



HEALTH CARE REFORM PROPOSALS

Achieving comprehensive health reform has emerged as a leading priority of the President and Congress. This summary of the Senate Finance Committee Policy Options, Senate HELP Committee Affordable Health Choices Act and the House Tri-Committee Health Reform Proposal describes the key components of these leading health reform proposals.

	Senate Finance Committee Policy Options	Senate HELP Committee Affordable Health Choices Act	House Tri-Committee Health Reform Proposal
Date plan announced	April – May 2009	June 9, 2009	June 19, 2009
Overall approach to expanding access to coverage	<p>The Senate Finance Committee released a series of papers laying out options for health reform. While not a formal proposal, these papers offer a framework for achieving health reform goals and present the range of options the Committee will consider as it works to draft health reform legislation.</p> <p>Require all individuals to have health insurance. Create a Health Insurance Exchange through which individuals and small businesses can purchase health coverage, with subsidies available to individuals/families with incomes between 100 and 400% of the federal poverty level. Impose new regulations on the non-group and small group insurance markets. Expand Medicaid and CHIP and offer a temporary Medicare buy-in for the pre-Medicare population.</p>	<p>Require all individuals to have health insurance. 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 federal poverty level. Impose new regulations on the individual and small group insurance markets. Expand Medicaid to all individuals with incomes up to 150% of the poverty level.</p>	<p>Require all individuals to have health insurance. Create a Health Insurance Exchange through which individuals and employers can purchase health coverage, with premium and cost-sharing credits available to individuals/families with incomes up to 400% of the federal poverty level. Require employers to provide coverage to employees or pay into a Health Insurance Exchange Trust Fund, with exceptions for certain small employers, and provide certain small employers a credit to offset the costs of providing coverage. Impose new regulations on plans participating in the Exchange and in the small group insurance market. Expand Medicaid to 133% of the poverty level.</p>
Individual mandate	<ul style="list-style-type: none"> Require all individuals to have insurance that meets minimum coverage standards. Enforced through an excise tax equal to a percentage of the premium for the lowest cost option available through the Health Insurance Exchange in the area where the individual resides. Exemptions will be granted for financial hardship; if the lowest cost plan option exceeds 10% of an individual's income; and if the individual has income below 100% of the poverty level. 	<ul style="list-style-type: none"> Require all individuals to have qualifying health coverage. Enforced through a tax penalty of no less than 50% of the average annual premium for a basic plan. Exemptions to the individual mandate will be granted to residents of states that do not establish an American Health Benefit Gateway, members of Indian tribes, those for whom affordable coverage is not available, and individuals enrolled in Medicare. 	<ul style="list-style-type: none"> Require all individuals to have "acceptable health coverage". Enforced through a tax of 2% of adjusted gross income less a threshold amount up to the cost of the average national premium for the basic plan in the Health Insurance Exchange. Exemptions granted for dependents, religious objections, and financial hardship.

