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Minnesota Department of Human Services Health Care

Our Mission

The Minnesota Department of Human Services, working with many others, helps people meet their basic needs so they can live in dignity and achieve their highest potential.

Our Values

- We focus on people, not programs.
- We provide ladders up and safety nets for the people we serve.
- We work in partnership with others; we cannot do it alone.
- We are accountable for results, first to the people we serve, and ultimately to all Minnesotans.

We practice these shared values in an ethical environment where integrity, trustworthiness, responsibility, respect, justice, and caring are of importance

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State Children's Health Insurance Program

A Proposal for Demonstration Project Waivers under Title XXI

March 2000

STATE OF MINNESOTA

OFFICE OF GOVERNOR JESSE VENTURA

130 State Capitol • 75 Constitution Avenue • Saint Paul, MN 55155

March 28, 2000

Nancy Ann Min DeParle, Administrator
Health Care Financing Administration
314G Hubert H. Humphrey Building
200 Independence Ave. SW
Washington, D.C. 20201

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Dear Ms. Min DeParle:

When we met in Washington last month, I mentioned to you Minnesota's current difficulty with Title XXI, the State Children's Health Insurance Program (S-CHIP). I appreciate your willingness to help us resolve this issue.

Enclosed is Minnesota's proposal for a demonstration project waiver under Title XXI. As you know, Minnesota has been a national leader in its commitment to provide accessible, affordable coverage for uninsured children, and it is my goal to see that all Minnesota children are insured by the end of my term.

We have 48,000 uninsured children in this state, most of whom are in families with income of less than 200 percent of the federal poverty guidelines. While we recognize that Congress intended for S-CHIP funds to be used for program expansions, such an expansion in Minnesota would do nothing for those 48,000 low-income children. Those children are disadvantaged by our inability to participate in the S-CHIP program.

I am therefore requesting a section 1115 demonstration project waiver that will do the following:

- Provide for enhanced matching funds for enrollment of children in our programs that is over and above the number of children enrolled in October of 1998;

- Revise the current premium schedule in the MinnesotaCare Program so that the program is in compliance with the S-CHIP laws; and

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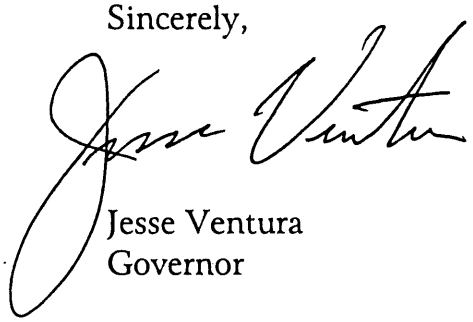
- Allow us to use the remainder of the allotment for special health initiatives.

This proposal will allow Minnesota to focus on getting eligible children insured by targeting resources on reaching children whose families cannot or do not want to enroll in our existing programs.

Minnesota wants to work with our federal partners to make this happen. I urge you to consider this waiver request in a timely manner.

Thank you.

Sincerely,



Jesse Ventura
Governor

cc: Secretary Donna Shalala

Table of Contents

Section 1: Introduction and Executive Summary

Section 2: Minnesota Programs and Other Available Coverage

Section 3: Demonstration Design

Section 4: Organization and Administration of the Demonstration

Section 5: Evaluation

Section 6: Cost Estimates

Section 7: Waivers Requested

Appendices

Appendix 1: Protocol for MinnesotaCare Health Care Reform Waiver - Phase 1, MinnesotaCare Program for Families with Children, Eligibility and Benefits

Appendix 2: Characteristics and Trends Among Minnesota's Uninsured Population

Appendix 3: Health Minnesotans, Public Health Improvement Goals 2004, Executive Summary

Section 1 - Introduction and Executive Summary

BACKGROUND

Congress enacted Title XXI, the State Children's Health Insurance Program (S-CHIP), with the express purpose of "providing states with the resources, flexibility, and tools they need to expand the provision of coverage and services to uninsured low income children."[1] The State of Minnesota has a long history of commitment, through public involvement, market reform, and state-subsidized programs, to reducing the rate of uninsurance in Minnesota, especially among children. President Clinton himself acknowledged that "Minnesota has shown exceptional leadership in implementing policies that ensure low-income children have access to meaningful, affordable health care," and that the MinnesotaCare Program was used as a model in designing S-CHIP.[2]

Through Medicaid Program expansions in the late 1980's and the Children's Health Plan, established in 1987 and renamed the MinnesotaCare Program in 1992, and through the health care reforms that began in the early 1990's, Minnesota has effectively reduced the rate of uninsurance, assisted many families on AFDC and TANF in moving into the work force, and has provided an option for people without reasonable means to obtain health care for their children. From 1990 to 1999, the rate of uninsurance among children under age 18 decreased significantly from 5.3 percent to 3.4 percent. We know that MinnesotaCare has not had a negative impact on the rate of insurance--there has been no measurable "crowd-out" effect despite the high income standards in this program.[3] During the same period, the national rate was rising.

In July 1995, the Health Care Financing Administration (HCFA) greatly enhanced Minnesota's efforts by granting approval of the MinnesotaCare Health Care Reform Waiver, which provided federal Medicaid funds for expenditures on behalf of pregnant women and children enrolled in MinnesotaCare. Due in part to the federal contribution, Minnesota has been able to improve the MinnesotaCare Program by increasing income standards and by expanding the benefit package.

Title XXI was designed to assist states to reduce the rate of uninsurance among lower-income children, but the funding is primarily available for states that provide coverage for children at income levels above their current income standards. Raising the income standard above the existing level--275% of poverty--is not the best solution to addressing the needs of uninsured children in this State. We have 48,000 uninsured children under age 19 in this State,

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[1] *State Children's Health Insurance Program (S-S-CHIP) Implementation Guide*, Chairman Tom Bliley, House Committee on Commerce, November 1997.

[2] Letter of December 6, 1999 from President Clinton to Governor Ventura.

[3] Call, K.T., *et al.*., "Who Is Still Uninsured in Minnesota? Lessons from State Reform Efforts," *Journal of the American Medical Association*, October 8, 1997, Vol. 278, No. 14.

approximately two-thirds of whom are in families with income below 200% of federal poverty. Many of them are eligible but not enrolled in the existing programs. Our focus in Minnesota must be on reaching those remaining low-income uninsured children.

In addition, there are other needs that should be addressed. We know that racial and ethnic minorities in Minnesota have higher rates of uninsurance, in particular Hispanic people. We also know that American Indians experience higher rates of uninsurance. While we have been successful at reducing chronic uninsurance in Minnesota, we know we have been less successful at reducing the number of people who frequently move on and off of insurance.

PROJECT PROPOSAL

We acknowledge that Congress intended S-CHIP funding to be used to expand enrollment for uninsured children. Minnesota intends to maintain its existing efforts in providing health care to children. But at the same time, Congress created allotments to individual states that were intended to address unmet needs of states. These allotments were already weighted downward for states like Minnesota with lower rates of uninsurance. Minnesota should not be expected to expand coverage and address the unmet need without the use of the S-CHIP funds. We therefore propose the following expansions to our programs, that are targeted toward the real unmet need in this State, without requesting the refinancing of MinnesotaCare under S-CHIP, as we did in our first waiver request.

- **Enrollment**. Expenditures related to the number of children enrolled in MinnesotaCare . above baseline enrollment will be matched at the S-CHIP rate, and will count against the S-CHIP allotment. The baseline is defined as the number of children under age 19 enrolled in MinnesotaCare in September, 1998, which is the month in which our S-CHIP state plan became effective.

- **Presumptive Eligibility.** We propose to introduce the use of presumptive eligibility for all children under age 19 who apply for either MA or MinnesotaCare. The expenditures related to the additional eligibility months will be matched at the S-CHIP rate and will count against the allotment. This change requires enactment by the Legislature, and therefore would not be effective until October 1, 2001.

- **Premiums**. We propose to reduce MinnesotaCare premiums so that they do not exceed the Title XXI maxima. That involves eliminating the premiums for children in families with income below 150% of poverty, capping the existing premium schedule at 5% of family income, and eliminating premiums for American Indian people. This change requires enactment by the Legislature, and therefore would not be effective until October 1, 2001.

- **Special Health Initiatives.** We propose to use the remainder of the allotment for special health initiatives designed to improve the health of low-income children that fit within Minnesota's Public Health Improvement Goals 2004 for children and adolescents. We have

identified a number of projects currently underway to improve access to dental care and to improve the identification and treatment of children with mental health needs. We have also identified a number of areas of need that will serve as the basis for development of new special health initiatives, such as reducing exposure to lead poisoning, and reducing the disparity in health outcomes among ethnic and racial minority populations. We will reserve all federal revenue earned from the expansions and initiatives under this demonstration to be used for the improvement of children's health. Also, we will develop a procedure for the development of new initiatives that will involve participation from the public, consumers, advocates, providers, other government agencies, and the Legislature.

EVALUATION

States that are now just starting programs similar to MinnesotaCare will be, within a few years, in the same place that Minnesota is now. Minnesota provides an ideal opportunity to demonstrate and evaluate a variety of approaches to address the health care needs of children who remain uninsured. A number of questions could be answered, such as:

- Are there methods, such as targeted health initiatives and direct provider payments that are more effective than insurance products in reducing the disparity in health outcomes for racial and ethnic minority populations?

- What can we do to create continuity of care for those that do cycle on and off?

- What methods of outreach are more effective than others?

- What are the reasons that people who know about the program do not apply for it, and how can this be addressed?

- Is there a "natural rate" of uninsurance that will be reached, at which point unmet needs have to be met outside of a plan of insurance?

We cannot use Minnesota's $28 million annual allotment to answer these and other questions without HCFA's assistance.

CONCLUSION

MinnesotaCare has contributed greatly to the collective knowledge in this country about the uninsured--most notably, how to reduce the rate of insurance without negative impact on the rate of private insurance, and how to provide a safety net to prevent people from falling into greater dependency. But there is much to learn. Through the help of communities, advocates, health care professionals, consumers, academics, local governments, and the federal government, we can learn and do more. Minnesota's uninsured children should not be disadvantaged because the Title XXI allotment is not available to them.

Section 2 - Minnesota Programs and Other Available Coverage

STATE-SUBSIDIZED HEALTH COVERAGE

Health Care Programs of the Department of Human Services

Minnesota currently provides coverage of health care services for about 500,000 low-income, uninsured individuals, some with special health care needs. This population is served through three programs administered by the Minnesota Department of Human Services: The Medical Assistance, MinnesotaCare and General Assistance Medical Care Programs. Children make up more than half of the enrollment in the Medical Assistance and MinnesotaCare programs.

Minnesotans in Public Health Care Programs, July, 1999 (as of January, 2000)

	Total	Under 21	Under 19
Medical Assistance	364,793	200,819	190,666
MinnesotaCare	110,500	57,623	52,009
General Assistance Medical Care	24,393	724	695
Total	479,686	259,166	243,370

The Minnesota Medical Assistance Program (MA) is the largest of the three programs. It is the "regular" Medicaid program in this state. Expenditures are matched by the federal government at the current rate of 51.48 percent. The program provides comprehensive health coverage for children and families, people with disabilities, and senior citizens. The income standards for children vary from approximately 65 percent to 275 percent of federal poverty, depending on age. There is no asset test for children in MA. There are no premium or other cost-sharing requirements in this program. Services are delivered both through enrolled fee-for-service providers and through managed care organizations. Some populations (disabled, children in out-of-home placements, etc.) are not required to participate in managed care. Although most services are included in the managed care contracts, some services, such as case management, school-based services, and home and community-based waiver services, are carved out an provided on a fee-for-service basis. There are also some counties that do not yet participate in managed care.

The MinnesotaCare Program began as a state-funded program to provide coverage for uninsured people who could not afford insurance in the private market. In 1995, HCFA approved a section 1115 demonstration project waiver, which provided for federal matching funds at the regular federal medical assistance matching percentage for expenditures on behalf of pregnant women and children in the program. At that time, the benefit limits and copayments were eliminated for

children and pregnant women. Pregnant women and children are eligible if their family income does not exceed 275 percent of the federal poverty guidelines. Applicants must have been uninsured for four months, and must not have access to employer-based coverage. Enrollees pay a monthly premium according to a schedule which is $4 per child at the lowest income levels, and rises in steps based on income. A family of five or more can pay up to $423 monthly at the highest income level. There is no asset test for children and pregnant women an children in this program. Services are provided entirely through mandatory enrollment in managed care organizations. For more information on MinnesotaCare, see Appendix 1, the protocol for the Minnesota Health Care Reform Waiver.

The General Assistance Medical Care Program (GAMC) is a state-funded program that covers people who do not have a basis of eligibility in MA. For that reason, there are very few children enrolled in this program.

Health Services of the Department of Health

The Minnesota Department of Health's Division of Family Health administers, coordinates and supports many activities statewide addressing maternal and child health, including the Title V Block Grant funds for maternal and child health. The responsibilities of the Department of Health are carried out in conjunction with its many activities related to the public health. These include the statewide planning and coordination of maternal and child health services through the acquisition and analysis of population-based health data; the provision of technical support and training; the coordination of various public and private maternal and child health efforts; and support for targeted maternal and child health services in communities with significant populations of high risk, low-income families through the grant process.

These program goals are accomplished through both state and local partnerships. The Minnesota Department of Health has interagency agreements with the Department of Human Services to carry out shared responsibilities related to Early and Periodic Screening, Diagnosis and Treatment (EPSDT) requirements, and partnerships with the Minnesota Department of Children, Families and Learning, and local community health boards. In addition, maternal and child health program efforts involve an extensive system of community health agencies, schools, private non-profit and public agencies, volunteer organizations, hospitals and other health professionals.

Current five-year goals of the Title V Block Grant include reducing in the infant mortality rates of two minority populations -- African Americans and American Indians; improving the initiation of prenatal care during the first trimester for these two populations as well as the Asian/Pacific Islander women; and improving the adequacy of prenatal care in these groups. For a more detailed description of child health efforts of the Minnesota Department of Health, refer to the Minnesota State Child Health Insurance Plan (Title XXI State Plan).

OUTREACH AND COORDINATION

Programs of the Department of Human Services. The Minnesota Department of Human Services (DHS) supervises, and counties administer the MA program through agency offices of the 87 counties. County agencies make available basic program information through written material, and respond to inquiries made by phone or in person, and make eligibility determinations for the Minnesota Medical Assistance and General Assistance Medical Care programs.

Metropolitan counties and counties with large geographic areas have multiple office locations. In major metropolitan areas (Minneapolis, St. Paul and Duluth) staff are out-stationed in hospitals and other community-based settings (including public health offices, social service agencies, and medical providers). A single form, the Minnesota Health Care Application, is used for all health care programs, including the MinnesotaCare Program.[1] A toll-free number is available for health care program inquiries. Application forms are made available at various community sites. These sites include provider offices, school districts, elementary schools, community health offices, Women, Infants and Children Program (WIC) sites, and local human services agencies. Applicants have the option of mailing in application forms.

Eligibility determinations in the MinnesotaCare Program are made by Minnesota Department of Human Services staff, and now 36 county offices who chose to accept MinnesotaCare applications. All MinnesotaCare applications are submitted by mail. Wage stubs are used to verify income for wage earners and tax returns are used for the self-employed. A toll-free number is available for MinnesotaCare program inquiries and eligibility questions. Eligibility renewal is required annually and is also conducted by mail. A MinnesotaCare member handbook outlines service coverage and eligibility requirements for participants. MinnesotaCare enrollees with income greater than 200 percent of the federal poverty level also receive materials on the private insurance market at application and at renewal.

Minnesota is in the process of implementing a number of new strategies that will improve outreach and coordination across Minnesota's health care programs. Special attention is being paid to the long-term need of TANF participants for health insurance in order to remain in the work force. Advocates and agency staff are currently being trained to assist families in determining their health care options, and in assessing the option most beneficial to them. Material is currently being developed to educate working families about health care alternatives to publicly-subsidized programs, and how to access these alternatives.

The Department of Human Services provides training to the staff of outreach sites that make the health care application forms available, such as hospitals, health care providers, local community

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[1] However, applicants for cash assistance are not required to complete the separate Health Care Program Application, in order to have eligibility for health care programs determined. All necessary eligibility information is contained in the form used by the cash programs.

organizations and other advocacy groups. The training acquaints them with the application process for Minnesota health care programs and includes assessment of private market health care options.

Recent Improvements in Outreach and Coordination Improvements to Increase Coverage of Low-Income Children.

Since 1998, DHS has awarded a total of $1.2 million per year in grants for health care outreach activities. The goal of the MinnesotaCare Outreach Grant Project is to reduce the number of Minnesotans without health insurance, by funding community organizations to educate people about the importance of having health insurance, and assist residents to enroll in the most appropriate program or private market option.

Outreach contracts were awarded to 24 community-based organizations throughout Minnesota in the current biennium of July 1, 1999 through June 30, 2001. Grantees formed collaborative groups in their counties/regions to total 61 agencies that are providing outreach in 63 Minnesota counties. Outreach agencies include: neighborhood and culturally specific social service programs, county public health and economic assistance agencies, primary care clinics serving uninsured, legal aid, hospitals, volunteer groups and community action programs.

Outreach agencies focus on three primary strategies:

- education about health care, public programs and health insurance;
- one-to-one assistance with health insurance applications, including intense follow up through the application and enrollment process; and
- sustaining enrollment by monitoring premiums and assisting with recertification.

Targeted outreach efforts focus on hard-to-reach clients, including people with limited English proficiency. Outreach information is translated, and offered over broadcast media to reach the largest possible population. Project collateral that has been successfully used by outreach agencies includes: sports cards featuring Minnesota sports figures, coloring books, toothbrushes, and band-aid.

The first 15 months of outreach resulted in the enrollment of 3,500 people into the MinnesotaCare Program. In addition, it is estimated that outreach efforts resulted in an equal number of new enrollees in MA.

Outreach findings indicate that the most likely reasons for not enrolling are paperwork, eligibility criteria and premiums. Other responses show that people do not think they are eligible, cultural barriers exist towards insurance and assistance, and families are affected by unstable and chaotic life situations, and in some cases a belief that health care coverage is not needed.

An outreach and education team at the Department of Human Services provides training and education on health care options to county workers, community agencies and other local organizations that deal directly with people who are uninsured. This team is also involved in cooperative efforts with other state agencies to assure that health coverage information is provided to Minnesotans that have a greater likelihood of being uninsured. The team is currently providing ten training sessions throughout the State for school nurses, to educate them on the uninsured populations, Minnesota Health Care Programs, eligibility criteria for those programs and the application form. They will also be introduced to the outreach grantee organizations that can receive referrals for application assistance.

The application process for Minnesota Health Care Programs has been improved recently by a shortened application form. A four-page form gathers the essential information and is used to determine if additional information is required to make an eligibility determination. The application form was introduced on February 1, 2000 along with a procedure to determine initial eligibility from the information on the application, and provide a 30 day post-eligibility period to submit any necessary verification. The new application, along with other program materials, is being translated into Spanish, Russian, Lao, Hmong, Khmer, Somali and Vietnamese to provide health care program information to Minnesotans with limited English proficiency.

COORDINATION OF PROGRAMS BETWEEN THE DEPARTMENT OF HEALTH AND DEPARTMENT OF HUMAN SERVICES

Because of the importance of health care coverage for the populations they serve, both the Title V and WIC programs are aggressive in their attempts to identify children who are uninsured or underinsured; and to assist families in determining what public/private program best meets their needs, assist the family through the application process, and assist families in obtaining access to services once eligibility has been established. This is accomplished by:

- Requiring Maternal and Child Health grantees to discuss health care coverage with all clients
- Use of an toll-free telephone hotline for children with special health care needs to assist parents in identifying appropriate public or private sources of coverage
- Use of the same application by MinnesotaCare and Minnesota Children with Special Health Care Needs Program.
- Making available at Title V/WIC clinic sites Minnesota Health Care Program applications and a screening tool for pregnant women and children under age two.
- Discussing health care coverage issues with families at the 300 WIC clinics throughout the State.
- Providing information on available public resources to general public through fliers and

brochures.

- Providing formal training for professionals about available public resources via Title V-sponsored workshops or ad hoc meetings.

In addition, grantees of Maternal and Child Health Special Project funds have specific outreach plans for high risk pregnant women, and strategies to assure complete prenatal care including referral for Minnesota Health Care Program eligibility determinations.

CHARACTERISTICS OF MINNESOTA'S UNINSURED

As policymakers search for ways to decrease the number of uninsured people in the State, the Minnesota Department of Health, Health Economics Program points out the following:

- In general, Minnesota's rate of uninsurance has remained stable in the 1990's, while the rate in the U.S. has increased.

- The number of uninsured children has decreased since 1990 and 73.5% of children who are currently uninsured may qualify for MinnesotaCare.

- Populations of color report higher rates of uninsurance and their representation among the uninsured increased significantly from 1990 to 1999.

- The low-income uninsured comprised a smaller proportion of the uninsured in 1999 than in 1990, but they are still at greater risk of being uninsured than higher income individuals.

- Approximately two-thirds of uninsured Minnesotans may already be eligible for some form of coverage, either employer-based health insurance coverage or MinnesotaCare.

For more details about the characteristics of the uninsured in Minnesota, and the changes in the rates of uninsurance and characteristics of the uninsured over the last decade, see Appendix 2, "Characteristics and Trends Among Minnesota's Uninsured Population," by the Minnesota Department of Health, Health Economics Program.

EFFORTS RELATED TO THE CHILDREN'S HEALTH INSURANCE PROGRAM SINCE ENACTMENT

In September 1997, the Department of Human Services initiated dialogue with a committee of 35 stakeholders and other advocates for children to identify barriers to children's access to health care and to explore strategies for addressing those barriers under the S-CHIP legislation. The committee convened several times between September and December of 1997. The committee consists of representatives from advocacy organizations for children, including disability advocacy, communities of racial and ethnic minorities, and legal advocacy; the Minnesota Department of Health; community health providers, medical provider associations and managed

care organizations.

The committee received, in advance of the 1998 legislative session, a copy of the Governor's supplemental budget recommendation to the Legislature on the Children's Health Insurance Program. The Department met with the committee once during the legislative session to discuss the Governor's proposal, the overall strategy on S-CHIP, and alternatives to the Governor's proposal. Since then, the committee convened once to discuss strategies on outreach.

The Minnesota Legislature convened on January 19, 1998, for the second half of its biennial session, and adjourned on April 9, 1998. During the session, bills related to State Children's Health Insurance Programs were introduced in both houses. The supplemental health and human services funding bill was signed by the Governor on April 21, 1998. Minnesota law provides that the Department of Human Services shall request Title XXI funding for:

- The expansion of the MA income standard for children under age two from 275 percent to 280 percent of federal poverty guidelines;

- Expenditures for children enrolled in MinnesotaCare, and other services and administrative activities that may be eligible for enhanced funding; and

- A proposal to subsidize employer-based insurance for children of employees who are ineligible for MinnesotaCare due to the availability of employer-subsidized insurance.

The Title XXI plan to increase the MA income standard for children under age two to 280 percent of federal poverty was submitted to HCFA on April 24, 1998. On May 22, 1998, the State submitted its initial request for section 1115 waivers of Title XXI, seeking access to enhanced matching funds for children enrolled in MinnesotaCare and special health initiatives, administrative expenditures and outreach activities. This proposal was made available for comment and review to various groups and agencies, including the Stakeholders and Advocates Committee for the State Children's Health Insurance Program, the Medical Assistance Citizens Advisory Committee, the Minnesota Department of Health, members of the Minnesota Legislative Commission on Health Care Access Commission, other members of the State Legislature, Minnesota Indian Tribes and local government associations. On July 17, 1998, the State received approval of a State Children's Health Insurance Program plan as a Medicaid expansion; and the State's request for waivers of Title XXI under section 1115 was denied. The waiver request was not considered on its merits. Rather, HCFA determined that section 1115 waivers of title XXI were premature at the time.

The 1998 Minnesota Legislature also directed the Department of Human Services to develop a proposal to subsidize employer-sponsored insurance for the group of low-income children who are locked out of the MinnesotaCare program due to access to health coverage subsidized by an employer. The Department met with insurance industry representatives, employers, consumers and other interested parties in the community during the fall of 1998. In December, 1998 the

Department met with the Legislative Commission on Health Care Access to advise them of program requirements under Title XXI. A number of barriers to using Title XXI funds to purchase private insurance resulted in a decision by the Commission not to recommend submission of a proposal to HCFA. However, bills were introduced in both the House and Senate during the 1999 session proposing to subsidize employer-sponsored health coverage using Title XXI funding. Families would have been required to pay a premium under the MinnesotaCare sliding fee scale. The program would have subsidized the balance of the employer's dependent health coverage and all other cost-sharing items in the employer's plan. Benefits in the employer's plan had to meet a benchmark test. The bills did not pass, in part because of the cumbersome federal requirements governing the S-CHIP programs that subsidize employer-based insurance, and the resulting high administrative costs.

The 2000 Legislature is considering a similar proposal, that may interact with this waiver request, and may generate a discussion about a simplified method of subsidizing employer-based insurance, in order to address unmet need.

Since enactment, DHS staff have had many meetings and conference calls with HCFA leadership and staff. Throughout, HCFA has maintained its willingness to work with Minnesota to find ways to access this funding to meet the needs of Minnesota's children. However, we have not identified any realistic means to that end, outside of a new section 1115 demonstration project waiver.

Section 3 - Demonstration Design

RATIONALE FOR WAIVER

Congress enacted Title XXI, the State Children's Health Insurance Program (S-CHIP), with the express purpose of "providing states with the resources, flexibility, and tools they need to expand the provision of coverage and services to uninsured low income children."[1] The State of Minnesota has a long history of commitment, through public involvement, market reform, and state-subsidized programs, to reducing the rate of uninsurance in Minnesota, especially among children. President Clinton himself acknowledged that "Minnesota has shown exceptional leadership in implementing policies that ensure low-income children have access to meaningful, affordable health care," and that the MinnesotaCare Program was used as a model in designing S-CHIP.[2]

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PROJECT PROPOSAL

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Enrollment in MinnesotaCare. Expenditures related to the number of children enrolled in MinnesotaCare above baseline enrollment will be matched at the S-CHIP rate, and will count against the S-CHIP allotment. The baseline is defined as the number of children under age 19 enrolled in MinnesotaCare in September, 1998, which is the month in which our S-CHIP state plan became effective.

