

John Grieco, business owner from Hampstead – Opposes the bill. New small group health cost increase-2006-43% 1-1-05; went with new company 6% 2-1-06

Dave Juvet, BIA – Opposes the bill. Possible constitutional issue.

Respectfully Submitted:

Charles L. Clark, Clerk

STEPANEK, MARTIN
MCLEOD

HOUSE COMMITTEE ON COMMERCE

PUBLIC HEARING ON HB 1704-FN-A

BILL TITLE: establishing a health care fund, continually appropriating a special fund, and requiring certain employers to report certain information to the department of health and human services.

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Time Adjourned: {Time}

(please circle if present)

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Bill Sponsors: Reps.Moody, Walz, Marshall Quandt, Matthew Quandt, Harvey and Sen. Fuller Clark

TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.

* REP MOODY — FOR —

* REP HARVEY — FOR —
MARY BETH WALZ — FOR —

Q REP. McLEOD — COST SHIFT TO MEDICAID NOT REASONABLE.

Q REP. MITCHELL

Q REP STEPANEK — 1500 EMP.? WHY? — SUBJECTIVE JUDGEMENT
COMPANION BILL 1703 / 500 EMP.
MODEL LEGISLATION — MARYLAND
& N.H. FOR HEALTHCARE

SEN. MARTHA FULLER CLARK — FOR — FAIR SHARE BILL
100"-146" UNINSURED
COMPANY FUNDED INS.
SOS RECOMMENDATION

HIGHLY PROGRESSIVE INCOME TAX
90% TOP TAXBRACKET HLTH. BENE. ED. TAX

HB 1704-FN-A
M. FULLER CLARK – CONT. –

REP.
* LEE QUANDT – FOR

*REP. H.E DICKINSON – FOR

REP PAM MANEY – OPPOSE – WALMART EMPLOYEE

JOHN THYNG – FOR – ERISA COMPLIANT
N.H. FOR HEALTHCARE

*CURTIS BARRY – OPPOSE –
NANCY KYLE
RETAIL MERCHANTS ASSOC.
Q. STEPANEK – PART TIME HELP EFFECT? NEGATIVE.

SUSAN BRUCE – FOR
N.H. CITIZENS ALLIANCE

NEW SMALL GRP HLTH COST INCREASE
2006 – 43% 4/1/06

JOHN GRIECO – OPPOSE – WENT WITH NEW CO. 6% 2/1/06
BUS. OWNER

DAVE JUVET – OPPOSE – POSSIBLE CONSTITUTIONAL
BIA ISSUE.

Sub-Committee Actions

HOUSE COMMITTEE ON COMMERCE

SUBCOMMITTEE WORK SESSION ON HB 1704-FN-A

BILL TITLE: establishing a health care fund, continually appropriating a special fund, and requiring certain employers to report certain information to the department of health and human services.

DATE: January 25, 2006

Subcommittee Members: Reps. Stepanek, Francoeur and Egbers

Comments and Recommendations:

Amendments:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Motions: OTP, OTP/A, ITL, Interim Study (Please circle one.)

Moved by Rep.

Seconded by Rep.

Vote:

Motions: OTP, OTP/A, (ITL), Interim Study (Please circle one.)

Moved by Rep. Francoeur

Seconded by Rep. Stepanek

Vote: 2-1

Respectfully submitted,

Rep. Stephen B. Stepanek
Subcommittee Chairman/Clerk

HOUSE COMMITTEE ON COMMERCE

SUBCOMMITTEE WORK SESSION ON HB 1704-FN-A

BILL TITLE: establishing a health care fund, continually appropriating a special fund, and requiring certain employers to report certain information to the department of health and human services.

DATE: {Type DATE}

Subcommittee Members: Reps. {Type NAMES} REP. STEPANEK, REP FRANCOEUR
REP EGBERS

Comments and Recommendations:

Amendments:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Motions: OTP, OTP/A, ITL, Interim Study (Please circle one.)

Moved by Rep. FRANCOEUR

Seconded by Rep. STEPANEK

Vote: 2-1

Motions: OTP, OTP/A, ITL, Interim Study (Please circle one.)

Moved by Rep.

Seconded by Rep.

Vote:

Respectfully submitted,

Rep. {Type NAME}
Subcommittee Chairman/Clerk

Testimony

State of New Hampshire

HOUSE OF REPRESENTATIVES
Legislative Office Building, 33 North State Street
Concord, NH 03301-6328

FAX

Date: 1-19-06
Number of pages
(including cover sheet): 2

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Fax No.: 603-929-2704

From: CAROL / COMMERCE

Home Tel. No.:

Home FAX No.:

LOB Tel. No.: 271-3369

LOB Fax No.: (603) 271-6689

REMARKS: ☐ Urgent ☐ For your review ☐ Reply ASAP ☐ Please comment

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House Commerce Committee Public Hearing on HB 1704 - January 11, 2006
Curtis J. Barry on behalf of the
Retail Merchants Association of New Hampshire

The Retail Merchants Association represents New Hampshire's retail industry generally, and its 900+ members of all shapes and sizes specifically.

Several generalizations are generally made when addressing how much employers provide health benefits. First, might be that retail as a whole doesn't provide much in the way of health benefits, then they will point to Wal-Mart. Second, that "large corporations don't provide health care". There is no evidence of this.

The fact is that Wal-Mart and other major retailers do provide health benefits. Those retailers that cannot are typically the smaller retailers. That is supported in a study conducted by professors from Dartmouth and the University of Michigan.

The reason smaller retailers cannot is cost. And *this bill does absolutely nothing to address the cost of healthcare*. When it comes right down to it, no matter who pays, the system as we know it is not sustainable, period.

In 2003 a survey of RMANH members showed that the number 1 impediment to hiring new workers was the rapidly rising cost of health care.

A more recent survey, asking different questions, showed that health care benefits costs rose an average of 16.9% from 2003 to 2004 and nearly 20% the year before. The only ways retails said their costs were reduced were through attrition or offering less costly plans.

When Medicare and Medicaid were established it was because we as a country made a conscious decision that 1) there needs to be a program for the uninsured and underinsured; and 2) employers shouldn't be burdened solely with that expense - costs should be shared by a broad tax base.

This proposal is directed at retail, and one retailer in specific, but from our estimation at least 3 retailers would meet the threshold. I do not have information on the percentage of their health care costs relative to total wages for any, but have provided Wal-Mart health insurance plan information available at walmartfacts.com.

<u>This approach is flawed first philosophically</u>.

- Health care benefits emerged as an enticement to recruit and retain good workers. This bill changes that philosophy.

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- This is back-door nationalized health care that couldn't be won through the front door. If this approach is taken, why not just put a tax on payroll in place generally and have the state pay for health care? If supporters were to present the full story, that is the goal.

- Governor Ehrlich in Maryland, who vetoed similar legislation calling it a "chilling anti-business message" and "anti-jobs", said this "is only a starting point. Vincent DeMarco, the lead advocate for the so-called Wal-Mart bill, said he would like to see the concept expanded to target smaller employers in Maryland."

- From 12-5-05 Union Leader, reprinting a Washington Post Editorial:
  Moreover, it's ironic that Wal-Mart's enemies, who are mainly progressives, should even raise this issue. In the 1990s progressives argued loudly for the reform that allowed poor Americans to keep Medicaid benefits even if they had a job. Now that this policy is helping workers at Wal-Mart, progressives shouldn't blame the company. Besides, many progressives favor a national health system. In other words, they attack Wal-Mart for having 5 percent of its workers receive health care courtesy of taxpayers when the policy that they support would increase that share to 100 percent.

A look at the retail business and labor model is necessary to understand how this approach is flawed in practice.

- HB 1704 counts part-time employees in the wage calculation; should businesses pay health insurance costs for part-time students who are covered by their parent's or schools policies?

- This proposal also doesn't take into account employees who do not accept the health benefits because a spouse is already covered.

- It is interesting to note that the same Dartmouth / University of Michigan study referenced earlier found that 25% of employed persons with no health coverage have access to coverage through their employer but declined.

What will be the results from an employment perspective?

- lowering total wages to comply by cutting summer jobs, welfare to work, and other part time jobs

- more self-check out lanes

- puts at risk non-health care benefits i.e. profit sharing, retirement, etc

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- companies that find themselves approaching the threshold especially will be taking measures to avoid the law, including for example eliminating two part-time jobs to create one full-time employees.

The negatives of this bill include:

- potentially making health coverage even more costly by forcing a company with access to good health coverage unnecessarily increase health insurance costs to comply,

- placing some retail businesses who do not meet the threshold at a competitive advantage with other large businesses in the same industry by forcing higher prices or forcing cuts to customer service,

- a negative financial impact on pensions, retirement accounts etc. that invest in any major retailer,

Further Problems with this approach:

- The percentages required in this bill and the employees threshold are arbitrary; the supporters in their documentation admit so. Maryland's bill had levels of 6% & 8%

- How does this bill treat Vermont or Maine residents that might work for a New Hampshire-based company that falls above the threshold?

- Conversely, how does this bill treat New Hampshire residents who work for a company in Massachusetts?

Clearly this bill is not the answer to America's or New Hampshire health access problem.

Put aside the health insurance issue for a second and ask would you put a tax of this kind on business for the general fund?

The George Washington University
WASHINGTON DC
MEDICAL CENTER

SCHOOL OF PUBLIC HEALTH AND HEALTH SERVICES
CENTER FOR HEALTH SERVICES RESEARCH & POLICY

January 5, 2006

Jonathan Parker
National Director
SEIU, Americans for Health Care
1313 L St., NW
Washington, DC 20005

Dear Mr. Parker:

This is in response to your request for me to review the provisions of the Maryland Fair Share Health Care Fund Act ("the Maryland Act"), which was adopted by the Maryland Legislature in the 2005 Session, to determine whether its provisions imposing an assessment on certain employers who do not spend a specified percentage of total wages on "health insurance costs" are preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"). Although no court has directly addressed this issue, for the reasons described below, I have concluded that ERISA does not preempt the Maryland Fair Share Health Care Fund Act.

Overview of Current ERISA Preemption Jurisprudence

In the more than thirty years since the Federal law was passed, no issue of statutory interpretation under ERISA has so occupied the attention of the U.S. Supreme Court as the interrelationship of state laws and ERISA through ERISA's preemption clause. The Court has heard nearly twenty-five cases on this topic alone during this period.

It is fair to say that until 1995, the Supreme Court took a very narrow view of the extent to which state laws could survive an ERISA preemption challenge. Since then, however, beginning with the Court's 1995 watershed decision, *New York State Conference of Blue Cross &Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995) ("*Travelers*"), the Court has revisited, redefined and broadened its historical view of two critical components of the ERISA preemption test: whether a state law "relates to" an ERISA plan and whether a state law is a "law regulating insurance" that should be saved from preemption under ERISA's so-called "savings clause." For purposes of analyzing the Maryland Fair Share Health Care Fund Act, however, the Court's new "relates to" interpretation is most relevant.

The effect of the Court's shifting view of the relative relationship between state laws and ERISA's preemption provisions is to give states considerably more latitude in regulating matters that may affect ERISA covered-employee benefit plans, while preventing in most instances direct state regulation of the plans themselves. It is in this context that one must examine the Maryland Fair Share Health Care Act to determine whether its provisions can withstand an ERISA preemption challenge.

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What Does the Maryland Law Require?

The Maryland Fair Share Health Care Fund Act requires employers, beginning January 1, 2007, to report to the Maryland Department of Labor, Licensing and Regulation (DLLR) the number of its employees and the amount and percentage of payroll spent by the employer in the year preceding the previous calendar year. In addition, the employer must report the amount spent by the employer for the same period on "health insurance costs" in the state. Non-profit employers that do not spend at least 6% of total wages and for-profit employers that do not spend at least 8% of total wages during the same period are required to pay the Fair Share Health Care Fund an assessment equal to the difference between the amount spent and the applicable percentage. "Health insurance costs" include any "payments for medical care, prescription drugs, vision care, medical savings accounts, and any other costs to provide health benefits" as those payments and costs are defined in Section 213(d) of the Internal Revenue Code.

What Criteria Is Used for Determining Whether A State Law Is Preempted by ERISA?

The general statutory framework under ERISA for deciding whether a state law will be preempted can be simply stated:

1. Does the challenged law "relate to" an ERISA plan (regardless of whether the plan is insured or self-insured)?

2. If so, does the challenged law fall into one of the statutory exceptions (state insurance, banking, and securities laws, as well as generally applicable criminal laws) and therefore, within the ambit of the "savings" clause?

3. Is the "saved" state insurance law, nevertheless, preempted because it violates the "deemer" clause?

For purposes of analyzing whether the Maryland Fair Share Health Care Fund Act is preempted, the relevant question is whether this law "relates to" an ERISA plan. If the answer is no, then the remaining questions asked above are irrelevant.

Section 514(a) of ERISA provides that ERISA will "... supersede any and all state laws insofar as they may now or hereafter *relate to* any employee benefit plan described in section 4(a) and not exempt under section 4(b) (emphasis added)."[1] As previously noted, the early Supreme Court cases interpreting the "relate to" clause of ERISA took a very expansive view of whether a state law related to an ERISA plan. Some argued that, in effect, the Court assumed

[1] 29 U.S.C. §1144(a) – (b).

that any state law or regulation that had an impact on an ERISA plan would be preempted. However, that is not the framework for analysis that the Court has used since 1995.

In *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995) ("*Travelers*"), the Court examined a New York statute that required hospitals to collect surcharges on hospital bills from patients or payers on their behalf (only Empire Blue Cross Blue Shield was exempt from these surcharges). The revenue from the surcharges was used to subsidize the state's uncompensated care programs. The New York statute was challenged by commercial insurers and health maintenance organizations (HMOs) who argued that, with respect to their covered enrollees in ERISA plans, the surcharges were taxes imposed on ERISA plans and thus preempted by ERISA.

The Supreme Court disagreed, holding, among other things, that even if the surcharges had an indirect economic influence on ERISA plans, they were not preempted by ERISA because they did not "relate to" employee benefit plans. 514 U.S. at 649. Adopting the traditional presumption that federal law (ERISA) should not preempt state laws unless Congress clearly intended it to do so (514 U.S. at 654-55), the Court refused to overturn the New York law, since it did not "bind plan administrators to any particular choice" or "preclude uniform administrative practice or the provision of a uniform interstate benefit package, if a plan wishes to provide one. It simply bears on the **cost of benefits** and the relative costs of competing insurance to provide them [emphasis added]." 514 U.S. at 659. Moreover, the Court recognized that although the surcharges were meant to increase the costs of health insurance and health care for some of the HMOs, they did not interfere with the choices that ERISA plans make for benefit coverage. 514 U.S. at 654.

Finally, Justice Souter, writing for a unanimous Court, described the *Travelers'* decision as follows:

> ...we do not hold today that ERISA pre-empts only direct regulation of ERISA plans, nor could we do that with fidelity to the views expressed in our prior opinions on the matter ... (citations omitted). We acknowledge that a state law might produce such acute, albeit indirect, economic effects, by intent or otherwise, to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers, and that such a state law might indeed be pre-empted under § 514...."

In a subsequent case, the Supreme Court expanded on this more narrow view of when ERISA preemption should nullify state law. For instance, in *California Div. of Labor Standards Enforcement v. Dillingham Constr.*, 519 U.S. 316 (1997), a unanimous Court reinforced the

presumption against preemption articulated in *Travelers*. 519 U.S. at 331. *Dillingham* involved the enforcement of California's prevailing wage law that allowed employers to pay a lower wage to employees who were participating in a state-approved apprenticeship program. Employers whose employees were enrolled in non-state approved apprenticeship programs were required to pay prevailing wages, not the lower wage. Among other things, the state law was challenged as preempted by ERISA, since the contractors argued that the California prevailing wage law "related to" an ERISA covered plan.

However, the Court rejected that argument since to be a state-approved apprenticeship program, the apprenticeship program did not need to be an ERISA plan. So in *Dillingham*, the Court reaffirmed that a state law only "relates to" an ERISA plan if it refers to or has a significant connection with an ERISA plan. 519 U.S. at 324. For a state law to meet this requirement, the existence of an ERISA plan is essential to the law's operation. 519 U.S. at 325.

As the *Dillingham* Court concluded, if the state law merely "alters the incentives" which exist for an ERISA plan, but "does not dictate the choices," then the law is not sufficiently connected with an ERISA plan to trigger preemption. 519 U.S. at 333.

Does the Maryland Fair Share Health Care Fund Act Violate ERISA's Preemption Provisions?

Based on existing current Supreme Court precedent, it cannot be reasonably argued that the Maryland Act is preempted by ERISA.

The Maryland Act imposes an assessment on employers based on the extent to which their health care expenditures for their employees as a percentage of their total wages for a measuring period fall below a specified percentage. This is a regulation on employers, not ERISA plans.

Moreover, the Maryland Act does not "relate to" ERISA-covered plans. It does not require employers to establish ERISA plans; it only requires employer to spend a certain amount of their payroll on health-related expenditures. Under the structure of the law, an employer may choose to spend no percent of its payroll on health expenditures for its employees. If an employer chooses that route, it simply pays the applicable assessment to the state's DLLR.

If an employer chooses to meet the applicable expenditure target, for instance, by establishing a series of on-site medical clinics where its employees can receive care or by hiring a nurse on an ad hoc basis to provide periodic immunizations for employees and their families, the employer may do so and those costs count toward the expenditure target. The Act permits any expenditures for health care costs that meet the Internal Revenue Service's definition of medical expenses to be counted toward this expenditure level.

If an employer subject to the law chooses to meet the expenditure level through the establishment or maintenance of an ERISA plan, the employer is free to do so. The employer

may design its plan to cover as many or as few benefits as it wishes, as many or as few employees as it chooses, and using whatever financing and employer-employee cost-sharing formula it chooses to adopt. Clearly the Maryland Fair Share Health Care Fund Act does not in any way constrain an employer's plan design choices.

Thus the Maryland Fair Share Health Care Fund Act cannot be said to require any employer to establish an ERISA plan to comply. Under the analysis used by a unanimous Supreme Court in *Dillingham*, the Maryland law would not be preempted. Nor can it be said that the Maryland Act binds plan administrators to any particular choice or prevents uniform benefit administration or plan design for a covered employer who operates in many states. Under the precedent established by a unanimous Supreme Court in *Travelers*, the Maryland Act would not be preempted either.

Based on existing current Supreme Court precedent, therefore, it cannot be reasonably argued that the Maryland Fair Share Health Care Fund Act is preempted by ERISA.

If I can be of any further assistance, please let me know.

Phyllis C Borzi

Phyllis C. Borzi, J.D., M.A.
Research Professor
Department of Health Policy
School of Public Health and Health Services
The George Washington University

PHYLLIS C. BORZI

Ms. Borzi is a Research Professor in the Department of Health Policy at the School of Public Health and Health Services, The George Washington University Medical Center, where she is involved in legal and policy analysis, research, and teaching involving managed care, employer-sponsored health coverage and other related issues. Ms. Borzi is also a practicing lawyer serving of counsel with O'Donoghue & O'Donoghue, LLP, a Washington, D.C. law firm. Ms. Borzi specializes in ERISA and other legal areas affecting employee benefit plans, including group health plans, pensions and retirement savings, and discrimination based on age or disability.

From 1979 to 1995, Ms. Borzi served as Pension and Employee Benefit Counsel for the U.S. House of Representatives, Subcommittee on Labor-Management Relations of the Committee on Education and Labor (now called the Committee on Education and the Workforce).

