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State of Minnesota

S.F. No. 2725 - Health Care (First Engrossment)

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Date: March 22, 2006

S.F. No. 2725 establishes the prescription drug discount program and makes the following changes in the MinnesotaCare program: eliminates the limited benefit set; increases the income eligibility for single adults; raises the inpatient hospital annual cap; modifies the definition of income for self-employed farmers; and establishes a small employer buy-in option.

Section 1 (256.9545) establishes the Prescription Drug Discount program.

Subdivision 1 authorizes the Commissioner of Human Services to establish and administer the Prescription Drug Discount program.

Subdivision 2 requires the commissioner to administer a drug rebate program for drugs purchased by enrollees of the program. The commissioner shall execute a rebate agreement from all manufacturers who choose to participate in the program for those drugs covered under the medical assistance program. The rebate amount shall be equal to the basic rebate provided through the federal rebate program.

Subdivision 3 defines the terms: "commissioner," "participating manufacturer," "covered prescription drug," "health carrier," "participating pharmacy," and "enrolled individual."

Subdivision 4 establishes eligibility requirements for the program.

Paragraph (a) states that an applicant must:

(1) be a permanent resident of Minnesota;

(2) not be enrolled in medical assistance, general assistance medical care, or MinnesotaCare;

(3) not be enrolled in prescription drug coverage under a health plan offered by a health carrier or employer or under a pharmacy benefit program offered by a pharmaceutical manufacturer; and

(4) not be enrolled in prescription drug coverage under a Medicare supplemental policy.

Paragraph (b) states that notwithstanding paragraph (a), an individual enrolled in a Medicare Part D prescription drug plan or Medicare Advantage plan is eligible but only for drugs that are not covered under the Part D plan or for drugs that are covered under the plan, but pursuant to the terms of the plan, the individual is responsible for 100 percent of the cost of the prescription drug.

Subdivision 5, paragraph (a), requires applications and information on the program to be available at county social services agencies, health care provider offices, and agencies and organizations serving senior citizens. Requires individuals to submit any information deemed necessary by the commissioner to verify eligibility to the county social services agencies. Requires the commissioner to determine eligibility within 30 days from receiving the application. Upon approval, the applicant must submit the enrollment fee established under **subdivision 10**. Eligibility begins the month after the enrollment fee is received.

Paragraph (b) requires an enrollee's eligibility to be renewed every 12 months.

Paragraph (c) requires the commissioner to develop an application that does not exceed one page in length and requires information necessary to determine eligibility.

Subdivision 6 requires participating pharmacies to sell a prescription drug to an enrolled individual at the medical assistance rate until January 1, 2008. After January 1, 2008, the prescription drug must be sold at the medical assistance rate, minus an amount equal to the rebate described in **subdivision 8**, plus any switch fee established by the commissioner. Requires a participating pharmacy to provide the commissioner with any information the commissioner determines necessary to administer the program, including information on sales to enrolled individuals and usual and customary retail prices.

Subdivision 7 requires the commissioner to notify the participating manufacturers on a quarterly basis or on a schedule established by the commissioner of the amount of rebate owed on the prescription drugs sold by a participating pharmacy to enrolled individuals.

Subdivision 8 requires a participating manufacturer to provide a rebate equal to the rebate provided under the medical assistance program for each prescription drug distributed by the manufacturer that is purchased by an enrolled individual at a participating pharmacy. Requires the manufacturer to provide full payment within 38 days of receipt of the state invoice for the rebate or according to a schedule established by the commissioner. Requires the commissioner to deposit all rebates received into the prescription drug dedicated fund. Requires the manufacturers to provide the commissioner with any information necessary to verify the rebate determined per drug.

Subdivision 9 requires the commissioner to distribute on a biweekly basis an amount equal to the amount collected under **subdivision 8** to each participating pharmacy based on the prescription drugs sold by that pharmacy to enrolled individuals on or after January 1, 2008.

Subdivision 10 authorizes the commissioner to establish an annual enrollment fee that covers the expenses of enrollment, processing claims, and distributing rebates. This subdivision also requires the commissioner to establish a switch fee to cover the expenses incurred by participating pharmacies in formatting for the electronic submission of claims for prescription drugs.

Subdivision 11 establishes a prescription drug dedicated fund as an account in the state treasury. Requires the Commissioner of Finance to credit the fund with the rebates and any appropriations designated for the fund, and any federal funds received for the program. Requires the money in the fund to be appropriated to the commissioner to reimburse participating pharmacies for prescription drugs discounts and for other administrative costs related to the program.

Section 2 (256L.01, subdivision 4) eliminates the add back of depreciation for farm self-employed income for purposes of determining income eligibility under MinnesotaCare.

Section 3 (256L.03, subdivision 1) contains a change related to eliminating the limited benefit set for single adults in MinnesotaCare.

Section 4 (256L.03, subdivision 3) contains a change related to the increase of the income eligibility limit to 190 percent of the federal poverty guideline (FPG) for single adults and increases the inpatient hospitalization annual limit from $10,000 to $20,000 in MinnesotaCare.

Section 5 (256L.03, subdivision 5) contains changes related to the income eligibility limit increase and the inpatient hospitalization limit increase.

Section 6 (256L.04, subdivision 7) increases the income eligibility limit from 175 percent to 190 percent of FPG for single adults and households without children in MinnesotaCare.

Section 7 (256L.04, subdivision 14) requires the commissioner to award grants to organizations to provide information regarding the MinnesotaCare program in areas of the state with high uninsured populations.

Section 8 (256L.07, subdivision 1) contains a change related to the income eligibility limit increase.

Section 9 (256L.20) establishes the small employer option for MinnesotaCare.

Subdivision 1 defines the following terms: "dependent," "eligible employer," "eligible employee," "participating employer," and "program."

Subdivision 2 authorizes enrollment in MinnesotaCare coverage for all eligible employees and their dependents, if the eligible employer meets the requirements of **subdivision 3.**

Subdivision 3 states that to participate, an eligible employer must:

(1) agree to contribute toward the cost of the premium for the employee and the employee's dependent;

(2) certify that at least 75 percent of its eligible employees who do not have other creditable health coverage are enrolled in the program;

(3) offer coverage to all eligible employees and the dependents of those employees; and

(4) not have provided employer subsidized health coverage as an employee benefit during the previous 12 months.

Subdivision 4 requires the employer to pay 50 percent of the premium for eligible employees without dependents with income equal to or less than 175 percent of FPG and for eligible employees with dependents with income equal to or less than 275 percent of FPG. States that for eligible employees without dependents with income over 175 percent of FPG and eligible employees with dependents with income over 275 percent of FPG, the employer must pay the full cost of the maximum premium. Permits employer to require the employee to pay a portion of the cost of the premium so long as the employer pays 50 percent of the total cost. If the employee is required to pay a portion of the premium, the payment shall be made to the employer. Requires the commissioner to collect the premiums from the participating employers.

Subdivision 5 states that the coverage provided shall be the MinnesotaCare covered services with all applicable co-pays and coinsurance.

Subdivision 6 states that upon the payment of the premium, eligible employees and their dependents shall be enrolled in the MinnesotaCare program. States that the insurance barrier of Minnesota Statutes, section 256L.07, subdivisions 2 and 3, do no apply. Authorizes the commissioner to require eligible employees to provide income verification to determine premiums.

Section 10 repeals the limited benefit set for single adults and households without children.

Section 11 provides an effective date.

KC:ph

DRAFT

Fiscal Note Request Worksheet

Bill #: SF 2725 Title: MinnesotaCare Changes

Companion #: Author: Berglin; Koering; Solon; Johnson, D.E.; Lourey Agency: Human Services

Urgent: Due Date: Committee:

Consolidated: Lead Agency: Contact Person: Steve Nelson 651-431-2201

What version of the bill are you working on? 1A
(Changing the version of the bill will automatically create a new fiscal note request.)

(The following four fiscal impact questions must be answered before an agency can sign off on a fiscal note.)

Fiscal Impact	Yes	No
State (Does this bill have a fiscal impact to your Agency?)	X	
Local (Does this bill have a fiscal impact to a Local Gov Body?)		X
Fee/Dept Earnings (Does this bill impact a Fee or Dept Earning?)		X
Tax Revenue (Does this bill impact Tax Revenues?)		X

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
Fund-General-Transfer to Special Rev. Fund			0	594	1,389
Fund-HCAF			0	447	9,858
Fund					
Less Agency Can Absorb					
Fund					
Fund					
Fund					
Net Expenditures					
Fund-General			0	594	1,389
Fund-HCAF			0	447	9,858
Fund					
Revenues					
Fund-HCAF			0	20	0
Fund					
Fund					
Net Cost <Savings>					
Fund-General			0	594	1,389
Fund-HCAF			0	427	9,858
Fund					
Total Cost <Savings> to the State			0	1,021	11,247

	FY05	FY06	FY07	FY08	FY09
Full-Time Equivalents					
Fund					
Fund					
Fund					
Total FTE			0	0	0

FI-00085-14 (09/02)

Bill Description
All sections are effective August 1, 2006, or upon implementation of HealthMatch, whichever is later.

Section 1 - Prescription Drug Discount Program: Establishes a prescription drug discount program. Participating pharmacies must sell prescriptions to enrollees at the Medical Assistance rate. After January 1, 2008, pharmacies would sell prescriptions to enrollees at the Medical Assistance rate minus the pharmaceutical rebate, plus the amount of a switch fee established by the commissioner. Provides coverage for individuals enrolled in Medicare Part D, for drugs not covered by their Part D plan and for drugs during the 100% coinsurance period (donut hole). Enrollees must be permanent residents; not be enrolled in Medical Assistance, General Assistance Medical Care, or MinnesotaCare; and not have any other prescription drug coverage through a health plan, employer plan, pharmacy benefit program, or Medicare supplement. Enrollees would pay an annual enrollment fee.

Section 2 - MinnesotaCare Farm Self-Employment Income: Eliminates the add back of depreciation in the MinnesotaCare calculation of farm self-employment income.

Section 3 - MinnesotaCare Covered Services: Extends MinnesotaCare Basic + One benefits to adults without children with income above 75 percent of the federal poverty guidelines (FPG).

Section 4 - MinnesotaCare Inpatient Hospital: Removes the inpatient hospital limit for parents with income between 175 and 190 percent FPG. Increases the inpatient hospital limit for adults from $10,000 to $20,000.

Section 5 - MinnesotaCare Copayments: Eliminates the 50 percent dental coinsurance for adults without children. Eliminates the 50 percent dental coinsurance for parents with income at or below 175 percent FPG and institutes it for parents with income above 190 percent FPG.

Sections 6 & 8 - MinnesotaCare Adults without Children: Raises the income limit for adults without children from 175 to 190 percent FPG.

Sections 7 & 10, as amended (A-1): Restores MinnesotaCare outreach grants with an unknown appropriation amount.

Section 9 - MinnesotaCare Option for Small Employers: Adds a MinnesotaCare buy-in option for small employers. Eligible employers include businesses that employ 2-50 eligible employees, the majority of whom are employed in Minnesota, and municipalities with 50 or fewer employees. Eligible employees are those who work at least 20 hours per week and more than 26 weeks annually. Employers must certify that at least 75 percent of their eligible employees who do not have health insurance are enrolled, they must offer the plan to all eligible employees, their spouses and dependents, and they must not have provided employer-subsidized insurance as an employee benefit in the past 12 months.

The premium would be based on the average monthly payment for families with children, excluding pregnant women and infants under age two. Employers would be charged half the premium for employees and dependents with income within the relevant MinnesotaCare income standard, and the full premium for employees and dependents with income above the relevant MinnesotaCare income standard. Employers who pay the full premium must agree to pay at least 50 percent of the premium. Employers would collect the employee contributions.

Section 11 - Repealer: Repeals the MinnesotaCare limited benefit set for adults without children.

Assumptions
The analysis assumes that all provisions will be effective January 1, 2009, after completion of HealthMatch implementation.

Section 1 - Prescription Drug Discount Program: There are no income or asset limits for participation. The enrollment fee will fund administration of the program. Given that an enrollment fee reduces expected enrollment, and a higher fee has a greater reduction effect, we project that it is not possible to establish a fee which will cover DHS's costs. So we have assumed the lowest fee which comes close to maximizing projected fee revenue

and have assumed that the balance of administrative costs is made up by reducing discounts.
No federal approval is needed to implement.

The Department could implement the prescription drug discount program as an independently administered health care program on MMIS effective January 1, 2009. The additional rebate discounts would begin at the same time.

Section 2 - MinnesotaCare Farm Self-Employment Income: Federal approval is needed prior to implementing this change.

Sections 3, 4, 5, 6, 8 and 11 - Eligibility, Benefit and FPG Changes: Managed care contracts would need to be negotiated to include the changes, and federal approval would be required for certain provisions. The Department could implement the benefit set and FPG changes effective January 1, 2009, with federal approval.

Section 9 - MinnesotaCare Option for Small Employers: Employers will attest to meeting the requirements of participation, such as employing 2-50 individuals, being located in Minnesota, not having offered ESI in the past 12 months. Verification of these criteria will be requested only as needed to clarify information or resolve discrepancies.

The calculation of income for purposes of determining full or half premium will be in accordance with MinnesotaCare income calculation. There will be no auto-newborn or pregnant woman protections against cancellation.

This section specifies a different premium from the MinnesotaCare "maximum premium", with separate premiums for families with children and for adults with no children. We have interpreted these to be premiums the amounts of which are projected based on anticipated costs for certain enrollee groups under this option. The bill does not make clear how the premium charges are applied. Pending clarification, we have treated it in our projections as a per-enrollee premium.

Federal approval is not needed to implement this change.

Incorporating this into HealthMatch would likely be cost prohibitive due to the significant delay this would cause. The Department could implement the small employer option as in independently administered health care program on MMIS effective January 1, 2009.

Sections 7 & 10, as amended (A-1): The Department will dedicate FTEs to administer and monitor the outreach grants to assure effectiveness.

Expenditure and/or Revenue Formula

Fiscal Summary
SF-2725

HCAF

BACT	Section	Description	FY07	FY08	FY09
40-MnCare Grants	Various	Program Costs	0	0	9,858
50-HC Admin.	9	Actuary Costs	0	50	0
51-HC Operations	9	MMIS (state share)	0	343	0
51-HC Operations	3	MMIS (state share)	0	4	0
51-HC Operations	4	MMIS (state share)	0	45	0
51-HC Operations	Various	MMIS (state share)	0	5	0
Total HCAF Costs			0	447	9,858
Dedicated FFP @ 40%			0	20	0
Net Cost to State-HCAF			0	427	9,858

General Fund

41-MA Basic HC Grants F&C	1	Transfer to Spec. Revenue Fund	0	594	1,389
Net Cost to State			0	1,021	11,247

The effective date on this legislation is August 1, 2006 or upon implementation of HealthMatch, which ever is later. Provisions effective upon HealthMatch implementation are assumed to be in effect January 1, 2009.

Minnesota
MINNESOTACARE
Fiscal Analysis of Senate File 2725

Minnesota Pharmacy Access Program (MnPAP)
No age limit, DHS administers eligibility, no asset test

Estimates the cost to the state to advance rebate revenues to pharmacies for discounted drugs provided to individuals without prescription drug coverage. Rebate revenues are billed and received by the second quarter after the quarter of rebate payment. We assume that all of revenue for a quarter is received by the end of the second subsequent quarter.

	Total Population
Minnesota population in 2009	5,408,000
Assume 16% lack prescription drug coverage	865,000
Number with Medicare lacking prescription drug coverage,	257,200
Number without Medicare lacking prescription drug coverage,	607,800
Assume 57% of those with Medicare have drug costs at least $250 / year	146,604
Assume 5% of those w/o Medicare have drug costs at least $250 / year	30,390
Assume 5% enrollment by those with Medicare	7,330
Assume 50% enrollment by those without Medicare	15,195
Total enrollment by second quarter of CY 2009 (with no enrollment fee)	22,525
Effect of enrollment fee on projected enrollment	1
Total enrollment by second quarter of CY 2009 (adjusted for fee)	15,410
Assume program participants with Medicare will have 18 Rx per year	18.00
Assume program participants w/o Medicare will have 24 Rx per year	24.00
Weighted average Rx per year (without fee adj. to enrollment)	22.05
Effect of fee adjustment to enrollment on avg. Rx per year	1.5
Weighted average Rx per year (with fee adjustment to enrollment)	32.2
Weighted average Rx per quarter	8.1

Calculation of admin fee per prescription:

	MMIS	Enrollment	Recipient Hlp Dsk	Rebates	Other	DHS Admin. Costs
DHS administrative costs:						
FY 2008	404,000	75,000	10,000	80,000	25,000	594,000
FY 2009		302,000	38,000	80,000	50,000	470,000
FY 2010		588,000	75,000	80,000	50,000	793,000

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FY 2011	588,000	75,000	80,000	50,000	793,000
FY 2012	588,000	75,000	80,000	50,000	793,000
FY 2013	588000	75,000	80,000	50,000	793,000
FY 2014	588,000	75,000	80,000	50,000	793,000
FY 2015	588,000	75,000	80,000	50,000	793,000
Total					5,822,000

	Proj. Number of Prescriptions	Admin. Cost per Rx
FY 2008	0	
FY 2009	68,286	6.88
FY 2010	319,701	2.48
FY 2011	459,377	1.73
FY 2012	517,422	1.53
FY 2013	552,211	1.44
FY 2014	557,733	1.42
FY 2015	563,310	1.41
Total	3,038,039	1.92

Projected avg rebate per Rx	18.38
Offsets to discount per Rx retained by DHS:	
to offset cash-flow costs:	$1.0
for DHS admin. costs:	$1.6
Total retained by DHS per Rx	$2.6
Offset to discount for switch fee:	$0.0
Net rebate per Rx to consumer:	$15.83
Enrollment fee	$30.00

Section 1, Subd. 10 requires that the enrollment fee be set at a level which covers DHS costs for the operation of the program. Given that an enrollment fee reduces expected enrollment, and a higher fee has a greater reduction effect, we project that it is not possible to establish a fee which will cover DHS's costs. So we have assumed the lowest fee which comes close the maximizing projected fee revenue and assumed that the balance of administrative costs is made up by reducing discounts.

	Fee Revenue	Admin. Costs	Excess of Admin Costs Over Fee Revenue
FY 2008	$0	$594,000	$594,000
FY 2009	$300,504	$470,000	$169,496
FY 2010	$416,083	$793,000	$376,917
Total	716,587	$1,857,000	$1,140,413

Enrollment and Cost Projections

CY 2008	Q1	Q2	Q3	Q4
Enrollment				0
Prescriptions	0	0	0	0
Rebate Outlay	0	0	0	

Rebate Revenue	0	0	0	0
Premium Revenue	0	0	0	0
DHS Admin. costs	297,000	297,000	117,500	117,500
Quarterly Balance	-297,000	-297,000	-117,500	-117,500
Running Balance	-297,000	-594,000	-711,500	-829,000
CY 2009	Q1	Q2	Q3	Q4
Enrollment	3,082	5,394	7,320	9,246
Prescriptions	24,831	43,455	58,974	74,494
Rebate Outlay	393,078	687,886	933,559	1,179,233
Rebate Revenue	0	0	456,397	798,695
Premium Revenue	92,463	69,347	69,347	69,347
DHS Admin. costs	117,500	117,500	198,250	198,250
Quarterly Balance	-418,115	-736,039	-606,065	-509,441
Running Balance	-1,247,115	-1,983,153	-2,589,218	-3,098,659
CY 2010	Q1	Q2	Q3	Q4
Enrollment	10,787	12,328	13,099	13,869
Prescriptions	86,909	99,325	105,533	111,740
Rebate Outlay	1,375,772	1,572,310	1,670,580	1,768,849
Rebate Revenue	1,083,943	1,369,191	1,597,390	1,825,588
Premium Revenue	104,021	104,021	104,021	104,021
DHS Admin. costs	198,250	198,250	198,250	198,250
Quarterly Balance	-386,058	-297,348	-167,419	-37,490
Running Balance	-3,484,717	-3,782,065	-3,949,484	-3,986,974
CY 2010	Q1	Q2	Q3	Q4
Enrollment	14,640	15,410	15,449	15,488
Prescriptions	117,948	124,156	124,466	124,777
Rebate Outlay	1,867,119	1,965,388	1,970,301	1,975,227
Rebate Revenue	1,939,688	2,053,787	2,167,886	2,281,985
Premium Revenue	116,157	116,157	116,157	116,157
DHS Admin. costs	198,250	198,250	198,250	198,250
Quarterly Balance	-9,524	6,306	115,492	224,666
Running Balance	-3,996,498	-3,990,192	-3,874,700	-3,650,034
CY 2012	Q1	Q2	Q3	Q4
Enrollment	16,258	17,029	17,071	17,114
Prescriptions	130,985	137,193	137,536	137,880
Rebate Outlay	2,073,497	2,171,766	2,177,195	2,182,638
Rebate Revenue	2,287,690	2,293,410	2,407,509	2,521,608
Premium Revenue	128,354	128,354	128,354	128,354
DHS Admin. costs	198,250	198,250	198,250	198,250
Quarterly Balance	144,298	51,748	160,418	269,074
Running Balance	-3,505,736	-3,453,987	-3,293,569	-3,024,495
CY 2013	Q1	Q2	Q3	Q4
Enrollment	17,157	17,200	17,243	17,286
Prescriptions	138,225	138,570	138,917	139,264
Rebate Outlay	2,188,095	2,193,565	2,199,049	2,204,547
Rebate Revenue	2,527,912	2,534,232	2,540,568	2,546,919
Premium Revenue	129,643	129,643	129,643	129,643
DHS Admin. costs	198,250	198,250	198,250	198,250
Quarterly Balance	271,210	272,060	272,911	273,765

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Running Balance	-2,753,285	-2,481,225	-2,208,314	-1,934,549
CY 2014	Q1	Q2	Q3	Q4
Enrollment	17,329	17,372	17,416	17,459
Prescriptions	139,612	139,961	140,311	140,662
Rebate Outlay	2,210,058	2,215,583	2,221,122	2,226,675
Rebate Revenue	2,553,286	2,559,669	2,566,069	2,572,484
Premium Revenue	130,944	130,944	130,944	130,944
DHS Admin. costs	198,250	198,250	198,250	198,250
Quarterly Balance	275,922	276,780	277,641	278,503
Running Balance	-1,658,627	-1,381,846	-1,104,205	-825,702
CY 2015	Q1	Q2	Q3	Q4
Enrollment	17,503	17,547	17,590	17,634
Prescriptions	141,013	141,366	141,719	142,074
Rebate Outlay	2,232,242	2,237,822	2,243,417	2,249,025
Rebate Revenue	2,578,915	2,585,362	2,591,826	2,598,305
Premium Revenue	132,258	132,258	132,258	132,258
DHS Admin. costs	198,250	198,250	198,250	198,250
Quarterly Balance	280,682	281,549	282,417	283,288
Running Balance	-545,021	-263,472	18,945	302,234

Net funding needed:		
Transfer in From General Fund	FY 2008	$594,000
Transfer in From General Fund	FY 2009	$1,389,153
Transfer in From General Fund	FY 2010	$1,798,912
Transfer in From General Fund	FY 2011	$208,127
Negative = Held in Fund Balance	FY 2012	($536,204)
Negative = Held in Fund Balance	FY 2013	($972,762)
Negative = Held in Fund Balance	FY 2014	($1,099,379)
Negative = Held in Fund Balance	FY 2015	($1,118,374)
	Total	$263,472

The figures above represent projected cash-basis costs, by fiscal year, to advance the rebates.

Rationale:

1) 5,408,000	Projected Population of MN in 2005, increased by 1% per year to 2009
2) 16%	Estimated percentage of Minnesotans without prescription coverage.
3) 5%	Percentage of people without Medicare and prescription drug coverage who spent more than $250 on prescriptions annually
	non-Medicare population of people lacking pharmacy coverage by 20%.
4) Cash Flow	All rebates billed for a quarter will paid in full in the second subsequent quarter.

Footnotes:

1) Items 1-2 are based on data from "Prescription Drug Coverage in Minnesota and the United States", Minnesota Dept. of Health, December 2000.
2) Item 3 is based on information form "Report to the President, Prescription Drug Coverage, Spending, Utilization and Prices", Federal Department of HHS, April 2000
3) Since DHS is to recover admin costs from rebates that are collected, this change effectively reduces the average discount per prescription received by participants.

Section 2. Self-employed farm income depreciation
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 section 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.

The effective date is assumed to be January 1, 2009 (following HealthMatch implementation).

Families with Children		FY 2006	FY 2007	FY 2008	FY 2009
Average cases with premiums reduced		0	0	0	710
Avg. monthly revenue		($13.07)	($13.47)	($13.87)	($14.29)
Total payments		$0	$0	$0	$0
	Federal share %	55.67%	52.36%	51.76%	51.18%
	Federal share	$0	$0	$0	$0
	State share	$0	$0	$0	$0
Total revenue		$0	$0	$0	($121,662)
	Federal share %	55.67%	52.36%	51.76%	51.18%
	Federal share	$0	$0	$0	($62,268)
	State share	$0	$0	$0	($59,393)
Net cost		$0	$0	$0	$121,662
	Federal share	$0	$0	$0	$62,268
	State share	$0	$0	$0	$59,393

Families with Children	FY 2006	FY 2007	FY 2008	FY 2009
Average additional cases	0	0	0	13
Average additional enrollees	0	0	0	38
Avg. monthly payment	$236.62	$251.49	$286.14	$319.42
Avg. monthly revenue	$25.02	$27.16	$27.46	$27.46

Total payments		$0	$0	$0	$146,062
	Federal share %	55.67%	52.36%	51.76%	51.18%
	Federal share	$0	$0	$0	$74,757
	State share	$0	$0	$0	$71,305
Total revenue		$0	$0	$0	$12,558
	Federal share %	55.67%	52.36%	51.76%	51.18%
	Federal share	$0	$0	$0	$6,427
	State share	$0	$0	$0	$6,131
Net cost		$0	$0	$0	$133,504
	Federal share	$0	$0	$0	$68,329
	State share	$0	$0	$0	$65,175

Adults without Children	FY 2006	FY 2007	FY 2008	FY 2009
Avg. cases with premiums reduced	0	0	0	531
Avg. monthly revenue	($5.79)	($5.96)	($6.14)	($6.33)
Total payments	$0	$0	$0	$0
Total revenue	$0	$0	$0	($40,315)
Net state cost	$0	$0	$0	$40,315

Adults without Children	FY 2006	FY 2007	FY 2008	FY 2009
Average additional cases	0	0	0	62
Average additional enrollees	0	0	0	70
Avg. monthly payment	$338.83	$392.80	$437.33	$471.24
Avg. monthly revenue	$19.41	$20.49	$20.08	$19.59
Total payments	$0	$0	$0	$393,335
Total revenue	$0	$0	$0	$16,352
Net state cost	$0	$0	$0	$376,983

Total Program		FY 2006	FY 2007	FY 2008	FY 2009
Total payments		$0	$0	$0	$539,397
	Federal share	$0	$0	$0	$74,757
	State share	$0	$0	$0	$464,641
Total revenue		$0	$0	$0	($133,066)
	Federal share	$0	$0	$0	($55,841)
	State share	$0	$0	$0	($77,225)
Net cost		$0	$0	$0	$672,463
	Federal share	$0	$0	$0	$130,598
	State share	$0	$0	$0	$541,866

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Sections 3 and 11. Eliminate MinnesotaCare limited benefit set
These sections eliminate the MnCare Limited Benefit Set for adults with no children with income over 75% FPG. It is assumed that this would equalize the rates paid for adults with no children with income above and below 75% FPG. This would result in an increase in average payment for adults with no children with income over 75% FPG by about $35-$40 per month on average.

The effective date is assumed to be January 1, 2009 (following HealthMatch implementation).

	FY 2006	FY 2007	FY 2008	FY 2009
Number of eligibles (over 75% FPG)	16,458	16,899	17,066	16,809
Change in avg. monthly payment	$0.00	$35.53	$36.27	$38.99
Months	0	0	0	5
Total payments	$0	$0	$0	$3,277,013
HMO performance payment	$0	$0	$0	$0
Total state cost	0	0	0	3,277,013

Section 4. Increase inpatient hospital cap
This section increases the inpatient hospital cap in MinnesotaCare from the current law level of $10,000 to $20,000. This would result in some additional inpatient hospital cost to the MinnesotaCare program.

Based on the Department's claims data, it is estimated that the PMPM cost will increase by about $2 for adult caretakers above 175% FPG and $6 for adults without children.

The effective date is assumed to be January 1, 2009 (following HealthMatch implementation).

Families with Children (Caretakers > 175% FPG)	FY 2006	FY 2007	FY 2008	FY 2009
Number of eligibles	8,544	8,561	8,793	8,943
Avg. monthly payment increase	$1.97	$1.97	$1.97	$1.97
Months	0	0	0	5
Cost before performance payment	$0	$0	$0	$88,011
Performance payments	$0	$0	$0	$0
Total cost for families with children	$0	$0	$0	$88,011
Federal share %	55.38%	52.61%	52.03%	51.47%
Federal share	$0	$0	$0	$45,304
State share	$0	$0	$0	$42,707

Adults without Children (Adults <= 75% FPG: non-MLB)	FY 2006	FY 2007	FY 2008	FY 2009
Number of eligibles	13,829	22,818	33,916	34,641
Avg. monthly payment increase	$5.89	$5.89	$5.89	$5.89
Months	0	0	0	5
Cost before performance payment	$0	$0	$0	$1,020,641
Performance payments	$0	$0	$0	$0

Total cost for adults <=75% FPG	$0	$0	$0	$1,020,641

Adults without Children (Adults > 75% FPG: MLB)	FY 2006	FY 2007	FY 2008	FY 2009
Number of eligibles	16,458	16,899	17,066	16,809
Avg. monthly payment increase	$5.92	$5.92	$5.92	$5.92
Months	0	0	0	5
Cost before performance payment	$0	$0	$0	$497,650
Performance payments	$0	$0	$0	$0
Total cost for adults >75% FPG	$0	$0	$0	$497,650

Total state cost	$0	$0	$0	$1,560,999

Section 5. Dental copays and inpatient hospital cap for parents
This section changes which MinnesotaCare enrollees are impacted by the 50% dental copay and the inpatient hospital cap on benefits.

Under current law, adults with incomes equal to or less than 175% FPG are subject to a 50% dental copay for non-preventive services. This section changes the dental copay policy to make adults with incomes greater than 190% FPG subject to the 50% copay.

A. Eliminate Dental Copay for Adults Under 175% FPG

The effective date is assumed to be January 1, 2009 (following HealthMatch implementation).

Families with Children Caretakers Under 175% FPG	FY 2006	FY 2007	FY 2008	FY 2009
Number of eligibles	31,855	31,918	29,455	24,827
Avg. monthly payment	$0.00	$0.00	$0.00	$2.38
Net cost	$0	$0	$0	$710,202
Federal share %	57.36%	53.35%	52.90%	52.73%
Federal share	$0	$0	$0	$374,480
State share	$0	$0	$0	$335,722

Adults without Children Adults Under 75% FPG	FY 2006	FY 2007	FY 2008	FY 2009
Number of eligibles	13,829	22,818	33,916	34,641
Avg. monthly payment	$0.00	$0.00	$0.00	$3.25
Net cost	$0	$0	$0	$1,349,215

B. Add Dental Copay for Adults Over 190% FPG

The effective date is assumed to be January 1, 2009 (following HealthMatch implementation).

Families with Children Caretakers Over 190% FPG	FY 2006	FY 2007	FY 2008	FY 2009
Number of eligibles	6,010	6,022	6,185	6,290
Avg. monthly payment	$0.00	$0.00	$0.00	($2.38)

Net cost		$0	$0	$0	($179,947)
	Federal share %	55.38%	52.61%	52.03%	51.47%
	Federal share	$0	$0	$0	($92,627)
	State share	$0	$0	$0	($87,320)
Total state cost for the dental copay change		$0	$0	$0	$1,597,617

C. Exempt Parents Between 175-190% FPG From Inpatient Cap

Under current law, MinnesotaCare parents with incomes above 175% FPG are subject to the inpatient hospital cap on benefits. This section moves this income threshhold to 190% FPG. In other words, relative to current law, this section exempts parents with incomes between 175%-190% FPG from the inpatient hospital cap.

The effective date is assumed to be January 1, 2009 (following HealthMatch implementation).

Families with Children	FY 2006	FY 2007	FY 2008	FY 2009
Caretakers Between 175%-190% FPG				
Number of eligibles	2,534	2,539	2,608	2,653
Avg. monthly payment increase	$1.66	$1.66	$1.66	$1.66
Months	0	0	0	5
Cost before performance payment	$0	$0	$0	$22,008
Performance payments	$0	$0	$0	$0
Total cost for the inpatient hospital cap change	$0	$0	$0	$22,008
Federal share %	55.38%	52.61%	52.03%	51.47%
Federal share	$0	$0	$0	$11,329
State share	$0	$0	$0	$10,680

Sections 6 and 8. Adults without children eligible to 190% FPG
Prior to the benefit limits implemented in October 2003, enrollment of adults with no kids with incomes from 150% FPG to 175% FPG was approximately 4400. Based on the corresponding ratio of enrollment by parents from 175% FPG to 200% FPG compared to enrollment from 150% FPG to 175% FPG, we project that expanding eligibility for adults with no kids to 200% FPG would result in increased enrollment equal to 75% of 4400 or 3300. Limiting the enrollment expansion to 190% FPG is assumed to reduce the 3300 projection by one-third, resulting in a projected increase of 2200.

The effective date is assumed to be January 1, 2009 (following HealthMatch implementation).

	FY 2006	FY 2007	FY 2008	FY 2009
Number of eligibles	0	0	0	275
Avg. monthly payment	$299.20	$384.14	$438.08	$471.88
Avg. monthly revenue	$77	$77	$77	$77
Total payments	$0	$0	$0	$1,297,722
HMO performance payment	$0	$0	$0	$0
Total revenue	$0	$0	$0	$254,113

Net state cost	$0	$0	$0	$1,043,609

Section 9. MinnesotaCare option for small employers

This section provides an option for small employers (2-50 umployees) to enroll uninsured employees and dependents in MinnesotaCare. To use this option employers must enroll 75% of their employees who not not have other health coverage. The employer must not have provided employer-subsidized health coverage during the previous 12 months. For enrollees within the income limits of the MinnesotaCare program (175% FPG for singles / 275% FPG for families) the employer must pay an amount equal to 50% of the MinnesotaCare full cost premium. For enrollees over these limits the employer must pay the entire full cost premium but may charge the employee up to 50% of the full cost premium.

The following data describes the estimated population of employees and their dependents of businesses that do not offer health coverage. (estimates provided by Health Economics, Minnesota Dept. of Health):

Employed by Small Employer (2-50) Not Offering Health Coverage

Uninsured Employees / Dependents

		Status If Covered		
	Total Persons	Number of Single Persons	Number of Family Persons	Family Policies
All	79,500	21,800	57,700	16,600
Within income limits	54,300	13,100	41,200	10,500
Above income limits	25,200	8,700	16,500	6,100

Insured Employees / Dependents

	Total Persons	Single Individuals Covered	Individuals with Family Coverage
All	249,500	7,700	241,800
Within income limits	64,700	1,100	63,600
Above income limits	184,800	6,600	178,200

Employed by Small Employer (2-50) Not Offering Health Coverage

Total of Insured Employees / Dependents and Uninsured Employees / Dependents

	Total Persons	Single Individuals	Family Members
All	329,000	29,500	299,500
Within income limits	119,000	14,200	104,800
Above income limits	210,000	15,300	194,700

"Healthy New York", a generally similar program experienced an enrollment rate after three years equal to 2.9% of the number of employees in small firms not offering coverage. MinnesotaCare offers more comprehensive coverage, but the cost to employers, assuming 50% of the full cost premium, is about 50% higher than in Healthy New York.

Based on this experience, we assume an average enrollment rate of 3.0% from the total population of uninsured or insured employees and dependents of small firms not offering health coverage, phased in over three years.

We assume relatively higher enrollment by families with children, and relatively higher enrollment by the more subsidized group within MinnesotaCare income limits. We assume 5.5% enrollment by family members and 3.3% enrollment by individuals in the more subsidized group within MinnesotaCare income limits. Enrollment by the group above MinnesotaCare income limits is projected at one-third of the rates for those within the limits.

The effective date is assumed to be January 1, 2009 (following HealthMatch implementation).

