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The employer may transfer more risk to the hospital by negotiating broad based per diem rates with a much higher stop-loss level. We will return to the issue of stop-loss provisions later.

Hospital X should calculate Employer A's broad based per diem rates based on: (1) the experience of all patients admitted to its facility; and (2) the experience of the Employer A employees admitted over the past several years. Rates based on the experience of *all* patients will give the hospital the most statistically valid per diem values. The hospital should, however, also have a good idea of Employer A's inpatient costs per diem; these rates can be calculated if the hospital's claim system uses an identifier that tracks employer group. Were the employer's broad based per diems greater than, equal to or less than Hospital X's overall per diem values? This comparison gives the hospital some baseline information on the severity of illness and case mix of Employer A's employees. Also, by capturing several years of experience data, Hospital X can determine whether employees seeking care have increased or decreased their overall severity of illness and case mix composition over time.

After obtaining an experience claims tape, Employer A also calculates broad based hospital per diem rates (refer to Table I). The medical per diem is $764, surgical is $1,983, general maternity is $1,331, mental health is $570, and alcohol and drug abuse is $470. Several of these broad based categories are divided into more refined subcategories. For example, surgery is divided into cardiovascular operations ($6,388/day) and other surgical operations ($1,784/day).

The employer compares its calculated broad based per diem values with those calculated by the hospital. These two rates are expected to be somewhat different because the employer and hospital calculated their values based on different databases. Therefore, the employer's negotiated group-specific per diems should fall somewhere between the hospital's per diem values and its own calculated values.

Table II

Employer A's Calculated 1988 Per Case Rates for Hospital X

Case Mix Classes	Inpatient Admissions	ALOS	Total Paid Charges	Charge/ Case
Medical	67	7.5	$ 382,569	$5,710
Surgical	31	5.2	321,264	10,363
Cardiovascular	1	7.0	44,716	44,716
Other surgery	30	5.2	276,548	9,218
General maternity	42	3.3	183,692	4,374
Normal delivery	22	2.1	78,646	3,575
Other obstetric	20	4.6	105,046	5,252
Mental health	8	10.1	46,146	5,768
Alcohol and drug	10	16.6	77,984	7,798
Totals	158	6.6	$1,011,655	$6,403

Negotiating Per Case Rates

The day-volume response caused by per diem payment systems can be corrected by moving to per case reimbursement. Under per case payment, hospitals are reimbursed a fixed predetermined amount based on a patient's resource requirements — and not on the actual costs or charges of resources used during diagnosis and treatment. This gives hospitals an incentive to reduce both length of stay and the amount of ancillary resources used to treat each case.

Before the Medicare prospective payment system (PPS) was implemented on October 1, 1984, ALOS of Medicare patients was declining at an annual rate of about 2%. For example, between 1981 and 1982 the ALOS for pre-PPS states decreased from 9.7 days to 9.5 days (a change of 2.1%). In 1984, however, the ALOS for PPS states declined 9.8% (from 9.2 days to 8.3 days); the decline continued in 1985.[2]

Other evidence suggests that the PPS also has had an effect on the use of diagnostic and therapeutic tests conducted in a hospital. In 1984, there were major reductions in routine serology and blood chemistry tests as well as declines in well-established hospital procedures, such as electrocardiograms and transurethral cystoscopy.[3] These facts support the hypothesis that per case payment systems should reduce length of stay and the number of ancillary services.

Case-based systems may use one all-inclusive per case rate (such as that used by the California Medi-Cal system from 1980 to 1982) or broad based per case rates. The most common example of a broad based system is diagnosis-related groups (DRGs), which classify an admission into one of 23 major diagnostic categories based on principal diagnosis. Each admission then is assigned to one of over 460 DRGs based on patient age, procedures performed and comorbidity or complications.

Employers should not negotiate an all-inclusive per case rate for much the same reason they should not negotiate an all-inclusive per diem rate: all-inclusive rates encourage hospitals to admit only those patients who require less intensive resources. Returning to Employer A, Table II shows that the all-inclusive rate for Hospital X is $6,403/case. On average, charges for medical

Table III

1988 Per Case Rates for Hospital X at Different Threshold Levels

Case Mix Classes	Total		STOP-LOSS THRESHOLDS					
			< $10,000		< $15,000		< $25,000	
	Total Inpatient Admissions	Case Rate Payment	Total Inpatient Admissions	Case Rate Payment	Total Inpatient Admissions	Case Rate Payment	Total Inpatient Admissions	Case Rate Payment
Medical	67	$5,710	56	$2,968	60	$3,593	65	$4,931
Surgical	31	10,363	19	5,191	26	7,096	29	8,395
Cardiovascular	1	44,716	0	0	0	0	0	0
Other surgery	30	9,218	19	5,191	26	7,096	29	8,395
General maternity	42	4,374	40	4,013	42	4,374	42	4,374
Normal delivery	22	3,575	22	3,575	22	3,575	22	3,575
Other obstetric	20	5,252	18	4,548	20	5,252	20	5,252
Mental health	8	5,768	8	5,768	8	5,768	8	5,768
Alcohol and drug	10	7,798	8	7,137	10	7,798	10	7,798
Totals	158	$6,403	131	$4,035	146	$4,848	154	$5,661

cases were $5,710/case, while charges for surgical cases were $10,363. By negotiating an all-inclusive case rate of $6,403/case, Hospital X can increase profits by changing its current case mix away from treating surgical and toward treating medical cases.

Also, Employer A should not attempt to negotiate per case rates based on DRGs because it cannot establish statistically valid per case values — there are too many DRGs and too few patients. The hospital, on the other hand, should have a good idea of its overall costs and charges for each DRG category; this gives Hospital X a competitive advantage in the negotiation process.

Employer A should calculate broad based per case rates using similar categories to those it established for negotiating per diem rates. Table II indicates that the medical per case rate is $5,710, surgical is $10,363, general maternity is $4,374, mental health is $5,768 and alcohol and drug abuse is $7,798. The employer then uses these values to negotiate case-based rates with Hospital X.

Because per case systems transfer more risk to the hospital than per diem systems, most hospitals will require some type of stop-loss provision to reduce their financial liability for outlier cases. PPS (a system designed to pay a predetermined amount per DRG case) defines *outliers* in several ways. For instance, a *length-of-stay outlier* is defined as a case whose length of stay exceeds the mean DRG length of stay by 20 or more days. A *cost outlier* is one whose costs exceed the average cost by 1.5 times the established DRG rate. Outliers usually represent about 3% of all Medicare cases and account for between 5% and 7% of Medicare's total payments to hospitals. Many recently adopted state case-based systems use similar outlier criteria.[4]

Table III shows three different possible stop-loss thresholds set by Employer A for Hospital X: $10,000, $15,000 and $25,000. Over 17% of the cases exceeded a $10,000 threshold. These cases accounted for 47.8% of total payments to Hospital X. After eliminating the outliers from the analysis, the overall case rate was reduced from $6,403 to $4,035; the medical case rate was reduced from $5,710 to $2,968; and the surgical case rate was reduced from $10,363 to $5,191. Surgical cases had the greatest percentage — almost 39% — excluded at the $10,000 threshold level.

About 7.6% of the cases had payments greater than $15,000, accounting for 30% of total hospital payments. After excluding the outliers, Table III shows that the overall case rate decreased to $4,848. Only 2.5% of the cases exceeded a $25,000 threshold; they accounted for 13.8% of total payments to Hospital X. Excluding the outliers, the overall case rate now was $5,661. The employer and hospital may decide to implement one of these stop-loss thresholds, or they may use an even higher threshold level. This depends largely on the degree of financial risk the hospital is willing to assume.

Other Effects of Per Case Payment Systems

Case-based payment systems give hospitals an incentive both to perform fewer tests and treatments and to reduce ALOS. Per case systems, however, also are susceptible to their own perverse utilization responses. For instance, hospital occu-

pancy rates are a function of ALOS, admission rate and number of hospital beds. Decreasing ALOS reduces a hospital's occupancy rate and, therefore, its total revenues. This gives the hospital a strong incentive to increase its admission rate to fill empty hospital beds. The hospital's other alternative to increase its occupancy rate is to close beds; however, this does not produce revenue.

Evidence from Medicare's PPS shows that from 1980 to 1983 the discharge rate in pre-PPS states was slightly increasing (from 380 discharges/1,000 to 403 discharges/1,000); this was an annual increase of about 2%. In the first year of PPS, however, the Medicare discharge rate in PPS states declined for the first time (3.5%).[2] This trend continued in subsequent years.[5]

New Jersey introduced a case-based payment system in 1980. Data released from the New Jersey Department of Health showed that the introduction of the per case program resulted in decreases in ALOS and cost per case. There was, however, no significant increase in the admission rate over the first several years of system implementation.[4]

These facts do not support the hypothesis that case-based payment systems will generate more hospitalizations. Other forces may have been operating, however, to oppose incentives to increase admissions, such as utilization review (UR) firms developing more objective and stringent admission criteria and physicians moving away from inpatient treatment toward less costly ambulatory care. Without a clearer understanding of why admission rates decreased in the PPS and New Jersey systems, employers should assume that a strong prospective UR program is necessary to counteract provider incentives to admit more patients.

As a hospital's occupancy rate declines, it has at least two other alternatives to increase its total revenue base. First, a reduction in revenues could motivate staff physicians to admit a more profitable patient case mix (e.g., more patients who require low resource-intensive care). Moreover, profits per case can be further enhanced by admitting only the least severely ill patients in the low resource-intensive categories. An employer's UR firm should continually monitor and evaluate admitted cases to protect the employer from these perverse incentives.

Second, the hospital may decide that treating some patients in an outpatient setting will provide more revenue than treating them on an inpatient basis. Negotiated rates under many case-based systems do not apply to a hospital's outpatient departments, so hospitals continue to bill charges for these patients. Outpatient charges for a given procedure, therefore, are often greater than when the same procedure is performed on an inpatient basis.

These hospitals have successfully "gamed" the per case payment system in an effort to maintain their revenue base. This has a dramatic effect on an employer's ability to contain hospital costs — considering that, in 1986, over 40% of all hospital operations were performed in outpatient settings (as compared to only 16% in 1980).[6,7]

To correct for deficiencies in the per service and per diem payment systems, large employers will increasingly turn to direct contracting with hospitals on a per case basis. UR firms will have to use stringent admission guidelines to control, monitor and evaluate hospitalizations. They also will need to verify that the hospital is not withholding necessary medical services to increase its profit margin. This could affect the hospital's quality of care — an issue beyond the scope of this paper. Employers should also develop a payment strategy for outpatient services to ensure that the case-based payment system controls hospital costs as effectively as possible.

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Summary Of State Legislation Governing PPOs: Survey Of The American Medical Care And Review Association

With 608 operational preferred provider organizations identified and the growth of multi-state PPOs, many states have started to develop legislation to monitor PPO development. The American Medical Care and Review Association (AMCRA) has surveyed all 50 states to determine the current status of legislation on PPOs.

The following is a brief summary and is not intended for any purpose other than for basic information. Additional information may be obtained by contacting the insurance commissioner and/or the department of health in each state.

Alabama—No PPO legislation.

Alaska—Currently, Alaska insurance law contains no provisions that specifically relate to PPOs. Any PPO desiring to operate in the state needs to be authorized as either a "commercial insurer" or as a hospital or medical service corporation (e.g., Blue Cross).

Arkansas—The Arkansas Insurance Department Bulletin 9-85 states its official opinion that insurers may form and/or participate in PPOs.

Arizona—No PPO legislation.

California—"True" PPOs (those that do not assume risks) are not licensed by the state, nor are they regulated per se. Entities that call themselves PPOs, but which assume risks, are subject to licensing either as health care service plans regulated by the cited agency, or as insurers subject to Department of Insurance jurisdiction. §10133 and §10401, §11512 of the California Insurance Code (Deering 1977 & Supp. 1986).

Colorado—No PPO legislation.

Connecticut—A PPO is an arrangement existing between an individual insurance company and participating physicians and, as such, is not required to be licensed by the state.

Delaware—No PPO legislation.

District of Columbia—No PPO legislation.

Florida—As follows:

1. Third-party administrator (TPA)—regulated by Department of Insurance (DOI), Chapter 626, Part VI, Florida Statutes.

2. Self-insurer—either: (a) single employer—regulated under ERISA, U.S. Department of Labor; or (b) multiple employer trust—regulated under ERISA and by DOI, Section 624.436 and 624.440, Florida Statutes.

3. Insurance company—regulated by DOI - Insurance Code.

Note: Self-insurer, insurance company, or TPA can administer health benefit plan. If self-insurer does administration, the self-insurer does not have to be licensed as a TPA.

Enabling PPO legislation Senate Bill 28B-1983. Amending 626.9541(25); 627.6371(1), (2); 627.6691(1), (2). Fla.Stat.Ann. §627.6375 and 627.6695 (West Supp. 1986).

Georgia—No enabling legislation permitting insurers to establish PPOs.

Hawaii—No PPO legislation.

Idaho—No PPO legislation, but some action on PPOs is pending.

Illinois—Senate Bill 1311 and House Bill 2089 signed into law on Sept. 19, 1985, requires registration of administrators of preferred provider programs and clarifies certain insurance statutes with respect to the ability of insurance companies to issue policies with preferred provider options. The Illinois PPO Statute is Article XX-1/2, Chapter 73 (1985), paragraph 982 f to g.

Indiana—The PPO law simply provides specific authority of insurers to operate such plans. Ind.Code. Ann. §27-8-11-1, -2, -3, -4 (West Supp. 1985).

Iowa—House Bill No. 570.(1985) amended sections 508.29 and 515.48(5)(a) of the Iowa Code to provide that insurers may contract with health care service providers.

Kansas—Senate Bill No. 19 (1985). This bill amends statute §40-231 to allow insurance-company-sponsored PPOs. Kan. Ins. Dept. Bill 1985-16. PPO filing requirements.

Kentucky—No PPO legislation.

Louisiana—In 1984, the legislature enacted PPO legislation under its Health Care Control Chapter. They define PPOs and authorize group purchasers to enter

Summary Of State Legislation Governing PPOs: Survey Of The American Medical Care And Review Association

to contracts with health care providers at alternative rates of payments. La. Rev. Stat. Ann. §40:2201-2204 (West Supp. 1986).

Maine—PPO legislation was passed on March 31, 1986 (1986 Me. Legis. Serv. 288.). It calls for registration and minimum solvency requirements. It also lists duties such as provider lists, contracts, utilization experience, etc., in the form prescribed by the superintendent.

Maryland—In 1985, the legislature enacted PPO legislation that is applicable to nonprofit health service plans (§354EE), health insurers (§470X), and group and blanket health insurers (§477FF) (Supp. 1985).

Massachusetts—No PPO legislation.

Michigan—The general statutory provisions concerning PPOs are contained in the Prudent Purchaser Act, Mich. Comp. Laws. Ann. §550.51-550.63 (West Supp. 1985). They call for written standards for all agreements, institute or review for quality of health care, filing annual reports with the commissioner of insurance, etc.

Minnesota—PPO legislation was passed in 1983 that allows group health insurers to pay different amounts to insureds who elect to receive health care goods or services from providers designated by the surer. Minn. Stat. Ann. §72A.20(15)(4) (West. Supp. 1986).

Mississippi—No PPO legislation.

Missouri—No PPO legislation.

Montana—No PPO legislation.

Nebraska—No PPO regulations. Neb. Rev. Stat. §44-4101e to 44-4113 (1984 and Supp. 1985). Applies to preferred provider insurance arrangements.

Nevada—Senate Bill No. 286 (1985) provides that an insurer shall include provisions in a policy of health insurance encouraging an insured's use of services and facilities that are efficient and that tend to control or reduce the cost of health care.

New Hampshire—Enacted PPO legislation in House Bill No. 80 1985 entitled "Accident and Sickness Insurance - Reimbursement Agreements" which amends the insurance law by adding Chapter 420-C. N.H. Rev. Stat. Ann. §420-C:1.

New Jersey—No PPO legislation.

New Mexico—No regulations on PPOs.

New York—No legislation that specifically recognizes PPOs. A PPO, which does not have an established definition in the state, may need to obtain insurance or health department licensure, depending upon its structure. Any entity that is doing the business of insurance required to be licensed by the state.

North Carolina—Currently in the process of developing regulations under the new statutes that went into effect in October 1985 (H.B.1037) N.C. Gen. Stat. §7-1, 57-16.1, 58-260.5, 58-260.6 (Supp. 1985).

North Dakota—No regulation on PPOs.

Ohio—No regulations on PPOs.

Oklahoma—No regulations on PPOs.

