Protecting, maintaining and improving the health of all Minnesotans

March 8, 2005

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

Dear Senator Linda Berglin:

This letter is in response to requests for additional information regarding the Minnesota Department of Health's (MDH) budget overview provided to the Finance Committee, Health and Human Services Budget Division on February 3, 2005.

1. How much has the lab certification fee increased?

Please see the attached table entitled "Environmental Laboratory Certification Program."

2. What is the procedure for submitting a new construction-plumbing plan to MDH for review and why do we expedite reviews for a fee?

The Governor's budget includes a program appropriation increase of $250,000 to pay for additional staff to provide plan review service, so that MDH can meet demand for both standard and accelerated review in a 1 to 3 week timeframe. If staff levels are adequate to meet demand during most times of the year, a party would generally not have to pay a double fee for delivery of review within 3 weeks, and that option would only be selected by those parties wanting to "guarantee" service. Failure by MDH to deliver an accelerated review within 15 business days results in a refund of half the fee to the submitter.

3. What is the license fee for well contractors and does it recover costs?

The current annual license fee for a full Well Contractor's license is $250, and the annual license fee for a Limited Well Contractor's License (can do limited types of well contracting work, such as installing pumps) is $75. These fee amounts currently cover licensing costs, and are not being proposed for an increase at this time. The installation of a contamination source closer than the isolation distances established in Minnesota Rules, Chapter 4725 is a violation of those rules, and MDH requires correction of such violations.

5. Provide an explanation for each fee proposal where expenditures and revenues in the change request do not match.

Please see attached Table: MDH Fee Proposal Detail

6. A request was made for a breakdown of FTE changes for GF and SGSR fund.

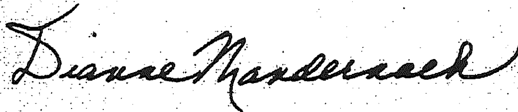
The Governor's Budget reduces GF FTEs by 6.7 (from 181.7 to 175 FTEs) and increases the SGSR Fund FTEs by 20.9 (from 238.1 to 259 FTEs).

7. For the OCAP program, of the closed investigations, how many had been referred to other agencies?

Since opening the office July 1, 2001 we have received 63 complaints. We have closed 28 of these complaints. Of these 28 complaints, 8 have been referred to other agencies (2 to the MN Board of Chiropractic, 2 to the MN Board of Medical Practice, 1 to the MN Board of Social Work, 1 to the MN Board of Pharmacy, 1 to the Food and Drug Administration, and 1 to the Federal Trade Commission).

If you have further questions, or if I can provide you with additional information, please feel free to call.

Sincerely,



Commissioner Diane Mandernach
MN Department of Health

CC:

Yvonne Prettner Solon
Brian LeClair
Leo T. Foley
Linda Higgins
Paul E. Koering
Becky Lourey
Julie Rosen
Lou Larson Tofte
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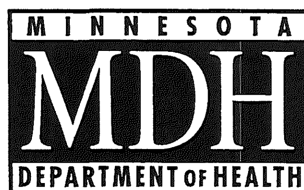

Environmental Laboratory Certification Program
Impact of 2005 Proposed Fee Increase (by lab type)

Lab type	Current fee[1]	Proposed fee[2]	% increase
municipal water supply	$1800	$2400	33%
municipal wastewater treatment plant	$2400	$3200	33%
small contract lab	$2400	$3200	33%
large contract lab (in-state)	$10,000	$14,100	41%
contract lab (out of state)	$12,500	$17,850	43%

[1] Calculations based on a typical scope of certification for each laboratory type. Fees of actual labs can vary significantly.
[2] Assumes: no change in scope of certification; ten sample preparation techniques.

Additional Information:

1. Environmental Certification fees are assessed on a biennial basis.

2. Fees paid vary depending on the number of test categories for which the laboratories request certification.

3. All laboratories pay the same base fee, plus additional fees for each of the test categories for which they request certification.

4. MDH proposes to expand the number of test categories to include additional certification categories for emerging contaminants, such as methamphetamine.

5. MDH, in collaboration with the Minnesota Department of Agriculture, proposes to add test categories so laboratories can be certified to analyze pesticide samples.

MDH Fee Proposal Detail

	FY 2006			FY 2007			FY 2008			FY 2009		
	Current Law	Governor's Rec	Change Item	Current Law	Governor's Rec	Change Item	Current Law	Governor's Rec	Change Item	Current Law	Governor's Rec	Change Item
Drinking Water Protection Fee												
Accumulated Balance	2,111	2,111		1,487	1,106		858	1,275		229	509	
Revenue	6,278	6,278	0	6,273	7,706	1,433	6,273	7,706	1,433	6,273	7,706	1,433
Expenditures	6,902	7,283	381	6,902	7,537	635	6,902	8,472	1,570	6,902	8,472	1,570
Annual Difference	(624)	(1,005)	(381)	(629)	169	798	(629)	(766)	(137)	(629)	(766)	(137)
Accumulated Difference	1,487	1,106		858	1,275		229	509		(400)	(257)	

	FY 2006			FY 2007			FY 2008			FY 2009		
	Current Law	Governor's Rec	Change Item	Current Law	Governor's Rec	Change Item	Current Law	Governor's Rec	Change Item	Current Law	Governor's Rec	Change Item
Food Manager's Certification Fee												
Accumulated Balance	(15)	(15)		(36)	(7)		(44)	14		(52)	35	
Revenue	116	207	91	129	220	91	129	220	91	129	220	91
Expenditures	137	199	62	137	199	62	137	199	62	137	199	62
Annual Difference	(21)	8	29	(8)	21	29	(8)	21	29	(8)	21	29
Accumulated Difference	(36)	(7)		(44)	14		(52)	35		(60)	56	

	FY 2006			FY 2007			FY 2008			FY 2009		
	Current Law	Governor's Rec	Change Item	Current Law	Governor's Rec	Change Item	Current Law	Governor's Rec	Change Item	Current Law	Governor's Rec	Change Item
Food, Beverage and Lodging Program Fee												
Accumulated Balance	283	283		527	301		771	319		1,015	337	
Revenue	2,779	4,105	1,326	2,779	4,105	1,326	2,779	4,105	1,326	2,779	4,105	1,326
Expenditures	2,535	4,087	1,552	2,535	4,087	1,552	2,535	4,087	1,552	2,535	4,087	1,552
Annual Difference	244	18	(226)	244	18	(226)	244	18	(226)	244	18	(226)
Accumulated Difference	527	301		771	319		1,015	337		1,259	355	

	FY 2006			FY 2007			FY 2008			FY 2009		
	Current Law	Governor's Rec	Change Item	Current Law	Governor's Rec	Change Item	Current Law	Governor's Rec	Change Item	Current Law	Governor's Rec	Change Item
Lab Certification Program												
Accumulated Balance	19	19		(3)	(29)		(25)	(22)		(47)	(90)	
Revenue	350	510	160	350	565	215	350	490	140	350	581	231
Expenditures	372	558	186	372	558	186	372	558	186	372	558	186
Annual Difference	(22)	(48)	(26)	(22)	7	29	(22)	(68)	(46)	(22)	23	45
Accumulated Difference	(3)	(29)		(25)	(22)		(47)	(90)		(69)	(67)	
Plumbing Program												
Accumulated Balance	296	296		558	303		820	310		1,082	317	
Revenue	1,843	1,838	(5)	1,843	1,838	(5)	1,843	1,838	(5)	1,843	1,838	(5)
Expenditures	1,581	1,831	250	1,581	1,831	250	1,581	1,831	250	1,581	1,831	250
Annual Difference	262	7	(255)	262	7	(255)	262	7	(255)	262	7	(255)
Accumulated Difference	558	303		820	310		1,082	317		1,344	324	
Well Management Program												
Accumulated Balance	205	205		281	(75)		357	(49)		433	(23)	
Revenue	3,600	3,600	0	3,600	4,151	551	3,600	4,151	551	3,600	4,151	551
Expenditures	3,524	3,880	356	3,524	4,125	601	3,524	4,125	601	3,524	4,125	601
Annual Difference	76	(280)	(356)	76	26	(50)	76	26	(50)	76	26	(50)
Accumulated Difference	281	(75)		357	(49)		433	(23)		509	3	

	FY 2006			FY 2007			FY 2008			FY 2009		
	Current Law	Governor's Rec	Change Item	Current Law	Governor's Rec	Change Item	Current Law	Governor's Rec	Change Item	Current Law	Governor's Rec	Change Item
Occupational Therapy Fee Suspension												
Accumulated Balance	314	314		400	146		486	(22)		572	64	
Revenue	304	50	(254)	304	50	(254)	304	304	0	304	304	0
Expenditures	218	218	0	218	218	0	218	218	0	218	218	0
Annual Difference	86	(168)	(254)	86	(168)	(254)	86	86	0	86	86	0
Accumulated Difference	400	146		486	(22)		572	64		658	150	

	FY 2006			FY 2007			FY 2008			FY 2009		
	Current Law	Governor's Rec	Change Item	Current Law	Governor's Rec	Change Item	Current Law	Governor's Rec	Change Item	Current Law	Governor's Rec	Change Item
Vital Records Program												
Accumulated Balance	(112)	(112)		37	353		136	868		235	583	
Revenue	1,850	3,270	1,420	1,800	3,220	1,420	1,800	3,220	1,420	1,800	3,220	1,420
Expenditures	1,701	2,805	1,104	1,701	2,705	1,004	1,701	3,505	1,804	1,701	3,505	1,804
Annual Difference	149	465	316	99	515	416	99	(285)	(384)	99	(285)	(384)
Accumulated Difference	37	353		136	868		235	583		334	298	

1 A bill for an act

2 relating to health; modifying ambulance service
3 provisions; modifying requirements for first
4 responders and emergency medical technicians;
5 providing for emergency suspension of certain
6 requirements; amending Minnesota Statutes 2004,
7 sections 144E.001, subdivisions 8, 15, by adding a
8 subdivision; 144E.27, subdivision 2; 144E.28,
9 subdivisions 1, 3, 7, 8; proposing coding for new law
10 in Minnesota Statutes, chapter 144E.

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

12 Section 1. Minnesota Statutes 2004, section 144E.001,
13 subdivision 8, is amended to read:

14 Subd. 8. [LICENSEE.] "Licensee" means a natural person,
15 partnership, association, corporation, Indian tribe, or unit of
16 government which possesses an ambulance service license.

17 Sec. 2. Minnesota Statutes 2004, section 144E.001, is
18 amended by adding a subdivision to read:

19 Subd. 14a. [TRIBE.] "Tribe" means a federally recognized
20 Indian tribe, as defined in United States Code, title 25,
21 section 450b, paragraph (e), located within the state of
22 Minnesota.

23 Sec. 3. Minnesota Statutes 2004, section 144E.001,
24 subdivision 15, is amended to read:

25 Subd. 15. [VOLUNTEER AMBULANCE ATTENDANT.] "Volunteer
26 ambulance attendant" means a person who provides emergency
27 medical services for a Minnesota licensed ambulance service
28 without the expectation of remuneration and who does not depend

1 in any way upon the provision of these services for the person's
2 livelihood. An individual may be considered a volunteer
3 ambulance attendant even though the individual receives an
4 hourly stipend for each hour of actual service provided, except
5 for hours on standby alert, or other nominal fee, and even
6 though the hourly stipend or other nominal fee is regarded as
7 taxable income for purposes of state or federal law, provided
8 that the hourly stipend and other nominal fees do not exceed
9 ~~$3,000 within one year of the final certification~~
10 ~~examination~~ $6,000 annually.
11 Sec. 4. [144E.266] [EMERGENCY SUSPENSION OF AMBULANCE
12 SERVICE REQUIREMENT.]
13 (a) The requirements of sections 144E.10; 144E.101,
14 subdivisions 1, 2, 3, 6, 7, 8, 9, 10, 11, and 13; 144E.103;
15 144E.12; 144E.121; 144E.123; 144E.127; and 144E.15, are
16 suspended:
17 (1) throughout the state during a national security
18 emergency declared under section 12.31;
19 (2) in the geographic areas of the state affected during a
20 peacetime emergency declared under section 12.31; and
21 (3) in the geographic areas of the state affected during a
22 local emergency declared under section 12.29.
23 (b) For purposes of this section, the geographic areas of
24 the state affected shall include geographic areas where one or
25 more ambulance services are providing requested mutual aid to
26 the site of the emergency.
27 Sec. 5. Minnesota Statutes 2004, section 144E.27,
28 subdivision 2, is amended to read:
29 Subd. 2. [REGISTRATION.] To be eligible for registration
30 with the board as a first responder, an individual
31 shall complete a board-approved application form and:
32 (1) successfully complete a board-approved initial first
33 responder training program. Registration under this clause is
34 valid for two years and expires at the end of the month in which
35 the registration was issued; or
36 (2) be credentialed as a first responder by the National

1 Registry of Emergency Medical Technicians. Registration under
2 this clause expires the same day as the National Registry
3 credential.
4 Sec. 6. Minnesota Statutes 2004, section 144E.28,
5 subdivision 1, is amended to read:
6 Subdivision 1. [REQUIREMENTS.] To be eligible for
7 certification by the board as an EMT, EMT-I, or EMT-P, an
8 individual shall:
9 (1) successfully complete the United States Department of
10 Transportation course, or its equivalent as approved by the
11 board, specific to the EMT, EMT-I, or EMT-P classification; ~~and~~
12 (2) pass the written and practical examinations approved by
13 the board and administered by the board or its designee,
14 specific to the EMT, EMT-I, or EMT-P classification; and
15 (3) complete a board-approved application form.
16 Sec. 7. Minnesota Statutes 2004, section 144E.28,
17 subdivision 3, is amended to read:
18 Subd. 3. [RECIPROCITY.] The board may certify an
19 individual who possesses a current National Registry of
20 Emergency Medical Technicians registration from another
21 jurisdiction if the individual submits a board-approved
22 application form. The board certification classification shall
23 be the same as the National Registry's classification.
24 Certification shall be for the duration of the applicant's
25 registration period in another jurisdiction, not to exceed two
26 years.
27 Sec. 8. Minnesota Statutes 2004, section 144E.28,
28 subdivision 7, is amended to read:
29 Subd. 7. [RENEWAL.] (a) Before the expiration date of
30 certification, an applicant for renewal of certification as an
31 EMT shall:
32 (1) successfully complete a course in cardiopulmonary
33 resuscitation that is approved by the board or the licensee's
34 medical director; ~~and~~
35 (2) take the United States Department of Transportation EMT
36 refresher course and successfully pass the practical skills test

1 portion of the course, or successfully complete 48 hours of
2 continuing education in EMT programs that are consistent with
3 the United States Department of Transportation National Standard
4 Curriculum or its equivalent as approved by the board or as
5 approved by the licensee's medical director and pass a practical
6 skills test approved by the board and administered by a training
7 program approved by the board. The cardiopulmonary
8 resuscitation course and practical skills test may be included
9 as part of the refresher course or continuing education renewal
10 requirements. Twenty-four of the 48 hours must include at least
11 four hours of instruction in each of the following six
12 categories:
13 (i) airway management and resuscitation procedures;
14 (ii) circulation, bleeding control, and shock;
15 (iii) human anatomy and physiology, patient assessment, and
16 medical emergencies;
17 (iv) injuries involving musculoskeletal, nervous,
18 digestive, and genito-urinary systems;
19 (v) environmental emergencies and rescue techniques; and
20 (vi) emergency childbirth and other special situations; and
21 (3) complete a board-approved application form.
22 (b) Before the expiration date of certification, an
23 applicant for renewal of certification as an EMT-I or EMT-P
24 shall:
25 (1) for an EMT-I, successfully complete a course in
26 cardiopulmonary resuscitation that is approved by the board or
27 the licensee's medical director and for an EMT-P, successfully
28 complete a course in advanced cardiac life support that is
29 approved by the board or the licensee's medical director; ~~and~~
30 (2) successfully complete 48 hours of continuing education
31 in emergency medical training programs, appropriate to the level
32 of the applicant's EMT-I or EMT-P certification, that are
33 consistent with the United States Department of Transportation
34 National Standard Curriculum or its equivalent as approved by
35 the board or as approved by the licensee's medical director. An
36 applicant may take the United States Department of

1 Transportation Emergency Medical Technician refresher course or
2 its equivalent without the written or practical test as approved
3 by the board, and as appropriate to the applicant's level of
4 certification, as part of the 48 hours of continuing education.
5 Each hour of the refresher course, the cardiopulmonary
6 resuscitation course, and the advanced cardiac life support
7 course counts toward the 48-hour continuing education
8 requirement; and
9 (3) complete a board-approved application form.
10 (c) Certification shall be renewed every two years.
11 (d) If the applicant does not meet the renewal requirements
12 under this subdivision, the applicant's certification expires.
13 Sec. 9. Minnesota Statutes 2004, section 144E.28,
14 subdivision 8, is amended to read:
15 Subd. 8. [REINSTATEMENT.] (a) Within four years of a
16 certification expiration date, a person whose certification has
17 expired under subdivision 7, paragraph (d), may have the
18 certification reinstated upon submission of:
19 (1) evidence to the board of training equivalent to the
20 continuing education requirements of subdivision 7; and
21 (2) a board-approved application form.
22 (b) If more than four years have passed since a certificate
23 expiration date, an applicant must complete the initial
24 certification process required under subdivision 1.

