FINAL REPORT

AIDS
ISSUE TEAM

State of Minnesota
Executive Branch
Policy Development
Program

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ACKNOWLEDGEMENTS

This report summarizes the work of the AIDS Issue Team, whose members represented 14 Minnesota State agencies. The members of the AIDS Issue Team were:

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TABLE OF CONTENTS

TABLE OF CONTENTS (Continued)

I. EXECUTIVE SUMMARY

The AIDS Issue Team

Acquired immunodeficiency syndrome (AIDS) was identified by the 1986-1987 Executive Branch Policy Development Program as a state policy issue requiring analysis by an interagency team. Representatives from fourteen state agencies were asked to participate in the AIDS Issue Team; the Minnesota Department of Health was selected as the lead agency for the effort.

The charge given to the AIDS Issue Team was as follows: "The AIDS Issue Team will identify and prioritize issues in each agency's area of responsibility and develop policies, plans, and/or proposals to deal with those issues. These draft policies, plans, and/or proposals will then be reviewed and discussed by the Issue Team in order to assure consistency between agencies and avoid duplication of effort."

The AIDS Issue Team met five times between December 1985 and June 1986 to identify AIDS issues with current or potential state policy impact, and to review and discuss policies, plans, and proposals for addressing those issues. Team members from line agencies made presentations on their agency's AIDS-related activities and shared draft policies and proposals to address issues in their agency's area of responsibility. The Issue Team served as a good mechanism for facilitating cooperative efforts between agencies on AIDS issues that were of concern to more than one agency. It also provided a forum for the Minnesota Department of Health to share information with other agencies on the epidemiology of human immunodeficiency virus (HIV)*, the causative agent of AIDS, and public health prevention efforts.

Financing of health care for persons with AIDS and AIDS-related conditions emerged as an issue meriting considerable attention because of concerns about access to care and about the potential impact of AIDS on state-financed health care programs. A Health Care Financing Subgroup was formed, with representatives from MDH, Human Services, Finance, State Planning, Commerce, and Administration, to address these issues. The subgroup met five times in addition to the Issue Team meetings, and developed the health care financing recommendations of the report.

Summary of Recommendations

The AIDS Issue Team made the following recommendations about state agencies' responsibilities regarding AIDS issues. Some state agencies, namely the Departments of Health, Education, and Human Services, may require additional resources in order to carry out their responsibilities.

1. The Minnesota Department of Health should continue to implement the Statewide Risk Reduction and Disease Prevention Plan recommended by the Commissioner's Task Force on AIDS and continue community-based and state-based risk reduction projects that assist individuals who are HIV infected and those who are not infected to refrain from high-risk activities.

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* Previously termed the Human T-cell Lymphotrophic Virus Type III/Lymphadenopathy Associated Virus (HTLV-III/LAV).

2. The Minnesota Departments of Health and Commerce should continue to make information about health maintenance organization (HMO) and health insurance coverage, and the Minnesota Comprehensive Health Association (MCHA) program available to persons who have AIDS, AIDS-related conditions, HIV infection, or are at increased risk of infection. These Departments should also monitor their complaint systems and data on the MCHA program to determine if additional problems are arising with access to care for persons who are HIV antibody positive, or have AIDS or AIDS-related conditions.

3. Persons with AIDS, AIDS-related conditions, or HIV infection who are not eligible for Medical Assistance or General Assistance Medical Care but lack the financial means to purchase health care coverage are part of a larger problem of financial access to care. An interagency group in state government has been studying the overall financial access issue and preparing a report and recommendations for legislative consideration in the 1987 Session. For public health as well as humanitarian reasons, the Health Care Financing Subgroup recommends that consideration be given to including persons with AIDS, AIDS-related conditions, and HIV infection as a priority group in efforts undertaken to increase financial access to care.

4. The State of Minnesota should consider seeking a limited exemption from the federal Employee Retirement and Income Security Act (ERISA) preemption of state regulation of employer-provided health plans. A limited exemption would allow the State to monitor all health plans and to protect enrollees of all plans equally.

5. The Department of Human Services should continue to monitor data from the Medical Assistance and General Assistance Medical Care programs on the number of persons with AIDS and AIDS-related conditions and expenditures made on their behalf for budget projection and program planning purposes.

