Senators Murphy, Rosen, Koering, Kierlin and Vickerman introduced--

S.F. No. 267: Referred to the Committee on State and Local Government Operations.

A bill for an act

relating to counties; providing for fees and standards for the recording of certain documents; amending Minnesota Statutes 2004, sections 357.18; 386.30; 507.093; 508.82; 508A.82; 515B.1-116.

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

Section 1. Minnesota Statutes 2004, section 357.18, is amended to read:

357.18 [COUNTY RECORDER.]

Subdivision 1. [COUNTY RECORDER FEES.] The fees to be charged by the county recorder shall be ~~as-follows~~ and not exceed the following:

(1) for indexing and recording any deed or other instrument ~~$1-for-each-page-of-an-instrument,-with-a-minimum-fee-of-$15~~ a fee of $40; $4 shall be paid to the state treasury and credited to the general fund; 50 cents shall be retained by the county to cover the administrative costs; $10 shall be deposited in the technology fund pursuant to subdivision 3; and $25.50 to the county general fund;

(2) for documents containing multiple assignments, partial releases or satisfactions $10 for each document number or book and page cited;

(3) for certified copies of any records or papers, $1 for each page of an instrument with a minimum fee of $5;

(4) for an abstract of title, the fees shall be determined

1 by resolution of the county board duly adopted upon the
2 recommendation of the county recorder, and the fees shall not
3 exceed ~~$5~~ $10 for every entry, ~~$50~~ $100 for abstract
4 certificate, $1 per page for each exhibit included within an
5 abstract as a part of an abstract entry, and ~~$2~~ $5 per name for
6 each required name search certification;
7 (5) for a copy of an official plat filed pursuant to
8 section 505.08, the fee shall be ~~$9.50~~ $10 and an additional ~~50~~
9 ~~cents~~ $5 shall be charged for the certification of each plat;
10 (6) for filing an amended floor plan in accordance with
11 chapter 515, an amended condominium plat in accordance with
12 chapter 515A, or a common interest community plat or amendment
13 complying with section 515B.2-110, subsection (c), the fee shall
14 be 50 cents per apartment or unit with a minimum fee of ~~$30~~ $50;
15 (7) for a copy of a floor plan filed pursuant to chapter
16 515, a copy of a condominium plat filed in accordance with
17 chapter 515A, or a copy of a common interest community plat
18 complying with section 515B.2-110, subsection (c), the fee shall
19 be $1 for each page of the floor plan, condominium plat or
20 common interest community plat with a minimum fee of $10.
21 Subd. 1a. [ABSTRACTING SERVICE FEES.] Fees fixed by or
22 established pursuant to subdivision 1 shall be the maximum fee
23 charged in all counties where the county recorder performs
24 abstracting services and shall be charged by persons authorized
25 to perform abstracting services in county buildings pursuant to
26 section 386.18.
27 Subd. 2. [FEES FOR RECORDING INSTRUMENTS IN COUNTY
28 RECORDER OFFICE.] Notwithstanding the provisions of any ~~general~~
29 ~~or~~ special law to the contrary, the established fees pursuant to
30 subdivision 1 shall be the recording fee per document charged in
31 all counties. The fees prescribed by this section shall govern
32 the filing or recording of all instruments in the office of the
33 county recorder other than Uniform Commercial Code documents,
34 and documents filed or recorded pursuant to sections 270.69,
35 subdivision 2, paragraph (c), 272.481 to 272.488, 277.20, and
36 386.77.

Subd. 3. ~~[SURCHARGE.] In addition to the fees imposed in subdivision 1, a $4.50 surcharge shall be collected: on each fee charged under subdivision 1, clauses (1) and (6), and for each abstract certificate under subdivision 1, clause (4). Fifty cents of each surcharge shall be retained by the county to cover its administrative costs and $4 shall be paid to the state treasury and credited to the general fund.~~

~~Subd. 4.~~ [~~EQUIPMENT~~ TECHNOLOGY FUND.] ~~$1 of each~~ The $10 fee collected under subdivision 1, clause (1), shall be deposited in ~~an equipment~~ a technology fund ~~to~~ for obtaining, maintaining, and updating current technology and equipment to provide services from the record system. The fund shall be disbursed at the county recorder's discretion to provide modern information services from the records system. The fund is a supplemental fund and shall not be construed to diminish the duty of the county governing body to furnish funding for expenses and personnel necessary in the performance of the duties of said office pursuant to section 386.015, subdivision 6, paragraph (a), clause (2), and to comply with the requirements of section 386.30.

Subd. ~~5~~ 4. [VARIANCE FROM STANDARDS.] A document ~~that does not~~ should conform to the standards in section 507.093, paragraph (a), ~~shall not be recorded except upon payment of an additional fee of $10 per document~~ but should not be rejected unless the document is not legible or cannot be archived. This subdivision applies only to documents dated after July 31, 1997, and does not apply to Minnesota uniform conveyancing blanks ~~contained in the book of forms~~ on file in the office of the commissioner of commerce provided for under section 507.09, certified copies, or any other form provided for under Minnesota Statutes.

Sec. 2. Minnesota Statutes 2004, section 386.30, is amended to read:

386.30 [DEEDS RECORDED WITHIN ~~30~~ 15 BUSINESS DAYS.]

Each county recorder shall, within ~~30~~ 15 business days after any instrument entitled to record is left for that

purpose, actually record the same in the manner provided by law and return the same in person or by mail to the person who left such instrument for record, if the person's residence is known, or to such other person and at such address as the recorder may be directed to deliver the same. If the instrument is submitted electronically, the recorder must return it in the same manner within five business days. Persistent failure to so record and return instruments entitled to record, upon demand therefor and payment of recording fees, shall constitute nonfeasance in office and be sufficient ground for removal therefrom. The 15-business-day and five-business-day periods begin on the day that the tax certifications required by chapters 272 and 287 are made. In a county in which the office of county recorder has been combined with another county office, the ~~30-day~~ 15-business-day time period begins when the tax certifications required by chapters 272 and 287 are made, but the total period to complete the time period after receipt of the instrument by the office must not exceed ~~60~~ 30 business days.

Sec. 3. Minnesota Statutes 2004, section 507.093, is amended to read:

507.093 [STANDARDS FOR DOCUMENTS TO BE RECORDED ~~OR FILED~~.]

(a) The following standards are imposed on documents to be recorded with the county recorder or ~~filed~~ with the registrar of titles:

(1) The document shall consist of one or more individual sheets measuring no larger than 8.5 inches by 14 inches.

(2) The form of the document shall be printed, typewritten, or computer generated in black ink and the form of the document shall not be smaller than 8-point type.

(3) The document shall be on white paper of not less than 20-pound weight with no background color~~,~~ or images~~, or writing~~ and shall have a ~~clear~~ border of ~~approximately~~ one-half inch on the top, bottom, and each side.

(4) The first page of the document shall contain a blank space at the top measuring three inches, as measured from the top of the page. The right half is to be used by the county

recorder or registrar of titles for recording information ~~or registrar-of-titles-for-filing-information~~ and the left half is to be used by the county auditor or treasurer for certification. An administrative page may be attached to the face of the document to accommodate this standard.

(5) The title of the document shall be prominently displayed at the top of the first page below the blank space referred to in clause (4).

(6) No additional sheet shall be attached or affixed to a page that covers up any information or printed part of the form.

(7) A document presented for recording ~~or-filing~~ must be sufficiently legible to ~~reproduce~~ produce a readable copy using the county recorder's or registrar of ~~title's~~ titles' current method of ~~reproduction~~ archiving records.

~~The-standards-in-this-paragraph-do-not-apply-to-a-document that-is-recorded-or-filed-as-part-of-a-pilot-project-for-the electronic-filing-of-real-estate-documents-implemented-by-the task-force-created-in-Laws-2000,-chapter-391.~~

(b) ~~The-recording-or-filing-fee-for-a-document-that-does not-conform-to-the-standards-in-paragraph-(a)-shall-be-increased as-provided-in-sections-357.18,-subdivision-5,-508.82,-and 508A.82.~~

~~(c)~~ The ~~recorder-or-registrar~~ general fund shall refund the recording ~~or-filing~~ fee to the applicant if the real estate documents are not ~~filed-or-registered~~ recorded within ~~30~~ 15 business days after receipt or after five business days if the document is submitted electronically, or as otherwise provided by section 386.30.

Sec. 4. Minnesota Statutes 2004, section 508.82, is amended to read:

508.82 [~~REGISTRAR'S~~ REGISTRAR OF TITLES' FEES.]

Subdivision 1. [STANDARD DOCUMENTS.] The fees to be ~~paid to~~ charged by the registrar of titles shall be ~~as-follows~~ and not exceed the following:

(1) of the fees provided herein, ~~five-percent~~ $1.50 of the fees collected under clauses (3), ~~(5),-(11),-(13),~~ (4), (10),

1 (12), (14), (16), and (17)~~,~~ for filing or memorializing shall be
2 paid to the ~~commissioner-of-finance~~ state treasury pursuant to
3 section 508.75 and credited to the general fund; ~~plus-a-$4.50~~
4 ~~surcharge-shall-be-charged-and-collected-in-addition-to-the~~
5 ~~total-fees-charged-for-each-transaction-under-clauses-(2),-(3),~~
6 ~~(5),-(11),-(13),-(14),-(16),-and-(17),-with-50-cents-of-this~~
7 ~~surcharge-to-be-retained-by-the-county-to-cover-its~~
8 ~~administrative-costs,-and-$4-to-be-paid-to-the-state-treasury~~
9 ~~and-credited-to-the-general-fund;~~
10 (2) for registering a first certificate of title, including
11 issuing a copy of it, ~~$30~~ $40. Pursuant to clause (1),
12 distribution of this fee is as follows:
13 (i) $4 shall be paid to the state treasury and credited to
14 the general fund;
15 (ii) 50 cents shall be retained by the county to cover
16 administrative costs;
17 (iii) $10 shall be deposited in the technology fund
18 pursuant to section 357.18, subdivision 3; and
19 (iv) $25.50 shall be deposited to the county general fund;
20 (3) for registering each instrument transferring the fee
21 simple title for which a new certificate of title is issued and
22 for the registration of the new certificate of title, including
23 a copy of it, ~~$30~~ $40. Pursuant to clause (1), distribution of
24 this fee is as follows:
25 (i) $1.50 shall be paid to the state treasury and credited
26 to the general fund;
27 (ii) $4 shall be paid to the state treasury and credited to
28 the general fund;
29 (iii) 50 cents shall be retained by the county to cover
30 administrative costs;
31 (iv) $10 shall be deposited in the technology fund pursuant
32 to section 357.18, subdivision 3; and
33 (v) $24 shall be deposited to the county general fund;
34 (4) ~~for-issuance-of-a-CECT-pursuant-to-section-508.351,~~
35 ~~$15;~~
36 ~~(5)~~ for the entry of each memorial on a

1 certificate, ~~$15~~ $40. For multiple certificate entries, $20
2 thereafter. Pursuant to clause (1), distribution of this fee is
3 as follows:
4 (i) $1.50 shall be paid to the state treasury and credited
5 to the general fund;
6 (ii) $4 shall be paid to the state treasury and credited to
7 the general fund;
8 (iii) 50 cents shall be retained by the county to cover
9 administrative costs;
10 (iv) $10 shall be deposited in the technology fund pursuant
11 to section 357.18, subdivision 3;
12 (v) $24 shall be deposited to the county general fund; and
13 (vi) $20 shall be deposited to the county general fund for
14 each multiple entry used;
15 ~~(6)~~ (5) for issuing each residue certificate, ~~$20~~ $40;
16 ~~(7)~~ (6) for exchange certificates, ~~$10~~ $20 for each
17 certificate canceled and ~~$10~~ $20 for each new certificate
18 issued;
19 ~~(8)~~ (7) for each certificate showing condition of the
20 register, ~~$10~~ $50;
21 ~~(9)~~ (8) for any certified copy of any instrument or writing
22 on file or recorded in the ~~registrar's~~ registrar of titles'
23 office, the same fees allowed by law to county recorders for
24 like services;
25 ~~(10)~~ (9) for a noncertified copy of any certificate of
26 title, other than the copies issued under clauses (2) and (3),
27 any instrument or writing on file or recorded in the office of
28 the registrar of titles, or any specified page or part of it, an
29 amount as determined by the county board for each page or
30 fraction of a page specified. If computer or microfilm printers
31 are used to reproduce the instrument or writing, a like amount
32 per image;
33 ~~(11)~~ (10) for filing two copies of any plat in the office
34 of the registrar, ~~$30~~ $50. Pursuant to clause (1), distribution
35 of this fee is as follows:
36 (i) $1.50 shall be paid to the state treasury and credited

1 to the general fund;
2 (ii) $4 shall be paid to the state treasury and credited to
3 the general fund;
4 (iii) 50 cents shall be retained by the county to cover
5 administrative costs;
6 (iv) $10 shall be deposited in the technology fund pursuant
7 to section 357.18, subdivision 3; and
8 (v) $34 shall be deposited to the county general fund;
9 (12) (11) for any other service under this chapter, such
10 fee as the court shall determine;
11 (13) (12) for filing an amendment to a declaration in
12 accordance with chapter 515, $10 $40 for each certificate upon
13 which the document is registered and $30 for multiple
14 certificate entries, $20 thereafter; $50 for an amended floor
15 plan filed in accordance with chapter 515. Pursuant to clause
16 (1), distribution of this fee is as follows:
17 (i) $1.50 shall be paid to the state treasury and credited
18 to the general fund;
19 (ii) $4 shall be paid to the state treasury and credited to
20 the general fund;
21 (iii) 50 cents shall be retained by the county to cover
22 administrative costs;
23 (iv) $10 shall be deposited in the technology fund pursuant
24 to section 357.18, subdivision 3;
25 (v) $24 shall be deposited to the county general fund for
26 amendment to a declaration;
27 (vi) $20 shall be deposited to the county general fund for
28 each multiple entry used; and
29 (vii) $34 shall be deposited to the county general fund for
30 an amended floor plan;
31 (13) for issuance of a CECT pursuant to section 508.351,
32 $40;
33 (14) for filing an amendment to a common interest community
34 declaration and plat or amendment complying with section
35 515B.2-110, subsection (c), $10 $40 for each certificate upon
36 which the document is registered and $30 for multiple

1 certificate entries, $20 thereafter and $50 for the filing of
2 the condominium or common interest community plat or amendment.
3 Pursuant to clause (1), distribution of this fee is as follows:
4 (i) $1.50 shall be paid to the state treasury and credited
5 to the general fund;
6 (ii) $4 shall be paid to the state treasury and credited to
7 the general fund;
8 (iii) 50 cents shall be retained by the county to cover
9 administrative costs;
10 (iv) $10 shall be deposited in the technology fund pursuant
11 to section 357.18, subdivision 3;
2 (v) $24 shall be deposited to the county general fund for
13 the filing of an amendment complying with section 515B.2-110,
14 subsection (c);
15 (vi) $20 shall be deposited to the county general fund for
16 each multiple entry used; and
17 (vii) $34 shall be deposited to the county general fund for
18 the filing of a condominium or CIC plat or amendment;
19 (15) for a copy of a condominium floor plan filed in
20 accordance with chapter 515, or a copy of a common interest
21 community plat complying with section 515B.2-110, subsection
2 (c), the fee shall be $1 for each page of the floor plan or
23 common interest community plat with a minimum fee of $10;
24 (16) for the filing of a certified copy of a plat of the
25 survey pursuant to section 508.23 or 508.671, ~~$10~~ $40. Pursuant
26 to clause (1), distribution of this fee is as follows:
27 (i) $1.50 shall be paid to the state treasury and credited
28 to the general fund;
29 (ii) $4 shall be paid to the state treasury and credited to
30 the general fund;
31 (iii) 50 cents shall be retained by the county to cover
32 administrative costs;
33 (iv) $10 shall be deposited in the technology fund pursuant
34 to section 357.18, subdivision 3; and
35 (v) $24 shall be deposited to the county general fund;
36 (17) for filing a registered land survey in triplicate in

1 accordance with section 508.47, subdivision 4, ~~$30~~ $50.
2 Pursuant to clause (1), distribution of this fee is as follows:
3 (i) $1.50 shall be paid to the state treasury and credited
4 to the general fund;
5 (ii) $4 shall be paid to the state treasury and credited to
6 the general fund;
7 (iii) 50 cents shall be retained by the county to cover its
8 administrative costs;
9 (iv) $10 shall be deposited in the technology fund pursuant
10 to section 357.18, subdivision 3; and
11 (v) $34 shall be deposited to the county general fund; and
12 (18) for furnishing a certified copy of a registered land
13 survey in accordance with section 508.47, subdivision 4, ~~$10~~ $15.
14 Subd. 1a. [FEES FOR RECORDING INSTRUMENTS WITH REGISTRAR
15 OF TITLES' OFFICE.] Notwithstanding the provisions of any
16 general or special law to the contrary, the established fees
17 pursuant to subdivision 1 shall be the recording fee per
18 document charged in all counties. No other fee may be required
19 for recording a document with the registrar of titles without
20 amending section 508.82. The fees prescribed by this section
21 shall govern the filing or recording of all instruments in the
22 office of the registrar of titles other than Uniform Commercial
23 Code documents and documents filed or recorded pursuant to
24 sections 270.69, subdivision 2, paragraph (c); 272.481 to
25 272.488; 277.20; and 386.77.
26 Subd. 2. [VARIANCE FROM STANDARDS.] A document ~~that does~~
27 ~~not~~ should conform to the standards in section 507.093,
28 paragraph (a), ~~shall not be filed except upon payment of an~~
29 ~~additional fee of $10 per document~~ but should not be rejected
30 unless the document is not legible or cannot be archived. This
31 subdivision applies only to documents dated after July 31, 1997,
32 and does not apply to Minnesota uniform conveyancing
33 blanks ~~contained in the book of forms~~ on file in the office of
34 the commissioner of commerce provided for under section 507.09,
35 certified copies, or any other form provided for under Minnesota
36 Statutes.

1 Sec. 5. Minnesota Statutes 2004, section 508A.82, is
2 amended to read:
3 508A.82 [~~REGISTRAR'S~~ REGISTRAR OF TITLES' FEES.]
4 Subdivision 1. [STANDARD DOCUMENTS.] The fees to be ~~paid~~
5 ~~to~~ charged by the registrar of titles shall be ~~as-follows~~ and
6 not exceed the following:
7 (1) of the fees provided herein, ~~five-percent~~ $1.50 of the
8 fees collected under clauses (3), (5), (11), (13), ~~(14)~~ (15),
9 and ~~(17),~~ (18) for filing or memorializing shall be paid to the
10 ~~commissioner-of-finance~~ state treasury pursuant to section
11 508.75 and credited to the general fund; ~~plus-a-$4.50-surcharge~~
12 ~~shall-be-charged-and-collected-in-addition-to-the-total-fees~~
13 ~~charged-for-each-transaction-under-clauses-(2),-(3),-(5),-(11),~~
14 ~~(13),-(14),-and-(17),-with-50-cents-of-this-surcharge-to-be~~
15 ~~retained-by-the-county-to-cover-its-administrative-costs,-and-$4~~
16 ~~to-be-paid-to-the-state-treasury-and-credited-to-the-general~~
17 ~~fund;~~
18 (2) for registering a first CPT, including issuing a copy
19 of it, ~~$30;~~ $40. Pursuant to clause (1), distribution of the
20 fee is as follows:
21 (i) $4 shall be paid to the state treasury and credited to
22 the general fund;
23 (ii) 50 cents shall be retained by the county to cover
24 administrative costs;
25 (iii) $10 shall be deposited in the technology fund
26 pursuant to section 357.18, subdivision 3; and
27 (iv) $25.50 shall be deposited to the county general fund;
28 (3) for registering each instrument transferring the fee
29 simple title for which a new CPT is issued and for the
30 registration of the new CPT, including a copy of it, ~~$30;~~ $40.
31 Pursuant to clause (1), distribution of the fee is as follows:
32 (i) $1.50 shall be paid to the state treasury and credited
33 to the general fund;
34 (ii) $4 shall be paid to the state treasury and credited to
35 the general fund;
36 (iii) 50 cents shall be retained by the county to cover

1 administrative costs;
2 (iv) $10 shall be deposited in the technology fund pursuant
3 to section 357.18, subdivision 3; and
4 (v) $24 shall be deposited to the county general fund;
5 (4) for issuance of a CECT pursuant to section 508A.351,
6 $15;
7 (5) for the entry of each memorial on a CPT, ~~$15,~~ $40; for
8 multiple certificate entries, $20 thereafter. Pursuant to
9 clause (1) distribution of the fee is as follows:
10 (i) $1.50 shall be paid to the state treasury and credited
11 to the general fund;
12 (ii) $4 shall be paid to the state treasury and credited to
13 the general fund;
14 (iii) 50 cents shall be retained by the county to cover
15 administrative costs;
16 (iv) $10 shall be deposited in the technology fund pursuant
17 to section 357.18, subdivision 3;
18 (v) $24 shall be deposited to the county general fund; and
19 (vi) $20 shall be deposited to the county general fund for
20 each multiple entry used;
21 (6) for issuing each residue CPT, ~~$20~~ $40;
22 (7) for exchange CPTs or combined certificates of title,
23 ~~$10~~ $20 for each CPT and certificate of title canceled and
24 ~~$10~~ $20 for each new CPT or combined certificate of title
25 issued;
26 (8) for each CPT showing condition of the
27 register, ~~$10~~ $50;
28 (9) for any certified copy of any instrument or writing on
29 file or recorded in the ~~registrar's~~ registrar of titles' office,
30 the same fees allowed by law to county recorders for like
31 services;
32 (10) for a noncertified copy of any CPT, other than the
33 copies issued under clauses (2) and (3), any instrument or
34 writing on file or recorded in the office of the registrar of
35 titles, or any specified page or part of it, an amount as
36 determined by the county board for each page or fraction of a

