JUN-17-1994 05:07 FROM TO 94567431 P.01

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE ASSISTANT SECRETARY FOR LEGISLATION
HEALTH LEGISLATION
WASHINGTON, D.C. 20201

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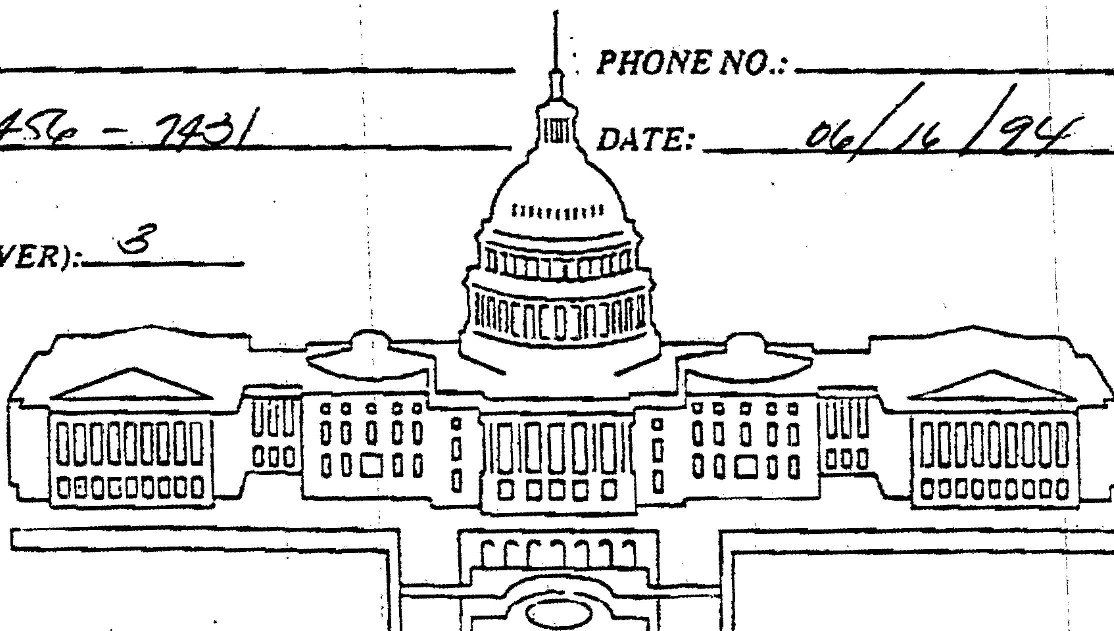
DATE: 06/16/94

TOTAL PAGES (INCLUDING COVER): 3



REMARKS:

the Krystal letter! // BT

(1) Group Gone

(2) Separately & quickly

PROJECT FOR THE

REPUBLICAN FUTURE

June 7, 1994

MEMORANDUM TO: REPUBLICAN LEADERS

FROM: WILLIAM KRISTOL

SUBJECT: Reading the President's Lips on Universal Coverage

"If you send me legislation that does not guarantee every American private health insurance that can never be taken away, you will force me to take this pen [and] veto the legislation." (President Clinton, January 25, 1994)

"[W]e're certainly going to be prepared to discuss any matter, but there's been nothing forthcoming from the White House. The President is the cause of the deadlock, and it isn't going to be broken until he's prepared to act." (Senator George Mitchell, April 2, 1990, demanding that President Bush abandon his "no new taxes" pledge)

Congress stands in recess and Dan Rostenkowski stands indicted as a 17-count felon. But the scramble to create passable legislation from what remains of the Clinton health care plan continues unabated. The June 2 *Los Angeles Times* reports that Republican and Democratic staff of the Senate Finance committee have been "working together," during the recess, to present that committee with a set of options when it returns today. In other words, some Hill Republicans are working overtime to pull Democratic chestnuts out of the fire. Will we ever learn?

Not if we believe that we can at this point forge a bipartisan health bill with the Democratic leadership that serves the national interest (and Republican principle). The problem is this: the Democratic leadership still has no interest in a sound, sensible health care bill. Speaking before the New York State Democratic Convention in Buffalo last week, Senator Moynihan himself brashly declared: "In this Congress my mission is clear -- get the President his bill."

There you have the openly and stubbornly expressed goal of the president and the Democratic leadership: *his* bill. Of course, as Pat Moynihan knows better than anyone else in Washington, the president has no chance of getting "his bill" as originally written. But backroom dealings could still produce a bill different

enough from the White House package to be viable in the legislative process, but sufficiently similar ("Clinton-lite") to protect the president's "read my lips" pledge on health care. And that bill would be a bad one for the country. That's why Republicans should hold off on health care negotiations until Mr. Clinton eats his words.

Once again: we are *for* a sound bipartisan bill. And such a bill will require negotiations. But if we are to negotiate with Democrats over health care reform, it must be on *our* terms, not theirs. The current atmosphere of Democratic anxiety -- signalled most recently by Senator Dianne Feinstein removing her name as a co-sponsor of the president's bill -- is an opportunity for Republicans finally to force a decisive change in the terms of debate. George Mitchell, Jay Rockefeller, and others in Congress have so far demanded that federally enforced universal coverage be the minimum requirement of an acceptable health care bill. And universal health care coverage, as defined by the president and his allies, cannot exist without a system of federal mandates on employers or individuals or both. Democrats are no longer in any political position to make such haughty demands. Why do we still accord them any deference? And why should Republicans be party to an effort to "get the president his bill?" We shouldn't.

We think Republicans should condition their cooperation in passing health care legislation on explicit Democratic abandonment of a universal system based on mandates of any sort: immediate, phased in, triggered, or linked to soft or hard targets. Just as George Mitchell forced President Bush to break his no new taxes pledge as a precondition to budget negotiations in 1990, President Clinton should now be forced to buckle under and give up on federally mandated universal health insurance coverage. Absent such a concession by the president, we must convince the public that his obstinacy is the real obstacle to health care reform. And we must continue to advance true, targeted health care reform that has bipartisan and public support.

This strategy can only work if Republicans resist current entreaties to join the Democrat leadership in crafting a watered-down Clinton bill. But if Democrats continue to insist on universal coverage achieved through Clinton-lite means, then we should take this battle to the country, make it a centerpiece of the fall campaigns, and explain why no bill is better than a bad one.

The next few months provide us the chance not only to block Clinton's legislation, but to deliver an unqualified defeat of Clinton's principles generally. The best way to seize health care from the Democrats is to fight for a bill that explicitly rejects the central tenets of Clintonism: federal mandates, politically determined benefit packages, price controls, state-run "alliances," and the like. The result will be a better health care bill and a triumph for our principles of limited government and measured, targeted reform.

NOTE TO CHRIS JENNINGS 6/17/94

RE: CAPITATED DRUG BENEFIT OPTION DEMO

Attached is my draft of a capitated drug benefit option demo. I talked with Bruce yesterday morning. He was OK with the idea and the attached write-up reflects his comments.

Where do we go from here? Ellen would like to sit down with Kopetski's staff this afternoon and would like to find out what we want ASAP.

Peter

Peter Hickman

Riegle

Friends

DEMONSTRATION OF CAPITATED DRUG BENEFIT OPTION

SUMMARY - The Secretary would be required to initiate a demonstration under which beneficiaries would be given the option of receiving their drug benefits through a drug benefit management (DBM) plan instead of standard Medicare. This option would structured similar to the current Medicare risk program. The demonstration would start two years after the effective date of the standard drug benefit and would be authorized in 6 states for 5 years.

ENROLLMENT

- During an annual, 30-day open enrollment period, beneficiaries in the demonstration states would have the option of enrolling to receive their drug benefits through a DBM plan with a Medicare contract or HMO/CMP with a risk contract. Beneficiaries who become entitled to Medicare between open enrollment periods would have the option of enrolling in the month preceding entitlement to Medicare. As with the risk program, no health screening would be permitted.

- The Secretary would prepare materials that would provide information that would assist beneficiaries in making a choice among the available drug benefit plans, HMO options and standard Medicare. The cost of preparing these materials would be born by the plans. As with the risk program, all marketing materials would have to be approved in advance by the Secretary. Direct marketing (e.g. door to door, telemarketing) to beneficiaries would be prohibited.

- Beneficiaries wishing to enroll in a plan could do so only through a third party designated by the Secretary. Enrollment in the plan would be for one year, or until the next open enrollment period.

STANDARDS

In order to be eligible to participate in this demonstration, drug benefit management plans would have to have a contract with the Secretary. There would be no limit on the number of contractors in a demonstration state. The Secretary would develop standards similar to those under the risk contracting program and other standards that would address:

- Access to community pharmacies

- Drug utilization review requirements

- Formulary structure (definition of major indications, minimum requirements and procedures for a physician obtaining coverage of a drug not on the formulary)

- Beneficiary safeguards in regard to use of prior authorization
- Compliance programs
- Procedures for out-of-area claims
- Financial requirements
- Quality standards and 50% commercial enrollment

These standards would be developed by the Secretary one year prior to the start of the demonstration.

DBM plans would be required to provide access to a pharmacy in every community throughout the state. In addition to this statewide pharmacy network, mail-order pharmacies could be offered by plans as an option to enrollees.

BENEFICIARY COST-SHARING

Similar to the risk contract program, plans would have the option of offering a cost-sharing structure that would be different from that under standard Medicare. They could

- require a monthly premium in lieu of part or all other cost-sharing.
- offer a point-of-service option with coinsurance higher than the 20% under standard Medicare.

However, the actuarial value of the plan's premium and cost-sharing could not exceed 95% of the actuarial value of the deductible and coinsurance under standard Medicare.

In addition, plans would be prohibited from having differential cost-sharing based on the therapeutic class of drug prescribed or other cost-sharing structures that the Secretary believes would be likely to discourage enrollment by individuals with medical conditions that require extensive use of prescription drugs.