She is the co-chair of the Advisory Board of the BNA Pension & Benefits Reporter and the 1994 recipient of the Public Service Award presented by the International Foundation of Employee Benefit Plans. Ms. Borzi is a former member of the Advisory Committee of the Pension Benefit Guaranty Corporation. Ms. Borzi is also a Charter Fellow and President of the American College of Employee Benefits Counsel and serves on its Board of Governors. She is also a member of the Advisory Board of the Pension Research Council of the Wharton School, The University of Pennsylvania. Since 1996, Ms. Borzi has served on the Board of the Women's Institute for a Secure Retirement (WISER).

Ms. Borzi has served on various expert panels and boards, including the Institute of Medicine's Subcommittee on Creating an Environment for Quality in Health Care, the Committee on Quality of Health Care in America. The work of this group led to the publication of the IOM's landmark report on medical errors, *To Err Is Human*. She has also testified before Congress and the U.S. Department of Labor's ERISA Advisory Committee on several health and pension-related topics.

Ms. Borzi has published numerous articles on ERISA as well as health law and policy issues and has been a frequent speaker on programs sponsored by legal, professional, business, and consumer organizations. An active member of the employee benefits committees of six sections of the American Bar Association, Ms. Borzi also serves on the Continuing Legal Education Committees of the ABA Joint Committee on Employee Benefits, the ABA Section of Labor and Employment Law and the D.C. Bar Association.

She is the co-author of the ERISA preemption chapter in the recent treatise published by the Section of Health Law of the American Bar Association and BNA entitled *Managed Care Litigation*, and a contributing editor on preemption topics to the *Employee Benefits Law* treatise published by the Employee Benefits Committee of the Section of Labor and Employment Law of the American Bar Association.

Ms. Borzi holds a Masters in English from Syracuse University and is a graduate of the Catholic University Law School where she served as Editor-in-Chief of the Law Review. She became a member of the DC Bar in December, 1978 and also has been admitted to practice before the U.S. Court of Appeals for the District of Columbia and the U.S. Supreme Court.

TOP 30 EMPLOYERS IN NEW HAMPSHIRE

Rank	Company	NH Employees
1	State of New Hampshire	10,583
2	Wal-Mart Stores, Inc.	8,662
3	Federal Government	8,100
4	Dartmouth-Hitchcock Medical Center	7,100
5	DeMoulas & Market Basket	6,600
6	BAE Systems	4,900
7	Shaw's Supermarkets	4,600
8	Liberty Mutual Group	4,487
9	Fidelity Investments	4,273
10	Dartmouth College	4,074
11	Elliot Hospital	3,875
12	Hannaford Brothers-Shop 'n Save	3,200
13	Home Depot	2,500
14	Concord Hospital	2,320
15	Southern NH Medical Center	1,800
16	Verizon Communications	1,750
17	Hewlett-Packard Co.	1,700
18	Catholic Medical Center	1,700
19	Osram Sylvania, Inc.	1,685
20	Sears	1,626
21	Teradyne Connection Systems	1,600
22	NH International Speedway	1,500
23	St. Joseph Hospital	1,500
24	Freudenberg-NOK	1,421
25	Wentworth-Douglas Hospital	1,361
26	United Parcel Service	1,311
27	Public Service of New Hampshire	1,250
28	Citizens Bank	1,225
29	Pleasant View Retirement	1,200
30	Bank of New Hampshire	1,153

Source: Government Performance Project, NH Business Review 2005 Book of Lists, NH Employment Security Labor Market Information Bureau

HB 1704 Concerning Health Care

Good afternoon Madam Chair and Honorable Committee members. I am Marcia Moody Representative from Newmarket/Newfields Rockingham County District 12.

As most of you know, the health care system we have for the people of New Hampshire is employer based and this system is in trouble. Through incremental steps, we can begin to address this situation. This bill is designed to help fix one small part of the problem.

The question before you is how does HB 1704 benefit the people of New Hampshire? This bill is divided into two sections, reporting and funding. The reporting element will give us supportive information such as numbers of employees eligible for health insurance benefits, who qualifies for benefits, and the percentage of employer payroll spent for health care. The funding section is designed to reimburse the state for Medicaid expenses incurred providing health care for uninsured workers.

The text of the amended bill states that an employer with 1,500 employees or more in the state of New Hampshire shall spend up to 8% of the total wages paid towards health insurance for their employees or pay the difference of what the employer spends and any shortfall of the 8% into a fund to be known as the Fair Share Health Care Fund. This fund is to be used to support the state Medicaid program.

As you are well aware, we face a national health care crisis. Health care costs have skyrocketed. One of the factors driving these costs upward is the increased number of uninsured who consequently rely on Medicaid and or emergency room services. According to the NH Center for Public Policy, a census bureau report and a UNH survey estimated that the number of uninsured New Hampshire residents in 2003 was about 120,000. The Kaiser Family Foundation compiled a report last year in which they found that 74% of the uninsured in New Hampshire have at least one full-time worker at home and that 13% of the uninsured are children under the age of 18.

A recent Kaiser Family Foundation study found the number of employees receiving coverage through their employers declined from 65% in 2001 to 61% in 2004. The study also shows that the national percentage of people counting on Medicaid for their health care coverage increased from 12.4% to 12.9%

The federal government has approved $10 billion in cuts to the very programs millions depend upon. The New Hampshire DHHS Medicaid Business and Policy Bureau, Health Care Research Division states that for the last fiscal year the total for all categories of people receiving Medicaid assistance is 96,184. NH DHHS says that as of January 31, 2005, about 18,000 or 18%, are children with employer-linked parents. The proposed $10 billion in cuts to the federal programs will shift the cost to state and local communities. Just last week, this very legislature was forced to vote to return $43,619,288 to the federal government for Medicaid payments known as "clawback".

1/11/2006

One aspect of cost shifting to the state and the taxpayer occurs when some large corporations in New Hampshire reduce their operating costs by offering inadequate and expensive health insurance. By setting high health insurance premiums, imposing a long waiting period for eligibility (up to 24 months), imposing high deductibles and offering only minimum coverage (less than Medicaid provides), they have made health insurance unaffordable for most of their employees. Many of these uninsured employees have turned to Medicaid for coverage. This increases the Medicaid cost paid by the state and in turn by New Hampshire taxpayers. These corporations are using the New Hampshire taxpayers to subsidize their bottom line. This is wrong.

Another burden on taxpayers is the cost of care provided to the uninsured not on Medicaid. According to the New Hampshire Hospital Association, last year hospitals alone provided $93.5 million in charity care and wrote-off $143.8 million in bad debt for a total of $237.4 million. This is not free. Hospitals must still meet their payroll and operating costs. To do so, they must raise their charges for service. In a NH Center for Public Policy study in 2001, New Hampshire Hospitals shifted $198 million in costs to insurers and self-pay patients as a 23% surcharge or tax in the form of higher premiums.

Emergency room care is the most expensive. A large number of the uninsured rely on emergency room service for their primary care. The cost, estimated by the insurance industry to be 13.9%, is once more passed on as a hidden tax to the insured by raising their premiums.

Requiring large corporations to pay a fair share towards health care is good for everyone and will benefit all businesses. Employees with affordable health insurance have access to preventive care. A healthy workforce is a stable workforce. Healthy employees have less absenteeism. Employees are loyal to a company that provides benefits. Employers have less turnover and are able to retain their most valuable employees.

In summary, taxpayers and responsible businesses throughout the state of New Hampshire are now asked to subsidize those corporations that have not paid their fair share of health care costs. This bill addresses this inequity by having those large corporations be responsible for devoting 8% (which is the national average) of their payroll cost towards health insurance for their employees. It also holds the potential to generate a sum of money to help ease the Medicaid funding crisis, by having these large corporations pay the difference of what they do provide and any shortfall into the fund established to support the operation of the state Medicaid program.

This approach could also alleviate some of the costs that have been shifted to New Hampshire businesses and taxpayers in the form of higher insurance premiums. Taxpayers feel that they should not be subsidizing corporations that are not paying their fair share, and this bill answers that concern. Fair share health care is a nation wide initiative. New Hampshire is not alone in submitting legislation. Similar legislation is already being proposed in Connecticut, Rhode Island, Massachusetts, Kansas, Florida, Colorado and Wisconsin. Though Maryland was first in the nation, let us in New Hampshire do our fair share to promote health care.

Thank you Madam Chair and Honorable Committee members for the opportunity to attend this hearing and present this testimony.

1/11/2006

HB 1704 Testimony

Rep. Suzanne Harvey

Hillsborough 21

Thank you, Madam Chairman and Good Afternoon, Committee Members.

I'm here today to talk to you about one aspect of the problem regarding low-income working folks who have either no health benefits from their employers or inadequate healthcare benefits.

The problem I want to call to your attention?

It's the kids. It's the kids. And it's the kids.

The healthcare system we have is inequitable not only for people who have the misfortune of getting ill without coverage, but also for many large companies that do act in good faith to provide adequate health benefits to their employees and their families while other employers offer none – or such inadequate coverage that employed families seek state assistance.

Who's subsidizing who here?

I applaud companies that consider it good policy to provide health coverage to their employees and their families.

But how can we allow some large profitable companies to take advantage of the system and force their employees to seek programs such as Medicaid and Healthy Kids?

The alternative for these working folks and their children is no coverage at all.

Are you comfortable telling the CEO of the "Do-right Company" that she's foolishly spending her stockholders profits on employee benefits, including children, while the tax payers of New Hampshire foot the bill for coverage of the "Do-wrong Company's" employees and their children?

Meanwhile, Mr. Do-wrong, likely living in another state, is laughing all the way to the bank, and his employees are paying strangling premiums or they're declining unaffordable coverage altogether.

Should the legislature continue to be an enabler of this inequity?

We're talking about healthcare for honest, hard-working folks and their children here— the saleswoman at the store holding down two part-time jobs, the young father stocking the shelves at the market, the single mom cleaning your mother's hospital room—they may be your neighbors, members of your house of worship, or even your relatives.

Here are some NH numbers from John Steven's department to think about:

- >10,000 NH employers have Medicaid-linked employees

(many are small companies or have only a few employees with this link)

- ~18,000 Healthy Kids Gold recipients (almost 1/3 of TANF Medicaid recipients) can be linked to NH employers (Fact sheet, State of NH, DHHS, OMBP, BHCR, 4/15/05)

- The top 10 employers accounted for 1,366 cases (<10%)

- Among industries employing parents of Medicaid-covered children:

Retail (22%)

Healthcare (16%)

Restaurants (13%)

Govt & Education (10%)

Services (15%)

Nonprofit (4%)

Other (20%)

I'm not suggesting that we need to rethink our model Healthy Kids program—not for one minute. I for one will vote for the health and welfare of children every chance I get.

What this bill is asking is that we hold our state's largest companies accountable for their fair share as employers and for their participation in our state's economy.

Thank you.

Employers of individuals associated with Healthy Kids Gold cases - as of 1/31/05		
Wal-Mart	393	2.15%
Dunkin Donuts	211	1.15%
NP State of New Hampshire	107	0.58%
Hanaford Bros	106	0.58%
Market Basket	99	0.54%
Unknown	99	0.54%
Shaws	98	0.54%
Home Depot	90	0.49%
MCDONALDS	88	0.48%
NP First Student Transportation	75	0.41%
NP GENESIS	55	0.30%
NP Concord Hospital	52	0.28%
NP UNH	51	0.28%
GRANITE STATE INDEPENDANT LIVING	46	0.25%
Burger King	45	0.25%
NP Easter Seal Society of NH	45	0.25%
Laidlaw Transit	42	0.23%
IRVING MAINSTAY OIL CO	41	0.22%
Harborside Health Care	37	0.20%
Applebees	36	0.20%
Friendly's Ice Cream	36	0.20%
NP Elliot Hospital	35	0.19%
Interim Health Care	34	0.19%
Mt. Washington Hotel	34	0.19%
VNA	34	0.19%
Sears	33	0.18%
RITE AID	31	0.17%
NP United States Postal Service	31	0.17%
NP City Of Nashua	30	0.16%
K-Mart	30	0.16%
SunBridge Care & Rehabititation	30	0.16%
CCT (Car Component Tech)	28	0.15%
Ninety Nine Restaurant and Pub	28	0.15%
Perfect Fit	28	0.15%
Citizens Bank	27	0.15%
Strum Ruger co	26	0.14%
Wendy's	26	0.14%
Bank North	25	0.14%
NP Child and Family Health Services of NH	25	0.14%
NP CROTCHED MOUNTAIN	25	0.14%
KOHLS	25	0.14%
SURGE RESOURCES	25	0.14%
Cumberland Farms	24	0.13%
INSIGHT TECHNOLOGIES	24	0.13%
Attitash Bear Peak	23	0.13%
NP Dartmouth Hitchcock	23	0.13%
HARVEY INDUSTRIES	23	0.13%
Hitchiner Mfg	23	0.13%
NP Huggins Hospital	23	0.13%

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MEMORANDUM

To: Interested Parties

From: Lake Research Partners

Subject: Voters' Views on Fair Share Health Care

Date: December 16, 2005

Lake Research Partners conducted a recent national survey[1] in conjunction with on-going research across several states to gauge voters' views on health care reform.

Voters broadly and intensely want large, profitable companies to take their fair share of the responsibility for addressing the health care issue.

- ✓ **Eighty-three percent of voters nationwide support (67% strongly) requiring profitable companies with over 500 employees to either provide health insurance for their employees, or pay a percentage of their payroll into a health care fund [+70 net].**

- ✓ **Support for the proposal is strong across gender lines as both men and women intensely support holding profitable companies accountable to pay their fair share.** Men support this proposal with a net margin of +63 and women are even stronger netting a margin of +77.

- ✓ **Holding companies accountable to pay their fair share is strong across party lines, even in these times of strong partisan divisions.** Democrats support this proposal with a net margin of +78, independents support this with a net of +69, and Republicans have a net support of +64.

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[1] SEIU Americans for Health Care and EMILY's List commissioned Lake Research Partners to design and administer this survey that was conducted by telephone using professional interviewers from November 10-15, 2005. The survey reached 1000 likely voters nationwide (300 men and 700 women), who indicated that they are registered to vote and likely to vote in the 2006 general election. For purposes of calculating margin of error, the effective sample size of the combined totals when the men and women are weighted together is 624, resulting in an error margin of +/-3.9%. For the larger sample of women only, the sample size is 700 and the error margin is +/-3.7%.

1726 M Street, NW, Suite 500 • Washington, DC 20036 • tel. 202/776-9066 • fax 202/776-9074 • info@lakeresearch.com
1000 Broadway, Suite 294 • Oakland, CA 94607 • tel. 510/286-2097 • fax 510/286-2022
655 G Street, Suite H, San Diego, CA 92101 • 619/702-0070 • fax 619/702-0075

- ✓ **Fair share proposals are strong across all parts of the country.** Holding profitable companies accountable for health care is supported by net margins of: +74 in the South, +72 in the Northeast, +71 in the Midwest, and +61 in the West.

- ✓ **In other states where we have tested similar proposals, we have seen intense support.**

    - o North Carolina voters support requiring large, profitable businesses that do not provide health insurance to pay into a fund for the uninsured (51% strongly favor, 79% favor).[2]

    - o Maryland voters support a proposal to ensure that everyone in Maryland has access to affordable health care by requiring businesses that do not provide health insurance to pay into a fund for the uninsured (39% strongly favor, 73% favor).[3]

    - o Wisconsin voters support a proposal to provide comprehensive health insurance coverage to all Wisconsin workers and their families by creating a single statewide insurance pool that all employers would be required to pay into (42% strongly favor, 66% favor).[4]

- ✓ **Voters overwhelmingly support the goals of fair share health care reform as 87% agree (74% strongly agree) with the statement "Everyone has the right to quality, affordable health care coverage." We have seen this value hold true in previous research we have done across the country.**

- ✓ **Voters across the country also agree that "We can't have real health care reform until large, profitable companies pay their fair share for their employees' health care coverage."** More than three out of four voters (77%) agree with that statement (57% strongly agree).

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[2] The survey has a margin of margin of error of +/- 4.4% and reached a total of 500 adults at least 18 years of age in North Carolina who indicated they are registered to vote and that they are likely to vote in the 2004 general elections. The survey was conducted March 22 -25, 2004.

[3] The survey has a margin of error of +/- 4.0% and reached a total of 600 adults at least 18 years of age in Maryland who indicated they are registered to vote and that they are likely to vote in the 2004 general elections. The survey was conducted January 5 -7, 2004.

[4] The survey has a margin of error of +/- 4.4% and reached a total of 500 adults at least 18 years of age in Wisconsin who indicated they are registered to vote and that they are likely to vote in the 2004 general elections. The survey was conducted February 5 -9, 2004.

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114 North Main Street
Suite 401
Concord, NH 03301

Phone: 603.228.3322
Fax: 603.228.0713
www.dupontgroup.com

TO: House Commerce Committee Members

FROM: Curtis J. Barry

RE: HB 1704, establishing a health care fund, continually appropriating a special fund, and requiring certain employers to report certain information to the department of health and human services.

DATE: January 12, 2006

Enclosed is my testimony from the public hearing on HB 1704.

Today, as you may know, the Maryland legislature overrode the Governor's veto of legislation similar to this bill, making Maryland the only state to pass this legislation.

It is interesting to note some of the reasons behind the success bill in Maryland:

- The state retail association in Maryland took a neutral position on the legislation there.
- The retail association in Maryland includes grocers.
- The grocery chain Albertson's was a prime impetus and supporter of the Maryland legislation.
- Albertson's workers are unionized. Wal-Mart's employees are not.
- In fact, unions have been trying for years to organize Wal-Mart employees, without success.
- Committee members present at the hearing will recall that, in response to the question of who wrote the model legislation upon which HB 1704 is based, I presented a package of informational material, including the model bill, from "Americans for Health Care, a project of SEIU" (Service Employees International Union).

In addition, I would like to note that some testimony at the hearing indicated that this was not a "Wal-Mart bill", but the head of New Hampshire for Health Care indicated that they know this probably applies to only one business. Its no secret who they think that business is. It is also no secret why the SEIU is funding this anti-Wal-Mart effort nationwide. Taxing one business will not address the problems this bill claims exist.

For your information, I've also enclosed two editorials, one reprinted by the "Union Leader" and another that appeared in today's "Washington Post".

Please feel free to contact me with any questions on this bill or any other issue.

EDITORIAL

Beating Up on Wal-Mart

Thursday, January 12, 2006; Page A20

AMERICAN BUSINESS has few whipping boys so irresistibly whippable as Wal-Mart Stores Inc., whose treatment of employees, competitors and suppliers conjures cold-eyed corporate heartlessness. It's hard to root for Wal-Mart; one might as easily cheer on Scrooge or the shark in "Jaws." But state lawmakers in Maryland are preparing to impose legislation on the retailer so arbitrary that it may achieve the near-impossible feat of casting Wal-Mart as the victim.

The Maryland bill would force firms with more than 10,000 in-state employees to spend at least 8 percent of their payrolls on workers' health insurance plans or make compensatory payments to the state. Only three other Maryland employers have more than 10,000 workers on their payrolls -- Johns Hopkins University, Northrop Grumman Corp. and Giant Food Inc. -- and they already meet or exceed the 8 percent threshold. Apparently, only Wal-Mart, with about 15,000 full- and part-time employees in Maryland, does not; thus the bill applies uniquely to Wal-Mart.

