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Senate Counsel, Research, and Fiscal Analysis

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Jo Anne Zoff Sellner
Director

Senate

State of Minnesota

TO: Members of the Senate Health and Human Services Budget Division

FROM: David Giel, Senate Research (296-7178)

DATE: February 25, 2005

SUBJECT: Questions Regarding the Consumer-Directed Community Supports (CDCS) Option

This is in response to questions that were raised during public testimony at a recent Division meeting regarding the changes occurring in the Consumer-Directed Community Supports (CDCS) option.

Background. CDCS is a service option for recipients of Medical Assistance home and community-based waivered services. It has been available since 1998. CDCS gives recipients more flexibility and responsibility, within a budgeted amount, to plan and direct their service package, including hiring and managing their direct service providers.

Prior to October 1, 2004, CDCS was only available to recipients of services under the Mental Retardation or Related Conditions (MR/RC) waiver and only to recipients of that waiver residing in one of the 37 Minnesota counties that provided the option. In March 2004, the Department of Human Services received necessary federal approval to modify the CDCS option. DHS proposed to make CDCS available statewide in all of the waivered services programs. DHS also proposed, and was given approval for a number of other program modifications, including:

- limiting CDCS to recipients living at home;
- setting a maximum budget amount of 70 percent of average costs for non-CDCS recipients with comparable conditions and service needs; and
- prohibiting the purchase of certain items, including membership dues, pet-related expenses, tickets to sporting events, etc.

The first phase of this expansion involves implementing CDCS, in the 37 counties currently offering this option in the MR/RC waiver, across all of the other waiver programs – Community Alternative Care (CAC), Community Alternatives for Disabled Individuals (CADI), Traumatic Brain Injury (TBI), and Elderly Waiver (EW), and in Minnesota Disability Health Options

(MnDHO), and Minnesota Senior Health Options (MSHO) programs. As part of that expansion, the new budgeting methodology is being implemented.

The second phase of the expansion, which is scheduled to occur prior to April 1, 2005, will make CDCS available in all waiver programs in the other 50 Minnesota counties.

Legal Authority for Changes. The 2001 Legislature directed DHS to take the following actions:

- seek federal approval to expand the CDCS option statewide within the MR/RC waiver (Minnesota Statutes, section 256B.0916, subdivision 6a); and

- establish a common service menu for all recipients in the various waiver programs (section 256B.49, subdivision 16, paragraph (b)).

The reason stated by DHS for capping CDCS budgets at 70 percent is that "1) we have not been given 'more money' to be able to offer the CDCS option to more people and we wanted to make certain that counties have enough money in their county waiver budgets to meet the needs of waiver recipients not using CDCS who may have extremely high levels of disability and less family support; and 2) we have provided an alternative under the waiver for people who cannot get their needs met within the assigned budget."

One incentive to adopt budgetary limits for CDCS was an apparent lack of sufficient oversight with respect to client budgets. A February 2004 report by the Legislative Auditor criticized the lack of sufficient DHS controls over spending in the CDCS option, including the use of funds to pay for "cell phones, playground equipment, Internet connectivity fees, tax preparation costs, and various community activities such as museum memberships, tickets to Minnesota Wild hockey games, and annual passes to Camp Snoopy at the Mall of America." According to DHS, families of consumers, county agencies, and advocates were also expressing concerns about the program.

Impact on Current Clients. According to DHS data, as of October 28, 2004, 2,386 persons were receiving CDCS services under the MR/RC waiver. Of that number, 1,054 persons, or 44 percent of the caseload, were more than 15 percent over their budget cap; 268 persons, or 11 percent of the caseload, were over their cap by less than 15 percent; 251 persons, or ten percent of the caseload, were under their cap by less than 15 percent; and 813 persons, or 34 percent, were under their cap by more than 15 percent. Clients have one service plan year to reduce their budget to get within the cap. Reductions will begin taking effect On October 1, 2005, and must be completely implemented by April 1, 2006. Clients who are under the budget cap will have the opportunity to increase their services as appropriate.

According to DHS, these numbers exclude 252 former CDCS clients who were determined to be residing in an institutional setting, generally foster care. Those persons are not eligible for CDCS and most have since left CDCS and are receiving services under other available programs.

DG:rdr

Senators Kubly; Vickerman; Neuville; Johnson, D.E. and Marty introduced--
S.F. No. 930: Referred to the Committee on Agriculture, Veterans and Gaming.

A bill for an act

relating to gambling; appropriating money for compulsive gambling prevention and education.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. [APPROPRIATION.]

$150,000 in fiscal year 2006 and $150,000 in fiscal year 2007 are appropriated from the lottery prize fund to the commissioner of human services for a grant to the Northstar Problem Gambling Alliance, located in Arlington, Minnesota. The Northstar Problem Gambling Alliance must provide services to increase public awareness of problem gambling, education and training for individuals and organizations providing effective treatment services to problem gamblers and their families, and research relating to problem gambling. Of this appropriation, $75,000 in each year of the biennium is contingent on the demonstration of nonstate matching funds. Matching funds may be either cash or qualifying in kind. The commissioner of finance may disburse the state portion of the matching funds in increments of $37,500 upon receipt of a commitment for an equal amount of matching nonstate funds.

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DIRECTOR

Senate

State of Minnesota

S.F. No. 930 - Appropriating Money for Compulsive Gambling Prevention and Education

Author: Senator Gary Kubly

Prepared by: Joan White, Senate Counsel (651/296-3814)

Date: March 2, 2005

S.F. No. 930 appropriations $150,000 for each year of the biennium from the lottery prize fund to the Commissioner of Human Services for a grant to the Northstar Problem Gambling Alliance (Alliance) in Arlington, Minnesota. The Alliance is required to provide services to increase public awareness of problem gambling, education and training to provide effective treatment services, and research related to problem gambling. $75,000 per year is contingent on nonstate matching funds, either cash or in-kind funds. The Commissioner of Finance may disburse the state portion in increments of $37,500 upon receipt of a commitment for an equal amount of matching nonstate funds.

JW:rdr

Northstar Alliance

Northstar Problem Gambling Alliance, Inc.
T. Lance Holthusen, Executive Director
Box 555
Arlington, MN 55307

Phone: 507-964-5184 **Fax: 507-964-2950**
Cell: 612-756-1945 **E-mail:** npga@frontiernet.net

'ate of Minnesota Problem Gambling Helpline
1-800-333-HOPE

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The Northstar Problem Gambling Alliance, Inc.

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FOR YOUR INFORMATION:
NORTHSTAR PROBLEM GAMBLING ALLIANCE, INC.

The Northstar Problem Gambling Alliance, Inc., a non profit organization, came into being as a result of a concern that there was not an independent entity, representing *at the same table,* the concerns of all of the stakeholders and gatekeepers in the arena of problem gambling in the State of Minnesota and this Region.

Stakeholders are defined as those who have a vested interest in gambling, including all of the gambling venues such as The Minnesota State Lottery, The Minnesota Indian Gaming Association, the independent tribal communities, Allied Charities of Minnesota, and Canterbury Park, as well as the recovering compulsive gambler, and those affected by problem gambling, such as families and friends, retail finance and banking, the judicial system, and information transfer systems.

Gatekeepers are defined as those who provide a door to recovery or other appropriate help, such as researchers who help to provide reality regarding the issue of problem gambling, school counselors, clergy, physicians and nurses, county social workers, and residential and out patient treatment providers.

Despite our sometimes conflicting missions we all share one commonality, the belief that *problem* gambling is a serious public health issue, and that it is both treatable and preventable. There is help and there is hope.

Our **mission** is to:

1. Increase public awareness
2. Promote the widespread availability of treatment for problem gamblers and their families, and
3. Encourage education, research and prevention.

We are emphatically *neutral* on gambling policy, though we will advocate in public forums for programs that benefit problem gamblers and those affected by problem gambling. Our mission can be summarized that we serve the problem gambler and those affected by problem gambling.

The Northstar Alliance cooperates with the National Council on Problem Gambling and the State of Minnesota DHS Compulsive Gambling Program. We commend their initiatives in the problem gambling area and seek continuing support and collaboration with their efforts in whatever way appropriate.

The Northstar Alliance is a 501(c)(3) non-profit corporation (Federal tax ID number:920185978) and contributions are tax-deductible to the extent allowable by law. Northstar Alliance will not accept any restrictions on the use of funds except as required under State and Federal non-profit guidelines.

Legislative Arguments
2005 - 2006

- **The Northstar Problem Gambling Alliance, Inc.** is a private non-profit **gambling neutral** entity that, as a non-governmental entity, can do some things that government can't. For example:

  We bring together **all** of the diverse parties involved in gambling, -all of the gambling venues in the State of Minnesota including The Minnesota State Lottery, Canterbury Park, Allied Charities of Minnesota, The Minnesota Indian Gaming Association and the Independent Tribal Nations, and other **stakeholders** such as residential treatment providers, out-patient providers, financial service providers, lawyers, academic and practical research, and recovering persons, - and **gatekeepers** such as clergy, school counselors, teachers, and probation officers, - to the same table, which is **gambling neutral** by definition, to address our primary mission which is ***concern, advocacy and support for the problem gambler and those affected by problem gambling***. No other agency has been able to bring this diverse group together.

- We produce a quality newsletter called the ***Northstar Roundtable*** which is available to all stakeholders, gatekeepers, providers of services, legislators and other policy makers, and related agencies. We initiated this important effort because the State of Minnesota DHS Compulsive Gambling Advisory Committee and program eliminated this much needed professional and public information venue.

- When DHS dropped the Annual Problem Gambling Awareness Week Conference for providers, stakeholders, gatekeepers and all other interested parties, a very important statewide event held in conjunction with the National Council on Problem Gambling's National Awareness Week, we picked that up as well in 2003. (See our brochures for the 2003, 2004, and 2005 Minnesota Problem Gambling Awareness Week Conferences.)

- We are working with the Inter Faith Community in developing training programs and other ways that local faith communities can help their own effectively deal with the problem gambler and families and others affected by problem gambling. This includes participation by **all** faith systems. No other profession has such immediate and broad exposure to Minnesotans. However, clergy and other religious professionals are not trained, at this point, to see, listen for, or recognize problem gambling issues.

- Two other action committees are The Financial Services Industry Committee and The Judiciary/Legal Services Committee. Both of these committees involved research, white papers, and practical "what do we need to know" brochures for providers of services, clients and customers.

- We would like to begin a more aggressive program of research for the State of Minnesota. As is painfully clear, we lack good information and research regarding all aspects of gambling and co-existing mental illness disorders. Part of the reason is that gambling has only been given appropriate attention in the last decade, in contrast to drugs and alcohol addiction, which has close to a century of research.

- We have been chosen by the **National Council on Problem Gambling** in Washington, D.C. to be its official **Minnesota Affiliate.**

- **Why and how would the funds be used?** The State, itself, is directly and significantly involved in the gaming industry. The funds would be matched dollar for dollar with non-state funds, and used for:

  Operating expenses **Research start up funds** **Expand newsletter to be**
  Fact sheets **Public information** **"online". Create website**
  Brochures for specific audiences **Training for stakeholders, gatekeepers and providers**

Problem Gambling's Impact on Family and Others

April 1st, 2005 at Gloria Dei Lutheran Church, St. Paul, MN

A Training Conference Sponsored by
The Northstar Problem Gambling Alliance, Inc.
Northstar is the Minnesota Affiliate of the National Council on Problem Gambling, Washington, DC

Co- Sponsored by:
Canterbury Park Minnesota Fund and Minnesota State Lottery
With
Lutheran Social Service of Minnesota, Project Turnabout-Vanguard, New Wave Training, and Lake Superior Area Family Services

(Tentative) Agenda

Moderator: T. Lance Holthusen, Executive Director NPGA

8:00 – 8:30 AM: Registration and Continental Breakfast.

8:30 – 8:45 AM: Welcome, Overview and Opening Remarks.
Sponsor's Welcome: Randy Sampson, President of Canterbury Park

8:45 – 9:30 AM: *One Family's Saga.* Speaker: Nancy Dahlin-Teich, BSW, Social Service Supervisor, Isanti County Family Services, Cambridge, MN.

9:30 – 10:30 AM: *How Problem Gambling Impacts Families.* Lisa Vig, LAC and NCGC, Director, and Dawn Cronin, LSW and NCGC, both of gambler's Choice, a program of Lutheran Social Service of North Dakota.

10:30 – 10:45 AM: Break and Refreshments.

10:45 – 11:45 AM: Panel: *Treatment and Recovery Services for Families, Friends, and Others.* Moderator: Steve Dettinger, Executive Director, Lake Superior Area Family Services.
Panel: Greg Anderson,LP MSW, Senior Therapist, Lake Superior Area Family Services, Duluth, MN.
Greg Robertson, MSW, Fairview Recovery Services, Minneapolis, MN.
Kelly Reynolds, MA, L.I.C.S.W., Director, Minnesota Problem Gambling Helpline Roseville, MN.
Sandy Brustuen, Project Turnabout-Vanguard, Granite Falls, MN.

11:45 – 12:15 PM *Update on Gambling Research and Youth Gambling in Minnesota, Part 1: Gambling Treatment Outcomes Monitoring system,* Randy Stinchfield, Ph.D., Dept. of Psychiatry, University of Minnesota Medical School.

12:15 – 12:45 PM: Lunch Break

Sponsor's Welcome: Clint Harris, Executive Director, Minnesota State Lottery

12:45 – 1:15 PM: Randy Stinchfield, Ph.D., Part 2: *2004 Student Survey.*

1:15 – 2:15 PM: *What About a Minnesota Gambling Court?* Speakers: The Honorable Gary Larson, Ass't Chief Judge of Hennepin County and Presiding Judge of Hennepin County Drug Court; Marjorie Rapp, Attorney, Bridgeport Family Law, St. Paul and Mantorville, MN.

2:15 – 3:15 PM: Panel(Those in recovery and/or affected by problem gambling): *How Effective Are Present Treatment and Counseling Services In Minnesota?*
Moderator: Kathleen Porter, Program Manager, State of MN DHS Compulsive Gambling Program.
Panel: Mike J. (Panel includes recovering persons and affected persons.)
Mary S.
Nancy D.
Len P.

3:15 – 3:30 PM: Short Break and Refreshments.

3:30 – 4:30 PM: Panel: *Financial Impact of Problem Gambling On Families and the Road Back.*
Moderator: Don Feeney, Director of Research and Planning, MN State Lottery
Panel: Todd Sipe, Executive Vice President Greater MN Bremer Bank.
Susan Aulie, Senior Director Financial Services LSS MN, Duluth.
Others

4:30 – 4:45 PM: Closing Remarks, Evaluation and Adjourn.

CEUs Applied for with the following:
MN Bd. of Social Work
MN Bd. of Psychology
MN Bd. of Marriage and Family Therapy
MN Bd. of Pharmacy
MN Bd. Of Legal Education

Registration Form

3rd Annual Minnesota Problem Gambling Awareness Conference:

Problem Gambling's Impact on Family and Others

April 1st, 2005 at Gloria Dei Lutheran Church

700 S. Snelling Avenue, St. Paul, MN

Registration Deadline is March 23rd, 2005

Name_____

Organization_____

Address_____

City_____**State:**_____**Zip:**_____

Phone:_____**E-Mail:**_____

Mail form and payment to:
Northstar Alliance
Box 555
Arlington, MN 55307
(Checks payable to Northstar Alliance)

___I am a member of the Northstar Alliance. Enclose is my check for $75.00.

___I'd like to join. Enclosed is my check for $75.00 plus_____ for my chosen level of membership:
___$35 ___$100 ___$250 ___$500
(Add membership in the National Council for just $35.00 more.)

___Enclosed is my check for $110.00 Registration as a non-member.

Questions: 1-507-964-5184
E-Mail: npga@frontiernet.net

The following is information that should be in a separate boxes someplace in the brochure:

NEW WAVE TRAINING
2005 SCHEDULE:

One Day Training: May 6 in Duluth, Sept. 30 in Minneapolis

60 Hour Training: "Working With the Compulsive Gambler"
May 9-14, also in Minneapolis

Courses approved by the American Council on Compulsive Gambling and The MN Dept. of Human Services Fee-For-Service Program.

For More Information Contact: Judy Gaskill, New Wave Training, 6915 Three Lakes Road, Canyon, MN 55717 E-Mail:bgaskill@cpinternet.com
Or call:1-218-345-8042.

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Northstar Alliance is emphatically *neutral* on gambling policy, though we will advocate in public forums for programs that benefit problem gamblers and those affected by problem gambling. *Our mission can be summarized that we serve the problem gambler and those affected by problem gambling.*

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The Northstar Problem Gambling Alliance, Inc.

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PROBLEM GAMBLING: WHAT A GAMBLING MANAGER SHOULD KNOW

Problem gambling: It's a subject nobody likes to talk about, but it's one that can affect your friends, your families, your employees, and your customers. This document is designed to help you understand compulsive gambling, its causes, its effects, and what we can all do about it.

Most Minnesotans gamble, and most do it because it's fun. But sometimes gambling goes beyond the bounds of fun, recreation, or entertainment. This can be an occasional problem, like sometimes betting more than you can really afford, or it can become an addiction. "Problem gambling" refers to the broad range of inappropriate gambling behavior that goes beyond fun and entertainment, while "compulsive" or "pathological" gambling refers to the inability, over an extended period of time, to resist the impulse to gamble. As one compulsive gambler put it, "I couldn't think of one day of life without gambling. Even when I didn't gamble that day, my world revolved around it. And I got so tired and so depressed and so emotionally drained. Everything else had long since disappeared from my life – relationships, friendships, everything."

Compulsive gambling, in many ways, is similar to alcohol or drug dependence, even though no substance is ingested. It is one of a wide range of activities that can lead to addictive behavior, including sex, food, and even shopping. Indeed, as stated by noted gambling researcher Dr. Peter Collins, "Anything that gives pleasure is potentially addictive."

Fortunately, it's a rare condition. Estimates on the number of compulsive gamblers differ, but most recent studies in the U.S. place the rate at less than 1 percent of the adult population. Nevertheless, that number is not zero, and if you or someone you know is one of the unfortunate few, the consequences can be devastating. Pathological gamblers can lose their jobs, their families, and even, through suicide, their lives.

What are the signs of problem gambling?

Problem gambling is an invisible affliction. You can't smell a slot machine on someone's breath, or see any "tracks" on the gambling addict's arms. Yet as we know, the consequences of a gambling addiction can be every bit as devastating as a chemical one. How, then, can you spot a gambling problem in an employee, a customer, a friend or a relative?

Spending a lot of money on gambling does not, by itself, make one a compulsive gambler. Gambling, for most people, is a hobby, and like any hobby some pursue it with more interest than others. If they stay within preset limits, don't "chase" their losses, recognize that they are likely to lose, and gamble for fun rather than for money, they likely do not have a problem. Problem gambling is characterized by a loss of control and by continued gambling despite negative consequences.

Nor do compulsive gamblers always fit the stereotype of the middle-aged white male who "plays the horses." Problem gamblers can be male, female, white, black, Asian, Hispanic, or Native American. They can be 14 years old, 80 years old, or all points in between. They can play the horses, slots, pull-tabs, cards, or the lottery. They can be poor or wealthy. It is a very democratic condition.

The Vanguard Compulsive Gambling Treatment Program of Granite Falls has a list of eight warning signs of a gambling problem. These include:

- ✓ Looking for the "high" that comes from gambling
- ✓ Increasing isolation from family and friends
- ✓ Declining work performance
- ✓ Neglecting basic needs like money for food and rent
- ✓ Pressuring others for money as financial problems crop up
- ✓ Lying about how money is spent
- ✓ Escaping to other excesses (alcohol, drugs, sleep)
- ✓ Denying there is a problem

It is also important to know that problem drinking and problem gambling are strongly linked. In several studies about 50 percent of problem gamblers were also found to have substance abuse problems. People may have both addictions simultaneously, or switch from one addiction to another.

What can I do?

Recognizing these signs in an employee, customer, friend, or family member is not always easy. Even more difficult is knowing what to do once you suspect the existence of a gambling problem.

The Minnesota Problem Gambling Helpline has produced a video, "What Should I Say? What Can I Do?," that outlines six steps that can help deal with this difficult situation. They are:

1) Assure the person that you care about them.
2) Describe the behavior that is troubling you.
3) Describe how you feel when you see these behaviors.
4) Assure them that you'll listen to what they have to say.
5) Tell them what you want them to do about it.
6) Tell them what you are willing to do to help.

