AGENDA

the Principal Financial Group

Government Relations

The Principal Financial Group
Government Relations Department

FAX TRANSMITTAL SHEET

Date: March 29, 1994

To: Tom Synhorst

Company:

Phone:

Fax No.: 913-722-5607

From: Jim Crawford

Phone: 1-800-325-2532 Ext. 247-5480 or (515) 248-3263
Fax No.: (515) 248-8469

Total No. of Pages (including this cover page) 1

Message: Des Moines Meeting with Senator Dole

The individuals listed below will attend the 4:45 P.M. "private meeting" with Senator Dole:
Dave Drury, President
Ted Hutchison, Executive Vice President
Dick Neil, Senior Vice President, Group
Dick Helms, Second Vice President, Group Support
Jim Van Lew, Vice President, Group Operations
Jim Charling, Second Vice President, Group Development
Lucia Riddle, Director-Group Life and Health Compliance
Jim Crawford. Director-Government Relations Coordination

Salon F.

As I understand, the meeting will be at the Embassy Suites Hotel, Salon D. I'm also faxing a copy of a document entitled "Where We Stand on Health Care Reform." I hope you will pass this information alsong to Senator Dole.

Please call me immediately if there is a change in plans.

Home Office: Des Moines, Iowa 50392-0220 (515) 247-5111/FAX (515) 248-8469

HEALTH INSURANCE ASSOCIATION OF AMERICA
THE PRINCIPAL FINANCIAL GROUP
Where We Stand on Health Care Reform

WHAT WE ARE FOR	WHAT WE ARE AGAINST
✓ Cradle-to-grave health insurance core benefits for all Americans.	✓ Price controls on insurance.
✓ Mandate that individuals be covered and pay toward coverage (only if financially able).	✓ Exclusive (monopoly) health alliances.
✓ Mandate employers pay towards coverage (only if financially able).	✓ Pure community rating.
✓ Insurers do not underwrite -- take everyone.	
✓ No pre-existing conditions.	
✓ No fear of loss of coverage.	
✓ Tax bargain capped at core benefit.	
✓ Managed care -- further development to control both volume and price.	
✓ Remove state law barriers that interfere with managed care.	
✓ Put Medicaid and Medicare covered individuals under managed care.	
✓ Publish price and quality outcome data from all managed care organizations.	
✓ Professionals develop practice guidelines to reduce malpractice suits and better educate the physicians on what works.	
✓ Tort reform.	
✓ Electronic exchange of information and a single universal claim form.	
✓ Individuals personally responsible for their health.	
✓ Move away from sickness and repair toward wellness and health.	
✓ Incentives for healthy lifestyles.	
✓ End cost shifting from Medicaid and Medicare to private insurance patients.	
✓ Change societal attitudes as to the end of life so death is not an exercise in invasive technology.	

GLOSSARY OF TERMS

WHAT WE ARE FOR

•**Cradle-to-grave health insurance core benefit package for all Americans.** Also known as "universal coverage." This means that everyone (employees, unemployed, senior citizens, dependents, etc.) is covered by health insurance (the benefits probably defined by the government) throughout his or her lifetime.

•**Individual mandate.** This means that everyone would be required to have health insurance covering essential services. It is likely that the government would subsidize the cost of coverage for those who can't afford to pay, but those who can pay will be required to.

•**No pre-existing conditions. No fear of loss of coverage.** Also called "portability." Coverage is continuous for all conditions once you qualify. There is no cancellation due to health status. You can remain covered even if you change your job, or lose it.

•**Tax bargain capped at core benefit.** You can deduct the cost of the core benefit package from your taxes. You pay taxes only on the cost of premiums for benefits that exceed the core benefit plan. This makes consumers more price conscious and provides greater incentive for choosing benefit plans that do not exceed the core benefit plan levels.

•**Managed care.** Benefit plans which include incentives to the insured for appropriate use of their medical coverage. Such incentives are typically in the form of lower benefits, or no benefits at all, when the insured uses providers other than those specified under the plan.

•**Publish price and quality outcome data from all managed care organizations.** Quality outcome data is information on the effectiveness of providers' practices. Making this data, along with price information, available to consumers allows them to become better informed purchasers of medical care and leads to more consistent provider practices.

•**Professionals develop practice guidelines.** Practice guidelines establish standard acceptable treatment plans for providers to follow in order to provide consistency in treatment, educate physicians about what works best and reduce the potential for malpractice suits.

•**Tort reform.** One factor driving up health care costs is excessive, unnecessary medical procedures driven by the fear of malpractice suits. Government must enact laws reforming the legal system to control the cost of lawsuits, defensive medicine and malpractice insurance premiums.

•**Electronic exchange of information and a single universal claim form.** Reform should require a reduction in insurance related paperwork by simplifying claim processing and, therefore, lower administrative costs.

•**End cost shifting.** Medicaid and Medicare reimbursements have been reduced to where they do not cover the entire cost of the care given. Cost shifting occurs when providers charge higher prices to private insurance patients in order to offset costs not covered by Medicaid and Medicare.

•**Change societal attitudes as to the end of life so death is not an exercise in invasive technology.** Currently, our society encourages prolonging life for a brief period for the terminally ill by using expensive and invasive technology. As a society we need to consider dignity and quality of life for the terminally ill when making decisions to incur high costs for the purpose of extending life.

WHAT WE ARE AGAINST

•**Price controls on insurance.** This freezes insurance premiums, and makes little sense because insurers act as intermediaries between providers and individuals, and insurers can't control provider prices or the type and number of services performed.

•**Exclusive or monopoly health alliances.** Also known as "exclusive purchasing pools." This requires that all employers below a certain size, and individuals, purchase their insurance coverage from one of a handful (3-5) of insurers in each geographic region of the country. Such arrangements restrict competition and will eventually prove less efficient or cost effective than open markets.