Maryland's legislature passed the bill last year, but Gov. Robert L. Ehrlich Jr. (R) vetoed it. Lawmakers, urged on by big unions, appear on the verge of overriding the veto despite furious lobbying by Wal-Mart. The legislators, joined by Giant Food (Wal-Mart's unionized competitor), insist disingenuously that they are not singling out the big-box retailer but are merely setting a standard. Yet hundreds of

Today in Opinions

No Consequences for Bad Behavior

» John Feinstein | Star athletes like Marcus Vick inhabit The Land of Never Wrong. It's no wonder they behave so badly.

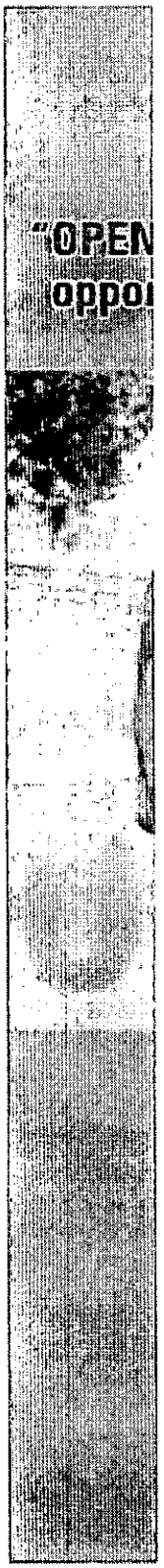
Applebaum: Lobbygate Deja Vu
Dionne: A Lesson From Somalia
Editorial: Unchecked Abuse of Prisoners

OPINIONS SECTION: Froomkin, Toles,

smaller companies in Maryland that fail to meet the 8 percent spending threshold for health care are untouched by the legislation; in total their uninsured employees may be a greater drain on the state's health system than Wal-Mart's. The bill's backers say that Wal-Mart, because it is so large, bears a special obligation to set a good example. But since when do states have the right to penalize firms simply because they are big and successful?

The Maryland bill is a legislative mugging masquerading as an act of benevolent social engineering. It is true that skyrocketing health care costs and the growing ranks of uninsured workers represent a burden on the state's health system that other corporations in effect help subsidize. But Wal-Mart employees, like the employees of other large retailers that employ many low-wage workers, are only slightly more likely to collect Medicaid benefits than the national average. And unlovable as it may be, Wal-Mart serves low- and middle-income people, both by creating entry-level and part-time jobs for people who might otherwise be unemployed and by saving its moderate-income customers a staggering amount of money.

The legislation has prompted imitators in 30 states. Where it passes, no one should be surprised by unintended consequences. Wal-Mart and other targeted firms may shift jobs or planned facilities elsewhere. Many low-wage younger workers may still opt out of health coverage even if offered a more generous plan. In trying to address the national problems of health care and uninsured workers, lawmakers in Maryland and other states could inflict on themselves a new set of problems while failing to solve the underlying one.



NEW HAMPSHIRE UNION LEADER

Sebastian Mallaby: Wal-Mart: a progressive's dream company, really

By SEBASTIAN MALLABY
Another View

THERE'S A COMIC side to the anti-Wal-Mart campaign brewing across the country. Only by summoning up the most naive view of corporate behavior can the critics be shocked — shocked! — by the giant retailer's machinations.

Wal-Mart is plotting to contain health costs! But isn't that what every company does in the face of medical inflation? Wal-Mart has a war room to defend its image! Well, yeah, it's up against a hostile campaign featuring billboards, newspaper ads and a critical documentary movie. Wal-Mart aims to enrich shareholders and put rivals out of business! Hello? What business doesn't do that?

Wal-Mart's critics allege that the retailer is bad for poor Americans. This claim is backward: As Jason Furman of New York University puts it, Wal-Mart is "a progressive success story."

Furman advised John "Benedict Arnold" Kerry in the 2004 campaign and has never received any payment from Wal-Mart; he is no corporate apologist. But he points out that Wal-Mart's discounting on food alone boosts the welfare of American shoppers by at least $50 billion a year. The savings are possibly five times that much if you count all of Wal-Mart's products.

These gains are especially important to poor and moderate-income families. The average Wal-Mart customer earns $35,000 a year, compared with $50,000 at Target and $74,000 at Costco. Moreover, Wal-Mart's "every day low prices" make the biggest difference to the poor, since they spend a higher proportion of income on food and other basics. As a force for poverty relief, Wal-Mart's $200 billion-plus assistance to consumers may rival many federal programs. Those programs are better targeted at the needy, but they are dramatically smaller. Food stamps were worth $33 billion in 2005, and the earned-income tax credit was worth $40 billion.

Set against these savings for consumers, Wal-Mart's alleged suppression of wages appears trivial. Arindrajit Dube of the University of California at Berkeley, a leading Wal-Mart critic, has calculated that the firm has

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caused a $4.7 billion annual loss of wages for workers in the retail sector. This number is disputed: Wal-Mart's pay and benefits can be made to look good or bad depending on which other firms you compare them to. When Wal-Mart opened a store in Glendale, Ariz., last year, it received 8,000 applications for 525 jobs, suggesting that not everyone believes the pay and benefits are unattractive.

But let's say we accept Dube's calculation that retail workers take home $4.7 billion less per year because Wal-Mart has busted unions and generally been ruthless. That loss to workers would still be dwarfed by the $50 billion-plus that Wal-Mart consumers save on food, never mind the much larger sums that they save altogether. Indeed, Furman points out that the wage suppression is so small that even its "victims" may be better off. Retail workers may take home less pay, but their purchasing power probably still grows thanks to Wal-Mart's low prices.

To be fair, the $4.7 billion of wage suppression in the retail sector excludes Wal-Mart's efforts to drive down wages at its suppliers. "Wal-Mart: The High Cost of Low Price," the new anti-Wal-Mart movie that's circulating among activist groups, has the requisite passage about Chinese workers getting pennies per day, sweating to keep Wal-Mart's shelves stocked with cheap clothing. But no study has shown whether Wal-Mart's tactics actually do suppress wages in China or elsewhere, and suppression seems unlikely in poor countries. The Chinese garment workers are mainly migrants from farms, where earnings are even worse than at Wal-Mart's subcontractors and where the labor is still more grueling.

Wal-Mart's critics also paint the company as a parasite on taxpayers, because 5 percent of its workers are on Medicaid. Actually that's a typical level for large retail firms, and the national average for all firms is 4 percent. Moreover, it's ironic that Wal-Mart's enemies, who are mainly progressives, should even raise this issue. In the 1990s progressives argued loudly for the reform that allowed poor Americans to keep Medicaid benefits even if they had a job. Now that this policy is helping workers at Wal-Mart, progressives shouldn't blame the company. Besides, many progressives favor a national health system. In other words, they attack Wal-Mart for having 5 percent of its workers receive health care courtesy of taxpayers when the policy that they support would increase that share to 100 percent.

Companies like Wal-Mart are not run by saints. They can treat workers and competitors roughly. They may be poor stewards of the environment. When they break the law they must be punished. Wal-Mart is at the center of the globalized, technology-driven economy that's radically increased American inequality, so it's not surprising that it has critics. But globalization and business innovation are nonetheless the engines of progress; and if that sounds too abstract, think of the $200 billion-plus that Wal-Mart consumers gain annually. If critics prevent the firm from opening new branches, they will prevent ordinary families from sharing in those gains. Poor Americans will be chief among the casualties.

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New Hampshire Center for PUBLIC POLICY Studies

Cost-Shifting in New Hampshire Hospitals

Author
Douglas E. Hall

October 2003

Cost-Shifting in New Hampshire Hospitals

Contents

About this Paper

This paper is one of a series of reports to be published by the NH Center for Public Policy Studies on the broad topic of health-care finance and insuring the New Hampshire workforce. The Concord-based Endowment for Health has sponsored this research.

Executive Summary

New Hampshire's hospitals generally lose money every time they care for an elderly person whose charges are paid by Medicare. The same is true for low-income patients whose charges are paid by Medicaid. Those public programs don't reimburse hospitals enough for the hospitals to cover their costs, let alone generate enough income to invest in new equipment or other services. Those hospitals with disproportionately high percentages of elderly or poor patients are generally in worse financial condition than those that treat more patients with conventional health insurance. That's because those patients—and the companies that employ them and provide their insurance—are making up much of the revenue the hospitals need to stay in business.

The Center estimates that in 2001—the last year for which all data are available—New Hampshire's employers and individuals with private health insurance paid what amounts to a hidden tax of 17 percent on that portion of their insurance bills that pays for hospital care. That tax helps hospitals offset underpayments elsewhere. Private payers—including health insurance carriers, self-insured businesses, and individuals—paid $197 million to hospitals in excess of what might be considered the real cost of their services.

The total amount of "cost-shifting" in 2001 was even larger, however. Hospitals themselves "contributed" some $39 million in reduced operating margins. In total, the Center estimates, New Hampshire's 26 hospitals shifted $237 million in costs from Medicare, Medicaid, and patients unable to pay.

The extent of cost-shifting has not been apparent to employers, insurance providers, patients, voters and the elected and appointed people who set Medicare and Medicaid reimbursement rates. The lack of easily available public information about hospital charges and payments has weakened the cost signals that could help foster more market competition in health care. More clarity would also help the legislature and Congress make more rational decisions about health care policy and finance. The Center calls on hospitals and insurance carriers to make relevant data public.

1. Introduction: The Business of Hospitals

New Hampshire has 26 acute-care hospitals, two of which are for-profit enterprises. The financial well-being of all of these institutions is important to the communities they serve and to the state as a whole. Whether it is a non-profit organization or is part of a profit-making corporation, each hospital attempts to balance its revenue and its expenditures and still leave a positive net margin. The hospitals' annual reports typically announce how successful their boards and managers have been in this business enterprise.

Those financial reports show operating costs and revenues, and the amount of "charity care" and bad debt absorbed by the hospital. But the reports do not reveal much about the kind of costs each hospital confronts nor about how much it charges various types of patients to cover those costs and generate an operating margin. This paper does that for the first time in New Hampshire. The paper defines "cost-shifting" in hospitals and quantifies its magnitude across

the 26 hospitals combined and in four particular hospitals. Using a series of graphs, the paper displays how cost-shifting is affecting these hospitals and, in turn, the state's health care system.

Understanding cost-shifting will help voters, health-care consumers, and policy makers understand the impact of their decisions. The paper shows, for example, that federally set Medicare reimbursement rates are too low, in New Hampshire at least, and are thus raising costs to those employers providing health insurance to their workforce. Raising reimbursement rates—and the payroll taxes that fund Medicare—would spread those costs among a much broader workforce. This paper raises policy choices that it cannot yet answer; it is an introduction to the topic, not the last word.

2. Cost-Shifting Defined

Cost-shifting is in part a function of a hospital's "patient mix" and "funding mix."

Most hospital care is paid for by commercial health insurance, by the federal Medicare program for seniors, the state Medicaid program for low-income and disabled individuals, and directly by patients who have received care. Hospitals also provide charity care for which they receive no payment. A hospital may be paid very different amounts for the same service by different payers. When the payment received is inadequate to cover the actual costs, hospitals must find the financial support for services from some other source or they will soon become financially impaired. A common term for this is "cost-shifting." One definition of cost-shifting is, "the allocation of unpaid costs of care delivered to one patient population through above-cost revenue collected from other patient populations."[1] Other terms that are used to describe the same facts are "price shifting," "margin shifting," "price discrimination," and "reimbursement shifting." This cost-shifting in health care is often described qualitatively, but rarely quantified.[2]

Hospital "patient mix" refers to the relative proportion of patients whose medical care is paid for by different payer types. Some are Medicare patients, some are self-pay, some have their services paid for by third-party insurers, some by Medicaid. The patient mix differs by type of service. Figures 1 and 2 display the mix of patient types served in aggregate by New Hampshire's 26 acute care hospitals in 2001.[3]

[1] "Cost Shifting: An Integral Aspect of U.S. Health Care Finance," Al Dobson, The Lewin Group, November 13, 2002, at an invitational meeting "When Public Payment Declines Does Cost-Shifting Occur? Hospital and Physician Responses," sponsored by The Robert Wood Johnson Foundation and conducted by AcademyHealth in Washington, DC, November 13, 2002.

[2] Participants at the meeting noted in footnote 1 included foundation managers, consulting firms, health finance experts from academia, health care policy analysts, and government officials. None was able to cite any quantitative studies of cost-shifting.

[3] Patients counts are for the calendar year 2001. Source: Foundation for Healthy Communities, derived from Uniform Hospital Discharge Data Set.

Figure 1

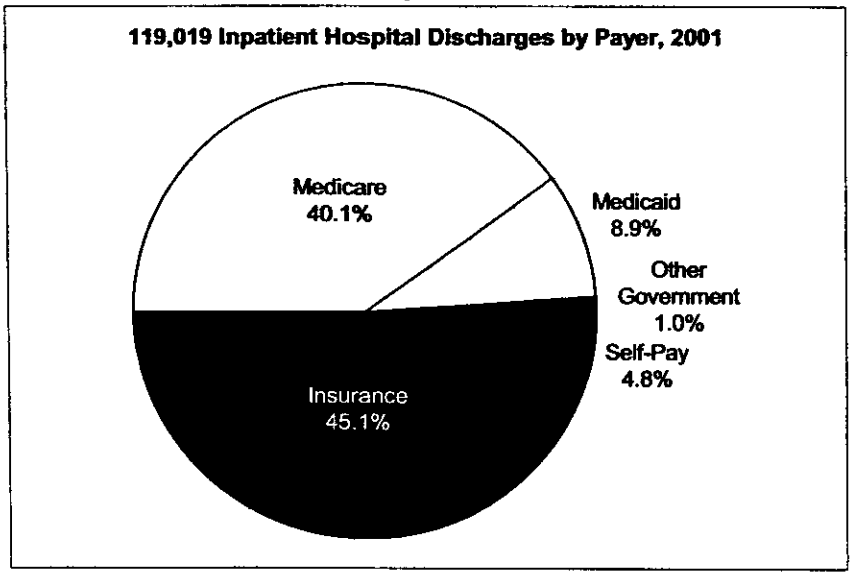
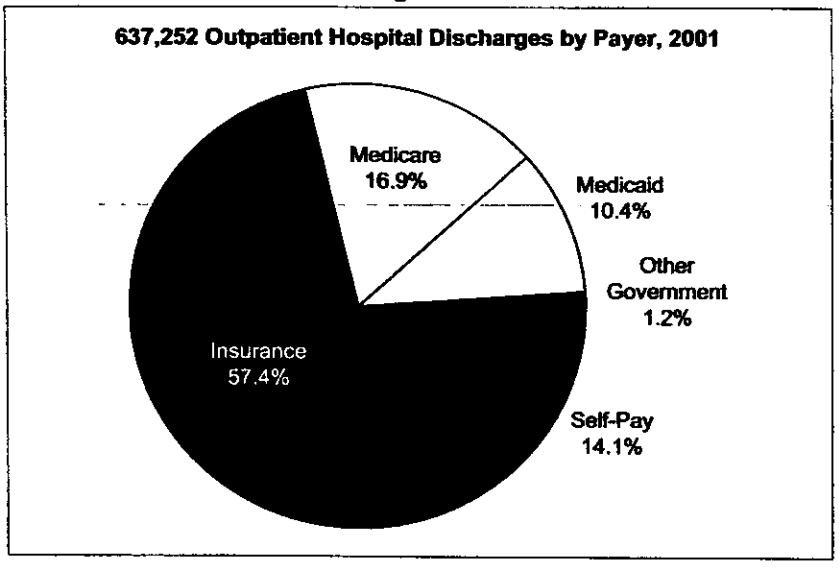


Figure 2

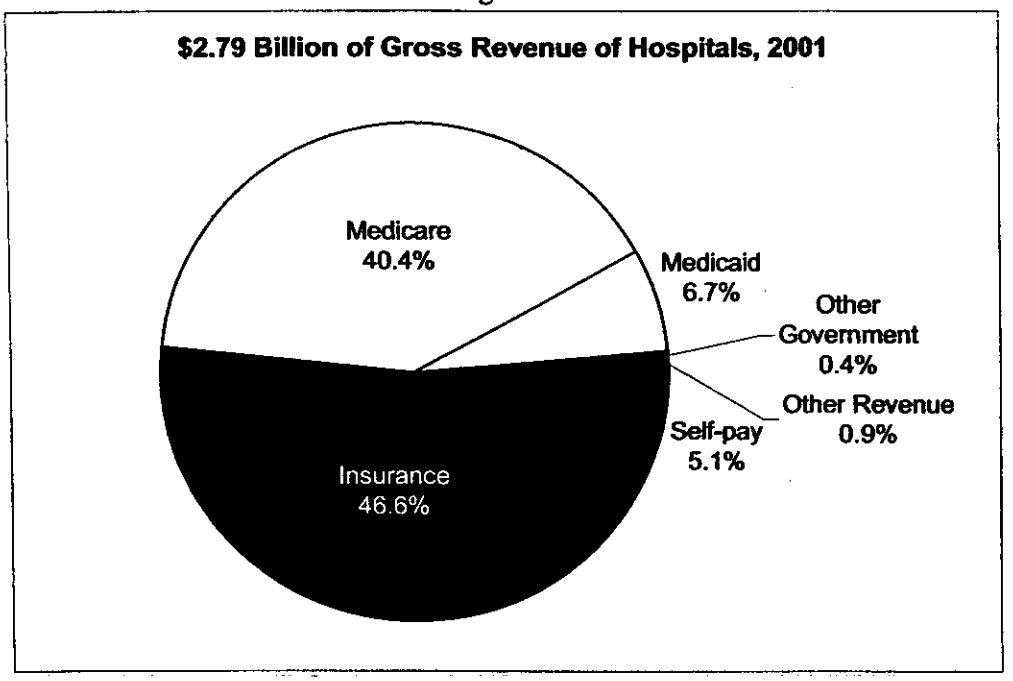


Almost exactly 50 percent of the 119,019 patients who received inpatient services had their services paid for by government programs. Among patients who received outpatient care (not admitted for overnight stay), however, only 28 percent had their services paid for by government programs.

Medicare was the responsible payer for 40 percent of the inpatient discharges but only 17 percent of the ambulatory discharges. Patients who were responsible to pay for the hospital's services out of their own pocket were slightly less than 5 percent of inpatients, but nearly triple that percentage among outpatients.

Based on rates they establish internally, hospitals bill for each service they provide. In 2001 the 26 acute care hospitals billed a total of $2,789,731,668 for the services they provided.[4] Figure 3 displays the percentage of those charges that were attributable to different payer types.