Oregon—Passed PPO legislation in House Bill 2031 (71) (1985) appointing the Oregon Health Council to consider cost containment issues and to develop a policy consistent with the legislative intent of fostering new types of cost containment health care services. Ore. Rev. Stat. §743.531 (1985).

Pennsylvania—Senate Bill No. 935 (11-13). Amends Pa. Ins. Code §621.2© and 626 and add §630 (1986) PPO legislation.

Rhode Island—No PPO legislation.

South Carolina—No PPO legislation.

South Dakota—No PPO legislation.

Tennessee—No PPO legislation.

Texas—Tex. Admin. Code Tit. 28, §3.3701 et. seq. (1986). PPO authorizing regulations.

Utah—Senate Bill No. 91(181-182) amending Code §31A-22-617 and 31A-22-618 (1986). Authorizes preferred health care provider contracts.

Vermont—No PPO legislation.

Virginia—PPOs are considered insurance policies or contracts, and they are not specifically regulated. Va. Code §38.1-347.2, 38.1-813-4 (Supp. 1985).

Washington—The legislation is very specific as to the requirements to become registered as a health care contractor under Chapter 48.44RCW, but otherwise, there is no specific PPO legislation. An organization looking into setting up a PPO in the state should contact the state insurance commissioner for a copy of the law and regulations. If prepayment is involved, the PPO must obtain a certificate of registration.

West Virginia—No PPO legislation. But the PPOs are reviewed on a case-by-case basis to determine if an insurance mechanism is present.

Wisconsin—PPO legislation is part of the Wisconsin Administrative Code Section Insurance 3.48 and Chapter 609. All PPOs should review these laws to insure that they meet these guidelines. The state does not license PPOs.

Wyoming—The Health Care Reimbursement Reform Act of 1985 allows preferred provider arrangements. Wyo. Stat. §26-22-501 to 503 (Supp. 1985).

Structure, Operation Of Preferred Provider Organizations: How To Assess Program Efficiency, Quality Of Services

Preferred provider organizations (PPOs) are the fastest growing alternative delivery system. This Research Report discusses the structure of PPOs and how to assess the efficiency of the providers, and overall quality of services.

In general, a preferred provider organization (PPO) is a health care delivery system that tries to combine the best elements of the fee-for-service and HMO systems. Common characteristics of PPOs are as follows:

- limited group of physicians and hospitals,
- fee schedule negotiated in advance,
- utilization controls or claims review,
- consumer choice of providers,
- rapid claims payment, and
- flexible benefit levels.

PPOs can be organized in several ways. Insurance companies or third-party administrators can negotiate contracts directly with providers. In some cases, insurance carriers have enough claims history to target lower cost providers. Sometimes PPOs are marketed by insurers to current policyholders as an extension of their existing business; providers can tap into the insurers' claims administration system. Hence, the easier the administration of the PPO, the more beneficial to the employer, due to lower administrative expenses.

PPOs can also be developed by the providers themselves. If a hospital is the nucleus in the formation of the health service delivery system, it could enlist its existing medical staff or extend privileges to other physicians in order to expand its service area. If a medical group is the focus, hospitals where physicians have admitting privileges would be included. These provider-oriented organizations then make their services available to carriers, unions, and self-funded employers.

Negotiated Fee Schedule

Initially, the most attractive feature of PPOs may be their negotiated fees, which are almost always discounted. The ability to negotiate a PPO arrangement often depends on who and where the employer is and with whom it is negotiating.

Few rules guide the negotiations between PPOs and health care providers. There is no prepayment or capitation amount paid to providers; all services are paid for on a fee-for-service basis, and physicians may accept some percentage of the local area's "usual and customary" determination as full payment. This can be viewed as a discount, but it is actually a standardization of payments made to physicians.

Through a PPO, consumers maintain freedom of physician choice with incentives, such as waiving copayments or deductibles, to use PPO providers. Subscribers can still choose to go to nonparticipating providers, but at additional out-of-pocket expenses. Other PPOs offer subscribers additional benefits that might include coverage of some preventive or specialized services (psychiatric or substance abuse) that may not be covered under the employer's existing health plan.

On the hospital side, hospital payments may be determined through straight discounts, incremental discounts based on volume, or some kind of prospectively determined reimbursement. The ability to negotiate significant concessions may be limited if the company is in an area served by a single hospital. Since most of the employees probably use the hospital already, the cost of discounts or other concessions probably won't be offset by increased admissions. On the other hand, if there are two or three hospitals, an employer might be able to make a favorable arrangement with one of them.

Utilization Management

To assure that cost reduction efforts do not reduce the quality of care, utilization review and quality assurance programs are incorporated in the structure of a PPO. An effective utilization review program should include:

- Pre-admission review and certification in nonemergency cases to be sure that hospitalization is necessary.
- Admission and continued-stay review of all inpatient days to be sure they are medically necessary.
- Appropriateness evaluation to decide whether admissions and hospital days are medically necessary.
- Non-acute profiling, a variety of utilization review results to identify physicians who prescribe more or

more expensive treatment than protocols indicate is needed. Once identified, physicians are counseled or removed from the PPO.

- Denial process, which notifies physician, patient, and payor when an admission or inpatient day is considered not medically necessary.
- Dispute resolution or appeals process, which allows physicians, patient, and payor to appeal review results.
- Discharge planning to determine if complications in a case may make prompt discharge from the hospital difficult.
- Effective reporting process, which provides employers with providers' overall utilization statistics and specific statistics on their employees.

Adding A PPO Option

Two approaches are prevalent when adding a PPO option:

1. Adding a PPO's discounted fees and health care utilization control to an existing benefit plan. Employees are encouraged to use preferred providers, but essentially benefits remain unchanged.
2. Installing a completely new plan that combines redesigned benefits, strict utilization management, and changes in reimbursement to direct employees and providers toward less expensive health care services.

An overlaid PPO is easier to put into effect than a redesigned benefit plan, but a new benefit plan can control health care costs over the long term by encouraging employees to change the way they use health care services, while at the same time giving providers incentives to provide care more efficiently.

Evaluation

Before a PPO proposal can be evaluated, the employer needs to know the cost of current medical benefits and be able to estimate what costs will be under the PPO.

Evaluating the providers associated with the PPO can be done by reviewing the selection criteria of the PPO. Some PPOs are not particularly selective initially but weed out poor performers as data becomes available. Employers will have to withstand the potentially adverse employee relations that result from this approach. The PPO may rely on the judgment of a group of community physicians to review the practice patterns of participating physicians. Another method is review of utilization profiles from third-party payors or other organizations. Also, the PPO may identify a series of common procedures and compare the costs for individual providers for these procedures.

To evaluate hospitals, Medicare cost reports offer a convenient, and largely untapped, data source. They are available from state or local fiscal intermediaries, local planning agencies, or coalitions. They provide hospital-specific data on average cost and charges per case, or per admission, for all patients, not just those on Medicare.

Care must be used in evaluating hospitals based on raw data, however. The main problem when this data is used for comparison purposes is that one hospital may have a higher cost per case, not because it is less efficient, but because it treats more seriously ill patients. Although the case mix index published by the federal government is derived using only Medicare patients, it is reasonable to assume that a hospital having a complicated case mix for Medicare patients would also have a complicated case mix for non-Medicare patients.

Adjusted cost data will allow the employer to make reasoned first-cut judgments not only about PPOs, but also about the efficiency of the hospitals their employees use.

Evaluating Quality

PPO quality can be measured in several ways. A PPO's facilities must be located where most employees can reach them conveniently, and it must provide access to the kinds of care needed. Generally this means primary care physicians, a range of specialists, and access to both general care and specialty hospital facilities.

If the PPO cannot provide services directly, it must be able to supply them through agreements with other providers. Otherwise, the employer must make sure employees aren't penalized for not using PPOs in these situations.

The finances of a PPO should be analyzed like the finances of any other potential business partner. Employers should be aware of the PPO's internal reimbursement procedures. The arrangement the PPO has with a contracting employer for reimbursement may be different from the way it reimburses providers. Employers should be sure these internal arrangements encourage efficient health care while providing sufficient financial incentives to retain quality hospitals and physicians.

Plans marketed by the large organizations may offer more financial stability and comprehensive services than a plan negotiated with local providers. That stability is often desirable, but it may require an employer to accept a standard plan instead of one tailored to its individual requirements.

1987 AMCRA Survey Of PPOs Lists 646 Plans Covering More Than 21 Million Lives

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The *1987 Directory of PPOs*, issued by the American Medical Care and Review Association, lists 646 operating plans in 43 states and Puerto Rico and the District of Columbia. Some 71 plans are operated by 23 organizations that have multiple state locations. Provider contracts have been signed with 2,571 hospitals and 194,420 physicians.

The directory discusses, among other things, the growth and development of PPOs, state legislative measures, as well as administration and operation practices industry-wide. The bulk of the Directory is devoted to profiles of the 646 plans. Individual copies of the *Directory* are available from AMCRA at a prepaid cost of $50. For further information, contact AMCRA, 5410 Grosvenor Lane, Suite 210, Bethesda, MD 20814, (301) 493-9552.

The 1987 *Directory of PPOs* lists 646 plans, of which 38 are in preoperational status. PPOs are located in 43 states and Puerto Rico and the District of Columbia (see Table 1). Physicians, hospitals, and joint ventures between physicians and hospitals comprised the main force behind the early PPO growth. According to the 1987 survey their sponsorship has declined from 49.4% reported last year to 44.6% (288 plans). Insurance companies sponsor 157 plans and physician-hospitals, 114. Physician-sponsored plans total 104, and hospitals sponsor 70 plans. Other sponsors include Blue Cross/Blue Shield Plans (67), investors (36), third-party administrators (30), HMOs (25), self-funded employers (12), and sponsorship by others (31).

Administration

Most plans (602) do not have lock-in arrangements that require members to use their services. Such arrangements involve specific providers, such as dental and mental health, or specific payors, such as unions or schools. Only 44 plans have a lock-in feature and these plans tend to be classified as exclusive provider organizations.

Most of the 646 PPOs operate on a for-profit basis (444 or 69%) and operate mostly in the Western region (136, of which 75 are in California). For profit plans in the other regions total 118 in the Southeast, 96 in the Midwest, and 94 in the Northeast.

Staffing depends on the comprehensiveness of services directly provided by the PPO. According to the 1987 survey, 23 plans have from 11 to 15 staff members and only four plans have a staff of more than 100 persons. Most plans have their own provider base (physicians and hospitals) and marketing staff. Functions such as utilization review and claims processing, are sometimes contracted to third-party administrators, insurance companies, and professional review organizations. A breakdown of contracted out services provided by the PPO include the following:

	PPO	Others
Physician/hospital contracting	254	11
Marketing	231	40
Claims processing	72	95
Preadmission certification	202	55
Utilization review/peer review	231	41
Provider payment	146	112
Consumer/provider grievances	244	32
Cost analysis and reporting	231	52

Provider Contracting

PPOs reported 506,938 physicians and 11,504 hospitals under provider contracts, representing approximately one-third of all providers in the country. Many providers have signed contracts with more than one PPO, as in California, Ohio, Florida, and Pennsylvania, where more than one PPO operates in the same metropolitan area.

The 61 PPOs reporting from the Northeast region have 1,322 hospitals under contract. In the Southeast, where 59 PPO reported, there are 1,069 participating hospitals. Sixty-five plans in the Midwest have participating contracts with 1,357 hospitals, and in the West, 5,244 hospitals have signed contracts with 356 plans.

1987 AMCRA Survey Of PPOs Lists 646 Plans Covering More Than 21 Million Lives

Table 1
PPOs By State

State	Operational	Pre-Operational
Alaska	1	
Alabama	16	
Arizona	20	
Arkansas	2	
California	109	1
Colorado	22	1
Connecticut	4	
District Of Columbia	9	
Florida	43	1
Georgia	16	2
Hawaii	3	
Illinois	33	1
Indiana	10	2
Iowa	3	
Kansas	8	1
Kentucky	8	3
Louisiana	12	2
Maryland	10	
Massachusetts	10	1
Michigan	15	3
Minnesota	9	1
Mississippi	3	2
Missouri	21	1
Nebraska	2	
Nevada	7	
New Jersey	4	1
New Mexico	5	
New York	11	1
North Carolina	10	1
Ohio	48	2
Oklahoma	11	
Oregon	7	1
Pennsylvania	30	1
South Carolina	4	
South Dakota		1
Tenessee	17	2
Texas	18	2
Utah	6	
Vermont	1	
Virginia	8	
Washington	19	3
West Virginia	2	1
Wisconsin	9	
Wyoming	1	
Puerto Rico	1	1
Total Number	608	38

continued on next page

1987 AMCRA Survey Of PPOs Lists 646 Plans Covering More Than 21 Million Lives

Table 2
Number Of Physician Contracts

	North East	South East	Mid-West	West	California	Total	%
Family Practice	10,181	5,155	3,159	4,455	10,559	33,509	12.4
Internal Medicine	13,069	7,069	3,685	3,190	12,063	39,076	14.4
Pediatrics	6,234	3,705	1,788	1,790	5,823	19,340	7.1
OB/GYN	6,053	3,535	1,929	2,045	6,902	20,464	7.6
General Surgery	6,706	3,530	1,869	1,781	5,769	19,655	7.3
Others	43,466	27,007	11,949	12,911	43,268	138,601	51.2
Subtotal	85,709	50,001	24,379	26,172	168,473	270,645	100.0
No. Physicians	30,871	6,316	29,623	1,010	168,473	236,293	
Grand Total	116,580	56,317	54,002	27,182	252,857	506,938	
No. of PPOs Reporting	46	46	40	37	39	208	
Average Per PPO	2,534	1,224	1,350	735	6,483	2,437	

Table 2, above, shows the number of physician contracts by region and by speciality.

Membership

Total membership in the 295 PPOs reporting this data is 21,623,817, an average of 73,301 members per PPO. AMCRA was able to identify 46 PPOs with 100,001 or more members. PPO membership by plan size is as follows:

PPO Membership	Total Plans
0 - 5,000	65
5,001 - 10,000	34
10,001 - 15,000	32
15,001 - 20,000	16
20,001 - 40,000	57
40,001 - 60,000	22
60,001 - 100,000	23
100,001 - 200,000	25
200,001 - 300,000	5
300,001 - 400,000	5
400,001 - 500,000	2
500,001 and up	9

Benefits Provided

Many PPOs are single benefit plans, providing psychiatric, pharmacy, physician therapy, and other specialized services. These plans work in cooperation with other PPOs and health maintenance organizations to supplement the basic core of services provided by a PPO. Benefits plans vary with each employer and the deductibles and copayments differ for each plan depending upon the contractual relationship the employer and PPO have with the providers.

Table 3, on the next page, shows the benefits offered by the PPOs.

Utilization Review

The participating provider agreements give the PPO a provider base to deliver necessary services, but utilization review provides the PPO with appropriate use of those services. The procedures for hospital inpatient utilization was reported by 258 PPOs. They include pre-admission certification (249 plans), admission certification (206 plans), concurrent length of stay review (238 plans), mandatory second surgical opinion (186 plans), retrospective inpatient services review (223 plans), mandatory ambulatory or outpatient service review (143 plans), and retrospective ambulatory service review (152 plans).

Data Collection/Reporting

Some 255 PPOs reported the data collection programs they have in place. Physician specific data is collected by 234 plans, average length of stay by 239 plans, lab usage by 172 plans, and 238 plans collect data on total charges.

Fully 251 plans provide reports to groups contracting with the plan. Reports include cost (207), UR (on exception basis) (134), general UR statistics comparison (160), and 84 plans provide other reports.

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Table 3
Benefits Offered By The PPOs

	Totals		North East		South East		Mid West		West		Calif.	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Unlimited Inpatient Hospitalization	171	56	33	13	35	12	35	10	39	8	29	13
Limited Inpatient Hospitalization	93	108	18	24	16	26	21	19	16	27	22	12
Psychiatric Inpatient Care	211	17	45	1	37	11	42	2	47	1	40	2
Alcoholic Drug Inpatient Care	203	23	44	1	35	13	40	3	45	3	39	3
Emergency Room Coverage	222	6	46		45	3	43	2	47		41	1
Physician Outpatient Office Visits	224	5	45	1	46	2	42	2	48		43	
Mental Health Outpatient Visits	208	22	43	4	38	11	42	2	47	1	38	4
Outpatient X-Ray Services	221	8	45	1	44	4	45		46	1	41	2
Outpatient Lab Services	219	9	45	1	46	2	45		43	4	40	2
Routine Injections	184	42	36	10	37	10	36	8	40	7	35	7
Podiatry Services	159	65	35	12	24	21	33	10	33	14	34	8
Chiropractic Services	123	103	23	24	20	25	24	18	29	20	27	16
Pharmacy Services	192	42	44	5	36	12	38	8	40	8	34	9
Prescription Eye Exams and Glasses	85	140	19	28	11	36	16	28	21	24	18	24
Dental Services	96	123	20	24	14	31	20	22	19	27	23	19

Marketing

Direct contact by personal visit and mail are the most popular methods of contracting PPOs used with employers and recruiting providers. Some 616 plans used direct personal contact, 418 made contact through direct mail, 348 advertised in newspapers, 135 on radio, and 77 on television. Flyers or brochures were handed out by 398 PPOs and 109 plans used other marketing methods.

