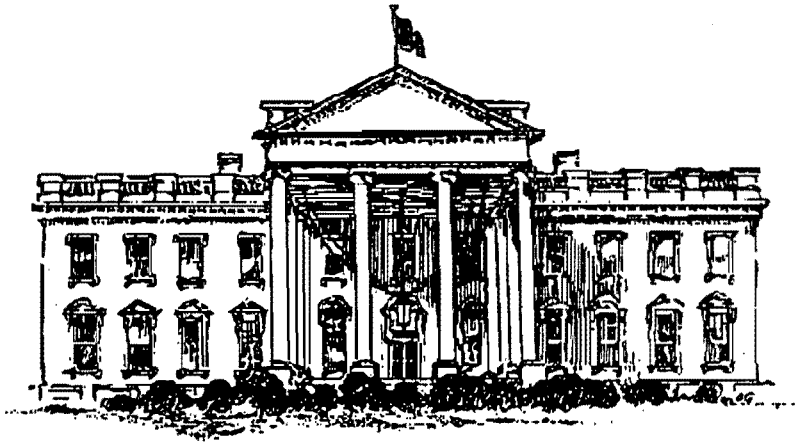


THE WHITE HOUSE

To: Jennings, Chris Date: 6-8-94

From: Jason Goldberg Page 1 of 3

CABINET HEALTH LINE

June 8, 1994

The 'Nation's Newspaper' Stands Up For Universal Coverage

- The editors of *USA TODAY* write today. "Don't compromise on universal health coverage: Congress could bargain itself right out of covering the people who need it most."

- *USA Today* aptly acknowledges that millions of middle class Americans will be bargained out of health security if the Congressional Committees choose to promote plans that do not include universal coverage.

- "Our health-care system is a costly mess, and only universal coverage can put it right."

More Than 1,000 Groups and Businesses Endorse Employer-Based Health Care Reform

- Today, more than 1,000 organizations and businesses across the country formally endorsed an employer-based approach to health care reform. Groups and businesses, representing over 93 million Americans, signed a letter to Congress calling for comprehensive health care reform and supporting guaranteed coverage through the workplace as the best approach.

- The letter, sent to Senator Mitchell by the Health Care Reform Project, says, "We believe than an employer mandate is a fair, effective and practical means for achieving universal coverage. We therefore urge its adoption."

- Senator Mitchell said of the endorsements "What this letter shows is that the political clout of the forces supporting comprehensive reform is formidable. These forces, representing over 93 million Americans -- 155 times the membership of the NFIB -- are standing up to let their voices be heard in this debate."

Employer Premium Payments

		2000
TOTAL		
All Firms	Baseline	324,023
	Reform	304,072
Currently Offering	Baseline	324,023
	Reform	270,156
Less than 10		
All Firms	Baseline	19,830
	Reform	22,856
Currently Offering	Baseline	19,830
	Reform	14,050
10 - 15		
All Firms	Baseline	18,799
	Reform	24,254
Currently Offering	Baseline	18,799
	Reform	14,825
25 - 99		
All Firms	Baseline	34,798
	Reform	36,908
Currently Offering	Baseline	34,798
	Reform	31,534
100 - 499		
All Firms	Baseline	52,843
	Reform	47,069
Currently Offering	Baseline	52,843
	Reform	44,336
500 - 999		
All Firms	Baseline	23,962
	Reform	19,865
Currently Offering	Baseline	23,962
	Reform	18,983
1,000 - 4,999		
All Firms	Baseline	91,513
	Reform	77,601
Currently Offering	Baseline	91,513
	Reform	74,766

CBO Premiums, Big Firms Out
Model 139
6-June-1994

HIGHLIGHTS FROM THE NBC POLL

Attached are selected results from the NBC survey on health care and other issues. Data do no include "don't knows"; questions are abreviated.

Universal Coverage

Insurance Reform vs. Universal Coverage
[two statements read, one describing insurance reform, one describing universal coverage]

Prefer universal coverage:	57%
Prefer insurance reform:	34%

Most Important Reason for Reform

To cover those with inadequate or no insurance now:	41%
To reduce and hold down costs	29%
To reduce costs and improve competitive edge for US business	11%
To improve quality of care	10%

Costs/Financing

Best Way to Pay for Health Care

First choice:

cost controls, such as premium caps and limits on doctor fees:	62%
requiring most employers to contribute	19%
broad based taxes	10%

First and second choices combined:

cost controls:	80%
employer contributions	63%
taxes	31%

Cost Expectations

Expect costs to increase	56%
Costs will stay the same	26%
Costs will decrease	14%

Quality of Care

If the President and Congress pass a health care bill, do you think availability of health care services will:

Increase	30%
Stay about the same	35%
Decrease	32%

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.

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

PHONE: (202) 690-7450 *FAX: (202) 690-8425*

TO: Chris Jennings / Judy Mohr *FROM:* Bridgett Taylor

NAME: *NAME:*

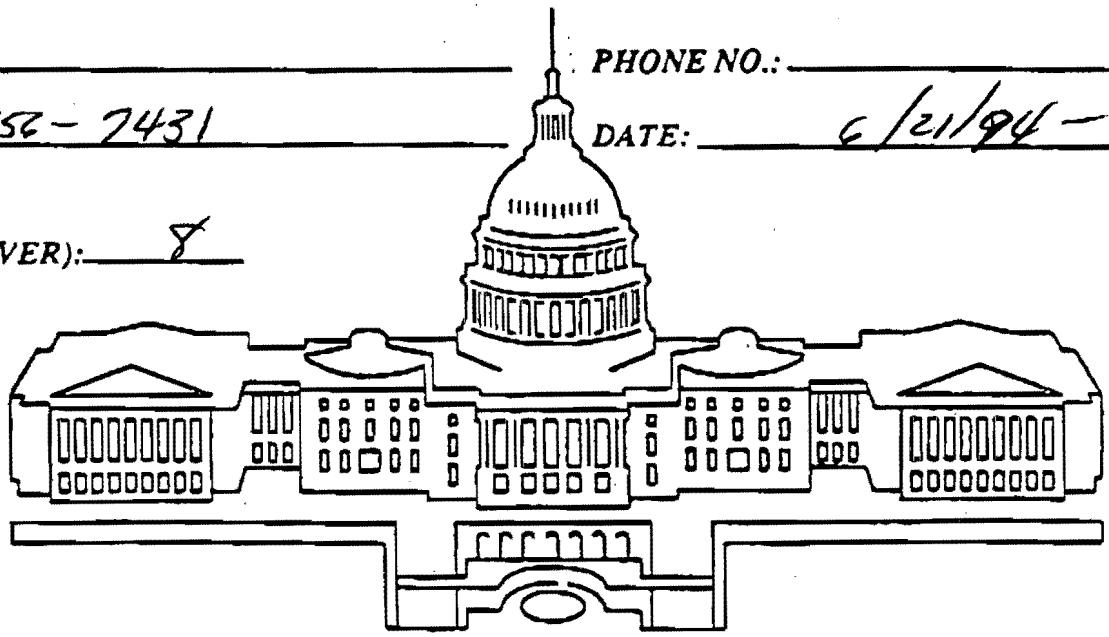
OFFICE: *OFFICE:*

ROOM NO.: *ROOM NO.:*

PHONE NO.: *PHONE NO.:*

FAX NO.: 456-7431 *DATE:* 6/21/94

TOTAL PAGES (INCLUDING COVER): 8



REMARKS:

There are 2 requests here!

