DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

Case No. 2004-663mb

April 19, 2004

COPY

Mr. Christopher J. Farrell
JUDICIAL WATCH, INC.
501 School Street, S.W., Suite 500
Washington, D.C. 20024

Dear Mr. Farrell:

This is in response to your March 22, 2004, Freedom of Information Act (FOIA) request, addressed to Lee Jackson, FOIA Officer, Centers for Medicare and Medicaid Services (CMS) and to me seeking certain documents pertaining to cost estimates for proposed Medicare legislation.

We have completed the search of the files within the Office of the Secretary (OS) and the Centers for Medicare and Medicaid (CMS) and have identified one hundred sixty-two (162) pages responsive to your request. I am releasing the full texts of thirteen (13) pages of records. I have determined to withhold one hundred forty-nine (149) pages in their entirety under exemption (b)(5) of the FOIA.

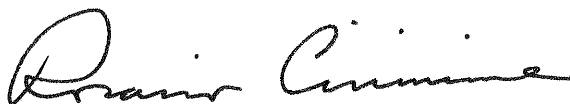
Exemption (b)(5) permits the withholding of inter-agency or intra-agency memorandums or letters, which would not be available by law to a party other than an agency in litigation with the agency." The withheld material is draft, preliminary, pre-decisional and contains staff advice, opinions, and recommendations. Withholding is necessary to preserve free and candid dialogue leading to decision-making.

You asked for specific identifying information about the records being withheld. Such descriptions are called Vaughn indices. HHS only provides Vaughn indices in litigation, when we are required to do so by the court.

There is no fee in this instance because charges do not exceed our billing threshold of $25.00.

If you have reason to believe that any denied records should not be exempt from disclosure, you may appeal. We ask that you mail your appeal within 30 days from the date of our final response to you, to the Deputy Assistant Secretary for Public Affairs (Media), U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 645-F, Hubert H. Humphrey Building, Washington, D.C. 20201. Clearly mark both the envelope and your letter "Freedom of Information Act Appeal."

Sincerely yours,



Rosario Cirrincione
Director
FOI/Privacy Acts Division
Office of Public Affairs

Enclosures

February 5, 2004

NOTE TO: Dennis Smith

SUBJECT: Summary of Differences Between OACT and CBO Cost Estimates for P.L. 108-173, the "Medicare Prescription Drug, Improvement, and Modernization Act of 2003"—Updated

As you know, the Office of the Actuary has estimated that the Medicare modernization act would increase net Federal costs by a total of $534 billion through fiscal year 2013.[1] The corresponding estimate by the Congressional Budget Office is $395 billion. OACT and CBO have independently estimated the cost of the modernization act using the best data, assumptions, and methods that each organization could develop. The following points summarize the nature of the differences in the estimates.

- The estimates differ principally because the future is uncertain, and this uncertainty is reflected in somewhat different assumptions regarding the numerous cost and behavioral factors that will affect actual future costs. In this regard, the difference in estimates is a useful reminder of the inherent uncertainty and a rough indication of the sensitivity of future costs to the underlying cost factors.

- Of the total difference of $139 billion between the estimates, approximately $100 billion relates to Title I of the act, the Medicare prescription drug program:

  — OACT estimates that about 94 percent of all Medicare beneficiaries would enroll in (or otherwise benefit from) the Medicare drug benefit,[2] compared to 87 percent for CBO, and we also estimate a slightly higher average, per-beneficiary value for the standard drug benefit. These factors account for $32 billion of the total difference.

  — While OACT and CBO estimate similar numbers of beneficiaries who are eligible for the low-income drug subsidy, OACT estimates a significantly higher enrollment rate by these individuals. In addition, our estimated average cost for the low-income subsidy per beneficiary is slightly greater than CBO's. Of the total difference in estimated drug costs, the low-income subsidy accounts for $47 billion.

  — The cost to Medicare of providing the drug benefit would be partially offset by net Federal savings for Medicaid. (Federal Medicaid drug expenditures would be eliminated, but other Federal Medicaid costs would increase somewhat; as beneficiaries enroll for the Medicare low-income drug subsidy, some will be found to qualify for Medicaid coverage). CBO estimates a greater degree of net Federal Medicaid savings, because their prior baseline projections included a rapidly growing cost for "pharmacy plus" Medicaid waivers. In total, the CBO savings estimate is $18 billion greater than OACT's.