Presumptive Eligibility. We propose to introduce the use of presumptive eligibility for all children under age 19 who apply for either MA or MinnesotaCare. The expenditures related to the additional eligibility months will be matched at the S-CHIP rate and will count against the allotment.

Premiums in MinnesotaCare. We propose to revise the existing premium schedule in MinnesotaCare so that premiums for children do not exceed the Title XXI maxima. This involves eliminating all premiums for children in families with income below 150% of federal poverty, capping the premium at 5% of family income for families with children, and eliminating the premium requirement for American Indian children. Since these changes require enactment by the Minnesota Legislature, these changes would not be effective until October, 2001. Conforming the premium structure to S-CHIP will enable the State to coordinate any future child health assistance expansions with MinnesotaCare. The net cost of this adjustment would be considered a special health initiative. We request matching funds at the S-CHIP rate for the costs related to eliminating the premium below 150% of poverty, and

capping the premium at 5% of family income. We request federal matching funds at 100% of cost for expenditures related to eliminating premiums for American Indian children, since federal government has a trust responsibility for Indian people, and this trust responsibility extends to the provision of health care.

Other Special Health Initiatives.

- Use unspent Title XXI funds to target child health needs through existing state and local projects that meet Public Health Improvement Goals. The State will contribute to, or fund special health initiatives for children and adolescents in the areas of mental health, oral health and childhood lead poisoning.

- Develop new special health initiatives that meet other Public Health Improvement Goals for children and adolescents, including but not limited to, assuring access to quality health services for children in racial and ethnic minority groups, eliminating disparities in health outcomes for children and adolescents in racial and ethnic minority groups; and promoting health for all children and adolescents.

DEMONSTRATION DETAIL

Upon HCFA approval, Minnesota will seek legislative authority for presumptive eligibility and adjustments to the MinnesotaCare premium schedule as special health initiatives. Those two changes would become effective October 1, 2001. We would claim S-CHIP match for enrollment in MinnesotaCare over the baseline, and for existing special health initiatives described in this proposal beginning with expenditures made in October, 1998. Also, upon HCFA approval, we would begin development of new special health initiatives, through a process that involves a steering committee of state agency leadership, and input from consumers, advocates, providers, other stakeholders, and the Minnesota Legislatures. All federal revenue earned under this waiver would be dedicated to meeting new state costs related to special health initiatives, including the enrollment expansions.

Enrollment in MinnesotaCare. Use of S-CHIP funds to pay for increased enrollment fulfills the basic premise of Title XXI to expand health care coverage of children. Expenditures related to the number of children enrolled in MinnesotaCare above baseline enrollment will be matched at the S-CHIP rate, and will count against the S-CHIP allotment. The baseline is defined as the number of children under age 19 enrolled in MinnesotaCare in September, 1998, which is the month in which our S-CHIP state plan became effective.

Federal matching funds will be calculated by multiplying the average cost per child in MinnesotaCare by the number of child enrollees above the baseline each month, beginning with the month of October 1998. Enrollment related to presumptive eligibility will be excluded from this calculation.

This proposal requires waivers of the definition of targeted low-income children and the limitation on funding for alternative expenditures.

Presumptive Eligibility for Children. The Balanced Budget Act of 1997 gave states the option of conducting presumptive eligibility for children applying for Medicaid. It authorized states to approve health care eligibility determined on the basis of preliminary information by Medical Assistance providers, and entities that determine eligibility for other child benefits such as HeadStart and WIC. Health coverage is provided until a final eligibility determination is made if an application is filed within two months.

Presumptive eligibility is a strategy for reaching the low-income uninsured who are eligible but not enrolled in MinesotaCare or MA. We propose to introduce presumptive eligibility under Section 1920A for all children under age 19 in both MA and MinnesotaCare. We would develop a screening tool, and a process whereby eligible entities would be trained, and screened in order to qualify to conduct presumptive determinations. Expenditures related to the additional eligibility months would be matched at the S-CHIP rate, and count against the S-CHIP allotment. Since this change would require legislative enactment, we propose an effective date of October 1, 2001. For purposes of federal matching funds, State expenditures would be actual expenditures for the presumptive eligibility months.

This proposal requires waivers of XXI requirements, to enable the State to claim the enhanced S-CHIP match for children during the presumptive period, to allow S-CHIP matching funds for the additional eligibility months in these two Medicaid programs.

Premiums in MinnesotaCare. We propose to revise the existing premium schedule in MinnesotaCare so that premiums for children do not exceed the Title XXI maxima. This involves eliminating all premiums for children in families with income below 150% of federal poverty, capping the premium at 5% of income for families with children, and eliminating the premium requirement for American Indian children. Since these changes require enactment by the Minnesota Legislature, these changes would not be effective until October, 2001. Conforming the premium structure to S-CHIP will enable the State to coordinate any future child health assistance expansions with MinnesotaCare. The net cost of this adjustment would be considered a special health initiative.

Adjustments to the MinnesotaCare sliding scale premium schedule will result in a loss of premium revenue, and increased costs due to a small increase in enrollment. The additional cost to the State for eliminating the premium for children in families with income below 150% of poverty, and capping the premium at 5% of family income will be considered a special health initiative, will be matched at the S-CHIP rate, and count against the S-CHIP allotment. We request 100% federal matching funds for the cost of eliminating premiums for American Indian children, since the federal government has a trust responsibility for Indian people, and this trust responsibility extends to the provision of health care. Since the loss of revenue, and increased expenditures related to increased enrollment due to premium changes cannot be attributable to

individual enrollees, we propose that, for purposes of calculating the S-CHIP match, we use an agreed upon estimate of state costs.

In the period prior to October, 2001, the MinnesotaCare premium schedule would be maintained through waivers of Title XXI.

Other Special Health Initiatives. We propose to use unspent Title XXI funds to:

- Target child health needs through existing state and local projects that meet Public Health Improvement Goals. The State will contribute to, or fund special health initiatives for children and adolescents in the areas of mental health and oral health.

- Develop new special health initiatives that meet other Public Health Improvement Goals for children and adolescents, including but not limited to, reducing lead poisoning among children, assuring access to quality health services for children in racial and ethnic minority groups, eliminating disparities in health outcomes for children and adolescents in racial and ethnic minority groups; and promoting health for all children and adolescents.

Minnesota proposes to use its unspent Title XXI allotments to fund special health initiatives for children and adolescents in need. These initiatives are selected because they meet one or more of the State's Public Health Improvement Goals 2004 for children and adolescents.

The "Minnesota Public Health Improvement Goals 2004" (Appendix 3) is an initiative of the Minnesota Department of Health to improve health statewide and to demonstrate that prevention and health promotion can hold down health care costs and improve qualify of life.

A statewide planning process was used to develop the 18 Public Health Improvement Goals. Assessments of health problems and identification of priorities were conducted by the States's 49 Community Health Boards and submitted to the leadership committee, the Minnesota Health Improvement Partnership, for development of the goals. Representation on the leadership committee came from 26 statewide organizations. The committee established 18 goals for Public Health improvement, many of which specifically involve health care needs of children. Having been established through a public planning process, these goals offer a valuable framework for establishing and developing special health initiatives for children and adolescents.

There are a number of projects currently being conducted in the State or identified as critical health initiatives which the State would adopt as special health initiatives. These initiatives are in the areas of mental health and dental health. Matching federal funds under Title XXI would allow the State to expand the available funding for these initiatives, and fund the nonfederal share of new special health initiatives. This process would involve ongoing stakeholder participation. Potential initiatives for development include reduction of blood lead poisoning, expansion of mental health services for children and adolescents, and eliminating health coverage disparities for populations of color.

1. **Mental Health Special Health Initiatives**. Minnesota seeks to enhance the State's ability to assure access to, and provide mental health services by targeting particularly vulnerable children and adolescents in three initiatives. They support the Public Health Improvement Goal to promote, protect and improve mental health of children and adolescents.

   A. **Mental Health Screening for Children in the Juvenile Court System**. The Children's Mental Health Division of the Department of Human Services conducts a grant program for the purposes of funding mental health screening, assessment and treatment of children who are in the juvenile court system, or at risk of entering the system. These are a group of children for whom assessments are needed but often missed. The target group includes both children found to be in need of protection or services, and children found to be delinquent. The project seeks to reduce recidivism, improve school performance and maintain family stability by identification and treatment of underlying emotional problems contributing to "at risk" behaviors.

   Qualified mental health professionals perform the assessments. Evaluation data show that approximately 23% of the children screened are referred for treatment services.

   State funding for this project is approximately $1 million per calendar year. This amount funds projects in only 15 of the State's 87 counties.

   Matching the State investment with Title XXI funds would enable the State to expand the available funding and would give other counties the opportunity to develop this effort. The grant requests each year are triple the amount of state funding available. A Request for Proposals would be issued to receive new grant requests.

   B. **Health Care Outreach and Services for Homeless Children and Adolescents**. A second vulnerable population is children and adolescents who are homeless. Surveys show that on a given night as many as 500 young people 17 years or younger are without shelter. During the course of a year, nearly 10,000 youths have at least one episode of homelessness. These groups may experience homelessness with their families, or without them.

   The Children's Mental Health Division of the Department of Human Services awards grants to provide for mental health screening and referral services for homeless children and unaccompanied homeless youth. Service contacts are made in shelter, transitional housing programs and drop-in centers. Currently about 1,000 adolescents are served under eight grant projects funded with $750,000 in state funds. Title XXI funds would enable the State to better serve this group of children and adolescents, either expanding access through additional grantees, or enhancing the capabilities of existing grantees.

   C. **Access to Mental Health Services for Children Without Coverage**. Each year many

family members and social workers seek assistance from county agencies to provide needed mental health services to many hundreds of children and adolescents. And each year counties fund mental health services for which no other payment source exists. These groups are not those who qualify for public health care programs, because those who qualify will be directed to those programs. These are children with serious and emotional disturbances whose needs cannot be met without public assistance. The families of these children may have health insurance that does not cover the needed service, or the family may be uninsured.

Minnesota currently makes available $19 million in grants each year to counties and local children's mental health collaboratives for the provision of community-based mental health services for children with emotional disturbance and their families. Approximately half that amount is used for mental health services not covered by Medical Assistance or MinnesotaCare, and the other half provides mental health services for children without Medical Assistance eligibility or other health coverage.

The services include both outpatient and home-based clinical and rehabilitative services. The continuum of services available is based on the Child and Adolescent Service System Program (CASSP) model advocated by the federal Center for Mental Health Services (CMHS), part of the Substance Abuse and Mental Health Services Administration (SAMHSA).

Services supported by these grant funds include:

- Education and prevention services
- Outreach
- Mental health early identification and intervention services
- Emergency and crisis intervention services
- Outpatient services
- Family community support services
- Day treatment services
- Screening for residential and inpatient care
- Case management services
- Therapeutic supports of children in foster care
- Professional home-based family treatment

These grant funds, along with other county funds, support the provision of these services to persons without third party coverage for the services -- either because they are not insured, or the insurance coverage they carry does not completely cover mental health treatment and rehabilitative services. Where third party coverage does exist, it must be used prior to using these grant funds.

A conservative application of the prevalence estimate methodology published by CMHS

estimates that there are over 71,000 children in Minnesota with a severe emotional disturbance. Of that amount, roughly 45% or 32,289 rely on the public sector for services. Even so, publically funded services reached 19,114 children in CY 1997, a little more than half the estimated public sector need.

With additional funding, Minnesota counties could be more aggressive in outreach activities and provide more intensive level of clinical and supportive mental health services to a larger number of emotionally disturbed children and their families. Proposed service enhancements and special initiatives include:

- Expansion of the availability of day treatment services. These school-based services are very effective in helping SED children in achieving improved functioning and skills appropriate to their developmental level. Unfortunately, within any community, the services are only available in some grade levels or schools.

- Improved availability of culturally competent services. Minnesota is becoming increasingly diverse in its population and this has important implications for the provision of children's mental health services. One's culture forms the basis on one's identity and perception, and both are key to a child's treatment and rehabilitation. Funds here could support efforts for provider development, including recruitment and retention of staff from minority cultures as well as approaches to intervention that are culturally specific.

- Improved crisis services. Because the need for public coverage of mental health services for children is so great, the public service system has difficulty planning for and effectively dealing with crisis situations as they occur. Many communities cite a need for mobile, community-based crisis intervention and stabilization services.

- Expanded early identification and intervention services. Much of the current public resources are devoted to a small portion of high need children and their families. If more effort was placed in tertiary prevention approaches, many of these children could avoid prolonged, intensive treatment later in their lives.

2. **Access to Dental Care**. The lack of oral health services for low-income children and their families is recognized as a public health crisis throughout the country. Minnesota has reported increased difficulty in children obtaining access to dental care. The Surgeon General is expected to recognize access to oral health as a priority health goal within the next few months.[4] Minnesota's Public Health Improvement Goals already do so. The objectives seek to increase the number of children with protective sealants and to increase to 75%, by 2004, the proportion of children with protective sealants on all chewing surfaces. Among a number of strategies designed to increase access to dental services, the State Legislature

[4] State of the State Report, January 2000, The Alpha Center.

appropriated funds to the Minnesota Department of Human Services to assist community dental clinics in maintaining or improving their ability to serve patients.

The Health Care Administration of the Department of Human Services proves grants to help community dental projects defray equipment and start-up costs. Awards were made in August, 1999 to eight grantees from a total of $600,000 in State funds for state fiscal year 2000. Of the people whom the grantees plan to serve through their projects, approximately two-thirds are children. To assure that the funds would improve access for clients, the grant awards were made on the basis of direct increase in ability to serve new patients. Two of the grants funded community clinics for children.

Minnesota seeks Title XXI funds to help expand these efforts. The increase in available funding would help fund a number of the proposals with merit which remain unfunded.

3. **Development of Other Special Health Initiatives.** Minnesota seeks authority to develop other proposals that meet Minnesota Public Health Improvement Goals for Children and Adolescents. Other relevant goals for children and adolescents are as follows:

   1. **Eliminate disparities in health outcomes and the health profile of child and adolescent populations of racial and ethnic minorities**

   - **Promote health for all children and adolescents.**

   - **Assure access to and improve the quality of health services for children and adolescents.**

   Following are potential projects that could be funded as special health initiatives.

   A. **Reduce Blood Lead Poisoning Hazards**. This proposal supports the Public Health Improvement Goal to reduce exposure to environmental health hazards, specifically childhood lead poisoning.

      Lead poisoning has been identified by the U.S. Centers for Disease Control and Prevention (CDC) as the most common pediatric environmental health problem in young children. Its effects are often not identified until long after exposure. Studies have established that lead levels as low as 10 micrograms per deciliter of blood can damage a child's developing nervous system; and that blood lead levels of 70 micrograms per deciliter can cause very serious health consequences that include seizures, coma and death. A pregnant woman's exposure to lead can harm the developing brain and nervous system of the fetus.

      Of homes built before 1978, 75% are estimated to contain some lead-based paint. Paints used before 1950 commonly contained up to 50% lead. Other sources of exposure for

children include soil, drinking water and living with an adult exposed through work or a hobby.

There is currently no state law requiring blood lead screening in children. However, it is required and conducted in Minnesota through the EPSDT Program. Of the children screened in 1996, approximately 10 percent were found with blood levels at or above 10 micrograms per deciliter. Children in Minnesota public health care programs have a funding source for blood lead screening. Uninsured children need to be screened. The goal of a special health initiative for blood lead screening is to detect and control blood lead levels at the early stages.

The Minnesota Department of Health published guidelines for a targeted childhood lead screening for use statewide in Minnesota. The guidelines are based upon the CDC's recommendations to state and local public health authorities. Targeted screening is designed to take into account the various risk factors for lead poisoning, which may vary by geographic region.

(i) **Initiative for Blood Lead Screening**. To assure that all children and pregnant woman who require screening for blood lead levels receive them, a fund is needed to serve those uninsured children from ages 6 months to 72 months and uninsured pregnant women. All screening would be conducted in accordance with the Minnesota Department of Health's guidelines for targeted childhood lead poisoning screening.

(ii) **Initiative for Lead Hazard Reduction**. The effects of childhood lead poisoning cannot be reduced or eliminated without accompanying lead hazard reduction efforts. Local public health programs need funding to engage in the necessary work. This effort would be administered by the Minnesota Department of Health accomplished through a grant program for lead hazardous reduction work in child-occupied facilities (homes, child care facilities, schools, and playgrounds).

B. <u>Preventive Dental Services</u>. The Surgeon General is expected to recognize access to oral health as a priority health goal within the next few months.[5] Minnesota's Public Health Improvement Goals already do so. The objectives seek to increase the number of children with protective sealants and to increase to 75%, by 2004, the proportion of children with protective sealants on all chewing surfaces.

Dental sealants have been found to be highly effective in protecting permanent teeth of young children from decay, and also in preventing the advance of oral health disease in children. It is even recommended in cases of oral disease of primary teeth in very young children. Protective dental sealants are extremely cost-effective. Currently the cost per

[5] State of the State Report, January 2000, The Alpha Center.

child (at the Medicaid rate) for sealants on all four molars is $104. Fluoride treatments at an additional cost of $14 would also be a cost-effective addition to preventive services.

Providing these services on a broader scale at community locations would enable children who are uninsured or not covered for such services to have access to oral health. The State would make grants available to community clinics and other non-profit community organizations, public health entities, professional associations, health care plan or other organizations demonstrating the ability to provide dental services to low-income children uninsured for dental services.

4. **Other Potential Special Health Initiatives.** The Minnesota Health Improvement Goals for children and adolescents would be supported by any of the following proposals:

   - Establish a grant program for tribes and urban Indian health programs to improve health care services and health care access for American Indian children, focusing on services for children not funded by the Indian Health Service.

   - Establish a grant program to increase funding for migrant health care programs that provide direct services to migrant workers and their families.

   - Address the specific needs of Minnesotans with limited English language proficiency through targeted outreach and health care access activities. Fund health care-related recommendations in DHS's Limited English Language Proficiency Plan.

   - Extend funding for the DHS health care access project. Funding for this project ends with the current biennium. In addition, expand the role of the health care access project:

   - Fund DHS health care access efforts at DHS regional sites. Establish links between Minnesota Health Care programs and other public programs such as WIC, HeadStart, and public schools and public school lunch programs.

   - Fund vision care for children who are uninsured or underinsured.

   - Fund school nurse positions needed to assure an on-site nurse at every school with 60% or more student population eligible for the school lunch program.

   - Establish a fund for uninsured children to meet health care needs related to certain diseases, such as those related to diabetes, asthma, iron deficiency anemia.

   - Include uninsured population figures in setting FQHC Medicaid rates; or establish a grant program to cover uncompensated care costs.

   - Use direct payments to provide health services to uninsured children not eligible for

Minnesota Health Care Programs (need to check with MDH for any existing state funds for this purpose).

- Establish a grant program to make transportation available to low-income families in rural areas needing health care services.

- Fund the immunization registry for non-MA eligible children.

Section 4 - Organization and Administration of the Demonstration

ORGANIZATIONAL STRUCTURE

There are two primary state agencies responsible for health care in the State of Minnesota: the Minnesota Department of Health (MDH) and the Minnesota Department of Human Services (DHS). The following is a brief overview of each agency's responsibilities as well as a brief description of key personnel. MDH and DHS will work closely in the development and implementation of special health initiatives established under this demonstration project.

Minnesota Department of Human Services (DHS). DHS is the State Medicaid agency responsible for providing and purchasing all health care services through fee-for-service and managed care models for Medical Assistance, General Assistance Medical Care, and MinnesotaCare enrollees. DHS supervises the counties in conducting eligibility determinations for MA and GAMC, and administers the MinnesotaCare Program directly at the state level. Statewide standards, investigations, enforcement, quality improvement and claims processing are conducted by DHS at the state level for all three programs. The Health Care Administration, within DHS, is responsible for all policy aspects and many operational aspects of these three programs.

Key personnel:

Michael O'Keefe is the Commissioner of Human Services.

Tom Moss is the Deputy Commissioner of Human Services.

Mary Kennedy, Assistant Commissioner of Health Care Administration, is responsible for the publicly-funded health care programs. She also serves as State Medicaid Director.

Ann Berg is the manager of the Federal Relations Unit, which is responsible for various activities related to ensuring that Minnesota draws federal funding in compliance with Title XIX requirements.

James Chase is the Director of Purchasing and Service Delivery, which includes policy development, rates, and purchasing for the Prepaid MA Program (PMAP), Prepaid GAMC (PGAMC), and Prepaid MinnesotaCare.

Vicki Kunerth is the Director of Performance Measurement & Quality Improvement, which includes quality assurance for managed care, performance management, and surveillance and integrity review.

Kathleen Henry is the Director of Health Care for Families with Children. This division is responsible for policy development and implementation related to eligibility for all

MA, GAMC, and MinnesotaCare populations. The division supervises county administration of MA, MinnesotaCare and GAMC eligibility, and administers MinnesotaCare eligibility.

Jane Wilcox Hardwick is responsible for Tribal relations, ongoing management of Minnesota's section 1115 demonstration projects, and development of new waiver initiatives.

Erin Sullivan Sutton is the Acting Assistant Commissioner of Family and Children's Services. She has responsibility for the Children's Mental Health Division.

George Hoffman is the Director of Reports and Forecasts in the Finance and Management Administration. He is responsible for forecasting expenditures for DHS programs.

Minnesota Department of Health (MDH). In the State of Minnesota, MDH is responsible for activities related to public health. It is also responsible for Medicare certification and licensing of nursing facilities, licensing of hospitals, health maintenance organizations, and community integrated service networks, among other health care providers. It develops public health care policy for the State, including disease prevention and control, health promotion, and control of environmental hazards.

Key personnel:

Jan Malcolm is the Commissioner of Health.

Julie Brunner is the Deputy Commissioner of Health.

Gayle Hallin is the Assistant Commissioner of the Family and Community Health Bureau. She directs two divisions: the Division of Community Health Services which includes the Offices of Rural Health and Primary Care, Community Development and Public Health Nursing; and the Division of Family Health, which includes the program for Minnesota Children with Special Health Needs, Maternal and Child Health, and Supplemental Nutrition Programs.

Aggie Leitheiser is the Assistant Commissioner of the Health Protection Bureau. Her duties include directing the Division of Environmental Health.

Scott Leitz supervises the Health Economics Program, which conducts research and applied policy analysis to monitor changes in the health care marketplace; to understand factors influencing health care cost, quality and access; and to provide technical assistance in the development of state health care policy. The information is used to inform policy makers, consumers, and other stake holders in Minnesota.

ADMINISTRATION OF THE DEMONSTRATION

DHS Health Care Administration supervises county administration of eligibility in Minnesota health care programs. DHS Health Care Administration also administers eligibility in MinnesotaCare.

DHS Family and Children's Services, Children's Mental Health Division, administers the programs that provide grants to counties for mental health services for children and adolescents, outreach and screening.

MDH has responsibility for environmental health, which includes responsibility for primary and secondary lead poisoning prevention activities, lowering of blood lead levels, and prevention of further exposure of those affected. MDH would be the administering agency of a special health initiative for blood lead hazard reduction.

WORK PLAN AND TIME LINE

The design of the waiver request is based on the ongoing participation of the Health Care Financing Administration (HCFA), the Minnesota Department of Human Services, the Minnesota Department of Health, the Minnesota Health Policy Commissioners, and major stakeholder groups. Minnesota considers the inclusion of major stakeholders essential in the development of special health initiatives. The work plan, like the waiver itself, is divided into two phases. The components to be immediately implemented are displayed as Phase One and those in Phase Two are identified as components requiring further development and input prior to implementation. The proposed effective date for the demonstration waiver is October 1, 1998.

Phase One. In phase one of the waiver, DHS will implement those projects that do not require legislative enactment. Upon HCFA approval of the waiver, DHS will be permitted to claim S-CHIP matching funds for costs related to increased enrollment over the September 1998 baseline. DHS will seek claims for increased MinnesotaCare enrollment in FFYs 99, 00 and 01 without changes to the MinnesotaCare premium structure.

Also in this phase, DHS will convert four special health initiatives currently in place to S-CHIP special health initiatives. These are the three mental health projects for children and adolescents: mental health screening in the juvenile court system; health care outreach and services for homeless children and adolescents; and mental health services for children without coverage. They would be converted to S-CHIP special health initiatives effective October 1, 1998. The fourth existing project involving infrastructure grants to improve access to dental services would also be converted to an S-CHIP special health initiative effective October 1, 1999.

Phase Two. This phase of the waiver demonstration requires legislative approval during the 2001 session for implementation of presumptive eligibility for Medicaid children, and

adjustments to the MinnesotaCare premium schedule to conform to Title XXI requirements. The earliest start date for both of these projects will be October 1, 2001, or later depending upon the time needed for systems work.

The second major part of phase two is the development of other special health initiatives that meet the Public Health Improvement Goals. Federal revenue generated by phase one projects will create a fund from which to expand existing initiatives and implement new ones. DHS establish a steering committee that will establish new projects, authorize expenditures, and accept input from state and local agencies, advocates, providers, consumers, the public.

Administration of new special health initiatives is expected to be conducted as a grant process, utilizing request for proposals and a committee selection process.

