MEMORANDUM

JANUARY 12, 1994

TO: SENATOR DOLE
FROM: JO-ANNE

ATTACHED IS FINAL SCHEDULE FOR TOMORROW. PLEASE NOTE THE ADDITION OF THE MEETING WITH DR. GREG GANSKE, REPUBLICAN CANDIDATE RUNNING AGAINST CONGRESSMAN NEAL SMITH IN DES MOINES.

CBS NATIONAL HAS A CREW FOLLOWING GANSKE AROUND ALL DAY FOR A SPECIAL "DAY WITH A CONGRESSIONAL CANDIDATE" PROFILE. THEY WANT TO DO 5 MINUTES FILMING OF YOU AND GANSKE TOGETHER, THEN GANSKE WANTS 10 MINUTES' PRIVATE TIME WITH YOU.

GANSKE DOES HAVE PRIMARY OPPOSITION, BUT THAT INDIVIDUAL IS NOT EXPECTED TO WIN THE PRIMARY.

FINAL
1/12/94

SENATOR DOLE SCHEDULE -- JANUARY 13-14, 1994

Thursday, January 13

10:05 A.M. Lv. residence

10:25 A.M. Ar. Washington National Airport
Signature Flight Support
703/419-8440

10:30 A.M. Lv. Washington

AIRCRAFT: Sabreliner
OWNER: Kirke-Van Orsdel
TAIL NO.: N 400 KV

PILOT: Gary Grandstaff
CO-PILOT: Bob Pinnell

MANIFEST: Senator Dole

FLIGHT TIME: 2 hrs 20 mins
TIME CHANGE: -1 hour

CONTACT: Nancy (Gary Kirke's office)
515/248-6010

11:50 AM Ar. Des Moines, Iowa
Signature Flight Support
515/285-4221

MET BY: Bill Hansen

12:00 PM Ar. Crystal Tree Inn (formerly Airport Hilton)
515/287-2932

PROCEED TO COURTYARD

12:00 PM-
1:30 PM ATTEND/SPEAK - ANNUAL CONVENTION LUNCHEON -
ASSOCIATED GENERAL CONTRACTORS OF IOWA

CROWD SIZE: 250

PRESS: CLOSED

FORMAT: Podium with mic

Thursday, January 13 (continued):

PROGRAM:

Brief recognition of State Legislators
Intro Senator Dole - Marlow Dickinson
REMARKS - SENATOR DOLE

HEAD TABLE:

Bert Beatty, Exec. Vice Pres.,
Associated General Contractors of America
Marlowe Dickinson, President, AGC of Iowa
Brad Manatt, Vice President, AGC of Iowa
W.R. Bill Hansen, Exec. V.P., AGC of Iowa
Kris Young, 2nd V.P., AGC of Iowa
Lyle Schlader, Secty/Treas., AGC of Iowa
John Schildberg III, Past President, AGC of Iowa
Robins Jackson, AGC of Iowa, immediate Past
President, AGC of America

CONTACT: Bill Hansen, Exec. V.P.
515/283-2424
515/244-6289 (FAX)

1:35 PM Lv. Crystal Tree Inn

DRIVERS: Gina Noll and Carolyn McGoldrick
Republican Party of Iowa Staff

DRIVE TIME: 10 minutes

1:45 PM Ar. Des Moines Marriott
515/245-5500

PROCEED TO 3RD FLOOR - COUNCIL BLUFFS ROOM

2:00 PM- PRESS AVAILABILITY
2:30 PM

2:45 PM- MEETING WITH DR. GREG GANSKE
3:00 PM (CANDIDATE FOR CONG. NEAL SMITH'S SEAT)
(Room to be determined)

2:45 PM- CBS EVENING NEWS (NATIONAL)
2:50 PM WILL FILM FOR FIVE MINUTES
("A DAY IN THE LIFE OF A
CONGRESSIONAL CANDIDATE")

2:50 PM- PRIVATE MEETING WITH DR. GANSKE
3:00 PM

Thursday, January 13 (continued):

3:00 PM — PROCEED TO ROOM ADJACENT TO COUNCIL BLUFFS ROOM

3:00 PM-
4:00 PM — MEET WITH REPUBLICAN PARTY OF IOWA EAGLES
($2,000+/year donors to Republican Party of Iowa)

FORMAT: Informal round-table discussion

ATTENDEES:
John Ruan
Hal Manders
Steve Roberts
Clark and Phyllis Kelly
Sharon Sievers (Iowa Bankers)
Neil Milner (Iowa Bankers)
Max Isaacson, CEO, Americas Best Inc.
Len Hadley, Maytag
David Stanley, Iowans for Tax Relief
Herman Kilpper
Robb Kelley, Retired CEO, Employees Mutual Co.
Ross Sidney, Attorney

4:00 PM-
5:00 PM — MEET WITH DOCTORS AND INSURANCE EXECUTIVES TO DISCUSS HEALTH CARE

ATTENDEES:
Dick Olson, Principal Financial Agency Office
Dr. Mike Richards, Heart Surgeon
Governor Bob Ray, CEO, Blue Cross/Blue Shield
Dr. Greg Ganske, Surgeon, Congressional candidate
Keith West, Administrator, Evergreen Health CAre
Pat Barry, Attorney, Principal Financial
Eldon Huston, President, Iowa Medical Society
Tim Gibson, Ex. Dir., Iowa Medical Society
Paul Bishop, Lobbyist, Iowa Medical Society
Hal Manders
Steve Roberts
Dr. and Mrs. Clark Kelly (Phyllis)
Dr. and Mrs. Tom Kelly (Donna)
Dr. and Mrs. Dick VerSteeg (Adele)
Dr. and Mrs. Young Oliver (Katherine)
Jim Greenfield, Exec. Dir., Republican Party of Iowa

FORMAT: Informal round-table discussion

CONTACT: Terri Hasselman
515/282-8105
515/282-9019 (FAX)

Thursday, January 13 (continued):

5:00 PM Lv. Marriott Hotel

5:15 PM Ar. Elliott Beechcraft
515/285-6551

5:20 PM Lv. Des Moines

AIRCRAFT: Chartered King Air 200
TAIL NO.: N 1660 W
SEATS: 8

PILOT: Lowell Weir
CO-PILOT: Denny Chestnut

FLIGHT TIME: 45 mins

CONTACT: Elliott Beechcraft
(Charlie)
515/285-6551

6:05 PM Ar. Rochester, Minnesota
Rochester Aviation
507/282-1717

MET BY: Helen Mundahl

6:30 PM RON: Kahler Plaza Hotel
507/280-6000

Friday, January 14

8:00 AM — Helen Mundahl will meet you at Kahler Plaza Hotel and escort to Mayo Clinic

CONTACT: Susan Laging (Dr. Dickson's office)
507/284-8700

6:00 PM — Lv. Rochester

AIRCRAFT: Citation V
OWNER: John Menard
TAIL NO.: N 583 M

FLIGHT TIME: 2 hr 30 mins (estimated)
TIME CHANGE: +1 hour

CONTACT: John Menard
715/874-5911

Gary McConnell (Chief Pilot)
715/876-2208 (O)
715/839-1024 (H)
715/835-3181 (Gibson Aviation)

~~10:30~~ PM — Ar. Washington National Airport
Signature Flight Support
703/419-8440

9:30

WEATHER REPORT

THURSDAY, JANUARY 13, 1994

DES MOINES, IOWA

CLOUDY WITH A CHANCE OF LIGHT SNOW; HIGH TEMPERATURE OF 10 DEGREES IN NORTHEAST IOWA, 20 DEGREES IN THE SOUTHEAST. HIGH IN DES MOINES IS FORECAST IN THE MID TEENS.

CEILINGS WILL BE BELOW 1000 FEET, VISIBILITY FOUR MILES.

ROCHESTER, MINNESOTA

CLOUDY WITH A CHANCE OF LIGHT SNOW AND FLURRIES. A MAJOR ARCTIC FRONT WILL RESULT IN HIGHS OF -15 DEGREES IN NORTHERN MINNESOTA, +15 IN SOUTHWEST PARTS OF THE STATE.

TEMPERATURES WILL BE COME MUCH COLDER OVERNIGHT THURSDAY, AND LOW ON FRIDAY WILL BE -25 TO -40 DEGREES IN THE NORTH, -12 TO -25 IN THE SOUTH.

CEILINGS WILL BE MARGINAL V.F.R., 1000-3000 FEET OVERCAST, WITH A CHANCE OF LIGHT SNOW OR FLURRIES.

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REMARKS - SENATOR DOLE

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CONTACT: Bill Hansen, Exec. V.P.
515/283-2424
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DRIVERS: Gina Noll and Carolyn McGoldrick
Republican Party of Iowa Staff

DRIVE TIME: 10 minutes

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2:45 PM-
3:00 PM MEETING WITH DR. GREG GANSKE
(CANDIDATE FOR CONG. NEAL SMITH'S SEAT)
(Room to be determined)

2:45 PM-
2:50 PM CBS EVENING NEWS (NATIONAL)
WILL FILM FOR FIVE MINUTES
("A DAY IN THE LIFE OF A
CONGRESSIONAL CANDIDATE")

2:50 PM-
3:00 PM PRIVATE MEETING WITH DR. GANSKE

MEMORANDUM

DECEMBER 21, 1993

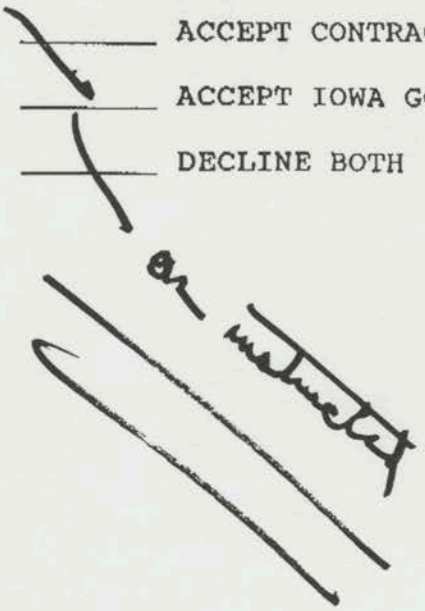
TO: SENATOR DOLE
FROM: JO-ANNE

Thursday, January 13. 12:00 noon, Des Moines, Iowa. Associated General Contractors of Iowa annual convention. 250 contractors plus spouses. Bill Hansen is extremely anxious to have you do this event (calls about 3 times daily). (Has a turboprop he can make available for your transportation, and is looking for a jet.) I have checked with Judy Brown and Iowa Republicans, both of whom report there is no other activity of significance around this date. However, Iowa Republicans would like to put together a fundraiser for their major donors to renew their membership for 1994, probably hosted by John Ruan.

_____ ACCEPT CONTRACTORS' LUNCH

_____ ACCEPT IOWA GOP FUNDRAISER

_____ DECLINE BOTH



SPEAK Thursday noon-Jan. 13, 1994

Associated General Contractors of Iowa

Airport Hilton Inn
Des Moines, Iowa

Established 1923
A Full Service Organization
701 East Court - Suite B - Des Moines, Iowa 50309
P.O. Box 757, Des Moines, Iowa 50303 - (515) 283-2424

Costs/Expenses + support of Senator's favorite PAC

August 20, 1993

The Honorable Robert Dole, Senate Minority Leader
Senate Hart Office Building # 141
2nd. & C Street, N.E.
Washington, D.C.

Re: Iowa Appearance @ Assoc. General Contractors Convention
Thursday noon, January 13, 1994
Airport Hilton Inn-Des Moines, Iowa

Dear Senator Dole:

You were well received at both of our previous conventions in 1987 and 1988. Our contractors statewide became strong supporters of yours in the 1988 caucus in Iowa and were pleased to be a part of your victory in this state that year.

As I'm sure you're aware, the parade of candidates for '96 Caucus has already begun, with various lesser Republican potentials making their appearance at some of the trade association meetings. However, the AGC of Iowa still holds you in high regard and during this past year you have enhanced your image in sparring with the Clinton agenda. For that reason, we'd like to invite you back as our featured speaker on Thursday noon, January 13, 1994. Our location is just across the street from the Des Moines, Iowa airport.

We would be pleased to incur your costs and support your favorite PAC. I hope that you can fit this into your schedule.

Sincerely,

W.R. Bill Hansen, Executive Vice President
Associated General Contractors of Iowa

8-30-93 Interim letter

8-30-93 copy to Jo-Anne

Associated General Contractors of Iowa

Established 1923
A Full Service Organization
701 East Court - Suite B - Des Moines, Iowa 50309-4901
P.O. Box 757, Des Moines, Iowa 50303 - (515) 283-2424

December 4, 1993

The Honorable Robert Dole
141 Senate Hart Office Building
2nd. & C Street
Washington, D.C. 20510

Attention: Yvonne L. Hopkins, Executive Assistant

Dear Senator Dole:

In August of this year, we extended a speaking invitation to you on behalf of the Associated General Contractors of Iowa for our annual convention on Thursday noon, January 13, 1994 at the Airport Hilton in Des Moines, Iowa. More than 250 Iowa highway contractors will be attending and will receive you with the same strong reception that they gave you at our conventions in 1987 and 1988.

I have visited with Jim Greenfield, Executive Director of the Iowa Republican party who is willing to work with your staff in pursuing additional appearances at that same time, if this would be helpful.

Enclosed find a clip from this week's Des Moines Register, in which their political writer talks about the visits and impact of other Republican contendors. It is just one more reason why I'm anxious to have you speak at our annual convention.

With our convention now slightly more than 30 days ahead, we'd like to firm up the arrangements. Please let us know if you can schedule us as we'd really like to have you in Des Moines, Iowa.

Sincerely,

W.R. Bill Hansen, Executive Vice President
Associated General Contractors of Iowa

Alexander sightings in Iowa

Alexander gets good marks from many GOP leaders for his folksy, easy-going style.

ON CAPITOL HILL

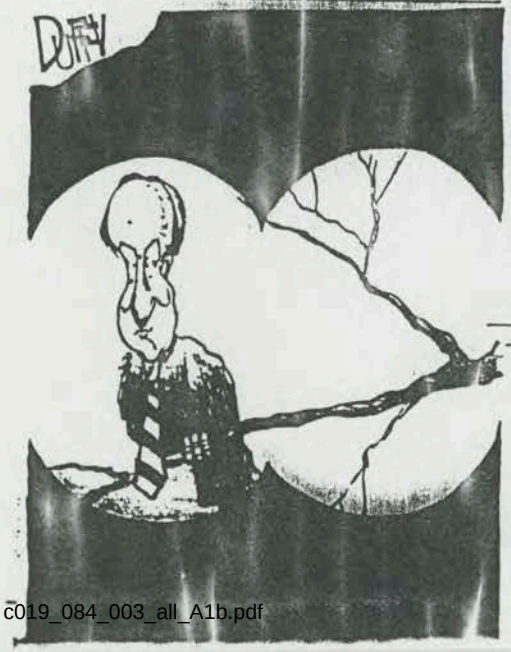
David YEPSEN

Those of us who watch Iowa politics have learned to keep an eye on out-of-office former Southern governors with little to do but run for president. And so it is that we've spotted former Tennessee Gov. Lamar Alexander, quietly making the rounds in Iowa as he prepares to run for the Republican presidential nomination in 1996.

Alexander, who served as Education secretary under George Bush, is getting good reviews from GOP moderates in Iowa. While it's far too early for them to make predictions about how he'll finish in 1996, many party leaders say they expect him to do well here.

Alexander gets good marks from many GOP leaders for his folksy, easy-going style. He is picking up a lot of early help from key moderates in Iowa, including Marvin Pomerantz, Dick Redman and Mary Louise Smith.

Alexander has more than those folks going for him in Iowa. First, he comes off as a moderate sort of guy in a party increasingly dominated by right-wing kooks. Second, the conservative vote inside the GOP could easily be split among Bob Dole, Jack Kemp, Phil Gramm and maybe others. In 1980, George Bush parlayed strong support among moderates into a plurality victory as the conservatives fractured their vote.



Third, Alexander has a lot of time to spend in Iowa campaigning — the way Jimmy Carter had in 1975 and Bush did in 1979. He's not bogged down in Washington. Fourth, he has campaigned in Tennessee, a rural state where retail, one-on-one campaign skills are required just as they are in Iowa. Five, he understands education and agriculture, issues Iowa voters value.

In addition to good retail political skills, Alexander has impressed Iowa Republicans with his television prowess when he did his monthly satellite GOP TV show out of West Des Moines. His use of state-of-the-art campaign television technologies enable him to pump his message far and wide. Innovative use of new campaign technologies has been an early sign of a winner for a long time in U.S. politics.

●

The 1996 Iowa GOP caucuses are likely to be as important as ever, according to Democratic National Chairman Dave Wilhelm, who was also back in the state recently. With California moving its primary up from June to March of 1996 and with the creation of a Midwestern regional primary, Wilhelm said the small states of Iowa and New Hampshire again become places where candidates look for a win to boost their media attention and money as they head into big states.

Gramm calls it "the slingshot" effect. With the calendar so bunched, it means the Republican nominee for president in 1996 will likely be decided

So no one is surprised to hear that former Labor Secretary Lynn Martin has scheduled a visit to Iowa on Jan. 25 to look at a presidential campaign. If she gets in, she would crowd Alexander for votes of GOP moderates.

●

Great Mentions and Trial Balloons: House Majority Leader Brent Siegrist, a Council Bluffs Republican, is mulling a bid for Congress against Neal Smith in 1996. Republicans believe Smith is vulnerable in his new district but no big-name candidates have surfaced for the 1994 fight. Besides, Smith has a ton of money and GOP resources are going to be deployed in the race for governor.

Siegrist figures if any Republican is going to knock off Smith it will most likely have to be a moderate Republican from outside Polk County. Such a candidate can sew up the anti-Des Moines vote while still appealing to suburban independents and evangelical Republicans living in Polk County.

Also, Republican sources say they're hearing that former state Representative Paul Johnson, a Decorah Democrat, is in line for a top appointment at the USDA. Johnson is a farmer with a lot of credibility in the environmental community and the GOPers say he might be tapped for a job at the Soil Conservation Service. Johnson's environmentalism tends to drive the fence-row-to-fence-row types bonkers.

●

The Republican victories in Davenport have energized the GOP and there's talk of trying to knock off Democrat Bob Arnould, the former House speaker and minority leader. Arnould has a "safe" Democratic district but some of those precincts were voting Republican in City Hall races earlier this month.

If nothing else, fielding a solid GOP challenger against Arnould is considered a worthwhile political exercise because it would force him to campaign at home instead of traveling around the state helping to elect other Democrats. That would work to the benefit of state Representative Phil Wise, D-Keokuk, who is trying to replace Arnould as Democratic leader.

●

How to Gut a Law: The Legislature approved a big ethics bill last year and members went home talking about how they were cleaning up the sleaze.

We'll see. This year they'll get to pay Campaign Disclosure Board has presented the governor and lawmakers with a budget to implement the new law and the tab is $133,000. Look for those who don't like the law — and there are plenty — to kill the request for more money to ensure the law has no teeth.

It does no good to have disclosure requirements without the auditors and equipment needed to monitor the disclosure. Honorable lawmakers, who complain they get tarred with the same brush as the duds, will have an opportunity to prove they are interested in cleaning up politics.

●

Gov. Terry Branstad's much-touted "health-reform committee" is drawing poor marks from Democrats, who say they were conned into thinking it would be a balanced group. Instead, they say it was dominated by the interest groups sent to produce a study that will make the governor look good.

