HEALTH CARE REFORM AND THE FUTURE OF MEDICAL EDUCATION

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Stony Brook University Medical Center
April 2011
The U.S. Health Care System!

CATEGORIES OF AMERICANS AND THEIR HEALTH-CARE DEALS
Simplified Schematic

The federal-state Medicaid program for certain of the poor, the blind and the disabled

The 40 million or so uninsured tend to be near poor

The employed and their families who are typically covered through their jobs, although many small employers do not provide coverage.

For the rich, "Disneyland" the sky-is-the limit policies without rationing of any sort (Boutique medicine)

Near poor children may be temporarily covered by Medicaid and S-Chip, although 7-10 million are still uninsured.

Persons over age 65, who are covered by the federal Medicare program, but not for drugs or long-term care. Often the elderly have private supplemental MediGap insurance

The very poor elderly are also covered by Medicaid

Source: Uwe Reinhardt, Ph.D., Princeton University
The Impetus for Reform

Unsustainable, Undesirable Trends:

• Large, growing uninsured population
• National health expenditures growing faster than the economy
• Overutilization of health care services
• Lack of adherence to best practices
Sobering Facts

- **Quality:**
  - U.S. life expectancy and chronic disease burden trail other countries who spend much less on healthcare.

- **Cost:**
  - In 2008, US spent >17% of GDP on healthcare ($2.3 trillion). Excessive administrative cost.
  - By 2017 expenditures projected at 20% GDP ($4.3 trillion).

- **Fraud:**
  - In 2008, Medicare fraud totaled $10.4 billion (3.6%).
National Health Spending: Per Person

<table>
<thead>
<tr>
<th>Year</th>
<th>Actual</th>
<th>Projected</th>
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<tbody>
<tr>
<td>1994</td>
<td>$3,604</td>
<td>$4,257</td>
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<tr>
<td>1996</td>
<td>$3,910</td>
<td>$4,729</td>
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<tr>
<td>1998</td>
<td>$4,257</td>
<td>$5,485</td>
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<tr>
<td>2000</td>
<td>$4,729</td>
<td>$6,280</td>
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<tr>
<td>2002</td>
<td>$5,485</td>
<td>$7,129</td>
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<tr>
<td>2004</td>
<td>$6,280</td>
<td>$8,090</td>
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<tr>
<td>2006</td>
<td>$7,129</td>
<td>$9,173</td>
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<tr>
<td>2008</td>
<td>$8,090</td>
<td>$10,339</td>
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<tr>
<td>2010</td>
<td>$9,173</td>
<td>$11,660</td>
</tr>
<tr>
<td>2012</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td></td>
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</tr>
</tbody>
</table>

Source: Centers for Medicare & Medicaid Services

Costs up to $21,000 in NYS for family of 4 in 2011.
Per Capita Spending for Health Care - 6 Countries

- U.S. $5,711
- Canada $2,998
- Germany $3,005
- France $3,048
- Australia $2,876
- Japan $2,249

US spends 2x avg of all other industrialized nations

OECD, 2006.

Data for Japan is an estimate.
Small Businesses Cannot Afford to Offer Insurance

Percentage of Firms Offering Health Benefits, by Firm Size, 1996-2005

Source:

* Estimate is statistically different from the previous year shown at p<.05.
† Estimate is statistically different from the previous year shown at p<.10.
Firms Shift Health Insurance Costs to Workers

Average Monthly Worker Premium Contributions for Single and Family Coverage, 1988-2005

Source:

* Estimate is statistically different from the previous year shown at p<.05. No statistical tests were conducted for years prior to 1999.

Note: Family coverage is defined as health coverage for a family of four.
1/3 Health Spending Consumed by Administration

- Clinical Care: 69%
- Administrative Costs (Billing, marketing, profits): 31%

($2500 per person)*


GROWTH SINCE 1970

Source: Bureau of Labor Statistics; NCHS; and Himmelstein/Woolhandler analysis of CPS
U.S. Budget Deficit % GDP, Options, 1962-2085
Figure 6. Life Expectancy at Birth over Time, 1980–2006

Source: OECD 2008 Health Data (June 2008).