1 page specified. If computer or microfilm printers are used to
2 reproduce the instrument or writing, a like amount per image;
3 (11) for filing two copies of any plat in the office of the
4 registrar, ~~$30,~~ $50. Pursuant to clause (1), distribution of
5 the fee is as follows:
6 (i) $1.50 shall be paid to the state treasury and credited
7 to the general fund;
8 (ii) $4 shall be paid to the state treasury and credited to
9 the general fund;
10 (iii) 50 cents shall be retained by the county to cover
11 administrative costs;
12 (iv) $10 shall be deposited in the technology fund pursuant
13 to section 357.18, subdivision 3; and
14 (v) $34 shall be deposited to the county general fund;
15 (12) for any other service under sections 508A.01 to
16 508A.85, the fee the court shall determine;
17 (13) for filing an amendment to a declaration in accordance
18 with chapter 515, ~~$10~~ $40 for each certificate upon which the
19 document is registered and ~~$30~~ for multiple certificate entries,
20 $20 thereafter; $50 for an amended floor plan filed in
21 accordance with chapter 515~~,~~. Pursuant to clause (1),
22 distribution of the fee is as follows:
23 (i) $1.50 shall be paid to the state treasury and credited
24 to the general fund;
25 (ii) $4 shall be paid to the state treasury and credited to
26 the general fund;
27 (iii) 50 cents shall be retained by the county to cover
28 administrative costs;
29 (iv) $10 shall be deposited in the technology fund pursuant
30 to section 357.18, subdivision 3;
31 (v) $24 shall be deposited to the county general fund for
32 amendment to a declaration;
33 (vi) $20 shall be deposited to the county general fund for
34 each multiple entry used; and
35 (vii) $34 shall be deposited to the county general fund for
36 an amended floor plan;

1 (14) for issuance of a CECT pursuant to section 508.351,
2 $40;
3 (15) for filing an amendment to a common interest community
4 declaration and plat or amendment complying with section
5 515B.2-110, subsection (c), and issuing a CECT if
6 required, ~~$10~~ $40 for each certificate upon which the document
7 is registered and ~~$30~~ for multiple certificate entries, $20
8 thereafter; $50 for the filing of the condominium or common
9 interest community plat or amendment~~;~~. Pursuant to clause (1),
10 distribution of the fee is as follows:
11 (i) $1.50 shall be paid to the state treasury and credited
12 to the general fund;
13 (ii) $4 shall be paid to the state treasury and credited to
14 the general fund;
15 (iii) 50 cents shall be retained by the county to cover
16 administrative costs;
17 (iv) $10 shall be deposited in the technology fund pursuant
18 to section 357.18, subdivision 3;
19 (v) $24 shall be deposited to the county general fund for
20 the filing of an amendment complying with section 515B.2-110,
21 subsection (c);
22 (vi) $20 shall be deposited to the county general fund for
23 each multiple entry used; and
24 (vii) $34 shall be deposited to the county general fund for
25 the filing of a condominium or CIC plat or amendment;
26 ~~(15)~~ (16) for a copy of a condominium floor plan filed in
27 accordance with chapter 515, or a copy of a common interest
28 community plat complying with section 515B.2-110, subsection
29 (c), the fee shall be $1 for each page of the floor plan, or
30 common interest community plat with a minimum fee of $10;
31 ~~(16)~~ (17) in counties in which the compensation of the
32 examiner of titles is paid in the same manner as the
33 compensation of other county employees, for each parcel of land
34 contained in the application for a CPT, as the number of parcels
35 is determined by the examiner, a fee which is reasonable and
36 which reflects the actual cost to the county, established by the

1 board of county commissioners of the county in which the land is
2 located;
3 ~~(17)~~ (18) for filing a registered land survey in triplicate
4 in accordance with section 508A.47, subdivision 4, ~~$30,-and~~ $50.
5 Pursuant to clause (1), distribution of the fee is as follows:
6 (i) $1.50 shall be paid to the state treasury and credited
7 to the general fund;
8 (ii) $4 shall be paid to the state treasury and credited to
9 the general fund;
10 (iii) 50 cents shall be retained by the county to cover
11 administrative costs;
12 (iv) $10 shall be deposited in the technology fund pursuant
13 to section 357.18, subdivision 3; and
14 (v) $34 shall be deposited to the county general fund; and
15 ~~(18)~~ (19) for furnishing a certified copy of a registered
16 land survey in accordance with section 508A.47, subdivision
17 4, ~~$10~~ $15.
18 Subd. 1a. [FEES TO RECORD INSTRUMENTS WITH REGISTRAR OF
19 TITLES.] Notwithstanding any special law to the contrary, the
20 established fees pursuant to subdivision 1 shall be the
21 recording fee per document charged in all counties. No other
22 fee may be required for recording a document with the registrar
23 of titles without amending section 508A.32. The fees prescribed
24 by this section shall govern the filing or recording of all
25 instruments in the office of the registrar of titles other than
26 Uniform Commercial Code documents, and documents filed or
27 recorded pursuant to sections 270.69, subdivision 2, paragraph
28 (c); 272.481 to 272.488; 277.20; and 386.77.
29 Subd. 2. [VARIANCE FROM STANDARDS.] A document ~~that-does~~
30 ~~not~~ should conform to the standards in section 507.093,
31 paragraph (a), ~~shall-not-be-filed-except-upon-payment-of-an~~
32 ~~additional-fee-of-$10-per-document~~ but should not be rejected
33 unless the document is not legible or cannot be archived. This
34 subdivision applies only to documents dated after July 31, 1997,
35 and does not apply to Minnesota uniform conveyancing
36 blanks ~~contained-in-the-book-of-forms~~ on file in the office of

1 the commissioner of commerce provided for under section 507.09,
2 certified copies, or any other form provided for under Minnesota
3 Statutes.

4 Sec. 6. Minnesota Statutes 2004, section 515B.1-116, is
5 amended to read:

6 515B.1-116 [RECORDING.]

7 (a) A declaration, bylaws, any amendment to a declaration
8 or bylaws, and any other instrument affecting a common interest
9 community shall be entitled to be recorded. In those counties
10 which have a tract index, the county recorder shall enter the
11 declaration in the tract index for each unit affected. The
12 registrar of titles shall file the declaration in accordance
13 with section 508.351 or 508A.351.

14 (b) The recording officer shall upon request promptly
15 assign a number (CIC number) to a common interest community to
16 be formed or to a common interest community resulting from the
17 merger of two or more common interest communities.

18 (c) Documents recorded pursuant to this chapter shall in
19 the case of registered land be filed, and references to the
20 recording of documents shall mean filed in the case of
21 registered land.

22 (d) Subject to any specific requirements of this chapter,
23 if a recorded document relating to a common interest community
24 purports to require a certain vote or signatures approving any
25 restatement or amendment of the document by a certain number or
26 percentage of unit owners or secured parties, and if the
27 amendment or restatement is to be recorded pursuant to this
28 chapter, an affidavit of the president or secretary of the
29 association stating that the required vote or signatures have
30 been obtained shall be attached to the document to be recorded
31 and shall constitute prima facie evidence of the representations
32 contained therein.

33 (e) If a common interest community is located on registered
34 land, the recording fee for any document affecting two or more
35 units shall be ~~the-then-current-fee-for-registering-the-document~~
36 ~~on-the-certificates-of-title-for-the-first-ten-affected~~

1 ~~certificates-and-one-third-of-the-then-current-fee-for-each~~
2 ~~additional-affected-certificate~~ <u>$40 for the first ten affected</u>
3 <u>certificates and $10 for each additional affected certificate</u>.
4 This provision shall not apply to recording fees for deeds of
5 conveyance, with the exception of deeds given pursuant to
6 sections 515B.2-119 and 515B.3-112.
7 (f) Except as permitted under this subsection, a recording
8 officer shall not file or record a declaration creating a new
9 common interest community, unless the county treasurer has
10 certified that the property taxes payable in the current year
11 for the real estate included in the proposed common interest
12 community have been paid. This certification is in addition to
13 the certification for delinquent taxes required by section
14 272.12. In the case of preexisting common interest communities,
15 the recording officer shall accept, file, and record the
16 following instruments, without requiring a certification as to
17 the current or delinquent taxes on any of the units in the
18 common interest community: (i) a declaration subjecting the
19 common interest community to this chapter; (ii) a declaration
20 changing the form of a common interest community pursuant to
21 section 515B.2-123; or (iii) an amendment to or restatement of
22 the declaration, bylaws, or CIC plat. In order for an
23 instrument to be accepted and recorded under the preceding
24 sentence, the instrument must not create or change unit or
25 common area boundaries.

1 Senator Reiter moves to amend S.F. No. 267 as follows:
2 Page 3, after line 31, insert:
3 "Sec. 2. [357.182] [COUNTY FEES AND RECORDING STANDARDS
4 FOR THE RECORDING OF REAL ESTATE DOCUMENTS.]
5 Subdivision 1. [APPLICATION.] Unless otherwise specified
6 in this section and notwithstanding any other law to the
7 contrary, effective August 1, 2005, this section applies to each
8 county in Minnesota. Documents presented for recording within
9 60 days from the effective date of this act and that are
10 acknowledged, sworn to before a notary, or certified prior to
11 the effective date of this act must not be rejected for failure
12 to include the new filing fee.
13 Subd. 2. [FEE RESTRICTIONS.] Notwithstanding any local law
14 or ordinance to the contrary, no county may charge or collect
15 any fee, special or otherwise, or however described, other than
16 a fee denominated or prescribed by state law, for any service,
17 task, or step performed by any county officer or employee in
18 connection with the receipt, recording, and return of any
19 recordable instrument by the county recorder or registrar of
20 titles, whether received by mail, in person, or by electronic
21 delivery, including, but not limited to, opening mail; handling,
22 transferring, or transporting the instrument; certifying no
23 delinquent property taxes; payment of state deed tax, mortgage
24 registry tax, or conservation fee; recording of approved plats,
25 subdivision splits, or combinations; or any other prerequisites
26 to recording, and returning the instrument by regular mail or in
27 person to the person identified in the instrument for that
28 purpose.
29 Subd. 3. [RECORDING REQUIREMENTS.] Each county recorder
30 and registrar of titles shall, within 15 business days after any
31 instrument in recordable form accompanied by payment of
32 applicable fees by customary means is delivered to the county
33 for recording or is otherwise received by the county recorder or
34 registrar of titles for that purpose, record and index the
35 instrument in the manner provided by law and return it by
36 regular mail or in person to the person identified in the

1 instrument for that purpose, if the instrument does not require
2 certification of no-delinquent taxes, payment of state deed tax,
3 mortgage registry tax, or conservation fee. Each county will
4 establish a policy for the timely handling of instruments which
5 require certification of no-delinquent taxes, payment of state
6 deed tax, mortgage registry tax, or conservation fee and that
7 policy may allow up to an additional five business days at the
8 request of the office or offices responsible to complete the
9 payment and certification process.

10 For calendar years 2009 and 2010, the maximum time allowed
11 for completion of the recording process for documents presented
12 in recordable form will be 15 business days.

13 For calendar year 2011 and thereafter, the maximum time
14 allowed for completion of the recording process for documents
15 presented in recordable form will be ten business days.

16 Instruments recorded electronically are to be returned no
17 later than five business days after receipt by the county in a
18 recordable format.

19 Subd. 4. [COMPLIANCE WITH RECORDING REQUIREMENTS.] For
20 calendar year 2007, a county shall be deemed to be in compliance
21 with the recording requirements prescribed by subdivision 3 if
22 at least 60 percent of all recordable instruments described in
23 subdivision 3 and received by the county in that year are
24 recorded and returned within the time limits prescribed in
25 subdivision 3. In calendar year 2008, at least 70 percent of
26 all recordable instruments must be recorded and returned in
27 compliance with the recording requirements; for calendar year
28 2009, at least 80 percent of all recordable instruments must be
29 recorded and returned in compliance with the recording
30 requirements; and for calendar year 2010 and later years, at
31 least 90 percent of all recordable instruments must be recorded
32 and returned in compliance with the recording requirements.

33 Subd. 5. [TEMPORARY SUSPENSION OF COMPLIANCE WITH
34 RECORDING REQUIREMENTS.] Compliance with the requirements of
35 subdivision 4 may be suspended for up to six months when a
36 county undertakes material enhancements to its systems for

1 receipt, handling, paying of deed and mortgage tax and
2 conservation fees, recording, indexing, certification, and
3 return of instruments. The six-month suspension may be extended
4 for up to an additional six months if a county board finds by
5 resolution that the additional time is necessary because of the
6 difficulties of implementing the enhancement.
7 Subd. 6. [CERTIFICATION OF COMPLIANCE WITH RECORDING
8 REQUIREMENTS.] A requirement is imposed effective in 2007 for
9 the 2008 county budget that requires the county recorder and
10 registrar of titles for each county to file with the county
11 commissioners, as part of their budget request, a report that
12 establishes the status for the previous year of their compliance
13 with the requirements established in subdivision 3. If the
14 office has not achieved compliance with the recording
15 requirements, the report must include an explanation of the
16 failure to comply, recommendations by the recorder/registrar to
17 cure the noncompliance and to prevent a reoccurrence and a
18 proposal identifying actions, deadlines, and funding necessary
19 for bringing the county into compliance.
20 Subd. 7. [RESTRICTION ON USE OF RECORDING
21 FEES.] Notwithstanding any law to the contrary, effective for
22 county budgets adopted after January 1, 2006, each county shall
23 segregate the additional unallocated fee authorized by this act
24 from the application of the provisions of chapters 386, 507,
25 508, and 508A, in an appropriate account. These funds are
26 available as authorized by the Board of County Commissioners for
27 supporting enhancements to the recording process, including
28 electronic recording, to fund compliance efforts specified in
29 subdivision 5 and for use in undertaking data integration and
30 aggregation projects. Funds shall remain in the account until
31 expended for any of the authorized purposes set forth in this
32 subdivision. These funds shall not be considered as available
33 to supplant the normal operating expenses for the office of
34 county recorder or registrar of titles."
35 Renumber the sections in sequence and correct the internal
36 references

1 Amend the title accordingly

#1

Fiscal Note – 2005-06 Session

Bill #: S0267-0 **Complete Date:** 03/01/05

Chief Author: MURPHY, STEVE

Title: REAL ESTATE RECORDING & REG FEE

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

Agency Name: Finance Dept

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

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

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

Bill Description

This bill modifies real estate recording and registering fees charged by counties, setting flat, uniform statewide rates. The bill also increases the contribution from recording fees to the county technology fund.

Assumptions

Sets a flat fee of $40 for indexing and recording any deed or other instrument. Under current law the fee is $1 per page with a minimum of $15. Provides for allocation of the $40 fee to the state general fund, the county for administrative costs, the county technology fund, and the county general fund.

Increases the maximum fee from $5 to $10 for every entry of an abstract of title, from $50 to $100 for an abstract certificate, and from $2 to $5 per name for each required name search certification.
Increases from $9.50 to $10 the fee for a copy of an official plat filed, and from $0.50 to $5 for certification of each plat.

Increases from $30 to $50 the minimum fee for filing an amended floor plan of a multiunit building.
The existing 5% surcharge collected on certain transactions and paid to the state treasury is amended to a flat $1.50 fee. The $4.00 existing additional surcharge per filing collected by the counties and paid to the state treasury and credited to the general fund does not change.

The state would be required to initiate refunds under 507.093 (b) which is amended deleting the "county recorder or registrar" references and adding the "general fund" as the recording fee refunding agent when real estate documents are not filed in a timely manner as prescribed by statute.

Expenditure and/or Revenue Formula

It can be estimated that the change from the 5% per recording transaction to the flat fee of $1.50 per transaction will be revenue neutral. The $4.00 exiting additional surcharge collected for the general fund does not change, therefore, no increase in revenues are expected.

In addition, because the numbers of county recording transactions affected by this bill are unknown, it is impossible to determine any affect this bill will have on general fund revenues.

Long-Term Fiscal Considerations

Language in 507.093 (b) requiring the state to become the refunding agent versus the county recorder or registrar may have fiscal considerations depending on the volume of refunds required annually. This refund data is unknown.

Local Government Costs

Because the numbers of county recording transactions affected by this bill are unknown, it is impossible to determine any affect that this bill will have on local government costs.

FN Coord Signature: PETER SAUSEN
Date: 02/24/05 Phone: 296-8372

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: KRISTI SCHROEDL
Date: 03/01/05 Phone: 215-0595

Senate Counsel, Research, and Fiscal Analysis

G-17 State Capitol
75 Rev. Dr. Martin Luther King, Jr. Blvd.
St. Paul, MN 55155-1606
(651) 296-4791
FAX: (651) 296-7747
Jo Anne Zoff Sellner
Director

Senate

State of Minnesota

S.F. No. 267 - Providing for Fees and Standards for the Recording of Certain Documents

Author: Senator Steve Murphy

Prepared by: Daniel P. McGowan, Senate Counsel (651/296-4397)

Date: Februrary 7, 2005

S.F. No. 267 was prepared by the Minnesota County Recorders Association's legislative committee, along with the Minnesota Real Estate Services Association and the Minnesota Land Title Association, to update the law that relates to real estate recording. S.F. No. 267 is an attempt to provide consistency in real estate recording fees by eliminating confusing and inconsistent fees, and providing for a flat, uniform statewide recording fee. The bill also enhances the County Recorder's technology fund that improves time lines for producing data and allows for electronic recording.

Section 1 limits fees imposed on the recording process to those established in these sections of law. Eliminates the per page charge. Eliminates the $10 nonstandard document fee. Includes an additional $9 for the County Recorder's technology fund. Adjusts miscellaneous fees to better reflect the actual cost of providing the service.

Section 2 reduces the allowable recording time from the current 30 days to 15 days.

Section 3 clarifies the standards for documents presented for recording.

Section 4 establishes similar fees for Torrens property as done for abstract property previously.

Section 5 sets forth the complicated allocation of the fees.

Section 6 modifies the fees that apply to CIC (common interest community) property filings.

DPM:vs

Senators Vickerman, Cohen, Larson, Michel and Ranum introduced--

S.F. No. 918: Referred to the Committee on Finance.

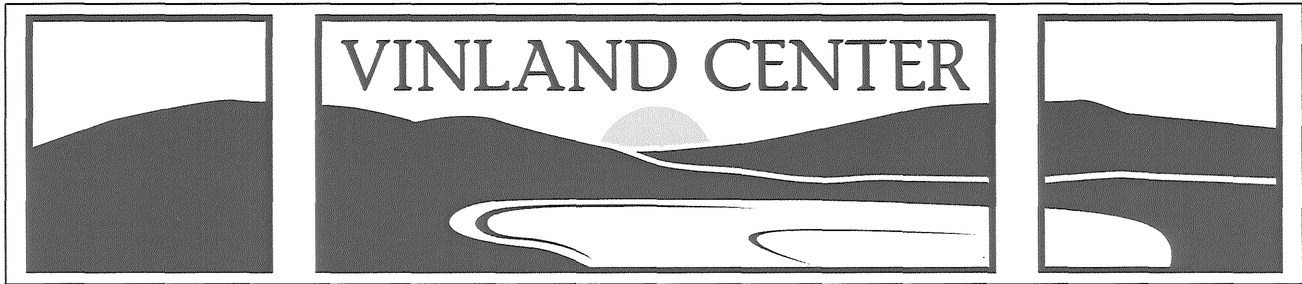
1 A bill for an act

2 relating to finance; providing certain services to
3 veterans; appropriating money.

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

5 Section 1. [SERVICES TO VETERANS; APPROPRIATIONS.]

6 $200,000 for fiscal year 2006 and $150,000 for fiscal year
7 2007 are appropriated from the general fund to the commissioner
8 of veterans affairs for grants to the Vinland Center to provide
9 services to veterans for vocational rehabilitation,
10 developmental disabilities, and chemical dependency.



The Organization

Vinland Center is a nonprofit rehabilitation center located in western Hennepin County on 178 acres of restored natural prairie with 2,000 feet of lakeshore on Lake Independence. Founded in 1976 with seed money given as a bicentennial gift to the United States from the government of Norway, Vinland was created to replicate Beitostolen, a Norwegian rehabilitation center that is one of the most innovative and holistic facilities in the world. Through a variety of programs designed to meet specialized rehabilitation needs in our community, Vinland strives to ensure full lives for people with disabilities.

The Employment Program History

The Vinland Employment Program was developed in the late 1980s in collaboration with the Department of Labor and Industry and the Department of Veterans Affairs specifically to address the multiple barriers to employment experienced by a particular group of potential workers.

The Employment Program was designed for people whose obstacles to greater independence and self-sufficiency include physical, mental, emotional and/or cognitive work injuries or disabilities, poor motivation and dysfunctional lifestyle habits as well as self-defeating attitudes. For this target population, traditional rehabilitation approaches are not sufficient to facilitate a return to work.

In a residential setting at Vinland, clients receive vocational rehabilitation, wellness and work conditioning services designed to provide clinically complex and chronically unemployed people with the skills, motivation and direction they need to go back to work.

The Employment Program Today

Demand for the Employment Program through the contracts housed in the Department of Labor and Industry and the Department of Veterans Affairs have historically been high, and this year is no exception.

By the end of January, with five months remaining in the contract fiscal year, 100% of the services of the Department of Veterans Affairs contract and 100% of the services under the Department of Labor and Industry contract have already been provided.

The original intent of the legislature in appropriating the funding for this contract was to enable Minnesota workers and Veterans with injuries and disabilities who have serious barriers to employment to re-enter the workforce.