Time Line

Date	**Task**
9/99	Baseline enrollment for claiming increased enrollment in MinnesotaCare, staring with FFY 2000.
10/1/99	Start date for claims under S-CHIP of existing DHS grant projects: • DHS mental health screening for children in juvenile court; • outreach services for homeless adolescents • mental health services for children and adolescents • for dental infrastructure grants
4/00 to 7/00	Negotiate terms and conditions of waiver
7/00 to 11/00	Implement accounting and systems changes necessary to claim and report enhanced S-CHIP match on increased enrollment in MinnesotaCare; and on existing DHS grant projects.
7/00	DHS begins preparations for 2001 legislative session to propose adoption of presumptive eligibility, and adjustments to MinnesotaCare premium schedule. Includes drafting legislation and preparing budgets.
7/00	Begin process for public participation in developing other special health initiatives: establish steering committee to develop and authorize special health initiatives.
1/01	Submit legislative proposals to Minnesota Legislature, including adjustments to premium schedule, presumptive eligibility, and special health initiatives.

10/01	Implement MinnesotaCare premium adjustment. Implement presumptive eligibility in MA and MinnesotaCare
10/01	Implement new special health initiatives

Section 5 - Evaluation

Evaluation Objectives

The objective of this evaluation will be to identify characteristics of those remaining low-income uninsured children in the State, and strategies that are effective in identifying them, enrolling them in health care programs or private insurance, and in maintaining health care that meets their needs. The State recommends that the evaluation of this project be coordinated with the evaluation currently underway for the original Minnesota Health Care Reform Waiver.

Potential Research Issues

Minnesota already has a good body of knowledge about the uninsured in the State. Continued monitoring of the uninsured population and changes is needed. Potential questions for study under the demonstration are many and varied. We have the following suggestions:

- Is presumptive eligibility effective in reaching low-income, uninsured children who would not have otherwise enrolled in MA or MinnesotaCare?

- Why have the number of uninsured persons of color increased greater than their proportion of the population in the State, despite beneficial effects of health insurance reform, MinnesotaCare and a good economy?

- What eligibility requirements most interfere with continuous enrollment? What family circumstances? Does removing the $4 per child premium for families with income below 150% of poverty better enable families to remain enrolled?

- Special health initiatives will provide an opportunity to assure that health services reach all uninsured children. Minnesota has structured its initiatives around public health improvement goals, and therefore the State will assess the impact of the special health initiatives on meeting these goals.

- Are grants for mental health services that are targeted towards children especially at risk a more effective way of helping children in families that may be eligible but are not enrolled in MA or MinnesotaCare?

- Does the improvement of dental infrastructure improve overall access to dental services for children?

- Does direct payment of preventive dental services for children improve overall oral health for children?

- To what extent can the State eliminate lead hazards for children?

Finally, there are potential issues for study related to the effects of targeted outreach efforts on the identification and enrollment of uninsured children eligible for Minnesota Health Care Programs, and the ability to maintain continuous coverage. The following are questions which might be assessed.

- What circumstances affect uninsured status, and do they vary by subgroups?
- Do problems relate to initial enrollment or continuing enrollment?
- What are effective methods of outreach for groups which have proportionately higher rates of uninsurance?
- What techniques yield real enrollment (the model of peer-delivered message and assistance, locations, home visits etc.).
- What effect does the amount of the premium have on continuous coverage?
- Is there a natural rate of uninsurance that will be reached, at which point government subsidies have limited effect?
- What methods of preventing "crowd-out" are successful? Which methods serve as barriers to enrollment but do little to actually prevent "crowd-out"?

Section 6 - Cost Estimates

MinnesotaCare as a State Children's Health Insurance Program

Estimated / Projected Net Costs for
Children Under Age 19
For Enrollment in Excess of September 1998 Baseline

FAMILIES WITH CHILDREN	FY 1999	FY 2000	FY 2001	FY 2002	FY 2003
Number of eligibles under age 19:					
September 1998	50,808	50,808	50,808	50,808	50,808
Estimated / Projected					
Average by FY	51,705	53,101	57,334	59,461	60,530
Increment over 9/98	897	2,293	6,526	8,653	9,722
Avg. mo. cost per eligible	77.66	93.79	105.48	113.35	121.85
Avg. monthly premium	20.47	20.88	21.92	23.02	24.17
Total payments	835,588	2,580,307	8,260,739	11,769,265	14,215,435
Total revenue	220,237	574,395	1,716,938	2,390,137	2,819,856
Net cost	**615,350**	**2,005,912**	**6,543,800**	**9,379,127**	**11,395,579**
Federal share @ CHIP	**406,439**	**1,324,704**	**4,308,438**	**6,169,590**	**7,496,012**
State share	**208,911**	**681,208**	**2,235,362**	**3,209,537**	**3,899,567**

MinnesotaCare
Adjust Premiums in MinnesotaCare

FAMILIES WITH CHILDREN	FFY 2002	FFY 2003
Revenue Loss Component:		
Number of eligibles	101,448	103,278
Avg. monthly revenue–Current	$23.70	$24.88
Avg. monthly revenue–Proposed	$19.12	$20.07
Total revenue–Current	28,846,394	30,835,325
Total revenue–Proposed	23,273,271	24,877,940
Net cost	5,573,123	5,957,385
Enrollment Expansion Component:		
Expanded Number of eligibles	536	1,072
Avg. monthly payment	$151.13	$162.46
Avg. monthly revenue	$60.95	$64.00
Total payments	972,103	2,089,963
Total revenue	392,073	823,353
Net cost	580,031	1,266,610
Loss of Premium Revenue from American Indian Children		
Affected enrollees	503	512
Avg. monthly revenue	$16.41	$17.23
Total revenue	($99,066)	($105,896)
Total cost-impact of Revenue Loss and Enrollment Increase & American Indian Premium Reduction	$6,252,220	7,329,891
Federal Share @S-CHIP rate	4,112,710	4,821,602
State Share	2,139,510	2,508,289

Presumptive Eligibility for Children

{To be determined}

Special Health Initiatives to Improve Public Health

Budgets for Existing Mental Health Grant Programs

S-CHIP Enhanced Match for Existing Grant Programs	**FFY 1999 @66.05%**	**FFY 2000 @ 66.04%**	**FFY 2001 @ 65.78%**
Mental Health Screening for Children in Juvenile Court			
Annual spending	$ 1,010,000	$ 1,047,800	$ 1,071,200
Annual S-CHIP match	667,105	691,967	704,635
Health Care Outreach and Services for Homeless Children and Adolescents			
Annual spending	$ 732,000	$ 759,665	$ 776,620
Annual S-CHIP match	483,486	501,676	510,861
Access to Mental Health Services for Children without Coverage			
Annual spending	$ 15,316,607	$ 18,338,329	$ 19,365,791
Annual S-CHIP match	10,116,619	12,110,632	12,738,817
Access to Dental Care			
Annual spending		$ 400,000	
Annual S-CHIP match		264,160	

Demonstration Project Totals:

Initiative	FFY 99	FFY 00	FFY 01	FFY 02	FFY 03
Increased enrollment in MinnesotaCare					
Total Cost	615,350	2,005,912	6,543,800	9,379,127	11,395,579
State	208,911	681,208	2,235,362	3,209,537	3,899,567
Federal	406,439	1,324,704	4,308,438	6,169,590	7,496,012
Premium adjustment in MinnesotaCare					
Total Cost				6,252,220	7,329,891
State				2,139,510	2,508,289
Federal				4,112,710	4,821,602
Presumptive Elgibility in MA and MinnesotaCare					
Total Cost	(To be determined)				
State					
Federal					
Special Health Initiatives					
MH Screening					
Total	1,010,000	1,047,800	1,071,200		
Federal match	667,105	691,967	704,635		
Homeless Children					
Total	732,000	759,665	776,620		
Federal Match	483,486	501,676	510,861		
Access to MH					
Total	15,316,607	18,338,329	19,360,791		
Federal Match	10,116,619	12,110,632	12,738,817		

	FFY 99	FFY 00	FFY 01	FFY 02	FFY 03
Access to Dental					
Total		400,000			
Federal Match		264,160			
Grand Totals:					
State	**17,267,518**	**21,227,002**	**23,448,973**	**5,349,047**	**6,407,856**
Federal	**11,673,649**	**14,893,139**	**18,262,751**	**10,282,300**	**12,317,614**

Section 7 - Waivers Requested

Targeted Low-income Child; section 2110(d). This section defines the group of children available for child health assistance under Title XXI. A "targeted low-income child" is one whose family income is at or below 200 percent of the federal poverty level, or within 50 percentage points above the Medicaid applicable income levels. Minnesota requests a waiver of the definition of targeted low-income child, to allow the State to claim S-CHIP funds for expenditures attributable to the number of enrollees above the baseline, presumptive eligibility, and changes in the MinnesotaCare premium schedule.

Ten percent limit on special initiatives, direct payments and outreach; section 2105(a)(2) and (c)(2)(A). Section 2105(a)(2) provides federal matching funds at the enhanced rate under Title XXI for the State's expenditures on costs other than child health assistance, and section 2105(c)(2)(A) limits the reimbursement of non-program expenditures to 10 percent of program expenditures under Title XXI. Minnesota seeks a waiver of that requirement in section 2105(c)(2)(A) so that up to 100 percent of the allotment can be used in alternative ways to fund enrollment expansion in Medicaid with presumptive eligibility, premium adjustments in MinnesotaCare and increased enrollment in MinnesotaCare, and to improve the health of targeted low-income children and other low-income children with special health services initiatives, direct provider payments and targeted outreach efforts.

Maximum premiums for families with income below 150 percent of federal poverty; section 2103(e)(3)(A). This section prohibits a State from charging families with income below 150 percent of poverty an enrollment fee or premium that exceeds the limits allowed under Title XIX. The Medicaid maximum allowable charges start with $1 for all family sizes with monthly income of $150 or less, and increase incrementally to monthly maximums of $19 for one or two people, $16 for three or four people, and $15 for five or more people with family gross income greater than $1,000 per month (42 CFR §447.52). The MinnesotaCare Program requires a minimum premium of $4 per month per child in families with income at or below 150% of the federal poverty level; and otherwise sets premiums of 1.5 percent of gross income at income levels at or below the medically needy income level of 133 and 1/3 percent of AFDC; and above that level, premiums increase (in evenly spaced steps at 1.8, 2.3, 3.1, 3.8, 4.8, 5.9, 7.4 and 8.8 percent of gross family income) by family size up to gross income of 275 percent of poverty level income. A waiver is needed temporarily until the Legislature revises the premium schedule to conform to Title XXI.

Limit on aggregate cost-sharing; section 2103(e)(3)(B). For all families with income at or above 150 percent of the federal poverty level, this section limits the family's aggregate obligation on cost-sharing (premiums, copayments, deductibles) to 5 percent of gross income. MinnesotaCare does not require copayments or deductibles for children, but the premiums in the MinnesotaCare sliding fee premium schedule exceed this cap when family income reaches approximately 200 percent of the federal poverty level. A waiver of this provision is also needed on a temporary basis pending the receipt of legislative approval for MinnesotaCare premium

schedule adjustments to conform with the 5% annual aggregate limit on cost-sharing.

Requirement to Remove Cost-sharing for all American Indian Children; section 2102(b)(3)(D) and Letter of October 6, 1999 from HCFA to State Health Officials. A waiver is needed temporarily until the Legislature revises the premium structure. This section of Title XXI requires a state to include a description in an S-CHIP plan of procedures to insure that American Indian and Alaska Native (AI/AN) children receive child health assistance. In the October 6, 1999 letter, HCFA issued a policy directive to states requiring that no cost-sharing be imposed on American Indian and Alaska Native children. A waiver of this policy is needed on a temporary basis pending the receipt of legislative approval for removal of all premium obligations for AI/AN children in MinnesotaCare.

Payment for Presumptive Eligibility under Title XIX; sections 1920A(a) and (d), and 2105. These subsections authorize a state to make health care items and services under a Medicaid State Plan available to children during a presumptive eligibility period, and to consider the services as medical assistance. A waiver of this provision is needed, in conjunction with the waiver of §2105(a) and (c), to allow the State to make Medicaid services available to children in a presumptive period in either MA or MinnesotaCare and to claim the S-CHIP enhanced matching rate for all expenditures in both programs during the presumptive period.

Other waivers. We request waivers of all provisions of federal law and regulation that are determined to be necessary to conduct the enrollment expansions and special health initiatives described in this document.

Protocol for MinnesotaCare Health Care Reform Waiver - Phase 1
MinnesotaCare Program for Families with Children: Eligibility and Benefits

Introduction Framework

The MinnesotaCare Program for Families with Children covers parents and their children in families with income up to 275 percent of the federal poverty guidelines (FPG). Effective July 1, 1995, expenditures for pregnant women and children under the age of 21 enrolled in MinnesotaCare became eligible for federal financial participation as a part of Minnesota's expanded Medicaid Program. Effective February 27, 1999, expenditures for parents and caretaker adults enrolled in MinnesotaCare became eligible for federal financial participation.

Section 1 Definitions

1.1 Applicant. "Applicant" means a person who submits a written application to the Department of Human Services (DHS) for a determination of eligibility for MinnesotaCare.

1.2 Child. "Child" means a person who is less than 21 years of age.

1.3 Dependent sibling. "Dependent sibling" means an unmarried child who is a full-time student under the age of 25 years who is financially dependent upon a parent. Proof of school enrollment is required.

1.4 Employer-subsidized health coverage. "Employer-subsidized health coverage" means health coverage for which the employer pays at least fifty percent of the cost of coverage for the employee. "Employer-subsidized health coverage" includes employer contributions to Internal Revenue Code, section 125 plans. "Employer-subsidized health coverage" excludes dependent coverage unless the employer offers dependent coverage to employees and pays at least fifty percent of the cost of dependent coverage. Employer-subsidized health coverage for children includes coverage through either parent, including a non-custodial parent.

1.5 Enrollee. "Enrollee" means an individual who: 1) has been determined eligible by the Department of Human Services (DHS) to receive covered health services under MinnesotaCare; and 2) has paid the required premium under section 4.

1.6 Family. "Family" means a parent or parents and their children; or guardians and their wards who are children; grandparents, foster parents and relative caretakers[1]; and dependent siblings

[1] Minnesota Laws 1998, chapter 407, article 5, section 7, subdivision 3a, effective January 1, 1999. "Relative caretaker" is defined as in the medical assistance program, 45 CFR §233.90(c)(1)(v).

residing in the same household; and includes children and dependent siblings temporarily absent from the household in settings such as schools, camps, or visitation with noncustodial parents. "Family" also means an emancipated minor and an emancipated minor's spouse.

1.7 Federal poverty guideline. "Federal poverty guideline" means the poverty guidelines for all states that are updated annually by the U.S. Department of Health and Human Services, as applicable to the family size involved. These guidelines are effective the April 1 following publication in the *Federal Register*.

1.8 Other health coverage. "Other health coverage" means any of items A to H:

A. Basic hospital coverage.

B. Medical-surgical or major medical coverage.

C. Medicare Part A and/or Part B coverage under title XVIII of the Social Security Act.

D. Supplemental Medicare coverage under Minnesota Statutes, sections 62A.31 to 62A.44.

E. Coverage through a health maintenance organization under Minnesota Statutes, chapter 62D.

F. Coverage through a health maintenance organization under Minnesota Statutes, chapter 62D, combined with Medicare benefits under title XVIII of the Social Security Act.

G. Coverage through the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) under United States Code, title 10, chapter 55, sections 1079 and 1086.

H. Coverage through a community integrated service network or integrated service network under Minnesota Statutes, section 62N.

"Other health coverage" does not include items A to E:

A. Medical Assistance.

B. General Assistance Medical Care.

C. MinnesotaCare Health Plan.

D. Coverage under a regional demonstration project for the uninsured funded under Minnesota Statutes, section 256B.73.

E. Coverage under the Hennepin County Assured Care Program.

1.9 Parent. "Parent" means the natural, step, or adoptive mother or father of a child.

Section 2 Eligibility for MinnesotaCare

2.1 General eligibility requirements. Except as provided in sections 2.2, 2.4 and 2.8, an applicant or enrollee must meet the MinnesotaCare eligibility requirements in items A to J:

A. Be a resident of Minnesota in accordance with 42 CFR 435.403 for the groups identified in section 2.12 and for 180 days for others.

B. Not currently covered by General Assistance Medical Care.

C. Not currently have other health coverage nor have had other health coverage during the four months immediately preceding the date coverage begins.

D. Not have current access to employer-subsidized health coverage and employer-subsidized health coverage is not lost due to

1. the employer terminating coverage[2] during the 18 months immediately preceding the date coverage begins, or

2. the employee failing to take up coverage offered by the employer during an open enrollment period within the preceding 18 months.

E. Identify potentially liable third-party payers and assist DHS in obtaining third party payments.

F. Have gross annual family income that does not exceed 275 percent of the federal poverty guideline.

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[2] Minnesota Laws 1998, chapter 407, article 5, section 33, subdivision 2, effective January 1, 1999.

G. Not have assets that exceed the requirements in section 2.5.[3]

H. Comply with the family enrollment requirements in section 2.6.

I. Cooperate with the child and medical support requirements of the state Medicaid plan.

J. Not be a resident of a correctional or detention facility. [4]

2.12 Federal Medicaid funding. Federal Medicaid funding is available for groups identified in items A to C.

A. Pregnant women.

B. Children (as defined in section 1.2 and including emancipated minors).

C. Parents (as defined in section 1.10) and adult caretakers (as defined in 45CFR §233.90 (c)(1)(v)) with a child residing in the same household (including children temporarily absent from the household in settings such as schools, camp, or visitation with noncustodial parents.)

2.2 Exceptions to general eligibility requirements.

A. Section 2.1, items C and D, do not apply to an applicant who is terminated from Medical Assistance, General Assistance Medical Care, or coverage under a regional demonstration project for the uninsured funded under Minnesota Statutes, section 256.73, the Hennepin County Assured Care Program if DHS receives a MinnesotaCare application before the last day of the month following the month in which termination occurred.

2.3 Gross annual family income. "Gross annual family income" means the total income of all family members determined in accordance with items A to E:

A. The income of self-employed persons is calculated in accordance with subitems (1) and

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[3] Minnesota Laws 1997, chapter 225, articel 1, section 17, effective upon federal approval.

[4] Minnesota Laws 1998, chapter 407, article 5, section 24, subdivision 12, effective January 1, 1999.

(2).

(1) The adjusted gross income from the applicant or enrollee's federal income tax form for the previous year is summed with the depreciation, carryover loss, and net operating loss amounts from the same tax form that apply to the business in which the family is currently engaged.

(2) If the applicant or enrollee reports that income has changed since the period of their last tax return, a percentage change is calculated by comparing this year's quarterly report with last year's quarterly report; or if the applicant or enrollee does not file quarterly reports, the applicant or enrollee shall estimate the percentage increase or decrease in income. The percentage increase or decrease is applied to the amount calculated in subitem (1).

B. Earned income is calculated in accordance with subitems (1) and (2).

(1) The income of wage earners, including all wages, salaries, commissions, and other benefits received as monetary compensation from employers before any deduction, disregard, or exclusion, is calculated by determining:

(a) income from the tax return from the preceding year, adjusted for changes, and projecting for the next 12-month period; or

(b) if the wage earner is employed on a seasonal basis or receives income too infrequently or irregularly to be calculated under subitem (1), total income for the past twelve months.

(c). The earned income of full-time and part-time students under age 19 is not counted as income.[5]

(d). Effective July 1, 1999 federal or state tax rebates are not counted as income or assets.

(2) When an applicant or enrollee reports that earned income has decreased from the amount calculated in subitem (1), the current amount is projected forward for 12 months.

C. Unearned income is calculated in accordance with subitems (1) and (2).

(1) The following unearned income received in the preceding tax year, with any reported changes, is projected to reflect a 12-month period:

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[5] Minnesota Laws 1998, chapter 407, article 5, section 7, subdivision 5, effective January 1, 1999.

(a) supplemental security income under title XVI of the Social Security Act;
(b) social security benefits;
(c) veterans' administration benefits;
(d) railroad retirement benefits;
(e) unemployment benefits;
(f) workers' compensation benefits;
(g) child support;
(h) spousal maintenance or support payments; and
(i) income from any other source, including interest, dividends, and rent.

(2) When an applicant or enrollee reports that unearned income has changed from the amount calculated in subitem (1), the current amount is projected forward for 12 months.

(3) Lump sums are only counted as income only for people who are self-employed if claimed as income on the tax return.

D. Noncitizen applicants and enrollees whose sponsor signed an affidavit of support as defined under United States Code, title 8, section 1183a shall be deemed to include their sponsor's income as defined in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, title IV, Public Law Number 104-193 in "gross family income." [6]

E. If the grandparent, relative caretaker, foster parent or legal guardian applies separately for the children, only the children's income is counted. If the grandparent, relative caretaker, foster parent or legal guardian applies with the children their income is counted in determining gross family income. [7]

2.4 Children in families with income at or below 150 percent of the federal poverty guideline. A child who has been continuously enrolled in the Children's Health Plan (and subsequently in MinnesotaCare) or a child in a family with gross annual family income at or below 150 percent of the federal poverty guideline is eligible for MinnesotaCare to the last day of the month in which the child becomes 21 years old if the child:

A. meets the requirements under section 2.1, items A, E, F, and G; and

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[6] Minnesota Statutes §256L.04, subdivision 10, 1997 Supplement, effective July 1, 1997.

[7] Minnesota Laws 1998, chapter 407, article 5, section 25, subdivision 13, effective January 1, 1999.

B. is not otherwise insured for the covered health services. A child is not otherwise insured for covered health services when subitems (1) or (2) or (3) apply:

(1) the child lacks coverage in two or more of the areas listed in subitems (a) to (e):

(a) basic hospital coverage;
(b) medical-surgical coverage;
(c) major medical coverage;
(d) dental coverage;
(e) vision coverage; or

(2) coverage requires a deductible of $100 or more per person per year; or

(3) a child with a particular diagnosis lacks coverage because the child has exceeded the maximum coverage for that diagnosis or the policy of coverage excludes that diagnosis.

2.5 Assets. "Assets" means cash and other personal property, as well as any real property, that a family owns which has monetary value. "Net asset" means the asset's fair market value minus any encumbrances including but not limited to, liens and mortgages.

Adult applicants and enrollees who are not pregnant must meet the following asset limits:

A. A household of two or more persons must not own more than $30,000 in total "net assets".

B. The following assets are excluded from total "net assets":

(1) a homestead;
(2) household goods and personal effects;
(3) any assets owned by children;
(4) vehicles used for employment;
(5) court-ordered settlements up to $10,000;
(6) individual retirement accounts; and
(7) up to $200,000 in capital and operating assets of a trade or business.

If an excluded asset has a negative value, the negative value shall be subtracted from the total net assets.[8]

Homestead. "Homestead" means the home that is owned by, and is the usual residence of, the

[8] Minnesota Statutes §256L.17, 1997 Supplement and Minnesota Laws 1998, chapter 407, article 5, section 40, subdivision 6, effective upon federal approval.

family, together with the surrounding property which is not separated from the home by intervening property owned by others. Public rights-of-way, such as roads that run through the surrounding property and separate it from the home, will not affect the exemption of the property. "Usual residence" includes the home from which the family is temporarily absent due to illness, employment or education or because the home is temporarily not habitable due to casualty or natural disaster.

Adult noncitizen applicants and enrollees, who are not pregnant, whose sponsor signed an affidavit of support must count their sponsor's assets when determining eligibility.

2.6 Family enrollment.

A. Parents who enroll in MinnesotaCare must enroll any eligible children and dependent siblings in MinnesotaCare or Medical Assistance.

B. Unless other insurance is available, children and dependent siblings may be enrolled in MinnesotaCare even if their parents do not enroll.

C. If one parent in a household enrolls in MinnesotaCare, both parents in the household must enroll in MinnesotaCare or Medical Assistance unless other insurance is available.

D. If one child in a family is enrolled in MinnesotaCare, all children in the family must be enrolled in MinnesotaCare or Medical Assistance unless other insurance is available.

E. If one spouse in a household is enrolled in MinnesotaCare, the other spouse in the household must enroll in MinnesotaCare or Medical Assistance unless other insurance is available.

F. Except as provided in item B, families cannot enroll only certain uninsured members in MinnesotaCare.

G. In families that include a grandparent, relative caretaker, foster parent or legal guardian, the grandparent, relative caretaker, foster parent or legal guardian may apply as a family or may apply separately for the children.[9]

2.7 Annual redetermination required.

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[9] Minnesota Laws 1998, chapter 407, article 5, section 25, subdivision 13, effective January 1, 1999.

A. DHS shall redetermine MinnesotaCare eligibility annually for each enrollee. The 12-month period begins in the month after the month the application is approved.[10]

B. Enrollees must provide annually the information needed to redetermine eligibility before the anniversary date of initial eligibility.

2.8 Reporting Changes. Enrollees must report to DHS any changes in income.

2.9 Continuous eligibility. An enrollee remains eligible for MinnesotaCare regardless of the age or the presence or absence of children in the household as long as the enrollee:

(1) maintains residency in Minnesota;

(2) has annual income that is equal to or less than 275 percent of the federal poverty guideline or 10 percent of their annual income is less than the annual premium for a policy with a $500 deductible through the Minnesota comprehensive health association (MCHA). Families whose income exceeds these requirements must be given an 18-month notice period prior to disenrollment;[11]

(3) meets all other eligibility criteria; and

(4) is continuously enrolled in MinnesotaCare or Medical Assistance. To be continuously enrolled, an enrollee's re-application must be received by DHS before the last day of the first calendar month following the date of notice of termination of coverage from MinnesotaCare or Medical Assistance.

Section 3 Application; Enrollment; Coverage Dates

3.1 Application sources. Applicants may apply directly to DHS or through appropriate referral sources.

A. Appropriate referral sources include but are not limited to: eligible provider offices; local social service agencies; school district offices; public and private elementary schools in which

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[10] Minnesota Laws 1998, chapter 407, article 5, section 31, subdivision 3a, effective January 1, 1999.

[11] Minnesota Laws 1998, chapter 407, article 5, section 33, subdivision 1b, effective January 1, 1999. Families who no longer have a child under age 21 residing in the household must have income that is equal to or less than 175 percent of the federal poverty guideline and are not eligible for federal financial participation.

25 percent or more of the students receive free or reduced price lunches; community health offices; WIC program sites.

B. Referral sources that accept applications from applicants must send applications to DHS within five working days after receipt.