PAYMENT

One year prior to the start of the demonstration, the Secretary would develop a payment methodology based on the costs of the drug benefit under standard Medicare. Payment to plans would be discounted to take into account the savings generated by restrictive formularies and pharmacy networks.

During the first three years of the demonstration, the Secretary could require plans to provide complete utilization data in order to refine the payment methodology. The Secretary would have the authority to audit this data.

SCOPE

The demonstration would be authorized for six states selected by the Secretary. In selecting the states, the Secretary would include both highly rural and urban states and states with both a high and low managed care penetration.

The demonstration would begin two years after the start of the standard drug benefit and would continue for five years.

EVALUATION

After the third year of the demonstration, the Secretary would conduct an evaluation to determine whether the capitated DBM plan option should be made available to all beneficiaries.

In particular this evaluation would examine:

- The desirability of a drug only option as compared with a drug benefit provided by an HMO/CMP under a risk contract.
- The differences in effectiveness of drug utilization review provided in standard Medicare, plans under the drug benefit option and HMO/CMPs with risk contracts.
- The extent to which plans experienced favorable selection and the impact of this selection on potential savings under the payment methodology.
- Whether differences existed in potential cost-savings of capitated drug benefit management plans in rural vs urban areas.

Any across pools
94% of HSA at beginning

avg = 1.0
<100 = 1.08
>100 = .97
5

Large + shrink associations

Fiscal Summary

Changes from Baselines

($ Billions)

	1995-1999	1995-2004
Outlays		
Low Income Voucher Program	+142.1	+613.6
Medicaid	- 43.6	-268.9
Medicare	- 46.9	-279.9
Other Federal Health (1)	- 10.0	- 25.0
Revenues		
Tobacco tax (2)	- 70.9	-138.4
High Cost Plan Assessment	- 4.7	- 17.1
Tax Expenditures	+ 6.8	+ 70.2
Other Revenues	+ 2.7	+ 7.1
Net Deficit Effect	-24.5	-38.4

STAFF ESTIMATES. PRELIMINARY AND UNOFFICIAL.

(1) This includes Postal Service reforms included in the proposal. Because of insufficient information, it does not include an estimate of the proposal's effects on FEHB, the PHS or the cost of administering the vouchers. The proposal does not appear to affect VA, DOD, or the IHS, so no spending change is estimated.

(2) This assumes a $1 per pack cigarette tax increase starting in 1995.

Quick: Does lower pool raise premium made in voluntary market

FAX MESSAGE COVER SHEET

CENTER ON BUDGET AND POLICY PRIORITIES
777 North Capitol Street, NE, Suite 705
Washington, DC 20002

Telephone: 202/408-1080

Fax: 202/408-1056

If there are any problems with the transmission of this document, please call 202/408-1080.

TO:	Chris Jennings
FAX NUMBER:	456-7431
FROM:	Ellen & Bob
NUMBER OF PAGES: (including cover)	3

If there are any problems with the transmission of this document, please call 202/408-1080.

CENTER ON BUDGET AND POLICY PRIORITIES

June 13, 1994

TO: Chris Jennings and Jack Lew

FR: Ellen Nissenbaum

RE: WIC and health care reform and Republican Amendment to Eliminate and Gut the WIC provision in Ed and Labor

Bob and I are increasingly concerned about what seem to be diminishing prospects to secure the President's WIC provision in health care reform. A small window of opportunity appears to remain and we wanted to touch base with you both about the next steps. In short, it seems to us that it's essential for the WIC provision to be included in the Senate Finance Committee bill given problems elsewhere.

In the Senate, the provision (as redrafted for Ed & Labor) is included in the Labor Committee bill but, obviously, is not financed. Chris, we were unable to get a meeting with Sen. Bumpers so the meeting between him and Carol Rasco is absolutely essential. We are particularly concerned since we've heard that Bumpers and Byrd let the WIC provision go through the Labor Committee for now, but may intend to "fix" it later, e.g. on the floor.

When we raised the WIC provision in the President's plan recently in a small meeting on other health care issues with the staff of Senators Rockefeller, Daschle and Mitchell, the general response indicated no familarity with the provision, a negative reaction that "... it's not in our jurisdiction," and a concern about how to finance the cost.

This is particularly troubling since there seem to be only two possible Finance Committee Senators who might help on WIC, both of whom also on the Ag Committee: Daschle and Pryor. Chris, we're hopeful that you've reached Teresa in Leahy's office to urge Leahy to talk to both of these Senators. We need to know when this has happened. Is there someway for the White House to indicate its interest in this provision very quietly to Mitchell and Moynihan?

211

777 North Capitol Street, NE, Suite 705, Washington, DC 20002 Tel: 202-408-1080 Fax: 202-408-1056
Robert Greenstein, Executive Director

We've asked Mark Powden if Jeffords would talk to some of the Republicans, but we don't expect any real results here. We should note, by the way, that Jeffords apparently is increasingly unhappy with the turn of events on health care: his amendments were all defeated in the Labor Committee, and he sees "little if any meaningful progress on WIC in either the House or Senate."

In the House, the provision is included in the Ed & Labor Subcommittee bill but -- Goodling will attempt (later this week or early next week) to strike it in full Committee. Since this will certainly fail, Goodling will then offer a substitute that guts the mandatory fund for WIC and essentially makes the remaining provision worthless since all the funds provided for WIC would count against the discretionary caps. *Jack, is there some way for the White House quietly to help here? We are quite concerned that Dems will be misled on this and think it's okay, especially since Goodling will raise the argument that not all states can absorb all the funds at the same rate.*

It is now clear that the Ways and Means Committee will not even consider the WIC provision since the Chairman indicated he would not consider things outside their jurisidiction. While perhaps the WIC provision could be included in the bill crafted by the Rules Committee for the House floor, we wonder if this really is possible since Ways and Means will not have financed the provision.

When we add all this up, the bottom line seems to us to be that if the WIC provision is not included -- and financed -- in the Senate Finance Committee bill, it may be virtually impossible for the provision to be included in the final health reform bill.

Please let either of us know if you have questions or suggestions for what we can do. Thanks.

- Market/structural reform superior

- Medicaid as Medicare/AFDC & non-cash

- Sequester is clever, but politically questionable

IMPLICATIONS OF REDUCING THE THRESHOLD FOR EMPLOYER PARTICIPATION IN THE COMMUNITY RATED POOL BELOW 1,000

♦ The community rated pool will be poorer and more expensive.

- A community rated pool that excludes public employees and all persons working for employers of 100 or more would have approximately 65–70 million fewer people than a commmunity rated pool that excludes all persons working for employers of 1,000 or more (but which includes public employees).

- Low income persons will be a larger percentage of the smaller than the larger community rated pool. Almost one–half of the smaller community rated pool will be in families with incomes below 150% of poverty, compared to one–third of the larger community rated pool.[1]

- Because health care expenditures for non–workers are greater than expenditures for workers, the premium in a community rated pool excluding employers above 100 will be higher than the premium in a community rated pool excluding employers above 1,000. Lewin estimates that premiums would be 14% higher for a community rated pool excluding public employees and employers above 100 than for a community rated pool excluding employers above 1,000 (but including public employees). This premium increase will increase the burden on small businesses paying into the community rate and will increase government subsidies.

♦ Oversight of employers excluded from the community rated pool will be problematic.

- An additional 45,000 to 65,000 firms will be purchasing experience rated insurance or self–insuring (comparing a community rated pool at 1,000 and below with a pool at 100 and below). If these firms are permitted to self–insure, the risks of insolvency will be substantial (this is true in today's market as well, but under the status quo there is no federal guarantee of benefits). Further, assuring that each of these firms is offering the comprehensive benefits package will require significant administrative resources.

♦ Many firms with 100 or 200 employees would be at risk of paying extremely high premiums if their employees were older and/or sicker. The risk of large year to year fluctuations in premiums for these firms is also substantial.

♦ Coordinating payments for employees in families with two workers will be difficult.

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[1] In the pool that excludes public employees and those employers with more than 100 workers, 47% are below 150% of poverty. In the pool that excludes those employers above 1,000 and includes public employees, 34% are below 150% of poverty. These estimates assume that families in which there is more than one full–time worker obtain insurance from the employer with the larger labor force.

To: Chris Jennings
From: Lorrie

EXPANDING INSURANCE COVERAGE WITHOUT A MANDATE

Prepared for:

THE HEALTH CARE LEADERSHIP COUNCIL

Prepared by:

LEWIN-VHI, INC.

May 18, 1994

The Managed Competition Act would make private health insurance coverage available to all individuals and would provide premium subsidies to lower-income persons who cannot afford coverage. The Act reforms the insurance market so that insurers cannot reject an applicant due to health status and prohibits insurers from varying premiums with the health status of applicants. The Act also provides premium subsidies to persons with incomes below 200 percent of poverty to remove financial barriers to obtaining insurance coverage. In addition, individual premium payments for non-group insurance coverage will become tax deductible. However, individuals are not required to purchase insurance coverage.

In this study, we present estimates of the number of persons who would become insured under these provisions and the amount of health spending for persons who remain uninsured. We also show how the number of uninsured persons would change as subsidies under the program are increased. In addition, we estimate the net federal cost of subsidies under such a program and the additional cost of subsidies if the program were to include a mandate for all uninsured persons to enroll in the program.

Our analysis shows that about 14.8 million persons would become insured under the Managed Competition Act. Overall, about 91 percent of the population would be insured. While nine percent of Americans would remain uninsured, about 97 percent of all potentially covered health spending would be covered by insurance.[1] This reflects the fact that those who remain uninsured would tend to be persons in relatively good health who are low users of care. Requiring all individuals to enroll under the Managed Competition Act would increase federal expenditures for premium subsidies and tax deductions under the Act by $142 billion over the 1996 through 2000 period.

The analysis is presented in the following sections:

- Factors Affecting Insurance Coverage
- Provisions of the Act Expanding Insurance Coverage
- Impact of Reform on Insurance Coverage
- Health Spending for Persons Who Remain Uninsured
- The Added Federal Cost of Mandated Coverage

[1] That is, about 97 percent of all health spending that would be covered under universal coverage would be covered by insurance under the Act.

