

Side-by-Side Comparison of Major Health Care Reform Proposals

This interactive side-by-side compares the leading comprehensive reform proposals across a number of key characteristics and plan components. Included in this side-by-side are proposals for moving toward universal coverage that have been put forward by the President and Members of Congress. In an effort to capture the most important proposals, we have included those that have been formally introduced as legislation as well as those that have been offered as draft proposals or as policy options. This side-by-side offers a summary of the major components of these proposals; detailed descriptions of provisions relating to the [Medicare](#) and [Medicaid](#) programs can be found online. It will be regularly updated to reflect changes in the proposals and to incorporate major new proposals as they are announced.

	President Obama Principles for Health Reform	Senate Finance Committee Policy Options	House Tri-Committee America's Affordable Health Choices Act of 2009 (H.B. 3200)
Date Plan Announced	February 26, 2009	April - May 2009	June 19, 2009
Overall approach to expanding access to coverage	<p>President Obama outlined eight principles for health care reform in his FY 2010 Budget overview. The President has indicated that comprehensive health reform should:</p> <ul style="list-style-type: none"> Reduce long-term growth of health care costs for businesses and government. Protect families from bankruptcy or debt because of health care costs. Guarantee choice of doctors and health plans. Invest in prevention and wellness. Improve patient safety and quality care. Assure affordable, quality health coverage for all Americans. Maintain coverage when you change or lose your job. End barriers to coverage for people with pre-existing medical conditions. 	<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 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 (or \$73,240 for a family of three in 2009). 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"> The plan must put the country on a clear path to cover all Americans. 	<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 individuals to have "acceptable health coverage". Those without coverage pay a penalty of 2.5% of modified adjusted gross income up to the cost of the average national premium for self-only or family coverage under a basic plan in the Health Insurance Exchange. Exceptions granted for dependents, religious objections, and financial hardship.
Employer requirements	<ul style="list-style-type: none"> Not specified 	<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 	<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. Eliminate or reduce the pay or play assessment for small employers with annual payroll of less than \$400,000: <ul style="list-style-type: none"> Annual payroll less than \$250,000: exempt Annual payroll between \$250,000 and \$300,000: 2% of payroll; Annual payroll between \$300,000 and \$350,000: 4% of payroll; Annual payroll between \$350,000 and \$400,000: 6% of payroll.

		<p>employer "pay or play" requirement.</p>	<ul style="list-style-type: none"> Require employers that offer coverage to automatically enroll into the lowest cost premium plan any individual who does not elect coverage under the employer plan or does not opt out of such coverage.
<p>Expansion of public programs</p>	<ul style="list-style-type: none"> As a foundation for health reform, the President signed the Children's Health Insurance Program Reauthorization Act (CHIPRA), which provides coverage to 11 million children. 	<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. <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"> Expand Medicaid to all individuals (children, pregnant women, parents, and adults without dependent children) 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. Provide Medicaid coverage for all newborns who lack acceptable coverage and provide optional Medicaid coverage to low-income HIV-infected individuals and for family planning services to certain low-income women. In addition, increase Medicaid payment rates for primary care providers to 100% of Medicare rates. The coverage expansions (except the optional expansions) and the enhanced provider payments will be fully financed with federal funds. Require Children's Health Insurance Program (CHIP) enrollees to obtain coverage through the Health Insurance Exchange (in the first year the Exchange is available) provided the Health Choices Commissioner determines that the Exchange has the capacity to cover these children and that procedures are in place to ensure the timely transition of CHIP enrollees into the Exchange without an interruption of coverage.
<p>Premium subsidies to individuals</p>	<ul style="list-style-type: none"> The plan must protect families' from bankruptcy or debt because of health care costs. The American Recovery and Reinvestment Act makes coverage more affordable for Americans who lose their jobs and their access to employer-based health coverage by offering a subsidy of 65 percent of the premium costs for COBRA coverage. 	<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 affordability premium credits to eligible 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 contributions are limited to the following percentages of income for specified income tiers: <ul style="list-style-type: none"> 133-150% FPL: 1.5 - 3% of income 150-200% FPL: 3 - 5% of income 200-250% FPL: 5 - 7% of income 250-300% FPL: 7 - 9% of income 300-350% FPL: 9 - 10% of income 350-400% FPL: 10 - 11% of income Provide affordability cost-sharing credits to eligible individuals and families with incomes up to 400% FPL. The cost-sharing credits reduce the cost-sharing amounts and annual cost-sharing limits and have the effect of increasing the actuarial value of the basic benefit plan to the following percentages of the full value of the plan for

