

ALASKA LEGISLATURE

985

HOUSE and SENATE FINANCE COMMITTEE FILES, 1993-1994

59

HB

168

SFIN

FILE

SENATE FINANCE COMMITTEE REPORT

DATE: 5/10/93

FURTHER:

DATE TURNED INTO OFFICE: 5-11-93

The Finance Committee considered CS FOR HOUSE BILL NO. 168(FIN) am
Charitable gaming; efd.

and recommends:

- replace with _____ CS _____ (FINANCE)
- or adopt previous _____ CS _____
- attaches amendment(s)

- same title
- new title
- technical title change (HB only)

adopts _____ Letter of Intent

further referral to the _____

do pass

do not pass

no recommendation

individual recommendations

NEW FISCAL NOTES

Department	Date	Zero	Fiscal
Revenue	5/8/93		\$ 381.0

PREVIOUS FISCAL NOTES

Department	Date	Zero	Fiscal

Appropriation No Fiscal Note

DO PASS:

OTHER RECOMMENDATIONS:

Best Chair Needs Answer
Have this No Rec
Send to No Rec
Dispute table up Rec
1. Full Rec - 10/93

1. *Don't Do Pass*
Co-Chair: Signature/Recommendation

2. *Full Rec - 10/93*
Co-Chair: Signature/Recommendation

FISCAL NOTE

STATE OF ALASKA
1993 LEGISLATIVE SESSION

BILL NO. CSHB 168 (Fin)

Revision Date: 5/8/93
 Title: An Act relating to Charitable Gaming, etc.
 Sponsor: House Rules Committee
 Requestor: House Rules

Department Affected: Revenue
 BRU: Gaming
 Component: _____
 COMPONENT SERIAL NO. _____

EXPENDITURES/REVENUES:

OPERATING	FY 94	FY 95	FY 96	FY 97	FY 98	FY 99
PERSONAL SERVICES	270	270	270	270	270	270
TRAVEL	7	7	7	7	7	7
CONTRACTUAL	50	50	50	50	50	50
SUPPLIES	2	2	2	2	2	2
EQUIPMENT	52	0	0	0	0	0
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	381	329	329	329	329	329

CAPITAL						
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REVENUE FUND SOURCE:	274	274	274	274	274	274
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FUNDING:

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts	381	329	329	329	329	329
1006 GF/MHTIA						
OTHER						
TOTAL						

POSITIONS:

FULL-TIME	5	5	5	5	5	5
PART-TIME						
TEMPORARY						

Estimate of current year (FY 93) impact: 0

ANALYSIS:

See Attached.

Prepared by: John Hansen, Gaming Program Manager
 Division: Gaming

Phone: 465-2581
 Date: 5/8/93

Approved by Commissioner: Paul Fuhs
 Agency: Commerce and Economic Development

Date: 5/8/93

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**Gaming Division
Budget Amendment Description**

100 Personal Services

FY 94

<u>Position</u>	<u>Location</u>	<u>Total Cost</u>
1 Auditor III	Fairbanks	\$ 61.1
1 Auditor III	Anchorage	61.1
1 Tax Examiner II	Juneau	49.2
1 Administrative Assistant I	Juneau	52.9
1 Document Processor II	Juneau	33.5
Convert Director's Position (currently Program Manager, 22F)		<u>4.6</u>
		\$268.4

200 Travel

Increase in travel for audits, investigations, and training 7.0

300 Contractual Services

Revenue Hearing Officers 50.0

400 Supplies

Increase in supplies due to additional staff 2.0

500 Equipment (1 time cost only)

6 each computers at \$3,200	19.2	
1 laser printer	4.0	
software package and programming	6.0	
workstations and files for five positions	<u>21.0</u>	
Total Equipment		50.2

IIAN

GBA

**ADDITIONAL
EXPLANATION
FORM**

AGENCY Commerce & Economic Development
 BRU Occupational Licensing
 COMPONENT Operations

FY 94

Page 2 of 2
 Revised Date

NO. 2
 CS/H3/198CF

STATE OF ALASKA

DEPARTMENT OF COMMERCE AND
ECONOMIC DEVELOPMENT

DIVISION OF OCCUPATIONAL LICENSING

NO. 2
CSHB 168 (Fla)
~~WALTER HICKEL, GOVERNOR~~
19-4

P O BOX 110806
JUNEAU, ALASKA 99811-0806
PHONE: 1907-463-2534

February 25, 1993

The Honorable Brian Porter
House of Representatives
State Capitol
Juneau, AK 99801-1182

Received

FEB 25 1993

BY BRIAN PORTER

Dear Representative Porter:

Re: Budget Increase Revenue Projection

Per your request of February 23, 1993, I have computed what I believe to be a conservative increase in net proceeds to permittees as well as increase in revenues to the state based upon the \$381.0 budget increase we proposed.

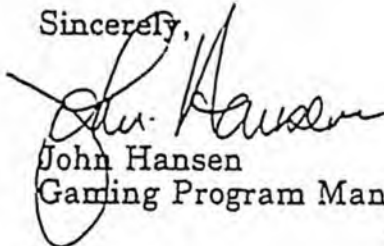
Net proceeds to permittees should increase by \$1.6¹ million. State revenues will increase by approximately \$274.0².

Revenue & Expenditures

<u>FY 94</u>	Revenue Estimate	\$1.974.0 ³
	Budget Expenditures	\$1.042.0
	Balance to General Fund	<u>\$ 932.0</u>

As reflected above the Gaming Program will generate more revenue and provide the general fund with approximately one million dollars in excess. Enclosed is the schedule used to arrive at these estimates.

Sincerely,



John Hansen
Gaming Program Manager

JH/go001 jh
022593c
Enclosures

¹Refer to revenue project - enclosed

²Refer to revenue project - enclosed

³Refer to revenue project - enclosed

Alaska State Legislature

Representative Carl E. Moses



CHAIRMAN
HOUSE RULES COMMITTEE

CHAIRMAN
HOUSE SPECIAL FISHERIES COMMITTEE

MEMBER
FINANCE SUBCOMMITTEES
FISH AND GAME
PUBLIC SAFETY

SESSION:
CAPITOL BUILDING, ROOM 204
JUNEAU, ALASKA 99801-1182
PHONE: (907) 485-4451
FAX: (907) 465-3445

INTERIM:
P.O. BOX 109
UNALASKA, ALASKA 99685
PHONE: (907) 581-1234
FAX: (907) 581-2875

SPONSOR STATEMENT FOR CS HB 168(FIN)

Representative Carl E. Moses

This bill reforms licensed gambling in Alaska. It increases the amount of money going to charitable nonprofits and it prevents the criminal element from gaining a foothold in our state gaming industry. It does this without increasing gambling in Alaska.

This bill restricts the way profits derived from gaming may be used. Currently, there is a diversion of pull-tab and bingo profits to registered lobbyists; this bill allows registered lobbyists to be paid only from profits of raffles. This bill benefits charities by increasing their guaranteed percentage return. It permissively allows charities alternatives to placing their permits with "for profit" operators. The bill does shift the flow of money in favor of the charities. It gives nonprofits additional avenues by which to generate money using their permits while restricting the activities of "for profit" operators.

The bill:

1) Prevents criminal elements from gaining a foothold in Alaskan gaming by denying felons access and controlling the access of others. If an individual has been convicted of a crime that was a class A felony, unclassified felony, or a crime involving theft, dishonesty, or gambling laws within the state of Alaska, or any other jurisdiction, this individual would be prohibited from involvement with gaming. This bill also allows the Department some discretion for people convicted of lesser crimes after 10 years have passed.

2) Prohibits the payment of any portion of the net proceeds from pull-tabs and bingo, directly or indirectly, to a registered lobbyist.

3) Provides a reasonable licensing scheme that allows charitable organizations alternatives to placing their permits with "for profit" operators. Permittees who operate their own permits often double their net proceeds. The bill allows permittees to contract with vendors to sell pull-tabs

for the permittee. Vendors would be required to pay permittees 70% of the ideal net proceeds to the permittee when the pull-tabs are delivered to the vendor. Vendors are limited to those facilities that possess a package store license or a beverage dispensary license granted by the ABC board. Those facilities possessing the beverage dispensary license and granted a restaurant designation by the ABC board would be restricted to selling pull-tabs only in those areas off limits to minors.

4) Adds multiple beneficiary language which allows the Department to issue permits authorizing 2 to 6 permittees to jointly operate their permits. This benefits permittees who band together by providing the economic benefits of jointly operating. While most operators run honest businesses, there are those that do extort concessions beyond what most people would consider ethical.

5) Requires the Department of Commerce to approve contracts between operators and permittees before the operator may conduct the gaming.

6) Allows the Department to revoke a permit, license, or vendor registration upon proof that insider information on the status of pull-tab prizes was given or acted upon.

7) Requires that the Department license out-of-state manufacturers of pull tabs.

8) Requires that operators increase the return of net proceeds from pull-tabs to charities from 15% to at least 30%. The return on other gaming activities is increased from 0% to at least 10%.

9) Provides that the N.A.G.R.A. pull-tab standards be required for pull-tab games sold in Alaska. These are higher quality standards than those currently required.

10) Provides specific suspension/revocation authority up to 5 years for licensee's or vendors.

11) Provides authority to Commissioner to issue an emergency 60 day order to stop unauthorized or illegal activity.

12) Requires that pull-tab manufacturers pay a \$2500 annual licensing fee.

13) Prohibits people under the age of 21 from playing pull-tabs, which conforms to the Alaska drinking age, and

14) Permittees may not contract with more than five vendors to sell pull-tabs under their permit.

Under existing law, pull-tabs can be sold in bars and liquor stores, but current statute does not provide clear guidelines for direct third party relationships between permittees and these facilities. The third party provisions contained in this bill provide for a reasonable licensing scheme for activities that are already occurring. This bill provides the department with the needed tools to effectively regulate third party activities.

In addition, the following House Floor amendments were made:

(1) All references to non-commercial broadcasting stations were deleted from the bill. This provision had been previously added in House Finance.

(2) villages and cities are given a local option to ban pull-tabs, if they wish to do so

(3) the calculation of ideal net proceeds was changed from a quarterly to an annual basis.

(4) requires that people in charge of operating a permit must pass a test on the contents of this Act.

(5) allows one distributor to distribute pull-tabs to another distributor

This bill does not expand gambling in Alaska, rather it reforms gaming. It does not put genuine charitable organizations out of business. It does not set unrealistic minimum returns for operators or charities or eliminate nonprofit charities from holding permits. Rather, every nonprofit now eligible stays eligible, and they would retain even greater proceeds.



Official Business

Alaska State Legislature

HOUSE OF REPRESENTATIVES

State Capitol
Juneau, AK 99801-1182

SECTIONAL ANALYSIS UPDATE

May 11, 1993

The following changes were made to CSHB 168 (FIN) on the floor of the house:

- 1) Amendment 3 deletes all references to charitable gaming by noncommercial broadcasting stations or networks.
- 2) Amendment 7 was passed to clarify that a community will have the option to vote to prohibit pull-tabs in their community. Previously the vote had covered the broader category of "charitable gaming" in general.
- 3) Amendment 8 changed the calculation of net proceeds to charities from a quarterly to an annual basis.
- 4) Amendment 9 requires persons in charge of operating a permit to pass a test on the contents of this Act.
- 5) Amendment 12 allows one distributor to distribute pull-tabs to another distributor.
- 6) Finally, amendment 19 deleted the short title of the Act.



Alaska State Legislature

HOUSE OF REPRESENTATIVES

Official Business

MEMORANDUM

State Capitol
Juneau, AK 99801-1182

TO: Representative Ramona L. Barnes
Speaker of the House

FROM: Douglas A. Wooliver
Staff Attorney

SUBJECT: Sectional Analysis of CSHB 168 (FIN)

DATE: May 8, 1993

The following is a sectional analysis of CSHB 168 (FIN) which is the charitable gaming bill. This sectional closely follows and is adapted from a sectional done by Jerry Luckhaupt in legal services.

Section 1 provides a short title.

Sections 2, 4, 11, 23, 27, 28 and 30 of the bill deal with allowing permittees (charitable organizations) to contract with vendors, defined in section 31 of the bill, to sell pull-tabs for the permittee through an endorsement of the charitable organization's permit. Section 28 is the "meat" of this area of the bill.

Sections 2, 5, 7, 8, 9, 14, 18, 19, 20, and 25 deal with multiple-permittee charitable gaming. Sections 5 and 14 are the substantive portion of these sections.

Section 3 requires that the Department of Commerce and Economic Development's regulations meet the standards set by the North American Gaming Regulators Association.