You can't expect this conversation to work the first time; it may have to be repeated many times to have an effect. You must also remember that you are not responsible for their behavior. If the person will not take responsibility for their gambling, you must protect yourself from the consequences. If the person is an employee, you should take steps to protect your finances and your business.

Sometimes even simple actions can be beneficial. Keep a poster or brochure for the Problem Gambling Helpline available and visible. If you see a customer looking at the brochure, encourage them in a non-threatening way, like "that's really good information if you think a friend might have a problem."

The video is available for free loan to Minnesota residents, or it can be purchased for $50. The approach it outlines is also useful for coping with other problems, such as alcohol or eating disorders. Call the Helpline at 1-800-437-3641 for more information.

But what if someone walks up to your pull-tab booth and says, "I have a problem. Where can I get help?"

You're thinking that this will never happen to you. And you're probably right. But it has happened, and if it does, it can be a terrifying moment. In order to cope, you need to have thought about the situation beforehand so that you or your staff have some idea what to do.

First, remember that as hard as it is for you to be confronted with this situation, it's harder for them. Asking for help is a very difficult thing to do. And for that reason, it's important to get them to act now. Next week, tomorrow, or an hour from now they might change their mind. Second, remember that their asking you for help doesn't make you responsible for solving their problem. That's the job of the professionals. Your job is to get them in contact with those professionals as soon as possible.

You should have the brochure for the Problem Gambling Helpline readily available. Get a copy. Give it to them. Explain that they can call this number any time. It will be answered by a trained professional who will talk them through their immediate crisis and help the gambler find the local resources that are best for them. They can also help the family member who needs to know how to cope with the gambler in their life. Offer the use of your phone. Offer to dial the number (1-800-437-3641) for them.

Reassure them that they are not alone. They need to hear that there's hope, that people do recover from gambling problems, and that they can get their lives back. They might ask for money. Don't do it – that's the same as giving a drink to an alcoholic and will just delay their seeking help. If they ask you not to sell them any more pull-tabs or bingo cards, accommodate them. (If you're asked not to sell someone else tickets, such as a spouse, it's a more difficult situation. I can only tell you to use your best judgment based on your knowledge of the individuals.) They might lash out at you for making gambling available. Don't take it personally and don't get defensive. Let them vent. Over the

course of treatment, they will learn that their problem is their responsibility. It is not someone else's fault.

I hope you're never confronted with this situation, but if you are, consider that you've been given a unique opportunity to make a difference in someone's life. You can best do this by getting them to the professionals as quickly as possible.

What resources are available?

We are fortunate in Minnesota to have a wealth of resources available to help the problem gambler or their family. We've already mentioned the Problem Gambling Helpline. This free service is staffed 24 hours a day, 365 days a year. Receiving about 4,000 calls a year, the Helpline's counselors are trained in crisis intervention and can refer callers to a wide range of social services. But the Helpline is not just for crisis situations. It's the place to call if you're a concerned family member wondering what to do, or if you're looking for a poster for a local senior or youth center, or if you are interested in a speaker on problem gambling for a civic club meeting, or if you're just a concerned citizen looking for a brochure or more information.

Many calls to the Helpline result in a referral to a program designed to help those with gambling problems. One commonly used resource is Gamblers Anonymous (GA). This 12-step program currently holds meetings in more than 50 communities around Minnesota. Gam-Anon, a related organization for families and close friends of problem gamblers, has meetings in 15 cities around the state. A list of GA and Gam-Anon meetings can be found on the Internet at http://www.miph.org/gambling/list.html.

For those needing more intensive assistance, there are now more than 50 state-approved treatment programs located throughout the state. These range from individual therapists to general mental health clinics to outpatient programs specializing in gambling to intensive inpatient treatment. There are even programs for populations with unique needs, such as Native Americans, Asians, or senior citizens. The Helpline counselors can help determine which program is the best fit for you or someone you care about.

2nd Annual Conference

Problem Gambling: Cultural Diversity and Co-existing Disorders

Sponsored by Northstar Problem Gambling Alliance

March 12, 2004
Gloria Dei Lutheran Church
700 South Snelling Avenue
St. Paul, MN

A conference providing treatment providers and other professionals an opportunity to discuss the diagnosis and treatment of problem gambling.

The Northstar Alliance thanks the Minnesota Indian Gaming Association for helping to make this conference possible in conjunction with the National Council on Problem Gambling Awareness Week.

GENERAL SESSION SPEAKERS

Earnie Larsen

Earnie has a BA degree in Philosophy from Immaculate Conception in Oconomowoc, Wisconsin, a Masters of Religious Education from Loyola University, Chicago and a Degree in Counseling with accreditation in chemical dependency and family counseling from the University of Minnesota. Earnie has made a video series for treatment centers, has been heard on hundreds of radio stations, and has appeared on television shows including Oprah Winfrey, CNN and the Sally Jessie Raphael show. Earnie created and wrote the initial structure and content of the "Life Management Program," which is used in Australia, England and Ireland, as well as by hundreds of professionals who have been trained to provide Life Management in the United States. As of 2003, Earnie has written approximately 60 books, produced 35 videos, made 15 audio tape albums and more than 20 single audio tapes.

Randy Stinchfield, Ph.D., L.P

Dr. Randy Stinchfield, a Licensed Clinical Psychologist, is the Associate Director of the Center for Adolescent Substance Abuse Research at the University of Minnesota Medical School. He has conducted research in problem gambling with adults and youth for over a decade. Dr. Stinchfield provided testimony to the National Gambling Impact Study Commission and was a contributor to the Committee on the Social and Economic Impact of Pathological Gambling, National Research Council, National Academy of Sciences. Dr. Stinchfield serves on the editorial board for the *Journal of Gambling Studies* and was the recipient of the 2002 National Council on Problem Gambling Research Award.

Harold Wynne, Ph.D.

Dr. Wynne has three decades of experience as a community development practitioner, adult educator and social science researcher. As CEO to three Canadian human development organizations, he has planned and implemented hundreds of social service, adult education and research programs. Dr. Wynne has conducted many seminal gambling and problem gambling studies, and he continues to advise governments, community organizations, and the gaming industry on gambling policy, program and research initiatives. Dr. Wynne lectures and conducts research on gambling topics and he is the co-developer of the widely used Canadian Problem Gambling Index. He holds academic appointments at the University of Alberta and McGill University, and serves as a research advisor to national and international institutions, including the Ontario Problem Gambling Research Centre, International Centre for Youth Gambling Problems and High Risk Behaviours (McGill University); Institute for Research on Pathological Gambling and Related Disorders (Harvard University); and Canadian Centre on Substance Abuse. Dr. Wynne is a co-editor of the International Gambling Studies Journal, and serves on the Editorial Boards of the Journal of Gambling Studies, The WAGER, and eGambling. Dr. Wynne has been recognized for his contributions to the field of gambling studies, and in September 2003, he received the International Excellence Award from the Responsible Gambling Council (Ontario).

Problem Gambling: Cultural Diversity and Co-existing Disorders

Sponsored by Northstar Problem Gambling Alliance

This conference will provide participants an opportunity to:

- Better understand compulsive gambling and co-existing disorders
- Better understand multi-cultural issues and compulsive gambling
- Meet and network with others who work with problem gamblers
- Become more aware of available resources and services

CONFERENCE AGENDA

7:30 Registration/Continental Breakfast

8:00 Welcome and Overview of the Day
Philip J. Kelly, President of the Board, Northstar Problem Gambling Alliance
Opening Prayer/Peace Ceremony, Native American Drum Group

8:20 Cultural Diversity, Co-existing Disorders and Mandates for Treatment
Harold Wynne, Ph.D., Wynne Resources

9:30 Break

9:45 Treatment Imperative: Remembering the Second Stage
Earnie Larsen, E. Larsen Enterprises, Inc.

10:45 Break

11:00 Cultural Diversity and Co-existing Disorders: Treatment Crises or Opportunity
Panel:
Foung Heu, Minnesota Council of Nonprofits (moderator)
Maxine Boswell, White Earth Reservation
Pablo Obregon, Vanguard, Project Turnabout
Sunny Sinh Chanthanouvong, Lao Assistance Center of Minnesota
Efren Maldonado, Chicano Latinos Unidos En Servicio

12:00 Lunch

12:30 Trends in Minnesota Youth Gambling: Cross-cultural Comparisons
Randy Stinchfield, Ph.D., L.P., University of Minnesota Medical School

1:30 Break

1:45 Workshops
- Steps to Change—Does "One Size" Fit All?
  Earnie Larsen, E. Larsen Enterprises, Inc.
- Recovering Gamblers Have an Agenda Too! You Might Be Surprised
  Mary Stream, Mike J.
- Helplines and Hotlines: Is There Help? Is There Hope? Our Experience and How We Fit In
  Kelly Reynolds, Minnesota Institute of Public Health

2:45 Break

3:00 Workshops
- Relating Research to Treatment Programs and Public Awareness
  Harold Wynne, Wynne Resources; Randy Stinchfield, University of Minnesota Medical School
- Recovering Gamblers Have an Agenda Too! You Might Be Surprised
  Mary Stream, Mike J.
- Helplines and Hotlines: Is There Help? Is There Hope? Our Experience and How We Fit In
  Kelly Reynolds, Minnesota Institute of Public Health

4:00 Break

4:15 Are Our Research Needs Related to Cultural Diversity and Co-existing Disorders Being Met? What More is Needed?
Panel:
Harold Wynne, Wynne Resources (moderator)
Sunny Sinh Chanthanouvong, Lao Assistance Center of Minnesota
Donald Feeney, Minnesota State Lottery
Efren Maldonado, Chicanos Latinos Unidos En Servicio
Randy Stinchfield, University of Minnesota Medical School
Sharon Walp, Minnesota Department of Human Services

5:15 Concluding Remarks, Evaluation and Adjournment

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Conference fee $75 ($60 for Northstar Problem Gambling Alliance members). Fee includes lunch and conference materials.

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Session 1: ❒ Steps to Change ❒ Recovering Gamblers ❒ Helplines & Hotlines

Session 2: ❒ Relating Research ❒ Recovering Gamblers ❒ Helplines & Hotlines

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2nd Annual Conference

Problem Gambling: Cultural Diversity and Co-existing Disorders

Sponsored by Northstar Problem Gambling Alliance

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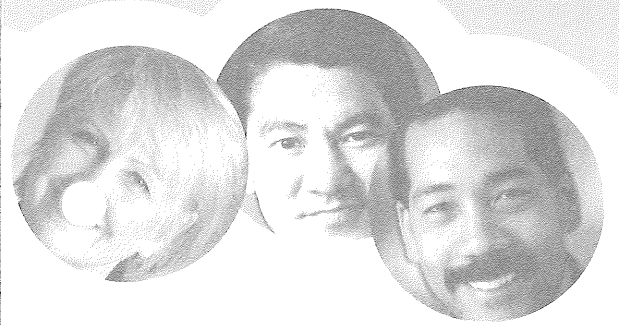

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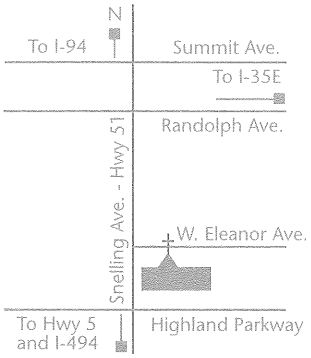

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NORTHSTAR ROUNDTABLE

The Newsletter of the Northstar Problem Gambling Alliance

Volume 2 • Issue 1 Winter 2005

From the Executive Director

Isn't it interesting that some of the best selling Christmas gift items for 2004 were anything related to "Texas Hold'em", chips or other gaming supplies. Surprised store managers mused that they couldn't keep enough of them in stock.

No, this is not going to be a litany of horror stories, bankruptcies or suicides. In this editorial I want to make a simple point: The State of Minnesota needs to catch up.

Our understanding of the harmful impacts of gambling activity, legal and illegal, and the relative amount of research, treatment, money and other resources invested thereto, is where we were with drugs and alcohol in the 1940s and 1950s. With drugs and alcohol, and now even smoking, we have come a very long way. But even there, as the article below suggests, we still have much to learn about all aspects of addiction and compulsive behaviors.

We have a long way to go, particularly in the area of problem gambling .For example, the State of Minnesota budgets about $1.5 Million per year for its Compulsive Gambling Program. It budgets over $100 Million annually for drug and alcohol programs. Is the harm caused by drug and alcohol use in Minnesota, greater than the harm cause by gambling by a factor of 70? We just don't know, and we behave as if we are afraid to even ask the question. We invest very little in research. Funding for treatment is limited to the extent that not only are gambling counselors leaving but fewer and fewer candidates are entering the field.

Inside this issue:

In September some 80 stakeholders, gatekeepers, and others interested in problem gambling issues met to participate in Joel Barker's *Implications Wheel®* process. The results suggest that not only does Minnesota not have adequate funding,

(Continued on page 2)

Addictions: Separate or Syndrome?

The American Psychiatric Association lists pathological gambling as a separate and distinct disorder in the fourth edition of its Diagnostic and Statistical Manual. And indeed gambling addiction has its own treatment specialists, professional journals and societies, and 12 step programs.

A small but growing number of researchers and clinicians, however, believe that gambling and other "excessive behaviors" are symptoms of a broader addiction syndrome, and that advances in treatment and prevention can best result from recognition of what different addictions have in common. At a December 2004 conference, Dr. Howard Shaffer of the Harvard Medical School likened the prevailing view of addictions to the early days of AIDS diagnosis, when physicians treated symptoms, but did not recognize their association with an underlying immune system disorder.

(Continued on page 4)

From the Executive Director

(Continued from page 1)

but that if it continues on its present course it will go backward at an increasingly harmful rate. I have often pondered how helpful it would be if, for every dollar spent on advertising for gambling, an equal amount would be invested on dealing with gambling information, problem prevention, research, counseling and treatment. Needless to say the usual response is laughter and "how naïve!". Is it?

Gambling in Minnesota is here to stay. We depend on it as the revenue source for an increasing number of programs and businesses in Minnesota. Whose responsibility is harm prevention, reduction and treatment? We all need to more aggressively step up to the plate. The longer we wait, the greater the consequences.

-T. Lance Holthusen, Executive Director

Problem Gambling: What the Public Thinks (and Why It Matters)

Problem gambling is not new. There are numerous examples of clinically accurate descriptions dating back to the 17th century. Many of these are phrased in moral terms. M.L. Weems wrote in 1812 of "God's revenge against gambling exemplified in the miserable lives and untimely deaths of a number of persons from both sexes, who had sacrificed their health, wealth, and honor at the gaming tables," while Samuel Johnson advised a gambler in 1750 to "rouse from this lazy dream of fortuitous riches." Excessive gambling (and often any gambling) was seen as a moral weakness, and gamblers could choose either to repent or to suffer the consequences of shame, dishonor, and damnation.

Freud was among the first to see gambling as something other than a moral problem, placing it in the same category as alcoholism and drug dependence and a fit subject for psychoanalysis. These days phrases like "illness," "behavior disorder," or "progressive disease" are commonly used when describing compulsive gambling. We've come a long way.

Or have we? Does Joe Citizen believe in the medical model? Or does the public still make the moral judgments of M.L. Weems? The answer sheds light on the attitudes of public officials towards problem gambling and the reaction that family, friends, employers, and the community are likely to have when someone comes forward with a gambling problem.

Three out of five Minnesota adults believe that "controlling problem gambling is mostly a matter of willpower."

In surveys conducted over the past two years, the Minnesota State Lottery has asked the public for their opinions on issues related to problem gambling. These surveys, conducted by the survey research center at St. Cloud State University, shed a great deal of light on a previously unexplored corner of problem gambling research.

The surveys found that the public is torn between the medical and morality models. Forty-four percent of the public agreed that "the main cause of compulsive gambling is moral weakness." An identical 44 percent disagreed, while 11 percent

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didn't know. You don't go to a clinic for a moral weakness.

Three out of five Minnesota adults believe that "controlling problem gambling is mostly a matter of willpower." Again, willpower is not a medical intervention. The medical model prevails on one count, however. Nine out of ten agree with Freud that "problem gambling is an addiction just like alcohol or drug addiction."

The public is also pessimistic about the benefits of treatment. Only 27 percent agreed that "treatment for problem gambling is often successful." If someone doesn't believe that treatment is effective, how hard will they try to get a spouse, friend, or relative to a clinician? This is consistent with a national survey that found fewer than one in three agreeing that "the majority of those who seek treatment for addiction to alcohol or drugs achieve lifelong recovery."

Stereotypes of the problem gambler are also common. Forty-one percent agreed that "poor people are the most likely group to become addicted to gambling." Biases like this have the effect of marginalizing the problem gambler, leading to a view of the gambler as being different than ourselves, and perhaps less worthy.

Finally, the public believes that compulsive gambling is rampant. When asked "what percentage of Minnesota adults have a gambling addiction?," only 4 percent answered "1 percent or less." Eighteen percent said the rate was between 2 percent and 5 percent, 14 percent said it was between 6 percent and 10 percent, 13 percent though it was between 11 percent and 20 percent, and 21 percent of the public thought that more than one Minnesota adult in five had a "gambling addiction."

Most who work with problem gamblers believe that the problem is psychological and medical, not moral. They believe that problem gambling cuts across the socio-economic spectrum. They believe it is prevalent among a relatively small percentage of the population. And they believe that treatment works (though not all the time). These data suggest that a large segment of the general public thinks the opposite.

Why do we care? Well, we want people to enter treatment. We want their circle of friends and family to be appropriately supportive. We want the legislature to fund our programs. How many of these goals can be accomplished with a common perception that problem gambling is a moral weakness, that it can be controlled through greater willpower, and that treatment doesn't work?

The Department of Human Services has decided to focus on a simple message: Treatment is available. It is affordable. And it works. This by itself is a critical message to communicate to the public. But we need to do more to educate the public on the truth about problem gambling. Doing so can only help in our efforts to reach more problem gamblers earlier in their disease and return them as productive members of society.

The author would like to acknowledge his debt to Dr. Bo Bernhard's work on this topic.

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Separate or Syndrome?

(Continued from page 1)

Shaffer recognizes that individual addictions each have some unique components. Chasing losses, for example, is unique to gambling, while infections from needle use result from substance abuse. His list of commonalities, however, is much more extensive. The same genetic risk factors, for example, seem to be involved in multiple addictions. The same risk factors—impulsivity, delinquency, poverty—are found in addicts of all stripes. Symptoms such as tolerance, withdrawal, shame, deceit, guilt, depression, and anxiety do not distinguish one addiction from another. And treatments have much in common, as evidenced by the spread of "12 step" programs from one addiction to another.

The idea of a common addiction syndrome is not new. Dr. Julian Taber, for example, wrote in 1991 that "whatever the addiction, the mood cycle is the same, the progression of use is the same, the immature personality organization is the same, the withdrawal is similar, the social consequences are equally drastic, and the tendency to be multiply addicted is the same." Dr. Durand Jacobs and colleagues noted similarities between alcoholics, pathological gamblers, and compulsive overeaters as early as 1985. Jacobs wrote in 1989 that "addicts of markedly disparate types share a common dissociative-like experience when indulging that clearly sets them apart from normal groups ... who also indulge in the same types of substances or activities." More recently, Jacobs has stated that some individuals have a greater predisposition for an addiction, and that this predisposition has both biological and psychological components.

Addiction, according to Shaffer, results from a highly complex interaction between biological factors, psychological factors, a person's environment, and exposure to an addictive

Shaffer expands on these earlier theories by citing biological and psychological evidence from studies done on a wide range of addictive behaviors. It has been found, for example, that drugs such as alcohol, cocaine, and heroin, and behaviors such as gambling can stimulate the brain's reward system in a similar way (particularly involving the brain chemical dopamine). Some scientists believe that a malfunction in the dopamine system makes one vulnerable to addiction. Other studies have found common genetic vulnerabilities to different addictions. One study, for example, linked the same genes to alcohol dependence and pathological gambling. No studies cited by Shaffer could find addiction-specific genetic links, that is, genes associated with one type of addiction but not others.

Numerous studies also find common psychological risk factors among those suffering from addictions. Conditions such as major depression and posttraumatic stress disorder have been found to precede a variety of addictions, though research on the links between these conditions and behavioral addictions is limited.