			<p>the specified income tier:</p> <ul style="list-style-type: none"> 133-150% FPL: 97% 150-200% FPL: 93% 200-250% FPL: 85% 250-300% FPL: 78% 300-350% FPL: 72% 350-400% FPL: 70% <ul style="list-style-type: none"> ■ Limit availability of premium and cost-sharing credits to individuals who meet the income limits and are not enrolled in qualified or grandfathered employer or individual coverage, Medicare, Medicaid (except those eligible to enroll in the Exchange), TRICARE, or VA coverage (with some exceptions). Individuals with access to employer-based coverage are eligible for the premium and cost-sharing credits if the cost of the employee premium exceeds 11% of the individuals' income.
Premium subsidies to employers	<ul style="list-style-type: none"> ■ Not specified. 	<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 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 and is not permitted for employees earning more than \$80,000 per year. ■ 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. Payments from the reinsurance program will be used to lower the costs for enrollees in the employer plan
Tax changes related to health insurance	<ul style="list-style-type: none"> ■ Not specified. 	<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. 	<ul style="list-style-type: none"> ■ Impose a tax on individuals without acceptable health care coverage of 2.5% of modified adjusted gross income.
Creation of insurance pooling mechanisms	<ul style="list-style-type: none"> ■ The plan should provide portability of coverage and should offer Americans a choice of health plans. 	<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 a National Health Insurance Exchange, through which individuals and employers (phasing-in eligibility for employers starting with smallest employers) can purchase qualified insurance, including from private health plans and the public health insurance option. ■ Restrict access to coverage through the Exchange to individuals who are not enrolled in qualified or grandfathered employer or individual coverage, Medicare, Medicaid (with some exceptions), TRICARE, or VA coverage (with some exceptions). ■ 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 the public plan to offer basic, enhanced, and premium plans, and permit it to offer premium plus plans. Finance the costs of the public plan through revenues from premiums. For the first three years, 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. In subsequent years, permit the Secretary to establish a process for setting rates. Health care providers participating in Medicare are considered participating providers in the public plan unless they opt out. Permit the public plan to develop innovative payment mechanisms, including medical home and other care management payments, value-based purchasing, bundling of services, differential payment rates, performance based payments, or partial capitation and modify cost sharing and payment rates to encourage use of high-value services. ■ Create four benefit categories of plans to be offered through the Exchange: <ul style="list-style-type: none"> ■ <i>Basic plan</i> includes essential benefits package and covers 70% of the benefit costs of the plan; ■ <i>Enhanced plan</i> includes essential benefits package, reduced cost sharing compared to the basic plan, and covers 85% of benefit costs of the plan; ■ <i>Premium plan</i> includes essential benefits package with reduced cost sharing compared to the enhanced plan and covers 95% of the benefit costs of the plan; ■ <i>Premium plus plan</i> is a premium plan that provides additional benefits, such as oral health and vision care.

