

What is American Health Benefits Program (AHBP)?

The American Health Benefits Program (AHBP) is a proposed system of managed competition, to provide all Americans with access to affordable health care. It is modeled after the Federal Employee Health Benefits Program (FEHBP), which currently manages health insurance for more than 8 million federal employees, retirees and their dependents. FEHBP, which is comprised of private insurance carriers, is administered by the federal government. The Office of Personnel Management (OPM) is responsible for approving or disapproving carriers and negotiating benefit and rate changes. This **managed competition program** offers enrollees a range of choices of health insurance plans, from very basic packages to more inclusive plans and including national fee-for-service plans, as well as local HMOs.

AHBP would leverage the negotiating power of the federal government by extending this program to all Americans. The government would assume primary responsibility for negotiating health benefit packages for all Americans. The government would provide a defined contribution toward every enrollee's premium and actively manage and regulate the process of informed consumer choice, motivating private insurance companies to produce a favorable combination of efficiency and equity. AHBP would set a national standard for a basic benefit package. Plans will compete for enrollees on the basis of benefits as well as efficiency, service and price.

Who will participate in AHBP?

All citizens, nationals and lawfully-residing immigrants are eligible 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 Veteran's Health programs are required to participate 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 plan or another private plan that meets the standard set by AHBP. Those who do not sign up for a plan will be enrolled in a basic AHBP plan by default (with premiums of below average in their region), should they fail to select one.

Who will pay?

As in the Federal Employees Health Benefits Program (FEHBP), the government will provide a defined contribution toward every AHBP enrollee's premium.

This contribution will come from a newly established Trust Fund. Employers who chose not to offer health plans to their employees will contribute to the Trust Fund through a fixed, predictable payroll tax. 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 annual negotiations with health insurance companies.

The government will pay enrollee premiums directly to the health care plan of the enrollee's choice. The enrollee is responsible for up to 28% of the premium (subsidies will be available for families for whom this would be a hardship), which he/she may opt to have withheld from his/her pay.

The government contribution will equal the lesser of 72 percent of the amount of the weighted average of premiums in effect for that individual's region OR 75 percent of the total premium for the particular plan an enrollee selects.

How will people sign up?

As in FEHBP, there will be an **open season** once a year. During this time, individuals can select or change health insurance plans. The administering federal agency will oversee production and distribution of material outlining the benefits, premiums and copay 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 season guidelines, containing plan brochures, and providing other information on the available plans. The Office of Personnel Management has been doing this since 1960 and manages FEHBP for 8.6 million employees, retirees and dependents across the country with incredibly low administrative costs. We can do this for all Americans.

What will the premiums be?

Because a number of plans will participate in AHBP, like FEHBP, 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:

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%	Not yet available

¹ Office of Personnel Management

² Kaiser Family Foundation and Health Research & Educational Trust. Employer Health Benefits, 2005 Summary of Findings.

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 8 million 18- to 24-year olds without health insurance. This age group is the fastest growing demographic of the uninsured. Their absence from the insurance market means insurance companies are dealing with a more expensive population to cover. 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. Under FEHBP, OPM has actively managed and regulated the process of informed consumer choice, motivating private insurance companies to produce a favorable combination of efficiency and equity. Plans 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 all Americans, the government will be able to negotiate premium increases on a larger scale.

What kind of coverage will be offered?

Participating plans will have to meet high standards of quality. As in FEHBP, a federal, administrative agency will contract (or renew contracts) annually with fee-for-service plans and HMOs. 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 (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 this same range of choice to all Americans.

The AHBP bill mirrors FEHBP statutes, in that it 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). FEHBP requires plans to limit enrollees' annual out-of-pocket expenses, but there is no standard definition of the expenses that count toward that limit. The AHBP legislation also includes language requiring that participating plans include defined patient protections and parity for coverage of mental and physical health care.

