THE FOLLOWING INDIVIDUALS WILL BE IN ATTENDANCE AT SENATOR DOLE'S MEETING ON WEDNESDAY, MARCH 30, 2:00PM, DES MOINES EMBASSY SUITES:

STEVE WETZEL
BUSINESS HEALTH CARE ACTION GROUP
MINNEAPOLIS, MN

TOM FORSYTHE
GENERAL MILLS
MINNEAPOLIS, MN

LARRY SCHWANKE
BEHMIS COMPANY
MINNEAPOLIS, MN

SCOTT WEISER
IOWA MOTOR TRUCK ASSOCIATION
DES MOINES, IA

LINDA JONES
HEALTH CARE POLICY CORPORATION OF IOWA
DES MOINES, IA

PAUL PIETZSCH
HEALTH CARE POLICY CORPORATION OF IOWA
DES MOINES, IA

CHARLIE EDWARDS
PUBLISHER
DES MOINES REGISTER
DES MOINES, IA

RON PEARSON
HYVEE FOOD STORES
CHARITON, IA

RANDY SACKETT
DIRECTOR OF HUMAN RESOURCES
RUAN COMPANIES
DES MOINES, IA

LARRY MILLER
RUAN COMPANIES
DES MOINES, IA

Roger Brooks
Central Life Ins. Co.
DSM, IA

Business Health Care Action Group
Public Policy Discussion
March 30 1994

Facts regarding the Business Health Care Action Group (BHCAG)

- Minneapolis/St. Paul group purchasing organization.
- 21 self-insured employers who have developed health plan offered to 250,000 employees, retirees and their families primarily located in Minnesota, western Wisconsin, with additional enrollees in eastern North and South Dakota, and Northern Iowa. (Member employers provide health care coverage for more than 1.5 million Americans in all 50 states and District of Columbia.)
- Member employers include:

Bemis Company, Inc.	General Mills, Inc.	Norwest Corporation
Cargill, Inc.	Honeywell, Inc.	Northern States Power
Carlson Companies	IDS Financial Services	Pillsbury Company
Cenex	Land O' Lakes	Rosemount, Inc.
Ceridian Corporation	Medtronic	Supervalu Inc.
Dayton Hudson Corp.	Minnegasco	Tennant
First Bank System	Minnesota Mutual	3M

- Reform is based on improved quality, increased provider accountability and competition, increased consumer knowledge and responsibility, and enhanced efficiency of the health care system.
- ERISA preemption has allowed this innovative approach to develop systems that improve quality and accountability and thereby contain costs.

Key features of BHCAG reform activity

- Common health plan design and administration effective 1/1/93.
- Self-insured "Point-of-Service" benefit design that includes comprehensive major medical, preventive care, mental health, substance abuse and pharmacy benefits.
- Common vertically integrated network of contracted providers, including the Mayo Clinic, which offers individual freedom to choose physician while offering consumers financial incentives to use the most cost effective, high quality health care professionals.
- Non-profit purchaser/provider governed quality improvement organization to develop and implement practice parameters, assess new technologies, develop automated medical record, conduct population health and member satisfaction surveys.
- Health care professionals and employers working together to define and measure quality standards, measure outcomes, assess new technologies, and develop and offer consumer education courses at the work site.

1993 Results

- 90,000 enrolled members in five states.
- Non-profit provider/purchaser governed organization established which in 1993 developed and implemented 16 guidelines, assessed 8 medical technologies, developed prototype for automated physician work station, measured outcomes measured for six conditions.
- First year savings of 11% compared to other managed care products in Minnesota, savings in addition to Minnesota costs that are 20% below national average.
- Savings due to improved efficiency and reduced utilization which benefits all purchasers, not due to additional discounts which would be cost shifted to other payers.
- 1993 average cost of $2,500 per employee - average family size of 2.1 people means average annual cost of $1,200 per covered life.
- Administrative costs are 8% to 10% of total plan expenses, coalition budget less than 1% of total plan cost.
- Current annual rate of increase of 4% - 5%.

General Public Policy Issues Pertaining to Self-Insured Employer Based Health Plans

- Primary concern is to maintain regulation of multi-state self-insured employers under the sole jurisdiction of the federal government.
- Change in federal regulation is needed to allow purchasers to negotiate creative risk sharing arrangements with providers outside state insurance regulation.
- Malpractice reform to make use of practice parameters an absolute defense.
- If standard benefit sets are imposed, should be at the federal level.
- Federal underwriting reform appropriate.
- Federal data standards to benchmark quality, satisfaction and value.
- Federal regulation and funding of new and evolving technologies and medical education is needed.
- Multi-state employers must have option to participate in Health Alliances on a market by market basis.
- Medicare/Medicaid reform a priority.

Business Health Care Action Group

1993 Annual Report

About This Report

This report highlights 1993 progress towards meeting the Business Health Care Action Group's health care system reform goals. It also provides background information about the organization and highlights strategic plans and key issues in 1994 and beyond.

The Business Health Care Action Group and Its Mission

Recently, a group of Minneapolis/St. Paul based organizations decided to create a model to demonstrate the positive role the private sector can play in meeting society's health care needs. The Business Health Care Action Group (BHCAG) is a working model of the value the private sector can bring to the nation's health care reform movement.

The BHCAG is a group of twenty one, large self-insured Minneapolis/St, Paul based employers. This coalition currently provides health care benefits for about 250,000 employees and their families in the greater Twin Cities community. Nationwide, BHCAG member employers cover in excess of 1.5 million lives. The twenty one BHCAG member companies include:

Bemis Company, Inc.
Cargill, Inc.
Carlson Companies
Cenex
Ceridian Corporation
Dayton Hudson Corporation
First Bank System
General Mills, Inc.
Honeywell Inc.
IDS Financial Services, Inc.
Land O' Lakes
Medtronic
Minnegasco
Minnesota Mutual
Northern States Power Company
Norwest Corporation
Pillsbury Company
Rosemount, Inc.
SUPERVALU INC.
Tennant
3M

The member employers of the BHCAG are dedicated to progressive reform of the health care system. This coalition is dedicated to reform through:

- Improved quality
- Increased provider competition
- Increased consumer knowledge and responsibility for health care decisions
- Enhanced efficiency of health care delivery

We believe that employers who purchase health care can use their influence as a catalyst for progressive reforms, not only for those to whom we provide coverage, but also for the community as a whole. This approach to reform will benefit consumers, purchasers, and providers who delivery high quality, cost effective care. We believe that the experience gained through this initiative can be applied to health care reform on a broader basis.

Principles to which the BHCAG has agreed include:

- *Consumer responsibility for health care:* The BHCAG is dedicated to stimulating competition between integrated systems of care based on cost and quality. This will allow consumers to choose care delivery systems based on the cost and quality of care over the long term. In addition, consumers are expected to take added responsibility for managing their own health and consumption of health care resources. Co-payments and plan incentives will also promote appropriate use of health care resources.

- *Provider accountability and continuous improvement:* Development of best practice parameters, outcomes-based comparative data, and quality indicators will occur over time to accommodate continuous quality improvement. To foster physician ownership and active use of practice parameters, development of these tools should occur in a provider governed setting.

  Third party involvement in the health care delivery system will be minimized as much as possible. Providers will be encouraged to work in partnership with purchasers and payers to share information to identify best practice standards and outcomes data and continuously learn from their peers.

- *Common plan design and administrative structure:* All BHCAG companies have agreed to common design and administration to reduce administrative and compliance issues currently faced by providers.

- *Meaningful quality and utilization data:* Clinical and population health data will be gathered over time to stimulate competition between integrated systems of care and assist providers and payers in identifying best practice standards and innovative tools to improve population health status. Data will not be used to identify "bad apples," but rather to stimulate improved quality and competition between competing systems of care.

Participating BHCAG companies began introducing a new health care plan designed around these principles effective January 1, 1993.

The Minneapolis/St. Paul Health Care Market

Managed care is not a new concept to the Twin Cities of Minneapolis and St. Paul. Organized systems of care have been evolving for many years.

At the time the BHCAG decided to engage in a group purchasing initiative, the market was dominated by Health Maintenance Organizations (HMO's) and Preferred Provider Organizations (PPOs). It is estimated that about 70% of the residents of the greater Minneapolis/St. Paul urban area are currently enrolled in some form of "managed care" health plan featuring contracted relationships between providers and insurance carriers or health maintenance organizations. In addition, the market has significant numbers of large group medical practices and multi-specialty clinics. Health care costs in the Twin Cities are about 18% to 20% below the national average.

However, in spite of this high penetration of managed care products and lower than national average costs, the member employers of the BHCAG strongly believed there was need for improvement in the quality and efficiency of the health care system. Meaningful quality data about competing health plans and provider networks was not available to consumers or purchasers. Because providers were often contracted with multiple managed care products, there was not a real incentive at the individual hospital or clinic level to compete for patients based on cost and quality.

In addition, managed care contracts with providers were largely based on discount fee for service arrangements. While addressing unit pricing, this approach did not get at the issue of futile and unnecessary care. Nor did it reward providers based on the quality of care provided.

In addition, like Medicare/Medicaid reimbursement policies over the past several years, the extensive use of discounts to generate "savings" resulted in significant cost shifting by health care providers within the Twin Cities market to participants in non-managed care (e.g. - indemnity) health plans. Medical inflation rates, while running well below the national average, still exceeded real growth in the economy.

In this environment, BHCAG decided that purchasers, working directly with preferred providers in a long term arrangement, could improve on the current health care delivery system.

The BHCAG Model for Group Purchasing

Health Care Coverage for the Participants

All twenty one companies have agreed to a common plan design and administration to reduce non-health care related expenditures. Administrative costs are estimated to be 8% to 10% of the total cost of the health plan. The plan is based on a concept called "point-of-service." This benefit design allows covered individuals the freedom to choose physicians which has historically accompanied indemnity type insurance plans. The plan also offers the option for participants to use more accountable, cost effective contracted providers in exchange for higher benefit coverage.

All BHCAG member companies have contracted with the same network of hospitals, physicians, nurses and allied health professionals with the assistance of a large managed care organization called HealthPartners. The network of contracted providers includes 50 medical groups with 175 clinic locations, more than 900 primary care providers, 30 hospitals, and 3,000 specialists.

When using contracted providers, plan participants receive "in-network" benefit coverage. A primary care clinic site must be designated by the participant and referrals to specialists must be made by the designated primary care provider to qualify for the higher in-network benefit coverage. Families may designate a different primary care clinic for each family member and may change their primary care clinic designation as often as once a month.

Generally, clinic based services provided by a contracted provider require a $10 co-payment by the consumer. In-patient coverage is 100% after a $100 deductible. Comprehensive adult and pediatric preventive care benefits are included when contracted providers are used for these services. In addition to preventive and comprehensive major medical coverage, the plan covers mental health, substance abuse, prescription drugs and durable medical goods. "Out-of-network" benefits are generally paid at 70% with an annual limit on expenses paid by the participant.

Provider Accountability

The health plan with which the BHCAG is contracted has agreed to a three year guarantee on cost increases. Contracted providers are held accountable for the cost of their care through negotiated fee schedules and cost targets. During 1994, the BHCAG will work with the health plan to negotiate an annual budget with select participating providers to deliver care for plan participants. The traditional reimbursement method based on number of units of services delivered will be abandoned over time in favor of reimbursement systems designed to incent providers to manage the overall health of an enrolled population.

Accountability for quality of care and the medical necessity of services delivered is attained through the development of mutually agreed to guidelines and measures of patient outcomes. A joint purchaser/physician governed organization called the Institute for Clinical Systems Integration is responsible for all guideline development and implementation and measurement of outcomes. Data is used as a tool to teach participating health providers how to improve the quality and cost effectiveness of their care, not as a "weapon" to search out "bad apples."

Joint purchaser/provider assessment of the appropriate application of new technologies has also been agreed to.

Population health will be measured over time to identify opportunities for development of guideline topics and consumer education programs to focus on keeping people well as opposed to the more traditional relationship between purchasers and providers of paying for illness.

The Institute for Clinical Systems Integration is also responsible for developing an automated medical record for use by participating network providers. This record will enable the integration of guidelines and the collection of outcomes data to be imbedded in the day-to-day practice of medicine.

The Consumer/Patient's Role

Both participating purchasers and providers believe that the consumer/patient has a significant role to play in solving our health care problems. Extensive investments in consumer education are underway. An emphasis on appropriate self-care, preventive care and consumer skills in understanding the health care delivery system will be paramount in joint purchaser/provider efforts to provide participants with the tools to better manage their own health. Patients are also be held accountable for services they consume by reasonable co-payments.

Estimated Financial Impact

First year savings range from 5% to 15% compared to other managed care options in the community. Administrative cost increases are limited to CPI and will remain flat if certain enrollment goals are met.

Aggregate trend guarantees are in place for three years. In addition, commitments have been made to reduce cost increases for physician and hospital services by 1% per year relative to real growth in the economy.

1993 Progress & Highlights

Enrollment and Membership

Nine of the original fourteen BHCAG member companies offered the coalition's "Choice Plus" health plan in 1993. The plan covered about 45,000 lives during the year. This represents about 70% of the benefit eligible population for these nine employers.

Seven large self-insured employers have joined the coalition during 1993 bringing total membership to 21 companies covering about 250,000 lives in the greater Minneapolis/St. Paul area. Twenty employers offered the coalition plan on January 1, 1994. Enrollment during 1994 is expected to range between 85,000 and 90,000 members. Several additional employers are considering membership in the coalition.

Financial Results

Although final 1993 claims experience will not be available until the end of the first quarter of 1994, current data indicates that the average cost for Choice Plus family coverage will be about $2,500. Single coverage will average about $1,200. Current trend data suggests an increase in plan cost of between 4% and 5% during 1994.

Estimated 1993 costs represent about a 11% reduction compared to expected costs if comparable HMO and managed care products previously available in the Minneapolis/St. Paul market had been offered. This reduction was achieved through reduced utilization and lower administrative costs, not by negotiating discounts on provider fees which could be cost shifted to other purchasers.

Provider Quality Improvement

Sixteen guideline topics were selected in 1993. Eight medical groups volunteered to serve as first year pilot sites for implementation of these guidelines. Topics selected include:

- Simple cystitis
- Active mgmt of labor
- VBAC
- Low back pain
- Pediatric asthma
- Depression
- Hypertension in adults
- Cigarette smoking
- Breast cancer detection
- Fetal distress during labor
- Pre-term birth prevention
- Common cold in adults
- Common cold in children
- Pediatric immunization
- Cervical cancer screening
- Chronic stable angina

Fourteen guidelines were completed by year end 1993 with the other two completed early in 1994. Installation and measurement of these guidelines is underway at all pilot medical groups. The first guideline developed was for simple cystitis (urinary tract infection) in adult women. This guideline will reduce the cost of treating uncomplicated urinary tract infections by as much as $90 - $100 per episode while improving the timeliness of treatment and reducing complications associated with excessive doses of antibiotics. If applied on a national basis, it is estimated that this guideline could save as much as $700 million per year while improving access and quality of care.