			<ul style="list-style-type: none"> ■ 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 a specified percentage. ■ Require plans participating in the Exchange to be state licensed, report data as required, implement affordability credits, meet network adequacy standards, provide culturally and linguistically appropriate services, contract with essential community providers, and participate in risk pooling. Require participating plans to offer one basic plan for each service area and permit them to offer additional plans. ■ 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 and provide information on open enrollment periods and how to enroll. ■ Allow states to operate state-based exchanges if they demonstrate the capacity to meet the requirements for administering the exchange.
Benefit design	<ul style="list-style-type: none"> ■ Not specified. 	<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 an essential benefits package that provides a comprehensive set of services, covers 70% of the actuarial value of the covered benefits, limits annual cost-sharing to \$5,000/individual and \$10,000/family, does not impose annual or lifetime limits on coverage, and is equivalent to the prevailing employer-sponsored coverage. The Health Benefits Advisory Council, chaired by the Surgeon General, will make recommendations on specific services to be covered by the essential benefits package as well as cost-sharing levels. ■ 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"> ■ The plan must end barriers to coverage for people with pre-existing medical conditions. 	<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"> ■ 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. ■ Impose the same insurance market regulations relating to guarantee issue, premium rating, and prohibitions on pre-existing condition exclusions in the small group market and in the Exchange (see creation of insurance pooling mechanism). ■ Limit health plans' medical loss ratio to a percentage specified by the Secretary to be enforced through a rebate back to consumers. ■ Improve consumer protections by establishing uniform marketing standards, requiring fair grievance and appeals mechanisms, and prohibiting insurers from rescinding health insurance coverage except in cases of fraud. ■ Adopt standards for financial and administrative transactions to promote administrative simplification. ■ Create the Health Choices Administration to establish the qualifying health benefits standards, establish the Exchange, administer the affordability credits, and enforce the requirements for qualified health benefit plan offering entities, including those participating in the Exchange or outside the Exchange.
State role	<ul style="list-style-type: none"> ■ Not specified. 	<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"> ■ Require states to enroll newly eligible Medicaid beneficiaries into the state Medicaid programs and to implement the specified changes with respect to provider payment rates, benefit enhancements, quality improvement, and program integrity. ■ Require states to maintain Medicaid and CHIP eligibility standards, methodologies, or procedures that were in place as of June 16, 2009 as a condition of receiving federal Medicaid or CHIP matching payments. ■ 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"> ■ The plan should reduce high administrative costs, unnecessary tests and services, waste, and other inefficiencies that consume money with no added benefit. 	<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. 	<ul style="list-style-type: none"> ■ Simplify health insurance administration by adopting standards for financial and administrative transactions, including timely and transparent claims and denial management processes and use of standard electronic transactions. ■ Modify provider payments under Medicare including: <ul style="list-style-type: none"> ■ Modify market basket updates to account for

		<ul style="list-style-type: none"> ■ 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. 	<p>productivity improvements for inpatient hospital, home health, skilled nursing facility, and other Medicare providers; and</p> <ul style="list-style-type: none"> ■ Reduce payments for potentially preventable hospital readmissions. ■ Restructure payments to Medicare Advantage plans, phasing to 100% of fee-for-services payments, with bonus payments for quality. ■ Increase the Medicaid drug rebate percentage and extend the prescription drug rebate to Medicaid managed care plans. Require drug manufacturers to provide drug rebates for dual eligibles enrolled in Part D plans. ■ Reduce Medicaid DSH payments by \$6 billion in 2019, imposing the largest percentage reductions in state DSH allotments in states with the lowest uninsured rates and those that do not target DSH payments. ■ Require hospitals and ambulatory surgical centers to report on health care-associated infections to the Centers for Disease Control and Prevention and refuse Medicaid payments for certain health care-associated conditions. ■ Require disclosure of financial relationships between health entities, including physicians, hospitals, pharmacists, and other providers, and manufacturers and distributors of covered drugs, devices, biologicals, and medical supplies. ■ Reduce waste, fraud, and abuse in public programs by allowing provider screening, enhanced oversight periods, and enrollment moratoria in areas identified as being at elevated risk of fraud in all public programs, and by requiring Medicare and Medicaid program providers and suppliers to establish compliance programs.
<p>Improving quality/health system performance</p>	<ul style="list-style-type: none"> ■ The plan must ensure the implementation of provide patient safety measures and provide incentives for changes in the delivery system to reduce unnecessary variability in patient care. It must support the widespread use of health information technology and the development of data on the effectiveness of medical interventions to improve the quality of care delivered. ■ To lay the foundation for improving the health care delivery system and quality of care, the American Recovery and Reinvestment Act invests \$19 billion in health information technology, including \$17 billion in incentives to providers to encourage their use of electronic medical records, and provides \$1.1 billion for comparative effectiveness research. 	<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. ■ 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"> ■ 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 (with larger bonuses paid to primary care practitioners serving in health professional shortage areas). ■ Conduct Medicare pilot programs to test payment incentive models for accountable care organizations and bundling of post-acute care payments, and conduct 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 or program within the Centers for Medicare and Medicaid Services. ■ Establish the Center for Quality Improvement to identify, develop, evaluate, disseminate, and implement best practices in the delivery of health care services. 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.
<p>Prevention / Wellness</p>	<ul style="list-style-type: none"> ■ The plan must invest in public health measures proven to reduce cost drivers in our system, such as obesity, sedentary lifestyles, and smoking, as well as guarantee access to proven preventive treatments. The American Recovery and Reinvestment Act provides \$1 billion for prevention and 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 	<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. Eliminate any cost-sharing for preventive services in Medicare and increase Medicare payments for certain preventive services to 100% of actual charges or fee schedule rates.