TECHNICAL ASSISTANCE REQUEST SHEET

NAME: BRIDGET TAYLOR

DATE: 6/21/94

PRIORITY:

SAME OR NEXT DAY: _____ WITHIN 2 WEEKS: _____
2 TO 3 DAYS: X OTHER: _____
WITHIN 1 WEEK: _____

REQUIST FROM: KATHY KING

COMMITTEE: SENATE FINANCE

PHONE: 224-4515 FAX: 228-5568

REQUEST: IN A MEETING WE HAD LAST WEEK W/ K. KING SHE ASKED FOR HCFA TO PUT TOGETHER INFORMATION ON HOW THE MEDICARE PART B REDUCTIONS (SPECIFICALLY MANDATORY ASSIGNMENT) WOULD IMPACT DME UPGRADES. ATTACHED IS HCFA'S RESPONSE

ASSIGNMENT:

TO: HCFA

DATE: 6/15/94

DUE DATE: 6/20/94

STATUS:

ASSIGNED _____ OMB REVIEW _____ COMPLETED _____

NOTE: _____

June 21, 1994

NOTE TO: Chris Jennings
Judy Whang

FROM: Bridgett Taylor

SUBJECT: Request from Kathy King

Attached is HCFA's response to a request from Kathy King regarding the Medicare Part B reductions in the Health Security Act. Kathy would like to include some of the reductions in the Senate Finance Committee Chairman's mark, but she was concerned about how the mandatory assignment provision would impact DME upgrades for Medicare beneficiaries. She asked HCFA to put together a method for how this would work. Attached is HCFA's response.

Could we get clearance on this by COB Wednesday, June 22?

If you have any questions please call.

Thanks.

cc: Karen Pollitz
Jerry Klepner

MANDATORY ASSIGNMENT AND DME UPGRADES

Issue: If suppliers are required to accept assignment under health care reform, how would a Medicare beneficiary purchase an upgraded item of DME (e.g., a luxury wheelchair) where Medicare coverage would normally be available only for the standard item?

Background: Under current law, if a beneficiary wants an upgraded item of equipment, this transaction can occur only on an unassigned basis. A nonparticipating supplier submits an unassigned claim for that purchase and bills the beneficiary the difference between the Medicare-approved amount for the standard item and the charge for the upgraded item. We have not supported allowing any payment exceptions for upgraded items on assigned claims because we have wanted to maintain the integrity of the term "assignment" where the only liability to the beneficiary is coinsurance and deductible.

Under health care reform, however, mandatory assignment may be required for items and services furnished to Medicare beneficiaries. A supplier would be required to accept the Medicare payment amount as payment in full and could charge a beneficiary only for deductible and coinsurance amounts.

There will certainly be instances where Medicare beneficiaries may choose to purchase an item with more features than are covered by Medicare. The following are examples:

- A beneficiary wants to purchase a light-weight top-of-the line wheelchair with an elevating legrest where Medicare has determined that a standard wheelchair meets the beneficiary's needs.

- A beneficiary wants to purchase accessories on a wheelchair that are not covered by Medicare for his condition.

- A beneficiary wants to purchase an electric hospital bed where Medicare covers only a standard hospital bed for his specific condition.

Option for Allowing Upgrades Under Mandatory Assignment:

Since the current upgrade process is based on the ability to file unassigned claims, a new approach becomes necessary in a world of mandatory assignment. Beneficiaries should have access to the type of equipment that they want for purposes of their convenience if they are willing to pay for the portion that Medicare does not pay. The following basic policy would establish a process for allowing exceptions to the mandatory assignment rules:

- Upgrades - If a beneficiary wishes to substitute an item that performs essentially the same function as a Medicare covered item but which has additional features that Medicare does not consider to be medically necessary for the beneficiary's condition, Medicare shall pay the fee schedule amount for the covered item. The supplier may charge the beneficiary for deductible and coinsurance amounts for the portion of the item covered by Medicare and for the difference between the fee schedule amount for the covered item and the charge (see below) for the more costly version purchased by the beneficiary.

- Charge Limits - The following limits would be established to assure that beneficiaries are not charged excessively for upgraded items:

  -- If a fee schedule amount exists for the upgraded item, the supplier could charge the beneficiary (in addition to deductible and coinsurance amounts) only the difference between the fee schedule amount for the covered item and the fee schedule amount for the upgraded item.

  -- If a fee schedule amount did not exist for the upgraded item, there would be no limit.

- Supplier Standard on Availability of Covered Item - In order to receive a supplier number and receive Medicare payments, suppliers that offer upgrades would be required to certify that they have the standard Medicare-covered item available and have given the beneficiary the choice of renting/ purchasing this item.

- Disclosure of Information to Beneficiaries - For every upgraded item purchased or rented, the beneficiary and supplier would be required to enter into a written agreement prescribed by the Secretary. This agreement would state that:
  - the beneficiary understands that he is voluntarily purchasing or renting the upgraded equipment and was not coerced into purchasing or renting it.
  - the supplier has the standard item available and has given the beneficiary the choice of purchasing this item.
  - the supplier has given the beneficiary an itemized summary of charges payable by him.
  - the beneficiary understands that he is responsible for the difference between the Medicare fee schedule for the covered item and the charge for the upgraded item.

- Sunset of Provision - This change to allow suppliers to bill the beneficiary for upgrades would initially be established for four years. Prior to the end of the four year period, the Secretary would be required to evaluate the provision to determine whether beneficiaries are being treated equitably and whether abuses are occurring.