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Employer requirements	<ul style="list-style-type: none"> • Proposed Option A: Require employers with more than \$500,000 in total payroll per year to offer coverage to their employees and contribute at least 50% of the premium or pay an assessment. The employer assessment could be structured in several ways: 1) a set fee per enrollee per month based on total annual payroll; 2) a tiered penalty calculated as a percentage of payroll; or 3) a larger penalty only on firms with annual payroll of more than \$1,500,000. • Proposed Option B: No employer “pay or play” requirement. 	<ul style="list-style-type: none"> • Require employers to offer health coverage to their employees and contribute at least 60% of the premium cost or pay \$750 for each full-time employee who is not offered coverage. • Exempt employers with 25 or fewer employees from the requirement to provide coverage. 	<ul style="list-style-type: none"> • Require employers to offer coverage to their employees and contribute at least 72.5% of the premium cost for single coverage and 65% of the premium cost for family coverage of the lowest cost plan that meets the essential benefits package requirements or pay 8% of payroll into the Health Insurance Exchange Trust Fund. • Exempt certain small businesses (to be determined) from the employer “pay or play” requirement.
Expansion of public programs	<p>Medicaid</p> <ul style="list-style-type: none"> • Expand Medicaid to all individuals with incomes up to 115% FPL, with a possible increase in eligibility for parents, pregnant women, and children to a higher level. Coverage could be provided through the current program structure or by enrolling children, pregnant women, parents, and childless adults in the Health Insurance Exchange. Another alternative is to enroll all populations except childless adults in Medicaid. Under this approach, childless adults would not be eligible for Medicaid but would be given tax credits to purchase coverage through the Exchange or to buy-in to Medicaid. <p>Children’s Health Insurance Program</p> <ul style="list-style-type: none"> • After September 30, 2013, expand CHIP eligibility to 275% FPL. Once the Health Insurance Exchange is fully operational, CHIP enrollees would obtain coverage through the Exchange and states would be required to continue to provide services not covered by plans in the Exchange, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services. 	<ul style="list-style-type: none"> • Expand Medicaid to all individuals with incomes up to 150% FPL. Individuals eligible for Medicaid will be covered through state Medicaid programs and will not be eligible for credits to purchase coverage through American Health Benefit Gateways. • Grant individuals eligible for the Children’s Health Insurance Program (CHIP) the option of enrolling in CHIP or enrolling in a qualified health plan through a Gateway. • Create a community health insurance option to be offered through state Gateways that complies with the requirements of being a qualified health plan. Require that the costs of the community health insurance option be financed through revenues from premiums and require the plan to negotiate payment rates with providers. Permit the plan to develop innovative payment policies to promote quality, efficiency, and savings to consumers. Additional requirements for the community health insurance option may be developed in collaboration with the National Association of Insurance Commissioners. 	<ul style="list-style-type: none"> • Expand Medicaid to all individuals with incomes up to 133% FPL. Newly eligible, non-traditional (childless adults) Medicaid beneficiaries may enroll in coverage through the Exchange if they were enrolled in qualified health coverage during the six months before becoming Medicaid eligible. After five years, states may request that some or all categories of Medicaid beneficiaries obtain coverage through the Exchange provided the state can demonstrate the ability to provide wrap-around coverage and the plans in the Exchange are deemed capable of supporting this population. • Provide optional Medicaid coverage to low-income HIV-infected individuals; provide optional Medicaid coverage for family planning services to certain low-income women. • Require CHIP enrollees to obtain coverage through the Health Insurance Exchange.

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Expansion of public programs (continued)	<p>Medicare</p> <ul style="list-style-type: none"> • Until the Health Insurance Exchange is underway, allow individuals aged 55-64 without coverage to buy-in to Medicare at full-cost. • Phase-out or reduce the two-year waiting period for Medicare eligibility for people with disabilities. <p>Public Health Insurance Option</p> <ul style="list-style-type: none"> • Proposed Option A: Create a new public plan to be offered through the Exchange that will be subject to the same rating and risk adjustment rules as the private plans. The public plan could be administered by the federal government, by multiple third-party administrators, or by the states. • Proposed Option B: Do not create a public plan option 		<ul style="list-style-type: none"> • Create a new public health insurance option to be offered through the Health Insurance Exchange that must meet the same requirements as private plans regarding benefit levels, provider networks, consumer protections, and cost-sharing. Require that costs of the public plan be financed through revenues from premiums. Set provider payment rates in the public plan at Medicare rates and allow bonus payments of 5% for providers that participate in both Medicare and the public plan and for pediatricians and other providers that don't typically participate in Medicare. Permit the public plan to develop innovative payment mechanisms, including medical home and other care management payments, value-based purchasing, bundling of services, performance based payments, or partial capitation.
Premium subsidies to individuals	<ul style="list-style-type: none"> • Provide refundable tax credits to individuals and families with incomes between 100 and 400% FPL to purchase insurance through the Health Insurance Exchange. The level of the premium tax credit could be set as a percentage of income or as a percentage of the premium, with additional limits on cost-sharing. 	<ul style="list-style-type: none"> • Provide premium credits on a sliding scale basis to individuals and families with incomes up to 400% FPL to purchase coverage through the Gateway. The premium credits will be determined by the Secretary, but will be such that individuals with incomes less than 400% FPL pay no more than 12.5% of income and individuals with incomes less than 150% FPL pay 1% of income, with additional limits on cost sharing. • Individuals are not eligible for premium credits through the Gateway if they have access to employer-based coverage that meets minimum qualifying criteria and affordability standards, or are eligible for Medicare, Medicaid, TRICARE, or FEHBP. 	<ul style="list-style-type: none"> • Provide affordability premium credits to individuals and families with incomes up to 400% FPL to purchase insurance through the Health Insurance Exchange. The premium credits will be based on the average cost of the three lowest cost basic health plans in the area and will be set on a sliding scale such that the premium contribution is no more than 1% of income for individuals with income at or below 133% FPL and no more than 10% of income for individuals with income at 400% FPL. • Provide affordability cost-sharing credits to individuals and families with incomes up to 400% FPL. The cost-sharing credits are offered on a sliding scale basis such that the cost-sharing limit for those with income at or below 133% FPL is \$250 per individual and \$500 per family and for those with income at 400% FPL is \$5,000 per individual and \$10,000 per family.