6. The Department of Human Services should continue its efforts to ensure that all Medical Assistance eligible persons with AIDS and AIDS-related conditions are covered under the Medical Assistance (MA) program rather than the General Assistance Medical Care (GAMC) program. These efforts may include periodic review of program data and implementation of procedures to expedite transfer of cases to the MA program, education of physicians and patients on the benefits of the MA program in comparison to GAMC, and training of county social services personnel on this issue.

7. The Department of Human Services should analyze options that may make it possible for the Medical Assistance program to provide more appropriate and cost-effective services to persons with AIDS and AIDS-related conditions, including the addition of case management and hospice care and applying for Medicaid waivers. Analysis of each option should include an assessment of whether the addition of the service or the waiver will be

beneficial for persons with AIDS and related conditions and what net financial impact the addition of the service or the waiver would have on the MA program and other state expenditures. Input should be sought from the Health Care Financing Subgroup, MDH, the Minnesota AIDS Project, other concerned members of the community, medical professionals, and health care providers.

8. The Departments of Health, Human Services, Finance, and Commerce, and the State Planning Agency should continue to meet on a periodic basis to analyze health care financing issues identified as requiring further study, to monitor implementation of the Health Care Financing Subgroup's recommendations, and to work on biennial budget issues such as forecasting for the Medical Assistance budget. Issues requiring further analysis include 1) defining what further role the State of Minnesota and local governments should take in ensuring access to psychosocial support services and alternative care for persons with AIDS, AIDS-related conditions, and HIV infection who do not have private or public health coverage, or whose coverage does not include needed services; 2) determining whether access to long term care, including nursing home care, is or will be a problem for persons with AIDS and AIDS-related conditions; 3) evaluating the cost effectiveness and appropriateness of Medical Assistance options for persons with AIDS and AIDS-related conditions, including case management, hospice care, and waivers; and 4) interagency monitoring of additional AIDS issues that may affect or be related to health care financing issues.

9. The Minnesota Department of Education should: ensure that local school boards have established AIDS policies; ensure that local educators integrate AIDS education into a variety of curriculum areas; ensure that student service staff are available and prepared to counsel students about HIV transmission; promote the community education system as a vehicle for providing information about AIDS to the general public; and support schools and communities where children and faculty are known to be HIV infected through implementation of the First Response Team and ongoing support. Ongoing technical and scientific expertise will be provided by the Minnesota Department of Health.

10. State agency employee leave forms for sick leave should either be revised or procedures should be established that protect private medical data that the employee may furnish on these sick leave forms. Data privacy concerns have arisen in some state agencies when employees have been asked to specify the illness for which they are taking sick leave and how that information is subsequently handled.

11. State agencies that collect data on individuals should review their existing statutory basis for protecting that data to ensure that it provides adequate protection of that data. Agencies may wish to accomplish this review in conjunction with their appropriate assistant attorney general.

II. EPIDEMIOLOGY OF AIDS

Definition of AIDS and Related Conditions

Acquired immunodeficiency syndrome (AIDS) is a disease complex characterized by a breakdown of the body's natural immune system. AIDS affects the body's ability to fight off infections, leaving persons with it susceptible to life-threatening "opportunistic" infections and cancers very rarely found in persons with intact immune systems. [1]

The first cases of AIDS in the United States were reported in 1981. Since that time, researchers have identified the human immunodeficiency virus (HIV) as the causative agent of AIDS, and developed laboratory tests which detect antibody to the HIV. There is currently no cure for AIDS. As of October 9, 1986, the Centers for Disease Control (CDC) had received reports of 25,642 cases of AIDS in the United States, with deaths occurring in 14,562 or 56% of these cases. [2]

The case definition of AIDS used by the CDC for national reporting defines AIDS as an illness characterized by: 1) one or more specified opportunistic diseases that are at least moderately indicative of underlying cellular immunodeficiency, and 2) absence of all known underlying causes of cellular immunodeficiency (other than HIV infection) and absence of all other causes of reduced resistance reported to be associated with at least one of those opportunistic diseases. Persons who meet both parts of the definition may still be excluded as AIDS cases if their laboratory test results do not indicate HIV infection.

