ning. Milbank Q 65: 371–396 (1987).
17. Committee on Health Care for Homeless People: Homelessness health and human needs. Institute of Medicine, Washington, DC, 1988.
18. Breakey, W. R.: Treating the homeless. Alcohol Health Res World 11: 42–46, 90 (1987).
19. Welch, W. M., and Toff, G.: Service needs of minority persons who are homeless and homeless mentally ill: *In* Proceedings of the third of four knowledge development meetings on issues affecting homeless mentally ill people. George Washington University, Washington, DC, December 14–15, 1987, pp. 1–77.
20. Bargmann, E.: Washington, D.C.: the Zacchaeus Clinic—a model of health care for homeless people. *In* Health care of homeless people, P. W. Brickner, L. K. Scharer, B. Conanan, A. Elvy, and M. Savarese, editors. Springer-Verlag, New York, 1985, pp. 323–332.
21. Brickner, P. W., et al., editors: Health care of homeless people. Springer-Verlag, New York, 1985.

Report on a Seminar on Financing and Service Delivery Issues in Caring for the Medically Underserved

CLEONICE TAVANI, MSW

Ms. Tavani is a Program Analyst with the Public Health Service's Health Resources and Services Administration (HRSA), Office of Planning, Evaluation, and Legislation.

The paper is based on reports prepared by Alpha Center, Washington, DC, for HRSA under contract HRSA 88-507(P). The seminar was held at Columbia, MD, July 6–7, 1988, sponsored jointly by the Robert Wood Johnson Foundation and HRSA.

Tearsheet requests to Cleonice Tavani, HRSA, OPEL, Parklawn Bldg., room 14–36, 5600 Fishers Ln., Rockville, MD 20857.

Synopsis

Current national activities directed toward improving access to health care and assessing the potential effectiveness of various financing and service delivery strategies were reviewed by an invited group of 39 public and private sector health policy experts. Health care access problems of the medically underserved population were defined and a range of strategies for addressing them were presented. The seminar was held at Columbia, MD, July 6–7, 1988, sponsored jointly by the Robert Wood Johnson Foundation and the Health Resources and Services Administration, PHS.

SEMINAR PARTICIPANTS EXAMINING THE HEALTH care needs of medically unserved and underserved populations, and the respective roles of the public and private sectors in developing solutions, agreed that financing strategies alone cannot solve the problems. Service delivery strategies must be devised to ensure access to health care for people who have trouble accessing health care systems or who live in medically underserved locations, participants urged.

Health policy experts from the public and private sectors reviewed current activities aimed at improving access to health care. The 39 invited participants assessed the potential effectiveness of various financing and service delivery strategies and the respective roles of the public and private sectors in developing solutions.

The invitational seminar, "Public and Private Partnerships in Caring for the Medically Underserved," sponsored by the Robert Wood Johnson Foundation and the Public Health Service's Health Resources and Services Administration (HRSA), was held July 6–7, 1988, at Columbia, MD.

Throughout the seminar, participants stressed that access is a problem for the insured as well as the uninsured. While financing solutions are an essential component of any overall strategy, it is equally important to consider changes in the service delivery system to improve access for persons such as those who live in medically underserved locations.

The three phases of the evolution of the access issue as a national concern were summarized by Lawrence Lewin, of Lewin/ICF, Washington, DC. In the first stage, which started in the 1970s, policy discussion centered around concerns about hospitals' uncompensated care costs. The issue was not only the level of uncompensated care, but also the unequal distribution of that burden.

In the next stage, the focus of concern shifted to the uninsured population. The perception was that we could deal with the problem of health care for the indigent by simply finding a way to provide coverage to the uninsured. As policy analysts studied this problem, they were surprised to find that about 70 percent of the uninsured population were employed or in the family of an employed person.

Today, the issue of care for the indigent has evolved into a concern over access. The question is not simply how we provide insurance for the indigent, but how we

ensure access to health care, especially for preventive and primary care services.

Three broad strategies were proposed by Lewin for improving access. At one extreme is the concept of marginal improvements in coverage, or keeping the existing system intact and expanding it where possible. At the opposite end is universal insurance coverage, which would require radical changes in our current system. It would concentrate on insuring just about everybody, providing services only for the few who fall through the cracks.

The middle approach involves restructuring the insurance system to provide coverage where it does not now exist and using service strategies to fill in the gaps. The seminar focused on this middle range strategy.