Figure 3



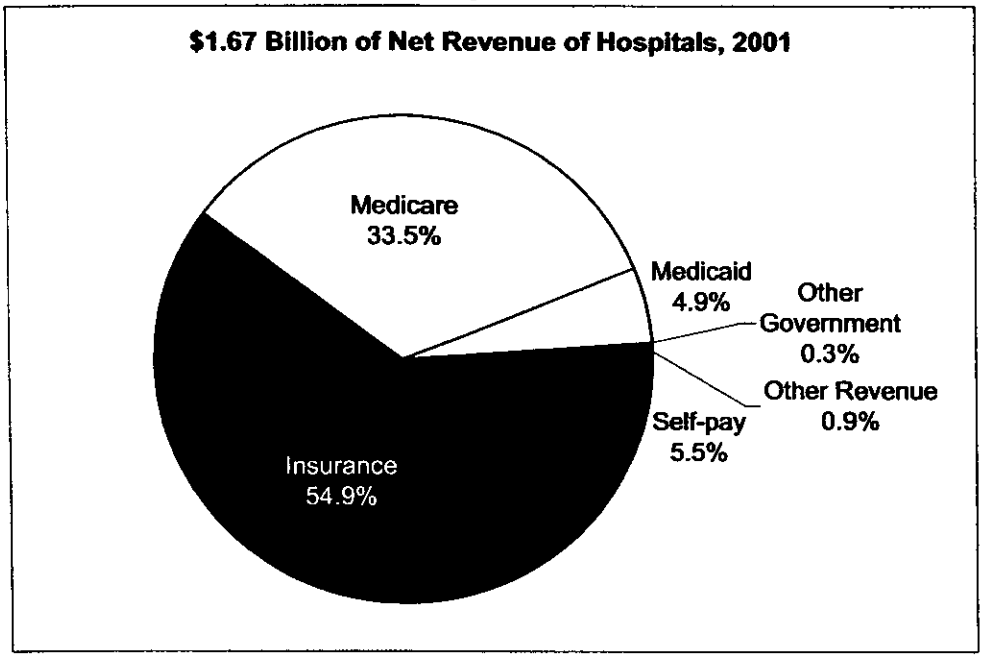
Patients whose bills were paid by private insurance companies accounted for about 47 percent of all charges. Medicare patients accounted for about 40 percent. The pie chart shows that there is nearly an even split between billings to government programs (Medicare, Medicaid, and other government) and to private sector payers (insurance and self-pay). When one considers that some of the patients whose charges are billed to their insurance are public sector employees (teachers, state and local government employees), it is clear that more than half of the gross charges are ultimately public responsibility.

Gross charges, however, considerably exceed the amount hospitals actually receive as revenue. Commercial insurers have negotiated discounts to the standard billed rates; Medicare and Medicaid establish their own payment scales; some individuals do not pay their bill in full, seeking charity care or defaulting on payment.

The revenue actually received for patient care in 2001 was $1,669,813,570. This was only 60 percent of the gross charges. Figure 4 displays the percentage of realized revenue from different payers.

[4] Revenue data from American Hospital Association survey spreadsheet tables prepared by the NH Hospital Association. This is an aggregate of reported 2001 fiscal year data; all hospitals do not use the same fiscal year.

Figure 4



Public programs only paid 39 percent of the revenue the hospitals actually received although they constituted about 47 percent of the gross charges. Insurance companies, however, paid 55 percent of the revenue while their patients represented only 47 percent of the gross charges.

3. Charges Are Not Costs

As noted above, gross charges for all patient services in the 26 hospitals in 2001 were $2,789,731,668. Actual operating expenses for 2001 were $1,723,705,402. If all gross charges had been paid in full, the hospitals in aggregate would have had a markup ratio of 62 percent and net operating income of over $1 billion.

The hospitals did not intend or expect to generate such a huge net income. Gross charges had been set high so that "discounts" could be negotiated with major payers and still result in a modest income.

In considering the issue of hospital cost-shifting, it is important not to assume that anyone underpaying gross charges is failing to pay a "fair share" of costs. Charges are not costs.

4. Marginal Costs and Average Costs

The marginal cost of providing a single additional service in a hospital may be small. At the unit of service level, nearly all costs, including staffing, equipment, maintenance, contracted services, and debt service would have to be considered fixed costs. Certain supplies and medications might be the only marginal costs actually incurred in treating one additional injury in an emergency room, for example.

While some economists have argued theoretically that cost-shifting occurs only when payment for services is below marginal costs, this is not a practical way of viewing hospital finance (or other health system finance). If all payers were expected to pay only for their marginal costs, that would leave no source of revenue to pay the hospitals' fixed costs.

We take the position that cost-shifting occurs whenever certain payers pay less than average cost while others pay more than average cost for any service.

5. The Cost-Plus Basis

If hospital charges were set so that gross revenue exactly equaled expenses, hospitals would not be able to generate a net income and increase their fund balances. Under such conditions, the state's two for-profit hospitals would not generate any profit. Even the 24 non-profit hospitals need to generate a small positive income in order to provide funds for investment in new equipment or hold as reserves against the possibility of unexpected losses in subsequent years. A net operating margin of 62 percent is implausibly high and a net operating margin of 0 percent is too low.

The aggregate net revenue of all hospitals in 2001 was $70,872,799 on net operating revenue of $1,723,705,402; this was an average margin of 4.1 percent. Table 1 contains the aggregate margin of the acute care hospitals for each year from 1992 to 2002.[5]

Table 1

Year	Net Operating Income	Total Operating Expenses	Operating Margin
1992	$43,410,545	$974,671,211	4.5%
1993	$29,989,583	$1,039,670,165	2.9%
1994	$63,196,739	$1,058,967,177	6.0%
1995	$56,671,474	$1,146,625,066	4.9%
1996	$52,444,145	$1,200,793,556	4.4%
1997	$70,902,929	$1,258,418,306	5.6%
1998	$42,478,391	$1,325,787,093	3.2%
1999	$41,640,425	$1,417,449,304	2.9%
2000	$46,592,048	$1,548,480,634	3.0%
2001	$70,872,799	$1,723,705,402	4.1%
2002	$84,520,774	$1,905,109,946	4.4%

We take the position that an average operating margin of 5 percent would be reasonable to ensure sufficient funds for future investment.[6]

[5] Source: spreadsheets from NH Hospital Association containing data from audited financial statements of the hospitals for these years. These data differ in small ways from the AHA data for the same time periods. The reasons for the differences are not known, but they are small and do not affect the general presentation or conclusions.

[6] A hospital's overall margin will differ from its operating margin. Hospitals may obtain revenue and have expenses unrelated to operations (e.g., interest income and capital gains and losses from investments). These other activities will result in a total margin that is greater than or less than the net operating margin.

Thus if all payers paid for actual costs plus a 5 percent margin, then hospitals would generate a 5 percent net income from patient services at the end of a year.

6. Charity Care, Self-Pay, and Bad Debt

A relatively small number of people are billed directly for their hospital care because they have no private insurance and are not eligible for a public program. Others are insured but must pay directly for certain services up to a deductible amount before their insurance will begin to pay.

Some individuals may not be able to actually pay the charges for their care.

"Charity care" is care that a hospital agrees in advance to provide for free. Based on an application by an individual for assistance, the hospital agrees not to bill for the care. For accounting reasons, because no billing is done, the charges are not included as revenue in a hospital's income statement. Gross charges for charity care that were not billed in 2001 were $45,736,960.[7]

Gross "Self-pay" charges are the billed amounts that hospitals expect patients to pay directly. These amounts are included in gross income. Some patients pay these charges in full. Others, however, never pay the full amount. Like any other business, a hospital must occasionally write-off its bad debts. For accounting purposes, the hospital records a "bad debt" expense equal in value to the billed charges that are being written off. As a result, the gross charges for the services it provided are included in both revenue and expense in the hospital's income statements.

Table 2

Payer	Gross Charges	% of Charges
Insurance	$1,298,801,314	45.8%
Medicare	$1,125,742,085	39.7%
Medicaid	$185,786,720	6.6%
Charity care	$45,736,960	1.6%
Bad debt	$96,243,326	3.4%
Self-pay received	$46,183,348	1.6%
Other government & other	$36,974,875	1.3%
Total	$2,835,468,628	100.0%

Table 2 reports the total of gross charges, including charity care. The rightmost column displays the percent of gross charges attributable to each payer type when the charity care is included. The amount that individuals should have paid directly consists of the three categories: charity care, bad debt, and self-pay received.

2001 operating expense as reported on the hospitals' income statements was $1,723,705,402. However, this amount includes $96,243,326 of bad debt write off. These write-offs must be subtracted from the stated expenses to determine the real cost of services. "Real cost" of services in 2001 was $1,627,462,076.

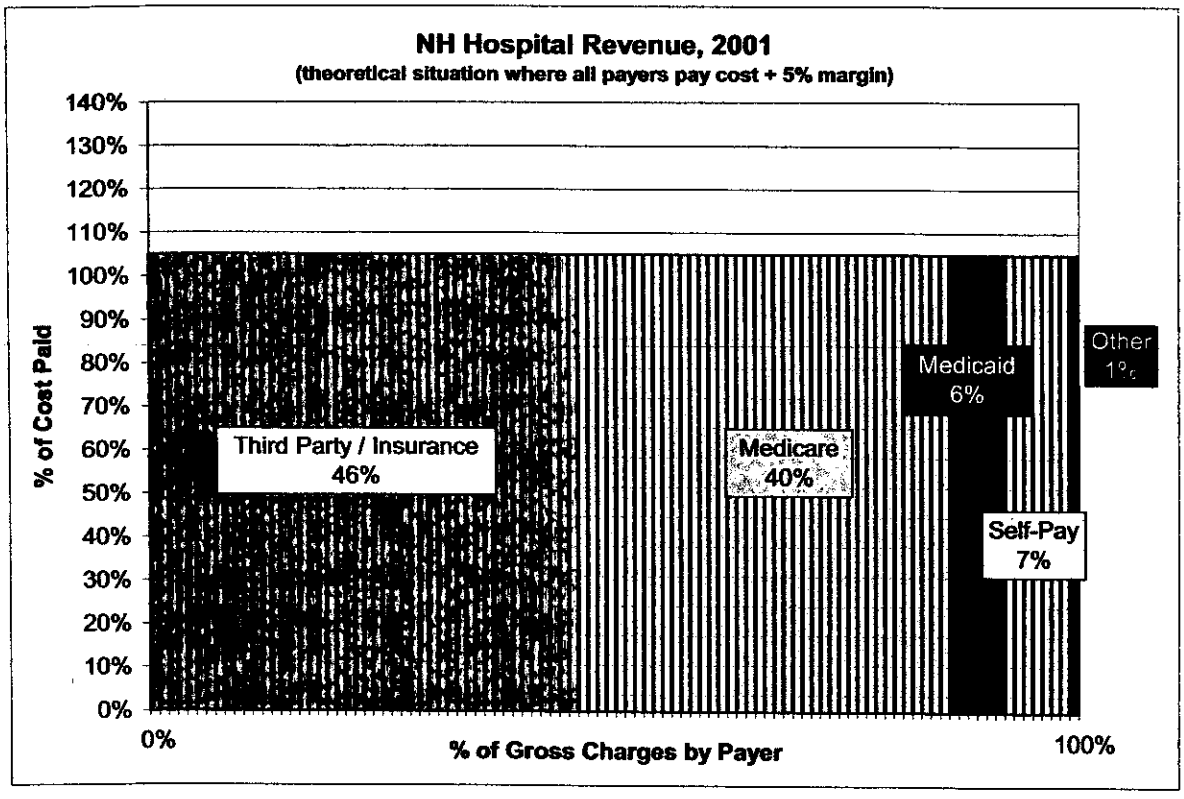
[7] This is obtained from the financial reports hospitals submitted to the NH Hospital Association.

7. The Base Case and the 'Hydraulics' Diagram

As noted above, major payers do not pay full charges, but benefit from some discount to charges. If all payers (including charity care cases now receiving care at no charge and persons responsible for the bad debt that is being written off) actually paid 105 percent of the real cost, hospitals would have an operating margin of 5 percent.

Figure 5, a "hydraulics" diagram[8], displays such a theoretical payment environment for New Hampshire's hospitals. The horizontal axis represents the percent of gross charges by payer. There are 100 narrow vertical bars on the chart. Each 1 percent of gross charges is represented by one vertical bar; for example, the left-most 46 bars represent the payments that hospitals receive from third-party insurance. The 6 percent of gross charges attributable to Medicaid patients are represented by 6 vertical bars farther to the right on the chart. This chart shows each payer paying exactly 105 percent of cost for all patients.

Figure 5



Under this scenario, the hospitals would have generated $1,708,835,180 in patient revenue in 2001 to cover their $1,627,462,076 real operating costs and also provide $81,373,104 of margin. In this situation, no cost-shifting would be occurring: each and every payer would be paying its share of costs plus margin.

[8] The design of the hydraulics diagram, as well as its name, were first brought to the author's attention by Al Dobson of The Lewin Group, in "Cost Shifting: An Integral Aspect of U.S. Health Care Finance," November 13, 2002.

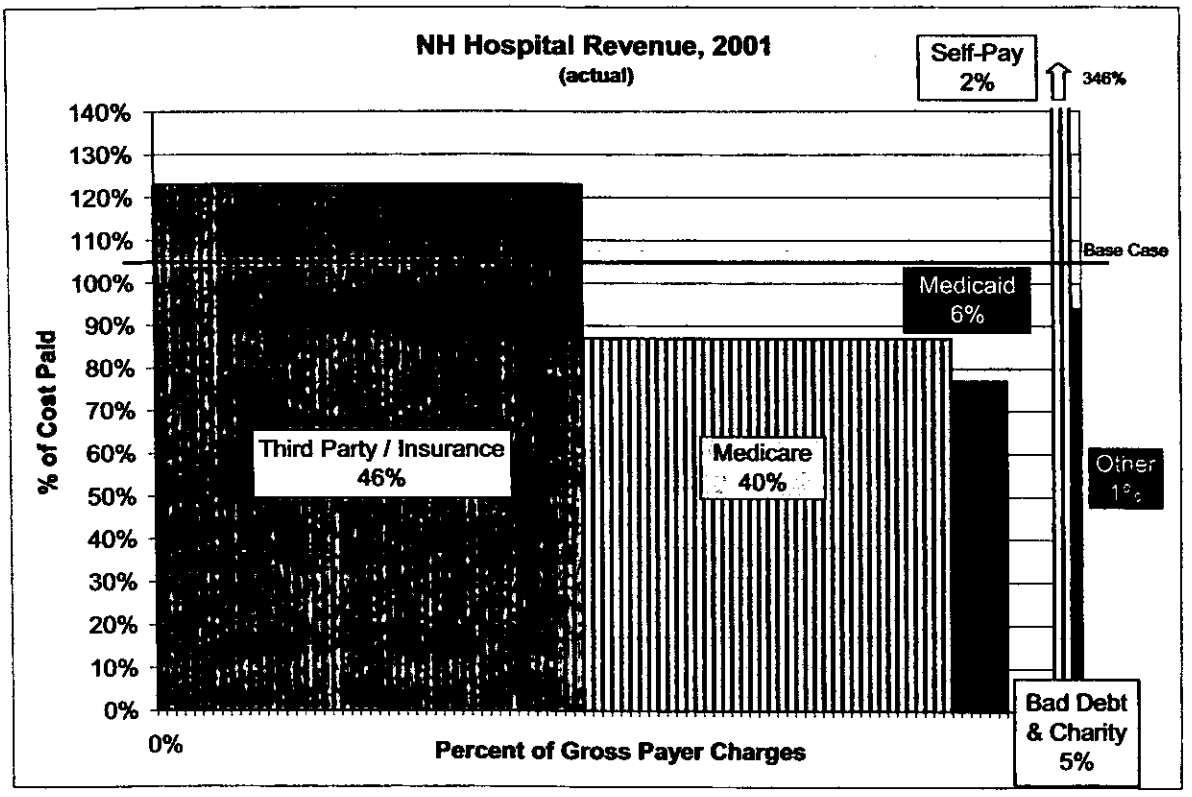
8. The Actual Situation in 2001

The actual situation was quite different as shown in Table 3 and Figure 6.

Table 3

Payment Source	% of Gross Charges	Net revenue received	Allocation of real operating expenses on basis of gross charges	Allocation of real operating expenses +5% margin	Net revenue as % of expense share
Third Party	45.8%	$916,840,046	$745,467,561	$782,740,939	123.0%
Medicare	39.7%	$559,189,410	$646,137,479	$678,444,353	86.5%
Medicaid	6.6%	$82,259,512	$106,635,227	$111,966,988	77.1%
Charity Care	1.6%	$0	$26,251,452	$27,564,024	0.0%
Bad debt	3.4%	$0	$55,240,380	$58,002,399	0.0%
Self-pay	1.6%	$91,660,528	$26,507,663	$27,833,046	345.8%
Other Government + Other	1.3%	$19,864,074	$21,222,314	$22,283,430	93.6%
TOTAL	100.0%	$1,669,813,570	$1,627,462,076	$1,708,835,180	102.6%

Figure 6

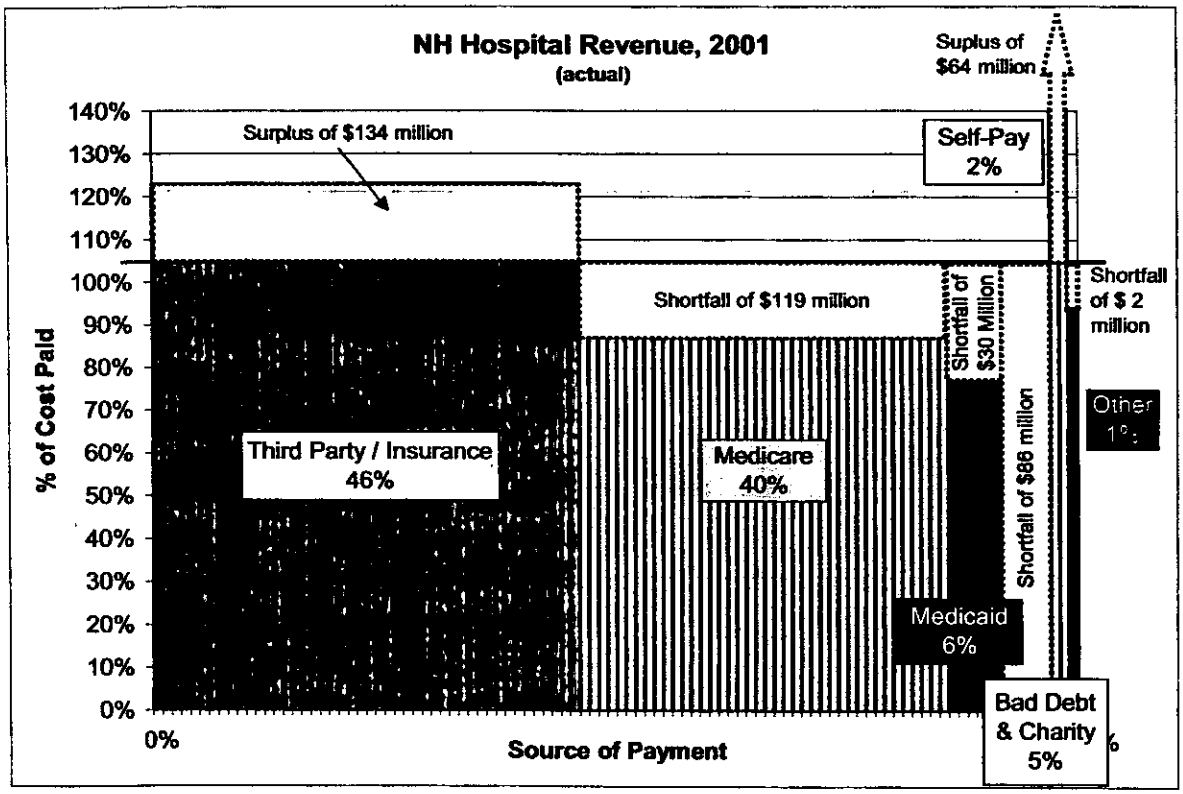


On average, third-party/insurance payers paid 123 percent of their share of actual expenses while Medicare paid 87 percent and Medicaid paid only 77 percent.[9] This means that insurance payments were 18 percent above what would be expected if they were to pay their share of expenses plus margin. One can think of this as an indirect and hidden "tax" or subsidy.