Persons with CDC-reportable cases of AIDS represent only a very small portion of persons with HIV infection. An estimated 1,000,000 to 1,500,000 Americans are infected with the HIV. Most of these individuals are currently asymptomatic. Some individuals have symptoms of AIDS-related complex (ARC) including generalized lymphadenopathy (swollen lymph glands), fever, weight loss, chronic diarrhea, fatigue, and night sweats. Recent case reports have also linked severe neurologic disorders, including dementia, to HIV infection. Neurologic symptoms have been found in persons with AIDS and ARC as well as in persons who have HIV infection but no apparent immune deficiency.

No precise estimates have been made of the current numbers of ARC patients and HIV-infected persons with neurologic symptoms. The number of persons infected with HIV who will go on to develop AIDS is also unknown. In various studies, 5% to 34% of HIV infected persons have developed AIDS within two to five years of becoming infected. [3] The recent Coolfont Report indicated a five year incidence of AIDS among HIV-infected persons at 20 to 30 percent. [4]

In May 1986, the CDC devised a classification system for HIV infection which recognizes that persons infected with the virus

may have a variety of clinical symptoms and laboratory findings attributable to HIV infection. This system classifies the manifestations of HIV infection into four groups: acute infection, asymptomatic infection, persistent generalized lymphadenopathy, and other disease. The fourth group is subdivided into five categories: constitutional disease, neurologic disease, secondary infectious diseases, secondary cancers, and other diseases. The public health purposes of the classification system include disease surveillance, epidemiologic studies, prevention and control activities, and public health policy and planning. [5]

Methods of Transmission

The methods of transmission of HIV have been well documented. The virus can be transmitted through intimate sexual contact, sharing of infected needles by intravenous drug users, receipt of infected blood or blood components, and perinatal transmission from an infected mother to an infant during pregnancy or at birth. There is no evidence that HIV can spread by casual contact. Several studies have documented the lack of transmission among household contacts of persons with AIDS or ARC. [6,7]

Persons at increased risk of HIV infection include gay and bisexual men, intravenous drug abusers, heterosexual contacts of infected persons, persons transfused with contaminated blood or blood products, and children born to infected mothers. [8]

The largest groups of persons at increased risk of HIV infection are gay and bisexual men and intravenous drug users. These two groups account for about 90% of AIDS cases nationally and about 94% of the AIDS cases in Minnesota.

Epidemiologic Data on AIDS Cases in Minnesota

As of October 20, 1986, 133 cases of AIDS had been diagnosed in the State of Minnesota and reported to the Minnesota Department of Health. Sixty-nine (52%) of these persons have died; 100% of cases diagnosed before July 1984 have died. The majority of the Minnesota AIDS cases have been young adults; 76% have been in persons aged 20 to 39 years old. The distribution of AIDS cases by age is shown below.

TABLE 1
AIDS CASES REPORTED TO THE MINNESOTA DEPARTMENT OF HEALTH
AS OF OCTOBER 20, 1986
BY AGE

AGE	CASES	%
Under 13	--	(0%)
13-19	--	(0%)
20-29	39	(29%)
30-39	61	(47%)
40-49	26	(20%)
Over 49	7	(5%)
Total	133	(100%)

Source: MDH AIDS Weekly Surveillance Report, October 20, 1986.

The majority of AIDS cases in Minnesota have been gay or bisexual men (85%); the remaining 15% of cases have included gay or bisexual men who use intravenous drugs, heterosexual intravenous drug users, heterosexual cases, persons with hemophilia/coagulation disorders, persons who received transfusions of blood or blood components, and persons who have not been classified in one of the above categories. The distribution of AIDS by patient group is shown in Table 2.

TABLE 2
AIDS CASES REPORTED TO THE MINNESOTA DEPARTMENT OF HEALTH
AS OF OCTOBER 20, 1986
BY PATIENT GROUP

CASES	%	PATIENT GROUPS
113	(85%)	Gay/Bisexual Men
2	(2%)	Intravenous Drug Users
9	(7%)	Gay/Bisexual IV Drug User
3	(2%)	Hemophilia/Coagulation Disorder
1	(1%)	Transfusions/Blood or Blood Components
3	(2%)	Heterosexual
2	(2%)	None of the Above/Other
133	(100%)	Total

Source: MDH AIDS Weekly Survelliance Report, October 20, 1986.