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Premium subsidies to employers	<ul style="list-style-type: none"> Provide certain small employers that purchase insurance for their employees with a tax credit. The full credit of 50% of the average total premium cost paid by the employer would be available to employers with 10 or fewer employees and whose employees have average annual wages of less than \$20,000. The tax credit would be phased out as firm size and earnings increase. The tax credit would not be payable in advance or refundable. 	<ul style="list-style-type: none"> Provide qualifying small employers with a health options program credit. To qualify for the credit, employers must have fewer than 50 full-time employees, pay an average wage of less than \$50,000, and must pay at least 60% of employee health expenses. The credit is equal to \$1,000 for each employee with single coverage and \$2,000 for each employee with family coverage, adjusted for firm size (phasing out as firm size increases) and number of months of coverage provided. Bonus payments are given for each additional 10% of employee health expenses above 60% paid by the employer. Employers may not receive the credit for more than three consecutive years. Create a temporary reinsurance program for employers providing health insurance coverage to retirees ages 55 to 64. Program will reimburse employers for 80% of retiree claims between \$15,000 and \$90,000. Program will end when the state Gateway is established. Payments from the reinsurance program will be used to lower the costs for enrollees in the employer plan. 	<ul style="list-style-type: none"> Provide small employers with fewer than 25 employees and average wages of less than \$40,000 with a health coverage tax credit. The full credit of 50% of premium costs paid by employers is available to employers with 10 or fewer employees and average annual wages of \$20,000 or less. The credit phases-out as firm size and average wage increases.
Tax changes related to health insurance	<ul style="list-style-type: none"> Considers several health insurance-related tax changes affecting the tax preference for employer-sponsored insurance, health savings accounts, flexible spending accounts, and deductions for medical expenses. 	Not specified.	Not specified.

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Creation of insurance pooling mechanisms	<ul style="list-style-type: none"> • Create one national or multiple regional Health Insurance Exchanges through which individuals and small employers can purchase qualified insurance. • Require all state-licensed insurers in the non-group and small group markets to participate in the Health Insurance Exchange(s). • Require guarantee issue and renewability and allow rating variation based only on age, tobacco use, family composition, and geography (not health status) in the Exchange(s). • Require the Exchange(s) to develop a standardized format for presenting insurance options, create a web portal to help consumers find insurance, maintain a call center for customer service, and establish procedures for enrolling individuals and businesses and for determining eligibility for tax credits. 	<ul style="list-style-type: none"> • Create state-based American Health Benefit Gateways through which individuals and small employers can purchase qualified coverage. States may form regional Gateways or allow more than one Gateway to operate in a state as long as each Gateway serves a distinct geographic area. • Require the Gateway to certify participating health plans, provide consumers with information allowing them to choose among plans, contract with navigators to conduct outreach and enrollment assistance, and create a single point of entry for enrolling in coverage through the Gateway or through Medicaid, CHIP or other federal programs. • Require states to adjust payments to health plans based on the actuarial risk of plan enrollees using methods established by the Secretary. • Require plans participating in the Gateway to provide incentives to providers to better coordinate care, reduce hospital readmissions and implement wellness and health promotion activities; prohibit plans from contracting with hospitals with greater than 50 beds unless those hospitals adopt patient safety and discharge planning programs. 	<ul style="list-style-type: none"> • Create a National Health Insurance Exchange through which individuals and employers (phasing-in eligibility for employers starting with smallest employers) can purchase qualified insurance. • Restrict access to coverage through the Exchange to individuals who are not enrolled in qualified or grandfathered coverage, Medicare, Medicaid (with some exceptions), TRICARE, or VA coverage. • Create four benefit categories (basic, enhanced, premium, and premium plus) of plans to be offered through the Exchange. Require participating plans to offer one basic plan for each service area and permit them to offer additional plans. • Require guarantee issue and renewability; allow rating variation based only on age (limited to 2 to 1 ratio), premium rating area, and family enrollment; and limit the medical loss ratio to 85%. • Require plans participating in the Exchange to be state licensed, report data as required, implement affordability credits, meet network adequacy standards, provide wrap-around coverage for Medicaid eligible individuals, provide culturally and linguistically appropriate services, and contract with essential community providers. • Require risk adjustment of participating Exchange plans. • Provide information to consumers to enable them to choose among plans in the Exchange, including establishing a telephone hotline and maintaining a website.