TECHNICAL ASSISTANCE REQUEST SHEET

NAME: Bridget Taylor

DATE: 6/21/94

PRIORITY:

SAME OR NEXT DAY: _____
2 TO 3 DAYS: X
WITHIN 1 WEEK: _____
WITHIN 2 WEEKS: _____
OTHER: _____

REQUEST FROM: Jane Horvath

COMMITTEE: Senate Finance Committee

PHONE: 224-4515 FAX: 228-5568

REQUEST: See attached

ASSIGNMENT:

TO: Don Johnson (HCFA)

DATE: 6/21/94

DUE DATE: _____

STATUS:

ASSIGNED _____ OMB REVIEW _____ COMPLETED _____

NOTE: _____

June 21, 1994

NOTE TO: Chris Jennings
Ken Thorpe
Judy Whang

FROM: Bridgett Taylor

SUBJECT: Request from Jane Horvath

Jane Horvath has asked if HCFA could provide an estimate on a State-by-State basis of the impact of the current Medicaid dollars (1993 or most recent data) of separating the AFDC cash recipients and all non-cash eligibles from the SSI and dual-eligibles (if possible) for acute care services using the best data available (HCFA 2082 or OAct data base). Don Johnson is working on this, but I am also notifying Ken Thorpe.

Once we get the document I will sent over to you for clearance.

If you have any questions please call.

Thanks.

cc: Karen Pollitz
Jerry Klepner

State Maintenance of Effort under the Health Security Act, Year 2000

	MOE 2000 (1) ($ millions)	Population 2000 (2) (thousands)	MOE Per Capita 2000	Index to US 2000
UNITED STATES	23,400	276,241	$85	1.00
Alabama	171	4,485	$38	0.45
Alaska	69	699	$99	1.17
Arizona	449	4,437	$101	1.19
Arkansas	101	2,578	$39	0.46
California	3,946	34,888	$113	1.34
Colorado	201	4,059	$49	0.58
Connecticut	537	3,271	$164	1.94
Delaware	33	759	$43	0.51
District of Colum	142	537	$264	3.11
Florida	884	15,313	$58	0.68
Georgia	408	7,637	$53	0.63
Hawaii	98	1,327	$74	0.87
Idaho	53	1,290	$41	0.48
Illinois	857	12,168	$70	0.83
Indiana	427	6,045	$71	0.83
Iowa	115	2,930	$39	0.46
Kansas	149	2,722	$55	0.64
Kentucky	186	3,989	$47	0.55
Louisiana	445	4,478	$99	1.17
Maine	118	1,240	$95	1.12
Maryland	486	5,322	$91	1.08
Massachusetts	638	5,950	$107	1.26
Michigan	629	9,759	$64	0.76
Minnesota	256	4,824	$53	0.63
Mississippi	98	2,750	$36	0.42
Missouri	618	5,437	$114	1.34
Montana	28	920	$30	0.36
Nebraska	85	1,704	$50	0.59
Nevada	146	1,691	$86	1.02
New Hampshire	54	1,165	$46	0.54
New Jersey	657	8,135	$81	0.95
New Mexico	43	1,823	$23	0.28
New York	3,656	18,237	$200	2.37
North Carolina	523	7,617	$69	0.81
North Dakota	20	643	$31	0.36
Ohio	950	11,453	$83	0.98
Oklahoma	160	3,382	$47	0.56
Oregon	124	3,404	$36	0.43
Pennsylvania	882	12,296	$72	0.85
Rhode Island	85	998	$85	1.01
South Carolina	268	3,932	$68	0.81
South Dakota	20	770	$26	0.31
Tennessee	465	5,538	$84	0.99
Texas	1,321	20,039	$66	0.78
Utah	71	2,148	$33	0.39
Vermont	30	592	$50	0.59
Virginia	427	7,048	$61	0.71
Washington	297	6,070	$49	0.58
West Virginia	110	1,840	$60	0.71
Wisconsin	148	5,381	$27	0.32
Wyoming	18	522	$34	0.41

(1) HCFA OAct; ASPE; NOTE: State estimates do not sum to U.S. total due to rounding.
(2) CPS State Population Projections (Series A).

MEDICARE WORKERS

POLICY

Under the Health Security Act, all Medicare beneficiaries who work, or whose spouses work, at least 40 hours per month for two consecutive months during the year, receive their health insurance coverage through the Alliance. Their employers contribute toward their health insurance just as they would for non-Medicare employees. Employers are responsible for the standard employer share of the alliance premium (80 percent for full-time, full-year workers). Beneficiaries are responsible for the remaining 20 percent of the premium.

For part-time eligible workers, Medicare fills in the remainder of the pro-rata employer share of the premium. If a beneficiary stops working during the year, Medicare will pay the full employer share of the premium for the remainder of the calendar year.

In addition to the Medicare worker's alliance-based coverage, the Medicare program will make wrap-around, or secondary, payments toward working beneficiaries' deductibles and coinsurance. Medicare will automatically fill in for Part A cost-sharing and will also pay the Part B deductible and coinsurance for beneficiaries who choose to enroll in Part B.

MEDICARE SAVINGS

Under current policy, employers who offer insurance to their workers must offer insurance to their Medicare beneficiaries as well. Beneficiaries may choose whether or not to accept that coverage. About 2.2 million beneficiaries currently do so.

Under the HSA, all eligible workers, or spouses of workers, must receive primary coverage through the Alliances. An additional 3.2 million Medicare beneficiaries are estimated to receive primary coverage in the Alliance as full, part-time, or part-year workers.

Medicare saves an estimated $25 billion over 5 years because for full-time workers, the wrap-around or secondary payments it pays are less than primary payments; and for part-time or part-year workers, the Medicare share of the community-rated premium plus the wrap-around payments are less than the primary payment.

Beneficiaries also save because 20% of a community-rated premium is less than their average Medicare cost-sharing.

EFFECT OF AGE RATING

If premiums are age-rated, the cost to Medicare for its share of the premium for part-time or part-year workers increases accordingly. ARC estimates this at 10% of the savings, $1.6 B. between 1996-2004.
The cost to all Medicare beneficiaries also increases for their 20% share of the premium.

To: Jean
Fr: Suzanne Calzoncit, 224-5117
Re: Early retiree -- state and local

Amendment to S. 1757/Kennedy Mark

SECTION 6114. SPECIAL TREATMENT OF CERTAIN RETIREES AND QUALIFIED SPOUSES AND CHILDREN

(b)(3) would be eligible (under section 226(a) of the Social Security Act) for hospital insurance benefits under part A of title XVIII of such Act if the individual were 65 years of age based only on the employment of the individual, or has completed 40 quarters of employment through a state and local government, and

or

David / Suzanne:

We don't believe this should have a significant cost impact

Chu J.

DRAFT

SOME ISSUES THAT WOULD NEED TO BE ADDRESSED WITHOUT A PER WORKER PREMIUM

1. Can a family with two workers choose to obtain coverage (and payment) through either employer?

   If so, there may be a subsidy increase due to families choosing to obtain coverage through the employer of the lower wage spouse. If the family does not have a choose (e.g. the family must get coverage through the higher earner), an enforcement mechanism must be developed.