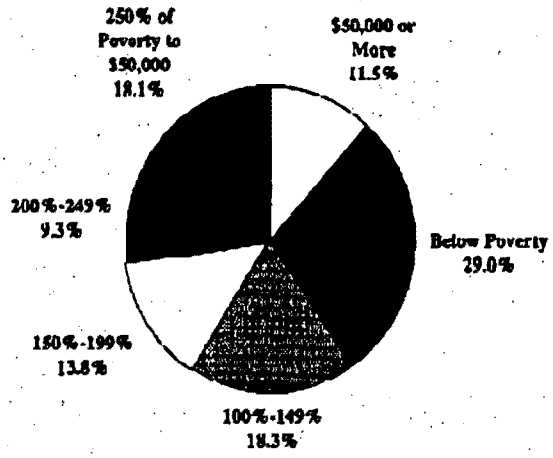
I. FACTORS AFFECTING INSURANCE COVERAGE

We estimate that there will be about 37.2 million uninsured persons at any given point in time during 1998. This estimate is based upon detailed insurance coverage data reported in the 1987 National Medical Expenditures Survey (NMES) data projected to future years based upon insurance coverage trends reported in the Current Population Survey (CPS) data for 1987 through 1993.[2] These data reflect trends toward an increasing uninsured population.

The uninsured are found among all income groups. About 29 percent of the uninsured will have incomes below the poverty level and about 32 percent will be between the poverty level and 200 percent of poverty ***(Figure 1)***. Not all uninsured persons are poor, however. For example, about 11 percent of the uninsured will have annual family incomes of $50,000 or more.

FIGURE 1

UNINSURED BY FAMILY INCOME AS PERCENT OF POVERTY IN 1998



TOTAL UNINSURED = 37.2 MILLION

Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

For many individuals and businesses, the affordability of insurance is a major barrier to coverage. Overall, about 61 percent of the uninsured will have incomes below 200 percent of poverty; most of these individuals would find coverage to be prohibitively expensive. Moreover, a nationwide survey of employers conducted by Lewin-VHI for the Small Business Administration indicated that 62 percent of employers that do not offer health insurance feel that they cannot afford the coverage ***(Table 1)***.

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[2] The NMES data is used because it provides a detailed accounting of insurance coverage by calendar quarter. NMES reports about 15 percent fewer uninsured persons than the CPS for that year.

TABLE 1

PERCENT OF FIRMS NOT OFFERING COVERAGE BY REASON AND FIRM SIZE

	Employment Size of Firm				
Reasons for Not Offering Coverage[a]	Total	1-9	10-24	25-99	100+[b]
Insufficient Profits	67%	68%	62%	54%	36%
Insurance Costs	62%	61%	70%	41%	68%
Turnover	19%	17%	31%	36%	83%
Group Coverage Not Available	16%	17%	3%	22%	0%
Lack of Interest	13%	13%	6%	5%	0%
Administrative Costs	9%	10%	2%	0%	51%
State Minimums	1%	1%	0%	0%	0%
Other	9%	8%	21%	5%	54%

a Responses sum to more than 100 percent because of multiple answers.

b Because virtually all firms with more than 500 employees offer health insurance, this size group have been combined with 100-499.

Source: Lewin-VHI analysis of Small Business Administration, Office of Advocacy, Health Benefits Data Base 1986.

Medical underwriting is also a major reason why firms do not provide insurance, however. Medical underwriting is a process where insurers review the health status of individuals who apply for insurance to determine whether they are an acceptable risk for the insurer. In today's market, insurers often decline to cover individuals and/or groups due to their health status. Insurers are also allowed to vary premiums with the health status of the individual. Although many states restrict medical underwriting, these insurer practices often leave many individuals uninsured. The Small Business Administration survey shows that about 16 percent of firms that do not offer insurance indicated that coverage was not available. Another survey of non-insuring firms in Florida indicates that 4.2 percent of such firms were unable to find a carrier that was willing to take their business and about 7.4 percent had one or more uninsurable employee(s) ***(Table 2)***.

TABLE 2

REASONS GIVEN BY NON-INSURING BUSINESSES IN FLORIDA FOR NOT PROVIDING COVERAGE

Reasons Offered	Percent of Responses
1. Premium are too high	46.6%
2. I have not found a carrier who will take my business	4.2%
3. My Group includes one or more uninsurable employees	7.4%
4. My employee have coverage elsewhere, so it is not needed	26.0%
5. Federal tax implications	8.0%
6. Other	7.8%
TOTAL RESPONSES	100.0%

Source: The Small Business Group health Insurance Survey, State of Florida Health Care Cost Containment Board

II. PROVISIONS OF THE ACT EXPANDING INSURANCE COVERAGE

The Managed Competition Act would expand insurance coverage in three ways. First, the Act would reform insurance markets so that individuals can obtain coverage regardless of their health status. Second, premium subsidies would be provided to lower-income persons to help them, pay for the cost of insurance. Third, individuals would be permitted to deduct the cost of individually purchased non-group coverage. The impact of these provisions is discussed below.

A. Insurance Market Reforms

The Managed Competition Act would address the problems of insurance availability and affordability through market reforms and premium subsidies to low-income individuals. The insurance market reforms would assure that all individuals can obtain insurance at a group rate regardless of their health status while the premium subsidies would eliminate financial barriers to coverage for many Americans.

Under the Act's insurance market reforms, insurers would be required to accept applications for coverage regardless of health status. The Act also requires community rating within age groups so that premiums will not be permitted to vary with health status. Community rating will tend to lower premiums for higher cost individuals while increasing premium costs for healthier populations. Premium charges are likely to result in increased coverage for higher cost groups which probably would be offset by a reduction in coverage for lower cost populations. However, a net increase in coverage is likely among

individuals that have been excluded from coverage altogether due to medical underwriting. We estimate that these market reforms would reduce the uninsured population by about 1.1 million persons.[3]

B. Premium Subsidies to Lower-Income Persons Proposed in the Act

The Act would also provide subsidies to low income individuals to help them purchase insurance. Under the subsidy schedules proposed in the Act, families below poverty would pay nothing for insurance. Premium subsidies would be provided on a sliding scale for persons between the poverty line and 200 percent of poverty. Persons above poverty would receive no direct premium subsidies. Overall, about 61 percent of all uninsured persons would be eligible for premium subsidies under the program. However, given past experience with Medicaid, we assume that many individuals will not obtain coverage even if they are eligible for subsidies. For example, we estimate that about 25 percent of those who are now eligible for Medicaid do not enroll.

We estimated the number of uninsured persons who would participate in the subsidized insurance program based upon an analysis of participation rates in the Medicaid program for individuals with various demographic and health status characteristics using the 1987 NMES data. The analysis showed that Medicaid enrollment rates tended to be higher among persons in poorer health as indicated by self-reported health status and hospital utilization. Enrollment rates tended to increase with age and tended to be lower for families with workers. These Medicaid enrollment rates were adjusted to account for individuals who are eligible for only partial subsidies (i.e., incomes between poverty and 200 percent of poverty).[4]

C. Tax Deductibility of Insurance

Under the Managed Competition Act, family premium payments for non-group insurance would become tax deductible. In addition, self-employed persons will be permitted to deduct the full cost of insurance. This would effectively reduce the cost of insurance for families resulting in an increase in insurance coverage. This provisions would tend to have its greatest impact on insurance coverage for middle and upper income groups where marginal tax rates are highest.

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[3] Based upon the percentage of non-insuring firms reporting that insurance was not available reduced by the share reporting that another reason for not offering insurance is that it is too costly. We assume that all uninsured persons who report themselves to be in poor health will become insured.

[4] An explanation of the data and methods used in this analysis is presented in Appendix A.

We estimated the increase in coverage resulting from this provision based upon an analysis of changes in insurance coverage as the price of insurance is reduced *(See Appendix A)*. We estimate that this provisions would reduce the number of uninsured persons by 1.1 million in 1998.

III. IMPACT OF REFORM ON INSURANCE COVERAGE

Based upon this analysis, we estimate that the insurance reforms and subsidy provisions of the Managed Competition Act would reduce the number of uninsured by 14.8 million persons in 1998 *(Table 3)*. The uninsured would be reduced from 14.3 percent of the population to about 8.6 percent. As *Table 3* shows, if the Act were amended to extend the income eligibility threshold for premium subsidies to 300 percent of poverty, we estimate that the number of uninsured would be reduced by 18.5 million persons in 1998.

TABLE 3

NUMBER OF PERSONS REMAINING UNINSURED AN ALTERNATIVE INCOME ELIGIBILITY LEVELS IN 1998

	Number of Persons Remaining Uninsured (millions)[a]	Newly Covered Under Policy (millions)[c]	Percent of Population Remaining Uninsured
Current Law	37.2		14.3%
Increase Eligibility for Premium Subsidies[d]			
Subsidies to 100% of Poverty	27.1	10.1	10.4%
Subsidies to 150% of Poverty	24.7	12.5	9.5%
Subsidies to 200% of Poverty[d]	22.4	14.8	8.6%
Subsidies to 250% of Poverty	20.7	16.5	7.9%
Subsidies to 300% of Poverty	18.7	18.5	7.2%

a Average monthly number of uninsured persons. Based on 1987 National Medical Expenditures Data projected to 1998 based upon insurance coverage trends reported in the Current Population Survey Data for 1987 through 1992.

b Assumes that persons below poverty are exempt from premium payments. Persons above poverty pay a premium on a sliding scale with income between poverty and a specified percentage of income as a percent of the poverty level (i.e., 150 percent, 200 percent, 250 percent, and 300 percent).

c Enrollment in the program is optional. Enrollment was estimated based upon an analysis of the share of persons eligible for the Medicaid program who enroll by age, sex and health status measures, adjusted for the amount of premium contribution required for persons above the poverty line *(See Appendix A)*.

d Subsidies in the Managed Competition Act.

