

## I. Health Care Reform - Insurance

1. Insurance mandated coverage regulated by Insurance Exchange(s)
  - (1) *Insurance company mandates*
  - (2) *Individuals mandate*
  - (3) *Employer mandates*
2. Expansion of Medicaid to persons not currently covered (133% - 150% FPL)
  - (1) *Changes in Federal Match formulas*
  - (2) *Potential changes in CHIP programs*
3. Premium Subsidies
  - (1) *Individual subsidies*
  - (2) *Small business subsidies*
4. Financing expansion and subsidies
  - (1) *Insurance company taxes*
  - (2) *Individual taxes*
  - (3) *Employer taxes*
5. Public Option and Co-ops
6. Insurance Exchange – coverage management
  - (1) *Federal Exchange*
  - (2) *State based Exchanges*
7. Benefit Design – Essential Coverage
  - (1) *Benefit design described and categorized*
  - (2) *Prohibition on pre-existing conditions, Guaranteed insurability, rating limitation*
  - (3) *Administrative simplification and other consumer protections*

## II. Health Care Reform – Cost Containment

1. Medicare Reform
  - (1) *Restructure Medicare Advantage*
  - (2) *Changes in payment formulas (market basket updates)*
  - (3) *Reduce DSH payments as uninsured numbers drop*
  - (4) *Incentive models for accountable care organizations and other cost saving methods*
2. Medicaid Reform
  - (1) *Changes to drug rebates, generics*
  - (2) *Reduce DSH payments as uninsured numbers drop*
  - (3) *Waste, fraud and abuse oversight*

### III. Health Care Reform – Quality and Performance

1. Community based Collaborative Care Network
  - (1) *Coordinate and integrate services*
  - (2) *Manage chronic conditions*
  - (3) *Reduce ER use*
2. Prevention and Wellness
  - (1) *Evidence based clinical practices, community based prevention and wellness*
  - (2) *Prevention and Screening without consumer costs*
  - (3) *Support of employer-based wellness programs*
3. Long Term Care
  - (1) *Community Living Assistance Services and Supports (CLASS)*
  - (2) *Medicaid flexibility for home-based services*
4. Medicare Improvements
  - (1) *Elimination of Part D coverage gap by 2019*
  - (2) *Increase payments to primary care providers*
5. Workforce Training
  - (1) *Redistribution of GME slots to ambulatory/primary care settings*
  - (2) *Increased funding for loan repayment, expansion into public health*
6. Community Health Center funding increases – expand capacity
7. Establishment of a Ready Reserve Corps
8. Non-profit hospitals requirement to conduct community needs assessments

Source: presentation by Michigan Department of Community Health-HPAC (information drawn from summaries of HR 3962 and HR 3590)