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[1] This estimate excludes Federal administrative costs, other than the $1.5 billion authorized by section 1015 of the act, and the impact on social insurance payroll taxes and general income taxes. An additional Medicare expenditure of $16 billion through 2013 would be made for employer drug subsidy payments to Federal employers.

[2] Beneficiaries in employer-sponsored retiree health benefit programs are included in this percentage.

- $32 billion of the remaining difference in the overall cost estimates is associated with Title II, the Medicare Advantage program. OACT's estimated costs for this title are $46 billion, versus CBO's estimate of $14 billion:

  — CBO's estimate is based on a $10 billion cost for the regional PPO stabilization fund, and $4 billion for the "immediate improvements" in 2004 and later MA payment rates. They estimate that these changes will slow the decline in private plan enrollment, with about 9 percent of beneficiaries ultimately so enrolled. Regional PPOs are estimated to have costs somewhat in excess of the prevailing "payment benchmarks," with the result that few such plans could participate and beneficiary enrollment would be minimal.

  — OACT's estimate includes $12 billion for the stabilization fund and another $34 billion due to the higher payment rates starting in 2004 and the restructured payment formula in 2006 and later. We estimate that HMO enrollment would increase from its current level of about 12 percent to 16 percent and that PPO enrollment would also reach 16 percent in 2009 and later. The latter projection is based on estimated PPO costs that are generally below the payment benchmarks, with the result that beneficiaries could qualify for significant premium rebates and/or additional benefits. Because these estimated PPO costs typically exceed fee-for-service levels, however, Medicare costs for such enrollees would be higher than under prior law.

- Other differences exist between the OACT and CBO estimates for Titles III through IX. These differences tend to be smaller and are also largely offsetting (with CBO sometimes higher and sometimes lower than our estimates).

As you know, it is not uncommon for these two organizations to differ somewhat in their estimates. For example, CBO's estimated Medicare savings for the Balanced Budget Act of 1997 totaled about $116 billion in the first 5 fiscal years. The corresponding OACT estimates were $152 billion. Similarly, the BBA savings estimates over the first 10 years were $394 billion for CBO versus $517 billion for OACT. I believe that CBO has prepared competent, good-faith estimates for the Medicare modernization act. I prefer the assumptions and methods employed in the Office of the Actuary, and stand behind our own estimates, while recognizing that an uncertain future could prove all of us wrong.

Please let us know if you have any questions about this information.

Rick Foster

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop N3-01-21
Baltimore, Maryland 21244-1850

Office of the Actuary

DATE: June 21, 2003

FROM: Richard S. Foster
Chief Actuary

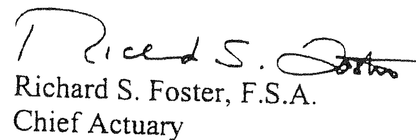
TO: Representative William M. Thomas
Chairman
Ways and Means Committee

SUBJECT: Estimated Proportion of Medicare Beneficiaries Who Would Purchase Drug Insurance Coverage under Ways and Means Medicare Reform Package

The Medicare reform legislative package reported earlier this week by the House Ways and Means Committee would provide for a voluntary program of prescription drug coverage for Medicare beneficiaries. Coverage would be offered through insurance companies and health plans, with partial Federal reinsurance for beneficiaries incurring high drug costs and with a Federal premium subsidy. Together, the reinsurance and premium subsidy would cover 73 percent of the average value of the drug benefit, for beneficiaries with annual incomes below $60,000. Beneficiaries could enroll in this program at any time but would face potential higher premium rates or preexisting condition exclusions if they delayed enrollment past their first opportunity.

We estimate that virtually all Medicare beneficiaries (i.e., at least 95 percent) would opt for such drug coverage. In general, we would expect a very high participation rate for any drug benefit with a substantial premium subsidy and potential penalties for late enrollment.

Please let us know if you have any questions about this information or if we can be of additional assistance.