	Total Persons	Single Individuals	Family Members
Enrollment Rates			
All	3.03%	2.16%	3.12%
Within income limits	5.24%	3.30%	5.50%
Above income limits	1.78%	1.10%	1.83%
Enrollment			
All	9,970	637	9,334
Within income limits	6,233	469	5,764
Above income limits	3,738	168	3,570

		FY 2006	FY 2007	FY 2008	FY 2009
Families with Children					
Average number of enrollees:					
	Pregnant women	0	0	0	18
	Under age 2	0	0	0	50
	Other children & parents	0	0	0	1,098
	Total	0	0	0	1,167
Avg. monthly payment					
	Pregnant women	$459.78	$506.70	$538.85	$557.30
	Under age 2	$300.90	$312.45	$343.47	$402.72
	Other children & parents	$236.62	$251.49	$286.14	$319.42
Total payments					
	Pregnant women	$0	$0	$0	$122,496
	Under age 2	$0	$0	$0	$241,880

Other children & parents	$0	$0	$0	$4,209,964
Total	$0	$0	$0	$4,574,339
Adults without children				
Average number of enrollees	0	0	0	80
Avg. monthly payment	$386.00	$424.49	$518.92	$556.40
Total payments	$0	$0	$0	$531,560
Revenue				
Family enrollees @ 50% of full premium	0	0	0	721
Family enrollees charged @ 50% of full premium	0	0	0	721
Individual enrollees @ 50% of full premium	0	0	0	59
Total enrollees charged @ 50% of full premium	0	0	0	779
Family enrollees @ full premium	0	0	0	446
Family enrollees charged @ full premium	0	0	0	446
Individual enrollees @ full premium	0	0	0	21
Total enrollees charged @ full premium	0	0	0	467
Half of full premium	$119	$126	$143	$160
Full premium (=avg. pmt. for children and parents)	$237	$251	$286	$319
Revenue @ 50% of full premium	$0	$0	$0	$1,491,150
Revenue @ full premium	$0	$0	$0	$1,788,537
Total revenue	$0	$0	$0	$3,279,687
Net Cost of small employer option	$0	$0	$0	$1,826,212

FISCAL SUMMARY	FY 2006	FY 2007	FY 2008	FY 2009
		(in thousands)		
Pharmacy program (transfer)	$0	$0	$594	$1,389
Self-employed farm income	$0	$0	$0	$542
Eliminate MLB	$0	$0	$0	$3,277
Increase inpatient cap	$0	$0	$0	$1,561
Dental copays and inpatient cap for parents	$0	$0	$0	$1,608
Adults to 190% FPG	$0	$0	$0	$1,044
Small employer option	$0	$0	$0	$1,826
Grand total state budget cost	$0	$0	$594	$11,247

Long-Term Fiscal Considerations

Local Government Costs

References/Sources

I have reviewed the content of this fiscal note and believe it is a reasonable estimate of the expenditures and revenues associated with this proposed legislation.

Fiscal Note Coordinator Signature: _____ Date: _____

A bill for an act

relating to health care; providing for MinnesotaCare outreach; creating a prescription drug discount program; expanding the benefit set for single adults; increasing the eligibility income limit for single adults; increasing the cap for inpatient hospitalization benefits for adults; modifying the definition of income for self-employed farmers; establishing a small employer option; appropriating money; amending Minnesota Statutes 2004, sections 256L.03, subdivision 3; 256L.04, subdivision 7, by adding a subdivision; Minnesota Statutes 2005 Supplement, sections 256L.01, subdivision 4; 256L.03, subdivisions 1, 5; 256L.07, subdivision 1; proposing coding for new law in Minnesota Statutes, chapters 256; 256L; repealing Minnesota Statutes 2005 Supplement, section 256L.035.

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

Section 1. **[256.9545] PRESCRIPTION DRUG DISCOUNT PROGRAM.**

Subdivision 1. **Establishment; administration.** The commissioner shall establish and administer the prescription drug discount program.

Subd. 2. **Commissioner's authority.** The commissioner shall administer a drug rebate program for drugs purchased according to the prescription drug discount program. The commissioner shall execute a rebate agreement from all manufacturers that choose to participate in the program for those drugs covered under the medical assistance program. For each drug, the amount of the rebate shall be equal to the rebate as defined for purposes of the federal rebate program in United States Code, title 42, section 1396r-8. The rebate program shall utilize the terms and conditions used for the federal rebate program established according to section 1927 of title XIX of the federal Social Security Act.

Subd. 3. **Definitions.** For purposes of this section, the following terms have the meanings given them.

(a) "Commissioner" means the commissioner of human services.

(b) "Covered prescription drug" means a prescription drug as defined in section 151.44, paragraph (d), that is covered under medical assistance as described in section 256B.0625, subdivision 13, and that is provided by a participating manufacturer that has a fully executed rebate agreement with the commissioner under this section and complies with that agreement.

(c) "Enrolled individual" means a person who is eligible for the program under subdivision 4 and has enrolled in the program according to subdivision 5.

(d) "Health carrier" means an insurance company licensed under chapter 60A to offer, sell, or issue an individual or group policy of accident and sickness insurance as defined in section 62A.01; a nonprofit health service plan corporation operating under chapter 62C; a health maintenance organization operating under chapter 62D; a joint self-insurance employee health plan operating under chapter 62H; a community integrated service network licensed under chapter 62N; a fraternal benefit society operating under chapter 64B; a city, county, school district, or other political subdivision providing self-insured health coverage under section 471.617 or sections 471.98 to 471.982; and a self-funded health plan under the Employee Retirement Income Security Act of 1974, as amended.

(e) "Participating manufacturer" means a manufacturer as defined in section 151.44, paragraph (c), that agrees to participate in the prescription drug discount program.

(f) "Participating pharmacy" means a pharmacy as defined in section 151.01, subdivision 2, that agrees to participate in the prescription drug discount program.

Subd. 4. **Eligibility.** (a) To be eligible for the program, an applicant must:

(1) be a permanent resident of Minnesota as defined in section 256L.09, subdivision 4;

(2) not be enrolled in medical assistance, general assistance medical care, or MinnesotaCare;

(3) not be enrolled in and have currently available prescription drug coverage under a health plan offered by a health carrier or employer or under a pharmacy benefit program offered by a pharmaceutical manufacturer; and

(4) not be enrolled in and have currently available prescription drug coverage under a Medicare supplement policy, as defined in sections 62A.31 to 62A.44, or policies, contracts, or certificates that supplement Medicare issued by health maintenance organizations or those policies, contracts, or certificates governed by section 1833 or 1876 of the federal Social Security Act, United States Code, title 42, section 1395, et seq., as amended.

(b) Notwithstanding paragraph (a), clause (3), an individual who is enrolled in a Medicare Part D prescription drug plan or Medicare Advantage plan is eligible for the program but only for drugs that are not covered under the Medicare Part D plan or for drugs that are covered under the plan, but according to the conditions of the plan, the individual is responsible for 100 percent of the cost of the prescription drug.

Subd. 5. **Application procedure.** (a) Applications and information on the program must be made available at county social services agencies, health care provider offices, and agencies and organizations serving senior citizens. Individuals shall submit applications and any information specified by the commissioner as being necessary to verify eligibility directly to the commissioner. The commissioner shall determine an applicant's eligibility for the program within 30 days from the date the application is received. Upon notice of approval, the applicant must submit to the commissioner the enrollment fee specified in subdivision 10. Eligibility begins the month after the enrollment fee is received by the commissioner.

(b) An enrollee's eligibility must be renewed every 12 months with the 12-month period beginning in the month after the application is approved.

(c) The commissioner shall develop an application form that does not exceed one page in length and requires information necessary to determine eligibility for the program.

Subd. 6. **Participating pharmacy.** (a) Upon implementation of the prescription drug discount program, and until January 1, 2008, a participating pharmacy, with a valid prescription, must sell a covered prescription drug to an enrolled individual at the medical assistance rate.

(b) After January 1, 2008, a participating pharmacy, with a valid prescription, must sell a covered prescription drug to an enrolled individual at the medical assistance rate, minus an amount that is equal to the rebate amount described in subdivision 8, plus the amount of any switch fee established by the commissioner under subdivision 10, paragraph (b).

(c) Each participating pharmacy shall provide the commissioner with all information necessary to administer the program, including, but not limited to, information on prescription drug sales to enrolled individuals and usual and customary retail prices.

Subd. 7. **Notification of rebate amount.** The commissioner shall notify each participating manufacturer, each calendar quarter or according to a schedule established by the commissioner, of the amount of the rebate owed on the prescription drugs sold by participating pharmacies to enrolled individuals.

Subd. 8. **Provision of rebate.** To the extent that a participating manufacturer's prescription drugs are prescribed to a resident of this state, the manufacturer must provide

a rebate equal to the rebate provided under the medical assistance program for any prescription drug distributed by the manufacturer that is purchased at a participating pharmacy by an enrolled individual. The participating manufacturer must provide full payment within 38 days of receipt of the state invoice for the rebate, or according to a schedule to be established by the commissioner. The commissioner shall deposit all rebates received into the Minnesota prescription drug dedicated fund established under subdivision 11. The manufacturer must provide the commissioner with any information necessary to verify the rebate determined per drug.

Subd. 9. **Payment to pharmacies.** Beginning January 1, 2008, the commissioner shall distribute on a biweekly basis an amount that is equal to an amount collected under subdivision 8 to each participating pharmacy based on the prescription drugs sold by that pharmacy to enrolled individuals on or after January 1, 2008.

Subd. 10. **Enrollment fee; switch fee.** (a) The commissioner shall establish an annual enrollment fee that covers the commissioner's expenses for enrollment, processing claims, and distributing rebates under this program.

(b) The commissioner shall establish a reasonable switch fee that covers expenses incurred by participating pharmacies in formatting for electronic submission claims for prescription drugs sold to enrolled individuals.

Subd. 11. **Dedicated fund; creation; use of fund.** (a) The Minnesota prescription drug dedicated fund is established as an account in the state treasury. The commissioner of finance shall credit to the dedicated fund all rebates paid under subdivision 8, any federal funds received for the program, all enrollment fees paid by the enrollees, and any appropriations or allocations designated for the fund. The commissioner of finance shall ensure that fund money is invested under section 11A.25. All money earned by the fund must be credited to the fund. The fund shall earn a proportionate share of the total state annual investment income.

(b) Money in the fund is appropriated to the commissioner to reimburse participating pharmacies for prescription drugs provided to enrolled individuals under subdivision 6, paragraph (b); to reimburse the commissioner for costs related to enrollment, processing claims, and distributing rebates and for other reasonable administrative costs related to administration of the prescription drug discount program; and to repay the appropriation provided by law for this section. The commissioner must administer the program so that the costs total no more than funds appropriated plus the drug rebate proceeds.

Sec. 2. Minnesota Statutes 2005 Supplement, 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 for the six-month period of eligibility using the net profit or loss reported on the applicant's federal income tax form for the previous year and using the medical assistance families with children methodology for determining allowable and nonallowable self-employment expenses and countable income.

(b) "Gross individual or gross family income" for farm self-employed means income calculated for the six-month period of eligibility 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) "Gross individual or gross family income" means the total income for all family members, calculated for the six-month period of eligibility.

Sec. 3. Minnesota Statutes 2005 Supplement, 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, 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, mental health telemedicine, psychiatric consultation, 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. 4. Minnesota Statutes 2004, section 256L.03, subdivision 3, is amended to read:

Subd. 3. **Inpatient hospital services.** (a) Covered health services shall include inpatient hospital services, including inpatient hospital mental health services and inpatient hospital and residential chemical dependency treatment, subject to those limitations necessary to coordinate the provision of these services with eligibility under the medical assistance spenddown. ~~Prior to July 1, 1997, the inpatient hospital benefit for adult enrollees is subject to an annual benefit limit of $10,000.~~ The inpatient hospital benefit for adult enrollees who qualify under section 256L.04, subdivision 7, or who qualify under section 256L.04, subdivisions 1 and 2, with family gross income that exceeds ~~175~~ 190 percent of the federal poverty guidelines and who are not pregnant, is subject to an annual limit of ~~$10,000~~ $20,000.

(b) Admissions for inpatient hospital services paid for under section 256L.11, subdivision 3, must be certified as medically necessary in accordance with Minnesota Rules, parts 9505.0500 to 9505.0540, except as provided in clauses (1) and (2):

(1) all admissions must be certified, except those authorized under rules established under section 254A.03, subdivision 3, or approved under Medicare; and

(2) payment under section 256L.11, subdivision 3, shall be reduced by five percent for admissions for which certification is requested more than 30 days after the day of admission. The hospital may not seek payment from the enrollee for the amount of the payment reduction under this clause.

Sec. 5. Minnesota Statutes 2005 Supplement, section 256L.03, subdivision 5, is amended to read:

Subd. 5. **Co-payments and coinsurance.** (a) Except as provided in paragraphs (b) and (c), the MinnesotaCare benefit plan shall include the following co-payments and coinsurance requirements for all enrollees:

(1) ten percent of the paid charges for inpatient hospital services for adult enrollees, subject to an annual inpatient out-of-pocket maximum of $1,000 per individual and $3,000 per family;

(2) $3 per prescription for adult enrollees;

(3) $25 for eyeglasses for adult enrollees;

(4) $3 per nonpreventive 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, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist;

(5) $6 for nonemergency visits to a hospital-based emergency room; and

(6) 50 percent of the fee-for-service rate for adult dental care services other than preventive care services for persons eligible under section 256L.04, subdivisions 1 to 7, with income ~~equal to or less~~ greater than ~~175~~ 190 percent of the federal poverty guidelines.

(b) Paragraph (a), clause (1), does not apply to parents and relative caretakers of children under the age of 21 ~~in households with family income equal to or less than 175 percent of the federal poverty guidelines. Paragraph (a), clause (1), does not apply to parents and relative caretakers of children under the age of 21 in households with family income greater than 175 percent of the federal poverty guidelines for inpatient hospital admissions occurring on or after January 1, 2001~~.

(c) Paragraph (a), clauses (1) to (4), do not apply to pregnant women and children under the age of 21.

(d) Adult enrollees with family gross income that exceeds ~~175~~ 190 percent of the federal poverty guidelines and who are not pregnant shall be financially responsible for the coinsurance amount, if applicable, and amounts which exceed the ~~$10,000~~ $20,000 inpatient hospital benefit limit.

(e) When a MinnesotaCare enrollee becomes a member of a prepaid health plan, or changes from one prepaid health plan to another during a calendar year, any charges submitted towards the ~~$10,000~~ $20,000 annual inpatient benefit limit, and any out-of-pocket expenses incurred by the enrollee for inpatient services, that were submitted or incurred prior to enrollment, or prior to the change in health plans, shall be disregarded.

Sec. 6. Minnesota Statutes 2004, section 256L.04, subdivision 7, is amended to read:

Subd. 7. **Single adults and households with no children.** The definition of eligible persons includes all individuals and households with no children who have gross family incomes that are equal to or less than ~~175~~ 190 percent of the federal poverty guidelines.

Sec. 7. Minnesota Statutes 2004, section 256L.04, is amended by adding a subdivision to read:

Subd. 14. **MinnesotaCare outreach.** (a) The commissioner shall award grants to public or private organizations to provide information on the importance of maintaining insurance coverage and on how to obtain coverage through the MinnesotaCare program in areas of the state with high uninsured populations.

(b) In awarding the grants, the commissioner shall consider the following:

(1) geographic areas and populations with high uninsured rates;

(2) the ability to raise matching funds; and

(3) the ability to contact or serve eligible populations.

The commissioner shall monitor the grants and may terminate a grant if the outreach effort does not increase enrollment in medical assistance, general assistance medical care, or the MinnesotaCare program.

Sec. 8. Minnesota Statutes 2005 Supplement, section 256L.07, subdivision 1, is amended to read:

Subdivision 1. **General requirements.** (a) Children enrolled in the original children's health plan as of September 30, 1992, children who enrolled in the MinnesotaCare program after September 30, 1992, pursuant to Laws 1992, chapter 549, article 4, section 17, and children who have family gross incomes that are equal to or less than 150 percent of the federal poverty guidelines are eligible without meeting the requirements of subdivision 2 and the four-month requirement in subdivision 3, as long as they maintain continuous coverage in the MinnesotaCare program or medical assistance. Children who apply for MinnesotaCare on or after the implementation date of the employer-subsidized health coverage program as described in Laws 1998, chapter 407, article 5, section 45, who have family gross incomes that are equal to or less than 150 percent of the federal poverty guidelines, must meet the requirements of subdivision 2 to be eligible for MinnesotaCare.

(b) Families enrolled in MinnesotaCare under section 256L.04, subdivision 1, whose income increases above 275 percent of the federal poverty guidelines, are no longer eligible for the program and shall be disenrolled by the commissioner. Individuals enrolled in MinnesotaCare under section 256L.04, subdivision 7, whose income increases above ~~175~~ 190 percent of the federal poverty guidelines are no longer eligible for the program and shall be disenrolled by the commissioner. For persons disenrolled under this subdivision, MinnesotaCare coverage terminates the last day of the calendar month following the month in which the commissioner determines that the income of a family or individual exceeds program income limits.

(c) Notwithstanding paragraph (b), children may remain enrolled in MinnesotaCare if ten percent of their gross individual or gross family income as defined in section 256L.01, subdivision 4, is less than the premium for a six-month policy with a $500 deductible available through the Minnesota Comprehensive Health Association. Children who are no longer eligible for MinnesotaCare under this clause shall be given a 12-month notice period from the date that ineligibility is determined before disenrollment. The premium for children remaining eligible under this clause shall be the maximum premium determined under section 256L.15, subdivision 2, paragraph (b).

(d) Notwithstanding paragraphs (b) and (c), parents are not eligible for MinnesotaCare if gross household income exceeds $25,000 for the six-month period of eligibility.

Sec. 9. **[256L.20] MINNESOTACARE OPTION FOR SMALL EMPLOYERS.**

Subdivision 1. **Definitions.** (a) For the purposes of this section, the terms used have the meanings given them.

(b) "Dependent" means an unmarried child under the age of 21.

(c) "Eligible employee" means an employee who works at least 20 hours per week for an eligible employer. Eligible employee does not include an employee who works on a temporary or substitute basis or who does not work more than 26 weeks annually. Coverage of an eligible employee includes the employee's spouse.

(d) "Eligible employer" means a business that employs at least two, but not more than 50, eligible employees, the majority of whom are employed in the state, and includes a municipality that has 50 or fewer employees.

(e) "Maximum premium" has the meaning given under section 256L.15, subdivision 2, paragraph (b), clause (3).

(f) "Participating employer" means an eligible employer who meets the requirements in subdivision 3 and applies to the commissioner to enroll its eligible employees and their dependents in the MinnesotaCare program.

(g) "Program" means the MinnesotaCare program.

Subd. 2. **Option.** Eligible employees and their dependents may enroll in MinnesotaCare if the eligible employer meets the requirements of subdivision 3. The effective date of coverage is as defined in section 256L.05, subdivision 3.

Subd. 3. **Employer requirements.** The commissioner shall establish procedures for an eligible employer to apply for coverage through the program. In order to participate, an eligible employer must meet the following requirements:

(1) agree to contribute toward the cost of the premium for the employee, the employee's spouse, and the employee's dependents according to subdivision 4;

(2) certify that at least 75 percent of its eligible employees who do not have other creditable health coverage are enrolled in the program;

(3) offer coverage to all eligible employees, spouses, and dependents of eligible employees; and

(4) have not provided employer-subsidized health coverage as an employee benefit during the previous 12 months, as defined in section 256L.07, subdivision 2, paragraph (c).

Subd. 4. **Premiums.** (a) The premium for coverage provided under this section is equal to the average monthly payment for families with children, excluding pregnant women and children under the age of two.

(b) For eligible employees without dependents with income equal to or less than 175 percent of the federal poverty guidelines and for eligible employees with dependents with income equal to or less than 275 percent of the federal poverty guidelines, the participating employer shall pay 50 percent of the premium established under paragraph (a) for the eligible employee, the employee's spouse, and any dependents, if applicable.

(c) For eligible employees without dependents with income over 175 percent of the federal poverty guidelines and for eligible employees with dependents with income over 275 percent of the federal poverty guidelines, the participating employer shall pay the full cost of the premium established under paragraph (a) for the eligible employee, the employee's spouse, and any dependents, if applicable. The participating employer may require the employee to pay a portion of the cost of the premium so long as the employer pays 50 percent. If the employer requires the employee to pay a portion of the premium, the employee shall pay the portion of the cost to the employer.

(d) The commissioner shall collect premium payments from participating employers for eligible employees, spouses, and dependents who are covered by the program as provided under this section. All premiums collected shall be deposited in the health care access fund.

Subd. 5. **Coverage.** The coverage offered to those enrolled in the program under this section must include all health services described under section 256L.03 and all co-payments and coinsurance requirements under section 256L.03, subdivision 5, apply.

Subd. 6. **Enrollment.** Upon payment of the premium, according to this section and section 256L.06, eligible employees, spouses, and dependents shall be enrolled in MinnesotaCare. For purposes of enrollment under this section, income eligibility limits established under sections 256L.04 and 256L.07, subdivision 1, and asset limits established under section 256L.17 do not apply. The barriers established under section 256L.07, subdivision 2 or 3, do not apply to enrollees eligible under this section. The commissioner may require eligible employees to provide income verification to determine premiums.

Sec. 10. **APPROPRIATION.**

$..... is appropriated from the health care access fund to the commissioner of human services for the fiscal year ending June 30, 2007, for the purposes of section 7.

Sec. 11. **REPEALER.**

Minnesota Statutes 2005 Supplement, section 256L.035, is repealed.

Sec. 12. **EFFECTIVE DATE.**

Sections 1 to 6, 8, 9, and 11 are effective August 1, 2006, or upon implementation of HealthMatch, whichever is later. Section 7 is effective July 1, 2006.

AARP Minnesota

STATEMENT OF
AARP MINNESOTA
BEFORE
THE SENATE HEALTH AND HUMAN SERVICES BUDGET DIVISION
MINNESOTA STATE SENATE

March 23, 2006

Good Morning. My name is Christeen Stone, a volunteer with AARP Minnesota, representing 650,000 people over the age of 50 throughout the state. Madame Chair, and Committee members, we thank you for the opportunity to testify today about Senate File 2725.

As we testified before Senator Lourey's Health and Family Security Committee, AARP Minnesota supports Section 1of Senate File 2725, which establishes a prescription drug discount program as well as proposals by the Governor and others that reduce the costs of prescription drugs for all Minnesotans. We believe it makes common sense to harness the purchasing power of consumers and the state to bring down drug prices.

Despite efforts at the federal level to introduce the new Medicare drug benefit, and efforts here in Minnesota to help consumers access lower-cost prescription drugs, the fact remains that prescription drug prices are still rising.

AARP's research shows that over the 12-month period ending March 2005, manufacturers raised the price they charge for 195 brand-name drugs most

commonly used by older Americans, on average, by 6.6 percent. That's more than double the rate of inflation.

For consumers across the state – especially those without insurance coverage, the high costs of prescription drugs can be debilitating to household budgets, and forces too many people to lessen their quality of life – or even put their health in danger. Prescription drug costs simply cannot continue to rise at their current rate. Millions of Americans can no longer afford the vital drug therapies they need. Drugs have become so expensive that many people don't even fill their prescriptions. Others are forced to take drastic measures such as splitting pills or skipping doses. Still others have been driven to selling their possessions in a desperate attempt to pay for the medications they need.

It makes common sense for the state to use its purchasing power, and the power of Minnesota's collective consumers who pay out-of-pocket for their prescriptions. AARP strongly believes that this legislation will be a step toward truly making a difference in the pocketbooks of those who continue to struggle to pay for their prescriptions.

Thank you .

Medical Alley® MNBIO

March 21, 2006

The Honorable Senator Linda Berglin
75 Rev. Dr. Martin Luther King Jr. Blvd., Room 309
St. Paul, MN 55155-1606

Dear Chair Berglin,

Medical Alley/MNBIO, the life science trade association represents 500 member organizations in pharmaceuticals, biotechnology, medical devices, health care and research. Combined these firms employ over 250,000 people in Minnesota and thousands more around the world. As an organization, we are deeply concerned that SF 2725 would have a strong negative impact on Minnesota's growing biotechnology industry

SF 2725 is a price control bill. It requires manufacturers to pay Medicaid-level rebates for a non-Medicaid program. History has shown that when price controls are considered investment in research and development inevitably decline. Pharmaceutical and biotechnology research and development is a high-risk endeavor, as most drugs never recoup investment costs. Approximately $800 million and 12 to 15 years of R&D are required to bring a drug to market. If passed, SF 2725 will reduce the amount of research and development conducted in Minnesota – reducing jobs, reducing tax revenue and stifling the development of innovative solutions to pressing health care issues.

New drug development is relatively stagnant in Canada, Japan and many European countries where governmental price controls are commonplace, decreasing the ability of drug firms to recoup their costs. In contrast, while the U.S. is home to only about 5% of the world's population, its share of global drug development is 45%, over three times more than the next closest competitor, the U.K.

It is our hope that you will fully consider impact SF 2725 will have on the development of life saving procedures in the state of Minnesota.

Sincerely,

Donald E. Gerhardt
President/CEO
Medical Alley/MNBIO

1550 Utica Avenue South, Suite 725 • St. Louis Park, MN 55416 • 952-542-3077 • Fax: 952-542-3088 • www.medicalalley.org

ATTACHMENT "A"

Senator ..... moves to amend S.F. No. 2725 as follows:

Page 9, after line 3, insert:

"Sec. 9. Minnesota Statutes 2004, section 256L.11, subdivision 1, is amended to read:

Subdivision 1. **Medical assistance rate to be used.** Payment to providers under sections 256L.01 to 256L.11 shall be at the same rates and conditions established for medical assistance, except as provided in subdivisions 2 to 6, and section 256L.115.

Sec. 10. **[256L.115] ASSISTANCE TO FINANCIALLY STRESSED SAFETY NET HEALTH CARE CENTERS AND CLINICS.**

Subdivision 1. **Definitions.** For purposes of this section:

(a) "Federally qualified health center" or "center" means an entity, which is receiving a grant under United States Code, title 42, section 245b, or, based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the secretary to meet the requirements for receiving such a grant.

(b) "Safety net community clinic" or "safety net clinic" means an entity that is not a federally qualified health center, but is certified by the Minnesota Department of Health as being eligible to receive a grant under section 145.9268 and more than 25 percent of its patients were uninsured for the most recent calendar year for which data is available.

Subd. 2. **Rate enhancement.** Within the limits of money appropriated for this purpose, when setting rates for federally qualified health centers and safety net clinics, the commissioner shall provide an additional rate increase for federally qualified health centers and safety net clinics for services provided on or after July 1, 2006, to MinnesotaCare enrollees. The commissioner shall determine the rate increase for each qualifying federally qualified health care center or safety net clinic in proportion to each federally qualified health center's or safety net clinic's share of the number of uninsured patients to the total number of patients served in federally qualified health centers and safety net clinics statewide. To qualify for a rate enhancement, a federally qualified health center or safety net clinic must submit to the commissioner, on a form and in the manner specified by the commissioner, the federally qualified health center's or safety net clinic's payor mix with the percentage of uninsured patients and verification of the clinic's status as either a federally qualified health center or a safety net clinic.

Subd. 3. **Disease management, information technology, and disparities grants.** The commissioner shall award MinnesotaCare administrative grants to federally qualified health centers and safety net clinics to be used for any of the following purposes:

(1) the development or enhancement of electronic medical record and communication systems;

(2) the acquisition of technology and equipment that enhance service delivery and access for the uninsured;

(3) the creation of information technology systems that support the development and maintenance of information required to implement evidence-based clinical practices;

(4) the establishment of systems, technology, and outreach that encourage and permit the development of quality initiatives for the prevention and management of chronic disease;

(5) the development of outreach activities that encourage uninsured individuals to seek medical, social, or mental health services;

(6) the creation of outreach activities to prevent or mitigate the effects of chronic disease among the uninsured population; or

(7) the development of outreach activities that increase access, reduce health disparities, and improve care coordination for uninsured individuals.

Subd. 4. **Coordinated safety net care network.** (a) To the extent authorized under federal requirements, the commissioner shall authorize special risk-adjusted payment rates for services provided to MinnesotaCare enrollees by federally qualified health centers or a prepaid health plan participating in a community care pilot project under which federally qualified health centers, a safety net hospital, and a health plan partner, working in cooperation with the Department of Human Services, to establish a specialized, integrated, and cost-effective care network for serving high-risk, low-income, and diverse populations. The purpose of the project is to develop a replicable model for providing high-quality, efficient, and continuous care to populations that experience significant disparities in access, health status, and quality of care.

(b) The commissioner shall award a grant to the pilot project to be used for project planning and management, electronic technology design and development, purchase of software and equipment, research and evaluation, or other costs associated with the project. The participants in the project must report to the commissioner regarding the amount and use of the grant funds, the development and achievement of project objectives, and the outcomes produced for the insured, underinsured, and uninsured populations.

Subd. 5. **Federal requirements.** If the commissioner determines that the rate ~~enhancement required under subdivision 2 or grants provided under subdivision 3 or 4~~ does not meet applicable federal requirements for rates or administrative services, the state share of the money appropriated for these purposes shall be provided in the form of a direct grant to the eligible federally qualified health centers and safety net clinics."

Page 10, line 32, before "$....." insert "(a)"

Page 10, after line 33, insert:

"(b) $..... is appropriated in fiscal year 2007 from the health care access fund to the commissioner of human services for the following purposes:

(1) $..... for rate enhancement for federally qualified health centers and safety net community clinics as provided in Minnesota Statutes, section 256L.115, subdivision 2; and

(2) $..... for rate enhancement for the coordinated safety net care network pilot project as provided in Minnesota Statutes, section 256L.115, subdivision 4, paragraph (a).

(c) $300,000 is appropriated in fiscal year 2007 from the health care access fund to the commissioner of human services for a grant to the coordinated safety net care network pilot project as provided in Minnesota Statutes, section 256L.115, subdivision 4, paragraph (b). This appropriation is a onetime appropriation and shall not be added to the budget base.

(d) $..... is appropriated in fiscal year 2007 from the health care access fund to the commissioner of human services for administrative grants to federally qualified health centers and safety net community clinics as provided in Minnesota Statutes, section 256L.115, subdivision 3. This appropriation is a onetime appropriation and shall not be added to the budget base."

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

ATTACHMENT "B"

Senator ..... moves to amend S.F. No. 2725 as follows:

Page 4, after line 33, insert:

"**EFFECTIVE DATE.** This section is effective January 1, 2007."

Page 5, after line 13, insert:

"**EFFECTIVE DATE.** This section is effective August 1, 2006, or upon implementation of HealthMatch, whichever is later."

Page 5, after line 34, insert:

"**EFFECTIVE DATE.** This section is effective January 1, 2007."

Page 6, after line 20, insert:

"**EFFECTIVE DATE.** This section is effective August 1, 2006, or upon implementation of HealthMatch, whichever is later."

Page 7, after line 21, insert:

"**EFFECTIVE DATE.** This section is effective August 1, 2006, or upon implementation of HealthMatch, whichever is later."

Page 7, after line 25, insert:

"**EFFECTIVE DATE.** This section is effective August 1, 2006, or upon implementation of HealthMatch, whichever is later."

Page 8, after line 4, insert:

"**EFFECTIVE DATE.** This section is effective July 1, 2006."

Page 9, after line 3, insert:

"**EFFECTIVE DATE.** This section is effective August 1, 2006, or upon implementation of HealthMatch, whichever is later."

Page 10, after line 30, insert:

"**EFFECTIVE DATE.** This section is effective August 1, 2006, or upon implementation of HealthMatch, whichever is later."

Page 11, after line 1, insert:

"**EFFECTIVE DATE.** This section is effective January 1, 2007."

Page 11, delete section 12

ATTACHMENT "C"

Senator ..... moves to amend S.F. No. 2725 as follows:

Page 4, after line 33, insert:

"Sec. 2. Minnesota Statutes 2004, section 256B.76, is amended to read:

256B.76 PHYSICIAN AND DENTAL REIMBURSEMENT.

(a) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for physician services as follows:

(1) payment for level one Centers for Medicare and Medicaid Services' common procedural coding system codes titled "office and other outpatient services," "preventive medicine new and established patient," "delivery, antepartum, and postpartum care," "critical care," cesarean delivery and pharmacologic management provided to psychiatric patients, and level three codes for enhanced services for prenatal high risk, shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992. If the rate on any procedure code within these categories is different than the rate that would have been paid under the methodology in section 256B.74, subdivision 2, then the larger rate shall be paid;

(2) payments for all other services shall be paid at the lower of (i) submitted charges, or (ii) 15.4 percent above the rate in effect on June 30, 1992;

(3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases except that payment rates for home health agency services shall be the rates in effect on September 30, 1992;

(4) effective for services rendered on or after January 1, 2000, payment rates for physician and professional services shall be increased by three percent over the rates in effect on December 31, 1999, except for home health agency and family planning agency services; and

(5) the increases in clause (4) shall be implemented January 1, 2000, for managed care.

(b) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for dental services as follows:

(1) dental services shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992;

(2) dental rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases;

(3) effective for services rendered on or after January 1, 2000, payment rates for dental services shall be increased by three percent over the rates in effect on December 31, 1999;

(4) the commissioner shall award grants to community clinics or other nonprofit community organizations, political subdivisions, professional associations, or other organizations that demonstrate the ability to provide dental services effectively to public program recipients. Grants may be used to fund the costs related to coordinating access for recipients, developing and implementing patient care criteria, upgrading or establishing new facilities, acquiring furnishings or equipment, recruiting new providers, or other development costs that will improve access to dental care in a region. In awarding grants, the commissioner shall give priority to applicants that plan to serve areas of the state in which the number of dental providers is not currently sufficient to meet the needs of recipients of public programs or uninsured individuals. The commissioner shall consider the following in awarding the grants:

(i) potential to successfully increase access to an underserved population;

(ii) the ability to raise matching funds;

(iii) the long-term viability of the project to improve access beyond the period of initial funding;

(iv) the efficiency in the use of the funding; and

(v) the experience of the proposers in providing services to the target population.

The commissioner shall monitor the grants and may terminate a grant if the grantee does not increase dental access for public program recipients. The commissioner shall consider grants for the following:

(i) implementation of new programs or continued expansion of current access programs that have demonstrated success in providing dental services in underserved areas;

(ii) a pilot program for utilizing hygienists outside of a traditional dental office to provide dental hygiene services; and

(iii) a program that organizes a network of volunteer dentists, establishes a system to refer eligible individuals to volunteer dentists, and through that network provides donated dental care services to public program recipients or uninsured individuals;

(5) beginning October 1, 1999, the payment for tooth sealants and fluoride treatments shall be the lower of (i) submitted charge, or (ii) 80 percent of median 1997 charges;

(6) the increases listed in clauses (3) and (5) shall be implemented January 1, 2000, for managed care; and

(7) effective for services provided on or after January 1, 2002, payment for diagnostic examinations and dental x-rays provided to children under age 21 shall be the lower of (i) the submitted charge, or (ii) 85 percent of median 1999 charges.

(c) Effective for dental services rendered on or after ~~January 1, 2002~~ July 1, 2006, the commissioner ~~may, within the limits of available appropriation,~~ shall increase reimbursements to dentists and dental clinics deemed by the commissioner to be critical access dental providers. ~~Reimbursement to a critical access dental provider may be increased~~ by not more than 50 percent above the reimbursement rate that would otherwise be paid to the provider. Payments to health plan companies shall be adjusted to reflect increased reimbursements to critical access dental providers as approved by the commissioner. In determining which dentists and dental clinics shall be deemed critical access dental providers, the commissioner shall review:

(1) the utilization rate in the service area in which the dentist or dental clinic operates for dental services to patients covered by medical assistance, general assistance medical care, or MinnesotaCare as their primary source of coverage;

(2) the level of services provided by the dentist or dental clinic to patients covered by medical assistance, general assistance medical care, or MinnesotaCare as their primary source of coverage; and

(3) whether the level of services provided by the dentist or dental clinic is critical to maintaining adequate levels of patient access within the service area.

In the absence of a critical access dental provider in a service area, the commissioner may designate a dentist or dental clinic as a critical access dental provider if the dentist or dental clinic is willing to provide care to patients covered by medical assistance, general assistance medical care, or MinnesotaCare at a level which significantly increases access to dental care in the service area.

(d) An entity that operates both a Medicare certified comprehensive outpatient rehabilitation facility and a facility which was certified prior to January 1, 1993, that is licensed under Minnesota Rules, parts 9570.2000 to 9570.3600, and for whom at least 33 percent of the clients receiving rehabilitation services in the most recent calendar year are medical assistance recipients, shall be reimbursed by the commissioner for rehabilitation services at rates that are 38 percent greater than the maximum reimbursement rate allowed under paragraph (a), clause (2), when those services are (1) provided within the comprehensive outpatient rehabilitation facility and (2) provided to residents of nursing facilities owned by the entity.

