STATE OF IOWA

TERRY E. BRANSTAD, GOVERNOR

DEPARTMENT OF GENERAL SERVICES
JACK B. WALTERS, DIRECTOR

DATE: November 15, 1990

TO: Diane Bolander
Legislative Service Bureau

FROM: Kristi Little
Superintendent - State Printing

RE: 1990 Election Law Supplement Price

The following costs have been submitted for preparation and publication of this years Election Laws supplement.

°Editing and preparation as reported by the Iowa Code Division	$2340.84
°Typesetting 315 pages by Centralized Printing	$1927.50
°Printing of 1500 copies by Wm. C. Brown Company, Inc.	$4153.50
°Distribution ($2.00 each) by Centralized Printing	$3000.00
°Free distribution (525)	$3995.25

Based on these figures, I recommend a price of $10.50, tax .42, to recoup costs as directed in the Code of Iowa.

cc-Loanne Dodge
Iowa Code Division

GENERAL ASSEMBLY OF IOWA

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DEPUTY IOWA CODE EDITOR

November 15, 1990

MEMORANDUM

TO: CHAIRPERSON HUTCHINS AND MEMBERS OF THE LEGISLATIVE COUNCIL

FROM: Diane Bolender, Director

RE: New Member Orientation

Approval is requested for the following expenses associated with the New Member Orientation Program:

1. Cost of coffee and doughnuts served during the Orientation to be divided equally between the Senate and the House of Representatives.
2. Travel, lodging, meal and related expenses of the members-elect to be paid by the house to which the member has been elected.
3. Per diem, travel and expenses of legislators assisting with the Orientation Program to be paid by the house in which the legislator is a member.
4. Cost of luncheon and dinner meals of legislative staff participating in the Orientation Program to be divided equally between the House of Representatives and the Senate.

LCOR
DB/dg

REPORT OF THE SERVICE COMMITTEE
TO THE LEGISLATIVE COUNCIL

November 15, 1990

The Service Committee of the Legislative Council met on November 15, 1990. The meeting was called to order by Representative John Connors, Chairman, at 10:32 a.m. in Room 22 of the State House, Des Moines, Iowa.

The Service Committee respectfully submits to the Legislative Council the following report and recommendations:

1. The Service Committee received and filed an administrative report from the Office of Citizens' Aide/Ombudsman relating to bids received for a proposed remodeling project. The Service Committee recommends that the Legislative Council authorize a $19,750 budget supplemental allocation under section 2.12 of the Code to permit the Office of Citizens' Aide/Ombudsman to carry out the remodeling project. $19,750 was the low bid on the project.

2. The Service Committee received and filed a personnel report from the Office of Citizens' Aide/Ombudsman.

3. The Service Committee received a personnel report from the Computer Support Bureau and referred it to the Computer Oversight Subcommittee, with instruction to review the proposals in t he report in light of recent growth in staff size and extent of services provided and to analyze the future direction of the Computer Support Bureau. The Service Committee recommends that any action taken with regard to proposals contained in the report be retroactive to November 15, 1990. The report recommends the following actions:

   a. The creation of the new position of Microcomputer Manager I at pay grade 33.
   b. The promotion of Mr. Ed Damman to fill the new position of Microcomputer Manager I.
   c. The promotion of Ms. Kay Evans from Mapper Coordinator I to Mapper Coordinator II.
   d. The promotion of Ms. Cheryl Porath from Run Designer I to Run Designer II.

4. The Service Committee received and filed a personnel report from the Legislative Fiscal Bureau.

5. The Service Committee recommends that the Legislative Council approve the creation of an Assistant Finance Officer position in the Legislative Service Bureau and the employment of Ms. K'Ann Morris Brandt as an Assistant Finance Officer at Grade 20, step 1. The Assistant Finance Officer position will not result in an increase in the number of total FTEs in the Legislative Service Bureau, since the elimination of four quarter-time unfilled positions, including three proofreader positions and one text processor position, is also proposed.

6. The Service Committee recommends that the Legislative Council approve the employment of Ms. Mary Ann Scott to fill the Assistant Indexer position that became vacant in the Iowa Administrative Code Division of the Legislative Service Bureau with the resignation of Toni Boyd. Ms. Scott is currently employed as a a part-time Proofreader/Indexer in the Administrative Code Division and the change in Ms. Scott's employment status will result in a change in her classification from grade 17, step 4, to grade 18, step 3.

7. The Service Committee recommends that the Legislative Council approve the alteration of certain titles in the Legislative Service Bureau. It is recommended that the Legal Division and Research Divisions be combined into a single Legal and Committee Services Division and that titles of Legal Division Chief and Research Division Chief be changed to Legal Services Administrator and Committee Services Administrator. These changes will not result in changes in the position descriptions for any positions affected, but are intended to more accurately reflect current responsibilities.

8. The Service Committee recommends that the Legislative Council approve the appointment of Mr. John Pollak to fill the vacant position of Committee Services Administrator in the Legislative Service Bureau. The promotion of Mr. Pollak to Committee Services Administrator will result in a change in his pay classification from grade 30, step 3, to grade 36, step 1.

9. The Service Committee received and filed additional personnel information from the Legislative Service Bureau.

10. The Service Committee recommends the Legislative Council approve the attached proposed budget and budget allocation of the Legislative Service Bureau for the fiscal year beginning July 1, 1991, pursuant to section 2.12 of the Code.

11. The Service Committee recommends the Legislative Council approve the attached proposed budget and budget allocation of the Legislative Fiscal Bureau for the fiscal year beginning July 1, 1991, pursuant to section 2.12 of the Code.

12. The Service Committee recommends the Legislative Council approve the attached proposed budget and budget allocation of the Computer Support Bureau for the fiscal year beginning July 1, 1991, pursuant to section 2.12 of the Code.

13. The Service Committee recommends the Legislative Council approve the attached proposed budget and budget allocation of the Office of Citizens' Aide for the fiscal year beginning July 1, 1991, pursuant to section 2.12 of the Code.

14. The Service Committee received, filed, and referred to the Computer Subcommittee a request for legislative oversight and guidance relating to possible changes in the manner in which the Iowa Administrative Code and the Iowa Administrative Bulletin are published. The request was initiated as a result of information received relating to current computer capabilities.

15. The Service Committee received a request to reschedule a grievance hearing on the complaint of Mr. David Robinson. The Committee agreed to reschedule the hearing to November 28, 1990, at 8:00 a.m.

16. The Service Committee referred a Compensation Comparison Report prepared by the Legislative Fiscal Bureau and the Legislative Service Bureau to the Joint Senate and House Pay Resolution Committee.

17. The Service Committee received and filed a Proposed Confidentiality Policy for the Legislative Service Bureau.

18. The Service Committee recommends that the Legislative Council reactivate and reappoint members to the Capitol Space Allocation Committee to study the current lack of space and cramped working conditions of Capitol Building employees. The Service Committee further recommends that the State Fire Marshall be requested to conduct an evaluation of the Capitol Building employee working conditions and provide the results of that evaluation to the Legislative Council.

The following new employees were introduced to the Service Committee members:

1. Ms. Wendy Sheetz, Assistant I, Office of Citizens' Aide/Ombudsman.
2. Mr. Roger Murtfeld, Software Analyst, Computer Support Bureau.
3. Mr. Bryan Boyd, Microcomputer Support Analyst, Computer Support Bureau.
4. Ms. Nicole Navara, Administrative Secretary, Legislative Fiscal Bureau.
5. Ms. Susan Crowley, Legal Counsel I, Legislative Service Bureau.
6. Mr. Michael Kuehn, Legal Counsel I, Legislative Service Bureau.

Respectfully submitted,
REPRESENTATIVE JOHN CONNORS
Chairman

src1115.sam

REPORT OF THE ADMINISTRATION COMMITTEE OF THE LEGISLATIVE COUNCIL

November 15, 1990

The Administration Committee met on November 15, 1990, without a quorum, and members present make the following report:

1. The Administration Committee members received information concerning the sale of the Code database and recommend that the Legislative Council approve any agreement reached with a vendor for the sale of the database. It is recommended that the initial agreement be for a one-year period and be negotiated by the staff for the Administration Committee and other appropriate individuals, in consultation with Legislative Leadership.

2. The Administration Committee members received information concerning the policy relating to pricing and free distribution of legal publications. The Committee members note that there is continued concern with respect to this policy and recommend that the Legislative Council should continue to review this policy with the goal of recovering all associated publication costs. The Legislative Service Bureau has been requested to compile additional information with respect to the current free distribution of state documents, including the Iowa Code, the Administrative Code, and the Court Rules, which will be reported to the Legislative Council. The information should include potential duplication of effort in the printing and distribution of portions of the Code by governmental agencies.

3. The Administration Committee members requested the Superintendent of Printing to provide a breakdown of the vendors on printing contracts for the Code and Administrative Code, including but not limited to the Mitchellville correctional printing unit, in-house printing by the State Printing Division, and private vendors.

4. The Administration Committee members recommend that consideration be given to printing a portion of the number of Codes in soft bound copy.

5. The Administration Committee members recommended that the Service Committee be alerted to the situation where speciality requests, such as for the election law supplement, often interfere with the Iowa Code Division's responsibility to publish the Session Laws and Code and Code Supplement in a timely manner.

6. The Administration Committee members recommend that the Superintendent of Printing attempt to compile additional information regarding the volume, sales, costs, and cost recovery of the various legal publications.

rptadm
MJ/dg

REPORT OF THE STUDIES COMMITTEE
TO THE LEGISLATIVE COUNCIL
November 15 1990

The Studies Committee of the Legislative Council met on November 15, 1990, and makes the following recommendations:

1. That the Value-added Process for Agricultural Products Study Committee be approved to hold an additional meeting day.
2. That the Financial Access to Higher Education Study Committee be reauthorized to hold its third meeting day.
3. That the MediPASS Implementation Oversight Study Committee be authorized to hold its final meeting after the November 30 deadline but before the start of the legislative session.
4. That the Civil Rights Laws in Iowa Study Committee be authorized to hold its final meeting after the November 30 deadline in early December.
5. That the expenses of Professor Jonathon C. Carlson incurred for his presentation to the European Trade Task Force on July 19, 1990, be reimbursed as submitted.
6. That the Legislative Capital Projects Committee be authorized to hold two meeting days.
7. That a Code Publication Study Committee be established as requested and be authorized to hold one meeting day and that the members of the Committee be appointed by the joint legislative leadership.

The Studies Committee has received and filed the final report of the Health Care Expansion Task Force.

The Studies Committee has received a letter from Mr. John A. Kish resigning from the European Trade Task Force .

Respectfully submitted,

SENATOR BILL HUTCHINS,
ACTING CHAIRPERSON

G/RPT1115
JP/dg

IN THE SUPREME COURT OF IOWA

ORDER

FILED
OCT 16 1990
CLERK SUPREME COURT

IN THE MATTER OF CHILD SUPPORT GUIDELINES

The supreme court has undertaken to prescribe uniform child support guidelines and criteria pursuant to the federal Family Support Act of 1988, Pub. L. No. 100-485. See H.F. 403, 73rd G.A., 1st Sess. § 6 (Iowa 1989) amending Iowa Code § 598.21(4).

By order of this court dated September 29, 1989, the temporary child support guidelines were adopted as the permanent child support guidelines while this court continued to study this issue.

The task force on child support and other groups have provided input on this issue. The latest proposal was again submitted for public consideration on June 8, 1990. Numerous comments and suggested amendments were received and considered. The following child support guidelines are hereby adopted, effective December 31, 1990, as shown in the attached Exhibit "A".

Dated this 16TH day of October, 1990.

THE SUPREME COURT OF IOWA

Arthur A. McGiverin

Arthur A. McGiverin, Chief Justice

Copies to:

Members of the Court
Members of the Court of Appeals
Judicial Council
State Court Administrator
District Court Administrators
West Publishing Company
Mead Data Central, Inc. (LEXIS)
Iowa State Bar Association
Task Force on Child Support
Iowa Department of Human Services
Fathers for Equal Rights
National Center for State Courts
Coalition for the Enforcement of Support
Commission on Children, Youth & Family
Legal Service Corporation of Iowa
Legislative Service Bureau

Exhibit "A"

CHILD SUPPORT GUIDELINES

The following charts are established as guidelines for use by the courts of this state in determining the amount of child support. The adoption of these guidelines shall not, standing alone, furnish the basis for a modification of a child support award entered prior to October 12, 1989. For support orders entered on or after October 12, 1989, see 1990 Iowa Acts ch. 1224, §45.

The purpose of the guidelines is to provide for the best interest of the children by recognizing the duty of both parents to provide adequate support for their children in proportion to their respective incomes. While the guidelines cannot take into account the specific facts of individual cases, they will normally provide reasonable support.

In ordering child support, the court should determine the amount of support specified by the guidelines. There shall be a rebuttable presumption that the amount of child support which would result from the application of the guidelines prescribed by the supreme court is the correct amount of child support to be awarded. That amount may be adjusted upward or downward, however, if the court finds such adjustment necessary to provide for the needs of the children and to do justice between the parties under the special circumstances of the case.

In the guidelines the term "net monthly income" means gross monthly income less deductions for:

(1) Federal income tax (properly calculated withholding or estimated payments);

(2) State income tax (properly calculated withholding or estimated payments);

(3) Social security deductions;

(4) Mandatory pension deductions;

(5) Union dues;

(6) Dependent health insurance coverage either deducted from wages or paid for dependent medical insurance pursuant to court order;

(7) Actual medical support paid pursuant to court order or administrative order;

(8) Unreimbursed individual health/hospitalization coverage or medical expense deductions not to exceed $25.00 a month;

(9) Prior obligation of child support and spouse support actually paid pursuant to court or administrative order; and

(10) Actual child care expense while custodial parent is employed, less the appropriate income tax credit.

Other items, such as credit union payments, charitable deductions, savings or thrift plans, and voluntary pension plans, are not to be deducted from a parent's income, since the needs of the children must have a higher priority than voluntary savings or payment of indebtedness.

Gross monthly income does not include public assistance payments.

The court shall not vary from the amount of child support which would result from application of the guidelines without a written finding that the guidelines would be unjust or inappropriate as determined under the following criteria:

(1) Substantial injustice would result to the payor, payee, or child;

(2) Adjustments are necessary to provide for the needs of the child and to do justice between the parties, payor, or payee under the special circumstances of the case; and

(3) Circumstances contemplated in Iowa Code section 234.39.

In addition, the court shall enter an order for medical support as required by statute. Unless the court specifically orders otherwise, medical support is not included in the monetary amount of child support. Any premium cost of a health benefit plan or medical support plan which has not been considered in computing net monthly income may be considered by the court as a reason for varying from the child support guidelines.

A stipulation of the parties establishing child support and medical support shall be reviewed by the court to determine if the amount stipulated and the medical support

provisions are in substantial compliance with the guidelines, and if a variance is proposed, whether it is justified and appropriate. A proposed order to incorporate the stipulation shall be reviewed by the court to determine its compliance with these guidelines.

