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and Fiscal Analysis**

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Senate

State of Minnesota

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

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

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

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

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

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

Subdivision 4 establishes eligibility requirements for the program.

Paragraph (a) states that an applicant must:

- (1) be a permanent resident of Minnesota;
- (2) not be enrolled in medical assistance, general assistance medical care, or MinnesotaCare;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- (1) agree to contribute toward the cost of the premium for the employee and the employee's dependent;
- (2) certify that at least 75 percent of its eligible employees who do not have other creditable health coverage are enrolled in the program;
- (3) offer coverage to all eligible employees and the dependents of those employees; and
- (4) not have provided employer subsidized health coverage as an employee benefit during the previous 12 months.

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

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

Subdivision 6 states that upon the payment of the premium, eligible employees and their dependents shall be enrolled in the MinnesotaCare program. States that the insurance barrier of Minnesota Statutes, section 256L.07, subdivisions 2 and 3, do not apply. Authorizes the commissioner to require eligible employees to provide income verification to determine premiums.

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

Section 11 provides an effective date.

KC:ph

Fiscal Note Request Worksheet

Bill SF 2725 Title: MinnesotaCare Changes
 #: Companion #: Author: Berglin; Koering; Solon; Johnson, D.E.; Agency: Human Services
 #: Urgent: Due Date: Lourey Committee:
 Consolidated: Lead Agency: Contact Person: Steve Nelson 651-431-2201

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

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

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

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

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

Bill Description

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

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

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

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

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

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

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

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

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

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

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

Assumptions

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

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

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

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

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

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

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

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

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

Federal approval is not needed to implement this change.

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

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

Expenditure and/or Revenue Formula

Fiscal Summary
SF-2725

HCAF

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

General Fund

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

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

Minnesota
MINNESOTACARE
Fiscal Analysis of Senate File 2725

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

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

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

Calculation of admin fee per prescription:

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

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

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

Projected avg rebate per Rx 18.38

Offsets to discount per Rx retained by
DHS:

to offset cash-flow costs:	\$1.0
for DHS admin. costs:	\$1.6
Total retained by DHS per Rx	\$2.6

Offset to discount for switch fee: \$0.0

Net rebate per Rx to consumer: \$15.83

Enrollment fee \$30.00

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

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

Enrollment and Cost Projections

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

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

Running Balance		-2,753,285	-2,481,225	-2,208,314	-1,934,549
CY 2014	Q1	Q2	Q3	Q4	
Enrollment	17,329	17,372	17,416	17,459	
Prescriptions	139,612	139,961	140,311	140,662	
Rebate Outlay	2,210,058	2,215,583	2,221,122	2,226,675	
Rebate Revenue	2,553,286	2,559,669	2,566,069	2,572,484	
Premium Revenue	130,944	130,944	130,944	130,944	
DHS Admin. costs	198,250	198,250	198,250	198,250	
Quarterly Balance	275,922	276,780	277,641	278,503	
Running Balance	-1,658,627	-1,381,846	-1,104,205	-825,702	
CY 2015	Q1	Q2	Q3	Q4	
Enrollment	17,503	17,547	17,590	17,634	
Prescriptions	141,013	141,366	141,719	142,074	
Rebate Outlay	2,232,242	2,237,822	2,243,417	2,249,025	
Rebate Revenue	2,578,915	2,585,362	2,591,826	2,598,305	
Premium Revenue	132,258	132,258	132,258	132,258	
DHS Admin. costs	198,250	198,250	198,250	198,250	
Quarterly Balance	280,682	281,549	282,417	283,288	
Running Balance	-545,021	-263,472	18,945	302,234	
Net funding needed:					
Transfer in From General Fund		FY 2008			\$594,000
Transfer in From General Fund		FY 2009			\$1,389,153
Transfer in From General Fund		FY 2010			\$1,798,912
Transfer in From General Fund		FY 2011			\$208,127
Negative = Held in Fund Balance		FY 2012			(\$536,204)
Negative = Held in Fund Balance		FY 2013			(\$972,762)
Negative = Held in Fund Balance		FY 2014			(\$1,099,379)
Negative = Held in Fund Balance		FY 2015			(\$1,118,374)
		Total			\$263,472

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

Rationale:

- 1) 5,408,000 Projected Population of MN in 2005, increased by 1% per year to 2009
- 2) 16% Estimated percentage of Minnesotans without prescription coverage.
- 3) 5% Percentage of people without Medicare and prescription drug coverage who spent more than \$250 on prescriptions annually

non-Medicare population of people lacking pharmacy coverage by 20%.

- 4) Cash Flow All rebates billed for a quarter will paid in full in the second subsequent quarter.

Footnotes:

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

Section 2. Self-employed farm income depreciation

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

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

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

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

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

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

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

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

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

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

Sections 3 and 11. Eliminate MinnesotaCare limited benefit set

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

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

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

Section 4. Increase inpatient hospital cap

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

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

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

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

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

Total cost for adults <=75% FPG	\$0	\$0	\$0	\$1,020,641
Adults without Children (Adults > 75% FPG: MLB)	FY 2006	FY 2007	FY 2008	FY 2009
Number of eligibles	16,458	16,899	17,066	16,809
Avg. monthly payment increase	\$5.92	\$5.92	\$5.92	\$5.92
Months	0	0	0	5
Cost before performance payment	\$0	\$0	\$0	\$497,650
Performance payments	\$0	\$0	\$0	\$0
Total cost for adults >75% FPG	\$0	\$0	\$0	\$497,650
Total state cost	\$0	\$0	\$0	\$1,560,999

Section 5. Dental copays and inpatient hospital cap for parents

This section changes which MinnesotaCare enrollees are impacted by the 50% dental copay and the inpatient hospital cap on benefits.

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

A. Eliminate Dental Copay for Adults Under 175% FPG

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

Families with Children Caretakers Under 175% FPG	FY 2006	FY 2007	FY 2008	FY 2009
Number of eligibles	31,855	31,918	29,455	24,827
Avg. monthly payment	\$0.00	\$0.00	\$0.00	\$2.38
Net cost	\$0	\$0	\$0	\$710,202
Federal share %	57.36%	53.35%	52.90%	52.73%
Federal share	\$0	\$0	\$0	\$374,480
State share	\$0	\$0	\$0	\$335,722
Adults without Children Adults Under 75% FPG	FY 2006	FY 2007	FY 2008	FY 2009
Number of eligibles	13,829	22,818	33,916	34,641
Avg. monthly payment	\$0.00	\$0.00	\$0.00	\$3.25
Net cost	\$0	\$0	\$0	\$1,349,215

B. Add Dental Copay for Adults Over 190% FPG

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

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

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

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

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

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

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

Sections 6 and 8. Adults without children eligible to 190% FPG

Prior to the benefit limits implemented in October 2003, enrollment of adults with no kids with incomes from 150% FPG to 175% FPG was approximately 4400. Based on the corresponding ratio of enrollment by parents from 175% FPG to 200% FPG compared to enrollment from 150% FPG to 175% FPG, we project that expanding eligibility for adults with no kids to 200% FPG would result in increased enrollment equal to 75% of 4400 or 3300. Limiting the enrollment expansion to 190% FPG is assumed to reduce the 3300 projection by one-third, resulting in a projected increase of 2200.

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

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

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

Section 9. MinnesotaCare option for small employers

This section provides an option for small employers (2-50 employees) to enroll uninsured employees and dependents in MinnesotaCare.

To use this option employers must enroll 75% of their employees who not have other health coverage. The employer must not have provided employer-subsidized health coverage during the previous 12 months.

For enrollees within the income limits of the MinnesotaCare program (175% FPG for singles / 275% FPG for families) the employer must pay an amount equal to 50% of the MinnesotaCare full cost premium. For enrollees over these limits the employer must pay the entire full cost premium but may charge the employee up to 50% of the full cost premium.

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

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

Uninsured Employees / Dependents

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

Insured Employees / Dependents

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

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

**Total of
Insured Employees / Dependents and
Uninsured Employees /
Dependents**

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

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

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

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

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

	Total Persons	Single Individuals	Family Members		
Enrollment Rates					
All	3.03%	2.16%	3.12%		
Within income limits	5.24%	3.30%	5.50%		
Above income limits	1.78%	1.10%	1.83%		
Enrollment					
All	9,970	637	9,334		
Within income limits	6,233	469	5,764		
Above income limits	3,738	168	3,570		
Families with Children					
Average number of enrollees:					
Pregnant women		0	0	0	18
Under age 2		0	0	0	50
Other children & parents		0	0	0	1,098
Total		0	0	0	1,167
Avg. monthly payment					
Pregnant women		\$459.78	\$506.70	\$538.85	\$557.30
Under age 2		\$300.90	\$312.45	\$343.47	\$402.72
Other children & parents		\$236.62	\$251.49	\$286.14	\$319.42
Total payments					
Pregnant women		\$0	\$0	\$0	\$122,496
Under age 2		\$0	\$0	\$0	\$241,880

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

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

Long-Term Fiscal Considerations

Local Government Costs

References/Sources

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

Fiscal Note Coordinator Signature: _____ Date: _____

A bill for an act

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

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

Section 1. [256.9545] PRESCRIPTION DRUG DISCOUNT PROGRAM.

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

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

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

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

2.1 (b) "Covered prescription drug" means a prescription drug as defined in section
2.2 151.44, paragraph (d), that is covered under medical assistance as described in section
2.3 256B.0625, subdivision 13, and that is provided by a participating manufacturer that has a
2.4 fully executed rebate agreement with the commissioner under this section and complies
2.5 with that agreement.

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

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

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

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

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

2.23 (1) be a permanent resident of Minnesota as defined in section 256L.09, subdivision
2.24 4;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4.34 Sec. 2. Minnesota Statutes 2005 Supplement, section 256L.01, subdivision 4, is
4.35 amended to read:

5.1 Subd. 4. **Gross individual or gross family income.** (a) "Gross individual or gross
5.2 family income" for nonfarm self-employed means income calculated for the six-month
5.3 period of eligibility using the net profit or loss reported on the applicant's federal income
5.4 tax form for the previous year and using the medical assistance families with children
5.5 methodology for determining allowable and nonallowable self-employment expenses and
5.6 countable income.

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

5.12 (c) "Gross individual or gross family income" means the total income for all family
5.13 members, calculated for the six-month period of eligibility.

5.14 Sec. 3. Minnesota Statutes 2005 Supplement, section 256L.03, subdivision 1, is
5.15 amended to read:

5.16 Subdivision 1. **Covered health services.** ~~For individuals under section 256L.04,~~
5.17 ~~subdivision 7, with income no greater than 75 percent of the federal poverty guidelines~~
5.18 ~~or for families with children under section 256L.04, subdivision 1, all subdivisions of~~
5.19 ~~this section apply.~~ "Covered health services" means the health services reimbursed
5.20 under chapter 256B, with the exception of inpatient hospital services, special education
5.21 services, private duty nursing services, adult dental care services other than services
5.22 covered under section 256B.0625, subdivision 9, orthodontic services, nonemergency
5.23 medical transportation services, personal care assistant and case management services,
5.24 nursing home or intermediate care facilities services, inpatient mental health services,
5.25 and chemical dependency services. Outpatient mental health services covered under the
5.26 MinnesotaCare program are limited to diagnostic assessments, psychological testing,
5.27 explanation of findings, mental health telemedicine, psychiatric consultation, medication
5.28 management by a physician, day treatment, partial hospitalization, and individual, family,
5.29 and group psychotherapy.