Infant Mortality is Higher in USA

Comparison of International Infant Mortality Rates: 2000

Source (II.2): Centers for Disease Control and Prevention, National Center for Health Statistics

<table>
<thead>
<tr>
<th>Country</th>
<th>Deaths per 1,000 Live Births</th>
</tr>
</thead>
<tbody>
<tr>
<td>Singapore</td>
<td>2.5</td>
</tr>
<tr>
<td>Hong Kong</td>
<td>3.0</td>
</tr>
<tr>
<td>Japan</td>
<td>3.2</td>
</tr>
<tr>
<td>Sweden</td>
<td>3.4</td>
</tr>
<tr>
<td>Norway</td>
<td>3.8</td>
</tr>
<tr>
<td>Finland</td>
<td>3.8</td>
</tr>
<tr>
<td>Spain</td>
<td>3.9</td>
</tr>
<tr>
<td>Czech Republic</td>
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</tr>
<tr>
<td>Germany</td>
<td>4.4</td>
</tr>
<tr>
<td>Italy</td>
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<td>France</td>
<td>4.5</td>
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<td>Austria</td>
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<td>Belgium</td>
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<tr>
<td>Switzerland</td>
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</tr>
<tr>
<td>Netherlands</td>
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<td>Northern Ireland</td>
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<tr>
<td>Australia</td>
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<td>Denmark</td>
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<tr>
<td>Canada</td>
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<tr>
<td>Israel*</td>
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<tr>
<td>Portugal</td>
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<tr>
<td>England and Wales</td>
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<tr>
<td>Scotland</td>
<td>5.7</td>
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<tr>
<td>Greece</td>
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<tr>
<td>Ireland</td>
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<tr>
<td>New Zealand</td>
<td>6.3</td>
</tr>
<tr>
<td>United States</td>
<td>6.9</td>
</tr>
<tr>
<td>Cuba</td>
<td>7.2</td>
</tr>
</tbody>
</table>
Maternal Mortality
Deaths/100,000 Births

Source: OECD, 2009
Note: Data are for 2007 or most recent year available
Americans are Sicker

<table>
<thead>
<tr>
<th>Percent</th>
<th>AUS</th>
<th>CAN</th>
<th>FR</th>
<th>GER</th>
<th>NETH</th>
<th>NZ</th>
<th>UK</th>
<th>US</th>
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<tbody>
<tr>
<td>Age 50 or older</td>
<td>56</td>
<td>57</td>
<td>67</td>
<td>72</td>
<td>73</td>
<td>58</td>
<td>71</td>
<td>58</td>
</tr>
<tr>
<td>Has 2+ chronic conditions (out of 7)</td>
<td>63</td>
<td>62</td>
<td>53</td>
<td>56</td>
<td>55</td>
<td>51</td>
<td>61</td>
<td>71</td>
</tr>
<tr>
<td>Health care use in past 2 years:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Hospitalized</td>
<td>58</td>
<td>47</td>
<td>57</td>
<td>58</td>
<td>45</td>
<td>59</td>
<td>42</td>
<td>48</td>
</tr>
<tr>
<td>Major surgery</td>
<td>25</td>
<td>29</td>
<td>33</td>
<td>36</td>
<td>23</td>
<td>29</td>
<td>26</td>
<td>34</td>
</tr>
<tr>
<td>Saw 4+ doctors</td>
<td>38</td>
<td>32</td>
<td>31</td>
<td>50</td>
<td>34</td>
<td>34</td>
<td>31</td>
<td>38</td>
</tr>
<tr>
<td>Taking 4+ prescription medications regularly</td>
<td>33</td>
<td>41</td>
<td>38</td>
<td>39</td>
<td>39</td>
<td>35</td>
<td>50</td>
<td>48</td>
</tr>
</tbody>
</table>

Base: Adults with any chronic condition

Data collection: Harris Interactive, Inc.
Source: 2008 Commonwealth Fund International Health Policy Survey of Sicker Adults.
Baby Boom Generation Creates Demographic Tidal Wave

(Millions of people)

Roughly 82 million retirees in 2050

Source: 2009 Social Security Trustees Report
Note: OASI beneficiaries
Most Healthcare is Publicly Financed

- **Taxpayers**: 60%
  - Medicare, Medicaid, Public employees, tax subsidies
- **Private employers**: 20%
- **Individuals**: 20%

Most of the Medically Bankrupt Had Coverage

Private: 60%
Uninsured: 22%
Medicaid: 10%
Medicare: 5%
VA/Military: 2%

Insurance at Illness Onset

* Proposed by the President. Strong public support for the principle. Failed in Congress.