"I'm really sad," said state Representative Mark Haverland, D-Polk City. "Like Charlie Brown, I believed the hype, ran up there and they pulled the football away. I shouldn't be as naive as I am, but I wanted it to work so bad."

●

No Heavy Lifting, Either: State Representative Steve Grubbs, a Davenport Republican, has been named head of the GOP's legislative campaign committee, the group that tries to elect Republicans to the assembly. He cut his teeth as a student body president at the University of Iowa and said, "Comparing my time in both positions, I would say that not only is the pay better as a state representative, it is also a far easier job."

●

Iowa's bureaucrats still haven't learned how to speak English. According to a report from the Legislative Service Bureau, the "intermediate criminal sanctions task force's resources analysis subcommittee" has concluded that two judicial districts "could maximize the use of incarceration resources by reducing the numbers of persons sentenced to prison and increasing utilization of community-based resources."

Or as they say in Lake Mills: Let more criminals out on the streets.

DAVID YEPSEN is The Register's ...

SENATOR BOB DOLE

TALKING POINTS

IOWA AGC CONVENTION

JANUARY 13, 1994

*THANK YOU. IT'S A PLEASURE TO BE WITH YOU AGAIN. IT'S ONLY 730 DAYS OR SO BEFORE THE 1996 IOWA

CAUCUS, AND I JUST HAPPENED TO BE IN THE NEIGHBORHOOD.

*ACTUALLY, I'M JUST DOING A LITTLE ADVANCE WORK FOR MY WIFE. SHE WILL BE IN DES MOINES NEXT THURSDAY, TO SPEAK AT THE ANNUAL DINNER OF THE DES MOINES CHAMBER OF COMMERCE.

*AS PRESIDENT OF THE RED CROSS, ELIZABETH WAS HERE MANY TIMES DURING LAST YEAR'S FLOODS, AND I KNOW SHE JOINS ME IN CONGRATULATING THE MEMBERS OF AGC ON YOUR PERSEVERANCE THROUGH A VERY TOUGH YEAR.

*I UNDERSTAND THAT THROUGH HARD WORK AND OVERTIME, YOU ARE NOW CAUGHT UP WITH ALL THE WORK THAT NEEDS TO BE DONE.

*AND I ALSO WANT TO SALUTE YOU FOR YOUR GENEROSITY IN HELPING YOUR

NEIGHBORS DURING THE FLOOD...I KNOW THAT AGC MEMBERS PLAYED A DOMINANT ROLE IN EMERGENCY FLOOD REPAIR--INCLUDING RESTORING INTERSTATE 80, AND REBUILDING THE LEVY AROUND THE DES MOINES WATERWORKS.

*THE GOOD NEWS IS THAT

MOTHER NATURE FINALLY LET UP.

*THE BAD NEWS IS THAT UNCLE SAM HASN'T. 1993 SAW THE WHITE HOUSE TRY TO DROWN SMALL BUSINESS IN AN AVALANCHE OF TAXES AND MANDATES--AND I DON'T THINK 1994 IS GOING TO BE ANY

DIFFERENT.

*LET'S START WITH HEALTH CARE. AND MAKE NO MISTAKE ABOUT IT, THE PLAN THE PRESIDENT AND MRS. CLINTON ARE PROPOSING WILL IMPACT EVERYONE AND EVERY BUSINESS IN THIS ROOM.

*DISCUSSION OF HEALTH CARE/OTHER ISSUES OF DAY

*I KNOW THIS ORGANIZATION IS VERY POLITICALLY ACTIVE...AND I HOPE YOU'LL KEEP IT UP. 1994 IS GOING TO BE A BIG, BIG YEAR, HERE IN IOWA AND ACROSS THE COUNTRY.

8

*REPUBLICANS HAVE BEEN ON A ROLL LATELY...THERE HAVE BEEN SIX ELECTIONS SINCE PRESIDENT CLINTON WAS ELECTED--SENATE ELECTIONS IN GEORGIA AND TEXAS...GUBERNATORIAL ELECTIONS IN NEW JERSEY AND VIRGINIA...AND MAYORAL ELECTIONS IN LOS ANGELES

9

AND NEW YORK.

*ALL SIX SEATS WERE HELD BY DEMOCRATS...AND ALL SIX ARE NOW HELD BY REPUBLICANS.

*BUT REPUBLICANS CAN'T JUST REST ON OUR LAURELS...WE CAN'T JUST SIT

BACK AND THROW ROCKS AT THE PRESIDENT...IF WE WANT TO BE THE MAJORITY PARTY, THEN WE HAVE TO TELL THE AMERICAN PEOPLE WHAT WE'RE FOR.

*AND I HOPE TO DO THAT ON JANUARY 25TH WHEN I WILL BE GIVING THE REPUBLICAN

RESPONSE TO THE STATE OF THE UNION ADDRESS.

*I'LL BE TALKING ABOUT REPUBLICAN SOLUTIONS TO PROBLEMS LIKE CRIME AND HEALTH CARE...AND ABOUT REPUBLICAN PRINCIPLES LIKE LESS TAXES, LESS SPENDING, AND LESS MANDATES.

12

*HAPPY TO ANSWER YOUR QUESTIONS.

From Governor Branstad's "State of the State

IOWA - A QUALITY PLACE TO LIVE

High quality of life is another essential component to Iowa's foundation for the future. Iowa offers a high quality of life represented by excellence in health care, a strong family support structure, low incidence of crime and a balance between natural resource utilization and preservation. Promoting Iowans' well-being by enhancing our commitment to making Iowa a quality place to live and visit will support our efforts to increase Iowa's population.

Health Care Reform

The issue of health care reform is being debated across the nation. Access to quality, affordable health care for Iowans is a key goal of Governor Branstad's health care reform proposals. Threats to the achievement of this goal, such as escalating costs and the number of uninsured Iowans, must be met head on.

The Iowa Health Reform Council

The Iowa Health Reform Council was created by Governor Branstad in the spring of 1993 to develop a health care reform plan for Iowa. The Council was made up of 60 members with diverse backgrounds and interests in health care, including providers, insurers, consumers, representatives of labor and business and legislators.

Membership of the Council reflected the Governor's desire to be inclusive, bi-partisan and responsive to the concerns of all Iowans. It also recognized the need to develop a consensus-based proposal with solutions to address Iowa's unique needs, focusing particularly on the state's rural and elderly populations.

While the membership of the Iowa Health Reform Council was large and diverse, Governor Branstad believed development of a successful reform plan would require the involvement of even more Iowans. Nearly 500 Iowans served on 16 subcommittees created to study and make recommendations relating to specific health care issues. Further input was provided by more than 5,000 Iowans who participated across the state at public hearings designed to solicit citizens' views on health care reform.

Consensus-Building Process

To provide a basis for developing its reform recommendations, the Iowa Health Reform Council first identified the problems that need to be addressed in our health care system.

- Health care costs are out of control. Inefficient and inappropriate use of services, fear of medical liability and lack of consumer information and education were among the reasons cited by the Council as contributing to the increasing costs of health care.

- Access to care is not adequate. High costs, health insurer risk selection and rating practices and a shortage of health care professionals in rural areas have created barriers to access for many Iowans.

- Health care quality is not well defined. Inadequate information exists to assist health professionals, consumers and purchasers of health care to define and monitor the quality of health care delivered.

- Responsibility by all parties in the current system is lacking. The current system encourages irresponsible decision making by consumers who are disconnected from the costs of health care and providers who overserve to protect themselves from the risk of lawsuits

- The administrative system is confusing. Consumers and health care providers are frustrated and confused by the amount of paperwork and government regulation they encounter in the health care system.

- Changes in society are not adequately addressed. The current health care system does not respond quickly or efficiently enough to changes in our society.

Principles which envision a reformed system that would provide access to affordable, quality health care for all Iowans were also developed. The Council believed agreement on the problems and principles was essential to finding consensus on the solutions.

The Iowa Health Care Reform Plan

The Council recognized that not all of the problems we are experiencing in our health care system lie within the reach of state law. Over half of Iowa employees fall under the jurisdiction of the federal Employee Retirement Income Security Act, known as ERISA, which governs self-funded employee benefits. Some of the problems, like low Medicare reimbursements, are actively caused by federal law. However, the Council members agreed that Iowa can and should move forward to make changes in our system to address the problems of cost, quality and access. Doing so will enable us to influence the reform debate at the federal level and position us well to implement changes when federal reform occurs.

Based on the recommendations made by the Iowa Health Reform Council, Governor Branstad proposes the following as Iowa's Plan to make quality health care more accessible and affordable for all Iowans.

Access

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

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

- Keeping Iowans from losing their insurance when they become sick by requiring that everyone, regardless of medical condition, be eligible for insurance that cannot be canceled or dropped ***(Guaranteed issue);***

- 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);*** and

- Making insurance more affordable and stable for all purchasers by moving to a 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 health care ***more affordable*** for all Iowans by:

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

- 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);***

- Changing the way we administer the health insurance system by adopting a single claim 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);***

- Changing the medical liability system through reduction of the practice of defensive medicine and costs of liability insurance by capping non-economic 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:

- 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 costs, quality and access ***(Statewide health accounting system);***

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

- Requiring reports to consumers on how well the insurer 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);*** and

- 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 fair and equal access for all Iowans to quality health services by providing:

- **Rural Access** developing and supporting a strong rural health care network aimed at:

  -- Providing a state income tax credit to new physicians locating and practicing in communities with populations of less than 10,000. The income tax credit would be for an amount up to $10,000 per year for a maximum of ten years;

  -- Allowing Iowa hospitals access to the Iowa Communications Network to provide telemedicine services to Iowans in rural and urban areas;

  -- Seeking Congressional reform of the federal Medicare program to eliminate the anti-rural reimbursement bias which underpays Iowa providers by over $200 million annually;

  -- Expanding the existing family practice residency program to provide rural health practice experience for more physicians, as well as nurses, dentists and pharmacists. Also, a respite program would be developed to make substitute practitioners available to physicians practicing in rural areas to reduce potential burnout. An appropriation of $330,000 is proposed to support these programs;

  -- Creating a rural health system program in the Department of Public Health to assist local communities in recruiting physicians and other health professionals; and

- **Tax Equity** to move 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.

4:00

January 12, 1994

TO: Senator Dole

FROM: Vicki

RE: Health Meeting in Iowa

Senator Grassley's office provided some information that may be helpful in your meeting with the physicians and insurance folks in Iowa.

Principal Financial Agency is the largest financial service corporation in Iowa, servicing predominately small businesses in their pension funds and health benefits funds. You will be meeting with Dick Olson from this group. His CEO is Dave Hurd who is Chairman of the Board of Bill Gradison's group, HIAA. Dave Hurd is a Democrat who supported Senator Grassley's opponent in the last election.

The major concerns for Principal Financial Agency are mandatory alliances and premium caps on insurance. These are the same concerns of the Iowa Medical Society. It is for these reasons that they oppose the Clinton plan.

The major issues for the physicians will also be price controls and anything that would limit a patient to choose his or her doctor. The physicians are very much in favor of Medical Savings Accounts and plans that encourage individual responsibility.

Iowa has a particularly large uninsured population. Because of that, the physicians are very opposed to the Medicare cuts in both the Clinton and Chafee plans. They do not have a large enough privately insured population to offset these reductions in Medicare reimbursement. The Medicare cuts in the Nickles bill are much smaller ($67 billion).

Of note: Senator Grassley attended some town meetings on December 6, 7 and 8. At these meetings many people voiced their support of the Gramm plan since Senator Gramm had been to Iowa only one week before.

SENATOR DOLE
TALKING POINTS FOR IOWA MEETING
JANUARY 13, 1994

- ONLY IN THE LAST TWO YEARS HAS THE COUNTRY COME TO AGREE THAT OUR HEALTH CARE SYSTEM IS BROKEN. SOME BELIEVE THAT PRESIDENT BUSH WAS DEFEATED BECAUSE HE FAILED TO DEMONSTRATE ANY REAL INTEREST IN THE SUBJECT.

- CLINTON GRASPED THIS OPPORTUNITY AND MADE IT THE CENTERPIECE OF HIS CAMPAIGN. WITH CLINTON'S ELECTION VICTORY AND HIS PROMISE TO DELIVER A HEALTH PLAN IN "100 DAYS", AND HIS PUTTING HIS WIFE IN CHARGE OF A HUGE TASK FORCE MEETING SECRETLY, THE LEVEL OF EXPECTATION ROSE DRAMATICALLY. THE CONSTANT HYPE AND THE FLOATING OF TRIAL BALLOONS SERVED TO PUT THE ISSUE ON THE FRONTS OF OUR NEWSPAPERS ALMOST DAILY.

- AS A RESULT, I BELIEVE THERE WILL BE SOME HEALTH CARE BILL THIS YEAR BECAUSE THE POLITICAL RISKS OF NOT DOING IT OUTNUMBER THE POLITICAL RISKS OF DOING IT. THE DEMOCRATS, CONTROLLING BOTH THE CONGRESS AND THE WHITE HOUSE, CANNOT GO HOME FOR THE 1994 ELECTIONS AND BLAME "GRIDLOCK" THIS YEAR.

- HAVING SAID THAT, MY CONCERN IS THAT THE REFORM WE FINALLY GET WILL BE NOT SO MUCH A CAREFULLY CRAFTED OVERHAUL OF ONE-SEVENTH OF OUR ECONOMY AS IT WILL BE A CAREFULLY CRAFTED <u>POLITICAL</u> SOLUTION TO A TOUGH ISSUE THAT CAN NO LONGER BE AVOIDED.

- AS YOU ARE TOO PAINFULLY AWARE, THE ORIGINAL CLINTON STRATEGY WAS TO SCORE A QUICK, PREEMPTIVE BLOW AGAINST THE SPECIAL INTEREST GROUPS. THE ADMINISTRATION WANTED TO PREEMPT THE OPPOSITION BY DEVELOPING, BEHIND CLOSED DOORS, A PLAN THAT WOULD ENTIRELY RESHAPE THE FINANCING AND DELIVERY OF HEALTH CARE AS WE KNOW IT IN THIS COUNTRY.

- BUT, A FUNNY THING HAPPENED ON THE WAY TO REFORM. TO OUTFLANK THE "SPECIAL INTERESTS" THE PRESIDENT NEEDED THE SUPPORT OF THE AMERICAN PUBLIC -- THOSE THAT ELECTED HIM AS A "NEW DEMOCRAT".

- HOWEVER, FALSE STARTS, INCLUDING THE FAILED STIMULUS PACKAGE, AS WELL AS THE BUDGET RECONCILIATION PACKAGE THOUGHT BY MANY TO BE HEAVY ON SPENDING AND LIGHT ON CUTS, MADE THE PUBLIC EVEN MORE CYNICAL.

- AS A RESULT, THE DEBATE HAS SHIFTED. IN ADDITION TO THE ADMINISTRATION'S PLAN, THERE ARE MANY OTHER IDEOLOGICAL INTERESTS COMPETING FOR A SEAT AT THE TABLE.

- WHILE THE PRESIDENT HAS A MORE SIGNIFICANT ROLE THAN ANY GROUP IN THE CONGRESS, IT IS CLEAR THAT HE HAS NO FIRM PUBLIC CONSENSUS BEHIND HIM. IN ADDITION, THERE IS A GREAT DEAL OF PUBLIC CONCERN AND CYNICISM ABOUT HOW HE CAN DELIVER

ON ALL OF THE PROMISES HE IS MAKING.

- THIS LACK OF CLEAR SUPPORT, EVIDENCED BY EARLY POLLS WHICH, EVEN AFTER ALL THE HYPE AND PUBLICITY, COULD NOT MUSTER MORE THAN FIFTY OR SIXTY PERCENT SUPPORT RATINGS, HAS ONLY EMBOLDENED THE OPPOSITION.

- IN THE END, THE PRESIDENT MUST HAVE BOTH DEMOCRATS AND REPUBLICANS ON HIS SIDE. THE BUDGET BATTLE PROVED THAT AN ISSUE AS FAR REACHING AND COMPLEX AS HEALTH CARE REFORM CANNOT BE ACCOMPLISHED WITH A PARTISAN DEBATE.

- WHILE REPUBLICANS SHARE THE PRESIDENT'S GOALS FOR REFORM, WE HAVE SOME FUNDAMENTAL DIFFERENCES WITH HIM ON HOW BEST TO ACHIEVE REFORM.

- REPUBLICANS DO NOT ENDORSE A ONE-SIZE-FITS-ALL APPROACH. WE DO NOT BELIEVE THAT THE GOVERNMENT SHOULD FORCE ALL AMERICANS TO PURCHASE INSURANCE THROUGH STATE-RUN MONOPOLIES.

- WE ALSO DISAGREE WITH THE PRESIDENT'S PROPOSAL TO IMPOSE GOVERNMENT COST CONTROLS ON HEATLH CARE. REPUBLICANS OPPOSE PRICE CAPS AND WE CERTAINLY DO NOT WANT TO RELY ON THE FEDERAL GOVERNMENT, WITH ITS TRACK RECORD, TO MANAGE ONE-SEVENTH OF THE ECONOMY.

- WHILE THE CLINTON PLAN WOULD MAKE GOVERNMENT A POWERFUL REGULATOR, THE COMPETING PLANS SEE GOVERNMENT MORE AS A REFEREE MAKING THE SYSTEM MORE FAIR AND EFFICIENT.

- THE CREATION OF MONOPOLIES IN THE FORM OF MANDATORY ALLIANCES IS A CRITICAL DIFFERENCE THAT EXISTS BETWEEN THE PRESIDENT'S BILL AND THE REPUBLICAN ALTERNATIVES.

- ANOTHER KEY DIFFERENCE IS THE EMPLOYER MANDATE TO PROVIDE INSURANCE WHILE THE OTHER PLANS BUILD ON THE CURRENT EMPLOYER-BASED SYSTEM, MAKE REFORMS IN THE INSURANCE INDUSTRY, AND DEAL WITH THE POOR WITH SUBSIDIES AND VOUCHERS.

- THE MEANS BY WHICH COSTS CAN BE CONTROLLED AND UNIVERSAL COVERAGE CAN OCCUR WILL BE AT THE CENTER OF DEBATE OVER THE FINANCING OF THE PLAN. THE CLINTON PLAN'S FINANCIAL ASSUMPTIONS ARE COMING UNDER INCREASED SCRUTINY, EVEN AMONG POWERFUL MEMBERS OF HIS OWN PARTY.

- EARLY ON SENATOR MOYNIHAN LABELED THE ADMINISTRATION'S NUMBERS AS "FANTASY". MORE RECENTLY HE HAS ASSERTED THAT "THE RAPID PACE OF SCIENTIFIC AND TECHNOLOGICAL DEVELOPMENTS... MAKE IT VIRTUALLY CERTAIN THAT EXPENDITURES WILL EXCEED ESTIMATES."

- WHATEVER THE POLITICAL OR MARKET SOLUTION, THE NAME OF THE GAME IS TO BE THE LOW-COST, QUALITY PROVIDER. REFORM IS BEING DRIVEN BY THE SIMPLE ECONOMIC PREMISE THAT HEALTH CARE SERVICES COST TOO MUCH, LEAVING MANY IN THEIR OWN "PERSONAL" HEALTH CARE CRISIS.

- HAVING AGREED ON THAT, REPUBLICANS CONTINUE TO ASSERT THAT WITH AN EQUAL MIX AND HEALTHY DOSE OF CHOICE AND COMPETITION, BALLOONING HEALTH CARE COSTS CAN BE DEFLATED WITHOUT JEOPARDIZING THE CURRENT HIGH LEVELS OF QUALITY CARE IN THIS COUNTRY.