As a guide for seminar participants, two matrices were developed by Lewin/ICF in conjunction with the Alpha Center. The first matrix outlines the health care access problems of the medically underserved. The second matrix describes a range of strategies to address those problems. Together, the matrices provide a useful framework for those studying health care access in a comprehensive context. For readability, the information from the matrices is shown in this article in outline format in two accompanying boxes. Copies of the matrices in their original table-like format are available from the author.

Assessing Access Problems

Solutions are likely to be structured around the problems of specific population groups in assessing services. The first box (page 22) shows types of access barriers, such as lack of insurance, as well as high copayments and deductibles; insufficient numbers of providers or inadequate care coordination; and language and cultural barriers.

The population is divided into the two major categories of insured and uninsured. The insured are grouped by income level and by whether they are publicly or privately insured. Even the insured, especially the publicly insured, face barriers to access. The uninsured are grouped by income level and according to whether or not they are in the work force, because groups in and out of the work force confront different access problems. The estimated size of each population group, and the extent of each group's access problems, is indicated.

Assessing Strategies

Both financing and service delivery strategies are required to address the full range of access problems for all population groups (second box, page 24). Insurance strategies are categorized by whether they are employer-based or individual-based. Service delivery strategies serve three purposes: to build capacity in areas with inadequate resources, to facilitate the use of services, and to increase access to services for high-risk populations.

Roles and Responsibilities

A partnership between the private and public sectors is required by the middle range strategy chosen for the seminar. Such a partnership implies a decision to retain the present pluralistic system of health care and to continue to build options into the system so that people can be free to purchase more amenities if they can afford to do so.

Lewin said that Americans want some sort of assured minimum, without sacrificing the flexibility possible in the pluralistic approach. This strategy not only costs money, but it also requires some degree of regulation to ensure that what is an essentially competitive system will respond to certain social expectations.

Implicit in the concept of a public-private coalition is the assumption that the private sector only can go so far in solving the indigent care problem; the public sector must then step in to fill the gaps.

Financing and Service Delivery Issues

The consensus of the participants was that new national policy endeavors for the medically indigent should be built on the existing infrastructure, which includes private, employment-based insurance; the Medicare and Medicaid programs; and direct-delivery health care supported by public and philanthropic resources.

Because employed persons and their dependents constitute the largest part of the uninsured population, the pluralistic, employment-based insurance system is the logical place to begin to extend health insurance to uninsured workers. Whatever approach is taken to cover this population, it should not interfere with the coverage now available through employers to an estimated 150 to 160 million people.

Efforts to expand insurance for uninsured workers could focus on the small employer, as in the Robert Wood Johnson Foundation's National Health Care for the Uninsured Program, which supports innovative State and local interventions designed to expand the provision of health insurance.

Participants expressed concern about the potential effects on employers of a nationally mandated, employment-based insurance program. Some were concerned about the minimum level that employers would have to contribute for employee insurance. They asked whether

a nationally mandated level is feasible when there is so much variation in the financial status of individual employers and in the economic condition of various States. Some participants were worried that employers who hire older or disabled workers would be penalized. What would happen to employers willing to go above the established level? Would workers then demand a higher quality insurance package? Any national program for employment-based insurance should leave room for flexibility and innovation, the participants concluded.

Another issue discussed was whether a prescribed set of minimum benefits or an actuarial equivalence approach is the best way to achieve a desired level of benefits. While certain core benefits should be provided, such as basic hospital and laboratory services, employees could negotiate an actuarially equivalent package beyond that.

The difficulty is in striking a balance between flexibility and affordability. If employers were given the option to exceed the floor set for actuarial equivalence, the result could be a rich benefit package that only high-income employees could afford to purchase. However, if the package could only be made affordable by severely limiting benefits, employers and employees might not be interested in buying it.

The Robert Wood Johnson Foundation-supported projects on health care for the uninsured may provide some answers on this issue because, for the most part, they are trying to keep insurance affordable by limiting benefits.

The participants discussed the question of whether Federal or State government would have to provide subsidies in order for certain employers to participate in an employee insurance program. One approach is for the government to subsidize persons who cannot afford to share in the costs. Another would be to subsidize businesses with high-risk employees, having the employer pay some of the large health costs, with the remaining costs covered through reinsurance mechanisms and State high-risk pools. A third approach, generally acknowledged to be less politically feasible, would be to subsidize through the tax system.