An additional twelve medical groups have been identified to participate in guideline development and implementation activities beginning in 1994. The twenty medical groups which will participate in guideline development and implementation represent about 88% of the volume of care delivered by participating providers in the BHCAG health plan. 1994 guideline development topics have been selected. Those topics include:

Colon cancer screening	Cholesterol screening
Adult immunization	Preventive counseling
Preventive service delivery	Adult asthma
Treatment of hypertension	Anxiety
Ear infections in children	Chest pain

Six clinical indicators have been identified to begin benchmarking quality across the provider network. Those indicators and the specific variables are:

- Breast Cancer

  % of women with mammogram ordered
  % of women aged 50-74 with mammogram
  % of newly diagnosed cases stage I or less
  % of diagnosed cases stage II or less

- Total Hip Replacement

  Measure of functional status before and after surgery

- Childbirth

  Vaginal birth after c-section rate
  C-section rate
  % of deliveries that occur at < 37 weeks

- Heart disease

  30 day mortality following Coronary Artery Bypass Graft

- Childhood infectious disease

  % of children aged 27 mos. who have had recommended immunizations

- Asthma in children

  Rate of hospital admission for asthmatic children aged 0-18 years

Joint purchaser/provider assessment of new and emerging technologies is another key quality control initiative. During 1993, a joint purchaser/provider group was established to review the effectiveness of certain medical technologies. The scientific assessment of these technologies is then linked to benefit coverage decisions. Topics reviewed to date include:

- Cochlear (ear) implants
- Bone marrow rescue with chemotherapy for breast cancer
- Laser surgery to correct vision problems
- Pancreas transplants
- Chest compression devices for cystic fibrosis
- Immune globulin for neurological conditions
- Lung transplantation
- PSA for prostate cancer screening
- PET and SPECT scans for seizure disorders
- Interferon for multiple sclerosis

Development of a prototype physician work station to support an automated medical record was completed in 1993. This prototype will have the following general capabilities:

- Patient profile & diagnostic summary
- Allergies and childhood immunizations
- Clinic appointment history
- Store and retrieve lab, x-ray, notes
- Electronic service orders
- Computerized guidelines

Provider Network Development

When Choice Plus was introduced on January 1, 1993, the network of participating providers consisted primarily of those providers who previously participated in the old Medcenters and Group Health HMO products.

During 1993, steps were taken to begin reducing the number of specialists to more properly align available network resources with the long term needs of the enrolled population. Specialty network refinement in 1994 will focus on orthopedics, ENT,

radiology and anesthesiology. A project is underway to identify Centers of Excellence for certain low frequency, high cost, high technology procedures such as transplants. A common prescription drug formulary will be developed and introduced in 1994.

With the addition of new BHCAG member employers with different geographic needs, network development is underway in several new markets, including Fargo/Grand Forks, western Wisconsin, and Duluth. A primary care contract was negotiated with the Mayo Clinic in 1993 and the Choice Plus product was offered through the Mayo Clinic beginning January 1, 1994.

Consumer/Patient Focused Initiatives

Ultimately, the success of the BHCAG project will be largely determined by employee, retiree and dependent perceptions of the quality and cost effectiveness of care delivered by contracted providers. As a first step to establish general levels of sophistication among BHCAG employees and assess current perceptions on the cost and quality of care, a series of focus group meetings were held early in 1993. Employees and dependents were interviewed to discuss their view of the consumers' role in the consumption and delivery of health care. Network providers were also interviewed regarding the current and 'ideal' health care consumer.

This feedback was used to develop a strategy to address consumer and provider education needs. At year-end 1993, plans were being finalized to improve consumer understanding of health care issues and make consumers more informed and active participants in health care decisions. Provider education to support guideline implementation and an improved consumer focus is also being developed. Aggressive consumer and provider education activities will be initiated in 1994. Two consumer courses covering self care and consumerism will be developed and offered at BHCAG employer work sites during 1994.

Community/Public Policy Issues

The BHCAG's influence has extended beyond the individuals covered by coalition employers and providers who are contracted to provide care for that population. All the major health plans, hospitals and provider groups in the region routinely cite the BHCAG's Request for Proposal as a tool that is being used in their strategic plans. With the addition of several employers in the east metro area, BHCAG influence with the St. Paul market has been substantially improved.

The goals of the BHCAG are not fully understood or viewed favorably by some leaders in the state reform movement. Because the coalition members are self-insured and not subject to state regulation, there is a certain degree of tension between the coalition and certain stakeholders currently leading the state reform movement.

To address this issue, the BHCAG has actively sought to communicate its role as an organization seeking to benefit the needs of the broader community. A presentation on the BHCAG and its objectives was given to the State Health Care Commission. Several meetings have been held with the Commissioner of Health and representatives from the Governor's office.

A representative of the BHCAG now participates as a member of the State Health Care Commission. The BHCAG has a representative on the ISN Advisory Committee, a group charged with developing recommendations to guide the development of competing integrated systems of care to meet the health needs of all Minnesotans. The BHCAG also has a representatives on the Governor's task force to track federal health care reform and its effect on Minnesota. Two BHCAG representatives serve on the Board of Directors of the recently formed public/private Health Care Data Institute. A BHCAG representative serves on a task force to identify methods to improve immunization rates for children throughout Minnesota.

The BHCAG is not favorably viewed by some members of the small employer community. Not understanding the organization's goal to reform the delivery system to benefit all purchasers, many small employers believe that these large employers are forcing providers to cost shift to small businesses. Representatives of the BHCAG have spoken at numerous seminars to correct this misconception, including several sponsored by the Minnesota Chamber of Commerce. The BHCAG is currently exploring methods to bring small employers into the coalition to allow businesses of all sizes to participate in BHCAG developed health plans.

Federal reformers have also followed the BHCAG project closely. During 1993, representatives from the BHCAG spoke with and submitted information to the Clinton Task Force on numerous occasions. During her 1993 visit to the Twin Cities, Mrs. Clinton was informed by three of four panelists at a session sponsored by Senator Durenberger that the driving force behind market reform in the Twin Cities is the BHCAG. Several BHCAG representatives also have testified before various senate and house subcommittees pertaining to various health care reform issues.

Health care policy experts have challenged the BHCAG's decision to offer only one coalition sponsored product. Common concerns include the creation of an oligopoly which would undermine competition in the Twin Cities market. Concerns are also expressed about provider choice when the coalition only offers one network.

Many experts not fully aware of the benefit practices of BHCAG member employers do not realize that the majority of BHCAG companies continue to offer competing health plans and provider networks not sponsored by the coalition. Further, the BHCAG is concerned with rewarding providers who participate in the Choice Plus network with the opportunity for improved market share in exchange for improved quality and cost effectiveness. The coalition has determined that it would be premature to develop

additional competing products prior to 1996. However, the BHCAG plans to introduce several competing health plans to the Minneapolis/St. Paul market effective January 1, 1996.

The BHCAG member employers have recognized the unique challenges faced by the University of Minnesota since the inception of the project. The BHCAG member companies recognize the need for a strong academic medical school to support the needs of Minnesotans. Early in 1993, the BHCAG established a special task force to dialogue with leaders from the University to see how the BHCAG and its member employers could help the University redefine its role in the community and establish adequate financial support to meet the needs of the restructured institution. The BHCAG hopes to use its influence in 1994 to continue working with the University as it seeks to meet the significant challenges it currently faces.

The BHCAG also recognizes that even though it advocates a model of managed competition, collaboration is still in the community's best interest relative to certain health care needs. The BHCAG is concerned about the proliferation of potentially redundant quality improvement initiatives in the Twin Cities market. During the fall of 1993, the BHCAG requested that all the major health plan and provider systems respond in writing to indicate where they believed competition was appropriate and when collaboration would best meet the needs of the community.

As a next step, the BHCAG plans on bringing all the key leaders in the health care community together at a 'Health Care Summit Meeting' to discuss these responses and develop consensus. One example where the BHCAG believes the there should be a spirit of community need and shared information is in the area of quality improvement and guideline development. The coalition believes that all clinical guidelines should be in the public domain and available to any interested provider.

There has been a growing national and international interest in the work of the BHCAG. During 1993, the BHCAG was featured in such publications as The Wall Street Journal, Baltimore Sun, Chicago Tribune, and the New York Times. The BHCAG was also featured on the CBS Evening News and a one hour PBS special on innovative approaches to health care reform.

Requests for information on the BHCAG have been received from throughout the country and the world. During 1993, employer coalitions in Rockford, Illinois and Dayton, Ohio contacted the BHCAG for information on its project and adopted the model for their own communities. Information was requested by and provided to employers, health plans and providers in San Francisco, Des Moines, St. Louis, Albany, Phoenix, Milwaukee, Chicago, Baton Rouge, Portland, Cleveland, Witchita, and Grand Forks, Michigan. Representatives from France, Great Britain, Finland and South Africa visited with BHCAG representatives to gather information about the project.

Strategic Issues for 1994 and Beyond

Recently, the BHCAG member employers met to discuss progress in 1993 and identify strategic initiatives in 1994 and beyond. The organization's future will be largely determined by the nature of any regulatory changes passed at the federal level. Under the current regulatory environment, the regulatory activity at the state level has little or no impact on the BHCAG and its member employers because of ERISA preemption.

The following strategic initiatives will dominate the BHCAG's activities during 1994:

- Audit of HealthPartners contractual performance guarantees & renegotiate outstanding HealthPartners contract issues.
- Develop and negotiate new provider reimbursement methods introduced for target medical groups.
- Continued Choice Plus network refinement, including new market development, specialty network refinement, and selection of Centers of Excellence.
- Improved management of Choice Plus pharmacy costs and quality.
- Implementation and measurement of work site education to improve BHCAG support of improved health care consumerism and individual health management.
- Development and implementation of consumer and provider education programs.
- Development and implementation of improved underwriting and actuarial calculation methods.
- Improved BHCAG outreach and support of participating Choice Plus providers.
- Continued application of BHCAG influence to maximize positive influence on the national and local health care market, including consideration of the introduction of competing networks in 1996 and establishing insured products for small businesses.
- Determine feasibility of workers compensation project.

Conclusion

The member companies of the BHCAG are committed to providing high quality, cost effective care for the people they cover. Further, by creating cost containment and quality improvement efforts in the health care industry, the coalition is benefiting the broader needs of society by serving as a catalyst to reform the health care system.

The future of this project will be dictated largely by the new regulatory environment created by national and state health care reform. Hopefully, the new regulations will support an active role for the private sector in reforming our health care system.

Anyone with questions about the BHCAG is encouraged to call Steve Wetzell, Executive Director, at (612) 854-7066. Written requests for information should be directed to:

Business Health Care Action Group
c/o Steve Wetzell
3639 Elmo Road
Minnetonka, Minnesota 55305

Correcting the Record on the Chafee Health Care Reform Bill: Misrepresentations Made in "Families USA Report -- The Human Impact of Health Reform"

Family and Problem	Families USA Misrepresentation	The Truth about the Chafee Bill
People Who Will Lose Their Insurance: Jerry and Donna Weldon Fenton, MO. Jerry is a plumber and gets insurance through his union. He must work a minimum number of hours to qualify for health insurance coverage. The Weldons are worried that they will lose their coverage in the future because of Jerry's lack of work and the increasing number of hours required for coverage.	Chafee: The Weldons would still have to worry about health insurance.	Under HEART, by 1998, no family would lose, or be charged a higher rate for their health insurance because of a change in health or employment status. Since the Weldon's are now covered, they will not have to worry about pre-existing condition exclusions or waiting periods or being dropped from coverage for health reasons. They will also benefit from a new community rating provision that will ensure they pay the same price for the same plan as any other family in their age

group.

The union will be required to offer the Weldons a comprehensive standard benefit package and information on the quality, service and price of all of the qualified insurers in the area, regardless of the number of hours he works. If the union does not contribute toward the Weldon's premiums, they will still be eligible for the lower group rate, and if their annual income is below $29,568, they will be eligible for federal vouchers to assist in the payment of premiums. In addition, premiums paid by the family will be deductible.

Daley 863-8700

3pm 224-6117 Pat 1596-2234

Inadequate Insurance:
Susan and David Mast
Wheaton, MD.
David is a self-employed contractor with an income of $20,000 and he and his wife have three young children. They had insurance coverage, but it does not include maternity care. In 1992, their son Joshua was born. Susan worked two jobs to pay off the $3,300 bill from the birth.

Chafee: Would not guarantee the Mast family comprehensive benefits.

The Chafee bill provides for a standard benefit package which would cover prevention services, including maternity services. A benefits commission will recommend changes and copayments to Congress. The Masts would have a greater selection of health insurance plans than they do now. In addition, they would be eligible for federal subsidies in the form of vouchers and tax deductions to assist in the payment of health insurance premiums.

High Prescription Drug Costs:
Iona O'Neill
Spring Hill, FL.
Mrs. O'Neill's income from Social Security is less than $700 per month. She has no

Chafee: Iona O'Neill would still have to spend $3,600 or more a year for prescription

Ms. O'Neill would have a variety of choices. First, she could take the value of her

coverage for prescription drugs and spends $300 per month on medicine.	drugs.	Medicare program and purchase the standard benefits package which will include drug coverage. Second, she could choose to enter a new Medicare managed care plan offering prescription drug coverage.
Early Retirees Losing Health Benefits: Casey and Bonnie Patelski Costa Mesa, CA. Mr. Patelski retired at the age of 63 and had health insurance coverage as a retiree through McDonnell Douglas. A year later, his former employer eliminated health benefits for retirees, and the Patelskis were allowed to purchase insurance coverage with their pension funds.	Chafee: The Patelskis would still have to pay 100 percent of their health insurance premiums.	The Patelskis would be able to choose from among any insurance plan offered in their area, and if their annual retirement income is below $23,616, they would receive vouchers from the federal government to pay their premiums and would be able to deduct the cost of any additional premium they incur. (Also, please note that the Clinton provision on this is not limited

to those who have lost coverage, but also to those who <u>have</u> coverage -- thus shifting the burden of retiree health commitments from large companies to taxpayers.)

Job Lock:
Melanie and Randy Wood
Houston, TX.

The Woods have three children and one has a serious health problem. Melanie wanted to quit working after the birth of their third child and become a full-time mother, but since her husband was self-employed and did not have access to a group health plan, Melanie was forced to return to work to keep health insurance for her family.

