AMERICAN HEALTH BENEFITS PROGRAM ACT OF 2008

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-White Paper-

Universal Coverage
Shared Responsibility
Access to Choice and Affordability

What is American Health Benefits Program (AHBP)?

The American Health Benefits Program (AHBP) is a proposed system of universal health care to provide every American with access to the same quality, affordable coverage as members of Congress. It is modeled after the Federal Employee Health Benefits Program (FEHBP), which currently provides health insurance at very low administrative costs to more than 8 million Federal employees, retirees and their dependents. AHBP will leverage the power of the Federal government to negotiate with private insurance carriers and offer enrollees a range of health insurance options, from very basic packages to more inclusive plans, including national fee-for-service plans, local HMOs, and high deductible health plans with tax advantage accounts. No one will be denied coverage or discriminated against based on their health status or pre-existing condition. Insurance plans will compete for enrollees based on quality, efficiency, service and price.

How will AHBP be administered?

AHBP will be administered by a newly established Health Benefits Administration (HBA) in the same manner that the Office of Personnel Management (OPM) administers FEHBP. This newly established independent Federal agency, under the direction of the Commissioner of Health Benefits, will assume the primary responsibility for negotiating health benefit packages for all Americans and approving plan participation in AHBP. HBA will also provide a defined contribution toward every enrollee's premium. It will actively manage and regulate the process of informed consumer choice, motivating private insurance companies to produce a favorable combination of efficiency and equity.

Who will participate in AHBP?

All citizens, nationals and lawfully-residing immigrants are <u>eligible</u> to participate in an AHBP qualified health plan.

All individuals who are not enrolled in the existing Federal programs of Medicare, Medicaid, Tricare/CHAMPUS, Indian Health Services or Veterans Health programs are <u>required</u> to participate in a health plan that meets the standard set by AHBP.

For those who are "required" – is that an individual mandate?

Yes. Under this plan, all Americans must demonstrate coverage through a Federal program (as listed above), an AHBP-participating plan or another private plan that meets the standard set by AHBP. Individuals may apply for a religious exemption. Those who do not sign up for a plan will be enrolled in a basic AHBP plan by default, should they fail to select one. Individuals subject to default enrollment will be enrolled in the lowest cost plan in their region.

How will people sign up?

The program will hold an open enrollment period once a year. During this time, individuals can select or change health insurance plans. The newly established Health Benefits Administration will oversee production and distribution of material outlining the benefits, premiums and co-pay structure of all participating plans for each region. Individuals may change plans at any time if their marital status or dependency status changes.

Currently, Federal employees can easily access localized plan information on OPM's website, which offers the details of the plans available to them. Employees also receive a mailing each year, describing open enrollment period guidelines, containing plan brochures, and providing other information on the available plans. The Office of Personnel Management has been doing this across the country since 1960 with incredibly low administrative costs. We can do this for all Americans.

Who will pay?

Individuals: Enrollees who make above 300 percent of the federal poverty level ($31,200 for an individual; $63,000 for a family of four) would be responsible for up to 28% of the premium cost, which he/she may opt to have withheld from his/her pay.

Employers: If employers offer actuarially equivalent coverage to the AHBP, they will have the option of not participating as long as they continue to offer this coverage. Employers who choose not to provide health plans for their employees will contribute to a newly established AHBP Trust Fund through a fixed, predictable payroll tax. This payroll tax will be calculated based on the firm's size and average employee earnings per year to ensure that it is equitable to all businesses, both large and small. The average employee yearly earnings subject to taxation will be adjusted for inflation. Furthermore, the total amount a firm may contribute per employee will be capped at $12,000 and will also be adjusted for inflation. Please see table below:

Employer Payroll Tax Table:

Firm size	Avg. wage < $21,000	Avg. earnings $21,000-42,000	Avg. earnings $42,001- $83,000	Avg. earnings $83,001 +
< 10	4.0%	5.00%	6.00%	8.75%
10-25	4.25%	5.25%	6.75%	9.50%
26-49	4.5%	5.50%	7.25%	10.00%
50-199	4.75%	5.75%	8.0%	10.00%
200-499	5.0%	6.00%	8.75%	10.00%
500+	5.25%	6.25%	9.50%	10.00%

Because this funding stream will finance the government's contribution to enrollee premiums, the employers' role in health care can be minimized to a fixed amount – relieving their burden of unpredictable and steep annual premium increases and frequent negotiations with health insurance companies. (However, employers operating under a collective bargaining agreement must wait until its expiration before making any changes in their health insurance coverage.)

Government: The HBA will provide a defined contribution toward every AHBP enrollee's premium. The government will pay its portion of enrollee premiums directly to the health care plan of the enrollee's choice. The government contribution will equal 72 percent of the weighted average premium of all plans available in that individual's region, not to exceed 75 percent of the total premium for any one particular plan an enrollee selects.

What will the premiums be?