(e) Effective for services rendered on or after January 1, 2007, the commissioner shall make payments for physician and professional services based on the Medicare relative value units (RVUs). This change shall be budget neutral and the cost of implementing RVUs will be incorporated in the established conversion factor."

Page 9, after line 3, insert:

"Sec. 10. Minnesota Statutes 2004, section 256L.11, subdivision 1, is amended to read:

Subdivision 1. **Medical assistance rate to be used.** Payment to providers under sections 256L.01 to 256L.11 shall be at the same rates and conditions established for medical assistance, except as provided in subdivisions 2 to ~~6~~ 7.

Sec. 11. Minnesota Statutes 2004, section 256L.11, is amended by adding a subdivision to read:

Subd. 7. **Critical access dental providers.** (a) Effective for dental services provided to MinnesotaCare enrollees on or after July 1, 2006, the commissioner shall increase payment rates to dentists and dental clinics deemed by the commissioner to be critical access providers under section 256B.76, paragraph (c), by 40 percent above the payment rate that would otherwise be paid to the provider. The commissioner shall adjust rates paid to prepaid health plans under contract with the commissioner to reflect the rate increases provided in this subdivision. The prepaid health plan must pass this rate increase to providers who have been identified by the commissioner as critical access dental providers.

(b) The commissioner shall award special hardship grants to nonprofit dental providers with a high proportion of uninsured patients that equals or exceeds 15 percent of the total number of patients served by that provider and the provider does not receive a financial benefit comparable to other critical access dental providers under the critical access dental provider formula described in paragraph (c). The commissioner shall award a grant to these providers allocated in proportion to each critical access dental provider's ratio of uninsured patients to the total number of patients served by all providers who qualify for a grant under this paragraph."

Page 10, line 32, before "$....." insert "(a)"

Page 10, after line 33, insert:

"(b) $..... is appropriated in fiscal year 2007 from the health care access fund to the commissioner of human services for critical access dental provider reimbursement rate increases as provided under section 256L.11, subdivision 7, paragraph (a).

(c) $..... is appropriated in fiscal year 2007 from the health care access fund to the commissioner of human services for special hardship grants to nonprofit dental providers as provided in Minnesota Statutes, section 256L.11, subdivision 7, paragraph (b)."

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

Minnesota Nonprofit Economy Report

2005

MINNESOTA COUNCIL OF NONPROFITS

An annual study that describes the role and input of nonprofit organizations in Minnesota's economy, with a statewide and regional analysis.

Using this Report

Like every other industry in the United States, nonprofit organizations benefit from current economic performance information. For ten years, the *Minnesota Nonprofit Economy Report* has offered the most comprehensive and continuous set of economic information on the nonprofit sector of any state in the country. Minnesota ranks at or near the top in virtually every measure of nonprofit and philanthropic activity. This success is due to substantial donations of time and finances by the people of Minnesota, generous support from Minnesota's business community, and strong partnerships with state and local governments.

The *Minnesota Nonprofit Economy Report*, together with the *Minnesota Salary and Benefits Survey* and other reports published by the Minnesota Council of Nonprofits, have important uses for five distinct audiences:

- **Managers of nonprofit organizations:** planning budgets, strategizing revenue streams, and identifying potential partnerships
- **Nonprofit boards of directors:** developing strategic plans, conducting board trainings, and evaluating staffing and compensation plans
- **Government officials:** understanding partnership capacity and funding streams of the nonprofit sector
- **Donors to nonprofits:** understanding the sources of support and nature of expenditures of nonprofit organizations
- **Economic and community development planners:** incorporating nonprofit employment trends into economic development plans and understanding regional differences and local economies

The Minnesota Council of Nonprofits (MCN) is the statewide association of more than 1,500 Minnesota nonprofit organizations. Through its Web site, publications, workshops and events, cost-saving programs, and advocacy, MCN works to inform, promote, connect, and strengthen individual nonprofits and the nonprofit sector.

 Additional copies of this report can be downloaded from MCN's Web site at www.mncn.org.

2005 Minnesota Nonprofit Economy Report Executive Summary

The *Minnesota Nonprofit Economy Report* is an annual study by the Minnesota Council of Nonprofits that describes the role of nonprofit organizations in Minnesota's economy by analyzing nonprofit employment, wage, and financial data. This year's report uses data from 2004, the most current information available.

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Nonprofit Organizations

Between 2003 and 2004, the number of nonprofits with employees in Minnesota increased by almost 80 organizations to 4,818, nearly a 2% increase. This was slightly stronger growth than the state has experienced in recent years.

A majority of nonprofit employers are located in the seven-county Twin Cities metro area. And a majority of nonprofit organizations in our state are engaged in delivering health care and human services.

There are a substantial number of nonprofits in the state, however, that operate without any paid staff. In 2004, there were over 5,900 organizations in Minnesota that reported a minimal level of financial activity, generally more than $25,000 for the year.

Nonprofit Employment

Nonprofit employment in the state has experienced strong and sustained growth since the late 1980s. Even after the 2001 recession and during the slow economic recovery that followed, nonprofit employment continued to increase, while total employment in the state actually declined.

In 2004, however, nonprofit employment in the state increased by less than 1% from the previous year, the slowest growth the sector has experienced since the mid-1980s. Nevertheless, there were still well over 250,000 nonprofit employees in the state, accounting for 9.8% of the state's total workforce in 2004.

Almost two-thirds of nonprofit employees in Minnesota work in health care. With increases of more than 3% per year for the last few years, it was growth in health care employment that helped sustain overall employment growth in the sector during difficult economic times. However, between 2003 and 2004, nonprofit employment in health care increased by less than 1%. This slowdown in health care employment is a concern for the nonprofit sector.

Nonprofit Wages

In 2004, nonprofits in the state paid $9.3 billion in wages to their employees. However, the statewide average weekly wage for nonprofit employees ($704) continued to lag behind the average wage for both government ($756) and for-profit ($790) employees. This may be due, in part, to a large number of part-time employees in the nonprofit workforce.

A closer look reveals that the median hourly wage for a full-time nonprofit employee was generally competitive with the median wage for government and for-profit employees in the same industry. Furthermore, in nearly every industry examined, the median wage for a full-time nonprofit employee was sufficient to support a family of four in that region (two adults working full-time, two children).

Nonprofit Finances

Statewide, nonprofits in Minnesota reported $23.8 billion in revenues and $22.4 billion expenditures for the most recently completed fiscal year.

However, two key sources of nonprofit revenue — charitable contributions and government funding — are under pressure. Natural disasters in our country and around the world continue to attract substantial levels of charitable contributions. And recent budget pressures have led to reductions in grants and contracts to nonprofit organizations at the local, state, and federal levels of government in some service areas.

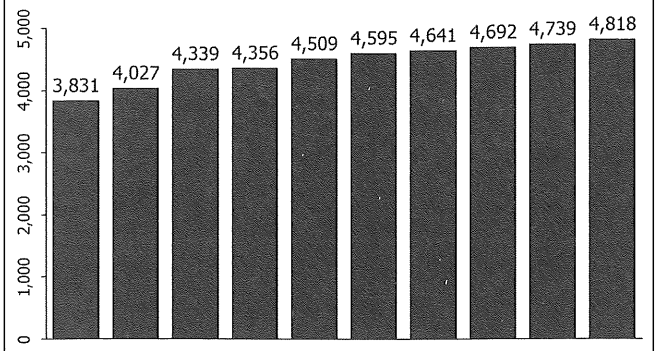
The potential vulnerability to these budget pressures varies among organizations. Smaller nonprofits are more reliant on charitable contributions, whereas larger organizations tend to rely more heavily on program service revenue, which includes government fees and contracts.

Similarly, health care and human service organizations are potentially more vulnerable to reductions in government funding. Other nonprofits —such as arts and environmental organizations — generally rely more on charitable donations, including corporate and foundation grants.

Statewide Analysis

Statewide Overview: The nonprofit sector in Minnesota continued to expand in 2004, with an increase in both the number of nonprofit employers and the size of the nonprofit workforce. However, growth in nonprofit employment, which averaged almost 4% per year for the last decade, slowed significantly in 2004. Nonprofit activity in the state is clearly centered in the seven-county Twin Cities metro area, but the counties of Olmsted (with the city of Rochester), St. Louis (Duluth), and Stearns (St. Cloud) also had a significant nonprofit presence in 2004. The majority of nonprofit employers and employees in the state were engaged in delivering health care and human services.

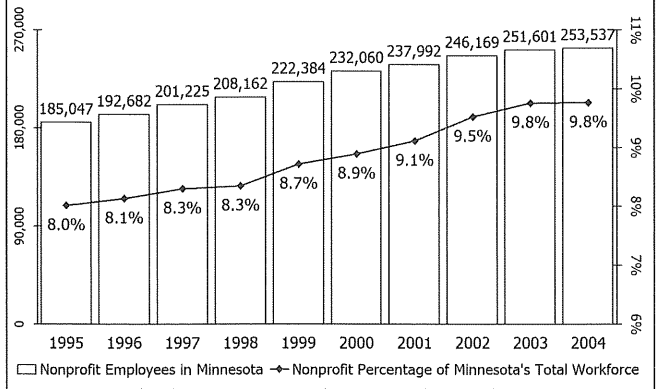
Number of Nonprofit Organizations in Minnesota (with at least one employee)



Source: MN Dept. of Employment & Economic Development, Quarterly Census of Employment & Wages

- In 2004, there were 4,818 nonprofit organizations with at least one employee in Minnesota. This was almost a 2% increase from the previous year.
- The majority of nonprofit employers, 51%, were located in the seven-county Twin Cities metro area in 2004. Northwest Minnesota had the second largest concentration of nonprofits with employees with 13%. The remainder of nonprofit employers were spread evenly throughout the rest of the state with 9% in the Southeast, 9% in the Southwest, 8% in Central Minnesota, and 8% in the Northeast. A definition of the counties included in these regions is provided in the regional profiles that follow.
- There were only small changes in the number of nonprofit employers in the six regions of the state. The Twin Cities experienced the strongest percentage growth, with a nearly 3% increase between 2003 and 2004, while the Northeast experienced the largest percentage decrease, with a 1% decline.
- In 2004, nonprofit employees accounted for 9.8% of the state's total workforce, which was unchanged from the previous year.
- Over the last ten years, nonprofit employment in the state increased an average of nearly 4% a year, while total employment in the state increased about 2% per year. Growth in nonprofit employment leveled off in 2004, but still kept pace with the minimal percentage increase in total employment in the state.
- The distribution of nonprofit employees in the state differed slightly from the distribution of nonprofit employers. In 2004, 52% of the nonprofit workforce was located in the Twin Cities, 18% in the Southeast, 9% in the Northwest, 8% in Central Minnesota, 7% in the Northeast, and 6% in the Southwest.
- Nonprofit employment in these regions experienced only minimal growth between 2003 and 2004, with percentage increases ranging from 0.2% in the Southeast to 1.9% in the Northeast.

Number of Nonprofit Employees in Minnesota and Percentage of the State's Total Workforce



Source: MN Dept. of Employment & Economic Development, Quarterly Census of Employment & Wages

Statewide Analysis

Nonprofit Organizations, Employers, and Employment by Activity Area in 2004

Activity Area	% of Nonprofit Organizations	% of Nonprofit Employers	% of Nonprofit Employees
Human Services	39%	42%	16%
Health	15%	25%	66%
Education	13%	9%	10%
Public, Societal Benefit	12%	10%	4%
Arts, Culture, and Humanities	11%	6%	2%
Religion-Related and Spiritual Development	4%	4%	1%
Environment and Animals	4%	2%	1%
International and Foreign Affairs	2%	1%	<1%
Mutual/Membership Benefit	1%	1%	1%

Source: Minnesota Attorney General's Office, Charities Division and the MN Dept. of Employment & Economic Development, Quarterly Census of Employment & Wages.
Notes: The columns may not add up to 100% due to rounding. For the purposes of this table and the analysis on this page, nonprofit employers and employees were recategorized from the NAICS classification system to match the NTEE classification system commonly used to categorize nonprofit organizations. A description of some of the major activity areas in the NTEE classification system is included on Page 5. More information on the NTEE and NAICS classification systems is available in Appendix B.

- In 2004, the greatest percentage of nonprofit organizations in the state were involved in delivering human services, including 42% of nonprofit employers and 39% of financially active charitable organizations in the state. However, human service organizations have fewer employees on average, and so employed only 16% of the nonprofit workforce in Minnesota.

- Health care, which includes hospitals, accounted for another 15% of financially active nonprofit organizations in Minnesota and 25% of the state's nonprofit employers. Health care organizations, however, employed two out of three nonprofit employees in the state.

- Although arts, culture, and humanities organizations accounted for only about 6% of nonprofit employers and 2% of nonprofit employment in the state, this same category accounted for closer to 11% of financially active nonprofit organizations in the state, which included organizations without any paid employees.

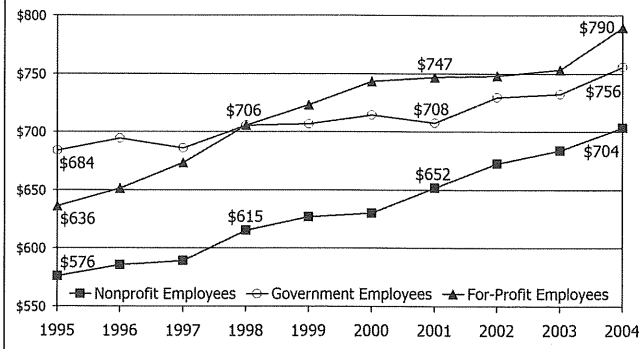
- Nonprofit employers in Minnesota paid $9.3 billion in wages to their employees in 2004. After adjusting for inflation, this represented a nearly 4% increase in the total nonprofit payroll from 2003. The nonprofit sector accounted for 9% of all wages paid in the state in 2004.

- Nonprofit average weekly wages in the state continue to lag behind both government and for-profit wages. In 2004, the average weekly wage for nonprofit employees was $704, while the average wage for government employees was $756 and $790 for for-profit employees.

- In some regions of the state, however, the average weekly wage for nonprofit employees surpassed both government and for-profit employees in 2004. This was true in both Northeast and Southeast Minnesota, two regions where the higher paying health care industry is particularly dominant.

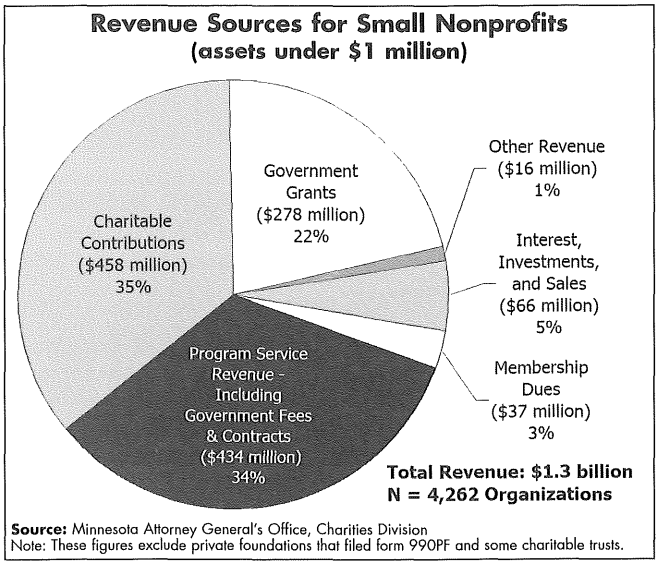
- Nonprofit wages, however, are more competitive than the averages suggest. Across the state, the median hourly wage for a full-time nonprofit employee in a given industry often exceeded the median hourly wage for a full-time government or for-profit employee working in the same industry. In most cases, the median hourly wage for a nonprofit employee was also sufficient to support the basic needs of a family of four in that region.

Average Weekly Wages in Minnesota by Sector (in constant 2004 dollars)



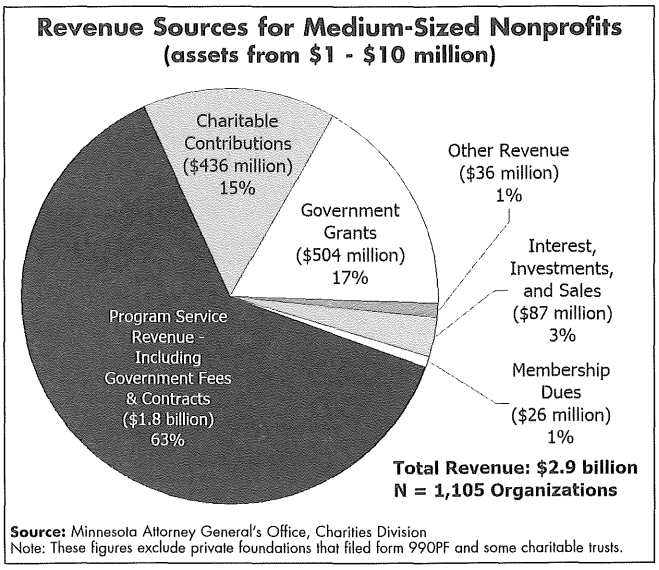
Source: MN Dept. of Employment & Economic Development, Quarterly Census of Employment & Wages

Statewide Analysis

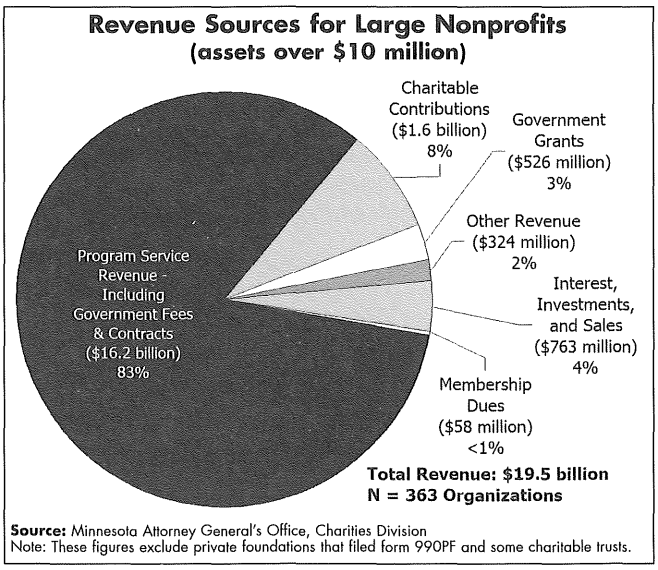


Source: Minnesota Attorney General's Office, Charities Division
Note: These figures exclude private foundations that filed form 990PF and some charitable trusts.

- Nonprofit organizations in Minnesota receive their revenues from four main sources: charitable contributions (which includes corporate and foundation grants), government grants, program service revenue (which includes government fees and contracts), and returns from investments, sales, and special events.
- The mix of nonprofit revenues, however, varies based on the organization's size, with small organizations more reliant on charitable contributions and government grants and larger organizations reporting a higher percentage of earned income (which includes government fees and contracts). The mix of revenues also varies depending on the organization's activity area.
- The Charities Review Council of Minnesota recommends that nonprofits spend at least 70% of their total annual expenses on programs services and no more than 30% on management and fundraising. In 2004, Minnesota nonprofits as a sector exceeded these recommendations, spending 87% of their revenues on program services and only 13% on management and fundraising. These percentages did not vary significantly by the size of the organization.



Source: Minnesota Attorney General's Office, Charities Division
Note: These figures exclude private foundations that filed form 990PF and some charitable trusts.



Source: Minnesota Attorney General's Office, Charities Division
Note: These figures exclude private foundations that filed form 990PF and some charitable trusts.

Statewide Analysis

- Health organizations in Minnesota reported $16.9 billion in revenues for the most recent fiscal year: 91% from program service revenue, 4% from charitable contributions, 2% from government grants, and 2% from interest, investments, and sales. These organizations reported $16.1 billion in expenses: 87% for program services, 13% for management and general expenses, and less than 1% for fundraising.

- Human service organizations in Minnesota reported $3.1 billion in revenues: 51% from program service revenue, 21% from charitable contributions, 20% from government grants, and 4% from interest, investments, and sales. These organizations reported $3.0 billion in expenses: 87% for program services, 10% for management and general expenses, and 2% for fundraising.

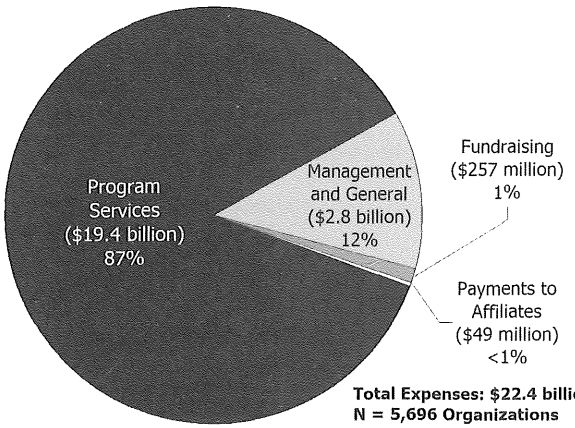
- Educational organizations in the state reported $2.4 billion in revenues: 58% from program service revenue, 21% from charitable contributions, 13% from interest, investments, and sales, and 7% from government grants. These organizations reported $2.1 billion in expenses: 85% for program services, 11% for management and general expenses, and 3% for fundraising.

- Arts, culture, and humanities organizations in Minnesota reported $558 million in revenues: 45% from charitable contributions, 30% from program service revenue, 12% from interest, investments, and sales, and 10% from government grants. These organizations reported $471 million in expenses: 80% for program services, 13% for management and general expenses, and 7% for fundraising.

- Environmental and animal-related organizations in the state reported $114 million in revenues: 41% from charitable contributions, 25% from program services, 15% from interest, investments, and sales, and 13% from government grants. These organizations reported $115 million in expenses: 84% for program services, 11% for management and general expenses, and 5% for fundraising.

- In 2004, 42% of nonprofits in the state reported a deficit for the fiscal year, meaning their expenses for the year exceeded revenues, which was down slightly from 44% reporting a deficit in 2003.

Expenditures by Nonprofit Organizations Located in Minnesota

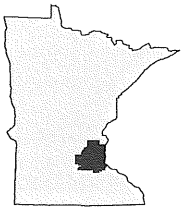


Source: Minnesota Attorney General's Office, Charities Division
Note: These figures exclude private foundations that filed form 990PF and some charitable trusts.

Classifying Nonprofits by Industry or Activity Area

This report uses two methods of classifying nonprofit organizations. Nonprofit employers, employees, and wages are classified using the North American Industry Classification System (NAICS), which is described in detail in Appendix A. Nonprofit financial information is classified using the National Taxonomy of Exempt Entities (NTEE) classification system. The five main activity areas of the NTEE system used in this report are described below.

- **Health:** activities include, but are not limited to, hospitals, ambulatory health care, rehabilitative care, public health, nursing care, mental health treatment, substance abuse prevention and treatment, and medical research.
- **Human Services:** activities include, but are not limited to, crime prevention and rehabilitation, abuse prevention, legal services, vocational counseling and rehabilitation, food programs, housing and shelter, disaster preparedness and relief, recreation and sports, youth development, children and youth services, emergency assistance, and centers for specific populations.
- **Education:** activities include, but are not limited to, elementary and secondary schools, vocational and technical schools, higher education, adult education, libraries, educational services, and student services.
- **Arts, Culture, and Humanities:** activities include, but are not limited to, arts education, media and communications, visual arts, museums, performing arts, and historical preservation.
- **Environmental and Animal-Related:** activities include, but are not limited to, natural resources conservation and protection, pollution abatement and control, horticulture, animal protection and welfare, wildlife preservation, veterinary services, and zoos and aquariums.

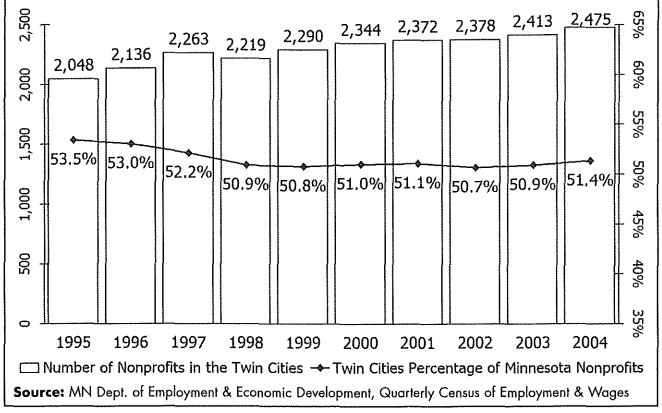


Twin Cities Metro Area Analysis

Counties: Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, Washington

Overview: With nearly 2,500 nonprofit employers and over 130,000 nonprofit employees, the seven-county Twin Cities metro was home to a majority of the state's nonprofit activity in 2004. Hennepin and Ramsey Counties alone accounted for 42% of all nonprofit employers and 44% of all nonprofit employees in the state. Nonprofit employment in the Twin Cities, however, increased by less than 1% between 2003 and 2004 after growing an average of 4% a year between 1993 and 2003. Nonprofits in the region reported significant financial activity in 2004, with $14.8 billion in revenues, $14.0 billion in expenditures, and paying $5.0 billion in wages to their employees.

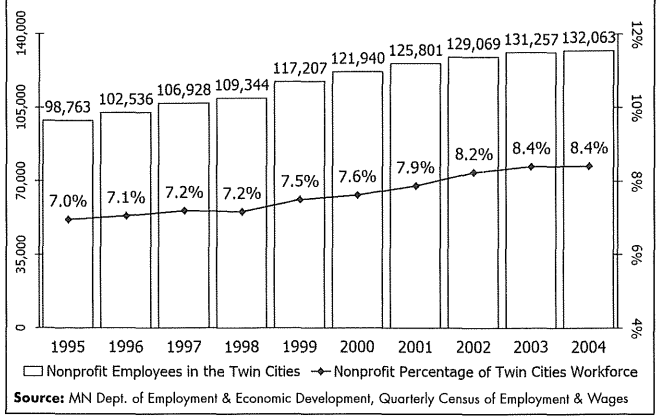
Number of Nonprofit Organizations in the Twin Cities and Percentage of Nonprofits Located in the Twin Cities (with at least one employee)



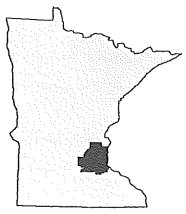
Source: MN Dept. of Employment & Economic Development, Quarterly Census of Employment & Wages

- In 2004, there were 2,475 nonprofit organizations with employees in the seven-county Twin Cities metro region, which was nearly a 3% increase from 2003. The region experienced the largest percentage increase in nonprofit employers in the state.
- Although the Twin Cities has been home to at least half of the state's nonprofit employers for the last decade, nonprofits accounted for just 3% of all employers in the region in 2004.
- With over 130,000 employees, nonprofits employed 8.4% of the region's total workforce in 2004. Nonprofit employees in the Twin Cities region accounted for 52% of the state's total nonprofit workforce.
- Between 1993 and 2004, nonprofit employment in the Twin Cities increased an average of nearly 4% each year, well ahead of the percentage increase in total employment which grew an average of 1.5% per year.
- Growth in the region's nonprofit workforce has been leveling off since 2001. Nonprofit employment in the Twin Cities increased only slightly between 2003 and 2004, but percentage growth in total employment in the region was also minimal.
- In 2004, Hennepin County led nonprofit activity in the Twin Cities metro area with 51% of the region's nonprofit employers and 55% of nonprofit employment. Indeed, 29% of the state's total nonprofit workforce was located in this one county.
- Ramsey County was a second area of concentration, with 31% of the region's nonprofit employers and 29% of nonprofit employment. Dakota County was a distant third, with just under 7% of the region's nonprofit employers and 5% of nonprofit employees.
- While Hennepin and Ramsey dominate nonprofit activity in the Twin Cities, nonprofit employment has been growing more rapidly in the other five counties in the region.

Number of Nonprofit Employees in the Twin Cities and Nonprofit Percentage of All Twin Cities Employees



Source: MN Dept. of Employment & Economic Development, Quarterly Census of Employment & Wages



Twin Cities Metro Area Analysis

Counties: Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, Washington

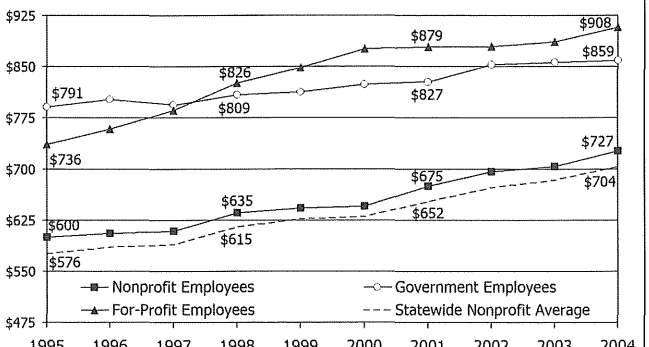
Median Hourly Wages for Full-Time Employees in the Twin Cities

Industry	Full-Time Median Hourly Wage by Sector (% of sector employment in the region)		
	Nonprofit	**For-Profit**	**Government**
Arts, Entertainment & Recreation	$19.18 (4%)	$15.72 (2%)	$20.43 (1%)
Educational Services	$19.15 (11%)	$19.51 (1%)	$21.40 (45%)
Health Care			
Ambulatory Health Care Services	$19.85 (10%)	$18.94 (3%)	$19.60 (<1%)
Hospitals	$23.44 (33%)	$20.85 (<1%)	$21.41 (6%)
Nursing & Residential Care Facilities	$14.58 (14%)	$14.00 (1%)	$18.49 (1%)
Social Assistance			
Individual & Family Services	$15.44 (6%)	$11.20 (1%)	$24.64 (1%)
Community Food, Housing, Emergency & Other Relief Services	$15.66 (1%)	$17.25 (<1%)	NA
Vocational Rehabilitation Services	$14.25 (3%)	$23.02 (<1%)	$24.80 (<1%)
Child Day Care Services	$12.55 (1%)	$11.29 (<1%)	$13.67 (<1%)
Other Services			
Religious Organizations	$17.62 (1%)	$13.13 (<1%)	NA
Grantmaking & Giving Services	$22.36 (1%)	$26.15 (<1%)	NA
Social Advocacy Organizations	$16.76 (2%)	$16.22 (<1%)	$24.58 (<1%)
Civic & Social Organizations	$14.97 (3%)	$15.00 (<1%)	NA

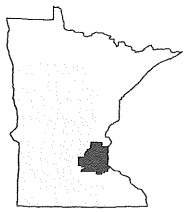
Source: MN Dept. of Employment & Economic Development, Enhanced Wage Records, 3rd Quarter 2004
Notes: "NA" indicates either that the sector did not have any employees in that industry or that the information for that category was suppressed for reasons of privacy. The selected industries represented 89% of nonprofit employment, 9% of for-profit employment, and 53% of government employment in the region in 2004. More extensive descriptions of these industries are available in Appendix A.

- In 2004, 57% of nonprofit employment in the Twin Cities region was in health care, which includes ambulatory health care services, hospitals, and nursing and residential care facilities. However, the Twin Cities was the only region in the state to have less than two-thirds of its nonprofit employment in health care.
- Compared to other regions in Minnesota, the Twin Cities had a higher percentage of its nonprofit workforce employed in educational services (11% of nonprofit employment and 13% of nonprofit employers), individual and family services (6% of employment and 14% of employers), and arts, entertainment, and recreation (4% of employment and 6% of employers).
- Nonprofit organizations in the Twin Cities paid $5.0 billion in wages in 2004, or 7% of all wages paid in the region. After adjusting for inflation, total nonprofit payroll in the region increased by 4% over 2003.
- Nonprofit organizations in Hennepin and Ramsey Counties together paid $4.3 billion in wages in 2004, or 47% of all nonprofits wages paid in the state.
- The average weekly wage for nonprofit employees in the Twin Cities lagged well behind average weekly wages for both government and for-profit employees in the region.
- The median hourly wage for a full-time nonprofit employee in most of the industries examined, however, exceeded the minimum wage necessary to support the basic needs of a family of four (two adults working full-time, two children). According to the JOBS NOW Coalition, in 2004, each adult needed to earn about $13.05 an hour to meet these costs in the Twin Cities. The exception was child day care services.

Average Weekly Wages in the Twin Cities by Sector (in constant 2004 dollars)



Source: MN Dept. of Employment & Economic Development, Quarterly Census of Employment & Wages



Twin Cities Metro Area Analysis

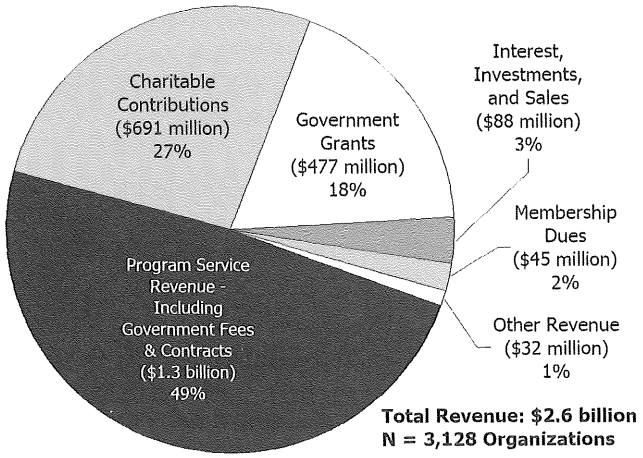
Counties: Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, Washington

- Health organizations in the Twin Cities reported $9.7 billion in revenues: 92% from program services, 3% from charitable contributions, 2% from government grants, and 1% from interest, investments, and sales. These organizations reported $9.3 billion in expenses: 84% for program services, 16% for management and general expenses, and less than 1% for fundraising.

- Human service organizations in the region reported $2.3 billion in revenues: 51% from program service revenue, 25% from charitable contributions, 16% from government grants, and 4% from interest, investments, and sales. These organizations reported $2.2 billion in expenses: 87% for program services, 11% for management and general expenses, and 2% for fundraising.

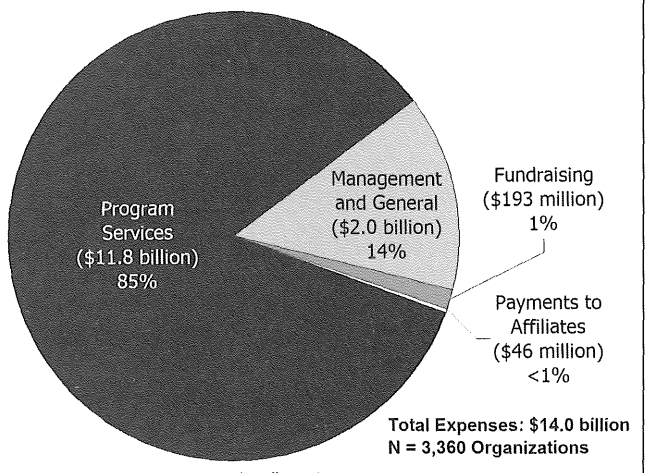
- Educational organizations in the Twin Cities reported $1.6 billion in revenues: 60% from program services, 19% from charitable contributions, 11% from interest, investments, and sales, and 8% from government grants. These organizations reported $1.4 billion in expenses: 84% for program services, 13% for management and general expenses, and 3% for fundraising.

Revenue Sources for Nonprofit Organizations Located in the Twin Cities (Organizations with assets under $10 million)



Source: Minnesota Attorney General's Office, Charities Division
Note: These figures exclude private foundations that filed form 990PF and some charitable trusts.

Expenditures by Nonprofit Organizations Located in the Twin Cities (All organizations)



Source: Minnesota Attorney General's Office, Charities Division
Note: These figures exclude private foundations that filed form 990PF and some charitable trusts.

- Arts, culture, and humanities organizations in the Twin Cities reported $517 million in revenues: 45% from charitable contributions, 30% from program service revenue, 12% from interest, investments, and sales, and 9% from government grants. These organizations reported $433 million in expenses: 80% for program services, 13% for management and general expenses, and 7% for fundraising.

- Environmental and animal-related organizations in the region reported $93 million in revenues: 42% from charitable contributions, 22% from program services, 15% from interest, investments, and sales, and 15% from government grants. These organizations reported $95 million in expenses: 86% for program services, 8% for management and general expenses, and 6% for fundraising.