Milliman & Robertson Lists Variables To Be Identified When Setting Rate For Preferred Provider Organization

This Research Report is an edited version of a speech given at a symposium jointly sponsored by the Society of Actuaries and the American College of Hospital Administrators by David V. Axene, principal consulting actuary, Milliman & Robertson, Seattle.

Mr. Axene listed factors to be taken into account when developing cost estimates to establish rates for merged health care systems (i.e., health maintenance organizations or preferred provider organizations).

Hospitals and physicians in a merged health care system (i.e., health maintenance organizations, preferred provider organizations) frequently agree to provide services for enrollees at discounted prices in return for increased volume. These discounted prices are usually expressed in terms of percentages; that is, 10% or 20% lower than the providers' usual charges.

It is necessary that the rates contracted for be adequate to cover expenses and yet also competitive. Therefore, it is necessary to actuarially project costs for the providers before quoting rates.

Identify Rating Variables

Rating variables must be identified. In order to set a rate, the actuary must ask questions such as the following:

1. What kind of people will be using the services? Are they a Medicare or Medicaid group? Are they an employee group?
2. What kind of providers are there in the community, and what are their charge levels?
3. What kind of utilization levels will develop?
4. What is the benefit design of the plan that will be offered?
5. What administrative costs and margins are anticipated?

Type Of People

In rating, one must consider the kind of people who will be using the PPO, demographic characteristics, health status characteristics, marketing methods, and relationships to other parties.

Demographic characteristics include age-sex distribution. How many people are there by various family status—that is, employee, spouse, and child(ren). How old are they? How many are married? What is the average number of dependents?

Health status of the group is difficult to ascertain because there is no working definition of health status.

If a large part of the potential enrollees work at an occupation with high risk, these adverse health characteristics would have to be factored into the rate.

A PPO attracting employed people will develop much different risk characteristics (i.e., costs) than a PPO marketed on an individual basis to people who otherwise would not have health coverage.

Marketing Considerations

Is the PPO going to be marketed to employer groups? Will the employees have free choice or will there be participation requirements? Will brokers be used? Depending on the marketing method, the costs will be different.

Consider the relationship to other parties: Do the employees constitute a group? Were the members patients of the physicians before they became participating providers? Depending on how many people were existing patients of the providers in the program, the costs will be different.

Look At Providers

Next, look at what kind of providers are going to be included in the network. What kinds of physicians are in the community? Are they associated with a medical school? Are they just solo practitioners? How were they chosen? How much can you negotiate? Are their offices empty?

How big is the provider group—can they provide all the care in the area? Do you have to have another group to provide tertiary care?

Are the physicians cooperative—do they really want to make the PPO work?

A thorough fee analysis or charge survey is recommended. Take a selective sample of about 100 charges that reflect about 75% of all physician charges. Com-

Milliman & Robertson Lists Variables To Be Identified When Setting Rate For Preferred Provider Organization

pare the surveyed charges sent in by prospective providers with the community norms. Without this information, it may not be feasible to go any further because the PPO might be dealing with the most expensive providers in the community.

Reimbursement Method

The PPO reimbursement method is important. An actuary cannot accurately figure out costs until the reimbursement method is known. What will be used, a prenegotiated fee schedule, 80th percentile, capitation?

The reimbursement method also affects utilization levels which in turn affects the cost.

Extent of discounts and other risk arrangements also are important to know, along with provider incentives. In many cases, 50 bed days can be taken off from the inpatient hospital assumptions if certain physician incentives are included in the plan design. With the right provider incentives, projected costs can be reduced.

Cost Per Service

Find out the cost per service. Look at each unit, such as an inpatient day, a doctor visit, a surgery, and find out how much would it typically cost if it were on a fee-for-service basis.

The sources for this information are many. For hospital costs, look at Medicare filings, DRG rate filings, hospital budgets, hospital financial statements, HIAA data, AHA data, DRG weights. For professional fees use fee surveys, claims data from carrier, HIAA data, relative value studies.

Utilization Levels

It may be difficult determining the community utilization level. Utilization controls, plan design, type of provider, and incentives affect utilization.

Utilization rates are determined by taking the number of services performed and dividing by the number of eligible persons. This results in data such as bed days per 1,000, physician visits per 1,000, admissions per 1,000. The product of utilization rate and cost per service is the projected health care cost.

Value Of Copays, Deductibles, Etc.

Next, subtract the actuarial value of deductibles and copayments from the projected cost, keeping in mind that deductibles and copayments may affect utilization. Competitive restraints and regulatory requirements also affect these numbers. Regulatory requirements usually add costs; competition may lower costs.

Expense Considerations

Finally, take into consideration administrative expenses and margins, investment income, reinsurance, marketing expenses. Expense margin and profit can be loaded in as a percent of premium.

You may want to develop variations to reflect age/sex mix, benefits, size of group, etc. The final results should be compared to competitive rate levels to be assured of a competitive product.

Assuming the product can be effectively marketed with both health care and administrative costs managed, the program can be successful.

Guidelines Of A Request For Proposal From Providers When Selecting Participants For A Preferred Provider Organization

This Research Report provides general guidelines for those who wish to solicit providers for participation in a preferred provider organization.

The basis of this report is a Request for Proposal (RFP) sent by Blue Cross and Blue Shield of Northern Ohio to hospitals in the area. The Blue plan used responses to the RFP to select hospitals to participate in its new method of reimbursement.

Blue Cross and Blue Shield of Northern Ohio invited hospitals in its area to enter a competitive bidding program in order to be included in direct reimbursement of hospital services provided to Blue Cross and Blue Shield members. The Blue plan sent out a Request for Proposal (RFP) to the hospitals from which this report was taken.

Many aspects of the RFP can be used by an entity seeking bids in order to set up a preferred provider organization.

Cover Letter

The cover letter accompaning the RFP may contain the following information:

Your office (hospital) is invited to submit a bid for the preferred provider organization to be formed by _____ Company. Bids must be submitted in accordance with the requirements of the enclosed Request for Proposal. Bids must be submitted no later than _____. Bids must be mailed or delivered to:

Name
Address
City, state, zip

Questions related to the Request for Proposal cannot be answered by telephone. All questions should be submitted in writing to the above address no later than_____. Written answers to questions will be provided to all potential bidders. A bidders' conference will be held on_____.

Introduction

The introduction is used to explain the preferred provider organization concept and the plans for establishing a PPO in the area.

The corporate structure, history, and financial backing of the entity requesting the bids should be disclosed.

Terms of the contracts to be offered to the selected providers should be explained, as well as the reimbursement structure and utilization review requirements. The deadline for responses should be given and implementation date of the PPO should be estimated.

The number of proposal copies needed should be stated.

Proposal Specifications

This section identifies the information the sender needs to evaluate proposals from medical service providers for participation in the PPO. Respondents should be advised that each question must be answered, and that they are free to include additional information.

Proposal Amendments And Withdrawals

No amendments, revisions, or alterations to proposals will be accepted after the due date. Prior to the due date, a submitted proposal may be withdrawn upon written notification. Any submitted proposal shall remain valid for 180 days after the due date.

Alternate Proposals

Bidders must submit proposals that meet the requirements of the RFP. In addition, alternate proposals from bidders will be considered, provided that a clear designation of all differences between proposals is made and that the proposal responsive to the RFP's requirements is clearly identified.

Proposal Format

The proposal should include a transmittal letter, the completed application, and all applicable attachments.

The transmittal letter should be signed by an individual authorized to legally bind the bidder. The letter should include.

1. A statement indicating the bidder is a legal entity.
2. A statement that no attempt has been made or will be made by the bidder to induce any other provider to submit or not to submit a proposal.
3. An explanation of deviations from the specifications of the RFP.

Guidelines Of A Request For Proposal From Providers When Selecting Participants For A Preferred Provider Organization

4. A statement that the bidder certifies that the prices proposed have been arrived at independently, without consultation, communication, or agreement, for the purpose of restricting competition, as to any matter relating to such prices with any other bidder or with any competitor, and unless otherwise required by law, the prices quoted have not been knowingly disclosed by the bidder prior to the award, directly or indirectly, to any other bidder or to any competitor.

Each person signing the proposal certifies that he/she is the person in the bidder's organization responsible for, or authorized to make, decisions as to the prices quoted.

Bids

Providers should consider the following factors in establishing their bids:

The need to operate efficiently and cost-effectively and the elimination of duplicative or unnecessary services and facilities.

The expectation of increased volume.

Competitiveness of the bidding process.

Availability of opportunities to reduce current costs.

Other Bid Requirements

In addition to the bid itself, providers should submit service mix information. Cases that the provider believes should be treated as outliers must be identified.

Evaluation Criteria

Some of the evaluation criteria to be used to select preferred providers include:

1. price,
2. quality,
3. use by prospective subscribers of the network,
4. ability to submit proper data for utilization review,
5. location, and
6. service availability.

Selection Process

A four-step selection process can be used.

First, the criteria chosen should be evaluated as to primary and secondary importance, and so weighted.

The second step is to rank providers by price bid and prospective subscriber use. Separate rankings are prepared for each criterion. A composite ranking is found.

The third step in the selection process is the review of composite rankings to identify duplication of services within locations.

The fourth step is the review of selections to determine whether a sufficient range of services is available within locations.

Sample Preferred Provider Organization Contract Between Sponsoring Agency And Providers

This Research Report is a sample contract between a sponsoring agency and a participating provider pursuant to establishment of a participating provider organization.

The sponsoring agency in this contract is the health plan administrator. PPOs can be sponsored by other entities as well. The contract has language for agreements with either a hospital or a physician. The language would have to be modified for a dental PPO.

THIS AGREEMENT, made this ____ day of ____, by and between ____ (herein referred to as "SPONSOR") and ____ (herein referred to as "PROVIDER")

WITNESSES:

WHEREAS, PROVIDER agrees to provide covered (health, hospital) services to persons who are covered individuals under group health (policies, plans) (issued, administered, underwritten) by SPONSOR; and

WHEREAS, PROVIDER agrees to accept as payment in full the scheduled benefits specified herein for the provision of covered (health, hospital) services to covered individuals; and

WHEREAS, SPONSOR agrees to remit scheduled benefits directly to PROVIDER if a covered individual executes a valid assignment of the right to payment of a scheduled benefit in favor of PROVIDER;

Now, therefore, the parties agree as follows:

I. DEFINITIONS

A. *Covered (health, hospital) services.* Those (health, hospital) services for which benefits are payable under the terms of a group health (policy, plan), subject to the exclusions and limitations described therein. These services are described in the appendix to this agreement.

B. *Covered individual.* A person certified by SPONSOR as eligible for benefits under a group health (policy, plan) (issued, administered, underwritten) by SPONSOR.

C. *Group health (policy, plan).* A contract between SPONSOR, and respectively, a policyholder (if the contract is issued on an insured basis) or an employee benefit planholder (if the contract calls for SPONSOR to provide only certain administrative services) under which SPONSOR provides reimbursement of covered (health, hospital) services for covered individuals designated by the (policyholder, planholder).

D. *Practitioner.* A licensed practitioner of the healing arts acting within the scope of the license.

E. *Scheduled benefit.* The maximum amount payable by SPONSOR under the terms of a group health (policy, plan) for the rendering (by a practitioner of a covered health service, of a covered hospital service) to a covered individual. These scheduled benefits appear in the attached appendix.

II. REPRESENTATIONS AND WARRANTIES

A. SPONSOR warrants and represents that it is a corporation duly organized and existing under the laws of the state of—and is authorized to transact the business of—in the state of _____ .

B. If PROVIDER is a hospital, PROVIDER warrants and represents that it is a hospital licensed by the state of—and accredited by the Joint Commission on Accreditation of Hospitals and that all persons who will render covered hospital services to covered individuals shall be practitioners and/or employees of PROVIDER.

If PROVIDER is practicing individually, PROVIDER warrants and represents that he/she is a practitioner and maintains an office for the full-time practice of—in the state of—and that he/she has not been suspended from professional practice or publically reprimanded by any court or agency of competent jurisdiction within the past five years. PROVIDER further agrees that all health services under this agreement shall be performed in strict accordance with all generally accepted legal and ethical standards of the _____ profession.

If PROVIDER is a legally constituted—partnership or a professional corporation, PROVIDER warrants and represents that only practitioners will perform services pursuant to this agreement, that it is involved in and maintains an office for the full-time practice of _____ in the state of _____, and that no partner, member, or

person associated with PROVIDER has been suspended or publically reprimanded by any court or agency of competent jurisdiction within the past five years. PROVIDER further agrees that all health services rendered to a covered individual shall be performed in strict accordance with all generally accepted legal and ethical standards of the _____ profession.

C. PROVIDER agrees not to reject any covered individual as a patient for a covered (health, hospital) service by reason of the alleged inadequacy of any scheduled benefit.

D. PROVIDER enters into this agreement as an independent contractor and not otherwise. Nothing herein shall be construed to create the relationship of employer and employee between PROVIDER, its agents or employees and SPONSOR.

E. PROVIDER shall operate in complete accordance with all laws and/or rules and/or requirements of the state of _____, including the filing of any necessary reports.

F. PROVIDER shall not promote or publicize his/her/its status under this agreement without the prior written consent of SPONSOR. PROVIDER agrees not to use SPONSOR'S name or service marks in any way to advertise or promote the business of PROVIDER or any of its affiliates unless the material making use of such name or service marks has been specifically approved in writing by SPONSOR.

G. SPONSOR shall cause PROVIDER'S name and address to be disseminated to covered individuals and to (policyholders, planholders). SPONSOR does not guarantee in any way that PROVIDER will be engaged by any covered individuals or any number of covered individuals.

H. SPONSOR shall deliver to PROVIDER a list of those entities which are (policyholder, planholders) under which covered individuals are eligible for covered (health, hospital) services pursuant to a group health (policy, plan).

SPONSOR shall update said list periodically. PROVIDER may rely upon the accuracy of the information contained in said list and shall not be held responsible in any way for any errors in such lists.

I. PROVIDER shall keep accurate and current medical files and records concerning each covered individual. PROVIDER shall make such files and records available to SPONSOR during normal business hours. Nothing contained herein shall require PROVIDER to reveal any physician-patient confidential information which is not subject to disclosure pursuant to SPONSOR'S standard claim form authorization.

J. Neither SPONSOR nor PROVIDER shall utilize or disclose any of either's proprietary processes and/or procedures without written consent of the other party.

K. SPONSOR shall have the right during the term of this agreement, without the consent of the PROVIDER, to modify the number of covered (health, hospital) services. SPONSOR shall have the right to determine the scheduled benefit to be assigned any added service and also shall have the right to increase the scheduled benefit for any existing covered (health, hospital) service. Any modifications granted under this subpart will take effect _____ days after written notice to PROVIDER.

L. In consideration of covered (health, hospital) services performed by PROVIDER, SPONSOR shall promptly make payments to PROVIDER following actual receipt of an itemized account of charges, provided covered individual has executed a valid assignment of the right to payment of a scheduled benefit in favor of PROVIDER. Payment will be made as established under this agreement.

III. AUDITS

A. SPONSOR shall, at its own cost and expense, have the right to investigate and audit the covered (health, hospital) services provided to covered individuals under the agreement. PROVIDER shall cooperate by making available all necessary files and records as may be reasonably requested by SPONSOR. Any such audit or investigation shall be carried out without requiring PROVIDER to reveal any physician-patient confidential information not otherwise subject to disclosure pursuant to SPONSOR'S standard claim form authorization.

B. SPONSOR agrees that all files relating to the rendering of covered (health, hospital) services for covered individuals by PROVIDER are the property of PROVIDER. In the event of termination of this agreement, said files shall remain with PROVIDER, subject, however, to the right of any covered individual to request that his/her file be transmitted elsewhere in accordance with his/her instructions.