Chafee: If Melanie Wood became a full-time mother, the family could purchase insurance through a number of local purchasing groups or on their own. They would be eligible for assistance with premium costs, but there is no way of knowing what benefits their premiums would cover and what out-of-pocket expenses they would have.

Melanie Wood could become a full-time mother without worrying about insurance coverage. The family could purchase a comprehensive standard health insurance plan through a purchasing group or directly from an insurance company. Insurers would be prohibited from charging the Woods a higher premium than the community rate because a member of the family has health problems. In addition,

if their annual income is below $41,472, the Woods family will receive a voucher to assist in the purchase of health insurance. Their out-of pocket expenses would be set by a federal benefits commission, subject to Congressional approval.

Small Business Owners and Their Families:
Ann and Hubert Maddux
Corpus Christi, TX.
The Madduxes have two children, the youngest with Downs syndrome and serious heart defects. Mr. Maddux owns a small business and purchases his own health insurance, however, their current policy is very expensive, has high deductibles, and does not cover prescription drugs.

Chafee: The amount the Maddux family would pay for premiums and the coverage they would have, including deductibles and copayments, are unknown.

Under the Chafee plan, the Maddux family, and indeed the Maddux employees, are likely to see much more comprehensive coverage at a lower price than they have now. They could purchase a comprehensive standard health insurance plan through a purchasing group or directly from an insurance company. Insurers would be

prohibited from charging the Madduxes a higher premium because a member of the family has health problems. In addition, if their income is below $35,520 per year, the Woods family will receive a voucher to assist in the purchase of health insurance. Any payments the family makes toward premiums will be deductible. Their out-of-pocket expenses would be set by a federal benefits commission and would be subject to Congressional approval.

Long Term Care at Home:
Roz and Harold Barkowitz
Spring Hill, FL.
Mrs. Barkowitz is 67 years-old and has multiple sclerosis. Mr. Barkowitz, 72, gave up his business

Chafee: The Barkowitzes would receive no assistance.

The Barkowitzs would be able to deduct their long-term care expenses and payment for long-term care

to care for his wife. He is concerned that, if something happens to him, he will no longer be able to care for her.

Employees Vulnerable to Arbitrary Limits on Benefits:
John and Joan Cleveland
St. Louis, Missouri
Joan Cleveland's employer is self-insured. In 1990, John was diagnosed with leukemia and needed a bone marrow transplant. John's transplant cost about $250,000, but their policy capped coverage of organ and tissue transplants at $75,000. John died of complications from his transplant in June of 1993.

Chafee: Joan Cleveland's employer could not impose arbitrary limits on the Clevelands' health benefits, but it is impossible to know if John's bone marrow transplant would have been covered under the standard benefits package. It is impossible to determine the amount the Clevelands' would have had to pay out-of pocket for John's medical care.

services from their taxes. They would also benefit from reform of long-term care insurance policies.

John Cleveland's bone marrow transplant would have been considered medically necessary and therefore would have been covered under the comprehensive standard benefit package. In addition, the Clevelands' out-of pocket expenses would be limited to the amount set by a federal benefits commission and would be subject to Congressional approval.

Employers with Skyrocketing Premiums:
Roger Flaherty
Kensington, MD.
Roger Flaherty owns a small business and has two employees both of whom have health problems. Mr. Flaherty has seen his premiums rise at a very high rate, and is concerned that he cannot continue to provide coverage to his employees.

Chafee: Mr. Flaherty and other employers would see their health insurance premiums continue to climb uncontrollably.

Mr. Flaherty's insurance premiums skyrocketed because under current law, insurers are permitted to experience rate, or charge higher premiums for persons with health problems, and because small businesses and individuals are not pooled to share risk. All of this would change under Senator Chafee's bill. In addition, Mr. Flaherty and his employees would all have a multitude of health care insurance choices each year. Insurers would have to compete with each other based on price, quality and service, and would have to accept all applicants of the same age range at the same rate. Insurers would be prohibited from

		charging higher premiums to his employees because they have health problems.
Care Unavailable for Medicaid Beneficiaries: Sherri Wilburn Blount County, TN. Sherri Wilburn qualifies for Medicaid coverage but was unable to find a doctor willing to provide prenatal care. Her child was born premature with serious health problems.	Chafee: Sherri Wilburn would continue to be covered through the Medicaid program.	Sherri Wilburn would have the choice of at least two managed care plans in her area if the state enrolls Medicaid beneficiaries in managed care. If the state opts into a federal program which would give those on Medicaid a choice to enroll in private insurance plans, she could change what kind of coverage she currently receives. In either case, Ms. Wilburn would receive a comprehensive package of benefits which would include prenatal care. In addition, the Chafee bill includes

provisions which would encourage providers to practice in medically-underserved areas, and would provide funds to community health centers and other provider groups located in medically underserved areas to serve all patients, regardless of the type of insurance coverage they have.

DRAFT
3/23/94
NOTE: SHOULD BE REPRODUCED ON GRASSLEY SENATE LETTERHEAD

HEALTH CARE TOWN MEETING
SPONSORED BY SENATOR CHARLES GRASSLEY
SPECIAL GUESTS: SENATOR BOB DOLE AND GOVERNOR TERRY BRANSTAD

WEDNESDAY, MARCH 30, 1994
3:00-4:15 PM
EMBASSY SUITES
101 EAST LOCUST STREET
DES MOINES, IOWA

WELCOME AND INTRODUCTION OF DISTINGUISHED GUESTS
Dave Lyons, Iowa Commissioner of Insurance

REMARKS
Governor Terry Branstad

REMARKS
Senator Charles Grassley

REMARKS
Senator Bob Dole

QUESTION AND ANSWER SESSION
Dave Lyons

CONCLUSION
Senator Charles Grassley

STATE OF IOWA

TERRY E. BRANSTAD, GOVERNOR

INSURANCE DIVISION
IOWA DEPARTMENT OF COMMERCE

DAVID J. LYONS

Iowa Insurance Commissioner

David J. Lyons was appointed Iowa Insurance Commissioner by Governor Terry Branstad on November 21, 1990. Before his appointment as Commissioner, Dave served as Acting Commissioner and First Deputy Commissioner. He has been with the Insurance Division since 1987. Prior to coming to the Division, Dave served as legal counsel with the Iowa Legislature.

While with the Division, Dave has set three major priorities for Insurance:

- Company solvency;
- Consumer protection; and
- Insurance economic development

While most would consider these priorities to be mutually exclusive, Dave perceives them to be mutually dependent.

The Commissioner of Insurance believes that firm but fair regulation enhances insurance, securities, and other industries under his jurisdiction. This belief is supported by Iowa's recent experience, including record consumer protection and record insurance economic development over the last four years.

Dave is a Northeast Iowa native and a graduate of Loras College and the University of Iowa School of Law.

Dave's other state and national official positions include:

- **Chair** -- Iowa Health Care Reform Council

- **Vice President** -- National Association of Insurance Commissioners (NAIC).

- **Member** -- North American Association of Securities Administrators.

- **Receiver** -- Iowa Trust.

Also is a member of the following; Iowa Insurance Economic Development Board, Iowa Underground Storage Tank Board, Iowa Grain Indemnity Board, Iowa Health Data Commission, Iowa Business Development Corporation.

☐ 136 Hart Senate Office Building
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TTY: (202) 224-4470

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United States Senate

CHARLES E. GRASSLEY

WASHINGTON, DC 20510-1501

Reply To:

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(319) 232-6657

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(319) 322-4331

☐ 307 Federal Building
8 South 6th Street
Council Bluffs, IA 51601
(712) 322-7103

March 23, 1994

Dear Friend:

I am writing to invite you and your membership to a public meeting with Senator Dole, Governor Branstad, and myself on health care reform that I will hold on Wednesday, March 30, in the Embassy Suites Hotel in Des Moines. The meeting will begin at 3:00 and end at 4:15 p. m. The general public will be invited through announcements in the local media.

I would also like to invite your members to attend listening posts that I will hold the following week, April 4 - 8, on health care reform in 12 Iowa communities. The schedule for those meetings is attached. Senator Dole and Governor Branstad will not participate in those meetings.

My purpose in convening these meetings is to hear from Iowans about their concerns with respect to health care reform, and to answer questions they may have about the issues involved and the proposals for reform which have been advanced in the Congress.

I would very much appreciate your help in making your membership aware of both the Des Moines meeting with Senator Dole, Governor Branstad, and myself, and the other meetings I will hold the following week. It would be very helpful in insuring that the broadest cross-section of the involved communities has the opportunity to participate.

If you have any questions, do not hesitate to contact my Des Moines office at 284-4890.

Sincerely,

Charles E. Grassley
U. S. Senator

CEG/tlt

Committee Assignments:

FINANCE
AGRICULTURE, NUTRITION, AND FORESTRY
JUDICIARY
OFFICE OF TECHNOLOGY ASSESSMENT
BUDGET
SPECIAL COMMITTEE ON AGING

CHUCK GRASSLEY

PRESS RELEASE

FOR IMMEDIATE RELEASE
Thursday, March 24, 1994

CONTACT: Jill Hegstrom
202/224-1308

Grassley to Host Health Care Reform Town Meeting

Washington -- Sen. Chuck Grassley (R-IA) today announced that he will host Iowa Governor Terry Branstad and Senate Republican Leader Bob Dole (R-KS) at a health care reform town meeting in Des Moines next Wednesday.

Grassley urged all interested Iowans to attend this open forum and "to bring their questions and concerns regarding health care reform." The town meeting is scheduled from 3:00-4:15 p.m., at the Embassy Suites in Des Moines. A press conference will follow from 4:15-4:45 p.m.

Grassley serves as a member of the Senate Finance Committee, which will begin markup of a health care reform bill later this spring.

-30-

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☐ 307 Federal Building
8 South 6th Street
Council Bluffs, IA 51601
(712) 322-7103

March 23, 1994

Terry E. Branstad, Governor
State Capitol
Des Moines, Iowa 50319

Dear Terry:

I hope you will join me at a public meeting on health care reform that I will hold on Wednesday, March 30, in the Embassy Suites Hotel in Des Moines. Senator Dole will also participate. I have asked Dave Lyons to be the moderator. The meeting will begin at 3:00 and end at 4:15 p. m. The public will be invited to attend through announcements in the local media. I am also writing to organizations in the Des Moines community that might be interested in the meeting, and to members of your Health Care Reform Task Force.

Given the discussions taking place in Washington and in Iowa, my purpose in convening this meeting is to hear from Iowans about their concerns with respect to health care reform, and to answer questions they may have about the issues involved and the proposals for reform which have been advanced in the Congress and in Iowa.

If you have any questions, please call me. Or your staff may contact Ted Totman or my office at 202-224-3744.

Sincerely,

Charles E. Grassley
U. S. Senator

CEG/tlt

Committee Assignments:

FINANCE
AGRICULTURE, NUTRITION, AND FORESTRY
JUDICIARY
OFFICE OF TECHNOLOGY ASSESSMENT
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Council Bluffs, IA 51501
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United States Senate

CHARLES E. GRASSLEY

WASHINGTON, DC 20510-1501

March 23, 1994

House Minority Leader Arnould
Iowa House of Representatives
State Capitol
Des Moines, Iowa 50319

Dear Mr. Arnould:

I am writing to invite you to attend a public meeting that I am holding on health care reform on Wednesday, March 30, in the Embassy Suites Hotel in Des Moines. The U. S. Senate Majority Leader, Bob Dole, Governor Branstad, and myself will discuss reform developments at the Federal and State levels and take questions from the audience.

I know that the legislature is considering health reform legislation. Many legislators may be interested, therefore, in learning more about reform developments at the Federal level. I have asked Dave Lyons, Iowa's Insurance Commissioner, to be the moderator. The meeting will begin at 3:00 and end at 4:15 p. m. The meeting will be publicized in the local media as open to the public. I am also writing to organizations in the Des Moines community that might be interested in attending.

My purpose in convening this meeting is to hear from Iowans about their concerns with respect to health care reform, and to answer questions they may have about the issues involved and the proposals for reform which have been advanced in the Congress.

If you have any questions, do not hesitate to contact Ted Totman of my staff at 202-224-3744.

Sincerely,

Charles E. Grassley
U. S. Senator

CEG/tlt

cc: Senate Minority Leader Rife
Senate President Boswell
Senate Majority Leader Horn
House Speaker Van Maanan
House Majority Leader Siegrist

Committee Assignments:

FINANCE
AGRICULTURE, NUTRITION, AND FORESTRY
JUDICIARY
OFFICE OF TECHNOLOGY ASSESSMENT
BUDGET
SPECIAL COMMITTEE ON AGING

OPENING REMARKS

IOWA TOWN MEETING

WEDNESDAY, MARCH 30, 1994

I WANT TO BEGIN BY THANKING SENATOR GRASSLEY FOR CALLING US ALL TOGETHER AND GIVING ME A CHANCE TO HEAR FROM YOU ON THIS MOST IMPORTANT TOPIC.

I CAN THINK OF LITTLE ELSE THAT IS AS PERSONAL OR AS CRITICAL TO EACH OF US THAN THE HEALTH OF OUR FAMILIES.

HOW WE GET CARE, WHERE WE GET IT AND HOW READILY ACCESSIBLE IT IS HAS A GREAT DEAL TO DO WITH WHERE WE LIVE, OUR PERSONAL

PREFERENCES, AND THE INSURANCE COVERAGE WE HAVE AVAILABLE TO US.

I, FOR ONE, BELIEVE THE BEST HEALTH CARE SYSTEM IS ONE THAT GIVES PEOPLE LOTS OF CHOICES AND MAINTAINS THE QUALITY OF CARE THAT PEOPLE IN THIS COUNTRY HAVE

COME TO EXPECT.

BUT MAKE NO MISTAKE ABOUT IT -- THERE ARE PROBLEMS THAT MUST BE ADDRESSED. THERE ARE THOSE WITHOUT PROTECTION WHO MUST USE THE EMERGENCY ROOMS OF OUR HOSPITALS FOR THEIR PRIMARY CARE. THERE

ARE THOSE WHO DELAY SEEKING NEEDED HELP BECAUSE THEY HAVE NO INSURANCE COVERAGE. THERE ARE THOSE WITH PRE-EXISTING CONDITIONS, THOSE WHO HAVE LOST THEIR JOBS AND THEIR INSURANCE, WHO NEED OUR HELP.

WE ARE STILL RELATIVELY EARLY IN THE PROCESS OF TRYING TO RESOLVE OUR DIFFERENCES AND DESIGN THE BEST COMPREHENSIVE REFORM PROPOSAL WE CAN.