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

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

6.1 Sec. 4. Minnesota Statutes 2004, section 256L.03, subdivision 3, is amended to read:

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

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

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

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

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

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

6.26 (1) ten percent of the paid charges for inpatient hospital services for adult enrollees,
6.27 subject to an annual inpatient out-of-pocket maximum of \$1,000 per individual and
6.28 \$3,000 per family;

6.29 (2) \$3 per prescription for adult enrollees;

6.30 (3) \$25 for eyeglasses for adult enrollees;

6.31 (4) \$3 per nonpreventive visit. For purposes of this subdivision, a "visit" means an
6.32 episode of service which is required because of a recipient's symptoms, diagnosis, or
6.33 established illness, and which is delivered in an ambulatory setting by a physician or
6.34 physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse,
6.35 audiologist, optician, or optometrist;

7.1 (5) \$6 for nonemergency visits to a hospital-based emergency room; and
 7.2 (6) 50 percent of the fee-for-service rate for adult dental care services other than
 7.3 preventive care services for persons eligible under section 256L.04, subdivisions 1 to 7,
 7.4 with income ~~equal to or less~~ greater than ~~175~~ 190 percent of the federal poverty guidelines.

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

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

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

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

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

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

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

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

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

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

7.34 (2) the ability to raise matching funds; and

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

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

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

8.7 Subdivision 1. **General requirements.** (a) Children enrolled in the original
8.8 children's health plan as of September 30, 1992, children who enrolled in the
8.9 MinnesotaCare program after September 30, 1992, pursuant to Laws 1992, chapter 549,
8.10 article 4, section 17, and children who have family gross incomes that are equal to or
8.11 less than 150 percent of the federal poverty guidelines are eligible without meeting
8.12 the requirements of subdivision 2 and the four-month requirement in subdivision 3, as
8.13 long as they maintain continuous coverage in the MinnesotaCare program or medical
8.14 assistance. Children who apply for MinnesotaCare on or after the implementation date
8.15 of the employer-subsidized health coverage program as described in Laws 1998, chapter
8.16 407, article 5, section 45, who have family gross incomes that are equal to or less than 150
8.17 percent of the federal poverty guidelines, must meet the requirements of subdivision 2 to
8.18 be eligible for MinnesotaCare.

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

8.28 (c) Notwithstanding paragraph (b), children may remain enrolled in MinnesotaCare
8.29 if ten percent of their gross individual or gross family income as defined in section
8.30 256L.01, subdivision 4, is less than the premium for a six-month policy with a \$500
8.31 deductible available through the Minnesota Comprehensive Health Association. Children
8.32 who are no longer eligible for MinnesotaCare under this clause shall be given a 12-month
8.33 notice period from the date that ineligibility is determined before disenrollment. The
8.34 premium for children remaining eligible under this clause shall be the maximum premium
8.35 determined under section 256L.15, subdivision 2, paragraph (b).

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

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

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

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

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

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

9.15 (e) "Maximum premium" has the meaning given under section 256L.15, subdivision
9.16 2, paragraph (b), clause (3).

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

9.20 (g) "Program" means the MinnesotaCare program.

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

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

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

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

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

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

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

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

10.9 (c) For eligible employees without dependents with income over 175 percent of the
10.10 federal poverty guidelines and for eligible employees with dependents with income over
10.11 275 percent of the federal poverty guidelines, the participating employer shall pay the
10.12 full cost of the premium established under paragraph (a) for the eligible employee, the
10.13 employee's spouse, and any dependents, if applicable. The participating employer may
10.14 require the employee to pay a portion of the cost of the premium so long as the employer
10.15 pays 50 percent. If the employer requires the employee to pay a portion of the premium,
10.16 the employee shall pay the portion of the cost to the employer.

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

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

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

10.31 **Sec. 10. APPROPRIATION.**

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

10.34 **Sec. 11. REPEALER.**

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

11.2 Sec. 12. **EFFECTIVE DATE.**

11.3 Sections 1 to 6, 8, 9, and 11 are effective August 1, 2006, or upon implementation of

11.4 HealthMatch, whichever is later. Section 7 is effective July 1, 2006.



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The Northstar Problem Gambling Alliance, Inc.

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(as of 2/1/06)

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Northstar Alliance

The Northstar Problem Gambling Alliance, Inc.

Northstar Problem Gambling Alliance, Inc.

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BOARD OF DIRECTORS:

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White Earth Band of

Chippewa Indians

Steven Dentinger

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Dept. of Psychiatry

University of Minnesota

Mary Stream

Recovering Person

Roger Svendsen, MS

Coordinator, Program

Development

Minnesota Institute of

Public Health

King Wilson

Executive Director

Allied Charities of Minnesota

EXECUTIVE DIRECTOR:

T. Lance Holthusen

FOR YOUR INFORMATION: NORTHSTAR PROBLEM GAMBLING ALLIANCE, INC.

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

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

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

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

Our mission is to:

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

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

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

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



Problem Gambling's Impact on Family and Others

Third Annual Minnesota Problem Gambling Awareness Conference

A Production of The Northstar Problem Gambling Alliance

Gloria Dei Lutheran Church
St. Paul, Minnesota

April 1, 2005

Co-Sponsored by



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



Agenda

Moderator: T. Lance Holthusen, Executive Director NPGA

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

8:30-8:45 AM: Welcome, Overview and Opening Remarks.

Sponsor's Welcome: Randy Sampson, President of Canterbury Park

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

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

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

10:45-11:45 AM: Panel: *Treatment and Recovery Services for Families, Friends, and Others*.

Moderator: Steve Dettinger, Executive Director, Lake Superior Area Family Services.

Panel:

Greg Anderson, LP MSW, Senior Therapist, Lake Superior Area Family Services, Duluth, MN.

Greg Robertson, MSW, Fairview Recovery Services, Minneapolis, MN.

Kelly Reynolds, MA, L.I.C.S.W., Director, Minnesota Problem Gambling Helpline, Roseville, MN.

Sandy Brustuen, Project Turnabout-Vanguard, Granite Falls, MN.



Agenda

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

12:15-12:45 PM: Lunch.

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

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

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

2:15-3:15 PM: Panel (Those in recovery and/or affected by problem gambling): *How Effective Are Present Treatment and Counseling Services in Minnesota?*

Moderator: Kathleen Porter, Program Manager, State of MN DHS Compulsive Gambling Program.

Panel (includes recovering persons and affected persons):

Mike J.

Mary S.

Nancy D.

Len P.

3:15-3:30 PM: Break and Refreshments.

3:30-4:30 PM: Panel: *Financial Impact of Problem Gambling on Families and the Road Back*.

Moderator Don Feeney, Director of Research and Planning, MN State Lottery.

Panel:

Todd Sipe, Executive Vice President Greater MN Bremer Bank

Susan Aulie, Senior Director Financial Services LSS MN, Duluth

John P.

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

CEUs applied for with the following:

MN Bd. Of Social Work

MN Bd. Of Psychology

MN Bd. Of Marriage and Family Therapy

MN Bd. Of Pharmacy

MN Bd. Of Legal Education



The Northstar Problem Gambling Alliance, Inc., a 501(c)(3) non-profit entity is the Minnesota affiliate of the National Council on Problem Gambling, and cooperates with the State of Minnesota DHS Compulsive Gambling Program. *We serve the problem gambler and those affected by problem gambling.*

Northstar Alliance is emphatically *neutral* on gambling policy, though we will advocate in public forums for programs that benefit problem gamblers and those affected by problem gambling.

T. Lance Holthusen, Executive Director
Box 555
Arlington, MN 55307
(Phone: 507-964-5184; Fax: 507-964-2950; E-mail: npga@frontiernet.net)

Registration Form

3rd Annual Minnesota Problem Gambling Awareness Conference:
Problem Gambling's Impact on Family and Others
April 1st, 2005 at Gloria Dei Lutheran Church, 700 S. Snelling Ave., St. Paul, MN.

Registration Deadline is March 23rd, 2005

Name _____

Organization _____

Address _____

City _____ State _____ Zip _____

Phone: _____ E-mail: _____

Mail form and payment to:
Northstar Alliance
Box 555
Arlington, MN 55307

_____ I am a member of the Northstar Alliance.
Enclosed is my check for \$75.00.

_____ I'd like to join.
Enclosed is my check for \$75.00 plus _____ for my chosen
level of membership: _____ \$35 _____ \$100 _____ \$250 or
_____ \$500

(Add membership in the National Council for just \$35.00 more.)

_____ I am a non-member. Enclosed is my check for \$110.00.

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

**New Wave Training
2005 Schedule**

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

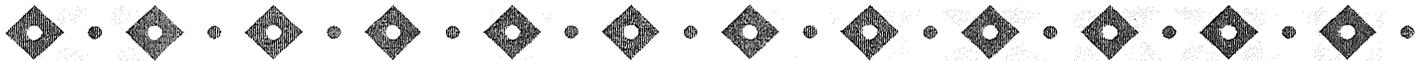
60 Hour Training: "Working With the Compulsive Gambler"

May 9-14, also in Minneapolis

Courses approved by the American Council on Compulsive Gambling
And the Minnesota Department of Human Services Fee-For-Service
Program.

For more information contact: Judy Gaskill, New Wave Training,
6915 Three Lakes Road, Canyon, MN 55717.