IV. INDEMNIFICATION AND HOLD HARMLESS

A. PROVIDER shall be solely responsible for services performed for or rendered to covered individuals by PROVIDER.

B. PROVIDER shall indemnify and hold SPONSOR harmless from any and all claims, lawsuits, settlements, judgments, costs, penalties, expenses, attorneys fees, or

continued on next page

liabilities incurred as a result of medical services provided or failed to be provided by PROVIDER to any covered individual.

C. PROVIDER shall maintain, at its sole cost and expense, in full force and effect during the term of this agreement a valid current policy or policies of insurance with an insurer acceptable to SPONSOR, which acceptance shall not be unreasonably withheld, insuring PROVIDER against any liabilities for any services provided or failed to be provided, any negligence, and/or judgment.

The coverage shall be in amounts not less than $ _____ per occurrence, $ _____ in aggregate claims per year, which minimum amounts SPONSOR retains the right to adjust annually on the anniversary of this agreement. Evidence of such insurance shall be provided to SPONSOR on request. PROVIDER hereby warrants that such insurance is now, and will be, continuously in effect so long as (health, hospital) services are being rendered by PROVIDER to covered individuals.

If the policy or policies described above are issued to a medical partnership or professional corporation of which PROVIDER is a member, or if PROVIDER is a medical partnership or professional corporation, the required minimum coverage shall be multiplied by the number of partners or members who are practitioners.

V. TERMINATION

A. Either party may terminate this agreement upon the giving of _____ days prior written notice by registered mail, return receipt requested, to the other party. Notices to PROVIDERS shall be sent to the last address on file with SPONSOR.

B. Except as may be precluded by law, PROVIDER shall complete the performance of covered (health, hospital) services for covered individuals in progress at the time of termination in accordance with this agreement provided covered individuals consent.

VI. ASSIGNMENTS

PROVIDER will not assign its rights, duties, or obligations under this agreement either in whole or in part without the written consent of SPONSOR; provided, however, that any assignment by SPONSOR to any of its affiliates or subsidiaries shall be permissible at any time.

VII. MODIFICATIONS

No changes in this agreement shall be effective unless they are in writing and signed by both parties.

APPENDIX

I. Physician services.

(All surgical and medical services commonly performed by the physician will be payable at the rate of _____ % of SPONSOR'S usual and prevailing fee schedule.)

All surgical services commonly performed by the physician will be payable (at the rate shown in the 1964 CRVS surgical schedule using a conversion factor of $ _____, at _____ % of the physician's normal charges, at _____ % of the SPONSOR'S usual and prevailing fee schedule, which will be updated annually).

All medical services commonly performed by the physician will be payable (at the rate shown in the 1964 CRVS medical schedule using a conversion factor of $_____, at _____ % of the physician's normal charges, at _____ % of the SPONSOR'S usual and prevailing fee schedule, which will be updated annually).

For the following surgical procedures performed in the physician's office, ambulatory surgical center, or hospital outpatient department where no inpatient confinement results, an incentive payment of % greater than the surgical reimbursement shown above will be paid.

II. Hospital services.

A. Inpatient and outpatient services will be reimbursed on the basis of (% of the SPONSOR'S usual and prevailing fee schedule, _____ % of the hospital's normal charges, the following table of diagnostic related groupings), adjusted annually.

B. Emergency room services will be reimbursed at _____ % of the (SPONSOR'S usual and prevailing fee schedule, hospital's normal charges), adjusted annually.

C. Outpatient surgeries will be reimbursed at the incentive rate of _____ % of the hospital's normal charges, adjusted annually, for the surgeries listed below when performed on an outpatient basis in lieu of an inpatient confinement.

Negotiating Prices And Services With Health Care Providers: A Guide For Employers

The art and science of negotiating as a health care purchaser was discussed at the Midwest Business Group on Health's Eighth Annual Conference at the end of February 1988 by Michael Rode, regional manager of Community Care Network of San Diego; David Redfield, vice-president of the DePaul Health Corporation; and Roger Freitag, manager of headquarter employee benefits for Allen-Bradley Company; all based in Milwaukee, Wis. Another workshop also dealt with purchasing health care for the small employer. A summary of these presentations follows.

"Preferred provider organizations represent providers' interests, and are weak in utilization review, while insurance companies do not always have the consumer's interest at heart," Michael Rode, Milwaukee regional manager for Community Care Network (CCN) of San Diego and administrator of Health Care Network of Greater Milwaukee (a business coalition's preferred provider organization), told the Midwest Business Group on Health's 1988 conference. The conference theme was "The Science of Health Care Purchasing."

"A purchaser system has an advantage in that it is controlled by the employer and it is the most effective way to put the purchaser's interest first." Mr. Rode and David Redfield, vice-president of DePaul Health Corporation in Milwaukee, discussed negotiating prices and services with health care providers.

A strong utilization review component is vital to the success of a contract provider arrangement, Mr. Rode emphasized. "If medically unnecessary days are identified by UR, the hospital must eat the cost."

Mr. Rode identified some steps the purchaser must take before it approaches negotiations with hospitals.

Initial Steps

1. How will the hospital be reimbursed? Some possibilities include:

a. A straight discount of billed charges—but rates continue to rise.

b. A discount off billed charges with some sort of cap.

c. Diagnosis related groups (DRGs) approach (such as Medicare's)—not the most effective because of coding inaccuracies, DRG creep, and their not accommodating.

d. Per diem approach, and very limited, with global rates for medical/surgical, physical rehabilitation, and psychiatric services, for example. CCN feels that this is the most effective way of controlling costs. To discourage shifting from inpatient to outpatient charges, hospital amounts must be capped.

e. Stratified per diem for pediatrics, obstetrics/gynecology, oncology.

f. A combination of the previous approaches.

2. Establish a deadline for contract negotiations.

3. Give the hospital an idea of who you are, what you do, and how many lives are covered by the plan.

4. Have a bid structure in mind.

5. Determine selection criteria by identifying the following factors:

a. What kind of discount are you getting? Understand that hospital's historic costs in relation to other hospitals.

b. Geography.

c. Services and range of services needed. Get all possible services in the community.

d. Historically, where have your employees gone for hospital care?

e. Quality—the Joint Commission on Accreditation of Healthcare Organizations is one source of information.

Physician Contracting

The following factors should be taken into consideration with physician contracting.

1. Reimbursement mechanism. For example, the Greater Milwaukee Health Care Purchasing Plan used the California Relative Value Studies adjusted for the area and did not allow any fee negotiations. The plan sent a fee schedule to physicians and invited them to join the network.

2. Doing the research, selecting physicians, using the following criteria.

- Geography
- Specialty
- Board certification
- Staff privileges to network hospitals

• Medical advisory committee, a local peer review organization, to help identify quality criteria. One of the biggest challenges, Mr. Rode observed, was to enlist into the network the best quality physicians.

3. Identify your organization, who you are, what you do and how many lives you control.

Providers' Perspective

Ideally, from the provider's perspective, how should the employer/purchaser approach provider negotiations? Mr. Redfield described the process.

1. First you seek the request for proposal. Seek information; providers want to tell you how good they are. Ask about the following:

a. Quality assurance plan, peer review, report of the Joint Commission or other specialized evaluator.

b. Outcome evaluation and consumer satisfaction.

c. Length of stay for a variety of procedures, practice pattern.

d. Experience and approach to, and dealing with managed care (current affiliations).

2. Give information about your organization, including experience, utilization review expectations (specific, if you wish), patient volume, and utilization for a variety of specialized benefits.

As far as pricing is concerned, Mr. Redfield said, providers would prefer graduated pricing. For example, the first $x thousand worth of business at one price, and a reduced price beyond that. "A percent discount is not useful because the provider can just adjust prices," Mr. Redfield said. "It is important to establish a partnership relationship, a win-win atmosphere."

3. Discuss non-cost issues, such as quality assurance. Emphasize that you are looking at more than just costs.

4. "If the deal is too good to be true, it *is* too good to be true."

Implementation, Administration

Members of the Milwaukee coalition promote the providers in the network, Mr. Rode explained. One company had a health fair. Mr. Rode also suggested that employer purchasers eliminate providers who are not in the network from access to employees. "Monitor and enforce incentives, or disincentives such as deductibles and copays," he encouraged.

It is important to communicate with your providers regularly, the speakers agreed, to keep them informed about any problems, issues, or concerns.

Milwaukee is making the health care purchasing network available to small employers, insurance carriers, and multiple employer trusts, Mr. Rode concluded. And employees are being pushed into managed care.

Small Employers

How can small employers also obtain health care savings such as those negotiated by large employers or employer health care coalitions? It is a very difficult and sometimes long process, but it can be done, panelists at a purchasing workshop for small employers agreed. Frequently, the local Chamber of Commerce and the Small Business Association provide opportunities to get group rates, Carol Greenberg, executive director of the Worcester (Mass.) Area Systems For Affordable Health Care suggested.

Two ways of obtaining more favorable health care rates are through community-based purchasing groups and through insurance carrier programs. Other possibilities include joining a benefit trust (companies that band together to provide benefits) or participating in a buyers' group through a credit union. "Community-rated pre-paid plans are a good value for smaller employers," Ms. Greenberg said, and reiterated that "there's safety and opportunity in numbers."

For example, groups can influence health care costs and systems by "encouraging" the elimination of some "excess" hospitals or reduction of hospital beds, Peter Lardner, president of Rock Island, Ill.-based Bituminous Casualty Corporation, emphasized.

Definitely, insurance carriers should be encouraged to become more involved in negotiating lower rates for their clients, some conferees said. The insurance industry is not very amenable to changes; larger employers get the rate breaks but smaller employers pay the difference, conferees complained.

What incentive does a small employer have to push for rate negotiations when it is fully insured through a commercial carrier? That incentive is to ultimately lower health care costs in the community.

Questions For Evaluation

Roger Freitag, manager of headquarter employee benefits for Allen-Bradley Company, offered the following questions for employers to consider when evaluating health care purchasing programs.

• Are they flexible to meet the needs of your company's environment?

• Are they compatible with your company's health program objectives?

• Will they fit in with employee relations policy?

• What are the legal implications?

• Do the systems now available deal effectively with quality of care and establish control for the employer?

Plan to provide all Americans with health insurance studied

By NANCY BENAC
THE ASSOCIATED PRESS

WASHINGTON – A draft proposal to spend $65 billion on two of the nation's biggest health care problems is running into behind-the-scenes White House opposition even before it comes up for a vote.

The U.S. Bipartisan Commission on Comprehensive Health Care planned to vote today on a proposal to provide health insurance to more than 31 million uninsured Americans and help 9 million Americans pay the high cost of long-term care.

Several sources said Thursday that approval was not guaranteed, noting that the White House had been pressuring Republicans on the 15-member commission to withhold their support.

Rep. Fortney "Pete" Stark, a California Democrat who is a member of the commission, predicted its recommendations to Congress would be a "dead letter" because of opposition from the White House.

"The postmaster in this case is President Bush and ... they don't want a plan which would embarrass them in the next election," Stark said.

The commission's draft plan would require all businesses with more than 100 employees to provide private health insurance to their workers, or to contribute to a public plan for employees and non-working dependents.

When fully implemented, all Americans would be provided health insurance through their employer or the public plan.

It also would offer all Americans coverage for long-term care in their homes and for the first three months in a nursing home. Federal benefits for additional time spent in a nursing home would be greatly improved.

The draft plan did not recommend how to pay for the benefits, saying "the commission is committed to raising whatever additional revenues are necessary."

The commission – including 12 members of Congress and three White House appointees – was created by Congress in 1988 to tackle the thorny questions of how to ensure quality, affordable care for the uninsured and for those devastated by the high costs of long-term care.

The panel is commonly known as the Pepper Commission in honor of its first chairman, the late Rep. Claude Pepper, D-Fla., an outspoken advocate for the elderly and disadvantaged.

Stark criticized the draft plan, saying it would not guarantee health coverage for all Americans, particularly those employed by small businesses. He noted it provided extended nursing home protection only to those of limited income and assets, and complained that it failed to recommend how to pay for the $65 billion program.

But two advocacy groups for the elderly said the proposed plan recommended important improvements in the nation's health care system.

John Rother, legislative director for the American Association of Retired Persons, called it "a promising start."

Ronald Pollack, executive director of the Families USA Foundation, a non-profit advocacy group for the elderly, said the plan "meets the crucial goals of health-care reform – protection from the devastation of long-term care costs at home or in a nursing home as well as affordable health care for all Americans, regardless of income or job status."

Rec'd from Dale - 1-9-90

Senate Bill 254 BY SENATOR DUNCAN

ALASKA STATE GROUP HEALTH INSURANCE AUTHORITY

"An Act relating to group health insurance; and providing for an effective date."

Section 1.

PURPOSE

The purpose of this act is to provide comprehensive group health insurance for all eligible employees of the state, a municipality, or a school district. It will also expand the pool of subscribers to provide the maximum opportunity for cost containment when purchasing group health insurance.

Section 2.

CREATION OF THE AUTHORITY

The Alaska State Group Health Insurance Authority is created within the Department of Commerce and Economic Development as a nonprofit corporation to provide group health insurance to eligible state, municipal, and school district employees.

BOARD OF DIRECTORS

The board of directors will be composed of 16 members representing:

(1) the commissioner of administration;

(2) the commissioner of health and social services;

(3) the director of the division of insurance;

(4) 13 members appointed by the governor representing the following:

(A) one member representing local governments;

(B) one member representing school boards;

(C) two members representing public school teachers;

(D) one member representing the public who is not a state or municipal employee;

(E) two members from the permanent public employees in the classified service of the state;

(F) one member from the permanent employees of the University of Alaska;

(G) two members from the permanent employees of school districts;

(H) two members from the permanent employees of municipalities; and

(I) one member representing health care providers.

These appointees serve for a five year term and elect officers from the board membership. They are entitled to per diem and travel expenses but may not otherwise be compensated for their services as a board member.

POWERS OF THE AUTHORITY

The Authority may:

(1) exercise the powers granted to insurers under the laws of the state;

(2) sue or be sued;

(3) enter into contracts or agreements;

(4) establish administrative and accounting procedures;

(5) collect, invest, and distribute funds;

(6) adopt necessary regulation and procedures for the operation of the Authority.

FIDUCIARY RESPONSIBILITY

The board is responsible for obtaining group health insurance that provides comprehensive coverage at the lowest

possible cost to eligible employees.

PROCUREMENT OF INSURANCE

The Authority shall purchase an insurance policy or policies from companies licensed to sell insurance in Alaska. This insurance shall cover eligible employees of the state, municipalities, and school districts. In addition the Authority may act as a self-insurer if it finds that self-insurance is a cost effective way to provide insurance coverage to eligible employees.

Except when acting as a self-insurer the Authority shall comply with the State Procurement Code and make bid specification for the desired group health insurance available to all qualified carriers. The specifications shall be available at least once every five years.

STATE GROUP HEALTH INSURANCE FUND

The Fund is an account in the state general fund that consist of money appropriated by the Legislature and insurance premiums collected by the Authority. The board is responsible for the management and investment of money in the Fund and has the authority to use money from the Fund for operation of the Authority.

INSURANCE PREMIUMS

Premiums are collected from participating agencies, municipalities, and school districts in amounts sufficient to provide the required insurance coverage and to cover the operating expenses of the Authority. All premiums are deposited in the State Group Health Insurance Fund.

REQUIRED PARTICIPATION

The state, each municipality, and each school district shall purchase Group Health Insurance from the authority.

WAIVER

A waiver of the requirement to purchase group health insurance from the Authority may be granted. The Authority shall establish minimum benefit and financial standards for desired group health insurance coverage. A participant seeking a waiver of coverage shall provide documentation before the deadline established by the board that their insurance coverage matches or is better than the minimum benefit and financial standards established by the Authority. The board may approve or disapprove the request for a waiver. Once the board has contracted for insurance coverage no waivers can be granted.

Participants may purchase additional coverage beyond that available from the Authority.

DEFINITIONS

(1) "authority" means the Alaska State Group Health Insurance Authority (ASGHIA);

(2) "board" means the board of directors of ASGHIA;

(3) "district" means school district including REAAs;

(4) "eligible employee" an employee of a participant who qualifies for group health insurance benefits as determined by the participant;

(5) "fund" means the state group health insurance fund;

(6) "group health insurance" means insurance coverage that includes life insurance, accidental death and dismemberment, medical care and treatment, dental care,

eye care, and other group health coverage as determined by the Authority;

(7) "municipality" includes a public corporation established by a municipality;

(8) "participant" means the state, a municipality, or a school district;

(9) "state" means the executive, legislative, and judicial branches of state government, or an organizational unit of a branch, and includes the University of Alaska, the Alaska State Building Authority, and the Alaska Railroad Corporation.

Section 3.

Provides that the Department of Administration shall obtain the group health insurance from the Alaska State Group Health Insurance Authority for the retirement programs it administers.