Finally, the same social risk factors appear to be present in a variety of addictions. Poverty seems to be one common link. Poor parental supervision and juvenile delinquency are others, though we don't know the extent to which these are causal or just an indicator of higher risk.

Are some people, then, destined to become addicts? Shaffer stresses that as with many other medical conditions, predisposition does not mean the condition is inevitable. We know, for example, that some people are more likely to become obese or to develop hypertension than others, but not all of those at risk develop the condition. In fact, knowledge of the risk factors can lead to changes in behavior and to therapies that make development of the condition less likely. Addiction, according to Shaffer, results from a highly complex interaction between biological factors, psychological factors, a person's environment, and exposure to an addictive object at a critical time. Some with multiple risk factors will never develop an addiction, either by luck or by the acquisition of preventative techniques. And some with relatively few factors can still develop a problem when exposed to

the right agent under the right circumstances at the right time.

Rethinking individual addictions as a common syndrome suggests rethinking treatment with a focus on the underlying condition rather than the object of the addiction. Jacobs suggests a three-pronged approach to addiction treatment, involving the teaching of stress management techniques, addressing and resolving underlying psychological problems and learning skills to cope with everyday reality. Shaffer and colleagues believe that "conventional wisdom discourages clinicians from paying sufficient attention to the underlying core of addictive behaviors." They propose a multi-modal "cocktail" approach with elements that address the overall addiction syndrome and others that deal with the specific addiction. Both the gambler and the alcoholic, for example, might benefit from improved coping skills, but the gambler must deal with unique financial issues while the drug abuser may have unique medical issues. Shaffer also believes that concentrating on the addiction object can lead therapists to ignore "addiction hopping" between chemical and behavioral addictions. Drs. Jon Grant and S.W. Kim have found that some of the same medications can be effective on addictions ranging from gambling to sex to kleptomania to chemicals, but emphasize that the medications must be combined with more traditional forms of therapy to have the greatest effect.

Prevention efforts may also need to be seen in a different light. With many physical diseases we focus prevention on those most at risk. Could the same be done for addiction? Jacobs has advocated that schools focus on teaching coping and life skills such as stress management, how to deal with emotions, and self-acceptance rather than focusing on specific behaviors such as drugs or gambling. Schools may welcome the opportunity to teach skills rather than being pressured to add curricula for one individual addiction after another. Too broad an approach, however, can ignore the dangers of non-addictive abuse. Teaching the risks of drinking and driving, for example, is not about preventing addiction.

And what of the gambling industry, and those who produce or market other "addictive" items? If the item itself does not cause the addiction, and the addiction is an indicator of underlying biological and/or psychological conditions, does the industry bear any responsibility?

People are more or less predisposed to an addiction. But predisposition is not destiny. There is a moment (or moments) of truth when the potential addict is exposed to the addiction object at the right time. Clearly the object plays a role. We don't know much about how that moment can be made safer, but common sense suggests that it can be done. The involved industries need to consider how a particular environment or design or marketing strategy might affect the person on the edge. And it is well-accepted that businesses have a responsibility to those who have crossed the line. The existence of a genetic predisposition does not absolve the bartender from taking steps to ensure that someone who has imbibed too much doesn't drive. There are likely also moments of truth when exposure to the right message at the right time can push someone to make the first steps to recovery or to make someone teetering on the edge of an addiction think twice. Industry has a responsibility to learn what that message is and then to provide it.

Shaffer believes that viewing different addictions as indicators of a common syndrome can only lead to improved treatment and prevention efforts. He urges those treating chemical addictions to consider treatment methods used by those treating behavioral addictions and vice-versa, and concludes that "the necessary tools for improving addiction treatment might be already available. All that is required to enhance the use of these devices is a rethinking of addiction." Cooperation between clinicians, researchers and businesses involved in a wide range of addictive objects can only hasten that rethinking.

Is problem gambling merely one manifestation of a larger syndrome? Share your thoughts on this article for the next issue of Northstar Roundtable. Write us at P.O. Box 555, Arlington, MN 55307 or e-mail us at npga@frontiernet.net

Interview with Dr. Harold Wynne

Harold Wynne Ph.D. is a renowned Canadian educator and researcher who has planned and implemented hundreds of social development and adult education programs. He has conducted provincial and national problem gambling research studies and continues to advise Canadian and international governments, agencies, and industry on gambling policy and programs. Dr. Wynne holds appointments at universities and research agencies including McGill University, Harvard Medical School, Canadian Centre on Substance Abuse, and University of Alberta. Dr. Wynne serves on the Editorial Board of the Journal of Gambling Studies, The WAGER, International Gambling Studies Journal, and the Electronic Journal of Gambling Issues. While in St. Paul to give the keynote speech at the 2004 Statewide Conference on Problem Gambling he spoke with *Northstar Alliance* board member Don Feeney.

Dr. Harold Wynne

DF: Could you describe for those of us who live south of the border what the state of gambling in Canada is and how, in your experience, it differs from what we see in the U.S?

HW: There's a fundamental difference in the model. In America, it's largely a private model, but in Canada, the state itself owns gambling in one way or another. It owns the lotteries, it owns the casinos or contracts with private businesses to run them on the government's behalf. So the government is very, very much involved in the whole of the gambling enterprise. Contrast that with gambling in Nevada, where the state's revenue comes from licensing and taxes and all of the casinos are owned by private corporations and, for the most part, the profits are theirs. In Alberta, the government doesn't have to lobby itself to expand or to get some comfort on regulation. In America the gaming industry has to lobby the government to get concessions. We'll probably see that battle fought now in the area of internet gambling in both of our countries.

DF: Do Canadians like to gamble or do you just prey on the tourists?

HW: Canadians like to gamble. Although, interestingly, I've noticed when we did prevalence studies in Alberta in 1998, I think there was something like 87 percent of the public in that survey said they gambled. We did another one in 2001, three years later, and it was down to 83 percent. The very first one we did in 1992 was up to 93 percent. So, from 1992 to 2001, we saw a drop of some 10 percent of people's self-reported gambling. So, while still a significant number of people gamble, it looks like, if anything, despite expansion there seems to be a downward trend.

DF: Are there certain parts of Canada where you see less gambling activity ?

HW: It's pretty universal wherever you go. The big difference is whether video lottery terminal gambling is provincially sponsored. Ontario and British Columbia don't have VLT programs yet, but there are VLTs in bars and lounges in the other provinces. Where the provinces have VLTs the participation rates are up significantly. And we know that there's a correlation between problem gambling and electronic gambling machines including VLTs. What I call the ticket trade—playing the lottery and lottery-like products like community-based raffles—is the most preferred form of gambling in every province. Then we move on down to casinos, video lottery terminals and

bingo. These draw roughly the same percentage of people, but it's a different mix of people participating in each of these. Horse racing is a more specialized group. On Prince Edward Island, it's extremely popular because of their long-standing horse racing industry.

DF: My sense is that the support services and programs available for problem gamblers in Canada, in general, far outstrip those available in the U.S. Is that fair?

HW: Oh, I would say that's absolutely fair. And maybe that has to do with the differences in the Canadian versus U.S. gambling model I mentioned earlier. With the government-owned and managed model there might be more of a moral obligation to do something about the consequences. For instance, in Canada we see that there are quite a few government sponsored resources for problem gamblers. But not just in Canada. The same can be said of Australia and New Zealand as well, where the government gambling model is very similar to the Canadian model. The Americans appear to be lagging behind as far as investing government funds in the prevention and treatment of problem gambling..

DF: In what ways? Is it in making treatment available? Is it in preventative services?

HW: I would say most noticeably in public awareness campaigns. For instance, in Minnesota I've heard people lament that there's more money being spent advertising and promoting gambling than there is raising people's consciousness about the issue of problem gambling. And I think you probably would find that across the United States. And, right now in Canada, there's a lot more provincial-level television-based public awareness campaigns saying that, "Look gambling is very harmful for a certain number and type of people. Do this at your own risk."

DF: Is there any evidence that those are in any way, shape or form effective?

HW: Well, that's the $64,000 question. Is it money well spent or is it money that's just being frittered away? The jury is out on that.

DF: Do you find that there are more treatment services available in Canada?

HW: I would say that the services are very similar in Canada and the U.S. We both have residential treatment services and outpatient programs that are, for the most part, two- to four-week models. Depending on where you go in Canada and the U.S. you'll find more or less services in the community. But, frankly, traditional treatment services in neither country seem to be reaching the population that has a disorder right now. When we do our prevalence studies, we'll show that, for instance, in the Province of Ontario, there are estimated to be some 340,000-problem gamblers. Yet, fewer than 1,500 people across the province are in treatment. That's a huge difference: 1,500 to 340,000. The question remains: How do you reach those problem gamblers who are not predisposed to coming in for treatment ?

We need to look at alternatives. Right now, I'm involved with a research project with the Center for Addictions and Mental Health in Toronto where we've developed a telecounseling treatment program. We're trying to promote and market telephone-based counseling of people so that it's at their convenience, in the privacy of their home, and it can be done 24-7. When they phone in they're matched up with their own therapist and a manual is shipped to them directly. The therapist and the gambler work through the manual over a half a dozen sessions. We're trying this approach to see, first of all, if we can reach problem gamblers– some of the 340,000 that we're not reaching –and then to see whether or not

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this telecounseling approach is effective.

This approach was influenced by research that David Hodgins and several other colleagues and I did back in 1998 at the University of Calgary. We looked at the difference between lifetime problem gambling prevalence rates and current rates and we saw that there were a lot of people who had a problem in the past but not in the present. And there were really no programs for gamblers in Alberta at the time, even very few GA chapters. So, we could reasonably expect that somehow or other these people had recovered over the course of their lifetime without professional intervention. So, we went out and we interviewed these people to try to see what would have triggered a spontaneous remission, or natural recovery, as it was called then. We didn't have many people to interview so the research wasn't particularly conclusive. But we thought that maybe we could get people started along that self-recovery road and that's where the self-recovery manual idea came from. The Ontario project is based on this notion that people can, for the most part, recover nicely by themselves, thank you very much, but we're going to help you a bit through telecounseling and through the manual. This approach, along with the problem gamblers' own devices, might just be enough to move the problem gambler along the road to recovery.

DF: Are ethnic differences a significant factor when dealing with both adjustments to gambling and problem gambling?

HW: Well, I'm working on three research projects right now with ethnic and aboriginal communities. The first one is with eight ethnic communities in Toronto and Windsor-Essex County. The methodology that we're using is known as "participatory action research." Essentially, the responsibility for doing the research is turned over to the community. My role is as a resource person to help empower the community and teach them how to do their own research. The first task is to help them build a research plan that has sound research questions and appropriate methodologies for gathering the data needed to address these. But, other than that, the community has the responsibility to go in and research gambling and problem gambling in their own population.

DF: These communities are?

HW: These communities are the Somalis, the Afghanis, the Iraqis, the Filipinos, the Greeks and the Indo-Caribbeans in Toronto. In Windsor, it's the Jewish community and the South Asian communities. They've done their research, and each community has just finished their action-planning phase. After their research was completed, each community devised action strategies to affect the social change that's needed to deal with the issue of problem gambling. In the months ahead, these ethnic communities will be implementing their action plans, which will involve mounting culturally-appropriate prevention and treatment programs and services.

DF: How different are they?

HW: Very. To start with, some communities have very different notions about the permissibility of gambling. For example, in the Muslim communities, gambling is forbidden in the Qur'an. When the researchers interviewed their religious leaders, they were basically told that they didn't want to talk about it: "There is no gambling in our community. It's forbidden in the Qur'an." People don't gamble, and if they did, never mind whether they're problem gamblers; they're just sinners. And so the only way we can help them is through spiritual counseling through the Imams and in the mosque. That's it. On the other hand, you

have some non-Muslim ethnic communities in Toronto who are much more tolerant of gambling. They recognize that gambling exists, and that it is not forbidden on religious or moral grounds.. However, all communities agree that problem gambling is a blight on the individual, his or her family, and the community itself.

DF: How is that then reflected in terms of any types of intervention you might do on behalf of a problem gambler?

HW: Well, that remains to be seen. It's one of the biggest challenges that faces all communities. Even if gambling is permitted and tolerated in communities one thing that all of the communities hold in common is that they don't tolerate problem gamblers. Problem gamblers are seen, amongst other things, to bring shame on the community. Problem gambling is also seen very much as being a private trouble, not any kind of a public issue. Given these attitudes, dealing with problem gambling is going to be very much an uphill battle for every community, some more than others. Right now each community has the task of raising awareness that there is problem gambling in the population, even in the Muslim communities. Then, beyond that, they need to develop some kind of a collective responsibility to deal with problem gamblers. It's essential that they do it themselves because I and other university types wouldn't have two clues in a sandbox what works in the Afghan community.

DF: Do you find in some of these communities that there's just denial that problem gambling exists?

HW: Absolutely.

DF: How do you get over that?

HW: I don't know. The community itself is going to have to come up with the answer to that one. How do you get over the Qur'an forbidding gambling in Muslim communities? Both the sacred and secular communities are going to, somehow, have to deal with the issue of problem gambling in their midst. That's why each ethnic community is participating in this research project and developing action strategies that will make sense in their community context.

DF: Is it possible that someone from, say the Afghan community, might actually be more comfortable coming in to a treatment program that is predominately Anglo because they wouldn't receive that same degree of shame that they would if they sought treatment in their own community?

HW: The answer is "yes". Some communities said as much. One of the questions all of the communities asked was about help-seeking preferences and many respondents said, "Listen. You know we would like treatment services in our language, obviously, so we can understand what's going on but not in our community because we don't want to be "outed" as a gambler, never mind a problem gambler." One of the well-respected, largest immigrant organizations in Canada is COSTI, which is the Toronto-based agency that sponsored this research project. Some communities are discussing whether COSTI can put some problem gambling services in place that will serve all the ethnic communities. because many of their people don't want to be seen to be going to their own community agencies.

DF: I'm guessing they gamble outside the community as well.

HW: Oh, sure. Many people want to hide their gambling. Very much so.

DF: Have you done any work in Canada with the First Nations populations at all?

(Continued on page 10)

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HW: Well, that's the second part of the ethnic research that we're doing. Right now, we are working with five aboriginal communities in Ontario doing the exact same thing we did with the ethnic populations in Toronto and Windsor. We're using participatory action research and working through a local research advisory committee that we helped each community establish so they can look at gambling and problem gambling in their populations. I'm just starting another study in Alberta with two aboriginal communities. We try to work with the community and help empower them to do their own research because they're the ones that are, first of all, going to gain access and probably get closer to finding out what the "truth" is as far as gambling and problem gambling goes and, more importantly, the community will have to plan the programs and services problem gamblers and their families will need. When all is said and done, the community leaders are not going anywhere, unlike most university researchers who leave Dodge when they're done collecting data. The leaders are still there and they're still interested in doing something to effect positive change. They're not interested in doing research as an academic exercise.

DF: What unique challenges do you find in these communities?

HW: One of the things we have to remind ourselves is that while our interest is in problem gambling, there's myriad problems in those communities and in the great scheme of things, problem gambling may be way down the list. Even as an addiction, it's way down the list. So, aboriginal communities are first and foremost still interested in dealing with alcoholism. But, there are other issues, too – neglect, abuse, abandonment, domestic violence, poverty. You load these problems on aboriginal communities and, in a way, problem gambling pales. One of our challenges is to get problem gambling on the radar screen and see how it's interconnected with these other problems. We need to help the community best use the meager resources they have to help people who have a gambling problem. That's the biggest challenge for both the researcher and the community itself.

DF: Is it a big enough problem that they should be devoting their resources to gambling as opposed to putting them into some of these other issues?

HW: No. I would prefer to see some kind of an omnibus approach in the communities to provide the resources and develop the wherewithal needed to deal with the whole constellation of social problems. In many First Nations communities, this begins with economic development and employment programs to address the systemic poverty issue. You could argue that if you want to eradicate alcoholism and problem gambling and domestic violence on reserves, put people to work and give them a reason to be proud; give them some reason to have positive self-esteem, the rest of the things we, in the dominant cultural group, take for granted.

DF: In the twenty-odd years that you've been in this business, what's changed?

HW: One of the things that's obviously changed is that gambling has expanded to unprecedented levels, in both of our countries and worldwide. Second, gambling has gone and continues to go electronic. It's far more cost-effective to have electronic gambling machines situated in "convenience locations"—such as bars, lounges and grocery stores—than it is to build stand-alone casinos. And we're going to see this continue, of course, with Internet gambling. Third, I don't think any of the governments, certainly in Canada, had any idea how much revenue would be generated by expanding

gambling. And right now they are pleasantly shocked. In Alberta 5 percent of the province's annual budget is coming from gaming. That outstrips the revenues that come in from crude oil royalties in that resource-rich province. Ironically, this revenue windfall has become a real problem for governments because, even if a government wanted to disavow gambling and dismantle the gambling apparatus and go back in time and reduce the opportunities, they'd have a devil of a time backfilling the revenue. We're talking about billions of gambling dollars right now flowing to the public coffers.

DF: What do we know now that we didn't know twenty years ago?

HW: Twenty years ago we weren't vexed by problem gambling. Twenty years ago in Canada gambling still hadn't been turned over legally to the provinces – the change in the Canadian Criminal Code in 1985 allowed for this. We didn't have a great deal of gambling out there in people's faces. So, along with the rise in gambling over the last twenty years came the rise in problem gambling and our consciousness and awareness about this as a social and public health issue. It's really just in the last ten years that we've seriously addressed problem gambling as an individual and community issue. But, we're catching up fast. We're learning a lot. For example, we know that there are physiological determents, and risk factors that predispose people to developing a gambling problem -- everything from genetic markers to brain chemistry. We have researchers working in that area and concurrently working on treatments that are medically based. We also have the psychological fraternity, who were the first ones to become interested in this issue, developing profiles of problem gamblers and testing various approaches to treat these individuals. Sociologists are beginning to study the extent to which social networks and interactions affect and influence people to have or not to have a gambling problem. Economists are now becoming interested in assessing the socio-economic impacts of gambling – determining whether or not it's net costly or net beneficial. So, there's more interest from the different academic disciplines now and, as a result, the knowledge base is beginning to grow as more disciplines become engaged.

"We need to learn about the nature and characteristics of problem gambling in different populations and what the cultural nuances are from one group to the other."

DF: What do you think are the big unknowns? Where should we be focusing research money and resources?

HW: All of our communities are not homogeneous--they're made up of many sub-cultural groups. People in different groups may be more or less afflicted with problem gambling disorders than others. We need to learn about the nature and characteristics of problem gambling in different populations and what the cultural nuances are from one group to the other. We have to do this all with a view to providing the resources that the community needs to deal with the problem itself, rather than the province or state trying to come up with some kind of one-size-fits-all program or service.

Another main research area is the need to examine the effects of the world-wide movement to electronic gambling machines. Understanding human-EGM interaction is critical to devising strategies to help people control their play on EGMs, and to ultimately treating problem gamblers who are addicted to these machines. This area of research is extremely important now, given the proliferation of Internet gambling. A related area of research needed is to examine the effects of EGMs and Internet gam-

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(Continued from page 11)

bling on children and adolescents. Given how much they're computer-savvy, I am most concerned that the Game Boy generation—especially young males--will be especially vulnerable to developing an EGM or Internet gambling problem.

DF: Are there any industry practices that you feel most strongly should be changed?

HW: Industry has recognized that there is fallout from their practices that has to do with problem gambling. That said, the gaming industry feels it has a responsibility to do something about it, to promote something called responsible gaming. This means taking initiatives such as training casino staff to deal with and intervene with problem gamblers, problem gambling signage in casinos, problem gambling advertising perhaps funded by industry, putting responsible gaming features on video lottery terminals and so on to try to help people gain some control back. And it's easy to be cynical and say the gaming industry's doing this to protect their revenues, but I would take the view that even if they're doing it for arguably the wrong reasons, at least they are doing it. I welcome these initiatives, but we still have to evaluate whether or not they're having any kind of an positive effect on problem gambling. It is all well and good to mount responsible gaming features on video lottery terminals, but how do you know if they work or not? I'm doing research right now for the Alberta government to find out if these VLT features do help gamblers control their play more effectively.

DF: A personal bias of mine is that we have not explored nearly enough the whole area of sub-clinical problem gambling. It may not meet the definition of an addiction, but it is still a problem, still has a cost, still causes damage and is probably much more widespread than an actual pathology. I think that these responsible gaming efforts would be much more likely to make a dent in the sub-clinical behavior than in the pathological behavior.