Source: Lewin-VHI estimate using the Health Benefits Simulation Model (HBSM).

The uninsured persons who would become covered under the program would tend to be older individuals who are higher users of care. For example, under the Act, about 46 percent of currently uninsured persons age 55 to 64 would become insured compared with only about 31 percent of those between the ages of 18 and 24 *(Table 4)*. If eligibility for subsidies were extended to persons with incomes up to 300 percent of poverty, we estimate that 55 percent of currently uninsured persons age 55 to 64 would become insured versus 41 percent of those age 18 to 24. In general, the increase in coverage would tend to be greatest among low income individuals. ***Table 5*** shows the percentage of persons who would remain uninsured under alternative income eligibility levels for premium subsidies.

TABLE 4

PERCENT OF UNINSURED WHO BECOME COVERED UNDER ALTERNATIVE INCOME ELIGIBILITY LEVELS BY AGE AND INCOME IN 1998

	Persons Who Become Insured Under Alternative Income Eligibility Levels[b,c]					
	Uninsured Under Current Law[d] (millions)	Subsidies to 100% of Poverty	Subsidies to 150% of Poverty	Subsidies to 200% of Poverty	Subsidies to 250% of Poverty	Subsidies to 300% of Poverty
Age of Individual						
Under 18	9.7	29.2%	38.9%	44.2%	49.9%	55.7%
18-24	6.9	21.9%	25.4%	31.3%	36.6%	41.3%
25-34	7.8	21.6%	28.4%	35.9%	41.9%	46.1%
35-44	5.7	27.9%	35.6%	43.9%	49.6%	53.4%
45-54	4.3	33.8%	37.1%	40.9%	45.1%	52.1%
55-64	2.7	34.4%	40.4%	45.8%	51.2%	55.1%
Under Age 65	37.1	26.9%	33.6%	39.7%	44.2%	50.2%
65 and above[e]	0.2	50.9%	62.2%	65.9%	65.4%	72.8%
Family Income as a Percentage of Poverty						
Below Poverty	9.3	84.5%	84.5%	84.5%	84.5%	84.5%
100%-150%	6.0	9.7%	49.7%	61.9%	67.1%	69.0%
150%-200%	4.6	4.6%	4.6%	39.6%	46.0%	51.2%
200%-250%	3.8	10.5%	10.5%	10.5%	37.8%	43.6%
250%-300%	3.3	10.2%	10.2%	10.2%	10.2%	53.7%
300% and above	10.2	6.9%	6.9%	6.9%	6.9%	6.9%
TOTAL	37.2	27.1%	33.6%	39.8%	44.3%	50.3%

a Average monthly number of uninsured persons. Based on 1987 National Medical Expenditures Data projected to 1998 based upon insurance coverage trends reported in the Current Population Survey Data for 1987 through 1992.

(FOOTNOTES CONTINUED ON NEXT PAGE)

these premium expenses but only to the extent that total family health spending exceeds 7.5 percent of adjusted gross income.

Under the Managed Competition Act, individuals will be permitted to deduct the full amount of their insurance premium payments. Self-employed persons will also be allowed to deduct the full amount of their insurance premium payments. These measures will, in effect, reduce the price of insurance resulting in an increase in insurance coverage.

We estimated this increase in insurance coverage based upon the change in the after-tax cost of insurance for currently uninsured persons. This was done by calculating the percentage increase in the probability of purchasing coverage with and without the tax deduction for an individual family as presented in ***Table A-3***. The probability that an individual uninsured family would take insurance was based upon the percentage increase in the probability of taking coverage as the price of insurance is reduced.

For example, a family facing a premium cost equal to 13 percent of income has a probability of taking insurance coverage of 30 percent ***(Table A-3)***. Assuming the individual faces a marginal tax rate of 23 percent, allowing a deduction for his/her premium expense would reduce the cost of insurance as a percentage of income to about 10 percent. Reducing insurance costs to 10 percent of income would increase this individual's probability of purchasing insurance from 30 percent to 38 percent ***(Table A-3)***. This represents a 27 percent increase in the probability of taking coverage. Thus, in this analysis, we assume that the probability that this uninsured family will take coverage due to the tax deduction is 27 percent.

In our analysis, a probability of enrollment is estimated for each individual who is potentially eligible for premiums subsidies using the logit model presented in ***Table A-2.*** If the individual is eligible for only partial premium subsidies (i.e., income between poverty and 200 percent of poverty), the probability estimated using the e logit model is reduced to reflect the price of insurance as a percentage of income as shown in ***Table A-3***.

III. CHANGE IN ENROLLMENT FOR THE MEDICAID POPULATION

In general, we assume that individuals who are currently eligible but not enrolled in the Medicaid program will remain uninsured under a program that expands coverage for low-income persons. However, the Managed Competition Act includes provisions which would increase incentives for the Medicaid eligible population to maintain their coverage under the program.

Unlike private insurance, the Medicaid program does not have pre-existing condition limitations. In fact, individuals can enroll in the program once they become ill and be covered for the illness often retrospectively. Thus, under the current Medicaid program, individuals do not need to maintain their Medicaid coverage to be covered once they become ill.

Under the Managed Competition Act, individuals would now face pre existing condition limitations which create incentives to maintain their coverage. This should result in an increase in the number of Medicaid eligible individuals who obtain coverage under the program. In this analysis, we assume that individuals who reported that they were enrolled in Medicaid for part of the year will continue their coverage in months where they would otherwise be uninsured. In all instances where premiums are fully subsidized under the program. For individual who are eligible for only partial premium subsidies, the likelihood of maintaining coverage is based upon levels by premium costs as a percentage of income shown in ***Table A-3***.

IV. THE IMPACT OF THE TAX DEDUCTION FOR INSURANCE COVERAGE

Under current tax law, individual insurance purchases generally are not tax deductible. Also, self-employed persons may deduct only 25 percent of the cost of insurance for themselves and their families as a cost of doing business.[5] The only exception to this is that some families may deduct a potion of

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[5] The self-employed may deduct the full cost of insurance for workers and dependents. Self-employed persons who have established themselves as a corporation may deduct the full cost of insurance.

2. We then estimated the value of the tax credit and deduction individuals would qualify for under the Managed Competition Act. Individuals were assumed to take the greater of the tax credit or the deduction.

3. We then calculated the after-tax cost of insurance under the Managed Competition Act by subtracting the greater of the tax credit or the deduction from the estimated cost of insurance. This allowed us to calculate the cost of insurance as a percentage of income.

4. The number of additional persons who would purchase individual coverage under the Managed Competition Act was then estimated using *Table A-3* based upon the after-tax cost of insurance as a percentage of income.

TABLE A-3

ESTIMATE PERCENTAGE OF PERSONS WITHOUT EMPLOYER OR PUBLIC COVERAGE WHO PURCHASE INDIVIDUAL INSURANCE BY INSURANCE COST AS A PERCENTAGE OF FAMILY INCOME IN 1990

Insurance Cost as a Percentage of Income	Estimated Percent Who Purchase Individual Coverage	Adjustments to Logit Probability for Persons Qualifying for Partial Subsidies[b]
0%[a]	73%	100%
1%	60%	82%
2%	52%	71%
3%-4%	46%	63%
5%-6%	46%	63%
7%-8%	41%	56%
9%-10%	38%	52%
11%-12%	33%	45%
13%-14%	30%	41%
15%-16%	27%	37%
17%-18%	24%	33%
19%-20%	23%	31%
21%-30%	21%	29%
31%-40%	19%	26%
41%-55%	18%	25%
56% or More	17%	23%

a Some individuals will find that the cost of insurance if fully covered by the tax credit. In these cases, we assume that the percentage taking the credit is the same as the percentage of persons potentially eligible for Medicaid who we estimate actually enroll in Medicaid (73 percent as estimated using the Lewin-VHI Health Benefits Simulation Model).

b The logit probability is adjusted by the factor correspond to the cost of insurance (i.e., premium less subsidy) to the individual as a percentage of income.

Source: Lewin-VHI estimates using the March 1991 Current Population Survey (CPS) data and non-group insurance premium estimates developed using the Health Benefits Simulation Model.

TABLE A-2
RESULTS OF LOGIC MODEL OF MEDICAID ENROLLMENT

Variable	Parameter Estimate
Intercept	0.9547
Age 45	0.3871
Age 65	0.1345
Female	0.0871
EMPLOY	0.3432
EMPINS	1.1326
POORHT	1.0127
HOSPVS	0.7428
INCPOV	0.1967
MONELIG	0.0833

Source: Lewin-VHI estimates.

II. ENROLLMENT FOR PERSONS PAYING PARTY OF THE PREMIUM

The logic model presented in ***Table A-2*** is used to select newly eligible families to participate in the program. The equation is used as shown for all individuals who are eligible for full premium subsidies under the program. The probability of enrollment is reduced for persons qualifying for only partial premium subsidies to reflect the fact that the likelihood of program enrollment is generally expected to decline as the amount that individuals pay for the coverage increases.

We adjusted enrollment probabilities for persons qualifying for partial premium subsidies using assumptions developed from an analysis of the relationship between the cost of insurance and the purchase of individual non-group health insurance policies. The March 1991 CPS reports that there were 52.9 million persons under age 65 who did not have coverage through either employment or public programs, of whom 35 percent (18.5 million) purchased individual non-group coverage. We used this information to estimate the increase in the number of persons who would purchase coverage with partial premium subsidies in the following steps:

1. We analyzed the March 1991 CPS data on the percentage of persons who did not have employer or public coverage but who purchased individual coverage. We tabulated the number who purchased insurance by the amount of the premium as a percent of the their income. This was done by estimating the cost of non-group insurance for these individuals (based upon the average value of non-group insurance benefits by age estimated using the Lewin-VHI Health Benefits Simulation Model). As shown in ***Table A-3***, the percentage of persons purchasing individual insurance decreases as premiums as a percentage of income increases.