The Employment Program Success

Client surveys completed during 2004 found **79% of the clients reached for follow-up six months post graduation were working or engaged in work related education, training or volunteer activities.** This exceeds the programs overall rate since its inception of 70% of the graduates who were reached for six month follow-up were employed, in school or training or in a volunteer position.

These success rates demonstrate the program's unique capacity to accomplish what more traditional programs could not for Minnesota's citizens facing overwhelming challenges.

Vinland National Center
P O Box 308 3675 Ihduhapi Road Loretto MN 55357
Telephone 763 479 3555 Fax 763 479 2605

2/28/05

Vocational Services

- Vinland National Center was established in 1976 by a gift from Norwegian government to the US government in honor of our bicentennial. The MN legislature matched the gift and as a result Vinland National Center was located in Minnesota. From then to now.....Vinland provides **services for people with disabilities who have fallen through the cracks of traditional systems**.

- Vocational programming has been a key offering since the late 1980's at which time the Minnesota Legislature established funding for Vinland to provide services for injured and disenfranchised workers with complex disabilities and veterans with disabilities.

- With the state dollars supporting the core program Vinland has been successful in securing funds from other sources to increase the number of clients served. **This year the program served a total of 78 people funded as follows**:
  - 21 MN Department of Veteran's Affairs
  - 17 MN Department of Labor and Industry
  - 25 US Substance Abuse and Mental Health Services Administration
  - 15 MN Department of Human Services (Federal grant dollars)

- The Vinland **vocational program clients are**:
  - 70% 30 – 50 years of age
  - 70% Caucasian
  - 22% African American
  - 3% Native American
  - 3% Hispanic American
  - 56% from seven county metro area
  - 44% from Greater Minnesota
  - over 50% of all vocational program clients have served in the United States military

- **The top five primary diagnoses** on admission (in order of prevalence) are:
  - Chemical Dependency
  - Depression
  - Post Traumatic Stress Disorder
  - Bi-Polar Disorder
  - Traumatic Brain Injury

- **The core program is a three-week** "back to work" program that focuses on the whole person, includes interest and skill testing as well as job seeking and job keeping skill training. Program cost: $2475 per week.

- The results over all of these years have been excellent. In the most recent evaluation **79% of the clients that could be reached for 6-month follow-up were working, in school or training, or engaged in work related volunteer activities.**

- **The program gets people back on their feet and the result is a productive citizen.**

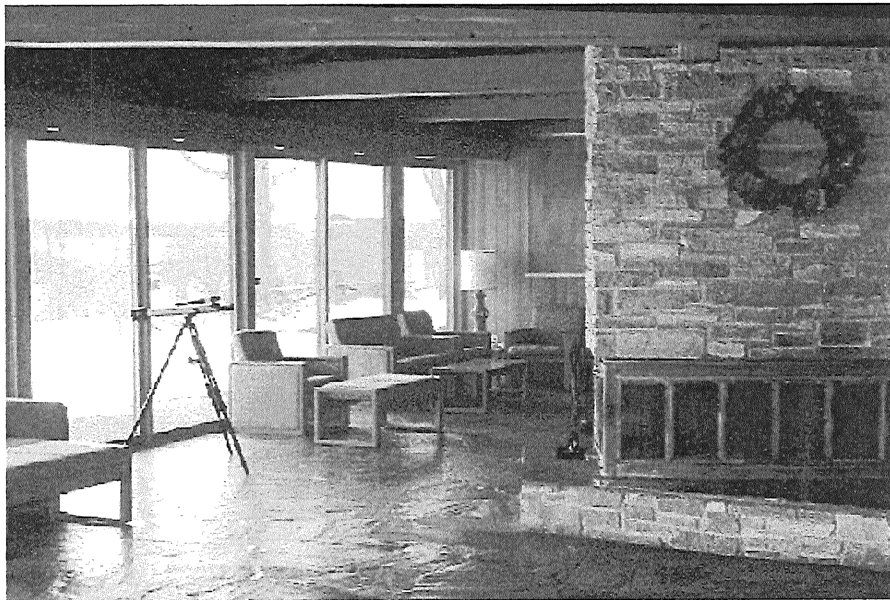
3675 Ihduhapi Road P O Box 308 Loretto Minnesota 55357 763 479 3555

Vinland National Center
Loretto, Minnesota

Main Campus

Welcome to Vinland

Vinland National Center
Loretto, Minnesota



Stordahl Center

Vinland Waterfront

#3

The Organization

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The Employment Program History

The Vinland Employment Program was developed in the late 1980s in collaboration with the Department of Labor and Industry and the Department of Veterans Affairs specifically to address the multiple barriers to employment experienced by a particular group of potential workers.

The Employment Program was designed for people whose obstacles to greater independence and self-sufficiency include physical, mental, emotional and/or cognitive work injuries or disabilities, poor motivation and dysfunctional lifestyle habits as well as self-defeating attitudes. For this target population, traditional rehabilitation approaches are not sufficient to facilitate a return to work.

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The Employment Program Today

Demand for the Employment Program through the contracts housed in the Department of Labor and Industry and the Department of Veterans Affairs have historically been high, and this year is no exception.

By the end of December, the mid-point in the contract fiscal year, 98% of the services of the Department of Veterans Affairs contract and 90% of the services under the Department of Labor and Industry contract will already have been provided.

The original intent of the legislature in appropriating the funding for this contract was to enable Minnesota workers and Veterans with injuries and disabilities who have serious barriers to employment to re-enter the workforce.

The Employment Program Success

Client surveys completed during 2004 found **79% of the clients reached for follow-up six months post graduation were working or engaged in work related education, training or volunteer activities.** This exceeds the programs overall rate since its inception of 70% of the graduates who were reached for six month follow-up were employed, in school or training or in a volunteer position.

These success rates demonstrate the program's unique capacity to accomplish what more traditional programs could not for some of Minnesota's most challenging citizens.

Vinland National Center
P O Box 308 3675 Ihduhapi Road Loretto MN 55357
Telephone 763 479 3555 Fax 763 479 2605

12/04

Senators Skoe, Saxhaug, Dille, Rosen and Frederickson introduced--

S.F. No. 1526: Referred to the Committee on Finance.

1 A bill for an act

2 relating to state government; appropriating money for
3 the legislators' forum.

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

5 Section 1. [APPROPRIATION.]

6 $10,000 in fiscal year 2006 and $10,000 in fiscal year 2007
7 are appropriated from the general fund to the Legislative
8 Coordinating Commission for purposes of the legislators' forum,
9 through which Minnesota legislators meet with counterparts from
10 South Dakota, North Dakota, and Manitoba to discuss issues of
11 mutual concern.

Senators Rest, Belanger, Moua, Marty and Tomassoni introduced--

S.F. No. 1216: Referred to the Committee on Taxes.

1 A bill for an act

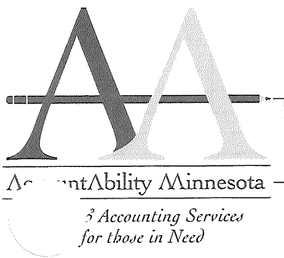
2 relating to taxation; income tax administration;
3 appropriating money for grants to nonprofit entities
4 to facilitate the delivery of volunteer assistance to
5 low-income taxpayers.

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

7 Section 1. [APPROPRIATION.]

8 (a) $125,000 in fiscal year 2006 and $125,000 in fiscal
9 year 2007 are appropriated from the general fund to the
10 commissioner of revenue to make grants to one or more nonprofit
11 organizations, qualifying under section 501(c)(3) of the
12 Internal Revenue Code of 1986, to coordinate, facilitate,
13 encourage, and aid in the provision of taxpayer assistance
14 services.

15 (b) "Taxpayer assistance services" mean accounting and tax
16 preparation services provided by volunteers to low-income and
17 disadvantaged Minnesota residents to help them file federal and
18 state income tax returns and Minnesota property tax refund
19 claims and to provide personal representation before the
20 Department of Revenue and Internal Revenue Service.



Bonnie Esposito
Executive Director

2300 Myrtle Avenue West
Suite 180
St. Paul, MN 55114

Phone 651.287.0187 ext. 1
Fax 651.287.0190

besposito@accountabilitymn.org

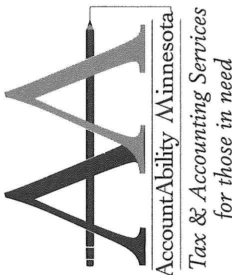
What to Bring Checklist

- Valid picture I.D.
- Social Security cards or Individual Taxpayer ntification Number cards or letters for all sons listed on the tax return
- Birth date for all persons listed on the tax return
- Prior year's tax return
- Direct deposit information showing account and routing numbers
- Copy of income forms for wages from each job (Form W-2), interest (Form 1099-INT), dividends (Form 1099-DIV), Retirement Plans (Form 1099-R), Gambling Winnings (Form 1099-2G), Unemployment (Form 1099-G), Social Security Benefits (Form SSA)
- Yearend income statements for MFIP, SSI, MSA, GA, veterans' benefits, and worker's compensation
- Education expenses you paid for your children in grades K-12. For example tutoring, rental/purchase of instrument, music lessons, pens, pencils, and notebooks
- Tuition expenses you paid to attend a university/technical college (Form 1098-T)
- ıterest paid on student loans (Form 1098-E)
- Daycare expenses you paid for your children. Bring provider's name, address, & tax ID or Social Security Number
- Charitable donations of cash and non-cash
- Homeowners: Mortgage interest and real estate taxes paid in 2004 (Form 1098) & Statement of Property Tax Payable in 2005 mailed by the county in March
- Renters: Certificate of Rent Paid (CRP) from your landlord

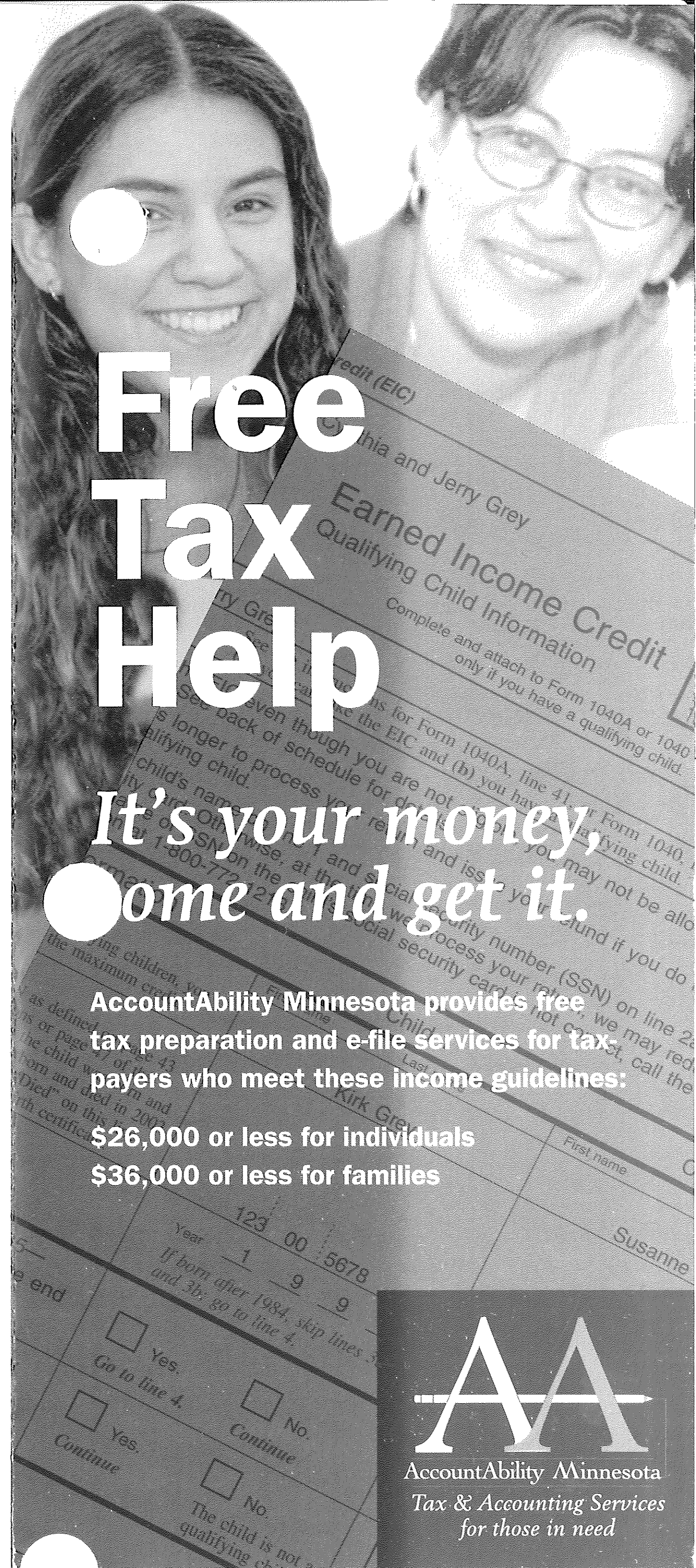
For a detailed checklist, visit www.accountabilitymn.org or contact one of the tax sites listed.

If you received a Form 1099-MISC or have a small business; i.e. self-employed, daycare, paper carrier; call AccountAbility Minnesota at (651) 287-0187 for a tax organizer.

NONPROFIT
ORGANIZATION
U.S. POSTAGE
PAID
PERMIT # 26854
MINNEAPOLIS, MN



2300 Myrtle Ave. W.
Suite 180
St. Paul, MN 55114



Free tax preparation and e-file services:

January 27 to April 15

Call the location [illegible]rest yo[illegible] dates and times.

St. Paul

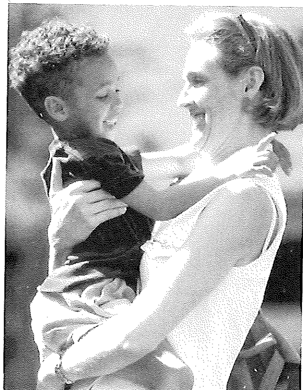
AccountAbility Minnesota
(Individual & Self-Employed)
2300 Myrtle Ave. W.
(651) 287-0187

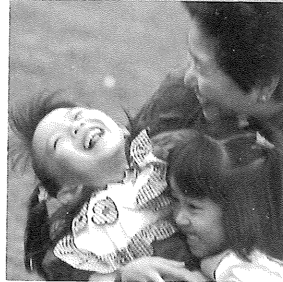
CLUES
797 E. Seventh St.
(651) 379-4200

Hallie Q. Brown Community Center
270 N. Kent
(651) 224-4601

Neighborhood Development Alliance
481 S. Wabasha
(651) 292-0131

Ramsey Action Programs
450 N. Syndicate St.
(651) 645-6445





Suburban

Community Action for Suburban Hennepin
Various locations
(952) 933-9639

Hopkins Minnetonka Family Resource Center
915 Mainstreet
(952) 988-5350

Hennepin South Services Collaborative FamiLink
9801 Penn Ave. S.
Bloomington
(952) 884-0444

Thorson Family Resource Center
7323 58th Ave. N.
Crystal
(763) 504-7680

US Federal Credit Union
2010 Jefferson Rd.
Northfield
(507) 650-4510

Minneapolis

Brian Coyle Community Center
420 15th Ave. S.
(612) 338-5282

Chrysalis
4432 Chicago Ave. S.
(612) 871-0118, ext. 2

Minneapolis Urban League
2100 Plymouth Ave. N.
(612) 302-3100

CLUES
2700 E. Lake St.
(612) 746-3500

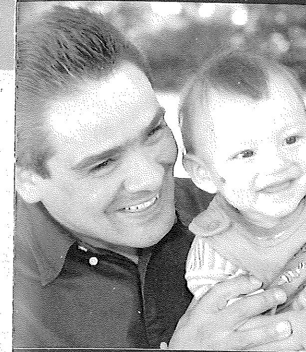
Faith in the City
2414 Park Ave. S.
(612) 879-5330

Sabathani Community Center
310 E. 38th St.
(612) 821-2302

US Federal Credit Union
2535 27th Ave. S.
(952) 736-5000

Walker Library
2880 Hennepin Ave. S.
(612) 630-6650

Why use Direct Deposit for your tax refund?



It's faster and saf[illegible] than having a che[illegible] mailed to your home.

With direct deposit you may get your refund in 5 to 10 business days with no fees, interest, or hassle!

What other types of payments can be made by Direct Deposit?

Payroll, social security, SSI, retirement, pension, veteran's, & unemployment benefits. No more waiting in line on payday or paying money order fees.

What if I don't have a checking or savings account?

Stop at your neighborhood credit union or bank to open an account. Many tax sites are working with financial institutions to help you open a savings account.

The AccountAbility Minnesota Taxpayer Services Program is funded in part by: American Express Philanthropic Program; the McKnight Foundation, the Minneapolis Foundation; the 3M Foundation; Minnesota Society of Certified Public Accountants; the State of Minnesota and the Wells Fargo Bank Foundation. We thank them for their support and also thank our many community and corporate partners that help make the program a success.

Printing funded by Wells Fargo Bank Foundation Minnesota.

WELLS FARGO

Free tax preparation and e-file services:

January 27 to April 15

Call the location nearest you for dates and times.

St. Paul

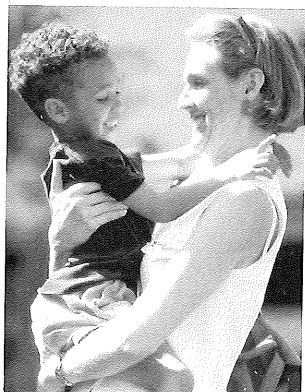
AccountAbility Minnesota
(Individual & Self-Employed)
2300 Myrtle Ave. W.
(651) 287-0187

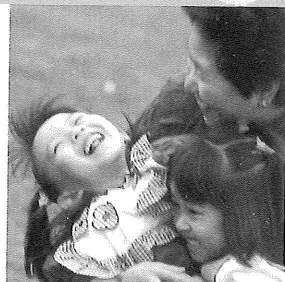
CLUES
797 E. Seventh St.
(651) 379-4200

Hallie Q. Brown Community Center
270 N. Kent
(651) 224-4601

Neighborhood Development Alliance
481 S. Wabasha
(651) 292-0131

Ramsey Action Programs
450 N. Syndicate St.
(651) 645-6445





Suburban

Community Action for Suburban Hennepin
Various locations
(952) 933-9639

Hopkins Minnetonka Family Resource Center
915 Mainstreet
(952) 988-5350

Hennepin South Services Collaborative FamiLink
9801 Penn Ave. S.
Bloomington
(952) 884-0444

Thorson Family Resource Center
7323 58th Ave. N.
Crystal
(763) 504-7680

US Federal Credit Union
2010 Jefferson Rd.
Northfield
(507) 650-4510

Minneapolis

Brian Coyle Community Center
420 15th Ave. S.
(612) 338-5282

Chrysalis
4432 Chicago Ave. S.
(612) 871-0118, ext. 2

Minneapolis Urban League
2100 Plymouth Ave. N.
(612) 302-3100

CLUES
2700 E. Lake St.
(612) 746-3500

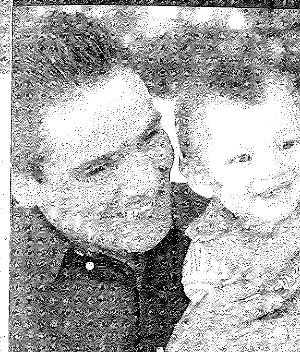
Faith in the City
2414 Park Ave. S.
(612) 879-5330

Sabathani Community Center
310 E. 38th St.
(612) 821-2302

US Federal Credit Union
2535 27th Ave. S.
(952) 736-5000

Walker Library
2880 Hennepin Ave. S.
(612) 630-6650

Why use Direct Deposit for your tax refund?



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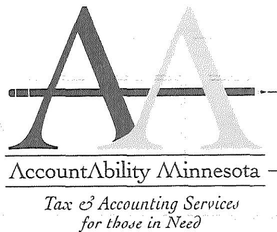
Printing funded by Wells Fargo Bank Foundation Minnesota.

WELLS FARGO

#4



Volunteer Tax Assistance

Helping Bring Millions of dollars in federal funds into Minnesota

Across the nation, public policy experts, lawmakers, and social service providers have seen that family-related tax credits offer essential financial assistance to millions of this country's working poor. According to Brookings Institution, the federal Earned Income Tax Credit (EITC) is by far the nation's largest and most effective anti-poverty programs, lifting an average of 5 million Americans above the poverty line each year. However certain segments of the business community have targeted this population and are taking advantage of these substantial refunds to charge exorbitant fees and interest for tax preparation and refund anticipation loans (RALs). Only 4.5% of all Minnesotans received a RAL last year, however according to the IRS 1 in 5 or 21% of EITC filers received a RAL in 2003. In fact, use of RALs by EITC filers increased 9.6% from 2002 to 2003. (CDF MN *Keeping What They've Earned: Working Minnesotans and Tax Credits* – February 2005.)

Consider these facts:

- Last year more than 235,000 families in Minnesota claimed the Earned Income Tax Credit (EITC) resulting in **over $359 million in federal funds pumped into the local economy**.
- Last year tax preparation fees and refund anticipations loans **cost Minnesota low income families more than $23 million in federal and state tax funds** – much of that going to out of state banks that service the loans.
- **Volunteer tax assistance** helps bring that money to Minnesota and those dollars are spent locally on food, clothing and rent.
- AAM partners with community-based organizations so we **reach low income taxpayers that otherwise would not file** returns or claim the credits
- Volunteer Tax Assistance offers tax preparation *for free* so **low income tax payers keep 100% of their refunds.**

Volunteer Tax Assistance reaches low-income taxpayers that would otherwise not file a return or claim the credits. Continued state funding is essential to ensure these federal dollars continue to reach Minnesota.