Projections of Future AIDS Cases in Minnesota: 1986-1990

Because of the long period between acquiring infection and developing AIDS symptoms (up to seven years), persons who are already infected will account for the majority of new AIDS cases in Minnesota between 1986 and 1990. The following predictions regarding future AIDS cases in Minnesota were derived from epidemiologic models developed by MDH at the beginning of 1986. The MDH report, The Epidemiology and Health Economics of Acquired Immunodeficiency Syndrome in Minnesota, contains further details about the projections and an explanation of the methodology used.

The report estimates that:

- 900 to 1860 new cases of AIDS will be diagnosed and reported in Minnesota from 1986 through 1990;
- 600 to 1200 new deaths will occur among diagnosed cases, including deaths among the 36 cases known to be living at the beginning of 1986; and
- 300 to 800 cases of AIDS will be under medical treatment at year-end 1990. [3]

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5. Centers for Disease Control. Classification System for Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus Infections. Morbidity and Mortality Weekly Report. 1986; 35 (20): 334-339.

6. Summary of Nine Studies that Demonstrate Lack of Human T-Lymphotrophic Virus Type III (HTLV-III) Transmission Among Family Member Contacts of HTLV-III Infected Persons. Minnesota Department of Health Disease Control Newsletter. 1985; 12 (7): 1-2.

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IV. STATE AIDS POLICY ISSUES IN MINNESOTA

A. PUBLIC HEALTH ISSUES

Policies Adopted by the Minnesota Department of Health and the Commissioner of Health's Task Force on AIDS

The Minnesota Department of Health, upon recommendation of the Commissioner of Health's Task Force on AIDS, has adopted the following AIDS policies:

- Minnesota Department of Health Guidelines for Placement in Schools of Children and Adolescents Infected with the Human Lymphotrophic Virus Type III.
- Minnesota Department of Health Guidelines for Placement in Day Care Settings of Children Infected with the AIDS Virus.
- Centers for Disease Control Recommendations for Preventing Transmission of Infection with Human T-Lymphotrophic Virus Type III/Lymphadenopathy-Associated Virus in the Workplace.
- Centers for Disease Control Recommendations for Assisting in the Prevention of Perinatal Transmission of Human T-Lymphotrophic Virus Type III/Lymphadenopathy-Associated Virus and Acquired Immunodeficiency Syndrome.
- Use of Human Immunodeficiency Virus (HIV) Antibody Testing in Public Health.

Human Immunodeficiency Virus (HIV) in Minnesota: Statewide Risk Reduction and Disease Prevention Plan

In July 1986, the Commissioner's Task Force on AIDS recommended and the Department of Health adopted the Human Immunodeficiency Virus (HIV) Infection Statewide Risk Reduction and Disease Prevention Plan. This plan outlines a multi-faceted approach to be taken to prevent the further spread of the AIDS virus in Minnesota.

The eight major objectives of the plan are as follows:

1. To evaluate the prevalence and incidence of HIV infection in Minnesota on an ongoing basis. This will allow determination of the magnitude of the problem, the characteristics of the outbreak, and disease trends. In addition, such evaluation can be used to measure success of risk reduction programs and identify areas for resource allocation.
2. To study and evaluate knowledge, attitudes, and behavior of gay and bisexual men and intravenous drug abusers related to the risk of acquiring or transmitting HIV. Such information can be used to design risk reduction programs and to evaluate their efficiency.
3. To develop outreach programs to reach persons who have potentially been exposed to HIV, thus making them aware of their risk status. Potential exposures include sexual contact or needle-sharing with infected persons, receipt of HIV contaminated blood or blood products, or being born to an infected mother. Outreach programs can serve to bring high-risk persons into a network of risk-reduction programs designed to limit future transmission.
4. To conduct risk reduction programs designed to lead to behavioral changes aimed at reducing the risk of acquiring or

transmitting HIV infection for persons identified in Objective 3.
5. To provide public education, including school-based programs, about HIV transmission, which may lead to increased public understanding of the AIDS epidemic and lessening of "AIDS hysteria."
6. To provide professional education so that health care providers can appropriately counsel and care for patients with HIV infection.
7. To develop programs for dealing with situations that pose particular problems, such as HIV infection among mentally ill, mentally handicapped and non-compliant persons.
8. To evaluate the effectiveness of all risk reduction programs and allocate resources accordingly.