Fiscal Note – 2005-06 Session

Bill #: S0223-1A **Complete Date:** 03/15/05

Chief Author: KUBLY, GARY

Title: EMERGENCY MEDICAL SERVICES REG PROV

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

Agency Name: Emergency Medical Svs Reg Bd

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 bill makes several housekeeping modifications to chapter 144E, including an increase in the earnings limit, from $3000 to $6,000 per year, for volunteer ambulance attendants. The Board receive $385,000 per year in general fund appropriations to administer a training reimbursement program for nonprofit ambulance services for the cost of training volunteer emergency medical technicians. This change would not increase the amount appropriated or spent, as any unexpended funds in this account are divided among the eight regional EMS programs, per law change in 2003. (The remaining amount last year was $30,423 -- divided among the eight regional EMS programs at $3803 each.) This change would enable more volunteer EMTs and their non profit ambulance services to make use of this training reimbursement fund. M.S. 144E.35 provides for a reimbursement of no more than $450 for successful completion of the EMT course and $225 for completion of the EMT refresher course (required every two years for recertification as an EMT). This reimbursement amount is below the current cost of course enrollment.

Assumptions

Expenditure and/or Revenue Formula

Long-Term Fiscal Considerations

Local Government Costs

References/Sources

FN Coord Signature: JULI VANGSNESS
Date: 03/01/05 Phone: 617-2120

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: DOUG GREEN
Date: 03/15/05 Phone: 286-5618

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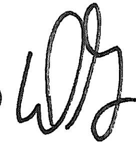
Senate
State of Minnesota

S.F. No. 223 - Emergency Medical Services

Author: Senator Gary Kubly

Prepared by: David Giel, Senate Research (651/296-7178) 

Date: March 11, 2005

S.F. No. 223 expands the definition of ambulance service "license" to include Indian tribes, increases the amount of income a volunteer ambulance attendant may earn and still be defined as a volunteer, and makes other modifications in Minnesota Statutes, chapter 144, governing the Emergency Medical Services Regulatory Board (EMSRB).

Section 1 (144E.001, subdivision 8) expands the definition of ambulance service "licensee" to include Indian tribes.

Section 2 (144E. 001, subdivision 14a) add a definition of "tribe."

Section 3 (144E.001, subdivision 15) allows a volunteer ambulance attendant to earn up to $6,000 annually and still be considered a volunteer for purposes of training cost reimbursement. (The current limit is $3,000 in this section, but is $6,000 plus inflation for purposes of the ambulance service personnel longevity award and incentive program.)

Section 4 (144E.266) suspends portions of Chapter 144E during a declared national security emergency, peacetime emergency, or local emergency.

Sections 5 to 9 add the requirement that the applicant complete a board-approved application form to various personnel certification statutes.

- **Section 5 (144E.27, subdivision 2)** adds the requirement to the first responder registration statute.

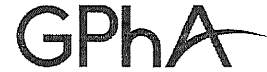
- **Section 6 (144E.28, subdivision 1)** adds it to the emergency medical technician (EMT) certification statute.

- **Section 7 (144E.28, subdivision 3)** adds it to the statute governing EMT certification through reciprocity.

- **Section 8 (144E.28, subdivision 7)** adds it to the EMT renewal process.

- **Section 9 (144E.28, subdivision 8)** adds it to the EMT reinstatement process.

DG:rdr



January 28, 2005

The Honorable Yvonne Prettner Solon
Minnesota State Senate
303 State Capitol
St. Paul, MN 55155

Dear Senator Solon:

The Generic Pharmaceutical Association (GPhA) would like to express our deep concerns regarding S 23 - the legislation you are authoring requiring pharmaceutical manufacturers to report various pricing structures of each drug to the Minnesota Department of Human Services. While we recognize and share your concerns for the high cost of prescription drugs, the highly competitive marketplace for generic pharmaceuticals keeps the cost of generics at a fraction of the cost of brands and results in billions in savings for consumers and public programs each year.

Generic pharmaceuticals not only offer the same medicine and same result as their brand counterparts, but also save consumers more than $10 billion a year nationally. The member companies of the Generic Pharmaceutical Association are pleased to provide Minnesotans with the medicines they need while helping state government achieve significant cost savings.

Generic manufacturers provide more than half of all drugs dispensed in the United States; yet generics account for only eight (8) percent of expenditures for prescription drugs. Due to the highly competitive marketplace for generic drugs, prices for generics can be as little as 20 percent the cost of its brand counterpart. Generic manufacturers keep have highly efficient manufacturing facilities, spend very little on marketing and have significantly less profits than brand pharmaceutical companies. We believe that increasing generic utilization and ensuring a strong competitive generic marketplace offers the best immediate solution to high drug expenditures.

We recognize that many policymakers find the current pricing structure of pharmaceuticals very complicated and confusing. This is an issue at the federal level and Congress and Centers for Medicaid & Medicare Services (CMS) are exploring ways to ensure greater consistency in drug pricing nationally. Late last year, the U.S. House of Representatives held a hearing on pricing and reporting issues, and we expect further inquiry of this matter. We believe that it is most appropriate for this issue to be addressed at the national level.

While we recognize your desire to provide the Department of Human Services with a mechanism for identifying potentially inflated prices for rebate and reimbursement purposes, this legislation would create a reporting procedure that unnecessarily duplicates federal reporting requirements and would create a burdensome reporting system for generic manufacturers.

Generic Pharmaceutical Association (GPhA)
2300 Clarendon Boulevard, Suite 400 • Arlington, VA 22201 • ph: 703.647.2480 • f: 703.647.2481 • www.gphaonline.org

Such requirements for generic manufacturers could undermine the competitive marketplace that currently provides huge savings on drugs and could result in higher costs for consumers and state programs. This competitive marketplace relies on confidentiality of pricing among customers and legislation such as S 23 could inadvertently undermine that process.

We are concerned that this legislation requires far more onerous reporting than is currently required federally. The federal reporting is not vendor specific nor is it publically available. This legislation does not specify whether the highly sensitive pricing data of generic manufacturers will remain completely confidential. In most instances, unlike the brand sector, there are multiple generic manufacturers for each drug. Moreover, consumers and physicians do not generally request generic drugs by name; rather generic manufacturers compete based on the price to customers such as the local pharmacies. This individual pricing information is proprietary and should remain proprietary and not be publicly available from the state.

One element of your proposed legislation that does not exist federally or in any other state is the "certification" by the company president or CEO. This is not part of the federal price reporting requirements and seems to be a highly extraordinary step.

Finally, in a time of severe budget deficit experienced by your state, managing this information could be a costly and a significant task for your Department of Human Services. We believe that there are more cost effective means to achieve your goals that will not interfere with critical program needs in the state. We would welcome the opportunity to work with you to achieve our common goal of ensuring that the State of Minnesota and its citizens are able to purchase effective drugs at affordable prices.

While we respect and share many of your goals, we cannot support legislation that would impose considerable burdens on generic manufacturers on a state-by-state basis. We also have strong concerns about the implication for the generic marketplace if pricing information must be reported and no longer remains confidential.

Thank you for opportunity to express the concerns of our members. Please feel free to call on me if I can provide additional information or answer questions. I look forward to the opportunity to work with you to ensure that the State of Minnesota can achieve needed savings in your health care programs.

Sincerely,

Bruce Lott
Senior Director of State Affairs

1 To: Senator Cohen, Chair

2 Committee on Finance

3 Senator Berglin,

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

6 S.F. No. 223: A bill for an act relating to health;
7 modifying ambulance service provisions; modifying requirements
8 for first responders and emergency medical technicians;
9 providing for emergency suspension of certain requirements;
10 amending Minnesota Statutes 2004, sections 144E.001,
11 subdivisions 8, 15, by adding a subdivision; 144E.27,
12 subdivision 2; 144E.28, subdivisions 1, 3, 7, 8; proposing
13 coding for new law in Minnesota Statutes, chapter 144E.

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

16

17

18 ....
19 (Division Chair)
20
21 March 16, 2005..................
22 (Date of Division action)

1 A bill for an act

2 relating to health; requiring the commissioner of
3 health to develop a statewide cervical cancer
4 prevention plan.

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

6 Section 1. [CERVICAL CANCER ELIMINATION STUDY.]

7 (a) The commissioner of health shall develop a statewide
8 integrated and comprehensive cervical cancer prevention plan,
9 including strategies for promoting and implementing the plan.
10 The plan must include activities that identify and implement
11 methods to improve the cervical cancer screening rates in
12 Minnesota, including, but not limited to:

13 (1) identifying and disseminating appropriate
14 evidence-based cervical cancer screening guidelines to be used
15 in Minnesota;

16 (2) increasing the use of appropriate screening based on
17 these guidelines for patients seen by medical groups in
18 Minnesota and monitoring results of these medical groups; and

19 (3) reducing the number of women who should but have not
20 been screened.

21 (b) In developing the plan, the commissioner shall also
22 identify and examine limitations and barriers in providing
23 cervical cancer screening, diagnosis tools, and treatment,
24 including, but not limited to, medical care reimbursement,
25 treatment costs, and the availability of insurance coverage.

1 (c) The commissioner may work with a nonprofit quality
2 improvement organization in Minnesota to identify evidence-based
3 guidelines for cervical cancer screening and to identify methods
4 to improve the cervical cancer screening rates among medical
5 groups; and may work with a nonprofit health care result
6 reporting organization to monitor results by medical groups in
7 Minnesota.
8 (d) The commissioner may convene an advisory committee that
9 includes representatives of health care providers, the American
10 Cancer Society, health plan companies, the University of
11 Minnesota Academic Health Center, community health boards, and
12 the general public.
13 (e) The commissioner shall submit a report to the
14 legislature by January 15, 2006, on:
15 (1) the statewide cervical cancer prevention plan,
16 including a description of the plan activities and strategies
17 developed for promoting and implementing the plan;
18 (2) methods for monitoring the results by medical groups
19 and by the entire state of cervical cancer screening improvement
20 activities; and
21 (3) recommended changes to existing laws, programs, or
22 services in terms of reducing the occurrence of cervical cancer
23 by improving insurance coverage for the prevention, diagnosis,
24 and treatment for cervical cancer.

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Senate
State of Minnesota

S.F. No. 24 - Cervical Cancer Elimination Study (First Engrossment)

Author: Senator Yvonne Prettner Solon

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

Date: March 4, 2005

S.F. No. 24, paragraph (a), requires the Commissioner of Health to develop a statewide integrated and comprehensive cervical cancer prevention plan. The plan must include activities that identify and implement methods that would improve the cervical cancer screening rates, including: (1) identifying and disseminating appropriate evidence-based cervical cancer screening guidelines; (2) increasing the use of appropriate screening based on these guidelines for patients seen by medical groups and monitoring results of these medical groups; and (3) reducing the number of women who should but have not been screened.

Paragraph (b) requires the Commissioner to identify and examine limitations and barriers in providing cervical cancer screening, diagnosis tools, and treatment.

Paragraph (c) authorizes the Commissioner to work with a nonprofit quality improvement organization to identify evidence-based guidelines for cervical cancer screening and to identify methods to improve the cervical cancer screening rates among medical groups. The Commissioner may also work with a nonprofit health care result reporting organization to monitor results by medical groups.

Paragraph (d) authorizes the Commissioner to convene an advisory committee to assist in developing the prevention plan.

Paragraph (e) requires the Commissioner to submit a report to the Legislature by January 15, 2006, on: (1) the statewide plan; (2) methods for monitoring the results by medical groups and by the entire state of the screening improvement activities; and (3) recommended changes to existing laws, programs, or services for reducing the occurrence of cervical cancer by improving insurance coverage.

KC:ph

Consolidated Fiscal Note – 2005-06 Session

Bill #: S0024-1E **Complete Date:** 03/08/05

Chief Author: SOLON, YVONNE PRETTNER

Title: CERVICAL CANCER PREVENTION PLAN

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

Agencies: Health Dept (03/08/05) Human Services Dept (03/08/05)

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					
General Fund		109			
Health Dept		109			
Revenues					
-- No Impact --					
Net Cost <Savings>					
General Fund		109			
Health Dept		109			
Total Cost <Savings> to the State		109			

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
General Fund		1.00			
Health Dept		1.00			
Total FTE		1.00			

Consolidated EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: CRAIG WIEBER
Date: 03/08/05 Phone: 282-5065

Fiscal Note – 2005-06 Session

Bill #: S0024-1E **Complete Date:** 03/08/05

Chief Author: SOLON, YVONNE PRETTNER

Title: CERVICAL CANCER PREVENTION PLAN

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

Agency Name: Health Dept

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

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
General Fund		109			
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
General Fund		109			
Revenues					
-- No Impact --					
Net Cost <Savings>					
General Fund		109			
Total Cost <Savings> to the State		109			

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
General Fund		1.00			
Total FTE		1.00			

Bill Description

This bill requires the Department to submit a report on a statewide cervical cancer prevention plan by January 15, 2006. The plan is to address: screening guidelines; methods to increase and monitor screening done by Minnesota medical groups; methods to reduce the number of women who should be screened but are not; limitations and barriers to screening, diagnosis, and treatment; and recommended changes to improve insurance coverage for the prevention, diagnosis, and treatment of cervical cancer. The Department may work with nonprofit organizations and an advisory committee.

Assumptions

- Some of the content of the report/plan can be taken from the Cancer Plan Minnesota, which will be published in the spring of 2005.
- The nonprofit organization(s) will contribute to the report without reimbursement from the Department, including identifying evidence-based guidelines for screening, identifying methods to increase cervical cancer screening rates among medical groups, and identifying methods to monitor screening results by medical groups.
- The Department will convene an advisory committee, which will meet four times, at a cost of $2,000 per meeting for photocopying, postage, member travel expenses, and refreshments.
- A full-time Planner Principal State will be needed for six months to review existing literature and documents, research changes that would improve insurance coverage, provide staff support for the advisory committee, and prepare the report for submission.
- A full-time Epidemiologist Principal will be needed for six months to: analyze cervical cancer screening, disparity, incidence and mortality data; research limitations to screening, diagnosis, and treatment; and develop recommendations for changes.
- Both salaries are assumed to be at the top of the range. The timeline for preparing the report is so short that it will be essential to attract staff who could accomplish the tasks with little or no training and oversight.

Expenditure and/or Revenue Formula

EXPENDITURES	**SFY06**
Salary – .5 FTE Planner Principal State	$30,767
Salary – .5 FTE Epidemiologist Principal	38,242
Fringe 29%	20,012
Subtotal Sal & Fringe	$89,020
Supplies & Exp:	
Communications	600
Travel expenses	400
Supplies	1,000
Task Force Meetings	8,000
Operation Support Services 9.7%	9,605
Subtotal S & E	$19,605
TOTAL EXPENSES	**$108,625**

Long-Term Fiscal Considerations

The costs to implement the recommendations of the plan are anticipated to be substantial.

Local Government Costs

None.

References/Sources

This information was based on the department's experience with similar activities.

Agency Contact Name: Pati Maier (651-281-9882)
FN Coord Signature: MARGARET KELLY

Date: 03/07/05 Phone: 281-9998

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: CRAIG WIEBER
Date: 03/08/05 Phone: 282-5065

Fiscal Note – 2005-06 Session

Bill #: S0024-1E **Complete Date:** 03/08/05

Chief Author: SOLON, YVONNE PRETTNER

Title: CERVICAL CANCER PREVENTION PLAN

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 24-1E

Bill Description

This bill requires the department of health (MDH) to develop a statewide cervical cancer prevention plan and submit recommendations to the legislature by January 15, 2006.

Currently the Minnesota Breast and Cervical Cancer Control Program - now called "the Sage Screening Program" is managed by MDH but enrollees are MA eligible (MA-BC) and claims are paid exclusively through the department of human services (DHS) claims processing system since MA-BC enrollees are exempt from managed care participation.