Section 4.

The Alaska State Group Health Insurance Authority is included under the state Conflict of Interest statutes.

Section 5.

The terms of office of the initial members of the board of directors of the Authority shall be staggered by the governor.

Section 6.

Provides for an immediate effective date.

re: CS SB 254

STATE OF ALASKA

HEALTH CARE COST CONTAINMENT

TASK FORCE

REPORT TO THE LEGISLATURE

By

Senator Tim Kelly, Chair
Representative Mike Navarre, Vice Chair
Senator Jim Duncan
Representative Mark Boyer
Michelle Castanedo
Bruce Cummings
Barbara Huff
Don Hitchcock
Karen Perdue
Greg O'Claray

January 31, 1990

LONG RANGE CONSIDERATION OF THE

HEALTH CARE COST CONTAINMENT TASK FORCE

While the Task Force has achieved particular success in reducing the supplemental funding request and reducing the FY 90 cost of the State's health plan, the inflationary trends of medical costs in Alaska portend future increases for the State. Indeed, the State will be paying in excess of $300 million in FY 90 for health care payments of all types. This is an increase from $75 million in 1980, a 300 percent increase over the past 10 years. Aetna's calculation of cost trend factors for the last three years has ranged from 14 percent to 23 percent.

It is with this view and concern that the Task Force identified several considerations to affect long-term strategies of minimizing medical inflation. These strategies are for the most part directed at the health provider industry itself. They utilize the State's size in both numbers and funding to health care providers to restrain or control medical inflation. These considerations also attempt to reduce direct cost shifting to the State from mandated benefit changes and federal program changes.

The following areas have been determined by the Task Force as needing further study and consideration in developing recommendations to the State.

1. Self-Insured Plan Options

Currently, the State purchases its State health care on a fully insured basis. The Task Force is presently investigating the funding alternatives, whereby the State could employ a variety of financing options in order to reduce the cost of the plan and keep premium dollars in Alaska until claims are paid. Exhibit E

illustrates the self-insured options that are available to the State at this time.

By utilizing alternate funding methods, the State could increase the flexibility by which it funds and pays benefits to participants. However, it must be noted that there would be some administrative expenses incurred as some of the record-keeping for the accounts would have to be handled internally by the State instead of the carrier.

The Task Force expects to issue a complete report regarding the advantages, disadvantages, and associated costs, with an estimate of the savings generated by alternate funding methods.

2. Health Care Purchasing Groups

The Task Force has determined that by utilizing buying groups, the State could effect substantial savings to its health care plans.

Currently, the State of Alaska is paying full retail price for medical and dental services. Just as the State does with other goods and services purchased in quantity, the State could negotiate with providers for a discounted rate.

The State can take advantage of current negotiated discounts by utilizing the P.P.O. arrangement through Aetna. There are several ways that the State can negotiate a discount. They include: contracting with a third party organization to negotiate on the State's behalf; or have the State of Alaska negotiate its own contracts, possibly in conjunction with the P.P.O. arrangement and contracting with a third party organization. These arrangements should include all forms of health care purchasing within Alaska, not just the employee benefit plan (e.g. Medicaid and Medicare).

If the State negotiates its own contracts, this generally offers the most flexibility. The State would establish the agreement and the relationship regardless of the claims paying operations. This could also be part of the pooling authorities scope.

Estimated Savings. Generally, negotiated discounts, have generated gross savings (before expenses) of 5 percent to 20

percent, depending on the service, locality and competition in the given area. Such arrangements could generate savings on the employee benefit plan alone of 1.7 million to 7.5 million dollars per year. The Task Force believes that negotiated discounts is an important consideration for containing the cost of medical care. The Task Force will continue to review the alternatives to determine feasibility of this important buying power. Necessarily, the feasibility will depend to an important degree on unique aspects of Alaska's health provider market, wherein many communities are served by one or few providers.

The Task Force recognizes that it is imperative that quality care is delivered to the participant on a cost efficient basis through the plan with negotiated discounts.

3. Provider Payment Schedules

The Task Force has identified provider payment schedules as a proven method effective in controlling health care costs and constraining long-term medical cost inflation. This strategy has been employed by the federal government through the Diagnostic Related Group System (DRG) and the Resource Based Relative Value System (RBRVS) which will be implemented in 1992.

In a further step to control costs, a payment schedule could also be employed by the State. This would be either a modified DRG, a RBRVS or a schedule specifically tailored to the State of Alaska's health care marketplace.

Essentially, under the DRG a schedule is predetermined for each procedure based on the diagnosis of the patient. Under RBRVS schedule, type of care, necessity of care, geographic area, and training of the physician are all taken into account. A system of this nature takes considerable lead time to implement. These payment schedules can only be effective, if:

- The schedule is set on a realistic basis;
- Modifiers are used to control cost shifting; and
- If utilization review is in place;
- Quality of care is assured; and
- Cost savings objectives are met.

Unless the payment system is carefully designed, cost shifting is likely to occur which would minimize overall savings.

The Task Force continues to review and consider alternatives in the way providers are paid (other than the customary, usual and reasonable basis). The Task Force will determine the savings generated by utilizing a provider payment system, and will make specific recommendations as to the type of system most appropriate and its overall operations and implementation.

4. Pooling Concepts

The Task Force is reviewing a cost containment strategy employed by many states called pooling. The purpose of pooling is to provide comprehensive group health insurance to a larger base of enrollment so that: the risk is spread out; health coverage is provided on the most economical basis; provides the maximum opportunity for cost containment when purchasing group health insurance through favorable payment schedules of providers and vendors; entity(ies) can employ a mechanism that provides benefits or coverages that may not be available or are too costly.

Generally, legislation is required to create an entity that provides the coverages needed and oversees the operation of those coverages effectively and in a cost efficient manner. Senate Bill 254, authored by Senator Duncan, has been introduced into legislation. This bill would create the Alaska State Group Health Insurance Authority which would enable the State of Alaska to offer pooled group health coverage to eligible state, municipal and school district employees.

Some of the advantages of pooling are:

- Economy of scale. Eliminate duplicate or multiple plan costs.

- Provides for plan flexibility, plan rating and risk sharing. Each sub-group could conceivably have a slightly different plan design and could be individually rated based on their experience.

However, the risk of large claims occurring could be shared within the pool to eliminate wide swings in experience.

- Data collection - Allows a simplified system for tracking claims, abnormalities or impacts on health care expenditures, instead of obtaining information from many different sources.

- Projection of future cost and trends. The data base would be valuable in projecting future costs and trends, so that the State could be proactive rather than reactive in the management of its health plans.

Pooling enables the State to combine many advantages including self-funding, utilizing the State's purchasing power to help negotiate and control health care cost, and provide benefits on a cost efficient and manageable basis.

The Task Force is currently reviewing other states that have enacted these programs in order to determine the advantages and disadvantages and complexities involved in setting up a pool for the State. It is anticipated that the savings would be generated in several areas:

- Simplification of administration could save 1% to 3%.

- Provider Payments Schedules and P.P.O. Agreements, 5% to 20%.

- Recognize trends and adjust quickly, 5% to 7%.

- In general, economies in a scale of 1% to 3%.

The greatest savings generated would be from the State becoming a cohesive buying group for health care. By increasing the size of the group, the State is better able to negotiate with providers of the service to afford the best possible care, proper utilization, and the maximum benefit to participants without impacting the plan negatively. It would also isolate the plan from an additional cost shifting from other sources, which have become a significant

CONSULTANTS' REPORT

TO THE

STATE OF ALASKA

HEALTH CARE COST CONTAINMENT TASK FORCE

JUNEAU, ALASKA

JANUARY 29, 1990

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SECTION IV

POOLING

POOLING FINDINGS UPDATE

There are several items discussed at the last Task Force meeting that we would like to clarify.

Hawaii Premium Rates

For fiscal year 1990, Hawaii's monthly premium rate for Medical. Vision, Prescription Drug and Dental are:

Single Coverage - State pays $ 52.88; Employee pays $ 35.28 = $ 88.16

Family Coverage - State pays $154.02; Employee pays $102.70 = $256.72

There was a misunderstanding on how Hawaii calculates the composite rate, creating the confusion on the $500.00 monthly rate.

Hawaii's health benefit agreements with Labor.

Approximately 90% of the 65,000 active participants in the Hawaii pool are covered by labor agreements. Hawaii's pool provides standard level of benefits for all participants and sets the premium rate. In labor negotiations, the units negotiate for the contribution provided by the State. The difference is (if any) paid by the employee. Hawaii also operates with a "me too" clause with its labor group resulting in similar state/employee contributions for all groups.

At the last Task Force meeting, it was requested additional information on pooling specifically, advantages, savings and long-term effect on health care cost containment. Included in this report is a closer look at the savings realized by UTAH's Public Employee Health Plan (PEHP).

Utah Public Employee Plan (PEHP)

The State of Utah's Public Employee Plan (PEHP) was established in 1977 by the state legislature to help reduce and control health care costs. The plan provides coverage to over 70,000 (23,000 primary insureds) state, county, city, and school district employees, retirees and

their dependents. All public entities must participate in the plan. The fund is governed by legislation, directed by a board of trustees and a full-time director. It requires 35 state employees to run the plan's operation.

Currently, the fund offers one plan design to all entities with separate rating based on each entities experience. The fund provides Dual Choice Medical and Dental, Two - H.M.O.'s, Life and Long-Term Disability coverage. The coverages are self-funded with in-house administration and claim payors.

PEHP has realized savings in three main areas. Lower cost of administration, negotiated provider payment, utilization standards and plan design including wellness programs. These findings are verified by UTAH's Legislation Auditor General's report dated February 2, 1989. (Included in attachment.)

ADMINISTRATIVE COSTS

UTAH's PEHP compared favorably in the audit report with five self-insured carrier administrative rates. The average was 6.8% compared to PEHP at 3.5%. Aetna, currently, charges the State of Alaska 6.5% to process claims totalling $5,656,424 for the 1989 plan year. If Alaska could effect similar savings in administrative costs, the savings would be $2.5 million per year, just for active and retiree plans.

Comparison of Administrative Cost Between Self-Insured Carriers for Health Care Source UTAH Legislative Audit Report

Carrier	Administration Costs As A Percent of Total Costs
Company A	6.3*
Company B	7.0
Company D	6.4*
Company E	9.3
Company F	5.1
Simple Average	6.8
Alaska (Aetna)	6.5
PEHP	3.5

*These companies also administer a 401(K) plan to employees as well as other programs.

Negotiated provider payment and utilization standards

PEHP has been able to reduce health care costs through negotiated discounts in preferred provider arrangements. In the comparison of PEHP's reimbursement of Seven Common procedure reimbursements (Page 3, Table I, Utah Legislative Audit Report) the savings ranged from 6% - 8% from usual carrier reimbursements. Claims payors (carriers) in Utah use a "Med Index" to ascertain usual and reasonable rates. In a comparison of Ten Common health care procedures (see Utah Legislation Audit Report, Page 4, PEHP, Table II), PEHP was reimbursing providers at a lower rate than the med index resulting in savings of 11% to 25%.

These similar savings could be achieved in Alaska's plan by using combination of preferred providers, revised usual, reasonable and customary (UCR) and provider payment schedules. In the 1989 plan year, $80,818,125 was paid for claims if savings similar to Utah's experience are realized, the State of Alaska would save between $6.4 million and $20.0 million per plan year.

Plan Design and Wellness Programs

PEHP has implemented plan design charges to incorporate cost containment and wellness plans.

Cost containment provisions that have been implemented include:

* Second Surgical Opinion
* Utilization Review
* Pre-Certification
* Managed Mental Health and Substance Abuse
* Alternate Care Settings (Home Health)
* Pharmacy P.P.O.
* Outpatient Surgery
* Preferred Provider Network
* Flex Plan (See Attachment)
* Three Phase Wellness Plan (See Attachment)

That Includes:

- Screening
- Education and Assistance
- One-On-One Guidance, If Necessary

These several plan designs, cost containment and funding arrangements have demonstrated reduced plan inflation. The Table below illustrates that PEHP has been able to hold costs at about the overall medical CPI level (6.7%) versus Alaska's plan increasing at 19.98%.

Comparison of Rate Increases For Family Premiums By Other Western States

State	Annual Premium Growth Rate For Last Five Years	Estimated Increased FY'90
Arizona	17.2%	N/A
Colorado	6.4	N/A
Idaho	4.0	30%
Montana	5.5	26
Nevada	4.6	15
New Mexico - Plan A	23.8	30
New Mexico - Plan B	9.6	30
Wyoming	6.7	52
Average	9.7	31
Alaska (Aetna 3 years)	19.98	0 (Revised)
Utah	6.6	23-31*
Medical CPI	6.7	N/A

*PEHP is requesting a 21% increase and a one-time appropriation of $2.4 million to rebuild its reserves. To fund the $2.4 million appropriation over time could increase premiums from 2% to 10%. PEHP also will reduce benefits by 10%.

Source: Utah Legislation Audit Report

Additionally, PEHP has been able to hold premium increases at 6.6% versus the insurance carriers average in Utah of 12.2% over the last 5 years.

Currently, PEHP is requesting a supplemental appropriation in funding for the plan from $308.00 to $325.00 tc cover short funding in the last session and rebuild reserves.

In previous good years when a surplus was generated, it was returned to the Utah State general fund.

Conclusion

By utilizing a pooling concept for Alaska's health plans, the following savings could be generated for the Active and Retiree Plan. Savings could be significantly greater by including total health care paid for by the state programs.

Estimated Savings:

Administration	$ 2.0 - $3.0 million
Provider Arrangements	6.4 - $20.0 million
Slowing Premium Increase	T.B.D.
Recognize Trends/Adjust	2.0 - $10.0 million
Total Estimated Savings for active and retiree plans	$10.4 - $33.0 million

SECTION C

REVIEW OF POOLING

PART ONE

OVERVIEW OF THE POOLING CONCEPTS

PART ONE

OVERVIEW OF POOLING CONCEPTS

Pooling enables entity(ies) to employ a mechanism that provides benefits (or coverages) that may not be available, are too costly, and/or helps to contain overall costs of the program. Generally, legislation is enacted (see Section C Part 2 for a Review of SB254) to create an entity that provides the coverages needed, and oversees the operations of those coverages effectively and cost efficiently.

Many states have enacted pooling legislation either for their employees/retirees uninsurable/uninsureds coverages. States that have enacted legislation include:

Connecticut	Maine	Oregon
Florida	Minnesota	Tennessee
Hawaii	Montana	Utah
Illinois	Nebraska	Washington
Indiana	New Mexico	Wisconsin
Iowa	North Dakota	

A pool provides many benefits not currently available under the arrangement utilized in Alaska, whereby each subgroup may have a separate plan(s).

Some of the advantages of pooling:

- **Economy of scale**

  Eliminate duplicate or multiple plan costs

- **Provides for plan Flexibility/Plan Rates**

  Each sub-group could have a different plan design and rates

- **Premium rates based upon sub-group experience**

  Sub-group pays their proportioned share of expenses

- **Data collection**

  Allows an easy system for tracking trends, abnormalities or impacts on health care expenditures, instead of having to get information from many different (possibly inaccurate) sources.

- **Projection futures costs/trends**

  The data base that would be available would be invaluable in projecting future costs/trends as you could identify changes immediately.

- **Predict/act on cost shifting**

  Effectively you could determine when there was any potential of actual cost shifting.

- **Could still utilize third party vendors for service**

  This would retain the integrity and cost economies that are necessary in these types of programs.

CONCLUSIONS

By utilizing the pooling concept you would have the best of all worlds, including centralized information, substantial savings, predict future cost/trends and probably improve service to all parties involved. Other states have investigated and implemented pooling for these very reasons. Now is the time for Alaska to be able to benefit from pooling also.

SECTION C

REVIEW OF POOLING

PART TWO

REVIEW OF SB254

AN ACT RELATING TO GROUP HEALTH INSURANCE

PART TWO

REVIEW OF SB254

"AN ACT RELATING TO GROUP HEALTH INSURANCE"

Following this section is a copy of the bill (SB254) and two sections.

The bill in its submitted version would create the Alaska State Group Health Insurance Authority to provide group health insurance benefits to all state employees, including: retired, municipal, and school district employees on a cost effective basis. The bill would give the authority the power to arrange for health coverage on the most economical basis while "spreading" the risk over a larger base of enrollment, affording the most favorable payment schedules to providers and vendors for the state.

COMMENTS ON SB254

- The Authority should have the option to be expanded to include Workmens' Compensation, Health and Social Services, medical coverages and payments, and uninsurable/uninsured benefits as sub-groups of the pool (Sec. 21.77.010).