If the employment-based system were expanded to cover such marginal populations as part-time employees and disabled workers, to what extent would the public sector have to subsidize the cost of coverage? Perhaps a better use of government funds would be to extend Medicaid coverage or to provide direct services to such workers through a publicly subsidized system. Perhaps health care policies for these special worker populations should be the same as those for persons with no attachment to the work force.

Such improvements as the recent extension of Medicaid eligibility to pregnant women with incomes up to 185 percent of the poverty level are important in expanding financing for health care. For certain persons living in medically underserved areas, however, or for those beset with problems unrelated to health, a direct service delivery strategy must also be considered.

'. . .access is a problem for the insured as well as the uninsured.'

Next Steps in Developing Strategies

Seminar participants identified a number of data needs which need to be met in order to develop further strategies to address the needs of the medically underserved, and they identified the following questions that need to be asked.

- Why do some people not buy health insurance, even when it is available? Would they buy it if it were subsidized?
- What is the effect on a person's health status of being uninsured?
- Why and when do businesses offer employees a health insurance benefit?

Additional data are needed on health care costs by State, delivery infrastructure, purchaser, service setting, and type of service. Other research issues include the role of subsidies, the role of physicians, a minimum benefits package, the concept of actuarial equivalence, the potential interface with Medicaid, and the efficacy of mandated insurance on costs and employment.

More difficult to answer than research questions are such value issues as

- Is our goal to provide universal access or is it the more limited goal of meeting the needs of certain vulnerable populations?
- What is both politically and socially acceptable, a one-, two-, or three-tiered system?
- How much paternalism is acceptable or desirable?
- How much pluralism and flexibility do we want to maintain?
- If cost control is a serious concern, are we ready to accept limits on freedom of choice?
- How can we assure equity?

Seminar participants urged the sponsors to continue the effort to synthesize what we are learning in an effort to forge a more coherent consensus about what the major public and private sector interests need to do to assure access to health for the medically underserved.

Assessing Problems of the Medically Underserved Population in Gaining Access to Health Services

Insured

Of the more than 200 million persons in the country, 165 million (82 percent) have health insurance. Of the 165 million insured

- 134 million (84 percent), are privately insured and have high or medium level incomes,
- 17 million (10 percent), are publicly insured and have low incomes; and
- 10 million (6 percent), are privately insured and have low incomes.

Insured publicly, low income: The 17 million persons of low income whose health benefits are publicly insured can experience health care access problems, especially if they are pregnant women, children with special needs, the elderly, or the mentally ill. Among the causes of their health care access problems are

Financing: For those on Medicaid, there are administrative problems, low fee levels that discourage providers from accepting Medicaid patients, limits on benefit levels and coverage, and for some patients, the need to spend down, or pay heavy up front costs before they can become eligible for Medicaid. For those on Medicare, there are few preventive health benefits, and often financial problems with patients' ability to pay for deductibles, copayments, and prescriptions.

Delivery system: Special needs, such as in nutrition, are not met by a system designed to care for medical problems; providers may not be located in inner cities or remote rural areas; service hours may be limited and long waits experienced; there is limited care management available; providers may be reluctant to deal with difficult cases; and there often are geographic problems associated with access, such as lack of transportation.

Other problems: Racial, cultural, and language barriers; patients not being linked to the system; and patient behavior.

Insured privately, low income: The 10 million persons with low incomes who have private health insurance find health care access problems moderate in extent. Among the causes of their health care access problems are

Financing: Restricted benefits, high cost sharing relative to income, low levels of employer contributions, limits on treatment of preexisting conditions, and lack of coverage for very high or catastrophic expenses.

Delivery system: Geographic problems associated with access, a fragmented system not addressing persons and families with multiple problems, limited access hours and lost wages when care is sought, limited care management available, little prevention, limited choice of providers, and malpractice costs that limit availability of providers.

Other problems: Racial, cultural, and language barriers; transportation difficulties; patients not linked to the system; patients not identified or reached; and patient behavior problems.

Insured, high or medium income: The 138 million insured persons with high or medium level incomes experience health care access problems, but of comparatively little difficulty. Among the causes of their health care access problems are

Financing: Preexisting conditions may not be covered, catastrophic expenses may not be covered, and insurance coverage may be lost because of disability.

Delivery system: Geographic problems associated with access, fragmentation of the delivery system, limited hours of access and the cost of lost time, and malpractice costs that limit the availability of providers.

Other problems: Patient behavior problems.

Uninsured

Of the more than 200 million persons in the country, 37 million (18 percent), have no health insurance. Of the uninsured

- 26 million (70 percent) are the employed or their dependents,
- 3 million (8 percent) are self-employed, and
- 8 million (22 percent) are nonworkers.