Sections 6, 13, 29 and 30 relate to what criminal convictions disable someone from working in charitable gaming. These sections also provide an exemption for people with certain convictions when those convictions are ten years old.

Section 10 requires the Department of Commerce and Economic Development's approval of contracts between operators and permittees.

Sections 12 and 16 deal with increasing the percentage that operators must pay to permittees for a pull-tab activity from 15 percent to 30 percent of adjusted gross income and requiring 10 percent of the adjusted gross income from gaming activities other than pull-tabs.

Section 15 states that no net proceeds from bingo and pull-tabs may be used to pay a lobbyist.

Sections 17 and 29 deal with procedures for the revocation and regulation of licenses, permits, and regulations.

Section 21 requires the licensing of out-of-state manufacturers of pull-tabs.

Section 22 allows the department to issue a pull-tab manufacturer's license to a person who pays an annual fee of \$2,500.

Section 24 prohibits anyone under the age of 21 from playing or buying pull-tabs. This section also prohibits the sale of pull-tabs to anyone under the age of 21.

Section 26 provides that any pull-tab game that allows some persons to participate in a lottery for additional prizes may not be conducted unless a surety bond is posted and approved by the attorney general. Under this section no prize can exceed \$250,000.

This section also allows public radio stations to sell pull-tabs under certain specified conditions.

Section 27 limits permittees, licensees, and vendors from purchasing their own pull-tabs and requires receipts for prizes of \$50 or more in pull-tab games.

Section 28 provides that if a permittee contracts with a vendor, the contract must provide that the permittee shall receive no less than 70 percent of the ideal net.

POSITION PAPER


DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT

House Finance Committee CS for HB168

The department supports the provisions of this CS including the amendments made during the 5/7/93 House Finance Committee meeting with the exception of the APRN amendment.

Concerning the APRN amendment: the department did attempt to implement the provisions adopted by the legislature in the existing statute allowing for an on the air game by APRN. We have been unable to implement these provisions without violating other provisions of the statute and our regulations.

In general, Governor Hickel opposes expanding gaming activity in Alaska and would oppose the creation of a statewide lottery in Alaska.


Paul Fuhs, Commissioner
5/8/93



Official Business

Alaska State Legislature

HOUSE OF REPRESENTATIVES

Representative Brian Porter

State Capitol
Juneau, AK 99801-1182

March 4, 1993

Honorable Ron Larson
Honorable Eileen Maclean
Co-Chair, House Finance Committee
State Capitol
Juneau, AK 99801-1182

Dear Representative Larson,

Attached is a letter from John Hansen, Gaming Program Manager. This program is moving (and appropriately so) to the Department of Revenue from the Department of Commerce and Economic Development.

The program receipts generated by this division are approximately \$1.6 million, while their budget is \$681.4 thousand. All our governments' efforts should be so productive.

I'm writing, though, to ask your consideration of the program's request (attached) for a budget increase. Obviously, this is a request not made lightly in view of our need to reduce overall spending. I urge your consideration for two primary reasons:

1. Historically, as states and cities have passed gaming laws, they have used too much of the resulting revenue for general fund needs and too little to adequately manage, supervise and control the gaming. We read almost weekly of the negative results of this practice. "Skimming" and other forms of corruption seem to automatically follow a lack of commitment to control gaming operations. Alaska needs to make this commitment.
2. Our state's gaming regulations were, from my recollection, not instituted to provide state revenue. Rather, they were designed to develop revenue for qualifying charities. As can be seen in Mr. Hansen's analysis, the intent of their increase request is to provide a more adequate level of review and audit of the reports and tax forms completed by gaming operators. These submissions provide

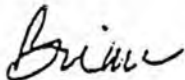
Representative Ron Larson
Representative Eileen Maclean
March 4, 1993
Page 2

revenue, but more importantly, the appropriate level of return to the (permitted) charity.

Mr. Hansen's attached second submission dated February 25, 1993, indicates that the increased audits and reviews generated by this budget increase would provide an additional \$1.6 million to charity and \$274.0 thousand to the State. I'm sure some of the \$1.6 million would offset current HESS funding for these kinds of activities.

I respectfully ask your consideration of this request for what arguably is a minimal increase that will provide substantive benefit to state government, the gaming industry and to necessary charity programs throughout our entire state.

Sincerely,



Brian Porter

BP:elm

Attachments

cc: House Finance Committee Members

*bcc: John Hansen
Gaming Manager*

WALTER J. HICKEL, GOVERNOR

DEPARTMENT OF COMMERCE AND
ECONOMIC DEVELOPMENT

DIVISION OF OCCUPATIONAL LICENSING

P O BOX 11806
JUNEAU, ALASKA 99811-0806
PHONE (907) 465-2534

February 17, 1993

Received

FEB 22 1993

F. J. HICKEL

The Honorable Brian Porter
House of Representatives
State Capitol
Juneau, AK 99801-1182

Dear Representative Porter:

RE: Gaming Program Support

Executive Order #82 transfers the administration of the Gaming program from the Division of Occupational Licensing, Department of Commerce and Economic Development, to the Gaming Division located in the Department of Revenue effective July 1, 1993.

Currently, the program is located in the Division of Occupational Licensing in DCED. The division is responsible for administering 36 various regulatory and licensing programs.

The Governor believes these activities require close supervision, including auditing of financial records which will be more effective in the Department of Revenue. The FY 94 request for program staff consists of 11 PFT positions and contractual funding for a seasonal (six-month) position.

Under the Department of Revenue, the Gaming Division would be responsible for administration of the Gaming program (AS 05.15) and the Coin-Operated Amusement and Gaming Device (AS 43.35) program. Currently, licensed gaming in Alaska is a \$205 million industry conducted by approximately 1,000 permittees and 40 licensed operators. Reviews of the tax returns and financial statements are a critical part of compliance. This program is funded through program receipts. FY 94 income is estimated to be at \$1.6 million for the Gaming program. Total expenditures will be approximately \$681.4, leaving the balance to the general fund. Revenues from the coin-operated device tax currently at \$100.0 would also increase substantially. Currently, enforcement efforts are minimal in this area. Approximately 500 licenses are issued annually. We believe more of these devices exist in Alaska. Gaming investigators are experienced in this area. Many of these devices are located in premises where gaming activity is being conducted. Collection of this tax would be more efficient and better compliance is anticipated.

February 17, 1993

Permittees and operators that conduct gaming are required to file financial statements on a quarterly basis and also annual financial statements and remit a 1% fee to the state. Pull-tab distributors also collect a 3% tax on the ideal net from permittees and remit those taxes on a monthly excise tax return.

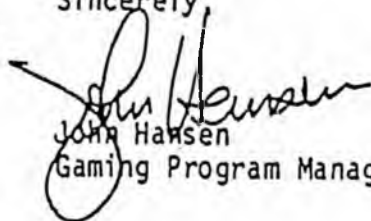
The review and audit of these financial statements are critical. Gaming is grossly understaffed. We have one auditor assigned to conduct these audits. Complex audits of operators can take as much as six months to complete. The audits that we have completed indicate a general lack of compliance. Noncompliance results in less money available to the permittees and underpayment of taxes to the state. Since 1990, our enforcement efforts were primarily in getting all gaming operations in compliance with our licensing requirements. If operations were not legal, they were shut down. This was accomplished through investigators working in the field. We now have three offices: Juneau, Anchorage, and Fairbanks, with a Chief of Compliance and three investigators. We believe there exists substantial compliance with our licensing requirements today. However, the financial statements need auditing.

As you requested, I have provided a proposed budget amendment for five new positions to support the audit of these financial statements and provide for administrative support for the Gaming Division in the DOR. The total increase for these positions is \$381,000. Any help in this area would result in an increase in accountability of this activity.

As I briefly described to you, at this point, the administration is not planning to request any new positions; however, any support in this area would be welcomed.

If I can provide any further information, please let me know. Thank you for your assistance.

Sincerely,


JOHN HANSEN
Gaming Program Manager

JH/dg14005D
021793c
Enclosures

cc: Cheryl Frasca, Office of Management and Budget
Rod Maurant, Department of Revenue

Gaming Division
Budget Amendment Description

100 Personal Services

FY 94

<u>Position</u>	<u>Location</u>	<u>Total Cost</u>
1 Auditor III	Fairbanks	\$ 64.1
1 Auditor III	Anchorage	64.1
1 Tax Examiner II	Juneau	49.2
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1 Document Processor II	Juneau	33.5
Convert Director's Position (currently Program Manager, 22F)		<u>4.6</u>
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Increase in travel for audits, investigations, and training 7.0

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Revenue Hearing Officers 50.0

400 Supplies

Increase in supplies due to additional staff 2.0

500 Equipment (1 time cost only)

6 each computers at \$3,200	19.2
1 laser printer	4.0
software package and programming	6.0
workstations and files for five positions	<u>21.0</u>

Total Equipment 50.2

001.HAN

GBA

ADDITIONAL
EXPLANATION
FORM

AGENCY Commerce & Economic Development
BRU Occupational Licensing
COMPONENT Operations

FY 94

Page 2 of 2
Revised Date _____

STATE OF ALASKA

DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT

DIVISION OF OCCUPATIONAL LICENSING

WALTER J. HICKEL, GOVERNOR

P O BOX 110806
JUNEAU, ALASKA 99811-0806
PHONE: (907) 465-2534

February 25, 1993

Received

FEB 25 1993

FOR BRIAN PORTER

The Honorable Brian Porter
House of Representatives
State Capitol
Juneau, AK 99801-1182

Dear Representative Porter:

Re: Budget Increase Revenue Projection

Per your request of February 23, 1993, I have computed what I believe to be a conservative increase in net proceeds to permittees as well as increase in revenues to the state based upon the \$381.0 budget increase we proposed.

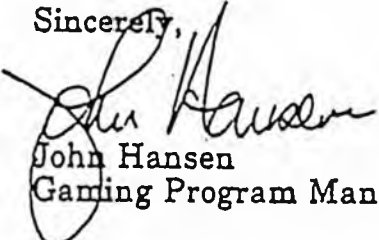
Net proceeds to permittees should increase by \$1.6¹ million. State revenues will increase by approximately \$274.0².

Revenue & Expenditures

<u>FY 94</u>	Revenue Estimate	\$1.974.0 ³
	Budget Expenditures	<u>\$1.042.0</u>
	Balance to General Fund	<u>\$ 932.0</u>

As reflected above the Gaming Program will generate more revenue and provide the general fund with approximately one million dollars in excess. Enclosed is the schedule used to arrive at these estimates.

Sincerely,


John Hansen
Gaming Program Manager

JH/go001.jh
022593c
Enclosures

¹Refer to revenue project - enclosed

²Refer to revenue project - enclosed

³Refer to revenue project - enclosed

Division of Gaming
Revenue Projection

FY 94 Revenue Estimate based on current budget.
AS 05.15. (Gaming)

License Fees	114.0
1%	219.0
3% Pull-tab Tax	<u>1258.0</u>

Gaming Total \$1,591.0

AS.43.35 (coin-operated device)

Machine Tax \$100.0

Estimate Total Combined Revenue \$1,700.0

FY94 Revenue Estimate based on Amended Budget
AS.05.15. (Gaming)

License Fees	114.0
1% Tax	300.0
3% Pull-Tab Tax	<u>1260.0</u>

Gaming Total \$1,674.0

AS 43.35 (coin operated device)

Machine Tax \$300.0

Estimate Total Combined Revenue \$1,974.0³
As Amended Increase \$274.0⁴

NET PROCEEDS

FY 94 Net Proceeds to Permittees (amended budget) \$17,500.0

FY 94 Net Proceeds to Permittees (current budget)
(per 91 Annual Actuals) \$15,900.0

Increase \$1,600.0¹

Back-up

Comparison

<u>Provision</u>	<u>Senate Bill 76</u>	<u>House Bill 168</u>
Campaign contributions	Prohibits the use of net proceeds for direct campaign contributions. Parties could still retain their permits and use the proceeds to pay for uses other than political contributions, such as office expenses	Allows net proceeds to be used for direct campaign contributions.
Felony exclusions	Prohibits from participating for life those individuals acting a supervisory or managerial capacity who have been convicted of a felony, unclassified felony or a crime involving theft, dishonesty or a violation of gambling laws. It provides for some departmental discretion for some lesser felonies and misdemeanors after 10 years have passed.	The same as in SB-76
Lobbyist fees	Prohibits the use of net proceeds from any type of gaming for any reason to registered lobbyists.	Prohibits the use of net proceeds from bingo and pull-tabs for any reason to registered lobbyists.
Third party vendors	Allows permittees to contract directly with third party vendors to sell pull-tabs for them. The permittee receives a 50% return immediately upon giving the vendor the pull-tabs. Operators currently can give the permittee a return as low as 15%. Permittees are defined to be only those facilities that are licensed by the ABC-board with a beverage dispensary license or a package store license. These are establishments that can sell hard liquor. Restaurants that have a beverage dispensary license would be restricted to selling pull-tabs in only those areas that exclude minors.	Vendors are the same as in SB-76 except that they must return at least 70% of the ideal net to the permittee.
Percentage return to charities	Increases the return to charities to 30% for pull-tabs and 10% from all other operations. This return is calculated quarterly. The return allowed under current law is 15% from total operations for two consecutive quarters.	The same as in SB-76, except that operators must pay an annual average of 30% for pull-tabs and 10% for all other activities.