September 23, 1993

PRESIDENT CLINTON'S HEALTH CARE PLAN

KEY AREAS OF AGREEMENT

- Universal coverage
- Malpractice reform
  - Includes:
    - Alternative dispute resolution
    - Caps on non-economic damages
- Paperwork simplification
- Tort Reform
- Small market insurance reform
  - Includes:
    - Portability -- if you change jobs
    - Limit on pre-existing conditions
    - Open enrollment

KEY AREAS OF DISAGREEMENT

- Employer mandates
  - Seventy-three percent of NFIB's members say a mandate would force them to cut or freeze wages, 26 percent say they would go out of business. In Kansas, it could mean a loss of up to 190,000 jobs.
- Price Controls
  - Premium caps
- Large new role for government
  - Mandatory single health alliances
  - National Health Board with broad regulatory powers.
- Financing
  - Commits to spending before savings realized
  - Assumes $238 billion in medicare and medicaid cuts -- a faster decline in medicare and medicaid than is realistic.
  - Assumes over $50 billion of savings are unspecified budget cuts that may or may not happen.
- New Entitlements
  - Federal responsibility for all early retirees (55 - 65 years old).
  - New medicare drug benefit estimated to cost in excess of $72 billion over 5 years.
  - New medicare long-term care program estimated to cost over $80 billion over 5 years.

S. 1743

CONSUMER CHOICE HEALTH SECURITY ACT

FACT SHEET

November 20, 1993

Sponsors (25): Nickles, Hatch, Mack, Bennett, Brown, Burns, Coats, Cochran, Coverdell, Craig, Dole, Faircloth, Grassley, Gregg, Helms, Hutchison, Kempthorne, Lott, Lugar, Murkowski, Simpson, Smith, Stevens, Thurmond, and Wallop.

WHAT IT DOES

The Consumer Choice Plan

- Provides **the security of universal health care coverage for all Americans**, guaranteeing them access to insurance that is portable, and available regardless of pre-existing conditions. It would take effect on January 1, 1997.

- Provides individuals and families with a **maximum choice of health insurance plans** with a wide variety of benefits and costs, including the ability to keep the employer-sponsored benefits they have now. That's more choice than most Americans have now.

- Individuals and families are provided with the **resources to purchase the health insurance plan that best fits their needs** with tax credits in place of the current employee tax exclusion for health care expenses. People whose health expenses consume a larger percentage of their incomes would get a bigger tax credit.

- **Controls rising health care costs** by empowering consumers with choice and individual responsibility and infusing real competition between insurance companies for the consumer's health care dollar.

- Further reduces rising health care expenses with **real reform of medical malpractice laws**, including capping awards for noneconomic damages.

- **Creates Medical Savings Accounts**, or MSAs, which can be used to pay medical bills or to pay for extra benefits.

- Modeled after the 33-year-old Federal Employee Health Benefit Program (FEHBP), **giving consumers the same option of choice now enjoyed by U. S. Senators and Representatives**. The FEHBP's annual cost increases have averaged a third less than other private health insurance programs.

What it does NOT do

- The plan has **no new, job-killing mandates on employers** to provide and pay for health insurance for their employees. Employers must only give their employees the option of retaining their current benefits, or "cashing out" their benefits and joining another plan.

- The plan requires **no new taxes**.

- The Consumer Choice and Health Security Act **does not wipe out existing health insurance policies, unlike the Clinton plan, which would outlaw nearly every health insurance plan now in existence.** Under the Consumer Choice Act, people who are happy with their employer-sponsored coverage can keep it.

- The plan places **no price controls** or "premium caps" on insurance plans that could reduce the quality of coverage and even result in the rationing of health care.

- The plan creates **no new national health board or government bureaucracies**.

- **There is no government coercion to purchase benefits not wanted or needed**, beyond a minimum catastrophic insurance requirement.

HOW IT WORKS

Insurance Reforms to Guarantee Access

- The Consumer Choice and Health Security Act provides for guaranteed issue of health insurance policies. Insurers could not exclude coverage of any preexisting medical condition of any applicant who switches from one insurance plan to another or of any currently uninsured person who buys insurance.

- Insurers cannot cancel or refuse to renew coverage of a health insurance policy except for non-payment of premiums or fraud or misrepresentation. Insurers could not offer bonuses to brokers for selling insurance to "healthy" people or avoiding the sale of policies to

people with preexisting conditions, or engaging in any other discriminatory sales practices.

- Health insurance underwriting would be limited, allowing insurers to vary premiums only on the basis of age, sex and geography. However, because of the importance of prevention and healthy lifestyles, the legislation would allow insurers to give incentive discounts to promote healthy behavior, prevent or delay the onset of illness, or provide for screening or early detection of illness.

- Certain state laws pertaining to mandated benefits and services, anti-managed care laws, and mandated cost-sharing would be preempted.

Tax Credits

- Individual tax credits would replace the current tax exclusion for company-sponsored health plans.

- Tax credits, which would become available on January 1, 1997, would be structured to give all Americans a basic level of tax relief on all of their health expenses, with greater tax relief targeted to those individuals and families who, because of illness or below average incomes, face proportionately higher health expense relative to their income. The credits would be structured as follows:

Health Insurance Premiums and Unreimbursed Medical Expenses as a Percent of Gross Income	Percent Reimbursed
Below 10 percent	25 percent
10 to 20 percent	50 percent
20 percent or more	75 percent

- At a minimum, for every $100 which is spent on health insurance premiums, or contributed to a Medical Savings Account (MSA), or spent on ANY out-of-pocket medical expenses, the individual or family would pay $25 less in taxes. The greater the ratio of health costs to income, the greater the tax benefits. Low-wage persons with higher percentage health costs would receive greater benefits. The tax credit would be as much as $75 per $100 spent on health care, and would be refundable as explained below.

- The credits are refundable, meaning that if the value of the credit is more than an individual's or family's tax liability, the government would pay the difference. Much like the treatment of the Earned Income Tax Credit (EITC), employers would reduce their tax

liability and provide the tax credit as additional income in the employees' paycheck, so they could purchase insurance.

Family Security Benefit Requirements

- Society should not have to pay the price for irresponsible individuals who refuse to purchase insurance and then expect us to pick up the tab when they become seriously ill or injured. Every individual and family would be required to have minimum health insurance coverage to cover medically necessary "acute medical care," including:
  - Physician services
  - Inpatient, outpatient, and emergency hospital services and appropriate alternatives to hospitalization
  - Inpatient and outpatient prescription drugs
  - A maximum deductible amount of $1,000 for an individual and $2,000 for a family and an out-of-pocket limit of $5,000. These amounts would be indexed to inflation in future years.

- For Medical Savings Accounts, or MSAs, the Consumer Choice plan would provide the same basic 25% tax credit for deposits. Each household would be permitted to have one MSA and to make an annual deposit no greater than the sum of $3,000 plus $500 for each dependent. The funds in an MSA could be used to pay medical bills not covered by their insurance plans, and to pay health insurance premiums.

- Transitional Rules: In order to provide individuals and families with secure, portable benefits, insurers and employers who currently provide health insurance coverage would be required to offer policyholders the option of converting their existing coverage to an individual or family plan. Employers would also be required to add the value of the coverage they now offer to their workers' wages. Thus, workers could take their coverage with them when they changed jobs or could use the money to buy a different plan that better suited their needs.

Employer Provisions

- Individuals and families could still purchase health insurance through their employers. This would not be their only option, since they would be able to receive the same tax relief if they purchased coverage on their own or through other groups such as unions, churches, farm bureaus, business coalitions, professional associations, or through some other group — similar to the choices that more than 10 million Federal employees, retirees and their families have today.

- To ensure that individuals and families are able to make regular premium payments on their health insurance, employers would be responsible for withholding premiums from their employees' paychecks and sending these premiums to the employees' chosen insurer. Employers would also be responsible for adjusting their workers' tax withholding to reflect the new tax credits. Thus, taxpayers would not need to wait until they filed their tax returns to claim back the new tax credits.

- Individuals who fail to enroll in private health insurance plans would be ineligible to claim the personal exemption on their federal income taxes. Employers would adjust their withholding to reflect this increased income tax liability.

Financing the Consumer Choice Plan

- Because the Consumer Choice tax credit is more generous than the tax deductions and exclusions that it would replace, it will result in a net revenue loss to the federal government of $133 billion between 1997 and 1999. To offset this revenue loss, the bill calls for savings in the Medicare and Medicaid programs of $139 billion over five years.

- Federal Medicaid payments to states for acute care would be distributed on a per capita basis beginning in fiscal year (FY) 1995. The capitated amounts would be set at 20 percent above the FY 93 level in FY 95. In subsequent years, the capitated payment would rise by one percent above the consumer price index (CPI). Total federal Medicaid acute care payments to a state for FY 95 could not exceed the payment for FY 93 plus 20 percent. In subsequent years, the total federal acute care payment to any state could not exceed the previous year's payment plus CPI plus 2.5 percent. This will produce a five-year savings of $72 billion. States would be given broad latitude in how they deliver acute medical care services to their Medicaid population.

- Medicare savings will be achieved by eliminating payments to "disproportionate share" hospitals, reducing payments to hospitals for indirect medical education costs, continuing the transition to a prospective payment system (PPS) for outpatient services, and by updating PPS payments on January 1 of each year, rather than on October 1. Further savings would be achieved by placing a 20- percent coinsurance requirement on laboratory and home health services. These changes will save the Medicare program $67 billion over five years.

Comparison of Savings Achieved
The President's health plan and the Consumer Choice plan

Program	Consumer Choice	President
Medicare	$67 Billion	$152 Billion
Medicaid	$72 Billion	$225 Billion

joint ventures that would increase access to health care, enhance health care quality, establish cost efficiencies from which consumers would benefit, and otherwise make health care services more effective, affordable and efficient.

- The Attorney General also is required to establish a program through which certain providers may obtain certificates exempting from anti-trust laws activities relating to the provision of health care services.

Long-Term Care

- Amounts withdrawn from individual retirement accounts (IRAs) and 401(k) plans for long-term care insurance are excluded from income. The bill also provides that certain exchanges of life insurance policies for long-term care insurance policies are not taxable. It also exempts from taxation any amount paid or advanced from a life insurance contract to a terminally or chronically ill individual who is confined to a hospice or nursing home.

THE COMPREHENSIVE FAMILY HEALTH ACCESS AND SAVINGS ACT

by Senator Phil Gramm
September 28, 1993

I. ENHANCE SECURITY FOR THOSE PRESENTLY INSURED BY MAKING PRIVATE INSURANCE PORTABLE AND PERMANENT:

Workers and families presently insured will be guaranteed continued medical insurance coverage by allowing those who leave jobs where insurance coverage was provided to continue their present coverage for an 18-month grace period (or until such individuals can qualify for other coverage) by paying the full premium directly. People who are no longer with their spouses but were previously covered under their spouses' plans or people who have recently become legally independent and are no longer covered by their families' plans will be allowed to continue their current health insurance arrangements for the same grace period by paying their pro rata share of the premium. In addition, all policies would be guaranteed renewable, belong to the family or individual, and premiums could not be raised based on the occurrence of illness. Insurance companies would not be able to cancel a policy except when the policy holder fails to pay the premiums or when the insurance company ceases to sell health insurance in the policy holder's state.

II. EXPAND FAMILY HEALTH INSURANCE CHOICES TO PROMOTE COMPETITION AND CONTROL COSTS:

As under present law, employer contributions for the purchase of medical insurance coverage will be excluded from employee income; however, employers must offer employees at least three options:

A) Maintain current insurance coverage;
B) Switch to HMO coverage or any other health care arrangement -- such as a voluntary health alliance, a preferred provider organization, or managed care -- by having the employer pay the current employer-paid share of existing health insurance costs into the alternate plan that the employee chooses; or
C) Switch to a Medical Savings Account program with the employer contributing the amount currently being expended on existing health insurance.

1) A new Medical Savings Account program would be established through enabling legislation allowing current employer and employee contributions to go first toward the purchase of a $3,000 deductible catastrophic insurance policy, which would be chosen by the employee from among plans offered by private insurers and paid for by the employer and employee in the same ratio as conventional insurance is now purchased, with remaining amounts currently spent on conventional insurance coverage going into a Medical Savings Account. Tax-free withdrawals from the Medical Savings Account could be made to pay for qualifying out-of-pocket medical expenses which apply toward the insurance policy's deductible. If the funds in the Medical Savings Account are not spent so that as new deposits are made, the sum grows beyond the $3,000 deductible, the employee can withdraw the excess and treat it as income.

The individual employee would contract with the HMO or Medical Savings Plan and pay those costs in excess of the employer's current contribution for the purchase of health insurance coverage. Employees will have a 2-month period each year (an "open season") to choose a new option for the following year. Should the cost of the HMO or Medical Savings Account program be less than the employer currently pays for conventional insurance, the employee can keep the difference.

Each employer shall determine whether the employer's contribution into the alternate plan shall be based on the **average cost** of providing coverage for its employees under the current plan or the **actual cost** per individual employee. Whichever method the employer selects shall apply to any employee leaving the employer's current plan and selecting an alternative plan. In addition, whichever method the employer chooses shall be used in determining the cost of coverage that employees leaving the employment of the company must pay to continue bridge coverage during the grace period or until other coverage can be obtained.

III. PROVIDE EQUAL TAX TREATMENT FOR THE SELF-EMPLOYED, UNINSURED WORKERS, AND ALL OTHERS:

Self-employed workers, who currently are permitted to deduct 25 percent of their expenses for medical insurance coverage, and those without employer-provided health insurance coverage will now be allowed to **exclude** from income a percentage of their medical insurance coverage costs equal to the national average that employers contribute. This percentage will be recalculated annually and will ensure that anyone without employer-based health insurance coverage will be treated equitably. The exclusion will be phased in over five years up from 25 percent to the national average for the employer's payment. The tax exclusion will apply to the purchase of conventional health insurance, HMO coverage, Medical Savings Account contributions, or any other prepaid medical plan.

IV. ASSIST HIGH RISK INDIVIDUALS WHO HAVE PRE-EXISTING CONDITIONS:

Those uninsured due to **unavoidable** pre-existing conditions that preclude affordable insurance cannot be denied coverage but will be expected to pay premiums up to 150 percent of the average premium paid by those of the same age, sex, and geographic area. The federal government will pay that amount of the premium which exceeds 150 percent of the average, but only if the entire cost of the coverage exceeds 7.5 percent of the individual's or family's income. Such assistance shall be given for the purchase of a high-deductible catastrophic policy and private insurers shall bid for the policy in a risk pool.

V. ENCOURAGE RESPONSIBLE BEHAVIOR BY THE FINANCIALLY CAPABLE:

Financially capable individuals ***(those with incomes above 200 percent of the poverty level--$13,864 for individuals and $27,848 for a family of four)*** who choose not to purchase at least a catastrophic insurance policy that covers major medical services with a deductible no higher than 20 percent of their adjusted gross income or $3,000, whichever is higher, will not be eligible to receive federal premium assistance based on any pre-existing condition after the first year of enactment of this legislation. In addition, such an individual who incurs medical expenses will be the "payer of first resort." Only after he has exhausted all his assets will the government or any institution receiving federal funds provide assistance.

VI. PROVIDE ASSISTANCE TO LOW-INCOME WORKERS:

85 percent of Americans currently have health insurance coverage. By providing equal tax treatment to those who purchase their own insurance coverage without employer-provided

assistance, by having the federal government partially subsidize the cost of insurance coverage for high-risk individuals, by providing incentives for financially capable individuals to obtain health insurance coverage now, and by making all health insurance policies portable and guaranteed renewable, we will ensure that **most** of the remaining 15 percent will have health insurance coverage.

To achieve **total** coverage, a credit will be available to families and individuals not eligible for Medicaid and having income below 100 percent of the poverty level. This will allow them to fully fund the cost of a catastrophic insurance policy covering major medical services with an annual deductible equal to the higher of 20 percent of adjusted gross income or $3,000 and a preventive package for immunizations, pap smears, mammograms, prostate exams, and other basic preventive care. This credit will be reduced as family income rises and will be eliminated at 200 percent of the poverty level. This credit will be phased in over five years.

Those receiving a partial subsidy who refuse to purchase health insurance will not be eligible to receive federal premium assistance based on any pre-existing condition after the first year of enactment of this legislation. In addition, if such an individual incurs medical expenses, he shall be the "payer of first resort." Only after he has exhausted all his assets will assistance be provided.

VII. REWARD PREVENTIVE MEDICINE AND HEALTHY LIFESTYLES:

Nothing in this act shall prohibit insurance companies from charging different rates based on the willingness of the insured family or individual to use preventive medicine, including vaccines and physical exams. Insurance companies can charge lower rates to those who restrict their use of health harming substances, such as alcohol, and live healthy lifestyles.

Those working people with moderate incomes receiving federal assistance will be required to pay more if they are overweight, smoke, drink excessively, or engage in other activities that are harmful to their health. These extra payments will be based on the differentials that develop in the private insurance market.

VIII. REFORM MEDICAID AND MEDICARE:

A) Medicaid payments to states will made on a per capita basis. That is, states will receive an annual payment, indexed for medical inflation, from the federal government equal to the average federal cost per Medicaid enrollee nationally. The payment will vary by major risk categories. States will then be allowed the flexibility to design their own systems which could:

1) continue the existing Medicaid coverage;
2) enroll recipients into a private Health Maintenance Organization or other health care arrangements; or
3) establish a Medical Savings Account plan to cover the recipient's medical expenses, where, except for qualified medical expenses, no amount can be withdrawn from the Medical Savings Account which takes the account below the annual catastrophic deductible amount.

Also, states would be permitted to develop other innovations and requirements, including use of copayments.

B) Those currently covered by Medicare could keep their present coverage or receive annual government assistance up to the expected cost of their annual Medicare coverage for the individual retiree to enroll in a private Health Maintenance Organization or other health care arrangement or buy a Medical Savings Account.

Those choosing to opt out of the current Medicare system who are able to purchase coverage for less than the expected cost of their current Medicare coverage will be permitted to keep one-half of the difference.

Upon becoming eligible for Medicare (currently at age 65), individuals would have one year to decide whether or not to stay in the current Medicare system. This decision is final.

Under the Medical Savings Account option, the expected Medicare annual expenditure would be paid on an annual basis and would be used to purchase the retiree's catastrophic coverage from a private vendor, with the remaining funds going into the retiree's personal Medical Savings Account. Additional Medical Savings Account contributions or out-of-pocket expenses could be made by the retiree or anyone else on the retiree's behalf. The Medical Savings Account would also be established and maintained with a private vendor.

IX. PROVIDE MEANINGFUL MEDICAL LIABILITY REFORM:

A) Before having standing to demand judgement against a health care provider for malpractice, the plaintiff would have to first prove negligence. Failure to do so will result in an automatic judgement against the plaintiff rendering the plaintiff liable for the cost incurred by the health care provider in defending himself, including any losses as a result of being away from his practice defending himself.

B) The widespread practice of suing for "joint and several liability" will be restricted. No longer will the negligence of one individual be permitted to provide grounds on which many uninvolved or marginally involved people and institutions can be sued.

C) A health care provider can negotiate with the buyer of health care services a waiver of medical liability in return for lower fees. Even with the waiver, the patient retains a full right to sue in cases of gross negligence. "Gross negligence" means actions which are a **clear** violation of generally accepted procedures and established medical ethics.

X. OFFSETTING THE COSTS

COSTS:

The taxpayers costs of the three new health care benefits contained in this proposal -- the universal health insurance tax exclusion; the high-risk insurance pool subsidy; and the low-income worker tax credit for insurance purchase -- will be put into effect under the following conditions:

A) None of the benefits shall take effect until savings accrued by the reforms contained in this plan have actually occurred.