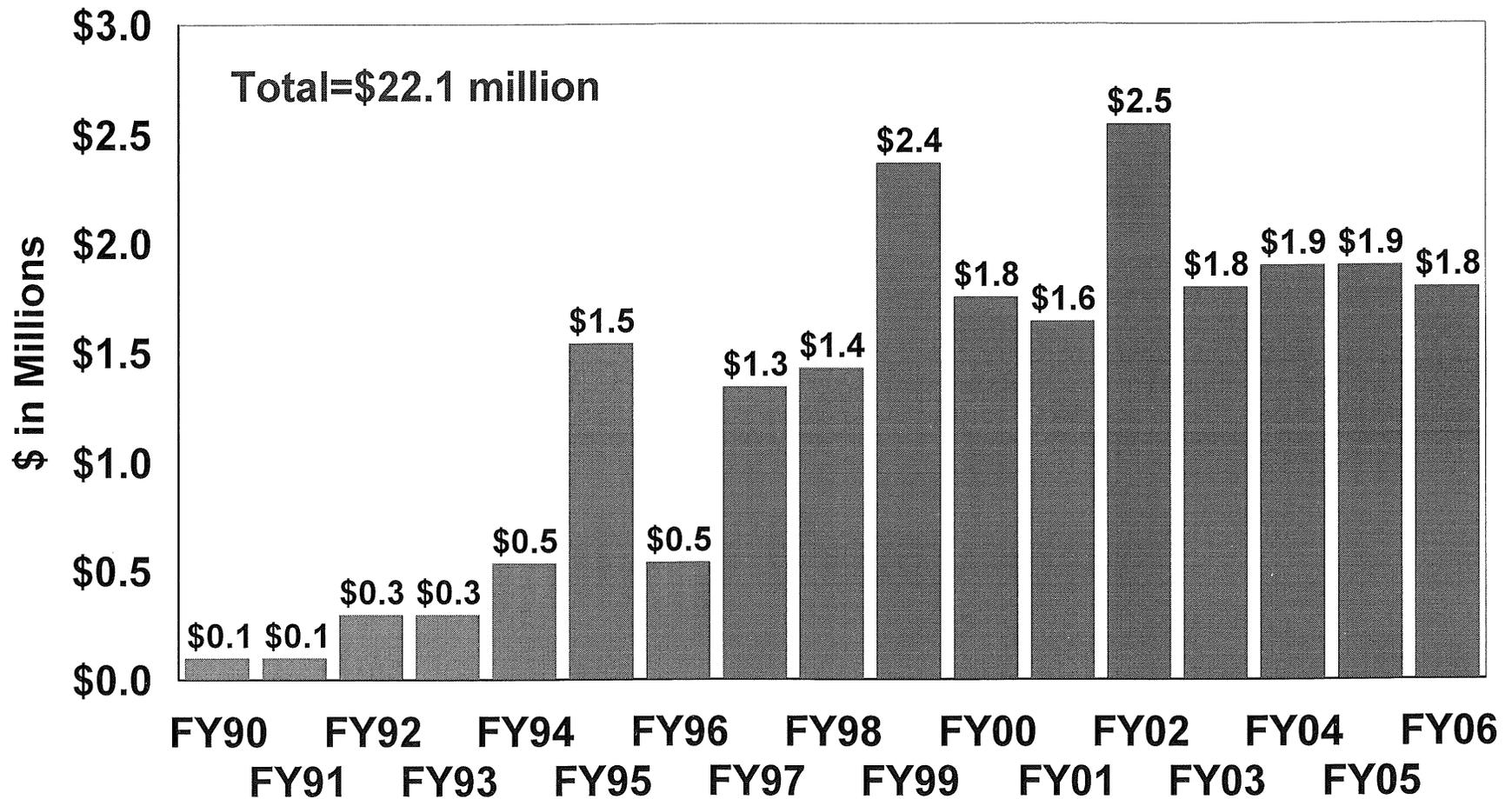
E-mail: bgaskill@cpinternet.com or call: 1-218-345-8042.



**Northstar
Alliance**

P.O. Box 555 Arlington, MN 55307

Lottery Contributions to Problem Gambling Programs



NORTHSTAR ROUNDTABLE

The Newsletter of the Northstar Problem Gambling Alliance

Volume 3 • Issue 1

Winter 2006

World's Largest Problem Gambling Conference Comes to St. Paul in June

The National Council on Problem Gambling and the Northstar Problem Gambling Alliance will present the 20th Annual Conference on Prevention, Research and Treatment of Problem Gambling in St. Paul from June 22 through June 24. This year's conference, the oldest and largest dedicated to problem gambling issues, will have a theme of *Addressing Gambling Problems in Underserved Populations*. Those in attendance at the St. Paul Radisson Hotel will include counselors, researchers, legislators, regulators, gaming industry executives and employees, media, policy makers and recovering gamblers.

Attendees will hear about innovative treatment, prevention, and responsible gaming programs and cutting-edge research on a wide variety of topics, including:

- Presentations on gambling issues in the African-American, Chinese, Hispanic, Hmong, Laotian, Native American, Pacific Islander, Punjabi, and other communities.
- Sessions on other at-risk populations including youth, seniors, and veterans.
- A special track on responsible gaming programs, with an emphasis on Native American casino initiatives.

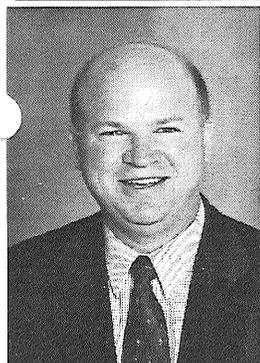
- An advanced clinical training track, including sessions on clinical supervision skills.

Among the plenary speakers scheduled to appear are Dr. Jeffery Derevensky, co-director of McGill University's International Centre for Youth Gambling Problems and High-Risk Behaviors, and Paul Bellringer, one of the pioneers in problem gambling treatment in Great Britain. Alison Beckman of the Center for Victims of Torture will discuss counseling multicultural clients on stigmatized issues, while Dr. Joseph Westermeyer of the Veterans Administration will speak on delivering mental health services to underserved populations.

Inside this issue:	
Treating problem gambling and substance abuse	2
Problem gambling in the military	4
A problem gambler's story	5
Life of a treatment provider	7
Pathways of youth gambling	10
Counselor training available	14

(Continued on page 2)

From the President



Todd Sipe

An organization is only as strong as its members.

For that reason, in 2006 we at Northstar Problem Gambling Alliance (NPGA) will focus on expanding our membership and, in turn, our mission.

By increasing our membership base we will continue to fulfill our mission of serving the problem gambling community through public aware-

ness, plus the promotion of treatment options, current education, and further research and prevention.

As a member, you'll find outstanding and diverse leadership. Phil Kelly, our outgoing president, positioned NPGA as the recognized leader in the state response to problem gambling. He has also attributed to our national recognition, which provides us the opportunity to host the 2006 National Conference on Problem Gambling and the chance to showcase our dedication to addressing this important issue. As succeeding president, I look forward to strengthening the NPGA and working to completely fulfill our mission.

Our board members are also committed and energetic individuals. As a gambling neutral organization, we are able to attract talent from the gaming venues, treatment centers, faith

(Continued on page 4)

National Conference

(Continued from page 1)

“We’re delighted to be coming to St. Paul for this year’s conference,” said National Council Executive Director Keith Whyte. “Minnesota has long been associated with innovations in health care, and we’re looking forward to bringing some of your local programs to a national and international audience.”

Attendees will be eligible for continuing education credit from a variety of national and state organizations. Partial scholarships will be available for Minnesota state approved gambling treatment providers through grants from Canterbury

Park and the Minnesota State Lottery.

Registration fees for the 2 ½ day conference are \$325 for Minnesota state approved gambling treatment providers, \$425 for Northstar Problem Gambling Alliance and National Council on Problem Gambling members as well as nationally certified gambling counselors, and \$475 for all others. An “early bird” discount of \$50 will be given to those registering before May 1. Discounts are also available for groups employed at the same workplace.

More information on the conference, including details on the program, registration, and hotel, can be found at www.ncpgambling.org, or by calling the National Council at

Treating Problem Gambling and Substance Abuse: What’s the Difference?

Many problem gambling counselors were first exposed to addiction treatment through work with chemically dependent patients. But how much of that experience and training is really transferable? What skills can the new problem gambling practitioner bring with them, and what will they have to learn?

Nina Littman-Sharp of Toronto’s Centre for Addiction and Mental Health believes that counselors coming from chemical dependency “have 75 percent of it.” But, she adds, “the other 25 percent is what makes it interesting and fun.”

Dr. Jon Grant, Professor of Psychiatry at the University of Minnesota Medical School, believes that some of the differences have a biological component. According to Grant, problem gamblers are sometimes found to have impairment in the area of the brain that helps with decision making. This condition is not found in chemically dependent patients, but it is often seen in those suffering from bipolar disorder, leading him to speculate that “this may be why bipolar medications (such as lithium) may work well in gambling but have not been helpful in chemical dependency.” Grant has also observed problems with the serotonin (a chemical that transmits messages between nerve cells) systems in the brains of problem gamblers, a feature common to many people with impaired impulse control.

A recent study by a team of Brazilian and Canadian researchers suggests significant emotional differences between those suffering from alcoholism and pathological gamblers. Dr. Hermanto Tavares and his colleagues studied 49 pathological gamblers and 101 alcoholics undergoing outpatient treatment.

They found that the gamblers were more likely to suffer from depression while the alcoholics were more likely to experience anxiety. They conclude that alcoholics “turn to alcohol as a way to deal with their proclivity to negative emotions, in particular, anxiety. Meanwhile, (pathological gamblers) seem to turn to gambling as a way to cope with depressive feelings and lack of positive experiences in life.” They also found that gamblers experienced more intense cravings, which the authors suggest place them at a higher risk for relapse.

A study found significant emotional differences between alcoholics and problem gamblers.

While cautioning that general rules might not apply to all patients, the researchers believe that the findings suggest different treatment strategies. Alcoholics might benefit from being taught relaxation techniques and other methods to cope with negative emotions, while gamblers might be better served with treatments for “early relief of depression symptoms and replacement of the activity and joy once prompted by gambling.”

Another study compared the demographic and social characteristics of those seeking treatment for gambling problems and those entering an alcohol program in Winnipeg, Manitoba. The authors found that “gambling clients were significantly more likely to be married and employed full-time, to have a higher education and income, and to own their own home, compared with alcohol clients. In turn, alcohol clients were more likely never to have been married, to have little formal education, and to be unemployed, with very low incomes.”

Those who have treated both gamblers and substance abusers also note personality differences. “With chemical depend-

(Continued on page 10)

From the Executive Director

Minnesota has long demonstrated its creative and effective leadership regarding people with, and those affected by, addictions. Since our founding in 2003, the Northstar Problem Gambling Alliance has been proud to be part of a state that at almost every turn has had research, residential and out-patient treatment opportunities, public information, and public policy initiatives as a priority. The "Minnesota model" has been recognized nationally and internationally for nearly half a century.

Thank you to countless people at every level for their contributions. In all probability that includes **you**. People's lives have been saved and changed because of **you**. We need to maintain that steady, high quality, and very important momentum. Your efforts and financial support will continue to be needed.

Forty eight states in the Union have legalized gambling in one form or another, the exceptions being Utah and Hawaii. Of those, thirty four have organizations that serve as affiliate members of the National Council on Problem Gambling. Most affiliate members receive a substantial portion of their program and operating budget from their state government. State funding is usually not the only source, but it has proven to be pivotal.

Minnesota has been a leader in many aspects of mental health issues, notably addictive behaviors. The state has demonstrated leadership in treatment, public awareness, public policy, and research (especially through the University of Minnesota Medical School). Much of this has been achieved through the leadership, program initiatives, and financial support of Minnesota's Department of Human Services and its Compulsive Gambling Program. Minnesota needs to maintain that leadership status.

However, our understanding of treatment for pathological gamblers, and help for those affected by the harm caused by problem gambling can be compared to that relating to drugs and alcohol related issues in the 1940s and 1950s. We need to do better.