Multiple beneficiary permits	Allows permittees to operate their permits without having to use the services of an operator. 2 to 6 permittees can band together to operate their permits jointly, using a management team that is answerable solely to the permittees. This allows economies of scale to benefit the permittees.	The same as in SB-76.
Departmental approval of contracts	Requires the Department to approve contracts between operators and permittees..	The same as in SB-76.
Prohibit insider information	Allows the Department to revoke, for a period of one year, the permit of an operator, vendor, or permittee upon proof that inside information about the game was given or acted upon.	The same as in SB-76.
Licensing out of state pull-tab manufacturers	Mandates that pull-tab manufacturers must be licensed by the Department before they can sell pull-tabs within the state.	The same as in SB-76 except the licensing fee was increased from \$500 to \$2500.
Local option	Not addressed in bill.	Current regulations allow local option action against operators. Bill gives local option to ban pull-tabs.
Testing	Not addressed in bill.	The individuals in charge of operating the permit must pass a test on the contents of this bill.
Sale of pull-tabs from distributor to distributor	Not addressed in bill.	Allows a distributor to distribute pull-tabs to another distributor.
Age limit	Not addressed in bill.	Prohibits people under the age of 21 from playing pull-tabs.

Roger Cunningham
P.O. Box 874731
Wasilla, Ak 99687

May 10, 1993

Senator Drue Pearce
Alaska State Senate
State Capitol
Juneau, Ak 99811-1182

Dear Senator Pearce Via Fax to 465-3872 Hard Copy By Mail

I was very pleased to learn that SB-76 passed out of the House this evening.

There is one aspect of the House Version that is ABSOLUTELY UNACCEPTABLE to both Non-profit/Charitable groups and potential vendors....the "70/30 split."

I was informed tonight that Mark Higgins appeared before a House Committee Meeting today and endorsed this house-passed amendment. Mr. Higgins is paid by the industry faction that has vehemently opposed nearly every provision of the Pearce bill. Why does he now appear in support?

If this unfair percentage arrangement is left stand, there may as well be no "Vendor Provision" in the bill. That's exactly what the "BIG BINGO" and Commercial Rippie Store owners want.

In years past, I have presented testimony which illustrates what this percentage means to both the non-profit/charity AND the vendor. Before presenting a number of popular Alaska games to illustrate this point, please consider the following facts:

1. Not all potential vendors will sell pull-tabs "out of the goodness of their heart."
Many rely on the added profit from pull-tab sales to pay a portion of overhead.
2. Many potential vendors will reason that 30% of Ideal Net is not sufficient for the time and trouble of selling pull-tabs for the following reasons:
 - A. The "up-front" payment to the cooperating charity/non-profit.
 - B. The realization that substantial pilferage is commonplace.
 - C. The realization that the percentages allowed to commercial operators selling pull-tabs in a "rippie store" or commercial Bingo Hall, are essentially the reverse, with the operator receiving 70% for expenses and profit and the permittee settling for 30%.

Senator Pearce, Page 2

UNDER THE FREE ENTERPRISE SYSTEM, please understand that when a merchant buys and later sells any other product, he or she keeps 100% of the profit....less expenses. For the legislature to require a merchant to give up 70% of the profit after having done all the work is simply UNREALISTIC!

HOW DOES THIS AFFECT THE NON-PROFIT/CHARITABLE PERMIT HOLDER?

Most potential vendor locations will opt NOT to sell pull-tabs. Permittees who's main mission precludes a suitable location to self-direct a pull-tab operation loose this valuable and viable fundraising vehicle. BIG BINGO and the COMMERCIAL RIPPIE STORES will flourish with the decreased competition for vendors.

The result ... a net loss in fundraising opportunities at the hands of the Alaska Legislature.

During the last ^{Several} session, I presented testimony about compensation allowed vendors by state-operated lotteries. There is a parallel to be drawn from this information but the following fact differentiates pull-tabs from lottery tickets:

1. Lottery ticket vendors do not vend from open containers of tickets. They vend tickets from an on-line computer terminal which prints the ticket at the time of purchase. This essentially provides the vendor with a solid accounting system and virtually eliminates pilferage. Moneys generated from lottery ticket sales are funds-transferred into the state lottery account.
2. The MINIMUM paid vendors is \$0.05 (5cents) per ticket, with the base rate going to a high of 11 cents. In the case of "Scratch-off" or "Instant Win" tickets, the norm is 10 cents because of extra risk and handling.^{1,2}
3. State Lottery Boards often allow advertising and promotion allowances which raise the amount paid vendors substantially. "Promotion" includes a prize for the vendor's sales person who sold the winning ticket....as much as \$30,000 on a Million-Dollar Sweepstakes.^{3,4,5}

Because pull-tabs are sold from open containers, the element of loss remains present. Rather than a funds-transfer mechanism, pull-tab vendors pay for the product "up-front". There is no electronic terminal provided by the lottery board, the merchant is left to his own devices for accounting, security and internal control. Further, Alaska does not permit an "advertising and promotion" allowance as state lotteries employ to boost sales.

Because of these substantial differences in the proposed Alaska Vendor provisions and state lotteries, it seems entirely appropriate that the original 50/50 split in SB-76 become law. This is not meant to enhance the vendor's profit so much as to induce him to cooperate with a permittee in a viable fundraising method.

Senator Pearce, Page 3

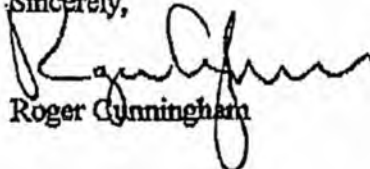
In the following brief analysis, (next page), I have compared several different pull-tab games commonly sold in Alaska. The figures are taken from my database of more than 10,000 games sold to Alaska non-profits and charities (permit holders).

There remains far more permittees seeking viable locations to conduct fundraising than operators or vendor locations at which to utilize a permit. Unless and until the balance is equalized, permittees will remain at the mercy of the commercial interests in this business. Your bill, as originally proposed, solved this problem equitably. Please.... do everything in your power to reinstate the original bill.

As this much-needed legislation sees its final hearing before the legislature, please dial my phone if you need any additional input.

I applaud your work on behalf of Alaska's non-profit/charitable organizations who, after all, are the intended beneficiaries of our "charitable gaming" statutes.

Sincerely,



Roger Cunningham

(907) 373-1500

Fax 376-0253

attachment: Spreadsheet, (unnumbered)
footnotes, as page 9

cc: John Nanesu
Paul Fuks
Ray. Carl Moses
Jim Fisk, Kodiak

Catalog Number	Game Name	Ticket Count	Gross Sales	Paid to Winners	Ideal Net	50/50 % Permitee	Vendor	60/40 % Permitee	Vendor	70/30 % Permitee	Vendor
928T	Diamond Cherry	3839	\$3,839.00	\$2,800.00	\$1,039.00	\$519.50	\$519.50	\$623.40	\$415.60	\$727.30	\$311.70
Per Ticket, expressed in cents:						13.532	13.532	16.238	10.826	18.945	8.119
1048T	Stampede	6431	\$6,431.00	\$4,640.00	\$1,791.00	\$895.50	\$895.50	\$1,074.60	\$716.40	\$1,253.70	\$537.30
Per Ticket, expressed in cents:						13.925	13.925	16.709	11.140	19.495	8.355
493T	Oink (\$.50)	2399	\$1,199.50	\$784.00	\$415.50	\$225.75	\$225.75	\$249.30	\$166.20	\$290.85	\$124.65
Per Ticket, expressed in cents:						9.410	9.410	10.392	6.927	12.124	5.196
Average of More Than 10,000 Alaska-Played Games:											
(Source: TabTrak Data Previously Supplied to DCED)											
		2981	\$2,866.63	\$2,219.93	\$646.70	\$323.25	\$323.25	\$388.02	\$258.68	\$452.69	\$194.01
						11.276	11.276	13.536	8.024	15.792	6.768

¹ 22 states pay a base rate of \$.05 per \$1.00 ticket (5cents per ticket), 2 states pay \$.055, and four states pay a base of \$.06 per ticket. SOURCE: Gaming and Wagering Business, February, 1991.

² California Lottery pays an additional incentive for display of promotional material and offers the vendor a co-op advertising allowance

³ New Hampshire State Lottery pays the VENDOR for having sold a winning ticket. Prizes range from \$15 to \$500 for instant games and \$30,000 if the vendor sold the winning ticket in the Million-Dollar Sweepstakes.

⁴ In Maryland and D.C., vendors are paid a bonus of 4% for paying off smaller winning tickets, thereby reducing the work load on the state lottery board.

⁵ Western Canada Lotteries pay vendors 5% for "on-line" tickets and 10% for "instant tickets" thereby recognizing the additional risk and paper work of instants which are similar in nature to pull-tabs.

HB

170

HFIN

FILE

HOUSE COMMITTEE REPORT

(11)

Date Referred: March 31, 1993

FURTHER REFERRALS:

Date of Committee Action: 4/12/93

The FINANCE Committee considered:

HB 170

HOUSE BILL NO. 170

EXTEND BOARD OF MARINE PILOTS

"An Act extending the termination date of the Board of Marine Pilots."

RECOMMENDATIONS:

be replaced with _____ [] the same title

[] have attached amendments(s)

[] do pass

[] do not pass

[] no recommendations

[] individual recommendations

[] additional referral to the _____ Committee

ADOPTS: _____ letter of Intent

ATTACHES NEW FISCAL NOTE(s): (Dept)

APPROVES PREVIOUS: (Dept/Date)

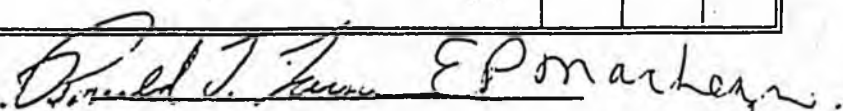
[] fiscal impact _____

[] fiscal note(s) _____

[] zero fiscal note _____

[] zero fiscal note(s) DCED 3/31/93

SIGNING DO PASS	DP	OTHER RECOMMENDATIONS	DNP	NR	AM
<i>Eileen P. Maclean</i> ^{maclean}	✓				
<i>Donald J. Larson</i> ^{larson}					
<i>Nick Stanley</i> ^{Hank}	X				
<i>Terry Martin</i> ^{martin}	✓				
<i>John Parnell</i> ^{Parnell}	X				
<i>Larry Brown</i> ^{Brown}	✓				
<i>Richard [unclear]</i> ^{FDS ER}	X				


 CHAIRMAN'S SIGNATURE
 Larson Maclean

FISCAL NOTE

No. 1
 Bill Version: HB 170
 (H) Publish Date: 3/31/93

STATE OF ALASKA 1993 LEGISLATIVE SESSION

Revision Date: _____ Dept. Affected: Commerce & Economic Development
 Title: An Act extending the termination date BRU: Occupational Licensing
of the Board of Marine Pilots. Component: Operations
 Sponsor: Reps. Sanders and Grussendorf
 Requestor: House Labor & Commerce COMPONENT SERIAL NO. 1844

Expenditures/Revenues:

(Thousands of Dollars)

OPERATING	FY 94	FY 95	FY 96	FY 97	FY 98	FY 99
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	.01	.01	.01	.01	.01	.01
CAPITAL						
REVENUE FUND SOURCE:	.01	.01	.01	.01	.01	.01

FUNDING:

(Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
TOTAL	.01	.01	.01	.01	.01	.01

POSITIONS:

FULL-TIME	01	01	01	01	01	01
PART-TIME	01	01	01	01	01	01
TEMPORARY	01	01	01	01	01	01

Estimate of current year (FY 93) impact: \$ None

ANALYSIS: (Attach a separate page if necessary)
 The bill extends the termination date of the Board of Marine Pilots to June 30, 1998. Funding for the Board of Marine Pilots is included in the FY 94 operating budget; therefore, new funds are not required.