TABLE A-1

EXPLANATORY VARIABLES

Variable	Description
Age 45	Age 45-64 Dummy
Age 65	Age 65 and Over Dummy
Female	Sex Indicator
EMPLOY	Employment Status
EMPINS	Employer Health Insurance Indicator
POORHT	Health Status Dummy
HOSPVS	Hospital Visit Indicator
INCPOV	Family Income/Poverty Index
MONELIG	Months in Year Eligible

Source: Lewin-VHI estimates.

A number of variables are included in the model to represent health status. The NMES survey asks respondents to indicate their health status. We developed a summary variable to indicate those people who responded they were in fair or poor health. We created a separate variable to indicate whether or not the person had a hospital visit. We included this measure separately to obtain an indicator of severity of illness.

The age and sex of the head of the household are included in the model as adjusters to determine whether they had any significant relation to participation rates. We create two dummy variables, one indicates those people age 45-64 and the other indicates people age 65 and over. Sex of family head is indicated by a dichotomous variable, with '1' indicating female and '0' indicating male. We also included a variable indicating the number in which the family is eligible for the program.

The equation was estimated using a logic specification which asymptomatically bounds the predicted values from the equation to zero and one. The logic model was estimated using a maximum likelihood estimation technique. The results of the logit model are presented in ***Table A-2***.

- **Form Filing Units** - In general, single parents and some married couples form individual program filing units along with their dependent children. Individuals and couples not included in the nuclear family are ineligible unless they are aged or disabled. Non-working persons who reported that they are disabled were counted as potentially eligible filing units if they reported they are disabled.
- **Determine Monthly Incomes** - The model estimates monthly incomes for each individual in the NMES data by allowing annual earnings across the quarter in which the individual reported that they were working. Non-earnings income was generally allocated uniformly across each quarter. Quarterly incomes were then divided equally across the months in each quarter.
- **Eligibility Levels** - The model estimates eligibility for the program using the income eligibility levels that apply in each state. NMES reports the census division in which the individual is living (nine census divisions) but does not report the state of residence. We allocated individuals to individual state within their reported census division based upon the distribution of persons within individual states in each census division by income and other demographic characteristics as reported in the March Current Population Survey (CPS) data.

Based upon this analysis, we estimate that about 25 percent of those who are eligible for Medicaid do not enroll. We estimate that there will be about 49.4 million persons who will be potentially eligible for the program sometime during the year of whom only about 38.1 million will enroll. Using the NMES observations for families simulated to be eligible for Medicaid, we estimated a multivariate model of factors affecting enrollment behavior which we use to select eligible individuals to enroll under various expansions in publicly subsidized coverage.

The dependent variable in the model indicates whether or not a family simulated to be eligible for Medicaid has enrolled in the program. A value of '1' indicates enrolled and a value of '0' indicates not enrolled. The model estimates the probability that an eligible family will enroll in the program, based on a set of explanatory variables including income, employment status and health status discussed below. The equation gives us the ability to estimate the number of newly eligible families that will enroll under various Medicaid expansion policies.

The individual variables in the equation are primary indicator variables derived to the NMES data file. These variables are listed in ***Table A-1***. Employment status is represented by an indicator showing whether or not any family member is employed. We also use a variable to indicate whether or not any employed family member is covered by an employer sponsored health insurance plan. In order to analyze the affects of these variables separately, the employment status variable only identified those people who are employed but do not have health insurance. Income level is indicated by an index that calculates family income as a percentage of the poverty level. This ratio is a composite measure of income adjusted for family size.

The Managed Competition Act would provide subsidies to low income persons to help them pay for the cost of insurance. Persons with incomes below poverty would pay no premium. Persons between the poverty line and 200 percent of poverty would pay a premium on a sliding scale with income. Furthermore, the Act allows health plans to impose pre-existing condition exclusions. Such exclusions actually serve as an incentive for individuals to enroll in health plans as soon as possible. If an individual does not enroll and becomes sick, he or she will not be able to opt into the program to cover medical expenses, as is currently permitted under Medicaid.

Our general approach was to estimate the number of eligible individuals who would enroll in the program based upon enrollment rates in the existing Medicaid program. These enrollment rates were adjusted for persons above poverty to reflect the fact that these individuals will be required to pay some portion of the premium. We also modified enrollment rates for persons now eligible under Medicaid to reflect the fact that individuals must maintain their coverage or face pre-existing conditions once they become ill and are in need of care. In addition, we estimated the change in coverage resulting from the tax deduction for non-group insurance coverage. The methods used to develop these enrollment projections are presented below in the following sections:

- Multivariate Analysis of Medicaid Enrollment
- Enrollment for Persons Paying Premiums
- Change in Enrollment for Medicaid Population
- The Impact of the Tax Deduction for Insurance Coverage

I. MULTIVARIATE ANALYSIS OF MEDICAID ENROLLMENT

We developed a multivariate analysis of enrollment patterns for persons potentially eligible for the Medicaid program by age, health status and various economic and demographic characteristics. We used the Medicaid eligibility module of the Health Benefits Simulation Model (HBSM) to estimate the number of persons who are potentially eligible for coverage under the Medicaid program. The multivariate analysis measures the likelihood of enrollment for the Medicaid program based upon the share of potentially eligible persons who enroll.

The population that is potentially eligible for Medicaid was estimated by forming National Medical Expenditures Survey (NMES) families into program filing units which conform to the eligibility rules under the program and testing to see whether each filing unit meets the income eligibility standard for the program during one or more months during the year. This involves three steps:

APPENDIX A

ESTIMATING ENROLLMENT UNDER A PROGRAM OF SUBSIDIZED INSURANCE COVERAGE

While the Act would extend coverage to the poorest and sickest portion of the uninsured population, it will still leave 22.4 million persons uninsured. These individuals are still at risk for incurring large uncompensated care expenses which ultimately will be shifted to insured individuals in the form of higher prices for health care. Moreover, allowing healthy individuals not to obtain insurance coverage will tend to result in higher premiums for those who purchase insurance.

The question we face is whether the benefits of requiring all individuals to purchase insurance will out weigh the cost of subsidizing insurance premiums for these individuals. Our estimates indicate that requiring all individuals to enroll under the Managed Competition Act would cost the federal government about $30 billion per year more than if optional enrollment is permitted. These costs must be weighed against the social costs of permitting individuals not to purchase insurance.

Thus, the incremental cost to the federal government of requiring universal coverage under the Act would be $28 billion in 1998 *(Table 8)*. The net additional federal costs of mandating coverage would be $142 billion over the 1996 through 2000 period. These estimates reflect the fact that overall average premiums would decline under a mandate as healthier individuals enter the insurance risk pool and cost-shifting for uncompensated care is reduced.

TABLE 8

THE ADDITIONAL COST OF REQUIRING ALL INDIVIDUALS TO HAVE INSURANCE UNDER THE MANAGED COMPETITION ACT

		Additional Cost of Mandatory Enrollment		
	Net Federal Cost of Managed Competition Act[a]	Additional Premium Subsidies[b]	Additional Tax Loss Due To Insurance Tax Deduction[c]	Total
1996	$35	$15	$10	$25
1997	$46	$16	$10	$26
1998	$42	$17	$11	$28
1999	$36	$18	$12	$30
2000	$30	$20	$13	$33
Total	$189	$86	$56	$142

a Net change in the federal deficit under the Managed Competition Act assuming the Health Security Act benefits package is adopted as the uniform benefits package. See, "An Analysis of the Managed Competition Act," Congressional Budget Office (CBO), April, 1994.

b Additional premium subsidies for persons who would be required to enroll. Assumes subsidies are available through 200 percent of poverty. Reflects premium reductions as lower-cost uninsured persons become insured.

c Tax deduction for insurance premiums for newly insured persons.

Source: Lewin-VHI estimate using the Health Benefits Simulation Model (HBSM).

VI. CONCLUSION

The Managed Competition Act is designed to make insurance available on a voluntary basis at a price that is affordable to lower income individuals. We estimate that the Act would provide coverage for about 39.8 percent of the uninsured population. Overall, about 91 percent of the population would be insured. While nine percent of Americans would remain uninsured, about 97 percent of all potentially covered health spending would be covered by insurance. That is, about 97 percent of all health spending that would be covered under universal coverage would be covered by insurance under the Act. This reflects the fact that those who remain uninsured would tend to be persons in relatively good health who are low users of care.

Thus, our analysis indicates that a disproportionate share of expenditures for uninsured persons would become covered under the program. We estimate that the uninsured currently consume about $45.4 billion in health care services that would be covered under a comprehensive insurance package similar to that proposed under the Health Security Act *(Table 7)*. Under the Managed Competition Act, total uninsured expenses would drop to about $24.8 billion.

TABLE 7

UNCOVERED EXPENSES FOR PERSONS WHO REMAIN UNINSURED UNDER ALTERNATIVE INCOME ELIGIBILITY LEVELS

	Uninsured Expenses[a] (billions)	Spending for Uninsured as a Percent of Total Spending
Current Policy	$45.4	5.9%
Income Eligibility for Premium Subsidies[b]		
Subsidies to 100% of Poverty	$29.8	3.7%
Subsidies to 150% of Poverty	$27.1	3.4%
Subsidies to 200% of Poverty	$24.8	3.2%
Subsidies to 250% of Poverty	$22.7	2.9%
Subsidies to 300% of Poverty	$21.0	2.6%

a Spending for uninsured persons which is potentially covered under the benefits package proposed in the Health Security Act.

b Assumes that persons below poverty are exempt from premium payments. Persons above poverty pay a premium on a sliding scale with income between poverty and a specified percentage of income as a percent of the poverty level (i.e., 150 percent, 200 percent, 250 percent, and 300 percent).

c Enrollment in the program is optional. Enrollment was estimated based upon an analysis of the share of persons eligible for the Medicaid program who enroll by age, sex and health status measures, adjusted for the amount of premium contribution required for persons above the poverty line *(See Appendix A)*.