Many, many of our citizens enjoy problem free gaming. Gambling proceeds have provided badly needed funding to many worthwhile programs. However, there are negative consequences. We are all familiar with sensational news stories of those who have committed crimes or destroyed their families to support their gambling addiction. But for every name in the news, there are many more who, in the words of Thoreau, live "lives of quiet desperation" caused by their gambling or that of someone they love. It is for them that we, the Northstar Problem Gambling Alliance, direct our efforts.

We have made great progress over the years. We know more about addictions and have more treatment programs serving more people than we did even five years ago. But we should not be hampered in our progress because of funding. More than \$10 billion is wagered annually in our state. The State of Minnesota receives almost \$200 million a year in direct revenue from gambling; tribal governments and charities also receive considerable amounts. Yet the state appropriation for programs relating to problem gambling is less than \$2 million a year. Moreover, this amount has actually declined in recent years. Where we once had the best funded program in the nation, we now struggle to catch up.

Minnesota's gaming venues should all be proud of the social good much of its profits have accomplished. But Minnesota's gaming venues need to continue their leadership in dealing with the problematic aspects of this economic engine. And may the great State of Minnesota, itself, continue to lead the way. You can be sure that others will also come to the table.

*T. Lance Holthusen
Executive Director*

Northstar Alliance

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From the President

(Continued from page 1)

and judicial communities and many others impacted by problem gambling. Together, we support the problem gambler and those affected by problem gambling. Please join me in a special welcome to our newest board members: Susan Aulie, Senior Director of Financial Services, for Lutheran Social Services; Julie Berglund, Vice President of Deposit Operations for Bremer Financial Services; and Steven Dentinger, Executive Director of Lake Superior Area Family Services and Gambler Intervention Services.

I invite you to join in our mission as well. You'll find a membership form on page 15. Please take a moment to join at whatever level you can afford – a strong membership base will give us the diverse and sustainable funding we need to ensure a strong culture of support. I look forward to working with you and thank you for your commitment and support.

Todd Sipe, President

Problem Gambling in the Military

More than 1 million people work for the nation's military, serving our country all over the globe. And as anyone who has served can attest, gambling is a common activity. In fact, the military itself earns more than \$120 million annually from the operation of gambling machines on bases outside the country. These funds pay for many recreational opportunities for our men and women in uniform.

But as in civilian life, there are those for whom gambling causes problems. A 2003 survey of 30,000 uniformed personnel found rates of problem and pathological gambling higher than in the civilian population. According to the survey, more than 50,000 members of the armed forces are likely to be problem or pathological gamblers. Yet unlike alcohol and drugs, the military does not require that those found to have a gambling problem be mandated for treatment. And, in fact, only one treatment program for servicemen and women exists, a small program at the Camp Pendleton Marine base in California.

This situation alarms Carl Mullen, a 27 year Marine veteran who recently retired after an additional 15 years as a clinician at Camp Pendleton. Speaking at the recent National Gambling Forum sponsored by the National Council on Problem Gambling, Mullen expressed his belief that those in the military are inherently at greater risk of developing a gambling problem. "Many of those most vulnerable in the civilian population are over-represented in the military," he said, notably young males who are under high levels of stress. "And the drug of choice

for an action gambler is adrenaline." Troops in combat experience frequent rushes of adrenaline, and when removed from the combat situation, often seek stimulus to replicate the high produced by combat. "We figure we survived in combat, so we're now bulletproof," says Mullen, a combat veteran.

Mullen also suspects that many with a gambling problem will not seek treatment for fear of the consequences, which can include loss of security clearance, demotion, or a less than honorable discharge. In his experience, most of those in the Camp Pendleton treatment program were more senior officials in whom the military had invested considerable training. As such, their talents were deemed too important to lose and they were able to attend with the support of their commanders. Those of lower rank and experience, he believes, would not receive the same level of support.

**Only one gambling
treatment program exists
for military personnel.**

Mullen urges the Department of Defense to adopt several measures. Most notably, he believes the military should adopt a "mandate to treat" program for gambling similar to the program now requiring treatment for servicemen and women who abuse drugs or alcohol. Second, "we need more than one little treatment center on one little base." Third, the military's health care personnel need to be trained to recognize the symptoms of problem gambling. And finally, he recommends an independent study of problem gambling in the military by the General Accounting Office.

NO JUDGMENT, ONLY HOPE 1-800-333-HOPE

The Minnesota Problem Gambling Helpline is available 24 hours a day, 7 days a week.
A service of the Department of Human Services and the Minnesota Institute of Public Health

A Problem Gambler's Story: Mary Stream

Mary Stream is a member of the Board of Directors of the Northstar Problem Gambling Alliance. Her story originally appeared in "Surviving Adversity: 32 Stories That Reveal the Power of Hope" by Gord Carley. We thank Mr. Carley for permission to reprint this chapter from his book, and we thank Mary for sharing her story. You can find out more about the book at www.survivingadversity.com.

My father was a violent alcoholic and I can remember hiding in the back seat of an old car in my pajamas because I had talked back to him. Our family all lived in fear of his violent nature.

I was not confident as a young girl. I was overweight, big busted, and felt that guys only liked me because of my breasts. In my junior year, I became pregnant. The baby's father was forced into the service by his parents, and I left school and took care of people in a Catholic charity home while pregnant. After delivering a baby boy, I was not even allowed to see him and he was put up for adoption.

One year after I graduated from high school, I married a man six years older than me. We had the first of four children the year after in January of 1967. My husband was a carpenter, while I stayed at home and raised our children in a beautiful house on a golf course. We had a good relationship and did lots of family things such as going camping in the summer.

When he turned 36, he started drinking with a new friend who was single, wealthy, and younger. As soon as alcohol came into the picture, I shut down the marriage instantly because I feared it would lead to a situation like the one I had grown up in. I insisted in 1978 that we separate even though he was not doing the negative things my father had. He moved out on a Thursday and the next day when he got paid, he brought over his paycheck. He was so good to the kids and me. He took them any time I wanted and never missed a school program.

In April of the following year, I told him he could have the kids the week of his birthday if he wanted. He replied that he would prefer a family dinner like we used to have. I really missed everything we had before we separated, but I was too afraid I would go back to a relationship and end up living like my mother did, with an alcoholic. As a result, I chose not to get together with him despite his efforts.

Two weeks later, I went out on my first date since our split. Later that same night, he died in a head-on car accident. It was determined he was under the influence of alcohol. It was very devastating. I felt tremendous guilt and shame.

I had been involved in teaching Sunday school and getting my kids to church, but I lost all faith in God when my husband died. I could not understand why a loving God would take this man and leave awful men and husbands on the earth.

My children were five, eight, ten, and twelve when he died. I focused on being a good mother for I knew that I was all my kids had. I went to every football game and track meet. The sign on the back of my car said, "Mom's taxi." When they finally grew up and started to leave home, I felt that no one needed me, and I had no purpose. I had lost my identity because everything I did involved my kids.

I started gambling in 1989, when my youngest daughter was a senior in high school. I found that when I gambled nothing bothered me. It was like a good drug. It was all that I could think about, and it was comforting. I also started to work in a casino. I realized I had a problem when I started bouncing checks. For a little while I did get things under control and I watched my gambling closely.

One day, a couple of boarders paid their rent and I took \$100 of it to the casino. I started on the blackjack table and won \$150. I then went to a red, white, and blue dollar machine and I hit \$120 on the first pull. Next, I went around the corner to another machine and hit red 7's and won \$5000. The casino did not ask if I wanted cash or a check. They just came back and gave me a stack of fifty \$100 bills.

I went home, and as I was about to make the bed, I took the money out and threw it up to the ceiling and watched \$100 bills fall all over me. It was such a thrill! I was literally rolling in the money like some kind of nut. Over the next few weeks, I gambled very little and did responsible things like paying bills. I had worked so hard all my life, since I was eleven. I felt that this was my reward for years of hard work.

The feeling of excitement of my big win was still in my head when, three weeks after I won that money, the casino I worked at opened up gambling to employees. As a cocktail waitress, even if I had no money, I would earn tips of \$80-100 and use that as my gambling money. I tried to avoid gambling by not bringing a change of clothes to work because rules did not allow me to gamble in a cocktail uniform. I would get around this by going to the gift shop and buying new clothes, or I would wear my coat over my uniform. It was crazy. I never felt so out of control in my life.

I stopped paying bills. Twice I got six months behind on house payments. I did not realize I was so far behind on payments as the gambling had taken over so much. I only responded to emergency notices that threatened to turn my power off. To support my habit, I refinanced my house seven times and the house payments went from \$225 a month to \$998 a month.

If somebody had told me that I would stay awake for 36 hours, not eat and only drink coffee and smoke cigarettes, I would not have believed it. It was nuts. In 1993, I gambled just about every day. I was under severe financial stress and

(Continued on page 6)

(Continued from page 5)

my work started to suffer. The casino fired me on January 1, 1994.

I told a counselor provided by the casino about my gambling. He suggested that I go to Minneapolis where there was a very intense outpatient program for addicted gamblers. I attended four days a week, for three or four hours per night. There was a small group of five or six of us and we discussed our problems, and learned more about our addiction.

It was really hard, especially since I drove by three casino exits on the way to Minneapolis. There were days I would pull my car off the road and bawl, or times I would take the exit to the casino, and somehow gather the strength and then turn around. I knew I could never let myself gamble again.

At one point, I had even thought of driving my car off a road at a spot where there was a steep drop. When I later told my son, he asked me, "How could you ever think of doing that after Dad died in a car accident?" That was the furthest thing from my mind at that time. I never even thought of my kids' reaction.

After I stopped gambling, I went on a mission to try to save my house. I put too much effort into it, and refinanced at 18% interest. I finally realized it was only a house and let it go in

1996, but it was very tough to do, because I felt like it was all I had.

My children were excellent and a great support group. They were all living their lives throughout the country when my addiction was at its worst. My son moved back in with me when I quit and he took over my finances.

The Gamblers Anonymous group because my faith. A person who had quit around the same time I did started hanging out with me and she would stay at my place after the Friday meeting until Sunday just so neither of us would gamble. Within a year, I had started a Gamblers Anonymous meeting in Red Wing and soon after that, I started sponsoring people.

I never did remarry and in retrospect, I wish my husband and I had stayed together. After some time, my faith returned stronger than ever and it has since helped keep me strong. The forgiving God I know and love suffered a lot for us.

I believe that we each have a purpose and a different thing to do on this earth. We also need to forgive ourselves. I have to look back on the toughest times with some sense of humor. The last person to forgive me for my mistakes was me.

If I ever forget the pain of my addiction, then I risk going back to it.

Staying in Action: The Gambler's "Dry Drunk"

Gamblers in treatment often find ways to "stay in action" even though they've stopped gambling, according to UCLA psychiatrist Richard Rosenthal. In an article in the March 2005 *Journal of Gambling Issues*, Rosenthal likens their actions to the "dry drunk" who has stopped drinking but still exhibits alcoholic attitudes and behaviors. He urges therapists to recognize these behaviors in gamblers and take action before they lead to relapse.