**None of these countries rely on private, for-profit insurance companies.
Despite the attention often paid to Social Security, spending on social security will increase very modestly thru 2050— from 5% to 6% of GDP.

Over the long run, the deficit impact of every other fiscal policy variable is swamped by the impact of health-care costs.  

Senate Finance, 2009
What Is The “Size Of The Prize” And Is It Achievable Or Feasible?

2006, $ billion

Total health care spending: 2,053
Outpatient care: 1,410
Inpatient care: 643
Drugs and nondurables: 436
Health administration and insurance: 414
Long-term and home care: 418
Durables: 98
Investment in health: 40

Expected spending according to wealth

<table>
<thead>
<tr>
<th></th>
<th>Above expected level</th>
<th>At expected level</th>
<th>Below expected level</th>
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</thead>
<tbody>
<tr>
<td>Health administration and insurance</td>
<td>91</td>
<td>54</td>
<td>53</td>
</tr>
<tr>
<td>Long-term and home care</td>
<td>178</td>
<td>24</td>
<td>19</td>
</tr>
<tr>
<td>Investment in health</td>
<td>95</td>
<td>50</td>
<td>0</td>
</tr>
</tbody>
</table>

1 Outpatient care includes care in the offices of physicians and dentists, same-day visits to hospitals (including emergency departments), ambulatory surgery, diagnostic-imaging centers and other same-day care facilities.

(Source: McKinsey Global Institute analysis of data from the Organization for Economic Co-operation and Development.)
Costs are Lower in Other Countries

- Administrative simplicity
- Negotiated prices
- More primary care and prevention
- Health planning
- Global budgets

A real system...
Obama Principles for Reform

1. Reduce long term health care costs
2. Protect families from bankruptcy
3. Retain choice: plans and physicians
4. Invest in prevention and wellness
5. Improve safety and quality
6. Create universal access
7. Ensure portable health insurance coverage
8. Eliminate barriers to coverage i.e. pre-existing conditions
Accountable Care Act is Complicated

The ACA is “...a collection of mandates, public insurance expansions, subsidies and regulations that affect different groups of Americans in different ways.”

Oberlander  J. Beyond Repeal-The Future of Health Care Reform. NEJM 363;24 12/9/10
Accountable Care Law
Reform: Sweeping Changes

- Expanded Medicaid eligibility
- Improved access: subsidized insurance premiums
- Insurance reforms to protect patients with pre-existing conditions
- Health insurance exchanges & greater accountability (MLR, medical loss ratio)
- Consumer protections
- Improved quality & lowering costs
Consumers will be able to:

• Receive cost-free preventive services.
• Keep young adults on a parent’s plan until age 26.
• Choose a primary care doctor, OB/GYN and pediatrician.
• Use the nearest emergency room without penalty.
Deny coverage to kids with pre-existing conditions. Health plans cannot limit or deny benefits or deny coverage for a child younger than age 19 simply because the child has a pre-existing condition like asthma.

Put lifetime limits on benefits.

Cancel your policy without proving fraud. Health plans can’t retroactively cancel insurance coverage.

Deny claims without a chance for appeal.
"I think you should be more explicit here in step two."
The Sec. shall 1200–times
“Navigating reform will require a “mind shift” as the focus changes from paying for units of service to rewarding quality and outcomes. These changes also will require a deliberate analysis of institutional priorities, as the legislation will affect each institution differently depending on its unique environment and the communities it serves.”

JoAnne Conroy, MD
Chief Health Officer, AAMC
November 2010
Disruptive Innovation

Innovations that improve a product or service in ways that the market does not expect, typically by lowering price or designing for a different set of consumers.