Source: Lewin-VHI estimate using the Health Benefits Simulation Model (HBSM).

V. THE ADDED FEDERAL COST OF MANDATED COVERAGE

The analysis presented above assumes that individuals are not required to enroll in the program. The Congressional Budget Office estimates that the cost of premium subsidies net of offsetting savings and tax revenue effects would be $42 billion under the Managed Competition Act in 1998. If all individuals are required to enroll in the program, the premium subsidy costs in 1998 would increase by $17 billion as low-income individuals who would not otherwise enter the program become insured *(Table 8)*. In addition, other individuals who purchase coverage under the Act would be allowed to deduct the cost of this insurance resulting in a loss of federal tax revenues of $11 billion.

d Subsidies in the Managed Competition Act.
e Includes persons who have not earned sufficient quarters of coverage to be covered under Medicare.
Source: Lewin-VHI estimate using the Health Benefits Simulation Model (HBSM).

IV. HEALTH SPENDING FOR PERSONS WHO REMAIN UNINSURED

In general, our analysis indicates that individuals who would become insured under the program would tend to be higher users of care. For example, the insurance market reforms are most likely to result in increased insurance coverage among persons in poor health status who have been excluded from coverage due to medical underwriting. Also, as discussed above, our analysis of Medicaid enrollment rates suggests that the individuals who are most likely to enroll in a program of subsidized insurance coverage would be older individuals in poor health status who are higher users of care.

This is reflected in our estimates of enrollment for families with various levels of health spending. For example, we estimate that, under the Act, about 73 percent of uninsured persons in families with health spending in excess of 30 percent of family income will enroll in the program ***(Table 6)***. By comparison, only 31 percent of those with spending equal to less than five percent of income will enroll.

TABLE 6

PERCENT OF UNINSURED WHO BECOME COVERED UNDER ALTERNATIVE INCOME ELIGIBILITY LEVELS BY UNINSURED EXPENSES AS A PERCENT OF INCOME

		Percent Who Become Insured Under Alternative Income Eligibility Levels[b,c]				
Uninsured Expenses as a Percent of Family Income	Uninsured Persons Current Law[a] (millions)	Subsidies to 100% of Poverty	Subsidies to 150% of Poverty	Subsidies to 200% of Poverty[d]	Subsidies to 250% of Poverty	Subsidies to 300% of Poverty
Under 5%	28.8%	18.2%	25.0%	31.3%	36.2%	43.3%
5%-10%	2.2%	42.5%	50.2%	56.8%	59.4%	65.5%
10%-20%	1.7%	54.7%	61.8%	67.9%	70.6%	71.5%
20%-30%	0.9%	69.5%	81.2%	85.1%	89.9%	90.8%
30% and above	3.6%	64.2%	34.8%	73.9%	75.9%	76.8%
TOTAL	37.2%	27.1%	33.6%	39.8%	44.8%	50.3%

a Average monthly number of uninsured persons. Based on 1987 National Medical Expenditures Data projected to 1998 based upon insurance coverage trends reported in the Current Population Survey Data for 1987 through 1992.
b Assumes that persons below poverty are exempt from premium payments. Persons above poverty pay a premium on a sliding scale with income between poverty and a specified percentage of income as a percent of the poverty level (i.e., 150 percent, 200 percent, 250 percent, and 300 percent).
c Enrollment in the program is optional. Enrollment was estimated based upon an analysis of the share of persons eligible for the Medicaid program who enroll by age, sex and health status measures, adjusted for the amount of premium contribution required for persons above the poverty line ***(See Appendix A)***.
d Subsidies in the Managed Competition Act.
Source: Lewin-VHI estimate using the Health Benefits Simulation Model (HBSM).

b Assumes that persons below poverty are exempt from premium payments. Persons above poverty pay a premium on a sliding scale with income between poverty and a specified percentage of income as a percent of the poverty level (i.e., 150 percent, 200 percent, 250 percent, and 300 percent).

c Enrollment in the program is optional. Enrollment was estimated based upon an analysis of the share of persons eligible for the Medicaid program who enroll by age, sex and health status measures, adjusted for the amount of premium contribution required for persons above the poverty line *(See Appendix A)*.

d Subsidies in the Managed Competition Act.

e Includes persons who have not earned sufficient quarters of coverage to be covered under Medicare.

Source: Lewin VHI estimate using the Health Benefits Simulation Model (HBSM).

TABLE 5

PERCENT OF TOTAL POPULATION THAT WOULD BE UNINSURED UNDER ALTERNATIVE INCOME ELIGIBILITY LEVELS IN 1998

	Percent Who Remain Uninsured[b,c]					
	Current Law[d]	Subsidies to 100% of Poverty	Subsidies to 150% of Poverty	Subsidies to 200% of Poverty[d]	Subsidies to 250% of Poverty[e]	Subsidies to 300% of Poverty
Age of Individual						
Under 18	13.9%	9.8%	8.5%	7.7%	6.9%	6.1%
18-24	29.4%	23.0%	21.9%	20.2%	18.6%	17.3%
25-34	19.5%	15.3%	13.9%	12.5%	11.3%	10.5%
35-44	14.5%	10.5%	9.3%	8.1%	7.3%	6.8%
45 54	12.4%	8.2%	7.8%	7.3%	6.8%	5.9%
55-64	11.0%	7.2%	6.6%	6.0%	5.4%	5.0%
Under Age 65	16.0%	11.7%	10.6%	9.6%	8.9%	8.0%
65 and above[e]	0.5%	0.3%	0.2%	0.2%	0.2%	0.1%
Family Income as a Percentage of Poverty						
Below Poverty	25.1%	3.9%	3.9%	3.9%	3.9%	3.9%
100%-150%	24.9%	22.5%	12.6%	9.5%	8.2%	7.7%
150%-200%	20.2%	19.2%	19.2%	12.2%	10.9%	9.8%
200%-250%	17.1%	15.3%	15.3%	15.3%	10.6%	9.6%
250%-300%	13.9%	12.5%	12.5%	12.5%	12.5%	6.4%
300% and above	7.7%	7.2%	7.2%	7.2%	7.2%	7.2%
TOTAL	**14.2%**	**10.4%**	**9.4%**	**8.6%**	**7.9%**	**7.2%**

a Average monthly number of uninsured persons. Based on 1987 National Medical Expenditures Data projected to 1998 based upon insurance coverage trends reported in the Current Population Survey Data for 1987 through 1992.

b Assumes that persons below poverty are exempt from premium payments. Persons above poverty pay a premium on a sliding scale with income between poverty and a specified percentage of income as a percent of the poverty level (i.e., 150 percent, 200 percent, 250 percent, and 300 percent).

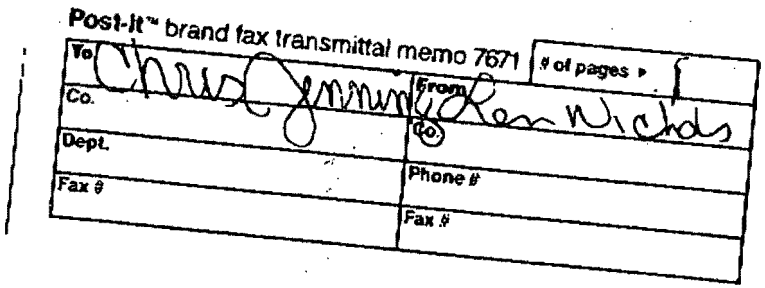
c Enrollment in the program is optional. Enrollment was estimated based upon an analysis of the share of persons eligible for the Medicaid program who enroll by age, sex and health status measures, adjusted for the amount of premium contribution required for persons above the poverty line *(See Appendix A)*.

(FOOTNOTES CONTINUED ON NEXT PAGE)

5 year Subsidy Savings Decomposed

Overall 5 year subsidy savings of Kennedy Mark vs. HSA		**21**
Better Targeting (individual wage cap vs. firm payroll caps)		**26**
More Generous Household subisides		**- 27**
Self-employed, nonworkers, and part-time workers	**-16**	
Workers in firms outside the mandate	**-11**	
Employer subisidy savings from the ≤ 5 worker exemption		**13**
2% Lower Premiums		**9**

1
PRELIMINARY STAFF ESTIMATES AFTER CONSULTATION WITH CBO AND THE ADMINISTRATION.



Mitchell–Breaux–Boren–Like Compromise

Government Subsidies:	
1 Year (1994) ($m)	83,218
employer	25,130
household	58,088
Government Subsidies:	
5 Years ($m)	373,982
employer	130,912
household	243,069
Government Subsidies:	
10 Years ($m)	1,009,331
employer	419,118
household	590,213
Select Revenue Estimates:*	
Corporate Assessment	45,200
Other Revenue	36,080
Total (5 Years)	81,280
Select Revenue Estimates:*	
Corporate Assessment	86,200
Other Revenue	64,080
Total (10 Years)	150,280
Net Effect on Deficit *	
(5 Years)	(2,398)
Net Effect on Deficit *	
(10 Years)	(43,149)
Net Effect on Deficit, Adjusted by 50% (10 Years)***	(21,574)

Notes on the estimates:

* Revenue estimates are for those components that differ from the HSA. Deficit effects are relative to the current system. Revenue estimates are preliminary; they are not official estimates.

** Sorting of firms is assumed to be 25% of HSA sorting. This is a preliminary estimate and may understate outsourcing effects.

*** **Due to the unofficial nature of these estimates, it is advisable to use a measure of conservatism in considering these models. We suggest a deficit reduction estimate that is half of that coming out of the model as a reasonable adjustment.**

**** 1 Year subsidy estimates assume a fully phased–in carve–out year.

Possible Mitchell–Breaux–Boren–Like Compromise

- An 80% employer requirement on firms of more than 20 workers. If after 3 years, 90% of workers in firms of 20 or less do not receive employment based coverage, a full employer mandate is triggered.