YOUR INPUT AND UNDERSTANDING IS CRITICAL TO THIS PROCESS. THE BEST

RESULT WILL BE A BILL WHICH HAS BROAD BI-PARTISAN SUPPORT AND YOUR BACKING.

TODAY'S DISCUSSION WILL HELP ALL OF US UNDERSTAND MORE CLEARLY YOUR THOUGHTS AND CONCERNS.

NARRATIVE PROFILE OF THE STATE OF IOWA

Iowa is a rural state; 56 percent of its population lives in rural areas. The population is relatively old; 15.4 percent are 65 years of age or older. Only Florida and Pennsylvania have higher percentages of older people (and Pennsylvania's is only slightly higher). Iowa has the highest percentage of people 85 years of age and older of any state.

Iowa is a small business state; 95 percent of Iowa businesses have fewer than 50 employees. Thirty-eight percent of the workforce is employed by firms of under 50 workers. Only 79 firms employ over 1000 workers.

Iowa is a major insurance center, much, if not most, of it headquartered in Des Moines. According to the Insurance Commissioner's Office, insurance is the State's second export product. Health insurance may constitute about 40 percent of the total value of Iowa's insurance business. Insurance is a major employer.

Iowans are relatively well-insured. Only 8 percent of those working are uninsured. A total of ten and one-half percent of the State's people is uninsured.

Iowa is very dependent on the Medicare program. A good indicator of this is the number of hospitals eligible to take advantage of the Medicare Dependent Hospital program --- 45. Some 30 hospitals actually receive higher reimbursement from the program. More than 60 percent of all patient days in Iowa rural hospitals were attributed to people age 65 and older.

Iowa's hospitals and physicians provide relatively low cost, good quality health care. Iowa hospitals ranked fifth and fourth lowest nationwide in average charges per inpatient day and per outpatient visit, respectively in 1991. Iowa's seven Medicare physician payment districts are at the bottom of the country's 226 payment districts. Four years ago, the best payment district ranks 184th, and the worst ranks 222nd. Most health care providers believe that the Medicare program unfairly discriminates against Iowa. It is common to hear providers say that the program is "broken".

A major problem is the recruitment and retention of health care providers in rural areas. There are usually around 150 to 200 communities seeking an additional physician.

The University of Iowa Medical College and the University of Iowa Hospitals and Clinics in Iowa City, Iowa, comprise one of the largest medical teaching complexes in the country.

The Governor's Health Care Reform Task Force proposal is similar to the Chafee plan, but without the tax caps on either employer deductibility or employee exclusion.

ANTICIPATED QUESTIONS/SPECIAL PROBLEMS AND CIRCUMSTANCES

Anticipated Questions for Des Moines Meeting

■ We invited all of the groups and organizations in Des Moines with any interest in health care reform. Thus, the meeting will be a carnival of interest groups. The level of knowledge about various reform proposals will be fairly high. Most of the questions will reflect the concerns of the interest groups represented. Although almost any question about reform could be asked, questions at Senator Grassley's December, 1993, listening posts around the State and in Des Moines came from:

■ insurers concerned about mandatory alliances and strict community rating,

■ advocates who want the Congress to define a benefit plan, who want it to be comprehensive, and who want it to specify the service or provider group in which they are interested. Well organized for Senator Grassley's December meetings were:

■ chiropractors concerned about being frozen out of health plans,

■ mental health and substance abuse advocates,

■ dentists (Delta Dental provides much of the dental insurance in Iowa; they have been running newspaper ads criticizing the taxation of employee health benefits),

■ single payer advocates (members of Iowa Citizens Action; see their letter to Ted Totman for their critique of Chafee and Nickles),

Special Problems and Circumstances in Iowa

■ In Senator Grassley's December, 1993, listening posts in 11 communities around Iowa, skepticism was high about the reform project. The attitude of many was that we should fix the problem, the uninsured, rather than overhaul the system. A Des Moines audience will be more knowledgeable about cost as the central problem. There appears to be considerable skepticism in Iowa about the Clinton plan; mail to our office is heavily against it. Small business in particular is opposed to it.

■ Availability of health care providers of all types is a problem for rural Iowa. Keep in mind that, although there is concern in Des Moines about the rural health problems in Iowa, there will be many advocates not particularly focused on rural concerns.

■ The State is very dependent on the Medicare program, and virtually all providers believe that the Medicare program unfairly discriminates against Iowa. It is also common to hear hospital administrators, and, to some extent, doctors, say that reform in Iowa will not be possible unless Medicare is included.

■ The development of organized health care networks is proceeding rapidly all over the State, and is creating a certain amount of tension among providers who feel they may be left out of the networks in their areas (some physicians, some retail pharmacists, most chiropractors, etc.).

■ Iowa is the center of chiropractic in the United States. Palmer College in Davenport is the first, and the largest, chiropractic educational and training institution in the United States. Some 900 chiropractors practice in Iowa.

■ The State of Iowa has developed a fiber optic network which is operational. Many believe that it has considerable potential in the health field. Iowa Methodist in Des Moines has submitted a grant for federal support for a fiber optic project.

■ The Governor's Health Care Reform Task Force has submitted recommendations to the legislature. See the briefing materials on the Task Force. As noted in the Narrative, the Governor's recommendations are similar to the Chafee plan, but without the tax caps.

Governor's Health Care Reform Proposals

Access

☐ **The Iowa Plan will make health care more <u>accessible</u> to all Iowans, so that coverage will continue during breaks in employment or during serious illnesses, by:**

1. Giving all employees access to more affordable group insurance by requiring all employers to offer standard group insurance coverage. **(Employer conduit.)**

2. Keeping Iowans who become sick from losing their insurance when they need it the most by requiring that everyone, regardless of medical condition, is eligible for insurance and cannot be canceled or dropped. **(Guaranteed issue.)**

3. Keeping Iowans who wish to change jobs from losing their health care by requiring that insurance coverage be portable and continuous, without exclusions, waiting periods or new health underwriting or reviews. **(Portability and continuity of coverage.)**

4. Making insurance more affordable and stable for all purchasers by moving to modified community rating of insurance, where previous experience, preexisting conditions, and a number of other problematic factors will no longer be used to price insurance coverage, but specifically allowing health choices to be considered. **(Modified community rating.)**

Cost

☐ **The Iowa Plan will make insurance more <u>affordable</u> for all Iowans by:**

1. Changing the way health insurance is purchased, by authorizing and encouraging Health Insurance Purchasing Cooperatives which will increase the market clout of and lower administrative costs for small buyers, especially individuals and small businesses. **(Voluntary purchasing cooperatives.)**

2. Changing the way health care is delivered, by authorizing and encouraging Accountable Health Plans where hospitals, doctors and other health professionals can combine in more efficient networks to provide care on a pre-planned and pre-funded basis. They will operate

within an overall budget tied to the locally negotiated capitated fee per enrollee. **(Capitated Accountable Health Plans.)**

3. Changing the way we administer the health insurance system by adopting a single claims form and electronic payment system that will significantly reduce administrative costs and allow health professionals to get away from the practice of paper pushing and back to the practice of medicine. **(Administrative simplification and savings.)**

4. Changing the medical liability system through reduction of the practice of defensive medicine and costs of liability insurance by capping noneconomic damages, decreasing the statute of limitations for minors, moving towards binding alternative dispute resolution systems and other tort system reforms. **(Medical liability reform.)**

Quality

☐ **The Iowa Plan will assure that Iowans receive enhanced quality and greater value for their health care dollar by:**

1. Developing a statewide health accounting system and corresponding expenditure target so the state can for the first time track how well it is doing on health care cost, quality and access. **(Statewide health accounting system.)**

2. Providing a standard benefits package to facilitate comparison shopping and to assure fair access to all. **(Standard benefits package.)**

3. Requiring reports to consumers on how well the insurer or health plan is doing in terms of key performance indicators and consumer satisfaction, and annually allowing consumers free movement between plans to reward those that provide better health care for less money. **(Health plan report cards.)**

4. Ensuring that preventive services will be provided without co-pays, deductibles or cost-sharing to capture future savings. **(Preventive care.)**

Equity -- Rural Access and Tax Equity

☐ **The Iowa Plan will assure <u>fair and equal access</u> for all Iowans to quality health services by:**

1. Developing and supporting a strong rural health care network through provider tax credits, support programs such as physician respite service (or *locum tenens*) and access to technology such as the ICN network to enable telemedicine support of rural practitioners. **(Rural access)**

2. Moving aggressively, where Iowa can, to improve the tax environment for health insurance by authorizing tax advantaged medical savings accounts and equal deductibility of health insurance purchases for big business and the self-employed small business person or farmer. **(Tax equity.)**

CHARACTERISTICS OF GREATER DES MOINES HOSPITALS

Source: Iowa Hospitals-A Profile of Service to the People, Iowa Hospital Association.

The area includes six community hospitals in Polk County and one in Dallas County. Polk County also has one federal hospital. Story County has three community hospitals.

Polk County	City	Hospital	Total Beds
	Des Moines	Broadlawns Medical Center	200
	Des Moines	Charter Community Hospital	66
	Des Moines	Des Moines General Hospital	150
	Des Moines	Iowa Lutheran Hospital	319
	Des Moines	Iowa Methodist Medical Center	710
	Des Moines	Mercy Hospital Medical Center	520
	Des Moines	Veterans Affairs Medical Center	273
Dallas County			
	Perry	Dallas County Hospital	53
Story County			
	Ames	Mary Greeley Medical Center	196
	Nevada	Story County Hospital	42
	Story City	Story City Memorial Hospital	36

THIRTY MOST FREQUENT DRGS

Normal newborns and vaginal delivery without complications diagnosis were the two most frequent DRGs (based on numbers of discharges) in 1991. Psychoses, heart failure and shock, simple pneumonia and pleurisy, major joint and limb reattachment and esophagitis and gastroenteritis were the most frequent non-birth related DRGs.

HOSPITAL UNIT COSTS

Iowa hospitals' per capita costs are 5.2 percent and 5.0 percent lower than the Midwest and Nation.

Iowa hospitals' unit costs per admission are 7.5 percent and 13.7 percent lower than the Midwest and Nation.

Iowa hospitals' unit cost per patient day are 8.4 percent and 26.8 percent lower than the Midwest and Nation.

HEALTH INSURANCE PREMIUMS FOR THE MOST POPULOUS CITY IN EACH STATE

	STATE	CITY	PERCENT OF NATIONWIDE AVERAGE	RANK (among 1050 cities surveyed)
1.	ALABAMA	BIRMINGHAM	103%	319
2.	ALASKA	ANCHORAGE	112%	198
3.	ARIZONA	PHOENIX	105%	293
4.	ARKANSAS	LITTLE ROCK	89%	587
5.	CALIFORNIA	LOS ANGELES	178%	1
6.	COLORADO	DENVER	94%	492
7.	CONNECTICUT	BRIDGEPORT	104%	303
8.	DELAWARE	WILMINGTON	89%	581
9.	D.C.	WASHINGTON, D.C.	119%	163
10.	FLORIDA	JACKSONVILLE	106%	286
11.	GEORGIA	ATLANTA	110%	221
12.	HAWAII	HONOLULU	96%	456
13.	IDAHO	BOISE	76%	938
14.	ILLINOIS	CHICAGO	117%	182
15.	INDIANA	INDIANAPOLIS	83%	782
16.	IOWA	DES MOINES	81%	836
17.	KANSAS	WICHITA	90%	562
18.	KENTUCKY	LOUISVILLE	85%	715
19.	LOUISIANA	NEW ORLEANS	126%	114
20.	MAINE	PORTLAND	76%	965
21.	MARYLAND	BALTIMORE	98%	409
22.	MASSACHUSETTS	BOSTON	106%	280
23.	MICHIGAN	DETROIT	112%	200
24.	MINNESOTA	MINNEAPOLIS	85%	694
25.	MISSISSIPPI	JACKSON	86%	677
26.	MISSOURI	KANSAS CITY	99%	392
27.	MONTANA	BILLINGS	79%	887
28.	NEBRASKA	OMAHA	84%	741
29.	NEVADA	LAS VEGAS	122%	147
30.	NEW HAMPSHIRE	MANCHESTER	78%	907
31.	NEW JERSEY	NEWARK	102%	338
32.	NEW MEXICO	ALBUQUERQUE	88%	613
33.	NEW YORK	NEW YORK	140%	90
34.	N. CAROLINA	CHARLOTTE	77%	928
35.	N. DAKOTA	FARGO	77%	934
36.	OHIO	COLUMBUS	82%	797
37.	OKLAHOMA	OKLAHOMA CITY	94%	496
38.	OREGON	PORTLAND	86%	686
39.	PENNSYLVANIA	PHILADELPHIA	111%	210
40.	RHODE ISLAND	PROVIDENCE	86%	671
41.	S. CAROLINA	COLUMBIA	81%	841
42.	S. DAKOTA	SIOUX FALLS	75%	981
43.	TENNESSEE	MEMPHIS	93%	614
44.	TEXAS	HOUSTON	128%	110
45.	UTAH	SALT LAKE CITY	87%	639
46.	VERMONT	BURLINGTON	76%	940
47.	VIRGINIA	VIRGINIA BEACH	87%	639
48.	WASHINGTON	SEATTLE	84%	758
49.	W. VIRGINIA	HUNTINGTON	83%	776
50.	WISCONSIN	MILWAUKEE	88%	619
51.	WYOMING	CHEYENNE	78%	897

Source: Milliman & Robertson, Inc.

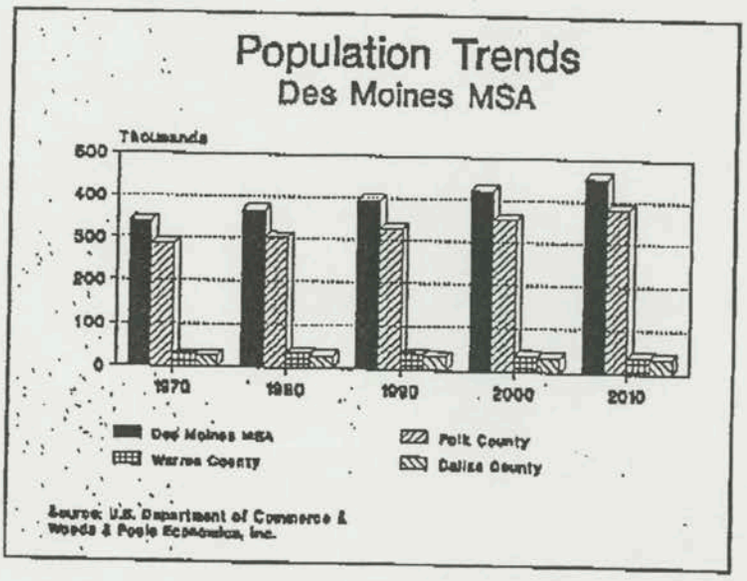
R=94%

POPULATION

Des Moines MSA ranked 94 out of 284 MSAs in the U.S., with a population of 392,928.