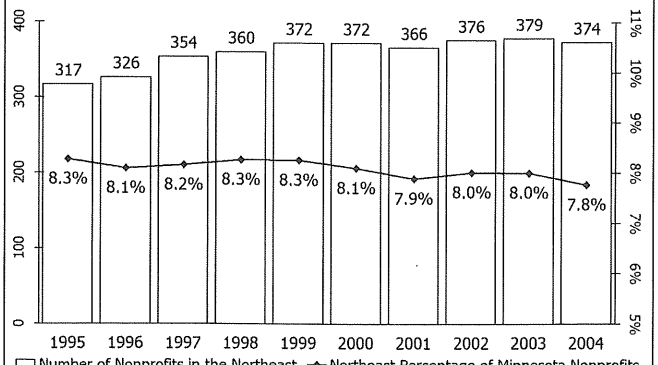
- In 2004, 44% of nonprofit organizations in the Twin Cities reported a deficit for the fiscal year, meaning their expenses for the year exceeded revenues.

Northeast Minnesota Analysis

Counties: Aitkin, Carlton, Cook, Itasca, Koochiching, Lake, St. Louis

Overview: The nonprofit sector in the seven-county Northeast region is characterized by a particularly high concentration of nonprofit activity in the health care industry, which accounted for 26% of nonprofit employers and 77% of nonprofit employees in 2004. After another year of growth, the nonprofit workforce accounted for nearly 14% of total employment in the Northeast. The strong presence of the health care and educational services industries has helped fuel the growth in nonprofit employment. These well-paying industries also contributed to the high average wage for nonprofit employees in the region. St. Louis County, with the city of Duluth, is the focus of nonprofit activity in the Northeast.

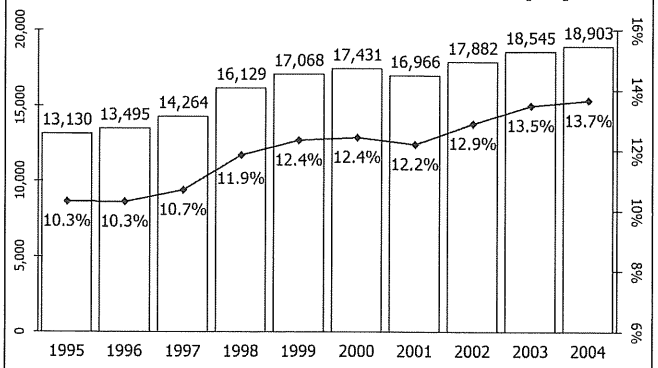
Number of Nonprofit Organizations in the Northeast and Percentage of Nonprofits Located in the Northeast (with at least one employee)



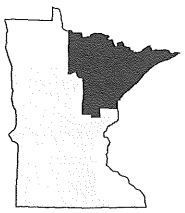
Source: MN Dept. of Employment & Economic Development, Quarterly Census of Employment & Wages

- With just 374 nonprofit organizations with employees in 2004, the Northeast region has the fewest nonprofit employers in the state. The region even experienced a slight decline in the number of nonprofit employers between 2003 and 2004.
- With only minimal changes in the number of nonprofits with employees, the Northeast's share of the state's nonprofit employers has remained steady at around 8% for the last decade.
- In 2004, nonprofits accounted for 4% of the region's employers and employed nearly 14% of the region's total workforce. Both of these percentages were well above the statewide average.
- Over the last decade, nonprofit employment in the Northeast has increased an average of 4% each year, substantially outpacing growth in total employment in the region, which averaged just 1% per year.
- Growth in nonprofit employment in the Northeast slowed in 2004, increasing by 2% from 2003. This was the strongest percentage increase in nonprofit employment in the state.
- In 2004, the majority of nonprofit activity in the Northeast was in St. Louis County (where the city of Duluth is located), with 60% of the region's nonprofit employers and 80% of employees.
- Itasca County, a distant second to St. Louis, was home to 15% of the region's nonprofit employers and employed nearly 9% of the region's nonprofit workforce.
- St. Louis County was also a statewide center of nonprofit activity. In 2004, St. Louis was home to 5% of the state's nonprofit employers, the highest concentration outside of the seven-county Twin Cities metro area. St. Louis County also had the second highest concentration of nonprofit employees outside of the Twin Cities, employing 6% of the state's total nonprofit workforce.

Number of Nonprofit Employees in the Northeast and Nonprofit Percentage of All Northeast Employees



Source: MN Dept. of Employment & Economic Development, Quarterly Census of Employment & Wages



Northeast Minnesota Analysis

Counties: Aitkin, Carlton, Cook, Itasca, Koochiching, Lake, St. Louis

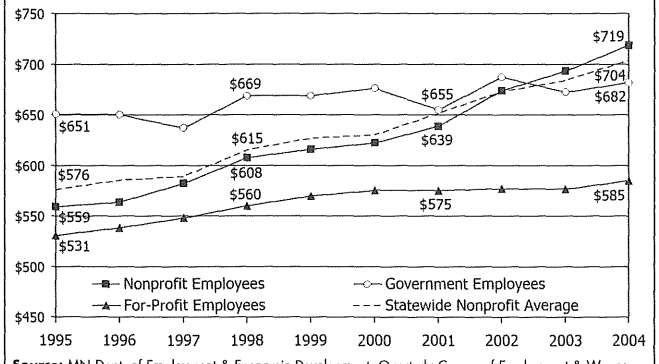
Median Hourly Wages for Full-Time Employees in the Northeast

Industry	Full-Time Median Hourly Wage by Sector (% of sector employment in the region)		
	Nonprofit	**For-Profit**	**Government**
Arts, Entertainment & Recreation	$14.49 (2%)	$11.01 (1%)	$12.51 (6%)
Educational Services	$16.67 (6%)	$14.46 (<1%)	$19.91 (37%)
Health Care			
Ambulatory Health Care Services	$15.79 (18%)	$15.30 (3%)	NA
Hospitals	$17.28 (42%)	NA	$17.54 (6%)
Nursing & Residential Care Facilities	$13.23 (18%)	$11.23 (4%)	$13.84 (3%)
Social Assistance			
Individual & Family Services	$14.86 (3%)	$12.46 (1%)	$20.80 (2%)
Community Food, Housing, Emergency & Other Relief Services	$13.09 (1%)	NA	NA
Vocational Rehabilitation Services	$11.12 (3%)	$22.96 (<1%)	NA
Child Day Care Services	$11.00 (1%)	$8.91 (<1%)	NA
Other Services			
Religious Organizations	$10.38 (<1%)	NA	NA
Grantmaking & Giving Services	$19.83 (<1%)	NA	NA
Social Advocacy Organizations	$15.60 (1%)	$12.17 (<1%)	NA
Civic & Social Organizations	$11.91 (3%)	$10.56 (1%)	NA

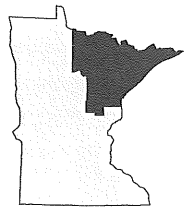
Source: MN Dept. of Employment & Economic Development, Enhanced Wage Records, 3rd Quarter 2004
Notes: "NA" indicates either that the sector did not have any employees in that industry or that the information for that category was suppressed for reasons of privacy. The selected industries represented 98% of nonprofit employment, 11% of for-profit employment, and 54% of government employment in the region in 2004. More extensive descriptions of these industries are available in Appendix A.

- In 2004, the health care industry employed 77% of the nonprofit workforce in the Northeast. Only Southeast Minnesota, with the city of Rochester and the Mayo Clinic, had a higher percentage of its nonprofit workforce in health care.
- Educational services was the second largest nonprofit employer in the Northeast after health care, accounting for 6% of nonprofit employment. Arts, entertainment, and recreation accounted for 12% of nonprofit employers in the region, but less than 2% of nonprofit employment.
- In 2004, nonprofit organizations in the Northeast paid $706 million in wages, about 16% of all wages paid in the region. After adjusting for inflation, this represented a 6% increase in the total nonprofit payroll from 2003, the strongest percentage increase in the state.
- While the average weekly wage for government and for-profit employees in the region has done little more than keep pace with inflation in recent years, the average nonprofit wage has steadily increased. Due to the high concentration of employment in the higher wage health care industry, in 2004, the nonprofit sector in the Northeast had a higher average weekly wage than both the government and for-profit sectors.
- In all of the industries examined, the median hourly wage for a full-time nonprofit employee met or exceeded the minimum wage necessary to support the basic needs of a family of four (two adults working full-time, two children). According to the JOBS NOW Coalition, in 2004, each adult needed to earn about $10.40 an hour to meet these costs in Northeast Minnesota.

Average Weekly Wages in the Northeast by Sector (in constant 2004 dollars)



Source: MN Dept. of Employment & Economic Development, Quarterly Census of Employment & Wages



Northeast Minnesota Analysis

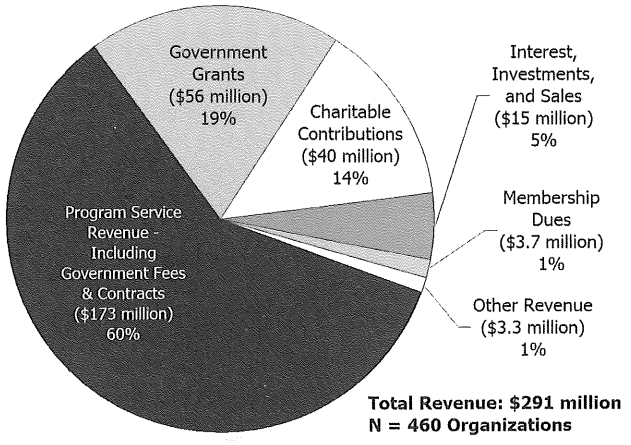
Counties: Aitkin, Carlton, Cook, Itasca, Koochiching, Lake, St. Louis

- Health organizations in the Northeast reported $1.3 billion in revenues in 2004: 94% from program services, 3% from charitable contributions, 2% from interest, investments, and sales, and 1% from government grants. These organizations reported $1.3 billion in expenses: 88% for program services, 12% for management and general expenses, and less than 1% for fundraising.

- Human service organizations in the region reported $164 million in revenues: 43% from program service revenue, 34% from government grants, 14% from charitable contributions, and 5% from interest, investments, and sales. These organizations reported $159 million in expenses: 88% for program services, 10% for management and general expenses, and 1% for fundraising.

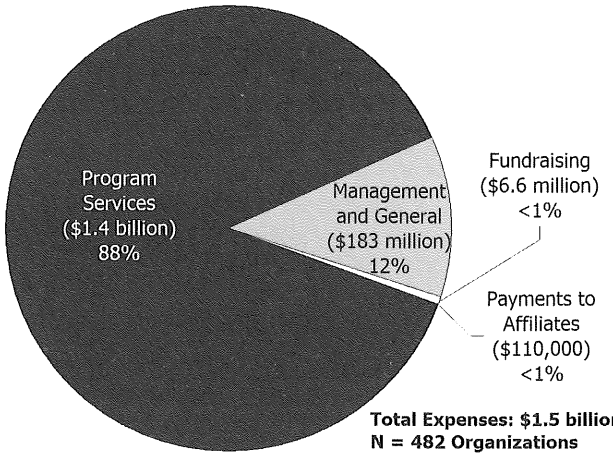
- Educational organizations in the Northeast reported $79 million in revenues: 71% from program services, 18% from government grants, 8% from charitable contributions, and 2% from interest, investments, and sales. These organizations reported $74 million in expenses: 89% for program services, 9% for management and general expenses, and 2% for fundraising.

Revenue Sources for Nonprofit Organizations Located in Northeast Minnesota (Organizations with assets under $10 million)



Source: Minnesota Attorney General's Office, Charities Division
Note: These figures exclude private foundations that filed form 990PF and some charitable trusts.

Expenditures by Nonprofit Organizations Located in Northeast Minnesota (All organizations)

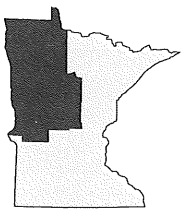


Source: Minnesota Attorney General's Office, Charities Division
Note: These figures exclude private foundations that filed form 990PF and some charitable trusts.

- Arts, culture, and humanities organizations in the Northeast reported $14 million in revenues: 40% from charitable contributions, 30% from program service revenue, 18% from government grants, and 9% from interest, investments, and sales. These organizations reported $13 million in expenses: 77% for program services, 18% for management and general expenses, and 4% for fundraising.

- Environmental and animal-related organizations in the region reported $6.0 million in revenues: 55% from program service revenue, 20% from charitable contributions, 11% from interest, investments, and sales, and 5% from government grants. These organizations reported $6.7 million in expenses: 66% for program services, 31% for management and general expenses, and 4% for fundraising.

- In 2004, 41% of nonprofit organizations in the Northeast reported a deficit for the fiscal year, meaning their expenses for the year exceeded revenues.

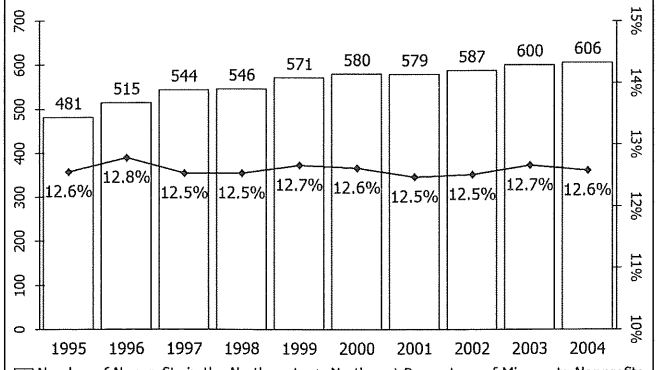


Northwest Minnesota Analysis

Counties: Becker, Beltrami, Cass, Clay, Clearwater, Crow Wing, Douglas, Grant, Hubbard, Kittson, Lake of the Woods, Mahnomen, Marshall, Morrison, Norman, Otter Tail, Pennington, Polk, Pope, Red Lake, Roseau, Stevens, Todd, Traverse, Wadena, Wilkin

Overview: After the Twin Cities, the 26-county Northwest region has the highest concentration of nonprofit employers outside of the Twin Cities. This is likely because the Northwest has more, but smaller, population centers than other regions, each attracting its own grouping of nonprofits. As a result, no single county dominates nonprofit activity in the region. The large number of nonprofit employers in the Northwest, however, has not resulted in a disproportionate share of the state's nonprofit workforce. Nonprofits in the region average just 36 employees per organization, well below the statewide average of 53.

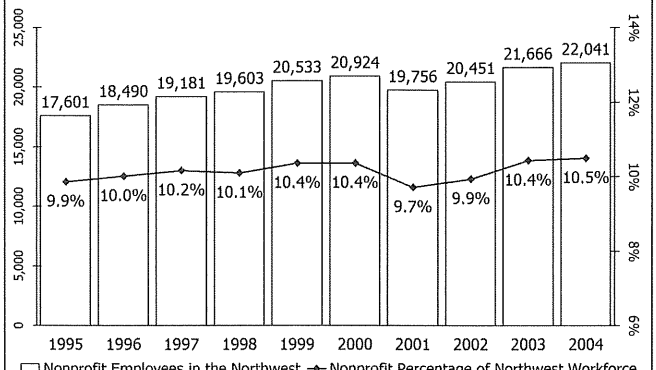
Number of Nonprofit Organizations in the Northwest and Percentage of Nonprofits Located in the Northwest (with at least one employee)



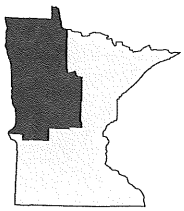
Source: MN Dept. of Employment & Economic Development, Quarterly Census of Employment & Wages

- In 2004, there were 606 nonprofit organizations with employees in the Northwest, accounting for nearly 4% of the region's employers.
- The Northwest region's share of the state's nonprofits with employees has held steady at about 12.5% for the last decade. The Northwest has the second largest concentration of nonprofit employers in the state.
- In 2004, 10.5% of the region's workforce was employed by nonprofits, which was slightly higher than the statewide average.
- As in all other regions of the state, growth in nonprofit employment in the Northwest slowed in 2004, increasing about 2% from 2003 after increasing by 6% the previous year. However, this still outpaced growth in total employment in the region, which increased by just 1% from 2003.
- Over the last decade, nonprofit employment in the Northwest has increased an average of 2.5% each year, which is slightly ahead of the total employment growth for the region, at just under 2% per year.
- Nonprofit organizations in the Northwest are smaller than nonprofits in other regions, averaging just 36 employees for each nonprofit employer.
- Nonprofit activity is widely dispersed in the Northwest. In 2004, 11% of nonprofit employers were located in Crow Wing County (where Brainerd is located), 10% in Otter Tail (Fergus Falls), 9% in Clay (Moorhead), 8% in Beltrami (Bemidji), and nearly 8% in Polk (Crookston and East Grand Forks).
- Nonprofit employment followed a similar pattern, with 14% of nonprofit employees in Clay County, 11% in Otter Tail, 8.5% in Crow Wing, another 8.5% in Polk, and 8% in Beltrami.

Number of Nonprofit Employees in the Northwest and Nonprofit Percentage of All Northwest Employees



Source: MN Dept. of Employment & Economic Development, Quarterly Census of Employment & Wages



Northwest Minnesota Analysis

Counties: Becker, Beltrami, Cass, Clay, Clearwater, Crow Wing, Douglas, Grant, Hubbard, Kittson, Lake of the Woods, Mahnomen, Marshall, Morrison, Norman, Otter Tail, Pennington, Polk, Pope, Red Lake, Roseau, Stevens, Todd, Traverse, Wadena, Wilkin

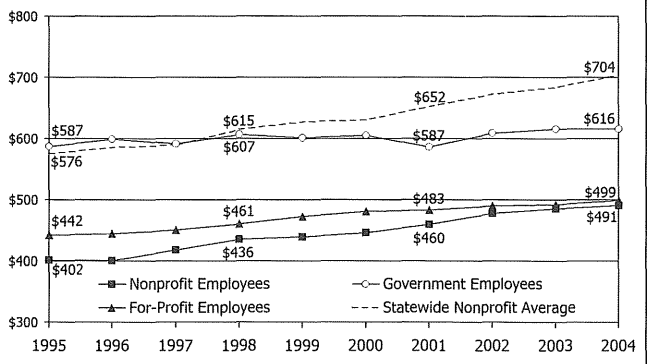
Median Hourly Wages for Full-Time Employees in the Northwest

Industry	Full-Time Median Hourly Wage by Sector (% of sector employment in the region)		
	Nonprofit	**For-Profit**	**Government**
Arts, Entertainment & Recreation	$10.35 (1%)	$11.33 (1%)	$10.62 (6%)
Educational Services	$17.98 (7%)	$12.53 (<1%)	$18.56 (43%)
Health Care			
Ambulatory Health Care Services	$14.56 (6%)	$14.60 (3%)	$20.53 (1%)
Hospitals	$16.00 (31%)	NA	$17.31 (7%)
Nursing & Residential Care Facilities	$11.51 (33%)	$11.19 (2%)	$15.64 (3%)
Social Assistance			
Individual & Family Services	$12.59 (5%)	$10.40 (1%)	$16.40 (<1%)
Community Food, Housing, Emergency & Other Relief Services	$11.09 (<1%)	NA	NA
Vocational Rehabilitation Services	$12.33 (4%)	$11.58 (<1%)	NA
Child Day Care Services	$11.68 (2%)	$8.31 (<1%)	$17.10 (<1%)
Other Services			
Religious Organizations	$12.53 (1%)	NA	NA
Grantmaking & Giving Services	$17.45 (<1%)	NA	NA
Social Advocacy Organizations	$14.62 (3%)	$9.98 (<1%)	NA
Civic & Social Organizations	$10.41 (1%)	$9.95 (1%)	NA

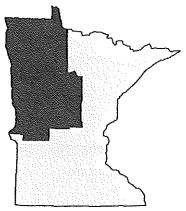
Source: MN Dept. of Employment & Economic Development, Enhanced Wage Records, 3rd Quarter 2004
Notes: "NA" indicates either that the sector did not have any employees in that industry or that the information for that category was suppressed for reasons of privacy. The selected industries represented 94% of nonprofit employment, 9% of for-profit employment, and 61% of government employment in the region in 2004. More extensive descriptions of these industries are available in Appendix A.

- In 2004, 18% of nonprofit employers in the Northwest were nursing and residential care facilities. This industry was also the largest nonprofit employer, accounting for nearly one-third of the nonprofit workforce in the region.
- Hospitals were the second largest employer in the region, with another 31% of nonprofit employment, but just 3% of nonprofit employers.
- Outside of health care, the largest nonprofit industries in the Northwest were individual and family services (12% of nonprofit employers) and arts, entertainment, and recreation (10% of nonprofit employers). Together, however, these two industries only accounted for 6% of nonprofit employment in the region.
- Nonprofit organizations in the Northwest paid $563 million in wages in 2004, or 10% of all wages paid in the region. After adjusting for inflation, total nonprofit payroll increased 3% over 2003.
- In 2004, average weekly wages for nonprofit employees in this region continued to lag far behind government wages, but closed in on the average weekly wage for the for-profit sector.
- When looking at the median hourly wage for a full-time nonprofit employee, every industry examined exceeded the minimum wage necessary to support the basic needs of a family of four (two adults working full-time, two children). According to the JOBS NOW Coalition, in 2004, each adult needed to earn about $10.05 an hour to meet these costs in the Northwest.

Average Weekly Wages in the Northwest by Sector (in constant 2004 dollars)



Source: MN Dept. of Employment & Economic Development, Quarterly Census of Employment & Wages

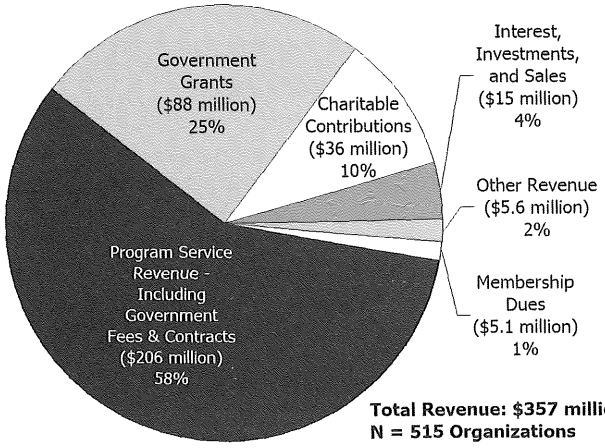


Northwest Minnesota Analysis

Counties: Becker, Beltrami, Cass, Clay, Clearwater, Crow Wing, Douglas, Grant, Hubbard, Kittson, Lake of the Woods, Mahnomen, Marshall, Morrison, Norman, Otter Tail, Pennington, Polk, Pope, Red Lake, Roseau, Stevens, Todd, Traverse, Wadena, Wilkin

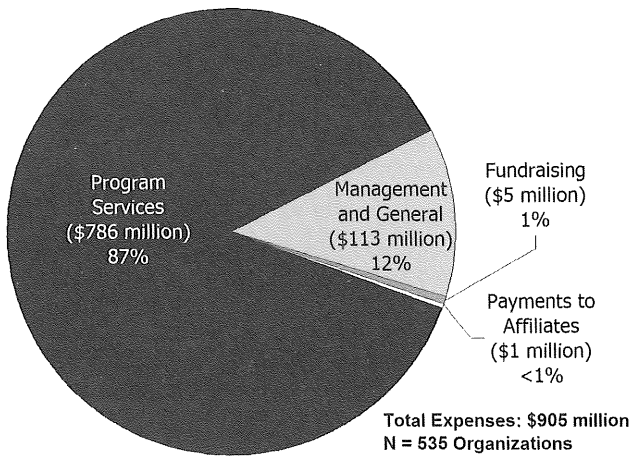
- Health organizations in the Northwest reported $679 million in revenues in 2004: 95% from program services, 2% from interest, investments, and sales, 1% from government grants, and 1% from charitable contributions. These organizations reported $649 million in expenses: 87% for program services, 12% for management and general expenses, and less than 1% for fundraising.
- Human service organizations in the region reported $176 million in revenues: 48% from program service revenue, 36% from government grants, 9% from charitable contributions, and 4% from interest, investments, and sales. These organizations reported $172 million in expenses: 89% for program services, 11% for management and general expenses, and 1% for fundraising.
- Educational organizations in the Northwest reported $23 million in revenues: 37% from government grants, 28% from charitable contributions, 12% from program services, and 12% from interest, investments, and sales. These organizations reported $19 million in expenses: 77% for program services, 20% for management and general expenses, and 2% for fundraising.

Revenue Sources for Nonprofit Organizations Located in Northwest Minnesota (Organizations with assets under $10 million)



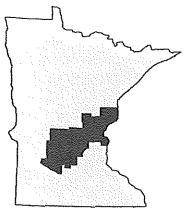
Source: Minnesota Attorney General's Office, Charities Division
Note: These figures exclude private foundations that filed form 990PF and some charitable trusts.

Expenditures by Nonprofit Organizations Located in Northwest Minnesota (All organizations)



Source: Minnesota Attorney General's Office, Charities Division
Note: These figures exclude private foundations that filed form 990PF and some charitable trusts.

- Arts, culture, and humanities organizations in the Northwest reported $7.6 million in revenues: 44% from charitable contributions, 23% from program service revenue, 17% from government grants, and 11% from interest, investments, and sales. These organizations reported $7.2 million in expenses: 77% for program services, 17% for management and general expenses, and 7% for fundraising.
- Environmental and animal-related organizations in the region reported $5.5 million in revenues: 36% from charitable contributions, 32% from program service revenue, 17% from government grants, and 9% from interest, investments, and sales. These organizations reported $4.8 million in expenses: 82% for program services, 15% for management and general expenses, and 3% for fundraising.
- In 2004, 40% of nonprofit organizations in the Northwest reported a deficit for the fiscal year, meaning their expenses for the year exceeded revenues.

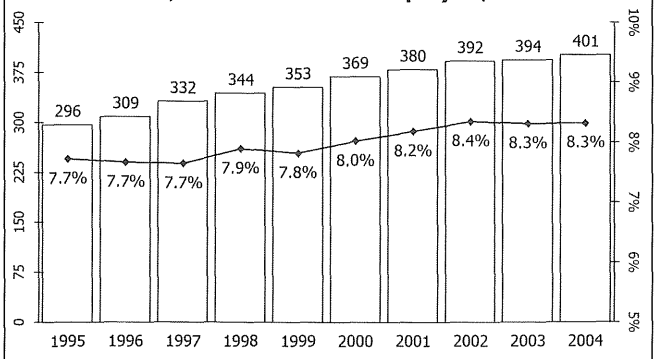


Central Minnesota Analysis

Counties: Benton, Chisago, Isanti, Kanabec, Kandiyohi, McLeod, Meeker, Mille Lacs, Pine, Renville, Sherburne, Stearns, Wright

Overview: With its close proximity to the Twin Cities and its own major regional population center, it is surprising that there is not more nonprofit activity in the 13-county Central Minnesota region. Instead, in 2004, just 8% of the state's nonprofit employers and 8% of the state's nonprofit employees were located in Central Minnesota. In turn, these nonprofits accounted for only 2% of the total employers in the region, the lowest percentage in the state. Likewise, nonprofit employees accounted for just over 8% of the region's workforce, well below the statewide average. Nonprofit activity in the region was centered in Stearns County, where most of the city of St. Cloud is located.

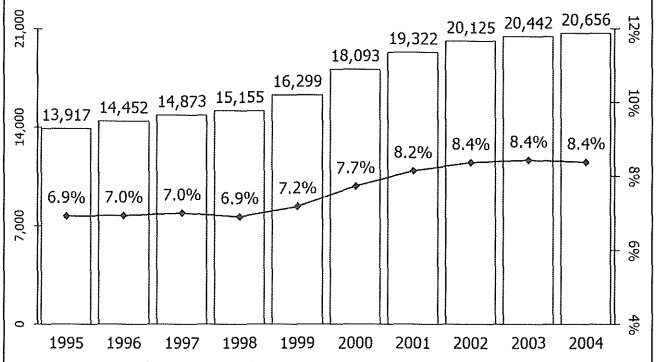
Number of Nonprofit Organizations in Central MN and Percentage of Nonprofits Located in Central MN (with at least one employee)



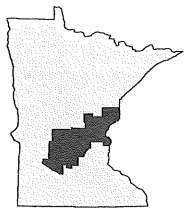
Source: MN Dept. of Employment & Economic Development, Quarterly Census of Employment & Wages

- In 2004, there were 401 nonprofit organizations with employees in Central Minnesota, which was about a 2% increase in nonprofit employers from the previous year.
- The Central region's share of the state's nonprofit employers has remained close to 8% for the last decade. Nonprofits, however, accounted for just 2% of the total employers in Central Minnesota, the lowest percentage in the state.
- In 2004, nonprofits employed 8.4% of the total workforce in Central Minnesota, one of the lowest percentages in the state, and well below the statewide average of 9.8%.
- Over the last decade, Central Minnesota experienced the strongest percentage growth in nonprofit employment in the state, increasing an average of 4.5% each year. This was nearly twice as fast as growth in total employment in the region.
- Between 2003 and 2004, nonprofit employment in Central Minnesota slowed substantially, increasing by just 1%. Growth in total employment in the region was closer to 2% for the same period of time.
- In 2004, Stearns County, where most of the city of St. Cloud is located, accounted for 24% of the nonprofit employers in Central Minnesota and about 38% of the region's nonprofit employment.
- Sherburne and Wright Counties, which lie between St. Cloud and the Twin Cities, each hosted about 10% of the region's nonprofit employers, but only 6% and 8% of nonprofit employment, respectively.
- Chisago and Mille Lacs Counties had fewer nonprofit employers, but employed a larger percentage of the region's nonprofit workforce, 12% and 9%, respectively.

Number of Nonprofit Employees in Central MN and Nonprofit Percentage of All Central MN Employees



Source: MN Dept. of Employment & Economic Development, Quarterly Census of Employment & Wages



Central Minnesota Analysis

Counties: Benton, Chisago, Isanti, Kanabec, Kandiyohi, McLeod, Meeker, Mille Lacs, Pine, Renville, Sherburne, Stearns, Wright

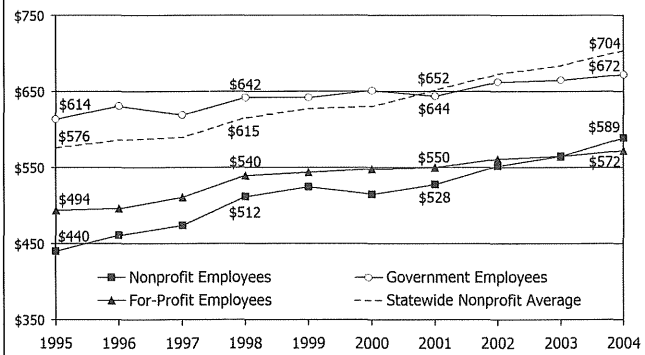
Median Hourly Wages for Full-Time Employees in Central Minnesota

Industry	Full-Time Median Hourly Wage by Sector (% of sector employment in the region)		
	Nonprofit	**For-Profit**	**Government**
Arts, Entertainment & Recreation	$16.14 (1%)	$12.54 (2%)	$11.97 (7%)
Educational Services	$15.25 (7%)	$12.57 (<1%)	$19.30 (45%)
Health Care			
Ambulatory Health Care Services	$15.25 (8%)	$17.06 (3%)	$18.17 (<1%)
Hospitals	$18.83 (36%)	$13.92 (<1%)	$19.54 (10%)
Nursing & Residential Care Facilities	$13.85 (28%)	$11.05 (3%)	$17.34 (2%)
Social Assistance			
Individual & Family Services	$14.39 (3%)	$10.83 (1%)	$16.87 (<1%)
Community Food, Housing, Emergency & Other Relief Services	$14.15 (1%)	$13.83 (<1%)	NA
Vocational Rehabilitation Services	$11.35 (5%)	$17.62 (<1%)	NA
Child Day Care Services	$11.52 (2%)	$9.26 (1%)	NA
Other Services			
Religious Organizations	$13.00 (1%)	NA	NA
Grantmaking & Giving Services	$14.35 (3%)	NA	NA
Social Advocacy Organizations	$14.89 (2%)	$15.28 (<1%)	NA
Civic & Social Organizations	$11.76 (1%)	$10.10 (1%)	NA

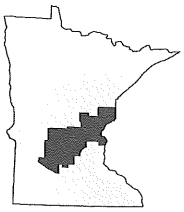
Source: MN Dept. of Employment & Economic Development, Enhanced Wage Records, 3rd Quarter 2004
Notes: "NA" indicates either that the sector did not have any employees in that industry or that the information for that category was suppressed for reasons of privacy. The selected industries represented 96% of nonprofit employment, 10% of for-profit employment, and 64% of government employment in the region in 2004. More extensive descriptions of these industries are available in Appendix A.

- In 2004, 72% of nonprofit employment in Central Minnesota was in health care, which includes ambulatory health care services, hospitals, and nursing and residential care facilities. These same industries accounted for 29% of nonprofit employers in the region.
- Outside of health care, the largest nonprofit industries in Central Minnesota were individual and family services (10% of nonprofit employers) and arts, entertainment, and recreation (8% of employers). Educational services, however, had the second largest number of nonprofit employees in the region with just over 7% of the nonprofit workforce.
- In 2004, nonprofits in Central Minnesota paid $633 million in wages, or about 8% of all wages paid in the region. After adjusting for inflation, total nonprofit payroll increased by 5% from the previous year.
- For the first time, the average weekly wage for nonprofit employees in this region surpassed the average weekly wage for the for-profit sector. However, nonprofit wages remained lower than average weekly wages for government employees in the region.
- In all but one of the industries examined, the median hourly wage for a full-time nonprofit employee met or exceeded the minimum wage necessary to support the basic needs of a family of four (two adults working full-time, two children). According to the JOBS NOW Coalition, in 2004, each adult needed to earn about $11.53 an hour to meet these costs in Central Minnesota. The exception was nonprofit employees working in vocational rehabilitation services.

Average Weekly Wages in Central MN by Sector (in constant 2004 dollars)



Source: MN Dept. of Employment & Economic Development, Quarterly Census of Employment & Wages

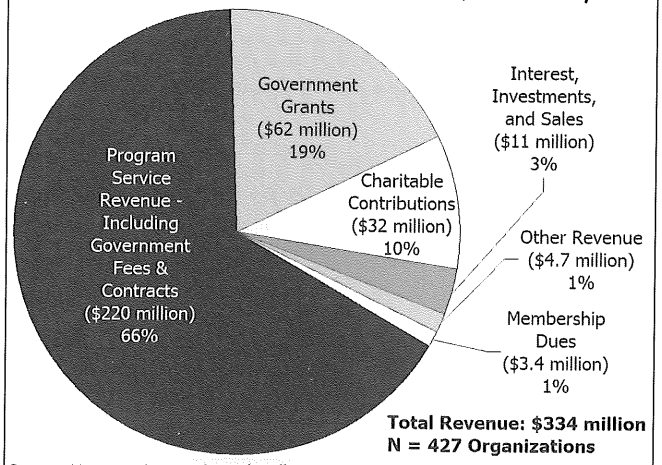


Central Minnesota Analysis

Counties: Benton, Chisago, Isanti, Kanabec, Kandiyohi, McLeod, Meeker, Mille Lacs, Pine, Renville, Sherburne, Stearns, Wright

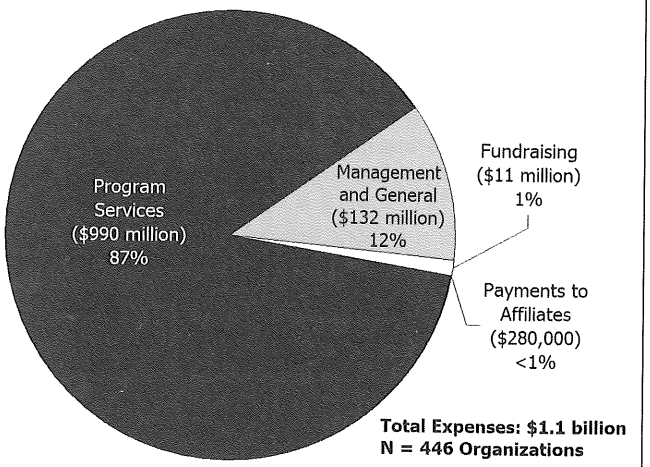
- Health organizations in Central Minnesota reported $925 million in revenues in 2004: 93% from program service revenue, 3% from interest, investments, and sales, 2% from charitable contributions, and 1% from government grants. These organizations reported $857 million in expenses: 87% for program services, 12% for management and general expenses, and less than 1% for fundraising.
- Human service organizations in the region reported $164 million in revenues: 53% from program service revenue, 31% from government grants, 9% from charitable contributions, and 3% from interest, investments, and sales. These organizations reported $160 million in expenses: 88% for program services, 10% for management and general expenses, and 2% for fundraising.
- Educational organizations in the region reported $89 million in revenues: 77% from program services, 12% from charitable contributions, 8% from government grants, and 3% from interest, investments, and sales. These organizations reported $84 million in expenses: 88% for program services, 9% for management and general expenses, and 3% for fundraising.