For more information:
Bonnie Esposito, Executive Director
AccountAbility Minnesota
651-287-0187

2300 Myrtle Avenue West
Suite 180
Saint Paul, MN 55114
Phone: 651.287.0187
Fax: 651.287.0190
www.accountabilitymn.org

THANK YOU COMMUNITY TAX SITES!

The following agencies, libraries, schools, businesses and churches help working families by partnering with AccountAbility Minnesota to offer volunteer free tax assistance in their community during the 2005 tax season.

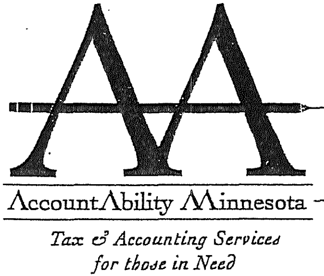
AccountAbility Minnesota 2005 Community-based Partner Tax Sites

Site	Location
Brian Coyle Community Center	*Minneapolis*
Chicanos Latinos Unidos En Servicio*	*Minneapolis* *St. Paul*
Chrysalis	*Minneapolis*
Community Action Duluth	*Duluth*
Community Action for Suburban Hennepin*	*Brooklyn Park, Eden Prairie, Edina, Hopkins, Mound, Richfield*
Faith in the City	*Minneapolis*
Hallie Q. Brown / Martin Luther King Center	*St. Paul*
Head Start / MACCC	*Morris*
Hennepin County Corrections	*Plymouth*
Hennepin South Service Collaborative FamiLink	*Bloomington*
Hopkins Minnetonka Resource Center	*Hopkins*
Lakes and Prairies Community Action Partnership*	*Moorhead* *Breckenridge*
Liberty Savings Bank	*Waite Park*
Neighborhood Development Alliance	*St. Paul*
Ramsey Action Program	*St. Paul*
Ramsey County Corrections	*St. Paul*
Rice Middle School	*Saulk Rapids*
Sabathani Community Center	*Minneapolis*
Thorson Family Resource Center	*Crystal*
Tri County Action Program*	*St. Cloud*
University of Minnesota*	*Duluth* *Fon Du Lac Indian Reservation*
Urban League	*Minneapolis*
US Federal Credit Union*	*Minneapolis* *Northfield*
Walker Library	*Minneapolis*
Wesley United Methodist Church	*Marshall*
West Central Community Action*	*Elbow Lake*

**These AccountAbility Minnesota partners coordinate multiple tax sites.*

AccountAbility Minnesota's St. Paul Office is open year round for tax assistance for late filers, out of state returns, and problems with the Internal Revenue Service or the Minnesota Department of Revenue.

AccountAbility Minnesota
2300 Myrtle Ave W. Suite 180 / St. Paul, MN 55114
651-287-0187 / www.accountabilitymn.org



2300 Myrtle Ave W. Suite 180
St. Paul, Minnesota 55114
651-287-0187

MEMORANDUM

February 11, 2005

To: Representative Neva Walker

From: Bonnie Esposito, Executive Director

Subj.: Minnesota State tax due

Here are the statistics that we discussed when we met last week. These are the dollars that our customers owed the state and federal government when we completed their tax returns.

For AccountAbility Minnesota sites only:

2003		
Minnesota State Tax	**Due**	**$271,190**
Federal Income Tax	Due	$674,290
2002		
Minnesota State Tax	**Due**	**$180,833**
Federal Income Tax	Due	$503,648
2001		
Minnesota State Tax	**Due**	**$131,367**
Federal Income Tax	Due	$379,726
2000		
Minnesota State Tax	**Due**	**$108,269**
Federal Income Tax	Due	$324,939

Total Paid to Minnesota over four years $691,659

To put the state dollars invested in the grants in perspective – last tax season AccountAbility Minnesota received $39,300 from the MNDOR competitive grant and our tax sites helped return $271,190 in taxes owed to Minnesota.

Please call me if you have any questions or want to see this information displayed in another way. Thanks for your help with this important funding.

AccountAbility Minnesota

Celebrating 33 years of Service

2004 Accomplishments

Since 1971 AccountAbility Minnesota (AAM) has been providing comprehensive, tax assistance services year round to a diverse population of low-income and other disadvantaged residents of Minnesota. AccountAbility Minnesota is the only community-based nonprofit organization in the state with a mission solely devoted to accounting and tax assistance. AccountAbility Minnesota has developed a highly effective and efficient structure by which thousands of individuals are assisted each year to navigate the tax reporting system and receive the maximum cash refunds they are due. **Our mission is to provide tax preparation and accounting services to individuals and small business owners with limited means by leveraging volunteer resources.**

Across the nation, public policy experts, lawmakers, and social service providers have seen that family-related tax credits offer essential financial assistance to millions of this country's working poor. According to Brookings Institution, the Earned Income Tax Credit (EITC) is by far the nation's largest and most effective anti-poverty program lifting an average of five million Americans above the poverty line each year. In Minnesota, combined federal and state refunds can add up to 50% of an individual's total annual income. For this reason, the value and importance of AccountAbility Minnesota's Taxpayer Services have soared over the years.

Highlights of 2004 accomplishments include:

- 9,500 low-income taxpayers received free tax assistance
- 350+ small businesses received tax assistance
- $10.9 million in cash refunds to low-income Minnesota families
- 17,699 federal and state tax returns prepared by 400 volunteers
- 10,845 volunteer hours worth over $379,000 in donated service
- 408 tax sessions held at 40 statewide tax sites

However, there is a huge unmet need for free tax assistance across the state. According to Internal Revenue Service (IRS) estimates, only 80% of eligible households claim the ETIC. Thousands of eligible households do not file for these credits and the federal dollars go unclaimed. In addition, certain segments of the business community have targeted this population and are taking advantage of these substantial refunds to charge exorbitant fees and interest for tax preparation and refund anticipation loans (RALs). Only 2-3% of non-EITC households use RALS, however *in some areas of Minnesota targeted by unscrupulous tax preparation services, over 50% of EITC filers use RALs.* According to a report by the Children's Defense Fund, EITC filers who got a RAL in 2001 paid an average of 10% of their return in tax preparation fees and interest. This study found that over $17 million in federal dollars that were intended for low-income taxpayers went instead to commercial tax preparers and affiliated national banks.

Each year AccountAbility Minnesota expands the number of taxpayers and communities served with free tax assistance. The following table is a summary of the last three years:

	2002	2003	2004	Increase 2002 -2004
Total Refunds	$8.4 million	$9.9 million	$10.9 million	30%
Taxpayers Served	7,416	8,489	9,535	29%
Tax Returns Completed (fed & state)	13,880	16,398	17,699	28%
Electronic Filed Tax Returns (fed & state)	2,744	4,948	8,332	204%
Taxpayers Served in Greater Minnesota	423	670	1,503	255%

AccountAbility Minnesota has taken advantage of the burgeoning growth and visibility of tax filing for low-income Americans by keeping pace with the rapid increase of immigrants and other non-English speaking taxfilers, the dramatic growth in the number and value of tax credits, and the escalating emphasis on electronic filing. We have established strong partnerships with community-based organizations that serve these disadvantaged populations. In fact, in the 2004 tax season, members of communities of color, English language learners, or persons with disabilities comprised 67% of the taxpayers we served. The following table, compiled from taxpayer surveys, reflects the populations that we serve:

TAXPAYERS SERVED 2004	% of Total
African-American / African	37%
White	33%
Chicano / Latino	18%
Asian	5%
Other	3%
Native-American	3%
Multi ethnic	1%
English language learners	22%
Individuals with disabilities	18%

This information is self reported by taxpayers.

A board of fifteen directors governs the agency, while four staff persons handle daily operations and manage more than 400 volunteers. The majority of tax preparation is accomplished by leveraging volunteer resources. AccountAbility Minnesota has 33 years of experience in both recruitment and training of volunteers to expertly complete tax returns and maximize tax credits for low-income working individuals, families and small businesses. Volunteers help accomplish the organization's goals efficiently and with a human touch. Last year, AccountAbility Minnesota volunteer hours were worth $379,000 in donated service. AccountAbility Minnesota's tax volunteers are among the most highly trained in the country. Each year we work closely with staff from the Internal Revenue Service and MN Dept. of Revenue to establish training classes and to develop effective learning models that cater to volunteers' unique levels of expertise.

For more information contact:
Bonnie Esposito, Executive Director
651-287-0187, Ext. 1 / besposito@accountabilitymn.org

2005

Organization / Contact	Amount
AccountAbility Minnesota	$35,673
Arrowhead Economic Opportunity Bonnie Ebnet 1-800-662-5711, ext 228	$7,563
Association for the Advancement of Hmong Women Ly Vang 612-724-3066, ext 1	$476
Beltrami County Senior Center Deanna Sletten 218-751-3136, ext 26	$6,350
Community Volunteer Services and Senior Centers Kathryn Miron 651-439-7434	$3,500
Episcopal Community Services Colleen Cunningham 612-874-8823	$250
Friends of the Skyway Senior Center Ruth Kildow 612-673-3004	$23,058
Ottertail-Wadena Community Action Council Danny Dunlap 218-385-2907, ext 115	$18,600
Rochester Senior Center Darryl Welde 507-287-1404	$3,440
Tri-County Action Program Judy Stene 320-251-1612, ext 142	$3,775

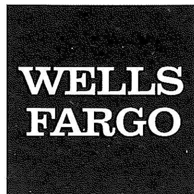
Organizations that received a Grant to Provide Volunteer Taxpayer Assistance Services to Low-Income and Disadvantaged Minnesota Residents for 2004

Organization	Amount of Grant
AccountAbility Minnesota	$39,305.00
Arrowhead Economic Opportunity Agency	$8,208.00
Association for the Advancement of Hmong Women in Minnesota	$760.00
Lao Assistance Center of Minnesota	$3,410.00
Nokomis Healthy Seniors Program	$15,941.00
Otter Tail – Wadena Community Action	$21,044.00
Salvation Army of St. Cloud	$4,770.00
Senior Place	$1,500.00
Southeast Asian Community Council	$2,377.00

It's up to you. If you are smart, your refund can work for you. In time, savings or investments can build a secure future including a home; college education; your own business; or whatever you dream for your family or yourself. Take that first step with this tax refund—the sky is the limit!

Tax & Accounting Services for those in need

2300 Myrtle Ave W. Suite 180
St. Paul, MN 55114
651-287-0187
www.accountabilitymn.org



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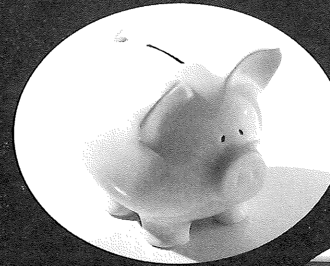
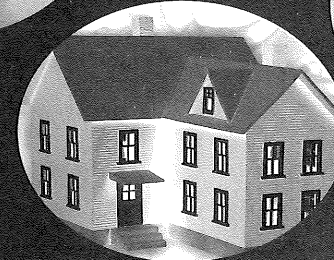
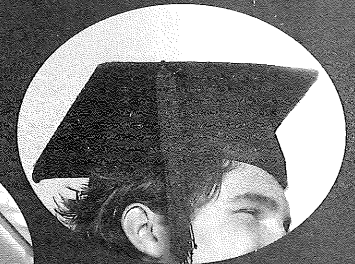




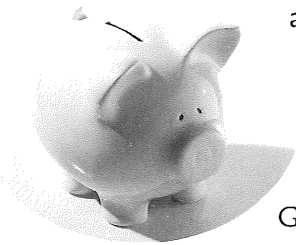


How Will You Use Your Refund?

You may be getting hundreds—even thousands—of dollars back in tax refunds in the next few days. This is a once-a-year opportunity to get ahead. Be smart with your refund and increase your net worth—not just your income!

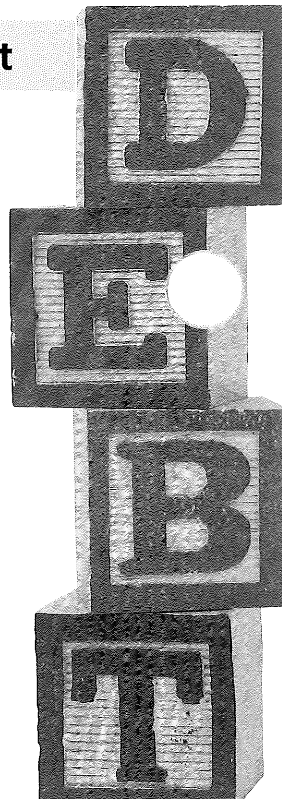
Start to realize your dreams by putting that money to work for you!

Create a Safety Net with a Savings Account



Have your tax refund direct deposited in a savings account. It pays interest (it works for you) and it will help you handle emergency expenses. Then keep adding to your account—even $10 a paycheck will build to $260 each year—and that earns interest as well! Get into the savings habit and make your money work for you.

Get Out of Debt and into Good Credit

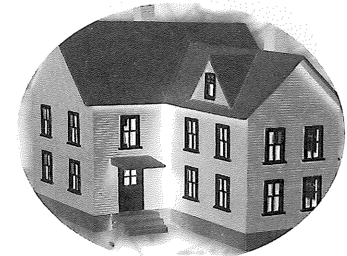


Pay off any small debts with your refund. For larger debts, put your refund in a savings account and send a payment each month until the debt is done. For credit card debt, always pay more than the minimum so you pay it down faster and pay less interest overall.

Call any of these credit bureaus and for $3 you can get a copy of your credit report. Know what you owe and watch your credit improve!

- **Experian** 1-866-200-6020
- **Transunion** 1-800-916-8800

Build a Secure Future



Invest some of your refund and it will really work for you!

- Open an Individual Retirement Account (IRA) and every dollar you invest is deductible off next year's taxable income.

  — *or* —

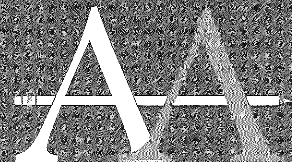
  Open a Roth IRA and your interest is tax-free and after five years you can use it to buy a home or go to college.
- Buy into a mutual fund to get high return with less risk. If you invest $1,000 from your refund each year and get a 10% return, in 20 years you would have $65,000! You can invest as little as $250 to start. For more information visit www.investing.rutgers.edu
- Buy U.S. government savings bonds: series I bonds pay you interest every year, and series EE bonds double in value. Buy an EE bond for $50 and in 20 years cash it in for $100. For more information visit www.publicdebt.treas.gov

There are several mutual fund companies with reputations for low costs that can help with both investing and opening IRAs:

- **T. Rowe Price**
  www.troweprice.com
  1-800-225-5132
- **Vanguard**
  www.vanguard.com
  1-877-662-7447
- **Charles Schwab**
  www.schwab.com
  1-866-855-9102

TAXING TIMES

The bi-monthly newsletter of AccountAbility Minnesota Volume 23, November - December 2004



Thrivent Volunteer Wins Volunteer Excellence Award

Recently, AccountAbility Minnesota volunteer **Valerie Martinson** received the Thrivent Financial for Lutherans **Volunteer Excellence Award** to honor her outstanding volunteer efforts in the community. Valerie and three other people are the first-ever Thrivent Financial employee volunteers of the year. She was recognized for outstanding volunteer service with AccountAbility Minnesota as well as several other non-profit organizations. As part of Valerie's award, Thrivent Financial nated $1,000 to AccountAbility Minnesota.

Valerie began volunteering with AccountAbility Minnesota as an Individual Tax Preparer after reading about the organization in a Thrivent Financial corporate newsletter. Valerie says it is pretty easy to recruit others to volunteer at AccountAbility. When asked how, Valerie said "I just share my personal experience and ask. It hasn't taken much else. The best recruiters are people who are already volunteering and it is fun to volunteer at the same site with someone you know."

Congratulations to Valerie on winning the Thrivent Financial Volunteer Excellence Award. It is privilege and honor to have Valerie as a member of AccountAbility's volunteer staff.

Workplace Giving Helps AccountAbility Minnesota

Now is a great opportunity to support both AccountAbility Minnesota (AAM) and the United Way through designated United ay contributions in the workplace. Most employers have the necessary forms that enable you to designate your workplace United Way contribution to a specific agency eligible to receive funding through the United Way, such as AAM. In some instances, you may need to specifically ask the United Way chairperson at your employer for the forms to make this designation. I have personally designated my United Way contribution to go to AAM for many years and encourage you to also. AccountAbility Minnesota, United Way and all of us benefit from your generosity.

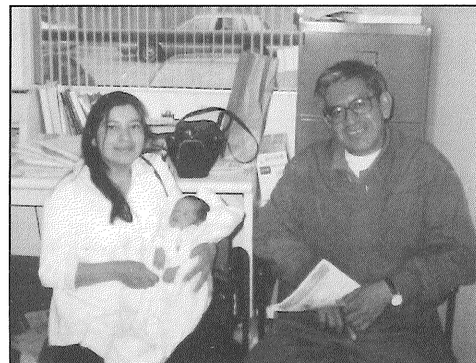
Ed Sturm, Partner
Comprehensive Tax Solutions • Deloitte & Touche LLP

Increasing Service to the Latino Community

Thanks in great part to our community partners, AccountAbility Minnesota has an impressive track record of reaching diverse populations with our services. Last tax season, AccountAbility Minnesota customers reported *76 different languages* as their primary language. Sixty-six percent of taxpayers served were English language learners, recent immigrants or from communities of color.

However, in our own office we still experienced a language barrier with many of our customers. We are happy to report that since September, we have been able to improve our capacity and better assist the Latino community. With the addition of Gabriela Perez to our permanent staff, we are now available everyday from 9:00 am to 1:00 pm to help our Latino customers. We also have a dedicated telephone line to assist our Spanish speaking customers and our web site has information about tax clinics and services in Spanish. Last year we increased Latinos served to 16%; with these tools we hope to help even more of the Latino community.

AAM necesita voluntarios que hablen español
Haz voluntariado como Preparador de impuestos,
Intérprete o Asistente de clínicas de impuestos
Tú puedes ayudarnos!
Por favor llama al 651.287.0187 ext. 3



AccountAbility Minnesota

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651.287.0187 ext. 2

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The Director's Corner

Bonnie Esposito, Executive Director

Planning for the 2005 tax season is well underway. We have enjoyed meeting our **new Greater Minnesota Partners** and will be expanding to a wide area of west central Minnesota thanks to partnerships with a number of Community Action Programs. Our new partners are *Lakes & Prairies Community Action Partnership* in Moorhead serving Clay and Wilkin Counties; *West Central Minnesota Communities in Action* in Elbow Lake serving Grant, Douglas, Traverse, Stevens, and Pope Counties; *Prairie Five CAC* in Montevideo serving Big Stone, Swift, LacQui Parlie; Yellow Medicine and Chippewa Counties; and *Community Action Duluth* serving residents in the Duluth area. In addition, one of our financial institution partners, the U.S. Federal Credit Union, ran a successful tax site at their Minneapolis office last tax season. Their success prompted them to expand their partnership with us to provide free tax assistance at their Northfield branch serving Faribault and Owatonna. If you have colleagues or friends in any of these areas, please contact Kathleen, our Director of Volunteer Resources, with names and contact information. Help us support and promote this new service and volunteer opportunities.

Fall also brings many companies' campaigns to promote *workplace giving* allowing employees to sign up for automatic payroll deduction for United Way and other public and private campaigns. Thanks to all of you that generously designate AccountAbi Minnesota as the recipient for your annual giving. And if you haven't yet donated, remember that we still have the McKnight Challenge Campaign and your donation will be matched $1 for every $2 you donate.

Welcome Gabriela and Kathleen

If you have called AccountAbility Minnesota in the last few weeks you have noticed that our telephone message is now in Spanish as well as English. This is thanks to one of our newest staff members **Gabriela Perez** who not only is working with Bonnie as an administrative assistant but also is helping with our Spanish speaking customers, translating materials, and is assisting with marketing and fundraising. Gabriela has a Bachelor of Law Degree from Universidad Santa Maria, Venezuela and she is a graduate student at Hamline University for a dual degree in Management and Law. She has experience with nonprofit organizations in Minnesota including the Immigrant Law Center, and Family and Children's Service. In Venezuela she worked in marketing and research for private companies and also worked for the Venezuelan Internal Revenue Service.

Kathleen Seestadt joined our staff early September as the Director of Volunteer Resources. She has over 20 years experience coordinating programs and volunteer services for various sized nonprofit organizations throughout the Twin Cities metropolitan area. She has designed and implemented volunteer orientations and training, policies and procedures, management practices, and support materials for staff and volunteers. Kathleen has established and managed her own consulting business to assist nonprofit organizations with volunteer management, event planning, staff training and program assessment. Since joining AccountAbility Minnesota she has established a number of new volunteer positions, a Volunteer Orientation and schedule for new and returning volunteers.

Volunteer Orientations Scheduled

Beginning this October AccountAbility Minnesota is inviting people who are interested in supporting free tax assistance to low-income individuals and families to attend an orientation. Conducting orientation sessions twice a month will enable us to respond quickly to potential new volunteers.

Orientations will give prospective volunteers and supporters an opportunity to learn about how important free tax assistance is to low-income taxpayers. At the orientations we will present a brief history of Account Ability Minnesota, explain the services we provide, and provide information about the volunteer opportunities.

Please invite your friends, family and co-workers to attend an AccountAbility Minnesota orientation. For dates and times contact Kathleen Seestadt, Director of Volunteer Resources. Orientations are held at AccountAbility Minnesota's office. Upcoming orientation dates and times are:

Saturday, Nov. 13th 10 a.m.
Tuesday, Nov. 16th 7 p.m.
Saturday, Dec 4th 10 a.m.