•**Pure community rating.** This means that an insurer is required to charge a fixed rate. Everyone pays the same rate, regardless of their age, sex, lifestyle or health history. Everyone in a designated region pays the same. There is no reward for healthy lifestyles or conservative use of available medical services.

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
Washington, DC 20510-1501
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☐ 206 Federal Building
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(319) 363-6832

United States Senate

CHARLES E. GRASSLEY

WASHINGTON, DC 20510-1501

Reply To:

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320 6th Street
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☐ 210 Waterloo Building
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☐ 116 Federal Building
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Davenport, IA 52801-1513
(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

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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United States Senate

CHARLES E. GRASSLEY

WASHINGTON, DC 20510-1501

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☐ 307 Federal Building
8 South 6th Street
Council Bluffs, IA 51501
(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

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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

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.

IOWA PROFILE

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.

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.

QUESTIONS / PROBLEMS

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 PROPOSAL

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.

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.)**

DES MOINES PROFILE

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.

HOSPITAL UNIT CHARGES

Iowa hospitals' low ranking in both charges per inpatient day and outpatient visit highlight the excellent value of care provided by Iowa hospitals in comparison to hospital charges across the Nation.

Iowa hospitals' charges per inpatient day of $724 are 18.6 percent and 38.1 percent lower than the Midwest and Nation. Iowa hospitals rank fifth lowest nationally.

Outpatient charges per outpatient visit of $188 in Iowa hospitals are 28.8 percent and 27.4 percent lower than the Midwest and Nation. Iowa hospitals are the lowest of the states in the Midwest and rank fourth lowest nationally.

HEALTH RANKINGS

Northwestern National Life has published "The NWNL State Health Rankings" for 1992. This publication presents an overall measure by state of the general health of the population in the United States. States are ranked for various components clustered into categories: lifestyle, access, occupational safety and disability, disease and mortality. Iowa is tied with Connecticut, Kansas, Vermont, and Colorado for 7th in overall ranking of the categories. This compares to an overall ranking of 8th in 1991 and 7th in 1990.

ehg/7/93/chamber.jpb

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

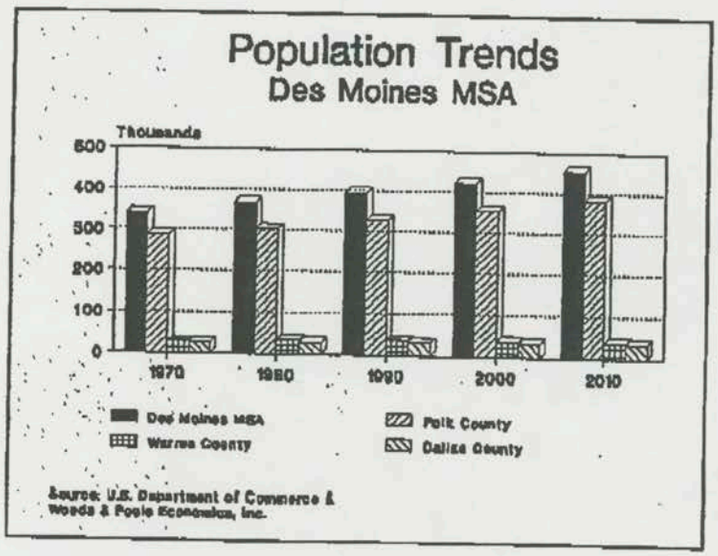
Source: Milliman & Robertson, Inc.

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.

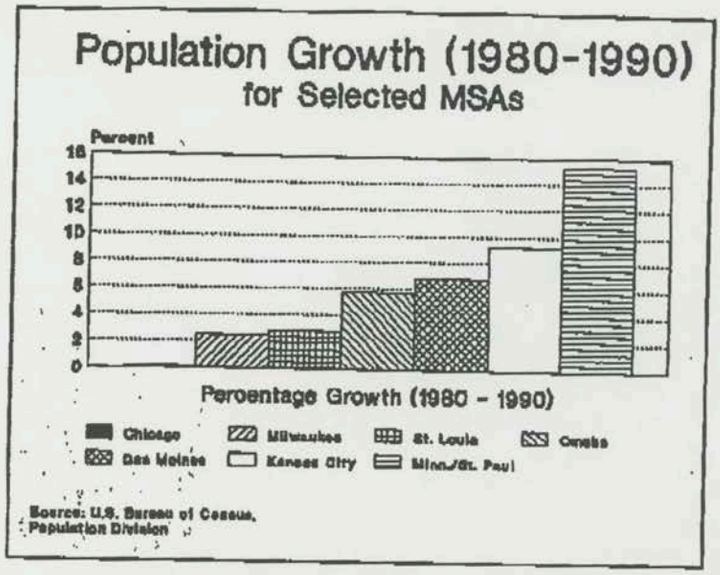
- Population growth from 1980 to 1990 in the Des Moines MSA was 6.9 percent. This ranked the Des Moines MSA as the 94th fastest growing MSA.

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).



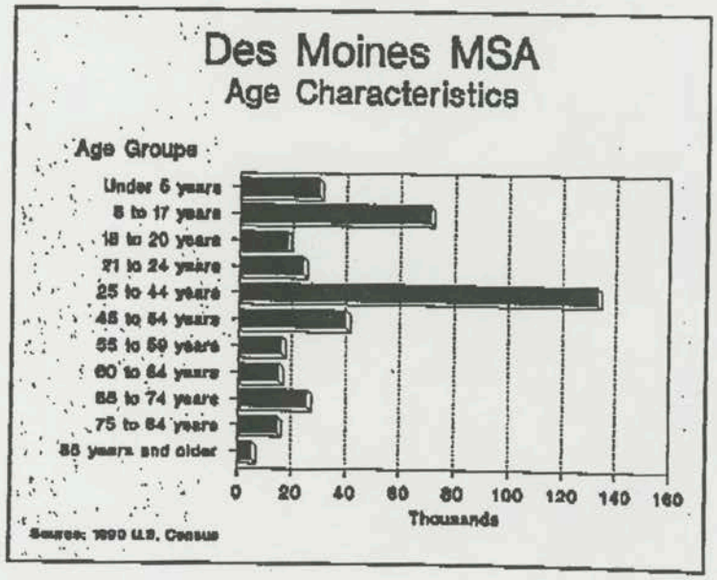
Households

- 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.