Revenue Sources for Nonprofit Organizations Located in Central Minnesota (Organizations with assets under $10 million)



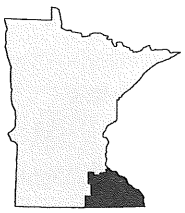
Source: Minnesota Attorney General's Office, Charities Division
Note: These figures exclude private foundations that filed form 990PF and some charitable trusts.

Expenditures by Nonprofit Organizations Located in Central Minnesota (All organizations)



Source: Minnesota Attorney General's Office, Charities Division
Note: These figures exclude private foundations that filed form 990PF and some charitable trusts.

- Arts, culture, and humanities organizations in Central Minnesota reported $5.9 million in revenues: 36% from charitable contributions, 24% from program service revenue, 19% from government grants, and 13% from interest, investments, and sales. These organizations reported $5.2 million in expenses: 79% for program services, 15% for management and general expenses, and 7% for fundraising.
- Environmental and animal-related organizations in the region reported $3.6 million in revenues: 49% from charitable contributions, 32% from program service revenue, 13% from interest, investments, and sales, and 3% from government grants. These organizations reported $3.5 million in expenses: 79% for program services, 14% for management and general expenses, and 6% for fundraising.
- In 2004, 42% of nonprofit organizations in Central Minnesota reported a deficit for the fiscal year, meaning their expenses for the year exceeded revenues.

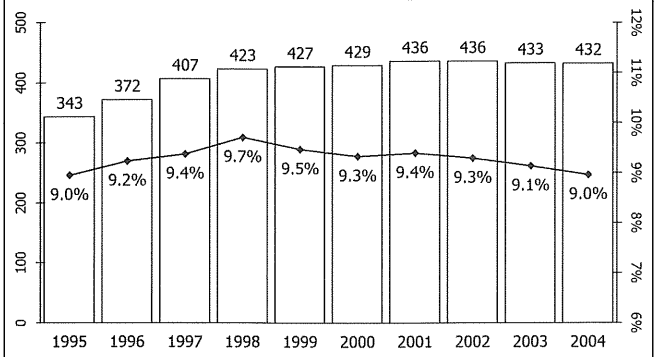


Southeast Minnesota Analysis

Counties: Dodge, Fillmore, Freeborn, Goodhue, Houston, Mower, Olmsted, Rice, Steele, Wabasha, Winona

Overview: The nonprofit sector in the 11-county Southeast Minnesota region is dominated by the health care industry, which accounted for 30% of nonprofit employers and 83% of the nonprofit workforce in the region in 2004. The concentration of nonprofit activity in health care has been a driving force behind the strong growth in nonprofit employment in the region over the last decade. In 2004, however, growth in the nonprofit workforce in the region slowed substantially. Nevertheless, nonprofits continued to play an unusually important role in the economy of Southeast Minnesota in 2004, employing nearly 20% of the region's total workforce and paying $2.0 billion in wages.

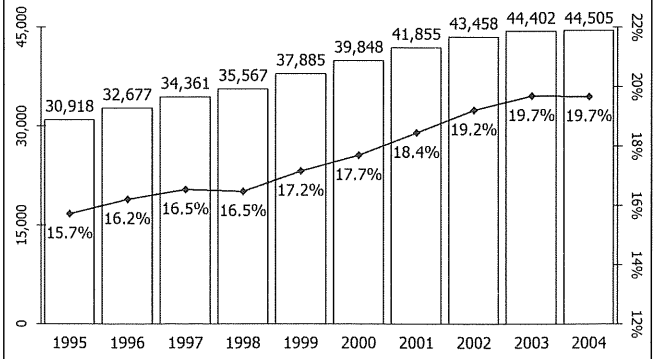
Number of Nonprofit Organizations in the Southeast and Percentage of Nonprofits Located in the Southeast (with at least one employee)



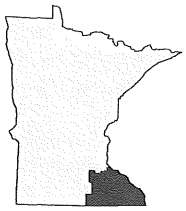
Source: MN Dept. of Employment & Economic Development, Quarterly Census of Employment & Wages

- In 2004, there were 432 nonprofit organizations with employees in the Southeast region, which represented virtually no change from the previous year.
- Growth in the number of nonprofit employers in the Southeast has leveled off in recent years, which has meant that the Southeast region's share of the state's nonprofit employers has been falling, dropping to 9.0% in 2004.
- In 2004, nearly 20% of the region's workforce was employed by nonprofit organizations, the highest percentage of any region in the state.
- After the Twin Cities, Southeast Minnesota has the largest nonprofit workforce in the state with just over 44,500 employees. This represents almost 18% of the state's total nonprofit workforce.
- Nonprofit employment in the Southeast has experienced strong growth in past years, averaging 4% per year for the last decade. In 2004, however, growth in nonprofit employment stalled in the Southeast, with a net increase of about 100 employees from 2003. Total employment in the region also experienced minimal growth, increasing just 0.4% over 2003.
- Nonprofits in the Southeast were the largest in the state, averaging 103 employees per organization in 2004. This was nearly twice the average size of nonprofits in the Twin Cities.
- In 2004, 30% of the region's nonprofit employers and more than two-thirds of the nonprofit workforce were located in Olmsted County (home to the city of Rochester). Indeed, nonprofits employed 35% of the county's total workforce. Olmsted County was not only a regional center of nonprofit activity, but also one of the centers for the state, employing 12% of the total nonprofit workforce in Minnesota.

Number of Nonprofit Employees in the Southeast and Nonprofit Percentage of All Southeast Employees



Source: MN Dept. of Employment & Economic Development, Quarterly Census of Employment & Wages



Southeast Minnesota Analysis

Counties: Dodge, Fillmore, Freeborn, Goodhue, Houston, Mower, Olmsted, Rice, Steele, Wabasha, Winona

Median Hourly Wages for Full-Time Employees in the Southeast

Industry	Full-Time Median Hourly Wage by Sector (% of sector employment in the region)		
	Nonprofit	**For-Profit**	**Government**
Arts, Entertainment & Recreation	$13.91 (1%)	$13.02 (2%)	$15.01 (5%)
Educational Services	$21.23 (8%)	$17.94 (<1%)	$19.06 (47%)
Health Care			
Ambulatory Health Care Services	$21.72 (45%)	$16.49 (3%)	NA
Hospitals	$22.72 (25%)	NA	$13.70 (3%)
Nursing & Residential Care Facilities	$12.98 (13%)	$12.18 (2%)	$14.37 (3%)
Social Assistance			
Individual & Family Services	$14.80 (3%)	$11.98 (<1%)	NA
Community Food, Housing, Emergency & Other Relief Services	$14.39 (<1%)	$15.12 (<1%)	NA
Vocational Rehabilitation Services	$11.66 (2%)	NA	NA
Child Day Care Services	$8.10 (1%)	$9.85 (<1%)	NA
Other Services			
Religious Organizations	$10.68 (<1%)	$17.86 (<1%)	NA
Grantmaking & Giving Services	$20.63 (<1%)	NA	NA
Social Advocacy Organizations	$13.39 (1%)	$21.94 (<1%)	NA
Civic & Social Organizations	$16.01 (1%)	$11.97 (1%)	NA

Source: MN Dept. of Employment & Economic Development, Enhanced Wage Records, 3rd Quarter 2004
Notes: "NA" indicates either that the sector did not have any employees in that industry or that the information for that category was suppressed for reasons of privacy. The selected industries represented 99% of nonprofit employment, 8% of for-profit employment, and 58% of government employment in the region in 2004. More extensive descriptions of these industries are available in Appendix A.

- In 2004, the major health care industries — ambulatory health care services, hospitals, and nursing and residential care facilities — employed 83% of the nonprofit workforce in the Southeast. This was the highest percentage in the state.

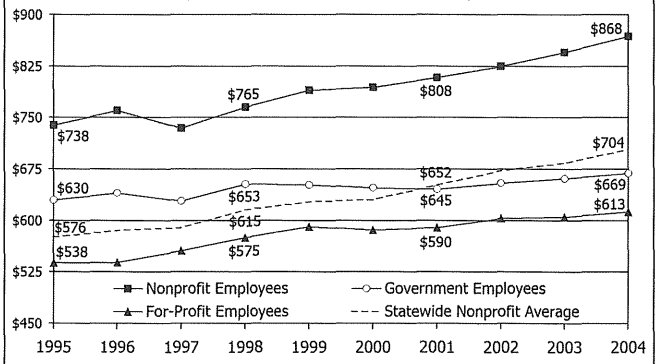
- In Southeast Minnesota, nonprofit employment in health care was distributed differently than in other regions, with a significantly higher percentage of the workforce in ambulatory health care services (45%), but a comparatively smaller percentage employed in nursing and residential care facilities (13%).

- In 2004, nonprofits employers in the Southeast paid $2.0 billion in wages, or 25% of all wages paid in the region, the highest percentage in the state. In Olmsted County alone, nonprofit employers paid $1.6 billion in wages, which accounted for 43% of the total wages paid in the county.

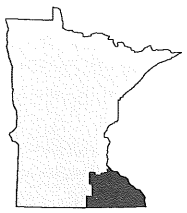
- Due to the concentration of nonprofit employment in the higher wage health care industries, average weekly wages for nonprofit employees in the Southeast were well above average weekly wages for both government and for-profit employees.

- In all but two of the industries examined, the median hourly wage for a full-time nonprofit employee exceeded the minimum wage necessary to support the basic needs of a family of four (two adults working full-time, two children). According to the JOBS NOW Coalition, in 2004, each adult needed to earn about $10.84 an hour to meet these costs in the Southeast. The exceptions were median hourly wages for nonprofit employees working in child day care services and religious organizations.

Average Weekly Wages in the Southeast by Sector (in constant 2004 dollars)



Source: MN Dept. of Employment & Economic Development, Quarterly Census of Employment & Wages



Southeast Minnesota Analysis

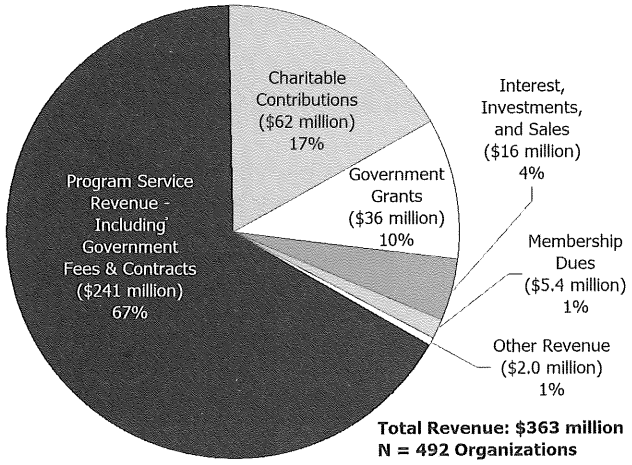
Counties: Dodge, Fillmore, Freeborn, Goodhue, Houston, Mower, Olmsted, Rice, Steele, Wabasha, Winona

- Health organizations in the Southeast reported $3.8 billion in revenues in 2004: 86% from program services, 6% from charitable contributions, 5% from government grants, and 3% from interest, investments, and sales. These organizations reported $3.6 billion in expenses: 93% for program services, 6% for management and general expenses, and 1% for fundraising.

- Human service organizations in the region reported $205 million in revenues: 68% from program service revenue, 14% from government grants, 12% from charitable contributions, and 4% from interest, investments, and sales. These organizations reported $192 million in expenses: 90% for program services, 9% for management and general expenses, and 1% for fundraising.

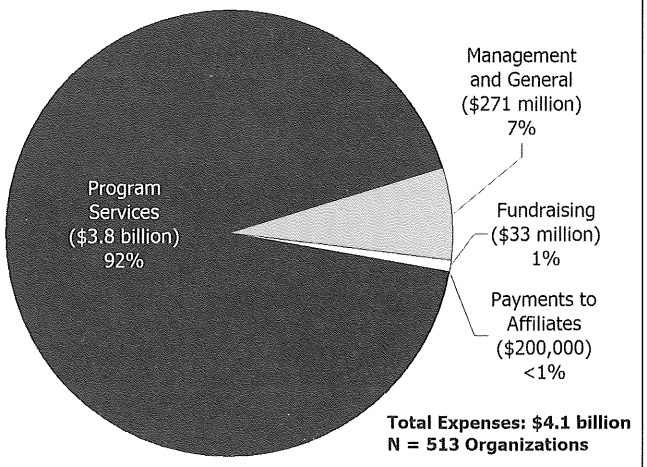
- Educational organizations in the Southeast reported $414 million in revenues: 56% from program services, 28% from interest, investments, and sales, 12% from charitable contributions, and 3% from government grants. These organizations reported $315 million in expenses: 86% for program services, 11% for management and general expenses, and 3% for fundraising.

Revenue Sources for Nonprofit Organizations Located in Southeast Minnesota (Organizations with assets under $10 million)



Source: Minnesota Attorney General's Office, Charities Division
Note: These figures exclude private foundations that filed form 990PF and some charitable trusts.

Expenditures by Nonprofit Organizations Located in Southeast Minnesota (All organizations)

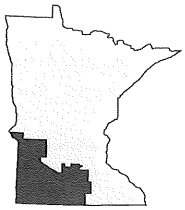


Source: Minnesota Attorney General's Office, Charities Division
Note: These figures exclude private foundations that filed form 990PF and some charitable trusts.

- Arts, culture, and humanities organizations in the Southeast reported $8.6 million in revenues: 42% from charitable contributions, 28% from program service revenue, 13% from government grants, and 11% from interest, investments, and sales. These organizations reported $7.4 million in expenses: 74% for program services, 22% for management and general expenses, and 5% for fundraising.

- Environmental and animal-related organizations in the region reported $4.5 million in revenues: 42% from charitable contributions, 40% from program service revenue, 7% from interest, investments, and sales, and 5% from government grants. These organizations reported $4.1 million in expenses: 77% for program services, 18% for management and general expenses, and 5% for fundraising.

- In 2004, 34% of nonprofits in the Southeast reported a deficit for the fiscal year, meaning their expenses for the year exceeded revenues.

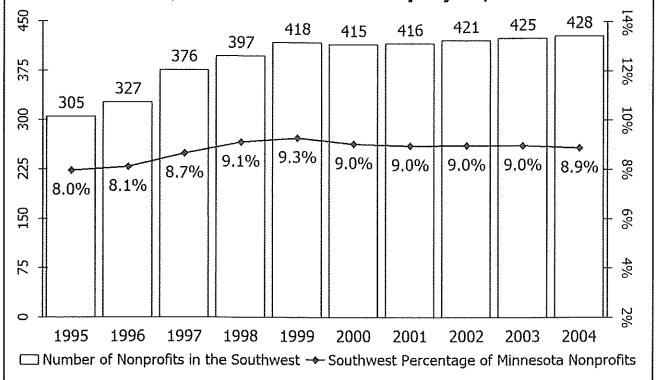


Southwest Minnesota Analysis

Counties: Big Stone, Blue Earth, Brown, Chippewa, Cottonwood, Faribault, Jackson, Lac Qui Parle, Le Sueur, Lincoln, Lyon, Martin, Murray, Nicollet, Nobles, Pipestone, Redwood, Rock, Sibley, Swift, Waseca, Watonwan, Yellow Medicine

Overview: Nonprofit activity in the 23-county Southwest Minnesota region is more dispersed than in most other regions of the state. Although Blue Earth County (with the city of Mankato) was the largest center of nonprofit activity in the region in 2004, several other counties also had a significant nonprofit presence. The nonprofit workforce in the Southwest was also the smallest in the state. With fewer than 15,000 employees, nonprofits accounted for less than 9% of the total workforce in the region in 2004. However, nonprofit employment increased slightly between 2003 and 2004, even as total employment in the region fell for the third year in a row.

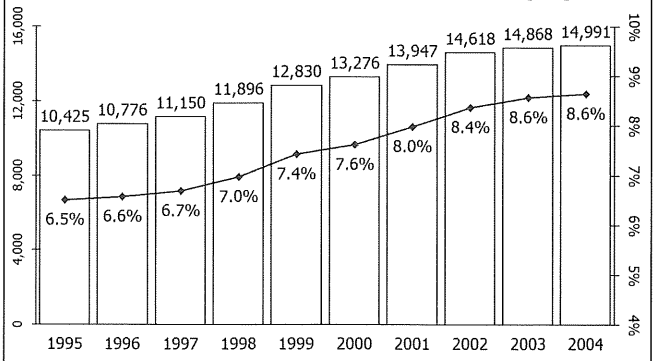
Number of Nonprofit Organizations in the Southwest and Percentage of Nonprofits Located in the Southwest (with at least one employee)



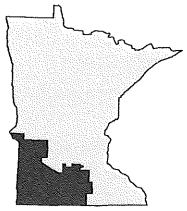
Source: MN Dept. of Employment & Economic Development, Quarterly Census of Employment & Wages

- In 2004, there were 428 nonprofit organizations with employees in Southwest Minnesota, representing a small increase from the previous year. Nonprofits accounted for just over 3% of the region's total employers.
- The Southwest region's share of Minnesota's nonprofit employers has remained stable at close to 9% in recent years.
- In 2004, 8.6% of the region's workforce was employed by nonprofit organizations, which was below the statewide average.
- With just under 15,000 employees, the Southwest region had the smallest nonprofit workforce in Minnesota, accounting for just 6% of the nonprofit employees in the state.
- Nonprofit employment in the Southwest region increased slightly between 2003 and 2004, while total employment in the region showed a negligible decline for the third year in a row.
- Over the last 10 years, nonprofit employment in the Southwest increased an average of 4% each year, well ahead of the growth in total employment for the region, which averaged just 1% per year.
- Nonprofits in the Southwest are smaller than nonprofits in other regions, averaging 35 employees per organization.
- In 2004, the largest center of nonprofit activity in the Southwest was Blue Earth County (where the city of Mankato is largely located), which accounted for 14% of the region's nonprofit employers and 25% of the region's nonprofit employees.
- Other counties in the Southwest with a significant nonprofit presence included Brown County (9% of nonprofit employers and 10% of nonprofit employment), Lyon (9% of employers and 5% of employees), Martin (4% of employers and 6% of employees), Nicollet (4% of employers and 7% of employees), and Nobles (8% of employers and 4% of employees).

Number of Nonprofit Employees in the Southwest and Nonprofit Percentage of All Southwest Employees



Source: MN Dept. of Employment & Economic Development, Quarterly Census of Employment & Wages



Southwest Minnesota Analysis

Counties: Big Stone, Blue Earth, Brown, Chippewa, Cottonwood, Faribault, Jackson, Lac Qui Parle, Le Sueur, Lincoln, Lyon, Martin, Murray, Nicollet, Nobles, Pipestone, Redwood, Rock, Sibley, Swift, Waseca, Watonwan, Yellow Medicine

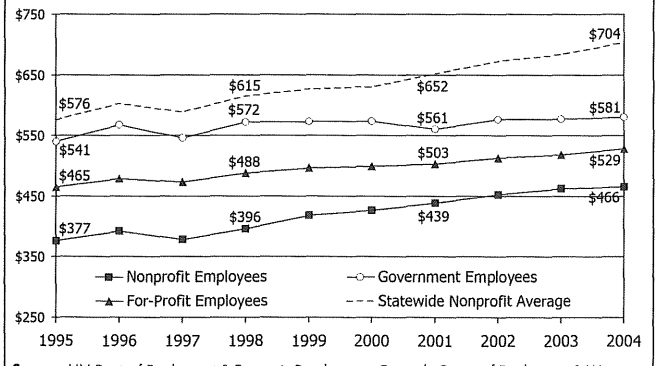
Median Hourly Wages for Full-Time Employees in the Southwest

Industry	Full-Time Median Hourly Wage by Sector (% of sector employment in the region)		
	Nonprofit	**For-Profit**	**Government**
Arts, Entertainment & Recreation	$12.52 (1%)	$12.03 (1%)	$12.06 (1%)
Educational Services	$20.32 (7%)	$17.98 (<1%)	$19.28 (44%)
Health Care			
Ambulatory Health Care Services	$15.72 (5%)	$14.18 (4%)	NA
Hospitals	$16.21 (28%)	$23.43 (<1%)	$18.32 (12%)
Nursing & Residential Care Facilities	$12.47 (34%)	$11.59 (3%)	$12.92 (4%)
Social Assistance			
Individual & Family Services	$12.99 (2%)	$10.99 (1%)	$16.30 (<1%)
Community Food, Housing, Emergency & Other Relief Services	$11.21 (2%)	NA	NA
Vocational Rehabilitation Services	$12.00 (10%)	$13.05 (<1%)	NA
Child Day Care Services	$8.46 (1%)	$8.31 (<1%)	NA
Other Services			
Religious Organizations	$13.92 (1%)	NA	NA
Grantmaking & Giving Services	$16.77 (1%)	NA	NA
Social Advocacy Organizations	$16.23 (4%)	$18.98 (<1%)	NA
Civic & Social Organizations	$12.28 (3%)	$9.71 (1%)	NA

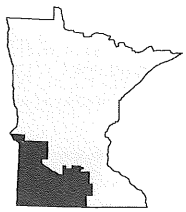
Source: MN Dept. of Employment & Economic Development, Enhanced Wage Records, 3rd Quarter 2004
Notes: "NA" indicates either that the sector did not have any employees in that industry or that the information for that category was suppressed for reasons of privacy. The selected industries represented 97% of nonprofit employment, 10% of for-profit employment, and 59% of government employment in the region in 2004. More extensive descriptions of these industries are available in Appendix A.

- As in every region of the state, health care was the largest nonprofit industry in the Southwest, accounting for one-third of nonprofit employers and two-thirds of nonprofit employment in 2004.
- Vocational rehabilitation services, however, was the second largest nonprofit employer in the Southwest, accounting for 10% of the nonprofit workforce in the region.
- Other major nonprofit industries in the region included individual and family services, which accounted for 12% of nonprofit employers, and arts, entertainment, and recreation, with another 11% of nonprofit employers.
- In 2004, nonprofit organizations in the Southwest paid $363 million in wages, or nearly 8% of all wages paid in the region. After adjusting for inflation, total nonprofit wages in 2004 increased by about 1% from 2003, the smallest percentage increase in the state.
- Average weekly wages for nonprofit employees in the Southwest continued to lag behind average weekly wages for both government and for-profit employees.
- In most of the industries examined, the median hourly wage for a full-time nonprofit employee exceeded the minimum wage necessary to support the basic needs of a family of four (two adults working full-time, two children). According to the JOBS NOW Coalition, in 2004, each adult needed to earn about $9.70 an hour to meet these costs in the Southwest. The exception was child day care services, with a median wage of $8.46 an hour.

Average Weekly Wages in the Southwest by Sector (in constant 2004 dollars)



Source: MN Dept. of Employment & Economic Development, Quarterly Census of Employment & Wages

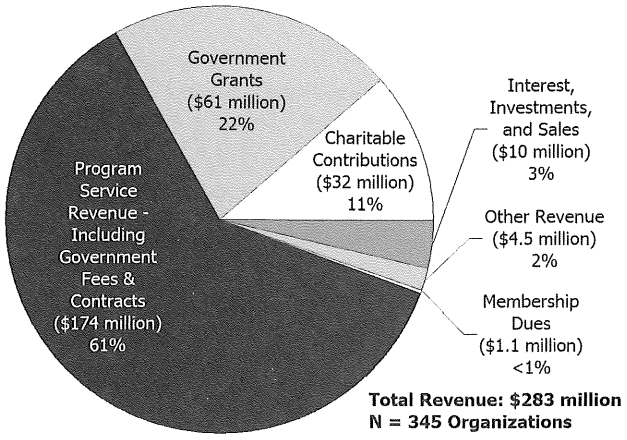


Southwest Minnesota Analysis

Counties: Big Stone, Blue Earth, Brown, Chippewa, Cottonwood, Faribault, Jackson, Lac Qui Parle, Le Sueur, Lincoln, Lyon, Martin, Murray, Nicollet, Nobles, Pipestone, Redwood, Rock, Sibley, Swift, Waseca, Watonwan, Yellow Medicine

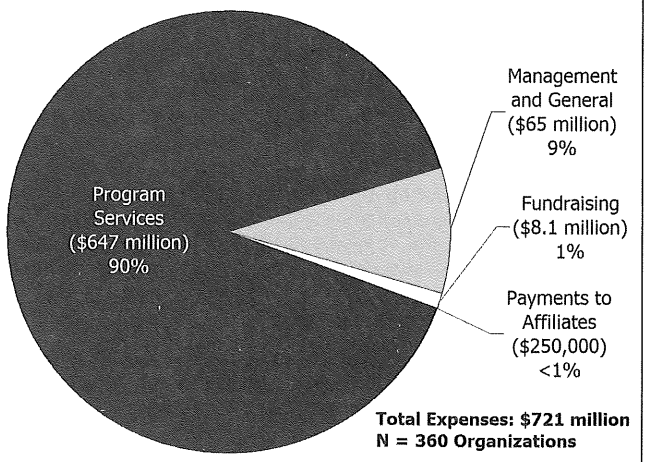
- Health organizations in the Southwest reported $406 million in revenues in 2004: 94% from program services, 2% from charitable contributions, 1% from government grants, and 1% from interest, investments, and sales. These organizations reported $391 million in expenses: 89% for program services, 11% for management and general expenses, and less than 1% for fundraising.
- Human service organizations in the region reported $119 million in revenues: 41% from program service revenue, 40% from government grants, 12% from charitable contributions, and 4% from interest, investments, and sales. These organizations reported $112 million in expenses: 90% for program services, 9% for management and general expenses, and 1% for fundraising.
- Educational organizations in the Southwest reported $205 million in revenues: 50% from charitable contributions, 43% from program services, 4% from interest, investments, and sales, and 3% from government grants. These organizations reported $199 million in expenses: 93% for program services, 5% for management and general expenses, and 3% for fundraising.

Revenue Sources for Nonprofit Organizations Located in Southwest Minnesota (Organizations with assets under $10 million)



Source: Minnesota Attorney General's Office, Charities Division
Note: These figures exclude private foundations that filed form 990PF and some charitable trusts.

Expenditures by Nonprofit Organizations Located in Southwest Minnesota (All organizations)



Source: Minnesota Attorney General's Office, Charities Division
Note: These figures exclude private foundations that filed form 990PF and some charitable trusts.

- Arts, culture, and humanities organizations in the Southwest reported $4.9 million in revenues: 52% from charitable contributions, 22% from government grants, 14% from program service revenue, and 6% from interest, investments, and sales. These organizations reported $4.5 million in expenses: 65% for program services, 27% for management and general expenses, and 8% for fundraising.
- Environmental and animal-related organizations in the region reported $1.1 million in revenues: 37% from charitable contributions, 27% from program service revenue, 25% from interest, investments, and sales, and 1% from government grants. These organizations reported $790,000 in expenses: 68% for program services, 17% for management and general expenses, and 15% for fundraising.
- In 2004, 40% of nonprofit organizations in the Southwest reported a deficit for the fiscal year, meaning their expenses for the year exceeded revenues.

Appendix A
North American Industry Classification System (NAICS)

Ambulatory Health Care Services (NAICS 621) – Industries in this subsector provide health care services to ambulatory patients, including physicians' offices, mental health practitioners, dentists, optometrists, physical, occupational and speech therapists, family planning centers, outpatient mental health and substance abuse centers, medical and diagnostic laboratories, and home health care services. In 2004, this industry accounted for 8.4% of nonprofit employers and 15.8% of nonprofit employees statewide.

Arts, Entertainment & Recreation (NAICS 71) – This sector includes establishments that are involved in producing, promoting, or participating in live performances, events, or exhibits intended for public viewing; establishments that preserve and exhibit objects and sites of historical, cultural, or educational interest; and establishments that operate facilities or provide services that enable patrons to participate in recreational activities or pursue amusement, hobby, and leisure-time interests. In 2004, this industry accounted for 7.8% of nonprofit employers and 2.3% of nonprofit employees statewide.

Child Day Care Services (NAICS 6244) – This industry comprises establishments primarily engaged in providing day care of infants or children. In 2004, this industry accounted for 3.3% of nonprofit employers and 1.0% of nonprofit employees statewide.

Civic & Social Organizations (NAICS 8134) – This industry comprises establishments engaged in promoting the civic and social interests of their members, including alumni associations, ethnic associations, scouting organizations, student clubs, and social senior citizens' associations. In 2004, this industry accounted for 4.9% of nonprofit employers and 2.3% of nonprofit employees statewide.

Community Food, Housing, Emergency & Other Relief Services (NAICS 6242) – Community food service establishments primarily collect, prepare, and deliver food for the needy. Community housing service establishments provide short-term emergency shelter, transitional housing for the low-income, volunteer construction or repair of low-cost housing, or repair of homes for elderly or disabled homeowners. Emergency and other relief service establishments primarily provide food, shelter, clothing, medical relief, resettlement, and counseling to victims of domestic or international disasters or conflicts. In 2004, this industry accounted for 3.0% of nonprofit employers and 0.8% of nonprofit employees statewide.

Educational Services (NAICS 611) – Industries in this subsector provide instruction and training through specialized establishments, such as schools, colleges, universities, and training centers. In 2004, this industry accounted for 9.8% of nonprofit employers and 9.3% of nonprofit employees statewide.

Grantmaking & Giving Services (NAICS 8132) – This industry comprises grantmaking foundations and charitable trusts, as well as establishments primarily engaged in raising funds for a range of social welfare activities. In 2004, this industry accounted for 3.7% of nonprofit employers and 0.7% of nonprofit employees statewide.

Hospitals (NAICS 622) – Industries in this subsector provide medical, diagnostic, and treatment services that include physician, nursing, and other health services to inpatients. Hospitals may also provide outpatient services as a secondary activity. In 2004, this industry accounted for 2.1% of nonprofit employers and 31.9% of nonprofit employees statewide.

Individual & Family Services (NAICS 6241) – This industry comprises establishments primarily engaged in providing nonresidential social assistance services for children and youth, such as adoption and foster care, drug prevention, life skills training, and positive social development. In 2004, this industry accounted for 12.8% of nonprofit employers and 4.6% of nonprofit employees statewide.

Nursing & Residential Care Facilities (NAICS 623) – Industries in this subsector provide residential care combined with either nursing, supervisory, or other types of care as required by the residents. Examples include nursing care facilities, residential mental health facilities, and community care facilities for the elderly. In 2004, this industry accounted for 14.9% of nonprofit employers and 18.0% of nonprofit employees statewide.

Religious Organizations (NAICS 8131) – This industry comprises churches, religious temples, monasteries, and establishments primarily engaged in administering an organized religion or promoting religious activities. In 2004, this industry accounted for 3.4% of nonprofit employers and 0.7% of nonprofit employees statewide.

Social Advocacy Organizations (NAICS 8133) – This industry comprises establishments primarily engaged in promoting a particular cause or working for the realization of a specific social or political goal to benefit a broad or specific constituency. These organizations may solicit contributions or offer memberships to support these goals. In 2004, this industry accounted for 6.9% of nonprofit employers and 2.1% of nonprofit employees statewide.

Vocational Rehabilitation Services (NAICS 6243) – This industry comprises establishments engaged in providing services such as job counseling, job training, and work experience to unemployed and underemployed persons, persons with disabilities, and persons who have a job market disadvantage because of lack of education, job skill, or experience. In 2004, this industry accounted for 4.0% of nonprofit employers and 3.4% of nonprofit employees statewide.

Appendix B

Quarterly Census of Employment and Wages
The Quarterly Census of Employment and Wages (QCEW), a cooperative endeavor between the U.S. Department of Labor's Bureau of Labor Statistics (BLS) and the Minnesota Department of Employment and Economic Development (DEED), is a virtual census of Minnesota employers, covering 97% of nonagricultural employment and wage data in Minnesota. Covered employment includes private sector employees, as well as state, county, and municipal government employees insured under the Unemployment Insurance (UI) Act and federal employees who are insured under separate laws. Religious congregations, proprietors, the self-employed, railroad workers, family farm workers, full-time students working for their school, elected government officials, and those working on a commission-only basis are excluded. Total wages include gross wages and salaries, pay for vacation and other paid leave, tips and other gratuities that are reported to the employer, bonuses (including severance pay), stock options, some sickness and disability payments, and the cash value of meals and lodging. This report uses QCEW data to analyze 501(c)(3) nonprofit employers, employees, and wages. For more information, visit www.deed.state.mn.us/lmi/tools/qcew/about.htm.

The QCEW program classifies employers using the North American Industry Classification System (NAICS). In order to classify nonprofit employers and employees by activity area for some of the analysis in the report, the NAICS codes were converted into the National Taxonomy of Exempt Entities — Core Codes (NTEE-CC) using guides available from the National Center on Charitable Statistics. For more information on the NTEE-CC classification system, please visit http://nccs.urban.org/ntee-cc/index.htm.

Enhanced Wage Records
The median wage data used in this report is from the Department of Employment and Economic Development (DEED). DEED merges data from the Quarterly Census of Employment and Wages (QCEW) program (described above) from 3rd quarter of 2004 with Unemployment Insurance (UI) Wage Records for the same quarter. UI records contain individual level employment and wage data on all employees and employers covered under the UI program. Merging these data sets enables DEED to determine an individual employee's wages as paid by a unique employer during that quarter. In order to be included in the analysis, each employee needed to have earnings in the 2nd and 4th quarter with the same employer as the 3rd quarter. This report uses the data to examine median hourly wages, or the mid-point in the range of wages, by region for full-time employees in selected industries. Full-time is defined as working 35 hours or more per week, or over 454 hours during the quarter.

Attorney General's Office, Charities Division
The Minnesota Attorney General's (AG) office has the primary responsibility for regulating, enforcing, and supervising charitable organizations and charitable trusts. This report uses data provided by the AG's office on charitable organizations exempted under IRS subsection 501(c)(3) — and a small number exempted under subsections (c)(4) through (c)(19) — that filed a Form 990 or 990EZ. Private foundations filing form 990PF and certain charitable trusts are excluded from the analysis because they are operationally distinct. Certain other organizations that are exempt from filing with the Attorney General's Office are also not reflected in the data, including organizations that do not employ paid staff and do not plan to receive more than $25,000 in total contributions; religious organizations that do not file a Form 990 federal return; certain educational institutions; organizations that limit solicitations to persons who have a right to vote as a member; organizations that solicit contributions for a single person specified by name; and private foundations that did not solicit contributions from more than 100 persons during the year. In most cases, this report uses financial information reported for the fiscal year that closed in 2004. However, for a small percentage of the organizations, 26%, fiscal year 2003 was the most current financial information available.

JOBS NOW Coalition, *The Cost of Living in Minnesota*
In *The Cost of Living in Minnesota*, the JOBS NOW Coalition calculates the wage necessary for a family to cover its basic needs, looking at a variety of family compositions as well as geographic differences. The "basic needs budget" constructs a realistic budget by measuring the actual costs of meeting basic needs for food, housing, healthcare, childcare, clothing, and transportation in 2004. The budget does not include any money for entertainment, vacation, eating out, emergencies, retirement, or education. *The Cost of Living in Minnesota* uses the thirteen economic development regions to examine geographic differences, while this analysis uses the six planning regions. Therefore, to determine the appropriate wage for the Northwest, Southwest, and Central planning regions, the unweighted budgets of the economic development regions within these planning regions were averaged together to determine the basic needs budget. *The Cost of Living in Minnesota* report and budget calculator are available online at www.jobsnowcoalition.org.

2314 University Avenue West, Suite 20, Saint Paul, MN 55114
Tel 651-642-1904 800-289-1904 Fax 651-642-1517 www.mncn.org

Twin Ports Area Nonprofit Coalition
424 West Superior Street, Suite 500
Duluth, MN 55802
Tel 218-726-4887 Fax 218-726-4885

Itasca Area Nonprofit Council
201 West 4th Street
Grand Rapids, MN 55744
Tel 218-327-8858

Community Resource Connections
616 America Avenue NW, Suite 170
Bemidji, MN 56601
Tel 218-333-8265 Fax 218- 759-8263

Unemployment Insurance
Minnesota

March 16, 2006

William Wilson
Committee Administrator
Health & Family Security Committee
G-24 Capitol
75 Rev. Dr. Martin Luther King Jr. Blvd.
St. Paul, MN 55155-1606

Re: S.F. 2672 - Large Employer Health Cost Payments

Dear Mr. Wilson:

I would like Senator Lourey to be aware that Minnesota Statutes §268.19, subdivision 1, clause 7, gives the Department of Labor & Industry full access to all unemployment insurance data, including all wage records and any other information we obtain on employers. Therefore, lines 29, 30, and 31 on page 2 of the bill are unnecessary. The authority in the bill for data access already exists in the statutes.