IOWA CHILD SUPPORT GUIDELINES

ONE CHILD

CUSTODIAL PARENT'S NET MONTHLY INCOME	NON-CUSTODIAL PARENT'S NET MONTHLY INCOME							
		$500 &* UNDER	501-600	601-700	701-800	801-900	901-1000	1001-3000	3001 &** OVER
	$0- 100		24.1	24.6	25.0	25.3	25.6	25.8	
	101- 200		23.6	24.0	24.5	24.9	25.3	25.5	
	201- 300	*	23.2	23.7	24.1	24.6	25.1	25.1	**
	301- 400		22.7	23.3	23.8	24.4	24.6	24.8	
	401- 500		22.2	22.9	23.5	24.1	24.3	24.5	
	501- 600		21.8	22.5	23.2	23.9	24.1	24.2	
	601- 700		21.3	22.1	22.8	23.6	23.7	23.8	
	701- 800	*	20.9	21.7	22.5	23.4	23.5	23.5	**
	801- 900		20.4	21.3	22.2	23.1	23.2	23.2	
	901-1000		19.9	20.9	21.9	22.6	22.8	22.8	
	1001-1100		19.5	20.5	21.6	22.4	22.5	22.5	
	1101-1200		19.0	20.1	21.2	22.4	22.5	22.5	
	1201-1300	*	18.5	19.7	20.9	22.1	22.4	22.5	**.
	1301-1400		18.1	19.3	20.6	21.9	22.4	22.5	
	1401-1500		17.6	18.9	20.3	21.6	22.4	22.5	
	1501-1600		17.2	18.6	19.9	21.4	22.4	22.5	
	1601-1700		16.7	18.2	19.6	21.1	22.4	22.5	
	1701-1800	*	16.2	17.8	19.3	20.8	22.4	22.5	**
	1801-1900		15.8	17.4	19.0	20.6	22.2	22.5	
	1901-2000		15.3	17.0	18.7	20.3	22.0	22.5	
	2001-2100		14.8	16.6	18.3	20.1	21.8	22.5	
	2101-2200		14.4	16.2	18.0	19.8	21.7	22.5	
	2201-2300	*	13.9	15.8	17.7	19.6	21.5	22.5	**
	2301-2400		13.4	15.4	17.4	19.3	21.3	22.5	
	2401-2500		13.0	15.0	17.1	19.1	21.1	22.5	
	2501-2600		12.5	14.6	16.7	18.8	21.0	22.5	
	2601-2700		12.1	14.2	16.4	18.6	20.8	22.5	
	2701-2800	*	11.6	13.8	16.1	18.3	20.6	22.5	**
	2801-2900		11.1	13.4	15.8	18.1	20.4	22.5	
	2901-3000		10.7	13.1	15.4	17.8	20.2	22.5	
	3000&Over	*	10.2	12.7	15.1	17.6	20.0	22.5	**

To determine the monthly child support payments, multiply the non-custodial parent's net monthly income, at the point where it intersects the custodial parent's net monthly income, by the percentage shown on the chart.

* It is the policy of this state that every parent contribute to the support of his or her children in accordance with the means available. In this range the appropriate figure is deemed to be within the sound discretion of the court or the agency fixing support by administrative order. Some amount of child support is required.

** In this range the appropriate figure is deemed to be within the sound discretion of the court or the agency fixing support by administrative order. The amount of support payable by a non-custodial parent with a monthly net income of $3,001 or more shall be no less than the dollar amount as provided for in the guidelines for a non-custodial parent with a monthly net income of $3,000.

IOWA CHILD SUPPORT GUIDELINES

TWO CHILDREN

CUSTODIAL PARENT'S NET MONTHLY INCOME	NON-CUSTODIAL PARENT'S NET MONTHLY INCOME							
		$500 &* UNDER	501-600	601-700	701-800	801-900	901-1000	1001-3000	3001 &** OVER
	$0- 100		35.7	36.2	36.6	36.8	37.1	37.2	
	101- 200		35.0	35.4	35.8	36.1	36.5	36.5	
	201- 300	*	34.3	34.8	35.2	35.7	35.8	35.8	**
	301- 400		33.6	34.1	34.7	34.8	34.9	35.0	
	401- 500		32.8	33.5	34.1	34.2	34.3	34.3	
	501- 600		32.1	32.9	33.6	33.6	33.6	33.6	
	601- 700		31.4	32.3	32.5	32.7	32.8	32.9	
	701- 800	*	30.7	31.7	31.9	32.0	32.1	32.2	**
	801- 900		30.0	31.1	31.2	31.3	31.4	31.4	
	901-1000		29.3	30.4	30.5	30.6	30.7	30.7	
	1001-1100		28.6	29.8	29.9	30.0	30.0	30.0	
	1101-1200		27.9	29.2	29.7	30.0	30.0	30.0	
	1201-1300	*	27.1	28.6	29.7	30.0	30.0	30.0	**
	1301-1400		26.4	28.0	29.2	30.0	30.0	30.0	
	1401-1500		25.7	27.3	28.6	30.0	30.0	30.0	
	1501-1600		25.0	26.7	28.1	29.5	29.9	30.0	
	1601-1700		24.3	26.1	27.6	29.0	29.8	30.0	
	1701-1800	*	23.6	25.5	27.0	28.5	29.7	30.0	**
	1801-1900		22.9	24.9	26.5	28.1	29.7	30.0	
	1901-2000		22.1	24.2	25.9	27.6	29.2	30.0	
	2001-2100		21.4	23.6	25.4	27.1	28.8	30.0	
	2101-2200		20.7	23.0	24.8	26.6	28.4	30.0	
	2201-2300	*	20.0	22.4	24.3	26.2	28.0	30.0	**
	2301-2400		19.3	21.8	23.7	25.7	27.6	30.0	
	2401-2500		18.6	21.2	23.2	25.2	27.2	30.0	
	2501-2600		17.9	20.5	22.6	24.7	26.8	30.0	
	2601-2700		17.2	19.9	22.1	24.3	26.4	30.0	
	2701-2800	*	16.4	19.3	21.5	23.8	26.0	30.0	**
	2801-2900		15.7	18.7	21.0	23.3	25.6	30.0	
	2901-3000		15.0	18.1	20.4	22.8	25.2	30.0	
	3000&Over	*	14.3	17.4	19.9	22.4	25.0	30.0	**

To determine the monthly child support payments, multiply the non-custodial parent's net monthly income, at the point where it intersects the custodial parent's net monthly income, by the percentage shown on the chart.

* It is the policy of this state that every parent contribute to the support of his or her children in accordance with the means available. In this range the appropriate figure is deemed to be within the sound discretion of the court or the agency fixing support by administrative order. Some amount of child support is required.

** In this range the appropriate figure is deemed to be within the sound discretion of the court or the agency fixing support by administrative order. The amount of support payable by a non-custodial parent with a monthly net income of $3,001 or more shall be no less than the dollar amount as provided for in the guidelines for a non-custodial parent with a monthly net income of $3,000.

IOWA CHILD SUPPORT GUIDELINES

THREE CHILDREN

CUSTODIAL PARENT'S NET MONTHLY INCOME	NON-CUSTODIAL PARENT'S NET MONTHLY INCOME							
	$500 &* UNDER	501-600	601-700	701-800	801-900	901-1000	1001-3000	3001 &** OVER
$0- 100	*	41.6	42.2	42.6	43.0	43.2	43.5	**
101- 200	*	40.8	41.2	41.7	42.1	42.6	42.7	**
201- 300	*	39.9	40.5	41.0	41.5	41.7	41.8	**
301- 400	*	39.1	39.8	40.4	40.9	41.0	41.0	**
401- 500	*	38.2	39.0	39.7	39.9	40.0	40.1	**
501- 600	*	37.4	38.3	39.0	39.1	39.2	39.3	**
601- 700	*	36.5	37.6	38.4	38.4	38.4	38.4	**
701- 800	*	35.7	36.8	37.0	37.1	37.4	37.6	**
801- 900	*	34.8	36.1	36.3	36.5	36.6	36.7	**
901-1000	*	34.0	35.4	35.6	35.7	35.8	35.9	**
1001-1100	*	33.1	34.6	34.8	35.0	35.0	35.0	**
1101-1200	*	32.3	33.9	34.5	35.0	35.0	35.0	**
1201-1300	*	31.4	33.1	34.4	35.0	35.0	35.0	**
1301-1400	*	30.6	32.4	33.7	35.0	35.0	35.0	**
1401-1500	*	29.7	31.7	33.0	34.4	34.9	35.0	**
1501-1600	*	28.9	30.9	32.3	33.8	34.8	35.0	**
1601-1700	*	28.0	30.2	31.7	33.2	34.7	35.0	**
1701-1800	*	27.2	29.5	31.0	32.6	34.1	35.0	**
1801-1900	*	26.3	28.7	30.3	32.0	33.6	35.0	**
1901-2000	*	25.5	28.0	29.7	31.4	33.1	35.0	**
2001-2100	*	24.6	27.2	29.0	30.8	32.5	35.0	**
2101-2200	*	23.8	26.5	28.3	30.2	32.0	35.0	**
2201-2300	*	22.9	25.8	27.7	29.6	31.5	35.0	**
2301-2400	*	22.1	25.0	27.0	29.0	31.0	35.0	**
2401-2500	*	21.2	24.3	26.3	28.4	30.6	35.0	**
2501-2600	*	20.4	23.6	25.7	27.8	30.2	35.0	**
2601-2700	*	19.5	22.8	25.0	27.2	29.8	35.0	**
2701-2800	*	18.7	22.1	24.3	26.6	29.4	35.0	**
2801-2900	*	17.8	21.4	23.7	26.0	29.0	35.0	**
2901-3000	*	17.0	20.6	23.0	25.4	28.6	35.0	**
3000&Over	*	16.1	19.9	22.3	24.8	28.2	35.0	**

To determine the monthly child support payments, multiply the non-custodial parent's net monthly income, at the point where it intersects the custodial parent's net monthly income, by the percentage shown on the chart.

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IOWA CHILD SUPPORT GUIDELINES

FOUR CHILDREN

CUSTODIAL PARENT'S NET MONTHLY INCOME	NON-CUSTODIAL PARENT'S NET MONTHLY INCOME								
		$500 &* UNDER	501-600	601-700	701-800	801-900	901-1000	1001-3000	3001 &** OVER
	$0- 100		48.9	49.7	50.3	50.8	51.2	51.5	
	101- 200		47.9	48.5	49.1	49.7	50.3	50.4	
	201- 300	*	46.9	47.7	48.3	49.0	49.1	49.2	**
	301- 400		45.9	46.8	47.5	47.7	47.9	48.1	
	401- 500		44.9	45.9	46.7	46.8	46.9	46.9	
	501- 600		43.9	45.1	45.3	45.5	45.7	45.8	
	601- 700		42.9	44.2	44.3	44.4	44.5	44.6	
	701- 800	*	41.9	43.3	43.3	43.4	43.5	43.5	**
	801- 900		40.9	41.2	41.5	41.8	42.1	42.3	
	901-1000		39.9	39.9	40.0	40.4	40.8	41.2	
	1001-1100		38.9	39.9	40.0	40.0	40.0	40.0	
	1101-1200		37.9	39.8	39.9	40.0	40.0	40.0	
	1201-1300	*	36.9	38.9	39.7	40.0	40.0	40.0	**
	1301-1400		35.9	38.1	39.4	40.0	40.0	40.0	
	1401-1500		34.9	37.2	38.6	40.0	40.0	40.0	
	1501-1600		34.0	36.3	37.8	39.3	39.8	40.0	
	1601-1700		33.0	35.4	37.0	38.5	39.6	40.0	
	1701-1800	*	32.0	34.6	36.2	37.8	39.4	40.0	**
	1801-1900		31.0	33.7	35.4	37.1	38.7	40.0	
	1901-2000		30.0	32.8	34.6	36.3	38.1	40.0	
	2001-2100		29.0	31.9	33.8	35.6	37.4	40.0	
	2101-2200		28.0	31.1	32.9	34.8	36.7	40.0	
	2201-2300	*	27.0	30.2	32.1	34.1	36.0	40.0	**
	2301-2400		26.0	29.3	31.3	33.3	35.3	40.0	
	2401-2500		25.0	28.4	30.5	32.6	35.1	40.0	
	2501-2600		24.0	27.6	29.7	31.8	34.6	40.0	
	2601-2700		23.0	26.7	28.9	31.1	34.1	40.0	
	2701-2800	*	22.0	25.8	28.1	30.4	33.6	40.0	**
	2801-2900		21.0	24.9	27.3	29.6	33.1	40.0	
	2901-3000		20.0	24.1	26.5	28.9	32.6	40.0	
	3000&Over	*	19.0	23.2	25.7	28.1	32.1	40.0	**

To determine the monthly child support payments, multiply the non-custodial parent's net monthly income, at the point where it intersects the custodial parent's net monthly income, by the percentage shown on the chart.

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IOWA CHILD SUPPORT GUIDELINES

FIVE OR MORE CHILDREN

CUSTODIAL PARENT'S NET MONTHLY INCOME	NON-CUSTODIAL PARENT'S NET MONTHLY INCOME							
		$500 &* UNDER	501-600	601-700	701-800	801-900	901-1000	1001-3000	3001 &** OVER
	$0- 100		48.9	49.7	50.3	50.8	51.2	51.5	
	101- 200		47.9	48.6	49.2	49.7	50.3	50.8	
	201- 300	*	46.9	47.7	48.4	49.0	49.7	50.2	**
	301- 400		45.9	46.9	47.6	48.3	49.0	49.5	
	401- 500		44.9	46.1	46.8	47.6	48.4	48.9	
	501- 600		43.9	45.2	46.1	46.9	47.7	48.2	
	601- 700		42.9	44.4	45.3	46.2	47.1	47.6	
	701- 800	*	41.9	43.5	44.5	45.5	46.5	47.0	**
	801- 900		40.9	42.7	43.7	44.8	45.8	46.3	
	901-1000		39.9	41.9	43.0	44.1	45.2	45.7	
	1001-1100		38.9	41.0	42.2	43.3	44.5	45.0	
	1101-1200		37.9	40.2	41.4	42.6	43.9	45.0	
	1201-1300	*	36.9	39.3	40.6	41.9	43.2	45.0	**
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	1401-1500		34.9	37.7	39.1	40.5	42.0	45.0	
	1501-1600		34.0	36.8	38.3	39.8	41.6	45.0	
	1601-1700		33.0	36.0	37.5	39.1	41.1	45.0	
	1701-1800	*	32.0	35.1	36.7	38.4	40.6	45.0	**
	1801-1900		31.0	34.3	36.0	37.7	40.2	45.0	
	1901-2000		30.0	33.4	35.2	36.9	39.6	45.0	
	2001-2100		29.0	32.6	34.4	36.2	39.2	45.0	
	2101-2200		28.0	31.8	33.6	35.5	38.7	45.0	
	2201-2300	*	27.0	30.9	32.9	34.8	38.2	45.0	**
	2301-2400		26.0	30.1	32.1	34.1	37.8	45.0	
	2401-2500		25.0	29.2	31.3	33.4	37.2	45.0	
	2501-2600		24.0	28.4	30.5	32.7	36.8	45.0	
	2601-2700		23.0	27.6	29.8	32.0	36.4	45.0	
	2701-2800	*	22.0	26.7	29.0	31.3	35.9	45.0	**
	2801-2900		21.0	25.9	28.2	30.6	35.4	45.0	
	2901-3000		20.0	25.0	27.4	30.0	35.0	45.0	
	3000&Over	*	19.0	24.2	26.7	29.4	34.6	45.0	**

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IMPROVING ACCESS TO NEEDED HEALTH CARE FOR UNINSURED AND UNDERINSURED IOWANS

FINAL REPORT

Submitted to:

The Iowa General Assembly

Submitted by:

The Health Care Expansion Task Force

Prepared by:

Health Systems Research, Inc.
Washington, D.C.

November 15, 1990

November 15, 1990

Senator Bill Hutchins,
Co-Chairperson of the Legislative Council,
Members of the Legislative Council, and
Members of the Iowa General Assembly

Dear Senator Hutchins and Members of the General Assembly:

On behalf of the Health Care Expansion Task Force, we are pleased to submit this final report to the Legislative Council and the General Assembly. The report provides an assessment of the very real and pressing health care access problems faced by uninsured and underinsured persons in Iowa, and examines the underlying causes of these problems. It also presents a series of recommendations that are designed, in the short-term, to reduce the financial barriers currently faced by many of the State's most vulnerable populations---including the State's most precious resource, its children---and, over the long-term, to chart a course for making major improvements in the ways health care is financed and delivered in the state of Iowa.

It is not the Task Force's intention that its proposals be viewed as solely the Legislature's recommendations, separate and distinct from the positions taken by other organizations examining the issue of health care access. Indeed, through both the composition of its membership and the outreach efforts of the Task Force and its consultant, Health Systems Research, Inc., the Task Force has sought to obtain the views of interest parties throughout the state and to coordinate its activities with those of such other entities as the Governor's Blue Ribbon Commission on the Uninsured. The Task Force would like to extend its thanks to the many individuals and organizations who took the time to share their information and perspectives with the Task Force.