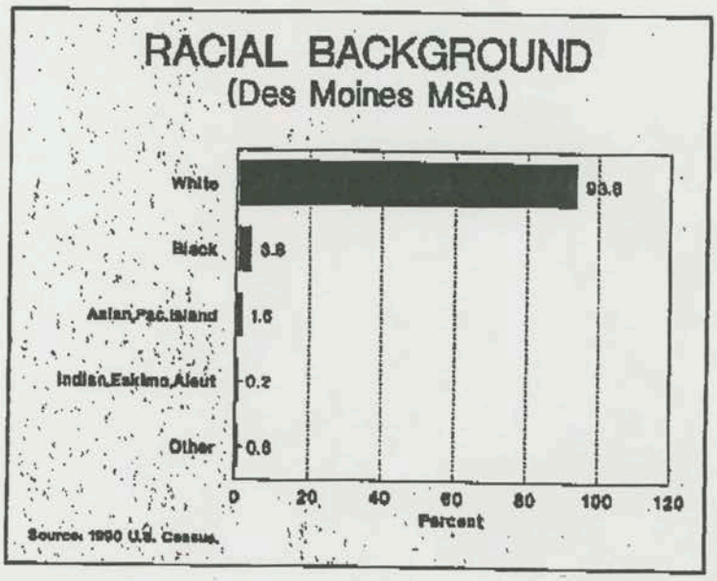
DES MOINES MSA AGE CHARACTERISTICS

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).

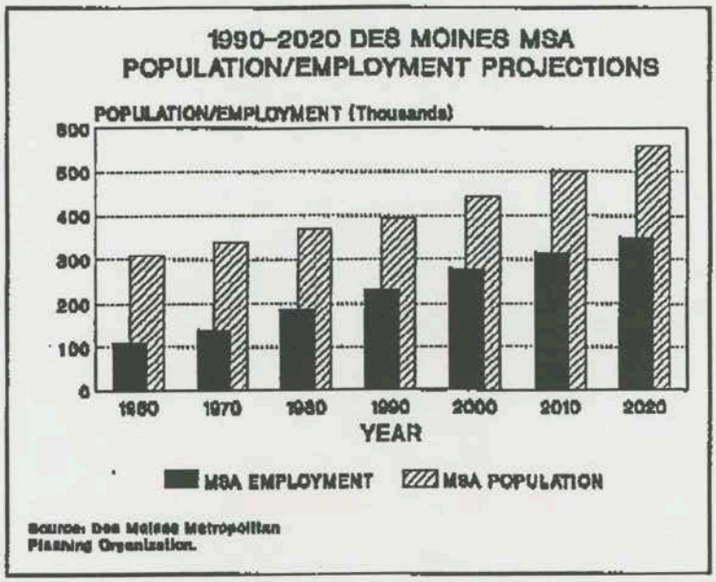
NUMBER OF EMPLOYEES IN DES MOINES MSA ANNUALLY

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

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

Des Moines Office: 415 Tenth Street, Des Moines, Iowa 50309 (515) 244-9311
Iowa City Office: 124 1/2 E. Washington, Iowa City, Iowa 52240 (319) 354-8116

> 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

TABLE OF CONTENTS

OVERVIEW OF MAJOR REFORM BILLS

	CLINTON	BREAUX-DURENBERGER	CHAFEE	GRAMM	LOTT-MICHEL	NICKLES
UNIVERSAL COVERAGE	Yes	No	Yes	No	No	Yes
LOW INCOME SUBSIDIES	Yes	Yes	Yes	Yes	Yes	Yes
LIMITATIONS ON FEDERAL $ FOR ENTITLEMENTS	Yes (not enforce-able)	Yes (baseline plus GDP increase)	Yes (pay as you save)	Yes (pay as you save)	Yes (baseline)	Yes-block grants; No-tax credits
INSURANCE REFORMS	Yes	Yes	Yes	Yes	Yes	Yes
UNIFORM BENEFITS	Yes	Yes	Yes	No	No	No
PURCHASING GROUPS	Yes	Yes	Yes	Yes	Yes	No
TAX CODE: Medical Savings Accounts	No	No	Yes	Yes	Yes	Yes
Increase deduct. for self-employed	Yes	Yes	Yes	Yes	Yes	No
Tax cap: Employer deduct. Employee exclus.	No Yes (in 2004)	Yes No	Yes Yes	No No	No No	No No (repeals exclusion)
DIRECT COST CONTROLS	Yes	None	None	None	None	None
ANTI-FRAUD AND ABUSE PROVISIONS	Yes	No	Yes	No	Yes	Yes
ADMIN. SIM-PLIFICATION	Yes	Yes	Yes	Yes	Yes	Yes

	CLINTON	BREAUX-DURENBERGER	CHAFEE	GRAMM	LOTT-MICHEL	NICKLES
LIABILITY REFORM	Yes	Yes	Yes	Yes	Yes	Yes
ANTITRUST	Yes	Yes	Yes	Yes	Yes	Yes
MEDICAL EDUCATION PROVISIONS	Yes	Yes	Yes	No	No	No
MEDICAID Private Option Eliminate DSH	Yes Yes	Yes Yes	Yes Yes	No No	Yes No	No Yes
MEDICARE Private Option Provider Cuts Means test	Yes Yes Yes	No Yes Yes	Yes Yes Yes	Yes No No	No No Yes	Study Yes No
NEW ENTITLEMENTS	Medicare prescript. drugs; retiree health; long-term care	Medicare prevent. services	No	No	No	No
QUALITY STANDARDS	Yes	Yes	Yes	Yes	Yes	Yes
CONSUMER VALUE INFORMATION	Yes	Yes	Yes	No	Yes	Yes
RURAL/INNER CITY PROVISIONS	Yes	Yes	Yes	No	Yes	Yes
HEALTH PLAN REQUIREMENTS	Yes	Yes	Yes	Yes	Yes	Yes

UNIVERSAL COVERAGE

1. Should We Require Universal Coverage?

   - There are many who believe universal coverage is not necessary because they believe significant increases in coverage can be made through changes in the insurance market and providing government subsidies for low-income individuals.