2. What is the administrative mechanism for verifying that a family with multiple employers signed up with one of the employers? How does the "non-selected" employer know it does not have to pay anything?

3. How is coverage for part-time workers handled (particularly part-time workers with multiple jobs)?

4. What happens when someone changes jobs? Do they have to switch plans? How long do they have before they have to switch plans? How is this all enforced?

5. What happens with someone who is self-employed and has a working spouse? (Note: Losing payments by the self-employed would increase federal subsidy costs.)

6. How much do non-workers have to pay? Do they only get credit for payments actually made by an employer? (Note: This could lead to some inequities. For example, a family where one spouse works for the first six months of the year and another spouse works for the second six months of the year would not have to pay anything beyond the 20% share. However, a family where both spouses worked for six months simultaneously would have to pay the 80% share of the premium for the other six months. Also note that subsidizing non-workers based on a full actuarial premium rather than a per worker premium would likely increase subsidies.)

7. For small employers, in particular, this structure could produce large changes in premium payments from year to year or even month to month. Is this acceptable?

8. Would you let families with two working spouses split coverage between both employers? Would one employer pay for a single and the other for a single parent family?

NEW YORK STATE
SAVINGS UNDER HEALTH SECURITY ACT

New York State will save $8.6 billion in public health care spending between 1996 and 2000.

CHANGE IN SPENDING UNDER HEALTH SECURITY ACT
$BB

	1996	1997	1998	1999	2000	TOTAL (1996–2000)
Acute Care Medicaid	NA	0.5	(1.3)	(2.5)	(3.3)	(6.6)
LTC Savings	(0.2)	(0.3)	(0.4)	(0.5)	(0.6)	(2.0)
State employee health care spending	NA	NA	NA	NA	(0.07)	(0.07)
TOTAL PUBLIC SAVINGS	**(0.2)**	**0.2**	**(1.7)**	**(3.0)**	**(4.0)**	**(8.6)**

* In addition, the private sector will save $4.9 billion in lower premiums in FY 2000 alone. (Earlier years are not available.)

KINGS COUNTY HOSPITAL
BENEFITS UNDER THE HEALTH SECURITY ACT

1) **Stable and increased funding from universal coverage and blended Medicaid rates**

Under reform, reimbursement will be assured and constant as a result of the provision of coverage for the area's high numbers of uninsured and the fact that reimbursement will be the same for Medicaid patients as it is for the rest of the insured.

2) **Increased funds for research and teaching**

Under reform, the new all-payer GME and the AHC pools will ensure that Kings County receives direct payments to fund important teaching and research activities; very little direct funding is currently available to this facility now since it serves a disproportionately low number of Medicare and insured populations -- the primary source of residency support funding.

3) **New payment streams to better attract physicians**

Under reform, the patient population will be covered with private insurance and physicians will be able to bill directly for services. Direct billing will enable Kings County to attract physicians, something that this facility has had extreme difficulty in doing previously and in the future should the status quo continue.

4) **Guarantee that insurers will not discriminate against institutions disproportionately serving the poor**

It is a practical certainty that Kings County will be designated as an Essential Community Provider under HSA, which will require insurers to contract with providers in medically underserved areas. This provision will ensure that providers who have traditionally served the underserved are not discriminated against by insurers and will assure a payment stream from patients.

5) **Targeted funding for facilities that have and will continue to serve difficult to treat populations**

The Health Security Act provides for a payment stream -- known as a Voluntary Payment Adjustment -- for those facilities that have traditionally served the uninsured, including those institutions that serve large numbers of undocumented residents.

Responses to Important Concerns Likely to Be Raised by Kings County:

1) **Reducing the number of residents.** The Health Security Act proposes to limit the proportion of residencies to a certain percentage of U.S. medical school graduates (our bill does not give a specific percentage; both Rockefeller and Cooper propose limiting the number of residencies to 110% of U.S. medical school graduates). Kings County has a very high proportion of residents/ patients and they have a huge number of foreign medical school graduates.

Response:

1) They will be able to reduce the resident/patient ratio as they substitute physicians for residents since physicians will be able to direct bill under universal coverage.

2) They won't have to rely so heavily on expensive supervising MDs from affiliated medical centers to supervise their residents.

2) **Access to capital.** Because many of their health facilities are in such poor shape, many New York hospitals -- obviously including Kings County -- are in need of a great deal of capital improvement. They are concerned that funds will be even more difficult to attract as health care growth is constrained.

Response:

The city of New York will achieve substantial savings under health reform and monies as monies that currently pay for the uninsured and other services that will be covered under the benefits package. At least some of these savings could be redirected toward capital investment.

3) **Opinion on the Kings County Renovation Crisis and Relevance to Health Reform.**

Response:

Although you do not know enough to make an informed comment about the Kings County situation, facilities like Kings County will do well under reform. Coverage of the uninsured, increased funds for research and teaching, and dedicated funding streams for underserved populations are just three reasons why this is the case. (You may also want to talk about the impact of violence on the costs and demands on these facilities, and a discussion of why it is so important to pass a workable crime bill -- Moynihan should like this.)

1½ reduction = $12 Billion savings

TO: Jack Lew
FROM: Jennifer Klein
DATE: 5/11/94

Benefit Savings Options for Energy and Commerce

- $1,500/3,000 to $2,500/3,000 and $250 per hospital admission and $10 prescription drug copayment in lower cost sharing = 5% reduction in premium.

Additional Benefit Savings Options

- Prescription drug changes

  - .2 to .4 in higher cost sharing and $10 to $13 in lower cost sharing = 1% reduction in premium. (HMO)

  - .2 to .4 in higher cost sharing and leave $10 in lower cost sharing = .5% reduction in premium. (HMO)

  - .2 to .6 in higher cost sharing and $10 to $16 in lower cost sharing = 2% reduction. Raising coinsurance to .5 in higher cost sharing is not sufficient.

  NOTE: These reductions may be added to the 5% reduction described above.

  BUT: We are continuing to look at the impact of thses changes on cost sharing subsidies.

  Changing HMO cost sharing to coinsurance has no useful effect. A $5 copayment is roughly equivalent to 20% coinsurance and a $10 copayment is roughly equivalent to 40% coinsurance.

- Dental changes

  Eliminate dental for children and cover Medicaid-eligible children or children under 150% of poverty in Medicaid wrap-around program = 2% reduction.

  NOTE: These reductions may be added to the 5% reduction described above.

  BUT: This will increase federal costs as more people are shifted into the wrap-around program.

- Lower cost sharing changes

  A $250 per admission deductible is comparable to a $60 per day copayment without a limit on the number of days it will be paid or a $75 per day copayment with a limit

of 10 days (i.e., if hospital stay is longer than 10 days patient stops paying per day copayment).