Trends and Projections

- Population trends from 1970 to 1990 show the Des Moines MSA (comprised of Dallas, Polk and Warren counties) increased 15% over the 20 year period.



- Des Moines MSA will continue to increase at a 15% growth rate over the next 20 years to 2010.

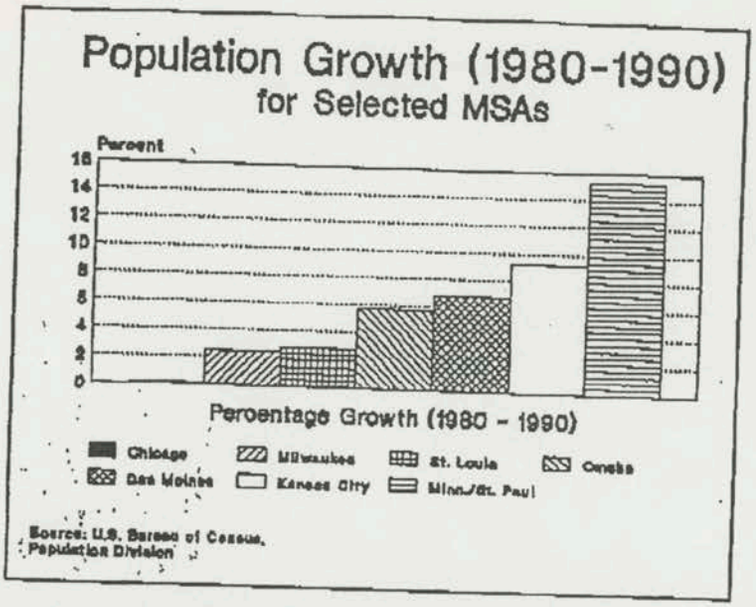
- Population growth from 1980 to 1990 in the Des Moines MSA was 6.9 percent. This ranked the Des Moines MSA as the 94th fastest growing MSA.

DES MOINES MSA POPULATION AND PROJECTIONS, 1970 - 2010

Year	Dallas County	Polk County	Warren County	Des Moines MSA
1970	26,100	286,900	27,600	340,600
1980	29,513	303,170	34,878	367,561
1990	29,755	327,140	36,033	392,928
2000	31,790	353,260	36,890	421,940
2010	33,390	382,120	37,800	453,310

Source: U.S. Department of Commerce and Woods & Poole Economics, Inc.

- The Des Moines MSA population growth rate of 6.9 percent from 1980 to 1990, outpaced the midwest MSAs of Chicago (.2% growth rate); Milwaukee (2.5% growth rate); St. Louis (2.8% growth rate); and Omaha (5.7% growth rate).



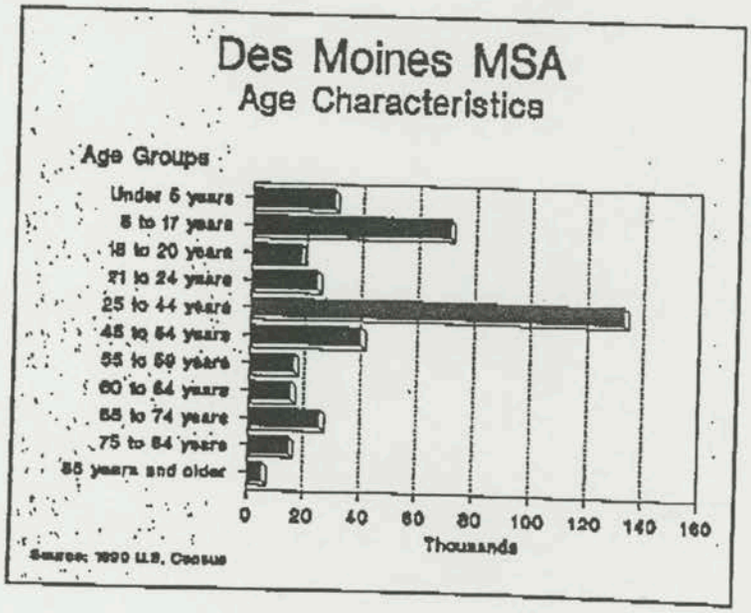
Households

- There are 166,382 households in the Des Moines MSA, an average of 2.47 persons per household, which is slightly lower than Iowa's average of 2.52 persons per household.

Median Age

- Median age in the Des Moines MSA is 32.4 years, which is slightly lower than Iowa's average (33.4 years) and the U.S. average (33 years).

- Thirty-four percent of the Des Moines MSA population is in the 25 to 44 age group. Iowa's figure for this age category is 29.7 percent.



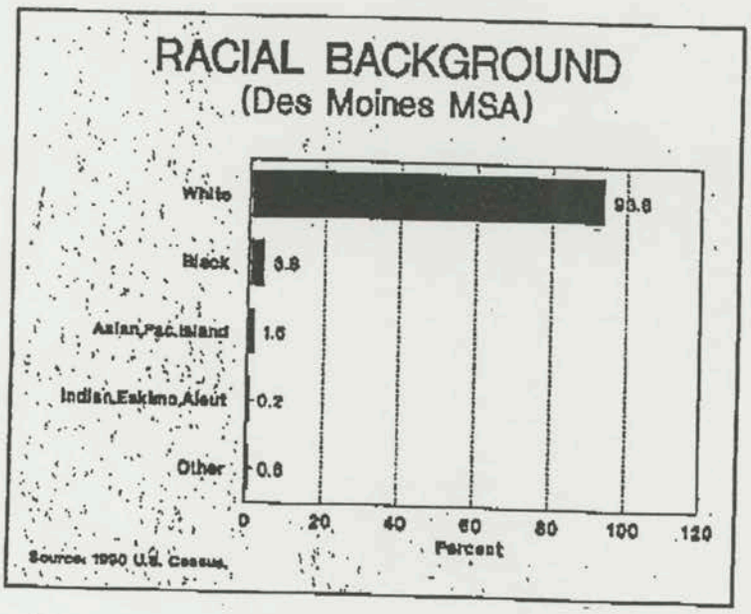
DES MOINES MSA AGE CHARACTERISTICS

Age Category	Total Persons	DM MSA Percent of Population	U.S. Percent of U.S. Population
Under 5 years	29,566	7.5 percent	7.4 percent
5 to 17 years	70,877	18.0	18.2
18 to 20 years	17,912	4.6	4.7
21 to 24 years	23,900	6.1	6.0
25 to 44 years	132,845	33.8	32.5
45 to 54 years	40,070	10.2	10.2
55 to 59 years	16,248	4.1	4.2
60 to 64 years	15,532	4.0	4.3
65 to 74 years	25,587	6.5	7.3
75 to 84 years	14,944	3.8	4.0
85 years and over	5,447	1.4	1.2

Source: 1990 U.S. Census.

Racial Mix

- The Des Moines MSA racial background is 93.8 percent white and 3.8 percent black.
- Hispanic origin (of any race) accounts for 1.7 percent of the Des Moines MSA population.



DES MOINES MSA RACIAL MIX

Race	Number of People	Percent
White	368,386	93.8 percent
Black	14,952	3.8 percent
American Indian, Eskimo or Aleut	1,015	.2 percent
Asian or Pacific Islander	6,218	1.6 percent
Other	2,357	.6 percent
Hispanic of any race	6,614	1.7 percent

Source: 1990 U.S. Census.

Area of Dominant Influence

- Area of Dominant Influence (ADI) is defined as the area or counties from where the total share of viewing for the home television stations exceeds those of any other market's stations. The Des Moines ADI includes 31 counties in Iowa:

- Adair	- Decatur	- Lucas	- Polk	- Wayne
- Appanoose	- Greene	- Madison	- Poweshiek	- Webster
- Boone	- Guthrie	- Mahaska	- Ringgold	- Wright
- Calhoun	- Hamilton	- Marion	- Story	
- Carroll	- Hardin	- Marshall	- Union	
- Clarke	- Humboldt	- Monroe	- Wapello	
- Dallas	- Jasper	- Pocahontas	- Warren	

- Total population of the ADI is 948,130 or 33 percent of Iowa's total population. Source: Arbitron Control Data Corporation.

HISTORICAL EMPLOYMENT TRENDS (1980 - 1991)
Wage and Salary Employment by Industrial Group
Des Moines MSA - Annual Averages (000)

Industry	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991
Manufacturing	25.9	24.8	22.3	22.1	23.5	22.5	21.8	22.9	25.6	26.5	26.5	26.0
Contract Construction	8.1	7.2	7.1	6.2	6.9	7.7	7.4	7.3	7.0	6.9	9.3	9.5
Wholesale & Retail Trade	49.3	48.0	46.4	47.9	50.3	50.8	51.7	52.3	55.8	57.6	59.6	59.0
Transportation & Public Utilities	11.9	11.5	11.4	11.1	11.2	12.4	11.8	12.1	12.5	12.6	12.7	12.2
Finance, Insurance & Real Estate	21.7	21.9	22.3	22.7	23.8	24.7	25.5	27.1	29.0	30.8	31.6	32.5
Services	41.4	41.6	42.6	43.6	45.2	45.8	49.5	52.5	54.0	56.0	60.6	61.8
Government	29.8	28.9	28.5	28.3	28.4	28.7	29.3	30.1	30.0	30.0	32.0	32.5
Total Nonagricultural Employment:	188.1	183.9	180.6	181.9	189.3	192.3	197.0	204.3	213.9	220.4	232.2	233.5

Source: Labor Market Information, Iowa Department of Employment Services, 1980 - 1991. Employment figures are based on the latest benchmark and are adjusted for the Current Population Survey (CPS).

DES MOINES AREA MAJOR EMPLOYERS

Firms with 1,000 or more Employees

Company	Product or Service
ALLIED Group	Insurance & Investments
AMOCO Oil Customer Service Center	Credit Customer Service
Blue Cross & Blue Shield of Iowa	Health Insurance
Bridgestone-Firestone Tire & Rubber	Tire Manufacturing
City of Des Moines	Local Government Services
Communications Data Services, Inc.	Data Processing System & Services
Dahl's Food Markets	Retail Food Distribution
Des Moines Ind. Comm. School Dist.	Education
Des Moines Register	Newspaper Publication
Hy-Vee Food Stores	Retail Groceries & Drugs
Iowa Lutheran Hospital	Hospital & Health Care
Iowa Methodist Medical Center	Hospital & Health Care
John Deere Des Moines Works	Farm Equipment Manufacturing
Mercy Hospital Medical Center	Hospital & Health Care
Meredith Corporation	Diversified Media Company
R.R. Donnelley & Sons, Co.	Printing & Publishing
Midwest Resources, Inc.	Electric Co./Utilities
Monfort, Inc.	Meat Processing
National By-Products, Inc.	Rendering
Neodata	Subscription fulfillment
Norwest Bank of Iowa, N.A.	Financial Services
Pioneer Hi-Bred Int'l, Inc.	Agribusiness
Pirelli Armstrong Tire Corp.	Tire Dist. & Manufacturing
Polk County Government	County Government Services
The Principal Financial Group	Diversified Financial Services
State of Iowa	State Government Services
United Parcel Service	Transportation
United States Government	Federal Government Services
U.S. West Communications	Telecommunications
Younkers	Department Stores

DES MOINES AREA MAJOR EMPLOYERS (Cont'd.)

Firms with 500 to 1,000 Employers

Company	Product or Service
Amusements of America (Adventureland)	Amusement Park
Building Maintenance Service, Inc.	Janitorial
Burger King	Restaurants
Casey's General Stores, Inc.	Convenience Stores
Deere Credit Services	Finance & Credit Operations
Des Moines Area Comm. College	Education/College
Des Moines General Hospital	Hospital/Health Care
Drake University	Education/College
Employers Mutual Company	Insurance
Greyhound Lines, Inc.	Accounting Services
Hawkeye Bancorporation	Financial Institution
Iowa Air National Guard	Government Offices
Iowa Farm Bureau Federation	Ag. Service/Insurance
Iowa Realty	Real Estate Broker
Iowa Resources, Inc.	Electric Utility
K mart Discount Stores	Department Stores
Kirke-Van Orsdel, Inc.	Insurance Broker
McDonalds Restaurants	Restaurants
Norwest Card Services	Credit Card Operations
Preferred Risk Insurance Group	Insurance
The Ruan Companies	Transportation Management & Securities
Sears, Roebuck & Company	Department Store/Retail
Sears Regional Credit Center	Credit Card Operation
The Statesman Group	Financial Services
Super Valu Stores, Inc.	Food Distribution
Target Stores	Department Stores
VA Medical Center	Hospital/Health Care
West Des Moines Schools	Education/Public Schools

Number Of Employers

- The service industry has the greatest number of employers in the Des Moines MSA with 34.4 percent in 3,790 establishments.
- In second place is the retail trade industry with 24.0 percent of the employers in the Des Moines MSA in 2,643 establishments.

EMPLOYMENT
Number of Establishments in the Des Moines MSA

Indust.	1-19 Emp.	20-49 Emp.	50-99 Emp.	100-249 Emp.	250-499 Emp.	500+ Emp.	Totals
Agric.	109	10	0	0	0	0	119
Mining	22	1	0	0	0	0	23
Const.	758	66	19	5	0	1	849
Manuf.	286	67	48	28	12	7	448
Trans. & Util.	307	67	25	18	4	4	425
Wholesale Trade	852	143	44	16	0	1	1,056
Retail Trade	2,180	274	117	62	8	2	2,643
Finance, Insur. & Real Estate	891	109	37	32	18	9	1,096
Serv.	3,299	309	101	57	12	12	3,790
Nonclass. Firms	569	11	0	0	0	0	580
Total:	9,273	1,057	391	218	54	36	11,029

Source: 1989 County Business Patterns, US Department of Commerce.

Number Of Employees

- The service industry has the greatest number of employees in the Des Moines MSA with 28.3 percent.
- Other industries employing a large number of employees include: retail trade (21.4 percent); and finance, insurance and real estate (17.0 percent).
- The industries showing the greatest percentage increases in employee numbers from 1988 to 1989 include: retail trade (9.6 percent); services (6.4 percent) and finance, insurance and real estate (5.3 percent).