Richard S. Foster, F.S.A.
Chief Actuary

cc: Thomas A. Scully

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop N3-01-21
Baltimore, Maryland 21244-1850

DATE: June 26, 2003

FROM: Richard S. Foster
Office of the Actuary

TO: Representative Charles B. Rangel
Ranking Member
House Committee on Ways and Means

SUBJECT: Estimated Impact of H.R. 1 on Premiums for Fee-for-Service Beneficiaries in 2010 and Later

Under H.R. 1, the "Medicare Prescription Drug and Modernization Act of 2003," premiums paid by beneficiaries in traditional fee-for-service Medicare would not be affected by the operations of private health plans prior to 2010. Beginning in 2010, the determination of such premiums for beneficiaries residing in "competitive" areas would be affected by the level of fee-for-service costs in the area compared to private plan costs. (In other areas—that is, those not meeting the criteria defining competitive areas—there would be no change in fee-for-service premiums.) A transition rule would limit year-to-year changes in fee-for-service premiums. This memorandum presents estimates of the changes in fee-for-service premiums under H.R. 1 in 2010 and later, for beneficiaries residing in "competitive Medicare Advantage areas" and "competitive Enhanced Fee-for-Service regions."[1]

It is important to understand that the impact of H.R. 1 on premiums for fee-for-service beneficiaries would vary substantially depending on such factors as:

- The cost of private EFFS and MA health plans relative to fee-for-service cost levels;
- The percentage of Medicare beneficiaries enrolled in traditional fee-for-service, EFFS plans, and MA plans, both for regions and for the nation overall; and
- The number of consecutive years that an area was "competitive," as defined in the bill.

As described below, we generally estimate that premiums for fee-for-service beneficiaries in competitive MA areas or EFFS regions would exceed those under current law. There are plausible situations, however, in which such premiums in some areas could instead be slightly lower than current-law levels.

[1] The beneficiary premium provisions in H.R. 1 for 2010 and later are complex, and a summary of these provisions exceeds the scope of this memorandum. Reference should be made to section 241 of the legislation for the specific definitions, rules, and formulas.

For areas in their fifth consecutive year as competitive MA areas or competitive EFFS regions (which would occur in 2014 at the earliest), the fee-for-service premium adjustment would be fully phased in, and we estimate that:

- For fee-for-service beneficiaries in competitive MA areas, premiums would be roughly 5 to 25 percent greater than under current law. This estimate is sensitive to the average cost of MA plans in the area and to the beneficiary enrollments in fee-for-service versus private plans.[2]

- For fee-for-service beneficiaries in competitive EFFS regions who are not also in competitive MA areas, monthly premiums would be slightly greater than under current law (for example, about 2 to 4 percent greater in 2014). This result is sensitive to the average level of private EFFS plan costs in the region and to the proportion of beneficiaries in fee-for-service compared to private plans.[3]

The transition provision would phase in any adjustments to fee-for-service premiums, based on the consecutive number of years that the area had been competitive. One-fifth of the full adjustment would be applied in the first such year, two-fifths in the second consecutive year, three-fifths in the third year, etc.[4] Consequently, the estimated ultimate premium impacts described above would be proportionally smaller during the initial transition (which would be 2010 through 2014 for many areas) or any later period involving fewer than 5 consecutive years as a competitive area. In addition, there is a possibility that, in some competitive MA areas during the transition, fee-for-service premiums would be adjusted downward rather than upward. This situation could occur if the average cost of HMOs in that area were greater than the fee-for-service cost level. By the final year of the transition, however, after the higher payment benchmarks for private plan premium determinations had phased out, we would expect any such areas to revert to non-competitive status. In this case, fee-for-service premiums would not be affected.

As noted above, these estimates apply only to Medicare beneficiaries residing in competitive MA or EFFS areas. Under H.R. 1, not all areas would meet the competitive criteria, in which case premiums for fee-for-service beneficiaries would not be affected. We have not yet estimated the proportions of beneficiaries who would enroll in fee-for-service Medicare versus MA or EFFS private health plans in 2010 and later. Prior to 2010, we estimate that roughly 57 percent of

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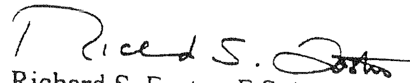
[2] With relatively high private plan enrollment, as we estimate, fee-for-service premium increases would be at the upper end of our estimated 5-25 percent range. With relatively low private enrollment, as estimated by the Congressional Budget Office, the fee-for-service premium increase would tend to be at the lower end of this range.

[3] We estimate that, by 2014, the average cost of the three winning PPO plans in most EFFS regions would be slightly less than the region's fee-for-service cost. If PPO costs were instead significantly greater, as estimated by CBO, then fee-for-service premiums in competitive EFFS regions would tend to be slightly less than current law, depending on the proportion of beneficiaries in the region enrolled in private plans.