While the recommendations made by MDH are likely to increase the number of persons eligible for MA-BC and therefore costs, the requirement for MDH to develop and submit a plan does not in itself have fiscal impacts on DHS.

Assumptions

$0 fiscal impact for DHS

Currently the Minnesota Breast and Cervical Cancer Control Program - now called "the Sage Screening Program" is managed by MDH but enrollees are MA eligible (MA-BC) and claims are paid exclusively through the department of human services (DHS) claims processing system since MA-BC enrollees are exempt from managed care participation.

Expenditure and/or Revenue Formula

Long-Term Fiscal Considerations

Local Government Costs

References/Sources

Agency Contact Name: Char Sadlak 296-5599
FN Coord Signature: STEVE BARTA
Date: 03/08/05 Phone: 296-5685

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

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

1 A bill for an act

2 relating to human services; providing for prescription
3 drug bulk purchasing; proposing coding for new law in
4 Minnesota Statutes, chapter 256.

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

6 Section 1. [256.9551] [PRESCRIPTION DRUG BULK PURCHASING
7 PROGRAMS.]

8 Subdivision 1. [INTRASTATE PRESCRIPTION DRUG BULK
9 PURCHASING PROGRAM.] The commissioner of human services is
10 directed to establish and administer an intrastate prescription
11 drug bulk purchasing program in order to try to save money for
12 the state, its agencies, and local governments in regard to the
13 cost of the prescription drugs they purchase. Under the
14 program, the Department of Human Services will consolidate drug
15 purchasing by the state prescription drug program, state
16 hospitals and other health care facilities, state educational
17 facilities, the State Health Plan, and other state and local
18 government entities and programs that purchase significant
19 quantities of prescription drugs and wish to participate in the
20 intrastate bulk purchasing program. The Department of
21 Administration will negotiate the prices of the prescription
22 drugs purchased under this program unless the prices of some or
23 all of the purchased drugs are negotiated by an agent of an
24 interstate prescription drug bulk purchasing program described
25 in subdivision 2.

1 Subd. 2. [INTERSTATE PRESCRIPTION DRUG BULK PURCHASING
2 PROGRAM.] The commissioner of human services is directed to
3 establish or join an existing interstate prescription drug bulk
4 purchasing program with other interested states. The program
5 will select an agent to negotiate prices for the states in the
6 program. The department shall administer the state's
7 participation in the program.
8 Subd. 3. [NEGOTIATION OF CANADIAN OR EUROPEAN PRESCRIPTION
9 DRUG PRICES.] The commissioner of human services shall request
10 the Department of Administration to negotiate with
11 state-approved Canadian or European pharmacies or wholesalers
12 the prices to be charged to Minnesota residents who purchase
13 their prescription drugs from Canada or Europe pursuant to the
14 state's prescription drug importation program. The commissioner
15 shall also determine whether it would save money for the state's
16 intrastate prescription drug bulk purchasing program to purchase
17 some or all of the prescription drugs from Canada or Europe and
18 will make such purchases if it would result in significant
19 savings. The commissioner shall also encourage the members of
20 the state's interstate prescription drug bulk purchasing program
21 to purchase some or all of the necessary prescription drugs in
22 Canada or Europe if it would result in significant savings.
23 Subd. 4. [PUBLIC/PRIVATE INTRASTATE PRESCRIPTION DRUG BULK
24 PURCHASING ALLIANCE.] The commissioner shall establish and
25 administer a public/private intrastate prescription drug bulk
26 purchasing alliance under which the state and interested private
27 entities can consolidate their drug purchasing to save money.
28 The participation of private entities in this alliance is
29 voluntary. The Department of Administration shall negotiate the
30 prices of prescription drugs purchased through the alliance.
31 Subd. 5. [COMMISSIONER DISCRETION.] The commissioner of
32 human services is not required to establish or administer any of
33 the bulk purchasing programs in subdivisions 1 to 4 if the
34 commissioner determines that any such program would not result
35 in significant savings to the state. The commissioner shall not
36 include the state Medicaid program, MinnesotaCare program, or

1 Department of Corrections in the bulk purchasing programs in
2 subdivisions 1 to 4. These programs may later be included in
3 any or all of the bulk purchasing programs in subdivisions 1 to
4 4 if the commissioner deems those bulk purchasing programs to be
5 beneficial to the state and that the inclusion of the state
6 Medicaid program, MinnesotaCare, and the Department of
7 Corrections in a bulk purchasing program would result in savings
8 to the state.

9 Subd. 6. [PHARMACY PARTICIPATION.] Any pharmaceuticals
10 purchased by state or local government entities or Minnesota
11 consumers pursuant to the bulk purchasing programs identified in
12 subdivisions 1 to 4 shall be distributed through Minnesota
13 pharmacies, unless the commissioner or the state or local
14 government entities select an alternate distribution system.

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S.F. No. 22 - Prescription Drug Bulk Purchasing Program (First Engrossment)

Author: Senator Yvonne Prettner Solon

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

Date: March 4, 2005

S.F. No. 22 requires the Commissioner of Human Services to establish prescription drug bulk purchasing programs if it is determined to result in significant state savings.

Subdivision 1 directs the Commissioner of Human Services to establish and administer an intrastate prescription drug bulk purchasing program. Requires the Commissioner to consolidate drug purchasing by the prescription drug program, the state hospitals and other health care facilities, state educational facilities, the State Health Plan, and other state and local government entities and programs that purchase significant quantities of prescription drugs that wish to participate. Requires the Department of Administration to negotiate the prices of the prescription drugs purchased under this program unless negotiated by an agent of an interstate prescription drug bulk purchasing program.

Subdivision 2 directs the Commissioner of Human Services to establish or join an existing interstate prescription drug bulk purchasing program with other interested states. Requires the program to select an agent to negotiate prices for the states in the program and requires the Commissioner to administer the state's participation in the program.

Subdivision 3 requires the Commissioner of Human Services to direct the Department of Administration to negotiate with state-approved Canadian or European pharmacies or wholesalers the prices to be charged to Minnesota residents who purchase their prescription drugs from Canada or Europe pursuant to the state's prescription drug importation program. Requires the Commissioner to determine whether there would be a savings if the state's intrastate prescription drug bulk purchasing program purchased some or all of the prescription drugs from Canada or Europe and to

make such purchases if it would result in significant savings. Requires the Commissioner to encourage the interstate bulk purchasing program to purchase prescription drugs from Canada or Europe if the result would be significant savings.

Subdivision 4 requires the Commissioner to establish and administer a public/private intrastate prescription drug bulk purchasing alliance in order to consolidate their drug purchasing. Requires the Department of Administration to negotiate the prices of prescription drugs purchased through the alliance. States that participation by private entities would be voluntary.

Subdivision 5 states that the commissioner is not required to establish or administer any of the bulk purchasing programs if the commissioner determines that the program would not result in significant savings. States that the MA program, MinnesotaCare program, or the Department of Corrections shall not be included in the bulk purchasing program unless it is determined to be beneficial to the state and would result in significant savings.

Subdivision 6 requires any drugs purchased by the state or local government entities or consumers through the bulk purchaser program to be distributed through Minnesota pharmacies unless an alternative distributing system is selected.

KC:ph

Consolidated Fiscal Note – 2005-06 Session

Bill #: S0022-1E **Complete Date:** 03/08/05

Chief Author: SOLON, YVONNE PRETTNER

Title: PRESCRIPTION DRUG BULK PURCHASE

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

Agencies: Human Services Dept (03/01/05) Administration Dept (02/23/05)
Employee Relations (03/04/05)

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					
General Fund		529	481	481	481
Human Services Dept		122	108	108	108
Administration Dept		407	373	373	373
Revenues					
General Fund		49	43	43	43
Human Services Dept		49	43	43	43
Net Cost <Savings>					
General Fund		480	438	438	438
Human Services Dept		73	65	65	65
Administration Dept		407	373	373	373
Total Cost <Savings> to the State		480	438	438	438

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
General Fund		5.00	5.00	5.00	5.00
Human Services Dept		1.00	1.00	1.00	1.00
Administration Dept		4.00	4.00	4.00	4.00
Total FTE		5.00	5.00	5.00	5.00

Consolidated EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

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

Fiscal Note – 2005-06 Session

Bill #: S0022-1E **Complete Date:** 03/01/05

Chief Author: SOLON, YVONNE PRETTNER

Title: PRESCRIPTION DRUG BULK PURCHASE

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

Agency Name: Human Services Dept

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

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
General Fund		122	108	108	108
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
General Fund		122	108	108	108
Revenues					
General Fund		49	43	43	43
Net Cost <Savings>					
General Fund		73	65	65	65
Total Cost <Savings> to the State		73	65	65	65

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
General Fund		1.00	1.00	1.00	1.00
Total FTE		1.00	1.00	1.00	1.00

NARRATIVE: SF 22-1E

Bill Description. Directs the Commissioner of DHS to establish intrastate and interstate bulk drug purchasing programs. Directs the DHS commissioner to work with the Dept. of Administration to negotiate drug prices charged to state residents by Canadian or European pharmacies participating in Minnesota RxConnect. Canadian drugs are to be made available to intrastate bulk drug purchasing program participants if possible. DHS commissioner required to establish a public/private bulk drug purchasing program.

Assumptions. Federal law already guarantees that Medicaid agencies receive a better price than other state or private purchasers can obtain. The Prescription Drug Program (PDP) also benefits from rebates equivalent to those received under Medicaid. The regional treatment centers currently purchase drugs at a good discount through the Minnesota Multistate Contracting Alliance for Pharmacy, which negotiates discounts on behalf of over 40 states. It is unlikely the RTCs would realize additional savings through another bulk purchasing program.

The workload for pharmacy program staff has increased substantially due to the pending implementation of the Medicare Part D benefit, the work we are starting on a program to improve the quality of prescribing for mental health drugs, the implementation of our preferred drug list/supplemental rebate program, and other projects, Consequently, we will need 1 FTE if this bill is passed.

Expenditure and/or Revenue Formula. None

1 FTE needed:

	FY06	FY07	FY08
Staff Costs	122	108	108
Revenue	49	43	43
Net Cost to State	73	65	65

Long-Term Fiscal Considerations. Other than continuing to require the additional 1 FTE, none for DHS. However, it is possible that other state agencies may see changes in the amount spent on prescription drugs. (For example, this might have an impact on the amount DOER pays for the prescription drugs used by state employees). To the extent that drug wholesale prices are decreased, this would decrease the amount of revenue collected via the 2% drug wholesale tax.

Local Government Costs. Since local governments would be allowed to participate in the drug purchasing pool, this might have an impact on the amount those governments would pay for prescription drugs.

References/Sources

Agency Contact Name: Cody Wiberg 282-6496
FN Coord Signature: STEVE BARTA
Date: 02/23/05 Phone: 296-5685

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: DOUG GREEN
Date: 03/01/05 Phone: 286-5618

Fiscal Note – 2005-06 Session

Bill #: S0022-1E **Complete Date:** 02/23/05

Chief Author: SOLON, YVONNE PRETTNER

Title: PRESCRIPTION DRUG BULK PURCHASE

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

Agency Name: Administration Dept

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

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
General Fund		407	373	373	373
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
General Fund		407	373	373	373
Revenues					
-- No Impact --					
Net Cost <Savings>					
General Fund		407	373	373	373
Total Cost <Savings> to the State		407	373	373	373

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
General Fund		4.00	4.00	4.00	4.00
Total FTE		4.00	4.00	4.00	4.00

Bill Description
The commissioner of human services is directed to establish new prescription drug purchasing programs: an intrastate prescription drug bulk purchasing program, an interstate prescription drug bulk purchasing program, a Canadian and European prescription drug program and a public/private intrastate prescription drug bulk purchasing alliance. The new programs are to be established if the commissioner of human services determines that they would result in significant savings to the state.

The Department of Administration will negotiate the prices of the prescription drugs purchased under this program.

Assumptions
Admin has not analyzed the potential significant savings. However, for purposes of the fiscal note, we are assuming that the commissioner of human services will determine that significant savings could be realized and will implement the new programs. (If the commissioner of human services finds no potential for significant savings under any of the four programs, there would be no implementation costs to Admin.)

We are assuming that Admin's role will be strictly limited to negotiating prices and managing the resulting contracts. Admin will not be doing the analysis of potential savings, marketing to potential participants, developing strategies or consensus among participants, directly handling pharmaceuticals purchased in bulk, monitoring safety and data privacy issues, etc.

Legislation assumes three or four simultaneous operations that need to be supported.

Dealing with Canadian and European drug manufacturers will require significant communications and travel expenses.

Implementation would not begin until FY 06.

Expenditure and/or Revenue Formula
Based on our experiences with other drug purchasing cooperatives, we estimate the need for one pharmacist, two contract managers and a data analyst at a combined annual payroll cost of $299,000 (in FY 06). In addition in FY 06, there is a one-time cost of $36,000 to furnish and enable workstations, and ongoing annual costs of $72,000 for communications, travel, supplies and other expenses. In FY 07 and beyond, ongoing annual costs of $74,000.

No revenue collection is authorized in the legislation.

Long-Term Fiscal Considerations
Potential savings to the state and its citizens on costs of prescription drugs.

Local Government Costs
Potential savings to local units of government on costs of prescription drugs.

Agency Contact Name: Paul Stembler (651-296-0498)
FN Coord Signature: LARRY FREUND
Date: 02/22/05 Phone: 296-5857

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: TIM JAHNKE
Date: 02/23/05 Phone: 296-6237

Fiscal Note – 2005-06 Session

Bill #: S0022-1E **Complete Date:** 03/04/05

Chief Author: SOLON, YVONNE PRETTNER

Title: PRESCRIPTION DRUG BULK PURCHASE

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					
-- 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:
Senate File 22-1E Requiring and providing for the commissioner of human services to establish and administer an intrastate prescription drug bulk purchasing program for state and local government cost savings purposes, providing for optional participation; requiring the commissioner of administration to negotiate the prices of the prescription drugs purchased under the program, exception; requiring the commissioner of human services to establish or join an existing interstate prescription drug bulk purchasing program with other interested states and the program to select an agent to negotiate prices for the states in the program; requiring the commissioner to request the department of administration to negotiate with state approved Canadian or European pharmacies or wholesalers the prices to be charged to Minnesota residents purchasing prescription drugs from Canada or Europe and to determine the cost savings to the program in purchasing drugs from Canada or Europe; requiring the commissioner to establish and administer a public private intrastate prescription drug bulk purchasing alliance for purchasing consolidation purposes, participation of private entities in the alliance to be voluntary, requiring department of administration price negotiation; granting the
commissioner of human services discretion in establishing or administering bulk purchasing programs upon determination of no significant savings to the state; prohibiting inclusion of the state medicaid or MinnesotaCare programs or department of corrections in the programs, authorizing later inclusion upon determination of benefit to the state; requiring the distribution of
pharmaceuticals purchased under the programs through state pharmacies, authorizing commissioner or state or local government entities selection of an alternate distribution system

SUMMARY:
The bill directs the commissioner of human services to establish and administer several new prescription drug purchasing programs: an intrastate bulk purchasing program, an interstate bulk purchasing program, a Canadian prescription drug program and a public/private intra state prescription drug bulk purchasing alliance. The new programs are to be established if the commissioner of human services determines that they would result in a significant savings to the state. The commissioner of administration is required to negotiate drug prices for the new programs. The State Health Plan is mentioned as a participant in the intrastate bulk purchasing program; however, it is unclear whether participation would be mandatory.

BACKGROUND:
The State Health Plan depends on local pharmacies to purchase and distribute prescription drugs to over 97% of state employees. The remaining 3% utilize the health plan mail order programs or the Advantage Meds Canadian drug purchasing program established by DOER in April 2004. The health plans (Blue Cross, Health Partners, and PreferredOne), through their pharmacy benefit managers (PBMs), negotiate the reimbursement rates with the local pharmacies for prescriptions dispensed to state employees. In addition, the health plans negotiate rebates from the drug manufacturers based on the volume of drugs purchased by their entire commercial population. DOER's contracts with the health plans mandate that all rebates attributable to state employee prescriptions be returned to the state.