B) Phase-in priorities based on achieved savings shall be as follows:

1) high-risk insurance pool subsidy.
2) universal health insurance tax exclusion will be phased up in annual 10 percentage point increments to 75 percent.
3) low-income worker tax credit for insurance purchase will be phased in first for families in poverty, then singles in poverty, and lastly, for families and singles above the poverty level.

Phased-In Costs
(in billions of $)

	1994	1995	1996	1997	1998	1999	TOTAL
High-Risk Pool		$4	$4.2	$4.2	$4.2	$4.2	$20.8
Health Insurance Exclusion		$6.2	$8.7	$11.4	$14.6	$18.2	$59.1
Low-Income Worker Tax Credit		$0	$4.3	$10.3	$19.6	$30.1	$64.3
TOTAL COSTS		$10.2	$17.2	$25.9	$38.4	$52.5	$144.2

SAVINGS:

A) MEDICAID

Medicaid savings are achieved in three ways. First, Medicaid spending is "capitated," meaning that states would receive an annual federal payment based on the number of Medicaid recipients and the risk classes they fall into. States would then be given the flexibility to institute the reforms outlined in section VIII. The payment to states would grow each year by the increase in the medical price inflation index.

Savings
(in billions of $)

	1994	1995	1996	1997	1998	1999	TOTAL
Medicaid Savings from Capitation and State Flexibility	$5	$11.1	$18.6	$27.5	$38.5	n.a.*	$100.4

Second, with the introduction of price competition in health care through expanded consumer choice contained in sections II and VIII, the current differential between the medical price inflation index and the consumer price index is projected to decrease by one-half over five years. The resulting Medicaid savings are as follows:

Savings
(in billions of $)

	1994	1995	1996	1997	1998	1999	TOTAL
Medicaid Savings from Lower Medical Inflation	.3	.9	2.0	3.8	6.4	n.a.*	13.3

Lastly, with the introduction of a high-risk individual subsidy and a universal tax exclusion, many Medicaid recipients will be brought under private plans. The resulting savings are as follows:

Savings
(in billions of $)

	1994	1995	1996	1997	1998	1999	TOTAL
Transfer out of Medicaid to Private Insurance	.6	1.3	1.4	1.5	1.6	n.a.*	6.5

B) MEDICARE

The introduction of price competition in health care generated by the reforms in sections II and VIII is assumed to cut the current difference between the medical price index and the consumer price index in half over five years. The resulting Medicare savings are as follows:

Savings
(in billions of $)

	1994	1995	1996	1997	1998	1999	TOTAL
Medicare Savings	$3.5	$7.5	$11	$16.5	$23	n.a.*	$62

C) OTHER OFFSETS

With creation of the risk pool coverage and universal access to catastrophic health care coverage, the use of the present deduction of health care costs in excess of 7.5% of income will drop dramatically. This estimate assumes a total reduction of 50%.

Savings
(in billions of $)

	1994	1995	1996	1997	1998	1999	TOTAL
Less Use of Medical Deduction	$2.8	$2.9	$3.1	$3.3	$3.6	n.a.*	$15.7

TOTAL SAVINGS (in billions of $)

1994	1995	1996	1997	1998	1999	TOTAL
$12.2	$23.7	$36.1	$52.6	$73.1	n.a.*	$197.7

Deficit Reduction **$53.5 Billion**

* "n.a." refers to not applicable. Savings in the sixth year are not applicable because the first five years of achieved savings will be used to fund benefits paid in each of the following years.

Gramm Sketches Another GOP Alternative

By Helen Dewar
Washington Post Staff Writer

Sen. Phil Gramm (Tex.) unveiled yet another Republican alternative to President Clinton's health care reform proposals, one Gramm said would rely almost entirely on market forces to cut costs and expand coverage.

As outlined by Gramm in a breakfast meeting with reporters, the plan would require employers to offer health care options to their workers, assure coverage of people with preexisting health conditions, continue coverage for workers who change jobs and provide some assistance for the working poor.

It bears little, if any, resemblance to Clinton's plan and differs significantly from an alternative outlined last week by a group of Senate Republicans led by Sen. John H. Chafee (R.I.).

In keeping government intervention to a minimum, it more parallels a plan proposed by House Republicans.

Gramm described the choice between Clinton's plan and his own as "collectivized medicine" versus "bringing price competition into the health care market." Gramm would provide no new benefits until savings were assured.

While it appears to have little chance of passage, Gramm's plan is likely to sharpen the debate by presenting a clear conservative alternative to what many see as a gradually evolving consensus between Clinton and Chafee, who has signed up 22 colleagues as cosponsors on his proposal. Gramm said he has not yet tried to get cosponsors for his proposal, although he said he is working with about 20 Republican senators on the plan.

The president will unveil his broad reform proposal to a joint session of Congress today at 9 p.m.

Gramm's proposal would require employers to offer workers at least three health care options, including continuation of current coverage, transfer to other plans including health maintenance organizations (HMOs) or creation of "medical savings accounts" on behalf of individual employees. The deposits in those accounts would come from money that employers would otherwise have paid for health insurance. Employees who chose such accounts would have to be provided a catastrophic-illness insurance policy.

Self-employed workers or those without employer-provided insurance would receive tax breaks equivalent to the national average of employer-paid benefits. Medicaid and Medicare would be continued but with the option of enrolling beneficiaries in HMOs or medical savings accounts. Pools would be set up to cover high-risk workers, with some government subsidy for poorer workers, and credits for catastrophic coverage would be provided for those not covered by other aspects of the bill.

Gramm, who is also chairman of the Republican senatorial campaign committee, said Clinton's plan, if adopted without change, would "bankrupt" the country and doom the Democrats. "People would be hunting Democrats with dogs by the end of the century," he said.

TO: SENATOR DOLE

FROM: SHEILA

TALKING POINTS FOR INTERVIEW WITH GLORIA BORGER

♦ THERE IS MUCH THAT IS AGREED UPON BY ALL REPUBLICANS -- AND LITTLE OVER WHICH WE DISAGREE.

♦ SENATOR GRAMM AND OTHERS BELIEVE THE INDIVIDUAL SHOULD BE GIVEN MAXIMUM FLEXIBILITY IN THE CHOICE AND DESIGN OF THEIR HEALTH PLAN -- I DON'T DISAGREE.

♦ THE PROPOSAL I HAVE JOINED IN DESIGNING WITH SENATOR CHAFEE AND 23 OTHERS TRIES TO INCORPORATE THE USE OF IRA'S AND CATASTROPHE COVERAGE AS AN OPTION.

♦ WHERE WE DIFFER WITH SENATOR GRAMM IS THE EXTENT TO WHICH EMPLOYERS SHOULD OR COULD REMAIN IN THE BUSINESS OF PROVIDING COVERAGE, AS WELL AS FINANCING. WE THINK MUCH OF TODAY'S EMPLOYMENT-BASED INSURANCE MAY CONTINUE TO MAKE SENSE.

November 12, 1993
11:00 a.m.

SIDE-BY-SIDE COMPARISON OF MAJOR DIFFERENCES BETWEEN
HEALTH CARE REFORM PROPOSALS

DRAFT: Needs to be updated!

ISSUE	CLINTON	SENATE REPUBLICAN TASK FORCE	GRAMM	HOUSE REPUBLICANS	NICKLES/HATCH CONSUMER CHOICE	COOPER/GRANDY
Employer Mandate	Yes; 80/20: Employer must pay 80% of average premium for employees and dependents. Part time employees pro-rated. Employer contributions capped at 7.9% of payroll, except those with 75 or fewer employees whose average wages are $24,000 or less. They would pay between 3.5 & 7.9% of payroll, (depending on the average wage). Federal government pays the remaining part of the employer share. No cap on employer contributions to corporate alliances. (Corporate alliances only available to employers of 5,000 or more.)	No mandate to pay any portion of employees' premium, only a mandate to offer coverage directly or through cooperative.	No mandate to pay any portion of employees' premium. However, if currently providing coverage for employees, must allow employees to use that money for other private coverage, including the establishment of a Medical Savings Account in combination with a catastrophic policy.	No financial mandate. Requires all employers to offer but not to help pay.	No new mandate to offer or pay for insurance to employees. However, companies that are currently providing health insurance must give their employees the option of continuing their current plan or "cashing out" their benefits and joining another plan.	No mandate to pay any portion of employees' premium, only a mandate to offer health plan to all employees through HPPC [Health Plan Purchasing Cooperatives] or company AHP [Accountable Health Plans] set up by large businesses.
Individual	Yes. All legal	Yes. Must show proof	No. However, those	No.	Yes. Heads of	No. However, those

ISSUE	CLINTON	SENATE REPUBLICAN TASK FORCE	GRAMM	HOUSE REPUBLICANS	NICKLES/HATCH CONSUMER CHOICE	COOPER/GRANDY
Mandates	residents would be required to be insured. Enforcement determined by the alliance.	of coverage to IRS or pay penalty of defined premium amount plus 20% excise tax. Financial assistance available to individuals below 240% of poverty.	choosing to go completely without coverage will lose their ability to obtain premium assistance for pre-existing conditions after one year and will be the "payer of the first resort" when incurring medical expenses. Only after all his assets have been exhausted will he receive government assistance for medical expenses, and amounts not recovered will be garnished from wages for a seven-year period.		households would be legally required to purchase at least a basic level of catastrophic insurance for themselves and their families. Enforced by the state governments. Financial assistance available to low income individuals.	choosing to go without coverage are subject to pre-existing condition limitations for up to 6 months.
Global Budget	Yes. National budget established for services covered under guaranteed benefit package. Budget enforced at alliance level through caps on rate of growth of premiums, limited to growth in CPI plus population by 1999. Separate budget for Medicare and Medicaid;	None	None	None	None	None.

ISSUE	CLINTON	SENATE REPUBLICAN TASK FORCE	GRAMM	HOUSE REPUBLICANS	NICKLES/HATCH CONSUMER CHOICE	COOPER/GRANDY
	rate of growth held to CPI plus population plus 0.4 percentage points by 2000.					
Tax Changes A. Tax Limit B. Deduct-ibility/ Exclusion	A. Benefits in excess of guaranteed benefit package already offered by employers would be taxable after 10 years. B. Yes. 100% tax deduction for self-employed.	A. Employer provided benefits above the average cost of the lowest 1/3 of plans offered in area treated as taxable income. B. Yes. Provides 100% tax deduction for self-employed and other individuals, up to average cost of lowest 3rd of plans offered in area.	A. None. B. Yes. Allows self-employed and those without employer-provided coverage to exclude from income a percentage of the cost of health care equal to the national average that employers contribute to employees' coverage.	A. Not addressed. B. Yes. Provides 100% tax deduction for all individuals, including the self-employed, who buy their own insurance.	A. None. B. Yes. Eliminate existing exclusion of employer provided health insurance from an employees taxable income. Establishes a new refundable tax credit for individuals and families for health insurance premiums and out-of-pocket medical expenses. People whose premiums and out-of-pocket medical expenses consume a greater share in income would receive larger credits.	A. Caps tax deductibility at the cost of the lowest price AHP plan meeting minimum Federal standards in the area. B. Yes. Provides 100% deductibility for all individuals and the self-employed purchasing coverage from federally-qualified AHP.
Medical Savings Accounts	Not addressed.	Creates tax benefits for employer and employee contributions to an MSA and a	Permits contributions to MSAs to be made and excluded from income in the same manner	Creates tax benefits for employers and employees contributions to an	Refundable tax credits for contributions to MSAs.	The commission shall consider incorporating the concepts of medical

ISSUE	CLINTON	SENATE REPUBLICAN TASK FORCE	GRAMM	HOUSE REPUBLICANS	NICKLES/HATCH CONSUMER CHOICE	COOPER/GRANDY
						Large businesses may form their own AHP locally or nationally. Any co-op will be governed by members.
Insurance Market Reforms	Portability, elimination of pre-existing conditions, etc. Plans within the regional alliances must use community rating (no adjustment for age). Plans sold to corporate alliances can experience rate but employee share must be community rated.	All policies would be guaranteed issue, renewable, portable; limitation on pre-existing condition exclusions; etc. Community rating, phased-in, WITH adjustments for certain characteristics like age and gender.	All policies would be guaranteed renewable, portable, and permanent. Policies could not be cancelled except for lack of payment, and premiums could not be increased based on the occurrence of illness. Nothing shall prohibit insurers from offering lower rates to those who restrict their use of health harming substances and live healthy lifestyles.	Moves toward community rating, but allows some variation. Provides guaranteed issue and guaranteed availability. Limits use of health risk factors; permits adjustment for age and gender.	All policies would be guaranteed issue renewable, portable and permanent. Limitation on pre-existing condition exclusion. Policies could not be cancelled except for lack of payment, and premiums would not be increased based on illness. Premiums could vary by age, gender and geographic location. Insurers may offer discounts for enrollment in wellness programs.	Providers and insurance companies form accountable health plans (AHPs) offering insurance and health care as a single product. AHPs must offer a standard package of federally defined uniform, health benefits at group rates. AHPs not allowed to deny coverage for pre-existing conditions or high risk individuals. All AHPs would be guaranteed issue and renewability. AHPs allowed to vary premiums based only on age (within

ISSUE	CLINTON	SENATE REPUBLICAN TASK FORCE	GRAMM	HOUSE REPUBLICANS	NICKLES/HATCH CONSUMER CHOICE	COOPER/GRANDY
						limits) and geographic location. HMO's, PPO's or Fees-for-Service are allowed. AHPS must require providers to report medical outcomes.
Benefits Package	An employer must provide a comprehensive package specified in legislation. Updated by National Health Board with approval by Congress.	Individuals must have coverage for a basic benefit package or catastrophic plan. Guidelines set in law. Clarification allowed by Benefits Commission -- must be approved by Congress.	None. However, Federal assistance provided in this plan is based on the cost of a catastrophic policy covering expenses such as physician services, hospital care, diagnostic tests, and other major medical expenses once the policy holder meets the $3,000 annual deductible.	Requires insurers who sell small group plans to offer a standard plan, catastrophic plan and medisave plan, within an actuarial framework established by the National Association of State Insurance Commissioners.	Requires that all individuals have at least catastrophic medical coverage.	HCCS [Health Care Standards Commission] sets and updates annually standard health benefits package -- must be approved by Congress. AHPs must require copayments except for preventive care.
Uninsured	Employer/employee mandate. Those who fail to enroll in a health plan would be enrolled upon seeking health care (i.e., "point-of-service" enrollment).	Individual mandate with vouchers for poor and tax benefits for others. Those who fail to purchase insurance will be liable for the cost of their care. If	Provide equal tax treatment to those who do not have employer-provided coverage. Give a tax credit to the working poor to assist in the purchase of coverage. Give	Assumes changes will cover most Americans.	Individual mandate with refundable tax credits to help them buy health insurance and medical care. These credits will be greater for households whose health care	Subsidies for the poor [see section on Subsidies] and tax benefits for others.

ISSUE	CLINTON	SENATE REPUBLICAN TASK FORCE	GRAMM	HOUSE REPUBLICANS	NICKLES/HATCH CONSUMER CHOICE	COOPER/GRANDY
		eligible for voucher, individual will be signed up when seeking care.	individuals with pre-existing conditions a partial subsidy to pay for coverage. Make insurance portable and guaranteed renewable.		expenses consume a greater share of income.	
Malpractice Reform	Requires ADR before court plus other tort reforms; 33% limits on attorney fees; collateral source rule; periodic payments; enterprise liability demos.	Mediation, then mandatory ADR. If appeal to court, loser pays court costs and attorney fees. Attorney fees capped at 20% of award. Non-economic capped to $250,000. Collateral source rule. Periodic payments over $100,000. Punitive damages go to state for education and monitoring. Joint and several liability reform. Rebuttable presumption for practice guidelines. Statute of limitation changed to 2 years (except for minors up to age 12).	Similar to the system in the United Kingdom where the "loser pays" court costs, any claim of negligence not "substantially justified" or improperly advanced will result in an automatic judgement against the plaintiff rendering the plaintiff liable for the costs incurred by the health care provider in defending himself, including any losses as a result of being away from his practice defending himself. The liability of any malpractice defendant will be limited to the proportion of damages attributable to such defendant's conduct.	Similar to Senate Task Force proposal except does not include references to practice guidelines.	Caps on non-economic damages of $250,000. Collateral source rule. Periodic payments over $100,000. Punitive damages go to state for education and monitoring. Joint and several liability. Statute of limitations changed to 2 years except for minors.	• Preempts state law where less stringent. • Requires all disputes to be initially resolved by an alternative dispute resolution (ADR) system prior to entering the court system. Provides grants to states to establish ADR systems. • Changes the standard for non-economic damages from joint and several to several liability.

ISSUE	CLINTON	SENATE REPUBLICAN TASK FORCE	GRAMM	HOUSE REPUBLICANS	NICKLES/HATCH CONSUMER CHOICE	COOPER/GRANDY
			A health care provider can negotiate limits on medical liability with the buyer of health care in return for lower fees. Non-economic damages cannot exceed $250,000 adjusted annually for inflation. Lawyer's contingency fees will be capped at 25 percent. Collateral source rule and periodic payment in excess of $100,000. No malpractice action can be initiated more than two years from the date the alleged malpractice was discovered or should have been discovered, and no more than four years after the date of the occurrence. No punitive damages will be awarded against manufacturers of a drug or medical			• Places a $250,000 cap on non-economic damages. • In the case of punitive damage awards, payments would go to the state to fund quality assurance programs, medical licensing activities, ADR, and efforts to reduce mal-practice costs of practitioners in underserved areas. • Imposes a higher standard of proof for liability associated with obstetric services. In the case of an obstetrician who delivered a baby whose mother he/she never

ISSUE	CLINTON	SENATE REPUBLICAN TASK FORCE	GRAMM	HOUSE REPUBLICANS	NICKLES/HATCH CONSUMER CHOICE	COOPER/GRANDY
			device if such drug or medical device has been approved by the Food and Drug Administration as safe and effective.			treated before the delivery, the standard for finding negligence is clear and convincing (instead of preponderance of the evidence). • Provides a uniform statute of limitations. Statutes of limitations is reduced to two years from when the injury was or reasonably should have been discovered. • Allows for structured periodic payment of compensatory awards over $100,000. • Authorizes $50 million annually for grants to states for implementing

ISSUE	CLINTON	SENATE REPUBLICAN TASK FORCE	GRAMM	HOUSE REPUBLICANS	NICKLES/HATCH CONSUMER CHOICE	COOPER/GRANDY
						practice guidelines. • Places limits on attorneys' contingency fees. • Discourages frivolous court actions by applying a modified English rule for payment of legal fees and requires plaintiffs to provide an expert affidavit within 90 days after filing a malpractice case or a $2,000 bond. • Requires liability action to include medical product producers. Punitive damages would not be assessed against a producer if the drug or

ISSUE	CLINTON	SENATE REPUBLICAN TASK FORCE	GRAMM	HOUSE REPUBLICANS	NICKLES/HATCH CONSUMER CHOICE	COOPER/GRANDY
						device was subject to FDA approval or generally recognized as safe and effective under FDA guidelines, except in the cases of withheld information, misrepresentation, or illegal payment. • Develops standard for interrogatories and motions. In every health care liability claim, the plaintiff must serve on the dependent complete answers to the standard questions within 45 days of filing. The defendant must respond within 45 days.