		health and wellness outcomes and providing tax credits to small businesses that implement proven wellness programs.	
Long-term Care	Not specified.	<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"> Improve transparency of information about skilled nursing facilities and nursing facilities.
Other investments	<ul style="list-style-type: none"> As an initial investment in strengthening the health care workforce, the American Recovery and Reinvestment Act provides \$500 million to train the next generation of doctors and nurses. 	<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"> Make improvements to the Medicare program: <ul style="list-style-type: none"> Reform the sustainable growth rate for physicians, with incentive payments for primary care services, and for services in efficient areas; Eliminate the Medicare Part D coverage gap (phased in over 15 years) and require drug manufacturers to provide a 50% discount on brand-name prescriptions filled in the "coverage gap"; Increase the asset test for Medicare Savings Program and Part D Low-Income Subsidies to \$17,000/\$34,000; and Eliminate any cost-sharing for preventive services in Medicare and increase Medicare payments for certain preventive services to 100% of actual charges or fee schedule rates. Reform Graduate Medical Education to increase training of primary care providers by redistributing residency positions and promote training in outpatient settings and support the development of primary care training programs. 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. Conduct a study of the feasibility of adjusting the federal poverty level to reflect variations in the cost of living across different areas.
Financing	President Obama dedicated \$630 billion over ten years toward a Health Reform Reserve Fund in his budget outline released in February 2009 to partially offset the cost of health reform.	Not specified. Considering a range of options for achieving savings and for generating new revenues.	The Congressional Budget Office estimates the net cost of the proposal (less payments from employers and uninsured individuals) to be \$1.042 trillion over ten years. Approximately half of the cost of the plan is financed through savings from Medicare and Medicaid, including incorporating productivity improvements into Medicare market basket updates, reducing payments to Medicare Advantage plans, changing drug rebate provisions, reducing potentially preventable hospital readmissions, and cutting Medicaid DSH payments. The remaining costs are financed through a surcharge imposed on families with incomes above \$350,000 and individuals with incomes above \$280,000. The surcharge is equal to 1% for families with modified adjusted gross income between \$350,000 and \$500,000; 1.5% for families with modified adjusted gross income between \$500,000 and \$1,000,000; and 5.4% for families with modified adjusted gross income greater than \$1,000,000. These surcharge percentages may be adjusted if federal health reform achieves greater than expected savings.
Sources of information	http://www.whitehouse.gov/omb/budget/ http://www.HealthReform.gov	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://waysandmeans.house.gov/MoreInfo.asp?section=52