C. A family member who is age 18 or over or an authorized representative may apply on an applicant's behalf. [12]

3.2 Necessary information for eligibility determination. Applicants must provide all information necessary to determine eligibility for MinnesotaCare and potential eligibility for Medical Assistance, including subitems (1) to (6).

(1) Social security number.
(2) Household composition.
(3) Availability of other health coverage, including access to employer-subsidized health coverage.
(4) Gross annual family income.
(5) Documentation of immigration status for applicants and enrollees who are not United States citizens.[13]
(6) Any additional information needed by DHS to determine or verify eligibility.

3.3 Eligibility determination deadline. DHS shall determine an applicant's eligibility within 30 days after a complete application is received by DHS. Applicants who, from the information provided on the application, appear to meet all eligibility requirements shall be enrolled. The enrollee must provide all required verifications within 30 days of enrollment or coverage shall be terminated. Enrollees who are determined to be ineligible when verifications are provided shall be disenrolled from the program. [14]

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[12] Minnesota Laws, chapter 407, article 5, section 26, subdivision 1a, effective January 1, 1999. "Authorized representative" is defined according to 42 CFR §435.908.

[13] Minnesota Laws 1998, chapter 407, section 23, subdivision 10, effective January 1, 1999.

[14] Minnesota Laws 1998, chapter 407, article 5, section 31, subdivision 4, effective January 1, 1999.

3.4 Enrollment and beginning of coverage.

A. An applicant is enrolled in MinnesotaCare on the date the following are completed:

(1) A complete application is received by DHS and the applicant is determined eligible under Section 2.

(2) The initial premium payment under Section 4 is received by DHS.

B. Coverage begins the first day of the calendar month following the date of enrollment, except:

(1) Coverage for newborns is automatic and begins immediately from the moment of birth if the mother is enrolled.[15]

(2) Coverage for eligible adoptive children of a family enrolled in MinnesotaCare begins on the date of placement for the purpose of adoption.

(3) Coverage for other new members of an enrolled family begins the first day of the month following the month in which the new member's eligibility is determined and the first premium payment is received.

(4) Coverage of enrollees who are hospitalized on the first day of the month following enrollment begins the day following the date of discharge from the hospital.

Section 4 Premium Payments

4.1 Premium payments. Applicants and enrollees must pay a premium to enroll and to continue enrollment in MinnesotaCare. The amount of premium is based on the family's gross annual family income. If a family reports increased income after enrollment, premiums shall not be adjusted until eligibility renewal. The amount of the premium is:

A. $4 per month for each child in a family whose income does not exceed 150 percent of FPG; plus

B. For any family member not included under Item A, the premium determined in accordance with the premium tables contained in Appendix A of the Phase 2 MinnesotaCare Health Care Reform Waiver amendment request.

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[15] Minnesota laws 1998, chapter 407, article 5, section 28, subdivision 3, effective January 1, 1999.

4.2 Premiums paid monthly, quarterly, or annually. Applicants and enrollees may choose to pay premiums on a monthly, quarterly or annual basis and may change payment schedules at the time a premium is due.

4.3 Billing notices. DHS shall mail premium payment billing notices as follows:

A. For monthly premiums, by the first day of the month preceding the month for which coverage will be provided.

B. For quarterly premiums, by the first day of the month preceding the first month of the quarter for which coverage will be provided.

C. For annual premiums, by the first day of the month preceding the first month of the year for which coverage will be provided.

4.4 Premium payment dates.

A. An initial premium must be received by DHS within four months after the date on the applicant's first premium notice.

B. Subsequent premiums must be received by DHS as follows:

(1) monthly premiums by the 15th of the month preceding the month for which the premium is paid;
(2) quarterly premiums by the 15th of the month preceding the first month of the quarter for which the premium is paid;
(3) annual premiums by the 15th of the month preceding the first month of the year for which the premium is paid.

4.5 Premium payment options. DHS may offer the following payment options to an enrollee:
A. Check.

B. Credit card.

C. Recurring automatic checking withdrawal.

D. One-time electronic transfer of funds.

E. Wage withholding with the consent of the employer and the employee.
F. Using state tax refund payments.

At application or reapplication an applicant or enrollee may authorize DHS to collect funds from the applicant's or enrollee's state income tax refund for premium obligations. The applicant or enrollee may also authorize the commissioner to apply for the working family tax credit on behalf of the applicant or enrollee for payment of premium obligations. [16]

4.6 Disenrollment.

A. DHS shall disenroll enrollees who fail to pay the required premium when due, unless the enrollee is pregnant or is a child under age two. A dishonored check is considered failure to pay the premium and the agency may demand a guaranteed form of payment to replace a dishonored check. [17] MinnesotaCare coverage terminates the last day of the calendar month following the date the premium was due unless the premium is received by the termination date.

B. If an enrollee who is pregnant fails to pay the premium, MinnesotaCare coverage shall continue to the last day of the month following the month of the 60th day post-partum.

C. If the premium is not paid for an enrollee who is a child under age two, MinnesotaCare coverage shall continue to the last day of the month following the month in which the child becomes two years of age.

4.7 Reenrollment.

A. An enrollee who voluntarily terminates coverage from the program[18] or who is disenrolled for failure to pay the required premium is not eligible to reenroll until four calendar months after the date coverage terminates unless the person demonstrates good cause for

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[16] Minnesota Laws 1998, chapter 407, section 39, subdivision 1a, January 1, 1999. The payment options have not been implemented. DHS will notify HCFA by quarterly report when the options are implemented.

[17] Minnesota Laws 1998, chapter 407, article 5, section 32, subdivision 3(b), effective July 1, 1998.

[18] Minnesota Laws 1998, article 5, chapter 407, section 32, subdivision 3(d), effective January 1, 1999.

nonpayment and:

(1) complies with sections 1 to 9; and
(2) pays the unpaid premium for any month in which coverage was provided.

B. The four month penalty under Item A is not applicable to children under section 4.5.

C. Good cause for nonpayment does not exist if a person chooses to pay other family expenses instead of the MinnesotaCare premium.

D. Good cause for nonpayment means, generally, circumstances that excuse an enrollee's failure to pay the required premium when due, including circumstances such as:

(1) because of serious physical or mental incapacity or illness, the enrollee fails to pay the premium;
(2) the enrollee voluntarily disenrolls under the mistaken belief that other health coverage is available;
(3) the enrollee does not receive a regular source of income on which the enrollee has relied to pay the required premium.

E. DHS shall determine whether good cause exists based on the weight of the corroborative evidence submitted by the person to demonstrate good cause.

Section 5 Coordination of MinnesotaCare and Medical Assistance

5.1 Medical Assistance information. Information regarding Medical Assistance eligibility shall be provided to all applicants and enrollees.

5.2 Enrollee eligibility for Medical Assistance.

A. Enrollees may apply for and become eligible for Medical Assistance if they choose and if they meet the eligibility requirements for Medical Assistance.

B. MinnesotaCare premiums paid by an enrollee may be used as medical expenses to meet a spenddown for Medical Assistance.

C. DHS shall disenroll an enrollee who is determined eligible for Medical Assistance without a spend-down. MinnesotaCare coverage terminates the last day of the calendar month in

which DHS receives notice of the enrollee's Medical Assistance eligibility.

Section 6 Quality Control

6.1 Random audits. DHS shall perform audits of randomly selected enrollees to verify enrollees' gross annual family income and MinnesotaCare eligibility. Enrollees being audited must provide additional income and eligibility information, including items A to H:

A. Federal income tax returns.

B. Federal W-2 forms.

C. Employment check stubs.

D. Family composition.

E. Residency.

F. Length of time without health insurance.

G. Access to employer-subsidized coverage.

H. Any additional information necessary to determine income and eligibility.

6.2 Disenrollment. DHS shall disenroll enrollees who fail to provide information required under Section 6.1. MinnesotaCare coverage will terminate the last day of the calendar month following the month in which notice of cancellation is sent. Persons may reenroll after complying with this section and being determined eligible for MinnesotaCare.

Section 7 Appeals

DHS shall follow the notice and fair hearing requirements of 42 CFR, Section 431, subpart E.

Section 8 Covered Health Services

8.1 Covered health services for children. Health services covered by MinnesotaCare for children who are less than 21 years of age are the services covered by Minnesota's Medicaid state

plan for optional categorically needy.

8.2 Covered health services for adults.

A. Health services covered by MinnesotaCare for adults who are pregnant are those covered by Minnesota's Medicaid state plan for a pregnant woman who is eligible as a qualified pregnant woman in accordance with §1902(a)(10)(A)(I)(iii) of the Social Security Act.

B. Health services covered by MinnesotaCare for adults who are not pregnant are those covered by Minnesota's Medicaid state plan for an adult who is categorically needy, with the exception of the services in subitems (1) to (10).

(1) Inpatient hospital services over a $10,000 annual benefit limit for adult enrollees with gross family income that exceeds 175 percent of FPG.
(2) Private duty nursing services.
(3) Personal care services.
(4) Non-preventive dental services, including orthodontic services.[19]
(5) Case management services.
(6) Nursing facility services.
(7) Intermediate care facility services for the mentally retarded.
(8) Services in an individualized education plan, provided by a school district.
(9) Outpatient mental health services beyond diagnostic assessments, psychological testing, explanation of findings, medication management by a physician, and individual, family and group psychotherapy.

8.3 Covered access services. Transportation and travel expenses are covered in accordance with 42 CFR §431.53.

8.4 Sign and spoken language interpreter services. Covered services include sign and spoken language interpreter services that assist an enrollee in obtaining health care services. [20]

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[19] Effective July 1, 1998, non-preventive dental services (with the exception of orthodontic services) are covered for enrollees with gross family income equal to or less than 175 percent of FPG. Minnesota Statutes, 1997 Supplement, §256L.03, Subd. 1.

[20] Minnesota Laws 1998, chapter 407, article 5, section 14, subdivision 3a, effective April 22, 1998.

8.5 Third party liability. The third party liability requirements of 42 CFR, Part 433, subpart D shall apply in accordance with Minnesota's Medicaid state plan. Cost-effective group health plan coverage shall not be purchased by MinnesotaCare, in accordance with the option afforded the State at §1906(a) of the Social Security Act.

Section 9 Copayments and Payment for Covered Health Services

9.1 Copayments required. Adult enrollees who are not pregnant must pay enrolled Medicaid providers and managed care health plans (or the managed care health plans' participating providers) the copayments in items A to C.

A. $3 for a prescription.

B. $25 for eyeglasses.

C. 50 percent of the cost of non-preventive dental services for adult enrollees (who are not pregnant) with gross family income equal to or less than 175 percent of FPG.

Copayments totaling $30 or more, paid by a pregnant woman after the date the pregnancy is diagnosed, shall be refunded.[21]

9.2 Payment for covered health services. Payment for covered health services is determined in accordance with the managed care service delivery provisions of this waiver.[22]

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[21] Minnesota Laws 1998, chapter 407, article 5, section 12, subdivision 1b, effective January 1, 1999.

[22] Effective for the period July 1, 1997 to June 30, 1998, payment for inpatient hospital services that exceeded $10,000 that were provided to adult enrollees (who are not pregnant) with gross family income equal to or less than 175 percent of FPG are made on a fee-for-service basis in accordance with the state plan. For the period beginning July 1, 1998, payment is incorporated into capitation in accordance with the managed care purchasing provisions of this waiver.

MinnesotaCare Premiums
April 2000 through March 2001

These tables are intended to approximate the required premium as calculated by the premium calculation program. The premium calcuation performed by the system is the official calculation.

These tables do not adequately deal with cases where there are children present with a minimum $4 per month premium. But the tables can be used to calculate the adult premium which is required in such cases. For example, to approximate the premium for a three-person family with two children who qualify for the $4 premium and one adult, use the table to calculate the adult premium; add the $4 premiums for the children.

Reports & Forecasts Division, DHS

MinnesotaCare Premiums
For April 2000 through March 2001

Family size:	**1**
FPG	$696
MA Maximum:	$467
MnCare maximum:	$1,914
Full premium:	$175

Gross monthly income		Premium Contribution by Number Covered	Premium Contribution as % of monthly income
from	to	1	1
$0.00	$46.69	$4	*minimum*
46.70	93.39	4	*minimum*
93.40	140.09	4	*minimum*
140.10	186.79	4	*minimum*
186.80	233.49	4	*minimum*
233.50	280.19	4	*minimum*
280.20	326.89	5	1.5%
326.90	373.59	5	1.5%
373.60	420.29	6	1.5%
420.30	467.00	7	1.5%
467.01	485.09	9	1.8%
485.10	503.18	9	1.8%
503.19	521.26	9	1.8%
521.27	539.35	10	1.8%
539.36	557.44	10	1.8%
557.45	575.53	10	1.8%
575.54	593.61	11	1.8%
593.62	611.70	11	1.8%
611.71	629.79	11	1.8%
629.80	647.87	11	1.8%
647.88	665.95	15	2.3%
665.96	684.04	16	2.3%
684.05	702.13	16	2.3%
702.14	720.22	16	2.3%
720.23	738.30	17	2.3%
738.31	756.39	17	2.3%
756.40	774.48	18	2.3%
774.49	792.57	18	2.3%
792.58	810.65	18	2.3%
810.66	828.74	19	2.3%
828.75	846.83	26	3.1%
846.84	864.92	27	3.1%
864.93	883.00	27	3.1%
883.01	901.09	28	3.1%
901.10	919.18	28	3.1%
919.19	937.27	29	3.1%
937.28	955.35	29	3.1%
955.36	973.44	30	3.1%
973.45	991.53	30	3.1%
991.54	1,009.60	31	3.1%
1,009.61	1,027.69	39	3.8%
1,027.70	1,045.78	39	3.8%
1,045.79	1,063.87	40	3.8%
1,063.88	1,081.96	41	3.8%
1,081.97	1,100.04	41	3.8%
1,100.05	1,118.13	42	3.8%
1,118.14	1,136.22	43	3.8%
1,136.23	1,154.31	44	3.8%
1,154.32	1,172.39	44	3.8%
1,172.40	1,190.48	45	3.8%

MinnesotaCare Premiums
For April 2000 through March 2001

Family size:	**1**
FPG	$696
MA Maximum:	$467
MnCare maximum:	$1,914
Full premium:	$175

Gross monthly income		Premium Contribution by Number Covered	Premium Contribution as % of monthly income
from	to	1	1
$1,190.49	$1,208.57	$58	4.8%
1,208.58	1,226.66	58	4.8%
1,226.67	1,244.74	59	4.8%
1,244.75	1,262.83	60	4.8%
1,262.84	1,280.92	61	4.8%
1,280.93	1,299.01	62	4.8%
1,299.02	1,317.09	63	4.8%
1,317.10	1,335.18	64	4.8%
1,335.19	1,353.27	65	4.8%
1,353.28	1,371.35	65	4.8%
1,371.36	1,389.43	81	5.9%
1,389.44	1,407.52	83	5.9%
1,407.53	1,425.61	84	5.9%
1,425.62	1,443.70	85	5.9%
1,443.71	1,461.78	86	5.9%
1,461.79	1,479.87	87	5.9%
1,479.88	1,497.96	88	5.9%
1,497.97	1,516.05	89	5.9%
1,516.06	1,534.13	90	5.9%
1,534.14	1,552.22	91	5.9%
1,552.23	1,570.31	116	7.4%
1,570.32	1,588.40	117	7.4%
1,588.41	1,606.48	118	7.4%
1,606.49	1,624.57	120	7.4%
1,624.58	1,642.66	121	7.4%
1,642.67	1,660.75	122	7.4%
1,660.76	1,678.83	124	7.4%
1,678.84	1,696.92	125	7.4%
1,696.93	1,715.01	126	7.4%
1,715.02	1,733.09	128	7.4%
1,733.10	1,751.17	153	8.8%
1,751.18	1,769.26	155	8.8%
1,769.27	1,787.35	156	8.8%
1,787.36	1,805.44	158	8.8%
1,805.45	1,823.52	160	8.8%
1,823.53	1,841.61	161	8.8%
1,841.62	1,859.70	163	8.8%
1,859.71	1,877.79	164	8.8%
1,877.80	1,895.87	166	8.8%
1,895.88	1,913.99	168	8.8%
1,914.00		175	*full cost*

MinnesotaCare Premiums
For April 2000 through March 2001

Family size:	**2**
FPG	$938
MA Maximum:	$583
MnCare maximum:	$2,579
Full premium:	$350

Gross monthly income		Premium Contribution by Number Covered		Premium Contribution as % of monthly income	
from	to	2	1	2	1
$0.00	$58.29	$8	$4	*minimum*	*minimum*
58.30	116.59	8	4	*minimum*	*minimum*
116.60	174.89	8	4	*minimum*	*minimum*
174.90	233.19	8	4	*minimum*	*minimum*
233.20	291.49	8	4	*minimum*	*minimum*
291.50	349.79	8	4	*minimum*	*minimum*
349.80	408.09	8	4	*minimum*	*minimum*
408.10	466.39	8	4	*minimum*	*minimum*
466.40	524.69	8	4	*minimum*	*minimum*
524.70	583.00	8	4	*minimum*	*minimum*
583.01	607.95	11	5	1.80%	0.90%
607.96	632.90	11	6	1.80%	0.90%
632.91	657.85	12	6	1.80%	0.90%
657.86	682.80	12	6	1.80%	0.90%
682.81	707.75	13	6	1.80%	0.90%
707.76	732.70	13	6	1.80%	0.90%
732.71	757.65	13	7	1.80%	0.90%
757.66	782.60	14	7	1.80%	0.90%
782.61	807.55	14	7	1.80%	0.90%
807.56	832.49	15	7	1.80%	0.90%
832.50	857.44	19	10	2.30%	1.15%
857.45	882.39	20	10	2.30%	1.15%
882.40	907.34	21	10	2.30%	1.15%
907.35	932.29	21	11	2.30%	1.15%
932.30	957.24	22	11	2.30%	1.15%
957.25	982.19	22	11	2.30%	1.15%
982.20	1,007.14	23	11	2.30%	1.15%
1,007.15	1,032.09	23	12	2.30%	1.15%
1,032.10	1,057.04	24	12	2.30%	1.15%
1,057.05	1,081.99	25	12	2.30%	1.15%
1,082.00	1,106.94	34	17	3.10%	1.55%
1,106.95	1,131.89	35	17	3.10%	1.55%
1,131.90	1,156.84	35	18	3.10%	1.55%
1,156.85	1,181.79	36	18	3.10%	1.55%
1,181.80	1,206.74	37	19	3.10%	1.55%
1,206.75	1,231.69	38	19	3.10%	1.55%
1,231.70	1,256.64	39	19	3.10%	1.55%
1,256.65	1,281.59	39	20	3.10%	1.55%
1,281.60	1,306.54	40	20	3.10%	1.55%
1,306.55	1,331.48	41	20	3.10%	1.55%
1,331.49	1,356.43	51	26	3.80%	1.90%
1,356.44	1,381.38	52	26	3.80%	1.90%
1,381.39	1,406.33	53	26	3.80%	1.90%
1,406.34	1,431.28	54	27	3.80%	1.90%
1,431.29	1,456.23	55	27	3.80%	1.90%
1,456.24	1,481.18	56	28	3.80%	1.90%
1,481.19	1,506.13	57	28	3.80%	1.90%
1,506.14	1,531.08	58	29	3.80%	1.90%
1,531.09	1,556.03	59	29	3.80%	1.90%
1,556.04	1,580.98	60	30	3.80%	1.90%

MinnesotaCare Premiums
For April 2000 through March 2001

Family size:	**2**
FPG	$938
MA Maximum:	$583
MnCare maximum:	$2,579
Full premium:	$350

Gross monthly income		Premium Contribution by Number Covered		Premium Contribution as % of monthly income	
from	to	2	1	2	1
$1,580.99	$1,605.93	$76	$38	4.80%	2.40%
1,605.94	1,630.88	78	39	4.80%	2.40%
1,630.89	1,655.83	79	39	4.80%	2.40%
1,655.84	1,680.78	80	40	4.80%	2.40%
1,680.79	1,705.73	81	41	4.80%	2.40%
1,705.74	1,730.68	82	41	4.80%	2.40%
1,730.69	1,755.63	84	42	4.80%	2.40%
1,755.64	1,780.58	85	42	4.80%	2.40%
1,780.59	1,805.53	86	43	4.80%	2.40%
1,805.54	1,830.47	87	44	4.80%	2.40%
1,830.48	1,855.42	109	54	5.90%	2.95%
1,855.43	1,880.37	110	55	5.90%	2.95%
1,880.38	1,905.32	112	56	5.90%	2.95%
1,905.33	1,930.27	113	57	5.90%	2.95%
1,930.28	1,955.22	115	57	5.90%	2.95%
1,955.23	1,980.17	116	58	5.90%	2.95%
1,980.18	2,005.12	118	59	5.90%	2.95%
2,005.13	2,030.07	119	60	5.90%	2.95%
2,030.08	2,055.02	121	60	5.90%	2.95%
2,055.03	2,079.97	122	61	5.90%	2.95%
2,079.98	2,104.92	155	77	7.40%	3.70%
2,104.93	2,129.87	157	78	7.40%	3.70%
2,129.88	2,154.82	159	79	7.40%	3.70%
2,154.83	2,179.77	160	80	7.40%	3.70%
2,179.78	2,204.72	162	81	7.40%	3.70%
2,204.73	2,229.67	164	82	7.40%	3.70%
2,229.68	2,254.62	166	83	7.40%	3.70%
2,254.63	2,279.57	168	84	7.40%	3.70%
2,279.58	2,304.52	170	85	7.40%	3.70%
2,304.53	2,329.46	171	86	7.40%	3.70%
2,329.47	2,354.41	206	103	8.80%	4.40%
2,354.42	2,379.36	208	104	8.80%	4.40%
2,379.37	2,404.31	210	105	8.80%	4.40%
2,404.32	2,429.26	213	106	8.80%	4.40%
2,429.27	2,454.21	215	107	8.80%	4.40%
2,454.22	2,479.16	217	109	8.80%	4.40%
2,479.17	2,504.11	219	110	8.80%	4.40%
2,504.12	2,529.06	221	111	8.80%	4.40%
2,529.07	2,554.01	224	112	8.80%	4.40%
2,554.02	2,578.99	226	113	8.80%	4.40%
2,579.00		350	175	*full cost*	*full cost*

MinnesotaCare Premiums
For April 2000 through March 2001

Family size:	3
FPG	$1,179
MA Maximum:	$709
MnCare maximum:	$3,243
Full premium:	$525

Gross monthly income		Premium Contribution by Number Covered			Premium Contribution as % of monthly income		
from	to	3	2	1	3	2	1
$0.00	$70.89	$12	$8	$4	*minimum*	*minimum*	*minimum*
70.90	141.79	12	8	4	*minimum*	*minimum*	*minimum*
141.80	212.69	12	8	4	*minimum*	*minimum*	*minimum*
212.70	283.59	12	8	4	*minimum*	*minimum*	*minimum*
283.60	354.49	12	8	4	*minimum*	*minimum*	*minimum*
354.50	425.39	12	8	4	*minimum*	*minimum*	*minimum*
425.40	496.29	12	8	4	*minimum*	*minimum*	*minimum*
496.30	567.19	12	8	4	*minimum*	*minimum*	*minimum*
567.20	638.09	12	8	4	*minimum*	*minimum*	*minimum*
638.10	709.00	12	8	4	*minimum*	*minimum*	*minimum*
709.01	740.68	13	9	4	1.80%	1.80%	*minimum*
740.69	772.35	14	9	5	1.80%	1.20%	0.60%
772.36	804.03	14	9	5	1.80%	1.20%	0.60%
804.04	835.70	15	10	5	1.80%	1.20%	0.60%
835.71	867.38	15	10	5	1.80%	1.20%	0.60%
867.39	899.05	16	11	5	1.80%	1.20%	0.60%
899.06	930.73	16	11	5	1.80%	1.20%	0.60%
930.74	962.40	17	11	6	1.80%	1.20%	0.60%
962.41	994.08	18	12	6	1.80%	1.20%	0.60%
994.09	1,025.74	18	12	6	1.80%	1.20%	0.60%
1,025.75	1,057.42	24	16	8	2.30%	1.53%	0.77%
1,057.43	1,089.09	25	16	8	2.30%	1.53%	0.77%
1,089.10	1,120.77	25	17	8	2.30%	1.53%	0.77%
1,120.78	1,152.44	26	17	9	2.30%	1.53%	0.77%
1,152.45	1,184.11	27	18	9	2.30%	1.53%	0.77%
1,184.12	1,215.79	28	18	9	2.30%	1.53%	0.77%
1,215.80	1,247.46	28	19	9	2.30%	1.53%	0.77%
1,247.47	1,279.14	29	19	10	2.30%	1.53%	0.77%
1,279.15	1,310.82	30	20	10	2.30%	1.53%	0.77%
1,310.83	1,342.49	31	20	10	2.30%	1.53%	0.77%
1,342.50	1,374.17	42	28	14	3.10%	2.07%	1.03%
1,374.18	1,405.84	43	29	14	3.10%	2.07%	1.03%
1,405.85	1,437.52	44	29	15	3.10%	2.07%	1.03%
1,437.53	1,469.19	45	30	15	3.10%	2.07%	1.03%
1,469.20	1,500.87	46	31	15	3.10%	2.07%	1.03%
1,500.88	1,532.54	47	31	16	3.10%	2.07%	1.03%
1,532.55	1,564.22	48	32	16	3.10%	2.07%	1.03%
1,564.23	1,595.89	49	33	16	3.10%	2.07%	1.03%
1,595.90	1,627.57	50	33	17	3.10%	2.07%	1.03%
1,627.57	1,659.23	51	34	17	3.10%	2.07%	1.03%
1,659.24	1,690.90	64	42	21	3.80%	2.53%	1.27%
1,690.91	1,722.58	65	43	22	3.80%	2.53%	1.27%
1,722.59	1,754.25	66	44	22	3.80%	2.53%	1.27%
1,754.26	1,785.93	67	45	22	3.80%	2.53%	1.27%
1,785.94	1,817.60	68	46	23	3.80%	2.53%	1.27%
1,817.61	1,849.28	70	46	23	3.80%	2.53%	1.27%
1,849.29	1,880.95	71	47	24	3.80%	2.53%	1.27%
1,880.96	1,912.63	72	48	24	3.80%	2.53%	1.27%
1,912.64	1,944.30	73	49	24	3.80%	2.53%	1.27%
1,944.31	1,975.98	74	50	25	3.80%	2.53%	1.27%