2. How Can Universal Coverage Be Achieved?

   - The approaches to achieving universal coverage include a single-payer system, an employer mandate, an individual mandate, or some combination of these.

3. Who Should Pay for Universal Coverage?

   - Individuals and/or employers?

4. Who Should Receive Subsidies?

   - If there is some form of mandate, low-income individuals and/or small businesses will need subsidies to make insurance affordable.

   - Subsidies could take several forms: tax credits, liability caps, vouchers, or premium discounts. Income range for individual subsidies and definition of small business eligible for subsidies need to be determined.

5. How Should Any Mandates Be Enforced?

   - Tax penalties and payroll deductions are the most frequently suggested method of enforcement. Some proposals give the states a fall back role to make sure all individuals are enrolled in a health plan. Another option is to require proof of insurance as a condition of receiving public assistance (such as, food stamp recipients).

SUMMARY OF UNIVERSAL COVERAGE PROPOSALS

	CLINTON	BREAUX-DURENBERGER	CHAFEE	GRAMM	LOTT-MICHEL	NICKLES
UNIVERSAL COVERAGE	Yes	No	Yes	No	No	Yes
APPROACH	Individual and employer mandates	N/A (no mandate)	Individual mandate; employer must offer insur.	N/A (no mandate)	N/A (no mandate); employer must offer insur.	Individual mandate
WHO MUST PAY	Individuals and employers	N/A	Individuals	N/A	N/A	Individuals
SUBSIDIES FOR IND-IVIDUALS	Premium discounts and 3.9% cap on family share of premium for families with income under $40,000	Premium discounts for individuals with income below 200% of poverty	Vouchers for individuals with income below 240% of poverty	Tax credits for individ-uals with income below 200% of poverty	Medicaid buy-in for individuals with income up to 200% of poverty	Refundable tax credits for individuals based on medical expenses and income
SUBSIDIES FOR BUSINESS	Premium discounts	No	No	No	No	No
ENFORCE-MENT OF MANDATES	Penalty for individual of 2 times family share of premium for time not enrolled; fines for businesses	N/A	Tax penalty of 120% of average of lowest cost plans in area	N/A	N/A	Can't claim personal exemptions on income tax return; employer withholds premium from paychecks; state system to enroll people who refuse to buy insur.

BENEFITS

1. Covered Items and Services

   - Should the benefit package be the same for everyone in terms of covered items and services; coverage for any additional items or services would have to be obtained through a supplemental policy (like Medicare)?

   - Or should health insurance policies have to include a minimum set of benefits, but be allowed to contain any variation of benefits above the minimum (like the Federal Employee Health Benefits Program)?

2. Standardization of Cost Sharing

   - Should cost sharing amounts be exactly the same for every type of health plan; should there be standard cost sharing for each type of plan (i.e., fee-for-service, HMO)?

   - Or should there be no standardization at all of cost sharing?

3. Definition of the Benefit Package

   - Should details of the benefit package be defined in legislation?

   - Or should another entity, such as a Commission, make a recommendation to Congress for approval once the legislation has been enacted?

4. Mental Health Benefits

   - Should coverage for mental health services be in the benefit package? If so, should they be treated the same or differently than medical benefits in terms of cost sharing?

5. Classes of Providers

   - Should the legislation prohibit discrimination against classes of providers?

6. State Law Preemption

   - Should state laws that mandate coverage for certain items and services or certain provider classes be preempted?

SUMMARY OF BENEFITS PROPOSALS

	CLINTON	BREAUX-DURENBERGER	CHAFEE	GRAMM	LOTT-MICHEL	NICKLES
COVERED ITEMS AND SERVICES	Uniform package	Uniform package	Uniform package	Variations in benefit packages allowed	Standard, catastrophic and Medisave plans based on actuarial values	Minimum Package - Variations above minimum are allowed
COST SHARING	3 sets correspond to type of delivery systems	To be defined by commission	Standard and catastrophic levels to be defined by commission	Catastrophic limit not to exceed $3000 per year (indexed)	Standard and catastrophic levels	Variations allowed; maximum deductible $1000 individuals and $2000 family
SPECIFICS ON COVERAGE	In law	By commission	By commission	N/A	NAIC to set target actuarial values	In law
MENTAL HEALTH BENEFITS INCLUDED	Included but treated different from medical in short term	Depends on commission recommend-ation	Severe mental illness treated same as medical; other mental health up to commission	Can be an option in a benefit package	Can be an option in a benefit package	Not part of minimum benefit package
PROVIDER CLASSES	All legal providers covered if particip-ants in plan	All legal providers covered if particip-ants in plan	All legal providers covered if participants in plan	No mention	No mention	No mention
PREEMPTS STATE LAWS	De facto preempts; no mention	Yes	Yes	Yes	Yes	Yes

COST CONTAINMENT

Because of the complexity of the reasons for escalating growth of national health care expenditures, there are varying opinions on whether, or how much, the government should intervene to control costs. The proposals can generally be categorized as reforms to change incentives in the health care marketplace and reforms to put governmental limits on health care spending.

I. CHANGING INCENTIVES IN THE HEALTH CARE MARKETPLACE

1. Encouraging Managed Care

   - The health care system has historically been organized on a fee-for-service basis. Fee-for-service arrangements have been criticized for giving providers an incentive to perform too many services.

   - As health care costs have escalated, there has been a trend towards organizing hospitals, physicians, and other providers into "managed care" networks which employ a variety of mechanisms to control costs by discouraging the delivery of unnecessary services.