If you have any questions, please feel free to contact me at lee.nelson@state.mn.us or at 651-296-6110.

Sincerely,

Lee B. Nelson/jrw

Lee B. Nelson
Director
Unemployment Insurance Legal Affairs

LBN: jrw

cc: Lynne Batzli

Department of Employment and Economic Development
Unemployment Insurance Legal Affairs
1st National Bank Building • 332 Minnesota Street, Suite E200 • Saint Paul, MN 55101-1351 • USA
651-296-6110 • Fax: 651-284-0170 • TTY: 651-296-3900 • www.uimn.org

Bill Summary | Senate

Senate Counsel & Research | State of Minnesota

S.F. No. 2672 - Health Care Cost Payment by Large Employers

Author: Senator Becky Lourey

Prepared by: John C. Fuller, Senate Counsel (651/296-3914)

Date: March 22, 2006

This bill amends the chapter of Minnesota Statutes related to labor standards and wages. It requires private employers with more than 10,000 employees in Minnesota to pay to the state for deposit in the health care access fund account the difference between eight percent of the wages paid to Minnesota employees and what the employer pays for medical costs of its employees. If the employer pays more than eight percent, there is no payment obligation.

Section 1 contains definitions.

Subdivision 2 defines "commissioner" as the Commissioner of Labor and Industry.

Subdivision 3 defines "employee" and excludes independent contractors from the definition.

Subdivision 4 defines an "employer" as an entity employing more than 10,000 individuals within the state and excludes public employers.

Subdivision 5 defines "health care costs" as those paid for by an employer to provide health care or health insurance and that are deductible by the employer under federal tax law.

Subdivision 6 defines "wages" by reference to the definition of wages contained in the unemployment compensation law. Excluded from wages are those paid to employees enrolled in Medicare and those wages that are in excess of the state median household income.

Section 2 requires employers that pay less than eight percent of wages for health care costs to make a payment to the state for the difference between eight percent and what the employer pays for health care costs. The obligation is enforced on an annual calendar-year basis. The payment must be made to the Commissioner for deposit into the health care access fund. The first year an employer has the obligation is calendar year 2007.

Section 3 requires the Commissioner of Labor and Industry to enforce section 2. The Commissioner is authorized to engage in various activities to ensure compliance with section 2. The Commissioner of Employment and Economic Development is required to cooperate with the Commissioner in providing wage and employment count information.

JCF:cs

Consolidated Fiscal Note – 2005-06 Session

Bill #: S2672-1A **Complete Date:** 03/20/06

Chief Author: LOUREY, BECKY

Title: LARGE EMPLOYER HEALTH COST PAYMENTS

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

Agencies: Labor & Industry (03/20/06)
Employee Relations (03/20/06)
Employment & Economic Dev Dept (03/17/06)
Human Services Dept (03/17/06)

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
Net Expenditures					
Health Care Access Fund			163	216	221
Labor & Industry			163	216	221
State Employees Insurance Fund		0	0	0	0
Employee Relations		0	0	0	0
Revenues					
-- No Impact --					
Net Cost <Savings>					
Health Care Access Fund			163	216	221
Labor & Industry			163	216	221
State Employees Insurance Fund		0	0	0	0
Employee Relations		0	0	0	0
Total Cost <Savings> to the State		0	163	216	221

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
Health Care Access Fund			1.20	2.00	2.00
Labor & Industry			1.20	2.00	2.00
Total FTE			1.20	2.00	2.00

Consolidated EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: KEITH BOGUT
Date: 03/20/06 Phone: 296-7642

Fiscal Note – 2005-06 Session

Bill #: S2672-1A **Complete Date:** 03/20/06

Chief Author: LOUREY, BECKY

Title: LARGE EMPLOYER HEALTH COST PAYMENTS

Agency Name: Labor & Industry

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

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			163	216	221
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
Health Care Access Fund			163	216	221
Revenues					
-- No Impact --					
Net Cost <Savings>					
Health Care Access Fund			163	216	221
Total Cost <Savings> to the State			163	216	221

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
Health Care Access Fund			1.20	2.00	2.00
Total FTE			1.20	2.00	2.00

Bill Description

This bill requires employers with more than 10,000 employees in Minnesota to make a payment to the Department of Labor and Industry (DLI) if they do not spend at least 8% of total wages paid to employees in a calendar year for health costs. The payment amount would be the difference between the actual amount spent for health care and 8% of total wages paid. The payments would be deposited into the Health Care Access Fund. DLI is allowed to retain up to 5% of the payment amount for administrative costs.

Wages are defined as the wages reported to the Department of Employment and Economic Development (DEED) for unemployment insurance purposes. Wages in excess of the state median household income as determined by the Department of Housing and Urban Development ($68,200 for 2006) and wages paid to an employee who is enrolled in or eligible for Medicare are excluded for the health care cost calculation.

Assumptions

There are approximately 11 employers with over 10,000 employees in Minnesota. DLI would hire two Labor Standards Investigators to develop a reporting process and inspect these employer health care cost records to ensure compliance. It will also require the assistance of a Research Analyst to compare wage detail information from the DEED with Medicare information maintained by the Department of Human Services and determine the aggregate amount of wages to be included in the calculation.

It is assumed that data collection, calculation, and auditing would begin in January 2007 for the calendar year 2006.

It is also assumed that DLI administrative expenditures would be funded from the Health Care Access Fund.

Expenditure and/or Revenue Formula

Revenue:

DLI does not have any information regarding the current health care benefit levels provided by these employers, therefore is unable to estimate the amount of revenue that might be generated under this bill.

Expenditures:

	2007	2008	2009
Personnel	$85,000	$144,000	$148,000
Other Operating	$78,000	$72,000	$73,000
Total	$163,000	$216,000	$221,000

Long-Term Fiscal Considerations

If all defined employers' health care costs exceed the 8% threshold there would be no revenue generated from which to offset DLI's administrative costs.

Local Government Costs

Local governments with more than 10,000 employees could be affected if they are not paying at least 8% of wages for employee health costs.

References/Sources

DLI Assistant Commissioner, Workplace Services
DLI Research Director
Business Journal

FN Coord Signature: CINDY FARRELL
Date: 03/17/06 Phone: 284-5528

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: KEITH BOGUT
Date: 03/20/06 Phone: 296-7642

Fiscal Note – 2005-06 Session

Bill #: S2672-1A **Complete Date:** 03/17/06

Chief Author: LOUREY, BECKY

Title: LARGE EMPLOYER HEALTH COST PAYMENTS

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					
-- No Impact --					
Net Cost <Savings>					
-- No Impact --					
Total Cost <Savings> to the State					

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

NARRATIVE: SF 2672-1A

Bill Description

As amended, SF 2672 would require employers with 10,000 or more employees who does not spend at least 8% of total wages in a calendar year to employees for health costs to make a payment to the commissioner of labor and industry equal to the difference between what the employer spends for health costs and 8% of total wages paid to employees in the state. The definition of employer includes any corporation or other legal entity with more than 10,000 employees in the state, including the state and any of its political subdivisions.

The payments must be deposited by the commissioner of labor and industry into the Health Care Access Fund. The commissioner of labor and industry is allowed to keep up to 5% of the payment for administrative costs.

The bill is effective January 1, 2007.

The amendments to the bill do not impact DHS.

Assumptions

It is anticipated that there would be no program, systems or administrative impacts attributed to DHS.

Expenditure and/or Revenue Formula

Long-Term Fiscal Considerations

Local Government Costs

References/Sources

Agency Contact Name: Steve Nelson 651-431-2202
FN Coord Signature: STEVE BARTA
Date: 03/17/06 Phone: 431-2916

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: LISA MUELLER
Date: 03/17/06 Phone: 296-6661

Fiscal Note – 2005-06 Session

Bill #: S2672-1A **Complete Date:** 03/20/06

Chief Author: LOUREY, BECKY

Title: LARGE EMPLOYER HEALTH COST PAYMENTS

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

Agency Name: Employee Relations

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					
State Employees Insurance Fund		0	0	0	0
Less Agency Can Absorb					
State Employees Insurance Fund		0	0	0	0
Net Expenditures					
State Employees Insurance Fund		0	0	0	0
Revenues					
-- No Impact --					
Net Cost <Savings>					
State Employees Insurance Fund		0	0	0	0
Total Cost <Savings> to the State					

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

BILL DESCRIPTION:
Senate file 2672-1A requires certain health cost payments by large employers.

BACKGROUND:
The Minnesota Advantage Health Plan is a self-insured health plan offered by the State of Minnesota to state employees and their dependents. Both the employer and the employee make contributions to the cost of premiums. The bill requires large employers (10,000 + employees) who do not spend at least 8% of total wages paid to employees for health costs to make a payment to the Commissioner of Labor and Industry.

Based on 2005 data, The State of Minnesota spent approximately 18% of total wages for health care costs.

ASSUMPTIONS:
DOER has assumed that health care costs will continue to rise at a faster rate than the rate of wage increases.

DOER has assumed the Employer Contribution formula, as specified by bargaining agreements, will remain relatively stable over the next five years.

DOER therefore concludes the state will continue to spend 18% of wages or more on health care costs, and would not be required to make an additional payment.

EXPENDITURE FORMULA:
Not applicable.

LONG-TERM FISCAL CONSIDERATIONS:
Not applicable.

LOCAL GOVERNMENT COSTS:
Not applicable.

REFERENCES:
- Current premium costs from the Minnesota Advantage Health Plan.
- Current average salary calculated from report PDHR6200, *Executive Branch Appointment and Employment Statistics*, dated July 19, 2005.

Agency Contact Name: Liz Houlding (651-259-3700)
FN Coord Signature: MIKE HOPWOOD
Date: 03/20/06 Phone: 259-3780

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: KRISTI SCHROEDL
Date: 03/20/06 Phone: 215-0595

Fiscal Note – 2005-06 Session

Bill #: S2672-1A **Complete Date:** 03/17/06

Chief Author: LOUREY, BECKY

Title: LARGE EMPLOYER HEALTH COST PAYMENTS

Agency Name: Employment & Economic Dev Dept

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

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					
-- No Impact --					
Net Cost <Savings>					
-- No Impact --					
Total Cost <Savings> to the State					

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

Bill Description

This agency is not involved in the administration of the program initiated by this bill. The data exchange with this agency, called for on Page 2, lines 29-31, is already authorized under MN Statutes 268.19, Subd. 1(7).

Assumptions

Expenditure and/or Revenue Formula

Long-Term Fiscal Considerations

Local Government Costs

References/Sources

FN Coord Signature: MIKE MEYER
Date: 03/17/06 Phone: 297-1978

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: KEITH BOGUT
Date: 03/17/06 Phone: 296-7642

A bill for an act

relating to employment; requiring certain health cost payments by large employers; proposing coding for new law in Minnesota Statutes, chapter 177.

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

Section 1. **[177.45] DEFINITIONS.**

Subdivision 1. **Applicability.** For purposes of sections 177.45 to 177.47, the terms defined in this section have the meanings given them.

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of labor and industry.

Subd. 3. **Employee.** "Employee" means a person who performs services for hire for an employer, and includes all individuals employed at any site in Minnesota owned or operated by an employer. Employee does not include an independent contractor.

Subd. 4. **Employer.** "Employer" means any corporation or other legal entity with more than 10,000 employees in Minnesota including the state or any of its political subdivisions.

Subd. 5. **Health costs.** "Health costs" means the amount paid by an employer to provide health care or health insurance to employees to the extent the costs are deductible by an employer under federal tax law. Health costs include payments for insurance, medical care, prescription drugs, vision care, medical savings accounts, exercise programs, and any other costs to provide health benefits as defined in section 213(d) of the federal Internal Revenue Code of 1986, as amended.

Subd. 6. **Wages.** "Wages" has the meaning provided in section 268.035, subdivision 29.

Wages do not include:

(1) wages paid to any employee in excess of the state median household income as most recently determined by the Department of Housing and Urban Development; and

(2) wages paid to an employee who is enrolled in or eligible for Medicare.

EFFECTIVE DATE. This section is effective January 1, 2007.

Sec. 2. **[177.46] EMPLOYER HEALTH COST PAYMENT.**

Subdivision 1. **When payment required.** An employer that does not spend at least eight percent of the total wages paid in a calendar year to employees for health costs must make a payment to the commissioner equal to the difference between what the employer spends for health costs and eight percent of the total wages paid to employees in the state. The payment must be made by December 31 of the year following the year for which payment is required.

Subd. 2. **Use of payments.** The commissioner shall deposit payments into the health care access fund created under section 16A.724 for the purposes of that fund, except that the commissioner may retain up to five percent of the payment for administrative costs related to sections 177.45 to 177.47.

Subd. 3. **Employee not responsible.** An employer may not deduct any payment made under subdivision 1 from the wages of an employee.

EFFECTIVE DATE. This section is effective January 1, 2007.

Sec. 3. **[177.47] DUTIES OF COMMISSIONER.**

The commissioner shall enforce sections 177.45 to 177.47 and may, in addition to other powers the commissioner may possess:

(1) investigate employers suspected of violating section 177.45, including inspecting the records of employers;

(2) request and receive information from other state agencies to enforce compliance with sections 177.45 to 177.47; and

(3) collect payments not timely made by commencing an action in district court and by any other collection method available, including referring the debt to the commissioner of revenue for collection under the Debt Collection Act.

The Department of Employment and Economic Development shall, upon request of the commissioner, provide the commissioner with unemployment insurance information related to wages and number of employees of an employer.

EFFECTIVE DATE. This section is effective January 1, 2007.

Minnesota
Business
Partnership

3610 IDS Center
Minneapolis, MN 55402
612-370-0840
612-334-3086 (fax)
www.mnbp.com

MBP Opposes SF 2672

ISSUE

This bill would tax certain large employers in Minnesota to finance public health programs. As currently written, the bill would apply to employers with over 10,000 employees in Minnesota – excluding government – and requires these employers to spend an amount equal to at least 8% of wages on health care costs. If an employer spends less than the required minimum, they must pay the difference to the health care access fund.

BACKGROUND

The state of Maryland has recently enacted similar legislation, which is currently subject to litigation brought by Retail Industry Leaders Association (RILA).

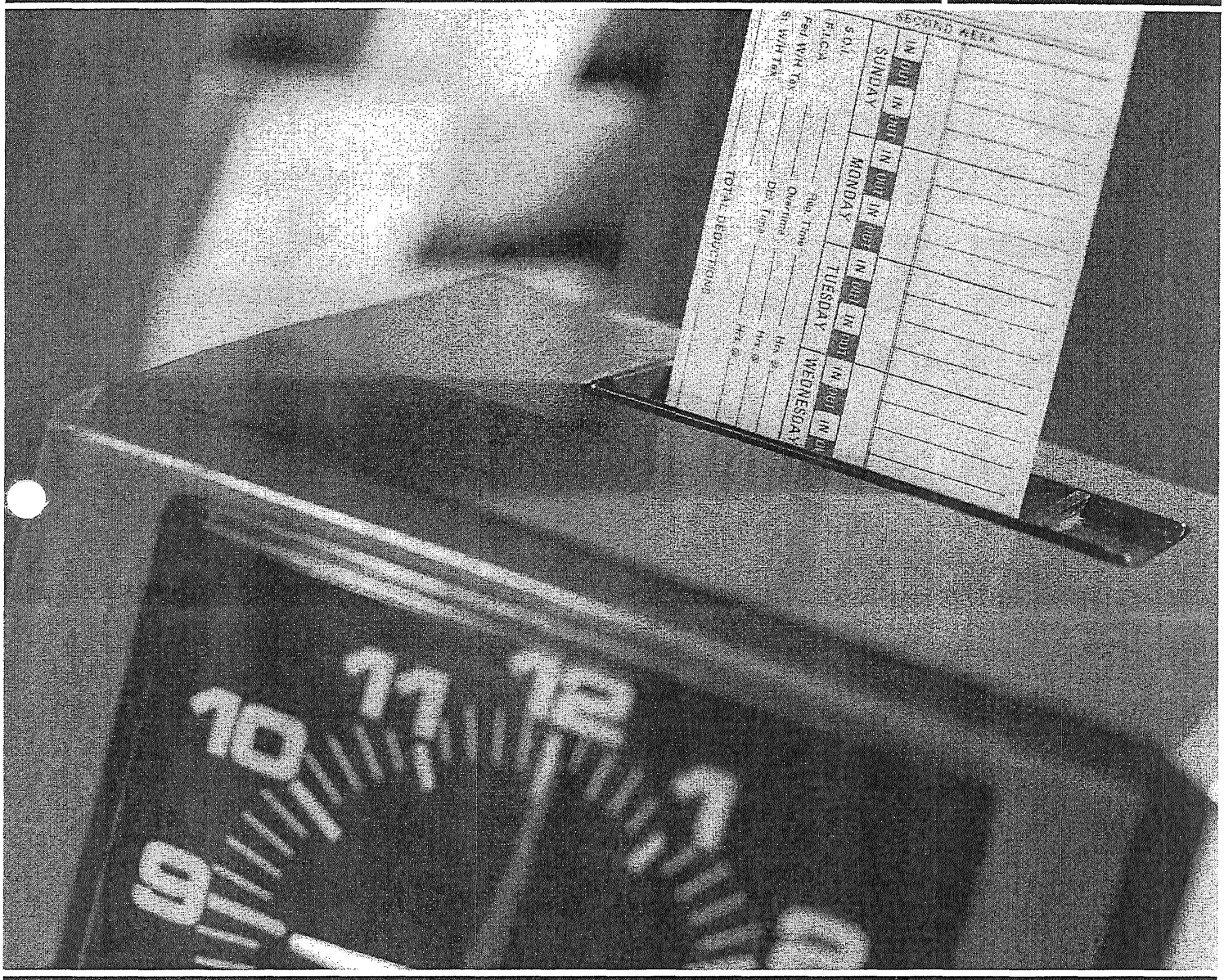
POSITION

The MBP opposes this bill because:

1) **It does nothing to address underlying cost drivers of health care, and little to lower the number of uninsured.** This bill simply creates an additional way to finance the uninsured programs in our state.
2) **It creates a disincentive for job creation in Minnesota.** This bill will put increased pressure on some companies to cut labor costs, which could mean job loss, and ultimately leave more individuals without that employer-sponsored coverage.
3) **It is an additional payroll tax on certain employers.** As written, it is unclear to how many employers this could potentially apply, but it is likely only a handful.
4) **This essentially creates employer-mandated health care coverage** for only certain businesses within our state. It places Minnesota businesses at a competitive disadvantage with businesses in other states, as well as globally.

For these reasons, we oppose SF 2672.

Employment Policies INSTITUTE



An Analysis of the Dynamics of Health Insurance Coverage and Implications for Employer-Mandated Insurance

by Robert W. Fairlie, University of California, Santa Cruz
& Rebecca A. London, University of California, Santa Cruz

January 2006

The Employment Policies Institute (EPI) is a nonprofit research organization dedicated to studying public policy issues surrounding employment growth. In particular, EPI research focuses on issues that affect entry-level employment. Among other issues, EPI research has quantified the impact of new labor costs on job creation, explored the connection between entry-level employment and welfare reform, and analyzed the demographic distribution of mandated benefits. EPI sponsors nonpartisan research that is conducted by independent economists at major universities around the country.

Robert Fairlie is an Associate Professor of Economics and the Director of the Masters Program in Applied Economics and Finance at the University of California, Santa Cruz. He was a Visiting Fellow at Yale University and is a research affiliate of National Poverty Center at the University of Michigan and the Institute for the Study of Labor (IZA). His research interests include ethnic and racial patterns of self-employment, entrepreneurship, access to technology and the "Digital Divide," the effects of immigration on U.S. labor markets, racial patterns in unemployment and job displacement, welfare reform, education, and health insurance. Dr. Fairlie holds a Ph.D. and M.A. in Economics from Northwestern University and a B.A. with honors from Stanford University.

Rebecca London, Ph.D., is an Associate Research Professor at the Center for Justice, Tolerance and Community (CJTC) at the University of California, Santa Cruz. She holds a Ph.D. in Human Development and Social Policy and an M.A. in Economics, both from Northwestern University. Prior to joining CJTC, Dr. London was Principal Analyst at Berkeley Policy Associates, during which time her research focused on evaluating family-related public assistance programs. Her research concentrates on issues facing low-income families and youth.

An Analysis of the Dynamics of Health Insurance Coverage and Implications for Employer-Mandated Insurance

Robert W. Fairlie, University of California, Santa Cruz
Rebecca A. London, University of California, Santa Cruz

Table of Contents

An Analysis of the Dynamics of Health Insurance Coverage and Implications for Employer-Mandated Insurance

Executive Summary

Over the last several years, there has been a lot of attention paid to the increasing number of Americans without health insurance. News reports often discuss the 45 million people—representing 16 percent of the population—who are uninsured. The increasing number of uninsured Americans is a concern because these individuals are less likely to receive adequate medical care. For example, studies have shown that the uninsured are three times more likely than those who are insured to delay seeking health services due to their expense.

Most current estimates of the uninsured, however, are point-in-time estimates that fail to fully grasp the dynamics of insurance coverage. For a host of factors—not the least of which is the dependence on the labor market for the provision of a large portion of health coverage—health coverage for many Americans is very volatile. As a result, point-in-time estimates potentially underestimate the number of uninsured and fail to provide the information necessary for crafting effective health care policies. For example, if the majority of the uninsured lost insurance because they frequently switched jobs, then a law mandating employer-provided coverage, such as California's recently defeated Proposition 72, would do little to assist them.

This study, by Drs. Robert Fairlie and Rebecca London, uses paired samples from multiple years of the Current Population Survey (CPS) to explore the dynamics of health coverage in the United States. In particular, it estimates the factors that cause an individual to gain or lose coverage from year to year. These dynamics are critical for the creation of constructive policies to increase access to health coverage.

In their study, the authors found that employer size plays a crucial role in insurance status. While most health insurance mandates exempt small employers, the authors found that "it is precisely these [small] firms that are associated with the higher rates of insurance loss and the lowest rates of gain." As such, policies that ignore these firms will be unable to effectively increase coverage. The authors also found that the unemployed suffer lower rates of insurance gain and higher gains of insurance loss from year to year. Again, mandated health insurance policies—because they affect only those who are in the labor force—can do little to help the unemployed uninsured.

Health Insurance Transition Rates

According to the CPS, 85.6 percent of adults had health insurance in the first year studied and 7.5 percent of these individuals lost coverage in the subsequent year. Examining the 14.4 percent who were uninsured, we see that 46.2 percent of those adults gained health insurance by the end of the following year.

Breaking out these transition rates for various groups, the authors found that skill level had a significant effect on insurance status. Specifically, high school dropouts are 28 percent less likely to be covered than college graduates, and 18 percent less likely to be covered than high school graduates. More than one-third of these high school dropouts (compared to 14.4 percent of the total adult population) are uninsured and only 34.4 percent of these uninsured dropouts get coverage in the subsequent year (compared to 46.3 percent of all adults).

Overall, minorities have lower rates of coverage than whites. For example, African

Americans have an insurance rate of 80.5 percent compared to 89.2 percent for white, non-Latinos. This difference is due almost entirely to a higher rate of insurance loss between the two years—with African Americans facing an insurance loss rate double that of whites.

Employment Status and Insurance Coverage

Perhaps unsurprisingly, employment status is a critical factor in coverage. In total, those working full-time and full-year have the highest rate of insurance coverage and gain, and the lowest rates of insurance loss. The authors found that "any part-time, part-year or unemployed period is associated with lower rates of health insurance gain." For example, 38.3 percent of the individuals who spent the entire first year unemployed were uninsured (compared to 14.4 percent of the population). Nearly 18 percent of insured but unemployed adults lose coverage within the year. Overall, the authors found that unemployment and part-time status are associated with lower rates of insurance coverage and gain.

Employees losing their job in the first year experienced a 19.9 percent decline in health insurance coverage. In addition, gaining a job between the two years caused a 16 percent decrease in insurance coverage—most likely as a result of a waiting period for new coverage and the end of stopgap health coverage such as Medicaid or COBRA. These results show that frequent job switching would be expected to result in lower coverage rates. Most mandates have a waiting period (normally three months) and don't cover unemployed adults—making them generally ineffective at improving coverage for these individuals.

Employer Size and Insurance Status

Employer size is one of the largest determinants of insurance gain. Uninsured individuals at small firms are least likely to gain insurance from year to year. In addition, those moving to employment in a small firm have the lowest rates of insurance gain, with only 32 percent of these individuals gaining insurance, compared to 68 percent of those moving to a large firm.

The correlation between insurance loss and employer size is equally striking. Employees working in the smallest firms have the highest likelihood of insurance loss compared to those at larger firms. Movement into employment at a small employer is associated with higher than average rates of health insurance loss and much higher rates than those faced by employees moving into employment in a large firm. All of these estimates are consistent with small firms being less likely to provide benefits or providing less attractive coverage (either in terms of cost or choices) than large firms. Many of the proposed employer mandates, including Proposition 72 in California, exempt these small businesses from their requirements.

Policy Implications

Overall, the authors find that groups such as high school dropouts, the unemployed, and those working at small firms (1–9 employees) have the highest risk of insurance loss from year to year. These factors are important because recent attempts to mandate employer-provided coverage exempted both employees of small firms and those that work few hours and, as a result, appear to miss a large portion of the uninsured. In addition, the very nature of attempting increase coverage by utilizing the labor market ignores the unemployed, despite the fact that this research "indicates that the unemployed are one of the groups at highest risk of health insurance loss."

Before moving forward with policies designed to address the problem of the uninsured, it is important that elected officials and policymakers fully understand the underlying dynamics of gains and losses in insurance as described in this paper. This research shows that certain demographic and employment groups have alarmingly low insurance rates and that the provisions of mandates such as Proposition 72 "exempted or excluded some of the most at-risk groups." The authors do state that these groups may have been exempted because it is difficult to create a mandate that reaches small employers and part-time employees without destroying job opportunities.

An Analysis of the Dynamics of Health Insurance Coverage and Implications for Employer-Mandated Insurance

Introduction

In 2003, nearly 45 million people, or 16 percent of the U.S. population, lacked health insurance. Trends indicate that both the number and rate of uninsurance have increased since the late 1980s (DeNavas-Walt, Proctor, and Mills 2004). Low-income individuals are especially likely to be uninsured, with 24 percent lacking health insurance in 2003. Even so, the majority of uninsured adults come from a working family (Kaiser Commission on Medicaid and the Uninsured 2003). Among those with insurance, employer-provided insurance accounts for the largest source—72 percent of covered individuals had an employment-based plan (DeNavas-Walt, Proctor, and Mills 2004). Yet there is evidence that among workers, the rate of employer-sponsored health coverage declined in the 1980s and 1990s (Farber and Levy 2000), and this decline was most pronounced among low-income workers (Holahan 2003).

Understanding the reasons for lack of health insurance and the characteristics of the uninsured is important because the absence of health insurance can result in negative externalities for society. For instance, people who are uninsured are three times as likely as those who are insured to delay seeking health services due to their expense (Kaiser Commission on Medicaid and the Uninsured 2003). The uninsured are far less likely to receive medical care in a doctor's office or other sources of regular care and are more likely than those with insurance to be seen in hospital emergency rooms (Kaiser Commission on Medicaid and the Uninsured 2003). One estimate suggests that the value of uncompensated health care services to the uninsured is roughly $35 billion annually (Institute of Medicine of the National Academies 2003). Miller et al. (2004), instead, estimate a lower bound of $65–$130 billion in economic losses (including social costs) resulting from uninsurance. From the patient's perspective, there is concern that lack of health insurance may place the uninsured at substantial financial risk. In contrast, the presence of health insurance has been associated with better health status, particularly for low-income groups and other vulnerable populations (Levy and Meltzer 2001).

The focus in past literature on health insurance coverage at a point in time and its consequences, however, may greatly understate the problem of uninsurance in the United States. Estimates from Survey of Income and Program Participation (SIPP) and those reported in this study indicate that health insurance coverage over time is volatile, especially for low-skilled workers. For example, data from the SIPP indicate that among full-time workers in 1999, 16 percent experienced at least one month without health insurance (Bhandari and Mills 2003). Nearly 25 percent of individuals without a high school diploma were uninsured for at least one month in the same year.

Furthermore, intermittent health insurance appears to be much less beneficial than continuous coverage and results in outcomes that more closely resemble the outcomes of the continuously uninsured (Baker et al. 2001). In particular, intermittent coverage has been shown to result in use of fewer preventive health services (Sudano and Baker 2003) and increased problems in accessing medical care and following up on this care (Schoen and DesRoches

2000). Previously uninsured or intermittently insured adults who gain access to health insurance tend to show improvements in their use of medical services, although it may take several years for this to occur (Sudano and Baker 2003; McWilliams et al. 2003).

Previous research does not identify a dollar value on the cost of health insurance volatility per se, but the cost of this volatility is partially embedded in the cost of uninsurance. In the cross-section, the uninsured are in the midst of a spell of uninsurance that will likely end at some point in the future. To the extent that being uninsured intermittently affects access to care during the spell of uninsurance, these costs are likely captured in the estimates of the costs of uninsurance. However, because intermittent coverage can lead to later access and follow-up care problems, there are likely to be additional costs associated with volatility in health insurance coverage.

Although low rates of health insurance among certain demographic and employment groups, such as disadvantaged minorities, less-skilled workers and the unemployed, have been well documented, we know relatively little about the dynamic patterns of health insurance coverage among these groups. To the extent that lapses in health insurance coverage measured in a static model are associated with turnover in coverage, it is important to understand the extent of this issue and its causes. Examining point-in-time insurance coverage may mask important differences in rates of health insurance transitions, which are the force behind differences in static rates. For example, the low rates of coverage among part-time and small-employer workers may be due to high rates of insurance loss, low rates of gaining insurance, or a combination of the two. Furthermore, very little is known about the extent to which changes in job characteristics are associated with gains and losses of health insurance. This may be especially important for less-skilled workers who have high rates of job turnover and unemployment.

An improved understanding of the dynamics of health insurance coverage may have important policy implications. Concerns about uninsured workers, particularly those working part-time and for smaller employers, have prompted a number of policy proposals aimed at addressing gaps in employer-provided insurance. Most recently, California's state legislature passed SB 2 in 2003, which included both a play-or-pay option—requiring most firms to pay for health insurance directly or pay into a public benefits system—and an individual mandate that employees be covered by health insurance. SB 2 was put on the November 2004 ballot as a referendum for California voters, who narrowly defeated the measure. Other states, such as Massachusetts and Oregon, have also attempted play-or-pay legislation, but have failed to implement such programs. The small margin of defeat in California and the appearance of other play-or-pay schemes in legislation across the United States suggest that mandated employer-sponsored insurance will reappear on the landscape in the not-too-distant future.

Previous research does not address whether the additional employees targeted for health insurance coverage under employer-mandate proposals align with those at highest risk for uninsurance or insurance loss. Furthermore, we know little about the extent to which other groups exist with similarly high risks of lacking health insurance. If individuals who are the most likely to experience health insurance losses from one year to the next are primarily the ones who change jobs, move to part-time work, or switch to having multiple jobs at different firms, employer-mandate programs such as California's SB 2 may have a significant effect. However, if individuals lose insurance due to movement from a larger employer (that would be covered by SB 2) to a very small one (that would not be covered by SB 2) or for other reasons, such as loss of spousal coverage, the effects of this type of insurance mandate could be

much smaller. An analysis of transitions will reveal the extent to which volatility in health insurance coverage is primarily associated with low-income or less-skilled workers, those whom SB 2 and other similar proposals most intend to assist.

In this study, we examine annual transitions into and out of health insurance coverage using matched data from the 1996 to 2004 Annual Demographic Files (ADF) of the Current Population Survey (CPS). We address several questions using one-year panel data created by matching consecutive years of the CPS. First, we examine patterns of health insurance coverage transitions across detailed demographic and employment characteristics. The focus is on identifying the causes of low rates of health insurance among specific groups, such as minorities, less-educated workers, part-time workers, and workers at small employers. Are they due to high rates of health insurance loss, low rates of obtaining health insurance, or both? Second, we examine which groups have the highest (lowest) probability of losing (gaining) health insurance. Of special interest is identifying the factors that are independently associated with health insurance loss or gain. Finally, the large sample sizes and longitudinally matched CPS data allow us to explore the relationship between changes in job characteristics and health insurance loss or gain over a two-year period. We examine whether and how much job loss, full-time to part-time work, large employer to small employer, and other changes in job characteristics are associated with health insurance loss. We also examine the factors associated with gaining health insurance.

Previous Studies

The literature on health insurance dynamics has concentrated on two areas: studies of the effects of health insurance on job mobility and analyses of the duration and characteristics of uninsurance spells. In this section, we provide a brief overview of the findings from each of these literatures. Research on year-to-year transitions in health insurance is limited, and, to our knowledge, the independent effects of both demographic and employment characteristics on health insurance gain and loss have not been examined in the previous literature.

Health Insurance and Job Turnover

Health insurance literature has established a relationship between health insurance and labor supply. Research has shown that when the source of health insurance is not linked to one's own employment, individuals are less likely to be employed (Gruber and Madrian 2001). This is particularly the case among married women, whose propensities to work depend on the availability of health insurance from their husbands.

This link between health insurance and labor supply may also have the inverse effect—the presence of health insurance may reduce job mobility. The literature on job turnover and health insurance has concentrated largely on the role of health insurance in creating "job lock," a phenomenon that results when employees opt to stay at their jobs because of their health insurance coverage. A problem with examining the effects of health insurance on job mobility is the potential endogeneity of health insurance coverage with other unmeasurable job characteristics. Jobs that provide health insurance might also be qualitatively better jobs for other reasons, leading to a reduced desire to leave these jobs for reasons unrelated to health benefits. The literature has dealt with this endogeneity problem in several ways (Gruber and Madrian 2001), and studies demonstrate wide divergence in estimated effects of health insurance on job lock. For instance, Madrian (1994) estimates that job lock results in a 25 percent reduction in job turnover. In response to Madrian (1994), Kapur (1998) uses comparable data and different econometric specifications and finds no evidence of job lock. In a review of the job lock literature, Gruber and Madrian (2001) con-

clude that job lock estimates range from a lower bound of 10 percent to an upper bound of 25–30 percent. Consistent with this, research has shown that job lock may pertain only to certain groups (Gilleskie and Lutz 2002). Even where job lock exists, the literature seems to indicate that it is a short-term problem, due at least in part to the availability of employer-provided insurance for former employees through the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (Gilleskie and Lutz 2002; Gruber and Madrian 1994).

Expanding the consequences of job lock to the children of low-income parents, Marquis and Kapur (2003) find that parents who do not have health insurance coverage remain in their jobs for shorter durations than those who have health coverage. When they control for other factors, the authors find that the role of insurance coverage diminishes, suggesting that other factors also play an important role in parents' job-moving decisions.

Health Insurance Dynamics

The literature on health insurance dynamics emphasizes that a dynamic approach to studying health insurance coverage represents an improvement over point-in-time analyses. If spells of uninsurance are short and end with regained insurance coverage, we might be less concerned about the problem of insurance. If, however, those who are uninsured remain uninsured for long periods, or repeatedly gain and lose insurance, we might be more concerned about the well-being of the uninsured.

Studies of health insurance dynamics have mostly focused on the duration of uninsurance spells and the characteristics of individuals with longer spells. One of the pioneering studies in this area found that half of uninsurance spells end within four months, and 15 percent last more than two years (Swartz and McBride 1990). More recent data published by the Congressional Budget Office (CBO) indicate an increase in the share with longer spells—41 percent of uninsurance spells lasted less than four months and 18 percent lasted more than two years (CBO 2003). The CBO study also documents that poor, less educated, and Latino families are more likely than others to have uninsurance spells that last more than two years. Certain factors lead to higher probabilities of exit from spells of uninsurance, including higher educational attainment, non-poverty family income, and prior employment in various industries (e.g., manufacturing, trade, utilities, finance/insurance/real estate, and business and professional services) (Swartz, Marcotte, and McBride 1993). Focusing specifically on poverty and uninsurance, McBride (1997) finds that one-quarter of the uninsured are poor individuals who have been uninsured for more than a year. Forty-two percent of the uninsured have incomes less than 150 percent of the federal poverty line and have been uninsured for more than a year.

Taking a slightly longer time perspective than other studies, Short and Graefe (2003) identify that the majority of individuals who were uninsured lacked insurance for more than 12 months over a four-year period. During this four-year period, one out of three working-age adults had a lapse in coverage of some duration. They identify several patterns of insurance coverage associated with these lapses, including onetime coverage gaps as well as repeated gaps in coverage.