The Task Force also wishes to thank its consultant, Health Systems Research, Inc. and to inform you that HSR, Inc., as part of its contract, will be available to provide testimony to the General Assembly.

It is the Task Force's hope that its recommendations that seek to improve upon the states current, fragmented health care financing system and provide coverage to a small, but very vulnerable, portion of the State's uninsured population can be implemented rapidly. We also hope that our recommendation concerning long-term systemic reform will provide a context for continued discussion and action on this issue.

Sincerely,

Senator Charles Bruner
Co-Chairperson

Representative Patricia Harper
Co-Chairperson

William W. Dieleman
SENATOR WILLIAM W. DIELEMAN

Dolores M. Mertz
REPRESENTATIVE DOLORES M. MERTZ

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I. INTRODUCTION

In 1989, the Iowa General Assembly enacted Senate File 538, which created the Iowa Health Care Expansion Task Force. According to this enabling legislation, the purpose of the Task Force is to oversee the conduct of a comprehensive study of the State of Iowa's health insurance needs and an analysis of extending health care coverage and/or services to persons in the State who are uninsured or underinsured[1].

Since it was formed in May of 1989, the Task Force, with the assistance of Health Systems Research, Inc., a Washington, D.C.-based consulting firm, has explored in detail the problems of the uninsured and underinsured in Iowa, as well as the underlying causes of these problems. It also examined a broad array of program and policy options for reducing the access barriers faced by these vulnerable populations. In conducting its analysis, the Task Force and its consultant have received input from a wide range of individuals and organizations in the State.[2]

This final report presents the Task Force's assessment of the health care access problems that exist in Iowa, the principles it developed to guide the formation of public policy in this area, and its specific recommendations for legislative action on the part of the Iowa General Assembly to address these problems.

It is the Task Force's expectation that the enactment of these recommendations will alleviate many of the pressing health care access problems faced by Iowa's most vulnerable citizens. At the same time, however, the Task Force recognizes that the final

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[1] The Task Force membership is presented in Appendix A.

[2] A list of the individuals and organizations with whom the Task Force and/or Health Systems Research, Inc. have consulted can be found in Appendix B.

solution to the problems of the uninsured and underinsured will require a much more fundamental and sweeping reform of our current system of health care financing. While it is the Task Force's view that such reform must ultimately occur at the national level, it understands that the impetus for such action must spring from involvement in the issue at the state and local level. It is the Task Force's hope that its effort to address the health care access problems that exist today in Iowa will be part of a broader movement toward an improved health care financing and delivery system nationwide.

II. TASK FORCE FINDINGS

The Task Force's examination of the health care access problems faced by uninsured and underinsured persons in Iowa led to a number of important findings concerning the nature of these problems and their underlying causes. These are summarized below.

FINDING # 1

In 1989, approximately 220,000 Iowans had no health care coverage.

According to data from the Iowa portion of the 1989 Current Population Survey (CPS), about 220,000 Iowans lacked health care coverage of any type, including coverage from private insurance carriers or government programs such as Medicare or Medicaid. This represents about nine percent of the State's under-65 population.[3]

An analysis of the socio-demographic characteristics of Iowa's uninsured population revealed that:[4]

- Over a quarter of the uninsured are children, while a fifth are young adults aged 18 to 24. The vast majority of the remaining uninsured are non-elderly adults. Because of the nearly universal coverage provided to the elderly by the federal Medicare program, less than one percent of Iowa's uninsured are aged 65 or older.

- Iowa's uninsured population is predominantly a low-income one. Nearly a third of the uninsured are in households with

[3] The fact that this estimate of the size of the Iowa's uninsured population is lower than previously reported figures is due in large measure to improvements in the way the current Population Survey collects information on insurance status.

[4] See Appendix C for further detail on the characteristics of Iowa's uninsured population.

incomes that fall below the poverty line.[5] Another 40% had incomes between one and two times the poverty level, while 20% had incomes between two and three times poverty. Only ten percent had incomes greater than three times the federal poverty level.

- The uninsured population appears to be relatively evenly distributed throughout the State's urban and rural areas.

FINDING # 2

Most uninsured persons have some link to the workforce.

Analysis of the 1989 CPS data revealed that over 80% of all uninsured, non-elderly adults in Iowa were employed at some time during the year in which they were uninsured. Nearly a third reported being employed full-time during the entire year. A quarter were employed full-time during part of the year, while another quarter were part-time workers. Only 17% of these uninsured adults were unemployed the entire year.

When both uninsured adults and children are considered, the link to the workforce becomes even stronger. More than half of these uninsured persons were members of families in which the head of the household was employed full-time during the entire year. Only 14% were in families in which the head of household was unemployed.

[5] The federal definition of poverty varies according to family size and changes from year to year. For example, in 1989, the annual federal poverty level for a family of three was set at $9,690.00.

FINDING # 3

Over half of all uninsured workers in Iowa are employed by small businesses.

As is the case in most other states, the majority of uninsured workers in Iowa (53%) are employed by firms with 25 or fewer employees. This means that workers in small Iowa firms are more than twice as likely to be uninsured as workers in larger firms.

FINDING # 4

One important reason for the large number of uninsured workers in small firms is the inability of many small businesses to obtain affordable health care coverage for their employees.

While businesses of all sizes encounter problems providing adequate health care coverage for their employees at a reasonable cost, the obstacles faced by small businesses can be particularly difficult to overcome.

For example, restrictive underwriting practices by insurers can often result in certain employees of small firms or even entire categories of small businesses being refused health care coverage. Those small firms for which health care coverage is available are faced with high premiums that reflect heavy administrative costs, the possibility of double, or even triple, digit increases in premiums for one year to the next due to rapid turnover in insurers' small business rating groups, and significant gaps in coverage due to such things as exclusions of benefits for pre-existing conditions. As a result, many small businesses find that purchasing adequate health care coverage for their workers is not an affordable alternative.

FINDING # 5

The affordability of health care coverage is a problem faced not only by employers, but also by employees and other individuals.

In an effort to control employer health care costs, there has been a trend toward greater employee cost sharing in the form of increased premium contributions and/or the imposition of higher deductibles and coinsurance requirements . For many lower income families, this increased cost sharing can mean that they cannot afford coverage.

In fact, a study by the National Health Care Campaign found that Iowa families earning $24,200 with incomes at or below 200% of the federal poverty level (e.g., $24,200 per year for a family of four) have little or no disposable income. It is only when families earn more than 250% of the poverty level that they begin to accumulate the disposable income required to contribute toward a portion of their health care premium costs.[6]

One unsettling indication of the difficult decisions low-income families may be forced to make with respect to health care coverage is the finding from the analysis of 1989 CPS data that approximately one-quarter of all uninsured children in Iowa were in families in which the head of the household had health insurance. Given that most firms require higher employee premium contributions to obtain dependent coverage, this finding may reflect the fact that many working parents who receive health insurance through their employers may be unable to afford the additional cost of extending coverage to their children.

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[6] See The Affordability of Health Care for Iowa's Working Families, December, 1989, Iowa Health Care for All, Des Moines, IA.

FINDING # 6

The lack of adequate health care coverage can have a negative effect on health status and limits access to cost-effective health services.

The finding is supported by national data showing that:

- The uninsured report lower health status than the insured or "underinsured" population.
- The uninsured use fewer health services than insured persons, including cost-effective preventive services such as prenatal care.
- When the uninsured do use health services, it is more likely to be in costly institutional settings, such as hospital emergency rooms.

FINDING # 7

It is not only uninsured Iowans, but also many inadequately insured persons who encounter financial barriers to receiving needed care.

The Task Force found that many insured Iowans have health care coverage that does not provide them with access to needed care or does not adequately protect them from catastrophic expenses. Given the Task Force's interest in promoting access to cost-effective preventive care, it was particularly disturbed by the results of a survey of major health insurers in Iowa conducted for the Task Force by Health Systems Research, Inc., which indicated that less than half of all policies sold in the State included coverage of preventive services for children. This gap in coverage means that for low-income insured families with such coverage gaps, significant financial barriers may exist to their receiving preventive services.

The Task Force found the size of the problem of underinsurance to be a significant one. For example, while approximately 66,000 Iowa children were uninsured in 1989, the Task Force estimated that over 85,000 privately insured children in families under 200%

of poverty were not covered for preventive services. Thousands more with such coverage faced extremely high deductibles before their coverage took effect. This combination of limited income and gaps in coverage means that for financial reasons, many of these children may not benefit from services that could prevent health care problems or detect and treat them in their early, less costly stages.

FINDING # 8

The Iowa Medicaid program provides health care coverage for many low-income persons in the State although many persons in need are not eligible for coverage and coverage of families is fragmented.

The number of uninsured and underinsured persons in Iowa would be much higher were it not for the Iowa Medicaid program. This program, which is presently funded with federal and state dollars and administered by the Iowa Department of Human Services, provides coverage to approximately over 195,000 low-income Iowans who are either elderly, disabled, children, or the parents of disabled children.

While the Iowa Medicaid program is a relatively expansive one in that it extends coverage to nearly all of the eligibility groups allowed by federal law, federal restrictions result in many low-income persons, including many people living below poverty, being ineligible for coverage.[7] However, one small, but particularly vulnerable, eligible group that is not currently covered for the full range of benefits under the Iowa Medicaid program are aged or disabled persons who have incomes that are below the federal poverty level but too high for SSI and Medicaid. Approximately, 1,000 Iowans are estimated to fall into this category.

Another important problem with the program is that Medicaid eligibility is particularly fragmented with respect to families with children, in that, according to federal

[7] In general, among the low-income groups presently not eligible for Medicaid coverage are single adults who are not disabled, childless couples, and children aged eight and older in families with incomes greater than two-thirds of the poverty level and caretakers in such families.

requirements, income eligibility is set at a higher level for younger children than for older ones. For example, Iowa Medicaid currently covers:

- Pregnant women and infants in families with incomes up to 185% of the federal poverty level;
- children aged one through five up to 133% of poverty;
- children aged six and seven up to the poverty level; and
- children aged eight to twenty-one through up to about two-thirds of poverty.

This means that, depending upon the family's income, some children in the family may be eligible for Medicaid and others may not. The recent Federal Budget Reconciliation Act will address some of these inconsistencies by extending Medicaid coverage to children under poverty through age eighteen. This change, however, will not be an immediate one, but will be phased in on an age-specific basis through the year 2002. And even when fully phased in, it will not eliminate the problem of family coverage for families between 100% and 133% of poverty. In these households within this income range, children will be eligible for Medicaid through age five, but ineligible thereafter.

The Task Force identified several other important issues associated with the Medicaid program:

- Many persons in need of health care services and who are eligible for the program may not apply for coverage. This may be due to the fact that they are not aware that they might be eligible or because they refuse to apply because of the perceived welfare stigma associated with the program.
- While the Iowa Medicaid program provides preventive services for children under its Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) program, the utilization of the benefit by Medicaid eligible children is extremely low. The combination of new federal requirements and the recognition of the importance of this benefit necessitates the program's taking steps to improve its performance in this area.

These problems must be addressed if the Iowa Medicaid program is to reach its full potential in meeting the health care needs of the State's low-income population.

Iowa's publicly-supported health care delivery programs provide important services to the State's uninsured and underinsured populations. However, they do not meet all the needs of these populations and their performance in a number of key areas could be improved.

There is a loose-knit system of public and quasi-public health care providers in the state that serves as a safety net for many uninsured Iowans. The network includes:

- 3 community health centers (CHCs) in Des Moines, Waterloo, and Davenport, funded by the Federal government under Section 330 of the Public Health Services Act, and one federally funded Migrant Health Center to serve farm workers.
- 11 Medicare-certified rural health clinics (RHCs) that are permitted to employ allied health personnel, such as Physician Assistants and Nurse Practitioners, under general physician supervision.
- 29 Maternal and/or Child Health Centers (M/CHs) funded primarily through the Iowa Department of Health that operate at least episodically in all 99 counties.
- 9 training sites of the Family Practice Residency Training Program (7 of which are under the direction of the University of Iowa) that train family physicians and receive $1.7 million in state funds.
- 4 school-based youth services programs that provide health services as part of their responsibilities were funded for FY 91 by the legislature, and which are currently under development.[8]

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[8] The State funds a number of other health care-related activities. State and federal funds support dental treatment for children and pregnant women in the M/CH program. Specialized services for chronically ill and disabled children are delivered through the University of Iowa Hospitals and Clinics. Homemaker/home health aide services in all counties provide long-term care to permit children and adults to remain at home. Well elderly clinics provide health assessment, counseling, and referral to treatment for people over age 55. Public health nursing services in all counties (funded by state and local sources, but using county-employed nurses) provide counseling, health promotion, health assessment, nursing care, and referral to treatment. These programs all serve families with incomes below from 100% to 185% of the federal poverty level free or at a reduced

Only the rural health centers and community health centers function as full-service primary care clinics for the low-income uninsured. The network of Maternal and Child Health Centers serving all 99 counties receives $3.5 million in state and federal (MCH block grant) funds to provide maternity and child health services to about 18,000 clients with incomes under 185% of the federal poverty level. The Maternal Health Centers provide or arrange for both prenatal and delivery services for low-income women. The Child Health Centers offer only preventive care, such as immunizations and well-child check-ups. However, they can refer sick children to community physicians for primary care for problems other than chronic illnesses or injuries under a $400,000 voucher program established by the legislature in 1989. As many as half of the children served by the centers do have some form of health insurance, but no coverage for preventive care.

The Task Force's specific findings with respect to the State's network of ambulatory care providers are as follows:

- <u>The Maternal and Child Health Centers provide an important foundation for the delivery of ambulatory care services to Iowa's uninsured and underinsured populations. However, they do not meet all the needs of these populations</u>.
  This network of centers is unique and forms the framework for a public and quasi-public delivery system where private providers are not available or willing to serve the uninsured. However, these centers do not meet all the needs of these populations, particularly with respect to preventive services for children. It is estimated that in 1989 there were about 50,000 uninsured children in Iowa under 200% of the federal poverty level and 85,000 privately insured

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charge and generally cover higher income persons for a higher fee.

In addition, a survey of Iowa counties conducted by Health Systems Research, Inc. with the cooperation of the Iowa State Association of Counties found that county expenditures on personal health services for low-income persons exceeded $10 million in 1989.

See Appendix F for Health Systems Research, Inc.'s August, 1990 report to the Task Force which provides additional information on Iowa's service delivery activities and a map showing the locations of publicly supported health centers.

children in this income category without preventive care coverage. Of these 135,000 children, about 11,000 uninsured children were served by Child Health Centers and about 11,000 other uninsured children were served by Community Health Centers.

- There is great variety among the M/CH centers in terms of structure and orientation.
  Some are traditional local public health nursing agencies, while others are local community service groups (Community Action Programs or family service agencies), or hospitals. Some of these agencies view their mission narrowly to provide specific services on request, while others seek to provide a broad range of services and promote them in the community. The programs that appear to work best combine or at least co-locate maternal and child centers (just over half the programs are combined) and have a good sense of the health care needs and resources of the communities in which they function.

- Relationships with local physicians, critically important to the centers' success, vary across the state.
  Child Health Center staffs have found the voucher program very useful. Physicians, who are paid Medicaid rates for a limited number of visits, have generally responded well to the program and are willing to participate. Other relationships between the centers and physicians seem to depend upon the local medical marketplace. The general shortage of physicians willing to deliver babies makes it difficult for some Maternal Centers to find contracting physicians.

- Coordination between M/CH Centers and Medicaid is vital but inadequate.
  Maternal Health Centers have seen their funding change from mostly federal MCH Block grant to almost exclusively Medicaid, as Medicaid eligibility for pregnant women and infants has expanded up to 185% of the federal poverty line. Nevertheless, some staff noted that their clients have difficulty completing the Medicaid application process. Even with presumptive eligibility, the follow-up Medicaid application is cumbersome and confusing. M/CH center staff do not always see their job as assisting clients to apply for Medicaid, and local social services staff are not always helpful in their attitudes.