2. Medical Liability Reform

   - The fear of lawsuits causes many providers to practice "defensive medicine" where they order more tests and procedures than necessary.

   - Proposals to address this problem include such things as establishing alternative dispute resolution mechanisms, capping damages, limiting attorney's fees, etc.

3. Anti-Fraud and Abuse

   - Fraud and abuse is a significant problem for both the public and private health care sector. According to the General Accounting Office (GAO), fraud and abuse account for as much as 10 percent of health care spending.

   - Proposals to stem fraud and abuse include extending existing penalties for defrauding Medicare or Medicaid to the private health sector, enhancing criminal and civil penalties, and improving information systems to identify abusers.

4. Administrative Simplification

   - Standardization and automation of health information systems would reduce costs now associated with administration of the health system.

5. Role of Employers

   - Employers have a large stake in controlling employee health care costs. Some proposals retain employers' role as purchasers, while others remove employers from this role.

6. Tax Subsidies

   - Some proposals place a limit on favorable tax treatment for health insurance costs to provide people an incentive to choose more efficient health plans.

7. Medical Savings Accounts

   - Some proposals establish medical savings accounts to give favorable tax treatment for funds set aside for health expenditures. Medical savings accounts will make consumers more cost conscious in their health care spending.

8. Consumer Information

   - Most market-oriented reform proposals provide information to consumers on the costs and quality of the health care they purchase.

II. GOVERNMENTAL REGULATORY APPROACHES TO COST CONTAINMENT

1. Global Budgets (Premium Caps)

   - Under a global budget, the government establishes an annual amount of spending on a defined set of health care items and services. The Clinton "premium cap" is essentially a global budget for all items and services in the standard benefit package. Each alliance is given a premium target by the National Health Board. The alliance's budget is computed by multiplying the premium target by the number of people in the alliance. The alliance can adjust premiums so that they stay within the global budget.

2. Rate setting

   - Another option is government-set payment rates for providers.

SUMMARY OF COST CONTAINMENT PROPOSALS

	CLINTON	BREAUX-DURENBERGER	CHAFEE	GRAMM	LOTT-MICHEL	NICKLES
ENCOURAGE MANAGED CARE	Yes	Yes	Yes	Yes	Yes	Yes
LIABILITY REFORM	Yes	Yes	Yes	Yes	Yes	Yes
ANTI-FRAUD AND ABUSE	Yes	No	Yes	No	Yes	Yes
ADMIN. SIM-PLIFICATION	Yes	Yes	Yes	Yes	Yes	Yes
EMPLOYERS AS PURCHASERS	No	Yes	Yes	Yes	Yes	No
LIMITS TAX SUBSIDIES	Yes-tax cap on employee exclusion (in 2004)	Yes-tax cap on employer deduction	Yes-tax cap on employer deduction and employee exclusion	No	No	Yes-repeals employee exclusion; less subsidy to upper incomes
MEDICAL SAV. ACCOUNTS	No	No	Yes	Yes	Yes	Yes
CONSUMER INFORMATION	Yes	Yes	Yes	No	Yes	Yes
GLOBAL BUDGETS & PREMIUM CAPS	National board sets for each alliance	None	None	None	None	None
RATE SETTING	Alliances set fee-for-service rates	None	None	None	None	None

FINANCING

1. Should individuals or employers bear the primary responsibility for financing health insurance?

   - Most proposals place the full responsibility with the individual. The Clinton plan (and some House proposals) requires an employer contribution.

2. Should a "tax cap" be implemented?

   - A tax cap may provide an incentive for consumers to purchase less expensive health plans if they want to avoid using after-tax dollars to pay for health plans that are more expensive than the tax cap amount.

   - A tax cap could be designed as any combination of a limit on: 1) the employer's deduction for health insurance provided to employees; 2) the exclusion of employer-provided health insurance from employees' taxable income; or 3) itemized deductions for health care expenditures. The tax cap could be set at a dollar amount nationwide or could vary by geographic regions.

3. Should "sin taxes" be increased?

   - Taxes on tobacco and other products may raise revenues as well as provide an incentive for individuals to lead healthier lifestyles by limiting consumption of tobacco and other products.

4. Should Medicare and Medicaid cuts be used?

   - Medicare and Medicaid payment reductions may produce significant savings to be used for financing new spending. However, if provider payment cuts are too large, they may actually decrease access to certain provider services.

5. Should Medicare be means-tested?

   - General revenues fund about 75 percent of the cost of Medicare Part B, beneficiaries pay 25 percent. Some proposals would require higher income beneficiaries to pay more than 25 percent.

SUMMARY OF FINANCING PROPOSALS

	CLINTON	BREAUX-DURENBERGER	CHAFEE	GRAMM	LOTT-MICHEL	NICKLES
MANDATORY INDIVIDUAL PREMIUM CONTRIBUTION	Yes	No	Yes	No	No	Yes
MANDATORY EMPLOYER PREMIUM CONTRIBUTION	Yes	No	No	No	No	No
LIMIT EMPLOYER DEDUCTION FOR EMPLOYEE HEALTH COVERAGE	No	Yes (tax cap)	Yes (tax cap)	No	No	No
LIMIT EMPLOYEE EXCLUSION FOR EMPLOYER-PROVIDED HEALTH COVERAGE	Yes (tax cap in 2004)	No	Yes (tax cap)	No	No	No (repeals exclus.)
TAX ON CORPORATE ALLIANCES	Yes	No	No	No	No	No
TOBACCO TAX INCREASE	Yes	No	No	No	No	No
HI TAX ON STATE & LOCAL GOVERNMENT EMPLOYEES	Yes	No	No	No	No	No
MEDICARE CUTS	Yes	Yes	Yes	Yes	No	Yes
MEANS-TEST MEDICARE PART B	Yes	Yes	Yes	No	Yes	No
MEDICAID CUTS	Yes	Yes	Yes	Yes	No	Yes

HEALTH INSURANCE MARKET REFORM

1. Guaranteed Issue

   - Should health insurers be required to accept everyone who applies for coverage?
   - Should guaranteed issue apply to the entire health insurance market (including having self-funded plans cover all employees and/or dependents) or only to a market segment (such as the small group market)?