We can't wait to tell people about the wonderful work that volunteers do at AccountAbility Minnesota!

Two Bits and More.....

Tax Tidbits

- The Earned Income Tax Credit started in 1975. The State of MN followed with the Working Family Credit in 1991.

*****

- For the 2004 tax year:

✓ $1,000 Child Tax Credit has been extended

✓ Standard mileage rate is 37.5 cents

✓ Tuition & fees deduction increased to $4,000

Thank You Donors July - September 2004

Thank you to the following individuals, foundations and companies for their support.

American Express
Anonymous
Beverly Jorgenson
Charles & Gwen Denning
Cheryl Ellefson
David & Joanne Buerke
Deloitte & Touche, LLP
Donna Stein
Hennepin County Human Services
Jill Schwimmer
John Urbanski
Leroy & D. Thomason
Maria Builes Ospina
MN Department of Human Services, Office of Economic Opportunity
Opportunity Partners
Pillsbury United Communities
Rose Gbadamassi
Stiles Foundation
Terrence Glarner
The Antioch Company/Creative Memories Fund
Thomson West
Thrivent Financial for Lutherans

We welcome contributions. Please use the enclosed envelope for your convenience.
All contributions are tax-deductible.

Marshall Tax Assistance Continues

You may have heard that AccountAbility Minnesota offered free tax assistance in Marshall and Worthington Minnesota last tax season. But did you know we still have a part-time staff person working there helping low-income customers with prior year tax returns and planning for 2005? Thanks to a grant from the Bremer Foundation and our partnership with Children's Defense Fund Minnesota, we hired **Barb Shaw** as the Tax Site Director in Marshall. In addition to preparing tax returns, Barb helped to coordinate the tax sites, recruit and train volunteers, and administer the e-file process. Even though the tax season ended, there was still more work to be done and thankfully Barb agreed to stay on. Currently, she is planning and marketing this free service for the upcoming tax season. She recruits many of the volunteers from The Schwan Food Company, Inc. where she is employed in their Marketing Department. We are also grateful to Bremer Bank for their support and volunteers as well as to Wesley United Methodist Church that opened their community room for tax assistance every Saturday. We are still looking for volunteers in that area of the state – give us or Barb a call if you know anyone that could help out. Our AAM telephone number in Marshall is (507) 350-9228.

AccountAbility Minnesota
2300 Myrtle Avenue, Suite
180 St. Paul, MN 55114

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Mission Statement

AccountAbility Minnesota is a nonprofit agency dedicated to providing tax and accounting assistance to individuals and small businesses with limited means by leveraging volunteer resources.

AccountAbility Minnesota is a 501(c)(3) nonprofit organization. Funding for our programs comes from foundations, corporations, individuals, accounting firms and government agenices.

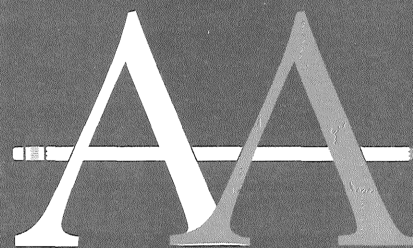
HAPPY BIRTHDAY TO YOU!

AUGUST
Timothy Kennedy
Larry Watts
Larry McNichols
Tina Eskro
John Griffiths
Dick Kelley
Mike Bublitz
Sayed Akailvi
Carlos Alberto Lima
Hanh Nguyen
Laura Kroeger
Mary Lou Robertson
Ed Caillier

SEPTEMBER
Merrill Ayers
Marietta Booth
Ruth Ann Michnay
Shamieka Hatter
Rick Miller
Rachel Clark-Hughey
Joe Beverage
Jenny Mattes
Dawne Christiansen
Kelly Hughes
Connie Anderson
Duane Field
Elaine Leonard
Abdulkadir Abow
Jon Solstad
Debie Hawks

OCTOBER
Kathy Lauwagie
Larry Schmitz
John Tuthil
Harold Coulter
Karin Kovacs
Marina Munoz Lyon
Lance Elston
Shirley Johnson
Charles VanGuilder
Artemio Alvarado
Ken Engle
Earl Robertson
Pati Maier
Mona M. Seth
Adrian Swanson
Kurt Zilley
Glenn Kirsch
Thomas Haley
Gwen Denninger
Paul Cullen
Edward Sturm
Margo Fah
Lisa Glass
Ann Loduha
Barb Benson

NOVEMBER
Thomas Houle
Kristin Cockburn
Anne Hildreth Huber
Amanda Wiens
Stephen Brunn
Tom Krocak
Susan Holladay
Gabriella Tsurutani
Okito Unyangunga
Darlene Polo-Kramer



Visit us on the web at
www.accountabilitymn.org

Mail preparation completed by
US Bank East Metro Volunteer Retirees

Senators Metzen, Sams, Kelley, Kubly and Vickerman introduced--

S.F. No. 1524: Referred to the Committee on Finance.

1 A bill for an act

2 relating to human services; appropriating money for
3 assistive technology.

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

5 Section 1. [APPROPRIATION.]

6 $300,000 is appropriated from the general fund to the
7 commissioner of administration for a grant to Assistive
8 Technology of Minnesota as follows:

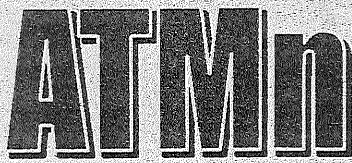
9 (1) $250,000 to administer a microloan program to support
10 the purchase of equipment and devices for people with
11 disabilities and their families and employers; and

12 (2) $50,000 to develop the Access to Telework program.

13 The appropriation is available until July 1, 2005.

14 [EFFECTIVE DATE.] This section is effective the day
15 following final enactment.

#5



*Assistive Technology of Minnesota

A non-profit organization serving all ages, all disabilities, all devices, all services

Senate File 1524: Assistive Technology of Minnesota seeks the support of Minnesota State Legislature to support this bill for a **one-time special general fund appropriation of $300,000** that will provide matching support for two federal grants awarded to Assistive Technology of Minnesota, ATMn*, in the fall of 2003. Over 2.2 million dollars of committed federal support requires Minnesota to match a portion with state / local funds. **Our request to the Minnesota State Legislature will cover a portion of the required federal match**. ATMN* will raise the additional funds to ensure the federal support is maximized.

The federal government grants provide seed capital and long-term support for the development of low-interest loan programs to be used by people with disabilities for the purchase of adaptive and employment related equipment. Following the initial investment of federal and state / local funds, both programs will be self-sustaining and available resources for years into the future. Thirty-five other states operate similar programs. In over 90% of these programs, the State provided all or a portion of the required matching funds. It is critical that the State of Minnesota support this request. Without the State of Minnesota's support, we face loosing the federal funds already awarded to ATMn*. The programs help families, individuals, and employers by providing a resource (in many cases the only available resource) for the purchase of necessary equipment used by people who have disabling conditions.

Why support this bill?

1. This is the **only** resource in Minnesota that provides low-interest loan programs for the purchase of assistive and employment related equipment. There are no other programs of this type available in our State.

2. The request to the Minnesota Legislature in the amount of $300,000 is a portion of the required match. ATMN, the community organization administering the programs is raising the remaining $218,000 required for the full federal appropriation.

3. The federal government believes that by investing its financial resources through the loan programs, people with disabilities will have access to the equipment they need today while paying for it over time. People with disabilities who have the right equipment can do just about anything, become successful at work, at home and in their communities and rely less on other government programs. President Bush invested an additional 20 million to develop Access to Telework to support loans related to equipment for employment. Minnesota is one of only twenty States to receive this special award.

4. People with disabilities have very limited resources to purchase equipment – this program is, in many cases – the only option of payment. If insurance does not cover the item, many will go without should this program not exist.

5. Employing people with disabilities and providing the equipment they need to do the job right has

1800 Pioneer Creek Center, Maple Plain, Minnesota 55359
763.479.8239 www.atmn.org

positive outcomes for everyone including the State as people pay taxes, own homes and are productive in their community.

6. As one-of-a-kind programs in Minnesota, we are providing a service that is needed. In a late 1990's survey of people with disabilities and the professionals who serve them, 67% identified funding as the major barrier to access of equipment. People re-pay the loan; there are no grants or free services. The programs are self-supporting following the initial investment and will operate independently for many years into the future.

7. It is sound business strategy to engage people with disabilities in using programs that improve their financial outlook. Loan programs can and do improve credit scores, increase one's financial status and allow people who in the past had no credit or poor credit to increase their financial situation now and into the future.

The federal government funding appropriations are as follows:

- US Department of Education awarded ATMN's ***Micro-Loan Program*** to provide loans for equipment and devices necessary for independent living, employment and access to the community. The federal award of $1,270,981 requires a local / state match of $423,660 for a total of **$1,694,641.**

- US Rehabilitation Services Administration awarded ***ATMN's Access to Telework*** $862,074 to provide loans for employment-related equipment. The local match is $95,786 for a combined total of **$957,860.**

- The federal government grants of **$2,132,981.00** pooled with the state / local match of **$518,660.00** will commit **$2,651,641.00** to support assistive technology services to individuals with disabilities now and many years into future. **ATMn* will raise $218,000 of the required match.**

The Senate Bill originated with Senator James Metzen as the chief author with Senators Vickerman, Cohen, Sams, Kubly & Kelley supporting as co-authors. The Revisor's language is reflected below.

A bill for an act related to human services; appropriating money for assistive technology.
BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA;
Section 1 [APPROPRIATION]
$300,000 is appropriated from the general fund to the commissioner of administration for a grant to Assistive Technology of Minnesota as follows:
(1) $250,000 to administer a microloan program to support the purchase of equipment and devices for people with disabilities and their families and employers; and
(2) $50,000 to develop the Access to Telework program.
The appropriation is available until July 1, 2005.
{EFFECTIVE DATE.} This section is effective the day following final enactment.

Funding for these important programs is critical or Minnesota will loose the federal funds. The state / local match must be raised by September 30, 2005 or the funds may return to the federal government for general fund disbursement. Your support today will provide resources now and years into the future.

Respectfully submitted,
Carol J. Fury – Executive Director, Assistive Technology of Minnesota

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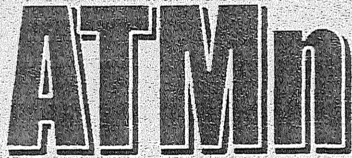

*Assistive Technology of Minnesota
A non-profit organization serving
all ages, all disabilities, all devices, all services

Special Request General Fund
Funding to Support Federal Grants Establishing Low Interest Loans
For People with Disabilities

Assistive Technology of Minnesota, ATMN, received two federal grants in late 2003 to develop low interest loan programs for people with disabilities. The programs will support the purchase of employment- related equipment and assistive technology, (AT), devices /services. In Minnesota, ATMN is the only statewide nonprofit to provide alternative financing options specifically for the purchase of AT and employment related equipment. ATMN is required to raise a local match as a condition of receiving the federal funds.

The Alternative Finance Program, funded in part by the US Department of Education provides over 1.2 million in federal support to expand ATMN's Micro-Loan Program. When fully funded, the new program will have set aside over 1.7 million to use as loan guarantees and to operate the program for many years in the future. ATMN's is seeking assistance from the State of MN through a one-time request to the 2005 Legislature for a $250,000 appropriation to assist us in reaching the required local match of $423,000.

Access to Telework-MN is a unique employment option that assists individuals with disabilities in the development and long-term sustainability of careers by providing low interest loans for the purchase of equipment. The goals of Telework are to increase employment outcomes with a focus on working from home, creating or sustaining business ownership and self-employment. The federal government awarded Assistive Technology of MN a grant through the US Rehabilitation Services Administration to develop and administer Access to Telework. The award of $864,074 requires Minnesota to raise a local match of $95,786. ATMN is seeking a one time general appropriation from the State of Minnesota for $50,000 for the local match requirement.

In 2004, ATMN's request to the State Legislature for both projects was approved only to be left unfunded when the session concluded before completing the final budget bills. ATMN has reintroduced the bill in the House (HF 0376) and the Senate (SF 1524) and seeks your support. In the House, Representative Erickson is the primary author, and Representatives Emmer and Samuelson have signed on as co-authors. In the Senate, Senator Metzen, as primary author, and Senators Sams, Kelley, Kubly and Vickerman graciously agreed to sign onto this important legislation.

#6

Senate Counsel, Research, and Fiscal Analysis
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(651) 296-4791
FAX: (651) 296-7747
Jo Anne Zoff Sellner
Director

Senate
State of Minnesota

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)

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

#7

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)
Employee Relations (03/04/05)
Administration Dept (02/23/05)

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)
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EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

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

#8

Testimony of Don Pylkkanen on behalf of the Minnesota Universal Health Care Coalition to the Senate Health and Human Services Budget Division, March 9, 2005

Overview

I'm speaking in behalf of the Minnesota Universal Health Care Coalition, which consists of 13 organizations (listed on pg. 2).

SF 22 will reduce prescription drug prices for most, and possibly all, Minnesotans in two ways: (1) by authorizing the Department of Human Services to create drug-purchasing coalitions with public and private entities both inside and outside Minnesota; and (2) by authorizing DHS to buy drugs from Canada and Europe if that is necessary to achieve lower prices for Minnesotans.

Both these tools – coalition-building and purchasing from foreign countries – have been publicly endorsed by Governor Pawlenty. He recently ordered DHS to join a multi-state coalition that purchases drugs for Medicaid programs in order to lower the cost of drugs for our Medical Assistance program.[1] And the Governor has established a Web site that facilitates the purchase of drugs from Canada.

SF 22 simply extends Governor Pawlenty's strategy to more people. It creates the possibility that all Minnesotans, not just MA enrollees, will be represented by a large coalition capable of negotiating low prices with the drug industry. And it creates the possibility that all Minnesotans, not just those with the time and resources to shop on the Internet, will benefit from the much lower drug prices that prevail in Canada and Europe. Moreover, by putting the state in charge of determining which drug importers are trustworthy, SF 22 reduces the risk that some Internet shoppers will purchase drugs that are of inferior quality.

Building a purchasing coalition

Over the last 25 years, the entire health care industry – insurers, clinics, hospitals, drug companies – has become highly consolidated. In response, purchasers have also begun to consolidate. Employers are banding together to increase their negotiating strength with insurers, hospitals, and doctors. In the drug sector, huge health insurance companies and Medicaid programs have used their clout to negotiate discounts from gigantic drug companies.

The result of this rush to get big is that the health care system, including the drug sector, resembles feudalism, a system in which the spoils go to those who can build the biggest fiefdoms the fastest. In the current health care system, those represented by small fiefdoms (smaller insurers, smaller employer coalitions, smaller states), and those who belong to no fiefdom at all (the uninsured and those who buy individual policies) suffer the most. We have seen this in the hospital sector. Hospitals charge the uninsured their highest prices in order to have the funds to

[1] The other states in the coalition are Hawaii, Michigan, Vermont, New Hampshire Alaska and Nevada (http://www.kaisernetwork.org/daily_reports/rep_index.cfm?DR_ID=25714, accessed February 28, 2005).

finance huge discounts to Medica, HealthPartners, and Medical Assistance. The same law of feudalism applies in the drug sector. Minnesota's big insurance companies and Medical Assistance, for example, have long enjoyed relatively low drug prices while Minnesota's seniors have had to pay the highest prices. Last year, West Virginia enacted a bill that resembles SF 22, and California's Senate passed legislation that would have authorized the State of California to represent all Californians in negotiations with drug manufacturers. In the face of so much consolidation, both inside and outside the state, Minnesota cannot remain passive. If we do, the drug industry will continue to cost shift onto our weakest citizens, and onto Minnesota as a whole.

SF 22 does not require any private-sector entity to participate in the coalition to be created by DHS. However, it is conceivable that Minnesota could build such a large coalition that even Minnesota's largest insurers and hospital chains, which buy their drugs through large national coalitions, would be better off joining the Minnesota coalition.

Conclusion

Minnesota needs relief from high drug prices. Congress and the White House refuse to act. This legislature must act. SF 22 authorizes the state to take the only steps possible to reduce drug prices, namely, forming a large purchasing coalition, and authorizing the coalition to deal with manufacturers in the US as well as in Canada and Europe.

Thank you.

MUHCC organizations

- *Minnesota COACT*
- *League of Women Voters*
- *MN Assoc. of Professional Employees*
- *Minnesota Nurses Association*
- *Physicians for National Health Program*
- *National Association of Social Workers-MN*
- *Minnesota Farmers Union*
- *Gray Panthers*
- *Green Party*
- *Business Owners*
- *Service Employees Int'l Union #113*
- *Int'l Brotherhood of Electrical Workers #110*
- *Minnesota Senior Federation*

www.ncsl.org/programs/health/bulkrx.htm #9

Issue Brief

Solan

NGA Center for
BEST PRACTICES

Health Division
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August 2004

State Purchasing Pools for Prescription Drugs: What's Happening and How Do They Work?

Summary
States are using their market power to achieve cost reductions, reduce inefficiencies in the purchase of prescription drugs, and manage pharmaceutical benefits. Prescription drugs are an integral and valuable part of medical care, representing approximately ten percent of national health expenditures[1] and contributing to shorter hospital stays and better health outcomes[2]. However, prescription drugs are also among the most rapidly growing health expenditures—growing 15 percent in 2002.[3]

In response, states are forming purchasing pools that garner several benefits. These include increased program purchasing power and efficiency, improved benefits management, and cost savings. As the impending federal Medicare benefit begins to provide prescription drug benefits for those dually eligible for Medicaid and Medicare—the Medicaid program's highest utilizers—states may see their ability to negotiate supplemental rebates in the Medicaid program reduced, making pooling strategies more appealing.

Pooled purchasing offers the promise of cost savings and of quality improvement; however, the goals of pooled purchasing programs can be difficult to achieve given regulatory, political, and logistical challenges. Some pioneering state efforts offer lessons about how best to align programs and procedures for procurement.[4] (See note) States pool prescription drug programs using the following strategies:

- **Intra-state Pooling.**

  Georgia's Department of Community Health (DCH) uses a single Pharmacy Benefits Manager (PBM) to negotiate manufacturer discounts and to manage the prescription drug benefit for its state employee health plans, its Medicaid program, and its state Board of Regents. This comprehensive approach saved the state $60 million overall between October 2000 and January 2003. However, the unique characteristics and rules of Medicaid have lead to a separation between rebates negotiated for Medicaid and for the other pooled programs.

- **Inter- or Multi-State Pooling.**

  The RxIS Coalition, an arrangement between **Delaware**, **Missouri**, **New Mexico**, and **West Virginia**, negotiates manufacturer discounts for prescription drugs for state

employees using a single PBM. Effective July 1, 2004, **Ohio** employees joined the coalition. The amount of savings depends upon the specific cost-saving programs that each state implemented. For example, West Virginia estimates a saving of $25 million.

Michigan and **Vermont** formed a pool in February 2003 to increase their purchasing power and to negotiate better discounts for prescription drugs in their Medicaid programs using a single Pharmacy Benefits Administrator (PBA). The federal Centers for Medicare and Medicaid Services (CMS) recently approved state plan amendments for these states as well as for **Alaska, New Hampshire**, and **Nevada**, creating the first-ever Medicaid multi-state prescription drug purchasing pool. All states estimate significant savings in their programs. In 2004, Michigan estimates that it will save $8 million; Vermont $1 million; Alaska $1 million; New Hampshire $250,000; and Nevada $1.9 million.[5] **Minnesota** and **Hawaii** also have submitted state plan amendments to CMS. Minnesota estimates that it could save $11 million.[6] **Montana** has expressed its intent to join as well[7].