- Even for eligible children, the sick care voucher program is limited.
  The Child Health Center voucher program pays for acute rather than chronic care or care for accident or injury. Such a limitation can

impede continuity of care and discourage providers from addressing the full health needs of the child.

- Adolescent health care is an unmet need.
  Adolescents are reluctant to attend child health clinics, due both to attitude and to the physical locations of many of these clinics. Most temporary and some permanent sites are in church basements and other settings in which limitations on privacy make them inappropriate for older children. Special education and outreach efforts also necessary to attract these youth to preventive health clinics.

- On the whole, M/CH centers appear to have the flexibility to meet local community needs, but the state has not established guidelines for their performance or rigorously evaluated their effectiveness.
  M/CH contracts have apparently been awarded based on historical patterns of local service delivery, and changes in contractors is rare. The new revenues from expanded Medicaid eligibility for pregnant women and young children may free up federal and state maternal and child health care funds and offer the opportunity to review M/CH center goals and performance. The contract process can strike a balance between identifying and addressing unique local needs and meeting state standards to improve accountability. Most centers have unsophisticated patient tracking systems that would need improvement to monitor their performance and compliance with state standards.

- Preventive and primary care for uninsured adults is limited and many communities are not served by a full-service ambulatory clinic.
  Community Health Centers provided preventive and primary care to about 37,000 patients in 1989 but exist in only three communities in the state. The University of Iowa's $27 million "state papers" program provides primary and acute care in Iowa City to about 550 obstetric/newborn and 800 orthopedic patients (non-quota patients) and 3,900 patients referred under the county quota system.

- The Department of Public Health will be undertaking new needs assessment and data collection duties under recent federal law changes.
  In the 1989 Omnibus Budget Reconciliation Act, Congress imposed new responsibilities upon state Maternal and Child Health agencies. These agencies will be required to submit to the Federal government statewide needs assessment data on services to women and children and to outline a plan to meet various national MCH goals.

States must also report health status indicators, such as perinatal and maternal mortality, immunization status, low birth weight rates, and rates of early prenatal care.

- There is the opportunity for improved coordination of multiple initiatives targeted to vulnerable children.
  A number of federally-supported initiatives dealing with particularly vulnerable children need to be integrated with one another and with other state activities to develop a coherent systems for these children. The State should seek to combine resources in planning and implementing the provisions of such federal initiatives as the CASSP program, M/CH services for children with special health care needs, Public Law 99-457 Part H, and Public Law 99-661.

- Although not well quantified, it is certain that there are shortages of primary care providers in many areas of the state. These shortages increase the problems the State's uninsured and underinsured populations face in accessing both the private and public sector delivery systems.
  Research by the University of Iowa, the Iowa Medical Society, health professional licensing boards, and the Health Professionals Shortage Committee and Governor's Task Force on Rural Health have all documented shortages of personnel such as obstetricians, family practitioners, physician assistants, pediatric nurse practitioners, nurse midwives, and registered dieticians. However, despite many independent studies of the health personnel shortage issues, there is no single focal point within State government to conduct or coordinate data collection, analysis, and solution development for this overarching health care delivery problem in the state.

FINDING # 10

The current health care financing system is neither an efficient nor an equitable structure for providing health care coverage for all.

Perhaps the most sweeping and significant conclusion reached by the Task Force is that the current health care financing system in operation in Iowa and in the nation as a whole represents a very inefficient and inequitable mechanism for providing appropriate health care for all.

The inequities of the current financing arrangements were often discussed during the course of the Task Force's deliberations. Among the specific examples cited by the Task Force were:

- "Cost-shifting" which finances the cost of providing hospital care and other services to uninsured individuals by increasing charges to persons with health care coverage. Private health care purchasers' bills also are increased due to "cost shifting" that results from inadequate reimbursement rates being paid by public programs such as Medicare and Medicaid.

- Inequitable tax policies that provide corporations a 100% tax deduction for the cost of providing health care benefits to their employees but allow self-employed persons to deduct only 25% of the cost of similar coverage.

- Inequitable eligibility requirements for public health care financing programs that can result in (a) one family receiving Medicaid benefits while a second family with only a few dollars more a month in income being denied coverage; or (b) the young children in a low-income family being covered by Medicaid while the older children are ineligible, even if these older children have serious health problems.

- The movement of insurance carriers away from community-rating that has made health care coverage extremely expensive for many segments of the population.

- The inability of some small or even mid-sized firms to obtain any type of health insurance coverage because of the nature of their business or the presence of even one employee with high health care needs.

The Task Force was equally distressed by the failure of the current system to provide for the health care needs of all citizens in an efficient and effective manner. Among the factors that the Task Force cited as evidence of the current system's inadequate performance in this area were:

- An inadequate focus on prevention and early intervention to detect and treat health care problems before they worsen and require more expensive treatment, including inpatient care.

- High administrative costs associated with the marketing and provision of health care coverage to individuals and small groups. One recent national survey found that administrative expenses for coverage of firms with four or fewer employees equaled about 40% of the amount paid out in claims, compared to 5.5% for very large businesses (i.e., more than 10,000 employees).

- The failure of the current financing system to effectively control spiralling health care costs.

Finally, the Task Force noted that the current pluralistic systems of health care coverage makes it difficult to direct public programs toward one uninsured group without the private sector's incentives for coverage of these and other populations. Among the Task Force's concerns in this area are that:

- A move to provide public sector coverage of one group (e.g., uninsured low-income working families) may cause some businesses to drop their own coverage of other low-income workers and their families.

- Incentives aimed at getting employers to cover uninsured workers raises equity issues with respect to the treatment of businesses that had already assumed the responsibility of providing such coverage to their employees.

These findings, along with a set of principles used by the Task Force to guide it in its policymaking process, provided the foundation upon which the Task Force developed its recommendations. Those guiding principles are described in the following section of this report.

III. GUIDING PRINCIPLES

As it began its review of different approaches to improve access to needed care for Iowa's uninsured and underinsured populations, the Task Force identified a set of twelve principles that it believed should be used to guide the development of both short-term and long-term public policy in this area. These principles are as follows:

Access

1. *All Iowans should have access to adequate, effective, appropriate, and quality health care services without regard to financial barriers.*

2. *A basic level of health care should be defined to which everyone has access, with priority on effective, appropriate, and quality care, especially preventive and primary care, early diagnosis and treatment, and incentives for healthy lifestyles.*

Financing

3. *All Iowans share a responsibility to obtain adequate coverage for themselves and their dependents, but the government should participate in financing care for those unable to pay.*

4. *Responsibility for the financing of options should be equitably distributed among payers.*

5. *Options for improving access should minimize the negative impacts on businesses and on current employer health benefits plans. In addition, disincentives should not be adopted which would cause employers currently offering health benefits to drop or reduce this coverage.*

Cost Containment

6. *Health care expenditure controls should be essential elements of approaches to expand access to care for the uninsured and to ensure continued adequate coverage for those currently insured.*

7. *Use of cost sharing may be considered to control excessive utilization but should take into account ability to pay.*

8. *Approaches should include incentives to seek and provide care in the most efficient and cost effective manner and location, including contractual arrangements for patient management and utilization controls.*

9. *Provider reimbursement should be set at reasonable levels and should promote efficient service delivery and constrain unnecessary expenditures.*

10. *Individuals should have reasonable choice in selecting health care providers, although they may be restricted to certain providers in cases where these arrangements significantly increase the cost-effectiveness of this care.*

General

11. *Approaches to expand access to care for the uninsured should be as simple to administer as possible and avoid duplication of resources. Special attention should be given to minimizing the administrative burden on small businesses, providers and consumers.*

12. *Program policy design should be sensitive to problems of provider availability and accessibility, especially in rural areas.*

The principles developed by the Task Force concerning cost containment reflect a balanced view that any coverage extended to the currently uninsured population should not be considered exempt from any and all cost management provisions, nor should it be considered an experimental setting in which highly restrictive cost containment features not seen in other private or public programs are tested. Instead, state of the art cost management features, such as utilization reviews based upon the development of appropriate practice guidelines, should be incorporated in this coverage in a manner that is consistent with both the health needs and low income status of this population and the practices of the other health care coverage plans.

Having agreed on these principles, the Task Force then made several additional decisions concerning the way in which several of these principles should be operationalized. These decisions focused on the definition of the population for which the government should provide assistance in financing health care coverage and the identification of population groups and health care benefits to which priority should be

given. These decisions, which were included in the Task Force's interim report to the General Assembly, are as follows:

- Individuals and families with incomes at or below the federal poverty line cannot afford to contribute to their health care coverage. It is appropriate for government to assume these individuals' portions of their health care coverage costs.

- Individuals and families with incomes above poverty but still considered low-income (e.g., below 200% of the poverty level) can be expected to assume some, but not necessarily all, of the cost of their health care coverage. Government should assist in financing coverage for this group on an income-related sliding scale basis.

- These income guidelines may be increased to allow either full or partial government subsidization of health care coverage costs associated with certain high priority populations. Pregnant women and children are considered as high priority populations because of the positive health effects associated with the provision of adequate prenatal care and preventive services to these groups. The next level of priority was given to disabled adults.

- With respect to health care benefits, highest priority was assigned to the provision of preventive care, followed by primary care services.

The Task Force's recommendations that draw upon these principles are described in the following section.

IV. RECOMMENDATIONS

Over the past year, the Task Force has reviewed a wide range of options for addressing the needs of Iowa's uninsured and underinsured populations.[9] These options included a number of different approaches to address the problem, including:

- The expansion of existing public health care financing programs and/or the establishment of new financing programs;
- improvements in the public sector health care service delivery system;
- efforts to make private health care coverage more affordable; and
- major reform of the Iowa health care financing and delivery system.

Based upon its analysis of this broad range of policy alternatives and their appropriateness to the Iowa environment, the Task Force developed the following recommendations for action by the Iowa General Assembly.

RECOMMENDATION # 1

Establish a new public financing program to provide coverage to non-Medicaid eligible children below 133% of the federal poverty level.

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[9] A further discussion of the range of approaches other states have taken to address the health care access problem can be found in Appendix D. A summary of other states' demonstration projects designed to expand private sector health care coverage, which was prepared by Health Systems Research, Inc. and provided to the Task Force at its June 12, 1990 meeting is presented in Appendix E. Finally, descriptions and preliminary cost estimates of specific options examined by the Task Force are included in Appendix F.

As described earlier under Finding # 8, Medicaid coverage in Iowa is available to children on a staggered age and income-related basis, as follows:

- Pregnant women and children under 185% of the federal poverty level;
- children aged one through five up to 133% of poverty;
- children aged six and seven to 100% of poverty; and
- children to age 21 up to about 67% of poverty.

The gaps in Medicaid coverage of low-income children and the fragmentation in coverage that occurs in some low-income families with children of different ages will be reduced substantially as the state implements the new federal requirements extending Medicaid to all children below the age of 19 in families below the poverty level. However, this expanded coverage will not be immediate, but must be phased over an 11 year period. In addition, it will not extend coverage to older children in families with incomes between 100% and 133% of poverty.

Given (1) the long implementation time-frames and the gaps that will remain even after these Medicaid expansions are fully implemented, and (2) the importance attributed by the Task Force to providing adequate health care -- including preventive services -- to all children in the State, the Task Force recommends the establishment of a new state-sponsored program that would provide health care coverage to all non-Medicaid eligible children under the age of 18 in families with incomes below 133% of the federal poverty level. In 1990, this income limit would be equal to an annual income of approximately $14,045 for a family of three.

Two alternative benefit packages were considered by the Task Force. Given the availability of state funds, it recommends the provision of a benefit package similar to that provided to other low-income children under the Iowa Medicaid program. However, if sufficient funds are not available to support this full benefit package, the Task Force then

recommends the provision of an ambulatory services-only package similar to that offered under state programs in Minnesota and New York.

Under this program, coverage of children under poverty would be fully subsidized by the state, while an annual enrollment fee of $50 per child would be charged for the Medicaid benefit package and $25 per child for the ambulatory benefit package. Some switching of coverage is expected to occur as some children covered by more expensive private coverage shift over to the public program. Different participation rates in the program are assumed, depending upon current coverage status of the children and the scope of benefits covered under the program.

Assuming the program becomes operational in late 1991, it is estimated that enrollment will grow over a three year period until it peaks at approximately 9,200 children in late 1994/early 1995. From that point on, enrollment is expected to decline gradually as the phase-in of the new Medicaid coverage requirements reduce the number of children eligible for the program. By the year 2002, assuming no new Medicaid expansions or other changes in health care coverage status of children, enrollment is projected to level-off at approximately 6,700 children aged eight through eighteen in the 100%-133% of poverty income range.

Assuming constant dollars, program costs are projected to increase from less than $1 million in 1991 (including start-up costs) to approximately $6.3 million in state expenditures in 1995 for the program covering Medicaid-like benefits ($2.6 million in state funds for coverage of ambulatory services only). In subsequent years, enrollment in the program is projected to decline as the phased-in Medicaid expansions will cover an increasing number of this program's target population.

RECOMMENDATION # 2

Strengthen the public sector primary and preventive service delivery system.

Even with the phased-in implementation of expanded Medicaid coverage of children and the establishment of a new public health care financing program for non-Medicaid eligible children under 133% of poverty, the services provided by Child Health Centers and Community Health Centers will continue to play a very important role in meeting the ambulatory care needs of low-income children throughout the State. This is expected to be the case because there are an estimated 30,000 uninsured children throughout the state are in households with incomes about 133% of poverty who would be unaffected by these program expansions. In addition, many low-income insured children will rely on these public clinics because their insurance coverage does not include preventive services and/or provider shortages restrict their access to other sources of care.

Given this scenario and the assessment of the strengths and weaknesses of Iowa's current public sector system for delivering primary and preventive services presented in Finding #9, the Task Force recommends that a number of measures be taken to improve the ability of the State's ambulatory care clinics to meet the needs of its low-income population. These measures include:

A. Expansion of preventive and acute care services for low-income children.

The Task Force recommends a series of measures to expand the services provided by child health centers throughout the State[10]. They are as follows:

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[10] A summary of the State costs associated with these and other recommendations is presented in the next chapter. A more detailed breakdown of the costs for the recommendations to improve the public service delivery system can be found in Appendix G.

1. Expand the provision of preventive care to low-income children

As noted in Finding #9, in 1989 only about 22,000 of the State's 135,000 uninsured children and low-income children without coverage of well child care received preventive services through the child health centers and community health centers. This recommendation would provide the additional funding required to provide preventive services to an additional 15,000 predominantly school-aged and adolescent low-income children who are not eligible for Medicaid. Coverage of these new children would be phased in over a four year period at a current year cost of $110 per child, or $1.65 million for a fully implemented program.

2. Expand the State's current voucher program to provide acute care services to additional low-income children

To assure follow-up care for sick children, the state should expand its current voucher program (appropriated at the level of $450,000 for FY 1991) to cover the additional 15,000 children receiving preventive care under the previous recommendation. Only about 70% of these newly eligible children are expected to be uninsured (the others would have private coverage for acute care), so the additional costs of covering 15,000 new children would be $462,000 ($88 per case for the 5,250 uninsured children estimated to be referred to follow-up care) at full implementation in year four.

3. Expand the voucher program to cover injuries and chronic illness

The state's current voucher program excludes payment for injuries and chronic illness. To add injury services for current uninsured clients of Child Health Centers would cost about $225,000 ($100 per case for the 2,250 children estimated to need treatment for injuries). To provide them to the newly eligible groups of uninsured children would cost about $236,250 ($150 per case for 1,575 children) when the program is fully operational in the fourth year.

Treatment of chronic illness for currently uninsured CHC clients would cost about $22,500 ($300 per case to cover an estimated 750 chronically ill children). To cover chronic illness among the newly eligible groups of uninsured children would cost about $157,500 ($300 per case for 52 children).