Clayton Christensen, Jerome Grossman & Jason Hwang
Triple Aim

• Patient Centeredness
• Transparency
• Lower Costs

Institute for Healthcare Improvement, Interim Director CMS, Donald Berwick MD
<table>
<thead>
<tr>
<th><strong>Information</strong></th>
<th>EMRs*</th>
</tr>
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<tbody>
<tr>
<td><strong>Infrastructure</strong></td>
<td>Medical homes; ACOs</td>
</tr>
<tr>
<td><strong>Incentives</strong></td>
<td>Value Based Performance (Penalties for readmission; CLBSI)</td>
</tr>
</tbody>
</table>

*Patient Centered Outcomes Research Institute
Independent Payment Advisory Board (2018, inflation plus 1%)
CMS Innovation Center, NEJM 363 (7) 2010
The New Reality

Required

• Penalty: Hospital Acquired Conditions
• Penalty: Value Based Purchasing
• Penalty: Readmissions

Voluntary

• Accountable Care Organizations
• Bundling
• Medical Homes
Payment system changes encourage patient safety, quality, value .... not volume

- **Value-Based Purchasing** – pay hospitals for actual performance on quality measures (not just reporting). Payments reduced 1% growing to 2% over 5 years (acute MI, pneumonia, CHF).

- **Hospital-Acquired Infections** – penalizes hospitals with high rates of hospital-acquired conditions (top 25%) with a 1% reduction in Medicare payment for all discharges.

- **Readmission Penalties** – hospitals with higher-than-expected readmissions will have a 1% (growing to 3%) reduction in Medicare payment for all discharges.
Hospital-Acquired Conditions

The 10 categories of Hospital-Acquired Condition (HACs) in effect at least through 2010. CMS does not currently reimburse for these conditions:

1. Foreign Object Retained After Surgery
2. Air Embolism
3. Blood Incompatibility
4. Stage III and IV Pressure Ulcers
5. Falls and Trauma
   - Fractures
   - Dislocations
   - Intracranial Injuries
   - Crushing Injuries
   - Burns
   - Electric Shock
6. Manifestations of Poor Glycemic Control
7. Catheter-Associated Urinary Tract Infection (UTI)
8. Vascular Catheter-Associated Infection
9. Surgical Site Infection Following Major Surgeries such as:
   - Coronary Artery Bypass Graft (CABG) - Mediastinitis
   - Bariatric Surgery
   - Gastric and orthopedic surgeries
10. Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE)
    - Total Knee Replacement
    - Hip Replacement
3 New Models of Care Delivery

- Medical Homes
- Health Innovation Zones
- Accountable Care Organizations
Patient-Centered Medical Home

Released October 2010

Key Components:

• Personal physician
• Physician directed medical practice
• Whole person orientation
• Coordinated or integrated care
• Quality and safety
• Enhanced access
• Additional (capitated) payment
“...Healthcare Innovation Zones, consisting of groups of providers that include a teaching hospital, physicians, and other clinical entities, that, through their structure, operations, and joint-activity, deliver a full spectrum of integrated and comprehensive health care services to applicable individuals while also incorporating innovative methods for the clinical training of future health care professionals.” American Association Medical Colleges, 2010
HIZs would...

- Provide fertile ground to test and implement a variety of care-delivery changes and supportive payment methodologies designed to improve quality and constrain overall cost growth in a sustainable manner.
- Re-engineering academic health system processes and practices across all three missions
- Rapidly evaluate the effects of multiple interventions using their advanced information systems and health services research capabilities
HIZs

• Reconfigure the health care workforce to promote efficiency and productivity aimed at improving both the patient and provider experience.

• Allow for training health professionals in a transforming delivery system and foster caregivers who will sustain the goal of innovation in delivery reform throughout their careers.
1. More consistent with academic values v. FFS
2. Enhances teaching and service missions
3. Challenges students to hone diagnostic skills using physical exam, history taking
4. Eliminates up to 20% of costs (unnecessary or inappropriate testing)
5. Impact on large numbers of people
6. Align education with regulatory policies and cost containment
Some Statutory Requirements of ACOs

- Legal structure to receive/distribute savings
- Serve minimum of 5,000 beneficiaries
- 3-year commitment to participate
- Defined process to report quality/cost data
- Medicare beneficiaries assigned to ACOs can continue to choose any providers (no “lock-in”)
- Shared savings if ACO savings and quality targets are achieved, after adjusting for random variation
- Option to use additional risk models including partial capitation
- PGP demo participants may convert and ACOs working with other payers get preference
Health Reform & Care