Uninsured, low income, employed: Among the 26 million uninsured employed, 19 million (73 percent), have low incomes and experience a high degree of difficulty with access to health care.

Those who are employed by firms that do not provide coverage may experience the following access problems

Financing: Personal coverage is not available or is too expensive, or they are excluded for medical underwriting reasons, such as exclusion of diabetics.

Delivery system: Geographic problems associated with access; special services, both medical and nonmedical, not available or not coordinated; limited hours of access and lost wages; and malpractice liability limiting provider access.

Other problems: Racial, cultural, and language barriers; transportation difficulties; and patient behavior problems.

Those employed by firms that do provide coverage experience the following access problems

Financing: Part-time employment may exclude coverage; dependents may be excluded; premiums may be too high;

there may be long waiting periods for coverage; some elect no coverage because of premium costs, or shallow or unattractive benefits; preexisting conditions may not be covered; insurance may require high cost-sharing; and some face exclusions for medical underwriting reasons.

Delivery system: Geographic problems associated with access; special services not available or not coordinated, both medical and nonmedical; limited access hours and lost wages; and malpractice liability limiting provider access.

Other: Racial, cultural, and language barriers; transportation difficulties; and patient behavior problems.

Uninsured, middle to high income, employed: Of the 26 million employed uninsured and their dependents, 7 million (27 percent), are in middle to high income levels. They experience few difficulties with access problems.

Among those employed by firms that do not provide coverage, the problems are

Financing: Individual coverage is not available, or they may be excluded for medical underwriting reasons.

Delivery system: Geographic problems associated with access; special services not available or coordinated, both medical and nonmedical; limited access hours and lost wages; and malpractice liability limiting provider access.

Other: Patient behavior problems.

Among those employed by firms that do provide coverage, these problems are experienced

Financing: Premiums for dependents may be too high, they may elect no coverage, and they may be excluded for medical underwriting reasons.

Delivery system: Geographic problems associated with access; special services not available or coordinated, both medical and nonmedical; limited access hours and lost wages; and malpractice liability limiting provider access.

Other: Patient behavior problems.

Uninsured, self-employed: Among the uninsured, 3 million persons (8 percent), are self-employed and experience access problems of moderate degree.

Financing: Individual coverage may not be available or too expensive; and they are unable to take advantage of the tax deduction available to corporations offering health insurance benefits.

Delivery system: Geographic problems associated with access; special services not available or coordinated, both medical and nonmedical; limited access hours and lost wages; and malpractice liability limiting provider access.

Other: Patient behavior problems.

Uninsured, nonworkers: The 8 million uninsured nonworking persons experience a high degree of difficulty in gaining access to health care. The particular problems are

Financing: Administrative or categorical barriers to public insurance; Medicaid spend down problems related to eligibility for Medicaid; they may be unable to afford individual private insurance coverage; and they may be unable to afford continuation of coverage.

Delivery system: The system may be too fragmented to cope with their multiple needs; inpatient care may be available, but community-based care may not; geographic access problems; the medical system mindset not being geared for their circumstances; providers not being trained to serve this group; and prevalence of so-called provider burn out.

Other: They do not perceive health care as a foremost need; they are not linked to the system, and may be in effect invisible, as well as distrustful; there is no clear responsibility for their care, and there may be a refusal to treat them; they often lack transportation and child care and cannot get to care facilities; others perceive them in categories and oversimplify their needs; special initiatives to provide them access are often of a temporary nature; and prevalent patient behavior problems.

Assessing Strategies to Improve Access to Health Services for the Medically Underserved Population

Insured publicly, low income

Financing: *Private and public:* Uncompensated care pools (care or share). *Public:* Raising provider fees. Adopting all-inclusive fee for Medicaid. Extending dental and prescription drug benefits to all Medically Needy. Extending Medicaid to children younger than 8 years who are below poverty level. Extending Medicaid to pregnant women and infants up to 185 percent of poverty level.

Service delivery: *Private:* Building capacity through efforts of medical societies and by restructuring outpatient departments. Facilitating use by hospital outreach efforts in transportation and prenatal education. *Private and public:* Building capacity by joint efforts among hospitals and primary care centers, and by rural networks of physicians, hospitals, and others. Having physicians circuit ride, or visit among locations. Facilitating use by subsidizing volunteer programs. Addressing needs of special populations with regard to malpractice problems. *Public:* Building capacity of primary care centers, public hospitals, and increasing service-contingent health professions training. Facilitating use by means of family health workers, transportation assistance, and emergency systems. Addressing needs of special populations through directing programs to high risk groups.