- Revise bill to remove requirement to be licensed as an insurer under AS21, remove the Authority from title 21 (see 21.77.030.).

- Revise purchase of insurance requirement to remove clause "that it has to be sent to all licensed insurers - (at least every 5 years)" rather to use an RFP notification process where by qualified bidders are maintained on a list or by request (section 21.77.050.).

- Required participation may be revised to clarify/simplify the requirements to evaluate whether or not a sub-group has an eligible waiver, while not undermining the necessity of as many eligible groups feasible to participate. (See 21.77.080.)

- Pool should have the ability to access members and or issue bonds to fund benefits or establish adequate reserves. (See 21.77.070.)

SECTION C

REVIEW OF POOLING

PART THREE

FEASIBILITY OF POOLING IN ALASKA

PART THREE

FEASIBILITY OF POOLING HEALTH CARE IN ALASKA

As a long term cost management strategy of health care costs, pooling provides the best vehicle, this has been proven by Hawaii, Utah, New Mexico, California (schools) and others.

Pooling has proven effective in areas outside of just health coverages, one example is the Alaska Municipal Leagues - Joint Insurance Association (AML-JIA) that is providing property, workers' compensation and liability coverage that previously was unavailable or not available at a reasonable cost.

There are a number of hurdles to be crossed in getting any pool in place and effective Alaska will be no exception to these.

- **Passage of Bill**

  The bill must gain support from legislature, administration, judicial, municipalities and participants in order to pass. This can only be accomplished through an effective communication campaign.

- **Challenges of Authority**

  In the past these bills have received some challenges (legal) after being enacted. However, the bill in its current form has been proven to be effective in answering these challenges.

- **Set up and operation of Authority**

  The success of the Authority will be measured by the effectiveness of its membership and participants. The Authority will have to rely on the expertise not only within, but also outside consultants, actuaries, administrators and providers. Only as a complete partnership will it be a successful venture.

It is our estimate that following the initial set up costs and associated fixed costs, the state could realize the following savings (as a percent of total health care expenditures outside of the pool):

1 - 3%	**Simplification of Administration**
15 - 40%	**Provider payment schedules/agreements**
5 - 7%	**Recognize trends adjust quickly**
1 - 3%	**General economics of scale savings (misc.)**
22 - 53%	**Total savings estimate: up to 50-100+ million dollars.**

This does not include the sentinel effect that would generally slow medical inflation for the state plan.

SECTION C

REVIEW OF POOLING

PART FOUR

SUGGESTED TIME LINE FOR IMPLEMENTATION OF POOLING

PART FOUR

SUGGESTED TIME LINE FOR IMPLEMENTATION OF POOLING

- Passing of SB254 creating "authority"

  "Alaska State Group Health Insurance Authority"

1. First Month
   - Selection of members
   - Organization of Authority/1st meeting
2. Second through Fourth Month
   - Evaluation of services required - (RFP those Services)
   - Selection of certain service providers (actuarial/consulting etc.)
   - Review of current plans and arrangements to be included in pools
   - Provider Payment options evaluation
3. Fifth through Eighth Month
   - Meetings with eligible sub-group participants
   - Develop pro form a benefit and cost analysis (actuarial study)
   - Outline to sub-groups the impact to their group(s)
   - Select provider payment strategy
4. Eighth through Twelfth Month
   - RFP Third party vendors
   - Determine/Evaluate required participation by sub-group or issue warriors
   - Establish final rates/benefit plans for each sub-group
   - Finalize providers payment arrangements
   - Finalize third party vendors arrangements
   - Notify participants

5. Thirteenth through Sixteenth Month (Ongoing)

Begin pool operations, i.e., premium collection, claim payments, etc.

- Evaluate pools operations/effectiveness
- Provide communication to sub-group and participants
- Review/settle disputes (claims)
- Analyze experience/trends
- Compare pool results to others "like organizations"
- Measure actual cost savings
- Monitor provider relations/payment schedule
- Advise on state/federal law change impacts

STATE OF ALASKA

HEALTH CARE COST CONTAINMENT TASK FORCE

CONSULTANTS REPORT

JANUARY 4, 1990

JUNEAU, ALASKA

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SECTION I

CONTINUED DISCUSSION REGARDING

POOLING CONCEPTS

I. CONTINUED DISCUSSION REGARDING POOLING CONCEPTS

Several states have enacted pooling legislation for a variety of reasons. Two case summaries, one for Hawaii and the other for Utah are presented below to gain an understanding as to how and why other states have exercised pooling for their benefit plans. Hawaii and Utah were chosen for this initial study because they both have been utilizing pooling for a number of years, Utah for 13 years and Hawaii for 28 years). We recommend that you accept the invitations from Hawaii and Utah to personally experience the benefits of pooling.

Utah Public Employee Health Plan

The State of Utah's Public Employee Health Plan was established in 1977 by the state legislature to help reduce and control health care costs. The plan provides coverage to over 70,000 (23,000 primary insureds) state, county, city, and school district employees, retirees and their dependents. All public entities must participate in the plan. The fund is governed by legislation, directed by a board of trustees and a full time director. It requires 35 state employees to run the required operation.

Currently, the fund offers one plan design to all entities with separate rating based on each entities experience. The fund provides Dual Choice Medical and Dental, Two - H.M.O.'s, Life and Long-Term Disability coverage. The coverages are self-funded with in-house administration and claim payors. Substantial savings have been realized by creating a buying group that is cohesive and proactive in cost containment and non-payment. One problem that has surfaced is that the fund has been setting rates 18 20 months in the future, and medical inflation has required increases in contributions earlier than originally anticipated.

The Utah Public Employee Fund has extended an invitation to the Task Force an on site look at their operation and answer any further questions you may have regarding their "pooling" experience.

Hawaii Public Employees Health Fund

The Hawaii Public Employee Health Fund was established in 1962 under Chapter 87 (revised) as a method to purchase and distribute employee benefit coverage for over 110,000 (65,000 primary insureds) state, county, city and school employees, retirees and their dependents. All public entities must participate in the fund.

The fund started in 1962 with the base benefit plan and added, dependent care in 1966, group life in 1968 and Dental, Vision (V.S.P.) and Prescription Drug plans effective January 1, 1990.

Currently, the fund offers a indemnity medical plan with Blue Cross, utilizing minimum Premium Funding, three - H.M.O.'s (Kaiser, Community Health Plan, Island Care Plan). Dental, Vision, Prescription Drug and Life Insurance are currently fully insured with the option of utilizing alternate funding methods. All plans are free standing and have separate rating and experience.

The fund currently negotiates with carriers on a two year rate guarantee basis that coincides with the labor agreements. All contracts are negotiated with the negotiating committee which usually occurs every two years.

Hawaii Public Employees Health Fund does not presently employ cost containment methods (ie: pre-certification and utilization review) or a preferred provider organization. Hawaii is currently experiencing medical inflation 4% to 5% lower than the mainland. The plan design includes higher deductibles and co-payments and the employees pay 40% of the medical premium.

Legislation governs the operations and power of the fund which is directed by a board of trustees and has of full-time director with a staff of eight. Hawaii utilizes the fund to purchase and distribute benefit coverages using outside vendors, however, they could self-fund and/or self-administrator the program.

The fund is currently investigating the ability to add Long-Term Care to the benefit package for their covered employees.

The Hawaii Public Employee Health Fund has offered to assist the Task Force in understanding the operation of their fund, and have extended an invitation to the Task Force to send a delegation to Hawaii for further on site discussions.

1.29.90
Dave Gray

ESTIMATED POPULATIONS OF ALASKANS WHOSE HEALTH CARE COSTS ARE DIRECTLY, INDIRECTLY, OR PARTIALLY PROVIDED FOR BY THE STATE

Employee/Retiree	Dependents	Totals
1. State Active Employees		
13,000	17,500	30,500
2. Retirees (State, Muni, School)(PERS & TRS).		
10,500	9,800	
Up to 60% reside in state		
6,300	5,900	12,200
3. Local Govt. Active Employees (PERS)		
13,600	18,400	32,000
$. Teacher Actives (TRS)		
8,200	11,000	19,200
Medicaid/Medicare Eligibles. Div. Of Medical Assistence		
41,000		41,000
		(134,900)

a) Some of the people appearing in item 2 will be counted in item 5.

b) Estimates of dependents in items 3 and 4 assume that the groups exhibit the same age and sex characteristics as in group 1.

My name is Barbara Huff, I am the President of the Anchorage Municipal Employees Association (AMEA). I represent approximately 575 Municipality of Anchorage employees. I am also a member of the Anchorage Municipal Coalition Unions and the State's Health Care Cost Containment Task Force.

Senate Bill 254, an Act relating to group health insurance or the pooling concept of public employee health benefit plans, is of great importance to my members and the Municipality of Anchorage.

The Municipality of Anchorage over at least the last 5 years has seen a drastic increase in the cost of health benefits which it provides for it's employees. The Anchorage School District has seen a similar dilemma.

Recently an agreement was reached between the Anchorage Municipal Employees Association and the Municipality of Anchorage which, in effect, reduced health benefits to offset a projected 22 percent cost increase for 1990.

There is just so much cost containment and cost shifting that can be accomplished. We have reached that point in the municipality and I can only anticipate that future insurance premium increase will result in two things happening: 1. Costs to the individual employee will reach the point where the family can't afford the protection and 2. The benefits will come down at the same time rendering what coverage is left virtually useless in certain common medical emergencies

Post-It™ brand fax transmittal memo 7671	# of pages ▸
To LAVE GRAY	From Barb HUFF
Co.	Co. AMEA
Dept. Senator Kelly's Office	Phone # 279-4236
Fax # 463-4867	Fax # 337-6668

Senate Bill 254 would establish a mechanism whereby the State, Municipality of Anchorage and various school districts and Universities could pool their numbers and use this economy of size to the advantage of all public employees in purchasing a basic health care plan. This large group of people could also jointly operate a cost containment program that, again, would realize significant savings by way of the economy of scale principle.

In an ideal situation each group of public employees would prefer to select it's own health care coverage. Unfortunately, the cost trends are making this impossible. The proposed legislation would allow pooling of numbers for basic coverage while still allowing individual employee groups to enhance the coverage depending on their own priorities and ability to pay.

This compromise, to me, seems to allow the employee to retain options while still benefiting from a far greater purchasing power than his own group could exercise.

I recommend the bill be adopted.

S B 263

FILE 1

VIDEO GAMING MACHINE SERVICE FORM
(Must be Legible)

Complete this form when any service work is done to a video gaming machine that effects any meters. Immediately fold, tape, stamp, and return to address on the reverse side.

_____	_____	____-____-____	Keno ____
Machine Serial #	Decal #(current)	Liquor License #	Bingo ____
			Poker ____
			CHECK ONE

DESCRIBE FAILURE/PROBLEM: _____

_____ _____

_____

METER READINGS BEFORE REPAIR/SERVICE

If machine does not have a printer, record all available meter readings

	Mechanical	Electrical	
credits in B.A.	_____	_____	Staple audit ticket here > <
coins in	_____	_____	
credits played	_____	_____	UNABLE TO PRINT AN AUDIT TICKET?
credits won	_____	_____	Record electrical readings from
credits paid	_____	_____	display and check here > ____

LABOR DESCRIPTION: _____

_____

_____

New Logic Board Serial Number: _____ N/A ____

METER READINGS AFTER REPAIR/SERVICE

	Mechanical	Electrical	
credits in B.A.	_____	_____	Staple audit ticket here > <
coins in	_____	_____	
credits played	_____	_____	YOU MUST SUPPLY AN AUDIT TICKET
credits won	_____	_____	HERE IF MACHINE HAS A PRINTER
credits paid	_____	_____	

_____	_____	____/____/____
Printed Name of Service Man	Company Name or Vendor I.D. #	Date of Service

Revised5/3/88 \SVC

****
* Place *
Postage
* Here *
****

TO:

DEPARTMENT OF COMMERCE
VIDEO GAMING CONTROL BUREAU
1125 Missoula Avenue
Helena, Montana 59620

New Phone Number
442-7325
Effective May 20, 1988

Fold Here

Fold Here

Please Tape Here

_____, 19_____

TO: Video Gaming Control Bureau

FROM: _____Liquor License # (12 digits)
(Print) _____Establishment Name
_____Licensee Name
_____Phone #

1) I hereby "Authorize" you to mail all quarterly reporting forms for the above establishment to the following business:

_____Business Name
_____Mailing Address
_____City, State, Zip
_____Phone #

2) I hereby designate the following to sign my quarterly reports. You may designate your vendor. Provide 1 or 2 (two) individual signatures. Only this/these signature(s) will be accepted.

_____ _____
Printed Name of Designee Signature of Designee

_____ _____
Printed Name of Designee Signature of Designee

This authorization is to apply to the following machines: (use another piece of paper if necessary)

Serial #	Decal #	Serial #	Decal #	Serial #	Decal #
1	( )	7	( )	13	( )
2	( )	8	( )	14	( )
3	( )	9	( )	15	( )
4	( )	10	( )	16	( )
5	( )	11	( )	17	( )
6	( )	12	( )	18	( )

I (licensee), understand that I may revoke this "Authorization" and/or "Designation" at any time by notifying the Video Gaming Control Bureau in writing.

This authorization does not release me, (the licensee), of my responsibility for the quarterly reports to be filed true, timely and in compliance with all laws. Furthermore, I understand that I remain liable for the quarterly report.

_____
Licensee Signature Only (Holder of Liquor License)
If Corporation - Corporate Officer

MONTANA
MTA
Tavern Association
Affiliated and Associated with the NLBA
PROFESSIONAL PLAZA - SUITE AB-2
900 N. MONTANA AVENUE - P.O. BOX 851
Helena, MT 59624 / PHONE 406-442-5040

5/12/89

BILLS PASSED 1989

GAMBLING (Yellow pages)

HB 36 50% Payout on sports pools allowed for nonprofit organizations
HB207 Revision of Lottery laws.
HB446 Increasing lottery commissions to agents.
HB448 Allow possession of antique slot machines
HB576 Used Keno machine licensing
HB573 Allow bill acceptors on machines
SB431 Revision to Gambling Laws
SB443 Allowing multistate lottery games
SB251 - Increase raffle prize

LIQUOR (White pages)

HB368 Negligent Vehicular Assault (DUI)
HB393 Increase penalty for possession between 18-21 years
HB417 Endorsement for resort tour boat all-beverage license
HB425 Stiffen DUI Penalties
HB497 Clarifying "unlawful possession".
HB608 Allow persons under 21 to get alcohol from parents, guardians, etc.
HB611 Revise liquor license protests
SB348 Wage Protection Act - exclusion for family members.

TAXES/FEES (Blue pages)

HB202 Increase cigarette tax for veterans nursing/domiciliary home.
SB323 Penalty for late payment of food license.

LABOR & MISCELLANEOUS (Pink pages)

HB 28 Increase minimum wage.
SB 95 Increase state travel allowance for lodging.

HB247 Ratemaking for volatile & noncompetitive insurance.

BILLS KILLED 1989

GAMBLING

HB 95 Exempt lottery prizes from taxes (income).
HB132 Increase live bingo prize from $100 to $800.
HB255 Cumulative total of 20 video machines
HB613 Centennial "21"
HB625 Reimburse loss of machine taxes on reservations.
HB746 Authorize punchboards and pulltabs.

(over)

BILLS KILLED (Cont'd)

GAMBLING (Cont'd)

HB753	Progressive prizes in video poker and keno.
SB369	Repeal calcutta pool law.

LIQUOR

HB 42	Prohibit minors in taverns.
HB271	Instruct abstinence of alcohol in schools.
HB369	Prohibit deferral of DUI sentence.
HB404	Increasing penalty for DUI.
HB414	Increasing penalty for possession between 18-21 years.
HB497	Suspend minor's drivers license for possession.
HB582	Requiring ignition lock on DUI conviction.
HB587	Lower BAC to .08
HB627	State out of liquor monopoly.
HB654	Warning signs - alcohol/pregnancy.
HB743	Allow sale of fortified wines by distributors.
SB263	Prohibit certain sexual conduct in bars.

TAXES/FEES

HB266	Increase cigarette tax 1¢/package for cancer research.
HB269	Amend constitution to establish restrictions on sales taxes.
HB343	Increase fees for food establishments.
HB747	4% General Sales Tax (Bradley's)
HB762	Tax beer and table wines.
HB779	4% luxury tax on drinks, food, etc.
HB479	Local option taxes.
SB462	4% excise tax on drinks, meals, entertainment.
SB469	4% General Sales Tax (Crippen)

LABOR & MISCELLANEOUS

HB 49	Increase minimum wage.
HB370	Increase state allowance for meals.
SB234	Include tips in minimum wage.
SB312	Constitutional Amendment - Tort Reform.