Congressional Research Service • The Library of Congress • Washington, D.C. 20540

May 16, 1994

TO : Senate Labor and Human Resources Committee
Attention: David Nexon and Mary Beth Fiske

FROM : Michael J. O'Grady
Specialist in Social Legislation
Education and Public Welfare Division

SUBJECT : Varying the Benefits in the Health Security Act, S. 1757—Premium Effects

In response to our meeting and subsequent phone conversations I have prepared the following memorandum analyzing the effect of various benefit changes on health insurance premiums.

In the first stage of this analysis we used the Health Security Act, S. 1757, as a basis for comparing any changes in the benefit package. In conjunction with our consulting actuaries at Hay/Huggins Co., Inc., we then estimated the actuarial value of the benefits changes specified in Chairman Kennedy's mark dated May 11, 1994.

With the estimates of actuarial value, I have used the Census Bureau's March 1993 Current Population Survey (CPS) to model the distribution of the U.S. population[1] into the four types of coverage groups specified in S. 1757: self only, two adults, single-parent families and two-parent families.

Table 1 details the effect of the benefit changes on the four premium types specified in S.1757. The percentage change estimates are of the total premium and have been calculated for both the high and low cost sharing plans. It is unclear how the premium estimates under the combination plan would be effected, but given the hybrid nature of the combination plan we are comfortable with the assumption that the high and low cost sharing estimates provide a reasonable range of estimates for the combination plan. No assumptions have been made about how people might sort themselves into the different plans. It is assumed that the populations covered by the high and low cost sharing plans are demographically similar to the population overall.

[1]Except those people who primarily rely on Medicare for their health insurance.

Table 2 provides some details of our interpretation of the provisions. We have tried to put ourselves in the position of an insurer determining what benefits are covered, at what cost sharing. If in any of these provisions we have misinterpreted the intent please let us know.

There are a few areas where we are not yet able to make estimates of the effects of Chairman Kennedy's mark. Our work on the premium effects of your changes to the mental health coverage should be completed shortly.

The overall effect of the benefit changes specified in table 1 reduces premiums between 1.2 and 2.6 percent. Keep in mind, that we have only analyzed the changes specified in table 1 and other modifications could alter the overall result considerably.

The methodology and assumptions underlying the estimates have been coordinated with the Budget Analysis Division of the Congressional Budget Office to ensure that they are consistent with estimates you may receive from them later.

If you have any questions or we can be of further assistance, I can be reached at 7-7347.

TABLE 1. Percentage Change in Premiums for Expanded Benefits, Under Four Types of Coverage

Benefit	Individual		Couple		Single-parent family		Two-parent family	
	Low cost sharing	High cost sharing	Low cost sharing	High cost sharing	Low cost sharing	High cost sharing	Low cost sharing	High cost sharing
Clinton baseline	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
A) Clinical preventive services								
1) Tests	0.0%	0.0%	0.0%	0.0%	0.3%	0.4%	0.2%	0.3%
2) Clinician visits under age 20	0.0%	0.0%	0.0%	0.0%	0.3%	0.4%	0.2%	0.3%
B) Hearing aids for children	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%	0.0%	0.1%
C) Rehabilitation services extensions	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
D) Home health care and extended care facilities	0.6%	0.7%	0.6%	0.7%	0.6%	0.7%	0.6%	0.7%
E) Enhanced mammograms								
1) Ages 50-64 annually	0.6%	0.6%	0.6%	0.6%	0.3%	0.3%	0.3%	0.4%
2) Ages 40-49 biennually	0.3%	0.4%	0.3%	0.4%	0.2%	0.2%	0.2%	0.2%
F) Enhanced pap smears	0.2%	0.2%	0.2%	0.2%	0.1%	0.1%	0.1%	0.1%
G) Contraceptive drugs and prescription devices	0.0%	0.1%	0.0%	0.1%	0.0%	0.1%	0.0%	0.1%
H) Extended care annual limit	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
I) Medical foods (PKU, etc.)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
J) Outpatient drugs—accessories and supplies	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
K) Outpatient speech pathology and audiology services	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
L) Durable medical equipment—replacement	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
M) Vision care limitation to periodicity schedule	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

TABLE I. Percentage Change in Premiums for Expanded Benefits, Under Four Types of Coverage								
Benefit	Individual		Couple		Single-parent family		Two-parent family	
	Low cost sharing	High cost sharing	Low cost sharing	High cost sharing	Low cost sharing	High cost sharing	Low cost sharing	High cost sharing
N) Investigational treatments--discretion of plan	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
O) Extracontractual items and services	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
P) Hospital deductible of $250--low cost sharing plan	-1.6%	0.0%	-1.6%	0.0%	-1.5%	0.0%	-1.5%	0.0%
Q) Drug copayment of $10--low cost sharing plan	-2.0%	0.0%	-2.0%	0.0%	-1.9%	0.0%	-1.9%	0.0%
R) Individual max. out-of-pocket increased from $1,500 to $2,500--high cost sharing plan	0.0%	-4.9%	0.0%	-4.9%	0.0%	-4.7%	0.0%	-4.7%
Insurance units--in thousands* (total = 107,076)	51,503		17,220		11,419		26,933	
Population--in thousands* (total = 223,621)	51,503		34,522		31,954		105,641	
Percentage children	0.0%		0.0%		60.6%		46.6%	

*Except those people who primarily rely on Medicare for their health insurance.

Source: Actuarial value of benefit variations calculated uses CRS Health Benefits Model v. 5.3. Demographic adjusters developed from data provided by major insurers, the Office of Personnel Management and the Nation Medical Expenditures Survey. Insurance units and population data developed using the Census Bureau's March 1993 Current Population Survey.

TABLE 2. Modifications to the Health Security Act

Benefit	Proposed Benefit Changes
A. Enhanced Children's Preventive Services 1. Tests 2. Clinician visits under age 20	Modifications to S. 1757 that either increase or decrease the incidence of clinical preventive services.
B. Hearing Aids and Comprehensive Hearing Assessments for Children under 18	Benefit added to S. 1757 for children who have failed a hearing screening as originally covered by S. 1757.
C. Rehabilitation Services Extensions	S. 1757 benefits clarified include coverage for outpatient respiratory therapy, and audiology services for outpatient speech-language pathology services. Established a maintenance or prevention program to include the following services: 1. Rehab health professional to provide initial evaluation & periodic oversight of the patient. 2. Rehab health professional to design a maintenance or prevention program appropriate for the patient. 3. Instruct patient and family members on how program is to be implemented. 4. Periodic reevaluations (in addition to a reevaluation at the end of each 60 day period). The plan will not deny coverage for outpatient occupational therapy, outpatient physical therapy, outpatient respiratory therapy and outpatient speech language pathology services and audiology services as a result of a disorder or other health condition. (S. 1757 only provides coverage if condition is a result of an illness or injury.
D. Home Health Care and Extended Care Facilities Extensions	Extends the coverage clause under S. 1757 to include conditions that did not result from an illness or injury. Also extends the annual number of visits in ECF if the care is found to be a "cost-effective alternative to necessary inpatient hospitalization".
E. Enhanced Mammograms	Augments the benefit under S. 1757 for: • Age 50-64 to cover mammograms annually rather than biannually. • For 40-49 to cover mammograms biannually.
F. Enhanced Pap Smears	Benefit added to S. 1757 to cover pap smears annually unless individual has 3 years of negative pap smears and no risk factors for STDs or cervical cancer.
G. Contraceptive Drugs and Prescription Devices	Extends benefit to include coverage for contraceptives drugs and prescription devices.
H. Extended care annual limit	Provides for an annual limit of 100 days for extended care services, with conditions under which the limit can be waived.