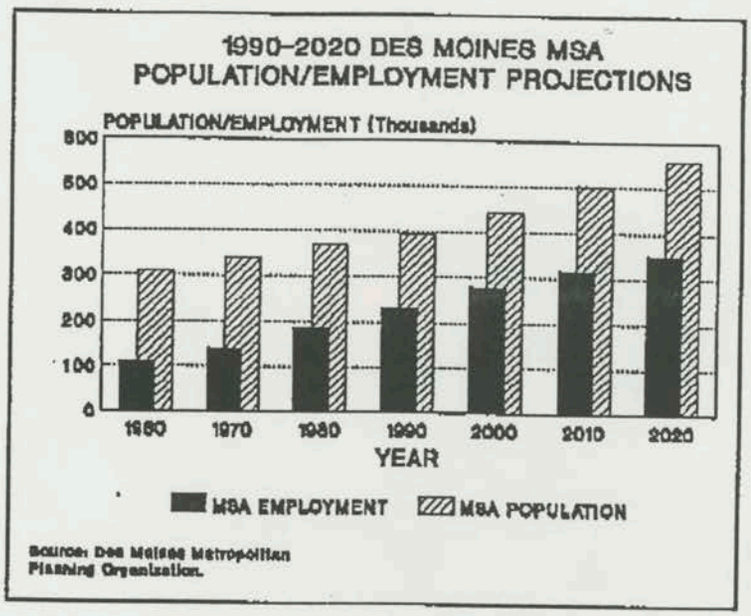
NUMBER OF EMPLOYEES IN DES MOINES MSA ANNUALLY

Industry	1985	1986	1987	1988	1989	% Inc. 1988-89
Agriculture	1,010	1,277	1,382	1,360	1,380	1.5%
Mining	174	206	150	195	175	-10.3%
Const.	7,821	7,141	7,770	8,105	7,751	-4.4%
Manuf.	23,468	23,492	24,473	27,753	26,028	-6.2%
Trans. & Util.	12,551	13,105	13,978	14,311	14,411	.7%
Wholesale Trade	15,052	15,052	15,520	16,476	15,858	-3.8%
Retail Trade	34,364	34,695	36,556	39,320	43,110	9.6%
Fin., Insur., & RE	28,110	29,337	29,146	32,576	34,295	5.3%
Services	47,820	50,383	52,256	53,596	57,049	6.4%
Nonclass. Firms	1,666	1,345	338	919	1,261	37.2%
Total:	172,036	176,033	181,569	194,611	201,474	3.5%

Source: 1985 - 1989 County Business Patterns, U.S. Department of Commerce.

Population And Employment Projections

- Population and employment figures for the Des Moines MSA follow an almost parallel upward trend. Projections for the years 2000 - 2020, provided by the Metropolitan Planning Organization, continue on this upward path.



- The Des Moines MSA population is projected to grow by 14 percent during the ten-year period of 2000 to 2010. Employment growth during this same period is projected to grow at a similar rate.

- A thirty-four percent increase in employment growth occurred during the ten-year period of 1970 and 1980; while the population grew only 8 percent during the same time period.

- Based on 1990 Census figures, 59 percent of the Des Moines MSA population is employed.

IHA Legislative Bulletin

IOWA HOSPITAL ASSOCIATION • 100 EAST GRAND • DES MOINES, IOWA 50309

Memorandum #26 **March 18, 1994**

CHMIS BILL PASSED BY HOUSE

Senate File 2069 passed 94-0 on March 16. The committee amendment was adopted which expands the definition of "provider" to include hospice and home care aide programs certified under Medicare and Medicaid, as well as those under the funding of the Department of Public Health. The amendment also directs that a self-insured plan will accept transaction submission, provide remittance and transmit eligibility electronically. An effort was made to remove dentists from the list of providers who must submit data or engage in transactions until the network is operational, but those amendments failed. The bill now goes to the Senate for concurrence with the amendment.

FIBER OPTICS

House File 2332 remains on the House "to do list". It has the status of an appropriations bill so it is exempt from the funnel process and may be debated the week of March 28. Currently, there are 26 amendments to this bill so it may not be the vehicle for passage of legislative authority for hospital access to the fiber optic network. The original strategy of separate bills for governance, access and release of requests for proposals (RFPs) has been modified; RFP language has been incorporated into **Senate File 2089**, the governance bill. That bill was debated and passed by the House last week. The Senate spent time caucusing on the fiber optic governance bill this week, but it is doubtful that hospital access will be amended to it. Therefore, it is important to talk with your legislators when they return to your home district and emphasize the need to address the issue of hospital access before the end of the 1994 session.

HEALTH CARE REFORM

Senate File 2222, passed by the Senate last week, has not changed since the report in last week's *Friday Mailing*. A House subcommittee has been meeting daily discussing all the issues and concerns connected with the bill. There is some doubt whether the House Human Resources Committee will recommend amendment and passage by the second funnel deadline of March 25. Key issues like access to the fiber optic network, physician tax credit and tort reform have been removed from the bill. Insurance reform (individual insurance market reform and restrictions relating to premium rates), income tax credits and composition of the accountable health plans (AHPs) remain in the bill. Other provisions included in the current bill include: an employer requirement to provide access to health care coverage, the establishment of a nonprofit health insurance purchasing cooperative, a task force on universal coverage, a study of medical screening

panel for alternative medical malpractice dispute resolution, study of the Iowa comprehensive health insurance association and a study of rural health care delivery models.

HEALTH DEPARTMENT APPROPRIATIONS
COURT ORDERED SUBSTANCE ABUSE

As reported in *IHA Legislative Bulletin #24*, the Health Department appropriations bill provides $500,000 for medical and social detoxification services for uninsured and court-ordered patients. The publicly-funded catchment area programs are heavily lobbying members of the House of Representatives to remove the language that would provide some relief to hospitals for court-ordered medical detoxification costs. The publicly-funded programs argue that allowing hospitals to have $500,000 will require the programs to lay-off staff and that next year the hospitals will request more funds and leave less money for treatment services. Hospitals are encouraged to contact members of the House and express support for retaining the appropriation; emphasize that the state has an obligation to pay its bills to providers of services. The bill had been scheduled for debate at mid-week, but debate on the controversial adoption bill preempted that scheduled floor debate.

HUMAN SERVICES APPROPRIATIONS

The Senate took up consideration of **Senate File 2313** on March 14. Among a number of amendments considered was one requiring the Department of Human Services to study the reimbursement for pharmacy services provided with home IV therapy instead of paying only for medicine. Another study would direct an assessment by the Department of Management, in cooperation with the Department of Human Services, Department of Inspection and Appeals and Department of Elder Affairs, of the overall programmatic and fiscal impact of certifying nursing facility beds for use by recipients of medical assistance and to admit people to nursing facilities as beds become available on the basis of the time of application and not upon the source of payment for the applicant's care.

Reimbursement provisions, implementation language on ambulatory patient group payment and revision of policy of screening and treatment for emergency room payment were described in *IHA Legislative Bulletin #25*. The bill now goes to the House Appropriations Committee for consideration.

EDUCATION APPROPRIATIONS

Awaiting floor debate in the House is **House File 2411**, the education appropriations bill. This bill appropriates $379,260 for forgivable loans for osteopathic medical students and $365,000 for an osteopathic physician initiative in primary health care to direct primary care physicians to shortage areas. The University of Iowa College of Medicine primary care initiative is appropriated $456,930. The Indigent Patient Care Program at the University of Iowa Hospitals and Clinics is appropriated $28.1 million. The supplemental disproportionate share and indirect medical education adjustment for medical assistance recipients at UIHC continues.

3/18/94

March 1994 (See Attachment for Details)

GOVERNOR'S HEALTH CARE REFORM PROPOSALS

Governor Branstad established a Health Care Reform Task Force in March, 1993. The project was supported by a Robert Wood Johnson Foundation Grant. Dave Lyons, Iowa's Insurance Commissioner, headed the project, and Dan Weingarten, Lyon's Deputy, served as Staff Director. The project completed its work in December, 1993, and submitted recommendations to the legislature. The Governor's recommendations are under consideration by the legislature.

The Governor's Task Force recommended ---

For access:

- that all employers offer (not pay for) standard group insurance coverage;
- guaranteed issue;
- portability and continuity of insurance coverage;
- modified community rating;
- improved rural access (provider tax credits, physician respite service, telemedicine services)
- tax equity (tax advantaged Medical IRAs, equal tax treatment of big business and self-employed).

For cost containment:

- authorizing and encouraging voluntary purchasing cooperatives;
- authorizing and encoureaging capitated accountable health plans;
- administrative simplification;
- medical liability reform;

For quality improvement:

- a statewide health accounting system;
- a standard benefits package;
- health plan report cards;
- preventive care.

FACTS AND FIGURES

Demographics: Total: 2,795m Rural: 56.0% Age 65+: 15.4%
Nonwhite: 3.4% Poverty Rate: 9.6% Age 85+: 2.0%

Workforce:
Total Firms: 63,678 Total Workers: 996,489
Under 50 Emp: 60,728 In Firms Under 50: 380,182
Over 1000 Emp: 79 In Firms Over 1000: 196,499
HMO Enrollment (%): 3.8

Non-elderly Insurance Coverage Status (%):

Employer Insured: 67.4 Other private: 14.4 Uninsured: 10.5
Medicaid: 8.6 Other Public: 2.6 Uninsured Working: 8.0

Costs: Spending per capita: $1,656 Hospitals: $1,049
Prescription Drugs: $144 Physicians: $463
Physician Payment: .86 compared to national av.

Medicare: Medicare Eligibles: 436,640 Assignment Rates (1992): 78.8
Med. Dep. Hosp; eligible/using: 45/30 Sole Community Hospitals (1994): 11 Rural Referral (1994): 7 Urban(1994): 23
Rural PPS Hosp (1994): 31 Medicare DSH(1994): 10

Health Resources: MDs per 100,000 pop (1992):
Generalists: 59 Specialists: 82
Hosp beds/100,000(1991): 608.7 Pop Underserved by Primary Care MDs (%): 7.5

Utilization: Hospital Admissions per 1,000 pop (1991): 139.3
Hospital Occupancy Rate (1991): 60.2
Nursing Home Occupancy Rate (1990): 93.9

Medicaid: Eligibles(1991): 261,419 Medicaid DSH (1994): 1
Av. Cost/Recip: $3,065 Medicaid Match: 63% federal

Academic Health Centers: University of Iowa Hospitals and University of Iowa College of Medicine.
Hospital(1991): 890 beds Doctors (1991): 1240
Resident and Fellow Doctors(1991): 657
Patients Served (1991): 495,601
Relationship with Iowa City Vets Med Center.

Health Care Reform: Governors Task Force on Health Care Reform completed work December, 1993. Recommendations included: (1) Continue insurance during unemployment or serious illness; (2) Voluntary purchasing coops, capitated accountable health plans, admin simplification; (3) standard benefits package, preventative care, etc.

Special Problems: 1) Unavailability of providers in rural areas; 2) Dependency on the Medicare Program and relatively low levels of Medicare reimbursement; 3) Growing numbers of uninsured.

IOWA CITIZEN ACTION NETWORK

January 3, 1993

Mr. Ted Totman
c/o The Honorable Charles E. Grassley
United States Senator
135 Hart Senate Office Building
Washington, D.C. 20510

Dear Mr. Totman:

We are writing to thank you for setting aside a portion of your busy schedule on December 9 to meet with the delegation from ICAN's Health Care for All coalition. We enjoyed the frank exchange of views.

As we stated during the meeting, we are concerned about the extent of Senator Grassley's commitment to universal health security. While the Senator has publicly expressed that he believes health care is a right of every American, he has not yet supported legislation that will make that right a reality. In fact the legislation that he has cosponsored -- the Chafee and Nickels bills -- fall far short of the goal of providing affordable, comprehensive health care coverage to every American.

Senator Chafee's individual mandate makes health care our responsibility, not our right. One would reasonably expect such a heavy-handed approach to at least soften the blow on American families and individuals by controlling costs, yet the Chafee bill makes no attempt to do so. In fact, Senator Chafee has moved his universal coverage target far into the future -- almost out-of-sight -- and backpedaled on providing subsidies to assist families and individuals in purchasing health insurance. If there are not sufficient cost savings, subsidies will be scaled back; either benefits will be slashed or the universal coverage target date will be extended well in to the next century.

The Chafee bill would produce a bonanza of new business for insurers, while burdening consumers with budget-busting premium payments that will be beyond the means of millions of average-income Americans. In short, Senator Chafee's plan contains no meaningful measures to control costs. Since there are no cost controls, savings won't materialize and adequate subsidies will not be provided. Therefore, the plan will be unaffordable. Hence, it will not be universal.

The Nickels bill is more heavy-handed and even less likely to succeed. Senator Nickel's individual mandate would actually be accompanied by tax penalties for non-compliance with the mandate. Those who do not purchase a private insurance plan lose their personal exemption.

In correspondence to members of our coalition the Senator has expressed criticisms of President Clinton's plan. For example, he states that,

IOWA CITIZEN ACTION NETWORK

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> At the present time, the plan appears to be underfunded. Substantial new benefits are promised . . . At the same time, however, much of the money to pay for these benefits would come from big, new reductions in currently anticipated Medicare and Medicaid spending. Many observers do not believe that cuts of the magnitude proposed -- $124 billion from Medicaid and $114 billion from Medicaid between 1994 and 2000 -- are possible.

A similar magnitude of cuts in Medicare and Medicaid are featured in Senator Chafee's bill, but, unlike the President's proposal, no new benefits are given to seniors, i.e., home and community-based long-term care services or prescription drug coverage. The Senator's criticism of the President on this issue seems curious given the fact of his support for Senator Chafee's bill. The Chafee bill is most definitely underfunded and promises little to nothing in the way of health cost savings.

We respectfully request that Senator Grassley join with Senator Wellstone, Senator Mitchell, and more than 30 of their colleagues in the U.S. Senate who have cosponsored legislation to make health care a right for every American no later than 1998. Senator Grassley's support for Senator Wellstone's American Health Security Act or Senator Mitchell's Health Security Act would assure us that the Senator does indeed believe and will act on his conviction that health care is a right of all Americans.

You indicated during the meeting that you would be willing to assist our efforts to arrange a meeting with the Senator early this year. We would be most grateful for your assistance and will contact you later this month to discuss details of such an engagement.

In the meantime, we sincerely appreciate the cordial reception our delegation received from you and Mr. Wulff on December 9.

Sincerely,

Peggy Huppert

Peggy Huppert/bl
Vice President

Brad Lint

Ted, I'll call you soon!
Brad

Brad Lint
Executive Director

cc/ Leila Carlson, National Association of Social Workers, Iowa Chapter
Max and Cheryl Cloke
Sarah Jewell
Marian Solomon, Church Women United
Iola Vanderwilt,
Henry Wulff

March 24, 1994

TO: SENATOR DOLE

FROM: MARCIE ADLER

RE: IOWA - DES MOINES

DEL STROMER, FORMER KC GSA REGIONAL ADMINISTRATOR, IS IN SENATOR GRASSLEY'S DES MOINES OFFICE, COVERING 21 COUNTIES, INCLUDING AMES.