4. Increase operational support for the expanded voucher program

The Department of Public Health staff have also estimated the need for approximately $90,000 in additional funds to administer the expanded voucher program, $30,000 to process claims for the current program, $30,000 as the program expands to cover additional services for injury and chronic illness, and $30,000 to cover 15,000 new children. Administrative costs include the processing of thousands of small claims. These funds would support administration for the entire program ($450,000 for the FY 91 program plus the $1.3 million expansion) and would represent about 5% of total care costs.

It should be noted that enhancing efforts to assure that all children eligible for Medicaid are enrolled should bring new federal revenues into the state. It is estimated that about 15% of the newly eligible children (primarily older children not now served by the centers) may become eligible for Medicaid. Child Health Centers receiving these new Medicaid funds would then be able to expand coverage to several hundred more low income, uninsured children.

On the other hand, it also must be noted that there are several impediments to significantly increasing Child Health Center capacity: the shortage of pediatric nurse practitioners and dieticians in many areas of the state; the physical space in which many child health clinics are located; the need to upgrade tracking systems to meet additional capacity and new case management responsibilities; and the potential resistance of the medical community to Child Health Center expansion. To address these problems, the Department of Public Health should assist centers in locating personnel and upgrading tracking and referral systems.

B. Actively pursue additional federal funding for one or more ambulatory community health centers in underserved areas of the state. Although federal funds for Community Health Centers have been limited in recent years, the Department of Public Health and other officials have discussed a possible grant application with the U.S. Public Health Service (PHS). There is optimism that the PHS may entertain an application for a new Community Health Center, possibly in western Iowa or in conjunction with a rural hospital. Additional state resources would be needed to develop such an application. A successful grant application requires coordinating local support among a core group of community leaders; some community needs assessment and health personnel assessment; strategic planning for primary care delivery; and development of the application with detailed administrative and programmatic description. Such an application could be expected to take about

two years and cost $50,000 per year, some of which might potentially be raised from the private sector, but some of which might need to be state resources.[11]

C. Improve coordination and integration of public programs. To obtain maximum Federal matching funds and assure that as many persons eligible for Medicaid as possible are enrolled in the program, the Department of Human Services should:

1. Expand Medicaid outreach activities to identify more eligible individuals, including eligibility coordination with Maternal and Child Health Centers, Rural Health Clinics, and Community Health Centers, preparation of a video on eligibility processing (for use by M/CH enters and other interested agencies), and the development of brochures for consumers and providers on Medicaid;

2. Outstation eligibility workers in selected public clinics, hospitals, community health centers and Maternal and Child Health Centers;

3. Consider changing Medicaid's name to lessen its welfare connotations;

4. Develop a public media campaign for the expanded Medicaid program; and

5. Increase efforts to enroll eligible children in Medicaid's preventive program for children, the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, including the distribution of information on the program through the school system.

A first-year budget of approximately $300,000 is assumed for these efforts, of which half could be financed with federal Medicaid matching funds. As has been the experience in other states, this estimate assumes substantial contributors from the private sector in the form of donated TV and radio air time for public service messages, etc.

D. Simplify the Medicaid application process. Medicaid currently uses an integrated application form that collects information needed to determine an applicant's eligibility not only for Medicaid, but also for a number of other publicly supported programs, including WIC and Food Stamps. However, an often-cited barrier to getting people through the Medicaid enrollment process is the length and complexity of this form.

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[11] A recently successful CHC grant application in metropolitan Denver cost over $100,000 to develop.

The Department of Human Services should consider assessing the relative benefits of using this comprehensive form compared to a streamlined one that might increase overall Medicaid enrollment and allow new recipients to apply for other benefits once they are in the system. The possibility of designing a demonstration that would examine the effectiveness of alternative approaches in several different sites should be considered. Federal support for such a demonstration should also be explored.

E. Review the state's process of contracting with M/CH Centers. The Department of Public Health should consider the following:

1. Improving the coordination of related services (WIC, prenatal care, child health care) through mechanisms such as a single contract for such services, co-location, or other means of coordination. WIC contracts are combined with existing M/CH contracts, and this strategy should continue. While state contracts for these services evolved due to traditional patterns of community interest and service, they may not today represent the best means of delivering related services to the target population. The Department should closely examine its contracting agencies and determine how care can be delivered in the most efficient and effective manner to meet local needs.

2. Require applicants for M/CH contracts to identify and propose means to address community needs. The Department should take a more active role in helping communities, including its M/CH contractors and other interested agencies, to assess community health needs and develop plans for meeting them with both private sector and public sector strategies. This is consistent with its new responsibilities under OBRA 1989 and with a new federal grant the Department has received to conduct community needs assessments in two areas of the state in order to develop primary care systems there. The objective of these needs assessments is to identify services, personnel, and providers currently available, capacity for expansion, and training needs. Rather than duplicating current activities, the Department could assist counties already undertaking health needs assessments to include a focus of maternal and child health by developing protocols to assure standardized and high quality analyses and by full or partial funding of such activities. It could also assist local agencies by coordinating current assessment activities and planning processes.

The Department estimates the costs for this needs assessment to be about $110,000 per year for two years, during which time all 22 M/CH Center services areas would undergo needs assessments resulting in a plan to care for all low income children in each area using private and public sector resources.

3. Enhance M/CH Center participation in Medicaid outreach. The Departments of Public Health and Human Services are currently undertaking a pilot to train M/CH center staff in Medicaid outreach activities. The results of this project should be monitored and an appropriate strategy replicated throughout the state.

4. Enhance Child Health Center outreach. Children under age six have been the primary client population of Child Health Centers. To encourage more use of these centers by school-age children and adolescents will require new kinds of outreach activities aimed at these hard-to-reach groups. Activities could promote the need for preventive care and health risk reduction as well as care for acute conditions. Promotion campaigns could use media popular to children and youth and their families, particularly television, and could also include printed materials, radio, PSA's and community events. Department of Public Health staff estimate that such an outreach program would cost about $60,000 per year.

F. Require M/CH contractors to meet performance standards. Consistent with its new data collection responsibilities under OBRA 1989, the Department of Public Health should consider requiring that M/CH Centers meet specific standards for contract renewal. These standards would be developed during the process of community needs assessments discussed above and could include such elements as:

1. Identification of women and children potentially eligible for Medicaid;

2. Actively providing assistance in completing Medicaid applications;

3. Follow up to determine numbers of clients who were potentially eligible for Medicaid, who were assisted, who actually applied, and who were ultimately enrolled; and

4. Community needs assessment, problem identification, and attempted problem resolution.

A more detailed listing of potential standards prepared by Department of Public Health staff can be found in Appendix G.

The costs of training M/CH staff in these new responsibilities is estimated to be about $50,000 per year in the first two years, with that amount declining in later years. Department responsibilities to monitor contract performance and track M/CH clients are estimated to cost $100,000 in the first year, increasing to $150,000 in the second year and $200,000 in the third and fourth years.

G. Improve the integration of multiple initiatives targeted to vulnerable children.

Given its finding that there is a need to strengthen the coordination of multiple initiatives and programs targeted to particularly vulnerable children (see Finding #9), the Task Force recommends that the Iowa Department of Public Health, Human Services, Education, and other involved entities should seek to improve the coordination of their resources and activities in the planning and implementation of the following initiatives: the CASSP program, M/CH services for children with special health needs, the provisions of P.L. 99-457 Part H and P.L. 99-661, child welfare efforts, and the state's Medicaid EPSDT program.

H. Further examine the health personnel shortage issue. Although a number of state and private agencies are studying various aspects of the health personnel shortage problem, there is no central coordinating agency that can conduct targeted studies of personnel need, pull together the efforts of these various agencies, collate and analyze data, and propose solutions to the problem. Department of Public Health staff estimate the cost for this activity to be about $63,000 in the first year, declining to about $42,000 in the fourth and subsequent years.

A summary of state expenditures associated with the specific measures included in this recommendation can be found in Appendix H. However, the Task Force further recommends that prior to the expenditure of any funds appropriated as a result of this recommendations, the Department of Public Health (and, as appropriate, the Department of Human Services) develop a detailed workplan of the specific activities to be carried out with such funds (including timeframes and milestones to be reached) and submit these workplans to the appropriate committees within the General Assembly.

RECOMMENDATION # 3

Authorize Medicaid to contribute toward the premium for employment-based coverage of otherwise eligible persons, including dependents, when such arrangements prove cost-effective.

As noted earlier in this report (See Finding # 5), the Task Force found evidence that a significant number of uninsured low-income children might live in households in which their parents had access to employer-based dependent health care coverage, but were unable to purchase it because they could not afford their portion of the premium.

The Task Force considers it appropriate public policy to assist low-income families to obtain employment-based dependent coverage when it is available. This position was reflected in its earlier endorsement of an application submitted by the Iowa Department of Human Services to the U.S. Health Care Financing Administration that would have allowed the State to conduct a special pilot program to extend Medicaid to children above its current eligibility levels and to use Medicaid funds, when appropriate, to cover the employee portion of the premium cost of employment-based dependent health care coverage. (Authorization for these pilot programs was subsequently awarded on a competitive basis to only three states. Iowa was not one of the awardees.)

The issue of coordinating Medicaid with available employment-based coverage was also addressed in the recently passed federal Omnibus Budget Reconciliation Act of 1990. A provision of that statute requires that state Medicaid programs begin purchasing employment-based group health insurance for Medicaid recipients when such arrangements prove to be cost-effective.

The Task Force encourages the Iowa Department of Human Services to implement this new requirement as expeditiously as possible, while at the same time encouraging the Department to develop mechanisms for coordinating these coverages that adhere to

the Task Force's principle of designing approaches that minimize the administrative burden imposed on employers, employees and their families, and the State.

The Task Force further encourages the Department to use this new federal requirement as an opportunity to design mechanisms to coordinate not only Medicaid and employment-based coverage, but also to:

- Coordinate between available employment-based dependent coverage and other public program coverage, including the state program for low-income children proposed under Recommendation # 2; and
- explore the possibility of developing a cost-effective mechanism for providing other forms of assistance, including direct subsidies, to non-Medicaid eligible low-income workers unable to afford dependent coverage.

RECOMMENDATION #4

Extend Medicaid coverage to aged, blind, and disabled persons with incomes at or below the federal poverty level and above the income eligibility level for the federal Supplemental Security Income (SSI) program.

Covering this optional eligibility group would extend Medicaid coverage to approximately 1,000 poor persons with high health care needs who are not currently covered for the full range of Medicaid benefits. It would also provide categorical Medicaid coverage to approximately 4,200 persons currently being covered under the program's medically needy "spend down" provisions. The annual cost of these new eligibles is estimated to be $3.2 million, of which approximately $1.2 million would be state dollars and the remainder federal matching dollars.

RECOMMENDATION # 5

Enact regulatory reform measures to correct problems in premium setting practices in the small group health insurance market.

As described earlier under Finding # 4, a number of problems in the current small group health insurance market make health care coverage unattractive to many small businesses. These problems include:

- Premium levels charged by the same insurer that may vary widely across firms with similar employee characteristics and utilization experience.
- Premium setting practices that result in many small businesses being offered very attractive first year rates, but then being hit by double -- or even triple -- digit increases in their premium costs in the following years. These staggering increases cause many businesses to not enter the market in the first place, drop their coverage, or switch to another carrier. The switching or "churning" that occurs only leads to further instability in the small group market and increases in premium costs because of the administrative expense associated with constantly re-enrolling these businesses.
- Insurers dropping some small businesses without notice or refusing to renew their coverage because of their claims experience.

A number of organizations, including the National Association of Insurance Commissioners (NAIC), have been working to develop a package of regulatory reform measures that would enable states to address these problems. At its September, 1990 meeting, NAIC approved an "exposure draft" of model state legislation concerning regulatory reform of premium rating practices. (A copy of this exposure draft is presented in Appendix I.) It is expected that NAIC will vote to adopt this draft regulatory reform

proposal, with perhaps minor modifications, as its official model legislation at its December 1990 meeting.

The content of this draft is consistent with provisions identified earlier by the Task Force at its June Meeting for addressing inappropriate rating practices in Iowa and reducing the volatility of health care premiums paid by small businesses. Specifically, the draft legislation being finalized by NAIC, which will apply to insurance sold to businesses of 25 or fewer employees, includes provisions in the following areas:

- Rating restrictions that:
  - limit annual premium increases faced by individual small businesses; and
  - limit the variation in premium rates charged to different types or classes of small businesses.
- Guaranteed renewability requirements that prohibit insurers from dropping specific small firms because of their claims experience.
- A requirement that insurers disclose their premium rating practices and renewability provisions to small businesses.
- A requirement that insurers maintain their records in proper order and submit an annual statement certifying that the rates they charge small businesses are actually sound and comply with all the above requirements.

Therefore, the Task Force:

- Endorses the provisions of the NAIC exposure draft; and
- Recommends that the Iowa General Assembly enact legislation implementing the NAIC model legislation. Should the final model legislation (which will not be available until after the Task Force's final meeting) differ significantly from the exposure draft, the Task Force further recommends that the Iowa Insurance Commissioner submit a brief report to the General Assembly that (a) identifies these differences, (b) assesses the potential impact of these changes in

Iowa, and (c) recommends whether these new changes should be adopted.

The adoption of the provisions of the proposed NAIC model legislation would have a negligible cost impact on the State of Iowa but could be expected to improve the affordability and stability of health care coverage for many small businesses within the state.

RECOMMENDATION # 6

Establish a state reinsurance program to ensure the availability of health care coverage to all small businesses and their employees.

Although the regulatory reform measures included in the previous recommendation can be expected to improve the small group market, they cannot ensure that all small businesses interested in obtaining coverage for their employees will find such coverage available to them. As was found in Health Systems Research, Inc.'s survey of health insurers operating in Iowa, most, if not all insurers, engage in medical underwriting to assess the risks associated with each small business. Many small businesses that may have one or more employees with high medical needs may find themselves unable to purchase coverage for that employee or perhaps for all of their workers. In some cases, insurers may consider all businesses within particular categories (e.g., barbers or health care institutions) to be unacceptable risks and refuse to sell coverage to any business in these categories.

To address this problem, the Task Force considered the option of a state-established reinsurance pool through which all small businesses would be able to purchase coverage and in which all insurers selling to small businesses would be required to participate. In general, under this reinsurance pool approach, insurers selling to small businesses would not be permitted to refuse to cover certain types of small businesses or specific firms with one or more high risk employees. Furthermore, the additional cost

of insuring high cost individuals is not borne solely by firms that employ these individuals, but is spread across a larger number of businesses. The establishment of such a reinsurance mechanism can be expected to increase the availability of health care coverage to small businesses with one or more employees with high health care needs.

The National Association of Insurance Commissioners is currently involved in developing model legislation to guide states in developing such a pool. NAIC has not yet completed work on its recommended specifications for a reinsurance mechanism, but is expected to have an initial report on the subject prepared for its December, 1990 meeting, with model legislation drafted by mid-summer of 1991.

Given the complexity of the issues involved in the development of a state reinsurance pool for small businesses and the significant resources that are being devoted to the development of the NAIC proposal, the Task Force recommends: (1) endorsing certain principles to be included in a state-authorized reinsurance mechanism, and (2) supporting the enactment of the NAIC model legislation when it is completed, assuming that it adheres to these principles.

More specifically, the Task Force's position on this issue includes:

- Support of state legislation that will:
  - eliminate multiple waiting periods for pre-existing conditions for persons switching carriers without a break in their coverage;
  - prohibit insurers selling to small businesses from blacklisting certain industries or refusing to offer coverage to high risk employees; and
  - establish a state reinsurance pool for small businesses that will:

- -- place a limit on the premiums that can be charged small businesses with one or more high risk employees; and

- -- spread any additional costs associated with this coverage across broader base of businesses.

- Recommend that the NAIC model legislation be used as the legislative vehicle for these new requirements, assuming that the model legislation includes all of the above provisions and pending the review and comment on the final NAIC model by the Iowa State Insurance Commissioner.

RECOMMENDATION #7

Keep the focus on health care reform until universal coverage becomes a reality.

As noted earlier in this report, one of the most important conclusions reached by the Task Force is that significant systemic changes must be made to our current fragmented health care financing structure if access to needed care is to be provided in a rational and affordable manner (see Finding #10).