ASSUMPTIONS:

- ***Local pharmacies must be included.*** The existing networks of local pharmacies are necessary in order to deliver prescription drugs to state employees. While it may be possible to require employees to use mail order for maintenance prescriptions, most non-maintenance prescriptions require individuals begin taking the medications before the 7 to 10 days necessary to receive a prescription through the mail. Therefore, the State Health Plan would not be able to participate in a bulk purchasing pool unless a provision was made to include local pharmacies.
- ***Participation by local pharmacies must be mandatory.*** If participation by local pharmacies was optional, it is very possible that pharmacies in greater Minnesota may elect not to participate if the administration required special ordering for a small customer base and if the profit margins were small. This could result in a loss of access unless participation by the pharmacies was mandatory.
- ***Loss of ongoing PBM cost comparison data.*** The state currently receives de-identified detailed claim data on state employee prescription claims from three major PBMs (Prime Therapeutics, Pharmacare, and Express Scripts). We utilize this information to compare the PBMs and hold them accountable for providing the lowest possible prescription drug cost through a combination of negotiated agreements with pharmacies and negotiated rebates with pharmaceutical manufacturers. If the state went to a single

source for purchasing pharmacy services, we would lose the leverage we currently have to force the PBMs to provide us with the most competitive net cost.
- ***Reference to "State Health Plan".*** We assumed the proposed legislation is intended to include the medical plan offered to state employees through the State Employee Group Insurance Plan (SEGIP).

EXPENDITURE FORMULA:

Based on some comparative analysis of some State Health Plan brand name prescription claims paid, we believe that there is some evidence to suggest that the bulk prices available through the Minnesota Multi-State Contracting Alliance for Pharmacy may be lower. However, because the department of human services has not yet determined how the proposed bulk purchasing program will be administered, we have no way of determining what additional costs may be incurred. Areas of concern would include:

- Additional cost of including local pharmacies to distribute prescriptions
- The spread or margin required by the local pharmacy for administration and profit
- The loss of formulary management currently provided by the PBMs
- The care management personnel at the health plans would no longer know what medications a member was taking and would not be able to coordinate that information into their treatment programs.

Therefore, because of these unknowns, we have no supportable information that the State Health Plan's participation in a bulk purchasing pool will save money and it may result in an additional cost.

Long-Term Fiscal Considerations:

Undetermined

LOCAL GOVERNMENT COSTS:

REFERENCES:

- Pharmacy utilization data from the Minnesota Advantage Health Plan.

Agency Contact Name: Liz Houlding (651-296-6287)
FN Coord Signature: MIKE HOPWOOD
Date: 03/03/05 Phone: 297-5220

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: KRISTI SCHROEDL
Date: 03/04/05 Phone: 215-0595

Senator Kiscaden introduced--

S.F. No. 1378: Referred to the Committee on Finance.

1 A bill for an act

2 relating to health; modifying medical education
3 funding provisions; amending Minnesota Statutes 2004,
4 section 62J.692, subdivisions 3, 4, 7.

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

6 Section 1. Minnesota Statutes 2004, section 62J.692,
7 subdivision 3, is amended to read:

8 Subd. 3. [APPLICATION PROCESS.] (a) A clinical medical
9 education program conducted in Minnesota by a teaching
10 institution to train physicians, doctor of pharmacy
11 practitioners, dentists, chiropractors, or physician assistants
12 is eligible for funds under subdivision 4 if the program:

13 (1) is funded, in part, by patient care revenues;

14 (2) occurs in patient care settings that face increased
15 financial pressure as a result of competition with nonteaching
16 patient care entities; and

17 (3) emphasizes primary care or specialties that are in
18 undersupply in Minnesota.

19 (b) A clinical medical education program for advanced
20 practice nursing is eligible for funds under subdivision 4 if
21 the program meets the eligibility requirements in paragraph (a),
22 clauses (1) to (3), and is sponsored by the University of
23 Minnesota Academic Health Center, the Mayo Foundation, or
24 institutions that are part of the Minnesota State Colleges and
25 Universities system or members of the Minnesota Private College

1 Council.
2 (c) Applications must be submitted to the commissioner by a
3 sponsoring institution on behalf of an eligible clinical medical
4 education program and must be received by October 31 of each
5 year for distribution in the following year. An application for
6 funds must contain the following information:
7 (1) the official name and address of the sponsoring
8 institution and the official name and site address of the
9 clinical medical education programs on whose behalf the
10 sponsoring institution is applying;
11 (2) the name, title, and business address of those persons
12 responsible for administering the funds;
13 (3) for each clinical medical education program for which
14 funds are being sought; the type and specialty orientation of
15 trainees in the program; the name, site address, and medical
16 assistance provider number of each training site used in the
17 program; the total number of trainees at each training site; and
18 the total number of eligible trainee FTEs at each site~~.--Only~~
19 ~~those-training-sites-that-host-0.5-FTE-or-more-eligible-trainees~~
20 ~~for-a-program-may-be-included-in-the-program's-application~~; and
21 (4) other supporting information the commissioner deems
22 necessary to determine program eligibility based on the criteria
23 in paragraphs (a) and (b) and to ensure the equitable
24 distribution of funds.
25 (d) An application must include the information specified
26 in clauses (1) to (3) for each clinical medical education
27 program on an annual basis for three consecutive years. After
28 that time, an application must include the information specified
29 in clauses (1) to (3) ~~in-the-first-year-of-each-biennium~~ when
30 requested, at the discretion of the commissioner:
31 (1) audited clinical training costs per trainee for each
32 clinical medical education program when available or estimates
33 of clinical training costs based on audited financial data;
34 (2) a description of current sources of funding for
35 clinical medical education costs, including a description and
36 dollar amount of all state and federal financial support,

1 including Medicare direct and indirect payments; and
2 (3) other revenue received for the purposes of clinical
3 training.
4 (e) An applicant that does not provide information
5 requested by the commissioner shall not be eligible for funds
6 for the current funding cycle.
7 Sec. 2. Minnesota Statutes 2004, section 62J.692,
8 subdivision 4, is amended to read:
9 Subd. 4. [DISTRIBUTION OF FUNDS.] (a) The commissioner
10 shall annually distribute 90 percent of available medical
11 education funds to all qualifying applicants based on a
12 distribution formula that reflects a summation of two factors:
13 (1) an education factor, which is determined by the total
14 number of eligible trainee FTEs and the total statewide average
15 costs per trainee, by type of trainee, in each clinical medical
16 education program; and
17 (2) a public program volume factor, which is determined by
18 the total volume of public program revenue received by each
19 training site as a percentage of all public program revenue
20 received by all training sites in the fund pool.
21 In this formula, the education factor is weighted at 67
22 percent and the public program volume factor is weighted at 33
23 percent.
24 Public program revenue for the distribution formula
25 includes revenue from medical assistance, prepaid medical
26 assistance, general assistance medical care, and prepaid general
27 assistance medical care. Training sites that receive no public
28 program revenue are ineligible for funds available under this
29 paragraph. Total statewide average costs per trainee for
30 medical residents is based on audited clinical training costs
31 per trainee in primary care clinical medical education programs
32 for medical residents. Total statewide average costs per
33 trainee for dental residents is based on audited clinical
34 training costs per trainee in clinical medical education
35 programs for dental students. Total statewide average costs per
36 trainee for pharmacy residents is based on audited clinical

1 training costs per trainee in clinical medical education
2 programs for pharmacy students.
3 (b) The commissioner shall annually distribute ten percent
4 of total available medical education funds to all qualifying
5 applicants based on the percentage received by each applicant
6 under paragraph (a). These funds are to be used to offset
7 clinical education costs at eligible clinical training sites
8 based on criteria developed by the clinical medical education
9 program. Applicants may choose to distribute funds allocated
10 under this paragraph based on the distribution formula described
11 in paragraph (a). ~~Applicants-may-also-choose-to-distribute~~
12 ~~funds-to-clinical-training-sites-with-a-valid-Minnesota-medical~~
13 ~~assistance-identification-number-that-host-fewer-than-0.5~~
14 ~~eligible-trainee-FTEs-for-a-clinical-medical-education-program.~~
15 (c) Funds distributed shall not be used to displace current
16 funding appropriations from federal or state sources.
17 (d) Funds shall be distributed to the sponsoring
18 institutions indicating the amount to be distributed to each of
19 the sponsor's clinical medical education programs based on the
20 criteria in this subdivision and in accordance with the
21 commissioner's approval letter. Each clinical medical education
22 program must distribute funds allocated under paragraph (a) to
23 the training sites as specified in the commissioner's approval
24 letter. Sponsoring institutions, which are accredited through
25 an organization recognized by the Department of Education or the
26 Centers for Medicare and Medicaid Services, may contract
27 directly with training sites to provide clinical training. To
28 ensure the quality of clinical training, those accredited
29 sponsoring institutions must:
30 (1) develop contracts specifying the terms, expectations,
31 and outcomes of the clinical training conducted at sites; and
32 (2) take necessary action if the contract requirements are
33 not met. Action may include the withholding of payments under
34 this section or the removal of students from the site.
35 (e) Any funds not distributed in accordance with the
36 commissioner's approval letter must be returned to the medical

1 education and research fund within 30 days of receiving notice
2 from the commissioner. The commissioner shall distribute
3 returned funds to the appropriate training sites in accordance
4 with the commissioner's approval letter.
5 (f) The commissioner shall distribute by June 30 of each
6 year an amount equal to the funds transferred under subdivision
7 10, plus five percent interest to the University of Minnesota
8 Board of Regents for the instructional costs of health
9 professional programs at the Academic Health Center and for
10 interdisciplinary academic initiatives within the Academic
11 Health Center.
12 (g) A maximum of $150,000 of the funds dedicated to the
13 commissioner under section 297F.10, subdivision 1, paragraph
14 (b), clause (2), may be used by the commissioner for
15 administrative expenses associated with implementing this
16 section.
17 Sec. 3. Minnesota Statutes 2004, section 62J.692,
18 subdivision 7, is amended to read:
19 Subd. 7. [TRANSFERS FROM THE COMMISSIONER OF HUMAN
20 SERVICES.] (a) The amount transferred according to section
21 256B.69, subdivision 5c, paragraph (a), clause (1), shall be
22 distributed by the commissioner annually to clinical medical
23 education programs that meet the qualifications of subdivision 3
24 based on the formula in subdivision 4, paragraph (a).
25 (b) Fifty percent of the amount transferred according to
26 section 256B.69, subdivision 5c, paragraph (a), clause (2),
27 shall be distributed by the commissioner to the University of
28 Minnesota Board of Regents for the purposes described in
29 sections 137.38 to 137.40. Of the remaining amount transferred
30 according to section 256B.69, subdivision 5c, paragraph (a),
31 clause (2), 24 percent of the amount shall be distributed by the
32 commissioner to the Hennepin County Medical Center for clinical
33 medical education. The remaining 26 percent of the amount
34 transferred shall be distributed by the commissioner in
35 accordance with subdivision 7a. If the federal approval is not
36 obtained for the matching funds under section 256B.69,

1 subdivision 5c, paragraph (a), clause (2), 100 percent of the
2 amount transferred under this paragraph shall be distributed by
3 the commissioner to the University of Minnesota Board of Regents
4 for the purposes described in sections 137.38 to 137.40.

5 (c) The amount transferred according to section 256B.69,
6 subdivision 5c, paragraph (a), ~~clause~~ clauses (3) and (4), shall
7 be distributed by the commissioner upon receipt to the
8 University of Minnesota Board of Regents for the purposes of
9 clinical graduate medical education.

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Senate
State of Minnesota

S.F. No. 1378 - Medical Education Funding

Author: Senator Sheila M. Kiscaden

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

Date: March 15, 2005

S.F. No. 1378 modifies the medical education funding (MERC) provisions.

Section 1 (62J.692 , subdivision 3) eliminates the requirement that only training sites that host .5 FTEs or more eligible trainees at each clinical medical education program site be included in the sponsoring institution's application for funding. This section also changes the requirement that each sponsoring institution submit to the Commissioner of Health cost data for each clinical medical education program from the first year of each biennium to when requested by the Commissioner.

Section 2 (62J.692, subdivision 4) eliminates the language allowing applicants to distribute funds to clinical training sites with a valid Minnesota medical assistance identification number that host less than .5 eligible trainee FTEs for a clinical medical education program.

Section 3 (62J.692, subdivision 7) is a technical change that clarifies that the amount transferred from the Commissioner of Human Services to the Commissioner of Health under Minnesota Statutes, section 256B.69, subdivision 5c, includes the amount from the capitation rates that began July 1, 2003, as well as the amount that began on July 1, 2002.

KC:ph

Consolidated Fiscal Note – 2005-06 Session

Bill #: S1378-0 **Complete Date:** 03/15/05

Chief Author: KISCADEN, SHEILA

Title: MEDICAL EDUCATION FUNDING PROVISIONS

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

Agencies: Health Dept (03/15/05) Human Services Dept (03/15/05)

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					
-- 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					

Consolidated EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: CRAIG WIEBER
Date: 03/15/05 Phone: 282-5065

Fiscal Note – 2005-06 Session

Bill #: S1378-0 **Complete Date:** 03/15/05

Chief Author: KISCADEN, SHEILA

Title: MEDICAL EDUCATION FUNDING PROVISIONS

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

Agency Name: Health 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					

Bill Description

Sec. 1 – Changes to MERC application
Strikes language limiting eligibility for MERC to training sites hosting at least 0.5 FTE clinical trainees from an applicant program. Changes collection of cost data through the MERC application from the first year of each biennium to 'upon request,' at a frequency that is at the discretion of the Commissioner.

Sec. 2 – Distribution of MERC funds
Removes language specifying that sponsoring institutions may use funds from the 10% discretionary pool to reimburse sites that host fewer than 0.5 FTE clinical trainees from an applicant program; with the elimination of the 0.5 FTE cutoff under section 1, this clause is no longer necessary.

Sec. 3 – Transfers from DHS
Makes a technical change to language describing transfers that occur between DHS and MDH, to include funds transferred under MN Statute 256B.69, subdivision 5c, paragraph (a), clause (4).

Assumptions

There is no fiscal impact from these changes. MERC staff will continue to collect data through MERC applications and distribute funds annually per the statute, with no staffing or administrative changes required. Change under section 3 does not increase or decrease the amount of funding available for MERC.

Expenditure and/or Revenue Formula

None

Long-Term Fiscal Considerations

None

Agency Contact Name: Scott Leitz (651-282-6361)
FN Coord Signature: MARGARET KELLY
Date: 03/07/05 Phone: 281-9998

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: CRAIG WIEBER
Date: 03/15/05 Phone: 282-5065

Fiscal Note – 2005-06 Session

Bill #: S1378-0 **Complete Date:** 03/15/05

Chief Author: KISCADEN, SHEILA

Title: MEDICAL EDUCATION FUNDING PROVISIONS

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 1378

Bill Description

This bill modifies the criteria that the health department follows for the distribution of medical education funds. It also updates statutory references to current law.

This bill does not affect the medical education payments by the department of human services to the health department and therefore has no fiscal impact on the department of human services.

Assumptions

Expenditure and/or Revenue Formula

Long-Term Fiscal Considerations

Local Government Costs

References/Sources

Agency Contact Name: Paul Olson 296-5620
FN Coord Signature: STEVE BARTA
Date: 03/07/05 Phone: 296-5685

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: KATIE BURNS
Date: 03/15/05 Phone: 296-7289

1 To: Senator Cohen, Chair

2 Committee on Finance

3 Senator Berglin,

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

6 S.F. No. 1378: A bill for an act relating to health;
7 modifying medical education funding provisions; amending
8 Minnesota Statutes 2004, section 62J.692, subdivisions 3, 4, 7.

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

11

12

13 ....
14 (Division Chair)
15
16 March 16, 2005....................
17 (Date of Division action)

Senator Solon introduced--

S.F. No. 23: Referred to the Committee on Health and Family Security.

1 A bill for an act

2 relating to pharmacy; modifying wholesale drug
3 distributor requirements; amending Minnesota Statutes
4 2004, section 151.47, subdivision 1, by adding a
5 subdivision.

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

7 Section 1. Minnesota Statutes 2004, section 151.47,
8 subdivision 1, is amended to read:

9 Subdivision 1. [REQUIREMENTS.] All wholesale drug
10 distributors are subject to the requirements in paragraphs (a)
11 to ~~(f)~~ (g).

12 (a) No person or distribution outlet shall act as a
13 wholesale drug distributor without first obtaining a license
14 from the board and paying the required fee.

15 (b) No license shall be issued or renewed for a wholesale
16 drug distributor to operate unless the applicant agrees to
17 operate in a manner prescribed by federal and state law and
18 according to the rules adopted by the board.

19 (c) The board may require a separate license for each
20 facility directly or indirectly owned or operated by the same
21 business entity within the state, or for a parent entity with
22 divisions, subsidiaries, or affiliate companies within the
23 state, when operations are conducted at more than one location
24 and joint ownership and control exists among all the entities.