Trading one addiction for another may be the best-known symptom of the dry drunk, but gamblers can find other ways to take risks and stay in action. Dr. Rosenthal identifies several ways that the gambler makes wagers with themselves, ranging from "If I had bet one hundred dollars on the Dallas Cowboys ..." to counting how many times a telephone will ring to driving without gas in the car. Procrastination is another common risk-taking behavior. Others look for substitutes for the stimulation previously supplied by gambling. This might involve physical activities like sky diving, or the gambler might consume large quantities of legal stimulants like coffee or tobacco. Some find stimulation in the problems caused by their gambling debt, working multiple jobs and juggling bills.

Lying, cheating, and stealing, of course, are common behaviors during the course of a gambling addiction. Rosenthal often sees these behaviors continue during the treatment process, and believes them to be another way the abstinent gambler stays in action, gambling, in essence, that they can get away

with it. They also continue the secrecy and sense of entitlement often found in pathological gamblers.

Rosenthal identifies several reasons for the persistence of these behaviors. The former gambler might find themselves overwhelmed with guilt, the realization of time wasted, or painful memories of childhood neglect or abuse. They are also susceptible to boredom. For some, he writes, "gambling was typically how they defined themselves. Without their identity as a gambler, they do not know who they are. Giving up gambling leaves a large vacuum or hole in their lives. They have no other interests, and there are few activities that can compete with the excitement of gambling." Boredom can also mean being "left alone with intolerable feelings, such as depression, helplessness, shame, or guilt."

Finally, they may "gamble" by ignoring the realities of everyday life. They might not mention that they're driving without insurance, or agree to a treatment fee they can't afford. Rosenthal cites one patient who regularly parked in a tow-away zone outside his therapist's office.

Gamblers, Rosenthal concludes, frequently attempt to "maintain attitudes and behaviors associated with gambling while superficially complying with treatment and Gamblers Anonymous." He urges therapists to continually look beyond gambling for other ways the recovering gambler tries to manipulate or control external events.

The Life of a Treatment Provider

For Steve Dentinger, Executive Director of Duluth's Lake Superior Family Services, it started with a divorce.

"I was a divorce mediator working with a couple where the husband was a problem gambler and a bookie," he says. "I started hearing stories that were like a foreign language to me. The stories had such an impact that when the casino first opened in Duluth I remembered this couple and thought that gambling treatment was a need our agency should be prepared to meet."

It wasn't easy. In 1988 there were few resources available to those treating problem gamblers. But Dentinger got help from an unexpected source. "I found myself on television one day talking about the program we were going to start. The next day I got a call from a gambler who had been through a treatment program in Baltimore. We got to know each other, and he actually gave me his files from when he was in treatment." Dentinger brought trainers in from the Maryland program and began to offer services. Seventeen years later, Lake Superior Family Services provides the largest problem gambling treatment program in the State of Minnesota.

Counseling the first client was "pretty scary," he recalls. "I felt like I was bluffing and that the client knew more than I did. But I had a long background in social services so it wasn't as if I was going to be surprised by too many things. I certainly had counseling skills and experience, and I was confident we could do something to help."

Joanna Franklin (currently Director of Training and Development for Trimeridian) came to problem gambling treatment in 1979 with a similar lack of resources. "We had not one book written on the topic at the time. We had no journals. We had nothing." When Maryland became the first state to offer a treatment program for gamblers, they hired Franklin (an experienced substance abuse counselor), a social worker, and two recovering gamblers, requiring that they work as a team. "The recovering gamblers taught us all the ins and outs about gambling—how to help with impulse control, budgeting, finances, legal concerns, and family issues. We helped them learn about co-occurring disorders, how to distinguish a real suicide risk, identify when medication might be appropriate and know when drugs and alcohol might be getting in the way. We trained each other for six months. It was one of the best learning experiences I've ever had in my entire life."

Franklin soon found that gamblers posed some unique issues. "I'd never had an addict sit across from me with \$40,000 rolled up in a wad right after he told his wife he didn't have money to buy their son pants for the first day of school. I'd never seen \$40,000 in my entire life and I'm ready to pop him in the nose. My eyes got big and my voice changed. I got accusatory and I got confrontational. After a little bit of time

working with these folks my eyes didn't get big anymore and the confrontation wasn't there. Now I just think 'Here we go again.'"

Both Franklin and Dentinger found work with addicted gamblers rewarding enough to make a long-term commitment to the field, a sentiment echoed by Nina Littman-Sharp, Manager of the Problem Gambling Service at Toronto's Centre for Addiction and Mental Health. "It's fun. I love it. These are very interesting people with interesting problems." The 10 year veteran of the field adds that "A big part is having a fair amount to offer people. It's a problem that can be dealt with, and we're always finding new ways to help." Franklin agrees, saying that as a drug counselor in the 1970s "we had one out of ten get well and we were proud of that. With gamblers, you can help at least half of the people you work with. They embrace recovery with a real passion." Dentinger adds that "once a gambler finally sees the light, they devote themselves to recovery, and it's amazing the amount of improvement they can make in a short period of time. They have incredible energy, and when you can get that channeled to a new direction they're marvelous people, they're marvelous citizens in the community."

"It's a problem that can be dealt with, and we're always finding new ways to help."

- Nina Littman-Sharp

The job certainly has its frustrations. Dentinger, Franklin, and Littman-Sharp all profess an intense dislike for the inevitable politics that get in the way of helping clients, citing confusing funding formulas, inconsistent insurance coverage, and a sometimes recalcitrant gambling industry. And they express a frustration that more isn't being done to help people before they reach the stage where intensive treatment is needed. Littman-Sharp also cites an increasing number of clients with "really severe mental health problems. We're really not set up to deal with that."

In addition, there is the stress that comes with dealing with troubled people day after day. Says Dentinger, "I think I did take the job home for a long, long time, and my family was probably the victim of me taking it out on them on occasion. Eventually I realized that I couldn't save the world and that I have to do the best job I can and leave it at the office." Adds Littman-Sharp, "You find a way to distance yourself from it. You don't take it personally." She believes that adequate supervision and support are critical to avoiding burnout.

Franklin advises therapists that when they finish sessions with a client to "think about how you could have done it better, what you should do next time. Put those thoughts into your next meeting with your supervisor and don't let it become your life." She adds that those who don't learn to separate their career and private life "burn out and go sell computers or shoes for a living."

(Continued on page 8)

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What advice would they have for those entering the field? Dentinger cautions that "it's a long-term process. Learn as much as you can. Read the research. Study the symptoms. Recognize that if you're in a rural area or small town you're going to struggle to have enough clients to put together a group."

Sandra Brustuen, Coordinator of the Vanguard Compulsive Gambling Program in Granite Falls, Minnesota, emphasizes that gamblers "are going to lie to you. You can't believe them, and you can't trust them being nice. They're humorous and they're fun and you can joke around with them, but don't ever trust that or think it means anything. It's their façade, and underneath that is the addiction."

Littman-Sharp urges aspiring clinicians to "try to find work at an innovative, supportive agency that is combining treatment

research and practice, and is always learning.

"This field does not stand still. You will find yourself amazed, enlightened, saddened, appalled and enthralled. You will find all your existing skills put to good use."

Franklin spends much of her time training new practitioners. She emphasizes that "this is an intriguing and rewarding and interesting and challenging group to work with. If you've ever gotten bored with one more depressed soul or one more crack addict, you're not going to get bored working with gamblers because they're going to be throwing something different at you. You're not in this all by yourself. All across the country there are a whole bunch of people who are ready, willing and able to help and are just a phone call or an e-mail away. It's going to be challenging, but that's the rewarding part of it too. When you help someone pull it together, you're going to see recovery like you've never seen it before."

Winters Honored by National Center for Responsible Gaming

Dr. Ken Winters, Director of the Center for Adolescent Substance Abuse Research at the University of Minnesota and former board member of the Northstar Problem Gambling Alliance, received the National Center for Responsible Gaming's (NCRG) 2005 Senior Investigator Award at that organization's annual conference on December 8, 2005.

The Center cited Winters for "his commitment and dedication to addressing youth drug and alcohol abuse and disordered gambling through academic, clinical and research channels."

"Winters' groundbreaking research in the field of addictions has provided considerable insight into identifying both the risk and protective factors associated with youth pathological gamblers and also has led to breakthroughs in understanding the course of early onset pathological gambling. These findings have significant implications for the prevention and intervention of youth disordered gambling," they added.

Much of Dr. Winters' early work related to gambling was done through grants awarded by the Department of Human Services' Compulsive Gambling Program. Among these was one of the first studies of the prevalence of problem gambling in adolescents. For this study, Winters and his University of Minnesota colleague (and Northstar Alliance board member) Dr. Randy Stinchfield revised the South Oaks Gambling Screen (SOGS) for use with adolescents. The resulting SOGS-RA (the RA stands for "revised for adolescents"; Winters jokes that it should stand for "rough approximation") has become the most widely used method for assessing problem gambling in adolescents.

More recently, Winters and Stinchfield collaborated on the first longitudinal study of adolescent gamblers, following the same group of adolescents as they aged from 16 to 24 (see page 10).

In addition, he has done significant research on the links between and co-occurrence of gambling and substance abuse, work the NCRG cites as having advanced both clinical treatment and the prevention of gambling problems.

"I am very flattered to receive this award," said Winters. "To be acknowledged for my work in problem gambling is a great honor. And to be recognized alongside past winners like Robert Ladouceur and Alex Blaszczynski is also very gratifying."

In addition to his service with the Department of Psychiatry at the University of Minnesota Medical School, Dr. Winters is senior scientist at the Treatment Research Institute of Philadelphia. He has been asked to consult with governments around the world on issues related to adolescent addictions, including Latvia and Dubai. He has co-authored 35 book chapters and written more than 65 articles in peer-reviewed journals. He was a member of the National Research Council Committee on the Social and Economic Impact of Pathological Gambling.

Winters is not the first University of Minnesota faculty member to be honored by the NCRG. Dr. Jon Grant of the Department of Psychiatry received the "junior researcher" award in 2004.

Poker Robots Invade the World of Internet Gambling

Poker games are based on two factors: the laws of probability covering the distribution of 52 randomly selected playing cards and the complex interactions between the individuals playing the game. But what if, unknown to you, one of the players isn't a person, but a sophisticated computer program?

According to the London *Mail on Sunday*, this is the reality faced by an increasing number of those playing poker on the Internet. One or more of your opponents may be a "player" who "doesn't take breaks. He'll go on playing forever, he'll never flag or make a wrong call and he won't become depressed or euphoric." In the few seconds a player has to make a decision, a computer can make many thousands of calculations to devise an optimal strategy. This is very bad news for the online gambling industry because, as the *Mail* points out, continued participation depends on a perception by the player that the game is fair. Unless a way can be found to stop the use of poker robots, the industry fears that the amateur player (who provides much of online poker's finances) will leave and the game will die.