- Firms covering their workers pay the lesser of the employer premium share or 2.8% to 12% of that worker's wages, whichever is less. Cap is determined by firm size and average wage in the firm.

- Firms not covering their workers pay, a payroll assessment of 1% if firms has 1–10 workers and 2% if 11–20 workers.

- Firms of 1000 workers or more are outside of the community rating pool and pay a 1% payroll assessment

- Families not receiving coverage through their employer have their contributions capped at 4–6% of income; appropriate cap is determined by family income.

- Premiums benefits package are 5% below the CBO scoring of the HSA.

Goal: To move the health care system toward broader coverage and greater efficiency at acceptable private and public costs.

Premise: Mitchell bill without automatic trigger to employer mandate

Policy Issue: Insurance Reforms

Policy: **Non-mandate reforms designed to minimize problems.**

- Partial community rating to prevent adverse selection and dropping: age bands instead of full community rating; no pre-existing condition exclusions for the currently insured; six month waiting period before pre-existing conditions would be covered for newly insured; same premium for all businesses with fewer than 500 workers and for individuals

Benefits:

- Protects workers from losing coverage when they change jobs, or when a family member becomes sick or injured.
- Permits mobility among firms that provide insurance without regard to size of firm.
- Eliminates much of the administrative cost associated with present underwriting and marketing practices.
- Ends discrimination against employers based on size or health of employees
- Permits individuals to purchase insurance at non-discriminatory rates.
- Allows competition based on efficiency to replace competititon based on avoiding risk.

Costs and Risks:

- Incremental insurance reform will cause average premiums to rise by approximately $4 per person per month -- according to the Lewin/VHI study for the Catholic Health Association.
- Small businesses and individuals whose risks are considerably below average may see larger increases while higher risk businesses and individuals will see larger benefits.

Evaluation:

- With proper design, substantial benefits can be accomplished with relatively small risks. Benefits would be less than full community rating but would solve many of the most visible problems, particularly of concern to middle class workers -- portability and job lock in particular.

Policy Issue: Subsidies

Policy: **Subsidies targeted to uninsured workers and vulnerable populations; partial Medicaid integration to minimize impact on private premiums.**

- Subsidies for 100% of community-rated premium (indexed) for people with incomes below 75% of poverty; sliding scale subsidies up to 200% of poverty (about $29,000 for a family of four). All current Medicaid recipients except SSI recipients (the elderly poor and disabled) are transferred to the new subsidy program. Other eligible categories for subsidies include pregant women and kids; people who become unemployed; people leaving welfare for work; employers expanding coverage for workers.

Benefits:

- Coverage for job losers provides middle class security (**example**)
- Coverage for vulnerable populations--children, pregnant women, low-wage workers, and other low income people whom Medicaid fails to reach
- Low income subsidies provide low wage workers with health care coverage now available only to people on welfare (5-6 million of the 11 million people reached by these subsidies are workers.)
- Expanded coverage reduces uncompensated care burden on currently insured
- Subsidy program shifts people now covered by a public program (Medicaid) to private insurance
- Moving Medicaid beneficiaries into a constrained subsidy program controls growth in federal spending and reduces the burden on taxpayers to finance deficit spending or taxes to support higher spending
- Medicaid shift to private insurance eliminates cost-shift to private payers from Medicaid's low payment rates
- Funding sources that may be available in the context of health care reform, such as the tobacco tax, cafeteria plan curtailment and premium assessments, may not be politically acceptable at another time or for other purposes

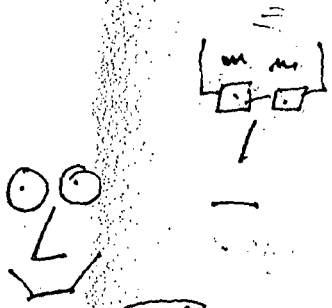
Costs and Risks:

- Revenues and savings necessary to pay for subsidies impose burdens that must be weighed against the benefits
- High cost plan assessment imposes obligation on employers whose cost growth exceeds average
- Elimination of health portion of cafeteria benefits is a loss of a popular middle class benefit
- Community rating the Medicaid population generates public (federal and state) savings, but increases private premiums by 1 percent (even after other savings from reduced cost-shifting are taken into account)--
- Medicare spending reductions in excess of new benefits will be perceived as shifting costs to the private sector and threatening access
- Insuring nonworkers in community-rated pool increases private premiums by x percent (even after savings from reduced uncompensated care are taken into account)
- With indexed subsidies, coverage improvements will decline over time unless there is effective cost containment
- With indexed subsidies (and without cost containment), people now covered by Medicaid will see a decline in protection, relative to the current system

Issues

Are likely premium increases worth the benefits?

Are transfers between groups justifiable and defensible?

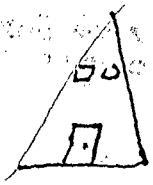


scenarios

Reduction of benef

water

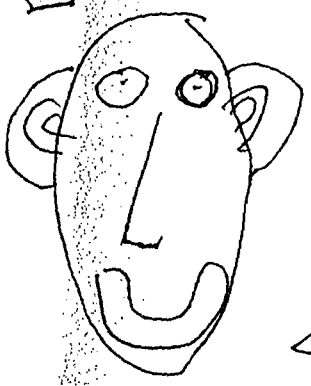
rain

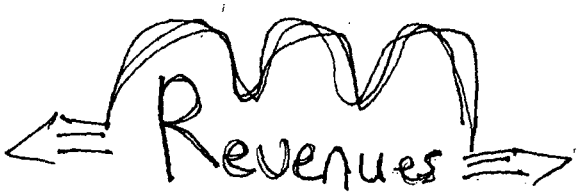


Age Rating

people

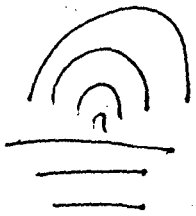
SUV

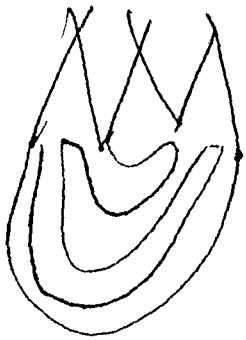




insured population

deviations from norm





Scenarios focused on ~~taxes~~ subsidies

Insurance Reforms

Packages to achieve goals

Voucher program - roll back

Adelstein, Jonathan (Aging)	202-224-6651
Alberghini, Theresa (Leahy)	202-224-2414/3595 fax
Allen, Barbara	
Altman, David (Rockefeller)	202-224-6472
Altman, Roger	202-622-0404 fax
Altman, Stuart	617-736-3803
Anderson, John (Wash Post)	202-334-7281
Apfel, Ken	202-690-6396
Arons, Bernie	301-443-0001
Atkins, Larry	202-775-9818
Atkinson, Leslie (Stokes)	202-225-7032/1339 fax
Barnett, Pam	202-456-2369
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Barstow, Scott (Kopetski)	202-225-5711
Bennett, Arnold	202-628-3030
Berenson, Bob	
Berry, Marion	202-720-7095/66586
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Berry, Roger (Johnston)	202-225-3001
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Bettigole, Kyle	
Bierbauer, Charles (CNN)	202-898-7542
Bierwirth, Maggie (Gejdensen)	202-225-2076
Biles, Brian	202-690-5824
Billy, Carrie (Bingaman)	202-224-5521/2852 fax
Bingaman, Ann	202-514-2410
Bloom, Felicia (Slaughter)	202-225-3615
Blount, John (AssocPrivPensPl)	202-289-6700
Bode, Holly (Levin)	202-224-
Bocchino, Carmella	202-778-3275/773-0569 bp
Boehm, Jennifer (Long)	202-225-4436
Bonmartini, Gioia (Roth)	202-224-4491/9603 fax
Boorstin, Bob	202-456-7151
Borzi, Phyllis (Ed&Labor)	202-225-5768/3614 fax
Bowles, Erskine (SBA Admin)	202-205-6690
Brassier, Ann	304-876-3611
Bridenbaugh, Tom	202-872-1155
Brock-Smith, Cynthia (OPM)	202-606-1300/1344 Fax
Brodbeck, Laura (McCurdy)	202-225-6165
Broder, David (Wash Post)	202-334-7444
Broeren, Katie	202-205-6690
Brostrom, Molly (Wofford)	202-224-4474
Bruderle, Tom (ASHP)	301-657-3000x301
Bruns, Kevin (PO&CivServ)	202-225-2265
Buckingham, Warren (Buck) (AIDS)	202-632-1090
Buonora, David (Kennelly)	202-225-2265
Burke, Sheila (Dole)(Marilyn)	202-224-5311/2105/3163 f
Burnett, Laird (Breaux)	202-224-4623/4268 fax
Candelaria, Alma (DOL Cong Aff)	202-219-
Cassel, Gene	202- - /682-6287 fa
Cavanaugh, Sean (Cardin)	202-225-4106
Certner, Cathy (WBGH)	202-408-9320
Chaffee, Mary Ann (Bumpers)	202-224-4843
Chambers, Caroline (Cooper)	202-225-6831/4520
Chang, Debbie (Riegle)	202-224-3612/8834 fax
Chen, Ed (LA Times)	202-861-9253
Chi, Judy (Hosp Pharm Report)	201-358-7258
Chism, Sharon	
Clark, Bill (Bumpers)	202-224-6433
Claxton, Gary	202-690-5751/668-8728 bp
Claxton, Isabelle	202-638-4170
Clemente, Frank (Govt Ops)	202-225-5051
Cohen, Cathy (Kodak GR)	202-857-3461
Cohen, Rima (Daschle)	202-224-2131/2321/2047 f

P6/b(6)