Because numerous plans will participate in AHBP, the premiums will vary from plan to plan. The recent experience in FEHBP has been that premiums (on average) rise at a slightly lower rate than the private insurance market. In fact, 2007 marked the smallest FEHBP average premium increase in more than a decade:

Comparative Percentage Increase in FEHBP Premiums to the Private Market Average:

Year	FEHBP percent change[1]	Private Market percent change[2]
2001	10.5%	10.9%
2002	13.3%	12.9%
2003	11.1%	13.9%
2004	10.6%	11.2%
2005	7.9%	9.2%
2006	6.6%	7.7%
2007	1.8%	6.1%

A cornerstone of the AHBP is that all individuals will be combined into one insurance market. With this larger, healthier risk pool, premium costs will come down over time. Currently, there are an estimated 18 million 19 to 34-year olds without health insurance[3]. This age group composes an increasing percentage of the uninsured. Their absence from the insurance market means insurance companies must cover a more expensive population. Bringing a younger and healthier population into the health insurance market will spread the risk more evenly, bringing down costs over time for everyone.

Furthermore, the oversight of the Federal government will keep insurance companies in check. Participation in AHBP will require insurance companies to reinvest at least 90 percent of the total premium payments that they receive into health care benefits or improvements, including health information technology. Plans will compete for enrollees on the basis of benefits as well as efficiency, service and price. By requiring the government to negotiate with private companies on behalf of <u>all</u> Americans, the government will be able to negotiate lower premium increases on a larger scale.

What kind of coverage will be offered?

Participating plans will have to meet high standards of quality for individual and family coverage. The Health Benefits Administration will contract (or renew contracts) annually with fee-for-service plans, health maintenance organizations (HMOs), or high deductible health plans with tax advantage accounts. In FEHBP, this has meant a choice of six nationwide fee-for-service plans – which reimburse a health care provider for the cost of covered services. Under such plans, one may choose his/her own physician, hospital, and other health care providers. Most fee-for-service plans have preferred provider organization (PPO) arrangements, wherein enrollees pay lesser co-pays to see in-network providers. More than 200 localized HMOs also participate in FEHBP, offering comprehensive health care services on a prepaid basis through designated plan physicians, hospitals, and other providers in particular locations. The goal of AHBP will be to offer a similar range of choices to all Americans.

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[1] Office of Personnel Management
[2] Kaiser Family Foundation and Health Research & Educational Trust, "Employer Health Benefits, 2005 Summary of Findings."
[3] Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured, "The Uninsured, A Primer – Key Facts About Americans without Health Insurance. October, 2007.

AHBP does not mandate a standard plan benefit package, although the government has the authority to impose certain coverage requirements, such as child immunizations, cancer screenings, organ transplants, and prescription drugs (enrollee costs for drugs vary widely among the plans). The AHBP legislation also includes language requiring that participating plans include defined patient protections and parity for coverage of mental and physical health care.

How will people pay their premiums?

The government will make all premium payments to health insurance plans and will then be responsible for collecting the enrollee share of the premium. Under this system, the government assumes the risk of non-payment.

Under AHBP, an enrollee may have the premium withheld from his/her pay. In cases where the amount cannot be/is not withheld from pay, the covered individuals will pay any owed premiums as part of the annual tax filing process.

How will this plan help lower-income individuals?

Under AHBP, people who qualify for state Medicaid programs may remain in those programs, which are often geared to meet the needs of certain populations – largely women and children. In fact, the bill contains a "maintenance of effort" requirement to prevent states from dropping people from their Medicaid rolls. The states have traditionally assumed a shared responsibility with the Federal government for lower-income individuals, and states should continue these investments.

However, two-thirds of the uninsured are working or live in households where one or both adults are employed. In many cases, these families are ineligible for Medicaid, but they either are not offered health insurance by their employer or cannot afford their share of the premium. AHBP will bring these families into the health insurance market.

The legislation also requires the development of premium subsidies, as well as cost-sharing subsidies for those who would be kept from going to the doctor because they cannot afford the co-payment – covering 100 percent of the co-payments for those individuals under 125% of the poverty level (150 percent for families of two or more individuals), and on a sliding scale for individuals up to 250 percent of the federal poverty level (300 percent for families). In the case of children and pregnant women -- groups that we cannot afford to discourage from seeking preventative care -- co-pays would be fully covered up to 250 percent of the federal poverty level.

Almost 160 million Americans have insurance through their employers[4]. Why would we begin to remove the tie between health care and employment?

<u>AHBP Benefits Employers</u>:

This system will offer relief to employers from the burden of negotiating health care plans for their employees year after year. Employers offer health coverage voluntarily, and recent soaring costs are threatening the sustainability of the system. Health insurance premiums rose 6.2% in 2007, once again outpacing inflation. The majority of employers wants to be involved in providing health care to their employees but can only sustain moderate health care cost increases. By offering a fixed

[4] Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured, "Health Insurance Coverage in America, 2005." Data Update, May 2007.

payroll tax as a means of participation, AHBP offers employers a more stable and predictable means of contribution than annual negotiations with private companies.