The robots cannot be used by everyone. The available software requires considerable programming by its owner; the *Mail* estimates that at least 2,500 hours of programming are needed to turn even a small profit. And the robot needs to be concealed on a computer system that cannot be detected by online casino operators.

Yet once these obstacles are overcome, the robots can be incredibly profitable. One operator, whose computers have played about 300,000 online games, says "I'm doing pretty well. I have two computer systems, and each one can run four poker bots, and each of these four can play up to five tables at once. At worst I make on average 2.90 pounds (about \$5 US) at each table. That's a minimum of 116 pounds an hour if I can get all the bots running at once." This same operator is currently working on a way to allow two computers posing as two players in the same game to collaborate, further diminishing the chances of the human player.

Source: You'll never beat poker robots. Phil Robinson, Mail on Sunday, 28 November 2005.

U. of M.: Impulse Control Disorders Common Among Psychiatric Inpatients

Researchers at the University of Minnesota found that impulse disorders such as gambling, shoplifting and pyromania appear common among psychiatric inpatients. In the first study conducted to examine how common these disorders are, researchers found that one-third of inpatients had at least one impulse control disorder, but only three had been previously diagnosed, suggesting that these disorders frequently go unrecognized. The results of this study are published in the November issue of the *American Journal of Psychiatry*.

"Our research showed that impulse control disorders are more common than previously expected," said Jon Grant, J.D., M.D., Associate Professor of Psychiatry, University of Minnesota. "We discovered that people with these disorders want to talk about them, but shame and embarrassment have kept them from opening up, even to their doctors."

Researchers found that 63 (30.9 percent) out of 204 patients studied were diagnosed with at least one current impulse disorder. 42 patients (20.6 percent) reported current symptoms of two impulse control disorders, 20 (9.8 percent) reported three impulse control disorders, and 1 (0.5%) reported more than three disorders. Only three of the study participants were admitted for an impulse control disorder and had reported the condition to their doctor.

The most common impulse control disorders were compulsive buying, kleptomania, and pathological gambling. Only 1.5 percent of the inpatients carried an admission diagnosis for an

impulsive control disorder. Prevalence estimates of impulse control disorders did not differ between patients admitted to the private and public hospitals, suggesting that these disorders are common in different inpatient treatment settings.

Impulsivity, defined as a predisposition to rapid, unplanned reactions to internal or external stimuli without regard to the negative consequences of these reactions to the impulsive individual or to others, is a core feature of many psychiatric disorders.

Researchers used the Minnesota Impulsive Disorders Interview, a semi-structured clinical interview assessing pathological gambling, trichotillomania (compulsive hair pulling), kleptomania (shoplifting), pyromania (fire setting), intermittent explosive disorder, compulsive buying and compulsive sexual behavior to screen 204 consecutively admitted psychiatric inpatients. One hundred twelve of the inpatients were women. The mean age of the 204 inpatients was 40.5 years. Patients who screened positive for an impulsive control disorder were evaluated with structured clinical interviews.

University of Minnesota Medical School News
<http://www.ahc.umn.edu/news/releases/impulse110705/home.html>
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Pathways of Youth Gambling

A number of jurisdictions have conducted one-time prevalence surveys of problem gambling among youth. These studies have a significant limitation: they tell us nothing about the progression of gambling problems over time. Does the experience of a few gambling problems at an early age result in more severe problems later? Do adolescents "age out" of problematic behavior as they move into adulthood?

To begin to answer these questions Ken Winters, Andria Botzet, Wendy Slutske and I interviewed 305 adolescents in 1992 and followed them into their young adulthood, interviewing them two years later in 1994 and again, three to four years later in 1997 and 1998. This eight year time period followed youth as they aged from 16 to 24. We administered the SOGS-RA at the first and second interviews and the SOGS at the third interview. Using the SOGS-RA, we classified those with SOGS-RA scores of 0 or 1 as "no problem gambling" (non-gamblers were automatically assigned a SOGS-RA score of 0). Those with scores of 2 or 3 were placed in the "at-risk gambling" category. Problem gambling was defined as a SOGS-RA score of 4 or more. Using these classifications at all three interviews, we developed four categories: (1) stable, with no problem gambling at all three assessments (resistors); (2) stable, with at risk or problem gambling at all three assessments (persistors); (3) change from either at-risk or problem gambling to no problem gambling without a return to at-risk or problem gambling (desistors); and (4) new incidence cases—those with no problem gambling at the first assessment and at-risk or problem gambling at the second and third assessments or no problem gambling at both the first and second

assessments and at-risk or problem gambling at the third assessment.

The most common pattern was resistors (60%)—those who were non-gamblers or no-problem gamblers at all three assessments. The next most common pattern was new incidence cases of either at-risk or problem gambling (21%). The third most common pattern was desistors (13%)—youth who were at-risk or problem gamblers at the first or second assessment, but were non-problem gamblers by the third assessment. The least common pattern was persistors (4%), that is, youth who were either at-risk or problem-gamblers across all three assessments.

Several conclusions emerged from this study. First, gambling involvement by young people does not reliably predict at-risk or problem gambling. Second, we found that at-risk gambling at an early age was not a good predictor of later problem gambling. Problem gambling at an early age, however, was a moderately good predictor of later problem gambling. Finally, young adulthood seems to be a particularly important age period, when gambling-related problems emerge in the form of at-risk gambling.

- Randy Stinchfield

For more information, see: Ken C. Winters, Randy D. Stinchfield, Andria Botzet and Wendy S. Slutske. Pathways of Youth Gambling Severity. *Psychology of Addictive Behaviors* 2005, Vol. 19, No. 1, 104-107.

Gambling and Substance Abuse

(Continued from page 2)

ency, they come in on a drug and are slowed down a lot of the time," says Sandra Brustuen, Coordinator of the Vanguard Compulsive Gambling Program, an inpatient program in Granite Falls, Minnesota. "You have to pep them up. When I was doing CD treatment I would have to pull teeth to get assignments done. Nobody gave feedback and they didn't talk. In gambling, they talk about nothing, but they talk." Joanna Franklin, Director of Training and Development for Trimeridian, adds that, compared to substance abusers, gamblers are "clear-headed, sharp, functional souls."

The two populations can arrive for treatment in different physical condition as well. Certainly what Franklin describes as "the physical ravages of drugs and alcohol" are often apparent—Grant notes the importance of checking heart function with cocaine abusers and liver function with alcohol abuse—but there are more subtle differences as well. Brustuen finds that Vanguard's gambling clients "come in on many more medications and with many more mental health diagnoses." She notes that gamblers are very often sleep-deprived, a sentiment echoed by Littman-Sharp.

Grant has found that medications sometime exacerbate gambling problems, with the recently documented link between certain medications for Parkinson's disease and problem gambling being one example. He also notes that "nicotine use is huge in gambling" and urges an examination of lung function and nicotine cessation counseling. Finally, he points out that gambling tends to be a sedentary activity, leading to problem gamblers being more prone to type 2 diabetes. This observation is confirmed by Brustuen, whose program requires that every new patient undergo a complete physical examination.

Money plays a significant role in addiction. Franklin comments that "I've never met an addict who had their finances in good working order." But, as the University of Minnesota's Grant puts it, finances are "a bigger deal for gamblers," adding that financial issues are a major cause of relapse. Littman-Sharp also mentions that cognitive disorders—erroneous beliefs about the way gambling works—are a much more significant issue for gamblers. She adds that gamblers often have a lot more family problems, as there's often been a "huge revela-

(Continued on page 11)

tion that was a disastrous surprise for the people around them.”

Then there are differences in the way addictions are seen by others in society. Brustuen notes that for many their “gambling has been such a secret” that important people in their life aren’t aware of it. She sees many fewer court-ordered treatment referrals for gambling than for alcohol or drugs.

Franklin also expresses frustration with a legal and social system that treats problem gamblers differently than people with substance addictions. “By and large, without physical injury being involved, (drug addicts and alcoholics) get a second chance, a third chance, but gamblers don’t. They don’t have the same protection that (chemical) addicts have when they go public with their problem. They are court-martialed, they are suspended, they are fired, they lose security clearances, they lose bonds, they lose licenses because society sees them as bad, not as sick.

“A major who had given his life to the military got in trouble because of gambling,” Franklin continued. “Had it been a drug or alcohol problem, they would have instantly sent him to one of several different treatment programs. Because it was gambling, he was court-martialed.”

Littman-Sharp points out that different types of addicts tend to be involved in different types of criminal activity and may therefore face different legal issues. Offenses such as “driving while intoxicated” and “possession of an illegal substance” are unique to chemical addictions, and violent crime is frequently associated with illegal substances. On the other hand, several studies have found that when gamblers commit crimes to support their addiction, they are likely to be non-violent, “white collar” crimes.

The differences between the addictions require differences in treatment programs. Franklin stresses that “direct translation from drugs and alcohol to gambling doesn’t work. You can’t just pull out the words ‘drug’ and ‘alcohol’ and plug in the word ‘gambling’ and be good to go with a treatment plan.” She believes that while abstinence and 12-step programs are suitable for the overwhelming majority of substance abusers, they are sometimes less appropriate for gamblers. “The minute I stopped the ‘one size fits all’ approach I really started getting better results.”

Brustuen only has to go as far as Vanguard’s exercise room to see the differences between those being treated for gambling addiction and the substance abuse patients who share the facility. “The gambler’s exercise has to be limited and structured. Gamblers want to run five miles a day or they want to pump iron for an hour a day, or they want to do push-ups in their rooms for a half-hour. We can’t just let them exercise on their own because some become compulsive exercisers. Even playing volleyball has to be structured. People get so competitive they end up injuring them-

selves. You really need to watch the games they play—even board games—because of their competitiveness and wanting to get into action.” Substance abuse patients require many fewer restrictions.

She also believes that therapeutic groups for gamblers need to be smaller than those for chemical dependency. The ideal size, she says, is between eight and ten; when a gambling group gets to be more than 15 people “we begin to notice more behavior problems and more chaos, and addictions feed off chaos.” She believes that gambling groups work best with two staff present because of the difficulty in keeping gamblers focused.

Brustuen notes that when working with gamblers “you really have to have good boundaries. With alcoholics, you can almost be their friend. You can be warm. You can be soft. With gamblers, you’re going to get burned because they’re going to take that warmth and softness and use it. You can’t talk to a gambler about your family or anything personal because that’s going to come back to bite you.”

In addition, she believes that aftercare needs to be longer for gamblers. “The longer (substance addicts) are chemical free the better their chances of recovery are. Gamblers continue to relapse years after treatment.” As a result, Vanguard’s aftercare “growth group” has no limits on duration. “A lot of our old-timers come and sit in every two or three months just to keep it fresh for them.”

