Mr. LANGEVIN. Right.

And I think that is an important point, if I could just interject. The high costs of health care now are putting not only a tremendous burden on our individuals and families, but it's putting our companies at a significant competitive disadvantage in terms of those companies overseas whose nations have universal health care. And so it is not particularly burdening in individual business itself in foreign countries where it is here where companies bear much of the costs of providing universal health care.

So we're helping to change the dynamic, if you would, of how health care is provided in America. And, again, we're changing it from an employer kind of run system, a sponsor system, to now a universal health care model that everybody is participating in, and it's not necessarily tied to employment. Again, businesses still have an important role to play, we all do. Businesses, government, health care providers.

Mr. SHAYS. But they won't have to negotiate a plan every year, and it won't be unique to that business. It will be a plan that will have been negotiated by the American Health Benefits Plan.

You know, I look at this trend line, and I see that we're looking that in the year 2016, we would be spending $4 trillion. But what will we be spending in the year 2020? And this is without doing what we need to do, which is to reform the system.

And so what we have done is we have established a commission, and the commission will be of nine members, the chair and vice chair, as well as two other members who will be chosen by the comptroller general. The President, the majority leader, the minority leaders of the Senate and Speaker, the minority leader of the House will choose one representative. And the commission shall examine and make recommendations regarding the major issues and cost drivers affecting the delivery of health services as it pertains to the American Health Benefit Program.

Within the legislation, we specifically are directing the commission to examine a comparison of the American Health Benefit Plan to other public health insurance programs, the proper implementation and utilization of electronic medical records and other health information technologies, including privacy and interoperability issues. We're directing them to look at the effects of medical malpractice insurance and defensive medicine on the delivery and cost of health care, and that's something that needs to be looked at.

The patterns and effects of overutilization. When do people overutilize care? Why do they overutilize it, and what steps can an overall plan do to encourage all of the insurance companies to have some of the basic same practices that would discourage overutilization?

We are having them look at the cost and implementation factor of retiree health coverage under the American Health Benefit Plan. What is the impact of retirees? And candidly, what is the impact of the last few months of someone's life when we see a huge amount of money spent?

A comparison of prescription drug prices under the American Health Benefit Plan to other public health programs, and the effects of insurance monopolies on health care costs and delivery, we need to look at that.

Now, what this commission will do, it has 18 months to file its findings, which is 6 months before the law actually goes into effect. But we're asking them to give us a preliminary finding 12 months in, a final version 18 months, but one 12 months.

So the legislation passes 2 years before it's implemented. The commission comes back in a year and says, You need to make these changes to help control costs, to help discourage overutilization, to help with preventative care. That would help save costs in the long run. We will come back 18 months later.

Now, one of the last points I would make, and I know that you have comments that you need to make as well, we are willing to amend this legislation as we get data. And, for instance, I hope that sometime again we can look at the chart that you had where you talked about employer contributions because we're asking employers to say, okay, what do you pay now and how would this legislation impact you. And even if now they would be paying a little bit more, I suspect that in the long run, because their costs are going up significantly without a plan, but if I could just point out how this chart works. It's rather small. But we look at an average wage earner of $21,000 or less, and then we say okay, there's 10 employees to 25 employees. There are 200 to 500 employees. That's on the left column. And in an average wage of $21,000 or less, even with 500 employees, they would only be paying about $1,000, slightly over $1,000 a year.

Now, when you go and look at someone who is making $83,000-plus, the amount that they would be contributing would ultimately max out, potentially, at a much higher rate, more than $10,000. But the question is, what do they pay now?

Did I get that right? Yeah.

But the point is, employers are going to say, I have 26 employees, their average salary is $42,000. They will know that they're going to be paying approximately $6,600 an employee. So that's what they would pay under this plan. What do they pay now, and are there employees having the same choices that now—do they have the same choices under their private plan as they would under this plan?

Mr. LANGEVIN. Right. And that's an important point to make.

There are some employers that, though they offer health insurance, the company may only offer one plan, and it may not fit the needs of all of the employees. It may be good for some but, again, not everyone.

Under this plan, there would be a variety of plans to choose from: again, a very basic plan with a small premium, a small copay, up to the more comprehensive-type programs, and several options in between. And it's basically bringing everyone into one insurance pool.

So you're bringing a younger, healthier population into the program; you're spreading risk, which leads to more stable costs; and we talked about the fact that the Federal Employees Health Benefit Program under last year only had a 1.8 percent increase in its health care plans on average and the private sector had about a 6.1 percent increase. And I think that's even modest.

So, again, a good model here.

I'm glad that you raised the issue of the commission because it is important to look at the reasons for the rising costs of health care and then look at what options we can employ to achieve cost containment and bring stability to the system. Things like employing health information technology, the electronic medical records that we're talking more and more about these days, the cost of prescription drugs and how that system is run, and how we pay for prescription drugs. I'm looking at performance-based outcomes that the commission would look at. Again, all important tenets of achieving cost containment.

And you rightly pointed out that employers, in determining whether they like the system or not, are going to look at the range of costs or percentage of payroll that they would contribute based on the size of their company. Employers, I suspect right now, hopefully this will encourage them to ask, what are we paying as a percentage of payroll right now, and that figure will determine, in many ways, whether this system works better or worse for them. I suspect that in many cases it will be better.

And we pointed out that the smaller companies with the lowest average salaries would pay no more than 4 percent of their payroll toward this payroll tax. And the larger companies with the highest salaries would pay no more than 10 percent of payroll and not to exceed more than $12,000 per employee.

Mr. SHAYS. Right. Because what we do is we cap the payroll at $120,000. And so it ends up being $12,000 an employer would pay.

But when I was speaking of someone with 500 employees, they would pay $21,000 salary, they pay 5.25, 5¼ percent of payroll. It gets up to, if they're making $83,000 on average, and that would be quite a company, then they would be paying the 10 percent rate. And the key is that when we drafted this legislation, we had the input of private foundations and experts. But in the end, this still is an estimate of what we