The background of the slide is a photograph of the San Francisco State Capitol building. The building is a large, white, neoclassical structure with a prominent central dome. The dome is topped with a lantern. The building features a series of columns and arches. The sky is a deep blue with some white clouds. The text is overlaid on the image in a white, serif font.

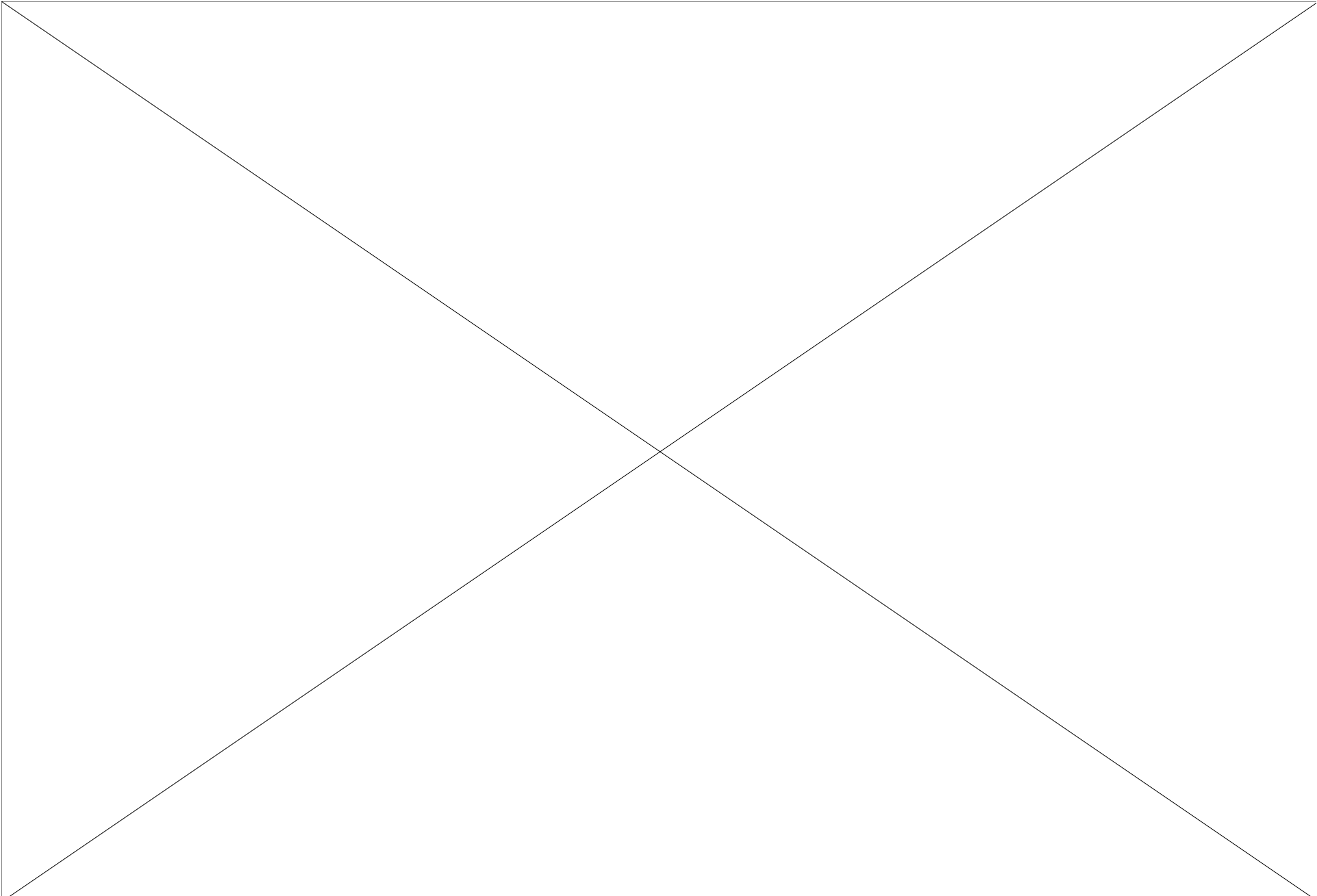
Health System Reform: A Look Ahead

2010 Annual Convention and Scientific Sessions

San Francisco, CA

Timothy W. McNichol, Esq.

ACOI Deputy Executive Director



Overview

- The Affordable Care Act – How did we get here?
- Overview of Healthcare Reform Legislation
- Where do we go from here?
- Questions

How Did We Get Here?

Special Message to the Congress

“Millions of our citizens do not now have a full measure of opportunity to achieve and enjoy good health. Millions do not now have protection or security against the economic effects of sickness. The time has arrived for action to help them attain that opportunity and that protection.”

Harry S. Truman

November 19, 1945



The Fundamentals of the Legislative Process

Regulatory Process Implements Enacted Legislation.