2. Guaranteed Renewability

   - Should termination be allowed, except for cases of premium nonpayment or fraud?

3. Preexisting Condition Exclusions

   - What, if any, exclusions or limitations on coverage should insurers be allowed to impose due to preexisting medical conditions?

4. Premium Rating

   - Should community rating be required?
   - If so, should it be pure community rating or modified with variations allowed for demographic characteristics?
   - If not, what variations in rating should be allowed and what, if any, limits should be imposed on the range of variation?
   - Should rating restrictions apply to only to certain market segments (i.e., the individual and small group markets)?

5. Geographic Areas

   - Should there be defined geographic areas for rating pools and if so, should these areas be allowed to cross state lines?

6. Purchasing Groups

- Should purchasing groups be exclusive, i.e., only one allowed in an area?
- Should participation be voluntary or mandatory?
- What segment of the market, in terms of employer size, should purchasing groups cover?

7. Risk adjustment

- Who should decide on the method?
- To what segment of the market should the risk adjustment apply?
- Are safeguards against cherry picking by insurers needed?

SUMMARY OF HEALTH INSURANCE REFORM PROPOSALS

	CLINTON	BREAUX-DURENBERGER	CHAFEE	GRAMM	LOTT-MICHEL	NICKLES
GUARANTEED ISSUE	Yes	Yes	Yes	No	Yes, group not individual market	Yes
GUARANTEED RENEWABILITY	Yes	Yes	Yes	Yes	Yes, group not individual market	Yes
PREEXISTING CONDITIONS AND PORTABILITY	No exclusions allowed	Exclusion for 6 months less 1 month for every month of previous continuous coverage None for pregnant women or newborns	Exclusion for 6 months less 1 month for every month of previous continuous coverage None for pregnancy or for newborns	State-run insurance pools to subsidize premiums for those with preexisting conditions New COBRA options; penalty-free IRA withdrawals	Exclusion for 6 months unless person previously covered within 60 days None for pregnancy or for newborns	Exclusion for 12 months less 1 month for every month of previous continuous coverage

Chart continued on next page.....

	CLINTON	BREAUX-DURENBERGER	CHAFEE	GRAMM	LOTT-MICHEL	NICKLES
RATING: ALLOWED VARIATIONS	Family type	Family type; age	Family type; age; administrative costs	Everything but health	Age; gender; geography; family type; group size; health	Age; gender; geography; healthy behavior
LIMITS ON VARIATIONS	N/A	Variation on age ltd to 2:1	Variation on age limited to 2:1	None	High cannot exceed low by over 50%	None
RATING RULES APPLY TO ALL PLANS?	Yes	Yes	Applies to all but lg. employers	Yes	Applies to small group market only	Yes
PURCHASING GROUPS	Alliances	HPPCs	Purchasing Groups	MEWAs(ERISA)	Purchasing Groups	None
EXCLUSIVE OR MULTIPLE?	Exclusive	Exclusive	Multiple	Multiple	Multiple	N/A
VOLUNTARY OR MANDATORY?	Mandatory	Mandatory	Voluntary	Voluntary	Voluntary	N/A
WHO CAN PARTICIPATE?	Everyone but large employers (over 5000) opting out	Individuals and employers of 100 or less	Individuals and employers of 100 or less	Any employers	Any employers	N/A
RISK ADJUSTMENT	Regional alliances risk adjust their plans; natl board sets method	HPPCs risk adjust HPPC plans; natl board sets method	States risk adjust small group market	No provision	States risk adjust small group market (or have an alternative risk system)	States risk adjust all health plans

HEALTH INSURANCE TAXATION

Existing tax subsidies have been criticized as contributing to the overutilization of health care and driving up health costs. Some proposals address this concern by imposing a tax cap on some or all of these tax subsidies. Another approach is to restructure the tax subsidies for individuals to encourage cost effective behavior.

1. Employee Exclusion

   - Should there be a tax cap on the employee exclusion for employer-provided health coverage? Should the employee exclusion be replaced with something else?

2. Employer Deduction

   - Should there be a tax cap on the deduction of employers for the cost of employee health coverage?

3. Self-Employed Individuals

   - Should self-employed individuals be able to deduct the full cost of their health coverage? (Up to 25% of health insurance premiums have been deductible in past years.) If so, should a tax cap apply?

4. Itemized Deductions of Individuals

   - Should individuals who are not eligible for the employee exclusion be allowed to deduct the cost of health coverage? (Right now, individuals can only deduct medical expenses that exceed 7.5 percent of their adjusted gross income.) If so, should a tax cap apply?

5. Tax Cap

   - Should it be a set dollar amount or should it vary based on health costs in a specified area?

6. Restructuring Tax Subsidies for Individuals

   - Should existing tax subsidies for individuals be restructured to make individuals aware of the true cost of health insurance so they can be better consumers? One proposal replaces the existing subsidies for individuals with a refundable tax credit.