Background

The Case for Group Purchasing Arrangements
Prescription drugs, an increasingly important part of medical care, represent less of the health care dollar than other expenditures such as those for inpatient hospital care and physician and clinical services.[8] They are, however, among the most rapidly growing health expenditures—increasing by 15 percent in 2002.[9]

States seek to become better purchasers and benefit managers in order to protect access to this important benefit and to improve care quality for the people they cover. Pooled purchasing offers the promise of cost savings and of quality improvement. However, the goals of pooled purchasing programs can be difficult to achieve given legal and political challenges.
States consider purchasing pools for prescription drug benefits principally to achieve savings. But where do the savings come from, and how can purchasing coalitions improve the quality of care that patients receive? The benefits realized from purchasing pools generally fall into the following categories:

- **Market Power**. Pooled purchasing can increase the market clout of buyers because manufacturers are more likely to negotiate favorable rebates with larger programs.
- **Efficiency**. Administrative costs—and therefore administrative fees—will decrease as the number of beneficiaries covered increases. Coalitions that allow a PBM to engage in rebate sharing might do so assuming that aligned economic incentives between the programs and the PBM will lead to greater program savings.
- **Benefits and Care Management**. Because most pools will utilize a pharmacy benefits manager, program savings and quality improvements result as states harness industry best practices in disease and benefits management. Such practices could include state-of-the-art evidence-based preferred drug lists and/or formularies. Further, enhanced drug utilization review (DUR) capability could allow plans to more accurately analyze prescriber habits and monitor the treatment of patients with complex needs, assuring their care is appropriate. Clinical management and education programs for these high utilizers could also be included, presenting great potential for quality improvement and care integration in fragmented systems. This is particularly true for programs that rely on traditional fee-for-service arrangements with the health care delivery system.[10] (See Note)

What Makes a Successful Purchasing Pool for Prescription Drugs?
Many states have discussed and pursued pooling programs to purchase prescription drugs. Purchasing pools generally involve agencies within a state or across multiple states that contract jointly with a PBM to negotiate manufacturer rebates and to manage benefits. The experiences of several states suggest design factors that make a pool successful. These include:

- **Volume.** The larger the number of pooled beneficiaries, the greater the potential to achieve discounts and rebates from manufacturers as well as realize administrative savings.
- **Technological Capacity.** In order to maximize the benefits of enhanced pharmacy and disease management programs, coalitions must be capable of sophisticated analysis of beneficiary utilization and prescriber habits. This is true especially for coalitions trying to drive physician prescribing habits toward a clinical standard.
- **Leadership, Cooperation, and Political Will.** A strong motivating force is necessary to overcome the logistical challenges to pooling multiple programs, particularly across state lines. This force can come from either a person or a political mandate. States must cooperate with each other for multi-state programs to be effective.
- **Similar Preferred Drug Lists.** For coalitions to negotiate enhanced manufacturer rebates associated with a preferred drug list or formulary, savings are maximized when the specific drugs on each coalition member's list or formulary are similar across therapeutic classes.
- **Single Negotiating Entity.** When pooling for Medicaid programs, the pool also should use one entity to negotiate rebates with pharmaceutical manufacturers.
- **Similarity of Plans and Plan Sizes.** PBMs dealing with commercial (non-Medicaid) groups such as employee benefit programs will have certain fixed costs—which are the same for a large group as for a small group. However, small groups will have fewer members across whom to disperse those costs. If all groups in a coalition of commercial (non-Medicaid) clients are charged the same fees, then the large groups will likely subsidize the smaller groups, making the arrangement less beneficial to the large group members.
- **Prioritized Savings Strategies.** Finally, pool members must determine how they will maximize savings from the group they form. States can choose to derive savings from among a lower administrative fee, rebate sharing, and state-of-the-art benefits administration and disease management. Opting to derive the bulk of a pool's savings from decreased administrative fees and from a full pass-through of manufacturer rebates provides a high level of transparency[11], (see note) but these choices decrease the aligned financial incentives between the coalition and the PBM. In other words, in this scenario a PBM does not enhance its own revenue by negotiating better rebates for its state clients. On the other hand, non-Medicaid coalitions that allow PBMs to share a percentage of the rebates negotiated from manufacturers in lieu of or along with a decreased administrative fee provide well-aligned financial incentives between the pool and the PBM, and provide less financial incentive for PBM interactions that result in a claim. (Pool members can also choose to pay either a per member per month fee or a per claim fee). However, this option provides less public transparency regarding the way savings are derived. In any case, coalitions can employ state-of-the-art benefits administration including evidence-based preferred drug lists and prior authorization. Coalitions also can engage in clinical management for high utilizers or for patients in specific disease states.

Regulatory Issues to Consider
There are some federal regulatory issues and concerns that states must be aware of when they decide to develop any kind of prescription drug purchasing collaborative. As states innovate

beyond existing regulatory constructs, federal and state rules continue to evolve. Much of this regulation is promulgated in the spirit of guaranteeing vulnerable populations better access to a wider range of therapies that might otherwise be unavailable to them.

The federal Centers for Medicare and Medicaid Services restricts the programs it will allow states to pool with Medicaid for the purpose of negotiating Medicaid supplemental rebates. For example, Medicaid rebates cannot be extended to state employee programs or to benefits such as those for prisoners. These programs therefore cannot be pooled with Medicaid in supplemental or other rebate negotiations. However, Medicaid pooling programs *can* include limited non-Medicaid programs for low-income individuals with CMS approval. [12]

Further, Managed Care Organizations that provide prescription drug benefits to Medicaid beneficiaries as part of a capitated managed care benefit are not entitled to federal Medicaid rebates. Therefore, their members cannot be pooled with fee-for-service beneficiaries unless the state has "carved out" the prescription drug benefit from the managed care plan and removed it from the capitation rate. Thus, states with significant numbers of Medicaid beneficiaries enrolled in Medicaid managed care plans that include prescription drug benefits that are not "carved out" by the state could have reduced potential for market power under a pooling scenario.

Intra-State Purchasing
States seeking to employ the concepts of collaborative purchasing and enhanced pharmacy benefits management can look within their borders to form purchasing pools. Rather than purchasing benefits separately by program, agency, or department, states can combine the market power of these purchasers by negotiating collectively.

Georgia
Georgia took the first step toward its intra-state coalition by creating the Department of Community Health (DCH) and giving the new department authority over the health benefits of the Board of Regents, state employee health plans, Medicaid, and the State Children's Health Insurance Program (SCHIP). The goals of the department include insuring two million state residents; maximizing the state's health care buying power; planning for coverage of uninsured state residents; and coordinating health planning for state agencies.

Specifically, DCH includes Medical Assistance, Public Employee Health Benefits, Health Planning, the Offices of Women's Health, Minority Health, Rural Health, and the Men's Health Commission. The Board of Regents is technically not a DCH unit, but it does have a contractual relationship with DCH so that its University Health System health plan is included in DCH vendor contracts.[13]

The state used consultants, internal staff, and external interested parties (including CMS) to craft a Request for Proposals for a PBM contract. Express Scripts Inc. (ESI) was awarded the contract in July 2001. Services began for Medicaid on October 1, 2000; for the Board of Regents on January 1, 2001; and for the State Health Benefit Plan on July 1, 2001.

How Does it Work?
The state pays a preset administrative fee to the PBM and allows the PBM to share in the rebate, excluding Medicaid rebates. The PBM manages the Medicaid-contracted networks with rates specified by the state and maintains PBM-contracted custom networks for the employees plan.

Prior to this effort, Georgia's Medicaid program had no preferred drug list, limited prior authorization and quantity limits, a limited Drug Utilization Review (DUR) program, limited

paper claim submission, and imposed a 50-cent copayment on all prescriptions. The new program design includes features such as a preferred drug list, a Maximum Allowable Cost expansion, tiered copayments for all programs, a provider generic substitution incentive program, and changes to its prior authorization system.

The system ensures that payment is made by the appropriate third party payer, such as Medicare, before making a Medicaid payment. The PBM also negotiates expanded rebates in the Medicaid program, including those for items that fall outside of the federal Medicaid rebate program, such as diabetic supplies. The unique characteristics and rules of Medicaid have lead to a separation between rebates negotiated for it and for the other pooled programs.

Clinical Programs
Georgia's contract includes some clinical programs that are managed by the PBM. Since it manages pharmaceutical benefits for all of the state-funded populations, the PBM has the data and ability to intervene when clinically appropriate regarding patient safety and quality. Some of Georgia's clinical programs include:

- An expanded DUR program;
- A long term care intervention team; and
- Six disease management programs in which the PBM sends letters to patients and/or their doctors to provide advice regarding the patient's care management or to present problems regarding the patient's care.

Results
This comprehensive approach saved the state $60 million between October 2000 and January 2003. Besides budget savings, the clinical initiatives launched as a part of the arrangement have enhanced quality of care and have educated physicians on standard treatment guidelines.[14] In Medicaid, on a Per Member Per Month (PMPM) basis, pharmaceutical expenditures were growing at a 22 percent rate in 2000. This growth rate dropped to 6 percent in 2002. Additional savings are anticipated due to the implementation of a Medicaid-specific preferred drug list program in 2004.

Inter- or Multi-State Purchasing
To date, the purchasing coalitions that have gained the most notice include those that reach across state lines.

The RxIS Coalition
The oldest of these is the RxIS coalition, an arrangement between four non-contiguous states—**Delaware**, **Missouri**, **New Mexico**, and **West Virginia**—to purchase prescription drugs for state employees and retirees. The coalition purchases drugs for 570,000 beneficiaries. Effective July 1, 2004, **Ohio** employees joined the coalition—adding another 106,000 beneficiaries.

The coalition grew out of the Pharmacy Work Group; a collection of 20-25 states sometimes referred to as the Southern States Coalition. Members of the Coalition included officials from state employee health benefits and Medicaid programs. Of the working group's members, six states from the group decided to issue an RFP to select a single PBM to be purchaser and manager of the states' employee health benefit plans. ESI was selected as the Coalition's PBM in 2002. Some states—Delaware, for example—obtained legislative authority to join the coalition, whereas others already had the authority through existing procurement laws to join.

Ultimately, the PBM began purchasing prescription drugs for the four states that make up the current RxIS Coalition. The states receive 100 percent of manufacturer rebates. The PBM guarantees minimum rebates to RxIS states and the states pay a per prescription administration fee.

How Does it Work?
The success of the RxIS coalition demonstrates that logistical challenges to multi-state pooling programs can be resolved to the benefit of participating states.

- The coalition meets periodically and the level of involvement is up to the individual RxIS state (although for maximum leverage and sharing of best practices, states should coordinate more rather than less). The states are permitted to include non-state groups at their discretion, though none currently do so[15].
- Each state can choose multiple options/packages for various populations and groups. Individual states can choose from any program the PBM offers and can have any benefit design, formulary, or combination—or can have one customized. The only limiting factor is that if a product is offered to one state, it must be offered to all participating states. Drugs are evaluated by an independent Pharmacy and Therapeutics Committee.[16] Evaluations are made first on the basis of public information regarding efficacy and thereafter on cost.
- Each state has its own contract with the PBM to fit individual state requirements. The minimum rebate guarantee made by the PBM is based on the benefit design the state chooses. As the RxIS group grows, the administrative fee decreases. The benefit design chosen determines the minimum rebate guaranteed by the PBM.
- When selecting pharmacy networks, states must strike a balance between greater beneficiary access provided by broader networks and deeper discounts provided by tighter networks.
- Mail service is an option for additional savings, both for beneficiary and the health plan.

RxIS Clinical Programs
Participating states can establish various clinical programs to better manage or inform beneficiaries with particular health conditions. These include services such as retro-active DUR, step therapy, and prior authorization. States can choose the clinical programs best suited for their needs and can negotiate guaranteed savings for a package of these programs. Savings are calculated based upon savings on prescription drug expenditures—not medical expenditures—with methodologies for calculating savings defined in advance. States can choose to pay by administrative fee, by sharing in the savings, or by a combination of both. Some clinical programs include:

- **Retroactive Drug Utilization Review.** The PBM transmits safety alerts to pharmacies regarding drug-to-drug interactions, and screens claims data for potential oversights in safety, notifying physicians of potential problems via mail.
- **Step Therapy.** Clients are encouraged or required at the point of service to try more common and less expensive alternatives to a medication before moving on to a newer, more expensive one.
- **Prior Authorization.** Clients must receive prior authorization from a plan pharmacist before receiving the drug, either for clinical purposes or for directing product selection.

Results
All participating states have reported significant savings. The amount of savings depends upon the specific components that each state implemented. For example, West Virginia estimates it has saved a total of $25 million.

Medicaid Prescription Drug Purchasing Group
According to the CMS Office of the Actuary, Medicaid is projected to incur 18 percent of all US prescription drug expenditures in 2004[17]. For years, states have considered ways to leverage this purchasing power by collaborating to negotiate supplemental rebates for Medicaid programs and to simplify benefits management.

In February 2003, **Michigan** and **Vermont**—who had contracts with First Health Services to manage their Medicaid pharmaceutical benefits—announced they would join forces to purchase prescription drugs for Medicaid and invited other states to participate. According to the arrangement, states could join the program in one of three ways:

- By signing an Intergovernmental Agreement (IGA) with Michigan;
- By having an existing contract with First Health authorizing that state to participate in the pool; or
- By becoming a new client of First Health with a contract that authorizes the state to participate in the pool after undertaking a competitive RFP process.

Although CMS will not allow states to participate in this program using the IGA option, CMS recently approved state plan amendments for Michigan and Vermont as well as for **Alaska, New Hampshire**, and **Nevada** that allow the five states to collectively purchase prescription drugs for their Medicaid programs. This approval marks the first time a multi-state purchasing pool for Medicaid prescription drugs has been implemented. **Minnesota**[18] and **Hawaii**[19] also have submitted a state plan amendment to join the pool and **Montana** has expressed its intent to join, and have awarded competitively procured contracts to First Health Services. CMS will issue guidance to states as to how they can join this existing pool or form a new one.[20]

How Does it Work?
As with the RxIS model, the concept behind this coalition allows participating states to maximize their bargaining power by using a single benefits manager to purchase and manage their prescription drugs. As more states join the pool program, discounts increase because of the "bidding model" used by the program. However, due to the unique rules of the Medicaid program, including the Medicaid "best price rule"[21] (see note), only Medicaid programs or certain low-income non-Medicaid programs approved by CMS can join this pool.

First Health Services is a Pharmacy Benefit Administrator (PBA). PBAs vary from PBMs in that they derive no revenue from manufacturer rebates. (However, it should be noted that commercial PBM contracts can also be structured so that all revenues are passed on directly to the state by paying a per claim administrative fee to the PBM, as in the RxIS contract). In this case, Michigan and Vermont receive all rebates negotiated with manufacturers—and all rebate revenue is shared with CMS.

While each participating state uses its own Pharmacy and Therapeutics Committee to craft its preferred drug list, similarity between states yields greater savings and deeper discounts. The pooling program focuses on the "lowest net-cost" of prescription drugs used in the benefits—the combined effect of compliance with low-cost therapeutically equivalent drugs and negotiated supplemental rebates.

Savings
All states estimate they will experience significant savings in their programs. In 2004, Michigan estimates it will save as much as $8 million; Vermont $1 million; Alaska $1 million; New Hampshire $250,000; Nevada $1.9 million[22]; and Minnesota $11 million.[23]

Conclusion
States have been working hard to become better purchasers and managers of pharmaceutical benefits, in all state-funded programs. Inter- and intra-state purchasing and management of prescription drug benefits are tools that some states are using to negotiate better discounts and supplemental rebates and to more efficiently manage their programs and benefits.

States find other advantages to pooling as well. Using a single PBM or administrator potentially provides a real benefit to patient safety and care management, encouraging integration in a largely fragmented health care delivery system. By better managing these important benefits, states are better able to maintain them for the residents they serve and to improve the quality of care that patients receive.

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[1] Janet Lundy et al., *Trends and Indicators in the Changing Health Care Marketplace, 2004 Update.* (Washington, DC: Kaiser Family Foundation, 2004).

[2] Frank R. Lichtenberg, "Benefits and Costs of Newer Drugs: An Update," (Cambridge, MA: National Bureau of Economic Research, June 2002).

[3] Janet Lundy et al., Trends *and Indicators in the Changing Health Care Marketplace, 2004 Update.* (Washington, DC: Kaiser Family Foundation, 2004).

[4] Many states and some cities city currently partner to bulk purchase pharmaceuticals and hospital supplies for facilities through the Minnesota Multi-State Contracting Alliance for Pharmacy (MMCAP). However, recent endeavors mark the first to pool beneficiaries in state programs to purchase pharmacy benefit management services as well as enhance manufacturer rebates. (see: http://mmcap.org/)

[5] HHS Press Release: "HHS Approves First-Ever Multi-State Purchasing Pools For Medicaid Drug Programs" April 22, 2004.

[6] Minnesota Governor's Office Press Release: "Minnesota Joins Multi-State Purchasing Pool to Negotiate Greater Prescription Drug Discounts." April 27, 2004.

[7] Montana Governor's Office Press Release: "Governor Martz Announces Plan to Cut Cost of Medicaid Prescription Drugs." May 14, 2004.

[8] Janet Lundy et al., Trends *and Indicators in the Changing Health Care Marketplace, 2004 Update.* (Washington, DC: Kaiser Family Foundation, 2004).

[9] Ibid.

[10] While not necessarily an exact model for state purchasing pools for prescription drugs, the US Department of Defense (DOD) and Veterans Administration (VA) have lowered prescription drug expenditures through partnership. It should first be noted that both the DOD and VA are direct purchasers of pharmaceuticals whereas Medicaid and state employee health plans are not. Further, the VA has established a national formulary that is far more restrictive than Medicaid preferred drug lists. However, lessons learned from these two purchasers' market power suggest policy options for states. The federal government requires manufacturers participating in the Medicaid rebate program to offer the VA a minimum discount of 24 percent (discounts offered below this minimum amount are not considered in the

best price calculation for the Medicaid program). However, partnering to purchase prescription drugs provided both agencies better discounts than they were already receiving.

In FY 2000, the VA and DOD joined together to negotiate 18 joint manufacturer contracts and saved $40 million. Current and future planned joint contracting save the departments approximately $170 million per year on their combined prescription drug expenditures. Source: Ventimiglia, Samantha, *Pharmaceutical Purchasing Pools* (Washington, DC: National Governors Association, October 2001).

[11] Medicaid rebates automatically pass through in totality.

[12] *Medicaid Multi-State Pooling Program.* Presentation at the National Academy for State Health Policy's Annual Health Policy Conference (Portland, OR, August 4, 2003).

[13] Managing Prescription Drug Benefits Commissioner Gary B. Redding Georgia Department of Community Health (Philadelphia, PA National Academy for State Health Policy Annual Health Policy Conference).

[14] Express Scripts *Express Scripts and State Government Programs Overview*

[15] Express Scripts.

[16] Express Scripts *Express Scripts: Making the use of Prescription Drugs Safer and Much More Affordable,* St. Louis, MO 2003.

[17] Centers for Medicare and Medicaid Services, Office of the Actuary "Table 11: Prescription Drug Expenditures Aggregate and per Capita Amounts, Percent Distribution and Average Annual Percent Change by Source of Funds: Selected Calendar Years 1980-2011[1] (Baltimore, MD: 2002).

[18] Minnesota Governors Office Press Release: "Minnesota Joins Multi-State Purchasing Pool to Negotiate Greater Prescription Drug Discounts." April 27, 2004.

[19] Hawaii Department of Human Services News Release: "Hawaii Joins Medicaid Multi-State Pooling Program to Negotiate Greater Prescription Drug Discounts." April 18, 2004.

[20] HHS Press Release: "HHS Approves First-Ever Multi-State Purchasing Pools For Medicaid Drug Programs" April 22, 2004.

[21] Much of the discussion about changes to Medicaid pharmacy benefits relates to the federal rebate agreement included in the Omnibus Budget Reconciliation Act of 1990 (OBRA 90). Under the arrangement, states choosing to participate agreed to cover almost all prescriptions in exchange for a rebate from participating manufacturers. The rebate agreement guarantees that the states receive the best or better than the *best price* available in the private sector. The law also provides for an additional rebate from manufacturers for any product for which the price increase exceeds the consumer price index.
[22] Ibid.

[23] Minnesota Governors Office Press Release: "Minnesota Joins Multi-State Purchasing Pool to Negotiate Greater Prescription Drug Discounts." April 27, 2004.

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#10

Solan

STRETCHING STATE HEALTH CARE DOLLARS: POOLED AND EVIDENCE-BASED PHARMACEUTICAL PURCHASING

One of a Series of Reports Identifying Innovative State Efforts to Enhance Access, Coverage, and Efficiency in Health Care Spending

Sharon Silow-Carroll and Tanya Alteras
Economic and Social Research Institute

October 2004

All four reports and an overview are available on the Fund's Web site at www.cmwf.org.

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STRETCHING STATE HEALTH CARE DOLLARS: POOLED AND EVIDENCE-BASED PHARMACEUTICAL PURCHASING

INTRODUCTION

In recent years, pharmaceutical costs have contributed in a major way to the growth of overall health care costs generally and of Medicaid expenditures in particular, with states estimating an average increase of some 14 to 15 percent per year in Medicaid prescription-drug spending from 2001 through 2004.[1] These expenses have been rising because of a number of factors: greater utilization of prescription drugs, introduction of new and more costly medications, price inflation for existing pharmaceuticals, and increases in capitation rates for managed care organizations.[2]

Thus many states have been addressing rising drug costs, not only for Medicaid but also for state employee health plans and other state programs, with purchasing strategies designed to stretch their limited dollars. Some are also attempting to make pharmaceuticals more affordable to vulnerable populations. In this section we examine such programs, especially those recent drug cost-containment mechanisms that do not merely pass state costs on to consumers in the form of higher copayments and deductibles but rather put into place innovative approaches that reduce state costs so as to expand or maintain access.

The matrix, state profiles, and snapshots that follow present examples of state initiatives in pharmaceutical purchasing. Some new and promising strategies involve pooling across states, or across groups within states, to achieve better negotiating clout with pharmaceutical manufacturers. Some are "pharmaceutical assistance programs"[3] that extend state-negotiated discounts to uninsured and low-income populations who are not eligible for Medicaid. Others involve incorporating clinical evidence into purchasing decisions and Preferred Drug Lists (PDLs) in order to obtain supplemental rebates and promote cost-effective use of pharmaceuticals.

Implementing these strategies has not always been smooth sailing, however. The major association representing the pharmaceutical industry, Pharmaceutical Research and Manufacturers of America (PhRMA), filed lawsuits against Michigan and Florida that challenged the legality of these states' PDLs. PhRMA also challenged Maine's use of Medicaid discounts for non-Medicaid populations. While most of these challenges were unsuccessful, they resulted in delays to full implementation or discouraged participation (by states and manufacturers), which reduced the programs' savings. At present, the pharmaceutical industry is challenging Minnesota's plans to reimport pharmaceuticals from Canada, and the federal government has been considering legal action as well. The state

has expressed plans to follow through with its approach, however, and others may follow suit.

In addition to the pharmaceutical industry, provider groups and patient advocates have voiced opposition to some state pharmaceutical initiatives, such as PDLs and generic substitutions that limit coverage for certain medications or require prior authorization from a provider. They argue that such restrictions hamper access to drugs that may be most appropriate for certain individuals, and they suggest that patients not responding well to the PDL or generic drugs may need more expensive care down the road, resulting in higher costs for those patients. Also, providers generally oppose new rules (e.g., obtaining prior authorization) that add to their administrative burdens.

Despite the challenges, many of the initiatives described here have produced significant savings for the states and have enhanced access, particularly when savings allowed states to expand eligibility or scope of benefits. Michigan, for example, reported some $68 million in savings in just over a year as a result of shifting people to less expensive drugs and obtaining supplemental rebates associated with its PDL and multi-state purchasing pool. And Vermont claims that its participation in that pool is helping the state "preserve essential pharmaceutical coverage for [its] most vulnerable residents."[4] Other initiatives are just beginning, and their impact on costs, access, and health outcomes should be carefully monitored and evaluated.