The figure and table show "self-pay" covering 346 percent of costs, a proportion that may be somewhat misleading. Payments directly from individuals is more complicated. The hospitals received no revenue for the charges represented by bad debt and charity care. They did receive $91 million in payments from individuals. Some charges for services were partially paid and partially written off. Unfortunately, there are no data regarding what portion of a given individual's charges was actually paid. Thus, in Figure 6, one could consider that some of the self-pay amount should actually fill in some of the empty space above the bad debt and charity portion. However, we do not know how much should be so represented from the data available.

The size of the rectangles above or below the base cost line in Figure 6 are proportional to the cost shift from one payer type to another. Excess payments by one set of payers are used to offset the shortfalls caused by other payers. This is shown more clearly in Figure 7 where the $ volume of each rectangle is included.

Figure 7



[9] For year 2000 the American Hospital Association reported aggregate payment-to-cost ratio of New Hampshire hospitals to be 0.91 for Medicare, 0.682 for Medicaid, and 1.267 for all private-payers. Thus, our results are fairly close to those calculated by the AHA for the prior year.

Bad debt and charity cases fell short of their ideal share by $86 million. Medicaid fell short by $30 million. Medicare paid a higher percentage of its share but because it covered so many more services for so many more people, it fell short of its share by $119 million. A small $2 million shortfall occurred in the "Other" category. These shortfalls are shown in Table 4 and total $237 million.

Table 4

Payer	Actual Revenue	Revenue Needed to Meet Expenses Plus 5% Margin	Excess or (Shortfall)
Shortfalls			
Medicare	$559,189,410	$678,444,353	($119,254,943)
Medicaid	$82,259,512	$111,966,988	($29,707,476)
Bad Debt/Charity Care	$0	$85,566,423	($85,566,423)
Other	$19,864,074	$22,283,430	($2,419,356)
		Total	**($236,948,198)**
Surpluses			
Insurance	$916,840,046	$782,740,939	$134,099,107
Self-Pay	$91,660,528	$27,833,046	$63,827,482
		Total	**$197,926,588**
		Remaining shortfall	**($39,021,610)**
Operating margin			
Theoretical operating margin		5.0%	$81,373,104
Actual margin		2.6%	$42,351,494
Reduced margin			**$39,021,610**

Third-party insurers paid $134 million in excess of their 105 percent while self-pay generated a surplus of $64 million. The remaining $39 million was made up by the hospitals themselves through a reduced operating margin. They did not achieve our theoretical margin of 5 percent.[10]

A non-profit hospital can operate on less than a 5 percent margin and the community it serves may see little difference, especially in the short run. However, if continued for many years, lower margins may prevent the hospital from making investments in new facilities or technology. Some hospitals may make up lost margin through fund-raising, profits from ancillary non-medical services, or special grants. Hospitals owned by profit-making corporations need to generate a somewhat greater margin as they must pay federal and state business taxes on net income and still return profit to investors. If the return on investment is insufficient, hospital corporations will not be attractive investments.

[10] The observant reader will note a difference between the cited 2.6 percent operating margin in Table 4 and the 4.1 percent margin cited in Table 1. Table 4 is based on the data in the American Hospital Association survey, while Table 1 is based on data submitted by the hospitals to the NH Hospital Association. We cannot fully explain the difference.

In 2001 New Hampshire's 26 hospitals shifted costs among their patient groups and payers totaling some $237 million. To cover that amount third-party insurance paid $134 million above its share of cost plus margin, individuals paying directly for their care covered an additional $64 million, and the hospitals "ate" the remaining $39 million by operating with margins below 5 percent.

Medicare is the largest contributor to cost-shifting in New Hampshire's hospitals and contributes in aggregate four times the amount to the total cost shift as Medicaid.

While insurers negotiate discounts from standard charges from the hospitals, the resulting insurance payments for claims includes $134 million to cover cost-shifting. This is essentially a hidden tax of 17 percent. This hidden tax on hospital claims is passed on to employers and employees through the premiums they pay for health insurance.

9. Individual Hospitals

The calculations above represent the aggregate of all 26 community acute-care hospitals. The relative amount of cost-shifting at any given hospital may be more or less. Hospitals with higher percentages of Medicare and Medicaid patients, for example, are engaged in more cost-shifting and typically have lower operating margins. Some hospitals operated at a loss in 2001.

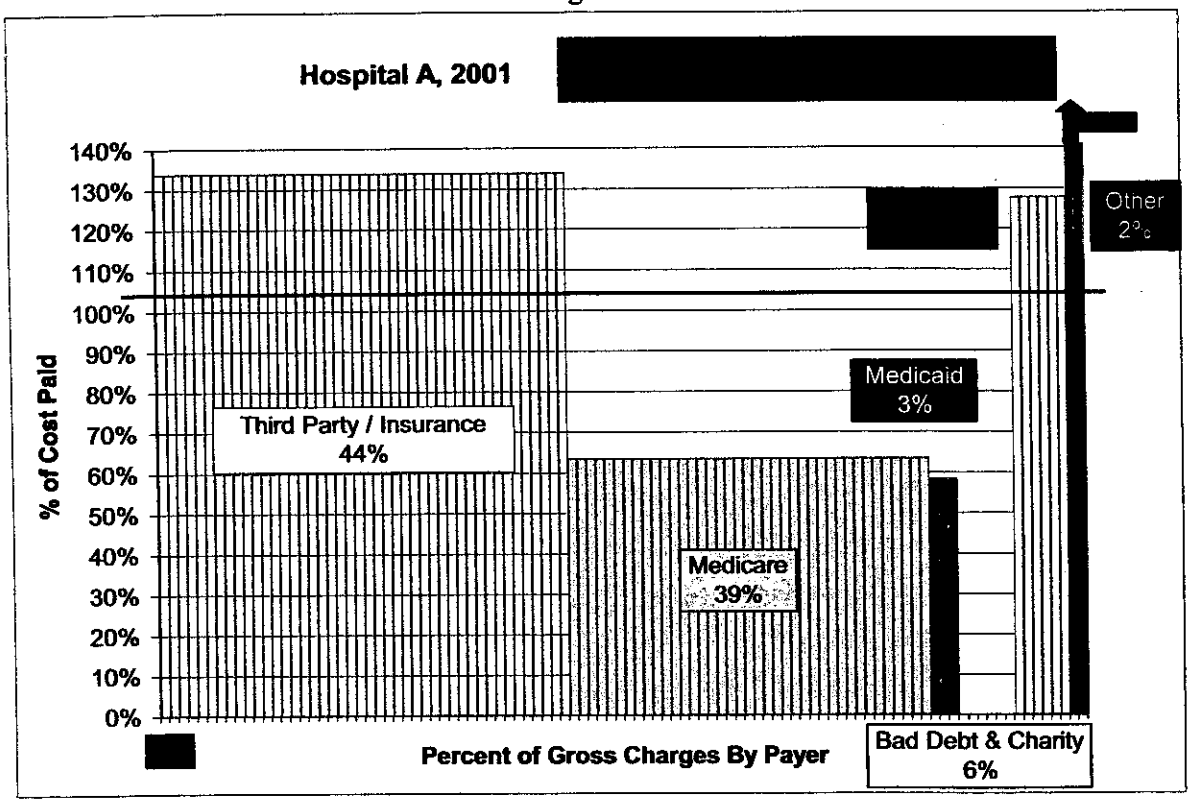
This section graphs the situation of four actual New Hampshire hospitals, using their own financial data for 2001. The four are illustrative of the variations across hospitals in patient mix and overall financial well-being. Because the examples are included to illustrate the general points of this paper, we identify them only as Hospitals A through D.

Hospital A

This hospital was operating very close to "break-even" in 2001. It had a net operating margin of only 1.1 percent. Figure 8 displays the data for this hospital.

The percentage of gross charges that are made to insurance companies are about the same as for the average hospital shown in Figure 6 (44 percent for Hospital A and 46 percent for the average). Medicare, too, represents about the same proportion of gross charges as it does for the average hospital. Note that Medicaid, however, represents a smaller percentage of gross charges (3 percent compared to 6 percent for the average hospital) while self-pay represents a greater percentage (6 percent versus 2 percent).

Figure 8



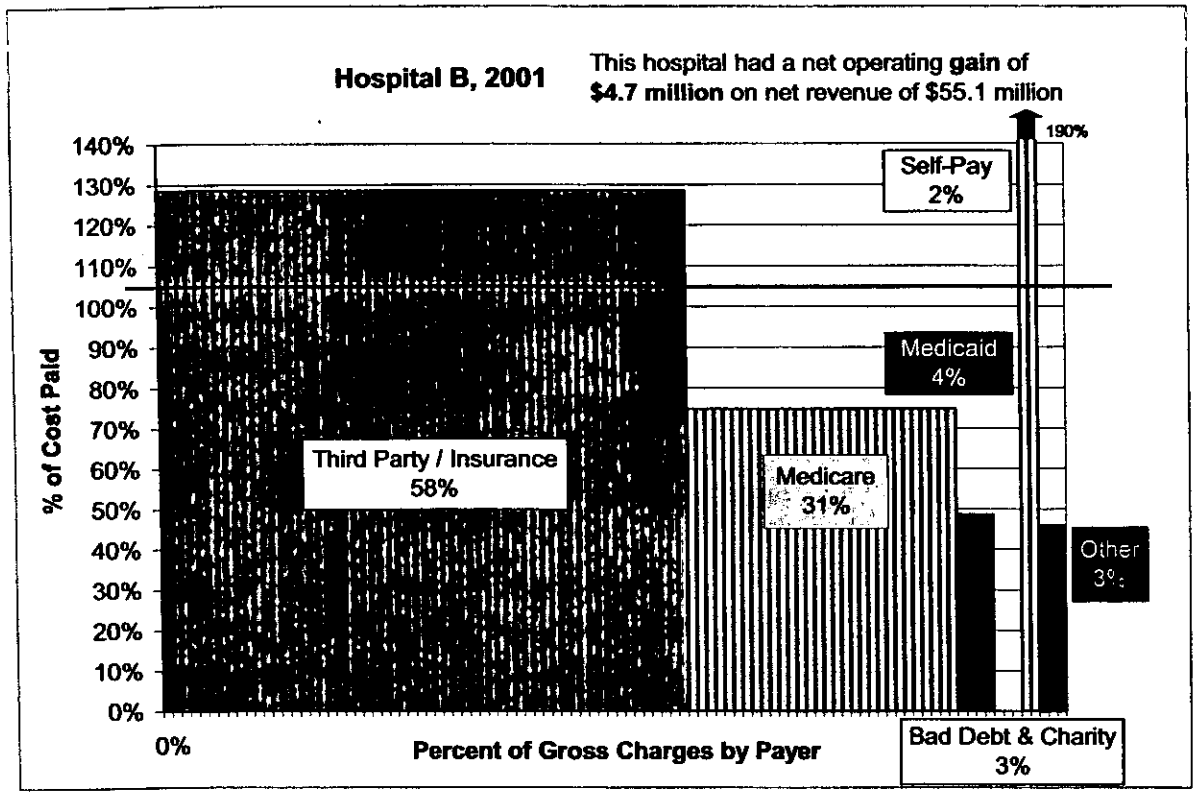
For this hospital, Medicare is only making payments that represent 62 percent of cost (for the average hospital it is 86 percent), thus resulting in a larger amount of deficit that must be filled by excess revenue from others. Insurance payments do fill much of that, representing 134 percent of cost in comparison to 123 percent for the average hospital.

Visually, one can see that the amounts in excess of 105 percent just about balance the amounts of shortfall from other payment sources.

Hospital B

This hospital had a solid operating gain in 2001. Its margin was 9.1 percent. Figure 9 shows how that margin of revenue over expense was achieved. Medicare represented only 31 percent of the gross charges for this hospital. Medicaid, charity care, and bad debt together represented only 7 percent of gross charges while they represented 11 percent of the average hospital's gross charges.

Figure 9



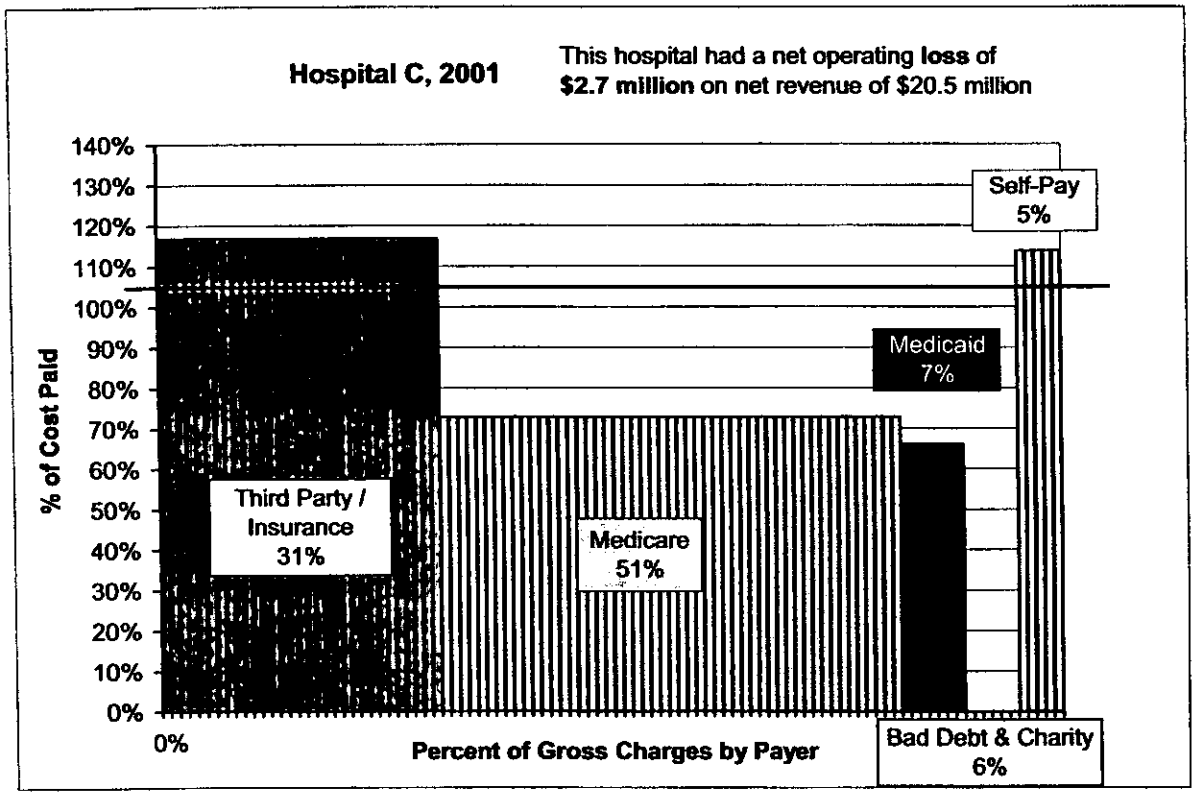
Insurance payers paid 128 percent of cost, slightly more than the state average. Because they constituted a larger percentage of charges as well, they contributed considerably more excess revenue toward the hospital's shortfalls from other payment sources.

Hospital C

This hospital was operating in the red in 2001. Its operating revenue was inadequate to cover its operating costs. Not only did it not achieve our theoretical operating margin of 5 percent, it had an operating margin of –11.7 percent. Its revenue was far short of what was needed to support its expenses.

Figure 10 shows why this was the case. Medicare represented 51 percent of gross charges while charges billed to insurance companies represented only 31 percent. The amount of excess revenue obtained from insurance companies and self-pay sources were grossly inadequate to cover the losses from Medicare, Medicaid, bad debt, and charity care.

Figure 10



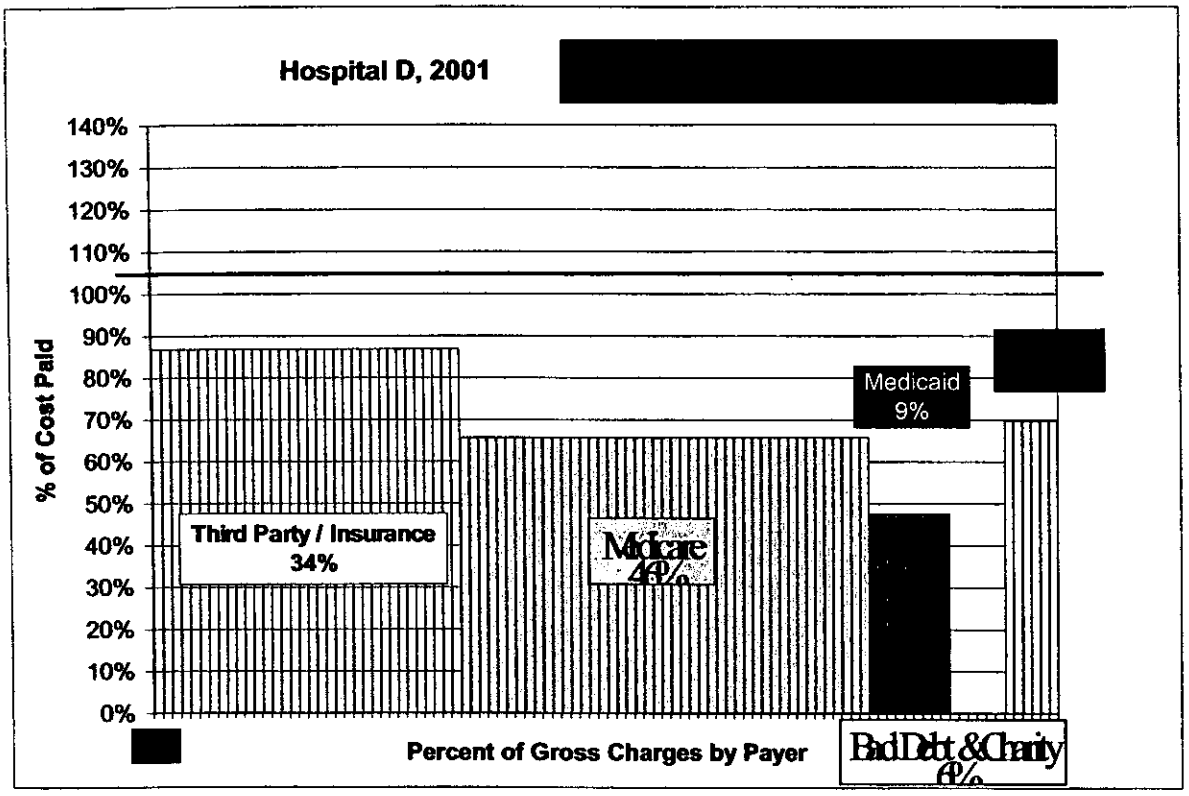
Comparing Hospital C with Hospital B indicates that the difference in patient mix (as represented by percent of gross charges billed to different sources) is largely responsible for the fact that Hospital C was operating at a large loss while Hospital B was able to operate with a healthy margin.

Hospital D

A quick glance at Figure 11 tells the story for this hospital. Not one source of payment for services was covering its costs. Every payer category was contributing to loss. There was no source of revenue to cover the cost-shifting caused by Medicare, Medicaid, bad debt, and charity care. In 2001 this hospital had an operating margin of –29.3 percent.

Obviously the operation of this hospital under these financial conditions could not continue for long.