HW: I would agree with that. In fact, the Canadian Problem Gambling Index that I helped develop identifies four gambler subtypes: non-problem, low risk, moderate risk and problem gamblers. In all the Canadian studies recently undertaken, the low and moderate risk populations are much larger than the problem group, and we are most interested in pursuing research, prevention and treatment programs aimed at this at-risk group.. It has been argued in the literature and by therapists that there's only so much you can reasonably be expected to do to help problem gamblers, particularly while they are still gambling. Consequently, prevention and treatment interventions would be most profitably directed at the people who are at risk rather than the ones who already have a severe problem. The challenge here is to prevent gamblers who are at some level of risk from developing a full-blown gambling problem. The good news is that many colleagues are now beginning to study this at-risk group and to develop interventions to prevent these gamblers from developing a problem. To me, this is the most exciting and promising research that is presently being done in the gambling studies field.

NO JUDGMENT, ONLY HOPE
1-800-333-HOPE
The Minnesota Problem Gambling Helpline is available 24 hours a day, 7 days a week.
A service of the Department of Human Services and the Minnesota Institute of Public Health

Northstar Alliance Receives Grant from Canterbury Park

The Canterbury Park Minnesota Fund (CPMF) awarded a $15,000 grant to the Northstar Problem Gambling Alliance in December to help finance a seminar series in 2005. The CPMF is a new donor-advised community fund established by Canterbury Park that focuses on aiding Minnesota's horse and agriculture industry as well as funding responsible gaming programs throughout the state.

Northstar Alliance Executive Director Lance Holthusen (middle) receives a check from Canterbury Park President Randy Sampson (right) and Director Eric Halstrom (left)

"We are proud to continue our support for the Northstar Problem Gambling Alliance through this grant," Canterbury Park Track President Randy Sampson said. "The gaming community has a duty to help address the issue of responsible gaming, and we are pleased to work toward that goal with the Alliance."

The grant raised Canterbury Park's total contributions to the Northstar Alliance to over $22,000 in 2004.

Featured Website: Compulsive Gamblers Hub

http://www.cghub.homestead.com

The Compulsive Gamblers Hub is an open community for individuals in recovery who, share their "Experience, Strength, and Hope", with each other that they may solve their common problems and help others in working a recovery program. Founded in 2001 by a group of recovering gamblers under the leadership of Charlie P., the site asks only that prospective participants have a desire to stop gambling. There are no dues or fees to participate, though contributions are encouraged.

Among the resources found on the page are a 24 hour interactive chat room, scheduled online Gamblers Anonymous-formatted meetings, a daily message board, 12 Step message boards, financial pressure relief resources and recognition of participants' last day of gambling.

One participant recently described her experience with the Hub. "As an ex-addict struggling to understand how her life and thinking had gotten so crazy, the people on (this) site quite literally saved my sanity. I still remember the feelings of relief I had the first time I visited … and discovered that I truly was not alone in doing what I had done.

"Unlike walking into a room full of strangers, visiting the Hub can be as anonymous as the visitor needs to be … they can read and remain silent until they feel comfortable/inspired/challenged enough to post. There are no awkward looks or embarrassing moments when a person first visits and because there is no record or indication of who is visiting at any given moment, there is absolutely no pressure on visitors to 'speak.'"

The site is not intended to replace face-to-face counseling or GA meetings. For those who can attend such sessions, the Hub serves as a complement or a way to ease into the recovery community. There are a variety of reasons, however, that can make this a critical resource for others. Gamblers who are geographically isolated, have a hearing impairment or have other physical limitations may find the site to be a lifeline.

Research Tidbits

Internet Gambling and Adolescents

Internet gambling is a relatively new phenomenon that does not seem to have yet captured the imagination of the general public. An April 2004 survey found that fewer than 2 percent of Minnesota adults had placed a bet using the Internet.

A Quebec study, though, suggests that online gambling may be making inroads among students. A sample of 2,087 high school and college students found that 89 percent reported gambling on the Internet with or without money in the past year. While only 5 percent reported gambling online for money, those reporting gambling problems were more likely to engage in Internet gambling without money than social gamblers. When asked what made Internet gambling appealing, the most common responses were ease of access, rapid play, convenience, and not having to leave home. To this list, probable pathological gamblers added the appeal of online competition.

Mood Disorders and Problem Gambling

A review of over 80 publications finds an "irrefutable" link between mood disorders and problem gambling. The review, conducted by the Mood Disorders Society of Canada, found greater prevalence of a number of mood disorders in pathological gamblers than the general population, including major depression, bipolar disorders, cyclothymia, and dysthymia.

In many cases, the mood disorder predated the onset of problem gambling, and the authors speculate that gambling may be a way to seek relief from the mood disorder. In fact, the disorder often worsens due to the negative consequences of the gambling, which in turn may lead to more gambling.

The authors urge those treating patients with mood disorders to be aware of the potential for gambling problems and to include questions about gambling as part of the clinical assessment process.

Beautiful Women Make Men Stupid

McMaster University researchers have proven that men perform less well on a gambling task after looking at photos of attractive women.

Male students were shown pictures of either attractive or unattractive women and then given dice to throw. When they threw a "winning" combination, they were given a choice of between $15 and $35 the next day or $50 to $75 after a longer wait. Those seeing the attractive women were far more likely to take the smaller sum right away.

When given the same task, however, women who had been shown pictures of attractive men responded no differently than those seeing unattractive men.

The researchers concluded that the pictures of attractive women caused courtship and mating responses in the brain, leading them to emphasize short-term benefits over long-term consequences. Women, on the other hand, are more likely to associate courtship with long-term consequences, and therefore become less likely to discount the future.

Upcoming Events

March 10-11, 2005
Seventh Annual Compulsive Gambling Conference. Radisson Hotel Paper Valley, Appleton, WI. Sponsored by the Wisconsin Council on Problem Gambling

April 1, 2005
Problem Gambling's Impact on Family. Gloria Dei Lutheran Church, St. Paul, MN. Sponsored by the Northstar Problem Gambling Alliance.

April 17-20, 2005
Discovery 2005. Niagara Falls, Ontario. Sponsored by the Responsible Gambling Council.

June 23-25, 2005
19th Annual Conference on Prevention, Research and Treatment of Problem Gambling. New Orleans, LA. Sponsored by the National Council on Problem Gambling.

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University of Minnesota

3rd Annual Minnesota Problem Gambling Awareness Conference: Problem Gambling's Impact on Family and Others

Registration Deadline is March 23rd, 2005

Name:_____

Organization:_____

Address:_____

City:_____ **State:**_____ **Zip:**_____

Phone:_____ **E-Mail:**_____

Mail form and payment to:
Northstar Alliance
Box 555
Arlington, MN 55307
(Checks payable to Northstar Problem Gambling Alliance)

____I am a member of the Northstar Alliance. Enclosed is my check for $75

____I'd like to join. Enclosed is my check for $75.00 plus_____ for my chosen level of membership ranging from $35.00 to $500.00. (Add membership in the National Council on Problem Gambling for just $35 more)

____Enclosed is my check for $110.

ADA needs:_____

No Foolin', Save This Date!
April 1, 2005

Problem Gambling's Impact on Family and Others

Presented by the Northstar Problem Gambling Alliance, Inc.

8:00 AM—4:30 PM
Gloria Dei Lutheran Church
700 S. Snelling Avenue
St. Paul, MN

Lunch and parking included. CEUs available

$75.00 Northstar Alliance members $110.00 non-members.
Register now using the form on the inside back page of this newsletter. See you there!

Presented with the support of
Canterbury Park and the Minnesota State Lottery

Northstar Problem Gambling Alliance, Inc.
P.O. Box 555
Arlington, MN 55307

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Senator Larson introduced--

S.F. No. 826: Referred to the Committee on Health and Family Security.

A bill for an act

relating to human services; modifying child care center license fees; amending Minnesota Statutes 2004, section 245A.10, subdivision 4.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2004, section 245A.10, subdivision 4, is amended to read:

Subd. 4. [ANNUAL LICENSE OR CERTIFICATION FEE FOR PROGRAMS WITH LICENSED CAPACITY.] (a) Child care centers and programs with a licensed capacity shall pay an annual nonrefundable license or certification fee based on the following schedule:

Licensed Capacity	Child Care Center License Fee	Other Program License Fee
1 to 24 persons	~~$300~~ $225	$400
25 to 49 persons	~~$450~~ $340	$600
50 to 74 persons	~~$600~~ $450	$800
75 to 99 persons	~~$750~~ $565	$1,000
100 to 124 persons	~~$900~~ $675	$1,200
125 to 149 persons	~~$1,200~~ $900	$1,400
150 to 174 persons	~~$1,400~~ $1,050	$1,600
175 to 199 persons	~~$1,600~~ $1,200	$1,800
200 to 224 persons	~~$1,800~~ $1,350	$2,000
225 or more persons	~~$2,000~~ $1,500	$2,500

(b) A day training and habilitation program serving persons

with developmental disabilities or related conditions shall be assessed a license fee based on the schedule in paragraph (a) unless the license holder serves more than 50 percent of the same persons at two or more locations in the community. When a day training and habilitation program serves more than 50 percent of the same persons in two or more locations in a community, the day training and habilitation program shall pay a license fee based on the licensed capacity of the largest facility and the other facility or facilities shall be charged a license fee based on a licensed capacity of a residential program serving one to 24 persons.

Senate Counsel, Research, and Fiscal Analysis

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JO ANNE ZOFF SELLNER
DIRECTOR

Senate

State of Minnesota

S.F. No. 826 - Child Care Centers Licensing Fee

Author: Senator Cal Larson

Prepared by: Joan White, Senate Counsel (651/296-3814)

Date: March 2, 2005

S.F. No. 826 reduces by 25 percent the annual license fees paid by child care providers for a child care license.

JW:rdr

Fiscal Note – 2005-06 Session

Bill #: S0826-0 **Complete Date:** 03/08/05

Chief Author: LARSON, CAL

Title: CHILD CARE LICENSE FEES MODIFIED

Fiscal Impact	Yes	No
State	X	
Local		X
Fee/Departmental Earnings	X	
Tax Revenue		X

Agency Name: Human Services Dept

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
-- No Impact --					
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
-- No Impact --					
Revenues					
General Fund	0	(217)	(217)	(217)	(217)
Net Cost <Savings>					
General Fund	0	217	217	217	217
Total Cost <Savings> to the State	0	217	217	217	217

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
-- No Impact --					
Total FTE					

NARRATIVE: HD 374/SF 826

Bill Description: The bill reduces the license fee for child care centers under Minnesota Statutes, section 245A.10 by 25 percent.

Assumptions: The revenue loss from the 25 percent reduction in child care center license fees continues in future years since it is the difference between current revenues and the revenues that will be generated if the reduction is enacted.

The revenue loss is based on the number of child care centers and their licensed capacity in October 2004, which is the billing for the 2005 license.

Expenditure and/or Revenue Formula

Licensed Capacity	Number of Programs	Current Fee	Current Revenues	Proposed Fee **HF 374**	Difference From Current	Revenues under **HF374**	Revenue Loss
1 to 24	499	$300	$149,700	$225	($75)	$112,275	($37,425)
25 to 49	370	$450	$166,500	$340	($110)	$125,800	($40,700)
50 to 74	265	$600	$159,000	$450	($150)	$119,250	($39,750)
75 to 99	158	$750	$118,500	$565	($185)	$89,270	($29,230)
100 to 124	106	$900	$95,400	$675	($225)	$71,550	($23,850)
125 to 149	60	$1,200	$72,000	$900	($300)	$54,000	($18,000)
150 to 174	42	$1,400	$58,800	$1,050	($350)	$44,100	($14,700)
175 to 199	14	$1,600	$22,400	$1,200	($400)	$16,800	($5,600)
200 to 224	9	$1,800	$16,200	$1,350	($450)	$12,150	($4,050)
225 or more	7	$2,000	$14,000	$1,500	($500)	$10,500	($3,500)
	1530		$872,500			$655,695	($216,805)

Long-Term Fiscal Considerations: The General Fund revenue loss will be ongoing.

Local Government Costs: There is no impact on local governments.

References/Sources: DHS, Licensing Division, 2005 Child Care Center billings

Agency Contact Name: Jerry Kerber 296-4473
FN Coord Signature: STEVE BARTA
Date: 03/08/05 Phone: 296-5685

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: DOUG GREEN
Date: 03/08/05 Phone: 286-5618

Senators Berglin, Koering, Foley, Tomassoni and Lourey introduced--
S.F. No. 255: Referred to the Committee on Health and Family Security.

A bill for an act

relating to MinnesotaCare; modifying covered health services; repealing the limited benefits for certain single adults and households without children; amending Minnesota Statutes 2004, sections 256L.03, subdivision 1; 256L.12, subdivision 6; repealing Minnesota Statutes 2004, section 256L.035.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2004, section 256L.03, subdivision 1, is amended to read:

Subdivision 1. [COVERED HEALTH SERVICES.] ~~For individuals under section 256L.04, subdivision 7, with income no greater than 75 percent of the federal poverty guidelines or for families with children under section 256L.04, subdivision 1, all subdivisions of this section apply.~~ "Covered health services" means the health services reimbursed under chapter 256B, with the exception of inpatient hospital services, special education services, private duty nursing services, adult dental care services other than services covered under section 256B.0625, subdivision 9, paragraph (b), orthodontic services, nonemergency medical transportation services, personal care assistant and case management services, nursing home or intermediate care facilities services, inpatient mental health services, and chemical dependency services. Outpatient mental health services covered under the MinnesotaCare program are limited to diagnostic assessments, psychological testing, explanation of

findings, medication management by a physician, day treatment, partial hospitalization, and individual, family, and group psychotherapy.

No public funds shall be used for coverage of abortion under MinnesotaCare except where the life of the female would be endangered or substantial and irreversible impairment of a major bodily function would result if the fetus were carried to term; or where the pregnancy is the result of rape or incest.

Covered health services shall be expanded as provided in this section.

Sec. 2. Minnesota Statutes 2004, section 256L.12, subdivision 6, is amended to read:

Subd. 6. [CO-PAYMENTS AND BENEFIT LIMITS.] Enrollees are responsible for all co-payments in ~~sections~~ section 256L.03, subdivision 5, ~~and 256L.035,~~ and shall pay co-payments to the managed care plan or to its participating providers. The enrollee is also responsible for payment of inpatient hospital charges which exceed the MinnesotaCare benefit limit.

Sec. 3. [REPEALER.]

Minnesota Statutes 2004, section 256L.035, is repealed.

APPENDIX
Repealed Minnesota Statutes for 05-1070

256L.035 LIMITED BENEFITS COVERAGE FOR CERTAIN SINGLE ADULTS AND HOUSEHOLDS WITHOUT CHILDREN.

(a) "Covered health services" for individuals under section 256L.04, subdivision 7, with income above 75 percent, but not exceeding 175 percent, of the federal poverty guideline means:

(1) inpatient hospitalization benefits with a ten percent co-payment up to $1,000 and subject to an annual limitation of $10,000;

(2) physician services provided during an inpatient stay; and

(3) physician services not provided during an inpatient stay, outpatient hospital services, freestanding ambulatory surgical center services, chiropractic services, lab and diagnostic services, and prescription drugs, subject to an aggregate cap of $2,000 per calendar year and the following co-payments:

(i) $50 co-pay per emergency room visit;

(ii) $3 co-pay per prescription drug; and

(iii) $5 co-pay per nonpreventive physician visit.

For purposes of this subdivision, "a visit" means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary.

Enrollees are responsible for all co-payments in this subdivision.

(b) The November 2006 MinnesotaCare forecast for the biennium beginning July 1, 2007, shall assume an adjustment in the aggregate cap on the services identified in paragraph (a), clause (3), in $1,000 increments up to a maximum of $10,000, but not less than $2,000, to the extent that the balance in the health care access fund is sufficient in each year of the biennium to pay for this benefit level. The aggregate cap shall be adjusted according to the forecast.

(c) Reimbursement to the providers shall be reduced by the amount of the co-payment, except that reimbursement for prescription drugs shall not be reduced once a recipient has reached the $20 per month maximum for prescription drug co-payments. The provider collects the co-payment from the recipient. Providers may not deny services to recipients who are unable to pay the co-payment, except as provided in paragraph (d).

(d) If it is the routine business practice of a provider to refuse service to an individual with uncollected debt, the provider may include uncollected co-payments under this section. A provider must give advance notice to a recipient with uncollected debt before services can be denied.

Fiscal Note – 2005-06 Session

Bill #: S0255-0 **Complete Date:** 02/16/05

Chief Author: BERGLIN, LINDA

Title: MNCARE PRGM; LIMITED BENEFITS REPEAL

Fiscal Impact	Yes	No
State	X	
Local		X
Fee/Departmental Earnings		X
Tax Revenue		X

Agency Name: Human Services Dept

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
Health Care Access Fund	0	13,874	37,238	61,643	72,228
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
Health Care Access Fund	0	13,874	37,238	61,643	72,228
Revenues					
-- No Impact --					
Net Cost <Savings>					
Health Care Access Fund	0	13,874	37,238	61,643	72,228
Total Cost <Savings> to the State	0	13,874	37,238	61,643	72,228

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
-- No Impact --					
Total FTE					

NARRATIVE: SF 255/HF

Bill Description.

There is currently a Minnesota Care Limited Benefit $5,000 annual cap and limits on services.
This bill eliminates the MinnesotaCare Limited Benefit for adults without children whose income is between 75% - 175% FPG and allows them to receive an expanded benefit set.

Assumptions

This bill is silent on the effective date. The effective date would therefore be July 1, 2005, by default, for fee for service recipients. This would be problematic for coordinating changes in Fee for Service and Managed Care contracts, which by default would not change until January 2006.

Amendment suggested: To accommodate both fee for service and managed care contract changes, amend bill with an effective date of January 1, 2006 for both.

Assumes an effective date of January 1, 2006.

If this bill is passed the impact on systems would likely be small with a state share cost of $18,000 in fiscal year 2006. However, it would take two months after passage for the needed MMIS changes (including client notification) to be made.

Expenditure and/or Revenue Formula

Minnesota
MINNESOTACARE
Fiscal Analysis of a Proposal to
Eliminate the $5000 / $2000 Cap and Benefit Limits for Adults with No Children
Effective January 2006

This bill eliminates the $2000 annual limit on outpatient services and other benefit limits which were enacted in the 2003 Session. The cost and projected enrollment effects escalate in FY 2008 because the current forecast assumes that the $5000 cap effective for FY 2004 through FY 2007 reverts to $2000 in FY 2008.

The projected cost difference is based on the difference in the November forecast between projected monthly cost per person (PMPM) for the limited benefit set vs. projected PMPM for adults with no children not subject to the limited benefit set. These projections assume that a $2000 outpatient cap applies in FY 2008 and FY 2009.

MinnesotaCare Adults with No Children

PMPM Cost Projections Excluding 5% Performance Payment

	FY 2006	FY 2007	FY 2008	FY 2009
Regular Benefit Set	$389.47	$421.42	$446.66	$498.24
Limited Benefit Set	$277.50	$296.42	$245.01	$258.19
Assumed in this analysis for adults over 75% FPG	$330.85	$421.42	$446.66	$498.24
Increase over base forecast:	19.23%	42.17%	82.30%	92.98%

Total MinnesotaCare Program

Adults with No Kids Over 75% FPG				
	FY 2006	**FY 2007**	**FY 2008**	**FY 2009**
November 2004 Forecast				
Average monthly eligibles	19,329	19,234	18,696	17,939
Total payments	$67,380,145	$71,588,703	$58,386,559	$58,712,088
Total revenue	$9,215,254	$9,285,354	$9,137,580	$8,875,400
Net cost	$58,164,891	$62,303,349	$49,248,978	$49,836,688

	FY 2006	**FY 2007**	**FY 2008**	**FY 2009**
Projected increases under this bill:				
Average monthly eligibles	260	1,446	2,001	3,006
Total payments	13,979,727	37,935,842	62,620,932	73,715,743
Federal share	0	0	0	0
State share	13,979,727	37,935,842	62,620,932	73,715,743
Total revenue	124,034	697,930	978,177	1,487,290
Federal share	0	0	0	0
State share	124,034	697,930	978,177	1,487,290
Net cost	13,855,694	37,237,912	61,642,756	72,228,452
Federal share	0	0	0	0
State share	13,855,694	37,237,912	61,642,756	72,228,452
Projected percentage changes:				
Average monthly eligibles	1.35%	7.52%	10.70%	16.76%
Average monthly cost	19.23%	42.17%	82.30%	92.98%
Total payments	20.75%	52.99%	107.25%	125.55%
Total revenue	1.35%	7.52%	10.70%	16.76%
Net cost	23.82%	59.77%	125.17%	144.93%

Long-Term Fiscal Considerations.