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

AHBP benefits employers:

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 11.2% in 2004, and a recent survey of employers found that 96% of corporate leaders believe the

cost of health care benefits is an area of significant or critical concern. The majority of employers want to be involved in providing health care to their employees but report that, on average, they can only absorb health care cost increases of about 9% per year.³ By offering a fixed, predictable 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:

- Extend the advantages of **group insurance** to all Americans, regardless of their employment status.
- Expand **choice** – as in FEHBP, all consumers 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.
- Offer **portability** – the ability to take one’s health plan and doctors with them when they change jobs. The lack of portability under the current employer based system has serious consequences for the quality and cost of health care. A recent study showed that 20 percent of people with insurance change plans each year⁴. 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 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?

People who qualify for state Medicaid programs may remain in those programs, which are often geared to meet the needs of that population – largely comprised of women and children. In fact, the bill contains incentives to states to keep them from dropping people off 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. Under AHBP, we will increase the matching funds the states receive from the federal government for Medicaid to those states who keep AHBP eligible individuals on the Medicaid rolls.

³ Hewitt Associates, “Survey Findings, Health Care Expectations: Future Strategy and Discussions, 2004”

⁴ P. Franks, C. Cameron and K.D. Bertakis, “On Being New to an Insurance Plan.” *Annals of Family Medicine*. September/October 2003

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 aren't offered health insurance by their employer or can't afford their share of the premium. AHBP will bring these families into the health insurance market. The AHBP legislation includes **premium subsidies** of 100 percent for those who cannot afford to make a contribution and requires subsidies, on a sliding scale, to those who might be able to afford some, but not all. The legislation does not define the income limit for premium subsidies, leaving it up to the Commissioner to establish regulations, in coordination with Medicaid administrators. The subsidy program must build upon Medicaid eligibility rules to fill in the gaps.

The legislation also requires the development of **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 under 125 percent of the poverty line; and on a sliding scale basis for individuals up to 250 percent of the poverty line. In the case of children and pregnant women -- groups that we cannot afford to discourage from seeking preventative care -- co-pays would be covered 100 percent up to 250 percent of the poverty line.

Does this bill have a chance of passing?

The goal in introducing this bill is to begin a dialogue about a new way of thinking about health insurance. Doing so will require a great deal of time, study, and work by many parties. The bill, as proposed, introduces a viable concept and leaves room for further discussion.

We expect that this bill will generate interest among health care advocates and the concept of managed competition will become a meaningful proposal in discussions about universal health care.

How much will this plan cost?

While the cost of implementing this program has not been assessed, it is critical to remember that the primary funding stream for the government contribution will come from the Trust Fund, primarily financed by employers. While the government will take on new responsibilities in terms of managing and administering health care and contributing to a portion of every individual's premium, the responsibility is shared among the government, businesses and individuals.

We expect to see savings in the area of uncompensated care – care that currently is delivered to those without insurance, often in emergency rooms. In 2004, uncompensated care costs were estimated at \$40 billion⁵. 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. This “uncompensated care” is ultimately paid for many times over. In fact, 75 to 85% of the \$40 billion in 2004 was paid for through some form of government support – through Medicare and

⁵ 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

Medicaid Disproportionate Share Hospital (DSH) payments, Medicare Critical Access Hospital program payments, etc⁶. State and local governments also contribute toward the cost of uncompensated care, representing about one-third of government expenditures on health care for the uninsured and underserved. The uninsured are charged more for health care services, because they have no one to negotiate on their behalf, which contributes to the inefficiency of the system.

Finally, the inclusion of cost growth containment measures is critical to the success of any health care system. If we are to be truly serious about lowering the cost of care and keeping it affordable for Americans, we must look at the strategies that have proven successful in other health care systems and adopt some common sense approaches to deal with the rapidly increasing expenses within the health care industry. Electronic medical records, for example, would generate significant savings in our nation's hospitals, as well as improve the quality of care for millions of Americans.

It will cost money to cover the nearly 45 million uninsured Americans. However, there is a significant amount of money in the existing system that is used inefficiently. We would be far better off using these funds to provide continuous, portable coverage to all Americans. The cost of having nearly 45 million uninsured Americans to society at large is extreme; the benefits of a universal system of health insurance are intangible. In order to bring down costs, we must bring in the uninsured.

⁶ 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