TABLE 2. Modifications to the Health Security Act	
Benefit	Proposed Benefit Changes
I. Medical foods (PKU, *etc.*)	Medical foods prescribed by a physician are added to the outpatient prescription drugs and biologicals coverage.
J. Outpatient drugs accessories and supplies	Clarifies accessories and supplies typically covered under current health insurance policies. For example, syringes and glucose testing supplies for diabetics.
K. Outpatient speech pathology and audiology services	Under outpatient rehabilitation services, clarifies that outpatient speech language and audiology services are covered for the purpose of attaining or restoring speech.
L. Durable medical equipment–replacement	Clarifying language covering the replacement of durable medical equipment. Conforms with typical current insurance practices.
M. Vision care limitation to periodicity schedule	Allows the Board to establish the periodicity schedule for benefit.
N. Investigational treatments–discretion of plan	Allows the plan to cover an investigational treatment at it's discretion, as long as it's done based upon objective protocols and applied consistently.
O. Extracontractual items and services	Allows the plan discretion to use cost effective alternatives, as long as appropriate treatment is provided.
P. Hospital deductible of $250 - low cost sharing plan	Increase from $0 to $250
Q. Drug copayment of $10–low cost sharing plan	Increase copayment from $5 to $10
R. Individual maximum out-of-pocket increased from $1,500 to $2,500–high cost sharing plan	Increase individual maximum out-of-pocket liability from $1,500 to $2,500. Leave family liability at $3,000.

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May 17, 1994

TO : Senate Labor and Human Resources Committee
Attention: Ron Weich

FROM : Michael J. O'Grady
Specialist in Social Legislation
Education and Public Welfare Division

SUBJECT : **Varying the Mental Health Benefits in the Health Security Act, S. 1757--Premium Effects**

In response to our meeting and subsequent phone conversations this memorandum analyzes the effect of various changes in the mental health benefits on health insurance premiums.

In the first stage of this analysis we used the Health Security Act, S. 1757, as a basis for comparing any changes in the mental health benefit package. In conjunction with our consulting actuaries at Hay/Huggins Co., Inc., we then estimated the actuarial value of the benefits changes specified in Chairman Kennedy's mark dated May 11, 1994.

The mental health benefits changes specified in the Chairman's mark would increase premiums by 1.6 percent in the high cost sharing plan for all four types of coverage groups, self only, two adults, single-parent families and two-parent families. In making these estimates we used a $2,500 maximum out-of-pocket limit for individuals and $3,000 for families. Further we allowed the maximum out-of-pocket limits to apply to mental health charges for inpatient, residential, intensive nonresidential and outpatient services. The coinsurance used was 20 percent for all four types of service.

A less costly alternative would be to use the cost sharing provisions specified in S. 1757 for outpatient psychotherapy--i.e., require a payment of 50 percent coinsurance. This modification increases premiums by only 0.1 percent in the high cost sharing plan for all four types of coverage groups.

If, in conjunction with the modification in the cost sharing provisions for outpatient psychotherapy, a further modification were made to strengthen the language regarding managed care, there would be no premium increase over S. 1757. Language that would require and specifically define quality managed care, rather than leaving it to the discretion of the plan would be sufficient for this purpose.

It is our understanding that these modifications to the outpatient cost sharing and managed care provisions are consistent with later versions of the Chairman's mark. With the modifications as specified, CRS estimates no premium increase for mental health benefits compared to S. 1757, the Health Security Act.

The methodology and assumptions underlying the estimates have been coordinated with the Budget Analysis Division of the Congressional Budget Office to ensure that they are consistent with estimates you may receive from them later.

If you have any questions or if we can be of further assistance, I can be reached at 7-7347.

Health Care Schedule

JUNE 20 - JUNE 26

Day/Dept	Scheduling		Press Office	Public Liaison	Paper/Research [incl. data book]	Congressional/ Intergovernmental	Misc.
	Principals	*Cabinet, Surrogates*					
Monday 6/20		Panetta Speech					
Tuesday 6/21							-BRT -NBC special
Wed. 6/22	HRC: DPC breakfast		GMA proposal		Letter writers bkgd		
Thursday 6/23	HRC/HealthRight	Business Breakfast					Rock the Vote survey
Friday 6/24	Working Group Meeting	Working Group Meeting		OK opinion leaders			OPL/Leg./Cab meeting re:schedule?
Weekend 6/25-6/26							
Misc./ Questions			Sperling breakfast? Economic pundit pairings		-Uwe op ed -Bentsen or Rubin op ed -Ed boards [Panetta/Altman, Rubin/Sperling]	Metzenbaum on HIAA?	

Health Care Schedule

JUNE 27 - JULY 2

Day/Dept	**Scheduling**		**Press Office**	**Public Liaison**	**Paper/Research** [incl. data book]	**Congressional/ Intergovernmental**	**Misc.**
	Principals	*Cabinet, Surrogates*					
Monday 6/27	POTUS Academic Health Centers	Bowles/Families small business study		Bowles/Families small business study			
Tuesday 6/28	HRC D.C. Economic Club VP opinion leaders			VP Opinion Leaders RI	Recess Paper Due		
Wed. 6/29	HRC opinion leaders HRC Disease Groups Event	Shalala Choice/provider press conference and White Paper		HRC Opinion Leaders OR Provider/choice press conference [national and local]			
Thursday 6/30	HRC Small business coalition HRC press rdtble? VP Opinion Leaders		HRC rdtble	VP Opinion Leaders ND Provider/choice press conferences [local]			
Friday 7/1	Cabinet meeting?	Cabinet meeting?					
Weekend 7/2-7/3							
Misc./ Questions	HRC with Gephardt swings			Recess planning	Recess planning	Recess planning	Recess planning