Local Government Costs.

References/Sources

Agency Contact Name: Ron Hook 297-7952
FN Coord Signature: STEVE BARTA
Date: 01/24/05 Phone: 296-5685

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: KATIE BURNS
Date: 02/16/05 Phone: 296-7289

From: Sen.Linda Berglin
To: Tom Deyo
Date: Wed, Mar 2, 2005 3:54 PM
Subject: Re: On Wednesday Agenda. MNCare Resched

I appreciate your e-mail.

I will make copies for the committee. I also will put you on a list to call when we have a hearing on the bill to remove the $5,000 cap and limited services in MnCARE.

>>> "Tom Deyo" <Gentlemantm@netzero.net> 2/23/2005 12:49:38 AM >>>
The following email was received from:

Tom Deyo
109225th Ave SE
Minneapois, MN 55414
Home Phone: 612-483-2605
Email Address: Gentlemantm@netzero.net

Message:

I requested to be on the agenda for Wednesday's Hearing, However I was not aware that my wife needs to go to the Doctor for a determination on a Hysterectomy, and I feel it is important that I be with her. I definately still would like to be on the agenda, if the commitee is taking testimony on other days. I am giving you a synopsis of our situation, Just in case I am not able to testify.

My Name is Tom Deyo. My Wife (Melissa) is on Social Security Disability, recieving approximtely $860 dollars a month. this puts us over the imcome level, for MNCare regular coverage. We are covered under the progrm with the $5000 limits. I am in prehearing review for Social Security Disability, due to complications from diabetis, and several heart incidents. My mediucations, come to $700+ per month.

Since I was instructed by my Endocrinologist to seek Social Security Disability, I have found out taht it is similar to Unjemployment Compensation, If I do not do EVERYTHING the doctors suggest I can be seen as not cooperating, and be declared ineligable, as turning down a job is seen for Unemployment. If I recieve SSDI, I will not be eligible for Medicare for approximately one year.

I have been referred for mental health counseling for stress, but find this is not covered at all. I have been puton a schedule for follow up and other evaluations, that lead me to calculate I would be out of coveragge by mid-march.

I have worked at least two jobs most of my life, and paid taxes on this income. I have the rural Minesota work ethic, and would much rather be working. I am at wits end as to what to do, in either case, and ask for direction, If I do Get SSDI, how m I supposed to cover even my Meds for the year I will not hve coverage. I checked with TogetherRX, a reduced

cost perscription service, but only a few of the Medications I am on, are eligable. If I do not get SSDI, I have no Idea how we will even survive, as we are using wht little savings we have to suppliment the Money my wife gets to make the mortgage ($1100). If it were noyt for the food shelves, we would not eat many days.

I have been watching the Legislative Broadcasts and learned if we do "SPEND DOWN" to qualify for Medical Assistance, it not really a benefit, in sofar as the Recapture feature would place a lien against my house. So in effect the State is only loaning me a benefit, since I worked so hard to get a house, unlike many that haven't works as hard.

Thank You

Tom Deyo

make copies for committee for hearing on Wed.

Senate Counsel, Research, and Fiscal Analysis

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Senate

State of Minnesota

TO: Senator Linda Berglin

FROM: Katie Cavanor, Senate Counsel (651/296-3801) KC

DATE: March 2, 2005

RE: Information on Enrollees in the Limited Benefit Set

Attached is data on the enrollees enrolled in MinnesotaCare's limited benefit set who exceeded the $5,000 benefit limit in 2004. I received this information from Medica. If you have any questions regarding this information, please let me know.

KC:ph
Attachment

Prevalence of MDCs for SPP Members Who Have Exceeded MNCare Benefit Limit Through 12/2004

MDC	Count	Prevalence*
Other Conditions	305	71.6%
Dx of Musculoskel, Connective Tissue	226	53.1%
Dx of Circulatory System	209	49.1%
Dx of Respiratory System	194	45.5%
Endocr, Nutri, Metab, Immun Dx	192	45.1%
Dx of Nervous System, Sense Organs	190	44.6%
Dx of Genitourinary System	152	35.7%
Injury and Poisoning	146	34.3%
Dx of Digestive System	127	29.8%
Infectious and Parasitic Dx	117	27.5%
Mental Disorders	117	27.5%
Neoplasms	86	20.2%
Dx of Skin and Subcutaneous Tissue	69	16.2%
Dx of Blood, Blood-Forming Organs	40	9.4%
Complic Preg, Birth, Puerperium	18	4.2%
Congenital Anomalies	13	3.1%
Perinatal Conditions	1	0.2%
(blank)	-	0.0%
Grand Total	**2,202**	

In 2004 ≈ 425 people hit their max
This is 10% of the individuals
enrolled on the MN Care Limited product

*prevalence = number of members with each condition/total members in study (n=426)

Prevalence of Diagnosis Chapters for SPP Members Who Have Exceeded MNCare Benefit Limit Through 12/2004

Chapter Description	Count	Prevalence*
Medical examination/evaluation	135	31.7%
Other connective tissue disease	119	27.9%
Essential hypertension	102	23.9%
Other lower respiratory disease	99	23.2%
Spondylosis; intervertebral disc disorders; other back problems	98	23.0%
Other screening for suspected conditions (not mental disorders or infectious disease)	97	22.8%
Other non-traumatic joint disorders	95	22.3%
Diabetes mellitus without complication	91	21.4%
Abdominal pain	85	20.0%
Nonspecific chest pain	80	18.8%
Immunizations and screening for infectious disease	72	16.9%
Residual codes; unclassified	72	16.9%
Other upper respiratory infections	71	16.7%
Disorders of lipid metabolism	64	15.0%
Affective disorders	60	14.1%
Other aftercare	60	14.1%
Other female genital disorders	55	12.9%
Coronary atherosclerosis and other heart disease	45	10.6%
Sprains and strains	45	10.6%
Other gastrointestinal disorders	44	10.3%
Headache; including migraine	43	10.1%
Other nervous system disorders	43	10.1%
Chronic obstructive pulmonary disease and bronchiectasis	42	9.9%
Other skin disorders	42	9.9%
Osteoarthritis	39	9.2%
Blindness and vision defects	37	8.7%
Diabetes mellitus with complications	37	8.7%
Genitourinary symptoms and ill-defined conditions	36	8.5%
Other and unspecified benign neoplasm	36	8.5%
Other nutritional; endocrine; and metabolic disorders	33	7.7%
Other circulatory disease	32	7.5%
Anxiety; somatoform; dissociative; and personality disorders	31	7.3%
Malaise and fatigue	31	7.3%
Other upper respiratory disease	31	7.3%
Cardiac dysrhythmias	30	7.0%
Neoplasms of unspecified nature or uncertain behavior	30	7.0%
Other mental conditions	30	7.0%
Deficiency and other anemia	27	6.3%
Urinary tract infections	27	6.3%
Allergic reactions	26	6.1%
Esophageal disorders	26	6.1%
Other injuries and conditions due to external causes	26	6.1%
Nonmalignant breast conditions	25	5.9%
Asthma	23	5.4%
Joint disorders and dislocations; trauma-related	23	5.4%
Superficial injury; contusion	23	5.4%
Thyroid disorders	23	5.4%
Fluid and electrolyte disorders	22	5.2%
Heart valve disorders	21	4.9%
Other eye disorders	21	4.9%
Glaucoma	19	4.5%
Hepatitis	18	4.2%
Other and ill-defined heart disease	18	4.2%
Other bone disease and musculoskeletal deformities	18	4.2%
Other ear and sense organ disorders	18	4.2%

*prevalence = number of members with each condition/total members in study (n=426)

Prevalence of Diagnosis Chapters for SPP Members Who Have Exceeded MNCare Benefit Limit Through 12/2004

Chapter Description	Count	Prevalence*
Pneumonia (except that caused by tuberculosis or sexually transmitted disease)	18	4.2%
Skin and subcutaneous tissue infections	18	4.2%
Peripheral and visceral atherosclerosis	17	4.0%
Conditions associated with dizziness or vertigo	16	3.8%
Congestive heart failure; nonhypertensive	16	3.8%
Contraceptive and procreative management	16	3.8%
Menstrual disorders	16	3.8%
Nausea and vomiting	16	3.8%
Cataract	15	3.5%
Pleurisy; pneumothorax; pulmonary collapse	15	3.5%
Retinal detachments; defects; vascular occlusion; and retinopathy	15	3.5%
Abdominal hernia	14	3.3%
Biliary tract disease	14	3.3%
Calculus of urinary tract	14	3.3%
Fever of unknown origin	14	3.3%
Inflammation; infection of eye (except that caused by TB or STD)	14	3.3%
Other inflammatory condition of skin	14	3.3%
Viral infection	14	3.3%
Acute bronchitis	13	3.1%
Epilepsy; convulsions	13	3.1%
Other liver diseases	13	3.1%
Rheumatoid arthritis and related disease	13	3.1%
Complications of surgical procedures or medical care	12	2.8%
Menopausal disorders	12	2.8%
Chronic renal failure	11	2.6%
Other diseases of kidney and ureters	11	2.6%
Otitis media and related conditions	11	2.6%
Acute and unspecified renal failure	10	2.3%
Disorders of teeth and jaw	10	2.3%
Inflammatory diseases of female pelvic organs	10	2.3%
Mycoses	10	2.3%
Substance-related mental disorders	10	2.3%
Administrative/social admission	9	2.1%
Cancer of bronchus; lung	9	2.1%
Diseases of white blood cells	9	2.1%
Fracture of upper limb	9	2.1%
Gastritis and duodenitis	9	2.1%
Gastrointestinal hemorrhage	9	2.1%
Occlusion or stenosis of precerebral arteries	9	2.1%
Ovarian cyst	9	2.1%
Peri-; endo-; and myocarditis; cardiomyopathy (except that caused by TB or STD)	9	2.1%
Schizophrenia and related disorders	9	2.1%
Secondary malignancies	9	2.1%
Anal and rectal conditions	8	1.9%
Noninfectious gastroenteritis	8	1.9%
Cancer of breast	7	1.6%
Diseases of mouth; excluding dental	7	1.6%
Gout and other crystal arthropathies	7	1.6%
Other congenital anomalies	7	1.6%
Other hematologic conditions	7	1.6%
Other male genital disorders	7	1.6%
Phlebitis; thrombophlebitis and thromboembolism	7	1.6%
Syncope	7	1.6%
Acquired foot deformities	6	1.4%
Acute cerebrovascular disease	6	1.4%

*prevalence = number of members with each condition/total members in study (n=426)

Prevalence of Diagnosis Chapters for SPP Members Who Have Exceeded MNCare Benefit Limit Through 12/2004

Chapter Description	Count	Prevalence*
Benign neoplasm of uterus	6	1.4%
Cancer; other and unspecified primary	6	1.4%
Coma; stupor; and brain damage	6	1.4%
Conduction disorders	6	1.4%
Fracture of lower limb	6	1.4%
HIV infection	6	1.4%
Hypertension with complications and secondary hypertension	6	1.4%
Other and ill-defined cerebrovascular disease	6	1.4%
Other disorders of stomach and duodenum	6	1.4%
Other fractures	6	1.4%
Other hereditary and degenerative nervous system conditions	6	1.4%
Alcohol-related mental disorders	5	1.2%
Chronic ulcer of skin	5	1.2%
Coagulation and hemorrhagic disorders	5	1.2%
Complication of device; implant or graft	5	1.2%
Diverticulosis and diverticulitis	5	1.2%
Maintenance chemotherapy; radiotherapy	5	1.2%
Open wounds of extremities	5	1.2%
Open wounds of head; neck; and trunk	5	1.2%
Other endocrine disorders	5	1.2%
Respiratory failure; insufficiency; arrest (adult)	5	1.2%
Acute and chronic tonsillitis	4	0.9%
Acute myocardial infarction	4	0.9%
Aortic and peripheral arterial embolism or thrombosis	4	0.9%
Aortic peripheral; and visceral artery aneurysms	4	0.9%
Cancer of rectum and anus	4	0.9%
Genitourinary congenital anomalies	4	0.9%
Hyperplasia of prostate	4	0.9%
Infective arthritis and osteomyelitis (except that caused by TB or STD)	4	0.9%
Inflammatory conditions of male genital organs	4	0.9%
Intracranial injury	4	0.9%
Lymphadenitis	4	0.9%
Multiple sclerosis	4	0.9%
Non-Hodgkin`s lymphoma	4	0.9%
Nutritional deficiencies	4	0.9%
Other acquired deformities	4	0.9%
Other diseases of bladder and urethra	4	0.9%
Other psychoses	4	0.9%
Poisoning by other medications and drugs	4	0.9%
Regional enteritis and ulcerative colitis	4	0.9%
Septicemia (except in labor)	4	0.9%
ther diseases of veins and lymphatics	4	0.9%
Transient cerebral ischemia	4	0.9%
Acute posthemorrhagic anemia	3	0.7%
Cancer of bone and connective tissue	3	0.7%
Cystic fibrosis	3	0.7%
Hemorrhoids	3	0.7%
Immunity disorders	3	0.7%
Intestinal infection	3	0.7%
Intestinal obstruction without hernia	3	0.7%
Melanomas of skin	3	0.7%
Nephritis; nephrosis; renal sclerosis	3	0.7%
Other non-epithelial cancer of skin	3	0.7%
Preadult disorders	3	0.7%
Rehabilitation care; fitting of prostheses; and adjustment of devices	3	0.7%

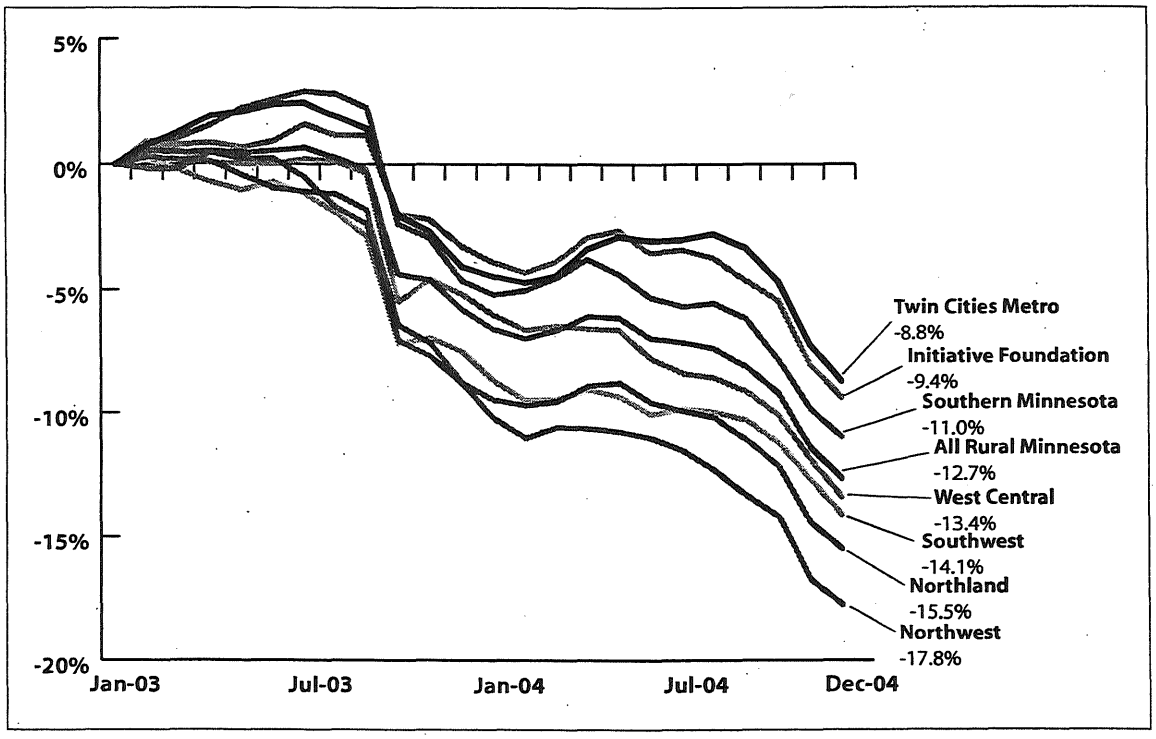
*prevalence = number of members with each condition/total members in study (n=426)

Prevalence of Diagnosis Chapters for SPP Members Who Have Exceeded MNCare Benefit Limit Through 12/2004

Chapter Description	Count	Prevalence*
Senility and organic mental disorders	3	0.7%
Systemic lupus erythematosus and connective tissue disorders	3	0.7%
Varicose veins of lower extremity	3	0.7%
Bacterial infection; unspecified site	2	0.5%
Burns	2	0.5%
Cancer of bladder	2	0.5%
Cancer of colon	2	0.5%
Cancer of esophagus	2	0.5%
Cancer of kidney and renal pelvis	2	0.5%
Cancer of other GI organs; peritoneum	2	0.5%
Cancer of prostate	2	0.5%
Crushing injury or internal injury	2	0.5%
Endometriosis	2	0.5%
Female infertility	2	0.5%
Late effects of cerebrovascular disease	2	0.5%
Leukemias	2	0.5%
Normal pregnancy and/or delivery	2	0.5%
Pancreatic disorders (not diabetes)	2	0.5%
Peritonitis and intestinal abscess	2	0.5%
Personal hx of mental disorder; mental and behavioral problems; observation and scree	2	0.5%
Aspiration pneumonitis; food/vomitus	1	0.2%
Cancer of brain and nervous system	1	0.2%
Cancer of cervix	1	0.2%
Cancer of head and neck	1	0.2%
Cancer of ovary	1	0.2%
Cancer of pancreas	1	0.2%
Cancer of stomach	1	0.2%
Cancer; other respiratory and intrathoracic	1	0.2%
Cardiac and circulatory congenital anomalies	1	0.2%
Cardiac arrest and ventricular fibrillation	1	0.2%
Ectopic pregnancy	1	0.2%
Gastroduodenal ulcer (except hemorrhage)	1	0.2%
Hemorrhage during pregnancy; abruptio placenta; placenta previa	1	0.2%
Liver disease; alcohol-related	1	0.2%
Nervous system congenital anomalies	1	0.2%
Osteoporosis	1	0.2%
Other complications of birth; puerperium affecting management of mother	1	0.2%
Other complications of pregnancy	1	0.2%
Other infections; including parasitic	1	0.2%
Other perinatal conditions	1	0.2%
Paralysis	1	0.2%
Pathological fracture	1	0.2%
Poisoning by nonmedicinal substances	1	0.2%
Pulmonary heart disease	1	0.2%
Sexually transmitted infections (not HIV or hepatitis)	1	0.2%
Skull and face fractures	1	0.2%
Trauma to perineum and vulva	1	0.2%
(blank)	-	0.0%
Grand Total	**3,524**	

*prevalence = number of members with each condition/total members in study (n=426)

Percent change in MinnesotaCare enrollees by region
Jan. 2003 to Dec. 2004
Center for Rural Policy and Development, March 2005



While MinnesotaCare is not typically viewed as a rural program, a recent analysis from the Minnesota Department of Health (using data from the Minnesota Department of Human Services) reveals that as of December 2004, 54.9 percent of all MinnesotaCare beneficiaries resided in rural Minnesota. This is in contrast to Census data which documents that only 41.6 percent of all Minnesotans reside in rural Minnesota. In their analysis, urban Minnesota was defined as the seven-county Twin Cities metro, along with the municipalities of St. Cloud, Duluth and Rochester.

Such a disproportionate representation of rural beneficiaries is likely due to the lower salary structure often found in rural places, as well as a large percentage of businesses in rural Minnesota that do not offer their employees employer-based health care coverage. In fact, in a 2001 study of rural businesses, Conner found that only half of the small businesses in northwest and southwest Minnesota (i.e., those with 10 or fewer employees) offered their employees health care coverage. Accordingly, MinnesotaCare is designed as a health insurance program for working, low-income Minnesotans.