The plan describes specific strategies aimed at achieving the eight major objectives described above. These strategies include:
Objective 1: Ongoing tabulation and followup of AIDS cases; seroprevalence surveys among gay and bisexual men, intravenous drug abusers, and persons with hemophilia; and studying seroprevalence rates from blood banks, counseling and test sites, and sexually transmitted disease clinics.
Objective 2: Surveys of persons attending counseling and test sites, persons participating in seroprevalence studies, and persons participating in specific education programs including drug treatment.
Objective 3: Media campaigns, voluntary partner referral programs, and contact notification services.
Objective 4: Availability of counseling and test sites and education programs.
Objective 5: Specific media coverage, public lectures and seminars, school-based education, education in the workplace, and the AIDS hotline.
Objective 6: The MDH newsletter and seminars for health care professionals.
Objective 7: Strategies and policies to be developed by MDH, the AIDS Task Force, and local public and private agencies.
Objective 8: Studies to evaluate efficacy of each risk reduction program to be developed and implemented.

A recent report on AIDS issued by the Surgeon General of the United States, C. Everett Koop, strongly emphasizes the importance of educating the general public and persons at high risk of acquiring AIDS about how to prevent transmission of the HIV. The report recommends that state and local AIDS task forces should "plan ahead and work collaboratively with other jurisdictions to reduce transmission of AIDS by far reaching informational and educational programs." [1] These types of programs are included in the Statewide Risk Reduction and Disease Prevention Plan described above, specifically under Objectives 4 and 5.

<u>Recommendation:</u>
1. The Minnesota Department of Health should continue to implement the Statewide Risk Reduction and Disease Prevention

Plan recommended by the Commissioner's Task Force on AIDS and continue community-based and state-based risk reduction projects that assist individuals who are HIV infected and those who are not infected to refrain from high-risk activities.

References
1. Surgeon General's Report. AIDS. October 1986.

B. HEALTH CARE FINANCING ISSUES

As data on the health care costs associated with HIV infection become available, and projections of future AIDS cases and health care costs are made, health care financing issues are emerging as critical AIDS policy issues. [1-7] From a state policy perspective, two AIDS health care financing issues are of particular concern: 1) ensuring access to care for persons who have AIDS or AIDS-related conditions, or are HIV antibody positive, and 2) planning for the care of persons with AIDS and AIDS-related conditions in state-financed health care programs.

Persons with AIDS, AIDS-related conditions, and HIV infection may require extensive medical, psychological and other support services. Services such as psychological support, long term care, case management, mental health counseling, and chemical dependency treatment go beyond what is traditionally thought of as "health care," and are frequently not covered by health insurance or HMO policies, or coverage may be very limited.

The availability of a full spectrum of these services for all infected persons must be assured, not only for humanitarian reasons but also to protect the public health. Persons subject to the stresses of a life-threatening condition and frustrated by the inability to find adequate care for this or other health related concerns may find it difficult to make a significant behavior change such is required in changing sexual behavior. Individuals that are extremely high risk because of IV drug use and/or prostitution will require a great deal of support services in order to refrain from these high-risk activities. Over time, providing infected persons with comprehensive services may prevent additional AIDS cases.

The ability of persons with AIDS, AIDS-related conditions, and HIV infection to obtain and maintain private health care coverage, however, may be limited by lack of financial resources or by insurers' efforts to use results of HIV antibody tests and other screening methods in underwriting of individual insurance policies. The Health Insurance Association of America and the American Council of Life Insurance (the national trade associations for life and health insurers) have stated the desire of their member companies to use HIV testing and other types of screening in underwriting for individual insurance policies, and several insurance companies have begun implementing such testing and screening. These actions have created fears that large numbers of HIV antibody positive persons will be considered "uninsurable" and therefore be unable to purchase insurance. In response, a few states have passed legislation prohibiting or restricting the use of HIV antibody test results in insurance underwriting. [8-10]

States are just beginning to address the issue of planning for the care of persons with AIDS in state financed health care programs. [5-7] The lack of a specific ICD-9 diagnosis code for AIDS prior to October 1986 has complicated the process of

tracking the number of persons with AIDS on Medicaid and associated expenditures. As the number of AIDS cases increases, it is becoming more important to plan for the financial impact of AIDS on Medicaid budgets. States also need to determine whether state-financed care being provided to AIDS patients is being provided in a manner which is most appropriate for the individual's needs and in the most cost-effective setting.