**Individual Patient**
(Episode of Care)

Fee for Service

**Population Based Medicine**

- Bundled Care
- Accountable Care Organizations
- Episode of Care
- Pay for Performance
- Penalties for “Bad” Care
  (Never Events)
Impact large numbers of people v. individual

- **Focus on Prevention**
- *Incentives* to change behavior, e.g. Advantage Home Telehealth (Canada) - provides coupons to movies/Best Buy for achieving disease management goals (e.g. weight reduction, glucose control, etc.)
1. **Aging population**: by 2030 >70 million over 65 years old

2. **Chronic illness** on the rise; lends itself remote management

3. **Advances in miniaturization** enable remote care/monitoring “Smart Home”

4. **Consumers demanding** more convenience. Concierge practices

5. ** Costs are lower**

Landers S. Why Healthcare is going home. NEJM 363; 18.1690-1691.2010
New Models of Care

PRIMARY CARE SHORTAGES SHIFT WORKFORCE

- Primary Care Internists

Internists
Osteopaths
Nurse Practitioners
Physician Assistants
Personal Monitors

Most Plausible Scenario

- Utilization rates will rise;
- Shift in work schedules;
- Moderate growth in GME (27,600 new residents per year); and
- Increase in productivity.

Relics of the Past

Stand Along Hospitals and Solo Practices...will move to...

Integrated NETWORKS

Employed Physicians

Incentive Payment Systems to Manage Focus and Behaviors
Hospitals will be:

- More Integrated
- More Accountable
- More At-Risk
155 medical schools in N. America. Differed greatly in curricula, methods of assessment, and requirements for admission and graduation.

New Recommendations

• *Higher admission and graduation standards*

• *Strict adherence to the protocols of mainstream science in teaching and research*

• *Half of medical schools should merge or close*

*n.b. Too many doctors were being trained at the time*
Flexner Adopts Hopkins Model

• **Medical school admissions**: require a **high school diploma** and >2 years of **college** or **university** study (primarily devoted to basic science).
  - Only 16 out of 155 medical schools in the United States and Canada required applicants to have completed 2 or more years of post secondary education.

• **Curriculum** content defined by CME agreed to in 1905.

• **4 years** of med school.

• **Medical schools** to be part of a larger university.

*Proprietary medical schools to close or be incorporated into existing universities.*
• **Duration:** 6 and preferably 8 years of post-secondary instruction in a university setting

• **Training** to adhere to the scientific method—thoroughly grounded in human physiology and biochemistry.

• **Medical research** to adhere fully to the protocols of scientific research

• **New schools** require permission of state government. (Each state branch of the [American Medical Association](https://www.ama-assn.org) to have oversight)

*Medicine in the USA and Canada becomes a highly paid and well-respected profession.*
Medical Education Today

- Education based upon rigorous understanding of science; 4 yrs of medical school
  - Two years of Basic Science
  - Two years of Clinical Rotations
- Apprenticeship: residency/fellowship (3-10 years)
- State licensure requirements
- Formal Board tests to assure competency
- Regulatory oversight of competence (Joint Commission, Departments of Health)
1. Standardize learning outcomes and individualize the learning process
2. Promote multiple forms of integration
3. Incorporate habits of inquiry
4. Focus on the progressive formation of physician’s personal identity
5. Underlying themes: team based skills & quality improvement

Curriculum Changes

Address changing health care trends

- Mgmt of chronically ill
- Changing population demographics
- Mismatch between care delivery locations and clinical training in inpatient settings (home care, outpt care, telemedicine)
- Rising importance of population health
- Rising importance of behavioral health and social sciences
- Changing models for reimbursement: fundamentally drive sites for educational opportunities
- Social accountability: altruism, professionalism, leadership

- Recognition of rising student debt
U.S. Medical Schools

- 133 accredited U.S. Medical Schools
Diversity in U.S. Medical Schools

Figure 2: Percentage and Number of U.S. Medical School Applicants by Race and Ethnicity, 2007