ISSUE	CLINTON	SENATE REPUBLICAN TASK FORCE	GRAMM	HOUSE REPUBLICANS	NICKLES/HATCH CONSUMER CHOICE	COOPER/GRANDY
Rx Drugs	Part of basic package.	Part of basic package.	Allowed but not required.	Allowed but not required.	Included in basic catastrophic plan.	Not addressed.
Veterans	Veterans can choose either VA plan which would be same as the basic benefits package or plan from alliance. VA hospitals could contract to provide services for other plans.	Not addressed.	Not addressed.	Not addressed.	Not addressed.	Not addressed.
Medicare	All plans must risk contract. Coverage of prescription drugs beginning 1996. Low-income seniors get help with cost-sharing. Drug companies to pay rebates to Medicare; certain overpriced drugs could be excluded. States could apply to fold Medicare beneficiaries under regional alliances.	Untouched, except TEFRA risk contracts provisions in current law changed to encourage more HMOs to accept Medicare recipients. Within one year, HHS conducts study of phasing in Medicare eligibles to private coverage. Long-term goal to allow Medicare eligible individuals to remain in their private health care plans.	Allows elderly to remain in medicare or receive annual payment from government of the "per capita" value of medicare which they could use to buy into an HMO or establish MSA or purchase any other private coverage. Election to drop out of medicare one time only.	Allows more Medicare beneficiaries to participate in HMOs and other managed care arrangements. Allows more HMOS to participate.	Not addressed.	Allows beneficiaries to enroll in AHPs. Preventive services available under Medicare will be expanded to include annual mammography, certain immuni-zations, and colorectal screening. Phase out Part B premium subsidy for individuals with an adjusted gross income greater than $75,000 and joint filers greater than $100,000.
Other	Modifies FEHBP;	Tax exclusion and	Not addressed.	Not addressed.	Not addressed.	FEHBP is subject to

ISSUE	CLINTON	SENATE REPUBLICAN TASK FORCE	GRAMM	HOUSE REPUBLICANS	NICKLES/HATCH CONSUMER CHOICE	COOPER/GRANDY
Government Programs (DOD, Indians, Champus, FEHBP)	Federal employees enroll through regional alliances; other programs continue for Medicare-eligible retirees, but generally, those eligible can elect to get insurance through alliance plans.	limitations apply along with individual mandate rules. No other changes.				same requirements as any other large employer.
Long-term care	Establishes a capped new Federal-State grant program to states to cover home and community-based services for disabled of all ages and income levels. Liberalizes Medicaid spend-down requirements for nursing home care; clarifies tax treatment of LTC insurance and establishes consumer protection standards for such insurance; and provides tax incentives to help persons with disabilities to work.	Clarifies tax treatment of LTC expenditures and establishes consumer protection standards for LTC insurance.	Not addressed.	Clarifies tax treatment of LTC insurance. Allows the option of using IRA's, 401(k) plans, or life insurance -- tax free -- to purchase LTC insurance. Lets states increase asset protection under Medicaid for purchasers of LTC insurance.	Not addressed.	States assume responsibility for long-term care for low-income individuals using money freed up from medicaid repeal.
Medicaid	Retains for long-term care but replaces	Managed care rules will be liberalized.	Medicaid payments to states will be made on	Provides increased flexibility to states,	Federal Medicaid acute care payments for the	Medicaid will be repealed. The

ISSUE	CLINTON	SENATE REPUBLICAN TASK FORCE	GRAMM	HOUSE REPUBLICANS	NICKLES/HATCH CONSUMER CHOICE	COOPER/GRANDY
	acute care component. Current Medicaid beneficiaries covered through alliance plans, but Medicaid also continues for AFDC and SSI enrollees. States pay maintenance of effort for non-cash beneficiaries, and per capita contribution for cash beneficiaries. Medicaid spending subject to Federal caps.	Provides increased flexibility to states, including allowing utilization of managed care and contracting with private health plans.	a per capita basis. That is, states will receive an annual payment, indexed for medical inflation, from the Federal government equal to the average Federal cost per Medicaid enrollee on a state-by-state basis. The payment will vary by major risk categories. States will then be allowed the flexibility to design their own systems.	including allowing utilization of managed care, contracting with private health plans and allowing a buy-in for individuals not covered by other insurance.	non-aged, non-disabled would be capitated and indexed in future years. States would be required to provide mandatory services to mandatory Medicaid population, but would be free to provide this coverage through vouchers, tax credits, enrollment in managed care plans or as they do now. Distribute disproportionate share payments to states on a formula basis.	Federal government will subsidize coverage purchased from AHPs for acute care for low-income individuals. States assume responsibility for long-term care portion of medicaid.
Subsidies	Provides Federal premium subsidies for low-income persons most early retirees; also provides Federal subsidy to cap the percentage of payroll paid by employers, with a larger subsidy for small employers with an above average number of low-wage workers. A cap is placed on the total amount available for the small business subsidy -- so the	A voucher will be available to families and individuals not eligible for Medicaid and having incomes below 240% of poverty. The voucher will be phased in over 6 years and will vary based on income.	A refundable credit would be available to the working poor and a partial subsidy would be available to those with pre-existing conditions.	Not addressed.	Refundable tax credits for all households. People whose medical expenses consume a greater share of income receive large credits. Former DSH payments used to subsidize insurance coverage as well as primary care for low incomes non-medicaid.	Federal program will pay the full premium for all individuals and families below 100% poverty level. Individuals between 100% - 200% of the poverty level will receive sliding scale subsidies towards purchase of insurance. Cost-sharing requirements are

ISSUE	CLINTON	SENATE REPUBLICAN TASK FORCE	GRAMM	HOUSE REPUBLICANS	NICKLES/HATCH CONSUMER CHOICE	COOPER/GRANDY
	value may be less than proposed.					also subsidized for the poor.
Retirees	Effective January, 1988, retirees 55 through 64 are treated as nonworkers. They would enroll in an alliance plan. Those with pension income below a specified threshold would have "employer" share of premium (80%) paid by Federal government. Retiree pays 20% share; low-income retirees eligible for subsidy of 20% employers with existing retiree health plans required to pay the 20% "employee" share.	Not addressed.	Not addressed.	Not addressed.	Not addressed.	Not addressed.
Financing	Raises taxes on cigarettes by 75 cents per pack. A levy of 1% of payroll on large corporations that choose to arrange for own health plan. Cuts in Medicare and Medicaid of $188 billion. Expects	Pay-as-you-save plan. Would raise $210 billion over 5 years to pay for vouchers by reducing Medicare and Medicaid spending by that amount -- primarily money now spent to compensate for care of the	Pay as you save. Cuts growth in Medicare by $61.5 billion over five years and Medicaid by $112.5 billion over five years. Less use of the 7.5% medical deduction saves $15.7 billion over five	Increases the Federal retirement age from 55 to 62. Prefunds government retirement health insurance costs. Phases-out Medicare subsidy for seniors with incomes over $100,000 (individuals)/$125,000	Eliminates policy of tax exclusion of employer-provided health benefits. Federal Medicaid acute care payments for the non-aged, non-disabled capitated and indexed in future years.	Estimated cost: $25 billion annually. Offsets: Capping employer deductibility ($16 billion); reduce increase in provider fees under Medicare ($6.5 billion) and phase-

ISSUE	CLINTON	SENATE REPUBLICAN TASK FORCE	GRAMM	HOUSE REPUBLICANS	NICKLES/HATCH CONSUMER CHOICE	COOPER/GRANDY
	large savings in private sector. Phases-out Medicare subsidy for seniors with incomes over $100,000 (individuals) $125,000 (couples).	uninsured. Establishes income. Adjusted Part B premium.	years.	(couples).		out Medicare Part B premium subsidy for upper income [see section on Medicare] beneficiaries ($1.5 billion). Prefunds government retirement health insurance costs.
States Rights	The Health Security Act provides substantial flexibility for states to design alliances and oversee health plans. It allows states to decide the number of alliances and determine the regional boundaries or if they wish, to choose a single payer approach. States have the flexibility to organize alliances as a state agency, as a nonprofit, or quasi-public entity. The board of directors of the alliances will also be determined by the states.	States are provided flexibility to establish an alternative system to more effectively meet the needs of the State and to permit experimentation in health care reform.	Not specifically addressed, however, states will be given the flexibility to design their own medicaid system.	States would be granted authority to restructure their Medicaid programs. State benefit mandates would be prohibited in the case of group insurance policies, as would any state restrictions on managed care. No other change from current law.		

ISSUE	CLINTON	SENATE REPUBLICAN TASK FORCE	GRAMM	HOUSE REPUBLICANS	NICKLES/HATCH CONSUMER CHOICE	COOPER/GRANDY
	Accountable health plans will be overseen by the states.					
Health Manpower	Restructures Medical Education Toward Primary Care • Establishes a National Council on Graduate Medical Education that tailor health professional training to the medical care needs of the American population and assures at least 55% physicians are training in primary health care by 2003. • The National Council manages the Annual Health Professions Account (derived from Medicare transfers and alliance payments) and allocates funds to approved training programs. Total	Establishes demonstration authority to increase the number of primary care providers, increases National Health Service Corps funding and increases funding for primary care provider education.	Not addressed.	No provisions.		

ISSUE	CLINTON	SENATE REPUBLICAN TASK FORCE	GRAMM	HOUSE REPUBLICANS	NICKLES/HATCH CONSUMER CHOICE	COOPER/GRANDY
	funds available for physician specialty training increase from $3.2 billion in 1996 to $5.8 billion in 2000. Expands the National Health Service Corps • Allocates additional funds beginning in 1995 to the National Health Service Corps to increase the field strength of the corps almost five fold to about 7,400 providers in 2004. Creates an Appropriate Provider Mix • Authorizes an additional $200 million to programs in the Department of Health and Human Services and the Department of Labor to: • train additional					

ISSUE	CLINTON	SENATE REPUBLICAN TASK FORCE	GRAMM	HOUSE REPUBLICANS	NICKLES/HATCH CONSUMER CHOICE	COOPER/GRANDY
	numbers of primary care physicians and physicians assistants, including emphasis on service in rural and inner-city medically underserved areas and practice in managed care settings; • increase the number of underrepresented minority and disadvantaged persons in all health professions including faculty and recruitment and retention support; and • support priority nursing workforce needs, including additional nurse					

ISSUE	CLINTON	SENATE REPUBLICAN TASK FORCE	GRAMM	HOUSE REPUBLICANS	NICKLES/HATCH CONSUMER CHOICE	COOPER/GRANDY
	midwives, nurse practitioners, nurse clinicians, and nurse anesthetists as well as the development of model professional practice statutes. Establishes Tax Incentives for Rural Providers • Tax credits are offered for primary care providers serving in underserved areas. Up to $1,000 per year is available for primary care physicians and $500 for other health professionals for up to 5 years of service. The tax credit may be recaptured on a sliding percentage scale for service less than 5 years					

ISSUE	CLINTON	SENATE REPUBLICAN TASK FORCE	GRAMM	HOUSE REPUBLICANS	NICKLES/HATCH CONSUMER CHOICE	COOPER/GRANDY
	in a designated area. Allowable depreciation expense for medical equipment is increased by $17,500 for primary care physicians practicing in designated underserved areas.					

THE REPUBLICAN PARTY OF IOWA

To: Suzanne Hellmann

From: Linda J. Wright, Political Director

Date: January 10, 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/were hoping in 1994 to pick up 2 more house seats to give us breathing room and to pick up 3 seats in the Senate to give us control.

However, we have 8 **House Republicans** and **4 Senate Republicans** not seeking re-election. We have a minimum of 6 incumbents in the House and 3 incumbents in the Senate that are in vulnerable positions. Going into the general election, we have 21 seats to protect just to maintain the status quo.

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. The Democrat challenger is currently the Attorney General for the State of Iowa. There will not be a primary contest on the Democrat side for the first time in over 20 years.

Factoring in what is happening with the retirements and the Gubernatorial primary, we are in danger of losing control of the House of Representatives and losing seats in the State Senate. We will probably have less incumbents seeking re-election in both Houses than the Democrats.

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.

521 E. Locust • Des Moines, Iowa 50309 • (515) 282-8105

GREG GANSKE

We have three Republican Incumbent Congressmen running for re-election in 1994; Jim Leach, Jim Ross Lightfoot and Jim Nussle. In the 4th Congressional District, a prominent Des Moines reconstructive surgeon is challenging 36 year Democrat incumbent Neal Smith. 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 currently have announced 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. This will leave us with 2 open Statewide contests.

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.

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

2300 Financial Center
Des Moines, IA 50309

(515) 243-2300 (o)
(515) 243-0654 (f)

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

(515) 282-8105 (GOP)
(515) 592-1031 (o)
(515) 592-1030 (f)
(515) 592-2902 (h)

IOWA DFP

Robert Van Vooren, Chairman
Davenport

Gerald M. Kirke
Des Moines

Steve Roberts, Chairman
Des Moines

Harry G. Slife, Chairman
Waterloo

John Ruan
Des Moines

Barbara Grassley, Co-Chairman
New Harford

Bev Tauke, Co-Chairman

STAFF

Jeanne Hedican, Deputy Campaign Director
Caryl Lehmkuhl, Office Manager
John Crowley, Field Representative
Keith Gudenkauf, Field Representative
Scott Matter, Field Representative
Jeane Brush, Volunteer coordinator
Kathy Irvine, Receptionist
Elaine Smith, Field Representative

Ganske Congress.

5907 Grand Avenue
Des Moines, IA. 50312

515/279-1994
Fax: 515/279-3841

To: Senator Robert Dole
Attention: Suzanne

From: Jeanette Schmett

Re: Ganske Biography

As requested please find the biography that follows. Dr. Ganske briefly met Senator Dole last year in Des Moines at a State GOP event.

Over the past few weeks, Dr. Ganske has received numerous calls from the national media, and was featured on the front page of *Roll Call* . On Thursday the CBS evening news will be following Dr. Ganske throughout the day. Greg would very much appreciate a few minutes to talk about his campaign with Senator Dole. We would offer the CBS crew an opportunity to shoot the first five minutes of the meeting but then would prefer a few minutes in private with Senator Dole.

Thank you.

Paid for by People for Ganske.

Ganske Congress

Greg Ganske

Family : Wife - Corrine M. Ganske, M.D.
Children - Ingrid, Briget, Karl

Occupation : Plastic & Reconstructive Surgeon - Des Moines, Iowa

Education : University of Iowa, B.A. with Honors, Political Science and General Science, 1972

Medical School : University of Iowa Medical School, M.D., 1976

Postdoctoral Training :

University of Colorado Medical Center
Denver, Colorado, General Surgery, 1976-1978

University of Oregon Health Science Center
Portland, Oregon, General Surgery, 1978-1982

Harvard Medical School
Boston, Massachusetts, Plastic Surgery, 1982-1984

Military : Lt. Col., Medical Corp, USAR

People for Ganske
5907 Grand Avenue
Des Moines, Iowa 50312
515-279-1994
fax 515-279-3841

FEATURE

WORDS OF POLITICAL CANDIDATE GREG GANSKE

Q. Why are you running for Congress?

A. Because I fear my three children will not have the opportunities their parents and grandparents had.

Greg Ganske was only 9 years old when Des Moines Attorney Neal Smith was first elected to Congress. The year was 1958. Dwight D. Eisenhower was the US President, Elvis Presley was in the Army, and cars had fins. Now, at age 44, Dr. Greg Ganske is running for Congress in Iowa's 4th District, determined to unseat Neal Smith.

Dr. Ganske, A Des Moines Plastic & Reconstructive Surgeon, says, "Professional politicians in Washington like Neal Smith are mortgaging our children's future." "They've created a $4 trillion national debt that threatens our financial security and greatly inhibits our ability to address other serious problems."

Dr. Ganske grew up in small town Iowa, sacking potatoes in his father's grocery store and competing on his high school wrestling team. He competed at the state wrestling tournament where he shared a locker with future Olympic Champion Dan Gable (who contributed to Greg's campaign). "All I need to do to get enthusiastic about this political campaign is to watch Dan Gable's motivational videotape!" exclaims Ganske.

After obtaining his undergraduate degree in Political Science and medical degree from the University of Iowa Medical School, he later completed postdoctoral training at the University of Colorado, University of Oregon, and Harvard Medical School. While attending medical school, he met his wife, Corrine, a

family practice doctor who teaches in a Des Moines family practice residency program.

Most political pundits would agree that defeating a 35-year incumbent congressman is no easy task, but Greg Ganske thinks Iowa voters are ready for change. "When I talk to people around the 4th Congressional District, it's clear there is a great deal of dissatisfaction with business as usual in Washington. Most people don't like the idea of paying more in taxes just so career politicians like Neal Smith can vote themselves a huge pay raise. And, they don't like the idea that 60 cents of every dollar we pay in income taxes goes to pay the interest on the national debt."

Defeating a 35-year incumbent is no easy task, but Greg Ganske thinks Iowa voters are ready for a change...

To reduce the national debt, Dr. Ganske says government should reduce spending and review the cost/benefit ratio of all government programs, including automatic increases in entitlement. "Neal Smith has voted for nearly every tax increase and spending bill in the last 35 years, including the largest retroactive income and estate tax increase in history," continues Ganske. "Clearly, Congressman Smith is out of touch with the voters in his district."

As a physician, Ganske is obviously concerned about health care reform. "I believe price controls, and overregulation, as proposed in the Clinton Health Plan, will only lead to decreased quality, long waiting lines, obsolete facilities and uncaring bureaucracies," says Dr. Ganske. "We need to cut back on paperwork and decrease unnecessary defensive medicine."

"In the last four years, we have seen the private insurance sector coming to grips with the problem of health care costs either through increased deductibles or HMOs."

"In addition, we have succeeded in re-establishing some sense of personal responsibility for the private sector in terms of consumers and providers. That is reflected in a medical inflation rate in the private sector that is approaching the nation's inflation rate," says Ganske.

He continues, "Interestingly, Medicare and Medicaid are experiencing dramatic increase because these government programs have not effectively addressed the issue of personal responsibility in terms of health care costs." Greg favors

free market approaches such as medical savings accounts, but he thinks that whatever system evolves will need input from "someone who has been there."

Dr. Ganske feels crime is one of the issues that most clearly defines the differences between himself and Neal Smith. "I've been on the front line taking care of those crime victims. I want to make crimes more costly to the criminal."