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Benefit design	<ul style="list-style-type: none"> • Create four benefit categories (lowest, low, medium, and high). Require all plans to provide a comprehensive set of services and prohibit inclusion of lifetime limits on coverage or annual limits on benefits. • All policies (except certain grandfathered employer-sponsored plans) must comply with one of the four benefit categories, including those offered through the Exchange and those offered outside of the Exchange. 	<ul style="list-style-type: none"> • Create three benefit tiers based on the percentage of allowed benefit costs covered by the plan, ranging from 76% of benefit costs for the lowest tier to 93% of benefit costs for the highest tier. Require plans to provide at least the essential benefits and prohibit inclusion of lifetime or annual limits on the dollar value of benefits. • Specify the essential health benefits to be included in a qualified health plan, criteria for minimum qualifying coverage, and an affordability standard such that coverage is deemed unaffordable if the premium exceeds 12.5% of an individual's adjusted gross income. 	<ul style="list-style-type: none"> • Create an essential benefits package that provides a comprehensive set of services as recommended by the Health Benefits Advisory Council. The essential benefits package covers 70% of the actuarial value of the covered benefits; limits annual cost-sharing to \$5,000/individual and \$10,000/family; and does not impose annual or lifetime limits on coverage. • All qualified health benefits plans, including those offered through the Exchange and those offered outside of the Exchange (except certain grandfathered individual and employer-sponsored plans) must provide at least the essential benefits package.
Changes to private insurance	<ul style="list-style-type: none"> • Require guarantee issue and renewability and allow rating variation based only on age, tobacco use, family composition, and geography (not health status) in the non-group, micro-group (2-10 employees), and small group markets. Require risk adjustment in all markets. • Require all state-licensed insurers in the non-group and small group markets to participate in the Health Insurance Exchange. • Require all insurers to issue policies in each of the four new benefit categories. • Allow states the option of merging the non-group and small group markets. 	<ul style="list-style-type: none"> • Require guarantee issue and renewability of health insurance policies in the individual and small group markets; prohibit pre-existing condition exclusions; and allow rating variation based only on family structure, geography, the actuarial value of the health plan benefit, and age (with only 2 to 1 variation). • Require health insurers to report cost information and to provide incentives to providers to better coordinate care, reduce hospital readmissions and reduce medical errors. • Require insurers to provide coverage for preventive care services without cost sharing. • Provide dependent coverage for children up to age 26. • Require insurers and group plans to notify enrollees if coverage does not meet minimum qualifying coverage standards. 	<ul style="list-style-type: none"> • Prohibit coverage purchased through the individual market from qualifying as acceptable coverage for purposes of the individual mandate unless it is grandfathered coverage. Individuals can purchase a qualifying health benefit plan through the Health Insurance Exchange. • Require guarantee issue and renewability and allow rating variation based only on age (limited to a 2 to 1 ratio), premium rating area, and family enrollment in the small group market and the Exchange. Prohibit imposition of any pre-existing condition exclusions. • Limit health plans' medical loss ratio to 85% enforced through a rebate back to consumers. • Require all insurers to offer coverage that meets the essential benefits package requirements. • Standardize health care claims forms, operating rules for using and processing health care transactions, and quality reporting requirements and increase electronic exchange of administrative and clinical data.