25 (d) As a condition for receiving and retaining a wholesale

1 drug distributor license issued under sections 151.42 to 151.51,
2 an applicant shall satisfy the board that it has complied with
3 paragraph (g) and that it has and will continuously maintain:
4 (1) adequate storage conditions and facilities;
5 (2) minimum liability and other insurance as may be
6 required under any applicable federal or state law;
7 (3) a viable security system that includes an after hours
8 central alarm, or comparable entry detection capability;
9 restricted access to the premises; comprehensive employment
10 applicant screening; and safeguards against all forms of
11 employee theft;
12 (4) a system of records describing all wholesale drug
13 distributor activities set forth in section 151.44 for at least
14 the most recent two-year period, which shall be reasonably
15 accessible as defined by board regulations in any inspection
16 authorized by the board;
17 (5) principals and persons, including officers, directors,
18 primary shareholders, and key management executives, who must at
19 all times demonstrate and maintain their capability of
20 conducting business in conformity with sound financial practices
21 as well as state and federal law;
22 (6) complete, updated information, to be provided to the
23 board as a condition for obtaining and retaining a license,
24 about each wholesale drug distributor to be licensed, including
25 all pertinent corporate licensee information, if applicable, or
26 other ownership, principal, key personnel, and facilities
27 information found to be necessary by the board;
28 (7) written policies and procedures that assure reasonable
29 wholesale drug distributor preparation for, protection against,
30 and handling of any facility security or operation problems,
31 including, but not limited to, those caused by natural disaster
32 or government emergency, inventory inaccuracies or product
33 shipping and receiving, outdated product or other unauthorized
34 product control, appropriate disposition of returned goods, and
35 product recalls;
36 (8) sufficient inspection procedures for all incoming and

1 outgoing product shipments; and
2 (9) operations in compliance with all federal requirements
3 applicable to wholesale drug distribution.
4 (e) An agent or employee of any licensed wholesale drug
5 distributor need not seek licensure under this section.
6 (f) A wholesale drug distributor shall file with the board
7 an annual report, in a form and on the date prescribed by the
8 board, identifying all payments, honoraria, reimbursement or
9 other compensation authorized under section 151.461, clauses (3)
10 to (5), paid to practitioners in Minnesota during the preceding
11 calendar year. The report shall identify the nature and value
12 of any payments totaling $100 or more, to a particular
13 practitioner during the year, and shall identify the
14 practitioner. Reports filed under this provision are public
15 data.
16 (g) Manufacturers shall, on a quarterly basis, report by
17 National Drug Code the following pharmaceutical pricing criteria
18 to the commissioner of human services for each of their drugs:
19 average wholesale price, wholesale acquisition cost, average
20 manufacturer price as defined in United States Code, title 42,
21 chapter 7, subchapter XIX, section 1396r-8(k), and best price as
22 defined in United States Code, title 42, chapter 7, subchapter
23 XIX, section 1396r-8(c)(1)(C). The calculation of average
24 wholesale price and wholesale acquisition cost shall be the net
25 of all volume discounts, prompt payment discounts, chargebacks,
26 short-dated product discounts, cash discounts, free goods,
27 rebates, and all other price concessions or incentives provided
28 to a purchaser that result in a reduction in the ultimate cost
29 to the purchaser. When reporting average wholesale price,
30 wholesale acquisition cost, average manufacturer price, and best
31 price, manufacturers shall also include a detailed description
32 of the methodology by which the prices were calculated. When a
33 manufacturer reports average wholesale price, wholesale
34 acquisition cost, average manufacturer price, or best price, the
35 president or chief executive officer of the manufacturer shall
36 certify to the Medicaid program, on a form provided by the

1 commissioner of human services, that the reported prices are
2 accurate. Any information reported under this paragraph shall
3 be classified as nonpublic data under section 13.02, subdivision
4 9. Notwithstanding the classification of data in this paragraph
5 and subdivision 2, the Minnesota Attorney General's Office or
6 another law enforcement agency may access and obtain copies of
7 the data required under this paragraph and use that data for law
8 enforcement purposes.

9 Sec. 2. Minnesota Statutes 2004, section 151.47, is
10 amended by adding a subdivision to read:

11 Subd. 3. [PENALTIES AND REMEDIES.] The attorney general
12 may pursue the penalties and remedies available to the attorney
13 general under section 8.31 against any manufacturer who violates
14 subdivision 1, paragraph (g).

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Senate
State of Minnesota

S.F. No. 23 - Pharmaceutical Pricing Disclosure

Author: Senator Yvonne Prettner Solon

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

Date: March 4, 2005

S.F. No. 23 requires drug manufacturers to disclose certain pharmaceutical pricing to the Commissioner of Human Services as a requirement for licensure under Minnesota Statutes, chapter 151.

Section 1 (151.47, subdivision 1) requires drug manufacturers to on a quarterly basis report to the Board of Pharmacy and to the Commissioner of Human Services the following pharmaceutical pricing criteria for each of their drugs: average wholesale price (AWP); wholesale acquisition cost (WAC); average manufacturer price (AMP) as defined under federal law; and best price as defined under federal law. Describes the calculation to be used to determine the AWP and WAC. Requires a detailed description of the methodology used to calculate the reported AWP, WAC, AMP, and best price be included in the report. Requires the president or chief executive officer of the manufacturer to certify to the medical assistance program on a form provided by the Commissioner of Human Services that the reported prices are accurate. States that any information reported shall be classified as nonpublic data under section 13.02, subdivision 9, but authorizes the attorney general's office or another law enforcement agency to access and obtain copies of th data and use it for law enforcement purposes.

Section 2 (151.45, subdivision 3) authorizes the attorney general to pursue penalties and remedies available under section 8.31 against any manufacturer who violates **section 1.**

KC:ph

Consolidated Fiscal Note – 2005-06 Session

Bill #: S0023-0 **Complete Date:** 02/14/05

Chief Author: SOLON, YVONNE PRETTNER

Title: WHOLESALE DRUG DISTRIBUTOR REQ

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

Agencies: Human Services Dept (02/14/05)
Pharmacy Board (01/31/05)
Attorney General (01/31/05)

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					
General Fund		122	108	108	108
Human Services Dept		122	108	108	108
Revenues					
General Fund		49	43	43	43
Human Services Dept		49	43	43	43
Net Cost <Savings>					
General Fund		73	65	65	65
Human Services Dept		73	65	65	65
Total Cost <Savings> to the State		73	65	65	65

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
General Fund		1.00	1.00	1.00	1.00
Human Services Dept		1.00	1.00	1.00	1.00
Total FTE		1.00	1.00	1.00	1.00

Consolidated EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: DOUG GREEN
Date: 02/14/05 Phone: 286-5618

Fiscal Note – 2005-06 Session

Bill #: S0023-0 **Complete Date:** 02/14/05

Chief Author: SOLON, YVONNE PRETTNER

Title: WHOLESALE DRUG DISTRIBUTOR REQ

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

Agency Name: Human Services Dept

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

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
General Fund		122	108	108	108
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
General Fund		122	108	108	108
Revenues					
General Fund		49	43	43	43
Net Cost <Savings>					
General Fund		73	65	65	65
Total Cost <Savings> to the State		73	65	65	65

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
General Fund		1.00	1.00	1.00	1.00
Total FTE		1.00	1.00	1.00	1.00

Bill Description: Requires pharmaceutical manufacturers to report certain pricing information to the Department of Human Services.

Assumptions While this bill requires manufacturers to supply certain drug pricing information to DHS, it does not specifically require the department to use that data to calculate reimbursement to providers. Consequently, this will have no impact on program costs. There will be an administrative cost because staff will have to somehow process, track and store the data. Assume Pharmacy Program would need 1 FTE on an ongoing basis for staff to process data and to follow-up with manufacturers as necessary. There would be only negligible systems cost to set up a database.

(Note – even if the authors of the bill assume that DHS would use the drug pricing information to establish reimbursement rates, DHS would not be able to do so given the current language of the bill. Consequently, the fiscal analysis remains the same – DHS would need 1 FTE to handle the data).

Expenditure and/or Revenue Formula

1 FTE needed for data collection and processing:

	FY06	FY07	FY08
Staff Costs	122	108	108
Revenue	49	43	43
Net Cost to State	73	65	65

Long-Term Fiscal Considerations Would have to continue processing this data for as long as it is being sent to us.

Local Government Costs None

References/Sources

Agency Contact Name: Cody Wiberg 282-6496
FN Coord Signature: STEVE BARTA
Date: 02/03/05 Phone: 296-5685

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: DOUG GREEN
Date: 02/14/05 Phone: 286-5618

Fiscal Note – 2005-06 Session

Bill #: S0023-0 **Complete Date:** 01/31/05

Chief Author: SOLON, YVONNE PRETTNER

Title: WHOLESALE DRUG DISTRIBUTOR REQ

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

Agency Name: Pharmacy Board

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					

This bill version has no fiscal effect on our agency.

FN Coord Signature: JULI VANGSNESS
Date: 01/27/05 Phone: 617-2120

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: DOUG GREEN
Date: 01/31/05 Phone: 286-5618

Fiscal Note – 2005-06 Session

Bill #: S0023-0 **Complete Date:** 01/31/05

Chief Author: SOLON, YVONNE PRETTNER

Title: WHOLESALE DRUG DISTRIBUTOR REQ

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

Agency Name: Attorney General

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					

This bill version has no fiscal effect on our agency.

FN Coord Signature: TERRY POHLKAMP
Date: 01/24/05 Phone: 297-1143

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: KRISTI SCHROEDL
Date: 01/31/05 Phone: 215-0595

January 28, 2005

The Honorable Yvonne Prettner Solon
Minnesota State Senate
303 State Capitol
St. Paul, MN 55155

Dear Senator Solon:

The Generic Pharmaceutical Association (GPhA) would like to express our deep concerns regarding S 23 - the legislation you are authoring requiring pharmaceutical manufacturers to report various pricing structures of each drug to the Minnesota Department of Human Services. While we recognize and share your concerns for the high cost of prescription drugs, the highly competitive marketplace for generic pharmaceuticals keeps the cost of generics at a fraction of the cost of brands and results in billions in savings for consumers and public programs each year.

Generic pharmaceuticals not only offer the same medicine and same result as their brand counterparts, but also save consumers more than $10 billion a year nationally. The member companies of the Generic Pharmaceutical Association are pleased to provide Minnesotans with the medicines they need while helping state government achieve significant cost savings.

Generic manufacturers provide more than half of all drugs dispensed in the United States; yet generics account for only eight (8) percent of expenditures for prescription drugs. Due to the highly competitive marketplace for generic drugs, prices for generics can be as little as 20 percent the cost of its brand counterpart. Generic manufacturers keep have highly efficient manufacturing facilities, spend very little on marketing and have significantly less profits than brand pharmaceutical companies. We believe that increasing generic utilization and ensuring a strong competitive generic marketplace offers the best immediate solution to high drug expenditures.

We recognize that many policymakers find the current pricing structure of pharmaceuticals very complicated and confusing. This is an issue at the federal level and Congress and Centers for Medicaid & Medicare Services (CMS) are exploring ways to ensure greater consistency in drug pricing nationally. Late last year, the U.S. House of Representatives held a hearing on pricing and reporting issues, and we expect further inquiry of this matter. We believe that it is most appropriate for this issue to be addressed at the national level.

While we recognize your desire to provide the Department of Human Services with a mechanism for identifying potentially inflated prices for rebate and reimbursement purposes, this legislation would create a reporting procedure that unnecessarily duplicates federal reporting requirements and would create a burdensome reporting system for generic manufacturers.

Generic Pharmaceutical Association (GPhA)
2300 Clarendon Boulevard, Suite 400 • Arlington, VA 22201 • ph: 703.647.2480 • f: 703.647.2481 • www.gphaonline.org

Such requirements for generic manufacturers could undermine the competitive marketplace that currently provides huge savings on drugs and could result in higher costs for consumers and state programs. This competitive marketplace relies on confidentiality of pricing among customers and legislation such as S 23 could inadvertently undermine that process.

We are concerned that this legislation requires far more onerous reporting than is currently required federally. The federal reporting is not vendor specific nor is it publically available. This legislation does not specify whether the highly sensitive pricing data of generic manufacturers will remain completely confidential. In most instances, unlike the brand sector, there are multiple generic manufacturers for each drug. Moreover, consumers and physicians do not generally request generic drugs by name; rather generic manufacturers compete based on the price to customers such as the local pharmacies. This individual pricing information is proprietary and should remain proprietary and not be publicly available from the state.

One element of your proposed legislation that does not exist federally or in any other state is the "certification" by the company president or CEO. This is not part of the federal price reporting requirements and seems to be a highly extraordinary step.

Finally, in a time of severe budget deficit experienced by your state, managing this information could be a costly and a significant task for your Department of Human Services. We believe that there are more cost effective means to achieve your goals that will not interfere with critical program needs in the state. We would welcome the opportunity to work with you to achieve our common goal of ensuring that the State of Minnesota and its citizens are able to purchase effective drugs at affordable prices.

While we respect and share many of your goals, we cannot support legislation that would impose considerable burdens on generic manufacturers on a state-by-state basis. We also have strong concerns about the implication for the generic marketplace if pricing information must be reported and no longer remains confidential.

Thank you for opportunity to express the concerns of our members. Please feel free to call on me if I can provide additional information or answer questions. I look forward to the opportunity to work with you to ensure that the State of Minnesota can achieve needed savings in your health care programs.

Sincerely,

Bruce Lott
Senior Director of State Affairs

Suite 722, 444 North Capitol Street, NW, Washington, DC 20001

January 20, 2005

Senator Yvonne Prettner Solon
303 State Capitol
St. Paul, Minnesota 55155

Dear Senator Solon:

Barr Laboratories, Inc. is a leading generic pharmaceutical company, currently manufacturing and distributing nearly 100 pharmaceutical products in therapeutic categories including female healthcare, cardiovascular, oncology, anti-infective and psychotherapeutics. We are a part of the generic pharmaceutical manufacturing industry that is providing massive savings to all Minnesotans as well as to the state through Medical Assistance and the other state pharmacy assistance programs. Generic pharmaceuticals offer the same safety and effectiveness as the brand counterparts, saving consumers more than $10 billion a year nationally. We share your concerns regarding the high cost of drugs and are doing our best to provide lower cost generic alternatives as soon as possible when a patent expires.

I am writing to you regarding SF 23, the legislation you are authoring requiring pharmaceutical manufacturers to report various pricing structures of each drug to the Minnesota Department of Human Services and to provide certification by the company president or CEO. We have a number of concerns with this legislation and encourage you to reconsider whether it will accomplish the intended purpose.

We recognize that many policy-makers find the current pricing structure of pharmaceuticals very complicated and confusing. This is an issue at the federal level; Congress and Centers for Medicaid & Medicare Services (CMS) are currently working towards developing greater consistency in drug pricing nationally. CMS is weighing many options including moving toward an Average Sales Price reporting system, and the House Energy and Commerce Committee held a hearing last month to discuss fixing the price reporting system as a part of Medicaid reform this year. The administration has made it a top priority a well. We believe that it is most appropriate for this issue to be addressed at the federal level and have been cooperating fully and eagerly with CMS, Congress and the Bush Administration in their efforts.

Despite the goal of trying to assist your Department of Human Services in identifying potentially inflated prices for rebate purposes, this legislation will instead be a reporting procedure that either a) unnecessarily duplicates federal reporting requirements, or b) creates a cumbersome price reporting system for each drug in each form and strength that identifies the price to each customer. Either scenario raises serious concerns regarding the confidentiality of our pricing among customers that

goes well beyond the needs of the Department of Human Services for identifying potential Medicaid fraud.

We are concerned that this legislation requires far more than is currently required to be reported federally. The federal reporting is not vendor specific and is not public data. This legislation does not specify whether our highly sensitive pricing data will remain completely confidential. Please keep in mind that the generic industry is a competitive marketplace. In most instances, there are multiple generic manufacturers for each drug. Consumers do not request our drugs by name – we compete based on the price we offer to our customers (such as the local pharmacies). This individual pricing information is proprietary and should remain proprietary and not be publicly available from the state. Similar concerns have been raised with the Texas law by the Generic Pharmaceutical Manufacturers Association (GPHA).

One element of your proposed legislation that does not exist federally or in any other state is the "certification" by the company president or CEO. This is not part of the federal price reporting requirements and seems to be a highly extraordinary step. Barr Laboratories, Inc., as a corporation, is diligent in reporting the required pricing information to the Federal and State governments. As an entity, we are responsible to give accurate and timely reports; a requirement for certification by our CEO is burdensome and unnecessary.