The graph above documents the changes in enrollment of MinnesotaCare beneficiaries between January 2003 and December 2004. The data is broken down for both rural and metro Minnesota, as well as for each of the six Minnesota Initiative Foundation (MIF) regions.

As one can see, enrollment decreased all across the state, but the loss of MinnesotaCare benefits was more severe throughout rural Minnesota. Overall, rural Minnesota experienced a 12.7-percent decrease, while the metro area experienced an 8.8-percent decrease. Finally, when partitioned by region, it is clear that the greatest percentage decrease was experienced by northern Minnesota, where the Northwest Initiative Fund region experienced a decrease of 17.8 percent and the Northland Initiative Fund (northeast) region experienced a 15.5-percent decrease.

I wish to thank you for the opportunity to address the committee. My name is Thomas Deyo and I live in SE Minneapolis. My wife and I are covered by Minnesota Care Limited coverage. My wife is receiving approximately $850 per month in Social Security Disability, and this is our only income. I am currently waiting for a Social Security Disability hearing. My doctor has submitted a statement that states:

> **Thomas suffers from diabetes mellitus complicated by nephropathy, hypertension, coronary artery disease, neuropathy and incapacitating depression. Diabetes was first diagnosed approximately 1991. His condition has deteriorated significantly in the time he has been under my care (He was first seen by me 6/02). His most significant and acute deterioration has been since a hospitalization 6/30/04. He is no longer able to work due to symptoms related to his diabetes related complications. This includes problems with dizziness, chronic fatigue, depression, chest and joint pain. It is likely he will require access placement for dialysis in the near future.**

The medications that I am currently on cost approximately $700 dollars per month. With this medical history, I have found that to get private insurance would be prohibitively expensive and I cannot work to qualify for employer group coverage. The last quote I investigated was over $1000 per month, and that was 4 years ago, before many of the problems mentioned were diagnosed.

We are awaiting a Social Security hearing to determine if I will receive Social Security Disability. It is my understanding is that there is a 12-month waiting period before I would become eligible for Medicare coverage after a positive determination from Social Security. The attorney that is representing me, told me that I MUST, see all the doctors and have all the tests that are recommended or it is like when you apply for unemployment and refuse a job. You can be declared ineligible for failure to cooperate. My estimation is that with these required tests, and doctor's visits, not to mention prescriptions; I am very near using up all my benefits for the year.

With my wife's Social Security income puts us over the amount to qualify for the regular Minnesota Care coverage by only a few dollars per month. We are covering our mortgage and expenses buy spending down the small IRA that we have. I estimate this will only get us by for 2-4 months. After this I do not know what we will do if I do not get the Social Security Disability.

I did not come here to beg, I was raised with the rural Minnesota work ethic, and have had at least two jobs most of my life. I have worked hard to support my family, and community. What I am hoping for is answers to what is someone in my situation to do. Minnesota has a long and rightfully proud reputation of social concern for not only its' citizens but the whole world.

I would hate to see this state lose this distinction. I understand that there are financial considerations that need to be addressed, and would like the committee to consider some possible ideas.

1. **Raise the income basis for eligibility for the Minnesota Care regular coverage on a graduated scale. This would still place a control on the expense to the state, but help those that are on the cusp, of the limits.**
2. **Change the eligibility to individual coverage rather that being based on the household. This would allow households that have one member that has severe medical problems to receive help, without strangling the other person from seeking employment and jeopardizing their spouse's medical coverage, if the employer does not offer health insurance.**
3. **Separate and have limits for each of the types of coverage. The program currently has inpatient and outpatient limits. The outpatient limits include doctor's visits as well as tests, and prescription coverage. If this was segmented, say for example that prescriptions are covered completely (minus a reasonable co pay), if all generic medications were used when ever possible.**
4. **Allow continued regular Minnesota Care coverage for those that are in process for Social Security Disability, until they become eligible for Medicare coverage, or are denied at final appeal. Since Social Security requires additional testing, that many probably would not pursue. During this time many people cannot work, or have even passive income, beyond what Social Security calls significant income, currently $800 per month.**

I have looked into the requirements of Medical Assistance. I have found I would have to SPEND DOWN our assets to qualify. This would include the IRA we are using to make our mortgage. In effect forcing us to sell our home, then spend down any profit we may have received, leaving us with nothing. I also found out if I am able to some how avoid having to sell the home, I saw testimony before I believe it was this committee that MA places a lien on the residence of anyone receiving benefits thru the recapture provision. I feel this is unfair as it places a discriminatory penalty on those that have worked hard, and managed to purchase a home. This same debt is not required of people that do not own a home. The state and community are farther ahead in many ways having homeowners rather than renters.

In conclusion I would like the committee to consider that even if financially the state may be better off if those of us that have worked hard, and contributed for many years, and can no longer do so, would move to another state or just die. I ask that the state seek out and find a Win-Win solution. A solution that is affordable, and allows those seeking and needing help, to maintain a modicum of dignity and self-respect.

APApractice.org

Psychologists Promote Health and Well-Being Throughout Our Nation

March 1, 2005 -- **Psychologists treat mental health and alcohol and substance abuse disorders.**

Did You Know? Mental disorders are common in the United States. An estimated 22.1% of Americans ages 18 and older -- about 1 in 5 adults -- suffer from a diagnosable mental disorder in a given year.

Training and Licensure. Psychologists receive a median of seven years of education and training beyond their undergraduate degree, including practica and internship training in hospitals and in other health care settings. Psychologists are licensed in all 50 states and the District of Columbia. Licensure is generally uniform, authorizing a psychologist to independently diagnose and treat mental and nervous disorders upon completion of both a doctoral degree in psychology (PhD, PsyD or EdD) and a minimum of two years of supervised direct clinical service.

Did You Know? The President's New Freedom Commission on Mental Health recommends that the nation must address mental health with the same urgency as physical health.

Psychotherapy. Psychologists provide psychotherapy, a treatment that in many cases is equally, if not more, effective than drug therapy. Cognitive and interpersonal psychotherapies, for example, are effective treatments for depression. Psychotherapy, as an alternative to drug therapy, is particularly valuable to elderly patients to avoid overmedication or side effects of various drugs and drug interactions. Psychotherapy is effective alone or in combination with medication to address a wide range of mental disorders, including anxiety disorders (such as panic, obsessive-compulsive, and post-traumatic stress disorders), depression, substance or alcohol abuse, and many other disorders that can devastate an individual's personal, family, social and work life.

Diagnostic Services. Psychologists also diagnose health problems with state-of-the-art diagnostic testing tools. Physicians and other health care professionals turn to psychologists for their diagnostic capabilities and services, including for example, detecting functional impairment and assessing the prognosis for improvement or deterioration in functioning. Psychologists apply these results and develop rehabilitative services and treatment.

Diversity. Psychologists are trained to and provide services to an increasingly diversified national population. By 2025, racial and ethnic minorities will comprise nearly 40% of Americans. These individuals experience access-to-care and socio-cultural issues that must be addressed to ensure quality care. People living in rural and frontier areas also commonly have access-to-care challenges, and psychologists in these areas tailor care and make use of innovative technologies to provide treatment. Women, children and adolescents, the elderly, persons of diverse sexual orientation and the disabled have special needs and require interventions that address their unique needs. Psychologists continue to work to solve issues related to diversity in mental health treatment.

In addition to mental health, psychologists provide primary, preventive and disease management services for patients dealing with both mental and physical disorders. The mind and body are linked, and mental disorders frequently co-exist with physical disorders. Psychologists, often working with physicians and other health care professionals, care for patients to prevent illness and to participate in chronic disease management.

Did You Know? 24% of patients who present themselves to primary care physicians suffer from a well-defined mental disorder. The majority of these patients (69%) usually present to physicians with physical symptoms and there is ample evidence that many of these cases remain undetected.

Did You Know? Of individuals who die by suicide, approximately 90% had a mental disorder, and 40% of these individuals had visited their primary care doctor within the month before their suicide.

Preventive Care. The President's New Freedom Commission on Mental Health recommends screening for mental disorders in primary health care, across the life span, and connection to treatment and support systems. Psychologists' screening services are key to meeting this need, and psychologists help patients develop coping strategies and healthy behaviors, which are effective in reducing the factors associated with the development of illness. For instance, psychotherapy and/or behavioral interventions help individuals to change habits to reduce risks for cardiovascular disease, cancer and HIV.

Primary Care. Recognizing that mental health is key to overall physical health, the President's New Freedom Commission on Mental Health cited primary care as an area where patients need to receive more effective mental health assessment and treatment. The Commission recommended widespread implementation of collaborative care models in primary care health care settings, highlighting for example a collaborative care model for treating late-life depression. Psychologists in primary care settings work together with physicians and other health care professionals and serve a crucial function in assessment, treatment planning, and provision of psychological services for patients with a wide variety of health complaints.

Psychologists also commonly provide behavioral interventions to ensure patient compliance with treatment regimens for physical health problems.

Chronic Disease Management. Psychologists commonly work in primary, acute and long-term care settings to provide services to patients with chronic conditions, such as diabetes and conditions stemming from obesity. These services include an array of individual, group, and family psychological interventions that are effective for depression, anxiety, pain and adjustment issues surrounding chronic illness. Psychologists help patients with life-threatening illnesses, such as coronary artery disease and cancer to manage pain, cope with medical interventions and the side effects of interventions, and by providing support to address family needs and the tangible and intangible aspects of illness.

Diabetes. As the President's New Freedom Commission on Mental Health cites, people with both diabetes and depression have an increased likelihood of experiencing diabetes complications compared to those without depression. Psychologists deliver a number of interventions to help patients address diabetes. For example, psychologists help diabetic individuals maintain diet and insulin treatments through psychotherapy.

Obesity is now recognized as a major national health concern due to its prevalence in adults and children, and its impact on mortality, diabetes, cancer, cardiac and other health conditions. In fact, the annual U.S. direct costs (such as treatment) and indirect costs (such as lost wages) associated with obesity and overweight are estimated at $122.9 billion, which is comparable to the costs of cigarette smoking. Psychologists are helping to fight obesity through behavioral interventions and counseling programs.

Did You Know? In a groundbreaking study conducted jointly by researchers at the Duke University Medical Center and APA, patients who were taught to manage their stress in addition to usual medical care had fewer adverse cardiac events and cost less to treat over a sustained period of time.

Cardiac Care. Psychosocial factors contribute significantly to coronary artery disease. Psychologists have expertise to help people reduce the risk of heart disease and the incidence of heart attacks. Psychologists also help patients recover from heart attacks. Incorporating psychological interventions, such as stress management, into the overall treatment of cardiovascular disease has been shown to have significant economic and health benefits.

Did You Know? Researchers estimate that as many as 50 to 75% of cancer deaths in the United States are caused by human behaviors such as smoking, physical inactivity and poor dietary choices.

Cancer. Psychologists are also often part of the team of health care professionals who treat cancer patients, working directly with the patient and his or her family and the entire medical team to personalize decisions, deal

with symptoms, manage treatment side-effects, improve communications and provide support and enhance recovery and well-being.

Psychologists provide services not only in health care facilities but also in many other settings.

Outpatient Care. Psychologists typically deliver psychotherapy and other services as solo or group practitioners. For many patients and payers of care, outpatient psychology treatment is effective, cost-efficient, and less restrictive and more accessible than inpatient care. Psychologists are trained to treat the most serious mental disorders, but they also help people in all aspects of daily life, such as parenting, caring for elderly parents, other family issues, or sexual issues.

Inpatient and Other Settings. Psychologists are important providers of inpatient care in general hospitals, psychiatric hospitals, VA and military hospitals, and in clinic settings such as community mental health centers, outpatient clinics, nursing homes, and rehabilitation facilities. Psychologists also teach and provide services in universities and colleges, medical schools, and university counseling or guidance centers.

Did You Know? One in 12 high school students is threatened or injured with a weapon each year. An individual between the ages of 12 and 24 faces the highest risk of being a victim of violence.

Elementary and Secondary Schools. Psychologists in elementary and secondary schools fulfill multiple roles. They deliver prevention, intervention and crisis services to students. They provide psychological educational assessment and evaluation. Psychologists consult with teachers and school administrators about student issues, classroom management and school-wide programs. Administrators and teachers also turn to them for their diagnostic and treatment capabilities, and for help in resolving students' family issues. Since the September 11, 2001 terrorist attacks, psychologists have increased efforts to help children and adolescents cope with and develop their resilience skills.

Did You Know? 4 of the 10 leading causes of disability in the United States are mental disorders.

Workplace. Psychologists help employers to make the workplace more psychologically healthy and productive. They help employees deal with stress and other workplace issues through employee assistance programs and initiatives. APA encourages psychologically healthy workplaces by honoring best practices as a part of the Psychologically Healthy Workplace Award Program.

Did You Know? About 16% of all inmates in state and federal jails suffer from a mental disorder and an astounding 80% of all children entering the juvenile

justice system have a mental disorder.

Criminal Justice System. Psychologists provide forensic evaluations and testimony, and they work in correctional and juvenile justice facilities, providing mental health services to criminal offenders with mental disorders. Psychologists are at the forefront of developing innovative initiatives, such as jail diversion, mental health courts, and community re-entry programs to prevent mentally ill offenders from recycling back into the criminal and juvenile justice systems. The President's New Freedom Commission on Mental Health recommended the widespread adoption of these programs to avoid the criminalization and extended incarceration of non-violent adult and juvenile offenders with mental disorders.

Psychologists aid people in a crisis or disaster, and psychologists have responded to terrorist attacks by helping Americans build their resilience to the threat of terrorism.

Disaster Response. In association with the American Red Cross, APA's Disaster Response Network of more than 2,000 volunteer psychologists, trained in disaster response, assist relief workers, victims, and victims' families in the wake of manmade or natural disasters. These psychologists help disaster victims cope with extremely stressful, often tragic circumstances in many ways, including providing emotional support and helping people marshal their own successful skills of resilience.

Terrorism. Since the September 11, 2001 terrorist attacks, psychologists are helping people build their resilience in response to a continuing threat of terrorism and the ongoing stresses of war. Psychologists active in outreach are conducting forums and bringing resources to communities to enable people to strengthen their resilience. To this end, APA has developed pamphlets and on-line material for psychologists and the public.

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Approximate monthly cost of routine pharmaceutical and medical care for diabetes, with and without complications, for two typical patients[81]

Item/ Service	Jeff		Elisabeth	
	Unit/dosage	Price (30 day supply)	Unit/dosage	Price (30 day supply)
Insulin	Lantus (20 units1x per day = 600 units/month). ($65.99/bottle = $.0660/unit)	$39.60	Humulin N (40 units 1x per day = 1200 units/month). ($29.19/bottle = $0.0292/unit)	$35.04
	Humalog pen (20 units 3x per day = 1800 units/month) (300 units per pen = 5 pens per month at $25.19 per pen)	$125.95		
Oral diabetes medication	n/a		Metformin (generic for glucophage) - 1000 mg 2x per day (60 count)	$66.59
			Avandia (8 mg 1x per day)	$162.99
Blood glucose testing equipment and supplies	Lancets – BD Ultra Fine II – 4 used per day (100 count @$7.98 - $.0798 per lancet)	$9.58	Lancets – BD Ultra Fine II – 2 used per day (100 Count @ $7.98 - $.0798 per lancet)	$4.79
	Syringes – ½ cc BD Micro Fine Needles – 1 per day (100 count = $0.2499 each)	$7.50	Syringes – ½ cc BD Micro Fine Needles – 1 per day (100 count = $0.2499 each)	$7.50
	CVS Brand Blood Glucose Meter ($14.99 - purchased every 2 years)	$0.625	CVS Brand Blood Glucose Meter ($14.99 - purchased every 2 years)	$0.625
	Blood glucose test strips – CVS Brand (100 count @ $44.99/box) – 4 strips used per day - $0.4499/per strip	$53.99	Blood glucose test strips – CVS Brand (100 count @ $44.99/box) – 2 strips used per day - $0.4499/per strip	$26.99
	Alcohol swabs – BD brand (100 count @ $2.49/box - $0.0249/swab) 4 per day	$2.99	Alcohol swabs – BD brand (100 count @ $2.49/box - $0.0249/swab) 2 per day	$1.49
	Glucagon Kit ($90.60 purchased one per year)	$7.55	n/a	
Other medication	Altace (10 mg 1x per day)	$60.59	Altace (10 mg 1x per day)	$60.59
			Hydrochlorothiazide (12.5 mg 1x per day)	$12.89
			Lipitor (40 mg 1x per day)	$109.99
			Neurontin (300 mg 3x per day) ($43.59 per 30 count)	$130.77
			Diltiazem (generic for Cardizem CD) - 300 mg 1x per day	$71.59
			Inderal LA (120 mg 1x per day)	$65.59
Physician visits	Endocrinologist visit (4 per year @ $82.15 per visit; includes blood pressure test and foot exam) plus lab tests: HbA1c test ($13.56), cholesterol test ($16.26 – once per year)[a]	$33.26	Internist visit (4 per year @$82.15 per visit; includes blood pressure test and foot exam) plus lab tests: HbA1c test ($13.56), cholesterol test ($16.26 – once per year)[a]	$33.26
	Ophthalmologist visit (1 per year @ $52.65 per visit)[b]	$4.39	Ophthalmologist visit (1per year @ $52.65 per visit)[b]	$4.39
			Podiatrist visit (2 per year @ $52.65 per visit)[2]	$8.78
Total avg. monthly cost		$346.03		$803.87

[a] Medicare fee schedule, CPT code 99214 (established patient, level 4 office visit) = $82.15; HbA1c test uses Medicare fee schedule, HCPC code 83036 = $13.56; cholesterol test HCPC code 83719 = $16.26; total cost = $111.97 per visit when a cholesterol test is performed; $95.71 per visit when a cholesterol test is not performed.

[b] Medicare fee schedule, CPT code 99213 (established patient, level 3 office visit) = $52.65.

Minnesota Department of Health Fact Sheet 2/15/05

Diabetes in Minnesota

For more diabetes data, please visit the full *Diabetes in Minnesota* report on the World Wide Web: http://www.health.state.mn.us/diabetes/diabetesinminnesota/

Scope of the Problem

One in 10 Minnesotans either have diabetes or are at high risk of developing it.[1,2]

- 281,000 Minnesotans have diabetes; of that total, 200,000 know they have diabetes and 81,000 do not know that they have diabetes.
- 232,000 Minnesotans have impaired fasting glucose (IFG), a form of pre-diabetes.

Source: Estimated prevalence of diagnosed diabetes is based on 2003 Minnesota Behavioral Risk Factor Surveillance Survey (BRFSS) data, 2003 Minnesota population estimates and the National Health Interview Survey (NHIS). Undiagnosed diabetes and IFG are estimated from the National Health And Nutrition Examination Survey (NHANES) 1999-2000.

Each year, more than 15,000 Minnesotans are newly diagnosed with diabetes. This means that every 30 minutes in Minnesota, a doctor tells someone for the first time that they have diabetes.

Source: Estimated incidence is based on National Health Interview Survey (1990-1992) and the 2003 Minnesota population.

Diabetes is the 6th leading cause of death in Minnesota.

- Every 2½ hours someone in Minnesota dies from diabetes or diabetes-related causes.
- Diabetes contributed to 3,731 deaths last year; of these, diabetes was the underlying cause of 1,314 deaths.[3]

Source: 2002 Minnesota death certificates.

Risk Factors

Among adult Minnesotans without diabetes, significant, common and potentially modifiable risk factors place many at risk for developing diabetes.

- 3 in 5 are overweight or obese.
- 1 in 2 have sedentary lifestyles.
- 1 in 4 have no leisure time physical activity.
- 1 in 5 are current smokers.

Source: Minnesota Behavioral Risk Factor Surveillance Survey (BRFSS).

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Preventive Care

Among Minnesotans with diabetes:

- 9 in 10 see a doctor or nurse at least once a year for their diabetes.
- 3 in 4 have had a dilated eye exam in the past year.
- 8 in 10 have had a foot exam in the past year.
- 7 in 10 have had their cholesterol checked in the past year, but 2 in 10 have *never* had their cholesterol checked.
- 6 in 10 check their blood glucose at least once per day.
- 6 in 10 have had a flu shot in the past year.
- 5 in 10 have ever had a pneumonia vaccination.

Source: Minnesota Behavioral Risk Factor Surveillance Survey (BRFSS).

Long Term Complications

The risk of cardiovascular disease (CVD) and stroke are *2 to 4 times* higher in people with diabetes.