Although much of the literature on health insurance transitions relies on monthly data, Monheit, Vistnes, and Zuvekas (2001) provide estimates of annual transitions in health insurance from using the 1996 Medical Expenditure Panel Survey (MEPS). They find that 30 percent of individuals who were uninsured in January 1996 gained insurance in the subsequent year. Conversely, among those with private insurance in January 1996, 8 percent lost coverage during the subsequent year (19 percent for those with public insurance).

These estimates point to the importance of studying health insurance dynamics; however,

previous studies have not examined in detail the job characteristics associated with individuals who gain and lose health insurance. The CBO report includes statistics on spell duration for those in different firm sizes, but is purely descriptive. This study contributes to the literature by identifying the groups most at risk of losing and gaining health insurance from one year to the next. Sample sizes in the CPS are large enough to examine transitions among very detailed demographic groups and employment characteristics. Finally, we model both sides of the transition: entry into insurance and exit from insurance. The large sample sizes available in the CPS are especially important for identifying factors associated with gaining health insurance because the analysis relies on the uninsured sample in the first survey year.

Data

We use data from the 1996 to 2004 Annual Demographic and Income Surveys (March) of the CPS. The survey, conducted by the U.S. Census Bureau and the Bureau of Labor Statistics, is representative of the entire U.S. population and interviews approximately 50,000 households and more than 130,000 people. It contains detailed information on health insurance coverage, employment, demographic characteristics and income sources.

Although the CPS is primarily used as a cross-sectional dataset offering a snapshot at a point in time, it is becoming increasingly common to follow individuals for two consecutive years by linking surveys. Households in the CPS are interviewed each month over a four-month period. Eight months later they are re-interviewed in each month of a second four-month period. The rotation pattern of the CPS makes it possible to match information on individuals in March of one year who are in their first four-month rotation period to information from March of the following year, which represents their second four-month rotation period. This creates a one-year panel for up to half of all respondents in the first survey. To match these data, we use the same criteria as Madrian and Lefgren (2000) for matching the CPS March ADF from 1996 to 2000, but use modified criteria for the 2001 to 2004 data.[1] Across the 1996–2004 CPS surveys we find that roughly 75 percent of CPS respondents in one survey can be identified in the subsequent year's survey.

Using the matched CPS data, we can identify whether an individual's health insurance status changes over time, as well as changes in employment, hours worked, and employer size. One drawback to these data is that when respondents leave a particular household they are not followed to their next household. A consequence of this is that when households dissolve due to marital breakup, the CPS does not reinterview both marital partners. We are therefore unable to reliably examine insurance gain and loss due to marital status changes, and focus instead on gain and loss due to changes in employment characteristics.

We examine the extent to which individual demographic and employment characteristics are associated with health insurance gain and loss from year to year. Included in our analysis are sex, race/ethnicity, education, age, hourly wage, family income, home ownership, labor force status, class of worker, employer size, and industry. Appendix Table A.1 provides descriptive statistics for these variables.

The health insurance variables used for this analysis refer to the respondent's health insurance in the year prior to the March survey. The one-year transition identifies any changes in coverage people experience over the course of one year to what they experience over the course of the next year. We rely on labor market variables that cover the same time period. The transitions can therefore be thought of as covering two full years, the 12 months prior to the first survey year and the 12 months prior to the second survey year.

Comparisons among estimates of health insurance coverage using the CPS and other datasets that include a point-in-time measure of health insurance reveal similar numbers of

uninsured individuals. Estimates from the SIPP, MEPS and National Health Interview Survey (NHIS) indicate that roughly 40 million individuals were uninsured at the time of the survey in 1998 (CBO 2003). Estimates from the CPS for the number of individuals with no insurance for the entire year are also roughly 40 million, suggesting that the CPS overstates the number of individuals uninsured over the entire year. Indeed, estimates from the SIPP and the MEPS, which also include multiple observations over the year, indicate that 21.1 and 31.1 million people, respectively, are uninsured for the entire year. Thus, CPS respondents may be underreporting health insurance coverage at any point over the previous calendar year because of recall bias or because they simply report their current coverage (see Bennefield 1996, Swartz 1986 and CBO 2003 for further discussion). Although these problems may alter the interpretation of our results, the measure of health insurance status does not change from year to year, and thus allows for an analysis of transitions in status. We assume that respondents interpret the question correctly.

The percentage of individuals who report not having insurance over the previous year provides an estimate of the percentage of individuals who are currently experiencing an uninsured spell of at least one year. We can also estimate the percentage of individuals who are currently experiencing an uninsured spell of at least two years by examining the percentage of individuals who were uninsured in the first survey year and the second survey year. Estimates from our matched CPS sample indicate that 15 and 8 percent of adults are currently experiencing an uninsured spell of at least 1 and 2 years, respectively. Although not directly comparable, estimates from the SIPP indicate that approximately 13 percent of individuals are currently experiencing an uninsured spell of more than 12 months (CBO 2003).

Results

Health Insurance Transition Rates

Table 1 reports health insurance coverage and transition rates using the CPS sample. The coverage rates measure health insurance at any point in the previous year and capture all types of health insurance coverage. In total, 85.6 percent of adults in the CPS sample have health insurance in the reference year, which we refer to as the first survey year or year *t*. Among the 14.4 percent of individuals without insurance in the first survey year, column 2 shows that 46.2 percent gain insurance in the subsequent year. For those who are insured in year *t*, column 3 reports that 7.5 percent lose coverage in the subsequent year.

By examining transitions into and out of coverage, we are able to better understand the reasons some groups have higher and lower rates of uninsurance. For instance, men and women have coverage rates that differ by approximately 2 percentage points. The rates of health insurance loss for men and women are nearly identical, but the rates of gain among the uninsured are not. Men have a lower propensity to gain insurance than women; 43 percent of uninsured men gain insurance in the subsequent year compared to 49 percent of women. Thus, the low rate of health insurance coverage for men relative to women is due entirely to the lower re-insurance rate among uninsured men.

Examining health insurance patterns by race and ethnicity, we find that the health insurance coverage rate for African Americans is 80.5 percent, compared to 89.2 percent for white, non-Latinos. This difference is due almost entirely to higher rates of insurance loss, which are nearly double for African Americans than for whites. Latinos have even lower rates of coverage at 66.9 percent. Unlike African Americans, the lower rate is due both to a lower rate of health insurance gain (33.3 percent compared to 50.4 percent for whites) and a higher rate of

health insurance loss (16.3 percent compared to 5.8 percent for whites). Asians also have a lower rate of health insurance coverage than whites, at 81.5 percent. Similar to African Americans, the difference is due entirely to higher rates of insurance loss.

Large differences in health insurance coverage and transition rates can be seen by education level as well. High school dropouts are 28 percentage points less likely to be covered than college graduates, and 18 percentage points less likely to be covered than high school graduates. More than one third of all high school dropouts are uninsured. The low rate is caused by a health insurance rate of 17.4 percent and a health insurance gain rate of 34.4 percent.

Finally, health insurance coverage varies by region of the country. Residents of the South and West have lower rates of coverage overall, compared to those in the East and Midwest. These lower rates stem from both higher rates of insurance loss among the insured and lower rates of insurance gain among the uninsured.

Table 2 reports health insurance coverage and transition rates by labor force and employment characteristics. Labor force and job characteristics are measured in the first survey year and refer to labor force participation and employment in the year prior to the survey.

In total, 77.5 percent of those without a job during the full year had health insurance. Of the 22.5 percent who were not insured, 42 percent gained insurance in the subsequent year and among those with insurance, 10.6 percent lost coverage during the following year. Unemployed individuals fare far worse than those who are not in the labor force in both their static and dynamic measures of health insurance coverage. Those who spend all of the first survey year unemployed have an insurance coverage rate of 61.7 percent. Just 34.4 percent gain health insurance during the subsequent year, a percentage far lower than those who are not in the labor force. Among the insured, 17.7 percent lose it during the subsequent year. Individuals who are not in the labor force retain coverage at higher rates than those who are unemployed, possibly because they are covered on another policy, such as that of a spouse or a government program.

Employed workers are more likely to be insured than those without employment. A total of 86.9 percent of those who had any employment in year *t* were insured. Among those without insurance who were employed, 47.2 percent gained insurance during the subsequent year. Among those with insurance, 7.1 percent lost it during the subsequent year. Those working full-time (35+ hours per week) and full-year (50+ weeks per year) have the highest rates of insurance coverage and health insurance gain, and the lowest rate of health insurance loss among the employment groups. Working full-year, even if it is in a part-time job, protects against health insurance losses, but does not necessarily improve health insurance gains over part-year employment. Those working part-year, particularly when accompanied by unemployment in the remainder of the year, have the lowest rates of insurance coverage and the highest rates of health insurance loss. As was shown in the statistics for those who are not working, being unemployed is far more damaging to health insurance status and the probability of health insurance loss than being out of the labor force.

Overall, unemployment, especially over the entire year, and part-time status are associated with lower rates of health insurance coverage. Our estimates of transition rates from the CPS clearly indicate that these differences are driven by both higher probabilities of losing health insurance and lower probabilities of gaining health insurance for these groups.

As noted above, the previous literature has shown that employees in smaller firms are less likely to be covered by health insurance. The estimates reported in Table 2 support this finding, indicating that health insurance coverage increases almost monotonically with detailed employer size. Our findings also show that as

employer size increases, the probability of moving from no insurance into insurance increases as well. And, as employer size increases, the probability of losing health insurance declines. Working at a very small firm is particularly damaging to health insurance coverage. Those working at very small firms of fewer than 10 employees have a health insurance loss rate that is the same as those who do not work during the year. In contrast, working at a firm that has 100 or more employees results in health insurance loss rates that are much lower than the U.S. average. Finally, fewer than 7 percent of workers at firms with 500 or more employees are uninsured and only 5.4 percent of these workers lose health insurance over the following year.

As one might expect, government employees are far more likely to be covered than those working for a private employer. Self-employed individuals are less likely than the other two groups to have health insurance, with rates comparable to those who have no job. The rate of health insurance gain for government employees is very high and the rate of insurance loss is quite low—the extremes we see in the table. Those working for private employers and in self-employed jobs have higher rates of loss and lower rates of gain. Self-employed workers are at a high risk of losing health insurance from one year to the next (9.3 percent) and if uninsured have a low probability of regaining insurance (41.7 percent).

Factors Associated with Risk of Health Insurance Gain and Loss

The estimates reported in Tables 1 and 2 point to the importance of examining transition rates in understanding the reasons that some groups face higher and lower rates of health insurance coverage. It is likely, however, that many of the characteristics associated with high rates of insurance loss and low rates of insurance gain are correlated. For example, less-educated workers are more likely to be unemployed, both of which contribute to health insurance loss. To identify the independent effects of these characteristics, we estimate probit regressions for health insurance transitions.[2] We first examine the factors associated with the probability of losing health insurance from the first to second survey years, which are reported in Table 3. We are reluctant to identify these as causal factors, and instead view them as characteristics that place certain individuals at higher risk of health insurance loss.

Specification 1 of Table 3 includes a detailed set of demographic characteristics as control variables. Findings indicate that being a minority is associated with a higher probability of health insurance loss. African Americans are 2.4 percentage points more likely to lose insurance than whites, Latinos are 3.3 percentage points more likely, and Asians are 1.6 percentage points more likely to lose health insurance. Being an immigrant increases the probability of losing insurance by 4.2 percentage points net of race and ethnicity. As was shown in the raw statistics, being less educated is associated with higher rates of insurance loss at all reported levels relative to college graduates. Being a high school dropout is associated with the largest probability of health insurance loss, at 8.2 percent, relative to college graduates. As expected, the independent effects of these characteristics on health insurance loss are smaller in this multivariate analysis. For example, the raw difference in health insurance loss rates between African Americans and whites is 5.7 percentage points compared to the 2.4 percentage point difference after controlling for other characteristics, such as education.

Specification 2 adds measures of income and wealth. In particular, we include the log hourly wage, the log family income, and a measure of whether the respondent owned a home for year t.[3] The inclusion of these explanatory variables reduces the magnitude of marginal effects of the demographic characteristics, but produces qualitatively comparable results for these variables. More advantaged individuals and families are at lower risk of health insurance loss. A 10 percent increase in family income, for instance, is asso-

ciated with a 0.15 percentage point reduction in health insurance loss, and a 10 percent increase in hourly wages is associated with a 0.08 percentage point decline in health insurance loss. Owning a home is associated with a reduction in health insurance loss of 1.2 percentage points. These findings corroborate point-in-time estimates indicating that higher-income families are at a lower risk of lacking health insurance. Our results pinpoint that one reason for this lower risk is their lower probabilities of health insurance loss.

In Specification 3 of Table 3, we include a set of explanatory variables that control for different employment status, such as unemployment, not in the labor force (NILF) and part-time work, and working multiple jobs during the year. Adding this set of controls seems to strengthen many of the marginal effects on the demographic and asset/income variables. The employment variables also show some interesting patterns. As seen in Table 2, being unemployed for part of the year places people at a high risk of health insurance loss (3.7 percent) relative to working full-time full-year. Working part-time relative to full-time is also associated with increased risk of health insurance loss of 2.3 percentage points. Working at multiple jobs during the year is also associated with a small increase in the probability of health insurance loss.

Specification 4 adds class of worker (government or self-employed relative to privately employed) and employer size variables. Government employment is associated with a decrease in the risk of health insurance loss relative to private employment, and self-employment is associated with a 1.6 percentage point increase in loss. Employer size is also important, with people working at larger employers far less likely to lose insurance. Workers at firms with 1–9 employees are 3 percentage points more likely to lose health insurance than are workers at firms with 500 or more employees.

In summary, we find that demographic characteristics, wealth and income, and employment characteristics all contribute to the probability of health insurance loss. At the highest risk for health insurance loss are high school dropouts, Latinos, immigrants, those working part-year and unemployed part of the year, and those working at very small employers of 1–9 employees. Many of the variables included in the models reported in Table 3 are statistically significant, in part due to the large sample sizes of the CPS.

Table 4 reports estimates for comparable specifications to those reported in Table 3 for the probability of gaining health insurance from the first survey year to the following survey year. The sample includes individuals who do not have health insurance in the first survey year. The results are somewhat different from those for health insurance loss. First, we find a striking pattern among the demographic characteristics. Uninsured African Americans are more likely than uninsured whites to gain insurance between year t and year $t+1$. Controlling for education and other individual characteristics, African Americans have a 3.7 percentage point higher likelihood of gaining health insurance than whites. The raw difference was essentially zero. In contrast, Latinos are 6.7 percentage points less likely to gain insurance than whites, and immigrants are 10.6 percentage points less likely than natives to gain insurance. Similar to the models for health insurance loss, having a lower level of education puts individuals at a disadvantage in terms of health insurance gain. Those without a high school diploma are 18.7 percentage points less likely to gain health insurance than those with a college degree. High school graduates have an 11.8 percentage point lower probability of gaining insurance than college graduates.

The variables denoting economic status show, not surprisingly, that those who own homes, have higher family incomes, and earn larger hourly wages are more likely to gain insurance. Contrary to the health insurance loss models, however, being unemployed is not the state with the highest risk of remaining uninsured. Being uninsured in a full-year part-time job, relative to a full-year full-time job, is associated with

the lowest probability of becoming insured—a 9.2 percentage point decline in the probability of insurance in year t+1. Being unemployed is also a strong risk factor for continued uninsurance, particularly if one is unemployed for the full year.

Finally, employer size variables are large and significant in the health insurance gain models. Working at a very small firm of nine or fewer employees is associated with a 12.4 percentage point lower probability of health insurance gain among the uninsured. Employment with a firm of 10–24 employees is associated with an almost 8 percentage point lower probability of becoming insured. These results strongly suggest that coming from a small firm is a serious disadvantage in gaining insurance among the uninsured.

Many of the factors associated with increased risk of health insurance loss are also associated with a decreased risk of gaining health insurance, such as being a high school dropout, Latino, immigrant, or employee at a very small firm. However, other contributing characteristics are unique to the health insurance gain model. For example, African Americans are substantially more likely than whites to gain health insurance, and being unemployed full-year is associated with a low rate of health insurance gain. A simpler cross-sectional analysis of health insurance coverage would not have identified these differences in the dynamic patterns.

Employment Characteristics in Years t and t+1 and Insurance Transition

The estimates reported in Tables 3 and 4 highlight the characteristics that place individuals at highest risk for insurance loss and lowest probability for insurance gain. In this section, we expand those results and combine employment status and characteristics in both t and t+1 to examine how employment and health insurance relate in a dynamic model. Tables 5, 6, and 7 present tabulations of health insurance loss and gain by employment status and characteristics at both year t and year t+1. To place some structure on the presentation of these results we focus on a few changes instead of the numerous possible combinations of changes in job characteristics.

Table 5 reports matrices of health insurance loss and gain by employment status in year t and year t+1. The first matrix shows, for example, that continuing from no job in year t to no job in year t+1 is associated with a 9.3 percent loss in health insurance. Continued employment over year t and year t+1 (though perhaps not at the same job) is associated with a 6.6 percent loss in insurance. Mobility between the two states is associated with health insurance loss at much higher rates. For instance, movement from a job in year t to no job in year t+1 is associated with a 19.9 percent decline in health insurance. These results suggest that job loss is a key contributor to health insurance loss. Movement from no job in year t to a job in year t+1, however, is also associated with a large loss of health insurance at 16.0 percent. This may be the result of waiting periods associated with gaining health insurance or other characteristics of the jobs into which individuals are moving.

Interestingly, there is far less contrast in the health insurance gain model across the four cells. Movement from either a job or no job in year t to no job in year t+1 is associated with a 41 to 42 percent gain in insurance. Movement from either employment state into a job in year t+1 is associated with slightly higher rates of insurance gain, particularly if one is employed in both periods. But the difference among the four states is relatively small, compared to the differences seen in the health insurance loss matrix.

To explore this further, we present comparable transition matrices by employment characteristics among those who were employed in both year t and year t+1. Table 6 shows the transition matrix by employer size, and Table 7 shows it for employment status. The patterns in Table 6 point to the importance of employer size in both the health insurance loss and gain probabilities. Movement from any employer size into the smallest size (1–9 employees) is associated with the highest rates of

insurance loss and the lowest rates of insurance gain. Insurance loss rates decline and gain rates increase as employer size increases. The differences between the largest and smallest employer sizes is striking, and is consistent with the conclusion of the previous analyses that employer size is a key driver behind health insurance loss and gain.

The estimates reported in Table 7 are less consistent, but also underscore the conclusions drawn from previous analyses. In particular, unemployment in years t and t+1 appear to be strongly associated with health insurance loss, but less so with health insurance gain. Moving from part-year employment and part-year unemployment into any other state is associated with the highest rates of health insurance loss. And moving from any state into part-year employment and part-year unemployment is associated with comparably high rates of insurance loss. In contrast, movement into full-time, full-year work is associated with the lowest rates of insurance loss.

The transition matrix for health insurance gain is quite different, indicating that part-year employment in year t or year t+1 (with or without unemployment) is associated with the lowest rates of health insurance gain. Movement into full-time full-year employment is associated with the highest rates of gain.

Summary and Conclusions

Our analysis of transitions in health insurance coverage offers support for cross-sectional findings that certain groups are at highest risk for uninsurance. Demographic characteristics, such as being a minority or having less education, are important predictors of uninsurance and health insurance loss. When we model health insurance gain among those without insurance, we find that Latinos, immigrants, and less-educated individuals have low rates of gaining health insurance. Thus, for these groups, their low rates of insurance coverage stem from both the increased propensity to lose insurance when covered, and their decreased ability to obtain health insurance over the course of a two-year period. In contrast, our estimates indicate that African Americans have higher rates of gain than whites, all else equal. The relatively low rate of health insurance coverage among African Americans is entirely due to high rates of losing health insurance and not due to low rates of gaining insurance.

Cross-sectional findings also point to the importance of job characteristics, such as hours worked per week (part-time vs. full-time) and employer size in determining health insurance status. Again, our findings support the cross-sectional work, but offer greater detail about the determinants of health insurance dynamics. In particular, being unemployed in year t (either for the full year or part of the year) places one at a high risk for insurance loss, as does being employed part of the year without unemployment in the remaining months. Although unemployment status appears to be a key factor in health insurance loss, any part-time, part-year, or unemployed periods are associated with lower rates of health insurance gain. Among those who are uninsured, even working the full year in a part-time position leads to a 9.2 percentage point decline in health insurance gain, relative to full-year, full-time work. This might be due to part-time workers not being offered employer health insurance at the same rate as full-time workers, even in the same job. When they are already insured, they have lower rates of insurance loss than others who are less attached to the labor market. However, when these full-year part-time workers are uninsured, they are less likely to gain insurance.

Another important risk factor associated with both insurance gain and loss is employer size. Risk of health insurance loss decreases almost monotonically as employer size increases. Those in firms with fewer than 10 employees are at highest risk of loss; they are 3 percentage points more likely to lose insurance than those in large firms of 500 or more employees. More damaging, however, is that these employees are substantially less likely to gain insurance when

they are uninsured and employed at a very small firm. Working for a firm of fewer than 10 employees is associated with a reduced gain of insurance of 12.4 percentage points, compared to those working at very large firms.

These findings rely on models that control for demographic and employment characteristics in year *t* only. It is important to also examine how health insurance gains and losses are affected by year *t* and year *t*+1 work behavior. When we examine health insurance transitions in the context of employment transitions, we find that health insurance loss is highly related to changes in employment, but that health insurance gain is less related. Losing a job, which one would expect to be associated with health insurance loss, is associated with a 20 percentage point loss in health insurance. Health insurance gain is associated with having a job in year *t*+1, but not to the extent that one might expect. Those who move from a job in year *t* to no job in year *t*+1 have a 42 percent rate of health insurance gain. Moving from no job in year *t* to a job in year *t*+1 is associated with a 45 percent gain in insurance.

Various employment characteristics help to explain why certain employees are more or less likely to gain or lose insurance. Most strikingly, movement from any size firm into a very small firm of fewer than 10 employees is associated with the lowest rates of gain. Among the uninsured, those who stay employed by a very small firm in both periods have a rate of insurance gain of 32 percent. In contrast, movement to a very large firm is associated with insurance gain of 68 percent. The statistics on insurance loss and employer size are equally striking. Movement from any employer size into a small or very small employer is associated with higher than average rates of health insurance loss, and much higher rates than among those moving into employment with larger employers. These estimates are consistent with small firms being less likely to provide health insurance coverage or providing less attractive coverage (e.g., higher premiums and less choice) than large firms.

Less clear-cut findings result from the analysis of hours worked and part-year or full-year status. It appears that movement to and from part-year unemployment is associated with the highest rates of insurance loss. Movement to and from any part-year employment is associated with lower rates of insurance gain, and movement into full-time full-year work is associated with the highest rates of insurance gain.

Policy Implications

There are a number of implications in these findings for employer-mandated insurance and other policies aimed at increasing health insurance coverage among specific at-risk populations. First, our findings emphasize the critical role that employer size plays in health insurance acquisition and loss. Legislation such as SB 2 does not address health insurance coverage at very small employers, but our research shows that it is precisely these firms that are associated with the highest rates of insurance loss and the lowest rates of gain. Workers at firms with fewer than 10 employees represent 19 percent of the workforce in the 25 to 55 age group. Those working at very small employers have a 3 percentage point higher probability of losing insurance than workers in very large firms, but a 12 percentage point lower probability of gaining insurance. In other words, workers at these small firms are four times less likely to gain insurance than they were to lose insurance relative to workers in large firms. The low rates of insurance coverage and insurance gain for this group are partly, but not entirely, due to the correlation between employment in very small firms and self-employment. Nearly half of those who are employed in firms of fewer than 10 employees are self-employed, placing them at a high risk for uninsurance. Alternative policies that attempt to address coverage for this high-risk group need to be careful about the potential negative effects for small businesses on hiring workers, and the potential adverse selection of pooling insurance purchases across employers.

A second implication of our findings is that the transition from unemployment is a point of needed attention. As mentioned previously, COBRA is available to many workers during periods of unemployment. According to Madrian (1998), only 20 percent of unemployed

workers qualifying for COBRA elected to use the program. Some of those who opted not to use COBRA may have moved immediately into a new job situation with health benefits or had a spouse's benefits to cover them. Although not reported in the tables, our data indicate that among those who spend all or part of both survey years unemployed, roughly 20 percent lose insurance. It may be that these individuals have exhausted their COBRA benefits. Part- or full-year unemployment is significantly related to the probability of health insurance loss even after controlling for other factors. Being unemployed part-year, for instance, is associated with a 4 percentage point increase in the probability of insurance loss in the next year and a 7 percentage point decrease in the probability of health insurance gain. In other words, those who combine employment and involuntary unemployment during a year are two times less likely to gain insurance in the next year than they were to lose it initially. SB 2 and similar proposals do not address the issue of lack of insurance among the unemployed. Our research, however, indicates that the unemployed are one of the groups at highest risk of health insurance loss. Part-time workers are another group targeted by SB 2 and similar proposals. Our estimates indicate that part-time workers, when they work year-round and consistently over the two years examined, are at relatively low risk for health insurance loss. They have slightly more than a 2 percentage point probability of losing insurance relative to those who work full-time, but are 9 percentage points less likely to gain insurance in the following year.

Part-time workers are the worst-off group we examined in terms of loss-to-gain ratio, being four and a half times less likely to gain insurance than to lose it. Part-time workers are a group that might benefit from employer-mandated insurance policies, however, there is a risk that employment opportunities may decline for this group as a result.

Finally, our work emphasizes the importance of demographic characteristics in placing adults at risk for uninsurance. Disadvantaged minorities and less-educated workers are at high risk of health insurance loss, and generally low probability of gaining insurance. For instance, Latinos are 3 percentage points more likely to lose insurance, relative to whites, but 8 percentage points less likely to gain insurance. Immigrants are similarly 4 percentage points more likely to lose insurance than non-immigrants, but 11 percentage points less likely to gain it. High school dropouts are also disadvantaged, being more than two times less likely to gain insurance than to lose it relative to college graduates. Although policies such as SB 2 have not explicitly targeted these demographic groups, it is clear that any policies aimed at improving health insurance coverage should consider ways to offer coverage to the demographic groups in greatest need. This may be a difficult task, however, because estimates from our probit regressions indicate that demographic characteristics are associated with health insurance loss and gain even after controlling for detailed job characteristics.

Taken together, we find that both demographic characteristics and employment characteristics are important factors that determine who loses and gains insurance. Health insurance reforms that aim to create purchasing pools or reinsurance programs for small employers and the self-employed in order to reduce risk are likely to target key groups at risk of uninsurance (Custer 2004; Ideman 2004). However, to the extent that other factors, such as part-time employment and job turnover, continue to be critical factors in creating health insurance volatility, it is unclear whether these policies will improve health insurance coverage for other working adults who are also at risk.

In conclusion, the findings presented above indicate that health insurance coverage is alarmingly low for several demographic and employment groups. The provisions of California's SB 2, however, exempted or excluded some of the most at-risk groups. For some of these groups—especially small employers and part-time employees—it may be extremely difficult, however, to create alternative policies that do not have deleterious employment effects.

Endnotes

1. We remove the supplemental samples to the 2001 to 2004 ADES, which are generally not reinterviewed in the following March, before matching years.

2. For comparison, Appendix Table A.2 provides estimates of the probability of health insurance in a static model. The signs of the estimates are generally consistent with the signs of the estimates from the health insurance gain and loss regressions. An interesting exception is the African Americans coefficient—African Americans are more likely to gain health insurance than whites, but are less likely to have health insurance, all else equal.

3. Individuals who were not working were coded as having a log wage of zero.

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Table 1	Health Insurance Transition Rates for Selected Demographic Groups Current Population Survey, Matched Annual Demographic Surveys (1996–2004)					
	Health Insurance Coverage		Health Insurance Gain (Among Uninsured)		Health Insurance Loss (Among Uninsured)	
	Percent	N	Percent	N	Percent	N
Total	85.6	166,123	46.2	23,093	7.5	143,030
Men	84.7	79,111	43.4	11,684	7.4	67,427
Women	86.5	87,012	49.1	11,409	7.6	75,603
White	89.2	129,230	50.4	14,171	5.8	115,059
African American	80.5	14,826	49.2	2,824	11.7	12,002
Latino	66.9	13,552	33.3	4,450	16.3	9,102
Asian	81.5	6,178	50.0	1,055	10.5	5,123
High School Dropout	65.6	16,807	34.4	5,614	17.1	11,193
High School Graduate	83.2	54,538	46.2	9,014	9.1	45,524
Some College	88.0	46,066	52.1	5,417	6.7	40,649
College Graduate	93.6	48,712	59.5	3,048	4.0	45,664
East	87.3	36,928	50.0	4,463	7.1	32,465
Midwest	89.7	41,336	52.5	4,211	5.9	37,125
South	83.4	48,688	43.6	7,847	8.5	40,841
West	83.0	39,171	43.3	6,572	8.2	32,599

Notes: (1) The sample consists of individuals (ages 25–55) in the first year surveyed. (2) Health insurance is measured in the first survey year, and health insurance transitions are measured from the first to second survey years. (3) All estimates are calculated using sample weights provided by the CPS.

Table 2 Health Insurance Transition Rates for Selected Employment and Job Characteristics Current Population Survey, Matched Annual Demographic Surveys (1996–2004)

	Health Insurance Coverage		Health Insurance Gain (Among Uninsured)		Health Insurance Loss (Among Uninsured)	
	Percent	N	Percent	N	Percent	N
No Job–All	77.5	22,148	42.2	4,865	10.6	17,283
No Job–NILF	78.5	20,870	43.1	4,385	10.2	16,485
No Job–Unemployed	61.7	1,278	34.4	480	17.7	798
Has Job–All	86.9	143,975	47.2	18,228	7.1	125,747
Part-Year–No Unemployment	82.2	15,939	43.7	2,736	9.3	13,203
Part-Year–Unemployed	72.4	9,987	42.4	2,681	14.0	7,306
Full-Year–Part-Time	81.8	10,529	43.5	1,843	8.2	8,686
Full-Year–Full-Time	89.4	107,520	49.9	10,968	6.2	96,552
Employer Size: 1–9	73.8	28,993	39.4	7,299	10.7	21,694
Employer Size: 10–24	79.5	12,285	44.6	2,377	9.3	9,908
Employer Size: 25–99	85.6	18,111	47.7	2,430	8.4	15,681
Employer Size: 100–499	90.1	20,586	55.0	1,914	6.3	18,672
Employer Size: 500+	93.2	64,000	57.9	4,208	5.4	59,792
Private Employer	86.5	103,703	47.4	13,497	7.5	90,206
Government Employer	95.0	23,947	62.6	1,220	4.0	22,727
Self-Employed	77.8	16,325	41.7	3,511	9.3	12,814

Notes: (1) The sample consists of individuals (ages 25–55) in the first year surveyed. (2) Health insurance is measured in the first survey year, and health insurance transitions are measured from the first to second survey years. (3) All estimates are calculated using sample weights provided by the CPS.

Table 3	Probit Regressions for Probability of Health Insurance Loss Current Population Survey, Matched Annual Demographic Surveys (1996–2004)			
	Specification			
Explanatory Variables	(1)	(2)	(3)	(4)
Female	0.0006	–0.0065 **	–0.0086 **	–0.0055 **
	(0.0014)	(0.0015)	(0.0016)	(0.0016)
African American	0.0236 **	0.0183 **	0.0219 **	0.0258 **
	(0.0021)	(0.0021)	(0.0021)	(0.0021)
Latino	0.0332 **	0.0296 **	0.0320 **	0.0344 **
	(0.0025)	(0.0025)	(0.0025)	(0.0025)
Asian	0.0156 **	0.0144 **	0.0168 **	0.0175 **
	(0.0037)	(0.0037)	(0.0037)	(0.0037)
Immigrant	0.0424 **	0.0371 **	0.0361 **	0.0347 **
	(0.0024)	(0.0024)	(0.0024)	(0.0024)
High School Dropout	0.0821 **	0.0594 **	0.0521 **	0.0509 **
	(0.0024)	(0.0026)	(0.0026)	(0.0026)
High School Graduate	0.0530 **	0.0401 **	0.0338 **	0.0330 **
	(0.0018)	(0.0019)	(0.0020)	(0.0020)
Some College	0.0320 **	0.0237 **	0.0192 **	0.0185 **
	(0.0019)	(0.0019)	(0.0020)	(0.0020)
Age	–0.0069 **	–0.0052 **	–0.0045 **	–0.0047 **
	(0.0008)	(0.0008)	(0.0008)	(0.0008)
Age Squared /100	0.0072 **	0.0053 **	0.0046 **	0.0049 **
	(0.0010)	(0.0010)	(0.0010)	(0.0010)
Log Family Income	–0.0149 **	–0.0092 **	–0.0093 **	
		(0.0010)	(0.0011)	(0.0011)
Log Hourly Wage	–0.0084 **	–0.0189 **	–0.0165 **	
		(0.0008)	(0.0014)	(0.0014)
Home Owner	–0.0118 **	–0.0105 **	–0.0109 **	
		(0.0017)	(0.0017)	(0.0017)
Not in the Labor Force–Full Year			–0.0131 **	–0.0056
			(0.0043)	(0.0044)
Unemployed–Full Year			0.0101	0.0169 *
			(0.0077)	(0.0077)
Employed–Part Year			0.0283 **	0.0268 **
			(0.0023)	(0.0023)
Employed–Part Year and Unemployed–Part Year			0.0369 **	0.0367 **
			(0.0027)	(0.0027)

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Table 3 (cont.)	Probit Regressions for Probability of Health Insurance Loss Current Population Survey, Matched Annual Demographic Surveys (1996–2004)			
	Specification			
Explanatory Variables	(1)	(2)	(3)	(4)
Employed–Full Year, Part Time			0.0225 **	0.0165 **
			(0.0029)	(0.0029)
Multiple Jobs			0.0045 *	0.0048 *
			(0.0022)	(0.0022)
Government Job				-0.0156 **
				(0.0024)
Self-Employed				0.0141 **
				(0.0029)
Employer Size: 1–9				0.0298 **
				(0.0025)
Employer Size: 10–24				0.0196 **
				(0.0027)
Employer Size: 25–99				90.0156 **
				(0.0023)
Employer Size: 100–499				0.0023
				(0.0022)
Industry Controls	No	No	Yes	Yes
Mean of Dependent Variable	0.0720	0.0712	0.0712	0.0712
Log Likelihood Value	–35415	–33890	–33448	–33219
Sample Size	143,030	139,448	139,448	139,448

Notes: (1) The sample consists of individuals (ages 25–55) who have health insurance in the first year surveyed. (2) All independent variables are measured in the first year surveyed. (3) Marginal effects and their standard errors are reported. (4) All specifications include a constant and dummy variables for marital status, Native American, multiple race, disability, veteran status, Census divisions, central city status and year effects, and number of children and its square. (5) All estimates are calculated using sample weights provided by the CPS.