Access to Care

The Health Care Financing Subgroup of the AIDS Issue Team approached the issue of access to care by first assessing the extent to which the health care needs of persons with AIDS, AIDS-related conditions, and HIV infection would be covered by existing private or public health care programs. Health care was viewed as including medical services such as hospital and physician care, and other health services (psychosocial support services, long term care, case management, mental health counseling, chemical dependency services). Included in this assessment was an examination of existing mechanisms for ensuring access to care in Minnesota.

It is necessary to view the health care needs of individuals with HIV infection as a spectrum of care. Individuals who are infected with the virus and exhibit no symptoms will require limited medical care but may need psychosocial support services, mental health counseling or chemical dependency treatment services. Although these individuals exhibit no symptoms, they are infectious and capable of spreading the virus to others. If these individuals can modify their behavior and refrain from high risk activities, the spread of the virus will be prevented. To the extent these individuals need assistance in accomplishing that behavior change, it should be available. At the other end of the spectrum are persons with severe symptoms, including cases which meet the Centers for Disease Control diagnosis criteria for AIDS, and some persons who do not have an AIDS diagnosis but whose ARC or other AIDS-related symptoms such as dementia are severe enough to prevent the individual from working. These individuals will require extensive medical care and may require extensive support services such as psychological counseling, long term care, case management services, housing, etc.

The Minnesota Department of Health estimates that there are currently about 15,000 to 25,000 persons in Minnesota who are HIV antibody positive and asymptomatic or mildly symptomatic. MDH epidemiologic projections indicate that at least 900 to 1860 new cases of AIDS will be diagnosed between 1986 and 1990. [5] No estimate of the number of persons with severe AIDS-related symptoms is available.

Epidemiologic data and survey data on the health coverage status of Minnesotans suggest that the majority of persons who are HIV infected and asymptomatic or mildly symptomatic will have some form of medical care coverage. Epidemiologic data indicate that the vast majority of individuals in this group will be

relatively young men (20 to 45 years old), an age/sex cohort that has high labor force participation rates. At any one point in time, approximately 92% of Minnesotans have some type of private or public medical care coverage; about 89% of Minnesotans have coverage throughout the year, while 5% are sometimes insured and 6% are never insured. Persons who are employed are more likely to have coverage. [11-12] Therefore, most persons who are HIV infected but not symptomatic are likely to be employed and to have group medical coverage through their employment or the means to purchase individual coverage. Many of these individuals may have inadequate or no coverage for psychosocial support services.

Some individuals who are HIV infected but asymptomatic or mildly symptomatic will not have medical care coverage because of lack of financial resources. Very low income persons in this group who meet the eligibility criteria for publicly funded programs such as General Assistance Medical Care and Medical Assistance will qualify for coverage under these programs. However, some individuals will not meet the eligibility criteria for publicly-funded health care programs but will still be unable to afford the premiums for private medical care coverage.

Most persons with severe AIDS and AIDS-related symptoms will also have some type of health care coverage. However, a higher percentage of these individuals are likely to have coverage through a publicly-funded health care program. As with the asymptomatic and mildly symptomatic persons, individuals with severe symptoms who cannot afford private coverage but do not qualify for publicly funded health care programs are of special concern. Those who are too sick to work but are unable to meet total disability criteria may have particularly difficult situations as far as gaps in coverage are concerned. [13]

Minnesota currently has three types of mechanisms in place to help ensure access to health care coverage for its residents: 1) state laws and regulations governing the provision of health insurance and HMO coverage; 2) the Minnesota Comprehensive Health Care Association (MCHA) which provides an opportunity to purchase private health care coverage for persons unable to obtain coverage in the market because of their health status; and 3) publicly funded health care programs, including Medical Assistance (MA) and General Assistance Medical Care (GAMC), which provide access to very low income persons. In addition, the "charity care" system provides some care directly to persons in need.