In the meantime, the new federal Medicare prescription-drug benefit law will also affect states' drug coverage for certain populations. State legislators and administrators must assess how the law will affect their existing programs that provide drug assistance to low-income elderly and disabled populations. In any case, states will continue to purchase pharmaceuticals for millions of individuals, and we can expect that the types of strategies described here will be replicated and expanded in coming years.

The kinds of pharmaceutical-purchasing strategies reviewed in the following profiles and snapshots include:

- Multistate purchasing and collaboration
- Intrastate purchasing
- State-negotiated discounts and drug-only benefits
- Evidence-based PDLs and supplemental rebates

Multistate Purchasing and Collaboration

A strategy that is receiving more and more attention is the multistate purchasing of pharmaceuticals. Through aggregation, states are able to enhance their bargaining clout—generally through a common pharmacy-benefits manager (PBM)—when negotiating drug purchases with manufacturers. Because prices and rebates are tied to volume, potential savings to states rise as participation in a purchasing pool expands. States may pool purchasing for Medicaid beneficiaries, or for state employees, State Children's Health Insurance Program (SCHIP) enrollees, and other groups in whose behalf states buy pharmaceuticals. Savings are enhanced when a pooling arrangement is combined with a preferred drug list, prior authorization requirements, and other mechanisms that shift individuals toward less expensive prescription drugs.

Michigan and Vermont began a multistate purchasing pool—the National Medicaid Pooling Initiative—for their Medicaid programs in 2002 (see profile below). In April 2004, the U.S. Department of Health and Human Services (HHS) approved that arrangement for these states, as well as for Alaska, Nevada, and New Hampshire, and additional states have expressed interest in joining.[5] Multistate pools are particularly promising for smaller states that do not represent a large volume of covered lives on their own but together can muster the purchasing power of larger states. Further, multistate pools may counter one negative consequence of the new Medicare drug benefit: The elimination of Medicaid pharmacy coverage for people dually eligible for Medicaid and Medicare in 2006 will reduce the volume and purchasing power of state Medicaid programs, even in large states.

States can also collaborate to realize price and administrative efficiencies when purchasing pharmaceuticals for state employees and other groups. West Virginia, Missouri, New Mexico, and Delaware (the "Rx Issuing States," or RXIS) hired a common PBM that negotiates and purchases drugs for their state employees (West Virginia's group also includes its SCHIP enrollees). The states benefit by capturing rebates from the manufacturers and reducing per-unit administrative expenses. West Virginia, for example, estimates that it saved $7 million in its first year.

A few initiatives, though not pooled purchasing per se, involve collaboration among states to achieve economies of scale and enhance efficiencies: Oregon's Drug Effectiveness Review Project involves the establishment of mutual standards, using evidence-based clinical research, for drug-effectiveness comparisons that participating states may then use for establishing PDLs and purchasing pharmaceuticals. Similarly, the Minnesota Multistate Contracting Alliance for Pharmacy (MMCAP) includes 41 states and

achieves administrative efficiencies through lower inventory levels; it also incurs lower costs associated with the ordering process and with individual state pharmaceutical contracts.[6]

Intrastate Purchasing

Another form of bulk pharmaceutical purchasing involves pooling *within* a state—across agencies. Like multistate purchasing, intrastate pooling allows states to stretch their dollars by enhancing their purchasing power through administrative streamlining. Georgia, for example, selected one PBM to implement an intrastate drug-purchasing program for the its Medicaid, SCHIP, employees of higher-education institutions, and state employees. The plan uses a single PDL and covers almost two million residents.

State-Negotiated Discounts and Drug-Only Benefits

Some states are using their purchasing clout to extend discounts to individuals who are not eligible for Medicaid and who may not have any drug coverage. Often taking the form of "pharmacy assistance programs" that are generally geared toward the elderly and people with disabilities, a few states are extending such assistance to additional groups facing escalating drug costs. Under Maine Rx Plus, for example, the state serves as pharmaceutical-benefit manager for residents without prescription-drug insurance who have incomes up to 350 percent of the federal poverty level. The state negotiates discounts in the form of manufacturer rebates, which are distributed to participating pharmacies that pass on the savings to Maine Rx Plus cardholders.

A related strategy that not only extends Medicaid discounts to additional populations but also taps federal matching funds involves an actual expansion of Medicaid with a drug-only benefit. The result is a "Pharmacy Plus" waiver that allows states to implement a Medicaid drug-only benefit to low-income elderly populations. The requirement for budget neutrality may be met based on the expected savings in institutional long-term care costs that result from improved access to outpatient medications. Vermont spearheaded this approach in 1995 when it implemented drug-only coverage for elderly persons with income up to 125 percent of the federal poverty level under an 1115 waiver (which involves experimental, pilot, or demonstration projects).[7]

Substitutions, Evidence-Based Preferred Drug Lists, and Supplemental Rebates

Nearly all states encourage generic or therapeutic substitutions of pharmaceuticals to reduce prescription drug costs. Generic substitution saves money through lower-priced versions of brand-name drugs. Some states require generic substitution in state pharmacy programs, while others simply encourage it by providing information about generic

alternatives.[8] Therapeutic substitution does not involve chemically equivalent compounds but rather "therapeutic equivalents" of the brand-name counterpart. The U.S. Food and Drug Administration determines therapeutic equivalencies, which then assist physicians and pharmacists in making substitutions. But some providers and patient advocates oppose such substitutions, arguing that they raise questions about effectiveness and safety.

As of April 2004, 33 states operated, were implementing, or had enacted legislation authorizing PDLs for Medicaid beneficiaries.[9] States may select "preferred drugs" from different classes of pharmaceuticals, based on a committee's findings of the drugs' therapeutic action, safety, clinical outcome, and cost. Drugs not on the list are not covered, or they require that the prescribing physician obtain prior authorization. Most states using a PDL also obtain supplemental rebates from manufacturers that want their products to be included on the PDL and available without prior authorization. Michigan has greatly enhanced its savings from the National Medicaid Pooling Initiative by incorporating its PDL into the arrangement (each participating state maintains its own PDL).

Reimportation of Pharmaceuticals

Though outside the scope of this study, we briefly mention an emerging strategy whereby states reimport—or encourage individuals to purchase—pharmaceuticals from other countries where prices are lower than in the United States. Minnesota has taken the lead by establishing a Web site that offers step-by-step instructions for ordering certain types of medications from participating Canadian pharmacies that meet the state's quality-control criteria. Further, state employees are given incentives to reimport medications.[10] The program is expected to save the state $1.4 million, and could save state employees nearly $1 million, by the end of 2004.

Reimportation has been the object of much opposition from the pharmaceutical industry, which claims that the practice reduces incentives for companies to invest in new medications; does not ensure quality control (e.g., allows counterfeit treatments to enter the United States); and raises liability issues. Oregon is requesting HHS approval for a reimportation program that addresses quality concerns by having the state's Board of Pharmacy inspect Canadian drug wholesalers to ensure that U.S. safety and quality standards are met. The Board could then license them to sell approved medications.[11]

An HHS task force recently held a series of public meetings on the safety of reimportation and its likely impact on drug development, prompting the Secretary of

HHS to acknowledge that the passage of legislation to allow the reimportation of pharmaceuticals is "inevitable."[12]

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As noted above, many of the pharmaceutical-purchasing strategies described here have been controversial. Skeptics argue that mechanisms such as PDLs, prior authorization requirements, and generic and therapeutic substitutions curtail full choice of medications, thereby restricting access to drugs that may not be the most appropriate for certain individuals. Proponents counter that these strategies are based on careful clinical evidence and therapeutic review; and that some limitations on choice are necessary, under current budget pressures, to help avoid more severe cutbacks in benefits or eligibility. So far, these strategies have survived legal challenges, though their long-term effects on health outcomes and costs remain unknown.

Additional Resources

Kimberley Fox, Thomas Trail, Susan Reinhard, and Stephen Crystal, *Managing Program Costs in State Pharmacy Assistance Programs* (New York: The Commonwealth Fund, February 2004).
http://www.cmwf.org/publications/publications_show.htm?doc_id=221461

Pharmaceutical Bulk Purchasing: Multi-state and Inter-agency Plans, 2004, Denver: National Conference of State Legislatures, Updated April 27, 2004).
http://www.ncsl.org/programs/health/bulkrx.htm

State Actions to Control Health Care Costs, issue brief (Washington, D.C.: National Governors Association Center for Best Practices, November 2003).

State Health Care Policy: First Quarter of 2004, state health policy brief, vol. 5, no. 1 (Denver: National Conference of State Legislatures, April 2004).

Matrix: State Activity—Multistate and Evidence-Based Pharmaceutical Purchasing

State	Program Name	Type of Strategy & Implementation Date		Participation
Current Examples				
West Virginia, Missouri, New Mexico, Delaware, Ohio	RXIS (Rx Issuing States) Multistate Pharmaceutical Purchasing Pool	Multistate purchasing • Pooled purchasing of pharmaceuticals for state employees, SCHIP enrollees, other groups	July 2002 (first contract with PBM)	Five states, nearly 700,000 lives as of July 2004
Oregon, Washington, Idaho, California, Wisconsin, Missouri, others	Drug Effectiveness Review Project	Multistate clinical reviews • Pooled effort to establish standards for drug effectiveness comparisons	Nov 2003 (first review began)	Eleven states and two nonprofit organizations as of July 2004
Michigan, Vermont, New Hampshire, Nevada, Alaska	Preferred Drug List and National Medicaid Pooling Initiative	Multistate purchasing and formulary • Medicaid multistate purchasing pool obtains supplemental rebates from pharmaceutical manufacturers	April 2002 (Approval by the Centers for Medicare and Medicaid Services, April 2004)	Two states as of May 2004
		• Preferred drug list with less expensive and clinically preferred drugs	February 2002	1.3 million Medicaid beneficiaries in Michigan
Georgia	Department of Community Health	Intrastate bulk pharmaceutical purchasing	2002	Two million residents
Maine	Maine Rx Plus	State-negotiated discounts for uninsured low- to moderate-income residents	2004	Approx. 100,000 members as of July 2004
Illinois	Rx Buying Club	State-negotiated discounts for elderly and disabled residents	2004	Over 62,000 members as of April 2004

STATE PROFILES

WEST VIRGINIA: RXIS MULTISTATE PHARMACEUTICAL PURCHASING POOL

Purpose/Goal

The primary purpose of the "Rx Issuing States" (RXIS) initiative is to address the dramatic increase in prescription-drug costs by consolidating states' negotiating power, achieving efficiencies, and capturing rebates through a multistate purchasing collective. The goal is to contain spending—thereby stretching limited dollars—on pharmaceuticals for public employees and State Children's Health Insurance Program (SCHIP) enrollees. This profile focuses primarily on West Virginia, which has the longest experience with the initiative.

Key Participants

West Virginia, Missouri, New Mexico, Delaware, and Ohio contract with a single pharmacy-benefits management (PBM) firm—Express Scripts, Inc.—to negotiate and purchase pharmaceuticals for certain groups and agencies within the states. These participants include West Virginia's Public Employees Insurance Agency (WV–PEIA) and the state's SCHIP; Missouri's Consolidated health care plan (public employees); New Mexico's Risk Management Division (public employees), Retiree Health Care Authority, Public School Insurance Authority, and Albuquerque public schools; Delaware's public employee group; and Ohio's Department of Administrative Services (public employees).

Program Description

RXIS aggregates nearly 700,000 lives: about 210,000 in West Virginia and 490,000 in the other four participating states. The group serves as a bargaining unit to negotiate with the drug manufacturers, through a PBM, based on total market share. Members pay the PBM an administrative fee and the states receive 100 percent of the rebates provided by the pharmaceutical manufacturers.[13]

When its Public Employees Insurance Agency contracted with the PBM, West Virginia became the first state to participate. PEIA arranges health insurance for about 187,000 state-agency employees, county board-of-education employees, higher-education institutions, and employees of some local and county governments. It also covers dependents and retirees associated with these groups. The state's SCHIP program, administered by a small staff in a stand-alone agency (i.e., it is not connected with the state's Medicaid program), essentially piggybacks onto PEIA for purchasing pharmaceuticals and is therefore included in the RXIS arrangement. The SCHIP covers

approximately 22,700 children with family income between 100 and 200 percent of the federal poverty level.

This pooled purchasing arrangement grew out of the Pharmacy Workgroup, in which officials representing state employees, Medicaid programs, and senior programs from nearly 20 states participated. The Workgroup was formed in 2001 to foster cooperation among states in addressing the double-digit increases in prescription-drug costs that had occurred over preceding years. Those states interested in forming a multistate pool issued a request for proposal (RFP) and selected a PBM for an Administrative Services Only (ASO)-type contract.[14] Savings depend on capturing the complete rebates, and on harnessing the enhanced bargaining power and reduced unit costs for services, that may be gained when relatively small states merge their populations into more sizable numbers.

Time Frame

Each participating state enters into a separate RXIS contract with Express Scripts. West Virginia was the first to join, commencing a three-year contract in July 2002. It has the option for two one-year extensions after that contract expires in June 2005.

Required Legislation/Authority

West Virginia's state legislature passed a bill (SB 127) providing clear authority, through its Public Employees Insurance Agency, to enter into prescription-drug purchasing agreements and pharmacy-benefit management contracts, including those involving other states and jurisdictions. SCHIP administrators did not need special governmental approvals to participate in RXIS.

Financing Mechanisms

After extensive research (conducted by the Pharmacy Workgroup) and discussions with consultants and pharmaceutical manufacturers, the RXIS states sought to change their drug-purchasing arrangement of paying PBMs small administrative fees with the PBMs retaining the bulk of the rebates from drug manufacturers.[15] The states issued an RFP stipulating that they benefit from the full rebate and other cost-cutting features (see Efficiencies, below). They then selected a PBM that agreed to an ASO-type arrangement whereby the states would pay higher administrative fees but receive all of the manufacturers' rebates. In West Virginia, both the administrative fees for the PBM and the state's costs of drugs for PEIA and SCHIP members come from a mixture of state revenues (SCHIP also receives a federal match).

Efficiencies

RXIS savings derive from the following:

- States receive 100 percent of manufacturer rebates, which are greater than the increase in administrative fees. This is West Virginia's main source of savings from the RXIS arrangement; the state's PEIA is now receiving rebates worth about 10 percent of total prescription-drug spending.
- Securing this type of rebate arrangement with the PBM is attributed in part to the collective power of the states that issued the RFP.
- The rebates will grow along with drug-cost escalation.
- Administrative fees are based on a sliding scale tied to volume, so pooling individuals in multiple states means lower per-unit administrative costs.
- It is expected that as the pool grows, bulk purchasing should enable the PBM to negotiate lower drug prices as well as higher rebates.
- It is less expensive to conduct periodic audits of the PBM when all participating states share the cost.

West Virginia realized $7 million in net savings (after accounting for higher administrative fees paid to the PBM) for its initial year (July 2002-June 2003).[16] It expects some $25 million in net savings over the three-year contract period.

West Virginia's SCHIP receives very little in rebates, as nearly all of its enrollees choose generic drugs (given the higher copayments for brand-name drugs), for which there are no manufacturers' rebates. The SCHIP has benefited, however, from the other efficiencies related to the multistate purchasing pool. According to its administrator, SCHIP drug costs in FY 2003 (after the RXIS contract began) were slightly lower than in FY 2002, despite higher enrollment.

The other participating states are experiencing or anticipating savings as well. Missouri expects savings of $1.4 million, or 2 percent of the plan cost, in its first year. New Mexico expects $2.0 million in savings, and Delaware reports $1.9 million in rebates.[17] Ohio, which just joined RXIS on July 1, 2004, anticipates that the program will save the state $15 million over the next three years.[18]

Challenges

Looking ahead, the major challenge for RXIS is to expand the pool in order to lower costs further and increase rebates. In developing the program, the RXIS group has had to grapple with multiple state regulations, garner political will (to change the status quo and take a chance with a project whose outcome was unknown), and make significant time commitments for planning and implementing the new PBM arrangement.

Future Plans

Each state will be monitoring its costs and savings during the contract period. After West Virginia's three-year RXIS contract has expired, it may continue the arrangement through one-year extensions. The participating states are considering the development of a joint drug formulary; as of early 2004, they were using standard formularies developed by the PBM.

For More Information

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OREGON: DRUG EFFECTIVENESS REVIEW PROJECT/ OREGON CENTER FOR EVIDENCE-BASED POLICY

Purpose/Goal

The aim of the Drug Effectiveness Review Project (DERP), led by the Center for Evidence-Based Policy ("the Center"), is to provide states and other purchasers with information on the relative effectiveness of similar pharmaceuticals in 25 drug classes and consultation in applying that evidence to purchasing and management decisions.[19] The project's participants and funders believe that purchasing in accordance with such evidence-based information will generate long-term efficiencies, more appropriate pharmaceutical utilization, and improved health outcomes.

Another mission of the Center is to help establish "the international standards for effectiveness comparisons between drugs in the same class." While others have evaluated specific pharmaceuticals,[20] this initiative is the first to conduct comparative systematic reviews of all drugs within their respective therapeutic classes. DERP's planners hope that the results of their research will ultimately be made available to insurance companies, health plans, and self-insured employers, as well as to state Medicaid purchasers.

Key Participants

All governance, oversight, administrative, and communications activities for DERP are being conducted by the Center, which is housed in the Department of Public Health and Preventive Medicine at Oregon Health and Science University (OHSU). The drug evaluations will be conducted by the Evidence-Based Practice Center (EPC) located at OHSU. It is possible that OHSU will also look to other EPCs—such as the Research Triangle Institute-University of North Carolina EPC and the Southern California-RAND EPC—for methodological and analytical support during the course of the research.[21]

The Center is negotiating with a number of entities, including state governments and nonprofit organizations, to participate in the project. As of July 2004, it has signed contracts with 11 states.[22] The project required at least 10 participants to begin its review process for the 13 drug classes, which then got under way in November 2003.

Program Description

Key Features

The DERP project is reviewing outcome data for 13 classes of drugs, as well as conducting follow-up reviews on the 12 classes of drugs originally studied by the Oregon EPC under an Agency for Healthcare Research and Quality (AHRQ) initiative. Thus the

OHSU-EPC/DERP will conduct a total of 25 drug-class reviews. In pursuit of that goal, the project's researchers are collecting and reviewing relevant published literature available on MBase, Medline, and the Cochran Registry of Systematic Reviews. They are also exploiting additional resources, including nonproprietary and unbiased studies conducted by pharmaceutical companies.

Outcomes are examined not according to intermediate measures (e.g., cholesterol level reductions following the use of a statin-class drug) but in terms of "final outcome" measures (e.g., decreased morbidity and mortality rates from heart disease and stroke for high-cholesterol patients on that drug). By focusing on clinical outcomes, the Center hopes to develop a body of evidence based primarily on patients' actual health experiences.

Toward this end, DERP is comparing effectiveness, comparing side-effect profiles, and examining evidence of differential responses among various subpopulations (according to age, gender, race, etc.) for each drug within each therapeutic class.

Role of Subscribing States and Organizations
Each participating entity gets an orientation to the project, which includes receipt of data on the 12 drug classes that have already been reviewed by the Oregon EPC.

By signing on to the DERP, participants are charged with helping to determine the following aspects of the review process:

- What drug classes to review
- Review methodology
- Questions to be answered by the research
- Dissemination format of the findings.

Participants work closely with the EPC. In fact, a key motivation to join the project (given that the findings may ultimately be made available to the public at no cost) is that participating organizations can play pivotal roles in the review effort.

Time Frame
As noted above, the reviews began in November 2003, once the obligatory 10 participating organizations had subscribed. Each month for 13 months, one new drug class

is chosen for review and the EPCs begin working on it. The Center estimates that the evaluation for each class will take approximately nine months. Reviews will then be updated at six-month intervals. The Oregon EPC will also continue to review and update at six-month intervals the original set of 12 drug classes.

Required Legislation/Authority

The Oregon state legislature passed a bill, during the final session of Governor John Kitzhaber's last term in office, that overturned a ban on the use of preferred-drug lists for the purposes of state pharmaceutical purchasing. The bill required that the list be based first on a given drug's effectiveness, and second on its cost. Within this context, the state embarked on a review process that would be marked by openness and a systematic nature. The Oregon EPC was asked to conduct the review, and thus it began its initial 12-drug-class evaluation. While no specific state legislation was required for the DERP to begin its work, it obviously built upon the administrative and legislative foundation underlying the Oregon EPC.

Financing Mechanisms

Initial planning and start-up funding for the project came from the Milbank Memorial Fund. Operational funding is provided by the participating organizations, each paying a subscription fee of approximately $96,000 per year for three years. The Center then oversees the collaborative process, commissions the research, and communicates its results to the participants.

Efficiencies

As described above, the objective of the project is to create an information base that allows pharmaceutical purchasers to make decisions based on quality and value. It is believed that this purchasing strategy will yield cost savings as well as improved health outcomes and utilization patterns.

Challenges

The Center's major challenge is to manage the logistics of this collaborative effort involving many participants. Toward that end, it is coordinating a massive communications endeavor involving face-to-face meetings, newsletter and fax alerts, and teleconferences. Other challenges include the development of consensus on important issues, such as how to disseminate the findings so that they are most useful to consumers and whether or not the results should be made available free of charge. Also, because

participants make joint decisions, states report that the initial work progresses more slowly than it would if each worked separately.