Table 4	Probit Regressions for Probability of Health Insurance Gain Current Population Survey, Matched Annual Demographic Surveys (1996–2004)			
	Specification			
Explanatory Variables	(1)	(2)	(3)	(4)
Female	0.0452 **	0.0668 **	0.0549 **	0.0452 **
	(0.0067)	(0.0071)	(0.0077)	(0.0077)
African American	0.0373 **	0.0524 **	0.0413 **	0.0249 *
	(0.0099)	(0.0102)	(0.0102)	(0.0102)
Latino	–0.0667 **	–0.0615 **	–0.0671 **	–0.0787 **
	(0.0113)	(0.0115)	(0.0115)	(0.0114)
Asian	0.0333	0.0397 *	0.0340	0.0287
	(0.0171)	(0.0175)	(0.0174)	(0.0173)
Immigrant	–0.1062 **	–0.0894 **	–0.0877 **	–0.0824 **
	(0.0106)	(0.0109)	(0.0108)	(0.0108)
High School Dropout	–0.1871 **	–0.1560 **	–0.1280 **	–0.1313 **
	(0.0116)	(0.0120)	(0.0123)	(0.0123)
High School Graduate	–0.1177 **	–0.0971 **	–0.0745 **	–0.0771 **
	(0.0104)	(0.0108)	(0.0110)	(0.0109)
Some College	–0.0631 **	–0.0553 **	–0.0377 **	–0.0392 **
	(0.0112)	(0.0115)	(0.0116)	(0.0115)
Age	–0.0111 **	–0.0123 **	–0.0123 **	–0.0107 **
	(0.0037)	(0.0038)	(0.0038)	(0.0037)
Age Squared /100	0.0144 **	0.0155 **	0.0153 **	0.0140 **
	(0.0047)	(0.0048)	(0.0048)	(0.0047)
Log Family Income		0.0161 **	0.0064	0.0053
		(0.0037)	(0.0037)	(0.0037)
Log Hourly Wage		0.0278 **	0.0505 **	0.0499 **
		(0.0036)	(0.0063)	(0.0063)
Home Owner		0.0512 **	0.0484 **	0.0487 **
		(0.0073)	(0.0073)	(0.0073)
Not in the Labor Force–Full Year			–0.0227	–0.0712 **
			(0.0189)	(0.0201)
Unemployed–Full Year			–0.0884 **	–0.1357 **
			(0.0279)	(0.0286)
Employed–Part Year			–0.0710 **	–0.0763 **
			(0.0111)	(0.0111)
Employed–Part Year and Unemployed–Part Year			–0.0664 **	–0.0819 **
			(0.0112)	(0.0112)
Employed–Full Year, Part Time			–0.0922 **	–0.0896 **
			(0.0131)	(0.0131)

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Table 4 (cont.)	Probit Regressions for Probability of Health Insurance Gain Current Population Survey, Matched Annual Demographic Surveys (1996–2004)			
	Specification			
Explanatory Variables	(1)	(2)	(3)	(4)
Multiple Jobs			0.0231	0.0122 *
			(0.0104)	(0.0104)
Government Job				0.0049
				(0.0169)
Self-Employed				–0.0481 **
				(0.0118)
Employer Size: 1–9				–0.1235 **
				(0.0115)
Employer Size: 10–24				–0.0776 **
				(0.0128)
Employer Size: 25–99				–0.0653 **
				(0.0126)
Employer Size: 100–499				–0.0079
				(0.0135)
Industry Controls	No	No	Yes	Yes
Mean of Dependent Variable	0.4614	0.4655	0.4655	0.4655
Log Likelihood Value	–15135	–14202	–14037	–13913
Sample Size	23,093	21,823	21,823	21,823

Notes: (1) The sample consists of individuals (ages 25–55) who do not have health insurance in the first year surveyed. (2) All independent variables are measured in the first year surveyed. (3) Marginal effects and their standard errors are reported. (4) All specifications include a constant and dummy variables for marital status, Native American, multiple race, disability, veteran status, Census divisions, central city status and year effects, and number of children and its square. (5) All estimates are calculated using sample weights provided by the CPS.

Table 5	Health Insurance Transitions by Changes in Job Status Current Population Survey, Matched Annual Demographic Surveys (1996–2004)			
	Health Insurance Loss		Health Insurance Gain	
	No Job in t+1	Job in t+1	No Job in t+1	Job in t+1
No Job in t	9.28	15.99	40.96	44.95
Job in t	19.91	6.57	42.33	47.68

Notes: (1) The sample consists of individuals (ages 25–55) in the first year surveyed. (2) All estimates are calculated using sample weights provided by the CPS.

Table 6 Health Insurance Transition by Changes in Employer Size
Current Population Survey, Matched Annual Demographic Surveys (1996–2004)

Health Insurance Loss

	1–9 Employees in *t*+1	10–24 Employees in *t*+1	25–99 Employees in *t*+1	100–499 Employees in *t*+1	500+ Employees in *t*+1
1–9 Employees in *t*	10.25%	12.04%	10.66%	10.90%	9.26%
10–24 Employees in *t*	13.57%	6.91%	7.36%	10.99%	8.35%
25–99 Employees in *t*	21.00%	12.40%	5.26%	5.65%	6.82%
100–499 Employees in *t*	19.72%	14.29%	7.48%	3.40%	4.57%
500 + Employees in *t*	19.93%	16.66%	10.08%	6.24%	3.02%

Health Insurance Gain

	1–9 Employees in *t*+1	10–24 Employees in *t*+1	25–99 Employees in *t*+1	100–499 Employees in *t*+1	500+ Employees in *t*+1
1–9 Employees in *t*	31.64%	38.90%	52.55%	58.94%	67.74%
10–24 Employees in *t*	38.32%	36.94%	43.79%	60.31%	61.51%
25–99 Employees in *t*	34.19%	44.55%	43.85%	52.91%	62.83%
100–499 Employees in *t*	42.15%	49.57%	52.19%	57.25%	63.85%
500 + Employees in *t*	40.92%	45.11%	59.75%	63.38%	62.97%

Notes: (1) The sample consists of individuals (ages 25–54) in the first year surveyed. (2) All estimates are calculated using sample weights provided by the CPS.

Table 7 Health Insurance Transition by Changes in Employment Characteristics
Current Population Survey, Matched Annual Demographic Surveys (1996–2004)

Health Insurance Loss

	Part Year No Unemployment in *t*+1	Part Year Unemployment in *t*+1	Full Year Part Time in *t*+1	Full Year Full Time in *t*+1
Part Year, No Unemployment in *t*	7.07%	11.48%	8.40%	8.40%
Part Year, Unemployment in *t*	14.32%	15.31%	16.34%	10.90%
Full Year, Part Time in *t*	6.87%	16.61%	6.87%	9.18%
Full Year, Full Time in *t*	10.08%	15.46%	13.90%	5.05%

Health Insurance Gain

	Part Year No Unemployment in *t*+1	Part Year Unemployment in *t*+1	Full Year Part Time in *t*+1	Full Year Full Time in *t*+1
Part Year, No Unemployment in *t*	35.73%	33.02%	42.73%	51.16%
Part Year, Unemployment in *t*	38.22%	32.66%	38.05%	52.56%
Full Year, Part Time in *t*	45.53%	34.45%	39.94%	49.60%
Full Year, Full Time in *t*	46.27%	39.44%	42.07%	51.86%

Notes: (1) The sample consists of individuals (ages 25–55) in the first year surveyed. (2) All estimates are calculated using sample weights provided by the CPS.

Table A.1 Means of Analysis Variables Used in Probit Regressions Current Population Survey, Matched Annual Demographic Surveys (1996–2004)

Explanatory Variables

	Insurance Coverage	Insurance Loss	Insurance Gain
Female	0.5150	0.5202	0.4940
African American	0.1113	0.1046	0.1223
Latino	0.0984	0.0770	0.1927
Asian	0.0395	0.0376	0.0457
Immigrant	0.1266	0.1035	0.2293
High School Dropout	0.1105	0.0847	0.2431
High School Graduate	0.3249	0.3158	0.3903
Some College	0.2736	0.2814	0.2346
Age	40.5486	40.8676	38.9358
Log Family Income	10.8208	10.9385	10.1265
Log Hourly Wage	2.3523	2.4413	1.8190
Home Owner	0.7793	0.8068	0.6353
Not in the Labor Force–Full year	0.1284	0.1177	0.1899
Unemployed–Full Year	0.0081	0.0059	0.0208
Employed–Part Year	0.0931	0.0895	0.1185
Employed–Part Year and Unemployed–Part Year	0.0609	0.0515	0.1161
Employed–Full Year, Part Time	0.0606	0.0580	0.0798
Multiple Jobs	0.1063	0.1031	0.1298
Government Job	0.1389	0.1541	0.0528
Self-Employed	0.0933	0.0847	0.1520
Employer Size: 1–9	0.1675	0.1445	0.3161
Employer Size: 10–24	0.0733	0.0681	0.1029
Employer Size: 25–99	0.1073	0.1073	0.1052
Employer Size: 100–499	0.1228	0.1293	0.0829
Sample Size	166,123	143,030	23,093

Notes: (1) The sample consists of individuals (ages 25–55). (2) All independent variables are measured in the first year surveyed. (3) All estimates are calculated using sample weights provided by the CPS.

Table A.2	Probit Regressions for Probability of Health Insurance Coverage Current Population Survey, Matched Annual Demographic Surveys (1996–2004)			
	Specification			
Explanatory Variables	(1)	(2)	(3)	(4)
Female	0.0165 **	0.0359 **	0.0362 **	0.0272 **
	(0.0016)	(0.0017)	(0.0018)	(0.0018)
African American	–0.0234 **	–0.0074 **	–0.0152 **	–0.0269 **
	(0.0025)	(0.0025)	(0.0025)	(0.0025)
Latino	–0.0518 **	–0.0392 **	–0.0433 **	0.0492 **
	(0.0029)	(0.0028)	(0.0028)	(0.0028)
Asian	–0.0082	–0.0050	–0.0110 **	–0.0143 **
	(0.0044)	(0.0043)	(0.0042)	(0.0042)
Immigrant	–0.0935 **	–0.0748 **	–0.0719 **	–0.0666 **
	(0.0028)	(0.0027)	(0.0027)	(0.0026)
High School Dropout	–0.1739 **	–0.1034 **	–0.0830 **	–0.0800 **
	(0.0028)	(0.0029)	(0.0029)	(0.0029)
High School Graduate	–0.1071**	–0.0641 **	–0.0482 **	–0.0467 **
	(0.0023)	(0.0023)	(0.0023)	(0.0023)
Some College	–0.0654 **	–0.0390 **	–0.0274 **	–0.0262 **
	(0.0024)	(0.0024)	(0.0024)	(0.0024)
Age	0.0093 **	0.0049 **	0.0037 **	0.0046 **
	(0.0009)	(0.0009)	(0.0009)	(0.0009)
Age Squared /100	–0.0086 **	–0.0041 **	–0.0030 **	–0.0038 **
	(0.0012)	(0.0012)	(0.0011)	(0.0011)
Log Family Income		0.0523 **	0.0405 **	0.0391 **
		(0.0011)	(0.0011)	(0.0011)
Log Hourly Wage		0.0231 **	0.0455 **	0.0370 **
		(0.0009)	(0.0016)	(0.0016)
Home Owner		0.0161 **	0.0129 **	0.0132 **
		(0.0019)	(0.0019)	(0.0018)
Not in the Labor Force–Full Year			0.0101 *	–0.0301 **
			(0.0049)	(0.0050)
Unemployed–Full Year			–0.0279 **	–0.0659 **
			(0.0079)	(0.0079)
Employed–Part Year			–0.0499 **	–0.0451 **
			(0.0027)	(0.0027)
Employed–Part Year and Unemployed–Part Year			–0.0647 **	–0.0659 **
			(0.0029)	(0.0029)

continued on next page

Table A.2 (cont.)	Probit Regressions for Probability of Health Insurance Coverage Current Population Survey, Matched Annual Demographic Surveys (1996–2004)			
	Specification			
Explanatory Variables	(1)	(2)	(3)	(4)
Employed–Full Year, Part Time			–0.0617 **	–0.0464 **
			(0.0032)	(0.0032)
Multiple Jobs			–0.0068 **	–0.0097 **
			(0.0025)	(0.0025)
Government Job				0.0161 **
				(0.0031)
Self-Employed				–0.0256 **
				(0.0030)
Employer Size: 1–9				–0.1040 **
				(0.0027)
Employer Size: 10–24				–0.0773 **
				(0.0030)
Employer Size: 25–99				–0.0437 **
				(0.0027)
Employer Size: 100–499				–0.0199 **
				(0.0028)
Industry Controls	No	No	Yes	Yes
Mean of Dependent Variable	0.8610	0.8647	0.8647	0.8647
Log Likelihood Value	–59680	–54046	–52363	–50874
Sample Size	166,123	161,271	161,271	161,271

Notes: (1) The sample consists of individuals (ages 25–55) who have health insurance in the first year surveyed. (2) All independent variables are measured in the first year surveyed. (3) Marginal effects and their standard errors are reported. (4) All specifications include a constant, dummy and variables for marital status, Native American, multiple race, disability, veteran status, Census divisions, central city status and year effects, and number of children and its square. (5) All estimates are calculated using sample weights provided by the CPS.

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Minnesota Department of **Human Services**

MSOP – GROWTH IN COMMITMENTS

Request - Net $26 million for 2006 - 07 Biennium

Funding is to address increased operational costs resulting from an increase in the number of referrals and commitments of individuals determined to be a Sexually Dangerous Person (SDP) or a Sexual Psychopathic Personality (SPP) to the Minnesota Sex Offender Program (MSOP).

Project Description

In order to accommodate the accelerated growth of approximately 58 per year in the MSOP, DHS will need to expand operations by 6 units during the 2006 – 2007 biennium. The 2005 Legislature has already funded 2 units for this biennium and this proposal requests additional funding for the remaining 4.

Need

While the MSOP currently has funding to operate at a growth rate of 23 per fiscal year, growth is projected to be 58.

Staffing

This proposal would add approximately 300 direct care, administrative & general support and clinical leadership FTEs to the program.

Space

This proposal utilizes space at the Minnesota Correctional Facility-Moose Lake and assumes adoption of the Governor's 2006 Capital budget for building a 400-bed modified "K" structure by FY 2009.

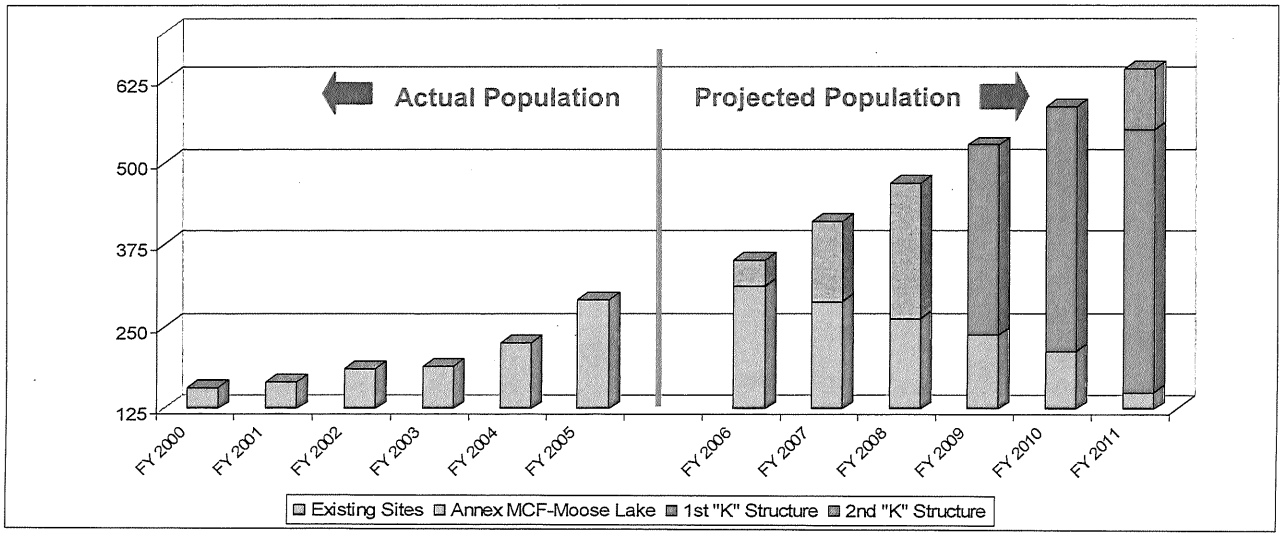
Security

This proposal ensures that the MSOP meets the same security standards as used by the Minnesota Department of Corrections (DOC). Security is enhanced by:

- Upgrading perimeter fencing with 24x7 supervision.
- Adding electronic monitoring and ankle bracelets.
- Adding additional razor-wire fencing.
- Installing security cameras on the grounds.
- Staffing access gates to the St. Peter facility.

Smart

- Utilizes the security expertise within the DOC and treatment expertise of the DHS.
- Creates a $7.5 million **savings** in operations beginning in FY 2009 upon opening of modified "K" building.
- Maximizes program effectiveness and responsiveness to treatment by subdividing the SPP/SDP population by clinical characteristic and participation in traditional sex offender treatment.
- Ensures the safety of staff, clients, and the public.
- Gradually transitions treatment of civilly committed sex offenders to one site in the state.
- Allows DOC to utilize 2nd modified "K" structure if MSOP growth subsides.



March 15, 2006

Minnesota Department of **Human Services**

MINNESOTA DEPARTMENT OF CORRECTIONS

MODIFICATIONS & USE OF MOOSE LAKE DOC SPACE

Request - $9.9 million in 2006 - 07 Biennium

$2.31 million is for one-time funding to renovate buildings 8 and 10 at the Minnesota Correctional Facility-Moose Lake for use by the Minnesota Sex Offender Program (MSOP) operated by the Minnesota Department of Human Services (DHS). The cost of utilizing this space is $1.71 million in fiscal year 2006.

Project Description

In order to accommodate the accelerated growth in the MSOP, the DHS has partnered with the Minnesota Department of Corrections (DOC) to utilize space at the Moose Lake DOC site until the scheduled opening of the new modified "K" structure. This building is designed similar to the one used at the MCF-Lino Lakes and will be used at the MCF-Faribault.

The DOC will temporarily relocate inmates in order to meet DHS' immediate space needs. Under this proposal, the DHS will prepare the space and reimburse the DOC for costs over their current budget that are associated with the alternative lease location and for the costs of housing and security provided to MSOP clients while at the Moose Lake DOC site.

Need

The MSOP program will be at capacity by June 2006. At that time all available MSOP secure space on the St. Peter and Moose Lake sites will be in use to house clients committed by the court system as a Sexually Dangerous Person or a Sexual Psychopathic Personality.

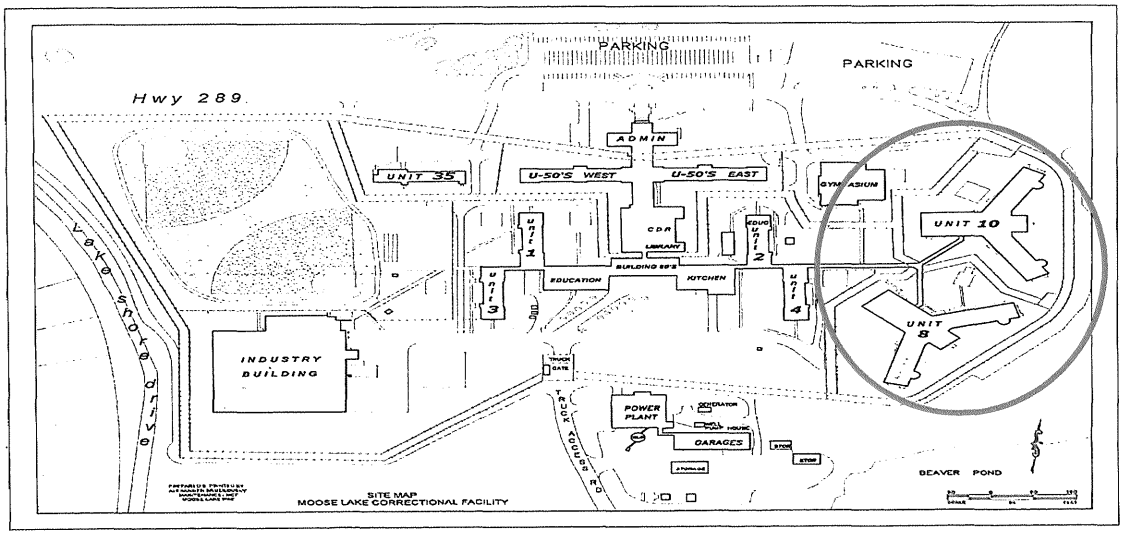
Space

Additional space is urgently needed to meet the statutory obligations required under M.S. §253B.185.

Use of the DOC space will yield a total of 250 secure beds for the MSOP.

Objectives

- Continues to expand upon a partnership between the DHS and DOC.
- Utilizes the security expertise within the DOC and treatment expertise of the DHS.
- Employs the most cost effective space available across DHS and DOC.
- Ensures the safety of staff, clients, and the public.
- Provides secure housing for dangerous offenders.



March 15, 2006

Minnesota Department of **Human Services**

MSH – GROWTH IN COMMITMENTS

Request – Net $34 million for 2006-07 Biennium

Funding is to address increased operational costs resulting from an increase in the number commitments of individuals determined to be Mentally Ill and Dangerous (MI&D) to the Minnesota Security Hospital (MSH).

Project Description

DHS will need to expand operations by 2 - **secure** units and 2 – **transition** units during the 2006 – 2007 biennium to accommodate the unanticipated growth of approximately 25 per year in the MSH.

DHS opened 1 – **secure adolescent** unit specializing in serving clients (up to age 21) committed as MI&D, who cannot be served in the secure adult program due to differences in age, vulnerabilities, needs, and licensing.

S has seen an increased utilization of the **Forensics Nursing Home** (FNH) which serves clients who have been committed to DHS as MI&D, Sex Offenders, or are on medical release from the Minnesota Department of Corrections. DHS presently has funding for 1 unit and requires funding for 1 additional unit for this population.

Space

This proposal assumes adoption of the 2006 operational budget proposal for the Minnesota Sex Offender Program (MSOP) where space for the MSH is made available as the MSOP gradually vacates the St. Peter site.

Need

In 2005, MSH secure units were funded to sustain a growth of approximately 7 per fiscal year. Current projected growth has accelerated to 25 per fiscal year in the **secure** beds.

Client progression into the **transition** units and a decreased movement out of the transition units are driving the need to expand transition capacity, which is currently running a waiting list of 22 clients.

Four **adolescent clients** have been committed to DHS as MI&D and due to their age, vulnerabilities, needs, and licensing cannot be served in the adult program.

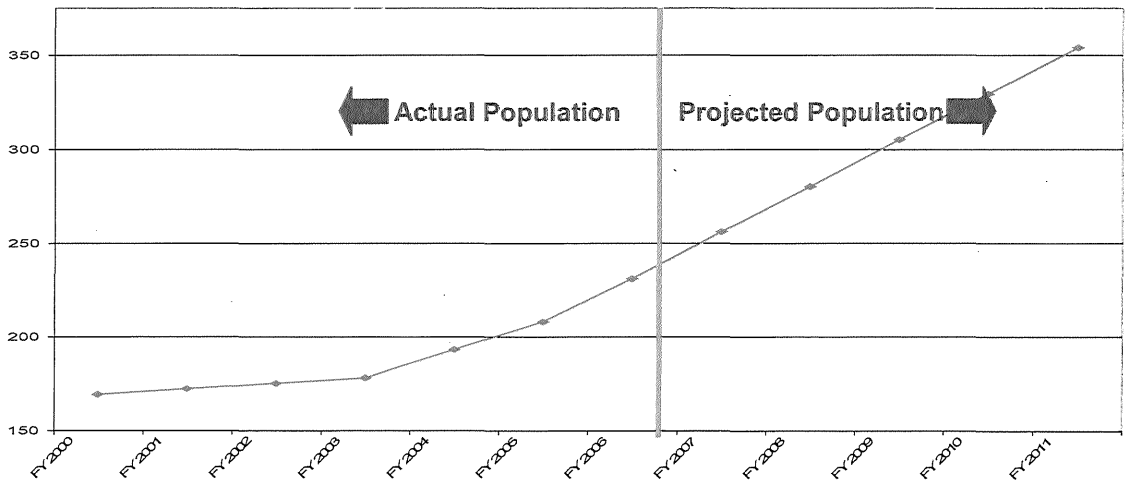
The **FNH** presently has funded capacity for 20; however, it is presently serving 30 forensics clients who need nursing home level of care.

Staffing

This proposal would add approximately 477 direct care, administrative & general support and clinical leadership FTEs to the program for the biennium.

Smart

- No capital investment is necessary for secure residential space at the St. Peter site.
- Gradually transitions the St. Peter site to specialize in treatment of MI&D only.
- Creates an enhanced level of treatment to ensure the safe transition of MI&D clients into lower levels of custody.



March 15, 2006

Minnesota Department of **Human Services**

METO – STRATEGY TO MITIGATE GROWTH

Request - $5.3 million for 2006-07 Biennium

Funding is to provide support and crisis services to people in the community who are at risk of commitment to the Minnesota Extended Treatment Options (METO), in an effort to reduce growth in the number of referrals and commitment to METO.

Project Description

This proposal funds additional staffing necessary to mitigate growth being experienced in the METO program since June 2005.

Need

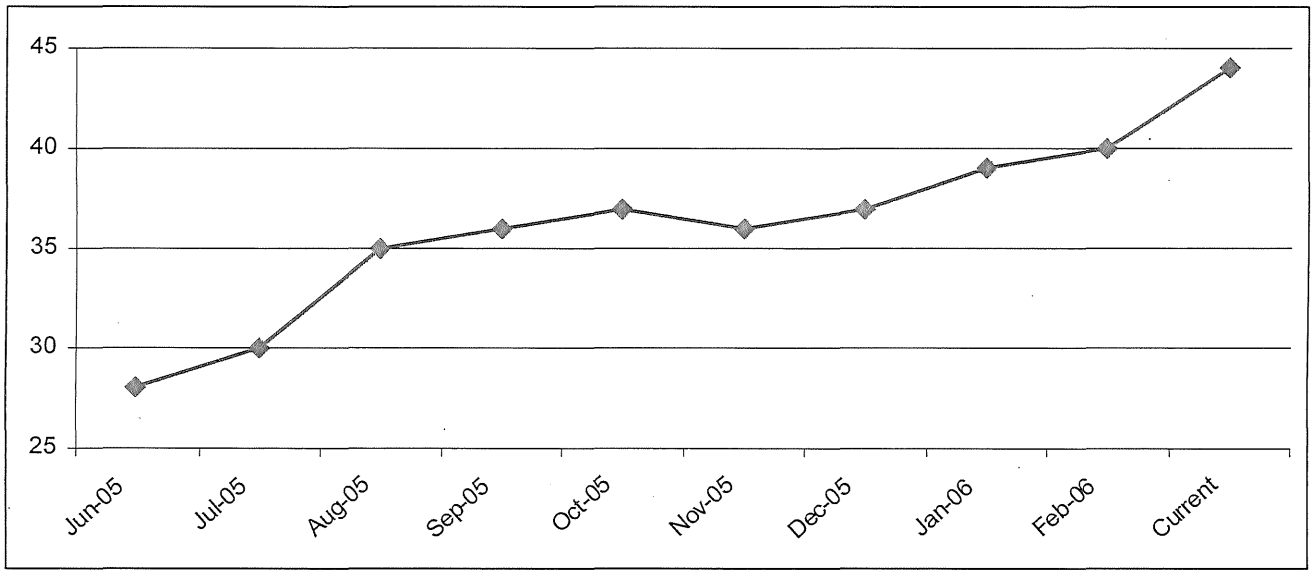
METO is a 48-bed program located in Cambridge that provides treatment services to clients with mental retardation who are committed by the court system because they present a risk to public safety. Since June 2005, growth has been seen within METO and current census is at 44.

Staffing

This proposal would add approximately 52 FTEs to the program for the biennium. These staff would provide community support and crisis services to clients with mental retardation who are at risk of commitment to the METO program and will assist with discharge planning and transition for those who are committed.

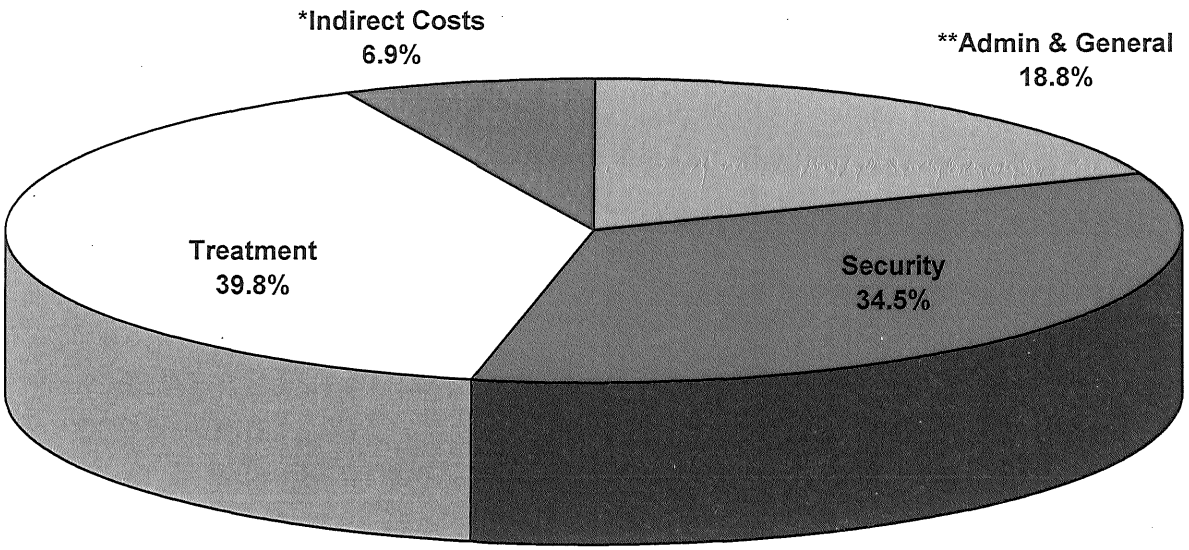
Smart

- Employs a cost effective alternative to increasing the operational capacity of METO, which also requires additional capital investments.
- Allows clients to stay in a least-restrictive community setting whenever appropriate.
- Honors the de-institutionalization movement.
- Ensures the safety of staff, clients, and the public.

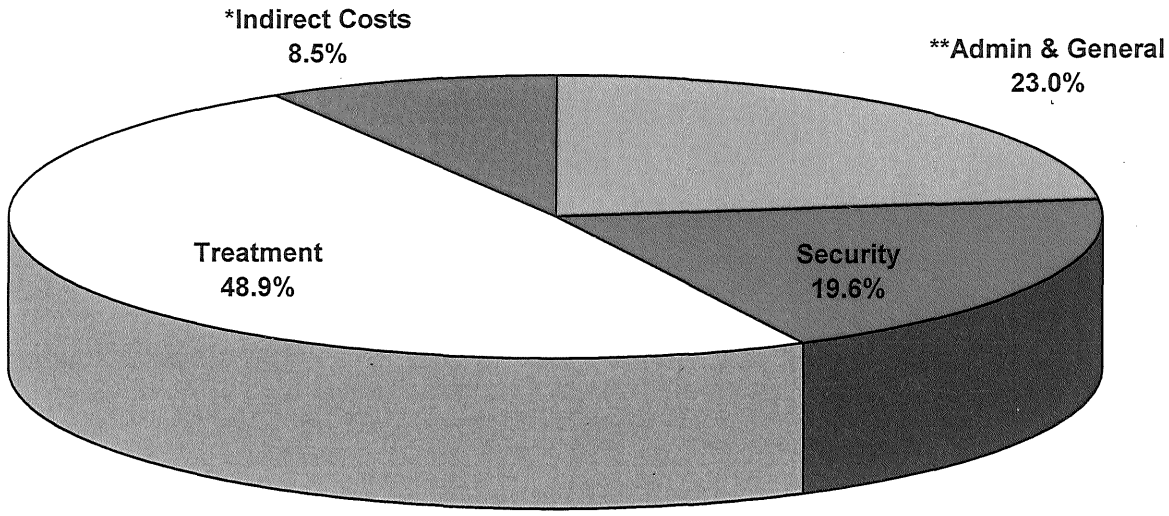


March 15, 2006

DHS - State Operated Services Breakdown of MSOP Per Diem



DHS - State Operated Services Projected Breakdown of MSOP Per Diem using "K" Model



Notes:

*Indirect costs include statewide & department overheads, bond debt service, and depreciation.
**Administrative & general costs include program administration, support services (food, housekeeping, maintenance, etc.), and other direct services (food, supplies, mileage, utilities, etc.).

The DHS per diem rate is calculated using the specifications outline by M.S.§246.50, Subd. 5. The per diem rate is the rate DHS bills for the services it provides. It includes both direct and indirect appropriated costs.

The FY 2006 MSOP Per Diem Rate is $281.00 per client per day. Estimated savings by utilizing "K" structure is approximately $52 per day per client.

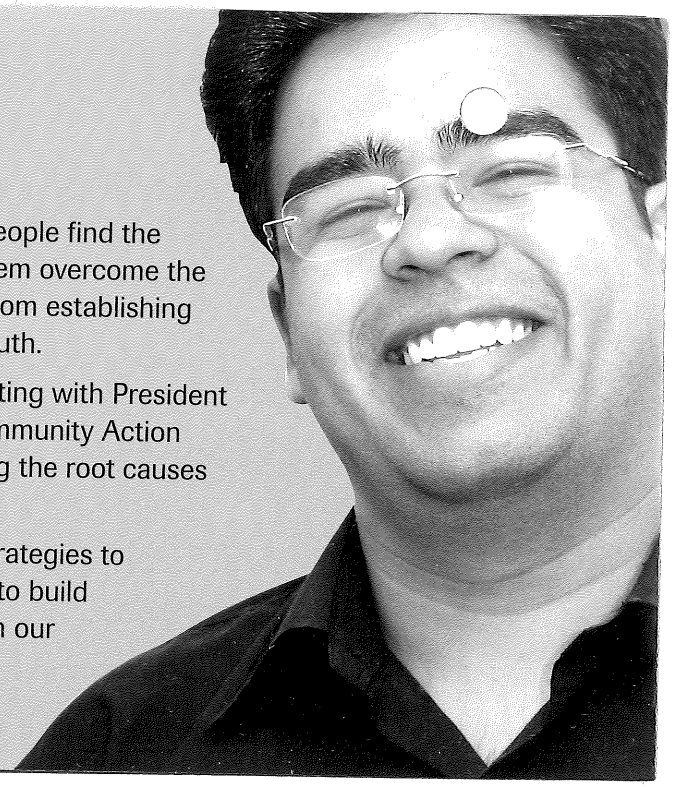

Community
Action Duluth
It's possible
Engaging our community to end poverty.

It's possible

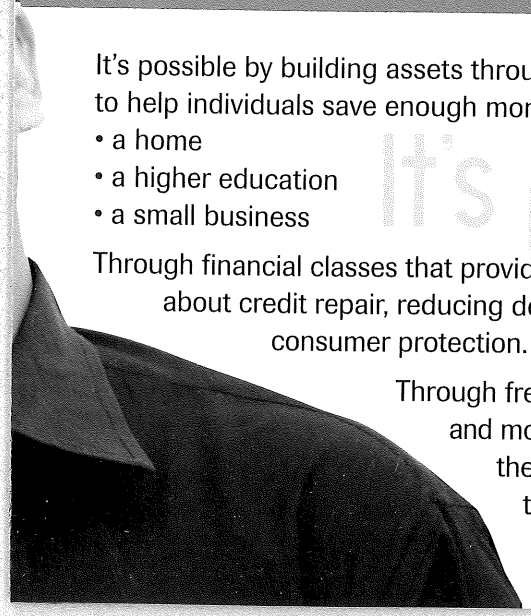
by building community partnerships where low-income people find the support, resources and relationships they need to help them overcome the economic, racial and cultural barriers that prevent them from establishing and maintaining self-sufficient and connected lives in Duluth.

Community Action Agencies have a forty year history starting with President Lyndon Johnson's "War on Poverty." Today, over 1,000 Community Action Agencies fulfill Presidents Johnson's charge of "addressing the root causes and effects of poverty."

Community Action Duluth's mission is to use innovative strategies to mobilize low-income people, and the broader community, to build assets that prevent poverty, create equality and strengthen our social fabric.



"I'm a single mother and wanted desperately to own my own home.
I was watching the evening news and [illegible]ard a story about the kickoff of the matched savings progr
Now I own my own home and my payments are less than I used to pay for rent! And, I opened a licensed f



It's possible by building assets through matched saving plans designed to help individuals save enough money to acquire an asset like:

- a home
- a higher education
- a small business

It's possible

Through financial classes that provide support, coaching and information about credit repair, reducing debt, saving for the future and consumer protection.

Through free tax preparation sites where low- and moderate-income people can get their taxes prepared without having to pay the high fees charged by many commercial preparers.

...m. I was so excited. I ended up being one of the first peop... to apply.
...mily childcare business in my home."

It's possible because Circles of Support provide a place for people to come together to:

- build meaningful, reciprocal relationships that cut across class and race lines.
- understand the many issues surrounding poverty and the barriers low-income people face daily.
- do something about poverty by being an important part of a support system that can help a person in poverty move toward permanent self sufficiency.

circlesofsupport

It's possible

It's possible through Family Employment Advocacy for participants to achieve their dreams and realize their potential by increasing their money, meaning and friendship.

"I have been a part of Community Action Duluth for over four years.
It was a life-changing experience in my way of thinking, as well as the beginning
of my path out of poverty. I represent the third generation of poverty in my family.
I am a recovering battered wife and have, through the experience of this support system,
gained skills and the empowerment to feel that I will make a difference
in the Duluth community for the betterment of our people and families."

"Living in poverty has stunted us from growth.
Circles of Support has given us hope. It has placed
three wonderful and willing people in our lives.
The relationships we have are like no other. We appreciate
the security, laughter and all the support.
It feels good to be accepted and not judged for
who we are and where we come from."

Community Action Duluth

Your help is always welcome. We're looking for people with all levels of resources, who are passionate about ending poverty, to help us in any way they can. Call us anytime to discuss your interest in volunteering.

Engaging our community to end poverty

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