Average Annual Costs: \$125.0
 Average Annual Revenue: 172.7

Prepared by: Jennifer Strickler, Administrative Officer Phone: 465-2144
 Division: Occupational Licensing Date: 3/22/93

Approved by Commissioner: Paul Fuhs Date: 3-22-93
 Agency: Commerce & Economic Development

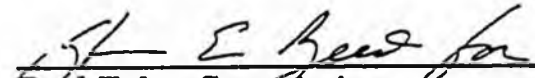
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HB 170

The Board of Marine Pilots is created under AS 08.62.040, and includes membership of two marine pilots licensed under Alaska Statutes and Regulations, two vessel agents or managers, two public members, and the Commissioner or his designee. The board ensures the maintenance of efficient and competent pilotage service on the inland and coastal water of and adjacent to the state to assure the protection of shipping, the safety of human life and property, and the protection of the marine environment. It establishes qualifications of and the required training for pilots, provides for the examination of the pilots, and the issuance of original and renewal licenses to qualified persons.

The current Pilot Bill creates competition within the established pilot regions. To this end, the Board of Marine Pilots must continually resolve disputes within regions between competing pilot associations involving the question of competition. Additionally, since competition has been encouraged, the matter of pilot tariffs and the setting thereof has become a large portion of the Board of Marine Pilots responsibilities, ensuring fairness to both trade and the pilots. One of the most recent actions was the establishment of the Kuskokwim Pilotage Region in response to a need to produce state-regulated and licensed pilot services to a region which is vital to the Bethel region of the state.

Continuance of the Board of Marine Pilots is considered essential due to the continued emphasis on competition, the requirement to set tariffs, and the constant evolution of State Statutes and Regulations which require implementation in the interest of commerce and safety.


Paul Fuhs, Commissioner

3-22-93
Date

dgl157pp.ol

Kuskokwim Marine Pilot's Association

P.O. Box 57
Bethel, AK 99959
(907) 543-3977

March 21, 1993

Representative Jerry Sanders
Alaska State House of Representatives
Room 123
State Capitol
Juneau, AK 99801

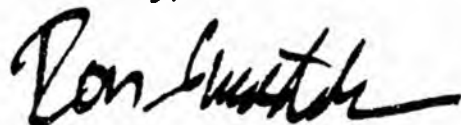
Dear Representative Sanders:

Please accept this letter as support for your House Bill 170 which, when enacted, will extend the Board of Marine Pilots.

As you know, this board primarily oversees marine pilot licensing and marine safety issues regarding foreign hulled vessels traversing state waters. It is imperative they continue to function under the powers granted to them by the Legislature when the Marine Pilotage Act of 1991 was passed. To do so, the sunset date contained in that legislation must be extended.

Thank you for submitting this important legislation. If you need any additional information, please do not hesitate to contact me.

Sincerely,



Capt. Ron Sumstad

HB

170

SFIN

FILE

SENATE FINANCE COMMITTEE REPORT

RETURNED TO FINANCE FROM RULES

DATE: 5/2/94

FURTHER:

DATE TURNED INTO OFFICE: _____

The Finance Committee considered HOUSE BILL NO. 170

"An Act extending the termination date of the Board of Marine Pilots."

Died in SFC 1994.

and recommends:

- replace with _____ CS _____ (FINANCE)
- or adopt previous _____ CS _____
- attaches amendment(s)

- same title
- new title
- technical title change (HB only)

adopts _____ Letter of Intent

further referral to the _____

do pass

do not pass

no recommendation

individual recommendations

NEW FISCAL NOTES

Department	Date	Zero	Fiscal

PREVIOUS FISCAL NOTES

Department	Date	Zero	Fiscal

Appropriation No Fiscal Note

DO PASS:

OTHER RECOMMENDATIONS:

1. _____
Co-Chair: Signature/Recommendation

2. _____
Co-Chair: Signature/Recommendation

SENATE RULES COMMITTEE REPORT

DATE: 1/26/94

DATE TURNED INTO OFFICE: _____

The Rules Committee considered HOUSE BILL NO. 170

"An Act extending the termination date of the Board of Marine Pilots."

and recommends it be placed on the calendar:

5-2-94

replace with _____ CS _____ (RULES)

attaches amendment(s)

adopts _____ Letter of Intent

- same title
- new title
- technical title change (HB only)

NEW FISCAL NOTES

Department	Date	Zero	Fiscal

PREVIOUS FISCAL NOTES

Department	Date	Zero	Fiscal

Appropriation No Fiscal Note

MEMBERS SIGNING FOR PLACEMENT ON THE CALENDAR

Chair: Signature and Recommendation

OTHER RECOMMENDATIONS:

Calendar on: _____

Approved by: _____

SENATE COMMITTEE REPORT

final DATE: 4/23/93

FURTHER: *No Further*

DATE TURNED INTO OFFICE: 1/27/94

JUDICIARY Committee considered HOUSE BILL NO. 170

"An Act extending the termination date of the Board of Marine Pilots."

and a majority of the committee recommends do pass

and recommends:

- replace with _____ CS _____ (_____)
- or adopt previous _____ CS _____ (_____)
- attaches amendment(s)

- same title
- new title
- technical title change (HB only)

- adopts _____ Letter of Intent
- further referral to the _____

- do pass
- do not pass
- no recommendation
- individual recommendations

update of Fm H Pot

NEW FISCAL NOTES

Department	Date	Zero	Fiscal
<i>Commerce (updated)</i>	<i>1/94</i>	<i>0</i>	

PREVIOUS FISCAL NOTES

Department	Date	Zero	Fiscal

Appropriation No Fiscal Note

DO PASS:

Robert J. ...
Suzanne K. Little 1.29.94
Rick Halford

OTHER RECOMMENDATIONS:

John do pass

 Chair: Signature and Recommendation

SENATE COMMITTEE REPORT

DATE: 4/16/93

FURTHER: JUDICIARY

DATE TURNED INTO OFFICE: 4/22/93

L&C Committee considered HOUSE BILL NO. 170

"An Act extending the termination date of the Board of Marine Pilots

and a majority of the committee recommends do pass

and a majority of the committee recommends do pass

and recommends:

- [] replace with CS ()
or [] adopt previous CS ()
[] attaches amendment(s)

- [] same title
[] new title
[] technical title change (HB only)

[] adopts Letter of Intent

[] further referral to the

[] do pass

[] do not pass

[] no recommendation

[x] individual recommendations

NEW FISCAL NOTES

Table with 4 columns: Department, Date, Zero, Fiscal. Contains handwritten entries.

PREVIOUS FISCAL NOTES

Table with 4 columns: Department, Date, Zero, Fiscal. Contains handwritten entries.

[] Appropriation No Fiscal Note

DO PASS

Handwritten signatures: Alvin Thier, J. E. Sald...

OTHER RECOMMENDATIONS:

Handwritten note: 2 Best Kings N R

Tim Kelly - Do Pass

Chair: Signature and Recommendation

FISCAL NOTE

No. 2
 Bill Version: HB 170
 (S) Publish Date: 1-21-94

STATE OF ALASKA
1994 LEGISLATIVE SESSION

Revision Date: 1/24/94
 Title: An Act extending the termination date of the Board of Marine Pilots.
 Sponsor: Reps. Sanders and Grussendorf
 Requestor: Senate Judiciary

Department: Commerce and Economic Dev.
 DRU: Occupational Licensing
 Component: Operations
 COMPONENT SERIAL NO. 1844

Expenditures/Revenues (Thousands of Dollars)

OPERATING EXPENDITURES	FY 95	FY 96	FY 97	FY 98	FY 99	FY 00
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES	0.0	0.0	0.0	0.0	0.0	0.0

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 General Fund						
1005 GF/Program Receipts						
1006 GFMHTA						
Other						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY 94) cost: \$ None

POSITIONS

FULL-TIME	0.0	0.0	0.0	0.0	0.0	0.0
PART-TIME	0.0	0.0	0.0	0.0	0.0	0.0
TEMPORARY	0.0	0.0	0.0	0.0	0.0	0.0

ANALYSIS: (Attach a separate page if necessary)

The bill extends the termination date of the Board of Marine Pilots to June 30, 1998. Funding for the Board of Marine Pilots is included in the FY 95 operating budget; therefore, new funds are not required.

Average Annual Costs: \$125.0
 Average Annual Revenue: 172.7

Prepared by: Jennifer Strickler, Administrative Officer Phone: 465-2144
 Division: Occupational Licensing Date: 1-24-94
 Approved by Commissioner: Paul Fuhs Date: _____
 Agency: Commerce and Economic Development

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FISCAL NOTE

No. 1

Bill Version: HB 170

(H) Publish Date: 3/31/93

STATE OF ALASKA 1993 LEGISLATIVE SESSION

Revision Date: _____ Dept. Affected: Commerce & Economic Development
 Title: An Act extending the termination date BRU: Occupational Licensing
of the Board of Marine Pilots. Component: Operations
 Sponsor: Reps. Sanders and Grussendorf
 Requestor: House Labor & Commerce COMPONENT SERIAL NO. 1844

Expenditures/Revenues:

(Thousands of Dollars)

OPERATING	FY 94	FY 95	FY 96	FY 97	FY 98	FY 99
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	.0	.0	.0	.0	.0	.0
CAPITAL						
REVENUE FUND SOURCE:	.0	.0	.0	.0	.0	.0

FUNDING:

(Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
TOTAL	.0	.0	.0	.0	.0	.0

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

Estimate of current year (FY 93) impact: \$ None

ANALYSIS: (Attach a separate page if necessary)

The bill extends the termination date of the Board of Marine Pilots to June 30, 1998. Funding for the Board of Marine Pilots is included in the FY 94 operating budget; therefore, new funds are not required.

Average Annual Costs: \$125.0

Average Annual Revenue: 172.7

Prepared by: Jennifer Strickler, Administrative Officer
 Division: Occupational Licensing

Phone: 465-2144

Date: 3/22/93

Approved by Commissioner: Paul Fuhs
 Agency: Commerce & Economic Development

Date: 3-22-93

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COMMITTEE COPY

**ALASKA STATE LEGISLATURE
HOUSE BILL NO. 170**

HISTORY IN THE HOUSE

1993
2/22 Read first time and referred to:
L&C FIN

3/31 L&C RPT CS() New Title
6 DP DNP NR AM
FN 1 OFN Previous FN

4/13 Fin RPT CS() New Title
7 DP DNP NR AM
FN OFN 10 Previous FN

4/15 Read second time
CS() Adopted

Amended

4/15 Advanced

4/15 Read third time

Return to second /or specific amendment

PASSED	EFD Same	or
Yeas <u>36</u>	Yeas	
Nays <u>0</u>	Nays	
Excused <u>1</u>	Excused	
Absent <u>3</u>	Absent	

Intent adopted

Reconsideration
Reconsideration not taken up

PASSED ON RECON.	EFD Same	or
Yeas	Yeas	
Nays	Nays	
Excused	Excused	
Absent	Absent	

Intent adopted

4/15 Reported correctly engrossed
Signed by Speaker, to the Senate

[Signature]
Chief Clerk of the House

HISTORY IN THE SENATE

1993
4/16 Read first time and referred to:
5/2 L&C JUO
RETURNED TO FINANCE

4/27 LC RPT() CS 3 DP 1 NR DNP AM
New Title Same Title Previous FN
FN OFN To JUD

1994
1/26 JUD RPT() CS 3 DP NR DNP AM
New Title Same Title Previous FN
FN OFN applied To rule

5/2 return to FINANCE

RPT() CS DP NR DNP AM
New Title Same Title Previous FN
FN OFN To

Rules Calendar() CS AM Other
New Title Same Title Previous FN
FN OFN

Read second time

CS Adopted () New Title
Amended Advanced

Read third time

Letter of Intent adopted
Return to second for specific amendment

PASSED	EFD Same	or
Yeas	Yeas	
Nays	Nays	
Excused	Excused	
Absent	Absent	

Reconsideration
Reconsideration not taken up

PASSED	EFD Same	or
Yeas	Yeas	
Nays	Nays	
Excused	Excused	
Absent	Absent	

Reported correctly engrossed
Signed by President, to the House

Secretary of the Senate

HOUSE-SENATE HISTORY Continued

19

Received from the Senate _____

Concur in Senate amendment
 Y ___ N ___ E ___ A ___
 _____ Efd same or Y ___ N ___ E ___ A ___

Failed to concur Senate amendment, ask Senate recede
 Y ___ N ___ E ___ A ___

Senate failed to \ receded from amendment
 Y ___ N ___ E ___ A ___

CC appointed by House _____ Chair

CC appointed by Senate _____ Chair

(H) Granted Limited Powers of Free Conference

(S) Granted Limited Powers of Free Conference

19

(H) Adopted CC Rpt _____
 Y ___ N ___ E ___ A ___
 _____ Efd same or Y ___ N ___ E ___ A ___

(S) Adopted CC Rpt _____
 Y ___ N ___ E ___ A ___
 _____ Efd same or Y ___ N ___ E ___ A ___

To enrolling
 Reported enrolled and sent to Governor

_____ By Governor

Legislative Resolve Number _____

Filed with Lieutenant Governor

HB

171

HFIN

FILE

HOUSE COMMITTEE REPORT

(11)

Date Referred: March 22, 1993

FURTHER REFERRALS:

Date of Committee Action: 3/29/93

The FINANCE Committee considered:

HB 171

HOUSE BILL NO. 171

MEDICAID COVERAGE FOR HOSPICE CARE

"An Act providing coverage for hospice care under the Medicaid program; reordering the priorities given to optional services under the Medicaid program; and providing for an effective date."