Indeed, it is the Task Force's view that we must move toward a universal system of health coverage because the current mixture of public, employer, and individual financing, by its very nature, almost inevitably creates coverage gaps for some people, particularly when employment status changes. It is the Task Force's further view that, while ultimate responsibility for enactment and implementation of policies creating universal access to needed health care must rest at the federal level, the pressure for change, and perhaps the first steps toward major system reform, must spring up from the state and local level.

The Task Force recognizes that the fundamental restructuring of our current health care financing system into one that is more equitable, efficient, and rational represents a

task of heroic proportions. It is not a matter of dollars in the absolute sense, since it is the Task Force's belief that there are sufficient inefficiencies in the current system which, if corrected, could in large measure offset the additional expenditures associated with providing universal access to needed care. Rather, it is more a matter of major shifts in the distribution of the responsibility for financing health services. For example, the establishment of a publicly administered health care financing system would relieve employers of the significant costs associated with providing employee health benefits but would require a substantial increase in public tax revenues to finance such a system[12].

The Task Force recognizes that the challenges to be faced in making universal health care a reality are certainly daunting, but not unsurmountable. It also understands that overcoming these challenges may take significant time and effort. In fact, it was in recognition of the time required to achieve consensus on major health care reform that the Task Force adopted the first six of its recommendations. While these recommendations seek to improve upon the current fragmented system rather than establish a major new approach to health care financing, it is hoped that they represent measures around which political consensus can be developed rapidly and which will address the very real and pressing needs of vulnerable and underinsured persons in Iowa today. One other possible recommendation on which the Task Force focused considerable attention, but around which it was unable to reach consensus, involved a "pay or play" proposal which, beginning in 1994, would require Iowa businesses with ten or more workers to either provide health care coverage to their employees or contribute

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[12] It is estimated that the costs of providing health care coverage to the 220,000 uninsured persons in Iowa would be approximately $147 million. This represents less than a 4% increase in the estimated $3.9 billion being spent in 1990 for Iowa's non-elderly population. If health care spending for all Iowans is considered, including the State's elderly population, the estimate of 1990 spending is $6.6 billion. The incremental cost of covering the State's uninsured figure represent approximately 2% of this amount.

to a new payroll tax. (More detailed information on the "pay or play" proposal considered by the Task Force is presented in Appendix J.)[13]

Nonetheless, perhaps the Task Force's most significant long-term contribution to the improvement in the health care system, in Iowa and across the country, is the adding of its voice to the call for the enactment of a system of universal health care access. The Task Force strongly encourages a continuing and significant dialogue among citizens, policymakers, and health care providers in Iowa to discuss and identify the preferred form of a universal system and, in the absence of a successful initiative at the federal level, to push for enactment of such a system at the state level.

The Task Force believes that the results of its deliberations found in this report, including its findings, guiding principles, and recommendations, provide a context within which the dialogue in Iowa can be framed. However, they represent only a starting point. Only with continued discussion of the issues and strong grassroots involvement will the goal of universal health access become a reality for all Iowans.

The Task Force recommends that the State take responsibility for continuing this dialogue through the establishment of a broad-based "Universal Health Care Access Commission" that would remain in operation until its goals are attained and that seeks grassroots community involvement at all stages of its deliberations.

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[13] An analysis of th implications of the provisions of the federal Employee Retirement and Income Security Act of 1974 (ERISA) with respect to state "pay or play" strategies can be found in Appendix K.

IV. COST SUMMARY

Presented in the table on the following page are estimates of the cost to the State of Iowa to implement the Task Force's recommendations. These estimates cover a four year period beginning in 1991 and ending in 1994 and are presented in constant dollars.

TABLE V-1.
SUMMARY OF STATE OF IOWA COSTS ASSOCIATED WITH IMPLEMENTATION OF TASK FORCE RECOMMENDATIONS
(In Constant Dollars)

RECOMMENDATION	1991	1992	1993	1994
1. Public Program Covering Non-Medicaid Children <133% Poverty low - ambulatory services only high - Medicaid-like benefits	$500,000 - $750,000	$1,030,000 - $2,140,000	$1,560,000 - $3,530,000	$2,090,000 - $4,920,000
2. Delivery System Improvements (for further details see Appendix H)				
a. Expanded Preventive Services	$110,000	$550,000	$1,100,000	$1,650,000
b. Expanded Voucher Program	$554,000	$795,250	$1,110,500	$1,395,750
c. Medicaid Outreach*	$111,000	$111,000	$111,000	$111,000
d. Community Assessment	$315,000	$365,000	$285,000	$280,000
e. CHC Application	$50,000	$50,000	-	-
f. Personnel Shortage Coordination	$63,000	$48,000	$43,000	$42,000
Subtotal, Recommendation 2	$1,203,000	$1,919,250	$2,649,500	$3,478,750
3. Examine Potential for Expanding Medicaid/Private Sector Coordination	Minimal Additional Cost to State			
4. Extend Full Medicaid Coverage to Elderly and Disabled Below Poverty*	$1,197,000	$1,197,000	$1,197,000	$1,197,000
5. Regulatory Reform of Insurance Rating Practices for Small Groups	Minimal Additional Cost to State			
6. State-sponsored Reinsurance Program for Small Businesses	Minimal Additional Cost to State			
7. Continued Activities Regarding Health Care Reform	$200,000	$200,000	$200,000	$200,000
Total, All Recommendations	$3,100,000 - $3,350,000	$4,616,250 - $5,456,250	$5,606,500 - $7,576,500	$6,965,750 - $9,795,750

* State Funds Only

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October 3, 1990

MEMORANDUM

TO: CHAIRPERSON HUTCHINS AND MEMEBERS OF THE LEGISLATIVE COUNCIL

FROM: Diane Bolender, Director DB

RE: CANCELLATION OF OCTOBER MEETING

Chairperson Hutchins and Vice Chairperson Avenson have cancelled the October meetings of the Iowa Legislative council and its committees, scheduled for Thursday, October 11, 1990.

Enclosed are copies of Minutes of the following September meetings: Studies Committee, Service Committee, Computer Oversight Subcommittee of the Service Committee, and The Legislative Council.

The November meeting of the Legislative Council is tentatively scheduled for Thursday, November 15, 1990.

Coun1003
db/sw

TENTATIVE AGENDA

LEGISLATIVE COUNCIL

COMMITTEE ROOM 22

November 15, 1990

2:00 p.m. Call to Order

Roll Call

Consideration of Minutes of September 13 meeting
(Previously Distributed)

Election Laws Pricing Policy

Report on Legislator Orientation

Report of Fiscal Committee

Report of Service Committee

Report of Administration Committee

Report of Studies Committee

Additional Business, if any

Adjournment

agenccl
db/dg

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November 15, 1990

MEMORANDUM

TO: CHAIRPERSON HUTCHINS AND MEMBERS OF THE LEGISLATIVE COUNCIL

FROM: Diane Bolender, Director

RE: New Member Orientation

Approval is requested for the following expenses associated with the New Member Orientation Program:

1. Cost of coffee and doughnuts served during the Orientation to be divided equally between the Senate and the House of Representatives.
2. Travel, lodging, meal and related expenses of the members-elect to be paid by the house to which the member has been elected.
3. Per diem, travel and expenses of legislators assisting with the Orientation Program to be paid by the house in which the legislator is a member.
4. Cost of luncheon and dinner meals of legislative staff participating in the Orientation Program to be divided equally between the House of Representatives and the Senate.

LCOR
DB/dg

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November 5, 1990

MEMORANDUM

TO: CHAIRPERSON HUTCHINS, VICE CHAIRPERSON AVENSON, AND MEMBERS OF THE LEGISLATIVE COUNCIL

FROM: Diane Bolender DB

RE: Notice of Legislative Council Meeting Thursday, November 15, 1990

The Legislative Council and several of its committees are scheduled to meet on November 15, 1990, as follows:

10:00 a.m.	Service Committee Room 22
10:00 a.m.	Administration Committee Room 24
1:15 p.m.	Studies Committee Room 22
2:00 p.m.	Legislative Council Room 22

Tentative agendas for the meetings are attached.

PLEASE NOTE: Chairperson Hutchins is changing the dates of the December and January Legislative Council meetings and Council Committee meetings to Thursday, December 20, 1990, and Thursday, January 10, 1990.

Please notify the Legislative Service Bureau if you will be unable to attend the November Council meeting or one of its committees to which you have been appointed.

DATA PURCHASE AGREEMENT

THIS DATA PURCHASE AGREEMENT (the "Agreement"), dated _____, 19____, is entered into by and between MEAD DATA CENTRAL, INC., a Delaware corporation ("MDC"), and _____ _____ ("Provider").

WHEREAS, Provider maintains a database containing _____ _____ (the "Information"); and

WHEREAS, MDC desires to purchase copies of the Information in machine readable form;

NOW, THEREFORE, MDC and Provider hereby agree as follows:

1. MDC shall purchase from Provider, and Provider shall sell to MDC, a machine readable copy of the Information within _____ working days after [the execution of this Agreement by both parties/MDC's written request therefor from time to time during the term of this Agreement/the record layout, form and form of the Information to be purchased hereunder is developed and documented pursuant to the procedures set forth in Schedule A hereto].

2. MDC shall purchase from Provider, and Provider shall sell to MDC, [an updated machine readable copy of/a machine readable copy of all additions and revisions to] the Information on a [monthly/quarterly/annual] basis [within _____ working days after the inclusion of such additions and revisions in Provider's database/by _____ of each _____] [, but in no event later than any delivery of the same in printed or machine readable form to any users, subscribers or distributors of Information in any form]. Such updates shall consist of all Information [pertaining to a statutory or constitutional section if any component thereof has changed since the previous purchase of Information by MDC hereunder].

3. MDC will pay Provider $_____ [per year/for each copy of Information purchased by MDC from Provider pursuant to this Agreement/Section 1 of this Agreement and $_____ for each copy of Information purchased pursuant to Section 2 of this Agreement].

4. All Information delivered to MDC by Provider pursuant to this Agreement shall be in the machine readable record layout, form and format [described on/developed and documented pursuant to the procedures set forth in] Schedule A hereto. [If at any time subsequent to the initial delivery of Information to MDC hereunder, Provider desires to modify such record layout, form or format, it shall notify MDC in writing of the proposed modification and of the proposed effective date for such modification at least 60 days in advance of the proposed effective date. If such modification is not acceptable to MDC,

it may terminate this Agreement by written notice thereof to Provider, effective upon Provider's receipt of such notice.]

5. Provider shall send all copies of Information purchased by MDC pursuant to this Agreement by overnight courier service at MDC's expense to the following address (or such other address as MDC may designate in writing):

Mead Data Central, Inc.
Attention: _____
9473 Springboro Pike
Miamisburg, Ohio 45342

6. Upon payment of the consideration therefor, the copies of Information purchased by MDC hereunder shall become the sole and exclusive property of MDC.

7. Provider represents and warrants that it is authorized to sell copies of Information to MDC and covenants that [, to its knowledge,] neither the use nor distribution of Information by MDC will infringe any copyright or other right of any entity or person.

8. This Agreement will remain in effect until [_____, 19____/the ____ anniversary of the date of this Agreement/terminated by either party giving the other at least _____ days advance written notice of its desire to terminate this Agreement] [, unless sooner terminated by MDC pursuant to Section 4 of this Agreement [or by either party pursuant to Schedule A to this Agreement]].

IN WITNESS WHEREOF, the parties have set their hands as of the first date above written.

_____	MEAD DATA CENTRAL, INC.
BY: _____	BY: _____
NAME: _____	NAME: _____
TITLE: _____	TITLE: _____

SCHEDULE A

FORMAT OF INFORMATION

1. Within 14 days after the Effective Date, Provider shall provide MDC with a sample of the Information in machine-readable form (the "Test Data") containing samples of the various components of the Information (including text, section numbers, section titles and annotations). The Test Data shall be provided to MDC without charge, except that MDC shall reimburse Provider for any delivery costs incurred by Provider in providing the Test Data to MDC.

2. MDC will evaluate the Test Data to determine the suitability of the record layout, form and format of the information therein for use by MDC. Within 30 days after its receipt of the Test Data, MDC shall deliver to Provider a proposed written description of the record layout, form and format of the Information (the "Proposed Format Description") suitable for use by MDC.

3. Within 14 days after its receipt of the Proposed Format Description, Provider will notify MDC as to whether it is willing to provide the Information to MDC in the record layout, form and format described therein. If Provider is not willing to provide Information in such record layout, form and format, the parties will consult with each other and attempt in good faith to determine whether modifications to the Proposed Format Description can be made which will be acceptable to both parties. If so requested by MDC during the course of such consultation, Provider will provide MDC with additional Test Data in a revised record layout, form and format agreed to by both parties. If the parties agree to modifications to the Proposed Format Description, MDC will deliver to Provider a revised Proposed Format Description. If no such modifications are agreed to within 90 days after Provider's receipt of the original Proposed Format Description, this Agreement shall terminate and be of no further force or effect upon written notice thereof from either party to the other.

CODE DATA BASE

I. Contract

A. Cost

1. Costs associated with tape creation
   a. 1989 Code
      i. $31,820 -- Editing and text processing
      ii. $83,544 -- Assistant editors, indexing, and proofing
      iii. $23,073 -- Benefits
   b. 1989 Code Supplement
      i. $61,515 -- Labor costs
   c. 1990 Session Laws
      i. $59,269 -- Editing, proofing, and indexing
      ii. $ 4,300 -- Text processing
      iii. $ 7,691 -- Indexing
2. Computer costs appear to be negligible. Estimate that $200-250 would cover cost of tapes and computer time.

B. Contract

1. Length
2. Consideration
   a. Services available from publisher. Contracts now exist where Meade supplies 48 hours of Lexis computer time to contracting states. Time in excess of this 48 hours is billed at normal government rates.
   b. Cash price

II. Considerations

A. When does the consideration requested exceed the value of the benefit to be derived by the vendor?

B. Should we attempt to contract with more than one vendor?

C. What protections should be included in the contract?

D. What are the other essential provisions which should be in the contract? (Refer to examples provided by NCSL.)

1. Primary consideration should probably be given to states with codes similar to Iowa's.
2. Liability
    a. Inability to provide usable data
    b. Mistakes contained in data provided
3. Limitations on use

E. Timetable

1. Action soon enough to provide 1990 Code?
    a. Mead Data can still use 1990 tapes. Two-three month period from now during which tapes still useful to them.

Sec. 43. NEW SECTION. 97D.1 GUIDING GOALS FOR FUTURE CHANGES IN PUBLIC RETIREMENT SYSTEMS -- SOCIAL SECURITY -- PORTABILITY.

1. The general assembly declares that legislative proposals for changes in specific public retirement systems should be considered within the context of all public retirement systems within the state, with emphasis on equity and equality among the systems. The following list of guiding goals shall apply to the consideration of proposed changes:

a. Select those benefit enhancement options which most successfully deliver the greatest good to the greatest number of employees.

b. Choose those options which best correct existing inequities between and among the various retirement groups in the state.

c. Determine those options which most ably serve the twin objectives of attracting and retaining quality employees.

d. Avoid enacting further incentives toward earlier retirement with full benefits.

e. Avoid further splintering of benefits by disproportionate enhancement of benefits for one group beyond those available to another.

2. The public retirement systems committee established by section 97B.76 shall periodically weigh the advantages and disadvantages of establishing participation in the federal social security system for the members of public retirement systems operating under chapters 97A and 411 and the impact of such a change on total contributions and benefits.

3. The public retirement systems committee established by section 97B.76 shall consider proposals to achieve greater portability of pension benefits between the various public retirement systems in the state. Special attention should be given to the actuarial cost of transfers of value from one system to another.

Sec. 44. NEW SECTION. 97D.2 ANALYSIS OF COST OF PROPOSED CHANGES.

When the public retirement systems committee established by section 97B.76 or a standing committee of the senate or house of representatives recommends a proposal for a change in a public retirement system within this state, the committee shall require the development of actuarial information concerning the costs of the proposed change. If the proposal affects police and fire retirement under chapter 411, the committee shall arrange for the services of an actuarial consultant to assist in developing the information.