To Chris

Date 6/24 Time 9:39

WHILE YOU WERE OUT

M Theresa Albergeen

of Sen Feehy

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Attendees for Monday, June 27 Academic Medicine Event

Bobby Ray Alford, MD
Baylor College of Medicine
One Baylor Plaza
Houston, TX 77030
Phone: 713/798-4846
Fax: 713/790-0055

Carol Ann Aschenbrener, MD
Chancellor
University of Nebraska Medical Center
42nd & Dewey Avenue
Omaha, NE 62198
Phone: 402/559-4200
Fax: 402/559-4396

Mr. Steven D. Baron, President
The Miriam Hospital
164 Summit Avenue
Providence, RI 02906
Fax: 401/331-8505

Ms. Jane T. Barry
VP Network Devel. & Community Affairs
The University Hospital
88 E. Newton Street
Boston, MA 02118
Fax: 617/638-6905

Harry Nelson Beaty, MD
Dean
Northwestern University Medical School
303 East Chicago Avenue
Chicago, Ill 60611-3008
Phone: 312/503-8649
Fax:

Stanley Silver Bergen, Jr., MD
President
UMDNJ-New Jersey Medical School
185 South Orange Avenue
Newark, NJ 07103-2714
Phone: 201/982-4300
Fax: 201/982-7104

Ms. Theresa Bischoff
Exacutive Vice President
NYU Medical Center
560 First Avenue
New York, NY 10016
Fax: 212/545-8846

Giles G. Bole, MD
Dean
University of Michigan Medical School
1301 Catherine Road
Medical Science Building I.
Ann Arbor, MI 48109
Phone: 313/764-8175
Fax: 313/763-4936

Stuart Osborne Bondurant, MD
Dean
University of North Carolina at Chapel Hill
School of Medicine
Room 125 MacNider, Campus Box 7000
Chapel Hill, North Carolina 27599-7000
Phone: 919/966-4161
Fax: 919/966-7564

Lester Richard Bryant, MD, Sc.D.
Dean
University of Missouri-Columbia School of Medicine
MA204 Medical Sciences Building
One Hospital Drive
Columbia, MO 65203
Phone: 314/882-1566
Fax: 314/884-4808

Mr. Leo P. Brideau
Executive Director
Strong Memorial Hospital
601 Elmwood Avenue
Rochester, NY 14642
Fax: 716/244-1163

Roger James Bulger, MD
President, Association of Academic Health Centers
1400 Sixteenth Street, NW, Suite 410
Washington, DC 20036
Phone: 202/265-9600
Fax: 202/265-7514

Gerard Noel Burrow, MD
Dean
Yale University School of Medicine
333 Cedar Street, P.O. Bos 3333
New Haven, CT 06510
Phone: 203/785-4672
FaX: 203/785-7437

Robert M. Carey, MD
Dean
University of Virginia School of Medicine
Medical Center, Box 395, McKim Hall
Charlottesville, VA 22908

Phone: 804/924-5118
Fax: 804/982-0874

Dr. Chobanian
Dean
Boston University School of Medicine
80 E. Concord St.
Boston, MA 02118
Phone: 617/638-5300
Fax: 617/638-5258

Thomas Joseph Cinque, MD
Dean
Creighton University School of Medicine
California at 24th Street
Omaha, NE 68178
Phone: 402/280-2600
Fax: 402/280-2599

Jordan Jay Cohen, MD
President, Associatino of American Medical Colleges
2450 N. Street, NW
Washington, DC 20037
Phone: 202/828-0460
Fax: 202/828-1125

Richard Alan Cooper, MD
Executive Vice President and Dean
Medical College of Wisconsin
8701 Watertown Plank Road
Milwaukee, WI 53226
Phone: 414/456-8213
Fax: 414/257-0449

Dr. Stacey Cyphert, Assoc. VP
for Statemwide Health Services
Univ. Iowa Hospitals & Clinics
Newton Road
Iowa City, Iowa 52242
Fax: 319/353-8475

Charles Harry Epps, Jr., MD
Dean
Howard University College of Medicine
520 W. Street, NW
Washington, DC 20059
Phone: 202/806-5677
Fax: 202/806-7934

C. McCollister Evarts, MD
Senior Vice President for Health Affairs and
Dean, College of Medicine
Hershey Medical Center at Pennsylvania State University
Post Office Box 850

Hersehy, PA 17033
Phone: 717/531-8323
Fax: 717/531-5351

Harold J. Fallon, MD
Dean
Univesrsity of Alabama School of Medicine
University of Alabama at Birminghan
UAB Station
Birminghan, AL 35294-3294
Phone: 205/934-4011
Fax: 205/934-0333

Philip Jack Fialkow, MD
Vice President for Medical Affairs and Dean
University of Washington School of Medicine
1959 NE Pacific Street
Seattle, WA 98195
Phone: 206/543-1515
Fax: 206/685-8767

Mr. Carl Fischer
Executive Dorector
Medical College of Virginia
401 N. 12th St.
Richmond, VA 23298
Fax: 804/828-0170

Robert Clifford Fore, MD
Associate Dean
Mercer University School of Medicine
777 Hemlock Street
Macon, GA 31201
Phone: 912/633-1634
Fax: 912/633-1578

Spencer Foreman, MD
President
Montefiore Medical Center
111 E. 210 Street
Bronx, NY 10467
Fax: 718/652-2161

Ronald Dwyer Franks, MD
Dean
University of Minnesota-Duluth School of Medicine
10 University Drive
Duluth, Minnesota 55812
Phone: 218-726-7571
Fax: 218/ 726-6235

Kim Goldenberg, MD
Wright State University School of Medicine
P.O. Box 927

Dayton, OH 45401-0927
Phone: 513/873-2933
Fax: 513/873-3672

James Anthony Hallock, MD
Dean
East Carolina University School of Medicine
Office of the Dean
Brody Medical Sciences Building, Room AD 48
Greenvilles, NC 27858
PHone: 919/816-2201
Fax: 919/816-3192

Donal C. Harrison, MD
Senior VP and Provost for Health Education
University of Cincinnati College of Medicine
231 Bethesda Avenue
Cincinnati, Ohio 45267-0555
Phone: 513/558-7391
Fax: 513/558-1165

John James Hutton, Jr., MD
Dean
University of Cincinnati College of Medicine
Mail Locaiton 0555
Cincinnati, OH 45267
Phone: 513/558-7391
Fax: 513/558-1165

Nancy Wiegel Jensen
Director, Medical Center News Office
Duke University School of Medicine
Post Office Box 3710
Durham, NC 27710
Phone: 919/684-4148
Fax; 919/681-7020

Michael E. Johns, MD
Dean of the Medical Faculty
Johns Hopkins University School of Medicine
720 Rutland Avenue
Baltimore, MD
Phone: 410/955-3180
Fax: 410/955-0889