Finally, in a time of budget deficit experienced by your state, managing this information is a significant task for your Department of Human Services. In Texas, the agency hired many new staff people to administer a similar program and sort through thousands of reporting forms. We believe that there are more cost effective means to achieve your goals that will not interfere with critical program needs in the state.

In conclusion, we respect your goals but oppose state-by-state efforts for price reporting and instead support federal initiatives on price reporting and in reforming the AWP pricing system. We also have serious concerns about the competitive implications for generics if the pricing information we must report to the state is not private and confidential.

I appreciate your consideration of the concerns we have raised regarding SF 23.

Sincerely,

Jake Hansen
Vice President, Government Affairs

1 A bill for an act

2 relating to human services; authorizing a long-term
3 care partnership program; modifying medical assistance
4 eligibility requirements under certain circumstances;
5 defining approved long-term care insurance policies;
6 limiting medical assistance estate recovery under
7 certain circumstances; proposing coding for new law in
8 Minnesota Statutes, chapter 256B.

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

10 Section 1. [256B.0571] [LONG-TERM CARE PARTNERSHIP.]

11 Subdivision 1. [DEFINITIONS.] For purposes of this
12 section, the following terms have the meanings given them.

13 Subd. 2. [HOME CARE SERVICE.] "Home care service" means
14 care described in section 144A.43.

15 Subd. 3. [LONG-TERM CARE INSURANCE.] "Long-term care
16 insurance" means a policy described in section 62S.01.

17 Subd. 4. [MEDICAL ASSISTANCE.] "Medical assistance" means
18 the program of medical assistance established under section
19 256B.01.

20 Subd. 5. [NURSING HOME.] "Nursing home" means a nursing
21 home as described in section 144A.01.

22 Subd. 6. [PARTNERSHIP POLICY.] "Partnership policy" means
23 a long-term care insurance policy that meets the requirements
24 under subdivision 10, regardless of when the policy was first
25 issued.

26 Subd. 7. [PARTNERSHIP PROGRAM.] "Partnership program"
27 means the Minnesota partnership for long-term care program

1 established under this section.

2 Subd. 8. [PROGRAM ESTABLISHED.] (a) The commissioner, in
3 cooperation with the commissioner of commerce, shall establish
4 the Minnesota partnership for long-term care program to provide
5 for the financing of long-term care through a combination of
6 private insurance and medical assistance.

7 (b) An individual who meets the requirements in this
8 paragraph is eligible to participate in the partnership
9 program. The individual must:

10 (1) be a Minnesota resident;

11 (2) purchase a partnership policy that is delivered, issued
12 for delivery, or renewed on or after the effective date of this
13 section, and maintain the partnership policy in effect
14 throughout the period of participation in the partnership
15 program; and

16 (3) exhaust the minimum benefits under the partnership
17 policy as described in this section. Benefits received under a
18 long-term care insurance policy before the effective date of
19 this section do not count toward the exhaustion of benefits
20 required in this subdivision.

21 Subd. 9. [MEDICAL ASSISTANCE ELIGIBILITY.] (a) Upon
22 application of an individual who meets the requirements
23 described in subdivision 8, the commissioner shall determine the
24 individual's eligibility for medical assistance according to
25 paragraphs (b) and (c).

26 (b) After disregarding financial assets exempted under
27 medical assistance eligibility requirements, the commissioner
28 shall disregard an additional amount of financial assets equal
29 to the dollar amount of coverage utilized under the partnership
30 policy.

31 (c) The commissioner shall consider the individual's income
32 according to medical assistance eligibility requirements.

33 Subd. 10. [APPROVED POLICIES.] (a) A partnership policy
34 must meet all of the requirements in paragraphs (b) to (f).

35 (b) Minimum coverage shall be for a period of not less than
36 one year and for a dollar amount equal to 12 months of nursing

1 home care at the minimum daily benefit rate determined and
2 adjusted under paragraph (c). The policy shall provide for home
3 health care benefits to be substituted for nursing home care
4 benefits with one home health care day benefit worth at least 50
5 percent of one nursing home care day.

6 (c) Minimum daily benefits shall be $130 for nursing home
7 care or $65 for home care. These minimum daily benefit amounts
8 shall be adjusted by the commissioner on October 1 of each year
9 by a percentage equal to the inflation protection feature
10 described in section 62S.23, subdivision 1, clause (1).
11 Adjusted minimum daily benefit amounts shall be rounded to the
12 nearest whole dollar.

13 (d) A third party designated by the insured shall be
14 entitled to receive notice if the policy is about to lapse for
15 nonpayment of premium, and an additional 30-day grace period for
16 payment of premium shall be granted following notification to
17 that person.

18 (e) The policy must cover all of the following services:

19 (1) nursing home stay;

20 (2) home care service; and

21 (3) care management.

22 (f) A partnership policy must offer the following options
23 for an adjusted premium:

24 (1) an elimination period of not more than 100 days; and

25 (2) nonforfeiture benefits for applicants between the ages
26 of 18 and 75.

27 Subd. 11. [LIMITATIONS ON ESTATE RECOVERY.] For an
28 individual determined eligible for medical assistance under
29 subdivision 9, the state shall limit recovery under the
30 provisions of section 256B.15 against the estate of the
31 individual or individual's spouse for medical assistance
32 benefits received by that individual to an amount that exceeds
33 the dollar amount of coverage utilized under the partnership
34 policy.

35 **[EFFECTIVE DATE.]** (a) If any provision of this section is
36 prohibited by federal law, no provision shall become effective

1 until federal law is changed to permit its full implementation.
2 The commissioner of human services shall notify the revisor of
3 statutes when federal law is enacted or other federal approval
4 is received and publish a notice in the State Register. The
5 commissioner must include the notice in the first State Register
6 published after the effective date of the federal changes.
7 (b) If federal law is changed to permit a waiver of any
8 provisions prohibited by federal law, the commissioner of human
9 services shall apply to the federal government for a waiver of
10 those prohibitions or other federal authority, and that
11 provision shall become effective upon receipt of a federal
12 waiver or other federal approval, notification to the revisor of
13 statutes, and publication of a notice in the State Register to
14 that effect.

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Senate
State of Minnesota

S.F. No. 540 - Long-Term Care Partnership Program

Author: Senator Linda Berglin

Prepared by: David Giel, Senate Research (651/296-7178)

Date: March 11, 2005

S.F. No. 540 authorizes the establishment of a long-term care partnership program in Minnesota to finance long-term care through a combination of private insurance and Medical Assistance (MA), once federal law is modified to permit it or a federal waiver is obtained.

Section 1 (256B.0571) authorizes the program.

Subdivisions 1 to 7 define terms.

Subdivision 8 directs the Commissioner of Human Services, in cooperation with the Commissioner of Commerce, to establish the Partnership for Long-Term Care Program to finance long-term care through a combination of private insurance and MA. To be eligible, a person (1) must be a state resident; (2) must purchase and maintain continuous coverage under a qualifying long-term care insurance policy; and (3) must exhaust the minimum policy benefits. Benefits received before the effective date of the bill do not count towards exhaustion of benefits.

Subdivision 9 outlines MA eligibility for a person who meets the qualifications in subdivision 8. After disregarding assets otherwise exempt under MA, DHS must disregard an additional amount of assets equal to the dollar amount of coverage utilized under the qualifying long-term care insurance policy. The treatment of income is unchanged from current MA law.

Subdivision 10 establishes requirements for a Partnership Policy. They include:

- Minimum coverage must be for a dollar amount equal to at least 12 months of nursing home care. Home health benefits may be substituted for nursing home benefits, with one home health care day worth at least 50 percent of one nursing home day.

- Minimum daily benefits must be $130 for nursing home care and $65 for home health care. The minimums must be adjusted each October 1 according to the inflation protection feature described in Minnesota Statutes, section 62S.23, subdivision 1, clause (1). This clause requires an annual increase of not less than five percent.

- Special lapse protection features must be included.

- The policy must cover nursing home stays, home care services, and care management.

- Options, available for an additional premium, must include an elimination period of not more than 100 days and nonforfeiture benefits for applicants between 18 and 75.

Subdivision 11 protects from MA estate recovery procedures an amount of assets equal in value to the dollar amount of coverage utilized under the Partnership Program.

The Partnership Program does not become effective until full implementation is permitted by federal law. If federal law is changed to permit a waiver of any provisions prohibited by federal law, the Department of Human Services must apply for the waiver.

DG:rdr

Consolidated Fiscal Note – 2005-06 Session

Bill #: S0540-1E **Complete Date:** 03/15/05

Chief Author: BERGLIN, LINDA

Title: LONG TERM CARE PARTNERSHIP PROGRAM

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

Agencies: Human Services Dept (03/15/05) Commerce (03/01/05)

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					
General Fund		45	45	45	45
Commerce		45	45	45	45
Revenues					
General Fund		6	6	6	6
Commerce		6	6	6	6
Net Cost <Savings>					
General Fund		39	39	39	39
Commerce		39	39	39	39
Total Cost <Savings> to the State		39	39	39	39

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
General Fund		0.50	0.50	0.50	0.50
Commerce		0.50	0.50	0.50	0.50
Total FTE		0.50	0.50	0.50	0.50

Consolidated EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: DOUG GREEN
Date: 03/15/05 Phone: 286-5618

Fiscal Note – 2005-06 Session

Bill #: S0540-1E **Complete Date:** 03/15/05

Chief Author: BERGLIN, LINDA

Title: LONG TERM CARE PARTNERSHIP PROGRAM

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 540-1E

Bill Description

This bill requires the Commissioners of Human Services and Commerce to work together to establish a long-term care (LTC) partnership program in Minnesota to finance LTC through a combination of private long term care insurance and Medical Assistance (MA). A LTC Partnership program would allow an individual to be eligible for MA with an increased asset limit equal to the current MA asset limit plus the total amount of LTC expenses paid for by a qualified long term care insurance (LTCI) policy. The bill establishes the requirements that must be met in order for a LTCI policy to qualify as a partnership policy. Additionally, the bill would reduce estate recovery by an amount equal to the increased asset limit.

Current federal law does not permit the estate recovery exemptions and the bill only becomes effective if and when federal law is changed to permit its full implementation (asset limit and estate recovery exemptions).

Assumptions

There are no program or administrative fiscal impacts associated with the asset limit and estate recovery exemption provisions of the bill because they cannot take effect until such time as there is a change to federal law. There are no other DHS administrative fiscal impacts associated with this bill.

Expenditure and/or Revenue Formula

Long-Term Fiscal Considerations

Local Government Costs

References/Sources

Agency Contact Name: Lisa Knazan 297-5628
FN Coord Signature: STEVE BARTA
Date: 03/02/05 Phone: 296-5685

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: DOUG GREEN
Date: 03/15/05 Phone: 286-5618

Fiscal Note – 2005-06 Session

Bill #: S0540-1E **Complete Date:** 03/01/05

Chief Author: BERGLIN, LINDA

Title: LONG TERM CARE PARTNERSHIP PROGRAM

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

Agency Name: Commerce

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

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
General Fund		45	45	45	45
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
General Fund		45	45	45	45
Revenues					
General Fund		6	6	6	6
Net Cost <Savings>					
General Fund		39	39	39	39
Total Cost <Savings> to the State		39	39	39	39

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
General Fund		0.50	0.50	0.50	0.50
Total FTE		0.50	0.50	0.50	0.50

Bill Description

1) Senate File 540-1E authorizes a partnership program in Minnesota to finance long-term care through a combination of private insurance and medical assistance. The program would become effective when federal law is modified to permit such a program, or when Minnesota obtains a federal waiver.
2) The partnership program is designed to help people avoid spending down or transferring assets.
3) Under this proposal, Minnesota will create a long-term care policy with certain benefits. When a person exhausts the benefits under this policy, special medical assistance eligibility rules will allow continued coverage without regard to the person's financial assets.
4) Example:
   a) A person could purchase a long-term care policy to provide 12 months of coverage.
   b) When the person used the full 12 months of purchased coverage, medical assistance would provide an additional 12 months of coverage.
   c) Special eligibility rules for medical assistance will allow the second 12 months of coverage.
   d) The person would receive a total of 24 months of coverage, including the 12 months on medical assistance, without have to reduce assets.
5) The program will be administered by the Commissioner of Human Services in cooperation with the Commissioner of Commerce.

Assumptions

1) The Department of Commerce will review and approve long-term care policies.
2) Fees for policy review and approval will generate revenue.
3) Revenue will be paid into the General Fund.

Expenditure and/or Revenue Formula

Expenditure

	FTE	FY 2006	FY 2007
Policy Analyst	0.25	$15,000	$15,000
Actuary	0.25	$30,000	$30,000

Revenue

Policies Reviewed	Fee	FY 2006	FY 2007
75	$75.00	$5,625	$5,625

Long-Term Fiscal Considerations

Continuing staff expenditures and fee revenues.

Local Government Costs

Not applicable.

References/Sources

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Agency Contact Name: John Gross 651-297-2319
FN Coord Signature: MICHAEL F. BLACIK
Date: 02/28/05 Phone: 297-2117

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: KEITH BOGUT
Date: 03/01/05 Phone: 296-7642

Report of the Long-Term Care Reform Committee

New York State Bar Association
Elder Law Section

February 2005

The Elder Law Section is solely responsible for the contents of this report and the recommendations contained herein. Unless and until adopted in whole or in part by the Executive Committee or the House of Delegates of the New York State Bar Association, no part of the report should be attributed to the Association.

The first printing of this Report, on February 15, 2005, was distributed in Albany primarily to legislators and their aides on committees whose responsibilities include the Medicaid program.

This printing adds an Appendix C with a digest of basic rules for Medicaid coverage at home and in nursing homes. It also corrects some typographical errors in Chapter 6 on the proposed Long-Term Care Insurance Compact.

Chapter 6
A Proposal for a New York State LTC Compact

Overview This chapter proposes the creation of a New York State Compact that would consist of an agreement between the state and its chronically ill citizens to share the risks associated with paying for long-term care, an undertaking that market forces have proved unable to address.

Instead of frantically giving away assets when diagnosed with a chronic illness, citizens would have the option to "pledge" that they would use a defined amount of their then-existing assets to pay for their long-term care needs. The pledged amount would be a set maximum (perhaps $300,000 as the average three-year cost of facility care), or up to one-half of their assets, whichever was smaller.

Until they spent the pledged amount, Compact members would pay entirely for their own care without Medicaid assistance. They would have full access to all their income and assets, rather than the current practice in which Medicaid recipients are reduced to a poverty level of assets and a net income (after the contribution required by Medicaid) that is seldom adequate to meet the needs of those who remain at home.

Once they spent the pledged amount, Compact members would have two options—regular Medicaid coverage requiring them to turn over most of their income, or an option to retain "private pay" status in which they would keep 75% of their income while Medicaid subsidized their long-term care obligations by paying 90% of what it would otherwise have paid to their providers.

Regardless of which option they chose, Compact members would not be "impoverished," because they would retain the unpledged portion of their assets. Portions of the assets could be used for needs that Medicaid has never covered such as private duty aides in a nursing home or geriatric care managers to do errands, etc.

As shown by the illustrations, the program would be unlikely to increase Medicaid's liability for providing services, and could significantly reduce its outlay as individuals paid for a greater portion of their care, particularly in the first years after they began to suffer from chronic illnesses.

In short, rather than being the "first resort" for individuals scared that they will outlive their resources, Medicaid would serve as a true "safety net" for those who live many years after being diagnosed with a chronic illness.

By Gail Holubinka

6.1 Design Parameters

The subject of this proposal is financing—not services. There are many issues related to the development of better and more efficient long-term care services, but without a viable payment source, concerns about the quality of service are moot.

At present, 80% of long-term care expenses in New York State are paid by Medicaid. The goal is to privatize as much of that expense as possible. Privatization of up-front coverage would address a dilemma that has faced public officials for years—how to avoid harm to the truly needy while controlling the costs of long-term care.

The majority of total long-term care expenses occur in the first 1 to 3 years after an individual is diagnosed with a chronic illness. Rather than frantically divest themselves of assets upon learning of a chronic illness, Compact members would initially retain all their income and use assets to pay the remainder of their costs for long-term care. At the same time, they would have the security of knowing that, under terms of the Compact, they would qualify for Medicaid assistance once they had used a "pledged" amount—never more than half of the assets in their names when they were diagnosed with a chronic illness—to pay for their long-term care needs.

Those who must come to grips with the realization that they have a chronic illness would be able to retain the dignity and self-reliance they crave, but they would also have the reassurance that if their illnesses lingered for an extended period, Medicaid would be a true "safety net." Even after qualifying, however, they would retain access to a significant portion of the assets that are now often given outright to their children or placed in irrevocable trusts until they die.