MinnesotaCare Premiums
For April 2000 through March 2001

Family size:	**3**
FPG	$1,179
MA Maximum:	$709
MnCare maximum:	$3,243
Full premium:	$525

Gross monthly income		Premium Contribution by Number Covered			Premium Contribution as % of monthly income		
from	to	3	2	1	3	2	1
$1,975.99	$2,007.65	$96	$64	$32	4.80%	3.20%	1.60%
2,007.66	2,039.33	97	65	32	4.80%	3.20%	1.60%
2,039.34	2,071.00	99	66	33	4.80%	3.20%	1.60%
2,071.01	2,102.68	100	67	33	4.80%	3.20%	1.60%
2,102.69	2,134.35	102	68	34	4.80%	3.20%	1.60%
2,134.36	2,166.03	103	69	34	4.80%	3.20%	1.60%
2,166.04	2,197.70	105	70	35	4.80%	3.20%	1.60%
2,197.72	2,229.38	106	71	35	4.80%	3.20%	1.60%
2,229.39	2,261.06	108	72	36	4.80%	3.20%	1.60%
2,261.07	2,292.72	109	73	36	4.80%	3.20%	1.60%
2,292.73	2,324.40	136	91	45	5.90%	3.93%	1.97%
2,324.41	2,356.07	138	92	46	5.90%	3.93%	1.97%
2,356.08	2,387.75	140	93	47	5.90%	3.93%	1.97%
2,387.76	2,419.42	142	95	47	5.90%	3.93%	1.97%
2,419.43	2,451.10	144	96	48	5.90%	3.93%	1.97%
2,451.11	2,482.77	146	97	49	5.90%	3.93%	1.97%
2,482.78	2,514.45	147	98	49	5.90%	3.93%	1.97%
2,514.46	2,546.12	149	100	50	5.90%	3.93%	1.97%
2,546.13	2,577.80	151	101	50	5.90%	3.93%	1.97%
2,577.81	2,609.47	153	102	51	5.90%	3.93%	1.97%
2,609.48	2,641.15	194	130	65	7.40%	4.93%	2.47%
2,641.16	2,672.82	197	131	66	7.40%	4.93%	2.47%
2,672.83	2,704.50	199	133	66	7.40%	4.93%	2.47%
2,704.51	2,736.17	201	134	67	7.40%	4.93%	2.47%
2,736.18	2,767.85	204	136	68	7.40%	4.93%	2.47%
2,767.86	2,799.52	206	137	69	7.40%	4.93%	2.47%
2,799.53	2,831.20	208	139	69	7.40%	4.93%	2.47%
2,831.21	2,862.87	211	140	70	7.40%	4.93%	2.47%
2,862.88	2,894.55	213	142	71	7.40%	4.93%	2.47%
2,894.56	2,926.21	215	144	72	7.40%	4.93%	2.47%
2,926.22	2,957.89	259	173	86	8.80%	5.87%	2.93%
2,957.90	2,989.56	262	174	87	8.80%	5.87%	2.93%
2,989.57	3,021.24	264	176	88	8.80%	5.87%	2.93%
3,021.25	3,052.91	267	178	89	8.80%	5.87%	2.93%
3,052.92	3,084.59	270	180	90	8.80%	5.87%	2.93%
3,084.60	3,116.26	273	182	91	8.80%	5.87%	2.93%
3,116.27	3,147.94	276	184	92	8.80%	5.87%	2.93%
3,147.95	3,179.61	278	186	93	8.80%	5.87%	2.93%
3,179.62	3,211.29	281	187	94	8.80%	5.87%	2.93%
3,211.30	3,242.99	284	189	95	8.80%	5.87%	2.93%
3,243.00		525	350	175	*full cost*	*full cost*	*full cost*

MinnesotaCare Premiums
For April 2000 through March 2001

Family size:	**4**
FPG	$1,421
MA Maximum:	$828
MnCare maximum:	$3,908
Full premium:	$525

Gross monthly income		Premium Contribution by Number Covered			Premium Contribution as % of monthly income		
from	to	3	2	1	3	2	1
$0.00	$82.79	$12	$8	$4	*minimum*	*minimum*	*minimum*
82.80	165.59	12	8	4	*minimum*	*minimum*	*minimum*
165.60	248.39	12	8	4	*minimum*	*minimum*	*minimum*
248.40	331.19	12	8	4	*minimum*	*minimum*	*minimum*
331.20	413.99	12	8	4	*minimum*	*minimum*	*minimum*
414.00	496.79	12	8	4	*minimum*	*minimum*	*minimum*
496.80	579.59	12	8	4	*minimum*	*minimum*	*minimum*
579.60	662.39	12	8	4	*minimum*	*minimum*	*minimum*
662.40	745.19	12	8	4	*minimum*	*minimum*	*minimum*
745.20	828.00	12	8	4	*minimum*	*minimum*	*minimum*
828.01	866.50	15	10	5	1.80%	1.20%	0.60%
866.51	905.00	16	11	5	1.80%	1.20%	0.60%
905.01	943.50	17	11	6	1.80%	1.20%	0.60%
943.51	982.00	17	12	6	1.80%	1.20%	0.60%
982.01	1,020.50	18	12	6	1.80%	1.20%	0.60%
1,020.51	1,059.00	19	12	6	1.80%	1.20%	0.60%
1,059.01	1,097.50	19	13	6	1.80%	1.20%	0.60%
1,097.51	1,136.00	20	13	7	1.80%	1.20%	0.60%
1,136.01	1,174.50	21	14	7	1.80%	1.20%	0.60%
1,174.51	1,212.99	21	14	7	1.80%	1.20%	0.60%
1,213.00	1,251.49	28	19	9	2.30%	1.53%	0.77%
1,251.50	1,289.99	29	19	10	2.30%	1.53%	0.77%
1,290.00	1,328.49	30	20	10	2.30%	1.53%	0.77%
1,328.50	1,366.99	31	21	10	2.30%	1.53%	0.77%
1,367.00	1,405.49	32	21	11	2.30%	1.53%	0.77%
1,405.50	1,443.99	33	22	11	2.30%	1.53%	0.77%
1,444.00	1,482.49	34	22	11	2.30%	1.53%	0.77%
1,482.50	1,520.99	35	23	12	2.30%	1.53%	0.77%
1,521.00	1,559.49	35	24	12	2.30%	1.53%	0.77%
1,559.50	1,597.99	36	24	12	2.30%	1.53%	0.77%
1,598.00	1,636.49	50	33	17	3.10%	2.07%	1.03%
1,636.50	1,674.99	51	34	17	3.10%	2.07%	1.03%
1,675.00	1,713.49	53	35	18	3.10%	2.07%	1.03%
1,713.50	1,751.99	54	36	18	3.10%	2.07%	1.03%
1,752.00	1,790.49	55	37	18	3.10%	2.07%	1.03%
1,790.50	1,828.99	56	37	19	3.10%	2.07%	1.03%
1,829.00	1,867.49	57	38	19	3.10%	2.07%	1.03%
1,867.50	1,905.99	58	39	19	3.10%	2.07%	1.03%
1,906.00	1,944.49	60	40	20	3.10%	2.07%	1.03%
1,944.50	1,982.98	61	41	20	3.10%	2.07%	1.03%
1,982.99	2,021.48	76	51	25	3.80%	2.53%	1.27%
2,021.49	2,059.98	78	52	26	3.80%	2.53%	1.27%
2,059.99	2,098.48	79	53	26	3.80%	2.53%	1.27%
2,098.49	2,136.98	80	54	27	3.80%	2.53%	1.27%
2,136.99	2,175.48	82	55	27	3.80%	2.53%	1.27%
2,175.49	2,213.98	83	56	28	3.80%	2.53%	1.27%
2,213.99	2,252.48	85	57	28	3.80%	2.53%	1.27%
2,252.49	2,290.98	86	58	29	3.80%	2.53%	1.27%
2,290.99	2,329.48	88	59	29	3.80%	2.53%	1.27%
2,329.49	2,367.98	89	60	30	3.80%	2.53%	1.27%

MinnesotaCare Premiums
For April 2000 through March 2001

Family size:	**4**
FPG	$1,421
MA Maximum:	$828
MnCare maximum:	$3,908
Full premium:	$525

Gross monthly income		Premium Contribution by Number Covered			Premium Contribution as % of monthly income		
from	to	3	2	1	3	2	1
$2,367.99	$2,406.48	$115	$76	$38	4.80%	3.20%	1.60%
2,406.49	2,444.98	116	78	39	4.80%	3.20%	1.60%
2,444.99	2,483.48	118	79	39	4.80%	3.20%	1.60%
2,483.49	2,521.98	120	80	40	4.80%	3.20%	1.60%
2,521.99	2,560.48	122	81	41	4.80%	3.20%	1.60%
2,560.49	2,598.98	124	83	41	4.80%	3.20%	1.60%
2,598.99	2,637.48	126	84	42	4.80%	3.20%	1.60%
2,637.49	2,675.98	128	85	43	4.80%	3.20%	1.60%
2,675.99	2,714.48	129	86	43	4.80%	3.20%	1.60%
2,714.49	2,752.97	131	87	44	4.80%	3.20%	1.60%
2,752.98	2,791.47	164	109	55	5.90%	3.93%	1.97%
2,791.48	2,829.97	166	111	55	5.90%	3.93%	1.97%
2,829.98	2,868.47	168	112	56	5.90%	3.93%	1.97%
2,868.48	2,906.97	170	114	57	5.90%	3.93%	1.97%
2,906.98	2,945.47	173	115	58	5.90%	3.93%	1.97%
2,945.48	2,983.97	175	117	58	5.90%	3.93%	1.97%
2,983.98	3,022.47	177	118	59	5.90%	3.93%	1.97%
3,022.48	3,060.97	179	120	60	5.90%	3.93%	1.97%
3,060.98	3,099.47	182	121	61	5.90%	3.93%	1.97%
3,099.48	3,137.97	184	123	61	5.90%	3.93%	1.97%
3,137.98	3,176.47	234	156	78	7.40%	4.93%	2.47%
3,176.48	3,214.97	236	158	79	7.40%	4.93%	2.47%
3,214.98	3,253.47	239	160	80	7.40%	4.93%	2.47%
3,253.48	3,291.97	242	161	81	7.40%	4.93%	2.47%
3,291.98	3,330.47	245	163	82	7.40%	4.93%	2.47%
3,330.48	3,368.97	248	165	83	7.40%	4.93%	2.47%
3,368.98	3,407.47	251	167	84	7.40%	4.93%	2.47%
3,407.48	3,445.97	254	169	85	7.40%	4.93%	2.47%
3,445.98	3,484.47	256	171	85	7.40%	4.93%	2.47%
3,484.48	3,522.96	259	173	86	7.40%	4.93%	2.47%
3,522.97	3,561.46	312	208	104	8.80%	5.87%	2.93%
3,561.47	3,599.96	315	210	105	8.80%	5.87%	2.93%
3,599.97	3,638.46	318	212	106	8.80%	5.87%	2.93%
3,638.47	3,676.96	322	215	107	8.80%	5.87%	2.93%
3,676.97	3,715.46	325	217	108	8.80%	5.87%	2.93%
3,715.47	3,753.96	329	219	110	8.80%	5.87%	2.93%
3,753.97	3,792.46	332	221	111	8.80%	5.87%	2.93%
3,792.47	3,830.96	335	224	112	8.80%	5.87%	2.93%
3,830.97	3,869.46	339	226	113	8.80%	5.87%	2.93%
3,869.47	3,907.99	342	228	114	8.80%	5.87%	2.93%
3,908.00		525	350	175	*full cost*	*full cost*	*full cost*

MinnesotaCare Premiums
For April 2000 through March 2001

Family size:	**5**
FPG	$1,663
MA Maximum:	$929
MnCare maximum:	$4,572
Full premium:	$525

Gross monthly income		Premium Contribution by Number Covered			Premium Contribution as % of monthly income		
from	to	3	2	1	3	2	1
$0.00	$92.89	$12	$8	$4	*minimum*	*minimum*	*minimum*
92.90	185.79	12	8	4	*minimum*	*minimum*	*minimum*
185.80	278.69	12	8	4	*minimum*	*minimum*	*minimum*
278.70	371.59	12	8	4	*minimum*	*minimum*	*minimum*
371.60	464.49	12	8	4	*minimum*	*minimum*	*minimum*
464.50	557.39	12	8	4	*minimum*	*minimum*	*minimum*
557.40	650.29	12	8	4	*minimum*	*minimum*	*minimum*
650.30	743.19	12	8	4	*minimum*	*minimum*	*minimum*
743.20	836.09	12	8	4	*minimum*	*minimum*	*minimum*
836.10	929.00	13	9	4	1.50%	1.00%	*minimum*
929.01	974.54	17	11	6	1.80%	1.20%	0.60%
974.55	1,020.08	18	12	6	1.80%	1.20%	0.60%
1,020.09	1,065.61	19	13	6	1.80%	1.20%	0.60%
1,065.62	1,111.15	20	13	7	1.80%	1.20%	0.60%
1,111.16	1,156.69	20	14	7	1.80%	1.20%	0.60%
1,156.70	1,202.23	21	14	7	1.80%	1.20%	0.60%
1,202.24	1,247.76	22	15	7	1.80%	1.20%	0.60%
1,247.77	1,293.30	23	15	8	1.80%	1.20%	0.60%
1,293.31	1,338.84	24	16	8	1.80%	1.20%	0.60%
1,338.85	1,384.37	25	16	8	1.80%	1.20%	0.60%
1,384.38	1,429.90	32	22	11	2.30%	1.53%	0.77%
1,429.91	1,475.44	33	22	11	2.30%	1.53%	0.77%
1,475.45	1,520.98	34	23	11	2.30%	1.53%	0.77%
1,520.99	1,566.52	36	24	12	2.30%	1.53%	0.77%
1,566.53	1,612.05	37	24	12	2.30%	1.53%	0.77%
1,612.06	1,657.59	38	25	13	2.30%	1.53%	0.77%
1,657.60	1,703.13	39	26	13	2.30%	1.53%	0.77%
1,703.14	1,748.66	40	26	13	2.30%	1.53%	0.77%
1,748.67	1,794.20	41	27	14	2.30%	1.53%	0.77%
1,794.21	1,839.74	42	28	14	2.30%	1.53%	0.77%
1,839.75	1,885.28	58	38	19	3.10%	2.07%	1.03%
1,885.29	1,930.81	59	39	20	3.10%	2.07%	1.03%
1,930.82	1,976.35	61	40	20	3.10%	2.07%	1.03%
1,976.36	2,021.89	62	41	21	3.10%	2.07%	1.03%
2,021.90	2,067.43	63	42	21	3.10%	2.07%	1.03%
2,067.44	2,112.96	65	43	22	3.10%	2.07%	1.03%
2,112.97	2,158.50	66	44	22	3.10%	2.07%	1.03%
2,158.51	2,204.04	68	45	23	3.10%	2.07%	1.03%
2,204.05	2,249.58	69	46	23	3.10%	2.07%	1.03%
2,249.59	2,295.10	70	47	23	3.10%	2.07%	1.03%
2,295.11	2,340.64	88	59	29	3.80%	2.53%	1.27%
2,340.65	2,386.18	90	60	30	3.80%	2.53%	1.27%
2,386.19	2,431.72	92	61	31	3.80%	2.53%	1.27%
2,431.73	2,477.25	93	62	31	3.80%	2.53%	1.27%
2,477.26	2,522.79	95	63	32	3.80%	2.53%	1.27%
2,522.80	2,568.33	97	64	32	3.80%	2.53%	1.27%
2,568.34	2,613.87	98	66	33	3.80%	2.53%	1.27%
2,613.88	2,659.40	100	67	33	3.80%	2.53%	1.27%
2,659.41	2,704.94	102	68	34	3.80%	2.53%	1.27%
2,704.95	2,750.48	104	69	35	3.80%	2.53%	1.27%

MinnesotaCare Premiums
For April 2000 through March 2001

Family size:	**5**
FPG	$1,663
MA Maximum:	$929
MnCare maximum:	$4,572
Full premium:	$525

Gross monthly income		Premium Contribution by Number Covered			Premium Contribution as % of monthly income		
from	to	3	2	1	3	2	1
$2,750.49	$2,796.02	$133	$89	$44	4.80%	3.20%	1.60%
2,796.03	2,841.55	135	90	45	4.80%	3.20%	1.60%
2,841.56	2,887.09	137	92	46	4.80%	3.20%	1.60%
2,887.10	2,932.63	140	93	47	4.80%	3.20%	1.60%
2,932.64	2,978.17	142	95	47	4.80%	3.20%	1.60%
2,978.18	3,023.70	144	96	48	4.80%	3.20%	1.60%
3,023.71	3,069.24	146	97	49	4.80%	3.20%	1.60%
3,069.25	3,114.78	148	99	49	4.80%	3.20%	1.60%
3,114.79	3,160.32	151	100	50	4.80%	3.20%	1.60%
3,160.33	3,205.84	153	102	51	4.80%	3.20%	1.60%
3,205.85	3,251.38	190	127	63	5.90%	3.93%	1.97%
3,251.39	3,296.92	193	129	64	5.90%	3.93%	1.97%
3,296.93	3,342.46	196	131	65	5.90%	3.93%	1.97%
3,342.47	3,387.99	199	132	66	5.90%	3.93%	1.97%
3,388.00	3,433.53	201	134	67	5.90%	3.93%	1.97%
3,433.54	3,479.07	204	136	68	5.90%	3.93%	1.97%
3,479.08	3,524.61	207	138	69	5.90%	3.93%	1.97%
3,524.62	3,570.14	209	140	70	5.90%	3.93%	1.97%
3,570.15	3,615.68	212	141	71	5.90%	3.93%	1.97%
3,615.69	3,661.22	215	143	72	5.90%	3.93%	1.97%
3,661.23	3,706.76	273	182	91	7.40%	4.93%	2.47%
3,706.77	3,752.29	276	184	92	7.40%	4.93%	2.47%
3,752.30	3,797.83	279	186	93	7.40%	4.93%	2.47%
3,797.84	3,843.37	283	188	94	7.40%	4.93%	2.47%
3,843.38	3,888.91	286	191	95	7.40%	4.93%	2.47%
3,888.92	3,934.44	289	193	96	7.40%	4.93%	2.47%
3,934.45	3,979.98	293	195	98	7.40%	4.93%	2.47%
3,979.99	4,025.52	296	197	99	7.40%	4.93%	2.47%
4,025.53	4,071.06	300	200	100	7.40%	4.93%	2.47%
4,071.07	4,116.58	303	202	101	7.40%	4.93%	2.47%
4,116.59	4,162.12	364	243	121	8.80%	5.87%	2.93%
4,162.13	4,207.66	368	246	123	8.80%	5.87%	2.93%
4,207.67	4,253.20	372	248	124	8.80%	5.87%	2.93%
4,253.21	4,298.73	376	251	125	8.80%	5.87%	2.93%
4,298.74	4,344.27	380	254	127	8.80%	5.87%	2.93%
4,344.28	4,389.81	384	256	128	8.80%	5.87%	2.93%
4,389.82	4,435.35	388	259	129	8.80%	5.87%	2.93%
4,435.36	4,480.89	392	262	131	8.80%	5.87%	2.93%
4,480.90	4,526.42	396	264	132	8.80%	5.87%	2.93%
4,526.43	4,571.99	400	267	133	8.80%	5.87%	2.93%
4,572.00		525	350	175	*full cost*	*full cost*	*full cost*

Characteristics and Trends Among Minnesota's Uninsured Population[1]

Introduction

The Health Economics Program of the Minnesota Department of Health monitors Minnesota's health care market and develops estimates of the distribution of insurance coverage among Minnesotans. Studies describing the characteristics of the uninsured and trends among the uninsured population are important to policymakers as they continue to search for ways to increase access to health insurance for all people in the state. This issue paper examines various estimates of the rate of uninsurance in Minnesota, provides information on Minnesota's rate of uninsurance over time, describes changes in the demographic composition of the uninsured over the last decade, provides information on the characteristics of uninsured children, people of color, and low-income individuals in the state, and analyzes the availability of private and public health insurance for uninsured Minnesotans.

Estimates of the Number of Uninsured Minnesotans

Various surveys measuring health insurance coverage are conducted in Minnesota on a yearly and periodic basis. Results from these surveys continue to show that Minnesota has one of the lowest rates of uninsurance in the country.[1] Although these surveys agree on the low rate of uninsurance in Minnesota compared to other states, they do not agree on the number of uninsured Minnesotans. Current estimates of the uninsured in Minnesota range from 5.3% or 253,000 people to 9.6% or 458,000 people.

It is difficult to compare the estimates of the uninsured in Minnesota because each survey that measures the rate of uninsurance uses a different methodology. There are two surveys conducted on an annual basis that measure the rate of uninsurance at the national and state level. The Current Population Survey (CPS) provides a ***whole-year estimate*** of the uninsured, which means that the survey asks questions about insurance coverage during the entire year.[2] In addition, the CPS uses a ***residual approach*** to determine rates of uninsurance. In other words, the CPS does not directly ask about uninsurance, but assumes that a person is uninsured if they are not covered by the types of health insurance asked by the CPS. The Behavioral Risk Factor Surveillance System (BRFSS) also provides national and state estimates of the uninsured. However, the BRFSS does not ask about the insurance status of children. As a result, the uninsurance estimate provided by the BRFSS does not provide an estimate of the *entire* Minnesota population, but rather provides an estimate of the rate of uninsurance for adults over the age of 18.

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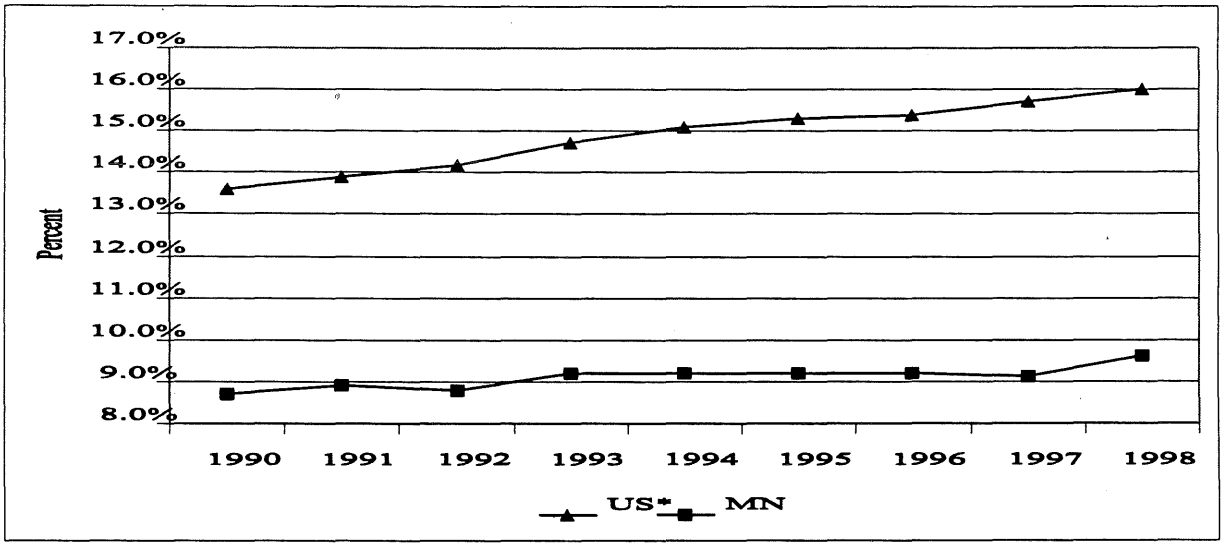
[1] Minnesota Department of Health economics Program, "Characteristics and Trends Among Minnesota's Uninsured Population." Forthcoming Issue Paper.

Periodic studies are also conducted that provide information on the insurance status of Minnesotans. The National Survey of America's Families (NSAF) conducted by the Urban Institute in 1997 provides a ***point-in-time estimate*** of the rate of uninsurance in Minnesota, which means that the estimate of the uninsured is based on the insurance status of a person at the time of the survey as opposed to during the entire year as assessed by the CPS. The University of Minnesota Health Access Survey conducted in 1990, 1995, and 1999 provides whole-year, point-in-time, and intermittent estimates of the uninsured.[3] Periodic studies tend to have larger sample sizes and provide more in depth information; however, a drawback to these surveys is that they are unsuitable either for making national and state comparisons or for tracking year-to-year trends in the uninsured.

Trends in the Rate of Uninsurance in Minnesota

Minnesota's rate of uninsurance, as estimated in the CPS and shown in Figure 1, has remained steady at around 9% during the 1990s. In contrast, the nation's rate of uninsurance has increased from 13.6% in 1990 to 16% in 1998. The changes in the rate of uninsurance from 1990 to 1998 are not significant for Minnesota, but they are for the U.S. Although the University of Minnesota's Health Access Survey and the BRFSS report different rates of uninsurance for Minnesota, they reach the same conclusion as the CPS. ***Minnesota's rate of uninsurance has remained stable, while the nation's rate of uninsurance has increased over the last decade.***

Figure 1 **Trends in Uninsurance Rates, MN and US**



* Uninsurance rates for the US from 1990 to 1998 are statistically significant at the 90% confidence level.

The uninsurance rates for the US and MN are based on three-year averages of CPS estimates. Because of year-to-year fluctuations that occur in data collection and estimation, the Census Bureau recommends that CPS data be averaged over a three-year period when comparing the uninsurance rates of a given state to those of another state or region.