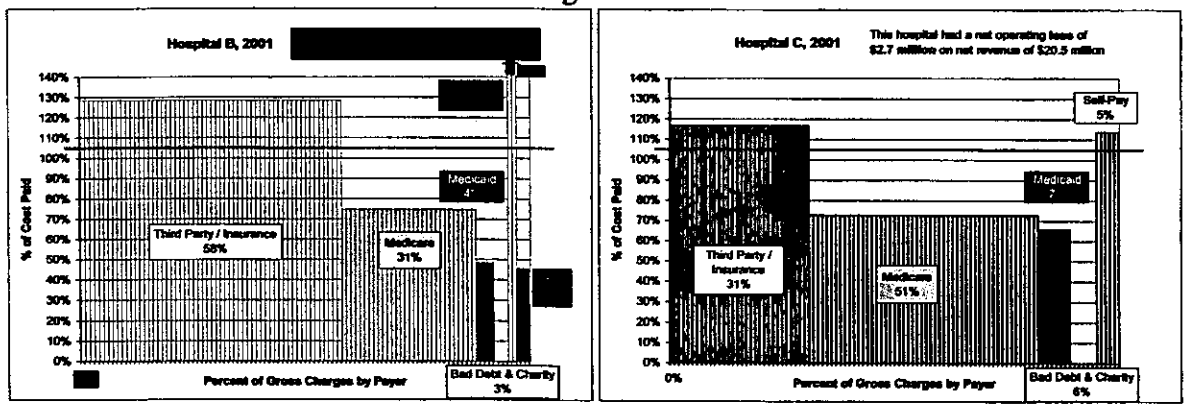
Figure 11



10. A Problem in Making Comparisons

While the hydraulics diagram of each hospital is a striking visual that fairly presents the status of finance in *that* hospital, it is not appropriate to compare two charts side by side. Such a possible comparison is shown in Figure 12. The problem lies in the vertical axis.

Figure 12



The vertical axis in these two charts is "% of Cost Paid." Because each hospital's cost structure is different, 100 percent of cost on the left hand chart does not necessarily represent the same

dollar amount as 100 percent of cost on the right hand chart. Thus, it is not possible to determine whether the differences are because one hospital's cost structure is higher or because the amount it receives in payment for services is lower.

We are currently unable to make a comparison using a vertical axis stated in absolute terms so that hospitals can be compared. The reason we cannot do so is that the information needed to calculate and display the data is not available to us.

11. More Data Required for Better Understanding

Further important analysis could be done on hospital finance.

How much cost-shifting is caused by higher than average cost structures?
How much cost-shifting is caused by lower than average payments?
How do charges and payments relate to average cost for different procedures?
What portions of gross charges are derived from which procedures and services?
Which services and procedures generate the most excess revenues?
Which services are "loss leaders?"

Answers to these questions and others would inform discussion of the kinds of policies needed to ensure continued support for workforce health insurance and adequate public programs that ensure access to services for those who are uninsured.

In regard to hospital finance, three types of data are needed for each hospital:

- The hospital's master list of charges;
- A count of the number of charges made for each charge type over each 12 month period;
- The amounts actually received as payment for each charge type from larger payment sources for which some amount less than charge is accepted as payment.

These data are available to each hospital. Without them, a hospital could not bill for the treatments and services it provides, nor could it credit income received against billed revenue. Currently hospitals assert that these data are private and proprietary and that disclosure might adversely affect competitive situations or violate anti-trust laws. Also, some of these data are protected by non-disclosure clauses in agreements negotiated between hospitals and insurers.

If health care is to function as a market-driven system – as some argue it should – it must provide price signals that inform and potentially impact behavior: behavior of consumers of health care, competitive behavior of providers, and payment behavior of third-parties, including public programs and commercial insurers. Currently the necessary price and cost information is not easily available to the public.

We urge release of the types of data identified here. While there is currently no legal requirement that such information be publicly available, employers (who ultimately fund much of health care through the premiums they pay for insurance for their employees) could request that this type of information be made available to them by their insurers and by the health care institutions that serve their communities.

In addition, we also urge hospitals to serve their communities – and health care policy generally – by summarizing and disclosing their cost-shifting information regularly and in an easily understandable format. In its annual report, each hospital should present a table similar to Table 4 and a "hydraulics diagram" like the ones presented in this report. These could be prepared or reviewed by the hospitals' auditing firms.[11]

12. Data Sources

The NH Hospital Association provided financial data on all hospitals for 2001 and earlier years. They loaned copies of the audited financial reports of the hospitals to the Center and also provided copies of NHHA Excel spreadsheets containing annual financial data.[12]

Additional data were obtained from unpublished tables and analysis prepared by The Lewin Group based on the American Hospital Association's Year 2000 Annual Survey of community hospitals.

Useful insights and background material can be found in "The Health of New Hampshire's Community Hospital System: A Financial and Economic Analysis," Office of Planning and Research, NH Department of Health and Human Services, December 13, 2000. The most relevant paper for this project that is contained in that report is "Analysis of Health Care Charitable Trusts in the State of New Hampshire: The Hospital Sector" by Nancy M. Kane.

[11] In 2001, eight auditing firms were employed by 24 acute care hospitals: Baker, Newman & Noyes; Berry, Dunn, McNeil &Parker; Dana S. Beane & Co.; Ernst & Young; KPMG; Price Waterhouse Coopers; Robin R. Grill; Tyler, Simms, & St. Saveur. As component parts of national profit-making firms, two of the hospitals do not have separately reported finances, but could still voluntarily disclose such information.

[12] Hospitals do not all share the same fiscal year. Some end on June 30, some on September 30, and some on December 31. The fiscal year totals across all hospitals are not, therefore, equal to figures reported by Medicare or Medicaid which use federal fiscal years (October-September) or state fiscal years (July-June). Some hospitals are part of a larger corporate entity that may include other functions such as home nursing or community health education. In those cases, the data used represents only the hospital's finances.

Reviewing and Revising Wal-Mart's Benefits Strategy
Memorandum to the Board of Directors
from Susan Chambers

The purpose of this memorandum is to update you on our efforts to review and revise Wal-Mart's benefits strategy. In response to concerns about cost trends and growing public scrutiny, I recently led a 15-person team, drawn from across the company, in (1) evaluating Wal-Mart's approach to benefits and (2) developing a strategy to address any short-comings.

We evaluated Wal-Mart's current benefits offering through three lenses – cost trends, Associate satisfaction, and public reputation – and are now recommending revisions to our benefits strategy built around nine "limited-risk" initiatives and five "bold steps."

This memorandum summarizes our work and is divided into three sections:

Section 1 provides a detailed analysis of the three most significant benefits-related challenges we face:

> Growth in benefits costs is unsustainable (15 percent per year) and driven by fundamental and persistent root causes (e.g., aging workforce, increasing average tenure). Unabated, benefits costs will consume an incremental 12 percent of our total profits in 2011, equal to $30 billion to $35 billion in market capitalization.
>
> While Associates are satisfied overall with their benefits, they are opposed to most traditional cost-control levers (e.g., higher deductibles). Satisfaction also varies significantly by benefit and by segment of Associates. Most troubling, the least healthy, least productive Associates are more satisfied with their benefits than other segments and are interested in longer careers with Wal-Mart.
>
> Healthcare is our most pressing reputation issue because well-funded, well-organized critics, as well as state government officials, are shining a bright light on Wal-Mart's offering. Moreover, our offering is vulnerable to at least some of their criticisms, especially with regard to the affordability of coverage and Associates' reliance on Medicaid.

Section 2 discusses in detail the nine limited-risk initiatives and five bold steps we are recommending. Given conflicts inherent in the challenges we face, any set of solutions will require carefully balancing, and sometimes making trade-offs between, cost, Associate satisfaction, and public reputation.

> *Limited-risk initiatives:* We are recommending that Wal-Mart realign eligibility requirements for health insurance; decrease cross-subsidization of spouses; give Associates more information about how to use healthcare and health insurance; lower company-paid life insurance coverage levels; capture savings from current initiatives to improve labor productivity; add a combination of best practice care management programs; further develop high performance provider networks; offer Associates bundles of other benefits (e.g., paid-time off) from which to choose; and continue to explore

adding health clinics in stores. These initiatives will reduce costs and will slightly improve Associate satisfaction.

Bold steps: The nine limited-risk initiatives will not fully address all the benefits-related challenges we face. To fully address these challenges, we recommend that Wal-Mart take five bold steps that will require more explicit trade-offs between cost, Associate satisfaction, and public reputation. The first two recommended steps primarily address cost trends, the third addresses attracting a healthier workforce, and the last two steps address improving our public reputation.

Move all Associates to "progressively-designed" consumer-driven health plans to help control cost trends while allowing Associates to build up savings in Health Savings Accounts

Restructure the retirement program (i.e., profit sharing and 401(k) program) to reduce costs and help Associates better save for retirement
Redesign benefits and other aspects of the Associate experience, such as job design, to attract a healthier, more productive workforce

Make some select strategic investments in our healthcare offering (e.g., lower maximum out-of-pocket expenses) so it can better withstand external scrutiny
Improve communication of Wal-Mart's benefits offering so we get more credit for what we provide, and, over the long-term, work to shape state and national outcomes on healthcare

Section 3 summarizes the combined impact of the limited-risk initiatives and the bold steps. The team believes this new strategy will bring powerful advantages to Wal-Mart, including:

Maintaining benefits spend at or below today's level as a percentage of sales

Offering a more attractive benefits package for healthy Associates

Better positioning us to fight Wal-Mart's critics

I presented this material to the Executive Benefits Steering Committee (Tom Hyde, Lawrence Jackson, and Tom Schoewe) in late July. They received the recommendations enthusiastically and asked that I syndicate them widely within Wal-Mart, something I have begun to do. They also asked that the team continue to test and refine the strategy, especially with Associates and external stakeholders. Our aspiration is to complete this work by late-September, receive Executive Committee approval on the overall strategy by early-October, and hold a special session with you in November for further discussion.

1 Major benefits-related challenges

We analyzed the benefits-related challenges facing Wal-Mart through three lenses – cost trends, Associate satisfaction, and public reputation.

Cost trends

From 2002 to 2005, our benefits costs grew significantly faster than sales, rising from 1.5 percent of sales to 1.9 percent. Benefits spend grew from $2.8 billion to $4.2 billion during this period, at a rate of 15 percent per year. Holding benefits costs as a percent of sales constant is critical for Wal-Mart's long-term economic success.

A few benefits made up the bulk of this increase: healthcare ($1.5 billion) grew by 19 percent, paid time off ($1.4 billion) grew by 14 percent, and the profit sharing and 401(k) program ($740 million) grew by 13 percent. (Over the period, the domestic Associate base grew at 5 percent and domestic sales grew at 11 percent.)

Increased utilization of medical services, which grew by 10 percent per year, was the primary driver of the rapid growth in our healthcare costs (Exhibit 1). Almost half of this utilization growth was due to three Wal-Mart-specific workforce factors (distinct from national trends):
Our workforce is aging faster (0.50 years per calendar year) than the national average (0.12 years per calendar year).

Our workers are getting sicker than the national population, particularly in obesity-related diseases. For example, the prevalence of coronary artery disease in Wal-Mart's population grew by 6 percent compared to a national average of 1 percent, and the prevalence of diabetes in our population grew by 10 percent compared to a national average of 3 percent. (That said, our workforce is no sicker at present in absolute terms than the national population.)
A segment of our workforce consumes healthcare inefficiently, in a pattern similar to a Medicaid population. Our population tends to over-utilize emergency room and hospital services and under-utilize prescriptions and doctor visits. This pattern is most evident among our low-income Associates, and the team hypothesizes that this behavior results from prior experience with Medicaid programs.

Compounding these problems are several national trends, such as the increased use of technological innovations, which are driving increased utilization of medical services across the U.S. healthcare system.

The cost of Wal-Mart's profit-sharing and 401(k) program and paid time off grew faster than overall Associate growth, due largely to increasing Associate tenure. Over the past 4 years, the average Associate tenure has increased by 0.2 months per calendar year. As a result, more Associates qualify for participation in benefits programs like the profit sharing and 401(k) plan and for more paid-time off. An even more important factor is wages, which increase in lock-step with tenure and directly drive the cost of many benefits (e.g., 401(k) is a percentage of wages).

Given the impact of tenure on wages and benefits, the cost of an Associate with 7 years of tenure is almost 55 percent more than the cost of an Associate with 1 year of tenure, yet there is no difference in his or her productivity (Exhibit 2). Moreover, because we pay an Associate more in salary and benefits as his or her tenure increases, we are pricing that Associate out of the labor market, increasing the likelihood that he or she will stay with Wal-Mart.

We have also not effectively leveraged our benefits spend per Associate, which should be thought of as a fixed cost for employing that Associate. We have allowed our full-time Associates to average only 34 hours of work per week; increasing the hours worked per Associate would enable Wal-Mart to lower our labor cost per hour by spreading benefits costs over more hours. We also have one of the highest percentages of full-time Associates in the retail industry, even though full-time Associates are more expensive per labor hour (in terms of both benefits and wages).

Associate satisfaction

Associates are satisfied with their overall benefits package, but they have expressed significant opposition to most traditional cost-control levers. For instance, Associates strongly oppose higher deductibles or limits to their choice of providers. Satisfaction varies significantly, however, by benefit and by segment of Associate, creating an opportunity to rebalance the benefits portfolio to improve satisfaction while reducing costs. In particular, the least healthy, least productive Associates are more satisfied with their benefits than other segments and are interested in longer careers with Wal-Mart.

Overall, Associates are satisfied with their benefits relative to peers at other retailers. In a survey of retail workers, Associates ranked Wal-Mart's benefits above the industry average in availability, ability to qualify, quality, and execution (e.g., claims processing). The cost of healthcare coverage was the only factor on which we scored poorly.

Associate satisfaction and view of importance vary significantly by specific benefit (Exhibit 3). For example, Associates rank health insurance as the most important benefit Wal-Mart offers, but they also say it is the one with which they are least satisfied. The stock purchase plan, the profit sharing and 401(k) program, and life insurance are all ranked high-satisfaction, low-importance, suggesting an opportunity to rebalance Wal-Mart's investment in these benefits into other more important benefits. Paid time-off and the discount card are the only high-satisfaction, high-importance benefits.

Associate satisfaction with benefits also varies significantly by segment of Associates. The team analyzed the Associate population on a wide variety of factors (e.g., attitude, health behavior, tenure), the most fruitful of which was annual healthcare spend. The so-called "low utilizers" are the most attractive Associate segment because they cost Wal-Mart less in terms of healthcare expenses and are more productive in their jobs. (Productivity findings were based on analysis of individual cashier items per hour data.) Moreover, this segment also showed healthier behaviors, specifically less prevalence of obesity. Unfortunately, the "low utilizers" were also least satisfied with our benefits and were planning shorter careers with Wal-Mart. This segment favors a different type of benefits package than the "high utilizers," a benefits package different than what we offer today: a health insurance offering more closely modeled on consumer-driven health plans – lower premiums, higher deductibles, and health savings accounts. They also prefer certain nonmedical benefits, such as help in saving to purchase a home and help in paying for more education, neither of which we offer in a robust way today.

It is worth noting, however, that overall benefits only play a small role in attracting Associates to Wal-Mart and in keeping Associates satisfied while at Wal-Mart. Our benefits offering played a key role in attracting just 3 percent of our Associates. Moreover, satisfaction with benefits does not correlate with satisfaction with Wal-Mart. A variety of factors – especially Associates' interactions with management – are more important.

Public reputation

Healthcare is the most pressing reputation issue facing Wal-Mart. Survey work done last summer shows that people's perception of our wages and benefits is a key driver of Wal-Mart's overall reputation. Several groups are now mounting attacks against Wal-Mart focused on our healthcare offering. These increasingly well-organized and well-funded critics – especially the labor unions and related groups, such as Wal-Mart Watch – have selected healthcare as their main avenue of attack. Moreover, federal and state governments are increasingly concerned about healthcare costs, and many view Wal-Mart as part of the problem (a view due, in part, to the work of Wal-Mart's critics). Medicaid costs are a major priority on most governors' agendas; already a quarter of states are spending more than 25 percent of their budgets on Medicaid, and observers across the political spectrum assert that the current system – with spiraling costs, a large population of uninsured, and an increasing number of medical bankruptcies – is unsustainable (although there is little consensus on what should take its place). In this environment, we can expect efforts like those in Maryland (which is trying to mandate that companies spend a certain percentage of revenue on healthcare) and New Hampshire (which requires health services to track where Medicaid enrollees are employed) to accelerate.

Proposals such as these, if successful, will bring added costs to Wal-Mart. Moreover, these battles with critics and governments are contributing to the decline of Wal-Mart's overall reputation.

Our healthcare offering is also vulnerable to attack. We have not effectively communicated the generosity of our healthcare benefits to the general public; instead, we have thus far allowed our critics to frame the debate. For instance, only 22 percent of Americans find it very believable that Wal-Mart provides health insurance to 900,000 people. Wal-Mart's critics can also easily exploit some aspects of our benefits offering to make their case; in other words, our critics are correct in some of their observations. Specifically, our coverage is expensive for low-income families, and Wal-Mart has a significant percentage of Associates and their children on public assistance. Consider the following:

On average, Associates spend 8 percent of their income on healthcare (premiums plus deductibles plus out-of-pocket expenses) for themselves and their families, nearly twice the national average. The number varies significantly by plan type, rising to 13 percent for those on the Associate and Spouse plan.

Critics contend that the costliness of Wal-Mart's healthcare coverage causes it to enroll fewer Associates in its health insurance plan than do most national employers (48 percent versus 68 percent) (Exhibit 4).

Associates also face significant financial risk when a medical catastrophe occurs. On the Family plan, an Associate must spend between 74 and 150 percent of household income on healthcare (approximately $13,000 to $27,000) before insurance takes over completely. Though few Associates reach this level of spending, those who do almost certainly end up declaring personal bankruptcy. In 2004, 38 percent of enrolled Associates spent more than 16 percent of the average Wal-Mart income on healthcare.

We also have a significant number of Associates and their children who receive health insurance through public-assistance programs. Five percent of our Associates are on Medicaid compared to an average for national employers of 4 percent. Twenty-seven percent of Associates' children are on such programs, compared to a national average of 22 percent (Exhibit 5). In total, 46 percent of Associates' children are either on Medicaid or are uninsured.

On both of these issues – affordability and public assistance – it is important to note that our offering and performance are on par with other retailers; Wal-Mart's critics, however, hold it to a "large company" standard, not a retailer standard. Despite the difference in industry economics, critics believe we should behave more like a GM or a Microsoft than a Target or a Sears. While critics have not yet harnessed all of these facts, they are successfully exploiting those they do have, suggesting that, when discovered, the others will also become effective ammunition.

2 Proposed revisions to benefits strategy

Against the backdrop of these challenges, the team is recommending that Wal-Mart implement the nine limited-risk initiatives and five bold steps discussed in detail in this section.

Limited-Risk Initiatives

These nine initiatives require little or no trade-off between cost, Associate satisfaction, and public reputation. Exhibit 6 provides an overview of these initiatives:

1. Realign eligibility requirements for health insurance so that Associates (full-time and part-time) and their children qualify after working 1,000 hours and spouses qualify after the Associate works 2,000 hours. This move would simplify external communications, make Wal-Mart even more competitive in the part-time labor market, and help align costs with the economics of the business (in that the benefit is based on hours worked). On average, these requirements translate into 6 months for full-time Associates (same as today) and 1 year for part-time Associates (versus two years today).