A complicating factor is the considerable overlap between the two populations. A recent survey of 43,000 U.S. households found that almost three-quarters of those with a lifetime history of problem gambling also had experienced an alcohol use disorder while more than one in three had a history of drug use. While the two addictions may not have occurred simultaneously, it is clear that when treating one addiction, the existence of a different prior or concurrent addiction needs to be considered.

When faced with co-occurring substance and gambling addictions, Vanguard and its sister chemical dependency program attempt to assess which addiction seems most dominant at the time and places the patient accordingly. “We also take into account the chemical used and the withdrawal from it,” says Brustuen. “This may be cause to refer to a chemical dependency unit first. If we find out about abuse of chemicals during (gambling) treatment we will have the person undergo an assessment of their chemical use. At that time we will make a determination of whether to have the person finish gambling treatment or be transferred to our chemical dependency unit.”

At the University of Minnesota, Grant prioritizes multiple addictions by determining which one is impairing the person the most. “If a person says, for example, that they only drink because of their gambling, then initially the focus

(Continued on page 12)

(Continued from page 11)

should be on the gambling.” Alternatively, “if the substance use is only mild, and they function fairly well overall, it’s possible to deal with both problems simultaneously.” However, in his experience, severe substance abuse makes complying with gambling treatment difficult, and in these cases the substance abuse should be dealt with first.

Franklin recalls being asked to see a client in a chemical dependency program. “In five minutes it was clear this client had had a gambling problem for most of his life. He had been through addiction treatment nine times by the age of 63 for alcohol dependence. He had been treated by some of the best addiction professionals, he had been treated by mental

health professionals- but no one caught the gambling connection. No one asked the important but simple questions found on the South Oaks Gambling Screen. This client had been treated for his addiction problem but never for his gambling problem. His untreated gambling disorder led to relapse after relapse with his alcohol problem.

“Once treated for his gambling problem he continued in quality recovery for some years until his death,” she continued. “When he died he was sober and abstinent.

“If a dually diagnosed client isn’t treated for both disorders, he is not treated effectively for either.”

Featured Web Site: www.beatthebet.com

While there are a number of excellent web sites dealing with adolescent gambling, beatthebet.com may be the only one specifically designed for college students.

When you click to the site, you see a photo of a college-age young man. The photo is then partially covered by a “post-it” note advertising “Guitar 4 Sale” and then another saying “Computer 4 Sale” followed by “Snowboard 4 Sale” and more until the photo is completely obscured. The image then morphs into a page where you’re introduced to Brad, “a typical all-American college student.” Brad tells us how his social card playing escalated into occasional casino visits, then frequent casino visits and ultimately to addiction and recovery. He introduces you to a series of questions closely modeled on the GA-20, and tells you that free, non-judgmental help is available. He also gives some advice on how to help a friend.

The site is written in plain language that never falls into the “old person trying to sound like a hip young person” trap that this sort of exercise so often falls into. It was developed by Russell Herder Marketing Services under the auspices of the Minnesota Department of Human Services.

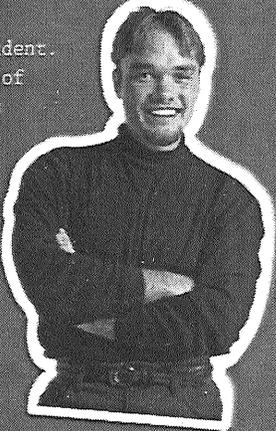
HOME MY STORY WHAT IS PROBLEM GAMBLING DISCOVERING THE PROBLEM FINDING HELP

I NEVER FOUND WHAT I WAS LOOKING FOR IN A CASINO. BUT I DID WITH A PHONE CALL.

Hey there. I'm Brad.

I guess I'm a typical all-American college student. I cram for tests, stay up late and eat plenty of ramen noodles. I also like to gamble, which is pretty typical among students these days. But there's something else you should know about me. I have a gambling problem. And it cost me everything.

Because of gambling, I lost my guitar, my snowboard, my computer, my mountain bike and everything else I had. Who knows, maybe I sold them to you? I lost my girlfriend, Sara, and my buddies, too, which is the worst of it all. Luckily, I found help for my gambling problem by calling 800-333-HOPE.



“Beatthebet.com was created in response to quantitative and qualitative research conducted with university students to find the best ways to share information about the issue of problem gambling and its treatment,” says Carol Russell of Russell Herder. “We developed the site as a non-threatening, gambling neutral resource. Our feedback thus far has been excellent.”

Special thanks to
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 For making this newsletter possible

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Alliance, Natl. Council Receive Grant from Canterbury Park

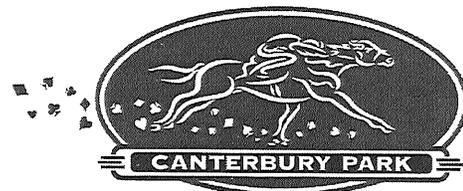
The National Council on Problem Gambling and its Minnesota Affiliate, The Northstar Problem Gambling Alliance, Inc., have *each* received a \$20,000 grant from the Canterbury Park Minnesota Fund. The purpose of the funds is both for general operating expenses, and scholarships for the 2006 National Conference on Problem Gambling. The scholarships are for Minnesota providers of services to those affected by problem gambling issues.

The Canterbury Park Minnesota Fund is intended to serve the Minnesota horse community, the state's agricultural and rural communities, and responsible gaming programs. Created in 2003, the fund is part of a commitment by Canterbury Park to donate 5 percent of its pre-tax profits as one of Minnesota's "Keystone Corporations." Eric Halstrom, Vice President for Racing and Simulcasting of Canterbury Park, is a founding member and current officer of the Northstar Alliance Board of Directors.

"Canterbury Park is proud to be associated with the Northstar

Problem Gambling Alliance," said Randy Sampson, Canterbury Park President and CEO. "As a founding member of the Alliance, Canterbury Park has seen the benefits the organization brings to responsible gaming in Minnesota. The Alliance, with its inclusive Board of Directors, has become the premier responsible gaming group in the state. We're happy to be able to lend some financial support to such a worthy cause."

The National Council and the Northstar Alliance are genuinely grateful for Canterbury's leadership role in supporting their efforts in serving those affected by problem gaming issues.



New Wave Training*

“Working with the Compulsive Gambler”

One-Day Training: May 12th and Oct. 6th

**Sixty-Hour Training: April 10th -14th and October 23rd – 27th
Minneapolis, MN.**

Advanced Training: “Understanding the Compulsive Gambler”: This one day offering is approved for 6.0 educational hours and 6.0 continuing education units by the accrediting entities listed below. Faculty includes experienced accredited professionals in this field.

- **Working with the Repeat Client:** Presentations on a variety of referral and other resources available to assist clients, their families, and others affected by compulsive gambling issues. This section will emphasize the importance of instilling hope and motivation in the recovering person and significant others.
- **Is Abstinence the Immediate Goal?:** Participants will understand that complete abstinence is not always reality for all populations. Progress in life functions and with other co-existing disorders may need to be addressed before abstinence becomes the goal.
- **Is There Life After Gambling?:** This section addresses the void that abstinence from gambling can leave and the importance of developing alternative activities.

Sixty Hour Training: Sixty Hour Compulsive Gambling Workshop: You will learn the many components that compulsive gambling treatment has to offer. You will learn how to identify problem behaviors associated with compulsive gambling and the related appropriate treatment modalities for this disease. **Workshop Topics Include:**

Assessment/Treatment Planning	Legal Issues	The 12 Steps of Recovery
Client Responsibility	Education and Prevention	Case Mgmt./Crises Intervention
Collateral Indicators	Family/Financial	Fantasy World
Outreach/Program Development	The Contagious Disease	Counseling & Recovery Model

Successful completion of this training course may be applied towards Gambling Counselor Certification and Minnesota DHS Fee-For-Service Provider status.

*New Wave Training courses are approved by the American Council on Compulsive Gambling, the Minnesota Board of Psychology, the Minnesota Department of Human Services Fee-For-Service Gambling Program, and other certifying programs. **New Wave Training** is a program in cooperation with Northstar Problem Gambling Alliance, Inc., the Minnesota Affiliate of the National Council on Problem Gambling.

Tuition and Registration:

(Fees cover the cost of training, materials, certificates, and refreshments.)

Name: _____

Agency: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

E-Mail: _____

Training Held at:
Kenwood Therapy Center, LLC
2809 South Wayzata Blvd.
Minneapolis, MN 55405

Training Session Desired:
One Day: Date _____
\$135 Due with Registration

Sixty Hour: Date _____
\$875 Due with Registration

For more information contact: Judi Gaskill, New Wave Training, 6915 Three Lakes Road, Canyon MN 55717. E-Mail: bgaskill@cpinternet.com or Call: 218-345-8042.

PLEASE JOIN US!

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

Our members include those who have a vested interest in gambling, including the Minnesota State Lottery, the Minnesota Indian Gaming Association, independent tribal communities, Allied Charities of Minnesota, and Canterbury Park, as well as the recovering compulsive gambler, and those affected by problem gambling, such as families and friends, retail finance and banking, and the judicial system.

They also include those who provide a door to recovery or other appropriate help, such as researchers, school counselors, clergy, physicians and nurses, social workers, and treatment providers.

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

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

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

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

The Northstar Alliance is a 501(c)(3) non-profit corporation (Federal tax ID number:920185978). Contributions are tax-deductible to the extent allowable by law.

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Name _____	Benefactor	\$10,000 and above _____
Organization _____	Sponsor	\$5,000 to \$9,999 _____
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City _____	Gold	\$1,000 to \$2,499 _____
State _____ Zip _____	Silver	\$500 to \$999 _____
Phone _____	Bronze	\$35 to \$499 _____
Fax _____		
E-Mail _____		
Today's Date _____		

Note: All of the above categories receive a year's membership, special recognition in our annual report, copies of all newsletters, a Northstar Alliance membership certificate, program discounts and other Northstar Alliance publications.

Northstar Alliance, Inc.

P.O. Box 555

Arlington, MN 55307

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

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Mille Lacs Band of Ojibwe
Minnesota Institute of Public Health (in-kind)
Prairie Island Indian Community

Silver Supporters: Lake Superior Area Family Services
Lutheran Social Services of MN
Project Turnabout/Vanguard

(This space reserved for you. See page 15)

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Critical Access Dental Provider Program (CADPP)

Funding Cuts

Background:

In 2001 the Minnesota Legislature directed the department of human services to designate "critical access dental providers" serving Medicaid, GAMC and MinnesotaCare recipients. The goal of the program was to stabilize access to care for Minnesota's public program patients. Increased reimbursements to "critical access providers" were made to sustain these providers by assuring that State reimbursements could at least cover their costs of providing dental care.

The department identified dental offices and clinics throughout the state that are essential sources of dental care and have demonstrated the greatest need for additional state support. Critical access providers include private dental offices in key rural areas of the state as well as community clinics and county hospital clinics. This small but extremely vital network includes just over 100 dentists and clinics.