Characteristics of the Uninsured

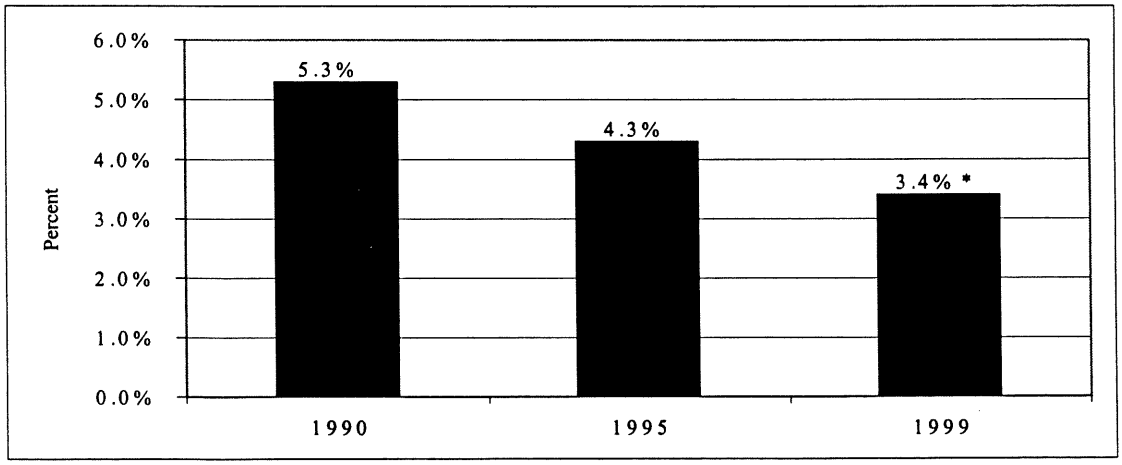
Although Minnesota's rate of uninsurance has remained stable since 1990, the demographic characteristics of the uninsured have changed from 1990 to 1999. Table 2 describes the current characteristics of the uninsured and compares the demographic composition of the uninsured from 1990 to 1999. Currently, the uninsured are most likely to be male (50.7%), be adults between the ages of 25 and 44 (42.4%), be white (83.4%), have incomes between 101% and 200% of the federal poverty level (37.6%), live in the Twin Cities metropolitan area (48.3%), be employed by someone else (55.2%), be single (41.2%), and have some college or technical school education (41.7%).

Several notable trends occurred among the uninsured population from 1990 to 1999. Statistically significant changes in the age, race, and income distributions of the uninsured occurred over this time period. Children made up a smaller proportion of the uninsured in 1999 (16.5%) than in 1990 (25%). Populations of color have an increased representation among the uninsured, rising from 5.6% in 1990 to 16.6% in 1999. The proportion of the uninsured with incomes below 200% of the federal poverty level dropped from 62.3% in 1990 to 47.7% in 1999 (table 2, page 4.)

Profile of Uninsured Children

Policymakers in Minnesota have placed particular emphasis on achieving universal access to health insurance coverage for children. From 1990 to 1999 the state of Minnesota succeeded in reducing the number of uninsured children. As shown in table 2, children made up a smaller proportion of the uninsured in 1999 (16.5%) than in 1990 (25%). In addition, figure 2 shows that the uninsurance rate for children decreased significantly from 1990 to 1999. Depending on the source, current estimates of the rate of uninsurance for children range from 3.4% to 5.5% or 42,000 to 68,000 children under 18.[4]

Figure 2 **Percent of Minnesota Children Uninsured**



Based on 1990-1999 University of Minnesota Health Access Survey data.
The percentages are based on point-in-time estimates of children ages 0 through 17.
* Significant difference from 1990 to 1999 at 90% confidence level.

TABLE 2: Demographic Characteristics of Minnesota's Uninsured Population

	1990	1995	1999
Gender			
Male	51.1%	55.2%	50.7%
Female	49.9%	44.7%	49.3%
Age			
0-5	6.1%	3.9%	3.9%
6-17	18.9%	14.3%	12.6%
18-24	19.9%	18.5%	23.1%
25-44	36.4%	46.0%*	42.4%
45-64	18.8%	17.2%	17.8%
Employment Status (adults)			
Self-employed	28.1%	24.4%	27.9%
Employed by someone else	51.4%	58.1%*	55.2%
Unemployed	17.3%	15.2%	15.4%
Retired	3.3%	2.2%	1.5%
Marital Status (adults)			
Single	41.5%	43.9%	41.2%
Married	42.4%	36.1%*	33.6%
Living with partner	N/A	12.1%	12.8%
Divorced/widowed/separated	16.0%	7.9%	12.5%
Race/Ethnicity			
White	94.4%	87.3%*	83.4%^
African American	3.2%	4.1%	7.5%^
American Indian/Alaskan	0.2%	2.5%*	2.1%*
Asian/Hmong/Pacific Islander	0.7%	1.2%	1.7%
Hispanic/Latino	1.2%	2.7%	2.7%
Other	0.1%	2.1%*	2.5%^
Education Level (adults)			
Less than high school	10.4%	10.1%	10.0%
High school degree	39.3%	36.6%	31.2%
Some college/tech school	38.6%	37.6%	41.7%
College graduate/Grad School/Beyond	11.7%	15.6%	17.2%
Geographic Region			
Twin Cities Metro	44.9%	55.3%*	48.3%
Other Metro	15.0%	11.8%	16.4%
Rural	40.1%	32.9%	35.3%
Income (as % of federal poverty guidelines)			
0%-100%	17.5%	11.8%	10.1%^
101%-200%	44.8%	33.3%*	37.6%
201%-300%	22.0%	27.3%	19.9%
301%-400%	8.9%	12.8%	10.5%
401%+	6.8%	14.6%*	21.9%^

Based on 1990-99 University of Minnesota Health Access Survey data.
The percentages are based on point-in time estimates of the uninsured.
* Significant difference from 1990 to 1995 at 90% confidence level.
^ Significant difference from 1990 to 1999 at 90% confidence level.

As shown in Table 3, uninsured children in Minnesota are most likely to be female (56.7%), be over the age of 6 (71.8%), be white (75.3%), belong to families with incomes below 200% of the federal poverty level (69.19%) and live with two parents (56.7%). (See table 3, page 6.)

There are at least two possible reasons for the decline in the uninsurance rate for children. The introduction and subsequent expansions of MinnesotaCare have helped to reduce the number of uninsured children. The MinnesotaCare program was created in 1992 to expand health care access to Minnesota's uninsured population through a publicly-subsidized health insurance plan. A University of Minnesota study published in 1997 concluded that the MinnesotaCare program had been successful in enrolling uninsured children.[5] Currently, 49,000 children ages 0 through 17 are enrolled in MinnesotaCare.[6]

Second, the decrease in the number of uninsured children may also be attributable to the rising incomes of Minnesota families. From 1990 to 1998, the inflation adjusted median household income in Minnesota increased by 22.1% while the median household income for the nation increased by only 4.1%.[7] This increase in household income may have helped families buy health insurance coverage for their children. From 1995 to 1999, the percentage of children enrolled in private group insurance plans increased significantly from 73.8% to 79%.[8]

Profile of Uninsured Populations of Color

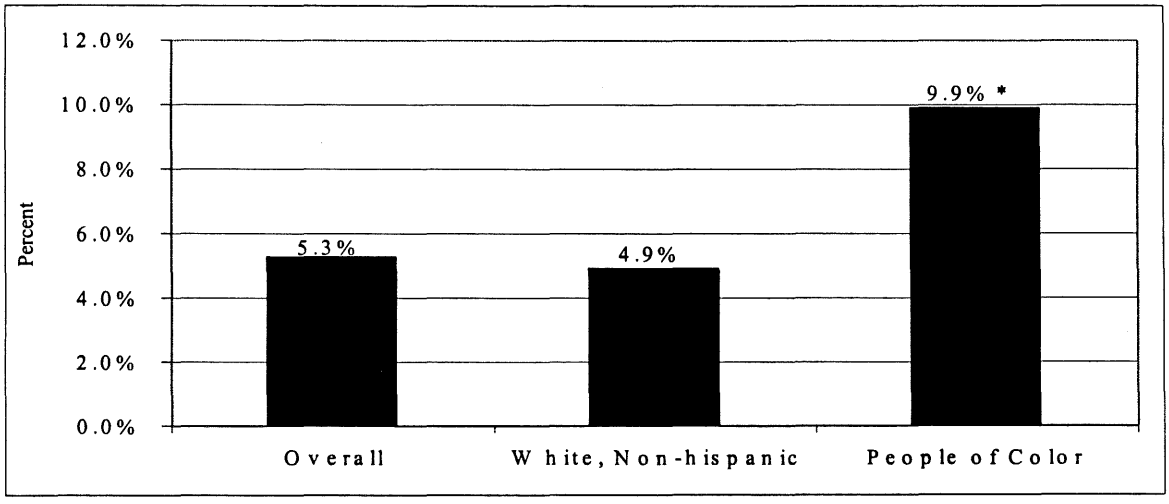
Although Minnesota continues to report one of the lowest rates of uninsurance in the country, certain racial and ethnic populations in the state report higher rates of uninsurance (see figure 3, page 6).[9] As shown in table 2, representations of populations of color among the uninsured increased from 5.6% in 1990 to 16.6% in 1999. Although populations of color have increased in size since 1990, this increase does not fully explain the increase in their representation among the uninsured. Populations of color comprised 6.2% of Minnesota's population in 1990 and 8.4% of Minnesota's population in 1998.[10]

One of Minnesota's health goals is to eliminate disparities in health insurance status among racial and ethnic groups. To eliminate this disparity, the state must do more to understand the characteristics of uninsured populations of color.

Table 3 Characteristics of Uninsured Children in Minnesota		
Sex	Male Female	43.4% 56.7%
Age	0 to 5 6 to 17	28.2% 71.8%
Race/Ethnicity	White Non-white	75.3% 24.7%
Income As % of Poverty		
	0% to 200%	69.1%
	201%	30.9%
Living Arrangements		
	Two parents in household	56.7%
	One parent in household	43.3%

Based on the Urban Institute's 1997 National Survey of America's Families (NSAF) data.
* Based on 1999 University of Minnesota Health Access Survey data.
The percentages are based on point-in time estimates of uninsured children ages 0 through 17.

Figure 3 **Uninsurance Rates by Race/Ethnicity, 1999**

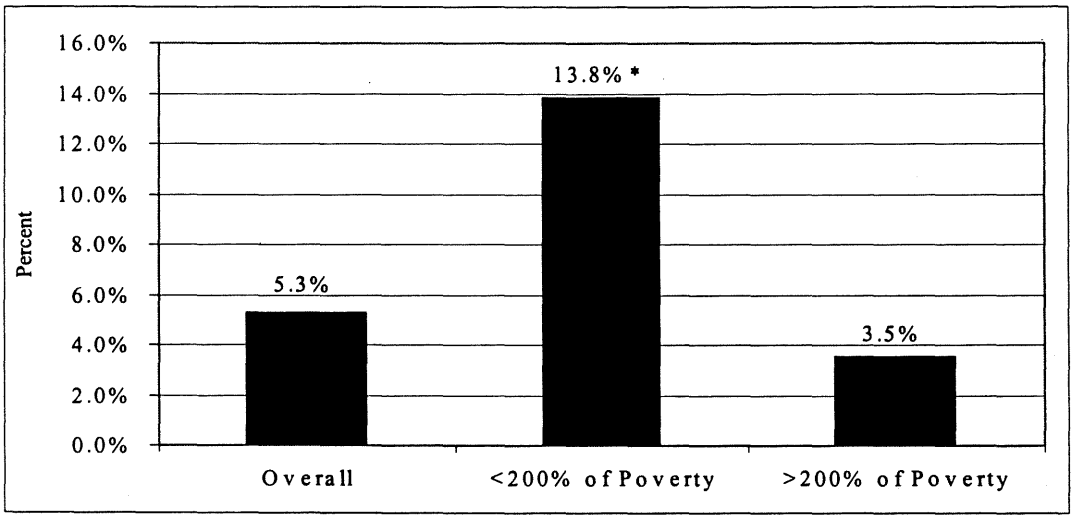


Based on 1999 University of Minnesota Health Access Survey data.
The percentages are based on point-in-time estimates.
* Significant difference from White, Non-Hispanic at 90% confidence level.

Profile of Low-Income Uninsured

Low-income people are at the greatest risk of being uninsured because they cannot afford to purchase insurance, do not work for an employer that offers health insurance, or are not eligible for employer-based coverage. Figure 4 shows that people with incomes below 200% of the federal poverty level are about four times more likely to be uninsured than people with incomes above 200% of the federal poverty level.

Figure 4 Low Income Uninsurance Rates



Based on 1999 University of Minnesota Health Access Survey data.
The percentages are based on point-in-time estimates.
* Significant difference from >200% of Poverty at 90% confidence level.

Although low-income people are more likely to be uninsured than high-income people, Minnesota has reduced the number of low-income uninsured. From 1990 to 1999, the proportion of the uninsured with incomes below 200% of the federal poverty level dropped from 62.3% to 47.7%. Part of the decline in the number of low-income uninsured is a result of the MinnesotaCare Program. Currently, 94,000 people or 85% of MinnesotaCare enrollees have incomes below 200% of the federal poverty level.[11] Without MinnesotaCare, a majority of low-income enrollees would go without health care coverage. A 1995 study reported that 88% of MinnesotaCare enrollees did not have access to employer-based insurance and that two-thirds would go without coverage if the program ended.[12]

The decrease in the proportion of the uninsured with incomes below 200% of the federal poverty level is also the result of economic prosperity. From 1990 to 1998, the inflation adjusted median household income in Minnesota increased by 22.1% and the percent of Minnesotans with incomes below the federal poverty level decreased from 12% to 10.4%.[13] Rising incomes and decreased poverty have likely contributed to the decline in the proportion of the uninsured with low-incomes.

There also appears to be geographic differences in the income levels of the uninsured. The low-income uninsured are more likely to live in a rural part of the state than the high-income uninsured. Data presented in table 4 suggest that there is still substantial opportunity to enroll people in MinnesotaCare in rural areas of the state. Approximately 45% of uninsured Minnesotans with low incomes live in rural areas, while only 35% of uninsured Minnesotans live in rural areas of the state (see table 2).

Table 4 Characteristics of the uninsured in Minnesota by Poverty Level

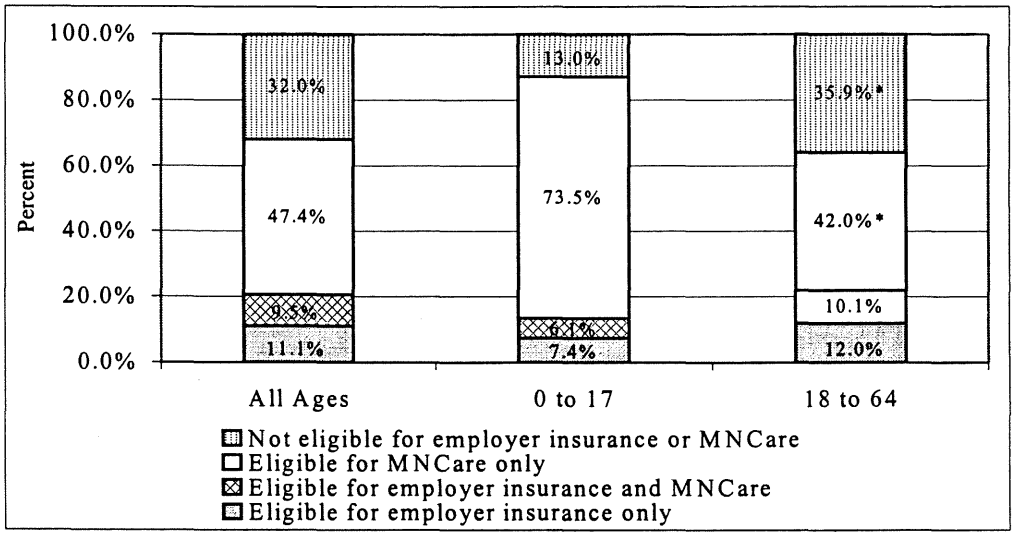
	< 200% of Poverty	> 200% of Poverty
Sex: Male	43.4%	56.8%
Female	56.2%	43.2%
Age: to 17	22.9%	12.7%
18 to 64	77.1%	87.3%
Race/Ethnicity: White	87.3%	92.1%
Populations of Color	12.7%	7.9%
Geographic Region		
Twin Cities Metro	36.0%*	56.1%
Other Metro	19.1%	14.0%
Rural	44.9%*	29.9%
Employment (Adults)		
Self-employed	23.2%	36.7%
Employed by Other	55.6%	52.6%
Unemployed	19.1%	10.2%
Retired	02.1%	00.6%
Marital Status (Adults)		
Single	35.1%	39.7%
Married	33.8%	35.3%
Living w/ partner	12.1%	16.3%
Divorced/widowed/se	19.0%*	8.7%
Educational Level (Adults)		
Less than High School	30.1%	20.8%
High school	26.9%	23.7%
Some college/tech	33.3%	36.1%
College Grad	9.7%	19.5%

Based on 1999 University of Minnesota Health Access Survey data.
The percentages are based on point-in time estimates of the uninsured.
* Significant difference from >200% of Poverty at 90% confidence level.

Availability of Health Insurance for the Uninsured

A large majority of the uninsured have access to employer-based coverage and/or MinnesotaCare. ***Approximately 73.5% of uninsured children in the state may qualify for MinnesotaCare based upon income and lack of access to employer-based coverage.*** Given this statistic, current programs appear to be in place to assure health insurance coverage for most of Minnesota's children. In total, 32% of uninsured Minnesotans do not have access to employer-based coverage or MinnesotaCare.

Figure 5 Availability of Private and Public Insurance for the Uninsured



Based on 1999 University of Minnesota Health Access Survey data.
The percentages are based on point-in-time estimates of the uninsured.
* Significant difference from age 0 through 17 at 90% confidence level.

Since most uninsured people in Minnesota either have access to employer-based coverage or potentially qualify for MinnesotaCare, it is important to understand why these people are uninsured. Of those who are eligible for employer-based coverage, 41.8% have incomes below 200% of the federal poverty level (see table 5, page 10). A recent national study also finds that approximately 20% of the uninsured have access to employer-based health insurance and that 75% of low-income uninsured workers cite cost as their main reason for declining employer coverage.[14] A large number of the uninsured with access to employer-based coverage may not be purchasing it because they cannot afford to pay their part of the premium. In addition, many of these people do not qualify for MinnesotaCare because they have access to employer-based coverage where their employer pays at least 50% of the premium.

Cost may be less of a barrier for most of the uninsured that are eligible for MinnesotaCare. In general, families and children with incomes below 275% of the federal poverty level and adults

without children with incomes below 175% of the federal poverty level are eligible for MinnesotaCare. The MinnesotaCare program operates on a sliding fee scale. Those with higher incomes pay higher premiums. Of those who are eligible for MinnesotaCare, 84.4% have incomes below 200% of the federal poverty level which places them in the middle to lower part of the sliding fee scale for MinnesotaCare (see table 5, page 10). Additional data indicates the importance of continuing the outreach efforts for MinnesotaCare already undertaken by the Minnesota Department of Human Services. In 1999, only 56.2% of the uninsured who were eligible for MinnesotaCare had heard of or been given information about the program.[15]

Table 5 Characteristics of the Uninsured by Insurance Eligibility

	Employer	MNCare	Not Eligible
Overall	20.6%	47.4%	32.0%
Sex Male	45.4%	48.4%	54.3%
Female	54.6%	51.7%	45.7%
Age 0 to 17	11.3%	26.7%*	7.0%
18 to 54	88.8%	73.3%*	93.0%#
Race/Ethnicity White	84.3%	81.2%	93.3%#
Populations of Color	15.7%	18.8%	6.7%#
Income as % of Poverty			
0% to 200%	41.8%	84.4%*	8.8%#^
210% to 300%	22.4%	15.6%	25.1%
301% to 400%	17.6%	00.0%	20.3%
401% +	18.2%	00.0%	45.8%^
Geographic Region			
Twin Cities Metro	45.0%	40.6%	57.0%#
Other Metro	18.3%	19.6%	13.4%
Rural	36.7%	39.9%	29.6%

Based on 1999 University of Minnesota Health Access Survey data.
The percentages are based on point-in time estimates of the uninsured.
* Significant difference between Employer and MNCare at 90% confidence level.
# Significant difference between MNCare and Not Eligible at 90% confidence level.
^ Significant difference between Employer and Not Eligible at 90% confidence level.

Conclusion

As policymakers search for ways to decrease the number of uninsured people in the state, several important facts should be remembered:

- In general, Minnesota's rate of uninsurance has remained stable in the 1990s, while the rate in the U. S. increased.
- The number of uninsured children has decreased since 1990 and 73.5% of

children who are currently uninsured may qualify for MinnesotaCare.

- Populations of color report higher rates of uninsurance and their representation among the uninsured increased significantly from 1990 to1999.
- The low-income uninsured comprised a smaller proportion of the uninsured in 1999 than in 1990, but they are still at greater risk of being uninsured than higher income individuals.
- Approximately two-thirds of uninsured Minnesotans may already be eligible for some form of coverage, either employer-based health insurance coverage or MinnesotaCare.

Current surveys conducted in Minnesota do not provide large enough sample sizes to allow for an in-depth analysis of the uninsured. To adequately assess and monitor the health insurance status of certain populations in Minnesota, surveys with larger sample sizes for populations of color, rural residents, low-income people, children, and young adults are needed. An annual or biannual Minnesota-specific survey with a large sample size would assist the Minnesota Department of Health and others in monitoring the rate of uninsurance and analyzing the uninsured population. The Health Economics Program will continue to use available data to monitor the rate of uninsurance and report periodically on the characteristics and trends of uninsured Minnesotans.

Notes

1. According to the CPS, Minnesota's rate of uninsurance in 1998 was 9.6%. Only Hawaii (8.7%) and Wisconsin (9.4%) had lower rates. The Behavioral Risk Factor Surveillance System (BRFSS) reports Minnesota's rate of uninsurance for 1998 as 8.5%. Only Hawaii (5.9%), Delaware (8.0%), Nebraska (8.0%), and Wisconsin (8.3%) had lower rates.

2. Although the CPS is intended to provide whole-year estimates of the uninsured, many researchers contend that the CPS actually reflects a point-in-time estimate or a mix between the two estimates. See Lewis, K., Ellwood, M., & Czajka, J. L. (1998). Counting the Uninsured: A Review of the Literature. The Urban Institute.

3. Call, K. T., et al. (1999). Minnesota Health Access Survey 1999, Final Report. University of Minnesota School of Public Health, Division of Health Services Research and Policy.

4. The point-in-time estimate of 3.4% or 42,000 uninsured children under age 18 is based on 1999 University of Minnesota Health Access Survey data. The Urban Institute NSAF data show that 5.5% or 60,000 Minnesota children under age 18 were uninsured in 1997.

5. Call, K. T., Lurie, N., Jonk, Y., Feldman, R., & Finch, M. D. (1997). Who is Still Uninsured in Minnesota? JAMA, 278(14), 1191-1195.

6. Minnesota Department of Human Services, enrollment as of July 1999.

7. U.S. Census Bureau, Statistical Abstract of the United States, 1999.

8. Based on 1996-1999 University of Minnesota Health Access Survey data.

9. The same sample sizes for populations of color were too small to report uninsurance rates for specific racial or ethnic populations.

10. U.S. Census Bureau, Population Division, Population Estimates Program.

11. Minnesota Department of Human Services, enrollment as of July 1999.

12. Lurie, N., Pheley, A., & Finch, M. (1995). Is MinnesotaCare Hitting its Target? Institute for Health Services Research, University of Minnesota School of Public Health and Hennepin County Medical Center.

13. U. S. Census Bureau, Statistical Abtract of the United States, 1999.

14. Cunningham, P. J., Schaefer, E. & Hogan, C. (1999). Who Declines Employer-Sponsored Health Insurance and is Uninsured? Center for Studying Health System Change, Issue Brief #22.

15. Based on 1999 University of Minnesota Health Access Survey data.

HEALTHY MINNESOTANS

Public Health Improvement Goals



2004

EXECUTIVE SUMMARY

Minnnesota Department of Health
September, 1998

Minnesota Public Health Improvement Goals

1. Reduce the behavioral risks that are primary contributors to morbidity and mortality.
2. Improve birth outcomes and early childhood development.
3. Reduce unintended pregnancies.
4. Promote health for all children, adolescents and their families.
5. Promote, protect and improve mental health.
6. Promote a violence-free society.
7. Reduce the behavioral and environmental health risks that are primary contributors to unintentional injury.
8. Improve the outcomes of medical emergencies.
9. Reduce infectious disease.
10. Promote the well-being of the elderly, those with disability, disease and/or chronic illness.
11. Reduce exposure to environmental health hazards.
12. Promote early detection and improved management of non-infectious disease and chronic conditions.
13. Promote optimal oral health for all Minnesotans.
14. Reduce work-related injury and illness.
15. Assure access to and improve the quality of health services.
16. Ensure an effective state and local government public health system.
17. Eliminate the disparities in health outcomes and the health profile of populations of color.
18. Foster the understanding and promotion of social conditions that support health.

INTRODUCTION

What is the vision for *HEALTHY MINNESOTANS*?

The *Healthy Minnesotans Public Health Improvement Goals* (henceforth referred to as *Healthy Minnesotans*) are statewide public health goals for Minnesota. The vision for *Healthy Minnesotans* is:

Healthy People in Healthy Communities - A Shared Responsibility

This statement is based on the spirit of social responsibility and the concept that there are fundamental linkages and a shared responsibility between all people in society.

While *Healthy Minnesotans* recognizes that protecting the health of the public is a basic responsibility of government, it also acknowledges that no one person, family, business, organization or government agency has the resources to bring about the changes needed. Therefore, *Healthy Minnesotans* also intends to focus broad community attention and inspire action toward addressing the three priority areas of opportunity, as well as the 18 identified public health improvement goals.