SUMMARY OF HEALTH INSURANCE TAXATION PROPOSALS

	CLINTON	BREAUX-DURENBERGER	CHAFEE	GRAMM	LOTT-MICHEL	NICKLES
LIMITS EMPLOYEE EXCLUSION	Yes, tax cap in 2004	No	Yes, tax cap	No	No	No (repeals exclusion)
LIMITS EMPLOYER DEDUCTION	No	Yes, tax cap	Yes, tax cap	No	No	No
ALLOWS SELF-EMPLOYED DEDUCTION	Yes (100%)	Yes, 100% up to tax cap	Yes, 100% up to tax cap	Yes-national average paid by employers (about 75%)	Yes (100%)	No, but gets tax credit (see below)
EXPANDS DEDUCTION OF INDIVIDUALS	No	Yes, up to tax cap	Yes, up to tax cap	Yes	Yes	No, but gets tax credit (see below)
TAX CAP SET AT COST OF:	Standard plan	Lowest priced AHP	Avg. of low-est ½ plans	N/A	N/A	N/A
TAX CREDITS FOR HEALTH EXPENSES	No	No	No	Yes, for workers with income below 200% poverty	No	Yes-minimum 25% tax credit replaces tax subsidies for individuals; can get up to 75% credit based on income and medical expenses
MEDICAL SAVINGS ACCOUNTS	No	No	Yes, for catastrophic and long-term care insurance	Yes, for catastrophic and Medicare insurance	Yes, for catastrophic, long-term care, and Medicare insurance	Yes

MEDICAID

1. State vs. Federal Role

   - Should Medicaid continue as a Federal/State program, should it be Federalized, or should it be given to the States? Some have suggested Federalizing some parts of the Medicaid program and turning the remainder of the program over to the States. For example, "swapping" the acute care portion of Medicaid for the long-term care portion is the most frequent suggestion. However, neither the Federal government nor the States are interested in assuming full responsibility for long-term care.

2. Acute Care vs. Long-Term Care

   - Should Medicaid be split into two parts--acute and long-term care? Should both parts be reformed? Most reform plans contemplate very few changes to Medicaid long-term care, placing most of the focus on Medicaid acute care.

   - Some health reform plans would require Medicaid beneficiaries to enroll in private health plans, while others would encourage states to enroll beneficiaries in private sector or Medicaid managed care health plans.

3. Mainstreaming Medicaid

   - Should Medicaid beneficiaries have the same choices of health insurance as other Americans? Some have raised concerns about enrolling Medicaid beneficiaries in any private health plans, especially managed care plans such as HMOs. The concerns usually center around financial incentives HMOs might have to deny or make it difficult to access services that Medicaid beneficiaries need. A second concern is that there will not be enough health plans, or that the health plans will be of lower quality, in the areas where Medicaid beneficiaries typically reside.

4. Controlling Medicaid Program Growth

   - There is much interest in slowing the growth in the Medicaid program, both at the Federal and State level. States and the Federal government have had limited success in trying to control Medicaid's growth.

   - Proposals for controlling program growth range from capping Federal Medicaid spending to giving States incentives to enroll Medicaid beneficiaries in more cost-efficient delivery systems such as managed care. States are most concerned about meeting the demands of Medicaid's "entitlement" to services if Federal spending is capped.

5. Medicaid Cuts

- A frequently proposed cut would reduce or eliminate Medicaid disproportionate share hospital payments.

SUMMARY OF MAJOR MEDICAID PROPOSALS

	CLINTON	BREAUX-DURENBERGER	CHAFEE	GRAMM	LOTT-MICHEL	NICKLES
MEDICAID ACUTE CARE	Beneficiaries enroll in private health plans	Similar to Clinton, but full federal funding	State option to enroll beneficiaries in private health plans, Medicaid managed care, or current law program	States can obtain waivers for innovative, cost-effective programs	State option to enroll beneficiaries in private health plans, Medicaid managed care, or current law program	No change to current law
MEDICAID LONG-TERM CARE	Minor changes to current law	States fully fund	No change to current law	See above	No change to current law	No change to current law
CONTROL MEDICAID GROWTH	Medicaid premium payments limited to national premium growth rate	Medicaid premium payments limited to GDP growth rate	Federal payments capped at fixed rate of growth (6%, then 5%)	Federal payments capped at fixed rate of growth	No provision	No provision
ELIMINATE DSH	Yes	Yes	Yes	No	No	Yes

MEDICARE

All of the major health reform bills keep Medicare as a separate program. They do, however, contain various provisions intended to bring Medicare closer to the system in place for the nonelderly. These provisions fall into the following areas:

1. New Medicare benefits

   - Should new benefits be added to the Medicare program?

2. Medicare Managed Care

   - Should the Medicare payment formula or membership requirements for HMOs be improved so that more HMOs will enter risk contracts and offer enrollment to the Medicare population?

   - Should the Medigap Medicare Select option be made permanent and extended to all states?

3. Mainstreaming Medicare

   - Should health reform include some alternatives for people as they become eligible for Medicare, including allowing Medicare beneficiaries to use Medicare funds to enroll in private health plans (beneficiaries would have to accept different benefits and coverage)?

SUMMARY OF MEDICARE (NON-FINANCING) PROPOSALS

	CLINTON	BREAUX-DURENBERGER	CHAFEE	GRAMM	LOTT-MICHEL	NICKLES
NEW MEDICARE BENEFITS	Prescription drugs; physician assistants; nurse practitioners	Preventative services	None	None	None	None
MANAGED CARE						
IMPROVE HMO PAYMENTS	Yes	No	Yes	No	Yes (also removes 50% membership requiremt)	No
EXPAND MEDICARE SELECT	No	Yes	Yes	No	Yes	No
MAINSTREAM MEDICARE - BENEFICIARY CAN ENROLL IN PRIVATE PLAN	Yes	No	Yes	Yes	No	Feasibility Study

STATES' ROLE IN HEALTH REFORM

1. State Solutions

   - Should there be a national system or should states be responsible for health care reform within their own borders? State-based health care reform would likely create 50-plus health care systems. This would cause headaches for Multi-state employers.

   - Should States be permitted to "opt out" of a national system? Giving States flexibility to design a system different from a national system could undermine the "universality" of the national system.

2. Implementation/Regulation of National System

   - If a national health care system is created, States could play a variety of roles in implementing pieces of the national system and play an on-going role in regulating and monitoring compliance within the system. States fear they will be asked to play a large role but not be given the tools necessary to regulate the system, as well as being expected to achieve unrealistic goals. States worry about being responsible for making up the difference if cost containment goals are not met.

3. State Financing

   - Currently, States contribute about 43 percent of the expenditures for the Medicaid program. Should States be forced to continue such spending through "maintenance of effort" requirements, or be relieved of responsibility?