Over the last five years the Critical Access Dental Provider Program has been quite successful, assuring the continued state program participation of "safety net" dental providers serving patients who might otherwise resort to emergency room care.

At Issue:

DHS learned that it had spent more than estimated for the Critical Access Provider Program in 2005, and effective January 1, 2006, it implemented spending reductions. With these reductions, Critical Access Dental Provider reimbursements paid to many providers have been cut by over half.

In 2005, Critical Access Dental Providers reported receiving reimbursements that totaled about 60 percent of typical dental fees. This level of reimbursement allowed them to offset financial losses so they could continue providing dental services to children and adults who have no where else to turn.

With the reductions in 2006, total reimbursements paid to most Critical Access Dental Providers are dropping below 50 percent of typical dental fees, well below the cost of providing treatment. These providers will be unable to provide the same level of service, and many public program patients will be forced to turn to emergency rooms and hospitals driving up total healthcare costs unnecessarily.

Solution:

Assure that the successful critical access provider program continues. **Restore funding to critical access dental providers to 2005 funding levels.**

Critical Access Dental Provider Program (CADPP)

Questions and Answers

1	Why does DHS pay higher reimbursements to certain "critical" providers?	<ul style="list-style-type: none"> • To maintain the dental safety net statewide • To focus limited state funding on critical dentists, rather than providing a small rate increase that would not make a meaningful difference to all dental providers,
2	How much did legislators authorize DHS to pay CADPP providers?	<ul style="list-style-type: none"> • DHS was authorized to spend <i>up to \$1.55 Million per year</i> on critical access dental provider payments. • The Department was authorized to <i>raise rates up to 50% higher than MA Base Rates.</i> • For many providers, a 50% increase covers about 65% of their submitted charges – covering their overhead costs, but still about 35% below typical dental fees.
3	How much dental care did CADPP providers deliver in 2004?	<ul style="list-style-type: none"> • All 113 CADPP providers reported receiving total dental reimbursements of <i>\$40.7 Million for MHCP services.</i> • An estimated <i>125,000 MHCP patients</i> were served and about <i>400,000 dental visits were provided</i> statewide.* • Estimated at average fees, over <i>\$90 Million</i> worth of dental care services were provided.*
4	How much did the State spend on the CADPP in 2005?	<ul style="list-style-type: none"> • The State spent more than <i>\$4 Million in 2005</i> on CADPP reimbursements. • The federal government matched this investment.
5	Why has State CADPP spending increased in recent years?	<ul style="list-style-type: none"> • More individual dentists are employed at larger CADPP clinics than were identified by DHS in 2001. • More dentists in rural areas are enrolled in the program. • The total value of dental care provided by CADPP providers has grown each year.
6	What has been the effect of the CADPP on dental access?	<ul style="list-style-type: none"> • Dental access overall has been stable since 2002, despite widespread provider discontent with the dental co-pays and caps imposed in 2003 and 2004.
7	How will DHS control CADPP Program growth in the future?	<ul style="list-style-type: none"> • DHS has a new process that establishes an annual limit. • Providers are informed each year of their annual limit.
8	Which dental providers are being impacted by the 2006 cuts?	<ul style="list-style-type: none"> • Almost all of the 113 currently designated CADPP providers including private dental practices are impacted. • For example, Children's Dental Services, serving at risk children, and Apple Tree Dental serving adults and seniors with disabilities are receiving combined cuts of over \$440,000.
9	How many MHCP patients could be impacted by the 2006 cuts?	<ul style="list-style-type: none"> • Many CADPP providers will need to scale back services to offset CADPP payments that have been cut in half. • <i>It is estimated that up to 60,000 patients may lose their only source of dental care*</i>
10	How much should State spending be increased to stabilize the CADPP?	<ul style="list-style-type: none"> • DHS estimates that its <i>current annual State spending authority would need to increase by \$3.2 Million</i> to stabilize current CADPP Providers and add other qualified dental care providers.

February 22, 2006



Governor Tim Pawlenty
State Capitol
St Paul, MN 55155

Governor Pawlenty,

When created in 2003, the MinnesotaCare Limited Benefit Program included the services that optometrists provide, but did not allow them to deliver them to their established patients. This unique limitation created barriers to continuity in care which increased costs and delayed important care in addition to disrupting well established care patterns that utilize optometrists as the primary care provider for eye trauma, acute care, and basic eye care delivery.

Since that time our association has worked with the administration, members of the legislature, and health plans to fix problems associated with this program. We have introduced specific legislation, worked with the Department of Human Services, and delivered amendments for inclusion in omnibus bills. Each time we have worked to fix this program in fiscally responsible ways. While DHS has enabled individuals within this program to receive care for acute and chronic eye conditions, these patients continue to be informed that they cannot go to their optometrist for services covered under this program.

Each legislative session since, we have been told that this problem will be fixed. Each legislative session has passed without a fix. The most frustrating aspect for both patients and optometrists is that the money is in the Health Care Access Fund to solve this problem. For the optometrists, writing the check to pay the sick tax and being told they cannot see some of the individuals within the MinnesotaCare program add insult to injury.

It is time to restore the cuts to MinnesotaCare. Using the surplus in the access fund will have no effect on the overall budget. Restoring access to services will have an effect on the health of individuals in this program. Don't wait until the next budget – fix the problem now.

Sincerely,

Lane C. Robeson, OD
President

CC: Senator Linda Berglin
Representative Fran Bradley

MINNESOTA CHAMBER
of Commerce
THE VOICE OF BUSINESSSM

March 23, 2006

Members of the Health and Human Services Budget Division:

On behalf of the 2,500 members of the Minnesota Chamber of Commerce I would like to express opposition to section 9 of S.F. 2725. Although the Chamber appreciates Senator Berglin's efforts to provide small employers with more purchasing options, we think this section will have a negative impact on the private insurance market and does nothing to address the real problem – health care is expensive.

This legislation will erode the private market. According to one health plan, 40% of their new small group business is groups that had not offered coverage for the previous year. If those employers are now purchasing MinnesotaCare, this will have a significant effect on the private market.

By moving more people from employer or individual coverage into MinnesotaCare we will be adding to the cost shift from government programs to the private market. The low MinnesotaCare reimbursement will only raise the cost of commercial insurance and force more and more small employers to look at dropping private coverage and placing their employees in MinnesotaCare.

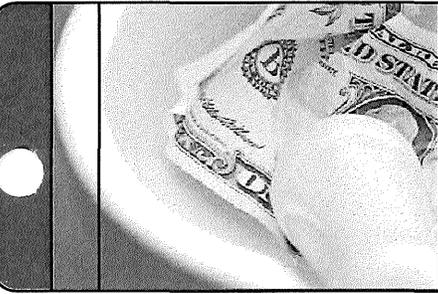
Current law requires guarantee issue to small employers and there are currently products in the private market that individuals can purchase that are equivalent or cheaper than MinnesotaCare. The Chamber would like to see the legislature focus on policies that will make health insurance more affordable in the private market instead of moving more people into a state subsidized program.

Employers want options and affordable health care benefits to offer their employees but we don't believe enrolling small businesses in a state program is a good option.

Sincerely,



Erin Sexton
Director of Health Policy



RESPONDING TO FEDERAL MEDICAID REFORMS: PHARMACY REIMBURSEMENT

>>> ISSUE BRIEF <<<

MEDICAID PHARMACY REIMBURSEMENT

Minnesota has 1,586 pharmacies and roughly 485,400 people on Medicaid. Minnesota loses on average 12-13 pharmacies per year and has a shortage of approximately 400 pharmacists. Pharmacists in rural Minnesota also serve many nursing homes, hospitals and other entities by providing medication reviews for patients and ordering and delivering medications.

- **FEDERAL CHANGES TO MEDICAID PHARMACY REIMBURSEMENT FORMULAS COULD UNINTENTIONALLY CREATE DISINCENTIVES FOR DISPENSING GENERIC DRUGS AND HARM PATIENTS' ACCESS TO MEDICATIONS AND ACCESS TO THE KNOWLEDGE OF A PHARMACIST. THIS IS PARTICULARLY LIKELY IF STATES DO NOT ADJUST REIMBURSEMENT TO ADDRESS STATE SPECIFIC CONDITIONS THAT ALTER THE COST OF DISPENSING.**

Average pharmacy profit margins are in the range of 1.8% - 2.2%. Further reductions in reimbursement will put pharmacists' profit margin below the cost of dispensing in many cases.

- **IN ORDER TO ENSURE THAT THE FEDERAL REFORMS ARE IMPLEMENTED IN A WAY THAT DOES NOT BRING ABOUT THESE UNINTENDED CONSEQUENCES:**
 - A study should be conducted to determine the cost of dispensing a prescription to Medicaid patients in Minnesota.
 - An advisory committee should be formed to review the new drug product reimbursement mechanism created and the cost of dispensing study results to make recommendations to the legislature on how to implement the federal reforms.
 - The cost of dispensing study must take state-specific policies that increase cost into consideration. For example expenses associated with the Minnesota Wholesale Drug Distributor Tax. **NO OTHER STATE HAS THIS TAX.**

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

1 A bill for an act
2 relating to gambling; appropriating money for
3 compulsive gambling prevention and education.
4 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:
5 Section 1. [APPROPRIATION.]
6 \$150,000 in fiscal year 2006 and \$150,000 in fiscal year
7 2007 are appropriated from the lottery prize fund to the
8 commissioner of human services for a grant to the Northstar
9 Problem Gambling Alliance, located in Arlington, Minnesota. The
10 Northstar Problem Gambling Alliance must provide services to
11 increase public awareness of problem gambling, education and
12 training for individuals and organizations providing effective
13 treatment services to problem gamblers and their families, and
14 research relating to problem gambling. Of this appropriation,
15 \$75,000 in each year of the biennium is contingent on the
16 demonstration of nonstate matching funds. Matching funds may be
17 either cash or qualifying in kind. The commissioner of finance
18 may disburse the state portion of the matching funds in
19 increments of \$37,500 upon receipt of a commitment for an equal
20 amount of matching nonstate funds.

1.1 To: Senator Cohen, Chair

1.2 Committee on Finance

1.3 Senator Berglin,

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

1.5 **S.F. No. 930:** A bill for an act relating to gambling; appropriating money for
1.6 compulsive gambling prevention and education.

1.7 Reports the same back with the recommendation that the bill be amended as follows:

1.8 Page 1, line 6, delete "\$150,000 in fiscal year 2006" and insert "\$25,000 in fiscal
1.9 year 2006"

1.10 Page 1, line 15, delete "in each year of the biennium" and insert "in fiscal year 2007"

1.11 Page 1, after line 20, insert:

1.12 "Sec. 2. EFFECTIVE DATE.

1.13 Section 1 is effective the day following final enactment."

1.14 Amend the title accordingly

1.15 And when so amended that the bill be recommended to pass and be referred to
1.16 the full committee.

1.17
1.18

Linda Berglin
.....
(Division Chair)

1.19
1.20

March 23, 2006
(Date of Division action)