[4] If a region or area that had been competitive subsequently became non-competitive, then fee-for-service premiums would revert to their normal, unadjusted level. If in later years the area again became competitive, then the transition would start over and fee-for-service premiums would again follow the pattern described above.

beneficiaries would remain in the fee-for-service program, with a total of roughly 43 percent in MA and EFFS plans.[5]

As suggested by the foregoing discussion, the impact of the post-2010 competition provisions on fee-for-service premiums is complex. In addition, the estimates shown in this memorandum reflect considerable uncertainty due to (i) lack of robust data on private plan costs, (ii) possible changes in beneficiary enrollments in reaction to the premium changes after 2010, (iii) ambiguity in certain of the draft legislative provisions, and (iv) the limited time available for preparation of these estimates, which necessitated simplified estimation methods. Consequently, while we believe that these estimates provide a reasonable indication of future fee-for-service premium levels under the draft legislation, they should be considered preliminary and used only with full awareness of their limitations.



Richard S. Foster, F.S.A.
Chief Actuary

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[5] For previous versions of the Medicare reform legislation, as developed in the Ways and Means Committee, we had estimated private plan enrollment at 48 percent prior to 2010. The lower estimate for H.R. 1 results from a change in the calculation of Medicare Advantage payment rates under section 212.

Rough estimates of increase in net Medicare and other Federal costs under selected draft Senate Finance proposals

(Based on June 10, 2003 "Chairman's Mark;" amounts in billions)

Proposal	Fiscal year										Total	
	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2004-2008	2004-2013
Medicare Advantage (effective 2006):												
HMOs	—	—	$1.4	$1.8	$1.8	$2.0	$2.1	$2.2	$2.3	$2.4	$5.0	$16.0
PPOs	—	—	$2.3	$3.8	$4.1	$4.2	$4.3	$4.4	$4.5	$4.6	$10.2	$32.0
Total for Medicare Advantage	—	—	$3.7	$5.5	$5.9	$6.2	$6.4	$6.6	$6.8	$7.0	$15.1	$48.0
Prescription drug benefit:												
Increase in Medicare costs	$3.6	$5.5	$36.5	$48.7	$53.1	$57.9	$62.7	$68.0	$75.8	$85.2	$147.5	$496.9
Net increase in Fed. Medicaid costs	—	—	$4.0	$5.8	$6.2	$6.7	$7.2	$7.7	$8.2	$8.8	$16.0	$54.6
Total for drug benefit	$3.6	$5.5	$40.5	$54.5	$59.3	$64.5	$69.9	$75.7	$84.0	$94.0	$163.4	$551.5

Notes:

1. Medicare Advantage estimates are very rough and provide only a general indication of the financial effect of this provision. In particular, under the draft legislation, there could be significant shifts in enrollment between HMOs and PPOs, which are not reflected in these estimates.

2. The draft SFC Medicare reform package has other provisions beyond those shown here. Estimates are not yet available for these other provisions.

3. See our June 5, 2003 note on alternative benchmarks for a description of why costs would increase under the Medicare Advantage PPO option. See cover e-mail regarding nature of HMO cost increase.

4. The "increase in net Medicare costs" refers to an increase in benefit expenditures and/or reduction in premium revenues. Estimates do not include impact of proposals on Federal administrative costs.

Office of the Actuary
Centers for Medicare Medicaid Services
June 11, 2003

FY	Deductible	Initial coverage limit	Coinsurance rate	Catastrophic out-of-pocket threshold	Catastrophic coinsurance rate	Average monthly premium	Federal costs ($ billions): General Premium Subsidy	Rein-surance	Low income subsidy	Rx card and transitional low-income subsidy	Total Medicare	Federal Medicaid	Total
2004										$3.6	$3.6	$0.0	$3.6
2005										$5.5	$5.5	$0.0	$5.5
2006	$275	$3,450	50%	$3,700	10%	$31.80	$17.0	$8.0	$9.2	$2.3	$36.5	$4.0	$40.5
2007	$303	$3,802	50%	$4,077	10%	$34.59	$24.4	$11.2	$13.1	$0.0	$48.7	$5.8	$54.5
2008	$333	$4,174	50%	$4,477	10%	$37.48	$27.0	$11.8	$14.4	$0.0	$53.1	$6.2	$59.3
2009	$364	$4,571	50%	$4,902	10%	$40.48	$29.8	$12.4	$15.7	$0.0	$57.9	$6.7	$64.5
2010	$398	$4,992	50%	$5,353	10%	$43.55	$32.7	$12.9	$17.1	$0.0	$62.7	$7.2	$69.9
2011	$434	$5,451	50%	$5,846	10%	$46.82	$35.9	$13.5	$18.5	$0.0	$68.0	$7.7	$75.7
2012	$474	$5,952	50%	$6,384	10%	$51.21	$40.3	$14.9	$20.6	$0.0	$75.8	$8.2	$84.0
2013	$518	$6,500	50%	$6,971	10%	$55.91	$45.5	$16.8	$23.0	$0.0	$85.2	$8.8	$94.0
2004-2013							$252.5	$101.5	$131.5	$11.4	$496.9	$54.6	$551.5