A well-designed Compact program could foster the type of cooperation that is best achieved by creating a sense of shared responsibility and fairness. Its approach would not involve "look back" periods, complex rules and requirements, or expectations that would be unacceptable to a reasonable person or entity. A person seeking Medicaid after spending the pledged amount would simply provide evidence that the assets had been spent on long-term care.

The potential viability of any program is first measured in expense and complexity. Therefore, in so far as possible, it should use products, systems, processes, and people already in place and explainable in one sentence. No new procedures or operational expenses would be required. Administration economies would be possible through use of current resources.

Options Beyond Medicaid and Medicare The problem to be addressed is not about Medicaid or Medicare. The crisis in public financing is an effect, not a cause, and is driven by demographics. While these public programs are important, they are only two options available in responding to needs.

Current and future Medicaid or other government program eligibility rules are not applicable to a private pay solution, even if that solution involves such programs.

Joint participation with government does not automatically imply government rights, oversight, or controls greater than would be in place outside the program.

The manner in which public funding is delayed is not important. The issue is how to avoid or delay it for as long as possible without imposing undue burdens on the chronically ill.

6.2 A Compact Between State and Its Citizens

The proposal is to create a compact between the citizens of New York and their government. The focus of the compact would be an agreement that there would be a limit to the liability of both parties. What that limit may be would be subject to consumer choice and based on personal risk tolerance and need.

Rationale Statements The following basic concepts underlie the approach to be taken.

- Long-term care can be extremely costly. For all but a few, eventual impoverishment is unavoidable given sufficient amounts and lengths of need.
- Impoverishment is neither a desirable nor a rational societal expectation.
- Forced impoverishment leads to avoidance of reasonable private contribution.
- Avoidance leads to increased reliance on public funding.
- Increased reliance on public funding is unsustainable.
- Neither the individual nor the public sectors are capable of managing the anticipated cost of long-term care on their own.
- Medicaid remains a resource if prolonged long-term care services are eventually necessary.

6.3 Design Summary

Eligibility Participation would be limited to chronically ill New York residents residing within the state at the times they apply for and participate in the program.

The Compact option would not be available to persons eligible for or currently receiving Medicaid benefits.

Program The New York State Compact would permit participants to protect assets and in some cases income, by agreeing to pay a "pledged" amount equal to a maximum of the cost for three years of facility coverage at the average daily rate, or up to one-half of their assets, whichever was smaller if the two figures were not the same.

Assume that the maximum pledge amount was $300,000 (based on the $98,185 yearly average cost of facility care cited in 4.1). An individual with $400,000 in assets could pledge a maximum of $200,000, an individual with $600,000 in assets could pledge $300,000, and the maximum pledge for an individual with $800,000 would also be $300,000.

Assets would include all funds and property, including the homestead, as defined in Medicaid rules and regulations. Where the amount to be protected exceeded the value of liquid assets, the consumer could still participate by signing a lien against the value of real property, agreeing that the home could not be sold without repaying the state as a creditor.

Participants could make payments out of pocket, through insurance or reverse mortgages. Individuals with some other funding such as a long-term care policy might be able to satisfy their pledge amount without agreeing to have a lien placed against their property.

General Rules Once participants paid their "pledge" amounts, they would have two choices for assistance from Medicaid—a Medicaid Option providing coverage essentially similar to the current Medicaid programs, or a Subsidization Option in which they would continue to be "private pay" clients and would retain 75% of their income, but Medicaid would subsidize their long-term care expenses with payments equal to 90% of its rate for those services.

Thus, if the Subsidization Option was chosen and Medicaid's normal reimbursement rate for the facility was $150 per day, Medicaid would pay $135 per day. Assuming the facility's private pay rate was $165 per

day, the Compact participant would pay the remaining $30 per day, most likely from the 75% of the monthly income the participant was retaining. Medicaid would pay only the $135, it would not pay for any of the other expenses it now bears for Medicaid recipients.

In general, those with relatively small incomes would be most likely to chose the Medicaid Option, because it would mean that the need to dip into their remaining assets would be minimal, particularly if they were in a nursing home. Those with relatively high incomes would be most likely to choose the Subsidization Option. The 75% of their monthly income that they would retain would be likely to pay all or most of their remaining daily obligation to a facility, together with the cost of services not covered by Medicaid. Assets would need to be tapped only for special needs such as private duty aides not covered by Medicare or Medicaid.

Those who chose the Subsidization Option would not be required to use providers contracted with the NYS Medicaid program. Even those who ultimately chose the Medicaid Option would not be required to use Medicaid providers until they actually applied for Medicaid.

6.4 Compact Definition of Expenses

Any New York State resident who had expended the amount pledged when he/she signed up for the Compact would be eligible for coverage upon demonstrating that the pledged amount had been spent. In no case would the amount exceed the cost for three years of nursing home care as computed by using the average statewide cost of such care.

To count as an expenditure under the Compact, an expense for Qualified Long-term Care Services made by or on behalf of a participant who had been assessed as eligible would need to be documented by proof that the expense had been paid (not incurred).

The definition of what was a Qualified Long-term Care service and what constituted eligibility would be in accordance with HIPPA rules and regulations.

6.5 Applying for the Compact Benefit

Resident consumers (or their representatives) who believed they would qualify as individuals requiring long-term care could contact their insurer, or in the case of cash payments, go directly to a state-approved assessment organization. Assessments would be at the expense of the applicant or their insurer where appropriate.

The consumer would contact the Compact office to arrange participation and sign appropriate agreements.

Proof of payment for Qualified Long-term Care services would have to be submitted to the Compact office. Qualified Long-term Care services would not need to be covered by or paid at the rates of Medicaid to count toward the agreed obligation.

6.6 The Compact Benefit

Participants who had met their agreed upon obligation could choose one of two Compact options, the Medicaid Option or the Subsidization Option.

Medicaid Option Those electing the Medicaid option would be entitled to all the benefits available under the Medicaid program and be subject to all its restrictions, with the exception of rights of recovery from assets protected by the Compact agreement.

Services would be those provided under the Medicaid program and would be paid at the Medicaid rate.

Income would be applied to the cost of care, and spousal obligations would be enforced.

Subsidization Option The Subsidization option would apply only to Qualified Long-term Care services. Participants could use any Qualified Long-term Care service they wished.

Where that service was covered by Medicaid, a participant would receive a subsidization amount equal to 90% of what Medicaid would have paid. However, Medicaid rules or restrictions would not apply. Participants would be required only to contribute 25% of their income to receive subsidization payments.

Persons receiving payments by Medicaid under this program would not be subject to Medicaid rules governing assets, recovery, or eligibility. Persons receiving payments from Medicaid under this program would not be required to use providers contracted with the NYS Medicaid program.

Participants in the subsidization program would be considered to be on private pay status, and would be charged a Compact Rate 10% higher than the Medicaid rate. (As indicated earlier, the Compact Rate at a facility would be $165 if the Medicaid reimbursement rate at the facility was $150.) The participant would be responsible for any difference between the subsidization from Medicaid ($135 in the example) and the Compact Rate.

Income, annuities, insurance and reverse mortgage arrangements would be likely sources of payment for the variance between Compact and subsidization rates. Should the participant find it impossible to maintain the cost of the difference, he/she could apply for regular Medicaid coverage. The asset protection shall be honored.

Medicaid waivers from the federal government might be required for approval to use funds to finance the subsidization program.

6.7 Operations/Expenditure

Use Current Resources The current Partnership program has staffing and funding. Most of its efforts are directed toward maintaining an unnecessarily cumbersome program that served a fledgling industry but is no longer necessary.

In addition, the program is modeled on Medicaid, again making the goal of privatization difficult. These staff could form the foundation of the Compact.

The program would best be administered under the aegis of a neutral agency. Neither Medicaid, DoH, DoI, nor SoFA has the focus, expertise, or sufficient stake to manage the proposed program.

Use Commonly Accepted Vendors/Regulations Long-term care insurance is highly regulated by both state and federal rules and regulations. There would be no need to recreate a new infrastructure to support the Compact.

6.8 Examples of Potential Compact Outcome

Mrs. Jones is 78-year-old widow, frail but in relatively good health. She has an income of $24,000 a year and assets of about $300,000, consisting of a home valued at $150,000 and savings of $150,000. Insurance is not an option because coverage would be too expensive and it is doubtful she could pass underwriting.

Mrs. Jones wants to remain home as long as possible. She and her family currently engage an aide who is not a Medicaid provider, but Mrs. Jones is comfortable with the aide. The cost of the aide is $200 a week for 10 hours of service. Their concern is the potential future need for help with multiple activities of daily living. With the higher level of need, at $20 per hour, she would quickly expend her savings. She considered a reverse mortgage, but the amount she could get would not be sufficient.

At age 80, Mrs. Jones falls and the result is a need for substantial health care support. The uncovered expenses amounted to $2,000. Her condition progresses to the point where she requires substantial assistance in bathing, dressing, and transferring to and from her bed. She wants to stay at home, but knows she needs help.

Present Options At present, the 78-year-old Mrs. Jones would have essentially two options to plan for her long-term care needs:

(1) She can give her home and her savings to her children so she can qualify immediately for Medicaid home care. If she later needs nursing home care before the penalty period resulting from the gifts (approximately 36 months for gifts totaling $300,000), she needs to feel confident that her children will use the funds she gave them to pay her nursing home expenses. There are two downsides: she is likely to lose the aide unless she can qualify for a consumer-directed home care program under Medicaid, and she will lose the income she would have received on her $150,000 in liquid assets.

(2) She can pay privately for home care, at least until her liquid assets run out (her $2,000 in monthly income gives her an advantage unavailable to many whose income is not that high), and she can postpone any divestiture of her assets until a need arises. If she needs nursing home care, she can take the "rule of halves" approach, giving the house to the children and using the $150,000 in liquid assets to pay her nursing home bill until the penalty period for the gift is satisfied.

Assumptions The examples that follow make the following assumptions about Mrs. Jones's financial circumstances and her likely needs for long-term care:

- Her care needs at home are constant at 10 hours per week for two years.
- Home health aides under Medicaid cost $18/hour; the private rate is $19.80/hour.
- Medicaid's rate at the nursing home is $150/day; the private-pay rate is $165/day.
- As a home Medicaid recipient, Mrs. Jones would be allowed to retain income of $700 per month (rounded up from the current $667 figure), and $150 for a Medicare supplementary insurance program), thereby requiring that $1,150 of her $2,000 income be paid to Medicaid to offset its costs for her care.
- If, instead of liquid assets of $150,000 and a house worth $150,000, the actual breakdown was $100,000 in liquid assets and a house worth $200,000, she would agree to have Medicaid place a lien for $50,000 on her home, to be repaid if the property is sold during her lifetime, or by the heirs to the property after her death.

Charts illustrating the Compact's principles begin on the next page.

Scenario #1—Standard Medicaid Mrs. Jones decides to divest today and apply for Medicaid.

Estimated Cost to Mrs. Jones

Mrs. Jones lives 5 years		Mrs. Jones lives 7 years	
Home health aide, 2 years [1]	$0	Home health aide, 2 years [1]	$0
Nursing home, 3 yrs @ $150/day [2]	$0	Nursing home, 5 yrs @ $150/day [2]	$0
Total *(before contribution)*	$0	Total *(before contribution)*	$0
Income contributed while home [3]	$27,600	Income contributed while home [3]	$27,600
Income contributed while in nursing home [4]	$64,800	Income contributed while in nursing home [4]	$108,000
Total Mrs. Jones Cost	**$92,400**	**Total Mrs. Jones Cost**	**$135,600**

1 - 104 weeks @ $180/week

2 - 1,095 days (3 yrs) @ $150/day Medicaid rate.

3 - 24 months (2yrs) @ $1,150/month. (Monthly income of $2,000 less $150 Medicare supplementary insurance premium and $700 retained income.)

4 - 36 months (3 yrs) @ $1,800/month ($2,000 less $50 personal needs allowance and $150 if used to pay the premium for a Medicare supplementary insurance policy. If no policy is purchased, the $150 is also payable to Medicaid, which will be responsible for prescription drugs and hospital co-payments not covered by Medicare.

1 - 104 weeks @ $180/week

2 - 1,825 days (5 yrs) @ $150/day Medicaid rate.

3 - 24 months (2 yrs) @ $1,150 /month. (Monthly income of $2,000 less $150 Medicare supplementary insurance premium and $700 retained income.)

4 - 60 months (5 yrs) @ $1,800/month ($2,000 less $50 personal needs allowance and $150 if used to pay the premium for a Medicare supplementary insurance policy. If no policy is purchased, the $150 is also payable to Medicaid, which will be responsible for prescription drugs and hospital co-payments not covered by Medicare.

Estimated Cost to Medicaid

Mrs. Jones lives 5 years		Mrs. Jones lives 7 years	
Home health aide, 2 years [1]	$18,720	Home health aide, 2 years [1]	$18,720
Nursing home, 3 yrs @ $150/day [2]	$164,250	Nursing home, 5 yrs @ $150/day [2]	$273,750
Total *(before contribution)*	$182,970	Total *(before contribution)*	$292,470
Income contributed while home [3]	- $27,600	Income contributed while home [3]	- $27,600
Income contributed while in nursing home [4]	- $64,800	Income contributed while in nursing home [4]	- $108,000
Total Medicaid Cost	**$90,570**	**Total Medicaid Cost**	**$156,870**

Scenario # 2—First Compact Option Mrs. Jones pays for an assessment. She is found eligible and pledges half of her assets.

Under the Compact rules, her first of two choices is to protect half of her assets ($150,000) with the understanding that virtually all of her income will go to Medicaid once she has spent $150,000 on long-term care.

She will immediately become eligible for Medicaid to pay for her prescriptions and other medical expenses not covered by Medicare or her supplementary policy.

She will pay for home care herself (easing her concerns about losing the trusted aide) until her home care expenses for her health aide total $150,000.

If she needs to enter a nursing home before she has spent $150,000 on her long-term care, she will pay privately until her combined payments for home care and nursing home care total $150,000.

Once she has spent $150,000 for long-term care, she will pay Medicaid $1,150 monthly from her $2,000 income if she is still at home, all but $50 monthly if she is in a nursing home.

Estimated Cost to Mrs. Jones

Mrs. Jones lives 5 years		Mrs. Jones lives 7 years	
Home health aide, 2 years [1]	$20,592	Home health aide, 2 years [1]	$20,592
Nursing home, 785 days @ $165/day [2] *	*$129,408	Nursing home, 785 days @ $165/day [2]	*$129,408
Total *(before contribution)*	$150,000	Total *(before contribution)*	$150,000
Income Contribution [3]	$18,000	Income Contribution [3]	$46,800
Total Mrs. Jones Cost	**$168,000**	**Total Mrs. Jones Cost**	**$196,800**

1 - Mrs. Jones pays $20,592 (104 weeks @ $198 /week).

2 - After Mrs. Jones pays $165/day 785 days (26 mos), she has fulfilled her commitment to spend $150,000 on her care, Medicaid pays for her final 310 days in the nursing home at its $150/day rate.

3 - 10 months @ $1,800/month ($2,000 less $50 personal needs allowance and $150 if used to pay the premium for a Medicare supplementary insurance policy. If no policy is purchased, the $150 is also payable to Medicaid, which will be responsible for prescription drugs and hospital co-payments not covered by Medicare.

1 - Mrs. Jones pays $20,592 (104 weeks @ $198/ week).

2 - After Mrs. Jones pays $165/day for 785 days (26 mos), she has fulfilled her commitment to spend $150,000 on her care, Medicaid pays for her final 1040 days in the nursing home at its $150/day rate.

3 - 34 months @ $1,800/month ($2,000 less $50 personal needs allowance and $150 if used to pay the premium for a Medicare supplementary insurance policy. If no policy is purchased, the $150 is also payable to Medicaid, which will be responsible for prescription drugs and hospital co-payments not covered by Medicare.

Estimated Cost to Medicaid

Home health aide, 2 years [1]	0	Home health aide, 2 years [1]	0
Nursing home, 1040 days @ $150/day [2]	$46,500	Nursing home, 310 days @ $150/day [2]	$156,000
Total *(before contribution)*	$46,500	Total *(before contribution)*	$156,000
Income Contribution [3]	- $18,000	Income Contribution [3]	- $46,800
Total Medicaid Cost	**$28,500**	**Total Medicaid Cost**	**$109,200**

* - The exact figure, $129,525, has been adjusted downward to provide rounded figures.