2. Decrease cross-subsidization of spouses through higher premiums or other charges. Spouses are by far the most expensive plan members to cover, and Wal-Mart pays more per spouse than per Associate. This change would allow us to put more dollars towards Associates and their children.

3. Give Associates more information about how to use healthcare and health insurance. Many Associates are making inefficient decisions about what healthcare services to use, e.g., over-relying on emergency rooms. We need to give Associates more information on the cost and

quality of specific health services, better educate them on how best to utilize healthcare, and develop education efforts specifically for those Associates who have previously been uninsured or on public assistance.

4. Lower company-paid life insurance coverage levels to a maximum payout of $12,000. Life insurance, although a small cost, is the fastest growing benefits cost. It is also a high-satisfaction, low-importance benefit, which suggests an opportunity to trim the offering without substantial impact on Associate satisfaction. The company-paid policy currently covers one times an Associate's annual salary, which is slightly more generous than most retailers.

5. Capture savings from current initiatives to improve labor productivity. These initiatives include reducing the number of labor hours per store, increasing the percentage of part-time Associates in stores, and increasing the number of hours per Associate. These changes represent a major cost-savings opportunity with relatively little impact on existing Associates. The most significant challenge here is that the shift to more part-time Associates will lower Wal-Mart's healthcare enrollment (even with the more generous part-time offering outlined above), which could have an impact on public reputation.

6. Add a combination of best practice care-management programs, including utilization management, case management, disease management, and errors and omissions programs. These programs primarily improve quality of care, but they will also produce modest cost savings by improving care coordination and compliance for extremely sick Associates, who drive a disproportionate share of the cost.

7. Further develop high-performance provider (e.g., doctors, hospitals) networks so as to direct Associates to the most efficient and effective healthcare providers. The quality of care and cost of care vary significantly among doctors. We should be on the cutting edge of efforts to identify the best doctors by, for instance, working with payors to find new ways to identify these doctors. We should then create provider networks made up only of those doctors and provide Associates with incentives for using those doctors.

8. Offer Associates bundles of other benefits (e.g., paid time off, education, discount card) from which to choose. Our benefits package today is "one size fits all," even though different segments of Associates value specific benefits differently. For instance, one segment would happily give up some paid-time off in exchange for a more generous discount card. While we believe every Associate should have a core healthcare and retirement offering, we could more effectively spend our remaining benefits dollars by allowing Associates to choose from among several packages of benefits.

9. Continue to explore adding health clinics in stores. Wal-Mart is starting an effort to put clinics in stores, a strategy currently framed as a real-estate opportunity. Longer-term and with several important modifications to the current offering (e.g., innovations to create lower cost visits), these clinics could become an important part of our healthcare strategy, especially as a substitute for emergency room visits.

Taken together these nine initiatives should reduce Wal-Mart's projected healthcare costs from a projected 2.3 percent of sales in 2011 to a projected 2.0 percent of sales, largely due to the impact of the productivity initiatives (initiative 5). The initiatives should also slightly improve Associate satisfaction. They will not likely have any significant impact – positive or negative – on public reputation.

Bold steps

The following five bold steps will be more difficult to execute than the limited-risk initiatives, but their impact will be much greater. Exhibit 7 provides an overview of these steps.

1. Move all Associates to "progressively-designed" consumer-driven health plans to help control cost trends while allowing Associates to build up savings in Health Savings Accounts

While relatively new in the United States, consumer-driven health plans have proven to control medical cost trends more effectively than traditional plans in both domestic (e.g., Logan Aluminum) and international (e.g., Singapore) settings. These plans eliminate the traditional deductible. In its place, Associates get a Health Savings Account (HSA), a pretax bank account for health expenses that is similar to a 401(k). An HSA is funded from three sources: annual seed money from Wal-Mart, an annual contribution from the Associate, and a matching contribution from Wal-Mart. The Associate uses the HSA to cover his or her first-dollar medical expenses every year. When an Associate has used up his or her HSA, there may be (depending on how much is in the HSA) a "bridge" the Associate must cover, which is the difference between the amount in the HSA and the point at which coinsurance takes over.

Consumer-driven health plans are more effective at controlling costs than traditional plans because enrollees have greater responsibility for their healthcare spending. HSA funds belong to the Associate, so he or she has a stake in using the money wisely. If the Associate leaves Wal-Mart, the HSA funds go with him or her. If HSA contains money at the end of the year, those funds roll over for use in the following year. An Associate with high healthcare expenses may also face a bridge, which serves as a further brake on spending. Consumer-driven health plans are particularly attractive to the healthy, productive Associate segment, because this segment now "gets something" for enrolling in health insurance and staying healthy – they can save money in their HSA.

The key to achieving these advantages is to have all Associates participate. Otherwise only the healthiest enroll and there is very little cost reduction because healthy people spend so little on healthcare. During this year's enrollment cycle, we are offering a few consumer-driven health plans (among many options); these existing offerings can serve as a starting point for a complete transition over the next 1 to 2 years.

Such plans would have several advantages for Associates. More than 80 percent of Associates would be better off financially under the proposed consumer-driven health plans than under traditional plans. Associates can also accumulate wealth in their HSAs. A typical Associate who is generally healthy would have $600 to $2,100 in savings after

3 years. Associates can use this wealth both for significant health events and retirement. Associates can also use their HSAs to cover a wide variety of health expenses, including vision, dental, preventive care, and other spending not covered by the plan.

To make this change palatable externally, the plan design must be "progressive," meaning it cannot involve any cost shifting. In transitioning to consumer-driven health plans, many companies have chosen to push more costs onto employees, a move that has given these plans a bad reputation among progressives. The plans proposed by the team do not involve any cost shifting. Moreover, a growing number of companies are implementing such plans, providing Wal-Mart with more political cover. Many retailers (e.g., Staples, Toys R Us) are offering consumer-driven health plans as one option among many, and the ever-progressive Whole Foods recently moved all of its employees to such a plan, to much media fanfare.

The primary reason for making this transition would be to reduce future benefits costs, and those savings would be significant: $400 million to $700 million in FY2011, all from reduced trend. This change does, however, come with several challenges. Overall consumer-driven health plans are less popular with Associates than traditional plans, albeit not dramatically so, and are more difficult to communicate. Strong opposition is isolated to approximately 10 percent of Associates. Wal-Mart will also face reputation challenges in implementing this change given that progressives view such plans as a "Republican answer." Wal-Mart will have to be sophisticated and forceful in communicating this change internally and externally.

2. Restructure the retirement program (i.e., the profit sharing and 401(k) program) to reduce costs and help Associates better save for retirement

We should reduce our overall investment in the profit sharing and 401(k) program from approximately 4 percent of wages to approximately 3 percent of wages. Doing so would bring the program more in line with retail offerings and would save Wal-Mart a substantial sum of money. Hewitt ranks our retirement program as the best in its non-union hourly retail benchmark set. Given the scrutiny that Wal-Mart receives on healthcare and that retirement is a low-importance benefit for Associates, the retirement program seems to be the wrong place for over-investment.

We should also redesign the specifics of our retirement program. In particular, we should convert the 401(k) program from a "no-strings-attached" flat contribution to a matching program in which Associates receive funds from Wal-Mart based on the contribution they make to their 401(k). Such a program would help Associates better prepare for retirement. A fully participating career Associate would be able to replace 30 to 40 percent of his or her income at retirement, compared to 15 percent today, resulting in some 80 to 90 percent of income replaced at retirement (when Social Security is included).

Overall this proposal would save Wal-Mart a significant amount of money: $650 million to $700 million in FY2011. With respect to Associate satisfaction, Associates reacted

positively to a matching retirement program, although they slightly preferred the current program. Although critics will contend that the new program is less generous than the current one, retirement has not been a major issue in the external environment.

3. Redesign benefits and other aspects of the Associate experience, such as job design, to attract a healthier, more productive workforce

Given the significant savings from even a small improvement in the health of our Associate base, Wal-Mart should seek to attract a healthier workforce. The first recommendation in this section, moving all Associates to consumer-driven health plans, will help achieve this goal because these plans are more attractive to healthier Associates. The team is also considering additional initiatives to support this objective, including:

Design all jobs to include some physical activity (e.g., all cashiers do some cart gathering)

Offer savings via the Discount Card on healthy foods (e.g., fruits and vegetables)

Offer benefits that appeal to healthy Associates (e.g., an education offering targeted at students).

A healthier workforce will lead to lower health insurance costs, lower absenteeism through fewer sick days, and higher productivity. It will be far easier to attract and retain a healthier workforce than it will be to change behavior in an existing one. These moves would also dissuade unhealthy people from coming to work at Wal-Mart. Even a modest shift in Wal-Mart's ability to attract and retain a healthier workforce could result in significant savings: $220 million to $670 million in FY2011. The key tasks in implementing this fourth bold step, once the team has developed a more complete list of actions, are to create a clear set of metrics to measure success, to run pilots in several stores to understand each idea's effectiveness, and then roll-out the most successful ones.

4. Make a series of strategic investments in our healthcare offering so it can better withstand external scrutiny

The team is investigating a few potential investments:

To address concerns about affordability, offer at least one insurance plan that covers Associates for $1/day (or $14 per pay period) and allows them to cover their children for another $1/day.

To further address concerns about affordability, lower an Associate's maximum exposure to medical financial risk (premiums plus deductibles plus co-payments) to a more manageable level, approximately 15 percent of the average income for a full-time Associate.

To address concerns about access, help Associates access the private insurance market after 30 days of employment and potentially provide them with limited funding for doing so while they wait to become eligible for Wal-Mart's plan.

These changes would give us a powerful set of messages to use in combating critics. (For instance, "Wal-Mart offers Associates access to health insurance after they've worked with us for just 30 days.") These kinds of changes would also make Wal-Mart's coverage more affordable and accessible, directly addressing critics' and Associates' most persistent arguments.

While this fourth bold step should create goodwill both internally and externally, it will be expensive. In FY2011, the cost of these three proposals would be between $300 million and $350 million. Given this steep price, the team is rigorously testing these ideas with the public and policymakers to determine what set of investments will most effectively "move the needle" on Wal-Mart's public reputation.

5. Improve communication of our benefits offering so we get more credit for what we provide and, over the long-term, work to shape the outcomes of state and national healthcare reform efforts

We need to be more proactive in the public arena. Three efforts are needed here:

Address the Medicaid issue head-on by reframing the debate (e.g., this is everyone's problem, not just Wal-Mart's) and by offering some type of counter proposal or compromise. This first effort is critical because Wal-Mart is under serious attack from state governments with regard to the number of Associates on publicly-funded health insurance. These attacks show no signs of abating – in fact, they seem to be accelerating – and elected officials are proposing increasingly costly solutions.

Clarify and improve messages about our healthcare offering (building on the proposed changes outlined above) and engage in a sustained communication campaign. This kind of communication will help us reframe public perception of our healthcare offering, the only way for us to start winning the debate with our critics. It will also help us build the credibility needed to weigh-in more broadly on U.S. healthcare issues.

Become more engaged in the national healthcare debate, to position Wal-Mart as a leader in healthcare in general and on access (e.g., individual mandates) and affordability (e.g., bringing IT to healthcare) in particular. Establishing Wal-Mart as a leader on this critical issue will help deflate our critics. It will also put us in a position to help shape the outcome of the public debate about the healthcare crisis in a way that is at least somewhat advantageous to our interests.

3 Impact of the proposed changes

Taken together the limited-risk initiatives and the bold steps create a powerful set of advantages for Wal-Mart.

Significant advantages

The new strategy will enable us to deal with all three of the benefits-related challenges we face. Cost control. Benefits costs will be at or below 1.9 percent of sales (i.e., level as of FY 2005) in 2011. (The limited-risk initiatives result in about a 16-percent reduction in projected 2011 benefits costs and the bold steps yield about another 9-percent reduction.)

Associate satisfaction. Associates will have a more generous healthcare benefit with an HSA to cover first-dollar expenses, greater protection against medical risk, and the ability to accumulate wealth in their HSAs; a retirement benefit that helps them prepare more effectively for retirement; and more choice, especially with regard to selecting other benefits (e.g., paid time-off). Moreover, we will be more effective at attracting and retaining the healthy, productive workforce Wal-Mart wants.

Public reputation. By providing Associates more affordable health coverage and responding to concerns about Wal-Mart's Medicaid/S-CHIP enrollment, we will have addressed our critics' most potent arguments. We will also have stepped-up our efforts to communicate the strengths of Wal-Mart's benefits offering and counter critics' claims. Finally, we will have positioned Wal-Mart to have a "seat at the table" in the public debate about healthcare reform.

Risks

The risks associated with these changes are worth carefully noting. Addressing them will require, among other things, attention to implementation planning, communication, and execution.

Cost risk. If savings and investments are not properly sequenced, costs could increase before they decrease.

Associate satisfaction risk. Some of the proposed revisions to the benefits strategy (e.g., the move to consumer-driven health plans, the changes in the retirement program) have the potential to upset Associates, especially more tenured Associates.

Public reputation risk. Healthcare enrollment will fall several percentage points due primarily to a shift to more part-time Associates, which could draw additional attacks from Wal-Mart's critics. Also, despite the proposed efforts, the Medicaid problem will not be "solved." A significant number of Associates and their children will still qualify for Medicaid. Because many of these programs will offer more generous health insurance than Wal-Mart provides, many Associates will still choose to enroll in Medicaid, leaving the door open for continued attacks.

The team believes that the advantages of the proposed strategy outweigh these risks.

I appreciate your taking the time to engage so fully on this topic and look forward to discussing it with you at the special Board meeting in November. In the meantime, I would welcome hearing your reactions to our work to date.

January 24, 2006

John Grieco
Quality Flame Cutting
828 Main Street
Fremont, NH 03044-3585

Dear John:

Enclosed is a spreadsheet comparison of the Standard, Network Saver, and Value health insurance plans outlined in the informational packets you provided. As mentioned, it was difficult to outline all the coverages since the majority of benefits are based on an allowable charge schedule. It is impossible to know what the plan would consider an allowable charge and what dollar amount would be covered for particular services. The benefits detailed do not cover any charges over the allowable amount and the amount paid by the member for over the allowable amount charges, do not apply to the maximum out of pocket costs. In addition, the first year a member is on the plan, the benefits are only payable up to $25,000 per member. The plan also imposes a $60 per month spousal surcharge if the spouse is eligible for coverage elsewhere. I was unable to locate any benefit information on the HMO plan offered, but the rates seem extremely high for an HMO plan if the handout accurately reflects the employee cost.

Due to the complexity of the benefit plans offered and the lack of information regarding fee schedule and allowable charges, we are unable to guarantee the accuracy of the enclosed benefit review. In addition, based on all the fine print regarding covered services and excluded coverages, it is difficult to determine the exact benefits and how they would be covered. Overall, the coverage levels seem very low and the severe network restrictions require the member to adhere to all network guidelines in order to obtain any decent level of coverage. Please review the enclosed and contact me with any questions.

Sincerely,

Greg DeNeill
Sales Representative

ABC

Comparison of Health Insurance

Effective Date: ***February 1, 2006***

	Standard $50 Plan		Standard $0 Plan		$2,000 $50 Plan	
	Network	Out of Network	Network	Out of Network	Network	Out of Network
Copay Per Office Visit	$20 Copay after Ded.	50%	$20 Copay after Ded.	50%	$20 Copay after Ded.	50%
Deductible Individual/Family	$350/$1050		$500/$1500		$750/$2250	
Out of Pocket Max (Individual/Family)	$2100/$4550	N/A	$3000/$6500	N/A	$4500/$9750	N/A
Hospital Inpatient	80% of allowable charges after deductible		80% of allowable charges after deductible		80% of allowable charges after deductible	
Surgery (Outpatient/Office)	80% of allowable charges after deductible		80% of allowable charges after deductible		80% of allowable charges after deductible	
Durable Medical Equipment	80% of allowable charges after deductible		80% of allowable charges after deductible		80% of allowable charges after deductible	
Prescription	$10 or 20% Generic $50 or 50% Brand		$10 or 20% Generic $50 or 50% Brand		$10 or 20% Generic $50 or 50% Brand	
Mental Health	50% OP 20 visit max 50% 50% IP 30 Day max. 40% after deductible		50% OP 20 visit max 50% 50% IP 30 Day max. 40% after deductible		50% OP 20 visit max 50% 50% IP 30 Day max. 40% after deductible	
Chemical Dependency	$20 Copay after Ded.	N/A	$20 Copay after Ded.	N/A	$20 Copay after Ded.	N/A
Skilled Nursing Facility	80% of allowable charges after deductible		80% of allowable charges after deductible		80% of allowable charges after deductible	
Emergency Room (ER)	80% after deductible	50%	80% after deductible	50%	80% after deductible	50%
Physical/Speech/Occ Therapy	80% after deductible $2,000 max	50%	80% after deductible $2,000 max	50%	80% after deductible $2,000 max	50%
Home Health / Hospice Care	80% after deductible	50%	80% after deductible	50%	80% after deductible	50%
Spinal Manipulation	Not covered		Not covered		Not covered	
Lifetime Maximum	$25,000 Max. First Year		$25,000 Max. First Year		$25,000 Max. First Year	

Monthly Premium			
Annual Premium			
Percentage Change			

Monthly Employee Rates

	Single	$90.16	$77.12	$58.66
	Employee & Spouse	$275.92	$248.76	$207.48
	Employee & Child	$228.12	$203.14	$167.29
	Family	$309.59	$272.66	$218.35
	Employee & Children	$228.12	$203.14	$167.29

For Standard plans you must use a Network Hospital for full benefits. Outpatient Services and Doctor Visits are generally paid at 80% of eligible expenses. Amounts exceeding Usual & Customary charges will not apply towards out of pocket maximum & are responsibility of member

ABC

Comparison of Health Insurance

Effective Date: ***February 1, 2006***

	Standard 1000 Plan	Network Saver 350 Plan	Network Saver 500 Plan
	Network Out of Network	Network Out of Network	Network Out of Network
	$20 Copay after Ded.	$20 Copay after Ded. 50%	$20 Copay after Ded. 50%
	$1000/$3000	$350/$1050	$500/$1500
	$6000/$13000 N/A	$2100/$4550 N/A	$3000/$6500 N/A
	80% of allowable charges after deductible	80% 50% after deductible	80% 50% after deductible
	80% of allowable charges after deductible	80% 50% after deductible	80% 50% after deductible
	80% of allowable charges after deductible	80% after deductible 50%	80% after deductible 50%
	$10 or 20% Generic $50 or 50% Brand	$5,000 per member max	$5,000 per member max
		$10 or 20% Generic $50 or 50% Brand	$10 or 20% Generic $50 or 50% Brand
	50% OP 20 visit max 50% 50% IP 30 Day max. 40% after deductible	50% OP 20 visit max 50% 50% IP 30 Day max. 40% after deductible	50% OP 20 visit max 50% 50% IP 30 Day max. 40% after deductible
	$20 Copay after Ded. N/A	$20 Copay after Ded. N/A	$20 Copay after Ded. N/A
	80% of allowable charges after deductible	80% 50% after deductible	80% 50% after deductible
	80% after deductible 50%	80% after deductible 50%	80% after deductible 50%
	80% after deductible 50% $2,000 max	80% after deductible 50% $2,000 max	80% after deductible 50% $2,000 max
	80% after deductible 50%	80% after deductible 50%	80% after deductible 50%
	Not covered	Not covered	Not covered
	$25,000 Max. First Year	$25,000 Max. First Year	$25,000 Max. First Year