GAMBLING

HB36 (Schye) 50% PAYOUT ON SPORTS POOLS

Nonprofit organizations only may retain up to 50% of the value of a sports pool if they verify that this 50% is used to support charitable activities, scholarships, educational grants, or community service projects. STATUS: Governor signed.

HB95 (Pavlovich) EXEMPT LOTTERY PRIZES FROM TAXES

Would have exempt amount of prize won in the Montana lottery from state income tax; if included as gross income for federal income tax purposes, would have been allowed as a deduction in computing taxable income. STATUS: Killed in House Taxation.

HB132 (Schye) INCREASING BINGO PRIZE AWARD

Would have increased live bingo prize from $100 to $800. STATUS: Killed on 2nd Reading in House (40-56).

HB207 (Gould) REVISION OF LOTTERY LAWS

Major provisions include: allowing commission to determine the percentage of prize payout, subject to a minimum of 45% of money paid for tickets; allowing Montana to participate in multistate games; removes requirement that the lottery operate on 15% of revenue and mandates only that the administrative costs be outlined in a budget to be approved by the legislature every two years. Immediate effective date. Changes expected to allow the lottery to operate more like a business; larger prizes will increase sales and mean more money for schools. Governor's budget office anticipates $8 million increase in sales. STATUS: Signed by Governor.

HB255(Pavlovich) CUMULATIVE TOTAL OF 20 VIDEO MACHINES

Would have limited bingo or keno machines to 10; poker machines to 10. If you were licensed for fewer than 10 poker machines, you could receive licenses for bingo or keno that would cause the total of all machines to be 20 or fewer. STATUS: Died in House Business without hearing and upon decision by Rep. Pavlovich.

HB446 (Daily) INCREASING LOTTERY COMMISSION

Increased agent's commission from 5% to 10%; no part is taken from revenue paid to Supt. of Public Instruction for teacher retirement. STATUS: Governor signed.

HB448 (Menahan) ALLOW POSSESSION OF ANTIQUE SLOT MACHINES

This has been coordinated into SB431. Allows possession of an antique slot machine (manufactured prior to 1950), the operation of which is exclusively mechanical. Can be possessed, located and operated only in private residential dwelling; possessed or located for display purposes only, not operation, in public museum owned by state or local government. Licensed manufacturer-distributor may possess and sell. STATUS: Governor signed.

HB576 (Roth) USED KENO MACHINE LICENSING

A used keno machine may be licensed without meeting the requirements of 23-5-609 (keno specifications) if: (a) it meets the requirements of 23-5-607 (80% payback) and 23-5-608 ($2 limit and $100/hand); (b) it has mechanical meters described in 23-5-609(4)(k) and electronic meters described in 23-5-609(4)(l), as that section read on 9/30/89; and the machine was licensed by the department prior to 1/1/89.

GAMBLING (Cont'd)

Effective 7/1/89 and terminates 6/30/90. STATUS: Governor signed. Coordinated into SB 431.

HB613 (Menahan) CENTENNIAL "21"

W[illegible]e included 21 as an authorized gambling activity. Local governments could [illegible]ed licenses for no more than two tables per premise between May 27, 1989, an[illegible]ember 4, 1989. STATUS: Killed in House Business Committee (10-6).

HB625 (Mercer) REIMBURSE LOSS OF MACHINE TAXES ON RESERVATIONS

This would have required the state to reimburse a local government located on a federally recognized Indian reservation for video poker and keno revenues lost as a result of an agreement entered into by the state and the tribal governments, pursuant to the new federal indian gaming regulatory act. This bill carried a $363,000 impact on the state's general fund. STATUS: Tabled in House Taxation.

HB746 (Pavlovich) AUTHORIZE PUNCHBOARDS & PULLTABS

Would have allowed licensing of punchboards and pulltabs, and their manufacture and distribution. Annual fee for retail license = $100; distributor = $1,000; manufacturer = $2,000. Maximum cost/ticket = $2; maximum prize = $500; minimum 70% payout. Tax = 5% of adjusted gross proceeds (money received less prizes paid). The bill passed out of House Business as amended. When it got to the floor on 2nd Reading, it was attacked by Rep. Bob Marks and he made his well-publicized statement about tavern owners being "the greediest sort of people in Montana", which he later retracted. The bill was defeated 57-36, and here is how your legislator voted:

HB 746 - Representative Pavlovich moved HB 746 do pass. Motion failed as follows:

Ayes: Aafedt, Bachini, D. Brown, Campbell, Compton, Daily, Davis, DeBruycker, DeMars, Driscoll, Gervais, Giacometto, Gilbert, Glaser, Gould, Hanson, Harrington, McCormick, Menahan, Moore, L. Nelson, Nisbet, O'Connell, Owens, Pavlovich, Peterson, Phillips, Quilici, Rehberg, Roth, Smith, Spaeth, Stang, Strizich, Swysgood, Whalen,
Total 36

Noes: Addy, Bardanouve, Blotkamp, Boharski, Brooke, J. Brown, Clark, Cobb, Cocchiarella, Cody, Cohen, Darko, Elliott, Eudaily, Good, Grinde, Guthrie, Hannah, Hansen, Harper, Hayne, Hoffman, Johnson, Kasten, Keller, Kilpatrick, Kimberley, Knapp, Koehnke, Lee, Marks, McDonough, Mercer, R. Nelson, T. Nelson, O'Keefe, Peck, Ramirez, Raney, Ream, Rice, Russell, Schye, Simon, Simpkins, Spring, Squires, Steppler, Stickney, Swift, Thoft, Thomas, Wallin, Westlake, Wyatt, Zook, Mr. Speaker.
Total 57

Paired: Daily, Spaeth, Whalen, Ayes; Hannah, Ramirez, Thomas, Noes.

Excused: None.
Total 0

Absent or not voting: Bradley, Connelly, Ellison, Grady, Iverson, Kadas, Patterson.
Total 7

GAMBLING (Cont'd)

HB753 (Pavlovich) MEGABUCKS

Would have allowed an unlimited progressive prize in video poker and keno machines connected to a centralized computer system; 1.25% of gross machine income tax on such machines in addition to existing 15% on net income; system could be leased, maintained and operated by a licensed manufacturer who may participate in the revenue of the machines on the system as payment for his services. Rep. Pavlovich, recognizing the differing opinions of MTA members on this concept, recommended that MTA take no position on the bill this year. He wanted to test the idea and was successful in gaining a respectable number of votes in the committee. STATUS: Tabled in House Taxation. Rep. Pavlovich considered, then abandoned taking action to get the bill off the table.

HB573 (McCormick) ALLOW BILL ACCEPTORS ON MACHINES

Amended existing video draw poker specs (23-5-606) and keno specs (23-5-609) to allow machine manufacturer bill acceptors. The bill specified that if this bill and SB431 passed (which they did) and SB431 repealed these sections (which it did), the Dept. of Justice shall by rule allow these acceptors. STATUS: Governor signed.

SB251 (Harding) INCREASE RAFFLE PRIZE

Allows nonprofit veterans groups to conduct raffles not exceeding $5,000 per individual raffle card and be exempt from a permit or investigative fee. Maximum prize for all others = $1,000. See SB431). STATUS: Governor signed.

SB369 (Bob Brown) REPEAL CALCUTTA POOLS

This was a straight repealer. STATUS: Passed the Senate but was tabled in House Business Committee. (SB431 retains legalization of calcuttas and clarifies provisions.)

SB443 (Stimatz) MULTISTATE LOTTERY GAMES

Allows Montana to participate with other states in lottery games. STATUS: Governor signed.

SB431 (Gage) REVISION OF GAMBLING LAWS

Detailed report of this bill mailed to all members 5/1/89.

LIQUOR

HB42 (Stang) PROHIBIT MINORS IN TAVERNS

Would have allowed local governments to enact an ordinance prohibiting minors from entering establishments licensed for on-premise sale of alcoholic beverages, but allowing entrance to areas where another business is operated (restaurant, hotel, sporting event, fair, etc.) MTA opposed. STATUS: Killed in House Judiciary.

HB271 (Wallin) INSTRUCT ABSTINENCE OF ALCOHOL IN SCHOOLS

MTA's interest was to see that taxes on alcoholic beverages were not expected to fund the $95,000 annual budget. STATUS: Tabled in House Education.

HB368 (Cocchiarella & Vincent) NEGLIGENT VEHICULAR ASSAULT

Adds negligent vehicular assault to list of offenses requiring mandatory revocation of drivers license upon conviction, plus 12 conviction points in determining habitual traffic offender. This is the same section that includes DUIs. Includes operating vehicle in negligent manner, causing bodily injury to another. STATUS: Governor signed.

HB369 (Cocchiarella & Vincent) PROHIBIT DEFERRAL OF DUI SENTENCE

Court may defer imposition of sentence except sentences for DUI or operating a vehicle with a .10 or more BAC. STATUS: Tabled in House Judiciary.

HB393 (Darko) INCREASING PENALTY FOR POSSESSION BETWEEN 18-21 YEARS

Fines for conviction: less than 18, not to exceed $50; age 18-21, $50 for 1st offense, $100 for second, $200 for third, $300 + 6 months for 4th. Person 18-21 does not commit offense if it is necessary to possess alcoholic beverages in the course of his employment. STATUS: Governor signed.

HB404 (Keller) INCREASING PENALTY FOR DUI

Would have increased maximum jail sentence on first conviction from 60 days to 6 months; on 4th conviction, imprisonment not to exceed 5 years or $5,000 or both. STATUS: Tabled in House Judiciary.

HB414 (Spaeth) INCREASING PENALTY FOR POSSESSION BETWEEN 18-21 YEARS.

Basically the same as HB393, except penalties would have been stiffer. STATUS: Tabled in House Judiciary.

HB417 (Pavlovich) ENDORSEMENT FOR RESORT TOUR BOAT A.B. LICENSE

Allows endorsement to resort license for operation of a tour boat within 30 miles of resort boundary only while boat is underway or in preparation for scheduled departure; boat must be at least 40' in length and equipped to carry at least 50 passengers; annual fee $200; registered owner of boat must be part of the liquor license. STATUS: Governor signed.

HB425 (Vincent) STIFFEN DUI PENALTIES

This was Vincent's major DUI bill. On 2nd or subsequent DUI offense, driver's license continues to be suspended until the person completes an alcohol information course, treatment prescribed by the court, or both; a per se conviction constitutes a conviction under DUI for the purpose of calculating the number of convictions; if there has been no additional conviction for DUI for a period of 5 years after a prior conviction, all records and data pertaining to the prior are confidential criminal justice information and public access to the information may only be obtained by a district court order upon showing good cause. There was language to expunge the record after 5 years but that language was stricken. STATUS: Governor signed.

HB495 (Strizich) CLARIFYING "UNLAWFUL POSSESSION"

A person under 19 commits the offense of unlawful possession if he consumes or has in his possession an intoxicating substance. He needs not be consuming or in possession at the time of his arrest to violate this section. A person under 21 commits the offense if he has an alcoholic beverage in his possession, except if he consumes or gains possession because it was lawfully supplied by parent, guardian, physician, etc. STATUS: Governor signed.

HB497 (Darko) SUSPEND MINOR'S DRIVERS LICENSE FOR POSSESSION

This would have stiffened existing laws on suspension or revocation of driver's license for minors guilty of possession. STATUS: Tabled in House Judiciary.

HB582 (Eudaily) IGNITION LOCK REQUIRED ON DUI CONVICTION

A court would have been allowed to impose the additional punishment for a person convicted of DUI of requiring the person to drive only a motor vehicle equipped with an ignition interlock device, which the offender would have to pay for. "Ignition interlock device" is ignition equipment that analyzes the breath to determine BAC and designed to prevent a car being operated by a person who has consumed a specific amount of alcohol. STATUS: Bill passed the House; died in Senate Judiciary

HB587 (Addy & Vincent) LOWER BAC TO .08

This would have reduced blood alcohol concentration from .10 to .08 and increased the mandatory fine on 3rd or subsequent DUI conviction to a maximum of 5 years or $50,000, or both (from 1 year or $1,000, or both). STATUS: Tabled in House Judiciary.

HB608 (Grady) ALLOW PERSONS UNDER 21 TO GET ALCOHOL FROM PARENTS, ETC.

At the same time Addy wanted to reduce BAC level to .08 (HB587, above), this bill came along to allow parent or guardian, minister or priest, physician, pharmacist or dentist to provide a person under 21 "nonintoxicating amounts of alcohol (not to product a BAC in excess of .05). STATUS: Governor signed.

(NOTE: It is particularly difficult to understand the rationale for this type of legislation, inasmuch as so much time and effort was devoted toward prohibiting minors from being able to drink.)

HB611 (Connelly) REVISE LIQUOR LICENSE PROTESTS

Provides that protests against the issuance or transfer of an alcoholic beverage license may be made only by creditors and residents of the county from which the application comes, and adjoining Montana counties. STATUS: Governor signed.

LIQUOR (Cont'd)

HB627 (Simon) STATE OUT OF LIQUOR MONOPOLY

MTA offered support of the bill, ONLY if its amendments were accepted. Simon agreed. Major provisions of the bill, with MTA amendments: The present 130 state stores, including agencies, would be put up for bid and have to be sold by 7/1/90. Successful bidders would operate stores as agencies until that date, then be issued an Original Package Store License, which couldn't be transferred to a new location until 1/1/92, nor could any additional package store licenses be issued until that date. After 1/1/92, however, these licenses would be unlimited in number. MTA and Rep. Pavlovich wanted amendment to provide that the present 130 outlets could not be exceeded, nor could there be any more in a town than the present number of state stores.

Holders of all beverage licenses could also hold package store license. Licensees would purchase directly from Helena warehouse at wholesale; freight would be equalized; payment would be made within 10 days after shipment. State excise tax would be flat rate of $1.80/liter; license tax = 75¢/liter. No changes in the quota or all beverage licensee's right to sell both on- and off-premise. Annual all beverage renewal fees would be increased $100 but licensee would not be required to pay separate $400 annual fee to purchase from warehouse. Licensees could purchase from eachother. In the subcommittee, the bill was further amended to provide $50,000 in severance pay for liquor store employees who would lose their jobs, and these workers would be entitled to a lifetime absolute preference to be hired for any state job for which they were qualified. Rep. Simon strongly opposed this. STATUS: Tabled in House Business & Economic Development Committee.

HB654 (Russell) WARNING SIGNS - ALCOHOL/PREGNANCY

This was a bill similar to the one supported by MADD and the Surgeon General, requiring a warning sign to be posted in any establishment licensed to sell alcoholic beverages, stating "Drinking alcohol during pregnancy may result in retardation or birth defects in your unborn baby." Excluded were special events (fairs, sports events, etc.), nonprofit arts organization functions, and common carriers. MTA opposed in House Public Health, but bill came out and passed through 3rd Reading. At the hearing in Senate Public Health, MTA again opposed, bringing in testimony from DISCUS and NLBA. STATUS: Died in committee.

HB743 (Gould) SALE OF FORTIFIED WINES BY DISTRIBUTORS

Would have allowed beer/wine distributors to market fortified wines as table wines are now marketed, and create franchise territorial rights. MTA opposed distributors getting the higher percentage wines for sale in grocery stores, contending that their next step would be to acquire marketing of liquor. MTA produced testimony from other states that have allowed the 24% wines to be sold in grocery stores, and the social and control problems this has created (blocking off sales in areas where itinerants and winos gather, for example). Bill tabled in House Business; subsequently amended to create no more than 8 to 10 off-premise wine shops in the state; excluded supermarkets and convenient stores in an effort to get it off the table. MTA again offered opposition. STATUS: Bill tabled.

SB348 (Nathe) WAGE PROTECTION ACT EXCLUSION

A person who owns or operates a restaurant, bar or tavern, is exempt from including wages paid to members of his immediate family when filing a bond under the Wage Protection Act. "Immediate family" means spouse, parents, children, grandchildren, brothers or sisters of the person operating the business. MTA strongly supported. STATUS: Governor signed.

SB263 (Hofman) PROHIBIT CERTAIN SEXUAL CONDUCT IN BARS

This was one of three anti-pornography bills introduced by Hofman. It explicitly described certain sexual acts or displays that would be prohibited only in on-premise consumption establishments. MTA argued that the bill was unconstitutional, but offered amendments that would, if passed, have made these acts/displays illegal in all premises open to the public. The Senate passed the bill out without amendments but when it got to House Judiciary, it was rejected by a subcommittee and confirmed by the full committee because they also believed it to be unconstitutional. Proponents admitted that the only way banning of the acts could be enforced is by attachment to an on-premise alcoholic beverage license. STATUS: Tabled in House Judiciary.