AHBP Benefits Consumers:

Consumers benefit in several ways from the development of a health care system that is citizen-based, rather than job-based. AHBP will offer:

- **Guaranteed Coverage**: Ensure access to quality, affordable health coverage to all Americans, regardless of employment or health status.
- **Expanded Choice**: Approximately three-fourths of all workers in private industry had no choice in medical insurance, either because they were not offered a plan or because they were offered only one plan[5]. AHBP enrollees will have a selection of plans pre-negotiated for them by the government. They will not have to rely on what their employer has chosen for them.
- **Portability**: The lack of portability under the current employer based system has serious consequences for the quality and cost of health care. A citizen-based system of portable and continuous coverage would increase insurers' incentives to invest in disease prevention and long term preventative care – investments that decrease the cost of care over time.

How much will this plan cost?

We will not know the total cost of the plan until the Congressional Budget Office and Joint Committee on Taxation score it; however, we modeled our plan with the expectation that we would need $540 billion[6] in revenue per year to finance the plan, largely from employer contributions. We are putting this forward as a good-faith proposal – in other words, should official projected costs differ from this estimate, we will make any necessary adjustments.

A significant amount of money in the existing system is used inefficiently. AHBP would utilize appropriate cost containment measures and revenue streams to harness those funds and provide continuous, portable health insurance to all Americans:

- **Uncompensated Care -** We expect to see savings in the area of uncompensated care – care that currently is delivered to those without insurance, often in emergency departments. The most recent estimates place the costs of uncompensated care at $**41 billion**[7]. The cost of caring for the uninsured is often unbearably high because the uninsured have no bargaining power and, as a result, no ability to negotiate discounted prices. Additionally, because the uninsured have no access to preventative health care, many illnesses are not diagnosed or treated until they reach catastrophic levels. This often results in dramatically higher costs to the patient, health care provider, as well as to potential employers in lost time and revenue.

- **DSH Payments** – Disproportionate Share Hospital (DSH) payments are now used by Medicare and Medicaid to ease the burdens of hospitals treating large numbers of low-income and uninsured patients. In 2005, total Medicaid DSH allotments exceeded **$10 billion**[8]. Universal

[5] Barbara English, "Health Benefits for Members of Congress." Congressional Research Service Report RS21982. September 25, 2007.
[6] Based on internal calculations on data extracted from the 2004 National Health Accounts: (Table 4 from http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf).
[7] Jack Hadley and John Holahan, "The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending," Issue Brief prepared for the Kaiser Commission on Medicaid and the Uninsured. May 10, 2004.
[8] Jean Hearne, "Medicaid Disproportionate Share Payments." Congressional Research Service Report 97-483. Updated July 30, 2007.

health care will virtually eliminate the burden of uncompensated care on hospitals and significantly reduce the need for the Federal and state governments to provide financial assistance. These DSH payments will, therefore, be reduced over a five-year period to 10 percent of their allotments in 2008. A small DSH stream will be maintained for hospitals that serve a high population of Medicaid beneficiaries.

- **Hospital Tax** – A universal health care system of shared responsibility will require a contribution from all members of the community, including health care providers. Hospitals that previously lost revenue due to the high costs of providing uncompensated care, sometimes at catastrophic levels to the uninsured and underserved populations will begin to see larger revenue streams. Therefore, a 2 percent federal tax on hospital revenues will be established to offset the decreased costs of providing uncompensated care. This is estimated to raise at least **$11.3 billion**[9] per year.

- **Health IT** - The inclusion of cost growth containment measures is critical to the success of any health care system. Electronic medical records, for example, could significantly improve the quality, safety and efficiency of health care delivery while saving an estimated **$77 billion**[10] per year. New guidelines will be established by the AHBP Commissioner and Secretary of HHS that promote the proper use and understanding of Health Information Technologies.

How will this program remain dynamic and responsive to the changing nature of health care delivery?

If we are serious about developing an efficient, high quality health care delivery system, we must continue to look at the strategies that have proven successful in other health care systems and adopt common sense approaches to deal with the rapidly increasing expenses within the health care industry. The American Health Benefits Program Act will establish an independent commission to examine and make recommendations to Congress on the major issues and cost drivers affecting the delivery of health care services as it pertains to the American Health Benefits Program.

These issues will include the integration of other public health insurance coverage with AHBP, the proper implementation and utilization of electronic medical records and other Health Information Technologies, the effects of medical malpractice insurance and "defensive medicine" on the delivery and cost of health care, the patterns and effects of overutilization on AHBP, cost and implementation factors of retiree coverage under AHBP, the growth of prescription drug prices, and the effects of insurance monopolies on health care costs and delivery. The commission will begin making annual reports to the commissioner of AHBP and the relevant Congressional committees within two years of its establishment.

[9] Calculation based on 2% of $564.4 billion estimate from 2004 Hospital Care expenditures. Centers for Medicare and Medicaid Services (CMS) National Health Expenditure Data.
[10] R. Hillestad et al. (2005). "Can Electronic Medical Record Systems Transform Health Care? Potential Health Benefits," Health Affairs. 24: 1103-1117.