Scenario #3—Second Compact Option Mrs. Jones pays for an assessment and is found eligible. She pledges half of her assets and elects to have Medicaid serve primarily as a source of a subsidy after she has used $150,000 of her assets to pay for long-term care.

She will receive no assistance from Medicaid until she has spent $150,000 on her long-term care. Medicaid will then subsidize her long-term care by paying 90% of what it pays for regular Medicaid recipients. She will pay Medicaid 25% of her income, and keep the other 75% to pay the balance of her long-term care bill and for personal and medical needs.

Estimated Cost to Mrs. Jones

Mrs. Jones lives 5 years		Mrs. Jones lives 7 years	
Home health aide, 2 years [1]	$20,592	Home health aide, 2 years [1]	$20,592
Nursing home, first 785 days @ $165/day [2] *	$129,408	Nursing home, first 785 days @ $165/day [2]	*$129,408
Nursing home, last 310 days @ $30/day [3]	$9,300	Nursing home, 1040 days @ $30/day [3]	$31,200
Total *(before contribution)*	$159,300	Total *(before contribution)*	$181,317
Income Contribution [4]	$5,000	Income Contribution [4]	$17,000
Total Mrs. Jones Cost	**$164,417**	**Total Mrs. Jones Cost**	**$188,317**

1 - Mrs. Jones pays $20,592 (104 weeks @ $198 /week).

2 - Because Mrs. Jones has spent $20,592 for home care, she must spent $129,408 to reach the $150,000 threshold for Medicaid long-term care assistance. At the $165 private pay rate, she will spent a fraction more than $129,408 in 785 days.

3 - Once Mrs. Jones becomes eligible for Medicaid, she remains responsible for the $30 difference between the private rate of $165 and Medicaid's $135 payment. For the last 310 days that make up her three-year stay, the works out to $93,000. During that time, Medicaid pays $135 a day, or 10% below its normal $150 rate.

4 - 10 months @ $500/month (after retaining 75% of monthly $3,000 income). The $15,000 she retains during the 10 months will be available to pay the premium for a Medicare supplementary insurance policy if she wishes, or for prescription drugs and hospital co-payments, which will not be covered by Medicaid. It may also be the source of funds for extra needs such as an occasional private duty aide in the nursing home.

1 - Mrs. Jones pays $20,592 (104 weeks @ $198 /week).

2 - Because Mrs. Jones has spent $20,592 for home care, she must spent $129,408 to reach the $150,000 threshold for Medicaid long-term care assistance. At the $165 private pay rate, she will spent a fraction more than $129,408 in 785 days.

3 - Once Mrs. Jones becomes eligible for Medicaid, she remains responsible for the $30 difference between the private rate of $165 and Medicaid's $135 payment. For the last 1040 days that make up her three-year stay, the works out to $93,000. During that time, Medicaid pays $135 a day, or 10% below its normal $150 rate.

4 - 34 months @ $500/month (after retaining 75% of $3,000 monthly income). The $51,000 she retains during the 34 months will be available to pay the premium for a Medicare supplementary insurance policy if she wishes, or for prescription drugs and hospital co-payments, which will not be covered by Medicaid. It may also be the source of funds for extra needs such as an occasional private duty aide in the nursing home.

Estimated Cost to Medicaid

Mrs. Jones lives 5 years		Mrs. Jones lives 7 years	
Home health aide, 2 years [1]	0	Home health aide, 2 years [1]	0
Nursing home, first 785 days [2]	0	Nursing home, first 785 days [2]	0
Nursing home, last 310 days @ $135/day [3]	$41,850	Nursing home, last 1040 days @ $135/day [3]	$140,400
Total *(before contribution)*	$41,850	Total *(before contribution)*	$140,400
Income Contribution [4]	- $5,000	Income Contribution [4]	- $17,000
Total Medicaid Cost	**$36,850**	**Total Medicaid Cost**	**$123,400**

* - The exact figure, $129,525, has been adjusted downward to provide rounded figures.

Comparison of Totals for Each Scenario

Scenario #1—Standard Medicaid

Mrs. Jones lives 5 years		Mrs. Jones lives 7 years	
Total Mrs. Jones Cost	**$92,400**	**Total Mrs. Jones Cost**	**$135,600**
Total Medicaid Cost	**$90,570**	**Total Medicaid Cost**	**$156,870**

Scenario # 2—First Compact Option

Mrs. Jones lives 5 years		Mrs. Jones lives 7 years	
Total Mrs. Jones Cost	**$168,000**	**Total Mrs. Jones Cost**	**$196,800**
Total Medicaid Cost	**$28,500**	**Total Medicaid Cost**	**$109,200**

Scenario #3—Second Compact Option

Mrs. Jones lives 5 years		Mrs. Jones lives 7 years	
Total Mrs. Jones Cost	**$164,417**	**Total Mrs. Jones Cost**	**$188,317**
Total Medicaid Cost	**$ 36,850**	**Total Medicaid Cost**	**$123,400**

Senator Solon introduced--

S.F. No. 116: Referred to the Committee on Finance.

1 A bill for an act

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

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

5 Section 1. [APPROPRIATION.]

6 $150,000 in fiscal year 2006 and $150,000 in fiscal year
7 2007 are appropriated from the lottery prize fund to the
8 commissioner of human services for a grant to a compulsive
9 gambling council located in St. Louis County. The gambling
10 council must provide a statewide compulsive gambling prevention
11 and education project for adolescents. The unencumbered balance
12 of the appropriation from the lottery prize fund in the first
13 year of the biennium does not cancel but is available for the
14 second year.

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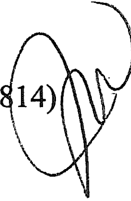
Jo Anne Zoff Sellner
Director

Senate
State of Minnesota

S.F. No. 116 - Compulsive Gambling Prevention and Education Appropriation (The Delete-Everything Amendment)

Author: Senator Yvonne Prettner Solon

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



Date: March 11, 2005

S.F. No. 116 appropriates $150,000 per year of the biennium from the lottery prize fund to the Commissioner of Human Services for a grant to Lake Superior Area Family Services for use in their gamblers outreach and counseling program. The unencumbered balance from the first year does not cancel and is available in the second year.

JW:rdr

Senators Berglin, Solon, Pappas, Kierlin and Larson introduced--

S.F. No. 1163: Referred to the Committee on Finance.

1 A bill for an act

2 relating to health; expanding the criteria for
3 participants of the loan forgiveness program;
4 appropriating money; amending Minnesota Statutes 2004,
5 section 144.1501, subdivisions 2, 4.

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

7 Section 1. Minnesota Statutes 2004, section 144.1501,
8 subdivision 2, is amended to read:

9 Subd. 2. [CREATION OF ACCOUNT.] (a) A health professional
10 education loan forgiveness program account is established. The
11 commissioner of health shall use money from the account to
12 establish a loan forgiveness program:

13 (1) for medical residents agreeing to practice in
14 designated rural areas or underserved urban communities~~,~~;

15 (2) for midlevel practitioners agreeing to practice in
16 designated rural areas~~, and~~ or to teach for at least 20 hours
17 per week in the nursing field in a postsecondary program;

18 (3) for nurses who agree to practice in a Minnesota nursing
19 home or intermediate care facility for persons with mental
20 retardation or related conditions or to teach for at least 20
21 hours per week in the nursing field in a postsecondary program;
22 and

23 (4) for other health care technicians agreeing to teach for
24 at least 20 hours per week in their designated field in a
25 postsecondary program. The commissioner, in consultation with

1 the Healthcare Education-Industry Partnership, shall determine
2 the health care fields where the need is the greatest,
3 including, but not limited to, respiratory therapy, clinical
4 laboratory technology, radiologic technology, and surgical
5 technology.
6 (b) Appropriations made to the account do not cancel and
7 are available until expended, except that at the end of each
8 biennium, any remaining balance in the account that is not
9 committed by contract and not needed to fulfill existing
10 commitments shall cancel to the fund.
11 Sec. 2. Minnesota Statutes 2004, section 144.1501,
12 subdivision 4, is amended to read:
13 Subd. 4. [LOAN FORGIVENESS.] The commissioner of health
14 may select applicants each year for participation in the loan
15 forgiveness program, within the limits of available funding. The
16 commissioner shall distribute available funds for loan
17 forgiveness proportionally among the eligible professions
18 according to the vacancy rate for each profession in the
19 required geographic area ~~or~~, facility type, or teaching area
20 specified in subdivision 2. The commissioner shall allocate
21 funds for physician loan forgiveness so that 75 percent of the
22 funds available are used for rural physician loan forgiveness
23 and 25 percent of the funds available are used for underserved
24 urban communities loan forgiveness. If the commissioner does
25 not receive enough qualified applicants each year to use the
26 entire allocation of funds for urban underserved communities,
27 the remaining funds may be allocated for rural physician loan
28 forgiveness. Applicants are responsible for securing their own
29 qualified educational loans. The commissioner shall select
30 participants based on their suitability for practice serving the
31 required geographic area or facility type specified in
32 subdivision 2, as indicated by experience or training. The
33 commissioner shall give preference to applicants closest to
34 completing their training. For each year that a participant
35 meets the service obligation required under subdivision 3, up to
36 a maximum of four years, the commissioner shall make annual

1 disbursements directly to the participant equivalent to 15
2 percent of the average educational debt for indebted graduates
3 in their profession in the year closest to the applicant's
4 selection for which information is available, not to exceed the
5 balance of the participant's qualifying educational loans.
6 Before receiving loan repayment disbursements and as requested,
7 the participant must complete and return to the commissioner an
8 affidavit of practice form provided by the commissioner
9 verifying that the participant is practicing as required under
10 subdivisions 2 and 3. The participant must provide the
11 commissioner with verification that the full amount of loan
12 repayment disbursement received by the participant has been
13 applied toward the designated loans. After each disbursement,
14 verification must be received by the commissioner and approved
15 before the next loan repayment disbursement is made.
16 Participants who move their practice remain eligible for loan
17 repayment as long as they practice as required under subdivision
18 2.

19 Sec. 3. [APPROPRIATION.]

20 $\underline{\$\ldots\ldots\text{ is appropriated for the biennium beginning July 1,}}$
21 $\underline{\text{2005, from the general fund to the commissioner of health for}}$
22 $\underline{\text{the loan forgiveness program in Minnesota Statutes, section}}$
23 $\underline{\text{144.1501.}}$

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Jo Anne Zoff Sellner
Director

Senate
State of Minnesota

S.F. No. 1163 - Loan Forgiveness Program

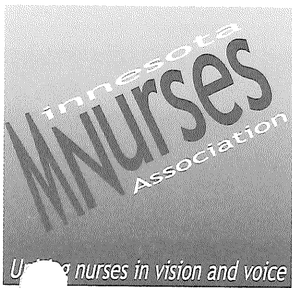
Author: Senator Linda Berglin

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

Date: March 15, 2005

S.F. No. 1163 states that a midlevel practitioner or nurse who commits to teaching at a postsecondary program for at least 20 hours in the nursing field may participate in the loan forgiveness program. These sections also add the option for other health care technicians who teach for at least 20 hours per week at a postsecondary program in their designated area to participate in the loan forgiveness program. The Commissioner of Health, in consultation with the health care education and industry partnership, is required to determine the health care fields where the need is the greatest, including, but not limited to, respiratory care, laboratory science, radiological technology, and surgical technology.

KC:ph



March 15, 2005

Senator Linda Berglin
309 Capitol
75 Dr Martin Luther King Jr Blvd
St. Paul, MN 55155-1606

Dear Senator Berglin:

The Minnesota Nurses Association, representing over 18,000 RNs throughout the state, would like to express our support for your legislation Senate File 1163, which addresses the shortage of nurse faculty through expansion of the Department of Health's RN loan forgiveness program.

Minnesota currently faces a nursing shortage of both practicing nurses as well as nurse faculty. Fortunately, many of the recruitment efforts to attract young people into the profession are paying off and students are responding. Yet, due to the shortage of nurse faculty, Minnesota schools and universities have not been able to accept all the students meeting the entrance requirements resulting in long waiting lists for the nursing programs.

The shortage is only expected to worsen in part due to demographic changes. As baby boomers age they will increasingly require more health services. This will occur at the same time that many nurses will be leaving the workforce due to retirement. While the average age of nurses in Minnesota is now about 48, the average age of nurse faculty is even higher at about 52 years of age.

For these reasons, we believe this legislation is critical in addressing the shortage of nurse faculty through loan forgiveness incentives. Thank you in advance for your support of this bill.

Sincerely,

Mary Jo George

Mary Jo George
Staff Specialist, Governmental Affairs
Minnesota Nurses Association

MJG:kw

Professional Distinction

Personal Dignity

Patient Advocacy

1625 Energy Park Drive
St. Paul, MN 55108
Tel: 651-646-4807
800-536-4662
Fax: 651-647-5301
Email: mnnurses@mnnurses.org
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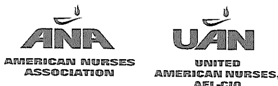

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Senators Lourey, Rosen, Higgins, Moua and Solon introduced--

S.F. No. 1258: Referred to the Committee on Finance.

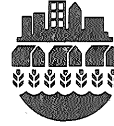
1 A bill for an act

2 relating to health; appropriating money for a lead
3 hazard reduction project to reduce and prevent lead
4 poisoning in Minnesota's children.

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

6 Section 1. [LEAD HAZARD REDUCTION PROJECT; APPROPRIATION.]

7 $300,000 in fiscal year 2006 and $300,000 in fiscal year
8 2007 are appropriated from the general fund to the commissioner
9 of health for a grant to a nonprofit organization currently
10 operating the CLEARCorps lead hazard reduction project. The
11 grant must be used to continue the lead hazard reduction project
12 and reduce and prevent lead poisoning in Minnesota's children.
13 The grant may be used as a match for federal funds to reduce
14 lead hazards. Any balance in the first year does not cancel but
15 is available in the second year.

SUSTAINABLE RESOURCES  CENTER

1916 Second Avenue South
Minneapolis, MN 55403
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The Center for Disease Control ranks childhood lead poisoning as the number one environmental health threat to children.

The CLEARCorps Program reduces the risk of lead poisoning for Minnesota children.

- **Legislative Request:** $300,000 for each year of the biennium for a total of $600,000, which was the previous funding level for 2002-2003. The Governor's budget recommends $100,000 each year for a total of $200,000. ***The federal government provides a dollar for dollar match for these local funds.***

- Lead poisoning in children can result in permanent developmental damage, lowered IQ, learning problems, hyperactivity, hearing loss, and increased aggression leading to criminal behavior.

- Lead poisoning is completely preventable.

- Taxpayers shoulder the costs of special education, health care, housing, social services, and corrections, which are incurred by lead poisoning. MDH estimates the special education costs due to a lower I.Q. from lead poisoning are $3,000 per child per year of school.

- In 2003 an average of **only 16%** of the at-risk children in Minnesota were tested for elevated blood lead levels. Of those, **311** children were found to have elevated blood lead levels of significance and who will suffer from this preventable disease.

- The **CLEARCorps** program is the most cost effective solution to prevention of childhood lead poisoning. Volunteers from the community are trained as licensed lead workers and perform the actual work in homes. ***Local companies donate the paint and materials to the project.***

- In the past eight years **CLEARCorps** has removed lead hazards in more than **1000** homes through wet scraping lead painted surfaces, encapsulating lead paint, replacing windows, removing carpet and deteriorated flooring, and soil abatement. **CLEARCorps** has reached more than **55,000** Minnesotans with education and outreach messages.

Community Solutions Fund member

100% postconsumer paper, vegetable inks

CLEARCorps has made homes lead safe in the following cities in Minnesota

Austin	La Sueur	Hubbard	Mapleton
Worthington	Kent	Owatona	Chatfield
Long Prairie	Anoka	Crystal	Crookston
Minneapolis	Montevideo	Richfield	St. Paul
St. Paul Park	Stockton	W. St. Paul	White Bear Lake
Willmar	St. James	Renville	Bloomington
Fairmont	Eagle Lake	Lake Crystal	Winona
Coon Rapids	Two Harbors	Chisholm	Milaca
Detroit Lakes	Moorhead	Montgomery	Duluth
Mankato			

CLEARCorps has made education presentations in the following cities in Minnesota

Kiester	Bemidji	Mankato	Wells
Waseca	St. Peter	Mapleton	Detroit Lakes
Park Rapids	Minneapolis	Sleepy Eye	Granite Falls
Rochester	Chatfield	Olivia	W St. Paul
Hayfield	Northfield	St. Paul	Grand Rapids
Duluth	White Earth	Wilmar	Mora
Worthington	Chisholm	St. Cloud	Metro Area
Norman County E			