It is what we do collectively, in our communities, and personally that will move us as individuals and as a state towards a healthier future. *Healthy Minnesotans* is a call to action and also a reminder that we all share the benefits of and the responsibility for a healthy society.

What is the *HEALTHY MINNESOTANS* initiative?

The *Healthy Minnesotans* initiative is an evolving partnership which seeks to engage diverse segments of the community in working with the state and local government public health system to:

- Set agreed-upon goals and priorities;
- Identify effective strategies to address these goals;
- Clarify the complementary roles that each entity can play; and
- Mobilize communities to work collectively to improve health.

At the essence of the *Healthy Minnesotans* initiative is the idea that prevention and health promotion can hold down health care costs and improve quality of life. As such, none of the public health goals or objectives contained in this publication are intended to prompt new legislative mandates. Instead, each is intended to inspire voluntary action on issues that impact the health and well-being of people across the state — from reducing the number of tobacco users, to ensuring babies are born healthy, to helping the aged maintain their independence, to preventing or controlling the spread of infectious diseases such as tuberculosis, hepatitis and sexually transmitted diseases.

What purpose does *HEALTHY MINNESOTANS* serve?

Healthy Minnesotans serves multiple purposes. For example, the document:

- Serves as a reference tool with a complete listing of 18 statewide public health improvement goals and more than 200 objectives;
- Takes an incremental step toward the development of a common agenda for health through three overarching priorities which are intended to raise a broad awareness of public health issues and mobilize the community to improve the health of our state's population;
- Presents a menu of strategies to address health issues identified within the goals, with references to additional sources of information including a companion document with detailed information about each strategy presented in the goals; and
- Identifies additional work needed to aid the implementation of the current goals and lays the groundwork for stronger partnerships for the future.

A philosophical underpinning of *Healthy Minnesotans* is the concept of shared responsibility for health. The *Healthy Minnesotans* document can serve as one tool in helping to define individual and community roles and determine how these roles will be implemented. The document will have served its intended purpose if it engages these entities in population-based approaches to improving the public's health.

How were the *HEALTHY MINNESOTANS* goals identified?

The foundation for the development of the statewide public health improvement goals is a local public health planning process, in which the 49 Community Health Boards conduct assessments and identify priority health problems. The resulting Community Health Services plans are invaluable sources of information on the health needs of communities across the state.

To develop the statewide goals, the state commissioner of health called together leaders from 26 statewide organizations to form the Minnesota Health Improvement Partnership (MHIP). Since its inception in mid-1997, the MHIP and its work groups have successfully extended the agenda for improving the public's health beyond those areas for which the state and local government public health system has direct responsibility.

A similar and related public health agenda is produced at the national level. The process of developing national *Healthy People 2010* goals and objectives is currently underway.

As a result of the contributions of each of the 49 Community Health Boards and the work of the MHIP, *Healthy Minnesotans* contains a rich mixture of perspectives, energies and resources. As such, it reflects the strengths and resources of many partners within the

health system, and provides a framework for the use of Minnesota's public, private and nonprofit sectors in improving health.

How can people use *HEALTHY MINNESOTANS*?

Everyone is encouraged to participate in improving the health of the state. Achieving Minnesota's goals and objectives will require the combined efforts of state and local public health agencies, health care providers, businesses, community-based organizations, health plans, educational institutions, faith communities, all levels of government, and other communities, as well as families and individuals. These entities are urged to consider carefully how they might address the overarching priority areas when looking at the goals and objectives presented in this document. For example:

- Health-related organizations are encouraged to use this document in developing organizational plans and identifying priorities for collaboration;
- Purchasers of health care (*e.g.*, employers) might use *Healthy Minnesotans* objectives to invest in health promotion and disease prevention and early detection which provide long-range opportunities to cut health care costs dramatically;
- Larger organizations can use these data-based goals, objectives, and strategies to develop employee programs addressing particular health issues which research concludes affect employee productivity, absenteeism or both;
- Many organizations can use the goals to guide decisions about entering into voluntary partnerships with community-based or other organizations in order to address a local health-related issue; to set benchmarks for systems and operational planning and evaluation; to set research agendas; or to use them as criteria for awarding grant dollars;
- Individuals and families are encouraged to use suggestions for improving health and valuable information regarding the impact of a wide variety of personal habits presented in *Healthy Minnesotans* to explore their own definitions of a healthy life;
- Communities can use *Healthy Minnesotans* as a framework to build an agenda for health improvement;
- Faith communities, community-based organizations and businesses can use the framework to guide worksite and health promotion activities, current programs, special events, publications and meetings;
- Educational systems can choose to work on particular goals or objectives that affect student achievement and student welfare; and

- State and local government can use *Healthy Minnesotans* to achieve their missions. All government agencies are encouraged to review the document to identify areas for future collaboration.

What are the 18 public health improvement goals presented in *HEALTHY MINNESOTANS?*

The full *Healthy Minnesotans* document contains a narrative, specific objectives and strategies for each topic area presented in a goal. A synopsis of each goal begins on page 13 of this Executive Summary.

GUIDING PRINCIPLES

What are the guiding principles and values underlying *HEALTHY MINNESOTANS?*

A set of fundamental principles and values were used to guide the development of *Healthy Minnesotans*. When studied collectively, the set of guiding principles highlights an intent to focus community attention and inspire action toward achieving the public health goals. When studied separately, many of the guiding principles provide a glimpse of the range of forces and tensions that, in a delicate and dynamic balance, shape public health activities throughout Minnesota. The guiding principles include the following:

Focus on the Greater Good and Respond to Diverse Populations.
The Minnesota public health improvement goals are a blueprint to focus activity toward addressing conditions which affect the health of all members of a community; however, an appropriately balanced discussion of focusing on the greater good must also consider the need to be responsive to unique or particular population groups.

Maximize Return on Investment.
Health promotion and disease prevention comprise perhaps our best opportunity to reduce the ever-increasing portion of our resources that we spend to treat preventable illness and functional impairment. Success in targeting approaches to public health issues demands rigorous attention to the needs of population groups, balanced by sensible decision making within limited resources.

Call for Collective Action.
The publication of *Healthy Minnesotans* is a statewide call for collective action. Together, state and local health departments must fulfill their governmental responsibilities for public health, and communities must foster alliances among business and other public and private organizations to achieve healthy communities.

Enhance Healthy Years of Life.
The public health improvement goals are shaped by the simple principle of enhancing the length of healthy life for all Minnesotans. The World Health Organization defines health as: "a state of complete well-being - physical, social, and mental - and not merely the absence of disease or illness." As such, the goals address the full range of components incorporated into this rich definition of health.

Emphasize Science and Acknowledge Community Priorities.
Epidemiologic methods of collecting, analyzing and sharing information about an entire population's health status provide the cornerstone for public health practice and policy. However, community and organizational norms and values also come into play as communities and organizations develop priorities to guide decisions about the allocation of resources.

Anticipate the Future.
The public health improvement goals are intended as a living document to provide a framework for developing policies and programs which anticipate the public health needs of the future. The process of



determining how Minnesotans' health can be improved includes building the capacity to measure and track important health indicators, deciding which health conditions will be tracked over time, committing resources to analyze and disseminate data and using the data to guide good public policy, implementation and evaluation of health programs.

Give Priority to Prevention.
The public health improvement goals are developed with the knowledge that health promotion and disease prevention activities reap impressive results in longer life and fewer illnesses and premature deaths. This long-standing commitment to the principle of giving priority to prevention is an investment in our future.

Highlight Underlying Conditions Affecting Health.
Highlighting underlying causes results in effective interventions that help to prevent disease, disability and premature death and their associated treatment expenses. The goals also highlight underlying causes for health promotion, such as assets and strengths that work to promote health.

PRIORITIES

What are the priority areas of opportunity for improving the health of Minnesotans?

Three themes emerge as critical priorities for assuring a healthy future for all Minnesota residents. All organizations are urged to consider carefully how they can address the three priority areas when looking at the goals and objectives presented in this document. It is only through concerted attention to these priority areas that we will move ahead in improving the health of Minnesota residents. The three critical priority areas of opportunity for improving the health of all Minnesotans include:

Assuring a Foundation for Health Protection.
At no time is the need for a responsive and effective foundation for health protection more evident than when residents of Minnesota are dealing with the effects of natural or human-made disasters. A variety of entities carry out activities to protect health. Minnesota's government public health system is an integral part of that foundation for health protection. The state and local government public health system's statutory responsibilities for health protection include an assurance function to see that appropriate health protection steps are taken. Thus, the ability to mobilize quickly to protect health rests, in part, on society's ongoing commitment to supporting and maintaining the government's public health system.

Eliminating Disparities in Health Status.
Minnesota consistently scores near the top in national surveys ranking states on the health of their residents. However, despite these relatively good overall health outcomes, disparities among special populations persist. In particular, Minnesota is among the states with the greatest ratio of health status disparity between Whites and African Americans, American Indians and other groups. Populations of color in Minnesota are at greater risk of suffering from cancer, heart disease, stroke, chemical dependency, diabetes, homicides, suicides, unintentional injuries and HIV/AIDS. If action is not taken immediately, the problem will only worsen. Concerted action on the part of state and local public health agencies, community-based organizations, and the entire health care industry is needed to address existing health disparities.

Increasing Years of Healthy Life.
A goal of Minnesota residents is to have a long and healthy life. While this concept may seem intuitive, the addition of quality of life considerations into discussions of health has major implications for many of the organizations that work to improve health. This will be particularly true as Minnesota's large population of baby-boomers ages.

LOOKING FORWARD

What needs to be done to advance the vision of *HEALTHY MINNESOTANS?*

The MHIP recommendations to the state commissioner of health for future work and improvements related to the goals are presented in the Looking Forward section of *Healthy Minnesotans.* In addition to aiding in the implementation of the current goals, these recommendations lay the groundwork for stronger partnerships and improvements in developing and implementing public health improvement goals to be published in 2002. The MHIP, therefore, urges the Minnesota Department of Health (MDH) to begin working to implement these recommendations immediately. The recommendations are summarized below:

Focus Efforts to Achieve Priorities.
The sheer volume of possible directions within the goals has led to numerous questions about health priorities in Minnesota. *Healthy Minnesotans* sets forth three priority areas to guide health improvement efforts of the public, private, and nonprofit sectors. Future iterations of the goals should improve the process and product of developing agreed upon state level health priorities through the systematic use of assessment data, the Community Health Services plans and broad community input. The work of the Population Health Assessment Workgroup, (PHAWG) a subgroup of the MHIP, should be incorporated, as appropriate.

Identify Measurement Capabilities to Better Define Healthy Life.
Future editions of the goals would benefit from a rigorous use of population health data to present a comprehensive picture of the factors that affect health. Since this presentation requires strengthening and expanding those measures so that reliable and valid information is available, the state commissioner of health has asked the PHAWG to take a future-oriented look at these issues.

The PHAWG has had numerous discussions that point to an evolution of surveillance and health information systems to include not only mortality data such as years of potential life lost (YPLL), but morbidity and disability measures such as quality-adjusted life years and disability- adjusted life years. The need for more sophisticated measures of health status will become increasingly evident as the aging of the state's population continues. Cost effectiveness and cost benefit analysis as well as burden of illness data are also needed to determine the return on investment of health care resources.

In the longer term, the work of the PHAWG can lead to a better-informed discussion of public health priorities by providing both a better understanding of the factors that affect health, and a framework for linking the economics of public health with the health care system.

Another concept to be explored is that of "public health impact statements," similar to the idea behind environmental impact statements which are part of a many projects.



Improve Understanding of the Resource Commitment Needed to Accomplish Public Health Improvement Goals and the Economic Benefits of Such Investments.
Accomplishing the goals will require a commitment of resources (*e.g.*, time, funds, and public support). However, the relationships between investments in health improvement goals and the economic benefits resulting from those investments have not been clearly understood or articulated. The relationships of specific actions, health outcomes, costs, and benefits are extremely complex and cannot be summed up in a short statement. More discussion and analyses are needed to move toward greater understanding of these issues and ultimately to a stronger resource commitment to public health improvement goals.

Identify and Disseminate Evidence-based Public Health Strategies.
The importance of having a solid evidence base for public health interventions is increasingly apparent. Not only are nontraditional partners investing time and resources to work toward improved health, but resources that the public health system has to devote to these issues are increasingly limited. The identification of cost-effective interventions is a critical step to maximizing return on investments in public health made by the public, private and nonprofit sectors.

Initial steps towards an evidence-based approach have been taken in producing this document. A number of strategies are presented in summary form within *Healthy Minnesotans*, while a separate document with a more detailed description of the strategies and the evidence-base supporting those strategies will be published as a companion document. These efforts should continue on a systematic and increasingly rigorous basis, building on federal work as it is disseminated. Information on effective strategies should be communicated regularly to Community Health Boards and other partners.

Identify and Communicate the Relationships Between Social Conditions and Health.
Fostering an understanding of the social conditions that affect health is a new goal area in *Healthy Minnesotans*. The eighteenth public health improvement goal is seen as a developmental goal, in that the initial efforts must focus on identifying and articulating the relationships between social conditions (*e.g.*, poverty, housing, education, isolation and transportation) and health. Since this is a new subject area within the goals, public health organizations do not necessarily have systems in place to address this goal. Therefore, it will take specific efforts on the part of the MDH and the MHIP members to identify and implement action steps to achieve the objectives that are set forth with respect to this goal. By laying the groundwork now, it is anticipated that future versions of *Healthy Minnesotans* can set forth objectives which describe actions that health-related organizations can take to address these issues.



Increase Broad Community Participation in the Development and Implementation of Public Health Improvement Goals.
Additional efforts to elicit the involvement of broad segments of the community in public health improvement goals are needed at both the state and local levels. At the state level, the MDH and the MHIP partners should seek to involve representatives of voluntary and nonprofit organizations, the educational system, the health care industry, and the business sector in discussions of prevention and public health goals, in a way that is sensitive to the differing interests and capacities of those entities. A mechanism for community input into local goals already exists as part of the Community Health Services planning process. This process should be supported and strengthened as a way to increase community support and participation in improved community health.

Together, public, private and nonprofit sectors should look for ways to identify and work jointly on areas of common concern. For example, affordable health care is a shared concern of the business and public health communities. In addition to an overarching interest in assuring affordable health care for Minnesota residents, the MHIP partners (including the MDH) are employers and are directly affected by rising health care costs. As one way to contain costs, representatives of the business community have advocated for a review process to examine legislative mandates related to health care coverage. Because legislative discussions of mandates are emotionally-charged and encompass many points of view regarding cost effectiveness, the MDH has also taken the position that these issues would benefit from an objective review of the scientific and fiscal evidence surrounding a particular benefit in a less emotionally charged venue.

Increase Health Care Provider/System Awareness and Commitment to Public Health Improvement Goals.
Health care providers (*e.g.*, physicians) and systems are critical to the achievement of many, if not most, of the health improvement goals set forth in *Healthy Minnesotans*. Although the relationship between medicine and public health was close prior to the early twentieth century, these systems have operated in a more isolated fashion in recent years. However, the need for these systems to work in coordination is becoming more widely articulated and accepted. The goals, objectives, and strategies identified in *Healthy Minnesotans* can provide a unifying framework and common agenda to work more closely together. Since past versions of public health goals have been seen as goals for the public health system exclusively, specific efforts will be needed to promote the goals to health care providers and systems.

Address the Health Needs of All Populations with Disparate Health Status.
Healthy Minnesotans has taken a step forward in highlighting health disparities that exist within racial and ethnic populations in Minnesota. Whenever possible, specific data were included to identify disparities and set forth targets to reduce or eliminate those disparities. Similar efforts are needed to



highlight and address the health needs of all populations with disparate health status. Future versions of *Healthy Minnesotans* should attempt to identify subpopulations experiencing disparities related to a specific goal, and develop objectives and strategies to reduce those disparities. This may be a long-range goal because refinements in assessment and health information will be necessary in many cases to obtain the type of data needed.

Working relationships should be developed with individuals and organizations that provide health care to populations experiencing disparate health status in order to jointly develop and implement strategies to reduce those disparities. One example is working with Indian tribal councils and their health care organizations.

Initiate Ongoing Communications Efforts Around the Public Health Improvement Goals.

A strong recommendation of the MHIP is that the MDH, with the assistance of the MHIP partners, undertake *ongoing* communications efforts around the public health improvement goals. Those communications efforts should be targeted in order to maximize the impact of available resources, and explain why it is important to achieve the goals in terms that are relevant to specific audiences and partners.

The three overarching priority areas of opportunity should be a major theme in communications efforts around *Healthy Minnesotans.* In addition, communications should be initiated on increasing awareness of the social determinants of health, which is a new subject area within *Healthy Minnesotans*. Whenever possible, specific suggestions should be made about how an organization or sector can contribute to the achievement of the goals. In addition, communications efforts should describe the role that the governmental public health system plays in achieving public health improvement goals.

The MDH and the 49 Community Health Boards (CHBs) should undertake joint communications about state and local goals. In addition, they should work on an ongoing basis to ensure that linkages are made to planning efforts of other state and local organizations. The MDH and the MHIP partners should communicate on an ongoing basis about critical issues in the public health goals with key decision makers about the goals, including the state legislature and the governor. In addition, communications efforts should target purchasers of health care such as businesses, the departments of Human Services and Employee Relations, other governmental units, school districts and unions. Specific efforts should be made to communicate about the goals to communities with disparate health status.

The MDH plays a unique role as the convener around public health goals at the state level. As part of this role, the department should undertake regular progress reports and updates around the goals, similar to the federal Centers for Disease Control and Prevention (CDC) updates for Healthy People 2000. This type of regular communication can serve as an



ongoing mechanism to accomplish the following:

- Keep the goals in front of diverse audiences;
- Document progress toward the goals;
- Highlight activities underway; and
- Share new information related to selected goals.

Refine Goals Development Process.
A number of process considerations and recommendations were identified by the MHIP and the Public Health Goals Work Group for the development of future versions of the goals, including the following: incorporating the next CHS plans into the expanded statewide goals process for 2002; building time for public input through public meetings and other mechanisms; aligning *Healthy Minnesotans* to national *Heathy People* goals; developing objectives and indicators that are relevant to different sectors and organizations; allowing ample time for organizations to move each part of the process through their organizations; and encouraging organizations to build internal processes to collect their organization's thoughts and ideas and funnel them into the process.

GOAL 1 Reduce the behavioral risks which are primary contributors to morbidity and mortality.

Every year, chronic diseases claim the lives of more than one and a half million Americans. These diseases account for seven of every 10 deaths in the U.S. each year and for more than 60 percent of total medical expenditures. In addition, the prolonged illness and disability associated with many chronic diseases result in decreased quality of life for millions of Americans.

Much of the chronic disease burden is preventable. To a considerable degree, the major chronic disease killers (e.g., heart disease, stroke, cancer, and diabetes) occur as a result of peoples' responses to their physical and social environments. As technology and industrialization advance, there is less demand for physical activity, unhealthy meals are often faster and less expensive than healthier choices, and there is easy access to an abundance of tobacco and alcohol. People's health-damaging responses (physical inactivity, poor nutrition, tobacco use and misuse of alcohol,) account for much of the chronic disease burden (see chart below). Effectively addressing these underlying causes of disease, therefore, has a multiplier effect, resulting in the prevention of multiple disease outcomes.

Figure 1.1 Actual Causes of Death in the U.S.

Cause	Estimated Number of Deaths in 1990	Percentage of Total Deaths*
Tobacco	400,000	19%
Diet/Activity Patterns	300,000	14%
Alcohol	100,000	5%
Microbial Agents	90,000	4%
Toxic Agents	60,000	3%
Firearms	35,000	2%
Sexual Behavior	30,000	1%
Motor Vehicles	25,000	1%
Illicit Use of Drugs	20,000	1%
TOTAL:	1,060,000	50%

(*) Total number of deaths in 1990 was 2,148,000.

SOURCE: J. Michael McGinnis and William H. Foege, "Actual Causes of Death in the United States," *Journal of the American Medical Association*, 270.18 (November 10, 1993): 2207-2212.



GOAL 1 (con't.) Reduce the behavioral risks that are primary contributors to morbidity and mortality.

Chronic diseases do not have to be an inevitable consequence of aging. Because chronic diseases develop over decades, they can be reduced if individuals engage in healthier behaviors. However, individuals' behaviors are largely determined by the social and physical environments in which they live, as it is there where norms are established and where people find support for, or barriers to, healthy behaviors. If a community does not support healthy behaviors, it is much more difficult for an individual to make lasting behavioral changes.

In order to create a healthy community, we must promote strategies which involve all sectors of the community, including families, schools, work sites, local government and community organizations. The entire community needs to take an active and positive role in changing those community factors that continue to place people at risk. Possible strategies include promoting work-site exercise programs to make it easier for individuals to be active, working with schools to provide more nutritious lunches, or advocating regulatory policies that make tobacco less accessible to children. Building healthier communities requires providing individuals with the knowledge and tools they need to continue with healthy behaviors or change unhealthy ones.

Because life-long health behaviors are often established in childhood and become increasingly difficult to change with age, creating healthier communities involves paying special attention to measures that work to prevent children from adopting unhealthy behaviors. By creating communities which prevent young people from adopting unhealthy behaviors, and which encourage and support healthy behavior at all ages, we can significantly reduce the chronic disease burden.

The following topic areas are specifically addressed in *Healthy Minnesotans:*

- Tobacco Use
- Alcohol and Other Drug Use
- Physical Activity/Inactivity
- Nutrition
- Weight Management



GOAL 2 Improve birth outcomes and early childhood development.

Healthy family development is one of the highest priorities and one of the biggest challenges facing public health at the national, state and local levels. Healthy families are essential for healthy communities, and improving birth outcomes of Minnesota mothers and infants is essential to the promotion of healthy family development.

Improving comprehensive approaches to the entire spectrum of reproductive health is necessary to improve birth outcomes, prenatal care and women's health. Health care systems, primary care providers and parents working together can reduce the occurrence of poor birth outcomes and enhance early childhood development. More health care systems which reflect the needs and makeup of the communities they serve are needed. Primary care providers who offer universal, comprehensive and culturally-acceptable preconception, prenatal and postpartum services will improve birth outcomes and women's health. Planning a pregnancy; enrolling in early prenatal care; eliminating alcohol, tobacco and other drug usage; and breastfeeding are all things parents can do to improve the health of their pregnancy and enhance the health of their infant.

The following topic areas are specifically addressed in *Healthy Minnesotans:*

- Birth Outcomes and Prenatal Care
- Breastfeeding
- Women's Health
- Early Childhood Development

GOAL 3 Reduce unintended pregnancies.

Whether intended or unintended, pregnancies result from individual decisions about sexual activity. Unintended pregnancies are those pregnancies that women report as unwanted or mistimed. It is estimated that 60 percent of all pregnancies in the U.S. are unintended, and recent studies show an increase in the number of births resulting from unintended pregnancies. Data reveal that adults, as well as adolescents, are having difficulty in preventing and planning pregnancy.

Unintended pregnancies, especially those unwanted (as distinct from mistimed), involve risks for the children, women, men and families concerned. Women whose pregnancies are unintended are less likely to seek early prenatal care and to avoid exposing the fetus to harmful substances such as tobacco and alcohol, than are women who become pregnant intentionally. Adequate use of prenatal care services is good insurance for a healthy pregnancy, birth and baby. It was reported that 11 percent of pregnant women under age 18 in Minnesota received no prenatal care or used it inadequately throughout their pregnancy.

Unintended pregnancy is also associated with many social problems which later affect children and families. These problems include poverty, school failure and juvenile criminal activity. A complex set of social and psychological factors put women at risk for unintended pregnancy. These factors include poverty and low self-esteem; lack of information, resources, and skills for finding and making use of appropriate preventive services; the stresses of coping with adolescence; estrangement from family; threats or encounters with violence and abuse; school failure; chemical use; and provocative portrayals of sexuality by the media.

Research indicates that educational programs (particularly for young adolescents) focusing on postponing sexual involvement and assertiveness skill building can help to reduce unintended pregnancy. For people who are sexually active, health education and non-directive counseling, increased access to family-planning-method services, and public education may prove effective in reducing unintended pregnancies. However, in order to effectively plan programs to prevent unintended pregnancies, better understanding is needed of communication relating to sexuality and relationships, of behaviors that affect use of contraceptives, and of use of family-planning methods. Accurate assessment data are required to better identify the demographics and needs of the population at risk so that effective strategies and adequate resources can be appropriately targeted.

This goal will require a multifaceted, comprehensive approach involving public health professionals, medical clinicians, nonprofit corporations, the educational system and communities. While it is important to implement strategies in Minnesota on the individual, community and system levels, experts at the Alan Guttmacher Institute have concluded that it is only when the entrenched poverty among disadvantaged women is alleviated, and women and their partners have access to good school and jobs, and come to believe that their futures can be brighter, that real change in their sexual behavior and the resulting outcomes is likely to occur.

The following topic area is specifically addressed in *Healthy Minnesotans:*

- Unintended Pregnancies



GOAL 4 Promote health for all children, adolescents and their families.

Assuring optimal health for all children, adolescents, and their families is a major goal for those interested in maintaining and improving the public's health. According to the 1996 census, almost 30 percent of Minnesota's population is 19 years or younger. This very large segment of the population presents a wide range of challenges to health professionals and policy makers because of the diversity it incorporates. Selected demographic trends, however, demonstrate some common themes: 1) an increase in the number of children living in poverty; 2) an increase in the number of adolescents; and 3) an increase in the number of children of color. These demographic trends will require different approaches in health care and will affect how health care is financed and delivered.

Successful health promotion activities for children and adolescents focus on:

- Healthy growth and development;
- The importance of parents and care givers in the healthy development of children and adolescents;
- Early identification of health risks; and
- Early intervention to address health risks before serious health problems occur.

These activities include a focus on the behavioral and social (in addition to physical) factors that influence health. They are delivered by a broad array of public, private, and voluntary providers, primarily in the health, education and social service fields. A collaboration of efforts increases the success of health promotion activities. Steps to achieve this goal are furthered through policies and programs that not only promote the health of Minnesota families, but also foster a system of quality health care services that are coordinated, family centered, developmentally appropriate and culturally competent.