RECOMMENDATIONS: the same title
 be replaced with CS HB 171 (Fin) a new title

have attached amendments(s)

do pass

do not pass

no recommendations

individual recommendations

additional referral to the _____ Committee

ADOPTS: _____ letter of Intent

ATTACHES NEW FISCAL NOTE(S): (Dept)

APPROVES PREVIOUS: (Dept/Date)

fiscal impact _____

fiscal note(s) HSS 3/22/93

zero fiscal note _____

zero fiscal note(s) _____

SIGNING <u>DO PASS</u>	DP	OTHER RECOMMENDATIONS	DNP	NR	AM
<i>Eileen M. McKeon</i> ^{McKeon}	✓				
<i>Ronald J. Hanson</i> ^{Hanson}	X				
<i>Lerner Martin</i> ^{Martin}	X				
<i>John Parnell</i> ^{Parnell}	X				
<i>Ben Grossard</i> ^{Grossard}	X				
<i>Mike Navane</i> ^{Navane}	X				
<i>Therese Therrault</i> ^{Therrault}	X				
<i>Richard Foster</i> ^{Foster}	X				

Eileen M. McKeon
 CHAIRMAN'S SIGNATURE

FISCAL NOTE

STATE OF ALASKA
1993 LEGISLATIVE SESSION

BILL NO. HB171

Revision Date: 02/22/93 Dept. Affected: Health and Social Services
 Title: An Act providing coverage for hospice care BRU: Medical Assistance Administration
 Component: Claims Processing
 Scensor: Larson
 Requestor: _____ COMPONENT SERIAL NO. 00243

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY94	FY95	FY96	FY97	FY98	FY99
PERSONAL SERVICES	0.0	0.0	0.0	0.0	0.0	0.0
TRAVEL	0.0	0.0	0.0	0.0	0.0	0.0
CONTRACTUAL	10.0	0.0	0.0	0.0	0.0	0.0
SUPPLIES	0.0	0.0	0.0	0.0	0.0	0.0
EQUIPMENT	0.0	0.0	0.0	0.0	0.0	0.0
LAND & STRUCTURES	0.0	0.0	0.0	0.0	0.0	0.0
GRANTS, CLAIMS	0.0	0.0	0.0	0.0	0.0	0.0
MISCELLANEOUS	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL OPERATING	10.0	0.0	0.0	0.0	0.0	0.0
CAPITAL	0.0	0.0	0.0	0.0	0.0	0.0

REVENUE FUND SOURCE						
---------------------	--	--	--	--	--	--

FUNDING: (Thousands of Dollars)

1002 Federal Receipts	5.0	0.0	0.0	0.0	0.0	0.0
1003 GF Match	5.0	0.0	0.0	0.0	0.0	0.0
1004 GF	0.0	0.0	0.0	0.0	0.0	0.0
1005 GF/Program Receipts	0.0	0.0	0.0	0.0	0.0	0.0
1006 GF/MHTIA	0.0	0.0	0.0	0.0	0.0	0.0
Other	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL	10.0	0.0	0.0	0.0	0.0	0.0

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

Estimate of current year (FY93) impact: 0.0

ANALYSIS: (Attach a separate page if necessary)

FY 94 funds are required to modify the Medicaid Management Information System to allow the payment of claims for hospice care.

Studies suggest that hospice care tend to be cost neutral or produce cost savings. Hospice care is already available to children covered by Medicaid and to Medicare-eligible adults. There are currently no Medicare-certified hospice providers in the state. We anticipate that only a small number of recipients will use hospice care as a result of this bill. Therefore, no other fiscal impact is projected.

Prepared by: Jon Sherwood, Program Coordinator
 Division: Medical Assistance

Phone: 465-5826
 Date: 03/01/93

Approved by Commissioner: Theodore A. Mala, MD, MPH
 Agency: Department of Health & Social Services

Date: 3/4/93

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Representative Ronald L. Larson

District 27
HB 171- Hospice Care
Sponsor's Statement

Hospice care is already a Medicaid-covered service for children and is available to people who qualify for Medicare.

This bill would extend coverage of hospice service to Medicaid-eligible adults who do not qualify for Medicare. Medicaid eligible adults are the aged, blind, disabled, and families with dependent children, as well as pregnant women. The "optional eligibles" also included, in Alaska are individuals under 21 who don't qualify for Aid to Families with Dependent Children because they aren't dependent children, and institutionalized individuals under a specified income level.

To qualify as a hospice care provider, a hospice care agency must be Medicare-certified.

Hospice care allows a terminally-ill person to receive medical care and psychological, social, and/or spiritual counseling through a single agency, the hospice care provider. Lacking hospice care, an individual may require extensive hospital and/or nursing facility care or have to rely on the sometimes fragmented or piecemeal provision of supportive services in the community.

- In addition to meeting physical needs, Hospice care offers a wealth of emotional, spiritual and practical supports to the patient and the family. Quality of life is maximized through an interdisciplinary team of physicians, nurses, physical, occupation and speech therapists, home health aides, social workers, chaplains, and volunteers. The patient and family are actually a part of the team, helping to plan and prioritize care.

- It will be the role of Hospice to provide all medications, medical equipment and supplies necessary for management of the terminal illness.



- Bereavement care is also available to the family for a period of 13 months after the death. Hospice offers written resources, phone calls, visits from volunteers, a support group and, as needed, bereavement counseling.

- Most important are the trained Hospice volunteers who give a wide range of services from staying with a patient while the caregiver takes a break to nursing care, homemaking services, or a listening ear.

In addition to all the positive services that Hospice care can offer a family, crucial facts make the Medicaid Hospice option a wise decision.

Hospice is a budget-neutral program. Hospice care is one of the few programs existing in our present health care structure that models fiscal responsibility and cost-effective quality care. Hospice offers the resources to allow terminally ill persons to spend the rest of their lives, or at least more of their lives, at home.

Quite often, the alternative to Hospice care is costly nursing home placement or frequent hospitalization.

Position Paper

The Department of Health and Social Services supports House Bill 171, which would include coverage of hospice care under the Medicaid program.

Hospice care is already a Medicaid-covered service for children and is available to people who qualify for Medicare. This bill would extend coverage of hospice service to Medicaid-eligible adults who do not qualify for Medicare. To qualify as a hospice care provider, a hospice care agency must be Medicare-certified. There are currently no Medicare-certified hospices in Alaska.

Hospice care allows a terminally-ill person to receive medical care and psychological, social, and/or spiritual counseling through a single agency, the hospice care provider. Lacking hospice care, an individual may require extensive hospital or nursing facility care or have to rely on the sometimes fragmented or piecemeal provision of supportive services in the community.

The Department supports this effort to expand the availability of a valuable alternative for terminally ill people. It also concurs with the placement of hospice services on the Medicaid priority list. Under HB 171, in the case of a budget shortfall, hospice care would be eliminated before most other long term care services, but after most optional Medicaid services.

The Department recommends changing the effective date of the legislation to January 1, 1994. Because of other scheduled program changes, the Division of Medical Assistance will not be able to implement hospice services earlier.

Recommended by:

Kimberly B. Busch

Kimberly B. Busch
Director

Div. of Medical Assistance

Date:

Approved by:

Theodore A. Mala

Theodore A. Mala, MD, MPH
Commissioner

Date:

3/4/93

Back-up

WHAT DOES HOSPICE MEAN?

PHYSICIAN INFORMATION SHEET

WHAT IT MEANS TO THE PATIENT

When a patient elects the Medicare hospice benefit, they revoke their other part A benefits for treatment of their terminal illness? The hospice becomes the sole provider for their service needs, and whatever products are necessary for palliation and symptom control. This includes:

- professional services,
- pharmaceuticals
- DME
- in-patient respite
- in-patient care for symptom management

The hospice becomes a managed care program for the patient.

Benefit periods: 2 90-day periods, 1 30-day period,
Indefinite 4th period

The fourth indefinite period was recently enacted. They do not go off the benefit if they fail to die in 7 months.

Revocation of benefit is possible during any benefit period, but there are limitations regarding reelection of benefit.

Admission criteria:

- * Certified by physician that terminal illness with 6 months or less life expectancy.
- * Choose palliative care; treatment mode past

When a person has a terminal illness, consider Hospice as an information resource on options--to patient & physician. The ultimate choice regarding treatment options (including hospice enrollment) is made by client.

WHAT IT MEANS TO THE FAMILY

The family is included as client in the plan of care:

- Support
- Respite
- Bereavement program
- Assessment
- Care

WHAT IT MEANS TO THE HOMECARE PROGRAM STAFF

Philosophy of approach to care.

- Emphasis on living fully
- Self determination
- Palliation --complete
- Totality of care

HOSPICE AND YOUR OTHER MEDICARE BENEFITS

Hospice under Medicare is designed to be more than just a collection of existing benefits with a new name. Many items and services are covered under hospice that are not covered through any other type of facility or provider.

This chart shows a comparison between hospice benefits and benefits available through hospitals and home health agencies.

SERVICE ITEM	MEDICARE COVERED IN		
	HOSPICE	HOSPITAL	HOME HEALTH AGENCY
Drugs for pain & symptom control to be used at home	YES	YES	NO
Services covered whether or not the patient is homebound	YES	---	NO
Deductibles waived	YES	NO	NO
Inpatient care to provide respite for family caring for the patient at home	YES	NO	NO
Continuous care at home during periods of crisis	YES	NO	NO
Counseling services at home for both the patient and the family	YES	NO	NO
Home Health Aides	YES	NO	YES
Bereavement Counseling	YES	NO	NO
Volunteers must be available	YES	NO	NO
Care must be continued if benefits run out	YES	NO	NO
Inpatient unit must have homelike decor	YES	NO	---

*Meeting the Challenge For
A Greater Kind of Care*



Standards of a Hospice Program of Care Recommended by the National Hospice Organization

Standards For A Hospice Program

Standard 7: At a minimum, the hospice inpatient unit provides for: medical direction and coverage for all patients either directly or through agreement with the patient's personal physician; staffing coverage by an interdisciplinary team available to meet the needs of the patient/family on a 24 hour basis as needed; and, specific policies and procedures, as well as personal comfort amenities and courtesies that support and encourage a non-institutional, "home-like" environment for the patient/family. All hospice inpatient personnel must be appropriately trained in the provision of hospice interdisciplinary team care.

PATIENT/FAMILY AS THE UNIT OF CARE

Principle: Inclusion of the family in the hospice care program is essential. The wishes and desires of the patient/family are reflected in assessments and plans of care developed by the interdisciplinary team. The family members are seen both as primary caregivers and as needing care and support so that their own stresses and concerns may be addressed. Attention is also given to assisting with the development of a community support network when family and friends are not available and a patient needs and wants that support.

Standard 8: The patient/family is the unit of care in hospice and support is provided to both the patient and the family. The hospice program encourages patient/family participation in the development of the interdisciplinary team plan of care and in the provision of hospice services.

Standard 9: The hospice program acknowledges that each patient/family has its own values and beliefs and is respectful of them.

Standard 10: The hospice program seeks to identify, teach, coordinate and supervise those persons acting as primary caregivers for the patient. If a primary care person is not available, the hospice program seeks to develop a substitute network. If the hospice program does not accept patients without primary caregivers, then it must provide adequate information about community resources available to them.