- Half of all Minnesotans with diabetes have been told by a doctor they have high blood pressure.
- Minnesotans with diabetes are 2-3 times more likely than those without to have been told by a doctor that they have high blood pressure.
- CVD is present in nearly 4 out of every 5 diabetes-related deaths in Minnesota.

Source: Minnesota Behavioral Risk Factor Surveillance Survey (BRFSS) and Minnesota death certificates.

Diabetes is the leading cause of non-traumatic lower extremity amputations (LEAs). Among Medicare beneficiaries in Minnesota, the rate of LEAs is almost 13 times greater for those with diabetes compared to those without diabetes.

Source: Morbidity and Mortality Weekly Report August 14, 1998, Vol. 47, No. 31.

Diabetes is the leading cause of blindness among people age 20-74.

- Approximately 88,600 Minnesota adults aged 18 and older have diabetic retinopathy.
- Approximately 3,700 Minnesotans have diabetes-related blindness.
- Each year between 500 and 800 Minnesotans lose their sight due to complications of diabetes.

Source(s): Estimated prevalence of diabetic retinopathy from *Vision Problems in the U.S.*: http://www.preventblindness.org/vpus/Minnesota.htm
Estimated prevalence and incidence of diabetes-related blindness are based on the Massachusetts State Commission for the Blind (MCB) registry and the Wisconsin Epidemiologic Study of Diabetic Retinopathy (WESDR).[4]

Diabetes in Minnesota– page 2

Diabetes is the leading cause of end-stage renal disease (ESRD), or kidney failure.

- Diabetes accounts for nearly 2 out of every 5 new cases of ESRD treatment annually.
- In 2002:
  - There were 468 new cases of ESRD treatment among Minnesotans with diabetes
  - 2,071 Minnesotans with diabetes were being treated for ESRD (estimate of prevalence).
  - 26 Minnesotans with diabetes received kidney transplants.
- There are marked racial and ethnic disparities in ESRD in Minnesota.

Source: U.S. Renal Disease System (2004).

New cases of diabetes-related ESRD.

Race/Ethnicity	Cases per million
Non-Hispanic White	75
Black	105
Asian	177
Hispanic	314
American Indian	433

Source: U.S. Renal Disease System, 1998 data, adjusted for age and sex.

Mothers and Infants

Diabetes during pregnancy, if not tightly managed, can raise risks for birth defects and perinatal death. Diabetes during pregnancy also predisposes infants to obesity, heart disease and diabetes as adults. For mothers, pre-existing diabetes (pre-GDM) can accelerate development of complications from diabetes, and mothers with gestational diabetes (GDM) have a significantly greater risk for developing type 2 diabetes.

- Last year, pre-GDM complicated 334 live births to Minnesota residents; gestational diabetes GDM complicated 2,390 Minnesota births.[3]
- Diabetes is the 2nd leading medical risk factor of pregnancy in Minnesota, behind hypertension.
- Babies born to Minnesota mothers with pre-existing diabetes have twice the risk of congenital anomalies and perinatal death.
- There are marked racial and ethnic disparities in diabetes-complicated pregnancy.

Prevalence of diabetes among live births to Minnesota residents.

	Per 1,000 Live Births	
Race/Ethnicity	PEDM	GDM
Non-Hispanic White	3.6	30.6
Black	8.9	42.8
Asian	4.1	56.5
Hispanic	8.8	62.5
American Indian	28.0	76.7

Source: Minnesota birth certificates. PEDM rates are for 1999-2002. GDM rates are for 2002. Both are age-adjusted to the total maternal population, 1993-2002.

Economic Cost

Diabetes costs Minnesota $2 billion annually, including medical care, lost productivity and premature mortality.
Source: Centers for Disease Control & Prevention (2001)

Management and Prevention

Blood glucose control reduces the risk of long-term complications for people with type 1 and type 2 diabetes.
Sources: Diabetes Control and Complications Trial (1993); United Kingdom Prospective Diabetes Study (1998).

Blood pressure control reduces the risk of complications, including stroke and heart failure, for people with type 2 diabetes.
Source: United Kingdom Prospective Diabetes Study (1998).

Blood lipid control reduces the risk of heart failure and death for people with heart disease and diabetes or impaired fasting glucose levels.
Source: Scandinavian Simvastatin Survival Study (4S) (1999).

Being active and eating healthfully sharply lowers the risk for developing type 2 diabetes among those at highest risk. The Diabetes Prevention Program showed that lifestyle changes are more effective than oral diabetes medications at preventing or delaying the onset of diabetes (58% vs. 31% reduction in risk). Lifestyle changes are effective for preventing diabetes among men and women of all ages and in all ethnic groups.
Source: Diabetes Prevention Program (2001).

For more information on diabetes management and prevention, please visit the Minnesota Diabetes Program's site on the World Wide Web: http://www.health.state.mn.us/diabetes/

Technical Notes

1. The Minnesota BRFSS is an annually administered telephone survey among randomly sampled Minnesota residents 18 years or older. The prevalence of diagnosed diabetes is assessed with the question: "Has a doctor ever told you that you have diabetes?"

2. Estimates derived from national surveys—National Health Interview Survey (NHIS) and the National Health and Nutrition Examination Survey III (NHANES III)—are based on a national sample, which may vary slightly from the Minnesota population.

3. Vital statistics may seriously underestimate diabetes prevalence and mortality. Surveys have found that diabetes is under-reported both as a cause and a contributing condition of death. Diabetes is mentioned on only about 40% of all death certificates among people with diagnosed diabetes. Diabetes may be reported for only 40%-75% of all live births to mothers with pregestational or gestational diabetes.

4. The Massachusetts State Commission for the Blind (MCB) registry includes those 20 years or older; the Wisconsin Epidemiologic Study of Diabetic Retinopathy (WESDR) includes all ages. Though estimates provided in this report assume they are the same, these populations may differ from the Minnesota population.

Background Information

Minnesota Department of Health

February 2005

Uninsured with Diabetes in Minnesota

Background

- Diabetes is a serious, life threatening, chronic disease with no cure.
- Managing diabetes is costly and complicated. Tools of good management typically include:
  - Medications
  - Equipment such as glucose meters or insulin pump
  - Supplies such as test strips and syringes
  - Regular medical testing
  - Routine physician visits
- Poor management of diabetes can result in costly, life threatening and disabling complications, loss of worker productivity, and premature death.
- Diabetes costs Minnesotans $2 billion annually.[1] One in ten health care dollars are spent on diabetes.

Uninsured in Minnesota

- In 2001, 3.1% of people with diagnosed diabetes 18 or older in Minnesota reported having no health coverage at the time they were surveyed.
- Approximately **4,800 adults with diagnosed diabetes were uninsured** in 2001.
- In 2001, 5.4% or an estimated 266,000 Minnesotans of any age reported having no health coverage at the time surveyed.

Data Sources: 2001 Minnesota Behavioral Risk Factor Surveillance Survey data and 2001 Minnesota population estimates for uninsured with diabetes; Minnesota Health Access Survey (2001) for uninsured overall (http://www.health.state.mn.us/divs/hpsc/hep/miscpubs/hhsrvrpt.pdf).

Under-Insurance and Diabetes

- Under-insurance for diabetes occurs when coverage does not include test strips or prescription drugs or when high deductibles discourage insured people from getting the care necessary to manage their diabetes.
- More than one in three people with diabetes in the U.S. lack coverage for medicines.[2]
- Emergencies due to complications are associated with lacking diabetes medication.[3]

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Impact of Being Uninsured or Under-Insured

- Uninsured people, particularly those with chronic conditions, are sicker and die sooner than their insured peers.[4]
- Lack of insurance is the third leading cause of death for adults ages 55-64.[5]
- The leading cause of personal bankruptcy filings is health-related debt, often due to inadequate health insurance.[4]
- Uninsured people pay up to twice as much as insurers do for the same health care services because insurers are able to negotiate discounts on behalf of a large group of policy holders.[6]

Impact on People with Diabetes

- Uninsured people with diabetes are far less likely to receive health care that meets professional standards and guidelines.[4]
- Uninsured people with diabetes receive significantly fewer eye exams, foot exams and cholesterol tests[7]–services that help reduce the incidence of blindness, amputations, and heart attacks and strokes, respectively.[8]
- More than two thirds of uninsured people with diabetes report high blood glucose levels,[9] significantly increasing their risk of complications such as heart attack, stroke, kidney failure and death.[8]

Cost to Health System and Society

- Poor diabetes control results in high health care costs. For example, a 1% rise in hemoglobin A1C (an indicator of diabetes control) increases health cares costs by 4-5%.[10]
- For the uninsured, more medical care is delivered in high-cost emergency departments than in physician offices.[4,11]
- Provision of care to uninsured or underinsured people, often called "uncompensated care", is directly related to lack of health insurance.[11]
- In 2001, U.S. tax payers covered as much as 85% of the $35 billion spent on uncompensated care.[13]

Background Information

Minnesota Department of Health February 2005

Uninsured with Diabetes in Minnesota

Increasing Health Disparities

- Two-thirds of uninsured people with diabetes in the U.S. report that they do not have health insurance because they cannot afford it.[9]
- For people with diabetes, the median income level for those with no health insurance is almost two-thirds lower than the income of those with private insurance.[2]
- Ethnic minorities with diabetes are 2-3 times more likely to lack health care coverage than non-Hispanic Whites.[14]

Examples of National Governors Association's Best Practices for Containing Health Care Costs[15]

- Prevent high cost, chronic diseases such as diabetes by implementing strategies to control obesity, reduce tobacco use, improve nutrition and increase physical activity.
- Improve care and management for chronic conditions, which are the most prevalent and costly yet preventable of health problems:
  - Diabetes, cardiovascular disease, cancer and obesity account for 80% of health care expenditures.
  - Every $1 invested in diabetes self-management training can cut health care costs by up to $8.76.
- Prevent unnecessary nursing home and hospital use by reducing falls and increasing physical activity and immunizations for older adults.
- Update Maximum Allowable Cost fees for items as medical testing services, equipment, supplies and prescription drugs to accurately reflect vendor acquisition costs, and work to reduce the maximum limits when possible.
- Ensure that Medicaid is not assuming payments that should be made by private insurers, Medicare, the VA and other third party payers.
- Increase coordination with private insurance to create affordable insurance products in small group or individual markets that expand access over traditional Medicaid benefits.
- Increase other sources of financing for long-term care costs, such as creating incentives for people to purchase individual long-term care insurance policies.

References

1. Minnesota Diabetes Program (2005). Diabetes in Minnesota. St. Paul, MN: Minnesota Department of Health. (http://www.health.state.mn.us/diabetes/diabetesinminnesota/FactSheet2004.pdf)
2. Harris M (1995), "Health Insurance and Diabetes." In Harris MI, Cowie CC, Stern MP, Boyko EJ, Reiber GE, Bennett PH (eds): *Diabetes in America*. 2nd ed., DHHS Pub. No. (NIH) 95-1468, Washington, DC: U.S. Department of Health and Human Services, pp. 631-659. (http://www.niddk.nih.gov/health/diabetes/dia/chpt4.pdf)
3. Wilson & Sharma (1995). Public cost and access to primary care for hyperglycemic emergencies, Clark County, Nevada. *J Community Health* 20(3):249-56.
4. Institute of Medicine: *Coverage Matters* (2001); *Care without Coverage* (2002); *Hidden Costs, Value Lost: Uninsurance in America* (2003); *Insuring America's Health* (2004). Washington DC: National Academies Press.
5. McWilliams, et al. (2004). Health insurance coverage and mortality among the near-elderly. *Health Affairs* 23(4): 223-33.
6. Wielawski I (2000). Gouging the medically uninsured: a tale of two bills. *Health Affairs* (Millwood),19(5):180-5.
7. Ayanian JZ, et al (2000). Unmet health needs of uninsured adults in the United States. *JAMA* 284:2061-9.
8. Diabetes Control and Complications Trial (1993); United Kingdom Prospective Diabetes Study (1998).
9. Harris MI, et al (1994). Health-insurance coverage for adults with diabetes in the U.S. population. *Diabetes Care* 17(6):585-91.
10. Gilmer T, et al (2005). Predictors of health care costs in adults with diabetes. *Diabetes Care* 28(1):59-64.
11. Health Economics Program (1999). Uncompensated Health Care in Minnesota. St. Paul, MN: Minnesota Department of Health. (http://www.health.state.mn.us/divs/hpsc/hep/reports/uncompcare99.pdf)
12. Strunk & Reschovsky. *Trends in U.S. Health Insurance Coverage, 2001-2003*. (Tracking Report No. 9). Center for Studying Health System Change. August 2004. (http://www.hschange.org/CONTENT/694/).
13. Kaiser Commission on Medicaid and the Uninsured: *Health Care for the Uninsured: How Much Do We Already Spend and Who Pays*, 2001 (http://www.kff.org/uninsured/20030212-index.cfm).
14. Gary TL, et al (2003). Racial/ethnic differences in the healthcare experience (coverage, utilization, and satisfaction) of US adults with diabetes. *Ethnicity & Disease* 13(1):47-54.
15. National Governors Association Centers for Best Practices. *Issue Brief: State Actions to Control Health Care Costs*. November 2003 (http://www.nga.org/cda/files/1103COSTCONTAIN.pdf).

For more information

To learn more about diabetes management and prevention: http://www.health.state.mn.us/diabetes/
Diabetes Program: 651/281-9849 or 800/627-3529
TDD: 651/215-8980.

If you require this document in another format, such as large print, Braille or cassette tape, call 651/281-9849.

Third-Party Reimbursement for Diabetes Care, Self-Management Education, and Supplies

AMERICAN DIABETES ASSOCIATION

Diabetes is a chronic disease that affects nearly 17 million Americans (1), with over 10 million cases diagnosed, and is characterized by serious, costly, and potentially fatal complications. The total cost of diagnosed cases of diabetes in the U.S. in 2002 was estimated to be $92 billion (1). To prevent or delay the costly complications and to enable people with diabetes to lead healthy, productive lives, appropriate medical care based on current standards of practice, self-management education, and medication and supplies must be available to everyone with diabetes. This paper is based on technical reviews titled "Diabetes Self-Management Education" (2) and "National Standards for Diabetes Self-Management Education Programs" (3).

The goal of medical care for people with diabetes is to optimize glycemic control and minimize complications. The Diabetes Control and Complications Trial (DCCT) demonstrated that treatment that maintains blood glucose levels near normal in type 1 diabetes delays the onset and reduces the progression of microvascular complications. The U.K. Prospective Diabetes Study (UKPDS) documented that optimal glycemic control can also benefit most individuals with type 2 diabetes. To achieve optimal glucose control, the person with diabetes must be able to access health care providers who have expertise in the field of diabetes. Treatment plans must include self-management training, regular and timely laboratory evaluations, medical nutrition therapy, appropriately prescribed medication(s), and regular self-monitoring of blood glucose (SMBG) levels. The American Diabetes Association position statement "Standards of Medical Care for Patients with Diabetes Mellitus" outlines appropriate medical care for people with diabetes (4).

An integral component of the DCCT was self-management education (inpatient and/or outpatient) delivered by an interdisciplinary team. Self-management training also helps people with type 2 diabetes adjust their daily regimen to improve glycemic control. Diabetes self-management education is the process of providing the person with diabetes with the knowledge and skills to perform self-care on a day-to-day basis. Self-management education teaches the person with diabetes to assess the relationships among medical nutrition therapy, activity level, emotional and physical status, and medications and then respond appropriately and continually to those factors to achieve and maintain optimal glucose control.

Today, self-management education is a critical part of the medical plan for people with diabetes, such that medical treatment of diabetes without systematic self-management education cannot be regarded as acceptable care. The National Standards for Diabetes Self-Management Education Programs establish specific criteria against which diabetes education programs can be measured, and a quality assurance program has been developed and subsequently revised (5).

Treatments and therapies that improve glycemic control and reduce the complications of diabetes will also significantly reduce health care costs (6,7). Numerous studies have demonstrated that self-management education leads to reductions in the costs associated with all types of diabetes. Participants in self-management education programs have been found to have decreased lower-extremity amputation rates, reduced medication costs, and fewer emergency room visits and hospitalizations.

Access to the integral components of diabetes care, such as health care visits, diabetes supplies and medications, and self-management education, is essential. The American Diabetes Association believes insurers must reimburse for medical treatment and also for self-management education programs that have met accepted standards, such as the American Diabetes Association's National Standards for Diabetes Self-Management Education Programs. All medications and supplies, such as syringes, strips, and meters, related to the daily care of diabetes must also be reimbursed by third-party payers. Organizations that purchase health care benefits for their members or employees should insist that self-management education, medications, and supplies be included in the services provided, and managed care organizations should include these services and supplies in the basic plan available to all participants.

It is recognized that the use of formularies, prior authorization, and related provisions (hereafter referred to as "controls"), such as competitive bidding, can manage provider practices as well as costs to the potential benefit of payors and patients. Social Security Act Title XIX, section 1927, states that excluded agents should not have "a significant clinically meaningful therapeutic advantage in terms of safety, effectiveness or clinical

The recommendations in this paper are based on the evidence reviewed in the following publications: Diabetes self-management education (Technical Review). *Diabetes Care* 18:1204–1214, 1995; and National standards for diabetes self-management education programs (Technical Review). *Diabetes Care* 18:100–116, 1995.

Approved 1995. Revised 2002.

Abbreviations: DCCT, Diabetes Control and Complications Trial; SMBG, self-monitoring of blood glucose.

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outcomes of such treatment of such population." A variety of laws, regulations, and executive orders also provide guidance on the use of such controls to oversee the purchase and use of durable medical equipment (hereafter referred to as "equipment") and single-use medical supplies (hereafter referred to as "supplies") associated with the management of diabetes. Consideration of certain principles should occur in creating and enforcing these controls that impact the comprehensive medical needs of people living with type 1, type 2, or gestational diabetes.

Reductions in hemoglobin A1C to ≤7% have been associated with improved outcomes and a reduction in the risk of diabetes-related complications. Outcome data are only available for animal source insulins, sulfonylureas, and metformin. Newer medications, blood glucose monitors, blood glucose test strips, insulin pumps, and related supplies, as well as other equipment and supplies associated with the use of these items, are expected to similarly reduce the risk of diabetic complications in proportion to glucose lowering. More than one agent is typically required to achieve glycemic targets, and the effect of multiple agents used in combination is additive. A variety of equipment and supplies are also necessary to manage diabetes and reach glycemic targets. Thus, any controls should ensure that all classes of antidiabetic agents with unique mechanisms of action are available to facilitate achieving glycemic goals to reduce the risk of complications. Similar issues operate in the management of lipid disorders, hypertension, and other cardiovascular risk factors, as well as for other diabetes complications. Furthermore, any controls should ensure that all classes of equipment and supplies designed for use with such equipment are available to facilitate achieving glycemic goals to reduce the risk of complications.

The major limitation to achieving stringent glycemic targets is treatment-emergent hypoglycemia, which can be a significant safety issue limiting effectiveness of care and can on occasion result in serious morbidity or mortality. In patients with severe or frequent hypoglycemia or certain diabetes complications, some antidiabetic agents, equipment, and supplies are associated with lower risks of hypoglycemia at similar levels of overall control and should be available to special populations.

Though it can seem appropriate for controls to restrict perceived items of convenience in chronic disease management, particulraly with a complex disorder such as diabetes, it should be recognized that adherence is a major barrier to achieving targets. Any controls should take into account the huge burden of intensive insulin management on patients, particularly in the management of type 1 diabetes. Protections should ensure that patients with diabetes can comply with therapy in the widely variable circumstances encountered in daily life. These protections should guarantee access to an acceptable range and all classes of antidiabetic medications, equipment, and supplies. Furthermore, fair and reasonable appeals processes should ensure that diabetic patients and their medical care practitioners can obtain medications, equipment, and supplies that are not contained within existent controls.

Diabetes management needs individualization in order for patients to reach glycemic targets. Because there is diversity in the manifestations of the disease and in the impact of other medical conditions upon diabetes, it is common that practitioners will need to uniquely tailor treatment for their patients. To reach diabetes treatment goals, practitioners should have access to all classes of antidiabetic medications, equipment, and supplies without undue controls. Without appropriate safeguards, these controls could constitute an obstruction of effective care.

The value of self-management education and provision of diabetes supplies has been acknowledged by the passage of the Balanced Budget Act of 1997 (8) and by stated medical policy on both diabetes education (9) and medical nutrition therapy (10).