HE AND HARRIET BOUGHT A HOME WITH A HOT TUB IN DES MOINES. THEY SOLD THEIR FARM TO THEIR TENANT. THEIR SON CONTINUES TO OWN AND WORK ADJOINING ACREAGE.

DEL MENTIONED SEEING YOU DURING YOUR IOWA VISITS AND LIKES IT WHEN YOU REFER TO YOURSELF AS THE "PRESIDENT OF IOWA."

HE AND HARRIET WERE DOWN TO SEE LAHOMA THE WEEKEND THAT DAVID PASSED AWAY. THE COUPLES BECAME CLOSE FRIENDS WHILE LIVING IN OVERLAND PARK.

DEL IS LOOKING FORWARD TO SEEING US AT THE KCK COURT HOUSE DEDICATION. I TOLD HIM THAT THE DATE IS NOT YET FIRM BUT THAT WE'RE HOPING TO SET THE DATE FOR A FRIDAY IN JUNE.

March 24, 1994

MEMORANDUM TO THE LEADER

FROM: SUZANNE HELLMANN SH

RE: IOWA

'96 PRESIDENTIAL ACTIVITIES

- **Dick Cheney** visited Iowa March 14, his first foray into the State. He was asked by one of the Realtors groups to be their keynote speaker. He was very "low key." Cheney did say there that "he will fully disclose" his health records "because he has had heart disease and bypass surgery and there will be questions about his fitness for office."

- **Lynn Martin** is scheduled to be in Iowa on April 22 for the State GOP Spring event (which you addressed last year).

- **Sen. Gramm** has not been in Iowa for about a month.

- **Jack Kemp** is returning in June. (However, Kemp's people are having an "organizational meeting" for Kemp for President on Saturday, March 26.

- **Dan Quayle, Gen. Powell, and Bill Weld** have responded that they will not be able to attend the GOP Party's invitation to address the GOP convention on June 22 or 23. (This invitation was sent to about 16 possible presidential contenders).

GUBERNATORIAL RACE

Filing deadline: March 18
Primary date: June 7

- Ad wars have begun between Gov. Branstad and Rep. Grandy.

- The latest Political/Media poll (2/24-27) shows Gov. Terry Branstad pulling ahead of Rep. Grandy in a GOP primary trial heat by 51% to 40%. But, the Des Moines Register gives Branstad a smaller lead over Grandy - 46% to 43%.

- In Iowa, it is possible for registered Ds and Is to change their voter registration the day of a primary and thus vote in a GOP primary. They can switch back after voting. One poll suggests that Branstad can't win in June without Democratic and independent crossovers.

- Rep. Grandy is focusing on the issue of taxes and a sixteen year limit on the governor's seat.

- Did Hillary Clinton profit "from a 1989 deal that artificially inflated the value of 45 retirement homes in Iowa"? The Sunday Times of London reported this around 2/14.

State Legislature

House:	Republicans	51
	Democrats	49
Senate:	Republicans	23
	Democrats	27

1992 Presidential Vote

Bush	37.5%
Clinton	43.6%
Perot	18.8%

THE REPUBLICAN PARTY OF IOWA

To: Suzanne
202-408-5117

From: Linda J. Wright, Political Director

Date: March 24, 1994

Subject: Political Briefing for Senator Bob Dole

The Iowa Legislature is made up of 100 House seats and 50 Senate seats. All 100 House seats are up for election in 1994, along with 1/2 or 25 of the Senate seats. Republicans control 74 of the 150 seats.

In 1990 the Republicans picked up seats in the legislature for the first time in 10 years. We gained 6 seats in the House of Representatives. In 1992, we picked up 6 more seats in the House and took control with a slim 51 to 49 majority and 2 seats in the Senate, which put us close at 23 to 27. With the policies of the Clinton administration, we are hoping in 1994 to pick up additional house seats and to pick up 3 seats in the Senate to give us control.

Filing deadline for legislative candidates was Friday, March 18th. Republicans filled 100 out of 125 seats, and left 25 of the Democrats unopposed. Democrats only filled 90 out of 125 races and left 35 of ours without opposition. 33 of those seats are Republican incumbents and 2 are open districts! However, we have 11 House Republicans and 3 Senate Republicans not seeking re-election. We have a minimum of 10 incumbents in the House and 1 incumbent in the Senate that are in vulnerable positions. The Democrats are not faring much better. They have 13 retirees in the House and 7 retiring in the Senate.

Our incumbent Republican Governor is in a primary with a strong 8 year Congressman from the most Republican Congressional District in the state, Fred Grandy. There is a Democrat primary with the current Democrat Attorney General for the State of Iowa and a popular Des Moines clothier.

Factoring in what is happening with the retirements, the Gubernatorial primary, and the lack of opposition to our incumbents in the legislature has made us reevaluate our position of a month ago. We are in a good position of holding control of the House of Representatives and making gains in the State Senate. We have more incumbents seeking re-election in both Houses than the Democrats.

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The House Democrat Minority Leader announced that he will not be running for re-election. This helps us in his seat, but probably hurts us overall in that there will be five or six Democrats trying to run for Speaker of the House by electing more Democrats.

We have three Republican Incumbent Congressmen running for re-election in 1994: Jim Leach, Jim Ross Lightfoot and Jim Nussle. In the 1st Congressional District, there will be a Democrat primary opposing Congressman Leach. The opponents are a former staffer for Senator Harkin and a person who lost in the Democrat primary 2 years ago. In the 2nd District, former Congressman Dave Nagle (D) is again challenging Congressman Jim Nussle. In the 3rd District, Congressman Jim Lightfoot's opponents in the Democrat primary are both currently state employees. The current Democrat Secretary of State is once again opposing the Congressman, along with an employee of the Department of Employment Services.

In the 4th Congressional District Greg Ganske, a prominent Des Moines reconstructive surgeon, and Paul Lunde, who ran in this race in 1992, are challenging 36 year Democrat incumbent Neal Smith. With Smith losing his battle for the acting chairmanship of the House Appropriations Committee, this seat could be a real pick up for Republicans. In the 5th Congressional District (Grandy's seat), we have two announced candidates; State Senator Brad Banks and a long time Republican State Central Committee member Tom Latham. This promises to be a very spirited race.

All of the Statewide Executive Committee is up for re-election. Our Republican State Auditor Dick Johnson is running for re-election and we have candidates for Attorney General, Secretary of Agriculture, Secretary of State and State Treasurer. These offices are currently being held by Democrats.

The Democrat Secretary of State has announced that she will run against Congressman Jim Lightfoot again, so that will leave the Sec. of State seat open. There will be a primary on the Democrat side, with the only announced Republican candidate being State Senator Paul Pate. The Democrat State Treasurer, the Deputy State Treasurer, along with a Democrat State Senator are being sued by a former employee in the State Treasurer's office. The plaintiff alleges that she was terminated because of her blowing the whistle on the "Iowa Trust Scandal" in 1991. The Republican candidate is an attorney from West Des Moines, Jay Irwin.

The Democrat Attorney General has announced that she will run for Governor. She has consistently taken shots at Governor Branstad in the media and in her speaking engagements. A popular former Attorney General, Democrat Tom Miller, is the only announced Democrat candidate. The Republican candidate is Joe Gunderson, a thirty-something attorney from Des Moines.

Tom Cory is the Republican candidate for Secretary of Agriculture, squaring off with an 8 year Democrat incumbent. Cory is an instructor in agriculture in a local vocational school.

As you can see, we have our work cut out for us. Democrats have a registration advantage of +90,000 over Republicans, statewide. The fact that Republicans tend to vote in greater percentages of their numbers in off year elections than do Democrats, would potentially help us, but Democrats are increasing their percentages that vote every election cycle. We must maximize the numbers of Republicans voting in the 1994 elections to maintain our Governorship, our Congressmen, control of the Iowa House and make gains in the executive branch and the State Senate.

On January 23, 1994 a Republican State Senator from northwest Iowa was found dead. The same week a Democrat State Senator from the Iowa City area announced that he would be resigning within the month to take a job with the University of Northern Iowa. This caused a Democrat State Representative to announce that he would resign his representative seat to run for the upcoming vacant State Senate seat, when it was vacant. All three of these special elections took place on February 22, 1994.

The outcome of the 3 special elections:
The Democrats had a registration edge of 20% over Republicans and 7% over no party's in the Iowa City area. The Republican candidate for the Senate seat was a staff nurse at the University of Iowa Hospitals and Clinics. We did not field a candidate in the vacant House district. Several factors in the decision for this; the Democrat in the House could not raise PAC money, he could not field a good organization if there was no opponent and he was the better, more well known candidate. We won the Senate seat in Iowa City on election day, but lost the election by 289 votes, which were absentee ballots. The area is highly influenced by the University of Iowa and is moderate in most voting areas. The Equal Rights Amendment in 1992 received 67% of the vote, Clinton won this area by 53%. However, popular Republican Senator Chuck Grassley easily won by over 62% of the vote against an Iowa City Democrat State Senator!

In the Senate district race in northwest Iowa, the Republican candidate was the late Senators campaign manager, Mary Lou Freeman. The district voter registration is 37% Republican, 29% Democrat and 34% No Parties. Republicans consistently win in this 5th Congressional District. A good campaign was waged, with a win on election night with Freeman garnering over 63% of the votes cast.

Both elections were hampered by two key items: 1) President's Day on Monday, February 21, 1994, the day before the election. No mail delivery and running an absentee mail ballot program. 2) 8 inches of blowing snow starting election afternoon. People were in a rush to get home safely, and once they got home, were not going back out.

MEMORANDUM

Date: March 21, 1994

Re: Facts on Filing

* On Friday March 18, 1994 Republicans filled 100 out of 125 races and left 25 of the "D's" unopposed. The Democrats filled 90 out of 125 races and left 35 of ours without opposition.

* In 1992, we filled 112 seats out of 132, and left 20 of theirs unopposed. In 1992, the Democrats filled 113 seats out of 132, leaving 19 Republicans without opposition. Remember, 1992 was the first year after reapportionment, and there were 32 Senate seats up.

* In 1990 Republicans filed 89 of the 125 races. In 1990 the D's filed 105 of 125 races on the deadline day.

* 24 of our 101 candidates are women. Currently we have 11 women in the legislature, 9 of those are candidates again. In 1992, 20 of the 112 were women, and we began with only 7 incumbents.

* 19 of the "D" candidates are women. Currently they have 12 women in the legislature, 7 of those are candidates again with 2 not up for re-election this year. In 1992, 24 of the D's candidates were women, they began with 15 incumbents.

* Republicans have 20 primaries in 1994. In 1992 we had 23.

* Democrats have 16 primaries in 1994. 5 Democrat Incumbents are involved in primaries in the House. In 1992 Democrats had 32 primaries.

* Republicans have 124 candidates: 23 in the Senate and 101 in the House. In 1992 we had 144 candidates.

* Democrats have 110 candidates: 23 in the Senate and 87 in the House. In 1992 they had 157 candidates.

* Republicans have 14 incumbents retiring: 3 from the Senate and 11 from the House. One of the House members is moving to the Senate. In 1992 we had 7 incumbents retiring, 2 from the Senate, 5 from the House and 5 moving from the house to the senate.

* Republicans have 9 incumbents running for re-election in the Senate: only 1 of those has a "D" challenger.

* Republicans have 39 incumbents running for re-election in the House: 14 of those have a "D" challenger.

* The D's have 20 incumbents retiring: 7 from the Senate, 8 from the House and 5 moving from the House to the Senate. In 1992 they had 5 incumbents retiring, 2 from the Senate, 3 from the House and 4 moving from the house to the senate.

* Democrats have 6 incumbents running for re-election in the Senate; 2 of those have a Republican challenger.

* Democrats have 36 incumbents running for re-election in the House: 20 of those have a Republican challenger.

* In 1992, both parties had 1 moving from the senate to the house.

IOWA
Filing date: March 18
Primary date: June 7

Incumbent: Terry Branstad (R)

FILED DEM CANDIDATE	OCCUPATION	ISSUES
Bonnie Campbell	AG	Sen. Harkin's choice
Darold Powers		
William Reichardt		

FILED GOP CANDIDATE	OCCUPATION	ISSUES
Terry Branstad	Governor	
Fred Grandy	U.S. Rep. (05)	

*14 IOWA: BRANSTAD CHALLENGES GRANDY'S PARTY LOYALTY

Gov. Terry Branstad (R) manager Brian Kennedy charged that Rep. Fred Grandy (R-05) ran into GOP opposition to a health care plan he supports during a cong. debate and threatened to "turn in his (party) pass." Kennedy: "The recent episode calls into question Grandy's temperament. For Grandy to get so upset over a policy disagreement that he would threaten to quit the GOP is extraordinary." Grandy: "It's sad and pathetic that all Terry Branstad can do after 12 years as governor is attack me" (AP/WORLD HERALD, 3/16).

ATTACK ADS: Branstad began airing a radio spot last week accusing Grandy of voting "to spend your tax money on pornographic NEA art programs." From the ad: "Terry Branstad's values were made in Iowa. Fred Grandy's? Tune in next week for the most amazing fact of all." Kennedy declined to say what that fact is. The Branstad ad charges Grandy has supported new taxes and expensive health care plans. Grandy: "He's questioning my party loyalty, my patriotism, and now he wants to see my tax returns and he's already questioning my fiscal conservatism. If it keeps up, he's going to demand citizenship papers and a blood test." Grandy began airing an ad 3/17 plugging his plan to freeze state spending and lower income and property taxes (Yepsen, DES MOINES REGISTER, 3/17). Branstad, on Grandy's charge he has raised taxes 71 times: "His rhetoric is just the opposite of his voting record. In Congress he's consistently bragged about cutting deals with Democrats. I'm told today [3/18] he missed the vote on the balanced-budget amendment. If he was concerned about spending and taxes, he should have been there to vote" (Kotok, OMAHA WORLD-HERALD, 3/18). Others: AG Bonnie Campbell (D) and businessman Bill Reichardt (D). Filing 3/18; primary 6/7.

*14 IOWA: HOW MUCH WILL DEM CROSSOVERS HELP GRANDY IN PRIMARY? A Political/Media Research poll, conducted 2/24-27, surveyed 808 registered voters, margin of error +/- 3.5%. GOP subsample: 312 likely voters; margin of error +/- 5.6% (KCCI-TV, 3/1). Tested: Gov. Terry Branstad (R), Rep. Fred Grandy (R-05) and AG Bonnie Campbell (D). The DES MOINES REGISTER poll, conducted 2/16-22, tested 361 likely GOP voters and 523 RVs total.