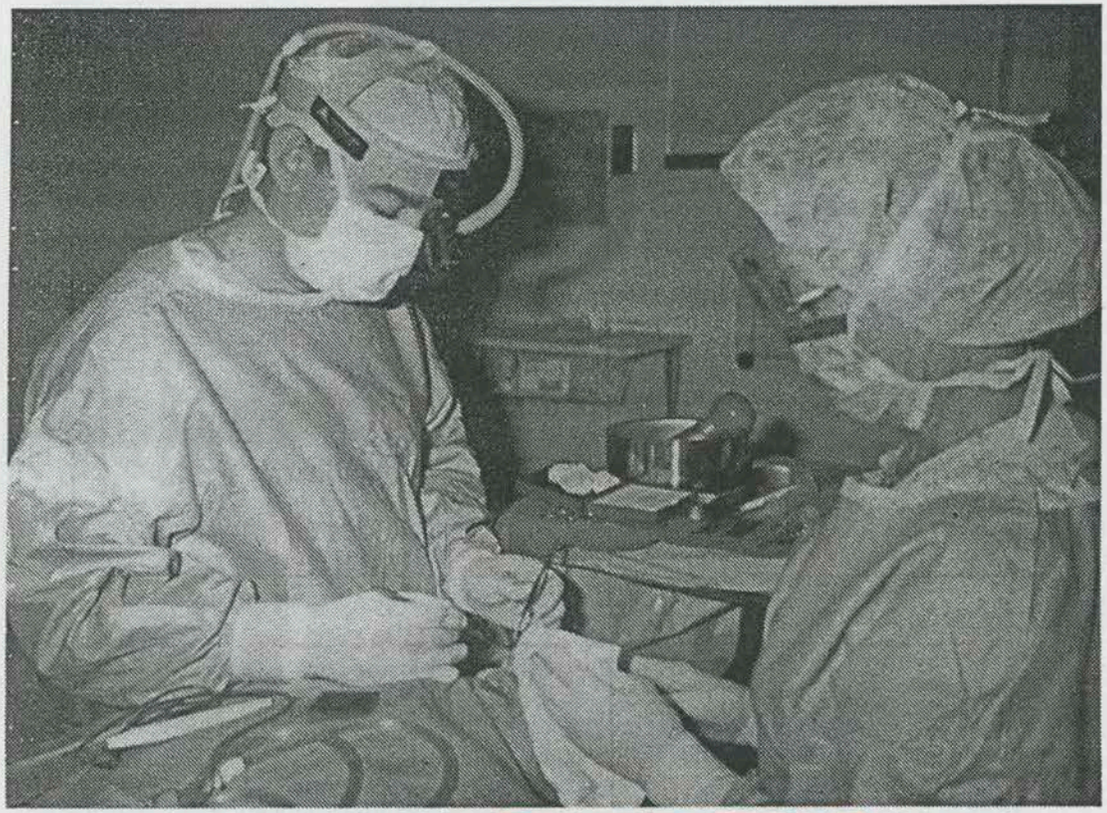
"Neal Smith has consistently protected criminal's rights at the expense of law abiding citizens," continues Ganske. "Mr. Smith voted against mandatory minimum sentences for criminals who use firearms to commit crimes and he opposed both the Brady bill and a nationwide computerized network intended to prevent convicted felons from purchasing handguns. He also favors allowing convicted criminals a seemingly endless number of appeals at taxpayers' expense."

Dr. Ganske says he still very much enjoys practicing medicine and plans to return to his practice after serving in Congress. "I strongly believe in term limits," Ganske adds. "The time has come to return to a citizen legislature comprised of people from all walks of life, not just career politicians."

Even though he will not officially announce his candidacy until 1994, Ganske has already received support from some key Des Moines business leaders as well as numerous physicians across the US. He also received a vote of support from the Iowa Medical Society's Board of Directors. ❁

A Capitol Christmas: Special Section Starts on p. 15

THE ROLL CALL
NEWSPAPER OF CAPITOL HILL
VOL. 39, MONDAY, DECEMBER 13, 1993 $2.50



A prominent plastic surgeon in Des Moines, Republican Greg Ganske (left) says he's running because he fears Rep. Neal Smith will embrace the Clinton Administration position on health care.

Physicians Line Up To Run in '94 Cycle

By Tim Curran

Nearly two dozen medical doctors — most of them Republicans — are planning bids for Congress next year, hoping to join just two physicians who now serve in the House.

Reps. Roy Rowland (D-Ga), a general practitioner, and Jim McDermott (D-Wash), a psychiatrist, are the only doctors who will bring practical medical experience to the health care debate that will dominate the second session of the 103rd Congress.

But the 104th could be different.

Morton Levine (R), for instance, is gunning to unseat Rep. Dan Hamburg (D) from the northern California district he won last year, but the only pediatrician in Lake County said last week he could not finalize a bid until he finds someone to take over his practice.

Greg Ganske (R), a plastic surgeon, wants to take on a cardinal,

Continued on page 12

Late Vote On Health Could Frame Election Day

By Tim Curran

With a final vote on health reform now almost certain to come just weeks before next November's elections, Democrats are saying privately

Continued on page 26

Medical Doctors Bid for Congress

To Join Only Two Current Physicians

Continued from page 1

Rep. Neal Smith (D-Iowa), an 18-term veteran and chairman of the Appropriations subcommittee on commerce, justice, state and judiciary.

Ganske, 44, is a prominent doctor in Des Moines who won an undergraduate degree in political science from the University of Iowa before going to medical school at Harvard.

As a doctor, Ganske said, he's used to solving problems. "When they walk out my door, they're fixed," he said. "I like to take a problem and see if I can help fix it."

'The issue of health care is much less complicated than the Administration would have you believe,' says Irwin Savodnik, a psychiatrist.

Like many of the other physician-candidates Roll Call contacted, Ganske cited health reform as a major concern but said it was no more important than such other issues as crime, the economy, and the debt. He promised to serve only a few terms before returning to his medical practice if elected.

Most of the physicians planning runs for Congress say they are skeptical about the Administration's ability to tackle health care responsibly.

Levine cited Hamburg's cosponsorship of single-payer legislation as a reason for his challenge. "The present incumbent scares me," Levine said last week, branding Hamburg "a socialist."

"I thought the voice of a conservative should be heard," said Levine, who favors, with some modifications, the managed-competition approach of Rep. Jim Cooper (D-Tenn).

But Levine could have trouble next year in a primary if former Rep. Frank Riggs (R) launches a rematch, or in a general against Hamburg in a district that gave Bill Clinton a 17-point win last year.

Irwin Savodnik is a Torrance, Calif., psychiatrist angling for the GOP nomination to face freshman Rep. Jane Harman (D) in a swing district.

"Health care was certainly one of the things" drawing him into the race, Savodnik told Roll Call last week, but he was also energized by the 36th district's high unemployment rate.

"The issue of health care is much less complicated than the Administration would have you believe," he said. Savodnik criticized the Administration's plan "to take control of the entire enterprise" of American health care, warning that the result will be that doctors will "lose a great deal of autonomy and their patients will not enjoy the same level of care."

Like many of the physicians planning bids, Savodnik is prepared to use his personal financial resources to boost his campaign. "We've put in about $280,000 and we're prepared to go beyond that," he said. "I think we're going to have to spend more than $1 million."

Harman spent $2.3 million last year, most of that from her own pocket, and Savodnik will also likely face a contested primary.

Brenda Fitzgerald (R), an obstetrician/gynecologist, is making her second run for Congress. About six weeks ago, she closed down her Carrollton, Ga., practice to campaign full-time for the nomination to face Rep. Buddy Darden (D).

Last year, Fitzgerald, 47, lost a primary for the same seat but feels her health care expertise will be an asset this time around. The nomination to face Darden will be a rich prize, as the incumbent will be high on GOP target lists after voting for the Clinton budget and against revealing names on discharge petitions.

"The Clinton health plan will destroy the ability of doctors to take care of patients in the best way," Fitzgerald said. "I think we have to have a system of personal health ownership" where consumers "make their own personal decisions."

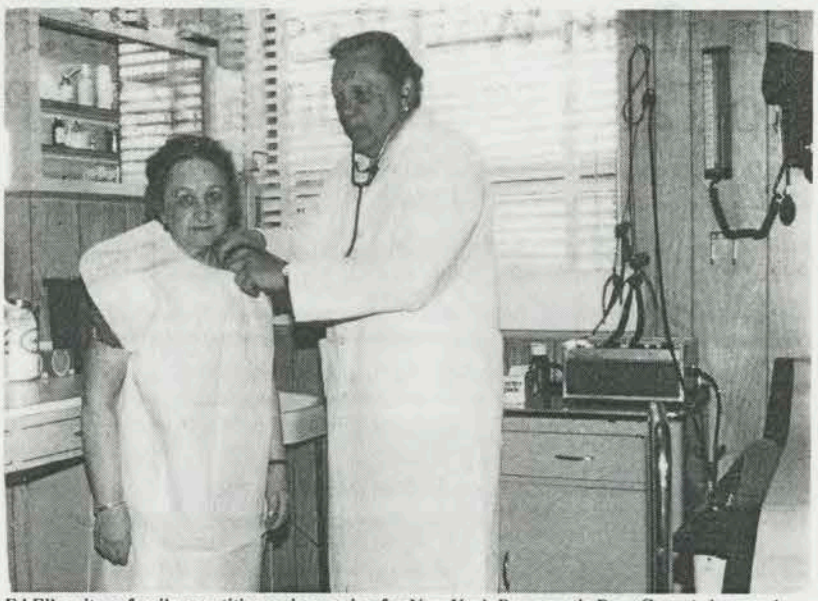
Fitzgerald, who will be the only woman in a crowded primary that includes former US Attorney Bob Barr, said the "other important thing about being a doctor is that most of us are small business people" who must also be employers schooled in the tax structure and business regulation issues.

She argues that her experience also ties into another key issue. As a doctor, Fitzgerald said she has "seen firsthand the impact on victims" of crime and violence and recognizes the need to "take the strongest measures possible so that we will be safe at home and on the streets."

John Steel said he is willing to give up his spot as chief of staff at Scripps Memorial Hospital in San Diego because he's "just mad as hell about what's going on."

Hoping to take on another freshman, Rep. Lynn Schenk (D), Steel railed against her vote for Clinton's budget and said, "My vote, had I been there, would have tied it and thrown it out of the House."

Brenda Fitzgerald has already shut down her gynecological practice in Georgia to gear up for a bid for the GOP nod to face Rep. Buddy Darden. "The Clinton health plan will destroy the ability of doctors to take care of patients in the best way," she says.



Ed Elkowitz, a family practitioner, is gunning for New York Democratic Rep. Gary Ackerman's seat and hoping to join the two other medical doctors who serve in the House now.

Steel, a Navy jet pilot before going to medical school, called the Clinton health plan "the biggest socialized push I've ever seen" and echoed Fitzgerald's sentiment that if it passes, both doctors and patients will see "freedoms removed."

John Steel is giving up his chief of staff job at a San Diego hospital because he's 'just mad as hell about what's going on.'

"I'm just very upset. I have a lot invested in this country," Steel said. "There's nobody like me behind Hillary's closed doors who understands this," he said.

Perhaps the best known of the physicians eyeing a seat in Congress is Bernadine Healy, a cardiologist and director of the National Institutes of Health in the Bush Administration who is seeking to replace retiring Sen. Howard Metzenbaum (D-Ohio).

Healy will have a tough road, and her fledgling campaign fell flat on its face recently when three of her staffers were implicated in the misappropriation of the state GOP's donor list and forced to resign.

She has already benefited from the focus on health care, however, and was much in demand on both the national and state talk-show circuit when details of the Clinton plan first emerged.

Lt. Gov. Mike DeWine (R), coming off an unsuccessful campaign against Sen. John Glenn (D), is the favorite for the GOP nomination, and state Sen. Gene Watts is also running. Another GOP physician joined the race for the nomination recently, when David D. Nitzsche filed campaign documents.

In Tennessee, Bill Frist (R), a surgeon and director of the Vanderbilt University organ transplant center, is looking to win the nomination next year to face Sen. Jim Sasser (D), the Budget Committee chairman. Frist's reputation as an expert on health care cuts across partisan lines: Gov. Ned McWherter (D) appointed Frist to head his task force on Medicaid reform last year. He's an underdog, but the emphasis on health care in next year's elections can only help him.

Democrats also have a handful of physicians running, including gastroenterologist David Doman in Maryland's 8th district, where he'll be hard-pressed to take out popular Rep. Connie Morella (R).

Other Democratic contenders include Stewart Turnanski, an underdog to succeed Rep. Jon Kyl (R-Ariz), and Joseph Randolph, facing an uphill climb to succeed Rep. Rick Santorum (R-Pa).

Other Republican doctors planning House campaigns include: Edward Miller, seeking the nod to take on Rep. Ed Pastor (D-Ariz); family practitioner Ed Elkowitz, who's bidding for Rep. Gary Ackerman's (D-NY) seat; and internal medicine specialist Noel Collis, bidding to unseat Rep. Collin Peterson (D-Minn).

Also, immunologist and emergency specialist Kevin Vigilante, in the open-seat race to replace Rep. Ron Machtley (R-RI); orthopedic surgeon John Elliott, in the race against Rep. Jack Reed (D-RI); Dr. Eugene Fontenot, who is also a lawyer, in the open-seat contest to follow Rep. Mike Andrews (D-Texas); and oral surgeon John Farnham, who will run for the nomination against Independent Rep. Bernie Sanders in Vermont.

In Georgia, Charles Norwood (R) is trying to become the third dentist in the House, joining Reps. Ron Packard (R-Calif) and Rep. John Linder (R-Ga). He faces a primary for the right to face freshman Rep. Don Johnson (D), who has been widely criticized for supporting the Clinton budget. Maryland state Del. Ron Franks (R), running to face Sen. Paul Sarbanes (D) is also a dentist.

ANDY EVANS, Iowa Editor
MICHAEL WEGNER, Metro Editor, 515-284-8065

The Des Moines Register

METRO
AND IOWA NEWS

WEDNESDAY, JANUARY 12, 1994 SECTION M

★★★★

ALLY FOR SENIORS
veteran police detective will run a new program for Des Moines' senior citizens
page 3M

HERE COMES THE JUDGE
Mark Cady, a Drake grad, becomes the youngest judge of the Iowa Court of Appeals.
Page 6M

Metro RECORD

One found dead; fumes suspected

One person was found dead and another person was found alive but injured early today in a house at 1321 E. 33rd St. in Des Moines early today.

The names of the victims were not immediately available.

Police said initial reports from officers indicated that the two people may have been poisoned by carbon monoxide inside the house.

One officer on the scene told commanders by radio, "It might be fumes, although we don't smell anything. We're going to keep checking."

Police were notified shortly before 1 a.m. today. The call for help came from someone inside the house, police said.

Officer, soldier of year named by Guard

Sgt. Carolyn Tenney of Des Moines has been named non-commissioned officer of the year by the Iowa Army National Guard.

Spec. Mark Fischer of Des Moines was named the Guard's soldier of the year.

Tenney, 39, is a journalist with the 185th Public Affairs Detachment at Camp Dodge in Johnston. In addition

Branstad courts GOP constituencies

Recognizing his core base of support and facing a primary election battle, the governor sounds conservative themes.

NEWS ANALYSIS

By DAVID YEPSEN
Register Staff Writer

Gov. Terry Branstad used his speech Tuesday on the condition of the state to court the Republican constituencies he needs to win his June primary fight with U.S. Rep. Fred Grandy.

While Statehouse politicians disagreed over the policies he proposed, they all gave him high marks for the electioneering he did with the speech — which was broadcast live to voters over state-owned public television and radio stations.

"He certainly took a more conservative tack through that speech than he has in the last couple of years. He was trying to make every conservative happy," said Rep. Mary Lundby, a Marion Republican who has endorsed Grandy. "It will serve him well."

House Majority Leader Brent Siegrist, a Council Bluffs Republican, said, "The primary voter is going to be comfortable with this speech. He solidified his base. At this point, this race is the governor's to lose. He's the incumbent."

Republican primaries are won by putting together coalitions of conservatives, evangelicals and rural voters. In his speech, Branstad veered to the right and wooed them all by:

- **Invoking numerous references to God.** He opened the address by describing how he was reading the Bible as he prepared his speech. It was all a clear move to court evangelical voters influenced by the Christian Coalition. Polls show half of the state's registered Republicans consider themselves to be evangelicals or born-again Christians.

State Rep. Steve Grubbs, a Davenport Republican who is leaning toward endorsing Branstad said: "He had references to the Bible, which the family values folks like. He's definitely reaching out to groups in the Republican primary coalition."

In addition, Branstad courted the religious right by not discussing women's issues.

"There was no reference to women's issues," Lundby said. "We've been struggling along with the ERA and issues crucial to women and there was no mention of women's issues."

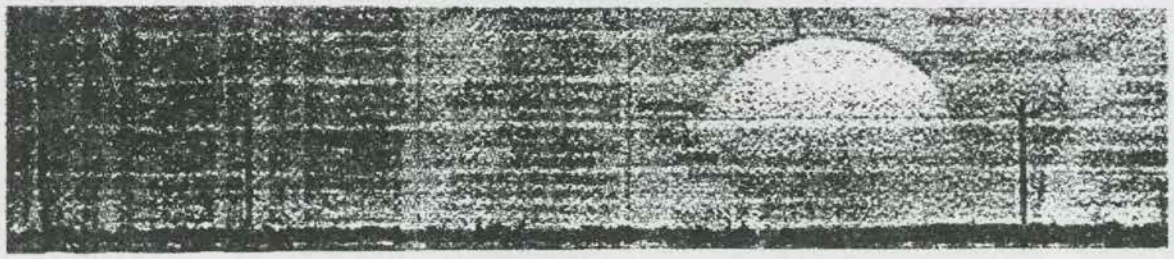
- **Not mentioning gambling.** Many on the religious right oppose expanded gambling. Yet key GOP business leaders in some of Iowa's larger communities support it.

"The fact he left out gambling was significant," Grubbs said. "As you talk to primary voters, it's clear he's caught in a crossfire on gambling."

- **Calling for property tax freezes and ethanol development.** The Iowa Farm Bureau Federation, an important GOP constitu-

ANALYSIS *Please turn to Page 5M*

WINTER ON THE PLAINS



PUBLIC HOUSING INQUIRY

Report finds no cronyism

Opinions vary on the cure for health care's ills

By Rod Boshart
Gazette Des Moines Bureau

DES MOINES — State lawmakers agree with the diagnosis that Iowa's health care system is ailing, but they enter this year's session widely divided on the best cure or whether they could afford to fund the prescription for change.

Reform proponents say the state must move forward with a health care plan this year that widens coverage for an estimated 288,000 uninsured Iowans, further contains costs and addresses Iowa's unequal treatment under federal Medicare rules.

■ Fourth in a series

Others agree that change is needed but are reluctant to embark on a costly overhaul without some indication of what Congress intends to do with President Clinton's health care plan.

More on the 1994 legislative preview:
■ Changes in adoption laws are likely, 1B

Critics fear that lawmakers will be forced to settle on a modest approach that looks good in election-year campaign brochures but does little to attack chronic problems of access, affordability and quality.

Finding a health care solution that will fit in with federal reforms being studied in Washington is one of a host of thorny social issues that could further divide the split-control Legislature.

Included among those controversial issues languishing from last year are parental notification in cases where minor girls seek an abortion, reinstating the death penalty and a host of others likely to flare during an election-year session.

Rep. Phil Tyrrell, R-North English, said he

■ Turn to page 4A: Legislature

AT-A-GLANCE

Here are highlights of the health care reform package that Gov. Terry Branstad intends to recommend to legislators when the Iowa General Assembly convenes next week:

- Require insurance companies to offer a basic package of benefits to allow consumers the chance for comparison shopping; the package would have to include offering preventive health care with a co-payment from the purchaser based on a modified community rating of insurance.
- Require all businesses to offer a basic health care plan to workers, but the businesses would not be required to pay for coverage.
- Encourage creation of voluntary health care purchasing networks to obtain coverage at better rates for smaller businesses and individuals.
- Require that insurance coverage be portable and continuous, without exclusions, waiting periods or new health underwriting or reviews to help Iowans who change jobs avoid losing their coverage.
- Simplify the claims process, allow electronic filing and use of standardized forms, and establish new accounting and auditing procedures to gather information on cost and quality of health care systems.

CR. Gazette

[redacted] Medical center spokeswom- she said. "At this point, we

3:00

MEMORANDUM

DATE: January 12, 1994

FROM: Rolf Th. Lundberg, Jr. Rolf

TO: Senator Dole

SUBJECT: Len Hadley of Maytag Corporation

He will be at the Iowa Eagle event tomorrow, Thursday, January 13.

FYI, you helped Maytag, and Sen. Grassley, during the NAFTA debate. You pressed USTR to obtain Mexico's consent to early negotiations to accelerate the reduction of the Mexican tariff on home appliances. Mexico agreed, and negotiations will begin soon.