Insured privately, low income

Financing: *Private:* Expanding managed care options to overcome access barriers resulting from copayments and deductibles. *Private and public:* Mandating benefits. *Public:* Making Medicaid a secondary source of coverage for excluded services, after private insurance.

Service delivery: *Private:* Building capacity through fees related to ability to pay (sliding fees), private care or share, and accepting patient assignment. Facilitating use of services by waiving cost sharing and encouraging voluntary work in health promotion. *Private and public:* Building capacity through specialty society sponsorship and State-subsidized programs. Facilitating use through voluntary agencies and churches helping to locate and serving with public health nurses. Insurers need to require health promotion activities. *Public:* Building capacity at primary care centers and public hospitals, having public agencies accept insurance, and mandating sliding fee scales. Facilitating use with family health workers and case finders. Using public clearinghouse concept.

Insured, high or medium income

Financing: *Private:* Limiting preexisting condition requirements. *Private and public:* Mandating catastrophic coverage. *Public:* Using high risk pools and catastrophic insurance plans.

Service delivery: *Private:* Patients buy care management. *Private and public:* Subsidized care management. Including alcohol and drug problems on a sliding scale with fees determined by income level.

Uninsured, low income, employed by firms that do not offer insurance

Financing: *Private:* Employer-based insurance option is creating pooling arrangements. Individual persons' insurance options are limited benefit plans and insurer cross-subsidy for individual plans. *Private and public:* Employer-based options including tax incentives, mandated insurance, subsidized insurance for small employers, and subsidized coverage of dependents. People's options are subsidized individual plans, regulatory mandates on Blue Cross-Blue Shield, and uncompensated care pools (care or share). *Public:* Employer option is Medicaid buy-in. A person's options include raising Medically Needy payment standard to 133 percent of AFDC (Aid for Families of Dependent Children) standard, Medicaid buy-in, and drug plans.

Service delivery: *Private:* Building capacity by having private physicians on call through the medical society, free clinics, and by having providers offer insurance-like package to employer or employee. *Private and public:* Building capacity by offering inducements to physicians and reorganizing outpatient departments. Facilitating use through increased language translation services, promoting workplace health, and use of triage among hospitals and physicians. *Public:* Building capacity through primary care centers, public hospitals, and using nurse practitioners and physician assistants in triage and in writing vouchers for specific charges. Mandating provider acceptance of public insurance as a condition of licensure and reimbursement. Facilitating use through evening and weekend primary care services, the use of care managers and advocates, and translation services.

Uninsured, low income, employed by firms that do offer insurance

Financing: *Private:* Employer-based options include managed care options to reduce access barriers resulting from high cost sharing, limited benefit plans, and greater employer premium share. *Private and public:* Employer-based options include creating pools to reduce costs of insurance; mandating maximum employee premium sharing; and subsidizing premiums for employees, dependents, and risk pools. *Public:* Individuals' options include subsidized high-risk pools, raising Medically Needy income ceiling to 133 percent of AFDC standard, and Medicaid buy-in.

Service delivery: *Private:* Building capacity by having private physicians on call through the medical society, free clinics, and having providers offer insurance-like package to

employer or employee. *Private and public:* Building capacity by offering inducements to physicians and reorganizing outpatient departments. Facilitating use through increased language translation services, promoting workplace health, and use of triage among hospitals and physicians. *Public:* Building capacity through primary care centers, public hospitals, using nurse practitioners and physician assistants in triage and voucher writing. Mandating provider acceptance as a condition of licensure and reimbursement. Facilitating use through evening and weekend primary care services, use of care managers and advocates, and translation services.

Uninsured, middle to high income, employed by firms that do not offer insurance

Financing: *Private:* Employer-based options include managed care options to reduce access barriers resulting from high cost sharing, limited benefit plans, and greater employer premium share. Individuals' options include catastrophic plans and private plans. *Private and public:* Employer-based options include tax incentives and mandated insurance. Individuals' options include catastrophic health plans and risk pools.

Service delivery: *Private:* Building capacity by having providers offer insurance-like packages to employer or employee. *Private and public:* Building capacity by offering inducements to physicians and reorganizing outpatient departments. Facilitating use through increased language translation services, promoting workplace health, and use of triage among hospitals and physicians. *Public:* Building capacity of primary care centers and public hospitals.