Monthly Employee Rates

	Single	$46.71	$79.30	$68.43
	Employee & Spouse	$175.98	$255.28	$229.21
	Employee & Child	$142.30	$208.57	$184.67
	Family	$181.41	$281.35	$246.59
	Employee & Children	$142.30	$208.57	$184.67

For Network Saver Plans you must use a Network Doctor & Hospital for full benefits. Outpatient Services and Doctor Visits within the network are generally paid at 80% of eligible expenses. Amounts exceeding Usual & Customary charges will not apply towards out of pocket maximum & are responsibility of member

ABC

Comparison of Health Insurance

Effective Date: ***February 1, 2006***

Carrier	Network Saver 750 Plan		Network Saver 1000 Plan		Value Plan 1000	
	Network	Out of Network	Network	Out of Network	Network	Out of Network
Copay Per Office Visit	$20 Copay after Ded.	50%	$20 Copay after Ded.		$20 Copay after Ded.	50%
Deductible (Individual/Family)	$750/$2250		$1000/$3000		$1000/$3000	
Out of Pocket Max (Individual/Family)	$4500/$9750	N/A	$6000/$13000	N/A	$6000/$13000	
Hospital (In Patient/Outpatient)	80% after deductible	50%	80% of allowable charges after deductible		$1000 IP Copay then 80% after deductible	50%
Surgical (In Patient/Outpatient)	80% after deductible	50%	80% of allowable charges after deductible		$500 IP Copay then 80% after deductible	50%
Durable Medical Equipment	80% after deductible $5,000 per member max	50%	80% of allowable charges after deductible		80% after deductible $5,000 per member max	50%
Prescription	$10 or 20% Generic $50 or 50% Brand		$10 or 20% Generic $50 or 50% Brand		$10 or 20% Generic $50 or 50% Brand after $300 RX Deductible	
Major Medical Benefit	50% OP 20 visit max 50% 50% IP 30 Day max. 40% after deductible		50% OP 20 visit max 50% 50% IP 30 Day max. 40% after deductible		50% OP 20 visit max 50% 50% IP 30 Day max. 40% after deductible	
Preventive Care (Child)	$20 Copay after Ded.	N/A	$20 Copay after Ded.	N/A	$20 Copay after Ded.	N/A
X-ray/Lab Services (Outpatient)	80% after deductible	50%	80% of allowable charges after deductible		80% after deductible	50%
Emergency Room copay	80% after deductible	50%	80% after deductible	50%	80% after deductible	50%
Physical Speech/Occ Therapy	80% after deductible $2,000 max	50%	80% after deductible $2,000 max	50%	80% after deductible $2,000 max	50%
Home Health/Hospice Care	80% after deductible	50%	80% after deductible	50%	80% after deductible	50%
Spinal Manipulation	Not covered		Not covered		Not covered	
Lifetime Maximum	$25,000 Max. First Year		$25,000 Max. First Year		$25,000 Max. First Year	

Monthly Premium			
Annual Premium			
Percentage Change			

Monthly Employee Rates

	Single	$49.97	$39.10	$22.81
	Employee & Spouse	$183.58	$154.25	$47.79
	Employee & Child	$149.91	$127.09	$36.93
	Family	$194.45	$158.60	$65.17
	Employee & Children	$149.91	$127.09	$36.93

For Network Saver Plans & Value Plan you must use a Network Doctor & Hospital for full benefits. Outpatient Services and Doctor Visits within the network are generally paid at 80% of eligible expenses. Amounts exceeding Usual & Customary charges will not apply towards out of pocket maximum & are responsibility of member

ABC

Comparison of Health Insurance

Effective Date: ***February 1, 2006***

Carriers	HSA 1250 Plan		
Copay Per Office Visit	Network Out of Network $20 Copay after Ded		
Deductible (Individual/Family)	$1,250/$2,500		
Out of Pocket Max. (Individual/Family)	$5,100/$10,200 N/A		
Hospitals (Inpatient/Outpatient)	80% 50% after deductible		
Surgery (Inpatient/Outpatient)	80% 50% after deductible		
Durable Medical Equipment	80% 50% after deductible		
Prescription	$10 or 20% Generic $50 or 50% Brand after deductible		
Mental Health Benefit	80% 50% after deductible		
Preventive Care/OBGYN	$20 copay 50%		
X-ray/Lab Services Outpatient	80% 50% after deductible		
Emergency Room Copay	80% after deductible 50%		
Physical, Speech & Occ. Therapy	80% 50% after deductible		
Home Health & Hospice Care	80% after deductible 50%		
Spinal Manipulation	80% after deductible 50%		
Lifetime Maximum	?		

Monthly Premium			
Annual Premium			
Percentage Change			

Employee Monthly Cost

	Single	$44.53		
	Employee & Spouse	$96.68		
	Employee & Child	$73.87		
	Family	$131.44		
	Employee & Children	$73.87		

Fallon Community Health Plan

New HMO option 2006

RATES EFFECTIVE JAN.1 2006

RATES ARE PER PAY PERIOD

		Twice/month HMO	Ee Cost Monthly
Associate only:	$151.92	~~394~~	329.16
Associate & Spouse	$301.10		652.38
Associate & Children	$ 253.77		549.8
Associate & Family	$447.79		970.2

Testimony of John Grieco, Jr., President, Quality Flame Cutting, Inc. of Fremont, NH

January 24, 2006

Honorable Legislators;

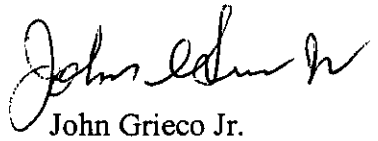
Before you pass judgment on House Bill 1704, I wanted to make sure you had all the facts pertaining to this legislation. I am a small business owner servicing the manufacturing sector located in Fremont, NH. I employ thirteen employees, ten of whom have full health coverage and pay a quarter of their premiums. I have seen increased health insurance rates for each of the past three years, and this year we are facing a 40% increase in premiums. This cost is extremely difficult for me and my employees to absorb. None of my employees are using the Medicaid program for their health care, because I provide them with quality, affordable health care. Unfortunately, unless something changes I may no longer continue to be able to do so.

I think it is unfair that I am being penalized for trying to do the right thing. I am struggling to provide good coverage for my employees, rather than encourage them to use taxpayer funded programs or rely on charity care. At the same time, a few of the largest and most profitable companies in our state are shifting their costs on to me as a taxpayer and as a business owner who provides good benefits. This is not right and sends the wrong message to small businesses who are struggling to grow and be good corporate citizens.

I want to let you know that I have nothing against Wal-Mart or any other large company in our state, but you were presented with testimony from a lobbyist from the Retail Merchants Association and a legislator employed by Wal-Mart that I believe was very misleading. When I left the public hearing I contacted a friend of mine who works for Wal-Mart as was told that someone would be crazy to select the plans that were highlighted for you, because "they don't cover anything". I've tried to put together some information for you that he gave me and would be glad to compare that to what I pay for. There is a huge difference.

As you make up your minds on whether to support this legislation, please listen to small businesses like me who are struggling to pay costs that a few huge corporations are shifting on to us. I don't want a free lunch for me or my employees, I just want to stop paying the tab for a wealthier friend's dinner. Please help make sure that Wal-Mart and other large companies pay their fair share before my company, and many other small businesses are forced to rethink the coverage we offer. Thank you and feel free to contact me at any time.

Sincerely,



John Grieco Jr.
President
Quality Flame Cutting, Inc.

WAL★MART FACTS

Wal-Mart offers a broad range of benefits to its associates ✓ Health Insurance ✓ Dental Insurance ✓ Company Paid Life Insurance ✓ 401(k)/Profit Sharing ✓ Stock Discount Purchase Plan ✓ Performance-Based Bonuses ✓ Store Discount Card	**74 percent of our jobs in the U.S. are full-time positions (34+hours per week).** **Wal-Mart's national average wage for full-time hourly associates is almost twice the federal minimum wage.**
We project we will create more than 100,000 new jobs this year in the United States.	**Medical plans are available to both full and part-time associates** Premiums start at less than $40 per month for an individual and less than $155 per month for a family.

- *As of January 2005,* ***over 568,000 associates rely on healthcare coverage provided by Wal-Mart to insure themselves or their families.***
- *Our medical plan protects families from catastrophic illnesses.* ***It has no lifetime limit.***
- *We provide outstanding opportunity for advancement.* ***Seventy-six percent of our store management team started at Wal-Mart in hourly positions.***
- *In recent years,* ***Wal-Mart has contributed 4 percent of an associate's eligible pay to the combined Profit Sharing & 401(k) plan.*** *Our hourly associates, just like our management and executive associates, receive bonuses and other incentives for helping the company achieve its goals.*

For more information on the facts about Wal-Mart, visit www.walmartfacts.com.

WAL★MART FACTS

Wal-Mart Associates Medical Plan – 2005 Monthly Rates and Plans

ANNUAL DEDUCTIBLE		ASSOCIATE ONLY	ASSOCIATE + SPOUSE	ASSOCIATE + CHILDREN	FAMILY COVERAGE	MAX OUT OF POCKET INDIVIDUAL	MAX OUT OF POCKET FAMILY	MAX FAMILY DEDUCTIBLE
$350	- Any Doctor	$ 86.90	$ 267.23	$ 220.52	$ 299.82	$ 1,750	$ 3,500	$ 1,050
$350	- Network	$ 77.13	$ 247.68	$ 202.05	$ 272.66	$ 1,750	$ 3,500	$ 1,050
$500	- Any Doctor	$ 74.96	$ 241.16	$ 196.62	$ 263.97	$ 2,500	$ 5,000	$ 1,500
$500	- Network	$ 66.26	$ 221.61	$ 179.24	$ 238.99	$ 2,500	$ 5,000	$ 1,500
$750	- Any Doctor	$ 56.49	$ 200.97	$ 161.86	$ 211.83	$ 3,750	$ 7,500	$ 2,250
$750	- Network	$ 48.88	$ 178.15	$ 145.57	$ 187.93	$ 3,750	$ 7,500	$ 2,250
$1,000	- Any Doctor	$ 45.63	$ 170.55	$ 137.96	$ 175.98	$ 5,000	$ 10,000	$ 3,000
$1,000	- Network	$ 38.02	$ 149.91	$ 122.75	$ 153.17	$ 5,000	$ 10,000	$ 3,000
Dental		$ 6.52	$ 13.58	$ 13.58	$ 20.64			

* Not all plans are available in all areas. Some areas may also offer HMO's.
* Waiting period for full-time hourly associates is 180 days, less for professional, management and logistics associates.
* Waiting period for part-time is two years; eligible for single coverage only.

- *Our healthcare plan is designed for catastrophic coverage, but also offers solid benefits for basic needs. Unlike many plans, after the first year,* ***the Wal-Mart medical plan has no lifetime maximum*** *for most expenses, protecting our associates against catastrophic loss and financial ruin.*

- *Once an associate's deductible is met,* ***the plan generally pays 80 percent of charges*** *for all services included in the plan.*

- *Historically,* ***Wal-Mart has paid about two-thirds of the cost of the Associates Medical Plan.***

- ***Associates have access to world class health care*** *at the Mayo Clinic, Stanford University Hospital, Johns Hopkins University Hospital and many other top health care facilities throughout the U.S., all without insurance approval.*

- ***Other benefits include a profit-sharing/401 (k) plan, merchandise discounts, company paid life insurance, vacation pay, performance-based bonuses, and a pay differential for those in active military service.***

For more information on the facts about Wal-Mart, visit www.walmartfacts.com.

Voting Sheets

HOUSE COMMITTEE ON COMMERCE

EXECUTIVE SESSION on HB 1704-FN-A

BILL TITLE: **establishing a health care fund, continually appropriating a special fund, and requiring certain employers to report certain information to the department of health and human services.**

DATE: February 8, 2006

LOB ROOM: 302

Amendments:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Motions: OTP, OTP/A, ITL, Interim Study (Please circle one.)

Moved by Rep.

Seconded by Rep.

Vote: (Please attach record of roll call vote.)

Motions: OTP, OTP/A, ITL, Interim Study (Please circle one.)

Moved by Rep. Stepanek

Seconded by Rep. Martin

Vote: 12-6 (Please attach record of roll call vote.)

CONSENT CALENDAR VOTE: Regular

(Vote to place on Consent Calendar must be unanimous.)

Statement of Intent: Refer to Committee Report

Respectfully submitted,

Rep. Charles L. Clark, Clerk

HOUSE COMMITTEE ON COMMERCE

EXECUTIVE SESSION on HB 1704-FN-A

BILL TITLE: **establishing a health care fund, continually appropriating a special fund, and requiring certain employers to report certain information to the department of health and human services.**

DATE: {Type DATE} 2/8/06

LOB ROOM: 302

Amendments:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Motions: OTP, OTP/A, ITL, Interim Study (Please circle one.)

Moved by Rep. STEPANEK

Seconded by Rep. MARTIN

Vote: 12-6 (Please attach record of roll call vote.)

Motions: OTP, OTP/A, ITL, Interim Study (Please circle one.)

Moved by Rep.

Seconded by Rep.

Vote: (Please attach record of roll call vote.)

CONSENT CALENDAR VOTE: ~~{Type VOTE}~~ Regular

(Vote to place on Consent Calendar must be unanimous.)

Statement of Intent: Refer to Committee Report

Respectfully submitted,

Rep. Charles L. Clark, Clerk

OFFICE OF THE HOUSE CLERK 2006 SESSION

COMMERCE

Bill #: HB 1704 FN-A Title: _____

PH Date: ___/___/___ Exec Session Date: 2/7/06

Motion: ITL Amendment #: _____

MEMBER	YEAS	NAYS
Francoeur, Sheila T, Chairman	✓	
Stepanek, Stephen B, V Chairman	✓	
Belanger, Ronald J	✓	
Langley, Jane S	✓	
Flanders, Donald H	✓	
Clark, Charles L, Clerk	✓	
Quandt, Marshall Lee		✓
Quandt, Matthew J		✓
Scamman, Stella		
Headd, James F	✓	
Kidder, David H	✓	
Martin, James R	✓	
Pelkey, Stephen T		✓
Taylor, Kathleen N	✓	
Reardon, Tara G		
DeStefano, Stephen T	✓	
Kopka, Angeline A	✓	
DeVries, Betsi L		✓
Egbers, Fran M		✓
McLeod, Martha S	✓	
Mitchell, Bonnie G		✓
TOTAL VOTE:	12	6

Printed: 12/19/2005

Committee Report

COMMITTEE REPORT

COMMITTEE: **Commerce**

BILL NUMBER: **HB 1704-FN-A**

TITLE: establishing a health care fund, continually appropriating a special fund, and requiring certain employers to report certain information to the department of health and human services.

DATE: February 7, 2006 CONSENT CALENDAR YES ☐ NO ☒

☐ OUGHT TO PASS

☐ OUGHT TO PASS WITH AMENDMENT

☒ INEXPEDIENT TO LEGISLATE

☐ REFER TO COMMITTEE FOR INTERIM STUDY
(Available only in second year of biennium.)

STATEMENT OF INTENT
(Include Committee Vote)

This is a poorly crafted bill which on its face says it is created to help defray health care costs of the state. In reality it has been carefully crafted to target only one company. Health insurance is still a voluntary benefit provided by the employer. This bill would make it a mandatory requirement. The bill would also dictate how much an employer is to spend and if they didn't it would impose what amounts to a tax on that employer, a health care tax. Of course a company could get around this by reducing its part time workers or by out-sourcing jobs to fall below the 1500 limit. The 1500 employee limit today could be 1000 tomorrow, 500 the next day and then just mandatory for every employer. This bill sets us on the road towards mandatory health insurance coverage by all employers coupled with mandatory levels of coverage or a health insurance tax. The committee felt this was not the direction this legislature or this state should be moving.

Vote 12-6.

Rep. Stephen B. Stepanek
FOR THE COMMITTEE

Original: House Clerk
cc: Committee Bill file

USE ANOTHER REPORT FOR MINORITY REPORT

Commerce

HB 1704-FN-A, establishing a health care fund, continually appropriating a special fund, and requiring certain employers to report certain information to the department of health and human services. **INEXPEDIENT TO LEGISLATE**

Rep. Stephen B. Stepanek for Commerce: This is a poorly crafted bill which on its face says it is created to help defray health care costs of the state. In reality it has been carefully crafted to target only one company. Health insurance is still a voluntary benefit provided by the employer. This bill would make it a mandatory requirement. The bill would also dictate how much an employer is to spend and if they didn't it would impose what amounts to a tax on that employer, a health care tax. Of course a company could get around this by reducing its part time workers or by out-sourcing jobs to fall below the 1500 limit. The 1500 employee limit today could be 1000 tomorrow, 500 the next day and then just mandatory for every employer. This bill sets us on the road towards mandatory health insurance coverage by all employers coupled with mandatory levels of coverage or a health insurance tax. The committee felt this was not the direction this legislature or this state should be moving. **Vote 12-6.**

HB 1704-FN-A
Rep. Stephen B. Stepanek

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1704

THIS IS A POORLY CRAFTED BILL

WHICH ON ITS FACE SAYS IT IS

CREATED TO HELP DEFRAY HEALTH CARE

COST OF THE STATE IN REALITY IT

HAS BEEN CAREFULLY CRAFTED TO

TARGET ONLY ONE COMPANY

IT'S PRIMARY PURPOSE IS NOT TO

HELP THE STATE OR ITS CITIZENS

THIS ONE COMPANY

BUT TO PUNISH

[redacted]

THAT ALONE IS REASON ENOUGH

TO KILL THIS BILL, BUT

IN ADDITION IT COULD

1704 (2)

AFTER [redacted] OR TWO

THE SECRETARY [redacted] THIS BILL WOULD

HEALTH INSURANCE IS STILL A

[redacted] VOLUNTARY

BENEFIT PROVIDED BY

YOUR EMPLOYER. THIS BILL WOULD

MAKE IT A MANDATORY REQUIREMENT

THE BILL

ON ONE EMPLOYER ONLY THE WAY

FORCED TO MAKE A CERTAIN WOULD ALSO

FORCED TO MAKE A CERTAIN WOULD ALSO

DICTATE TO THAT EMPLOYER HOW MUCH

THEY WERE TO SPEND AND IF THEY

IT

DIDN'T [redacted] WOULD IMPOSE WHAT

AMOUNTS TO ANOTHER TAX ON THAT

EMPLOYER. IT WOULD IN EFFECT

CREAT A HEALTH CARE TAX

1704 (3)

OF COURSE THE COMPANY COULD GET AROUND THIS BY REDUCING ITS AND THE WORKERS OR BY CONTRACTING OUT JOBS TO PAY BELOW THE 1500 LIMIT. WHAT IS TRULY RIGHT ABOUT THIS LEGISLATION IS WHERE DOES IT STOP THE 1500 EMPLOYEE LIMIT TODAY COULD BE 1000 TOMORROW SO THE NEXT DAY AND THEN JUST MANDATORY FOR ~~EVERY~~ EVERY EMPLOYER IN ADDITION TO ATTEMPTING TO PUNISH OUR COMPANY THIS BILL SETS US ON THE ROAD TOWARDS MANDATORY HEALTH INSURANCE

1704 (4)

COVERAGE BY ALL EMPLOYERS

COUPLED WITH MANDATORY LEVELS

OF COVERAGE [redacted] OR A HEALTH

INSURANCE TAX, THE [redacted] COMMITTEE

FELT THIS WAS NOT THE DIRECTION

[redacted] THIS LEGISLATURE

OF THIS STATE SHOULD BE MOVING

IN.