THE REPUBLICAN PARTY OF IOWA

MEMORANDUM

TO: Joanne Coe
FROM: Terri Hasselman
DATE: January 11, 1994
RE: Update on attendees for events

Eagle Event: 3:00 to 4:00 p.m.

John Ruan	
Hal Manders	
Steve Roberts	
Clark and Phyllis Kelly	
Sharon Sievers	Iowa Bankers Association
Neil Milner	Iowa Bankers Association
Max Isaacson	CEO, Americas Best Inc.
Len Hadley	Maytag
David Stanley	Iowans for Tax Relief
Larry Miller	
Herman Kilpper	
John Ruan III	
Robb Kelley	retired CEO of Employees Mutual Co.
Ross Sidney	Atorney

Event from 4:00 - 5:00 p.m.

Dick Olson	Principal Financial Agency Office
Dr. Mike Richards	Heart Surgeon
Gov. Bob Ray	CEO, Blue Cross/Blue Shield
Dr. Greg Ganske	Surgeon, Candidate for Congress
Keith West	Administrator, Evergreen Health Care
Pat Barry	Attorney, Principal Financial
Eldon Huston	President, Iowa Medical Society
Tim Gibson	Ex. Dir., Iowa Medical Society
Paul Bishop	Lobbyist, Iowa Medical Society
Hal Manders	
Steve Roberts	
Dr. and Mrs. Clark Kelly	(Phyllis)
Dr. and Mrs. Tom Kelly	(Donna)
Dr. and Mrs. Dirk VerSteeg	(Adele)
Dr. and Mrs. Young Oliver	(Katherine)
Jim Greenfield	Ex. Dir., Republican Party of Iowa

Staff: Gina Noll, Carolyn McGoldrick, Kathleen Masteller, Terri Hasselman

3:00

January 12, 1994

M E M O R A N D U M

TO: SENATOR DOLE

FROM: DENNIS SHEA

SUBJECT: IOWA TRIP--BANKING

As you know, you are scheduled to meet with Sharon Sievers and Neil Milner of the Iowa Bankers Association. Some issues they may raise with you:

1. **Community Reinvestment Act Reform.** On December 8, 1993, in response to a request from President Clinton, the federal bank regulatory agencies proposed a major revision to the Community Reinvestment Act ("CRA") regulations. The proposal contains a streamlined CRA examination system for banks with under $250 million in assets. This is designed to reduce the regulatory burden on community banks.

However, under the streamlined procedures, for community banks to be rated "satisfactory" for CRA purposes, they must have a loan-to-deposit ratio of at least 60%. Community bankers claim that the use of this 60% ratio, or any fixed ratio, fails to take into account other relevant factors such as local and regional economic conditions and loan demand.

Community bankers want to delete the ratio and use a "reasonableness" standard instead. The regulations have been published in the Federal Register and are now subject to a comment period.

2. **Regulatory Consolidation.** The Administration is advocating legislation that would abolish the Office of Thrift Supervision (OTS) and the Office of the Comptroller of the Currency (OCC) and consolidate the regulatory functions of the FDIC and the Federal Reserve Board into a new super-agency called the **Federal Banking Commission.** The Federal Banking Commission would have five members--a chairman appointed by the President; the Secretary of the Treasury; the Chairman of the Federal Reserve Board; an outside member from the President's own party; and an outside member from the opposition party. In a sense, four of the five members of the proposed Federal Banking Commission are "political."

Many small bankers, including the Independent Bankers, support the current regulatory structure, with the exception of the merger of the OCC and the OTS under the Treasury Department.

Another concern: Do we really want to concentrate all this regulatory authority in a single bank regulator--the Federal Banking Commission? Look at Clinton's record with the S&L

industry when he was governor of Arkansas.

3. **Community Development Banks.** The Banking Committee has reported the Administration's "community development bank" proposal. Senator D'Amato supports Riegle's efforts.

The bill authorizes $382 million over four years for a Community Development Financial Institutions Fund (the "Fund"). The Fund is designed to provide financial assistance to organizations whose "primary mission is community development." These organizations may include credit unions, minority-owned banks, and "micro-enterprise" funds. The bill also includes a number of provisions designed to reduce the paperwork burden on banks. In addition, the bill incorporates Senator D'Aamto's proposal to allow banks to package loans to small businesses and sell the package of loans as securities.

Senators Mack and Shelby will probably offer a series of floor amendments designed to provide the banking industry with greater regulatory relief. <u>You can also offer as amendments provisions taken from your bill, the Credit Crunch Relief Act</u>. Please see attached summary.

STATEMENT OF SENATOR BOB DOLE
CREDIT CRUNCH RELIEF ACT OF 1993
JUNE 24, 1993

MR. PRESIDENT, LATER TODAY, THE SENATE WILL ADOPT THE LARGEST TAX PACKAGE IN AMERICAN HISTORY--A WHOPPING $264 BILLION.

NO DOUBT ABOUT IT, WITH MAJOR TAX INCREASES LOOMING ON THE HORIZON, THE AMERICAN PEOPLE ARE UNCERTAIN ABOUT THEIR ECONOMIC FUTURE. AND, UNTIL THIS UNCERTAINTY GIVES WAY TO CONFIDENCE, THEY ARE POSTPONING THE HIRING, SPENDING AND INVESTMENT DECISIONS THAT COULD GIVE THE ECONOMY A MUCH-NEEDED JUMP-START. THIS IS A BIG REASON BEHIND OUR SLUGGISH ECONOMY.

ANOTHER REASON IS THE LACK OF AVAILABLE CREDIT, PARTICULARLY FOR SMALL BUSINESSES. UNFORTUNATELY, REGULATORY BURDENS AND OVERLY-RESTRICTIVE EXAMINATION PRACTICES BY THE BANK REGULATORS HAVE DISCOURAGED BANKS FROM MAKING EVEN PRUDENT LOANS, THEREBY CHOKING OFF CAPITAL TO CREDITWORTHY BUSINESSES AND FARMS. THE RESULT IS FEWER JOBS AND LESS ECONOMIC GROWTH.

THAT'S WHY I AM JOINING TODAY WITH MY DISTINGUISHED COLLEAGUE FROM NEW YORK, IN INTRODUCING THE CREDIT CRUNCH RELIEF ACT OF 1993. THIS IMPORTANT LEGISLATION OUTLINES A SIX-POINT PLAN TO HELP EASE CREDIT, REDUCE THE UNNECESSARY REGULATORY BURDENS ON OUR STRONGEST BANKS, AND PUT OUR COUNTRY BACK ON THE ROAD TO ECONOMIC RECOVERY.

"MINIMAL DOCUMENTATION" LOANS

THE FIRST PROVISION WOULD ALLOW THE STRONGEST BANKS TO MAKE LOANS TO SMALL BUSINESSES WITHOUT HAVING TO FULFILL ALL THE PAPERWORK REQUIREMENTS THAT BANK EXAMINERS NORMALLY REQUIRE. THESE REQUIREMENTS ARE OFTEN UNNECESSARY, PARTICULARLY WHEN A BANK WOULD LIKE TO EXTEND CREDIT TO AN INDIVIDUAL OR AN INSTITUTION WITH A LONGSTANDING REPUTATION OF CREDITWORTHINESS WITHIN THE LOCAL COMMUNITY.

TO PROVIDE SOME SAFEGUARDS, THE TOTAL OF THE "MINIMAL DOCUMENTATION" LOANS AT A SINGLE INSTITUTION WILL BE LIMITED TO 40 PERCENT OF ITS TOTAL CAPITAL. NO INDIVIDUAL LOAN MAY EXCEED $900,000 OR 5% OF THE LENDING INSTITUTION'S TOTAL CAPITAL, WHICHEVER IS LESS. THE FEDERAL BANKING REGULATORS MAY ALLOW A BANK TO EXCEED THESE LIMITS, CONSISTENT WITH SAFETY AND SOUNDNESS CONSIDERATIONS.

THIS PROVISION REFLECTS THE VIEW OF PRESIDENT CLINTON, WHO RECENTLY ORDERED THE FEDERAL BANKING REGULATORS TO ALLOW THE STRONGEST BANKS TO MAKE "MINIMAL DOCUMENTATION" LOANS. I COMMEND THE PRESIDENT FOR HIS LEADERSHIP ON THIS ISSUE. BY GOING THE STATUTORY ROUTE, RATHER THAN RELYING EXCLUSIVELY ON REGULATORY ACTION, THIS PROVISION GIVES THE PRESIDENT'S DIRECTIVE SOME ADDED PUNCH.

PRESIDENTIAL AUTHORITY

THE SECOND PROVISION IS ALSO AIMED AT GIVING THE PRESIDENT THE TOOLS HE NEEDS TO GET THE JOB DONE. SPECIFICALLY, IT VESTS WITH THE PRESIDENT THE AUTHORITY TO SUSPEND ANY BANK STATUTE OR REGULATION THAT HE DETERMINES IS UNNECESSARY, IMPOSES COSTS THAT OUTWEIGH ITS BENEFITS, OR HAS A NEGATIVE IMPACT ON THE AVAILABILITY OF CREDIT. THIS PROVISION WAS INTRODUCED EARLIER THIS YEAR BY SENATOR D'AMATO AS THE PRESIDENTIAL CREDIT AVAILABILITY AND ECONOMIC RECOVERY ACT.

PRESIDENT CLINTON HAS SPOKEN ELOQUENTLY ABOUT THE NEED TO "REINVENT GOVERNMENT" AND FOR A MORE RATIONAL APPROACH TO REGULATION, PARTICULARLY BANKING REGULATION. THIS PROVISION WILL HELP THE PRESIDENT ACCOMPLISH THIS IMPORTANT GOAL: IF HE BELIEVES THAT A PARTICULAR BANKING REGULATION RESTRICTS THE AVAILABILITY OF CREDIT, THEREBY SLOWING ECONOMIC GROWTH, THE PRESIDENT WILL HAVE THE UNDISPUTED AUTHORITY TO SUSPEND THAT LAW'S APPLICATION.

COMPLIANCE WITH THE COMMUNITY REINVESTMENT ACT

THE THIRD PROVISION ESTABLISHES A STATUTORY PRESUMPTION THAT A BANK IS MEETING THE CREDIT NEEDS OF ITS COMMUNITY AND IS IN COMPLIANCE WITH THE COMMUNITY REINVESTMENT ACT, IF THE BANK HAS RECEIVED A CRA RATING OF "SATISFACTORY" OR "OUTSTANDING" IN THE MOST RECENT EVALUATION OF ITS RECORD. THIS PRESUMPTION IS REBUTTABLE BY "CLEAR AND CONVINCING" EVIDENCE THAT A COMMUNITY'S CREDIT NEEDS ARE NOT BEING MET.

WHEN A BANK SEEKS TO BUY A NEW BRANCH OFFICE, IT SHOULD NOT HAVE TO RELITIGATE THE ISSUE OF CRA COMPLIANCE IF IT ALREADY HAS A "SATISFACTORY" OR "OUTSTANDING" CRA RATING. MANY BANKERS WONDER WHY THEY SEEK A CRA RATING IN THE FIRST PLACE, IF THE ISSUE OF COMPLIANCE IS RELITIGATED AGAIN...AND AGAIN...AND AGAIN. A STATUTORY PRESUMPTION OF CRA COMPLIANCE WOULD HELP PREVENT NEEDLESS LITIGATION AND ULTIMATELY REDUCE COSTS FOR BANK CONSUMERS.

REGULATORY IMPACT STATEMENT

THE FOURTH PROVISION PROHIBITS EACH OF THE FEDERAL BANKING REGULATORS FROM ISSUING NEW REGULATIONS UNTIL THE AGENCY HAS CONDUCTED AN ANALYSIS OF THE IMPACT OF THE REGULATION ON SMALL BANKS AND CONSUMERS, INCLUDING SMALL BUSINESS BORROWERS. BEFORE A PROPOSED REGULATION BECOMES EFFECTIVE, THE BENEFITS OF THE REGULATION MUST OUTWEIGH ITS COSTS.

MR. PRESIDENT, THIS MAY SOUND LIKE COMMON SENSE, BUT COMMON SENSE IS OFTEN A RARE COMMODITY IN WASHINGTON.

DELAYING THE EFFECTIVE DATE OF SECTION 132

THE FIFTH PROVISION DELAYS, UNTIL JANUARY 1, 1996, THE

EFFECTIVE DATE OF SECTION 132 OF THE FEDERAL DEPOSIT INSURANCE CORPORATION IMPROVEMENT ACT OF 1991. SECTION 132 REQUIRES FEDERAL REGULATORS TO SET NATIONAL STANDARDS FOR A WIDE ARRAY OF INTERNAL BANK PROCEDURES--ALL REGARDLESS OF WHETHER THESE STANDARDS ARE APPROPRIATE FOR INDIVIDUAL INSTITUTIONS.

ALTHOUGH ORIGINALLY DESIGNED AS A REFORM MEASURE, SECTION 132'S "ONE-SIZE-FITS-ALL" APPROACH TO BANK PROCEDURES COULD HAVE A NEGATIVE IMPACT ON BANK LENDING. AS FEDERAL RESERVE BOARD CHAIRMAN ALAN GREENSPAN RECENTLY EXPLAINED, AND I QUOTE: "THE NECESSARY REGULATORY RESPONSE...AND THE ANTICIPATED INDUSTRY RESPONSE TO THE NEW REGULATIONS HAVE AND WILL DIVERT SCARCE RESOURCES AT REGULATORY AGENCIES, ADD TO THE REGULATORY BURDEN ON THE INDUSTRY, AND CREATE UNCERTAINTIES, ALL OF WHICH REDUCE THE INCENTIVES OF BANKERS TO TAKE ON RISK, PERHAPS EVEN REASONABLE BUSINESS RISK."

DELAYING THE EFFECTIVE DATE OF SECTION 132 WILL GIVE BANKS, PARTICULARLY COMMUNITY BANKS, MORE TIME TO GRAPPLE WITH THE NEW REGULATORY REQUIREMENTS. THIS WILL HOPEFULLY REDUCE THE UNCERTAINTY AND SPUR PRUDENT LENDING.

CONSUMER SURVEYS

THE SIXTH AND FINAL PROVISION DIRECTS EACH FEDERAL BANKING REGULATORY AGENCY TO CONDUCT A SURVEY OF BANK CUSTOMERS TO DETERMINE WHETHER THOSE LAWS THAT CONGRESS DESIGNED TO PROTECT CONSUMERS ARE, IN FACT, ACHIEVING THEIR INTENDED GOALS. THE LAWS THAT WILL BE SURVEYED INCLUDE THE TRUTH-IN-SAVINGS ACT, THE TRUTH-IN-LENDING ACT, AND THE COMMUNITY REINVESTMENT ACT. THE SURVEYS MUST BE COMPLETED WITHIN SIX MONTHS OF THE ENACTMENT OF THIS BILL.

ALL TOO OFTEN, CONGRESS PASSES LAWS UNDER THE BANNER OF "CONSUMER PROTECTION" WITHOUT HAVING A CLEAR SENSE OF WHETHER THESE LAWS WILL WORK AS ADVERTISED. I SUSPECT THAT SOME CONSUMER PROTECTION LAWS ACTUALLY END UP HARMING CONSUMERS IN THE LONG-RUN, AS THE ADDITIONAL COSTS OF REGULATION ARE PASSED ON TO THEM. TO DETERMINE WHETHER BANK CONSUMERS ARE, IN FACT, BENEFITTING FROM THE LAWS WE PASS, CONGRESS AND THE REGULATORS SHOULD DO WHAT ANY BUSINESS WOULD DO--CONDUCT A SURVEY AND ASK THE CONSUMERS THEMSELVES.

WON'T END THE CREDIT CRUNCH OVERNIGHT

MR. PRESIDENT, THESE PROPOSALS WON'T END THE CREDIT CRUNCH OVERNIGHT, BUT THEY ARE A STEP IN THE RIGHT DIRECTION. WE ALL AGREE THAT REGULATION IS NECESSARY TO PROTECT THE TAXPAYERS FROM THE COSTS OF BANK FAILURES AND TO PROTECT CONSUMERS FROM THE UNSCRUPULOUS PRACTICES OF THE FEW BAD APPLES IN THE BANKING BUSINESS. BUT REGULATION SHOULD NEVER BE AN END IN ITSELF, AND IT SHOULD NEVER ACT AS AN OBSTACLE TO ECONOMIC GROWTH, ABSENT VERY STRONG JUSTIFICATIONS.

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MR. PRESIDENT, I ASK UNANIMOUS CONSENT THAT THE FULL TEXT OF THE CREDIT CRUNCH RELIEF ACT OF 1993 AND AN EXECUTIVE SUMMARY OF THE ACT BE INSERTED IN THE RECORD IMMEDIATELY AFTER MY REMARKS.

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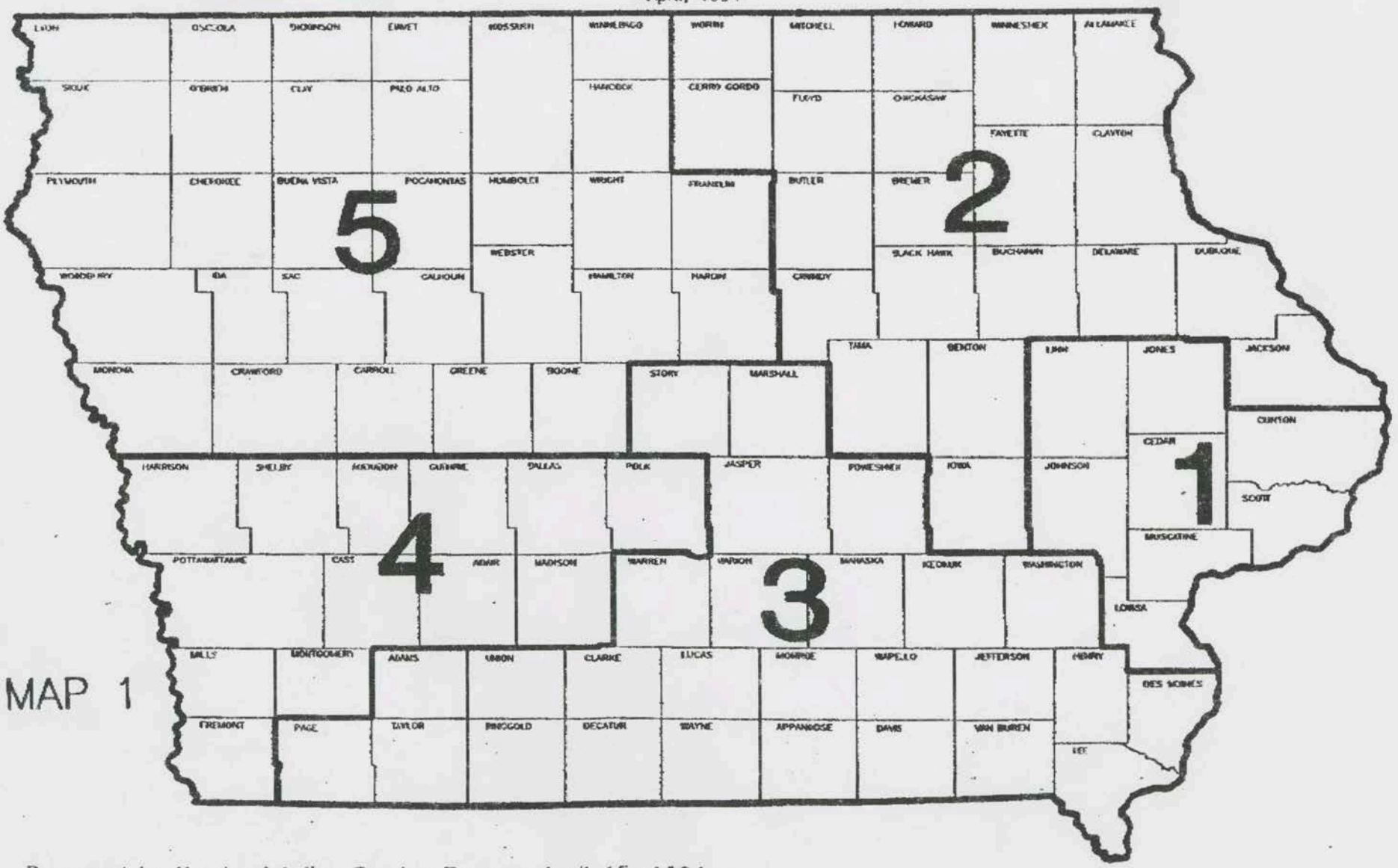
[redacted] CONGRESSIONAL REDISTRICTING PLAN

April, 1991



MAP 1

Perpared by the Legislative Service Bureau, April 15, 1991.