References

1. Centers for Disease Control and Prevention. *National Diabetes Fact Sheet: General Information and National Estimates on Diabetes in the United States, 2000.* Atlanta, GA, U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2002
2. Clement S: Diabetes self-management education (Technical Review). *Diabetes Care* 18:1204–1214, 1995
3. Funnell MM, Haas LB: National standards for diabetes self-management education programs (Technical Review). *Diabetes Care* 18:100–116, 1995
4. American Diabetes Association: Standards of medical care in diabetes (Position Statement). *Diabetes Care* 27 (Suppl. 1): S15–S35, 2004
5. American Diabetes Association: National standards for diabetes self-management education (Standards and Review Criteria). *Diabetes Care* 27 (Suppl. 1): S143–S150, 2004
6. Herman WH, Dasbach DJ, Songer TJ, Thompson DE, Crofford OB: Assessing the impact of intensive insulin therapy on the health care system. *Diabetes Rev* 2:384–388, 1994
7. Wagner EH, Sandu N, Newton KM, McCullock DK, Ramsey SD, Grothaus LC. Effects of improved glycemic control on health care costs and utilizatoin. *JAMA* 285:182–189, 2001
8. *Balanced Budget Act of 1997.* U.S. Govt. Printing Office, 1997, p. 115–116 (publ. no. 869-033-00034-1)
9. *Diabetes outpatient self-management training services.* Available from http://www.hcfa.gov/coverage
10. *Duration and frequency of the medical nutrition therapy (MNT) benefit.* Available from http://www.hcfa.gov/coverage

To: Senator Cohen, Chair

Committee on Finance

Senator Berglin,

Chair of the Health and Human Services Budget Division, to which was referred

S.F. No. 255: A bill for an act relating to MinnesotaCare; modifying covered health services; repealing the limited benefits for certain single adults and households without children; amending Minnesota Statutes 2004, sections 256L.03, subdivision 1; 256L.12, subdivision 6; repealing Minnesota Statutes 2004, section 256L.035.

Reports the same back with the recommendation that the bill do pass and be referred to the full committee.

Linda Berglin
(Division Chair)

March 9, 2005
(Date of Division action)

Senators Koering, Lourey, Higgins, Rosen and Berglin introduced--
S.F. No. 695: Referred to the Committee on Health and Family Security.

A bill for an act

relating to MinnesotaCare; modifying the definition of gross income; amending Minnesota Statutes 2004, section 256L.01, subdivision 4.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2004, section 256L.01, subdivision 4, is amended to read:

Subd. 4. [GROSS INDIVIDUAL OR GROSS FAMILY INCOME.] (a) "Gross individual or gross family income" for nonfarm self-employed means income calculated using as the baseline the adjusted gross income reported on the applicant's federal income tax form for the previous year and adding back in reported depreciation, carryover loss, and net operating loss amounts that apply to the business in which the family is currently engaged.

(b) "Gross individual or gross family income" for farm self-employed means income calculated using as the baseline the adjusted gross income reported on the applicant's federal income tax form for the previous year ~~and adding back in reported depreciation amounts that apply to the business in which the family is currently engaged~~.

(c) Applicants shall report the most recent financial situation of the family if it has changed from the period of time covered by the federal income tax form. The report may be in the form of percentage increase or decrease.

[**EFFECTIVE DATE.**] This section is effective July 1, 2005, or upon receipt of federal approval, whichever is later.

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S.F. No. 695 - MinnesotaCare Definition of Income

Author: Senator Paul Koering

Prepared by: Katie Cavanor, Senate Counsel (651/296-3801) KC

Date: February 18, 2005

S.F. No. 695 eliminates the add-back of depreciation for farm self-employed income for purposes of determining MinnesotaCare income eligibility. Income for farm self-employed would be determined by the adjusted gross income as reported on the applicant's federal income tax form for the previous year.

KC:rdr

Preliminary

Fiscal Note – 2005-06 Session

Bill #: S0695-0 **Complete Date:**

Chief Author: KOERING, PAUL

Title: MNCARE PRGM GROSS INCOME DEFINITION

Fiscal Impact	Yes	No
State	X	
Local		X
Fee/Departmental Earnings		X
Tax Revenue		X

Agency Name: Human Services Dept

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
Health Care Access Fund	0	1,312	742	578	597
Less Agency Can Absorb					
Health Care Access Fund	0	1	0	0	0
Net Expenditures					
Health Care Access Fund	0	1,311	742	578	597
Revenues					
Health Care Access Fund	0	16	18	6	7
Net Cost <Savings>					
Health Care Access Fund	0	1,295	724	572	590
Total Cost <Savings> to the State	0	1,295	724	572	590

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
Health Care Access Fund	0.00	1.00	1.00	0.00	0.00
Total FTE	0.00	1.00	1.00	0.00	0.00

Preliminary

NARRATIVE: SF 695/HF 924

Bill Description

This bill would eliminate the add-back of depreciation for farm self-employed income. The bill would be effective July 1, 2005, or upon federal approval, whichever is later.

Assumptions

This bill would cause a three month delay in HealthMatch. The complex design of the innovative HealthMatch system is near completion and programming has begun. Due to the intricacies of programming a new system, any change prior to system completion requires substantial analysis and design rework, in addition to programming the actual changes. This effort delays the HealthMatch implementation date and results in costs of $889,000 per month of delay. Currently, for each month of delay to the project, the associated vendor cost for maintaining staff on the project is $600,000. Concurrent state staff costs per month are $289,000. (Numbers reflect 100% of the cost; state budget costs are less when adjusted for federal participation)

Once HealthMatch is completely built and implemented, the cost for making requested changes will be significantly lower. Legislation with effective dates of August 1, 2006, or upon HealthMatch implementation, whichever is later, will not incur the additional time for analysis and associated vendor costs caused by implementation delay.

See attached for program impact assumptions.

Expenditure and/or Revenue Formula

2005
Session
SF-695
MnCare - remove depreciation addback to gross income
Fiscal Summary
(dollars in thousands)

Fund	Descp.	FY06	FY07	FY08	FY09
HCAF	Administrative	41	45	16	17
HCAF	MMIS (State SH)	1	0	0	0
HCAF	HealthMatch (State SH)	931	0	0	0
HCAF	Families with Children	80	271	258	284
HCAF	Adults without Children	259	426	304	296
Total Costs		1,312	742	578	597
Less Absorbed Costs		(1)	0	0	0
Net Expenditures		1,311	742	578	597
Less Revenues		(16)	(18)	(6)	(7)
Net Cost to State		1,295	724	572	590

2005 Session
SF 695: Modifies the calculation of farm income for MinnesotaCare.
HCEA Admin. & Systems Costs

	FY2006	FY2007	FY2008	FY2009

Preliminary

Average eligibles Numbers provided by George Hoffman	130	185	160	155
Number of approvals Average of current + next year eligibles + 30% "churning" factor	157	198	35	44
Number of cases approved Approvals divided by avg 1.5 individuals/case	105	132	23	30
Number of cases applying Cases approved multiplied by 2; in general, 2 applications result in one enrolled case	210	265	46	59
FTE for applications FY2006-07: 1 rep for each 850 applications FY2008--09: 1 rep for each 1072 applications	0	0	0	0
Average continuing cases Average eligibles divided by 1.5 avg/case	100	142	123	119
FTE for continuing cases For FY2006 and FY2007, 1 rep per 720 cases For FY2008 and FY2009, 1 rep per 900 cases	0	0	0	0
Total enrollment reps needed	0	1	0	0
Additional staff For each rep, add .10 sup, .05 trainer, .17 support staff	0	0	0	0
Total MnCare FTE	1	1	0	0
All AFSCME Staff Direct staff cost At average $53,000	26,981	35,597	12,569	13,129
Indirect staff cost At average $22,500 first year, $8500 thereafter	11,454	5,709	2,016	2,106
Total staff cost	38,436	41,306	14,585	15,235
Printing and postage	2,463	3,285	1,653	1,696
HCEA COST, not including systems	40,899	44,591	16,238	16,931
State share--60%	24,539	26,755	9,743	10,159
<u>SYSTEMS COSTS</u> MMIS Costs	3,700	0	0	0
MMIS Costs, state share (35%)	1,295			
MAXIS Costs--NONE	0	0	0	0
HealthMatch costs--total	2,660,000	0	0	0
HealthMatch costs, state share (35%)	931,000	0	0	0

Preliminary

MINNESOTACARE
Fiscal Analysis of a Proposal to
Eliminate the Add-Back of Depreciation to Farm Income
2005 Session, Senate File 695

To determine gross individual or gross family income for MinnesotaCare eligibility for self-employed applicants with farm income, current law requires that reported depreciation be added back to the adjusted gross income reported for income tax purposes. (Prior to legislation in 2001, the law required the add-back of depreciation, net operating loss and carry-over losses for both farm and self-employment income. In 2001 the add-back of net operating loss and carry-over losses was eliminated for farm income only. All three add-backs continue to be required for non-farm self-employment income.) This bill eliminates the depreciation add-back for farm income, which would result in lower gross income being calculated for individuals and families with farm income.

Based on a special sample of MinnesotaCare cases with farm or self-employment income, the elimination of the add-back of depreciation for farm income would be expected to reduce premiums charged to 7% of family cases and 4% of adult cases by the monthly amounts shown in the tables which follow.

Because of the premium reductions, which are substantial for some cases, the elimination of the depreciation add-back would also be expected to increase enrollment of the type of cases affected by 0.7% for family cases and by 10.5% for adult-only cases.

	FY 2006	FY 2007	FY 2008	FY 2009
FAMILIES WITH CHILDREN				
Average cases with premiums reduced	1,149	1,625	1,424	1,436
Avg. monthly revenue	(13.07)	(13.47)	(13.87)	(14.29)
Total payments	0	0	0	0
Federal share %	52.11%	48.37%	47.48%	46.10%
Federal share	0	0	0	0
State share	0	0	0	0
Total revenue	0	(262,555)	(237,019)	(246,106)
Federal share %	52.11%	48.37%	47.48%	46.10%
Federal share	0	(126,991)	(112,530)	(113,454)
State share	0	(135,564)	(124,488)	(132,652)
Net cost	0	262,555	237,019	246,106
Federal share	0	126,991	112,530	113,454
State share	0	135,564	124,488	132,652

	FY2006	FY2007	FY2008	FY2009
FAMILIES WITH CHILDREN				
Average additional cases	21	30	27	27

Preliminary

Average additional enrollees	62	87	76	77
Avg. monthly payment	254.66	291.72	322.62	351.07
Avg. monthly revenue	30.07	40.50	46.27	47.06
Total payments	188,494	305,403	296,019	324,736
Federal share %	52.11%	48.37%	47.48%	46.10%
Federal share	98,229	147,716	140,542	149,702
State share	90,264	157,688	155,477	175,034
Total revenue	22,260	42,397	42,459	43,529
Federal share %	52.11%	48.37%	47.48%	46.10%
Federal share	11,601	20,506	20,159	20,067
State share	10,660	21,890	22,301	23,462
Net cost	166,233	263,007	253,560	281,207
Federal share	86,629	127,210	120,384	129,635
State share	79,604	135,797	133,176	151,572
ADULTS WITHOUT CHILDREN				
Avg. cases with premiums reduced	520	751	639	596
Avg. monthly revenue	($5.79)	($5.96)	($6.14)	($6.33)
Total payments	0	0	0	0
Total revenue	(0)	(53,758)	(47,143)	(45,232)
Net state cost	0	53,758	47,143	45,232
	FY2006	FY2007	FY2008	Fy2009
ADULTS WITHOUT CHILDREN				
Average additional cases	61	88	75	70
Average additional enrollees	68	98	84	78
Avg. monthly payment	$340.10	$345.18	$288.29	$300.11
Avg. monthly revenue	$23.95	$29.54	$32.38	$32.36
Total payments	278,201	407,586	289,827	281,050
Total revenue	19,592	34,877	32,548	30,309
Net state cost	258,608	372,708	257,279	250,741
TOTAL PROGRAM: Section 1				
Total payments	466,694	712,989	585,846	605,786
Federal share	98,229	147,716	140,542	149,702

Preliminary

State share	368,465	565,273	445,304	456,084
Total revenue	41,853	(239,039)	(209,154)	(217,500)
Federal share	11,601	(106,485)	(92,372)	(93,387)
State share	30,252	(132,554)	(116,782)	(124,113)
Net cost	424,841	952,028	795,001	823,286
Federal share	86,629	254,201	232,914	243,089
State share	338,213	697,827	562,086	580,197

Long-Term Fiscal Considerations

Local Government Costs

References/Sources

Senator Solon introduced--

S.F. No. 1030: Referred to the Committee on Health and Family Security.

A bill for an act

relating to human services; modifying certain medical assistance reimbursement rates for nursing facilities; amending Minnesota Statutes 2004, section 256B.434, by adding a subdivision.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2004, section 256B.434, is amended by adding a subdivision to read:

Subd. 4f. [RATE INCREASE EFFECTIVE JULY 1, 2005.] For the rate year beginning July 1, 2005, a nursing facility that is a low-cost provider of nursing facility services for the medical assistance program and has 166 certified skilled nursing beds in the city of Duluth as of January 1, 2005, shall receive an increase in each case mix payment rate so that the nursing facility's reimbursement rates are equal to the average reimbursement rates for all nursing facilities in the city of Duluth. The increase shall be included in the facility's total payment rate for purposes of determining future rates under this section or any other section.

[EFFECTIVE DATE.] This section is effective July 1, 2005.

Senate Counsel, Research, and Fiscal Analysis

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S.F. No. 1030 - Duluth Nursing Facility Rate Increase (the Delete-Everything Amendment)

Author: Senator Yvonne Prettner Solon

Prepared by: David Giel, Senate Research (296-7178)

Date: March 4, 2005

S.F. No. 1030 provides a $25 rate increase for a 166-bed Duluth nursing facility with reimbursement rates substantially below the Duluth average. The Commissioner of Human Services must identify savings that occur as the result of admissions to the facility of persons transferring from another Duluth facility that is owned by the same entity and is downsizing. Any savings identified are appropriated to the commissioner to pay for the rate increase.

DG:rdr

1030

Fiscal Note – 2005-06 Session

Bill #: S1030-0 **Complete Date:** 03/08/05

Chief Author: SOLON, YVONNE PRETTNER

Title: DULUTH NURSING FAC MA CASE MIX RATE

Fiscal Impact	Yes	No
State	X	
Local	X	
Fee/Departmental Earnings		X
Tax Revenue		X

Agency Name: Human Services Dept

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
General Fund	0	343	375	375	376
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
General Fund	0	343	375	375	376
Revenues					
-- No Impact --					
Net Cost <Savings>					
General Fund	0	343	375	375	376
Total Cost <Savings> to the State	0	343	375	375	376

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
-- No Impact --					
Total FTE					

NARRATIVE: SF 1030/HF 1372

Bill Description
This bill will give a rate increase to the Bayshore (Rule 50) facility in Duluth. The increase will be equivalent to moving to the average of the other facilities in Duluth.

Assumptions
The resident days reported for the year ending September 30, 2004, will not change materially in the future.

Expenditure and/or Revenue Formula
The Duluth average is determine by summing the unweighted case-mix per diem with the other operating per diem. The 50th percentile of those sums is computed.

The target rate determined is applied to Bayshore in a ratio of their current weighted and unweighted portion of their rates. The two are summed to determine a new operating payment rate.

The same percentile is applied to the property, other, closure, and layaway components of the Duluth rates.

A new total payment rate is determine by summing the target amounts of each rate component.

The difference between the new rates is compared to the facility's current rates. The difference is multiplied by resident days for the reporting year ended September 30, 2004.

Long-Term Fiscal Considerations
The rate adjustment is perpetual.

Local Government Costs
There is a county share of the cost of this bill.

References/Sources
Nursing facility data reports, nursing facility rates database

Nursing Facility Fiscal Note
SF 1030 HF 1372

TOPIC: St. Louis County NF increased rates

ASSUMPTIONS: ALL AMOUNTS IN $000's

1. The Nursing Facility Rates and Policy Division used the following assumptions and computations to approximate the fiscal impact of this bill. After estimating the annual fiscal impact of the bill, the department adjusts that amount to determine the State Budget impact by using the following assumptions:
   - the rate year begins on July 1
   - payment for services lags the provision of services by one month
   - the annual cost/savings is adjusted by:
     - inflation factors
     - percentage of medical assistance occupancy
     - the percentage of federal and state shares

2. The Duluth average is determine by summing the unweighted case-mix per diem with the other operatin50 th percentile of those sums is computed.

3. The target rate determined is applied to Bayshore in a ratio of their current weighted and unweighted portion of their rates. The two are summed to determine a new operating payment rate.

4. The same percentile is applied to the property, other, closure, and layaway components of the Duluth rates.

5. A new total payment rate is determine by summing the target amounts of each rate component.

5. The difference between the new rates is compared to the facility's current rates. The difference is multiplied by resident days for the reporting year

ended September 30, 2004.

FISCAL NOTE COMPUTATIONS:

Total Annual Cost/(Savings)	FY 2006 Amount	FY 2007 Amount	FY 2008 Amount	FY 2009 Amount
Increase Bayshore's rates =	$1,028	$1,028	$1,028	$1,028
Operating Costs Item 2 =	$0	$0	$0	$0
Property Costs Item 3 =	$0	$0	$0	$0
Property Costs Item 4 =	$0	$0	$0	$0
Other Costs Item 5 =	$0	$0	$0	$0
Total =	$1,028	$1,028	$1,028	$1,028
Costs Not Subject to Inflation =	$0	$0	$0	$0
Costs Subject to Inflation =	$1,028	$1,030	$1,032	$1,033
(Includes Inflation on Prior Years)				
Adjust for Inflation				
Case-mix "creep" factor =	0.16%	0.16%	0.16%	0.16%
Adjusted for Inflation =	$1,030	$1,032	$1,033	$1,035
Plus Costs Not Subject to Inflation =	$0	$0	$0	$0
Total =	$1,030	$1,032	$1,033	$1,035
Adjust for Occupancy				
Forecasted change in MA paid days =	100.00%	100.00%	100.00%	100.00%
MA Occupancy Percentage =	73.12%	73.12%	73.12%	73.12%
Adjusted for Occupancy =	$753	$754	$755	$757
Adjust for Effective Date				
Effective Date: 7/1/05				
Includes One Month for Payment System Delay				
Factor =	91.67%			
Total Projected MA Costs/(Savings) =	$690	$754	$755	$757

	FY 2006	FY 2007	FY 2008	FY 2009
Total Projected MA Costs/(Savings) =	$690	$754	$755	$757
Federal Share =	$345	$377	$378	$378
State Budget =	$343	$375	$375	$376
County Share =	$2	$2	$2	$2

	FY 2006	FY 2007	FY 2008	FY 2009
MA Grants (State Budget)	$343	$375	$375	$376
Administrative Costs	$0	$0	$0	$0
Total Costs/(Savings)	$343	$375	$375	$376

Agency Contact Name: Greg Tabelle 296-5597
FN Coord Signature: STEVE BARTA
Date: 03/07/05 Phone: 296-5685

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: DOUG GREEN
Date: 03/08/05 Phone: 286-5618

Senator Berglin introduced--

S.F. No. 769: Referred to the Committee on Finance.

A bill for an act

relating to human services; appropriating money for the new chance program.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. [NEW CHANCE PROGRAM APPROPRIATION.]

$280,000 is appropriated from the general fund to the commissioner of human services for the biennium beginning July 1, 2005, for a grant to the new chance program. The new chance program shall provide comprehensive services through a private, nonprofit agency to young parents in Hennepin County who have dropped out of school and are receiving public assistance. The program administrator shall report annually to the commissioner of human services on skills development, education, job training, and job placement outcomes for program participants.

Senate Counsel, Research, and Fiscal Analysis

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State of Minnesota

S.F. No. 769 - Appropriating Money for New Chance Program

Author: Senator Linda Berglin

Prepared by: Joan White, Senate Counsel (651/296-3814)

Date: March 2, 2005

S.F. No. 769 appropriates $280,000 from the general fund to the Commissioner of Human Services for the biennium for a grant to the new chance program. The new chance program is required to provide comprehensive services through a private, nonprofit agency to young parents in Hennepin County who have dropped out of school or are receiving public assistance. The new chance program administrator is required to report annually to the Commissioner of Human Services on several outcomes related to program participants.

JW:rdr