Uninsured, middle to high income, employed by firms that do offer insurance

Financing: *Private:* Employer-based options include HMOs and catastrophic plans. *Private and public:* Individuals' options include catastrophic plans and risk pools.

Service delivery: Facilitating use through voluntary participation in health promotion programs and by employee assistance programs. *Private and public:* Building capacity by offering inducements to physicians and reorganizing outpatient departments. Facilitating use through increased language translation services, promoting workplace health, and use of triage among hospitals and physicians.

Uninsured, self-employed

Financing: *Private:* Creating pools of self-employed to reduce the cost of insurance. *Private and public:* Subsidized individual plans. *Public:* Medicaid buy-in.

Service delivery: *Private:* Hospital managed care. *Private and public:* Subsidized care manager.

Uninsured, nonworkers

Financing: *Private and public:* Subsidizing so-called Medigap coverage to low income elderly with incomes above level for Medicaid. *Public:* Making Medicare definition of disability more flexible. Expanding Medicaid to elderly and disabled up to poverty level. Providing for presumptive eligibility, or early determination of Medicaid eligibility to encourage primary and prenatal care. Administrative flexibility for public programs.

Service delivery: *Private:* Facilitating use through voluntary outreach, through churches and shelters, with volunteer physicians. *Public and private:* Facilitating use through health promotion activities, rewarding providers who serve the program, offering health professions training, and subsidizing community-based care. *Public:* Building capacity through primary care centers and hospitals; offering service-contingent health professions training; offering programs for alcohol, drug abuse, and mental health; and multi-year funding. Facilitating use through health care connected to higher priority services, use of family health workers and care managers, links to social and other services, and transportation services. Serving special populations by directing programs specifically to high-risk groups.

Participants in Invitational Seminar, "Public and Private Partnerships in Caring for the Medically Underserved," July 6–7, 1988, Columbia, MD

C. Ross Anthony, Health Care Financing Administration

Judy Arnold, Lewin/ICF, Washington, DC

Nancy Barrand, Robert Wood Johnson Foundation, Princeton, NJ

Jeffrey C. Bauer, The Bauer Group, Hillrose, CO

John Billings, Consultant, New York, NY

Richard Bohrer, Health Resources and Services Administration

Patricia Butler, Attorney, Boulder, CO

Ronald H. Carlson, Health Resources and Services Administration

Kathryn Carney, Alpha Center, Washington, DC

Deborah Chollet, Employee Benefit Research Institute, Washington, DC

Louis D. Coccodrilli, Health Resources and Services Administration

David Cooper, Office of the Assistant Secretary for Planning and Evaluation, DHHS

Carol Cronin, Washington Business Group on Health, Washington, DC

Richard Curtis, National Governors' Association, Washington, DC

Joseph M. Davis, Metametrics Group, Cleveland, OH

Randy Desonia, Alpha Center, Washington, DC

Irene Fraiser, American Hospital Association, Chicago, IL

Marsha Gold, Group Health Association of America, Washington, DC

Glenn Hackbarth, Health Care Financing Administration, DHHS, Washington, DC

Lucia Hatch, Health Insurance Association of America, Washington, DC

Kevin Haugh, Health Insurance Association of America, Washington, DC

W. David Helms, Alpha Center, Washington, DC

Karen Ignani, American Federation of Labor/Council of Industrial Organizations, Washington, DC

Kathy Kiedrowski, National Association of Community Health Centers, Washington, DC

Mary Nell Lehnhard, Blue Cross/Blue Shield, Washington, DC

Lawrence Lewin, Lewin/ICF, Washington, DC

Marion Ein Lewin, Institute of Medicine, Washington DC

Stephen Long, Congressional Budget Office, Washington, DC

Jeffrey Merrell, Robert Wood Johnson Foundation, Princeton, NJ

Jack A. Meyer, New Directions for Policy, Washington, DC

Harvie Raymond, Health Insurance Association of America, Washington, DC

Kathryn Swartz, Urban Institute, Washington, DC

David N. Sundwall, MD, Health Resources and Services Administration

Cleonice Tavani, Health Resources and Services Administration

Mary Uyeda, National Association of Counties, Washington, DC

Karen Williams, Health Insurance Association of America, Washington, DC

Barbara Yondorf, National Conference of State Legislatures, Denver, CO

Karl Yordy, Institute of Medicine, National Academy of Sciences, Washington, DC

Ann Zuvekas, Lewin/ICF, Washington, DC