M E M O R A N D U M

January 7, 1994

TO: Joyce & Jo-Anne

FROM: Tyler

SUBJECT: Mayo Clinic Details

-- I spoke with Susan Laging, Dr. E.R. Dickson's Assistant, yesterday regarding the details of the Senator's appointment on Friday, January 14. Susan has arranged for Helen Mundahl to greet the Senator at the airport when he arrives on the 13th and drive him to the Kahler Plaza Hotel. She will go over all the details of the examination with him then. The hotel is 20 minutes from the airport and attached to the Clinic by a covered walk. Helen will meet the Senator at the hotel at 8:00 a.m. on the 14th and walk him over to the Clinic. Susan expects the Senator to be busy until at least 4:00-4:30 p.m.

Jo-Anne is going to call Susan to discuss arrival and departure flight times.

Attached is a copy of his appointment confirmation, billing information and pre-examination information.

Yvonne has given them your insurance information.

Mayo Clinic

Rochester, Minnesota 55905 Telephone 507 284-2511

Appointment Office

December 29, 1993

4-330-894

Mr. Robert Dole
Apartment 112
700 New Hampshire Avenue
Washington, DC 20037-2406

Dear Mr. Dole:

We are pleased to confirm that an appointment has been scheduled for you on Friday, January 14, 1994. Your examination will be conducted in the Division of Gastroenterology by Dr. E. R. Dickson.

The enclosed admission card is to be presented as indicated. If this appointment cannot be kept, please notify us promptly so that the time reserved may be assigned to another patient.

Please carefully follow the enclosed pre-examination fasting instructions as this may save considerable time during the course of your examination.

Please be aware that Mayo Clinic and its affiliated hospitals, Saint Marys and Rochester Methodist, are smoke-free institutions. Smoking is not permitted in any Mayo facility or on Medical Center grounds.

If you have any questions concerning this appointment, please contact us at (507) 284-8700.

Sincerely,

Pat Burns

For Mrs. Susan S. Laging

ssl
Enclosure(s)

Pre-examination Instructions

Pre-examination Fasting

By following these instructions, you may be able to shorten the time required for your examination:

24 hours before your appointment . . .

- Abstain from alcohol.

On the evening before your appointment . . .

- **Eat your evening meal before 7 p.m.** Avoid foods containing fat, such as butter, margarine, cream, whole milk, ice cream, oils, salad dressing, gravy, fatty meats, & fried foods. You may drink as much fluid as you wish with your evening meal. If you have diabetes, follow your usual diet.
- **After your evening meal, eat no food** until your examination is completed the next morning. If you have diabetes and are taking insulin or a diabetes pill, eat your bedtime snack as usual, but avoid foods containing fat.
- Prior to midnight, you may drink an unlimited quantity of water, black coffee or tea without cream or sugar.
- After midnight, drink nothing except one cup (8 ounces) of water upon waking the morning of your examination. You should drink this cup of water prior to 7:30 a.m. After 7:30 a.m. restrict your intake of water to occasional sips.
- **Continue to take your usual medications.**
- If you have diabetes and are taking insulin or a diabetes pill, take your insulin or diabetes pill and eat breakfast on the morning of your appointment unless a prescheduled test indicates otherwise. (Follow the instructions on the envelope for the test. Do not take your insulin or diabetes pill on the morning of the test until after the test is completed.)
- If you are scheduled for other tests or examinations, you may be instructed to further limit your consumption of fluid and food. **Follow the most strict limits for fluids and food for any of your examinations.**

Current Medications

If you are currently taking medications, please bring the names and dosages of those medications when you come to Mayo Clinic. You can obtain that information from the physician who prescribed the medication or from the pharmacist who filled the prescription.

X-rays From Home

If you wish to provide x-rays from home, please ask your physician to select only those films pertinent to your present medical condition.

MC 1254-5/R893

state may require you to get pre-authorization before receiving services at Mayo. A pre-service deposit is required for services not pre-authorized.

Mayo is unable to provide service (except in emergency situations) to Medicaid patients from states other than those listed without a written guarantee of payment of full billed charges from the State Medical Assistance Office.

Disability Insurance

"Loss of time" waiver of premium and loan payment claims will be filed by a patient accounts representative. Please provide the dates of your claimed disability in addition to your disability insurance information.

Based on your medical condition, your physician will determine the length of your disability.

Workers' Compensation

Before you receive services at Mayo, you may need to get prior approval from your workers' compensation insurance company. You are responsible for contacting your insurance company.

Mayo will file a workers' compensation claim on your behalf. Please supply your workers' compensation insurance information with the date and type of injury.

You may be responsible for portions of your account that workers' compensation does not pay. A Mayo patient accounts representative will help you file a claim for denied services with your health insurance carrier.

Payment

Mayo holds each patient personally responsible for his or her account. At the end of your medical center visit, you are requested to stop at the Cashier's Office (Desk N-1, Mayo Building), so we can present your bill. You will be asked for payment in full and/or to complete financial arrangements.

If hospitalized, we will ask you to pay an estimated balance of hospital charges not covered by insurance. If this is not possible, a satisfactory payment plan will be established.

Personal checks, Discover™, MasterCard™, American Express™ and Visa™ credit cards are accepted.

Federal regulations require Mayo Medical Center to file a report annually on all *cash* payments in excess of $10,000.

mayo

Mayo Medical Center

Division of Accounts Receivable
Rochester, Minnesota 55905

MC 1907/R993

About Your Bill...

Insurance and Payment Information

General Information

Mayo Medical Center consists of Mayo Clinic Rochester, Rochester Methodist Hospital and Saint Marys Hospital. Each facility bills for its own services.

Patient accounts representatives are available to help you file insurance claims at Cashiers Offices at all three locations. You also can reach a representative by calling the numbers listed below:

Mayo Clinic Rochester
(507) 284-2872

Rochester Methodist Hospital
(507) 284-1550

Saint Marys Hospital
(507) 284-1550

Medical and Hospitalization Insurance

Mayo will file insurance claims for you. Please supply the name, address and policy number of your insurance company.

Mayo cannot predict what insurance benefits will be paid by individual insurers because coverage varies among policies. Many insurance companies limit payments using "Usual, Customary and Reasonable" (UCR) allowances. This may not cover all Mayo charges because Mayo Medical Center does not accept usual and customary payments as payment in full. In addition, coverage may vary with hospitalization insurance plans. We suggest you check with your employer or insurance agent about coverage.

If you have coverage with more than one insurance carrier, it is your responsibility to coordinate billing and payment information with them.

If you do not have health insurance, you may be asked for a pre-service deposit.

Pre-certification, Pre-authorization and Second Surgical Opinion

To assure maximum coverage, many insurance companies and employer-group plans require an approval ("pre-authorization" or "pre-certification") before your doctor performs certain tests or admits you to the hospital. Your policy may also require a second opinion before your insurance company will agree to pay for a particular surgical procedure. It could be beneficial for you to check with your insurance company or employer about specific authorization requirements before your appointment.

You can receive help with all pre-authorization and pre-certification requirements at Hospital Pre-Admissions (Desk West-1), main floor of the Mayo Building, (507) 284-3980. Pre-certification is not a guarantee of coverage. Please contact your employer or your insurance company's customer service representative if you have questions about coverage. You are responsible for payment of services not authorized by your insurance company.

Medicare

Medicare has two billing components, *Part A* and *Part B*. *Part A* includes hospital charges and *Part B* includes physician charges.

Mayo is a participant in *Part A* Medicare, therefore, if you are hospitalized at Saint Marys Hospital or Rochester Methodist Hospital, your *Part A* claim will be filed with Medicare on your behalf. Medicare payments will be sent directly to the hospital, however, you will still receive an explanation of Medicare benefits. Hospital personnel will also file your supplemental hospital insurance claim on your behalf.

And although Mayo is a non-participating provider with *Part B* Medicare, they will file the *Part B* claim with Medicare on your behalf. *Part B* does not pay your claims directly to Mayo Clinic, instead payments are sent to you along with an explanation of Medicare benefits. You will also receive an itemized statement and supplemental claims filing instructions.

Please note on your Mayo itemized statement that a separate claim for clinical laboratory services will be submitted to Medicare. Clinical laboratory services are not charged to your personal balance at the time of billing. If the clinical laboratory services are covered, Medicare will make payments directly to Mayo. However, you are responsible to pay for clinical laboratory services that are not covered by Medicare.

Health Maintenance Organization (HMO)

If you are a member of an HMO, you may need to get pre-authorization before receiving services at Mayo. Please contact Mayo's HMO Referral Office at (507) 284-4366 for an appointment. You are responsible for payment of services not authorized by your HMO. A pre-service deposit is required for visits not pre-authorized.

Medical Assistance (Medicaid)

Mayo provides services to patients ("participants") with the state Medicaid programs of Minnesota, Iowa, Wisconsin, Michigan, North and South Dakota, Montana, and Nebraska. If you are covered by any of these programs, your

Appointment Card

mayo

Mr. Robert Dole 4-330-894

Please present this card at:
8:00 a.m. on Friday, January 14, 1994
Desk West 19, Nineteenth Floor, Mayo Building

You may be scheduled for tests or other appointments before seeing the physician.

To cancel your Mayo Clinic medical appointment, please telephone 507 284-8700 or check here ☐ and mail this card to the address below. Your cooperation lets us give your appointment time to another patient who is waiting.

Thank you,

GIWEST
Mayo Clinic is a smoke-free institution.

Mayo Clinic Appointment Office
Rochester, Minnesota 55905

12/29/93
MC 1005-03/R892

DES MOINES REGISTER PHONE INTERVIEW:

CALL GEORGE ANTHAN (202) 347-9111

Wants to discuss farm and Ag policy and the large role you have played in its development leading up to the 1995 farm bill. Depicting you as one of the single most important framers of ag policy in Congress since your House days.

* MIKE TORREY AND STACY TALKING POINTS ATTACHED

January 12, 1994

TO: Senator Dole

FROM: Mike Torrey

SUBJECT: Des Moines Register interview

Below is a summary of your involvement in farm program activities dating back to the 1970's.

OVERVIEW OF FARM BILLS

1973 FARM BILL
--The target price and deficiency payment concept was started this year. Also, an income supplement was placed on top of the loan rate which the farmer got in spite of crop prices.

1977 FARM BILL
--The Farmer Owned Reserve (FOR) was started. Also, target prices were increased. The 70's were a good year for exports. However, exports started to slack off and farmers asked that target prices be increased to help off set lost income.

1978 EMERGENCY ASSISTANCE ACT
--This was in response to the tractorcade. Essentially, it expanded credit programs for farmers and increased loan rates which was later regretted in that this move increased the price of U.S. grain on the world market.

1981 FARM BILL
--The Administration unsuccessfully proposed the elimination of farm programs. Looking back, 1981 was probably the worst Farm Bill. Both Target prices and loan rates were high. At the same time, the world economy went into a slump and the dollar was weak which eventually priced the U.S. grain out of the world market. Consequently, the U.S. started to build grain stocks. Two years later, PIK was instituted to get rid of surplus stocks. Basically, the bill was inflexible which made it difficult to respond to the farm crisis and the world economy.

1985 FARM BILL
--You were the primary author of this bill. It was a market oriented piece of legislation which decreased loan rates and froze target prices. In order to get rid of surplus grains, the Export Enhancement Program was stepped up. This was also the beginning of the green revolution for Farm Bill's. The Conservation Reserve Program was instituted and every farmer in the program was required to have a conservation plan in place. This bill cost $26.6 billion in 1986 but was eventually phased down to between $10-12 billion in 1990.

1990 FARM BILL

--This bill continued down the path of the 1985 farm bill. In addition, this legislation was on a two track process with the Budget Reconciliation Package. Target prices were again frozen and savings were picked up in the Budget package through triple base (15% of a farmers base does not receive government payments). The green revolution continued through the implementation of sod buster and swampbuster.

1995 FARM BILL OUTLOOK

--One of the messages in 1995 could be to simplify. The 1981 farm bill was 151 pages, the 1985 farm bill was 206 pages and the 1990 bill was 719 pages. Every year, the Congress keeps adding more and more requirements and regulations. In addition, some commons sense will be necessary. Alot of things have been tried over the years and by now we should have learned what works and what doesn't. Of course, the environment will be a big issue. We probably won't get a bill out of committee unless the environmentalist are happy with it. The bill will also face budget pressure and some will try to eliminate farm programs altogether. However, as long as the U.S. is competing against a world market that is subsidized, we have to provide a way for our own farmers to compete in this unfair trading atmosphere. Finally, the CRP ground will start to come out of production and decisions will have to be made regarding it's use.

DOLE ACCOMPLISHMENTS REGARDING FARM LEGISLATION

--Responsible for Reagan Administration decision to lift 1980 embargo on agricultural trade with the Soviet Union in April 1981.
--In 1983, proposed the use of surplus, government-owned commodities as bonuses to all foreign buyers of U.S. farm products (Export Enhancement Program).
--Supported adoption of the marketing loan concept for rice and cotton in the Farm Bill, and included marketing loan authority for wheat, feed grains, and soybeans.
--Strongly supported including the Conservation Reserve Program in the 1985 Farm Bill as a cost-effective and environmentally-preferable alternative to annual acreage set-aside and diversions.
--Long-time supporter of P.L 480 (the Food for Peace Program) and other international food assistance plans, and of domestic hunger and nutrition programs.
--Responsible for including no-cost sugar program in the 1985 Farm Bill.
--Strongly supported establishing voluntary check-off programs for major commodities, including wheat, corn, soybeans, dairy, beef, and pork, as effective "self-help" tools to increase domestic consumption and develop foreign markets for U.S. farm products.
--Strongly pushed the Administration to reduce paperwork to farmers by 50 percent by 1995.
*Spon. amendment in 90 F.B. allowing for only 12 studies

January 11, 1994

TO: SENATOR DOLE
FROM: STACY HOFFHAUS
SUBJECT: YOUR NUTRITION ROLE FOR DES MOINES REGISTER ARTICLE

FOOD STAMPS

* YOU HELPED OVERHAUL THE PROGRAM IN 1977 TO BETTER TARGET BENEFITS TO THE NEEDY (ELIMINATED PURCHASE REQUIREMENT AND SEVERAL DEDUCTIONS)

* 1981-2 YOU ACHIEVED SAVINGS IN THE FOOD STAMP PROGRAM THROUGH ERROR RATE SANCTIONS ON STATES, DELAYING INFLATION INDEXING, CONTROLS ON FRAUD AND ABUSE

(REMINDER - CONGRESS PASSED A MAJOR FOOD STAMP EXPANSION LAST YEAR AS PART OF BUDGET RECONCILIATION, BUT YOU WEREN'T INVOLVED)

SCHOOL LUNCH PROGRAM

* YOU HELD THE LINE ON CUTS IN THE EARLY 80'S; IN 1987 YOU HELPED PASS LEGISLATION TO MAKE GOVERNMENT COMMODITIES EASIER FOR SCHOOLS TO USE

TEFAP

* YOU WERE AN ARCHITECT OF THE EMERGENCY FOOD ASSISTANCE PROGRAM (TEFAP), ESTABLISHED TO DISTRIBUTE SURPLUS COMMODITIES (LIKE CHEESE) TO THE POOR. THE PROGRAM HAS DONATED SOME 7 BILLION POUNDS OF SURPLUS COMMODITIES. (BECAUSE SURPLUSES HAVE DRIED UP, CONGRESS NOW APPROPRIATES MONEY TO FUND TEFAP)

YOU SHOULD BE AWARE THAT ELLEN HAAS' ATTACK ON FAT IN THE SCHOOL LUNCH PROGRAM HAS COMMODITY GROUPS CONCERNED -- THEY THINK SHE'S GOING OVERBOARD.

1995 FARM BILL: IT'S TOO EARLY TO PREDICT WHAT THE FOOD STAMP ISSUES IN THE '95 FARM BILL WILL BE -- A LOT WILL DEPEND ON THE TIMING AND CONTENT OF WELFARE REFORM. HUNGER ADVOCATES GOT MOST OF THE BENEFIT LIBERALIZATIONS THEY WANTED IN LAST YEAR'S BUDGET BILL.

January 12, 1994

TO: Senator Dole

FROM: Mike Torrey

SUBJECT: EEP letter

An article appeared today in the Des Moines Register saying that Administration officials will meet on Friday to consider whether or not to continue the Export Enhancement Program. This meeting has been confirmed. Apparently, the interagency task force has already vetoed the EEP for pork to Russia. In your speech to the Iowa Pork Producers, you mention Iowa's efforts in getting the EEP approved in the first place. A few comments regarding this move may be necessary.

Meanwhile, Senator Grassley wants to send the attached letter objecting to the elimination of EEP and other export incentive programs.

DO YOU WISH TO SIGN THE LETTER?

_____ YES _____ NO

Talk Carry along

Called Mike Torrey with Senator's answer

United States Senate

WASHINGTON, DC 20510

January 12, 1994

The Honorable William Clinton
President of the United States
Washington, D.C. 20500

Dear Mr. President:

We understand that the Administration is currently reviewing all agricultural export assistance programs and may recommend to eliminate, or severely limit, export assistance under the Export Enhancement Program (EEP), the Sunflower Oil Assistance Program (SOAP)m the Cottonseed Oil Assistance Program (COAP) and the Dairy Export Incentive Program (DEIP).

Notwithstanding the successful conclusion of the GATT talks, we question the need for the United States to unilaterally disarm in such a fashion. U.S. export programs have helped create an $18 billion trade surplus. Moreover, the European Community (EC) is likely to increase their own subsidies between now and July 1, 1995 -- the date when the agreement goes into effect. Given that the EC insisted on a gradual reduction of export subsidies over six years, the EC will certainly subsidize greater quantities of commodities into the world market even after the agreement enters into force. Without a doubt, the EC will themselves utilize any and all export subsidy options available. It is only fitting and proper that the United States utilize all policy options available to fight predatory pricing and unfair trading practices of our competitors. Should the United States curtail the EEP, SOAP, COAP, and DEIP programs at this time, we would be abdicating our commitment to gaining market share for our farmers and ranchers, and cede valuable markets to our overseas competitors.

We urge the Administration to continue to aggressively utilize all of its available export tools to open export markets for American pork, rice, wheat, eggs, oilseeds and poultry. Export programs have played a key role in capturing and maintaining world market share, and we would urge you give every due consideration to their continued viability.

Sincerely,

Chuck Grassley
Senator Chuck Grassley

Senator Thad Cochran

Senator Bob Dole