Sec. 86. NEW SECTION. 411.36 BOARD OF TRUSTEES FOR STATEWIDE SYSTEM.

1. A board of trustees for the statewide fire and police retirement system is created. The board shall consist of thirteen members, including nine voting members and four nonvoting members. The voting members shall be as follows:

a. Two fire fighters from different participating cities, one of whom is an active member of the retirement system and one of whom is a retired member. The fire fighters shall be appointed by the governing body of the Iowa association of professional fire fighters.

b. Two police officers from different participating cities, one of whom is an active member of the retirement system and one of whom is a retired member. The police officers shall be appointed by the governing body of the Iowa state police association.

c. The city treasurers of four participating cities, one of whom is from a city having a population of less than forty thousand, and three of whom are from cities having a population of forty thousand or more. The city treasurers shall be appointed by the governing body of the league of Iowa municipalities.

d. One citizen who does not hold another public office. The citizen shall be appointed by the other members of the board.

The nonvoting members of the board shall be two state representatives, one appointed by the speaker of the house of representatives and one by the minority leader of the house, and two state senators, one appointed by the majority leader of the senate and one by the minority leader of the senate.

2. Except as otherwise provided for the initial appointments, the voting members shall be appointed for four-year terms, and the nonvoting members shall be appointed for two-year terms. Terms begin on May 1 in the year of appointment and expire on April 30 in the year of expiration.

3. Vacancies shall be filled in the same manner as original appointments. A vacancy shall be filled for the unexpired term.

4. The board shall elect a chairperson from among its own members.

Sec. 87. NEW SECTION. 411.37 BOARD RESPONSIBLE FOR TRANSITION.

1. The board of trustees for the statewide system is responsible for effecting the transition from the city fire and police retirement systems to the statewide fire and police retirement system. The board shall adopt a transition plan and other appropriate transition documents it deems necessary to accomplish the transition in accordance with the requirements of this chapter. The city fire and police retirement systems shall comply with orders of the board issued pursuant to the transition plan or other transition documents.

2. The board shall include in the transition plan or other transition documents, provisions to facilitate continuity under sections 411.20, 411.21, and 411.30 and a recommendation for an equitable process for determining earnable compensation changes when calculating adjustments to pensions under section 411.6, subsection 12, to be submitted to the general assembly meeting in 1991.

3. For the fiscal year beginning July 1, 1990, ten percent of the amount appropriated for distribution to cities as provided in section 411.20 shall be made available to the board of trustees for the statewide system to cover the administrative costs of the transition. The amount distributed to each city shall be reduced accordingly. The moneys remaining unexpended at the end of the fiscal year shall be credited to the cities in the same proportion as the reduction.

Sec. 22. DEVELOPMENT OF CHILDREN'S PROGRAMS IN COMMUNITY SETTINGS AND OTHER CONCERNS RELATING TO JUVENILE JUSTICE.

1. a. The department of human services and the supreme court, in consultation with a planning group consisting of existing providers of services, 4 members of the general assembly equally representing the house and senate and both political parties, attorneys who are experienced in representing juveniles and in juvenile law, and experts in child welfare and juvenile justice, shall develop a plan identifying the types of residential programs which should be developed, either by enhancing reimbursement of foster care services or of psychiatric medical institutions for children, to serve the children who are currently in the following placements: the Iowa juvenile home, out-of-state facilities at high cost to the state, and the state training school when the children could be served in community settings if the proper type of program were available. The recommendations of the juvenile justice advisory committee, established by the legislative council in 1989, regarding the state training school and the Iowa juvenile home shall be considered. In addition, the need to develop specific programs to serve children who are sexual abuse perpetrators, substance abusers, or have a dual diagnosis, and the regions of the states where the specific programs should be located in order to serve children in community settings, shall be identified. The

department and the supreme court shall complete the plan involving the items required under this section on or before June 1, 1990.

b. Based upon the plan, the department shall request proposals to develop a total of 120 additional residential placement slots in community settings and the slots shall be available on or before October 1, 1991. The department shall work with the Iowa finance authority and service providers to finance the development of resources for these slots at the lowest possible cost. The requests for proposals shall be issued on or before July 1, 1990.

c. Notwithstanding the provisions of section 135H.6, subsection 5, psychiatric medical institution for children beds developed under this section are not subject to the limit upon the number of beds which may be provided under psychiatric medical institution for children licensure.

2. The planning group established in subsection 1 shall also develop a plan for the state juvenile justice system and related issues and shall perform other tasks when the tasks listed in subsection 1 are completed. The planning group shall conduct a review and develop recommendations regarding certain aspects of the system and perform the tasks designated in this subsection, and report to the governor and to the legislative council as recommendations are developed and tasks are performed and submit a final report no later than December 1, 1991. The plan and planning activities for the state juvenile justice system shall include but are not limited to all of the following:

a. Seeking public-private partnerships to modernize the educational and vocational programs offered at the state juvenile institutions.

b. The study group shall develop potential placement and program criteria for the state juvenile home, based upon the expectation that the home will continue to serve as a coeducational juvenile facility for 90 youth but shall

consider that residential treatment program expansions may eliminate the need for placements of children found to be in need of assistance (CHINA) at the home and that the population and population needs may change.

c. Developing a plan for converting the state training school at Eldora, or parts of the facility, to a statewide diagnosis and evaluation center used to identify appropriate treatment and placement alternatives. The plan shall include provisions, including estimated costs, to establish regional secure treatment facilities for youth who require intensive treatment in this type of setting for extended periods of time. The planning group shall consider potential locations for the facilities near areas of the state in which a wide variety of support services, work and training opportunities, and educational program support are available.

Section 1. ENTREPRENEURSHIP TASK FORCE.

The department of economic development shall convene an entrepreneurship task force on November 15, 1990, or as soon thereafter as practicable, for the purpose of studying how to encourage, promote, and support entrepreneurship in the state with the goal of increasing the formation and success of new business enterprises. The entrepreneurship task force shall be composed of twenty-five members appointed or designated by August 1, 1990, as follows:

1. The director of the department of economic development or the director's designee.

2. A member of the board of directors of the Wallace technology transfer foundation appointed by the board of directors of the Wallace technology transfer foundation.

3. A member of the board of directors of a small business economic development corporation appointed by the director of the department of economic development.

4. A member of the board of directors of the Iowa product development corporation appointed by the board of directors of the Iowa product development corporation.

5. A member of the board of directors of the Iowa business development corporation appointed by the board of directors of the Iowa business development corporation.

6. A member of the Iowa finance authority board appointed by the Iowa finance authority board.

7. A representative of the university of Iowa to be appointed by the president of the university of Iowa, a

representative of Iowa state university of science and technology to be appointed by the president of Iowa state university of science and technology, and a representative of the university of northern Iowa to be appointed by the president of the university of northern Iowa.

8. A representative of the community colleges appointed by the Iowa association of community college presidents.

9. A representative of the private colleges and universities appointed by the Iowa association of independent colleges and universities.

10. A designee of the governor from state government.

11. A senator appointed by the majority leader of the senate.

12. A senator appointed by the minority leader of the senate.

13. A member of the house of representatives appointed by the speaker of the house of representatives.

14. A member of the house of representatives appointed by the minority leader of the house of representatives.

15. Nine public members who are actively engaged as entrepreneurs appointed by the governor.

If a member has not been appointed by the date of the convening of the task force, the members already in place shall appoint the member at the task force's first meeting. A vacancy occurring in the membership of the entrepreneurship task force shall be filled in the same manner as the original appointment. The members' appointments shall terminate December 31, 1991. The members shall elect a chairperson at the first meeting of the task force. The chairperson shall call and conduct all future meetings.

The entrepreneurship task force shall submit a report of the task force's deliberations with a request for assistance to further study entrepreneurship or with specific recommendations to the department of economic development for transmission to the governor and the general assembly by January 15, 1991.

IOWA CIVIL RIGHTS COMMISSION

ANALYSIS COMPARING IOWA'S

FAIR HOUSING LAWS WITH THE

HUD CERTIFICATION CRITERIA

FOR STATE AGENCIES

HUD Certification Criteria for State Agencies	Commission Has:	Commission Does Not Have:
# 115.3 Criteria for adequacy of law. [a] In order for a determination to be made that a State or local fair housing agency administers a law which, on its face, provides rights and remedies for alleged discriminatory housing practices that are substantially equivalent to those provided in the Act, the law or ordinance must:		
[1] Provide for an administrative enforcement body to receive and process complaints and provide that:	# 601A.5.2	
[i] Complaints must be in writing;	# 601A.15.1	
[ii] Upon the filing of a complaint the agency shall serve notice upon the complainant acknowledging the filing and advising the complainant of the time limits and choice of forums provided under the law;		Acknowledgment not stated in 601A, but Admin. Rules # 161. 3.5 provides notice of complaint, but does not require choices be given.
[iii] Upon the filing of a complaint the agency shall promptly serve notice on the respondent or person charged with the commission of a discriminatory housing practice advising of his or her procedural rights and obligations under the law or ordinance together with a copy of the complaint;	# 601A.15.3a	
[iv] A respondent may file an answer to a complaint.		Respondent's right to file an answer is not stated in 601A.
[2] Delegate to the administrative enforcement body comprehensive authority, including subpoena power, to investigate the allegations of complaints, and power to conciliate complaint matters, and require that:	# 601A.15.3.a and 4.	
[i] The agency commence proceedings with respect to the complaint before the end of the 30th day after receipt of the complaint;	# 601A.15.3.a.	Does not state 30th day.
[ii] The agency investigate the allegations of the complaint and complete the investigation in no more than 100 days after receipt of the complaint;		Time limit not in # 601A. (The Admin. Rules may be the appropriate place place for the time limit.)

HUD Certification Criteria for State Agencies	Commission Has:	Commission Does Not Have:
[iii] If the agency is unable to complete the investigation within 100 days it shall notify the complainant and respondent in writing of the reasons for not doing so;		Not in # 601A. Belongs in Admin. Rules.
[iv] The agency make final administrative disposition of a complaint within one year of the date of receipt of a complaint, unless it is impracticable to do so. If the agency is unable to do so it shall notify the complainant and respondent, in writing, of the reasons for not doing so;		Not in # 601A. Belongs in Admin. Rules.
[v] Any conciliation agreement arising out of conciliation efforts by the agency shall be an agreement between the respondent and the complainant and shall be subject to the approval of the agency;		# 601A. does not require approval by the agency of conciliation agreements.
[vi] Each conciliation agreement shall be made public unless the complainant and respondent otherwise agree and the agency determines that disclosure is not required to further the purposes or the law or ordinance.		# 601A.15.4. prohibits the commission and its staff from disclosing information about complaints.
[3] Not place any excessive burdens on the complainant that might discourage the filing of complaints, such as:		
[i] A provision that a complaint must be filed within any period of time less than 180 days after an alleged discriminatory housing practice has occurred or terminated;	# 601A.15.12. requires complaints to be filed within 180 days.	
[ii] Anti-testing provisions;		Not in # 601A.
[iii] Provisions that could subject a complainant to costs, criminal penalties or fees in connection with filing of complaints.		Not in # 601A.
[4] Not contain exemptions that substantially reduce the coverage of housing accommodations as compared to section 803 of the Act (which provides coverage with respect to all dwellings except, under certain circumstances, single family homes sold or rented by the owners and units in owner-occupied dwellings containing living quarters for no more than four families).		# 601A.12.2 uses six rooms.

HUD Certification Criteria for State Agencies	Commission Has:	Commission Does Not Have:
[5] Be sufficiently comprehensive in its prohibitions to be an effective instrument in carrying out and achieving the intent and purposes of the Act, *i.e.*, prohibit the following acts:		
[i] Refusal to sell or rent based on discrimination because of race, color, religion, sex, familial status, or national origin;	# 601A.8.1-4.	
[ii] Refusal to negotiate for a sale or rental based on discrimination because of race, sex, familial status, or national origin;	# 601A.8.1-4.	
[iii] Otherwise making unavailable or denying a dwelling based on discrimination because of race, color, religion, sex, familial status, or national origin;	# 601A.8.1-4.	
[iv] Discrimination in the terms, conditions, or privileges of sale or rental of a dwelling, or in the provision of services or facilities in connection therewith, based on discrimination because of race, color, religion, sex, familial status, or national origin;	# 601A.8.3.	
[v] Advertising in a manner that indicates any preference, limitation, or discrimination because of race, color, religion, sex, familial status, or national origin;	# 601A.8.3.	Glen Fellows decision weakened this part of 601A.
[vi] Falsely representing that a dwelling is not available for inspection, sale or rental because of discrimination race, color, religion, sex, familial status, or national origin;	# 601A.8.1-4.	Glen Fellows decision weakened this part of 601A.
[vii] Coercion, intimidation, threats, or interference with any person in the exercise or enjoyment of, or on account of his or her having exercised or enjoyed, or on account of his or her having aided or encouraged any other person in the exercise or enjoyment of any right granted or protected by section 803, 804, 805, or 806 of the Act;	# 601A.8.2 & 4.	

HUD Certification Criteria for State Agencies	Commission Has:	Commission Does Not Have:
[viii] Blockbusting based on representations regarding the entry or prospective entry into the neighborhood of a person or persons of a particular race, color, religion, sex, familial status, or national origin;		Not expressly stated in # 601A.
[ix] Discrimination in residential real estate-related transactions by providing that: It shall be unlawful for any person or other entity whose business includes engaging in residential real estate-related transactions to discriminate against any person in making available such a transaction, or in terms or conditions of such a transaction, because of race, color, religion, sex, familial status, or national origin. Such transactions include:	# 601A.8.4.	Glen Fellows decision weakened this part of 601A. The Commission does not expressly have a provision for loans, but we have a bill which adds familial status to the unfair credit practice language.
[A] The making or purchasing of loans or the provision of other financial assistance for purchasing, constructing, improving, repairing, or maintaining a dwelling; or the making or purchasing of loans or the provision of other financial assistance secured by residential real estate; or		Not expressly stated in # 601A.
[B] The selling, brokering, or appraising of residential real property;		Not expressly stated in # 601A.
[a] Denying a person access to, or membership or participation in, a multiple listing service, real estate brokers' organization, or other service on account of race, color, religion, sex, familial status, or national origin.		Not in # 601A.
[b] In addition to the factors described in paragraph [a] of this section, the provisions of the State or local law must afford administrative and judicial protection and enforcement or the rights embodied in the law.		
[1] The agency must have authority to:		
[i] Seek prompt judicial action for appropriate temporary or preliminary relief pending final disposition of a complaint if the agency concludes that such action is necessary to carry out the purposes of the law or ordinance;	# 601A.5.4.	
[ii] Issue subpoenas;	# 601A.5.5	

HUD Certification Criteria for State Agencies	Commission Has:	Commission Does Not Have:
[iii] Grant actual damages, or arrange to have adjudicated in court at agency expense the award of actual damages, to an aggrieved person;	# 601A.15.8.a(4), (5)&(8).	
[iv] Grant injunctive or other equitable relief, or be specifically authorized to seek such relief in a court of competent jurisdiction;	# 601A.15.8.	
[v] Assess a civil penalty against the respondent, or arrange to have adjudicated in court at agency expense the award of punitive damages against the respondent.		Not in # 601A.
[2] Agency actions must be subject to judicial review upon application by any party aggrieved by a final agency order.	# 601A.17.	
[3] Judicial review of a final agency order must be in a court with authority to grant to the petitioner, or to any other party, such temporary relief, restraining order, or other order as the court determines is just and proper, affirm, modify, or set aside, in whole or in part, the order or remand the order for further proceedings; and enforce the order to the extent that the is affirmed or modified.	# 601A.17.	
[c] The requirement that the State or local law prohibit discrimination on the basis of familial status does not require that the State or local law limit the applicability of any reasonable local, State, or Federal restrictions regarding the maximum number of occupants permitted to occupy a dwelling.		Not in # 601A.
[d] The State or local law must assure that no prohibition based on discrimination because of familial status applies to housing for older persons substantially as described in Part 100 Subpart E.	# 601A.12.6.	
[e] A determination of the adequacy of a State or local fair housing law "on its face" is intended to focus on the meaning and intent of the text of the law as distinguished from the effectiveness of its administration. Accordingly, this determination is not limited to an analysis of the literal text of the law but must take into account such relevant matters of State		