TAXES/FEES

HB202 (Pavlovich) INCREASE CIGARETTE TAX

Final version reduced tax from 5¢ to 2¢ to pay costs of a study conducted by the Dept. of Military Affairs in considering locations for the construction of a state nursing or domiciliary home for veterans; provide revenue for construction and remodeling costs of such facilities. STATUS: To Governor

HB 266 (Bradley) INCREASE CIGARETTE TAX 1¢/PACKAGE

Revenues would have been earmarked for cancer and other health research awards. STATUS: Tabled in House Taxation.

HB269 (Koehnke) AMEND CONSTITUTION TO ESTABLISH RESTRICTIONS ON SALES TAX

No general statewide sales tax could be enacted unless approved by the voters; could not be increased or expanded without 2/3 vote of the legislature or approved by the voters. No local option sales tax could be adopted, increased or expanded without being provided for by law, authorized by the local government, and approved by the voters. House adopted floor amendment to delete local sales tax restrictions. STATUS: Amended bill killed on 2nd reading (42-55)

HB343 (S. J. Hansen) INCREASE FEES FOR FOOD ESTABLISHMENTS

Included food served in drinking establishments that is prepared by microwave or broiler ovens. Increase in fee from $30 to $50 if you conduct business under more than one of numerous categories. Revenue was to give more money for local health inspection. STATUS: Killed on 2nd reading in House.

HB747 (Bradley) 4% GENERAL SALES TAX

Would have been put to a vote of the people in a special June 13th election. The tax would generate $284 million, with $128 million for education, $60 million for property tax reduction, $36 million for rebates to low-income taxpayers, $41 million to the general fund, $20 million to local governments to replace lost property taxes. MTA offered testimony as to the failure of the bill to exclude alcoholic beverages; argued that liquor alone bears 56%+ of the entire cost in taxes and if gasoline was to be excluded because it already was heavily taxed, alcoholic beverages also should be. STATUS: Tabled in House Taxation.

HB762 (S. J. Hansen) TAX BEER & TABLE WINE

Would have imposed a tax of 5¢/bottle and can of beer, and 5¢/bottle of table wine to increase funding for children's trust fund; money to be used for services and activities relating to prevention of child abuse, day care programs, early intervention, etc. Rep. Hansen discovered that 5¢ would bring in something like $10 million (their present budget is $40,000) so she reduced it to 1¢ and made a few more amendments at the hearing. MTA offered testimony in opposition. Kevin Tipton, DISCUS, joined MTA. STATUS: Tabled in House Taxation.

HB779 (Janet Moore) 4% LUXURY TAX ON DRINKS, ETC.

Very similar to the World War II luxury tax. Would tax everything from drinks and electronic games to jewelry, campers, new and used cars, motor homes, souvenirs, admissions to any recreational or entertainment activity held for profit, plus more. Sponsor Moore was open to amendments but there was no support from the committee or interest groups. MTA joined the State Chamber and others in opposition. Estimated tax revenue $45.6 million annually. STATUS: Tabled in House Taxation.

TAXES/FEES (Cont'd)

HB479 (Addy) LOCAL OPTION TAXES

Originally would have allowed local governments to impose tax on income, all goods and services, and any other type of tax not prohibited by law. Bill then amended to include a 2% tax only on taverns that sell alcoholic beverages for on-premise consumption, restaurants, ski resorts and other recreational facilities, entertainment and sporting events except those conducted by nonprofit organizations. MTA strongly opposed. STATUS: Killed in House, 2nd Reading (45-53). Here's how your House member voted:

FOR: Addy, Bachini, Bardanouve, Blotkamp, Bradley, Brooke, J. Brown, Cocchiarella, Cohen, Compton, Connelly, Daily, Darko, DeBruycker, DeMars, Gilbert, Stella Jean Hansen, Harrington, Hayne, Hoffman, Iverson, Kadas, Kilpatrick, Kimberley, Koehnke, Lee, McDonough, Moore, L. Nelson, R. Nelson, T. Nelson, O'Keefe, Peck, Raney, Ream, Rice, Russell, Schye, Spaeth, Spring, Squires, Stang, Stickney, Strizich, Vincent (45)

AGAINST: Aafedt, Boharski, D. Brown, Campbell, Clark, Cobb, Cody, Davis, Elliott, Ellison, Eudaily, Gervais, Giacometto, Glaser, Good, Gould, Grady, McCormick, Menahan, Mercer, Nisbet, O'Connell, Owens, Patterson, Pavlovich, Peterson, Phillips, Quilici, Ramirez, Rehberg, Roth, Simon, Simpkins, Smith, Steppler, Swift, Swysgood, Thoft, Thomas, Wallin, Westlake, Whalen, Wyatt, Zook (53).

ABSENT: Driscoll EXCUSED: Grinde

SB462 (Eck) 4% EXCISE TAX ON DRINKS, MEALS, ENTERTAINMENT

Sponsor called this an "entertainment tax" that would bring in about $45 million over the next two years, and would give the legislature something to"fall back on". The 4% would have been imposed on all drinks sold for on-premise consumption, restaurant meals (including take-outs) admissions to entertainment functions, video cassette and car rentals, etc. MTA strongly opposed and was joined by Kevin Tipton, representing DISCUS. Money actually was earmarked for the University system. STATUS: Tabled in Senate Taxation.

SB323 (Vaughn) PENALTY FOR LATE PAYMENT OF FOOD LICENSE

Annual fee for food establishments remains at $30; penalty for payment after renewal date = $25. STATUS: Governor signed.

SB469 (Crippen) 4% GENERAL SALES TAX

MTA offered testimony similar to that submitted on HB747, Bradley's general sales tax bill. Passed the Senate. STATUS: Tabled in House Taxation.

LABOR

HB28 (Harrington) MINIMUM WAGE

Effective 1/1/90. Minimum wage to be set by the Labor Commissioner in accordance with federal law, but not to exceed $4/hour. New-hire wage: at least $3.35/hr. for no more than 120 days after hire. An employee may not be displaced by another employee (including partial displacement, such as a reduction in hours of nonovertime work, wages, or employment benefits) for the purpose of allowing the employer to pay the $3.35 minimum wage. STATUS: To Governor.

HB49 (Cohen) MINIMUM WAGE

Would have increased minimum wage to $4.35/hr. and excluded employees who are high school pupils under 18 and reside with parent or guardian. STATUS: Tabled in House Labor.

HB370 (Cocchiarella) INCREASE IN STATE MEAL ALLOWANCE

Would have allowed state employees, officials, board members, etc., an increase to $17.50 from $15.00 for meals while traveling in-state. MTA's interest was because many state employees are customers of our members who serve meals. STATUS: Passed both House and Senate but was vetoed by the Governor because it would cost $300,000/year additional.

SB 95 (Rasmussen) INCREASE STATE TRAVEL ALLOWANCE

Increased lodging to $27/day (from present $24) for state employees, appointees, etc. (Increase in meal allowance in HB370 was vetoed.) STATUS: To Governor

SB234 (Boylan) INCLUDE TIPS IN MINIMUM WAGE

Would have allowed employers to deduct from minimum wage paid employees if employee continuously received $30 or more each month in tips. STATUS: Killed in Senate Labor Committee.

MISCELLANEOUS BILLS

HB247 (Whalen) RATEMAKING FOR VOLATILE & NONCOMPETITIVE INSURANCE

MTA's support of this bill was requested by the sponsor because of our industry's problems in getting affordable rates on liability coverage. It's purpose is to ensure that rates are based as much as possible on claims resulting from exposures in Montana and similar states so they are not excessive, unfairly discriminatory, or inadequate. MTA offered testimony that rates should be based on Montana's experience, not a national norm, since claims from urban areas are generally responsible for driving up the cost of coverage. STATUS: Signed by Governor.

SB312 (Pinsonneault) CONSTITUTIONAL AMENDMENT - TORT REFORM

An attempt to put the issue originally passed in 1986 as CI-30 to allow the legislature to enact tort reform measures. CI-30 was subsequently declared invalid by the supreme court because of a printing error in the voter information pamphlet. This would have put it back on the ballot without having to go through the initiative process again. Bill strongly opposed by trial lawyers and labor. MTA offered testimony in support. STATUS: Passed the Senate; tabled by House Judiciary.

COMPLETE ALL BOXES!

GAMING MACHINE APPLICATION

FOR OFFICE USE ONLY

$100.00
Check # _____

Decal # _____

Refund $ _____

What Type of Machine Is This?

POKER ☐ KENO ☐ BINGO ☐

HAS THIS MACHINE BEEN LICENSED BEFORE?

☐ YES ☐ NO

IF THIS MACHINE HAS NOT BEEN PREVIOUSLY LICENSED, READ NEWSLETTER!!

— —
LIQUOR LICENSE # (9 digits) or
HAVE LOCAL LICENSE FORM COMPLETED

Establishment Name

Licensee: Actual Holder of License

Box/Mailing Address

Location Address

City

Zip Code

Is establishment in an incorporated city?

☐ Yes, inside city limits — City Name

☐ No, outside city limits — County Name

BE SURE!! THIS IS VERY IMPORTANT!!!

RETURN TO:

VIDEO GAMING CONTROL BUREAU
1125 MISSOULA AVENUE
HELENA, MT 59620

PHONE: 442-7325

MACHINE INFORMATION:
(See I.D. plate on the side of the machine)

MFG's Serial # of Machine

MFG of Machine

Machine Model #

METER READINGS: If you are licensing an approved game, you must staple a correctly programmed audit ticket to the back of this sheet.

BILL ACCEPTOR

CREDITS IN

CREDITS PLAYED

CREDITS AWARDED

CREDITS PAID

MACHINE OWNERSHIP: *(check one)*

☐ Owned by Establishment

☐ Owned by Vendor/Distributor

Give the vendor's license number.

I hereby agree to comply with all statutory and regulatory requirements. I declare with knowledge of the penalties for false swearing that this application is true and accurate. I, THE LICENSEE AM LEGALLY RESPONSIBLE FOR THIS MACHINE.

SIGNATURE of Licensee

— — Social Security #

Federal I.D. #

STAPLE $100.00 PAYMENT HERE

PRINT Name of Person Signing

Establishment Phone #

State law requires an applicant of a video draw poker machine to disclose any past history or involvement with gaming. Cover the period from 1975 or from the age of 18, whichever is shorter. If you answer yes to any of the following questions, provide detailed information. ONLY ONE STATEMENT IS NECESSARY FOR EACH ESTABLISHMENT. INFORMATION WILL REMAIN CONFIDENTIAL.

A) Have you ever had control of gambling device(s) as an owner or operator in another establishment within the state of Montana?

☐ YES
☐ NO

1) Date:
2) Types of devices:
(manufacturer, model, game etc.)
3) Location:
(city/address)

B) Have you ever been employed by an owner or operator of gambling devices?

☐ YES
☐ NO

1) Date Employed:
2) Types of Devices:
3) Employer:
(name/address)

C) Have you ever been employed in another establishment where gambling was offered to the public?

☐ YES
☐ NO

1) Date Employed:
2) Types of Gaming:
3) Employer:
(name/address)

D) Have you ever had any convictions of local ordinances or state laws in any states that are related to gambling within the last 10 years.

☐ YES
☐ NO

1) Date of Offense:
2) Date of Conviction
3) Location of Offense:
4) Nature of Offense:
5) Penalties Imposed:

		— —
SIGNATURE of Licensee	PRINT Name of Person Signing	Social Security #

DISC/89

PROOF OF LOCAL LICENSURE
Required for Video Keno/Bingo Machines

We, _____, have licensed _____ for the
(City/County Name) (Establishment Name)

operation of Video Keno/Bingo machines. This license will expire on _____.

_____
Local Licensing Official Signature

_____

_____

NOTARY SEAL

LL/89

DATE: _____

PROCESSED:	_____ YES
	_____ NO
SENT TO INV:	_____ YES
DATE SENT:	_____

TO: VIDEO GAMING CONTROL BUREAU
1125 MISSOULA AVENUE
HELENA, MONTANA 59620

RE: "WITHDRAWAL" OF DECAL REQUEST

FROM: #_____ (LIQ. LIC. #)

_____ (ESTABLISHMENT NAME)

_____ (LICENSEE NAME)

#_____ (MACHINE SERIAL #)

_____ (POKER/KENO/BINGO)

#_____ (DECAL #)

I, _____, the licensee of the (Print Name of Licensee)
establishment, request and authorize the withdrawal of the above referenced video gaming machine from my establishment.
Date of withdrawal is: _____

Final mechanical meter readings are: STAPLE

__/__/__/__/__/__/ -- Bill Acceptor AUDIT
__/__/__/__/__/__/ -- Credits In
__/__/__/__/__/__/ -- Credits Played TICKET
__/__/__/__/__/__/ -- Credits Won
__/__/__/__/__/__/ -- Credits Paid HERE!!!!!!!!!!

I understand that I, the licensee, am responsible and accountable for the filing of the quarter net income tax report on this machine. Report is due and tax payable from this machines activity up to the date of withdrawal.

_____ _____ _____
PRINT Name of Licensee SIGNATURE of Licensee Date
If Corporate Licensee - officer signature required.

STAPLE
DECAL
HERE!!!!!!!!!!!!!

DECAL # MUST BE READABLE

Check here if you want an investigator to destroy the decal.....

☐ YES***
I want an investigator to destroy the decal.

LOW/89

CORRECTION

THIS DOCUMENT
HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY

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A) Have you ever had control of gambling device(s) as an owner or operator in another establishment within the state of Montana?

☐ YES
☐ NO

1) Date:
2) Types of devices:
(manufacturer, model, game etc.)
3) Location:
(city/address)

B) Have you ever been employed by an owner or operator of gambling devices?

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☐ NO

1) Date Employed:
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3) Employer:
(name/address)

C) Have you ever been employed in another establishment where gambling was offered to the public?

☐ YES
☐ NO

1) Date Employed:
2) Types of Gaming:
3) Employer:
(name/address)

D) Have you ever had any convictions of local ordinances or state laws in any states that are related to gambling within the last 10 years.

☐ YES
☐ NO

1) Date of Offense:
2) Date of Conviction
3) Location of Offense:
4) Nature of Offense:
5) Penalties Imposed:

		_ _
SIGNATURE of Licensee	PRINT Name of Person Signing	Social Security #

DISC/89

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Required for Video Keno/Bingo Machines

We, _____ _____, have licensed _____ for the
(City/County Name) (Establishment Name)

operation of Video Keno/Bingo machines. This license will expire on _____.

_____
Local Licensing Official Signature

_____

_____

NOTARY SEAL

LL/89

ESTABLISHMENT OWNER INFORMATION:

1) Serial number of machine:

2) Manufacturer of machine:

3) Please specifically identify the name of the game in which the machine plays.
(i.e. Showdown Poker, Montana Keno etc.)

4) On what date did you acquire this machine?
Month
Day
Year

5) From whom did you acquire this machine?
Name
Address

MACHINE OWNER INFORMATION:

6) Submit written proof of ownership stating that the machine was in Montana prior to June 30, 1987. (Use: checks, city/county licenses, invoices, bills of sale, etc.) If no documentation is available, provide a written statement that tells when the machine was purchased, who from, price paid, and where the machine has been in operation since you acquired it.

Limitations on the amount of money played and value of prizes:
By law each keno/bingo machine may not allow more than $2.00 to be played on a game or award free games or credits in excess of the value of $100.00 per hand.

7) Does this machine meet the above requirements?

☐ YES ☐ NO

SIGNATURE of Licensee

Social Security # ___ ___

PRINT Name of Person Signing

PHONE #

DATE

ACQ/89

DATE: _____

PROCESSED:	_____	YES
	_____	NO
SENT TO INV:	_____	YES
DATE SENT:	_____	

TO: VIDEO GAMING CONTROL BUREAU
1125 MISSOULA AVENUE
HELENA, MONTANA 59620

RE: "WITHDRAWAL" OF DECAL REQUEST

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__/__/__/__/__/__/	-- Credits In	
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__/__/__/__/__/__/	-- Credits Won	
__/__/__/__/__/__/	-- Credits Paid	HERE!!!!!!!!!!

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_____ _____ _____
PRINT Name of Licensee SIGNATURE of Licensee Date
If Corporate Licensee - officer signature required.

STAPLE
DECAL
HERE!!!!!!!!!!!!!

DECAL # MUST BE READABLE

Check here if you want an investigator to destroy the decal.....

☐ YES***
I want an investigator to destroy the decal.

LOW/89