PAIN AND SYMPTOM CONTROL

Principle: For the hospice program, the goal of all interventions is to maximize the quality of the remaining life through the provision of palliative therapies that control and symptoms and minimize the negative side effects of interventions. Hospice programs recognize that when a patient and a family are faced with terminal disease, stress and concerns may arise in many aspects of their lives. Optimum symptom control includes addressing these stresses and concerns, in addition to the use of appropriate therapies.

Standard 11: The goal of hospice care is to provide optimum relief of pain and control of symptoms through appropriate palliative therapies.

Standard 12: Symptom control includes assessing and responding to the physical, emotional, social and spiritual needs of the patient/family.

VOLUNTEERS

Principle: An essential component of hospice care is the direct personal support for the patient/family by volunteers. Volunteers provide important perspectives in developing the interdisciplinary team plan of care

and in the provision of significant hospice services.

Standard 13: A hospice program offers volunteer support to each patient/family admitted to its program of care.

Standard 14: A hospice program has an organized training program and procedures for the selection, supervision and continuing evaluation of volunteers.

HOSPICE INTERDISCIPLINARY TEAM

Principle: Hospice care is provided by an interdisciplinary team which includes at least the following members: patient and patient's family, physician, nurse, social worker, volunteer, and clergy. Ancillary staff are added to the team when appropriate. The team meets regularly to develop and maintain an appropriate plan of care.

Standard 15: The hospice identifies and maintains an appropriately qualified interdisciplinary team of health professionals and lay persons.

Standard 16: Emotional support for staff/volunteers is provided as an integral part of a hospice program.

Standard 17: Inservice training and continuing education are offered on a regular basis to both paid and volunteer staff.

INTERDISCIPLINARY TEAM PLAN OF CARE

Principle: Documentation of services is necessary for the delivery of quality hospice care. Of critical importance is the development of an integrated plan of care which records assessments, proposed interventions by all

*Meeting the Challenge For
Freedom, Honor & Care*



Standards of a Hospice Program of Care Recommended by the National Hospice Organization

Standards For A Hospice Program

A DEFINITION

A hospice program is a coordinated program of palliative and supportive services provided in both home and inpatient settings which provides for physical, psychological, social and spiritual care for dying persons and their families. Services are provided by a medically directed interdisciplinary team of professionals and volunteers. Bereavement care is available to the family following the death of the person.

HOSPICE PHILOSOPHY

Hospice provides support and care for persons in the last phases of incurable disease so that they may live as fully and comfortably as possible. Hospice recognizes dying as part of the normal process of living and focuses on maintaining the quality of remaining life. Hospice affirms life and neither hastens nor postpones death. Hospice exists in the hope and belief that through appropriate care, and the promotion of a caring community sensitive to their needs, patients and their families may be free to attain a degree of mental and spiritual preparation for death that is satisfactory to them.

ACCOUNTABILITY

Principle: The hospice operates as an integral part of the health delivery system at the community level and is accountable to the community it serves and the public at large. In order to provide care in this system, a hospice must meet the fundamental requirements for operation and delivery of health services, as regulated by local, state and federal laws.

Standard 1: The hospice program establishes and maintains appropriate reports, policies and procedures to assure that the hospice is accountable to the community for the services it provides.

Standard 2: The hospice program complies with applicable local, state and federal laws and regulations governing the organization and delivery of health care to patients and families.

ACCESS TO HOSPICE CARE

Principle: Admission to the hospice program is based on an assessment of the patient and family needs, their desire for services and the program's specific admission criteria. The level of care received, including the frequency and type of services provided, is based on both initial and subsequent assessments of the patient and family's needs. Care may be provided on either a part time, intermittent basis, a regularly scheduled basis, or a continuous basis, depending upon the needs of the patient and family as reflected in ongoing assessments.

Standard 3: Access to hospice medical and nursing services is available to identified hospice patients on a 24 hour basis, 7 days a week. During hours covered by on-call staff, hospices provide for at least a minimum of medical and nursing coverage, with visit capability should further assessment or treatment be needed. Provisions are made to assure that on-call staff are informed and updated regarding care plans and level of care. Reporting mechanisms are in place to assure continuity and coordination among members of the hospice interdisciplinary team.

Standard 4: The hospice program has admission criteria that reflect the patient/family's desire and need for hospice care; the extent and role of physician participation; and diagnosis and prognosis. To the maximum extent possible, the hospice program will admit patients regardless of their diagnosis or ability to pay for services.

CONTINUITY OF HOSPICE CARE

Principle: Hospice patients and their families may experience physical, social, emotional and spiritual concerns and problems. Hospice addresses these by providing a comprehensive and coordinated program of care which includes an ongoing assessment of needs and determination of the level of care and scope of services necessary. Continuity implies that services, whether provided directly or contracted for, are coordinated in both home and inpatient settings. Services are reflective at all times of patient/family needs, and that the hospice is accountable for its care and services in both home and inpatient care settings.

Standard 5: The hospice program organizes its services to respond to patient/family needs whenever they arise. It provides both structure and staff to ensure continuation of the hospice care plan in all settings.

ACCESS TO HOSPICE INPATIENT CARE

Principle: Not all patients can be maintained at home throughout their terminal illness; some may require short term inpatient care. When such a need arises, hospice care is provided in an inpatient hospice unit. The hospice provides access to hospice inpatient services which reflect the hospice philosophy and emphasizes symptom control and enhancement of a quality of life acceptable to dying patients and their families.

Standard 6: Access to hospice inpatient care is available either directly by the hospice or through contract or arrangement with an inpatient facility. This hospice inpatient unit must comply with all applicable local, state and federal regulations, including fire and safety code regulations.

Standards For A Hospice Program

Standard 7: At a minimum, the hospice inpatient unit provides for: medical direction and coverage for all patients either directly or through agreement with the patient's personal physician; staffing coverage by an interdisciplinary team available to meet the needs of the patient/family on a 24 hour basis as needed; and, specific policies and procedures, as well as personal comfort amenities and courtesies that support and encourage a non-institutional, "home-like" environment for the patient/family. All hospice inpatient personnel must be appropriately trained in the provision of hospice interdisciplinary team care.

PATIENT/FAMILY AS THE UNIT OF CARE

Principle: Inclusion of the family in the hospice care program is essential. The wishes and desires of the patient/family are reflected in assessments and plans of care developed by the interdisciplinary team. The family members are seen both as primary caregivers and as needing care and support so that their own stresses and concerns may be addressed. Attention is also given to assisting with the development of a community support network when family and friends are not available and a patient needs and wants that support.

Standard 8: The patient/family is the unit of care in hospice and support is provided to both the patient and the family. The hospice program encourages patient/family participation in the development of the interdisciplinary team plan of care and in the provision of hospice services.

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Principle: Hospice care is provided by an interdisciplinary team which includes at least the following members: patient and patient's family, physician, nurse, social worker, volunteer, and clergy. Ancillary staff are added to the team when appropriate. The team meets regularly to develop and maintain an appropriate plan of care.

Standard 15: The hospice identifies and maintains an appropriately qualified interdisciplinary team of health professionals and lay persons.

Standard 16: Emotional support for staff/volunteers is provided as an integral part of a hospice program.

Standard 17: Inservice training and continuing education are offered on a regular basis to both paid and volunteer staff.

INTERDISCIPLINARY TEAM PLAN OF CARE

Principle: Documentation of services is necessary for the delivery of quality hospice care. Of critical importance is the development of an integrated plan of care which records assessments, proposed interventions by all

Standards For A Hospice Program

interdisciplinary team members and documents all services provided to the patient/family and their outcomes. Hospice clinical records reflect the full range of problems identified; services provided by level of care across both the home and inpatient settings; and progress notes documenting the care given on a day-to-day basis.

Standard 18: The hospice program has a written, interdisciplinary team plan of care for each patient/family unit that includes assessments, identified problems, proposed interventions, level and frequency of services and their outcomes.

Standard 19: The hospice program maintains accurate, current, integrated clinical records for all patient/family units and provides assurances for the confidentiality of these records.

Standard 20: These clinical records must include a signed informed consent form completed by the patient or a designated representative. The consent form must inform the patient/family of the palliative nature of hospice care; the avoidance, if at all possible, of injections, diagnostic testing and curative measures; and the non-use of heroic measures to prolong the dying process.

Standard 21: These clinical records must include specific, signed instructions regarding actions to be taken when life threatening situations occur to the patient. These instructions should be prepared by the physician and the interdisciplinary team, following consultation with the patient/family, and must be consistent with the patient/family's wishes.

BEREAVEMENT

Principle: Death of a family member may result in a wide range of physical, emotional, social, familial, economic and spiritual disruptions. Grief and bereavement are normal reactions to loss and death. Grief is the highly personal response to loss; bereavement is the extended period of deprivation following the loss of a loved one. Grieving may precede an anticipated death or may be delayed for a considerable period of time. Grief may manifest itself in emotional and/or physical distress and may affect family members in different ways at different times. Some persons can resolve grief with time and their own resources; others may require formal assistance and support over an extended period of time.

An important element of hospice care is an assessment of the needs of the bereaved family, and the development of a care plan that meets these needs, both prior to, and following, the death of the patient. Hospice encourages the expression of grief, recognizes social/religious and ethnic variables in bereavement and supports staff and family participation in meaningful funeral services and rituals.

Standard 22: The hospice program provides bereavement services to the surviving family members for at least one year after the death of the patient.

Standard 23: The hospice program maintains a process of risk assessment for surviving family members that identifies those individuals at risk of pathological grief. For those individuals at high risk, appropriate referrals are made to mental health professionals in the community.

QUALITY ASSURANCE AND UTILIZATION REVIEW

Principle: Hospice is committed to developing methods to measure and assure the quality of patient/family care and the appropriate utilization of hospice resources.

Standard 24: The hospice program has quality assurance and utilization review programs that include the following: statement of goals and objectives and established policies for conducting an ongoing assessment program that reflects the interdisciplinary nature of hospice services; designation of person(s) responsible for implementing policies and procedures; provisions for addressing specific problems identified in the quality assurance and utilization review processes.

Standard 25: At a minimum, the hospice program conducts on a regular basis the following activities: evaluation of services provided by both professionals and volunteers, audit of patient charts for outcomes of interventions, organizational review of hospice program, interdisciplinary team care plan review, evaluations provided by patient/families of care received, an review of appropriate/inappropriate use of services, facilities and personnel.

A Hospice Glossary



This glossary was prepared using a variety of source materials to provide definitions. These include: *NHO Standards of Care* (1983), *Joint Commission on Accreditation of Healthcare Organizations* (manuals, 1985), *Introduction to Health Education* (Bates, Wynder, 1984) and *Webster's New Collegiate Dictionary* (1986).

Ability to pay: A phrase used to describe a patient's capability to pay for health services received. Some health providers limit their services to patients who can pay for their services.

Access: An individual's or group's ability to obtain health care. Access has geographical, financial, social, ethnic and psychological elements. Many health programs have as their goal improving access to care for specific groups or equity of access for the whole population.

Accountability: To provide for an organization substantial reasons or convincing explanations for actions; to be accountable means to furnish a justification or detailed explanation of financial activities or responsibilities. Accountability entails an obligation to periodically disclose, in adequate, detailed and consistent form the purposes, principles, procedures, relationships, results, incomes, and expenditures involved in any activity, enterprise, or assignment, so that they can be evaluated by interested parties.

Accreditation: A voluntary process, generally developed and implemented by a non-governmental body composed of professionals within the field, with input from providers, and based on optimal standards of quality care.

Administration: The fiscal and general management of a hospice program, as distinct from the general policies and procedures of the hospice program.

Admissions: Numbers of patients/families that enter a hospice program and agree to accept the services provided by a hospice program.

Admission criteria: Guidelines or policies of a hospice program that specify the conditions under which a patient/family will be admitted. The purpose of the criteria is to control entry/admission to services, e.g., most hospices require a diagnosis of terminal illness by a physician as a prerequisite for admission.

Ancillary staff: Health professionals who provide additional services to support or supplement hospice interdisciplinary team services, including physical therapy, occupational therapy, speech therapy, nutritional counseling, respiratory therapy, and other services.

Appropriate: Descriptive of an action or policy that is suitable or compatible with a hospice program's objectives and philosophy.

Approved: Acceptable to the appropriate authority.

Assessment: Procedures by which strengths, weaknesses, problems, and needs are identified and addressed.

Audit, financial: An independent review of a hospice program's financial records that accurately reflects its financial status.

Bereavement: An important element of hospice care is an assessment of the needs of the bereaved family, and the development of a care plan that meets these needs, both prior to, and following the death of a patient. Hospice encourages the expression of grief, recognizes social/religious and ethnic variables in bereavement and supports staff and family participation in meaningful funeral services and rituals.