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State role	<ul style="list-style-type: none"> • Allow states the option of merging the non-group and small group insurance markets. • Require state insurance commissioners to provide oversight of health plans with regard to consumer protections, rate reviews, solvency, reserve fund requirements, and premium taxes and to define rating areas. 	<ul style="list-style-type: none"> • Establish American Health Benefit Gateways meeting federal standards and adopt individual and small group market regulation changes. • Create temporary “RightChoices” programs to provide uninsured individuals with immediate access to preventive care and treatment for identified chronic conditions. States will receive federal grants to finance these programs. 	<ul style="list-style-type: none"> • Require states to enter into a Memorandum of Understanding with the Health Insurance Exchange to coordinate enrollment of individuals in Exchange-participating health plans and under the state’s Medicaid program. • May require states to determine eligibility for affordability credits through the Health Insurance Exchange.
Cost containment	<ul style="list-style-type: none"> • Encourage adoption and use of health information technology by expanding eligibility for the Medicare HIT incentives in the American Recovery and Reinvestment Act to include additional providers. • Eliminate fraud, waste, and abuse in public programs through more intensive screening of providers, the development of the “One PI database” to capture and share data across federal and state programs, increased penalties for submitting false claims and violating EMTALA, and increase funding for anti-fraud activities. • Restructure payments to Medicare Advantage plans to promote efficiency and quality. • Require drug or device manufacturers to disclose payments and incentives given to providers and any investment interest held by a physician. • Improve transparency of information about skilled nursing facilities. • Allow providers organized as accountable care organizations that voluntarily meet quality thresholds to share in the cost-savings they achieve for the Medicare program. 	<ul style="list-style-type: none"> • Establish a Health Care Program Integrity Coordinating Council and two new federal department positions to oversee policy, program development, and oversight of health care fraud, waste, and abuse in public and private coverage. • Provide grants for improving health system efficiency, including grants to establish community health teams to support a medical home model; to implement medication management services; to design and implement regional emergency care and trauma systems. 	<ul style="list-style-type: none"> • Simplify health insurance administration by standardizing health care claims forms, operating rules for using and processing health care transactions, and quality reporting requirements and increasing electronic exchange of administrative and clinical data. • Modify provider payments under Medicare to: <ul style="list-style-type: none"> – Reform the sustainable growth rate for physicians and include incentive payments to physicians practicing in efficient areas; – Reduce payments to hospitals with excess readmissions and apply the readmissions policy to post acute care providers and physicians; and – Reform payment for post acute care services to include a bundled payment for post acute care services. • Restructure payments to Medicare Advantage plans to link to fee-for-services payments and incorporate incentives for quality; require Medicare Advantage plans to have medical loss ratios of at least 85%. • Increase the Medicaid drug rebate percentage and extend the prescription drug rebate to Medicaid managed care plans.

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Cost containment (continued)			<ul style="list-style-type: none"> • Reduce waste, fraud, and abuse in public programs by <ul style="list-style-type: none"> – Refusing Medicaid payments for health care-acquired conditions; – Allowing provider screening, enhanced oversight periods, and enrollment moratoria in areas identified as being at elevated risk of fraud in all public programs; – Requiring Medicare and Medicaid program providers and suppliers to establish compliance programs; and – Requiring evaluations and reports under Medicare and Medicaid integrity programs. • Improve transparency of information about skilled nursing facilities.
Improving quality/health system performance	<ul style="list-style-type: none"> • Strengthen primary care and chronic care management by providing bonus payments to certain primary care providers and providing reimbursement for certain care management activities for patients with hospital stays related to a major chronic condition. • Establish a framework to set national priorities for comparative clinical effectiveness research. • Create a Chronic Care Management Innovation Center within CMS to disseminate innovations that foster patient-centered care coordination innovations for high-cost, chronically ill Medicare beneficiaries. • Bundle payments for acute, inpatient hospital services and post-acute care services occurring within 30 days of discharge from a hospital. • Establish a hospital value-based purchasing program to pay hospitals based on performance on quality measures. • Develop a strategy for the development, selection, and implementation of quality measures that involves input from multiple stakeholders. Improve public reporting of quality and performance information that includes making information available on the web. 	<ul style="list-style-type: none"> • Develop a national strategy to improve the delivery of health care services, patient health outcomes, and population health that includes publishing an annual national health care quality report card. • Develop, through a multi-stakeholder process, quality measures that allow assessments of health outcomes; continuity and coordination of care; safety, effectiveness and timeliness of care; health disparities; and appropriate use of health care resources. Require public reporting on quality measures through a user-friendly website. • Create a Patient Safety Research Center charged with identifying, evaluating, and disseminating information on best practices for improving health care quality. • Develop interoperable standards for using HIT to enroll individuals in public programs and provide grants to states and other governmental entities to adopt and implement enrollment technology. 	<ul style="list-style-type: none"> • Support comparative effectiveness research by establishing a Center for Comparative Effectiveness Research within the Agency for Healthcare Research and Quality to conduct, support, and synthesize research on outcomes, effectiveness, and appropriateness of health care services and procedures. An independent CER Commission will oversee the activities of the Center. • Strengthen primary care and care coordination by increasing Medicaid payments for primary care providers, providing Medicare bonus payments to primary care practitioners serving in health professional shortage area, conducting a Medicare pilot program to test payment incentive models for accountable care organizations, and conducting pilot programs in Medicare and Medicaid to assess the feasibility of reimbursing qualified patient-centered medical homes. • Improve coordination of care for dual eligibles by creating a new office within the Centers for Medicare and Medicaid Services and allow certain Medicare Advantage plans to serve as fully integrated dual eligible special needs plans.