   - Some proposals divide certain programs financed jointly by the Federal government and the States and create separate programs financed by one or the other. For example, one proposal has the Federal government paying for Medicaid acute care and the states paying for Medicaid long-term care.

SUMMARY OF PROPOSALS ON STATES' ROLE IN HEALTH REFORM

	CLINTON	BREAUX-DURENBERGER	CHAFEE	GRAMM	LOTT-MICHEL	NICKLES
STATE SOLUTIONS	States can opt out of national system if they enact a single-payer plan	States determine features of Medicaid long-term care	States can enroll Medicaid beneficiaries in accountable health plans or Medicaid managed care programs	States can enroll Medicaid beneficiaries in private health plans or establish medical savings accounts	States can enroll Medicaid beneficiaries in private health plans or Medicaid managed care programs; States can allow low-income individuals to buy private health plans through Medicaid	No provision
STATES IMPLEMENT NATL RULES						
Establish purchasing groups	Yes-regional alliances	Yes-HPPCs	Yes-HCCAs	No	No	No
Certify plans	Yes	No	Yes	Yes	Yes	Yes
Risk adjust	No	No	Yes	No	Yes	Yes
Set fee schedules	Yes (state option)	No	No	No	No	No

UNDERSERVED AREAS (RURAL AND URBAN)

I. WAYS TO INCREASE HEALTH SERVICES IN UNDERSERVED RURAL AND INNER CITY AREAS

1. Incentives to Serve Underserved Areas

   - One option is to require health plans to serve underserved areas in order to be able to do health care business in other areas of the state.
   - Another alternative is to offer incentives in the form of higher premiums or special risk adjustments for plans in underserved areas.

2. Contracts with Essential Providers

   - One option is to require health plans to contract with essential providers in underserved communities for a set number of years. Essential providers include such organizations as community health centers, rural health clinics, federally qualified health centers, and rural emergency access care hospitals.
   - Additional grant funding to essential providers is another way to assure that these providers will continue.

3. Grants for New Primary Care Practitioners

   - Providing Public Health Service grants and demonstrations directly to increase the number of primary care practitioners is another strategy to build capacity.
   - Tax credits, loans, and loan repayment programs could be used to encourage new primary care practitioners to locate in underserved areas.
   - The National Health Service Corps funding could be increased to place more physicians into these areas.

4. Network Development Funds

   - The development and operation of networks in underserved areas (partnerships of hospitals, physicians, insurers) could be encouraged through grants or waivers of Medicare.

5. New Services

- Grants could be provided for the unique services needed in underserved areas (such as transportation).
- A "rural supplemental benefits package" could be studied and offered for special services as an addition to the standard benefits package.

II. WAYS TO BUILD A STABLE BASE OF FUNDING FOR HEALTH SERVICES IN UNDERSERVED AREAS

1. Special Medicare Payments

- With the differential in Medicare payments for urban and rural hospitals being phased out, other reimbursement formula changes could be made to assist underserved facilities.
- For example, the Medicare requirements for rural hospitals could be eased to allow them to reconfigure to offer fewer beds and more emergency services.
- Special Medicare payments could be increased for certain facilities and practitioners in underserved areas.

2. Academic Health Centers

- Inner city areas are very dependent on academic medical centers for care. These centers receive special Medicare payments--indirect medical education (IME) payments--for the higher cost of treating patients in an academic setting.
- Some reform provisions continue these IME payments, others cut them, and some create a new special payment recognizing the role of these academic medical centers.

3. Disproportionate Share Payments

- Many inner city hospitals serve a disproportionate number of the poor and receive special Medicare payments called disproportionate share hospital (DSH) payments. Some reform plans phase out these payments.

4. Lack of Coordination Among Services and Funding Sources

- Funding of health services in rural areas is fragmented and should be streamlined and coordinated.
- Incentives could be provided for private and public programs to coordinate with federal funding and services.
- Block grants could be provided to states to create a coordinated rural service program.

SUMMARY OF PROPOSALS ON UNDERSERVED AREAS

	CLINTON	BREAUX-DURENBERGER	CHAFEE	GRAMM	LOTT-MICHEL	NICKLES
INCREASE CAPACITY:						
INCENTIVES TO SERVE UNDERSERVED	Yes	Yes	Yes	No	Yes	Block Grant To States to Serve the Poor- Can Be Used For Any Number of Rural Initiatives To Expand Capacity
ESSENTIAL PROVIDER PROTECTIONS	Yes	No	Yes	No	No	
NEW PRIMARY CARE PRACTITIONER SUPPORT	Yes	Yes	Yes	No	Yes	
NETWORK DEVELOPMENT FUNDS	Yes	Yes	Yes	No	Yes	
NEW SERVICES (LIKE TRANS-PORTATION)	Yes	No	Yes	No	Yes	

Chart continued on next page .....

	CLINTON	BREAUX-DURENBERGER	CHAFEE	GRAMM	LOTT-MICHEL	NICKLES
STABLE BASE OF FUNDING:						
NEW MEDICARE FORMULAS FOR FACILITIES	Yes	Yes	Yes	No	Yes	No
NEW MEDICARE FORMULAS FOR DOCTORS	Yes	No	Waiver for networks	No	No	No
ACADEMIC HEALTH CENTERS' SPECIAL PAYMENTS	Yes, new fund for IME $ and special alliance assessments	Yes, transitional assistance for safety net hospitals to replace DSH and IME $	IME $ continues	IME $ continues	IME $ continues	IME $ cut
MEDICARE DSH PAYMENTS	Medicare DSH phased down	See above	DSH phased out	DSH continues	DSH continues	DSH phased out
NEW PAYMENTS TO HOSPITALS SERVING VULNERABLE POPULATIONS	Yes, for 5 years	See above	No	No	No	No
STREAMLINE SERVICES AND FUNDING SOURCES	No	Yes	Yes-Criteria to qualify for network demos	No	Yes	Block Grant-could streamline services