Bereavement services: The hospice program makes available bereavement services to the surviving family members for a period of at least one year after the death of the patient. They may include: cards to families; home visits; phone calls; group counseling; individual counseling; newsletters; and social activities.

Bylaws: The rules, regulations, or laws adopted by a hospice program for the regulation of its internal affairs and its dealings with other persons and the community at large.

Certification: A voluntary mechanism used to qualify organizations to receive public funds. If a provider chooses to participate in Medicare, for example, it must comply with a set of conditions of participation based on laws and regulations.

Chemotherapy: Provision of drugs (i.e., chemicals) taken orally, injected, inserted, topically applied, or otherwise administered to control pain and symptoms in hospice patients.

Clergy: A person who has met the requirements of a religious

A Hospice Glossary



organization or system to serve the constituency of that religious organization or system.

Clergy services: See spiritual services.

Clinical privileges: Authorization by the governing body to provide specific patient/family care and treatment services in the organization, within well-defined limits, based on the individual's license, education, training, experience, competence, and judgment.

Community: The individuals, groups, agencies, facilities, or institutions within the locality served by the hospice program.

Confidentiality: The relationship between the hospice staff patients/families in which information is shared and exchanged with the understanding that this information is used appropriately and with respect to the patient/families' wishes and rights to privacy.

Continuing education: Education beyond initial professional preparation that is relevant to the type of patient/family care delivered in the organization, that provides current knowledge relevant to the individual's fields of practice, and that is related to findings from quality assurance activities.

Continuity of care: Services that are organized, coordinated and provided in a way that is reflective at all times of patient/family needs, and which are structured to assure that the hospice is accountable for its care and services regardless of home or in-patient setting.

Continuous basis: Hospice care is provided in the home setting on a 24

hour basis until care is no longer needed. Usually this occurs when the patient/family goes into a medical crisis, but does not need or wish to return to an inpatient setting.

Contracted services: Services provided through a formal agreement with any organization, agency or individual. The agreement, which is approved by the governing body, specifies the services, personnel, and/or space to be provided to or on behalf of the hospice program and the consideration to be expended in exchange.

Counseling: A relationship in which a person endeavors to help another understand and cope with problems.

Curative: Medical interventions used to ameliorate the cause of a disease.

Dietetic services: Services that meet the nutritional needs of patients, with emphasis on patients who have special dietary needs.

Dietitian: A person who is registered by the Commission on Dietetic Registration of the American Dietetic Association or who has the documented equivalent in education, training and/or experience.

Discharge: The point at which the patient's active involvement with the hospice program is ended and the program no longer maintains active responsibility for the care of the patient.

The actual point of discharge is determined by the hospice program in accordance with the continuum of home care and inpatient services provided.

Documentation of services: The process of writing, recording and maintaining appropriate records of services that are provided by a hospice interdisciplinary team. This process is very important to assure continuity of services, high quality of care and to justify those services that have already been provided.

Dying: The progressive failure of body systems to retain normal functioning, thereby limiting the remaining life span.

Emotional: The feeling aspect of consciousness which is subjectively experienced and expressed by physiological reactions.

Emotional support: The provision of psycho-social services that assist and support the patient/family during that period of time when they cope with their feelings and responses to the loss, grief and change in their family structure which occurs when the patient dies.

Employees: Individuals who agree to work and provide their services under the administrative direction of the hospice program. Employees may receive wages and other compensation in exchange for their work, or they may provide their services without payment, as an in-kind contribution to the hospice program.

Facility: The building(s), equipment and supplies necessary for the

A Hospice Glossary

implementation of inpatient services for hospice patients/families.

Family: The relatives and/or other significantly important persons who provide psychological, emotional and spiritual support of the patient. The "family" need not be blood relatives to be an integral part of the hospice care plan.

Fiscal management: The policies and procedures used to plan and control a hospice program's overall financial operations.

Goal: An expected result or condition that takes time to achieve and is specified in a statement of relatively broad scope that provides guidance in establishing intermediate objectives directed toward attainment of that goal.

Governing body: The individual(s), group or agency that has ultimate authority and responsibility for the overall operation of the organization.

Grief: The highly personal response to loss. Grieving may precede an anticipated death or may be delayed for a considerable period of time. Grief may manifest itself in emotional and/or physical distress and may affect family members in different ways at different times. Some persons can resolve grief with time and their own resources; others may require formal assistance and support over an extended period of time.

Home: The patient's place of residence. Home is the place where most terminally ill patients choose to spend their remaining days.

Home care services: Formally organized services designed to provide and coordinate hospice interdisciplinary team services to

patients/families in the home.

Home health agency: An organization that provides services to individuals in their place of residence. Many home health agencies receive compensation for their services provided to Medicare beneficiaries. Some home health agencies operate a hospice program as a separate division of their total program.

Home health aide services: Personal care services provided in the home. Services may include assistance in the activities of daily living (e.g., helping the patient bathe, care for his or her hair or teeth, exercise and retain necessary self-help skills). Services may also include specific household tasks to maintain a safe environment in areas of the home used by the patient (e.g., changing the bed and doing laundry essential to the cleanliness of the patient).

Homemaker services: Services that are provided to assist patients to remain in their homes. Services may include assistance in personal care (e.g., assisting the patient to the bathroom or in and out of bed); maintenance of a safe and healthy environment (e.g., cleaning the patient's bedroom, bath and kitchen, doing personal laundry and preparing meals); and other services, as appropriate to the homemaker's responsibilities.

Hospice care: Care provided by a hospice program that is designed to meet the physical, social, emotional and spiritual needs of dying patients and their families.

Hospice program: A hospice program is a coordinated program of palliative and supportive services provided in both home and in-patient

settings which provides for physical, psychological, social and spiritual care for dying patients and their families. Services are provided by a medically-directed interdisciplinary team of professionals and volunteers. Bereavement care is available to the family following the death of the patient. Hospice provides support and care for persons in the last phases of incurable disease so that they may live as fully as comfortably as possible.

Hospice philosophy: Hospice recognizes dying as part of the normal process of living and focuses on maintaining the quality of life. Hospice affirms life and neither hastens nor postpones death. Hospice exists in the hope and belief that through appropriate care and the promotion of a caring community sensitive to their needs, patients and their families may be free to attain a degree of mental and spiritual preparation for death that is satisfactory to them.

Hospice program director: The chief administrative officer of the hospice program who provides overall policy direction, is responsible for the fiscal operations, and implements work plans and procedures.

Incident report: Documentation of an event of action that is likely to lead to adverse effects and/or that varies from established policies and procedures pertaining to patient/family care.

Infection control program: Organized, on-going activities within a hospice program to control and monitor the spread of infectious diseases within the hospice, including both home and in-patient settings. Part of this program involves establishing and maintaining specific policies and procedures proper

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procedures for proper disposal of human discharges and surveillance of staff and patients for infections acquired during their contact with a hospice program.

Informed consent: A full understanding by a competent body of the risks and benefits of particular medical procedure or set of procedures. Prior to admission to hospice, the patient/family must sign an agreement that states they understand the nature and scope of hospice care, including the fact that hospice care is palliative and not curative, and that they agree to cooperate in the provision of care.

Inpatient services: Formally organized services designed to provide and coordinate hospice interdisciplinary team services to patients/families in an inpatient setting.

Inpatient settings: Services provided in a setting where the needs of acutely ill patients/families can be met. This care is provided on a 24 hour basis and involves the full hospice interdisciplinary team. During the last months of life, a dying patient may have episodes of acute illness that require the intensive services capability of an in-patient setting.

In-service education: Organized education designed to enhance the skills of interdisciplinary team members or teach them new skills relevant to their responsibilities and disciplines.

Interdisciplinary team: Hospice care is provided by an interdisciplinary team which includes at least the following members: patient and patient's family, physician, nurse, social worker, volunteer, and clergy. The team is coordinated by a qualified health care professional and is

medically supervised. The team meets regularly to develop and maintain an appropriate plan of care. (See Interdisciplinary team services.)

Interdisciplinary team conference: A meeting during which interdisciplinary team members review one or more interdisciplinary team care plans to update patient/family physical and/or psychological status and initiate any changes in the care plan.

Interdisciplinary team plan of care: Documentation of services is necessary for the delivery of quality hospice care. Of critical importance is the development of an integrated plan of care which records assessments, proposed interventions by all interdisciplinary team members and documents all services provided to the patient/family and their outcomes. Hospice clinical records reflect the full range of problems identified, services provided by level of care across both the home and inpatient settings, and progress notes documenting the care given on a day-to-day basis.

Interdisciplinary team services: A group composed of individuals from various professions and disciplines who interact on a regular basis and have a working knowledge of the assessment and care of the patient/family by each member of the team. The team services are characterized by the ability by all members and disciplines to allow their roles to overlap while simultaneously providing emotional support to each other and maintaining a respect for each other's skills, training and interventions.

Intermittent basis: Provision of hospice services at intervals as they are needed by the patient/family. During the final six months of life, the patient/

family may go through a number of crises that require a higher level of intensity of hospice services than at other times.

Interventions: Specific actions designed to interfere, stop or ameliorate the natural course of an illness or human disease. In hospice, interventions are limited to those that are palliative and not curative. These interventions may, however, address a range of patient/family needs, including physical, spiritual, social and emotional concerns.

License: Authorization to practice in the professional discipline by an individual may be mandated by state law. The state grants permission to a provider organization to operate or individual to practice. It is a matter of specific state law and violation imposes a penalty.

Licensure: Licensure standards are the minimum standards which must be met to provide service as a hospice. In contrast to accreditation and certification, licensure is mandatory if specified by state law. The state grants permission to a provider organization to operate or individual to practice. It is a matter of specific state law, and violation imposes a penalty.

Medical director: A fully licensed physician who is charged with the responsibility of acting as consultant to the interdisciplinary team and, as requested, to attending physicians with regard to pain and symptom management, as well as acting as liaison with physicians in the community.

Medical records: Specific records maintained by a hospice that document all services provided by the

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interdisciplinary team to a patient/family.

Medical staff: A single organized body that is accountable to the governing body and has the overall responsibility for the quality of professional services provided by individuals with clinical privileges.

Medication: Any substance, whether prescription or over-the-counter drug, that is taken orally, injected, inserted, topically applied, or otherwise administered to the patient.

Nursing services: Patient/family care services pertaining to the palliative, curative, rehabilitative and preventive aspects of nursing, performed and/or supervised by a registered nurse pursuant to interdisciplinary team care plans.

Objective: An expected result or condition that takes less time to achieve than a goal, is stated in measurable terms, has a specified time for achievement and is related to the attainment of that goal.

Outcomes: The final results or consequences from specific interventions taken. In hospice, the death of the patient is anticipated and is not defined as an outcome. Appropriate hospice outcomes focus on control of pain and symptoms and quality of the remaining days that the patient/family spends together.

Pain and symptom control: For the hospice program, the goal of all interventions is to maximize the quality of the remaining life through the provision of palliative therapies that control pain and symptoms and minimize the negative side effects of interventions. Hospice programs

recognize that when a patient and a family are faced with terminal disease, stress and concerns may arise in many aspects of their lives. Optimum symptom control includes addressing those stresses and concerns, in addition to the use of appropriate therapies. Symptom control includes assessing and responding to the physical, emotional, social and spiritual needs of the patient/family.

Palliative care: Intervention that focuses primarily on reduction or abatement of the physical and psychosocial symptoms of terminal illness.

Patient/family as unit of care: The specific unit for whose needs hospice is organized. In hospice, this unit is the patient/family. Services are structured (e.g., record/keeping) and then delivered (e.g., visits at home with family members). In contrast, most health providers have, as their unit of care, the individual patient.

Personal care: Assistance rendered to the patient in bathing, dressing, mobility, or any other activities of daily living and personal hygiene.

Pharmacist: A person who has a degree in pharmacology and is licensed and registered to prepare, preserve, compound and dispense drugs and chemicals in the state in which he or she practices.

Physical: Relating to the body, its structure, characteristics and functions.

Physician: A doctor of medicine or doctor of osteopathy who is fully licensed to practice medicine in conformity with applicable law.

Physician, attending: The primary physician selected by the patient to be

responsible for his or her medical care.

Physician, hospice: Any licensed medical practitioner on the hospice staff (compensated or not) who is knowledgeable about hospice principles and active in the development and implementation of interdisciplinary team plans of care for patients and families.