Future Plans

The Center will continue to publicize the project in order to recruit additional organizations and to inform the field on the importance of quality-based purchasing. In addition, the Commonwealth Fund is supporting researchers at the National Academy for State Health Policy (NASHP) and Georgetown University who will evaluate the impact of DERP on states and patients. Finally, dissemination of findings will occur on a rolling basis as the review of each class is completed.

For More Information

Web sites: www.ohsu.edu/epc and www.ahrq.gov/clinic/epc/ohsuepc.htm

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MICHIGAN: PREFERRED DRUG LIST AND NATIONAL MEDICAID POOLING INITIATIVE

Purpose/Goal

The purpose of Michigan's Preferred Drug List (PDL) is to stretch state Medicaid dollars while preserving the quality of patient care. The cost-saving component operates in two ways: by shifting beneficiary utilization from higher-cost to lower-cost pharmaceuticals; and by obtaining "supplemental" rebates (beyond the standard rebates dictated by the federal government under OBRA '90)[23] from pharmaceutical manufacturers whose drugs are included on the PDL.

The purpose of the National Medicaid Pooling Initiative (NMPI) is to allow participating states to combine their populations of Medicaid recipients. In that way, they may acquire greater leverage for negotiating supplemental rebates from pharmaceutical manufacturers. Michigan and Vermont have been participating in the pool since October 2003, and several other states have recently joined or plan to join. Because the supplemental rebates are tied to volume, it is expected that as additional states enter the pool all participants will enjoy greater savings.

Key Participants

Michigan's Department of Community Health administers the Medicaid program and the NMPI. The Michigan Pharmacy and Therapeutics Committee, made up of physicians and pharmacists, plays a key role in reviewing and recommending drugs for the PDL.

The multistate purchasing pool includes Michigan, Vermont, New Hampshire, Nevada, and Alaska (as of June 2004). The states use First Health Services as their pharmacy-benefits manager (PBM) to negotiate with pharmaceutical manufacturers. Hawaii, Maryland, Minnesota, and Tennessee have expressed interest in joining NMPI.

Program Description

Preferred Drug List (PDL)

Michigan, like many other states,[24] has created a PDL with an expanded prior authorization list, based on clinical and therapeutic review as well as on cost.[25] Physicians and pharmacists serving on the Michigan Pharmacy and Therapeutics (P&T) Committee identified the most effective drugs from the 40 therapeutic classes that account for the majority of drug spending in the Medicaid program. On a continuing basis, they review scientific and clinical information in order to recommend additional drugs for inclusion in the list. There is a full review of the PDL each summer, and priority new-drug entities are

reviewed at each P&T meeting, which occur quarterly. The state includes on the PDL: 1) the least expensive, clinically effective medications in each drug class; 2) those that bring supplemental rebates to the state; and 3) those that are "clinically preferred" even if they are not the least expensive. Pharmaceutical companies can have their drugs added to the list if they lower their prices through supplemental rebate offers.

PDL drugs are automatically covered under Medicaid, although some are subject to age or other program restrictions. If a medication is not on the PDL, it requires prior authorization: a pharmacy-benefits technician asks the prescribing physician's office a set of questions, and if the responses meet established criteria, authorization is granted immediately. Otherwise, the request may be elevated to a pharmacist-level review or, finally, to the Department of Community Health's physicians for determination of the drug's medical necessity for that case.

Multistate Purchasing Pool

The savings from PDLs are magnified when states combine their purchasing power. Michigan and Vermont in particular were the first states to combine their Medicaid populations for the purposes of negotiating deeper discounts from pharmaceutical manufacturers. The U.S. Centers for Medicare & Medicaid Services (CMS) recently gave official approval of this multistate purchasing arrangement for pharmaceuticals, and numerous states and drug manufacturers have now expressed interest in participating. Though Michigan and Vermont were enjoying the benefits of the pooling arrangement before CMS's action, such broadened involvement is expected to enhance savings considerably.

Time Frame

Michigan implemented its PDL in February 2002, and in April 2002 it started collecting rebates based on negotiations between the manufacturers and Michigan's PBM. Although Michigan and Vermont initially hoped to collect multistate rebates from manufacturers beginning in April 2003, a CMS ruling pushed back the "official" start date to October 1, 2003. With CMS approval announced in April 2004, some of the states that had expressed interest have now joined, or are expected to join the pool later in 2004 (as noted above).

Required Legislation/Authority

Section 1927 of the Social Security Act allows states to negotiate additional rebates from manufacturers. In order to participate in a multistate Medicaid purchasing pool, states must obtain CMS approval and adhere to CMS standards of procurement.

Financing Mechanisms

Michigan's Department of Community Health spends over $1 billion annually to provide pharmaceuticals to 1.4 million Medicaid and other low-income-program beneficiaries.[26] Its PBM, First Health Services, is reimbursed through annual flat fees and per-claim payments.

Efficiencies

The PDL represents about 70 percent of drugs used in Michigan's Medicaid outpatient pharmacy benefit. State officials estimate that the PDL saved as much as $60.5 million in its initial year (Feb 2002 to March 2003), thereby helping to stretch health care dollars and avoid cutting Medicaid eligibility.

The state estimates that it realized savings of $7.2 million during the first 12 months of supplemental rebate collection (April 2002 to March 2003). Though this figure represents only about 1 percent of pharmaceutical costs, the state expects an increase in savings as additional states join the pool.

Challenges

The pharmaceutical-industry trade association PhRMA challenged the PDL in court when it was first implemented, but the state was able to proceed while under litigation. The program was ruled legal in December 2002 by the Michigan Court of Appeals, and a federal court dismissed PhRMA's lawsuit in March 2003 on the grounds that Congress has given states the freedom to begin "prior-authorization prescription-drug programs" and that PhRMA "failed to show" Michigan was acting illegally. The ruling was then appealed to the U.S. Court of Appeals, but the legality of the program was again confirmed in early 2004.[27]

Objections to the PDL were also raised by Medicaid providers and beneficiaries, who were unaccustomed to the new limitations and rules. Also, critics suggested that the PDL limits physicians' abilities to try different medications within a therapeutic class and that the list may hamper patients' access to drugs that best fit their individual needs. These challenges have been addressed in a number of ways, beginning with Michigan's education campaign focused on physicians who prescribe medications to Medicaid beneficiaries. For example, the state used Medicaid bulletins, communication with provider associations, and health-plan trade groups to familiarize prescribers with the new rules and procedures. Also, the state now gives longer notice when changes are planned for the PDL. And the Pharmacy and Therapeutics Committee's reviews ensure that the PDL is not based on

price alone. In June 2003, for instance, the committee recommended, and the Governor approved, the greater availability of mental-health drugs without the need for prior authorization.

Michigan faced additional barriers in gaining approval from CMS for its multistate purchasing pool. One state (South Carolina) joined the pool early on but withdrew, reportedly because of its concerns that the arrangement would not ultimately be approved. The stated reason why CMS initially halted the pool was that the contract between First Health and the pool members did not abide by federal procurement guidelines for the purchase of drugs. This was addressed by pointing out that the pool does not actually purchase drugs and store them in advance but that it simply negotiates a lower price. A second concern with the pool contract was that it was a single agreement between First Health and all involved states, which might create a monopoly situation. In response, the pool was modified so that each state establishes its own separate contract with the PBM. Though CMS officially approved the arrangement in April 2004, state officials contend that during the period when the agency was questioning the arrangement and approval was uncertain, some manufacturers' wariness to participate limited the savings achieved.

Future Plans

As noted above, with CMS approval of the multi-state arrangement announced in April 2004, some of the states that had expressed interest have now joined, or are expected to join the pool later in 2004. Many expect additional states to pursue this model in order to augment their purchasing power for pharmaceuticals.

For More Information

Web site: PDL found on http://www.michigan.gov/documents/MPPL-20031001_75210_7.pdf.

Contact: Brad Sprecher, Departmental Analyst, Pharmacy Section, Michigan Department of Community Health. E-mail: sprecherB@michigan.gov.

SNAPSHOTS OF ADDITIONAL PHARMACEUTICAL PURCHASING INITIATIVES

GEORGIA: INTRASTATE CONSOLIDATED DRUG MANAGEMENT

Implemented 2000

In 1999, Georgia created the Department of Community Health, consolidating the state's public health insurance purchasing into one agency. The Department solicited bids from pharmaceutical benefits managers (PBMs) to implement, in 2000, a single contract for pharmaceutical management services for the state's Medicaid, PeachCare for Kids, Board of Regents for higher education health insurance benefits, and State Health Benefit Plan for state employees programs. The plans cover almost two million residents. Express Scripts was selected as the PBM, which handles prior authorization, claims adjudication, and other administrative services for all of the above populations (actual negotiation and purchasing for Medicaid and PeachCare are performed by a different vendor under contract with the Department of Community Health). The state's Drug Utilization Review Board established a single preferred drug list (PDL) to be used across the programs. In addition, the state designed a three-tiered formulary for state employees and the Board of Regents (similar to one used in Medicaid), and expanded its Maximum Allowable Cost (MAC) list, which sets price ceilings on generic drugs and encourages their use when appropriate. Together, these changes have helped reduce the pharmaceutical cost growth trend line from 26% in FY 2001 to 16% in FY 2002 (the most recent estimate available). The state is exploring, nevertheless, additional mechanisms to address the double-digit cost growth faced by Georgia and most states.[28] In 2004, for example, the state began using a different PDL for Medicaid/PeachCare, in part to enable the state to solicit supplemental rebates from pharmaceutical manufacturers under these programs.

For More Information: Julie Kerlin, Georgia Department of Community Health. E-mail: jkerlin@dch.state.ga.us.

MAINE: RX PLUS

Implemented 2004

Under Maine Rx Plus, the state serves as pharmacy-benefits manager for residents who lack prescription-drug insurance and who have incomes up to 350 percent of the federal poverty level. The state uses its purchasing power (based on negotiating Medicaid prices with pharmaceutical companies) to obtain discounts for the uninsured; the state negotiates discounts in the form of manufacturer rebates, which are distributed to participating pharmacies that then pass on the savings to Maine Rx Plus card holders. Enrollees are

expected to save 15 percent on brand-name drugs and up to 60 percent on generic drugs on the state's Medicaid Preferred Drug List (PDL).[29] Implementation is now proceeding in steps, with ultimate enrollment expected to reach up to 270,000 members; as of July 2004, there were approximately 100,000 members.[30] Maine Rx Plus survived legal challenges by the pharmaceutical industry, and began operating in January 2004.[31] Hawaii has developed a similar program called Hawaii Rx Plus.

For More Information: http://www.maine.gov/dhs/mainerx/.

ILLINOIS: RX BUYING CLUB

Implemented 2004

In January 2004, Illinois created a "prescription drug buying club." Pooling the purchasing power of state employees, enrollees of various state-supported programs, and up to two million senior citizens and people with disabilities, the club negotiates discounts with drug manufacturers and pharmacies. In April 2004, for example, the state launched a partnership with Walgreen's, the nation's largest retail pharmacy chain, to promote and expand Illinois' new Rx Buying Club; and through direct negotiations the state implemented a new rebate agreement with the pharmaceutical manufacturer Merck. The rebates get passed on to enrollees in the form of discounts. Members pay an annual administrative fee of $25 and receive a discount card they can use for buying medication through a mail-order program or at more than 50,000 participating pharmacies both within and outside the state.[32] The club enrolled 62,450 individuals during its first three months (January to March 2004) and achieved average savings of 21 percent.

For More Information: http://www.illinoisrxbuyingclub.com/.

NOTES

[1] Based on 38 responses, the average estimated annual increase in prescription-drug costs was 14.7 percent in FY 2001 and FY 2002, 14.0 percent in FY 2003, and 13.8 percent projected for FY 2004 (Crowley et. al., *Medicaid Outpatient Prescription Drug Benefits: Findings from a National Survey, 2003* [Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, December 2003]).

[2] *State Actions to Control Health Care Costs,* issue brief (Washington, D.C.: National Governors Association Center for Best Practices, November 2003).

[3] State-sponsored pharmacy-assistance programs utilize a variety of mechanisms to provide prescription drug coverage for low-income, older, and disabled persons who are not eligible for Medicaid and who may have no other drug coverage (Fox et al., *Managing Program Costs in State Pharmacy Assistance Programs* [New York: The Commonwealth Fund, February 2004]).

[4] Governor Jim Douglas of Vermont, press release: "Governor Douglas Praises Hawaii Governor for Joining Rx Purchasing Pool—Hawaii's Participation Will Help Lower Costs for Vermonters," April 18, 2004.

[5] For more information on multistate and intrastate purchasing, see *Pharmaceutical Bulk Purchasing: Multi-state and Inter-agency Plans, 2004* (Denver: National Conference of State Legislatures, updated April 27, 2004), http://www.ncsl.org/programs/health/bulkrx.htm.

[6] *Pharmaceutical Bulk Purchasing: Multi-state and Inter-agency Plans, 2004* (Denver: National Conference of State Legislatures, updated April 27, 2004), http://www.ncsl.org/programs/health/bulkrx.htm.

[7] Fox et al., *Managing Program Costs,* 2004.

[8] *State Health Care Policy: First Quarter of 2004,* state health policy brief, vol. 5, no. 1 (Denver: National Conference of State Legislatures, April 2004).

[9] Ibid.

[10] State employees' $15 copayments for prescription drugs are waived for drugs obtained from Canada.

[11] "Oregon Governor Proposes Reimporting Drugs From Canada," *Kaiser Daily Digest,* May 19, 2004.

[12] Secretary Tommy Thompson, news conference, May 5, 2004 (*Kaiser Daily Digest,* May 5, 2004).

[13] It is common practice for pharmaceutical manufacturers to offer large purchasers rebates on brand-name drugs. Typically, however, PBMs that negotiate on behalf of purchasers retain much of the rebates "in exchange" for charging relatively low administrative fees.

[14] Several states participated in the RFP but did not join the pool because they negotiated favorable arrangements with their own PBMs.

[15] The states discovered that what they had been receiving in rebates from manufacturers amounted to only about 3 to 5 percent of their total drug spending.

[16] In its first plan year, PEIA spent almost $128 million before rebates and collected approximately $14 million in rebates.

[17] Source: Presentation by Tom Susman, Director of West Virginia's Public Employees Insurance Agency, at The Council of State Governments Annual Meeting, October 23–26, 2003.

[18] Ohio Department of Administrative Services, "Benefits Fax Bulletin 2004-09," March 1, 2004, http://das.ohio.gov/hrd/benefax/benefax0409.html.

[19] Drug classes are used for grouping drugs considered similar according to the disease that they treat or the to effects they have on the body. Subclasses further categorize these drugs into smaller groupings (www.phpni.com/form_faq.htm#Anchor-Wha-1941). The 25 classes include the 12 that were originally reviewed by the Oregon Center for Evidence-Based Policy under an AHRQ (Agency for Healthcare Research and Quality) grant, and the 13 new classes being reviewed by DERP.

[20] The Drug Effectiveness Review Project builds upon work already begun in Oregon, which has been systematically reviewing evidence on 12 drug classes. Unlike most state-based reviews, DERP is funded by subscriptions from states and other organizations that will share in the research activities.

[21] The AHRQ has established 13 EPCs in the U.S. and Canada to rigorously review, analyze, and synthesize all relevant scientific literature, and then produce reports and technology assessments.

[22] Contracted entities include Oregon, Washington, Idaho, California Health Care Foundation/CalPERS, Wisconsin, Missouri, and the Canadian Coordinating Office for Health Technology Assessment. Most participating states are represented by their respective Medicaid agencies.

[23] The Medicaid Drug Rebate Program, created by the Omnibus Reconciliation Act of 1990 (OBRA '90) that added Section 1927 to the Social Security Act (the Act), requires that manufacturers enter into an agreement with the U.S. Centers for Medicare & Medicaid Services to provide rebates for their drug products paid for by Medicaid. As of 1996, the rebate for "innovator" drugs was the larger of the following two measures: 15.1 percent of Average Manufacturer Price (AMP) per unit or the difference between AMP and best price per unit, with a CPI-U adjustment. The rebate amount for non-innovator drugs is 11 percent of AMP per unit. (http://www.cms.hhs.gov/medicaid/drugs/mrphistory.asp)

[24] About 25 states have or are developing PDLs for their Medicaid programs.

[25] Unlike a typical formulary, nonpreferred products may be covered with prior authorization.

[26] Includes the state's Children's Special Health Care Services (CSHCS), or Title V program, Dual Title XIX/Title V beneficiaries.

[27] California Healthline, http://www.californiahealthline.org/index.cfm?Action=dspItem&itemID=101664.

[28] Based on discussions with Julie Kerlin, Georgia Department of Community Health July 2004 and August 2004; and National Conference of State Legislatures, *State Health Lawmakers' Digest: Prescription Drug Pricing* 2 (Spring 2002).

[29] Also, individuals enrolled in the state's Low Cost Drugs for the Elderly and Disabled (DEL) program receive savings through Maine Rx Plus as well as under DEL.

[30] At the outset, the state sent Maine Rx Plus cards to the approximately 73,000 residents who participated in the phased-out Healthy Maine program—a similar pharmacy-assistance program that offered discounts on prescription drugs but was suspended because of legal challenges by PhRMA.

[31] In 2000, PhRMA was granted a U.S. District Court (Maine) injunction to block an earlier version of the program, Maine Rx, which was charged to be in violation of constitutional interstate commerce laws and an illegal expansion of the federal Medicaid Act. This injunction was overturned in 2001, and in 2003 the U.S. Supreme Court ruled the program was not unconstitutional. A slightly revised version, Maine Rx Plus, began in early 2004.

[32] The program also uses a national preferred-provider network of pharmacies arranged by Sav-Rx, a pharmacy-benefits management company.

RELATED PUBLICATIONS

Publications listed below can be found on The Commonwealth Fund's website at www.cmwf.org.

Stretching State Health Care Dollars During Difficult Economic Times: Overview (October 2004). Sharon Silow-Carroll and Tanya Alteras, Economic and Social Research Institute. This overview report summarizes a series of four reports identifying innovative state efforts to enhance access to care, coverage, and efficiency in health care spending. topics include: building on employer-based coverage; pooled and evidence-based pharmaceutical purchasing; targeted care management; and innovative use of uncompensated care funds.

Stretching State Health Care Dollars: Building on Employer-Based Coverage (October 2004). Sharon Silow-Carroll and Tanya Alteras, Economic and Social Research Institute. Whether subsidizing an existing employer plan or creating a new and more affordable program for uninsured workers, states are using their dollars, regulatory/legislative powers, and purchasing clout to leverage employer and employee contributions in order to cover more people. This is one of a series of four reports identifying innovative state efforts to enhance access to care, coverage, and efficiency in health care spending.

Stretching State Health Care Dollars: Care Management to Enhance Cost-Effectiveness (October 2004). Sharon Silow-Carroll and Tanya Alteras, Economic and Social Research Institute. With more than three-quarters of current Medicaid spending devoted to people with chronic conditions, states are pursuing efficiencies through various types of "care management" strategies for high-cost individuals. These services can be provided directly or contracted out to specialized vendors. This is one of a series of four reports identifying innovative state efforts to enhance access to care, coverage, and efficiency in health care spending.

Stretching State Health Care Dollars: Innovative Use of Uncompensated Care Funds (October 2004). Sharon Silow-Carroll and Tanya Alteras, Economic and Social Research Institute. Experts warn that providing uncompensated care could become more difficult for hospitals in the years ahead as a result of their rising costs and lower operating margins, limited state revenues, cuts in Medicaid DSH, and a growing uninsured population. These trends have spurred strategies in several states aimed at reducing the need for expensive uncompensated services over the long term. This is one of a series of four reports identifying innovative state efforts to enhance access to care, coverage, and efficiency in health care spending.

Dirigo Health Reform Act: Addressing Health Care Costs, Quality, and Access in Maine (June 2004). Jill Rosenthal and Cynthia Pernice. Jointly supported by The Commonwealth Fund and The Robert Wood Johnson Foundation, this report by the National Academy for State Health Policy comments on the status of Maine's Dirigo Health Reform Act, which aims to provide affordable coverage for all of the state's uninsured—approximately 140,000—by 2009.

Expanding Health Insurance Coverage: Creative State Solutions for Challenging Times (January 2003). Sharon Silow-Carroll, Emily K. Waldman, Heather Sacks, and Jack A. Meyer, Economic and Social Research Institute. The authors summarize lessons from 10 states that have innovative strategies in place for health insurance expansion or have a history of successful coverage expansion. The report concludes with recommendations for federal action that could help states

maintain any gains in coverage made and possibly extend coverage to currently uninsured populations.

Small But Significant Steps to Help the Uninsured (January 2003). Jeanne M. Lambrew and Arthur Garson, Jr. A number of low-cost policies could ensure health coverage for at least some Americans who currently lack access to affordable insurance, this report finds. Included among the dozen proposals outlined is one that would make COBRA continuation coverage available to all workers who lose their job, including employees of small businesses that are not currently eligible under federal rules.

Medicaid Coverage for the Working Uninsured: The Role of State Policy (November/December 2002). Randall R. Bovbjerg, Jack Hadley, Mary Beth Pohl, and Marc Rockmore. *Health Affairs,* vol. 21, no. 6 (*In the Literature* summary). The authors conclude that insurance coverage rates for low-income workers would increase if state governments chose to do more for their uninsured workers. But states decline to tackle this issue for several reasons. Federal law requires them to cover many low-income nonworkers before they insure workers. As well, poorer states cannot afford much coverage for their low-income workers.

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 OGRAM.] 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 he 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
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
2 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.

SENATE STATE GOVERNMENT BUDGET DIVISION

TESTIFIERS PLEASE SIGN

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SENATE STATE GOVERNMENT BUDGET DIVISION

TESTIFIERS PLEASE SIGN

Date March 30, 2005

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