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Improving quality/health system performance (continued)	<ul style="list-style-type: none"> Require enhanced collection and reporting of data on race, ethnicity, and primary language. Also require collection of access and treatment data for people with disabilities. 		<ul style="list-style-type: none"> Develop national priorities for performance improvement and quality measures for the delivery of health care services. Reduce racial and ethnic disparities by conducting a study on the feasibility of developing Medicare payment systems for language services and provide Medicare demonstration grants to reimburse culturally and linguistically appropriate services. Develop standards for the collection of data on race, ethnicity, and primary language.
Prevention/wellness	<ul style="list-style-type: none"> Improve prevention by covering only proven preventive services in Medicare and Medicaid and providing incentives to Medicare and Medicaid beneficiaries to complete behavior modification programs. Promote prevention and wellness by providing grants to states to implement innovative approaches to promoting integration of health care services to improve health and wellness outcomes and providing tax credits to small businesses that implement proven wellness programs. 	<ul style="list-style-type: none"> Develop a national prevention and health promotion strategy that sets specific goals for improving health. Create a prevention and public health investment fund to expand and sustain funding for prevention and public health programs. 	<ul style="list-style-type: none"> Develop a national strategy to improve the nation's health through evidenced-based clinical and community-based prevention and wellness activities. Create task forces on Clinical Preventive Services and Community Preventive Services to develop, update, and disseminate evidenced-based recommendations on the use of clinical and community prevention services. Improve prevention by covering only proven preventive services in Medicare and Medicaid and eliminate any cost-sharing for preventive services.
Long-term care	<ul style="list-style-type: none"> Improve the availability of long-term care services by increasing access to home and community based services through changes in Medicaid program requirements and through grants to states. 	<ul style="list-style-type: none"> Establish a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program). The program will provide individuals with functional limitations a cash benefit to purchase non-medical services and supports necessary to maintain community residence. The program is financed through voluntary payroll deductions: all working adults will be automatically enrolled in the program, unless they choose to opt-out. 	Not specified.

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Other investments	<ul style="list-style-type: none"> • Change the Medicaid FMAP formula to include data on a state's poverty level and increase Medicaid FMAP rates during economic downturns to assist states in financing increased Medicaid enrollment. • Reform Graduate Medical Education to increase training of primary care providers and promote training in outpatient settings, and ensure the availability of residency programs in rural and underserved areas. 	<ul style="list-style-type: none"> • Establish a National Health Care Workforce Commission to make recommendations and disseminate information on health workforce priorities, goals, and policies including education and training, workforce supply and demand, and retention practices. • Reform Graduate Medical Education to increase the supply, education, and training of doctors, nurses, and other health care workers, especially in pediatric, geriatric, and primary care. • Improve access to care by providing additional funding to increase the number of community health centers and school-based health centers. 	<ul style="list-style-type: none"> • Require a report on the continued role for Medicare and Medicaid Disproportionate Share Hospital payments including the appropriate targeting of Medicare and Medicaid DSH payments to hospitals and the distribution of Medicaid DSH among the states. • Reform Graduate Medical Education to increase training of primary care providers by redistributing residency positions and promote training in outpatient settings. • Support training of health professionals, including advanced education nurses, who will practice in underserved areas; establish a public health workforce corps; and promote training of a diverse workforce and provide cultural competence training for health care professionals. • Provide grants to each state health department to address core public health infrastructure needs. • Provide full federal funding for Medicaid expansions and enhanced federal funding for Medicaid improvements.
Financing	Not specified. Considering a range of options for achieving savings and for generating new revenues.	Not specified.	Not specified.
Sources of information	Go to following link: http://finance.senate.gov/sitepages/baucus.htm then select these items 5-11-09 Baucus, Grassley Policy Options for Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans 4-28-09 Baucus, Grassley Policy Options for Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs	http://help.senate.gov/	http://edworkforce.house.gov/

THE HENRY J. KAISER FAMILY FOUNDATION

www.kff.org

Headquarters: 2400 Sand Hill Road Menlo Park, CA 94025 650.854.9400 Fax: 650.854.4800

Washington Offices and Barbara Jordan Conference Center: 1330 G Street, NW Washington, DC 20005 202.347.5270 Fax: 202.347.5274

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