Primary caregivers: The person designated by the patient to give emotional support and/or physical care to the patient. This person may be an individual who has personal significance to the patient but no blood or legal relationship (e.g., significant other), such as a neighbor, friend or other person. If the patient has no designated primary careperson, the hospice may, according to individual program policy, make an effort to designate a primary careperson.

Prognosis: The prospect of recovery, or a forecast of the natural history of a disease or illness. In hospice, usually prior to admission, a patient must have been given a prognosis by a physician of less than six months to live.

Program director: The person who has the authority and responsibility, as delegated by the governing body, to accomplish program-specific goals and objectives, implement program policy and manage personnel and resources.

Psychological/social work services: Counseling and/or therapy, as appropriate, that assists the patient/family in minimizing stresses and problems that arise from social, economic or psychological situations and assists the patient/family in maximizing positive aspects and opportunities for growth. Services are provided, as appropriate to the skills

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required, by the persons who have education, training and/or experience in the care of hospice patients/families and demonstrated ability in counselling and casework.

Psychosocial assessment: The evaluation of a patient's/family's environment, religious background, financial status, and other pertinent psychosocial information that may contribute to the development of an interdisciplinary team care plan.

Qualified: Having the experience, education and demonstrated competence deemed appropriate by the hospice program to meet the requirements and fulfill the responsibilities of a specific function or duty.

Quality assurance: Ongoing assessment program that measures the quality of the interdisciplinary hospice services provided; It includes provisions for addressing specific problems identified and followup to determine the effectiveness of corrective actions.

Registered nurse: A nurse who is a graduate of an approved school of nursing and who is licensed to practice as a registered nurse.

Risk assessment: The hospice program maintains a process of risk assessment for surviving family members that identifies those individuals at risk of pathological grief. For those individuals at high risk, appropriate referrals are made to mental health professionals in the community.

Service: A functional division of a program or an interdisciplinary team. Also, the delivery of care.

Social: The interactions of persons with their families and communities.

Social services: See (Psychological/social work services.)

Spiritual service: Spiritual support provided by a member of the interdisciplinary team, community clergy, or a person identified by the patient/family as supportive with regard to spiritual or religious matters.

Staff: Paid or volunteer interdisciplinary team members who provide hospice services.

Staff support: Organized activities designed to provide psychological/social support to hospice employees as they respond personally to the loss, grief and change experienced by patients and their families.

Supervision: The direction of the provision of services and the individuals who provide the services, and the review of the services provided, in accordance with written program policies, procedures and job descriptions.

Terminal disease: An illness for which treatment directed toward cure or control of the disease process is no longer possible or effective.

Terminally ill: Individuals suffering from a disease with a prognosis of six months or less to live.

Transfer: Movement of the patient/family from one service or location to another (e.g., the patient and family or designated primary careperson).

Unit: A functional division of a facility or institution. Also, a person or group regarded as a whole (e.g., the patient and family or designated primary careperson.)

Utilization review: The process of using predefined criteria to evaluate whether the hospice's services and resources are necessary, cost efficient and effectively utilized.

Volunteer: An individual who agrees to provide services to a hospice program without monetary compensation. More specifically, a patient care volunteer is an individual who agrees to serve on an interdisciplinary team as a companion of the patient/family and provide psycho-social support to the patient/family during the remaining days of the patient's life. A bereavement care volunteer agrees to provide psycho-social support to the surviving family following the patient's death.

Volunteer support: Activities designed to assist and support volunteers as they work in their roles as patient care and bereavement volunteers.

Written agreement: A formal agreement with any organization, agency, or individual specifying the services, personnel and/or space to be provided to or on behalf of the hospice program, as well as the monies to be expended, if any, in the exchange. The agreement is approved by the governing body, in accordance with hospice program policy.



National Hospice Organization

Addendum to

Standards of a Hospice Program of Care
Recommended by the National Hospice Organization

Original Standard:

Standard 14

A hospice program has an organized training program and procedures for the selection, supervision and continuing education of volunteers.

Revised Standard:

Standard 14 (A)

The hospice program has an organized training program which covers at a minimum the following topics: introduction to hospice, concepts of death and dying, communication skills, care and comfort measures, understanding diseases and conditions, psychosocial and spiritual dynamics of death and dying, the hospice family, managing personal stress, the bereavement process, and the role of the volunteer in hospice.

Standard 14 (B)

The hospice program has established policies and procedures for the selection, retention and continuing education of hospice volunteers and volunteers are regularly evaluated using performance criteria defined by the hospice.

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NATIONAL HOSPICE ORGANIZATION

ABOUT HOSPICE

Hospice is a philosophy and concept of care for the terminally ill that is now one of the most frequently used terms in discussions of innovative approaches to health care. In 1990, the American College of Physicians presented to the National Hospice Organization the Richard & Hinda Rosenthal Foundation Award in recognition of the "recent original approach in the delivery of health care or in the design of facilities for its delivery [which] will increase its clinical and/or economic effectiveness." However, most people are unaware that the significant recent growth of hospice in the United States and internationally is nurtured by ancient roots.¹

The modern hospice can trace its roots to the Irish Sisters of Charity who established St. Joseph's Hospice at London in 1905. The hospice most often recognized as the model of contemporary hospice philosophy and care is St. Christopher's in London. Started by Dame Cicely Saunders, M.D. in 1968, St. Christopher's laid the basis for a philosophy that emphasizes palliative care, i.e., pain and symptom control rather than curative care for the terminally ill.

A community based service, hospice care is provided by an interdisciplinary team of health care professionals and volunteers including physicians, nurses, counselors, therapists and aides. Using a comprehensive case management approach, hospice care is guided by a plan of care which is developed by the interdisciplinary team in conjunction with the patient and family. The goal of the plan is to care for the patient and family as the "unit of care," to provide an alert, pain-free life and to manage other symptoms so that individuals can "live until they die" with personal dignity and quality of life at home or in a home-like setting.

Responding to the directives of the Medicare Hospice Benefit Conditions of Participation², as well as the National Hospice Organization and JCAHO standards, most hospices offer the

¹ The first references to "hospice care" can be found in the ancient writings of Constantine in A.D. 335, and later with the sixth century Benedictine monks and in the ninth century under the emperor, Charlemagne.

² Congress first added the hospice benefit to Medicare in TEFRA 1982. In 1986, Congress made the Medicare benefit permanent and established hospice as an optional Medicaid benefit.

following services to terminally ill patients with a prognosis of six months or less: Physician and nursing services on an intermittent basis; social work services, physical, occupational and speech-language therapy; home health aides; volunteers; drugs and medical supplies; spiritual, dietary and other counseling; short-term inpatient care; continuous home nursing care during periods of medical crisis; and bereavement care for surviving family members. Most services are available, as needed, 24 hours per day, seven days per week.

HOSPICE REIMBURSEMENT AND SAVINGS

As noted, hospice care is a covered Part A benefit under Medicare. Additionally, hospice care is a covered Medicaid Benefit in thirty-three states. Medicare and Medicaid directly pay hospices an all-inclusive, prospective daily rate based on a particular level of care delivered on that day. The four levels of care are: Routine Home Care, Continuous Home Care, Inpatient Respite Care and General Inpatient Care. No more than 20 percent of a hospice's aggregate days may be furnished at the inpatient level of care, and there is an annual aggregate expenditure cap per hospice, calculated on a per patient basis, of \$11,551 (1992). For 1992, the Congressional Budget Office projected a \$600 million Medicare outlay for hospice care. Approximately 60 percent of all hospice patients are Medicare beneficiaries.

Estimated expenditures for hospice care are not available from private payers; however, according to the Health Insurance Association of America, more than 80 percent of employees in medium and large companies have hospice care as a covered benefit. In 1984, only 11 percent of such employees had coverage for hospice care.

Health Care Financing Administration (HCFA) research suggests that approximately 28 percent of annual Medicare expenditures are associated with services, many of which are inappropriate and unwanted, provided to Medicare beneficiaries in their last year of life. Medicare beneficiaries electing hospice services waive their right to standard Medicare benefits for treatment of the terminal illness although their attending physician continues to bill Medicare Part B directly.

A 1988 HCFA commissioned report by ABT Associates suggested a savings of \$1,248 per patient in the last year of life, when hospice care is elected. Kaiser Permanente, an Oakland, California-based HMO, conducted a hospice cost-effectiveness study in the late 1980's focusing on non-Medicare and non-Medicaid terminally ill patients who entered hospice care. The study showed an average cost savings per hospice patient of about \$1,430 to the HMO.

A STATISTICAL PROFILE OF HOSPICE CARE

- First Hospice in the United States, New Haven, CT. 1974
- Current number of U.S. hospices, 1830 including planned and non-comprehensive programs. NHO estimates 1700 comprehensive programs, as described above.
- Approximately two-thirds of the comprehensive hospices are Medicare certified.
- Over 90 percent of hospices are non-profit or government affiliated programs. Four percent are for-profit entities.
- Hospices served approximately 210,000 patients in 1990.
- The average daily census of the typical hospice program is 25 patients per day. The average length of stay is 59 days. Approximately 90 percent of all patient days were provided in the patient's home.
- Approximately two out of three patients served are over the age of 65. One percent are under the age of 18, representing 71 percent of pediatric cancer deaths.
- Eighty-four percent of hospice patients have cancer, accounting for approximately 33 percent of all cancer deaths as reported by the American Cancer Society. People living with AIDS and those with cardiovascular disease constitute the bulk of remaining hospice patient census.
- Over 20,000 people are employed nationwide in hospices and include physicians, nurses, social workers, administrators, home health aides, clergy, therapists and bereavement specialists.
- Approximately 68,000 people volunteer in hospice programs, contributing more than 5 million hours of service annually. Two out every three hours are direct patient care hours. The Medicare Hospice Benefit Conditions of Participation require that a minimum of five percent of patient service hours be provided by volunteers.

II. Studies Showing Savings and Benefits of Hospice Care:

Through the national hospice demonstration projects conducted by the federal government, it was learned that not only was hospice care a more humane alternative of care but it resulted in cost savings as well. As a result of its cost effectiveness, the Medicare hospice benefit was created by the Tax Equity and Fiscal Responsibility Act of 1982 as a more humane alternative to the hi-technology care traditionally provided to the terminally ill. In 1986, hospice was made an option under Medicaid and the number of states offering the hospice benefit rose to 34 states by 1992.

- Savings can be realized by substituting the high cost of conventional care with the home-oriented approach of hospice care. A study by Abt Associates (Medicare Hospice Benefit Program Evaluation, Final Summary Report, July 21, 1989) stated that comparisons of hospice benefit and conventional care expenditures in the last month of life showed that conventional care was 30% higher in FY85 and 43% higher in FY86. The hospice savings were even more significant for non-cancer beneficiaries who cost \$3,135 for hospice care in the last month of life compared to \$4,730 for conventional care.

- Major savings in the cost of providing care to the terminally ill are directly related to the percentage of time patients are at home during the final months of life. Based on 1986 mortality data from the National Center for Health Statistics, an article in the Health Care Financing Review/Fall 1990, stated that there was an increase of 10% in the shift in place of death for cancer patients from hospitals to patients homes, and because about 94% of all hospice patients have cancer, the data suggests a possible impact of hospice use.

- A survey of hospital based hospices conducted by the American Hospital Association in 1986 identified a major reduction in the number of inpatient days for those patients cared for under the Medicare hospice benefit: the average

patient on the Medicare hospice benefit spent 68 days at home and 7.7 days in the hospital; the traditional Medicare patient spent an average of 58.1 days in home care and 21.3 days in the hospital; and the non-Medicare patient spent an average of 53.4 days at home and 13.8 days in the hospital.

- According to the most recent statistics gathered from Medicare certified hospice programs by the Health Care Financing Administration, the average length of stay was 48.38 days in a hospice program in 1990, and 96% of all patient days were spent in the home rather than in conventional health care settings. Additionally, the number of Medicare certified hospices in the country increased to 1,072 by April of 1992.

- Employee benefit packages surveyed by the Bureau of Labor Statistics showed 23% carrying hospice coverage in 1985 and 31% in 1986.

- General Motors Corporation covers hospice care on a per diem basis for all of its employees (Blue Cross is the intermediary for this reimbursement) and Metropolitan Life Insurance Company also uses a per diem system for all of its subscribers.

- Sixty-nine percent of Health Maintenance Organizations (HMOs) offer hospice care as surveyed by the Group Health Association of America in 1988.

- A survey conducted by Foster Higgins & Company, a benefits consulting firm, showed that 80% of major employers nationwide included hospice as an employee benefit in 1989. The survey represented over 12.5 million employees of 1,943 public and private-sector employers.