Notes: Dual-eligible Medicaid beneficiaries will retain their current Medicaid coverage. Medicare will waive the state requirement to pay the Part B premium for beneficiaries between 74% and 100% of the Federal poverty level. **Medicaid dual beneficiaries would not enroll in Medicare drug plans.**

Low-income persons (non dual-eligible Medicaid) will have the following benefit provisions and premium subsidies in 2006.

	QMB	SLMB / QI-1	<135% poverty	135-160% poverty
Deductible	$0	$0	$50	$50
Coinsurance to initial coverage limit	2.5%	5.0%	10.0%	10.0%
Coinsurance to catastrophic threshold	5.0%	10.0%	20.0%	20.0%
Coinsurance above catastrophic threshold	2.5%	2.5%	10.0%	10.0%
Premium subsidy	100.0%	100.0%	100.0%	Sliding scale

Low-income Medicare beneficiaries (under 135% of poverty) who apply and are determined to be eligible will receive up to $600 in 2004 and 2005 for the purchase of qualifying outpatient prescription drugs.

States would realize a Medicaid savings of $4.1 billion for the period 2006-2013.

Office of the Actuary
Centers for Medicare Medicaid Services
June 11, 2003

CHUCK HAGEL
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FOREIGN RELATIONS
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BANKING, HOUSING, AND URBAN AFFAIRS
CHAIR, SUBCOMMITTEE ON INTERNATIONAL TRADE AND FINANCE

SELECT COMMITTEE ON INTELLIGENCE

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March 16, 2004

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The Honorable Tommy Thompson
Secretary of Health and Human Services
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Secretary Thompson:

As you know, there have been recent allegations regarding a cost analysis by Richard Foster, the Chief Actuary of the Centers for Medicare and Medicaid Services (CMS). I understand that he has claimed in media accounts that his cost estimates showing higher cost figures than were announced by the Bush Administration were intentionally suppressed during last year's Medicare debate, and that he was threatened with termination if he revealed the higher cost figures to Congress.

While I am not surprised that the estimated cost of the new bill far exceeds official CBO figures, I am very concerned about these allegations and the possible threats against Mr. Foster.

Concerns about the cost of the bill were raised repeatedly during the Medicare debate. If your agency possessed higher cost estimates, those estimates should have been disclosed for full discussion and debate. Estimates by the CMS Chief Actuary are not binding on Congress, but the figures would have been helpful during the debate and should have been released.

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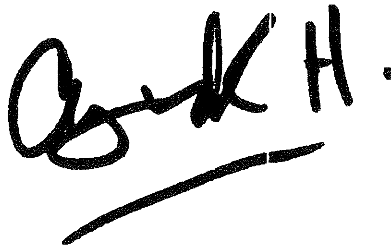
chuck_hagel@hagel.senate.gov

0316200400?

I would like to know if Members of Congress requested cost estimates from the Chief Actuary for the Medicare bill, and whether those requests were addressed. If the requests were not answered, why not? And what do you know about the threat of termination and withholding information from Congress that is alleged by Mr. Foster?

I look forward to your earliest response. Thank you.

Sincerely,



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Congress of the United States
House of Representatives
Washington, D.C. 20515

February 3, 2004

The Honorable Tommy G. Thompson
Secretary of Health and Human Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Mr. Secretary:

We are writing to you regarding the recent news that the Administration estimates that the Medicare prescription drug bill signed into law in December will cost more $534 billion over the next ten years — $134 billion more than estimated by the Congressional Budget Office at the time of passage. In particular, we are concerned about reports that although the Administration knew of these estimates well before passage of the legislation, this news was withheld from Congress and the public until just last week.