William Johnson, Jr.
CEO
University of New Mexico Hospital
2211 Lomas Boulevard, NE
Albuquerque, NM 87106
Phone: 505/843-2121
Fax: 505/272-1827

William Nimmons Kelley, MD

Executive Vice President for the Medical Center and Dean
University of Pennsylvania School of Medicine
36th and Hamilton Walk
Philadelphia, PA 19104
Phone: 215/898-5181
Fax: 215/898-5607

William Bernard Kerr
Director, Medical Center
Medical Center at the University of California, San Francisco
505 Parnassus Avenue
San Francisco, CA 94143
Phone: 415/476-1405
Fax: 415/476-2317

Mr. Donald L. McDowell, Pres.
Maine Medical Center
22 Bramhall Street
Portland, ME 04102
Fax: 207/871-6212

Leon S. Malmud, MD
Senior Vice President for the Health Sciences Center
Temple University
Broad and Ontario Street
Philadelphia, PA 19140
Phone: 215/707-4638
Fax: 215/221-3261

Donald J. Marsh, MD
Dean of Medicine and Biological Sciences
Brown University School of Medicine
97 Waterman Street
Providence, RI 02912
Phone: 401/863-3330
Fax: 401/8633431

Joseph Boyd Martin, MD, Ph.D.
Chancellor
University of California, San Francisco, School of Medicine
513 Parnassus Avenue
San Francisco, CA 94143
Phone: 415/476-2401
Fax: 415/476-9634

Robert Michels, MD
Dean
Cornell University Medical College
1300 York Avenue
New York, New York 10021
Phone: 212/746-5454
Fax: 212/746-0931

James John Mongan, MD

Dean
University of Missouri-Kansas City School of Medicine
2411 Holmes Street
Kansas City, MO 64108
Phone: 816/235-1809
Fax: 816/235-5277

Mr. Eric Munson
Executive Director
University of North Carolina Hopitals
Manning Drive
Chapel Hill, NC 27514
Fax: 919/966-7772

Herbert Pardes, MD
Dean
Columbia University College of Physicians and Surgeons
630 West 168 Street
New York, NY 10032
Phone: 212/305-3592
Fax: 212/305-3545

Nancy Moffatt Parker
Assistant in Governmental Relations
Washington University School of Medicine
660 S. Euclid, Box 8106
St. Louis, Mo 63110
Phone: 314/362-6832
Fax: 314/367-6666

William Arno Peck, MD
Executive Vice Chancellor and Dean
Washington University School of Medicine
660 South Euclid, Box 8105
St. Louis, MO 63110
Phone: 314/362-6827
Fax: 314/367-6666

Mr. Glenn E. Potter
Vice Chancellor-Hospital Administration
University of Kansas Hospital
39th and Rainbow Boulevard
Kabsas City, Kansas 66103
Fax: 913/588-1280

Mitchell T. Rabkin, MD
President
Beth Israel Hospital
330 Brookline Avenue
Boston, MA 02215
Phone: 617/735-2222
Fax: 617/735-2356

Morton I. Rapoport, MD

President/CEO
U. Maryland Medical system
22 South Greene St.
Baltimore, MD 21201
Fax: 410/328-8664

Perry G. Rigby, MD
Chancellor of the Medical Center
Louisiana State University School of Medicine in New Orleans
1542 Tulane Avenue
New Orleans, LA 70112-2822
Phone: 504/568-4007
Fax: 504/568-4008

Stephen Joseph Ryan, MD
President
University of Southern California School of Medicine
1975 Zonal Avenue
Los Angeles, CA 90033
Phone: 213/342-6444
Fax: 213/342-6440

Raymond Gilbert Schultze, MD
Director
UCLA Medical Center
10833 Le Conte Avenue
Los Angeles, CA 90024
Phone: 310/825-5041
Fax: 310/825-9690

Mr. C. Edward Schwartz, Director
Univ. Nebraska Hospital
600 South 42nd St.
Omaha, Nebraska 68198
Fax: 402/559-6493

Steve Gene Sloate
Associate Vice Chancellor For Health Affairs
Duke University School
Post Office Office Box 3710
Durham, NC 27710
Phone: 919/684-4148
Fax: 919/681-7020

Mr. Larry Smith
Chief Operating Officer
New England Medical Center
750 Washington Street
Boston, MA 02111
Fax: 617/956-7623
DOB: P6/b(6)

Ralph Snyderman, MD
Dean

Duke University School of Medicine
Post Office Box 3005
Durham, NC 27710
Phone: 919/684-2255
Fax: 919/681-7020

Jay Harold Stein, MD
Provost and Senior Vice President for Health Sciences
University of Oklahoma College of Medicine
Post Office Box 26901
Oklahoma City, OK 73190
Phone: 405/271-2332
Fax: 405/271-3151

Robert Cochran Talley, MD
University of South Dakota School of Medicine
2501 West 22nd Street
Sioux Falls, SD 57117-5046
Phone: 605/357-1300
Fax: 605/357-1311

Ms. Lorraine Tregde
Executive Director
Bronx Municipal Hospital Center
Pelham Parkway S. & Eastchester Rd.
Bronx, NY 10461
Fax: 718/918-4607
DOB: P6/b(6)

Reed Vaughn Tuckson, MD
President of the University
Charles R. Drew University of Medicine and Science
1621 East 120th Street
Los Angelles, CA 90059
Phone: 213/563-4987
Fax: 213/563-5987

Manuel Tzagournis, MD
Vice President for Health Sciences and
Dean, College of Medicine
Ohio State University
200 Meiling Hall
370 West Ninth Avenue
Columbus, OH 43210
Phone: 614/292-0926
Fax: 614/292-1544

Ms. Farah M. Walters, Pres.
University Hospitals of Cleveland
University Circle
Clevland, OH 44106
Fax: 216/844-3276
DOB: P6/b(6)

Harry P. Ward
Chancellor
University of Arkansas for Medical Services
4301 West Markham Street
Little Rock, Ar 72205
Phone: 501/686/5000
Fax: 501/686-8160

Donald Edward Wilson, MD
Dean
University of Maryland School of Medicine
655 West Baltimore Street
Baltimore, MD 21201
Phone: 410/706-7410
Fax: 410/706-0235

Emery Allen Wilson, MD
Vice Chancellor for Clinical Professional Services
University of Kentucky College of Medicine
A.B. Chandler Medical Center
800 Rose Street (MN-150)
Lexington, KY 40536-0084
Phone: 606/233-5000
Fax: 606/258-2039

I. Dodd Wilson, MD
Dean
University of Arkansas College of Medicine
4301 West Markham Street
Little Rock, AR 72205
Phone: 501/686-5350
Fax: 501/686-8160