

Rhode Island Business Group on Health

Issue Brief

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Health Care Reform – What’s Happening in Washington, D.C.

During the month of August and recently in President Obama’s September 9th address to Congress on health care reform, many voices have been heard with respect to the health care reform debate. Key reform issues include universal access to health care coverage, the concept of a “public plan” and most important, how to pay for health care reform have drawn the attention of many Americans. President Obama has indicated that his two basic requirements for a health care bill are expansion of health care coverage for the uninsured and making medical care more affordable.

RIBGH would like to provide you with a brief summary of the core issues currently under consideration:

Covering the uninsured and the “public plan” option – While President Obama has indicated he believes a government health plan for the uninsured is an “option,” and necessary to insure adequate choice and competition in the insurance marketplace, other reform bills pending in the House and Senate propose various methods for providing a “public option.” The Senate Finance Committee bill, introduced today, proposes substituting a not-for-profit “co-op” concept for the public option contained in other bills, along with health care affordability tax credits beginning in 2013, premium subsidies and out-of-pocket cost-sharing assistance to individuals and families with incomes between 100-200% of the federal poverty level (FPL), and the creation of web-based insurance exchanges that would standardize health plan premiums and coverage information. The Senate HELP Committee (now being chaired by Senator Tom Harkin) proposal would create state-based American Health Benefit Gateways through which individuals and small businesses can purchase health coverage with subsidies available to individuals/families with incomes up to 400% of the FPL (\$73,240 for a family of three in 2009). The House of Representatives plan would create a Health Insurance Exchange for purchase of health coverage by individuals/small employers, with similar credits to those in the Senate HELP Committee as well as an employer mandate to provide coverage or pay into an Insurance Exchange Trust Fund (again with exceptions for certain small employers). Employers would be required to provide coverage to their employees or pay an “annual fee” (with exceptions for small business) under several reform proposals or what has also been termed a “free

rider” surcharge against employers who don’t offer coverage and whose employees receive taxpayer subsidies to buy it on their own.

The House of Representatives “public plan” approach would use the Medicare infrastructure and would pay providers Medicare plus five percent. A second approach would have the public plan act like an insurer but would not have access to Medicare rates for providers. A third public plan, which has been referred to as a “trigger plan” would only commence if certain criteria are met (would kick in after several years if health care access and costs don’t improve while a pilot test is conducted in several states).

The House plan and the Senate HELP plan each include very substantial public options; the Senate Finance Committee plan does not include a government-run insurance plan that would compete with private payers.

A federal plan for covering the uninsured is expected to include some type of mandate for individuals to buy insurance and for employers to offer it to their employees, although the Senate Finance Committee bill, while not requiring employers to offer health cover, does require employers with 50 or more employees to reimburse the government for each full-time employee (one who works 30 or more hours/week) receiving a health care affordability tax credit equal to 100 percent of the average subsidy up to a cap. In addition to the subsidies for individuals/families that are described above, expanding and standardizing the threshold for Medicaid eligibility is under consideration as well as rules preventing payers from denying coverage for pre-existing conditions, canceling coverage due to high claims, and imposing annual or lifetime benefit limits. It is expected that employers above a certain size will most likely be required to provide coverage to their employees, at least a basic benefit level of coverage, and be expected to pay half of the cost for full-time employees in any final compromise bill.

Paying the Cost for Health Care Reform – Various proposals are under consideration including reductions in reimbursements, taxing health care benefits or taxing benefits above a certain amount (i.e. if you receive more than \$17,000 a year or \$25,000 a year in health care benefits, you would be taxed on benefits in excess of such amount). Another core method for paying for health care benefits being considered is increasing the tax rate for high income earners (part of the House and Senate HELP plans). Other considerations are a new tax on health insurers, drug companies and medical device makers, a \$2,000 annual cap on health flexible spending account benefits, an increase in the excise tax for taxable withdrawals from a Health Savings Account, and a requirement that employers who receive Medicare Part D subsidies would pay tax on the payments.

Other Key Reform Considerations: Other key issues are part of health care reform proposals under consideration, including small group market reform (to make it easier for small business groups to obtain coverage), health information technology, including a uniform place on the Web to obtain information on and compare health benefits and costs, minimum benefit standards and categorization of benefit package levels, creating a Medicare coverage option for people between 55 and 65 years of age, and possible incentives for preventative and healthy lifestyle choices.

The Senate Finance Committee expects to begin the debate on its proposal by September 21 and reconcile their bill with the Senate HELP proposal by early October.

Over the next few weeks, RIBGH will keep you updated as a potential health care reform bill shapes up in Congress.

Rhode Island News:

Health Insurer Rate Factor Filings - RIBGH has recently submitted to the Office of the Health Insurance Commissioner (OHIC) a position statement on the Tufts Health Plan rate factor filing, a copy of which can be found on the [RIBGH website](#).

Potential Legislative Initiatives in 2009-2010 – The OHIC is considering other legislative initiatives for the coming General Assembly session such as:

- Requiring health plans to collect information on a person's usual source of care at the time of enrollment to enhance ability to measure, pay for and improve primary care (key to improving performance),
- Tighter regulation of discount health plans that are often sold to people who think they are getting insurance but are getting discounted services instead with no cap on expenses, and
- Eliminating gender as a basis for health insurance underwriting.

For further information on health care news and reform issues, please visit the RIBGH website and review our "[Breaking News](#)" and "[Health Reform Resources](#)" information.