President Signs Legislation into Law or Veto is Overridden.

Other Chamber Considers Same or Similar Legislation. Any Differences in Approved Legislation Must be Conferenced and Approved by Both Chambers.

Chamber Approves Legislation With or Without Amendment.

Committee Conducts Hearings and Marks-up Legislation. Committee Refers Legislation to the Full Chamber.

Bill Introduced and Assigned to Committee(s) of Jurisdiction.

The Fundamentals of the Regulatory Process

Legislation is Introduced to Refine Final Rules – The Never-Ending Cycle Continues.

Public Comments are Compiled and Final Rules Issued and Implemented.

Proposed Rule is Issued with Request for Public Comment.

Agency Reviews Law and Associated Materials to Draft Proposed Rule.

Regulatory Agency Receives Law to Implement.

Evolution of Healthcare Coverage

- 1945 November 19 Special Message to the Congress Recommending a Comprehensive Health Program
- 1965 H.R. 6675 signed into law to create Medicare and Medicaid
- 1972 Social Security Amendments of 1972 signed into law to expand Medicare to SSDI beneficiaries
- 1985 Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) signed into law creating EMTALA

Evolution of Healthcare Coverage (Continued)

- 1988 Medicare Catastrophic Coverage Act of 1988 signed into law greatly expanding Medicare coverage
- 1989 Many provisions of the Medicare Catastrophic Coverage Act of 1988 repealed
- 1997 Balanced Budget Act of 1997 signed into law
- 2003 Medicare Prescription Drug, Improvement and Modernization Act of 2003 signed into law

Medicare was signed into law by President Lyndon Johnson on July 30, 1965.



Mr. Tony Palcaorolla of Baltimore, Maryland returned the first Medicare Part B application on September 1, 1965.

Overview of Healthcare Reform Legislation

Two Bills Reform Healthcare Delivery System

- “Patient Protection and Affordable Care Act (PPACA) (Pub. L. 111-148)
 - Signed into law March 23, 2010
- “Healthcare and Education Reconciliation Act of 2010 (Pub. L. 111-152)
 - Signed into law March 30, 2010

Goals of the ACA

- Expand health insurance coverage
- Control sky-rocketing costs
- Improve healthcare quality

Summary of ACA as Amended

- Cost \$938 billion over ten years.
- Expands coverage to 32 million Americans.
- Requires most US citizens and legal residents to carry health insurance.
- Provides a 10 percent bonus payment for physicians in general internal medicine. (2011-2016)

Summary of ACA as Amended (Continued)

- Creates a 10 percent bonus payment for primary care physicians who practice in health professional shortage areas. (2011-2015)
- Creates five-year demonstration grants to advance alternatives to medical malpractice litigation.
- *Does not* reform the Medicare Sustainable Growth Rate formula.
- Reforms graduate medical education.

GME Provisions of ACA

- Redistributes 65 percent of slots that have been unused by a hospital over a three-year period.
- Hospitals may apply for up to 75 slots.
- CMS must distribute 70 percent of the slots to states with resident-to-population ratios in the lowest quartile.
- CMS must distribute 30 percent of the slots in the 10 states with the highest proportion of their population living in health profession shortage areas.

GME Provisions of ACA (Continued)

- Redefines “all or substantially all” for training in nonhospital setting. (July 1, 2010)
- Clarifies that all or substantially all is met if the hospital covers the cost of the resident’s stipend and benefits.
- Resident time spent on vacation, sick leave, or other approved leave may be counted for DGME and IME payment purposes as long as it does not increase the total amount of time a resident spends in the program.

Where do we go from
here?

Legal Challenges to the ACA

- Maryland District Court
- California District Court
- Michigan District Court
- Florida District Court
- Virginia District Court



Mid-Year Elections?



November 2, 2010

Congressional Calendar

2009 Congressional Composition

- U.S. Senate
 - 57 Democrats
 - 41 Republicans
 - 1 Independent
 - 1 Independent Democrat

- U.S. House of Representatives
 - 255 Democrats
 - 178 Republicans
 - 2 Vacancies

*2/3 of Both the House and the Senate are needed to override a Presidential Veto (290 and 67 Respectively)





What do we do now?

“The Candidate” -- 1972



In Service
to all Members,
All Members
in Service

ACOI American College of Osteopathic Internists

- General Information
- Interact with ACOI
- News of Note
- Government Affairs
- Member Services
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- Certification
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HEALTH CARE REFORM *Resources*

- The Patient Protection and Affordable Care Act General Summary
- The Patient Protection and Affordable Care Act Graduate Medical Education Summary

Questions?

Contact Information

Timothy W. McNichol, Esq.
Deputy Executive Director
American College of Osteopathic Internists
3 Bethesda Metro Center, Suite 508
Bethesda, MD 20814

1-800-327-5183
tmcnichol@acoi.org