The President indicated on January 30, 2004, that he learned of the new estimate of the costs of the drug benefit only two weeks ago.[1] But recent press accounts suggest that the Administration was aware of these costs well before Congress passed the legislation. The *Washington Post* reported that "administration officials had indications for months that the new Medicare prescription drug law might cost considerably more than the $400 billion advertised by the White House and Congress."[2] According to the *New York Times*, Tom Scully, who was Administrator of the Center for Medicare and Medicaid Services (CMS) when the bill was passed, said, "the [cost] estimate may be surprising to some people, but it's not shocking to me."[3]

Yesterday, the *New York Times* reported that "the administration now says the actuaries' cost estimates have been over $500 billion since last summer."[4] The article also quotes you as saying that "Congressional staff knew our actuarial numbers . . . There was no attempt to keep

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[1] *Bush Says He's Undaunted by Drug Costs*, New York Times (Jan. 31, 2004); *White House Brushes Aside Criticism over Medicare Plan*, Los Angeles Times (Jan. 31, 2004).

[2] *Higher Medicare Costs Suspected for Months*, Washington Post (Jan. 31, 2004).

[3] *White House Defends Medicare Law Despite Higher Price Tag*, New York Times (Jan. 30, 2004).

[4] *White House Now Says Congress Underestimated New Medicare Costs*, New York Times (Feb. 2, 2004).

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our number camouflaged."[5] While we have no knowledge of what you communicated to Republican staff, we can say categorically that this information was not communicated to us or our staff. Moreover, you and other administration officials continued to state publicly that the legislation would cost only $400 billion when Congress was voting on the legislation.[6]

The new cost estimate for the final bill has critical implications. If the Administration's new higher estimate is correct, the limited prescription drug benefit, which was crafted by the White House and Republican leaders, will now have a far higher price tag for its meager services than previously estimated. And the federal budget deficit, which was already anticipated to reach record levels, will now be even larger than expected.

Moreover, critical parts of the Medicare program, not just the prescription drug provisions, could be put at risk. The $134 billion in additional costs could trigger a little-noticed provision of the Medicare law, potentially causing significant cutbacks in the drug benefit and Medicare payments to physicians and clinics.[7] Under this provision, if the costs of Medicare Part B (physician and outpatient services) and Medicare Part D (the new drug benefit) exceed 45% of total Medicare costs in any two-year period, Congress must consider legislation under expedited procedures to cut funding for the drug benefit or physician payments or both.

Congress and the public should know what the Administration knew about the costs of the prescription drug benefit and when the Administration knew it. For this reason, we request that you provide us with all estimates of the costs of adding a new prescription drug benefit to Medicare and cost estimates and other analyses (e.g., plan and beneficiary participation) for legislation to increase the presence of HMO and other private plans under Medicare that have been prepared since January 1, 2003, by the HHS Office of the Actuary. This information should include any estimates by the Office of the Actuary of the costs of:

(1) S. 1, the legislation passed by the Senate;

(2) H.R. 1, the legislation passed by the House;

(3) Versions of the final legislation that were under consideration by the conference committee appointed after Senate passage of S. 1 and House passage of H.R. 1; and

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[5] *Id.*

[6] See, e.g., Tommy G. Thompson, *Fox News Special Report with Britt Hume* (Nov. 24, 2003); Tom Scully, *The Medicare Bill: A Good Thing* (Letter to the Editor), New York Times (November 20, 2003) Tom Scully, *The Right Prescription for Medicare* (Letter to the Editor), Chicago Tribune (Nov. 23, 2003).

[7] Public Law 108-173, Section 801(e).

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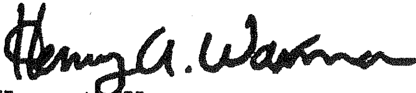
(4) The final legislation signed by the President on December 8, 2003.

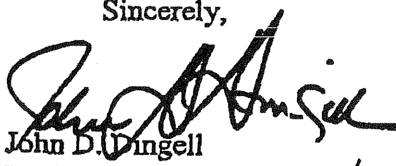
In addition, we are requesting the CMS Actuaries' analysis of the legislation's impact on the projected solvency dates of the Medicare Hospital Insurance Trust Fund and the actuaries' analysis comparing the payments to various private plans relative to Medicare.

Given the significance of this matter, we request that you provide these cost estimates to our offices by February 17, 2003.

Sincerely,



Henry A. Waxman
Ranking Minority Member
Committee on Government Reform



John D. Dingell
Ranking Minority Member
Committee on Energy and Commerce

Charles B. Rangel
Ranking Minority Member
Committee on Ways and Means