HUD Certification Criteria for State Agencies	Commission Has:	Commission Does Not Have:
or local law, e.g., regulations, directives and rule of procedure, or interpretations of the fair housing law by competent authorities, as may be necessary.		
[f] A law will be held to be not adequate "on its face" if it permits any of the agency's decision making authority to be contracted out or delegated to a non-governmental authority. For the purposes of this paragraph, "decision making authority" shall include:		
[1] Acceptance of the complaint;		
[2] Approval of the conciliation agreement;		
[3] Dismissal of a complaint;		
[4] Any action specified in # 115.3[a][2][iv] or # 115.3[b][1].		
[g] The State or local law must provide for civil enforcement of the law or ordinance by an aggrieved person by the commencement of an action in an appropriate court not less than 1 year after the occurrence or termination of an alleged discriminatory housing The court should be empowered to:	# 601A.16.	
[1] Award the plaintiff actual and punitive damages;	# 601A.15. provides for actual.	Punitive damages are not in # 601A.
[2] Grant as relief, as it deems appropriate, any temporary or permanent injunction, temporary restraining order or other order;	# 601A.15.8.	
[3] Allow reasonable attorney's fees and costs.	# 601A.15.8.a.(8).	
# 115.3a Criteria for adequacy of law--discrimination because of handicap.		
[a] In addition to the provisions of # 115.3, in order for a determination to be made that a State or local fair housing agency administers a law which, on its face provides rights and remedies for alleged discriminatory housing practices, based on handicap, that are substantially equivalent to those provided in the Act, the law or ordinance must be sufficiently comprehensive in its prohibitions to be an effective instrument in carrying out and achieving the intent and purposes of		

HUD Certification Criteria for State Agencies	Commission Has:	Commission Does Not Have:
the Act, *i.e.*, it must prohibit the following acts:		
[1] Advertising in a manner that indicates any preference, limitation, or discrimination because of handicap;	# 601A.8.1-4.	
[2] Falsely representing that a dwelling is not available for inspection, sales, or rental based on discrimination because of handicap;	# 601A.8.1-4.	The Glen Fellows decision weakened this part of 601A.
[3] Blockbusting, based on representations regarding the entry or prospective entry into the neighborhood of a person or persons with a particular handicap;		Not expressly stated in # 601A.
[4] Discrimination in residential real estate-related transactions by providing that: It shall be unlawful for any person or other entity whose business includes engaging in residential real estate-related transactions to discriminate against any person in making available such a transaction, because of handicap. Residential and real estate-related transactions include:	# 601A.8.1,2&4.	The Glen Fellows decision weakened this part of 601A.
[i] The making or purchasing of loans or the provision of other financial assistance for purchasing, constructing, improving, repairing, or maintaining a dwelling; or the making or purchasing of loans or the provision of other financial assistance secured by residential real estate; or	# 601A.8.1,2&4.	
[ii] The selling, brokering, or appraising of residential real property;		Not expressly stated in # 601A.
[5] Denying a person access to, or membership or participation in, a multiple listing service, real estate brokers' organizations, or other services because of handicap;		Not in # 601A.
[6] Discrimination in the sale or rental or otherwise making unavailable or denying, a dwelling to any buyer or renter because of a handicap of that buyer or renter, or of a person residing in or intending to reside in that dwelling after it is sold, rented, or made available, or of any person associated with the buyer or renter;	# 601A.8.1-4.	

HUD Certification Criteria for State Agencies	Commission Has:	Commission Does Not Have:
[7] Discrimination against any person in the terms, conditions, or privileges of sale or rental of a dwelling, or in the provision of services or facilities in connection with the dwelling, because of a handicap of that person, of a person residing in or intending to reside in the dwelling after it is sold, rented, or made available, or of any person associated with that person.	# 601A.8.1-4.	
[b] For the purposes of this section, discrimination includes--		
[1] A refusal to permit, at the expense of the handicapped person, reasonable modifications of existing premises occupied or to be occupied by the handicapped person, if the modifications may be necessary to afford the handicapped person full enjoyment of the premises, except that, in the case of a rental, the landlord may, where it is reasonable to do so, condition permission for a modification on the renter's agreeing to restore the interior of the premises to the condition that existed before the modification, reasonable wear and tear excepted;		Not in # 601A.
[2] A refusal to make reasonable accommodations in rules, policies, practices, or services, when such accommodations may be necessary to afford a handicapped person equal opportunity to use and enjoy a dwelling; or		Not in 601A.
[3] In connection with the design and construction of covered multifamily dwellings for first occupancy after March 31, 1991, a failure to design and construct dwellings in such a manner that--		
[i] The dwellings have at least one building entrance on an accessible route, unless it is impractical to do so because of the terrain or unusual characteristics of the site;		Not in # 601A.

HUD Certification Criteria for State Agencies	Commission Has:	Commission Does Not Have:
[ii] With respect to dwellings with a building entrance on an accessible route--		
[A] The public use and common use portions of the dwellings are readily accessible to and usable by handicapped persons;		Not in # 601A.
[B] All the doors designed to allow passage into and within all premises are sufficiently wide to allow passage by handicapped persons in wheelchairs; and		Not in # 601A.
[C] All premises within covered multifamily dwelling units contain an accessible route into and through the dwelling; light switches, electrical outlets, thermostats, and other environmental controls in accessible locations; there are reinforcements in the bathroom walls to allow later installation of grab bars; and there are usable kitchen and bathrooms such that an individual in a wheelchair can maneuver about the space.		Not in # 601A.
[c] The law or ordinance administered by the State or local fair housing agency may provide that compliance with the appropriate requirements of the American National Standard for buildings and facilities providing accessibility and usability for physically handicapped people (commonly cited as "ANSI A117.1-1986") suffices to satisfy the requirements of paragraph [b][3][ii][C] of this section.		Not in # 601A.
[d] As used in this section, the term "covered multifamily dwellings" means buildings consisting of four or more units if such buildings have one or more elevators and ground floor units in other buildings consisting of four or more units.		Not in # 601A.

HUD Certification Criteria for State Agencies	Commission Has:	Commission Does Not Have:
# 115.4 Performance Standards. [a] The initial and continued certification that a State or local fair housing law provides rights and remedies substantially equivalent to those provided in the Act will be dependent upon an assessment of the current practices and past performance of the appropriate State or local agency charged with administration and enforcement of the law to determine that, in operation, the law is in fact providing substantially equivalent rights and remedies. The performance standards set forth in paragraph [b] of this section will be used in making this assessment.		
[b] A State or local agency must:		
[1] Engage in comprehensive and thorough investigative activities; and	# 601A.5.2.	
[2] Commence proceedings with respect to a complaint before the end of the 30th day after the receipt of the complaint, carry forward proceedings with reasonable promptness, and in accordance with the memorandum of understanding described in section 115.6 of this part, make final administrative disposition of a complaint within one year of the date of receipt of the complaint and, within 100 days of receipt of the complaint, complete the following proceedings:		Not in 601A. Belongs in Admin. Rules.
[i] Investigation, including the preparation of a final investigation report containing--	# 601A.5.2.	Not in # 601A. Belongs in Admin. Rules.
[A] The names and dates of contacts with witnesses;		
[B] A summary and dates of correspondence and other contacts with the aggrieved person and the respondent;		
[C] A summary description of other pertinent records;		
[D] A summary of witness statements; and		
[E] Answers to interrogatories.		

HUD Certification Criteria for State Agencies	Commission Has:	Commission Does Not Have:
[ii] Conciliation activity.	# 601A.5.3.	
[3] Conduct compliance review of all settlements, conciliation agreements and orders issued by or entered into to resolve discriminatory housing practices.		Not in # 601A. Belongs in Admin. Rules.
[4] Consistently and affirmatively seek and obtain the type of relief designed to prevent recurrences of such practices;	# 601A.15.9.	
[5] Consistently and affirmatively seek the elimination of all prohibited practices under its fair housing law;	# 601A.5.3.	
[c] Where the State and local agency has duties and responsibilities in addition to administration of the fair housing law, the Assistant Secretary may consider such matters as the relative priority given to fair housing administration, as compared to such other duties and responsibilities, and the compatibility or potential conflict of fair housing objectives with the agency's other duties and responsibilities.		

LICENSING AGREEMENTS

Arizona
Florida
Michigan
Minnesota
Montana
New York
Oregon
Pennsylvania
Washington
Wisconsin

Contact:
Jo Martinez
National Conference of State Legislatures
1050 17th Street, Suite 2100
Denver, CO 80265
(303) 623-7800

2. Sale of MCL to Mead Data Central

The Legislative Service Bureau, as part of its computer automation program, has developed Bill Status and Michigan Compiled Laws (MCL) computer data bases. In 1985, the Council approved a program of dial-up access on a subscription basis to these data bases. We currently have 50 state agency, local library, and private subscribers. The rules governing access also provide that "The Council may authorize the Bureau to provide additional data processing services, including alternative delivery services, to non-legislative users at a cost approved by the Council".

A number of commercial publishers and computer-based information services have submitted inquiries as to the availability of the Michigan Compiled Laws and updates on computer tape. According to a December 1987 NCSL report, the statutes of 22 states are available through LEXIS (Mead Data Central's online system) or WESTLAW (West Publishing Company's online system). In October 1986, the Bureau notified commercial law publishers across the country that the MCL would be available on computer tape. Mead Data Central of Dayton, Ohio has responded to this offer. A proposed contract has been negotiated, subject to Council approval. The major points of the contract are as follows:

---On or before July 1, 1989, the Bureau will provide Mead a computer tape of the current version of the MCL including all laws enacted through December 31, 1988. Updated versions will be provided Mead in 1990, 1991, 1992, and 1993. The tapes will be provided in an "as is" condition and no further additions or changes to the contents or formats are intended or required.

---Mead is granted a license to use the MCL, which includes copyrighted information, in its online computer based services through July 1, 1994, at which time it will delete the licensed materials from its computer. Mead would be restricted from selling, leasing, loaning or transferring the contents of the computer tapes to a third party or using the tapes to publish a printed or compact disc version of the MCL.

---In consideration, Mead will pay the sum of $92,018 ($46,010 in 1989 and $11,502 in the subsequent four years). NCSL reports there is great variation in the prices the states will receive for copies of their statute data bases, depending upon the access policy adopted by the legislature and demand for each state's data base. For comparative purposes, states reporting finalized agreements include:

State	Term	Price
Minnesota	five years	$35,000
Montana	four years	$35,200
Washington	five years	$50,000
New York	---	$175,000
Utah	---	$5,000

---No warranty or representation of any kind will be made respecting the data or use thereof, or the accuracy or completeness of the tapes. Neither the State, the Bureau, nor any agency of the legislature shall be liable or responsible for any omissions or errors.

---The Bureau is not prohibited from granting similar license to other parties or providing its own online computer based services.

---The relationship of Mead Data Central and the Bureau is a contractual relationship of independent parties. The parties are not partners, joint venturers, or agents of onanother.

PROPOSED CHANGES TO LEGISLATIVE SESSION DEADLINES

Amend Joint Rule 20 as follows:

Rule 20

Time of Committee Passage and Consideration of Bills

1. This rule does not apply to concurrent or simple resolutions, joint resolutions nullifying administrative rules, senate confirmations, or bills passed by both houses in different forms. Subsection 2 of this rule does not apply to appropriations bills, ways and means bills, legalizing acts, administrative rules review committee bills, bills cosponsored by majority and minority floor leaders of one house, bills in conference committee, and companion bills sponsored by the majority floor leaders of both houses after consultation with the respective minority floor leaders. For the purposes of this rule, a joint resolution is considered as a bill. To be considered an appropriations or ways and means bill for the purposes of this rule, the appropriations committee or the ways and means committee must either be the sponsor of the bill or the committee of first referral in the originating house.

2. To be placed on the calendar in the house of origin, a bill must be first reported out of the committee of first referral by Friday of the 10th week of the first session and the ~~8th~~ 6th week of the second session. To be placed on the calendar in the other house, a bill must be first reported out of the committee of first referral by Friday of the 13th week of the first session and the ~~11th~~ 9th week of the second session.

3. During the 11th week of the first session and the ~~9th~~ 7th week of the second session, each house shall consider only bills originating in that house and unfinished business. During the 14th week of the first session and the ~~12th~~ 10th week of the second session, each house shall consider only bills originating in the other house and unfinished business. Beginning with the 15th week of the first session and the ~~13th~~ 11th week of the second session, each house shall consider only bills passed by both houses, bills exempt from subsection 2 and unfinished business.

4. A motion to reconsider filed and not disposed of on an action taken on a bill or resolution which is subject to a deadline under this rule may be called up at any time before or after the day of the deadline by the person filing the motion or after the deadline by the majority floor leader, notwithstanding any other rule to the contrary.

Amend House Rule 31.8 as follows:

31.8. No amendment to the rules of the house, to any resolution or bill, except technical amendments and amendments to bills substituted

for by senate files containing substantially identical title, language, subject matter, purpose and intrasectional arrangement, shall be considered by the membership of the house without a copy of the amendment having been filed with the chief clerk by 4:00 p.m. or within one-half hour of adjournment, whichever is later, on the day preceding floor debate on the amendment. This provision shall not apply to any proposal debated on the floor of the house after the fourteenth week of the first session and the ~~twelfth~~ tenth week of the second session. No amendment or amendment to an amendment to a bill, rule of the house, or resolution shall be considered by the membership of the house without a copy of the amendment being on the desks of the entire membership of the house prior to consideration.

RJ/1198c

REQUESTS SUBMITTED BY RESOLUTION

RESOLUTION NO.	SPONSOR	SUBJECT OF STUDY
SCR 103	Varn	Appointment of a Joint Code Publication Subcommittee
SCR 106	Pate, Soorholtz, Hedge, Rife, Hultman, Corning, Tinsman, Lind, Hagerla, Gentleman, Tieden, Taylor, and Rensink	Creation of a Task Force on Ozone Depletion
SCR 108	Rensink	Midwest Higher Education Compact
SCR 113	Tinsman, Husak, Welsh, Tieden, and Hultman	Taxation of Private Pensions, both Contributory and non-contributory
SCR 117	Horn	Distribution and Retail Sale of Alcoholic Liquors and Wine in Iowa
SCR 132	Committee on Agriculture	Regulation of Grain Dealers and Grain Warehouse Operators, and to the protection of the Grain Depositors and sellers Under chapters 542, 543, and 543A
SCR 134	Running	Continuance of the Department of Employment Services Review Interim Study Committee
SCR 135	Running, Hannon, and Sturgeon	Recommendations Relating to the Exposure of Emergency Medical Care Providers to to Contagious and Infectious Diseases, including the Human Immunodeficiency Virus
SR 106	Vande Hoef	Practices by Railroad Companies Delivering Iowa Grain
SR 109	Vande Hoef	Treatment of Head-Injured Persons

SR 110	Committee on Agriculture	Study Methods to Increase Livestock Production and Expand Value-added processes Involving Livestock Products in this State
SR 111	Committee on Agriculture	Study Business Practices Related to Consignment Sales of Agricultural Property
HCR 102	Maulsby	Studying Property Tax Relief through a Moneys and Credits Tax
HCR 109	Committee on Education	Area Education Agency Re-organization and Accreditation
NOT FILED	Transportation and Safety Approps. Subcommittee	Establishment of a Full-Time Position of State Medical Examiner
NOT FILED	Renaud	Exposure of Emergency Medical Care Providers to Contagious and Infectious Diseases, Including Human Immuno-deficiency Virus
NOT FILED	Nielsen, Neuhauser, Mertz, Beatty, Spear, Svoboda, Corbett, Brand, Kistler, and Plasier	Parenting Education and Assistance Programs

Requests,Res420
jp/jj/15