Cooper, Barbara	202-690-5500/8168 fax
Corr, Bill	202-690-7694
Coster, John (Aging)	202-224-5364/1262/9926 f
Crossfire	202-898-7655
Crow, Shelly	
Crump, Janice (Clayton)	202-225-3101
Daschle, Tom (Senator)	
Davies, Monica (Bingaman)	202-224-4266
Davidson, Nestor	202-456-7848
Davis, Lori	202-690-5621/7450/8425 f
Deignan, Kathy (Budget)	202-224-9284
DeLeon, Pat (Inouye)	202-224-3934
Delew, Nancy	202-690-7804
Democratic Caucus	202-226-3210
Democratic National Committee	202-863-8000
Denham, Lori (Dooley)	202-225-3341
Denton, Denise	303-692-2479/782-5576 fa
Doneski, Ellen (Rockefeller)	202-224-9837
Drummond, Faye (Finance)	202-224-4515/8-5568 fax
Eckert, Kevin (Wofford)	202-224-4474
Edelstein, Steve	
Edgell, John (Commerce)	202-482-4067/2741 fax
Einhorn, Ted (Deutsh)	202-225-7931
Eisen, Scott (Commerce)	202-482-2708/2-4420
Eisenbrey, Ross (Labor)	202-219-6141/5120 Fax
Elliot, Warren	202-861-1375
Ellwood, David	202-690-7858
Epstein, Arnie	202-456-2696
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Falk, Scott (BNA)	202-728-5241
Fariello, Dr.	703-415-0505
Feder, Judy	202-690-7858/7383 fax
Feighan, Ed	216-447-9000
Ferguson, Christy (Chafee)	202-224-6117/2853 fax
Finan, Steve (Labor)	202-219-6001
Finigan, Thomas (Baucus)	202-224-2651
Firshein, Janet (Med & Health)	202-822-1256
Fiske, Mary Beth (Kennedy)	202-224-7675
Flanders, Don (Adelphi)	516-877-3224
Flemming, Arthur	202-624-9552
Foote, Susan (Durenberger)	202-224-4055/9931 fax
Foreman, Ira (OPM Cong Affairs)	202-606-1300/1344 Fax
Forster, Theresa (Aging)	202-224-5364/6018/9926 f
Forsgren, Janet (OMB)	202-395-3925/6148 fax
Frantz, Molly (Pomeroy)	202-225-2611
Fried, Bruce	202-662-3744
Furman, Jim (United Seniors)	202-393-6222
Furst, Kurt (Searle)	202-842-0706
Gale, Joe (Moynihan)	202-224-4515
Gampel, Gwen	202-544-6264
Garamendi, John (CA Ins Comm)	916-955-2353 ?
Caudette, Sylvia (Olver)	202-225-5335
Gaus, Clif	202-401-7736
Gebbie, Kristine	202-632-1090/1096 fax
Gehan, Margery (Mike Andrews)	202-225-7508
Glaze, Steve (Pryor)	202-224-7827
Gobel, Herschel	202-535-8623
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Goldberg, Jason (Cab. Affairs)	202-456-2572/6704
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Goldstein, Naomi	202-690-7858
Goldstein, Steve (Phil Inquirer)	202-383-6048
Goldwater, David (Bilbray)	202-225-5965
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Gordon, Greg (Minn Star-Trib)	202-457-5171
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Greenstein, Bob	202-408-1080
Grever, Kim	
Gross, Lauren (Pell)	202-224-4673
Grote, Sara	202-456-2922/7560/2317 f
Grunwald, Mandy	202-973-9400
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Harahan, Mary	202-690-6613
Harbage, Peter	

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Hart, John	202-456-2896
Hash, Mike (Waxman)	202-225-4954
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Hoffman, Alan	202-690-6786
Hogue, Bonnie (Aging)	202-224-5364
Honig, Judy	703-902-5225
Hopper, Julie	202-456-7561/7560/2317 f
Horvath, Jane (Finance)	202-224-4515/8-5568 fax
Hosto, Lester	501-324-9200
Howard, Ed (Alliance for HR)	202-466-5626
Huckaby, Michelle (Clement)	202-225-4311
Human, Jeff	301-443-0835
Hunter, Nan (HHS Dep Gen Couns)	202-690-7780
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Ickes, Harold	202-456-2459
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Iskowitz, Michael (Labor&HR)	202-224-6572
Jennings, Chris	
Jennings, Lucile	
Jennings, Tom	703-836-7442
Jodrey, Darrel (Wofford)	202-224-7760
Johnson, Don	202-690-
Johnson, Haynes	202-298-6099 fax
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Jorling, Jim	202-408-7131
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Lux, Mike	202-456-2930/2976
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Miller, Meredith	202-219-8233
Min, Nancy Ann	202-395-5178
Mindy (Boren)	202-224-0152
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Moe, Kari (Wellstone)	202-224-8447/5641
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Montgomery, Bob	614-297-5889
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Moore, Walter (Genentech)	202-296-7272/7290 fax
Mossinghoff, Gerald (Pat)	202-835-3420
Murguia, Janet (Slattery)	202-225-6601/1445 fax
Muse, Don (Radiopharm Ind)	202-737-0100
Nader, Ralph	202-387-8030
Navarro, Vicente	410-955-3280
Nelson, Karen	202-225-0130/7090 fax
Nelson, Trish	202-898-4746
Neuberger, Neal (CtrPubServComm)	703-528-0801/0802 fax
Neuman, Tricia (W&M)	202-225-7785
Nexon, David (Kennedy)	202-224-7675/3533/5400
Nix, Sheila (Kerrey)	202-224-0295
Norrell, Judy	202-429-6543/833-2055 fax
Obey, Craig (Conrad)	202-224-2519/7776 fax
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O'Donnell, Laurence (Finance)	202-224-7800/8-5568 fax
Offner, Paul (Finance)	202-224-4515/9293 fax
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	Private fax 6351
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Potetz, Lisa (W&M)	202-225-7785/0111 fax
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Ricchetti, Steve	202-456-7054/2604 fax
Richardson, Sally	410-966-3870 Rm 200 E HiRise, 6325 Security Blvd, Balt, MD 21207

P6/b(6)

P6/b(6)

Richardson, Mary Ann (Labor)	202-219-6141/5120 fax
Rios, Elena	916-654-2827
Rissler, Pat (Ed & Labor)	202-225-4527/9070 fax
Rivlin, Alice	202- -4742
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Rosen, Bob (Mitchell)	202-224-5344/3840/2151
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Scheppach, Ray (NGA)	202-624-5320/5313 fax
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Shaffer, Ellen (Wellstone)	202-224-8446/8438 fax
Donna Shalala - Scheduling	202-690-6610 Virginia
Shearer, Gail (Consumers Union)	202-482-6262/265-9548 fa
Shriber, Donald (En&Comm)	202-225-3147/2525 fax
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Starr, Paul	609-258-4533
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Stout, Hilary (WSJ)	202-862-9233
Stram, Kenneth (SBA Leg Affairs)	202-205-67007374 fax
Sunderhauf, Steve	
Swedin, Kris (SBA Leg Affairs)	202-205-6700/7374 fax
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Terry, Donald (LaFalce)	202-225-3231
Testoni, Maureen (Baucus)	202-224-9317/8-3687 fax
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Thorpe, Ken (Joyce Marshall)	202-690-6870/401-7321 f
Thurm, Kevin	202-690-6133
Thursz, Daniel (Nat Coun on Aging)	202-479-6601/1200/0735 f
Tilley, Kim	202-456-2131/7845
Tilson, Hugh	202-690-6250/401-7321 fa
Toder, Eric	202-622-0120
Toohey, Megan	202-690-7858/7383 fax
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Turk, Barbara (NYC OMB)	212-788-5894
Tyson, Laura (Alice Wms, Sched)	202- -5042
Uhlman, Marian	215-854-2473
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Varma, Vivek (Synar)	202-225-2701/2796 fax
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Velasquez, Joe	202-456-6257
Veloz, Richard	202-456-2302/401-5193
Verveer, Melanne	202-456-6266
Vladeck, Bruce (Rena)	202-690-6726/6262 fax
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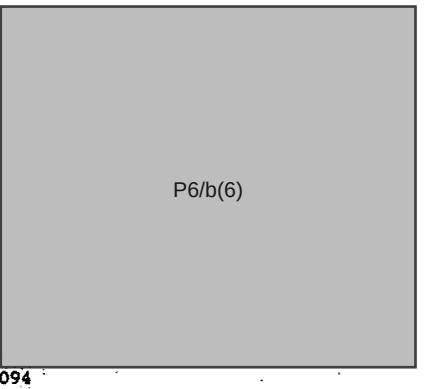
Waspe, Rob (NACDS)	703-549-3001
Weinstein, Naomi	718-519-2722
Weiss, Gail (PO&CivServ)	202-225-4054
Weiss, Marina	202-622-0090/2633 fax
Werner, Michael	202-393-1650
Westmoreland, Tim (Waxman)	202-225-4952/3043 fax

P6/b(6)

Whang, Judy	202-690-6797/490-0771 bp
Whedin, Chris	202-205-6700
White House Social Office	202-456-7136
Wilkins, Amy (DNC HC)	202-863-7184
Williams, Chris (Mitchell)	202-224-5344/1946 fax
Women's Information Network	202-467-5992
Woo, Michael (En&Comm)	202-225-3147/4014/2525 f
Wood, Susan (Cong Women Caucus)	202-225-6740
Yager, Marilyn	202-456-2930/6683
Yale, Ken	202-638-3535x242
Yamamoto, Cora	202-224-7470
Zelman, Walter	202-456-2449
Zettler, Susan (Strickland)	202-225-5705
Ziegler, Ron (NACDS)	703-549-3001
Zubkoff, Jordana (NACDS)	703-549-3001
Zuckerman, Diana (Vets)	202-224-9126
Ira Magaziner	H 537-8220 CAR 202-494-9094
John Hilley	804-253-8220 OR 804-253-8259



- Clark B re 10/5 – 2/1
- Biogenerics
- Project – David C
- $30 B re allowance change
- Talk about this re 5 – 10 → / outsourcing
- Ed Lopez – Finance → Glen A
- Number count re models for finance
- Need Mitchell ASAP – model – Ec. Money Assn / Gov. model
- Brandon