There are four types of objectives for child, adolescent, and family health promotion in this chapter. These four types of objectives are focused on:

- Fostering resiliency and positive youth development activities;
- Decreasing social risk factors;
- Increasing the number of children and youth who receive developmentally appropriate health promotion services; and
- Increasing early intervention for youth diagnosed with health problems.

The following topics areas are specifically addressed in *Healthy Minnesotans:*

- Children's Health
- Adolescent Health

GOAL 5 Promote, protect and improve mental health.

Mental disorders can occur throughout the life span, but the type and nature of the illnesses vary with age. According to a recent Institute of Medicine report, at least 12 percent of our nation's 63 million children and adolescents suffer from one or more mental disorders, including autism, attention deficit hyperactivity disorder, severe conduct disorder, depression, and substance abuse and dependence. Suicide is the second-leading cause of death among adolescents. At the other end of the life span, approximately four million older people suffer from Alzheimer's disease, and approximately 15 to 25 percent of elderly in nursing homes are clinically depressed. More than half of the people who have had a major bout of depression will have another episode at some point in their lives. Mental illness of this magnitude places an extraordinary burden on the financial and social resources of the state. It was estimated that for 1990 the total national costs related to mental illnesses (not including alcohol and drug abuse) were $147 billion (Rice, Kelman, Miller and Dunmeyer, *Economic Costs of Alcohol and Drug Abuse and Mental Illness Report*, 1990).

Mental and physical health are closely linked, and the contribution of mental health to physical well-being must be considered. Likewise, physical illness can also cause serious mental problems and, in some cases, may even have its origin in psychosocial processes (Institute of Medicine, 1989). Some studies indicate that 60 percent of visits to physicians for medical symptoms are due in part or in whole to psychosocial problems (Reiger, Goldberg, and Taube, 1978).

Although precise figures of the numbers of people with mental illness are hard to come by, it is estimated that 20 percent of adults suffer from an active mental disorder in a given year, and 32 percent can be expected to have such an illness sometime during their lives.

There is perhaps no illness or disability that is as shrouded in myth and marked by stigma as mental illness. Only 10 to 30 percent of those in need receive appropriate treatment (Institute of Medicine Report, 1993). Thus, it is critical that we take aggressive actions to promote, protect and improve mental health in Minnesota.

The following topic areas are specifically addressed in *Healthy Minnesotans:*

- Depression
- Mental Illness
- Children's Mental Health

GOAL 6 Promote a violence-free society.

Violence can be defined as words and actions that hurt people. Acts of violence include homicide, suicide, firearm-related injury, child maltreatment, domestic and intimate partner violence, sexual violence, youth violence, maltreatment of the elderly and vulnerable adults, workplace violence, and bias-motivated assaults. While overall crime rates remain fairly constant, the impact of interpersonal violence and suicide extends its reach across multiple generations of families, communities and systems.

While violence cannot be attributed to any one cause or prevented through a single approach, it is ideally suited to a community-based, public health approach. This approach includes:

- Collecting and analyzing violence data;
- Designing multidisciplinary interventions based on scientific evidence, violence prevention theory, and input from those community members most affected by violence;
- Developing community-wide, multiple source monitoring systems to track the effects of interventions;
- Utilizing a population focus to maximize reach and to include service providers, policy makers, and marginalized populations; and
- Examining individual behaviors and environments as well as social behaviors and environments.

As a Minnesota health issue, violence affects all aspects of life. Physical and mental health are nurtured and allowed to flourish in families and communities that are violence free.

The following topic areas are specifically addressed in *Healthy Minnesotans:*

- Interpersonal Violence
- Suicide



GOAL 7 Reduce the behavioral and environmental risks that are primary contributors to unintentional injury.

In Minnesota, injury causes more deaths among children and young people than does disease. Unintentional injury is the single greatest killer of Minnesotans between the ages of one and 34. In 1996, 40 percent of the deaths of people aged one to 34 were the result of unintentional injury. Furthermore, unintentional injury continues to be among the leading causes of death throughout a lifetime. Motor vehicle crashes are the foremost cause of injury fatalities, followed by falls, poisoning, suffocation, fire and drowning.

Each year, unintentional injuries affect many additional Minnesotans. They seek medical attention, are unable to perform normal activities, or are permanently disabled as a result of injury. Injuries from falls, being struck by or against something, and motor vehicle crashes accounted for 18 percent of all emergency room visits in Minnesota during 1993-1994.

Injuries are preventable. Multifaceted prevention strategies are the most effective. Successful injury prevention strategies include a focus on environmental design, product design, human behavior, education, and legislative and regulatory requirements that support environmental and behavioral change.

The following topic areas are specifically addressed in *Healthy Minnesotans:*

- Motor Vehicle-related Injury
- Home and Leisure Injury



GOAL 8 Improve the outcomes of medical emergencies.

Emergency Medical Services (EMS) are the group of related services that provide acute care for injury or disease prior to hospital admission. Service providers include dispatchers, first responders (public safety and fire services), ambulance services, and acute and tertiary care emergency medical facilities. Quality patient care remains the key concept around which any emergency medical system must operate.

Emergencies requiring emergency medical response need to be reported immediately to the appropriate community agencies that manage and control EMS resources and services in order that EMS resources are provided within a time period that will ensure the greatest reduction of morbidity and mortality. Once accessed, EMS resources, related health agencies, and health professionals must coordinate responses in the shortest effective time to meet medical emergency needs.

The following topic area is specifically addressed in *Healthy Minnesotans:*

- Emergency Medical Services Infrastructure



GOAL 9 Reduce infectious disease.

The prevention and control of infectious diseases are essential to achieving a healthy population. One of the principal public health activities of this century has been a significant reduction in the incidence of selected infectious diseases. This success is graphically illustrated by the global eradication of smallpox and the virtual elimination of diphtheria and poliomyelitis in the U.S. Much of the progress has been a result of improvements in living standards, basic hygiene, pasteurization and water treatment. The development and widespread use of childhood vaccines has also had a significant impact on the reduction of infectious diseases. Furthermore, the development and use of antimicrobial drugs has reduced the morbidity and mortality associated with a number of infectious diseases.

Despite these successes, infectious diseases continue to pose an important public health problem. Today, the issue of emerging and re-emerging infectious diseases is at the forefront of public health concern. A number of newly-recognized diseases, including Legionnaires' disease, toxic shock syndrome, Lyme disease, human immunodeficiency virus (HIV) infection, hantavirus, and new food borne infections have been well documented, as has the emergence of antimicrobial resistance. The very young, older adults, and hospitalized and institutionalized patients are at increased risk for many infectious diseases. Changes in lifestyle, technology, land-use practices, food production and distribution methods, and child care practices, as well as increasing poverty, have each played a role in emerging infections. Finally, for some infectious diseases, there is evidence of recent genetic changes in the infectious agent that results in substantially increased risks of serious disease. An example of this problem is the emergence of a more pathogenic and virulent strain of *Neisseria meningitidis* bacteria, which results in outbreaks of meningococcal meningitis.

Many infectious diseases which threaten the health of the general population are preventable and are controllable. Prevention and control of infectious diseases involve collection of accurate assessment data (such as surveillance data for specific conditions), outbreak detection and investigation, and development of appropriate control strategies (both short and long term) based on specific epidemiologic data. These activities require close collaboration between clinical providers (especially infection-control practitioners within hospitals and physicians), clinical laboratories, state and local health departments, and federal agencies. Furthermore, a need exists for continued education of the public, industries (particularly food producers and food service industries), health care students and providers, along with research to improve immunizations, diagnostic methods and therapeutic modalities. Thus, the prevention of infectious diseases requires multidisciplinary interventions involving public health professionals, medical practitioners, researchers, community-based organizations, volunteer and private groups, industry representatives and educational systems.

Measurable objectives for the control of infectious diseases have been set forth for tuberculosis, sexually transmitted diseases, HIV/AIDS, vaccine-preventable diseases, refugee health and

selected emerging infections. These diseases are included because: 1) surveillance systems are in place to accurately measure disease burden; and, 2) strategies are available that will likely decrease the incidence of these diseases. Further research on other important infectious diseases is needed so that appropriate prevention strategies can be developed.

The following topic areas are specifically addressed in *Healthy Minnesotans:*

- Tuberculosis
- Vaccine-Preventable Diseases
- Sexually Transmitted Diseases, Human Immunodeficiency Virus (HIV), and Acquired Immunodeficiency Syndrome (AIDS)
- Emerging Infectious Diseases
- Refugee Health



GOAL 10 Promote the well-being of the elderly, those with disability, disease and/or chronic illness.

The elderly and individuals with disability, disease and/or chronic illness have health promotional needs that require changes in policy and practice in relation to housing, social care, transportation, leisure and financing mechanisms. Matching appropriate services to the needs of these populations will require careful planning if the state is to live within its fiscal means. In order to promote the well-being of these populations, a focus on basic care needs (food, fluids, cleanliness, sleep, mobility and toileting) must be expanded to include physical and psychosocial wellness and the elimination of barriers to maximizing independence within the community.

The following topic areas are specifically addressed in *Healthy Minnesotans:*

- Promote Healthful Aging and the Well-Being of the Elderly
- Support the Well-Being of Those With Disability, Disease and/or Chronic Illness

GOAL 11 Reduce exposure to environmental health hazards.

Environmental health services work to protect the public's health by assuring that risks from exposure to environmental hazards are minimized and controlled. Environmental health hazards include biological, physical, chemical, and radiological agents and substances, both those that are human-made and those that are naturally occurring. Exposures to these hazards may occur in the workplace, home or natural environment, or in a public facility.

Those who benefit from environmental health services include the general public; regulated entities; and federal, state and local agencies. These services are delivered through a variety of regulatory, consultative, informational and educational programs.

Environmental health services protect Minnesotans from environmental hazards by ensuring that they have clean drinking water, safe food, sanitary lodgings and protection from hazardous materials in their environment. These services also protect Minnesotans from the hazards resulting from floods, landfill fires, chemical spills, contaminated wells and other environmental disasters.

Environmental health risks are identified through collection and assessment of environmental health data. Improved scientific information and technology have increased understanding of the effects of environmental contaminants, and fueled the public's demand for increasing protection. The development of appropriate interventions based on health risk is made possible with good environmental health data.

Environmental health risks are mitigated through the enforcement of state and federal standards; partnerships with local health agencies to enforce the standards; effective working relationships with the regulated community and other state agencies; evaluation of potentially health-threatening environmental conditions; and provision of health education aimed at the general public, health professionals, and other partners.

The number of requests from state and local agencies for assistance or support on health risk assessment and protection issues is growing. There is also increasing demand from the public for more information about hazardous environmental agents and inclusion in the risk-management decision process. Environmental health services continue to work hard to meet these demands.

The following topic areas are specifically addressed in *Healthy Minnesotans:*

- Safe Water
- Asbestos
- Nuisance Control
- Food Safety / Protection
- Clean Indoor Air / Radon / Carbon Monoxide Poisoning
- Radiation
- Childhood Lead Poisoning



GOAL 12 Promote early detection and improved management of non-infectious disease and chronic conditions.

Today, chronic diseases are among the most prevalent, costly and preventable of all health problems. Two-thirds of all Minnesotans who die each year die from a chronic disease. Although older Americans are particularly at risk, chronic diseases also target men and women in the prime of life. Chronic diseases represent the seven leading causes of death among men aged 50-64 and the 10 leading causes of death among women in that age group. Among younger men and women (aged 35-49) chronic diseases also take a heavy toll. Furthermore, most premature deaths among populations of color and the disadvantaged are due to chronic illness. These conditions account for the largest part of the health gap between African Americans and White Americans.

Considering deaths alone greatly understates the burden of chronic disease. The prolonged course of illness and disability from chronic diseases results in extended pain and suffering, as well as in decreased quality of life for millions of Americans. Chronic disabling conditions cause major limitations in activity for more than one of every 10 Americans. The medical care costs of people with chronic disease now account for over 60 percent of the nation's total medical care costs. Furthermore, as the state's population ages, the large number of people affected by chronic diseases and amassing enormous health care costs will escalate rapidly. We cannot reduce these enormous health care costs or major health problems without addressing the prevention and control of chronic disease more aggressively.

For those chronic diseases that can be effectively treated in their early stages, screening should be considered an essential element of the health care system. Breast, cervical and colorectal cancers; high blood pressure; and elevated cholesterol are among the diseases and conditions for which screening is known to save lives as well as money. Quality improvement programs can assist health care delivery systems to improve access and quality of care, and result in improved programs of screening and follow-up intervention for identified risks.

The following topic areas are specifically addressed in *Healthy Minnesotans:*

- Early Detection of Cancer
- Arthritis
- Heart Disease, Heart Attack and Stroke
- Asthma
- Diabetes
- Osteoporosis



GOAL 13 Promote optimal oral health for all Minnesotans.

Over the last 50 years, public health measures combined with professional dental services have resulted in substantial improvements in oral health, especially in preventing dental caries. This collaboration between the public and private sectors represents one of the major health care success stories in individual and community health.

However, despite a nearly universal community-fluoridated water supply, success in new treatments, increased access, expanded utilization and heightened personal knowledge, preventable oral disease continues to affect Minnesotans of all ages and all population groups. Specific groups such as the elderly (especially homebound and institutionalized elderly), low-income individuals, children and adults with special health needs, communities of color, and recent immigrants continue to have unique issues involving access, cost and prevention. Structural barriers such as geography, transportation and language also complicate the oral health care issues faced by these populations.

Optimal oral health is fundamental to an individual's overall physical, social and emotional well-being. In addition to the obvious advantages for one's health that accrue through freedom from pain, discomfort and suffering, sound oral health also contributes to an individual's quality of life, including self-image and self-esteem and the role those perceptions play in the social, educational and employment marketplaces.

Dental professionals, supported by dental research, now generally concur that dentition can be maintained throughout one's lifetime with recommended prevention and appropriate treatment. However, continued perseverance among individuals, providers and communities in acknowledging and encouraging the role of oral health and hygiene is necessary not only to maintain the accomplishments of the past few decades, but also to satisfactorily resolve issues faced by specific population groups.

The following topic area is specifically addressed in *Healthy Minnesotans:*

- Oral Health



GOAL 14 Reduce work-related injury and illness.

Occupational health and safety remains one of the major public health problems in Minnesota and the nation. Consider the following:

- Minnesotans suffer from approximately 400 work-related injuries each day. Approximately 50,000 of these injuries result in the loss of three or more days of work.

- There are an estimated 75.1 lost work days per 100 workers in Minnesota. (Minnesota Safety Annual Report: Characteristics of Minnesota Work-related Injuries and Illnesses, 1990)

- In the state, 48 percent of workers are employed in establishments with fewer than 50 workers. On a practical basis, these establishments are largely excluded from any oversight with regard to health and safety. (Injury Control: The Third National Injury Conference)

- Most small establishments lack the resources to address health and safety adequately within the work site. It is well established that the potential for exposure to heavy metals such as lead (Lussenhop, *et al.*, 1989) and other hazardous materials (Parker, *et al.*, 1991) exists within these small establishments.

The National Institute of Occupational Safety and Health (NIOSH) has developed a list of the leading work-related diseases and injuries. This list includes respiratory illness, musculoskeletal injury, cancer, traumatic disorders, cardiovascular illness, reproductive disorders, neurotoxic disorders, noise-induced hearing loss, dermatologic conditions and psychologic disorders. The list was developed for three purposes: 1) to encourage deliberation in the medical and industrial communities about work-related health problems; 2) to assist in setting national priorities to prevent health problems related to work; and 3) to convey to a diverse audience the concerns of the leadership of NIOSH and the focus of its activities (MMWR, 1983:32;24-32).

At this time there is a lack of data on the incidence and severity of work-related injury and illness. In order to determine the incidence and prevalence of work-related injury within the state, it is necessary to develop and test a disease-reporting system(s). Such a system will determine the incidence of work-related respiratory diseases and work-related fatalities in the agricultural and nonagricultural sectors.

The following topic areas are specifically addressed in *Healthy Minnesotans:*

- Work-related Injury and Illness
- Adult Blood Lead



GOAL 15 Assure access to and improve the quality of health services.

Minnesota-specific studies show that one of every 11 Minnesotans lacks health care coverage. Approximately one-fifth of those uninsured individuals are children. The inability to pay for health care services is often the most substantial barrier to getting needed medical treatment for the uninsured.

When uninsured individuals seek medical care, it is often for costly intensive treatment necessitated by the absence of routine and preventive services. These more intensive health care services create a greater health risk to individuals and a greater financial burden to both individuals and the health care system. The high-cost services received by uninsured individuals often exceed their financial resources, and the costs get transferred to the health care system which does not receive compensation for them. Shifting the costs of treating the uninsured to the health care system results in increased provider charges, higher insurance premiums and higher taxes.

In recent years, the debate over access to health care has often focused on the availability of affordable health insurance, but many other factors inhibit access to quality health care. Lack of cultural competence on the part of providers, inability to understand the health care system, lack of transportation and child care, ineffective outreach strategies, discrimination, and lack of comparative information about available health care services can all stand as obstacles to getting quality health care.

The first objectives of this goal are to ensure that all individuals have adequate health insurance coverage and that inability to pay for services is no longer a barrier to good health. Other objectives attempt to eliminate or minimize other barriers to receiving quality health care. These objectives include: (a) developing mechanisms to ensure that individuals have a practical ability to utilize the health care system; (b) increasing the health care system's capacity to appropriately address the needs of Minnesota's increasingly racially and ethnically diverse population; (c) ensuring an adequate rural health care infrastructure to meet the health care needs of rural Minnesota; and (d) providing more comparative information on the health care system to support consumer choice and system accountability.

The following topic areas are specifically addressed in *Healthy Minnesotans:*

- Health Care Coverage
- Eliminate Barriers and Improve Access to Health Care
- Rural Health Care Infrastructure
- Electronic Data Interchange



GOAL 16 Ensure an effective state and local government public health system.

Protecting the health of the public is a fundamental responsibility of government. State and local public health agencies in Minnesota are assigned specific duties and authorities to fulfill governmental responsibilities for public health.

Minnesota carries out this responsibility through a unique partnership between state and local government. The state commissioner of health is statutorily responsible for developing and maintaining an organized system of services for protecting, maintaining and improving the health of the public. The state health department shares the responsibility for protecting the public's health with 49 community health boards composed of single-county, multi-county and four city health departments. The legal authority for local public health is contained in Minnesota Statutes Chapter 145A, the Local Public Health Act. Under this law, counties may form community health boards if they meet certain organizational, planning and population requirements. In addition, counties have responsibilities under law as boards of health, regardless of whether they participate in community health services (CHS). The MDH supports the CHS system with funding, technical support and ongoing communications. Together, state and local government forms Minnesota's governmental public health system.

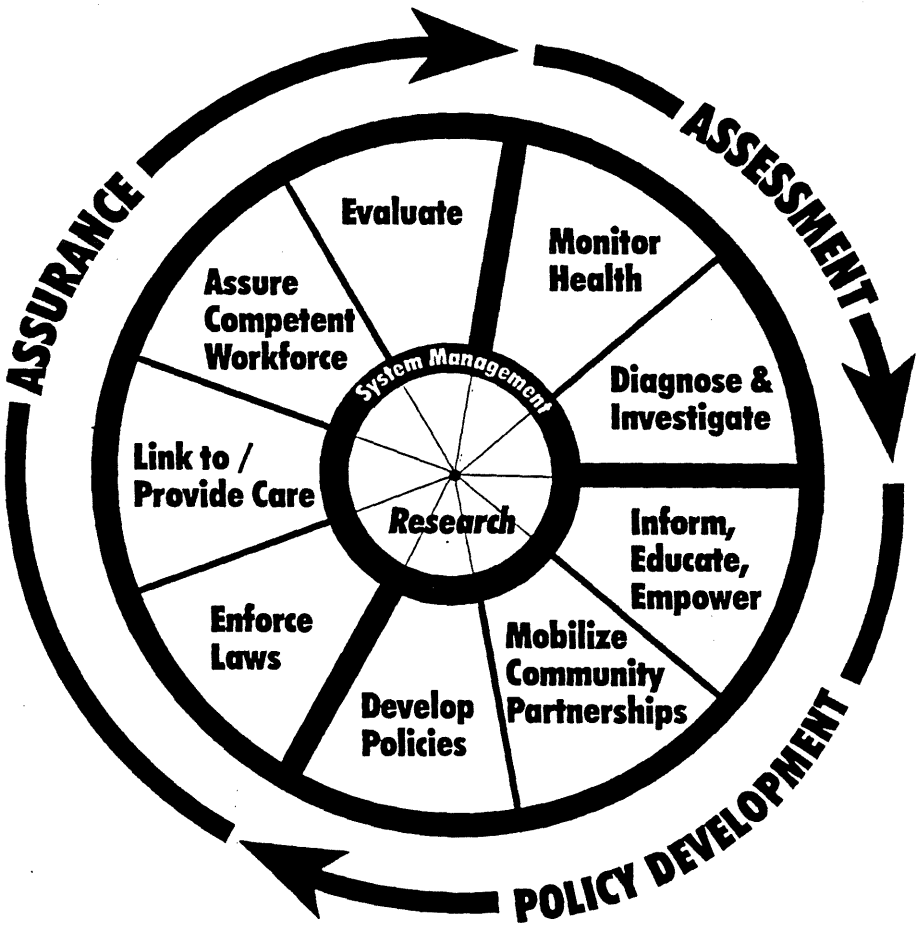
Government is responsible for certain core functions of public health. These core functions are assessment, policy development and assurance. They have always been critical responsibilities of all levels of governmental public health departments. However, changes in the health system in recent years have made it even more important to articulate government's unique contributions to protecting the public's health and to act on those responsibilities as one part of a coordinated health system. In the first half of this decade, therefore, state and local public health in Minnesota defined the core governmental functions and identified a range of activities to be performed in carrying out these core functions.

The core functions framework has been used at the national level to identify government's responsibilities for public health. Within these three core functions, the federal government has identified 10 essential services to further define government's contributions. These essential services are:

- Monitor health status to identify and solve community health problems;
- Diagnose and investigate health problems and health hazards in the community;
- Inform, educate and empower people about health issues;
- Mobilize community partnerships and action to identify and solve health problems;
- Develop policies and plans that support individual and community health efforts;
- Enforce laws and regulations that protect health and ensure safety;
- Link people to needed personal health services and ensure the provision of health care when otherwise unavailable;
- Assure a competent public health and personal health care workforce;

- Evaluate effectiveness, accessibility, and quality of personal and population-based health services; and
- Research for new insights and innovative solutions to health problems.

Although Minnesota has become accustomed to the core functions framework, the essential services framework is also important because it is used in the federal Healthy People 2010 objectives for the nation. In addition, performance measures are being developed around the essential services which may be tied to federal funding for state and local government. The essential services represent a list of activities that describe the core functions in terms more readily understandable to some people.



The following topic area is specifically addressed in *Healthy Minnesotans:*

- State and Local Government Public Health System



GOAL 17 Eliminate the disparities in health outcomes and the health profile of populations of color.

The health of the nation appears to have improved over the past 35 years. Within that time, we have experienced an overall decline in death rates from all causes. In Minnesota, in particular, the health and life expectancy of our people consistently rank number one in the nation. But despite this overall health improvement, populations of color continue to experience poorer health and disproportionately higher rates of illness and death.

The findings from the *Populations of Color in Minnesota Health Status Report*, published in the spring of 1997 and focusing on economic profiles, birth-related health indicators, mortality rates, cause of death, illness, injury, and access to health care, show some of the wide gaps and disparities in the overall health status of populations of color as compared to that of the White population. While these gaps and disparities did not develop over a short period of time and will not be resolved quickly, a concerted effort throughout the health system must address the following gaps and disparities in health outcomes and profiles of people of color in Minnesota:

- The incidence of low birth weight among African American women is three times greater than the incidence found in the White population and twice as high as in any other population of color. Infant mortality rates for African American and American Indian babies are more than twice as high (16.5 deaths and 16.2 deaths, respectively, per 1,000 live births) as those for any other racial or ethnic group in the state. Furthermore, women of color are less likely to receive adequate prenatal care. American Indian women are eight times more likely to receive inadequate prenatal care or no care at all than their White counterparts. Asian and African American women are six times more likely to receive inadequate care or no care at all.

- Mortality information concerning populations of color leads to one immediate and overarching conclusion: from adolescence through adulthood, African Americans and American Indians in Minnesota die at much higher mortality rates (two to three times higher) than other racial and ethnic groups. The large disparities between these populations and other racial and ethnic groups call for strong community and government action.

- There is a gap in available data on morbidity or health status and diseases of populations throughout the lifespan. Also, there is a lack of quality-of-life data, as affected by illness or injury, for populations of color. The lack of comprehensive information is a major concern in public health surveillance activities across the nation and in Minnesota.

Collecting data and sharing information are necessary prerequisites to developing strategies designed to reduce or eliminate the health status disparities between populations of color and the White population. Obtaining information and focusing statistical research on minority health issues are essential for developing sound policies, implementing appropriate services, and assessing whether the services provided are achieving stated goals and objectives. Race and ethnicity information must be collected in needs assessments conducted by public health agencies, health care plans, and the health system in general.

The following topic area is specifically addressed in *Healthy Minnesotans:*

- Eliminate the Disparities

GOAL 18 Foster the understanding and promotion of social conditions that support health.

If we, as a state, expect to improve the health of all Minnesotans, we need to understand and then address the connection between social conditions (such as poverty, employment opportunity, housing and education) and health. The intent of this goal is to raise awareness of, and stimulate dialogue about, some of these social conditions and their impact on the health and well-being of Minnesota's populations. Its aim is to promote the idea that individuals and organizations throughout Minnesota must examine and confront these types of societal issues and ultimately come together in voluntary partnerships with people from many segments of the community in order to achieve these public health improvement goals.

The following topic area is specifically addressed in *Healthy Minnesotans:*

- Social Conditions and Health

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