- White 57.0% (24,136)
- Black or African American 7.4%
- Asian 19.8% (8,390)
- Native Hawaiian and Other Pacific Islanders 0.3% (110)
- American Indian and Alaska Native 0.4% (151)
- Hispanic or Latino* 7.1% (2,990)
- Multiple Race 2.4% (1,004)
- Other/Unknown 1.4% (882)
- Non-U.S. or Permanent Resident (Foreign) 4.3% (1,810)

Note: Categories are Non-Hispanic, with the exception of Hispanics or Latinos and Non-U.S. or Permanent Resident (Foreign). Since 2002, individuals of multiple races were no longer required to report only one race, so the numbers reported are different. *Includes Cuban, Mexican American, Puerto Rican, Other Hispanic, and Multiple Hispanic.


Figure 5: Number of U.S. Medical School Applicants by Race and Ethnicity, 1977-2007
Figure 15: Number of U.S. Medical School Graduates by Race and Ethnicity, 1995-2007

- 1995:
  - White (11,052)
  - Asian (2,543)
  - Black or African American (903)
  - Hispanic or Latino (879)
  - American Indian and Alaska Native (61)
  - Native Hawaiian and Other Pacific Islander (1)

- 2007:
  - White (10,848)
  - Asian (3,344)
  - Black or African American (1,120)
  - Hispanic or Latino (1,115)
  - American Indian and Alaska Native (130)
  - Native Hawaiian and Other Pacific Islander (35)

*Hispanic or Latino includes Mexican American, Puerto Rican, and Other Hispanic or Latino.
**Prior to 1995 data is not available for Native Hawaiian and Other Pacific Islander.

Source: AAMC Data Warehouse: Student_IND, as of 1/08/2008.
# U.S. Medical Schools

- **# STUDENTS TAKING MCAT EXAM in 2010**: 82,004

## Average MCAT Scores by Section for the Following University Medical Schools:

<table>
<thead>
<tr>
<th>School</th>
<th>Verbal</th>
<th>Physical Science</th>
<th>Biological Science</th>
<th>Writing Section</th>
<th>Total Average Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harvard University</td>
<td>11</td>
<td>12</td>
<td>12</td>
<td>Q</td>
<td>35</td>
</tr>
<tr>
<td>University of California-San Francisco</td>
<td>10.6</td>
<td>11.5</td>
<td>11.7</td>
<td>P</td>
<td>33.8</td>
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<tr>
<td>SUNY Stony Brook</td>
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<td>11</td>
<td>11</td>
<td>P</td>
<td>32</td>
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<td>University of Connecticut</td>
<td>10</td>
<td>10.9</td>
<td>10.4</td>
<td>Q</td>
<td>30</td>
</tr>
</tbody>
</table>

*Table 1: Percentages of MCAT examinees achieving scaled score levels and associated percentile rank ranges by area of assessment. Combined 2010 administrations.*

*N = 82,004*
...I'M JUST WAITING FOR THE OTHER SHOE TO DROP...

ECONOMY
BANKS
INSURANCE
CO'S
WALL ST.

ASTEROID

WALT HANDELSMA
NEWSDAY
ACGME 2011 New Requirements

• Teamwork
• Professionalism
• Personal Responsibilities
• Patient Safety
• Transitions of Care
• Alertness Management
Relevant Congressional Committees

House:
1. Energy & Commerce: Chair Henry Waxman; Ranking member-Joe Barton
2. Ways and Means-Chair Charles Rangel; ranking member-David Camp
3. Education & Labor: Chair George Miller; Ranking member-John Kline

Senate:
1. HELP (Health, Education, Labor and Pension): Chair Ted Kennedy (Dood-Banking); Ranking member- Mike Enzi
2. Finance : Chair Max Baucus; Ranking member- Chuck Grassley
Reconciliation

- Legislative process in the US Senate intended to allow consideration of a contentious budget bill without the threat of filibuster.

- Provision in a budget resolution directing one or more committees to submit legislation changing existing law in order to bring spending, revenues, or the debt limit into conformity with the budget resolution. The bill arises when a prior budget resolution passed by the House and Senate calls for it.

- The House Budget Comm reports an omnibus reconciliation bill, but it may not make substantive changes in the recommendations of the other committees.

- Senate: 50 votes