	PMR		REGISTER	PMR	
GOP PRIMARY	NOW	10/93		FAV/UNFAV	ID
Branstad	51%	41%	46%	51%/ 22%	100%
Grandy	40	45	43	45 / 16	95
Undec.	9	14	11		

BRANSTAD RE-ELECT	NOW	5/93	10/92
Re-Elect	32%	28%	23%
Consider other	34	46	43
Replace	29	24	30

GENERAL ELECTION MATCH-UPS

	PMR	REGISTER		PMR	REGISTER
Branstad	49%	50%	Grandy	45%	49%
Campbell	40	40	Campbell	37	34

WHY THE DIFFERENT GOP SPREADS? The Branstad campaign took issue with the REGISTER's poll which showed it a 3-pt. race, criticizing the REGISTER poll's inclusion of some Dem and Ind. voters in the GOP primary sample. It is possible for registered Dems and Independents to show up on primary day, change their party ID and vote in the GOP primary. After voting, these people can pick up applications and switch their party ID once again. The Branstrad camp contends that among GOPers, they have a twenty point lead in the REGISTER poll and a 19 point lead in the PMR poll (Branstad release, 3/1).

PRIMARY CHALLENGE FOR CAMPBELL? Businessman Bill Reichardt (D) "won't say for sure" until the 3/18 filing deadline whether he will challenge Campbell. But he has "more than half" of the 2,932 signatures needed to file. "Letters of support have poured into Reichardt's clothing store. Friends and backers meet secretly, making behind-the-scenes preparations. Big money Democrats have confirmed that they're pushing Reichardt to run. Party officials are less eager to discuss the issue." Reichardt's "obsession" is troubled youths, and if he runs, "he'll try to ride that hot issue into office." Reichardt friend Randy Duncan: "The guy will drive 500 miles to speak in front of five people. ... He should be incarcerated in a mental institution. He'd like to be on the front page of the paper every morning. He's very bull-headed. ... If he were governor, I guarantee he'd be a very strong one" (Howard, REGISTER, 2/28).

HOTLINE 2/28/94

*11 IOWA: DEAD HEAT IN GOP PRIMARY; CAMPBELL TRAILS BOTH GOPers
The DES MOINES REGISTER's Iowa Poll, conducted 2/16-22, surveyed 523 likely voters; margin of error +/- 4.3%. GOP primary subsample: 361 LVs; +/- 5%. Tested: Gov. Terry Branstad (R), Rep. Fred Grandy (R-05) and AG Bonnie CAmpbell (D). Primary 6/7 (2/27-28).

		AMONG GOP SUBSAMPLE	
GOP PRIMARY	NOW	12/93	FAV / UNFAV
Branstad	46%	45%	69% / 30%
Grandy	43	35	60 / 22
Undec.	11		

GRANDY'S PRIMARY CHALLENGE EFFECT ON GOP RETENTION OF GOV SEAT	
Good	63%
Bad	27
No diff.	8

BRANSTAD'S 3 TERMS MAKES YOU ... TO VOTE FOR HIM	
More likely	40%
Less Likely	41
No diff.	16

WHICH WOULD DO BETTER JOB ON ...	BRANSTAD	GRANDY
Holding line on taxes	43%	40%
Providing vision	41	42
Attracting good jobs	46	35
Improving schools	47	33
Managing government	47	37

AMONG FULL SAMPLE

GENERAL ELECTION MATCH-UPS			
Grandy	49%	Branstad	50%
Campbell	34	Campbell	40

BRANSTAD APPROVAL	
Approve	58%
Disapprove	37

"Political insiders have criticized Grandy for poor organization. His advertising has stressed" Branstad's "long tenure, and has suggested that Iowans impose their own 'term limit' by throwing Branstad out of office." on the other hand, Branstad has criticized Grandy for "reneging on a commitment" he made not to run in the primary. Branstad "seems to be attempting to stay above the fray, and has yet to unleash a sustained attack" on Grandy (Fogarty, DES MOINES REGISTER, 2/27). The polo "marks the fifth consecutive improvement in Branstad's Iowa Poll job-approval rating since he hit his all-time low of 37 percent two years ago."

*6 IOWA: GRANDY TAX PLAN OFFERS GOP A CHOICE

Rep. Fred Grandy's (R-05) "call last week for big tax cuts gives Iowa conservatives something they've never had -- a supply-side candidate. For years, conservatives have tolerated [GOP Gov.] Terry Branstad's tax and spending increases ... Now, Grandy is giving them a choice, and that alters both the campaign for governor and the tax debate." Grandy's plan would give small business "the first big cut through more rapid deductions for new equipment," and in the second year, he would cut income taxes. "By focusing a two-pronged message in the primary campaign -- cutting taxes and arguing no one should be governor for 16 years -- Grandy hopes to re-ignite his campaign" (Yepsen, DES MOINES REGISTER, 2/21). The GOP primary is 6/7.

PRISON TALK: AG Bonnie Campbell (D) said "an insufficient number of maximum-security prison beds" is posing possible security risks in Fort Madison. She "downplayed the significance of a disturbance at the Iowa State Penitentiary this week," but said Branstad "jeopardized prison expansion efforts by mishandling a private group's proposal to build a prison at Clarinda." Campbell suggests IA's correctional system have "maximum-security beds outside Fort Madison so the state's most dangerous offenders aren't in one location" (Boshart, CEDAR RAPIDS GAZETTE, 2/19). Branstad "defended the management of Iowa's prison system" and "declared he won't tolerate the violence that struck state prisons last week." He "said he believes Iowa's prisons are adequately staffed," but "repeatedly criticized state lawmakers ... for trimming his requests for prison spending in recent years" (Petroski/Wiley, DES MOINES REGISTER, 2/22). Branstad also "made a fresh pitch for his proposal to reinstate the death penalty": "One of the best things we could do to protect our [prison] guards ... is to reinstitute the death penalty for someone who is serving a life sentence and then kills another person. Right now they have nothing to lose" (Roos, REGISTER, 2/22).

WE WANT TO KNOW: CEDAR RAPIDS GAZETTE's Boshart writes, "Just where is deadbeat Iowa dad Terry O'Neal? Enquiring minds apparently want to know." Campbell confirmed that her office "has shared information on the Des Moines father who owes more than $50,000 in child support" with the National Enquirer and TV tabloid show "Inside Edition" (2/19). Campbell said the ENQUIRER "is preparing an article on parents who are behind on their child support" and contacted her office for candidates. Campbell: "Tony may have his 30 minutes of national fame, which makes us happy" (Clifford, DES MOINES REGISTER, 2/19). Filing: 3/18.

IOWA

Richard P. Schwarm
Chairman

Present
Chairman, Republican State Central Committee of Iowa, elected - February 4, 1989
Executive Director, Republican State Central Committee of Iowa, 1992 -
Member, Republican State Central Committee, 1985 -
Practicing Attorney, 1974 -

Previous
Chairman, Iowa Victory '92 Committee
Director, Iowans Against Gerrymandering
Member, Governor Branstad's Campaign Steering Committee, 1978, 1982, 1986, 1990
Member, Congressman Fred Grandy's Steering Committee, 1986

RNC Activity
Member, Committee on Call, Republican National Convention, 1992
Delegate, Republican National Convention, 1992
Assistant Legal Counsel to Rules Committee, Republican National Convention, 1984

Personal
Spouse: Charise
Children: Two
Education: B.A., Morningside College;
J.D., Drake University

(cont.)

(cont.)

110 West Main
Lake Mills, IA 50450

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(515) 592-1031 (o)
(515) 592-1030 (f)
(515) 592-2902 (h)

IOWA

Gwen Boeke
National Committeewoman

Present
National Committeewoman, Iowa, elected - August 22, 1984
Advisory Board, Iowa Federation of Republican Women, 1972 -
Regent, Wartburg College, 1986 -
Iowa Representative, Foundation of Evangelical Lutheran Church in America, 1990 -
Iowa Board of Engineers and Land Surveyors, 1993 -
Trustee, Century Companies of America, 1988 -
Registered Nurse

Previous
Executive Board, Iowa Federation of Republican Women, 1976 - 1984
President, Iowa Federation of Republican Women, 1982 - 1983
Advisory Board, NFRW, 1982 - 1983
Chairman, Midwest Republican Leadership Conference, 1987
National Church Council, 1980 - 1990
Member, National Executive Committee, American Lutheran Church, 1984 - 1988
Chairman, Care Review Committee, Evans Memorial Home, 1973 - 1992
Iowa Board of Architectural Examiners, 1987 - 1993

RNC Activity
Member, Committee on Arrangements, Republican National Convention, 1988, 1992
Member, Committee on Rules, Republican National Convention, 1988
Delegate, Republican National Convention, 1988

(cont.)

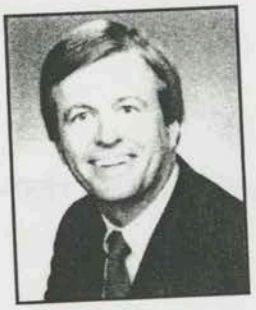
(cont.)

Member, RNC Rules Committee, 1989 - 1990
Member, Midwestern Region, RNC Executive Council, 1990 -
Member, Committee on Contests, Republican National Convention, 1992

Personal
Spouse: Gary
Children: Four
Education: B.S.N., University of Iowa

Route 2, Box 149
Cresco, IA 52136

(319) 547-2649 (h)



IOWA

Stephen W. Roberts
National Committeeman

Present

National Committeeman, Iowa, elected - August 16, 1988
President, Mid-Iowa Council, Boy Scouts of America, 1991 - 1993
Chairman of the Board, American Cancer Society, IA Division, Inc., 1989 - 1993
Member, Committee to Nominate Alumni Trustees, Princeton University, 1991 - 1993
Member, Des Moines "Y" Camp Board, 1982 -
Member, Board of Directors, Iowa Association of Business and Industry, 1988 -
Senior Shareholder, Davis, Hockenburg, Wine, Brown, Koehn and Shors, P.C.

Previous

Chairman, Iowa Republican Party, 1977 - 1981
Member, Republican National Committee, 1977 - 1981
Moderator, Des Moines Presbytery, 1989
Member, Iowa Criminal & Juvenile Justice Planning Agency, 1982 - 1986
Member, United States Department of Education Appeal Board, 1982 - 1986
Member, Iowa Reapportionment Commission, 1981
Member, Board of Directors, Des Moines Center of Science and Industry, 1984 - 1990
Member, University of Michigan Law School Fund National Committee, 1982 - 1988
Member, Polk County Charter Commission, 1989 - 1990
Member, Greater Des Moines Area Commission, 1990 - 1991

(cont.)

(cont.)

RNC Activity
Member, RNC Rules Committee, 1980, 1990 -

Personal
Spouse: Dawn
Children: Three
Education: B.A., Princeton University;
J.D., University of Michigan School of Law

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Iowa Rematches Headline '94 Races

ROLL CALL 3/24/94

Rematches of two of the closest 1992 House races in the nation will headline this year's lineup of Congressional campaigns in Iowa, as will the race to replace Rep. Fred Grandy (R), who is running for governor.

Rep. Jim Nussle (R) and former Rep. **Dave Nagle** (D) will face off again in the 2nd district, which comprises the northeast corner of the state. Nussle prevailed by fewer than 3,000 votes in the 1992 race when the two incumbents were thrown into the same territory after redistricting.

The 1994 race promises to be just as close. Nagle says private polling actually shows him ahead of Nussle, who was the subject of controversy in the district when he fought for budget cuts to offset flood relief funds. Nussle eventually voted in favor of federal flood aid, but Democrats intend to paint him as obstructionist.

Nagle and Nussle are both unopposed for their parties' nominations.

In the 3rd district, which spans the southern half of the state, another rematch is likely. But Democrat **Elaine Baxter**, the secretary of state, must dispatch fellow Democrat **Larry Walshire**, an administrative law judge, in a primary before she can face **Rep. Jim Ross Lightfoot** (R).

Baxter was favored to defeat Lightfoot in 1992 in a new district that is strongly Democratic. But the incumbent rallied — overcoming criticisms of his 105 overdrafts at the House Bank and promising to limit himself to two more terms. He won a three-way race with 49 percent to Baxter's 47 percent.

Walshire is trying to round up labor support, but Baxter is expected to get the nod and face Lightfoot again.

Two Republicans are vying for the nomination to face 18-term **Rep. Neal Smith** (D), who was defeated yesterday in his bid to assume the chairmanship of the Appropriations Committee. Republicans are talking up surgeon **Greg Ganske** of Des Moines, who outraised Smith last year. Smith, however, has more than $600,000 in his war chest. Also running in the GOP race is attorney **Paul Lunde**, who received 37 percent of the vote against Smith in the 1992 election.

In the 5th district, three Democrats and two Republicans will contend for the seat left open by Grandy.

Democrats say they can capture the district, which Clinton lost by 4 points. But Republicans have the early edge. State Sen. **Brad Banks** and businessman **Tom Latham** will contend for the GOP nomination. State Rep. **Mike Peterson**, dentist **Sheila McGuire**, and minister **Paul Dahl** face off for the Democratic nod.

— **Craig Winneker**

*5 GOP '96: CHENEY VISITS IA; WELD FOCUSES ON GRIDIRON DINNER
DES MOINES REGISTER's Yepsen reports, in his "first presidential campaign foray" into IA, Dick Cheney said the Bush admin. "was correct in not attempting to take Baghdad to capture Saddam Hussein during the Gulf war." Cheney noted that the objectives were to "liberate Kuwait and get rid of Saddam's offensive capabilities": "By the fourth morning of the war, we'd done that." Cheney said he has not made a final decision about '96 and said he "expects to decide by the end of the year." Cheney said if he does decide to run, "he will fully disclose" his health records "because he has had heart disease and bypass surgery and there will be questions about his fitness for office." Cheney described himself as "reasonably conservative," but in "the middle of the spectrum of GOP presidential candidates" (3/15).

HOTLINE 2/14/94

The SUNDAY TIMES of London reports that Hillary Rodham Clinton "profited from a 1989 deal that artificially inflated the value of 45 retirement homes in Iowa." The TIMES reports that HRC gained $15,000 from the deal, which netted the Rose Law Firm $500,000. Assoc. WH Counsel William Kennedy, then a Rose partner, "engineered" the deal which "raised the cost of caring for many of the elderly in the retirement homes by 14 percent" (Ferraro, N.Y. POST, 2/14). The N.Y. DAILY NEWS also reported the story (2/13).