1. State laws and regulations governing the provision of health insurance and HMO coverage.
Minnesota's state laws and regulations governing the provision of health insurance and HMO coverage provide persons who currently have health insurance or HMO coverage with certain protections, including continuation and conversion requirements. They also afford some protections to applicants for health insurance and HMO coverage.

For example, these laws and regulations protect individuals from arbitrary cancellation of coverage and increases in premiums which are not actuarially justifiable. They allow persons who leave their jobs and who have had group health coverage through their employer to continue group coverage or to convert to an individual policy (without interruption of coverage or evidence of insurability) by paying their own premiums. These laws and regulations will protect persons who currently have coverage and develop AIDS, AIDS-related conditions, or HIV infection from arbitrary cancellation of their coverage. They will also allow persons with severe AIDS or AIDS-related symptoms who have health care coverage through their employment but become unable to work to continue their coverage if they can continue to afford paying premiums.

Under Minnesota law, all qualified health insurance and HMO plans must cover certain minimum benefits including hospital and physician services, but are not required to cover experimental treatment or treatment that is primarily custodial in nature. Health insurance and HMO policies cover some alternative care and support services, but the type and amount may not meet the needs of many persons with AIDS and AIDS-related conditions. Health insurance and HMO coverage of nursing home care and other long term care is very limited.

Minnesota's state laws and regulations governing health insurers and HMOs coverage do not apply to employers who are self-insured. The federal Employee Retirement and Income Security Act (ERISA) preempts state regulation of employer-provided health benefits when an employer is self-insured. Self-insured employers may choose to offer health benefits which are comparable to those of other employers, but they are exempt from state laws and regulations regarding minimum benefits, continuation and conversion of coverage, and other requirements.

(Recent federal law changes have made employers with more than 20 employees, including self-insured employers, subject to continuation and conversion of coverage requirements under federal law.)

The MDH report, Minnesota Health Care Markets: Cost Containment and Other Public Policy Goals, discussed the potential consumer protection problems created by the ERISA preemption as well as options for addressing the situation, and concluded that the State of Minnesota should seek a limited exemption from the federal ERISA preemption of state regulation of employer-provided health plans. This exemption would allow the State to monitor all health plans, including those of self-insured employers, and to protect all enrollees equally. [14]

Further details about how Minnesota's health insurance and HMO laws and regulations affect health care coverage for persons with AIDS, AIDS-related conditions or HIV infection are

available in a fact sheet entitled Facts About Health Insurance, HMO Coverage, and AIDS. The fact sheet was developed by the Minnesota Department of Health, with assistance from the Department of Commerce, in response to requests for information about health insurance and HMO coverage with regard to AIDS from members of the gay community, health care professionals, and others. The fact sheet is being distributed to interested persons throughout the state.

Minnesota's insurance and HMO laws and regulations do not prohibit insurers and HMOs from requiring individual applicants for coverage to take an HIV antibody test. At this time, however, it is not known whether HIV antibody positive persons are currently being refused health insurance to any great extent in Minnesota. As of October 1986, no complaints regarding refusal of coverage for persons with HIV antibody positivity have been filed with the Minnesota Department of Commerce, which regulates health insurers, or with the Minnesota Department of Health, which regulates HMOs.

2. Minnesota Comprehensive Health Care Association (MCHA)
If individuals who are HIV antibody positive or have AIDS-related symptoms are refused health care coverage, Minnesota has a mechanism in place to provide these persons with access to coverage. Minnesota residents who are refused health insurance because of a chronic illness or health condition can obtain coverage through the Minnesota Comprehensive Health Association (MCHA). The MCHA program was set up by the 1976 Minnesota Legislature to provide an opportunity for individuals who are refused standard health insurance because of their health status to purchase health care coverage.

Currently, about 10,000 persons are covered under MCHA. The program is financed by premiums and by the State through tax deductions for insurance companies. The premiums are limited by statute to 125% of the average of the premiums of the five largest insurers in the state, and vary by the age of the insured person. In 1985, program expenses totalled $13,324,000; premium income was $9,492,000; the remainder of the program's expenses were indirectly funded by the State through the premium tax offset for insurance companies. There are no set limits on the number of persons that can participate in the program.

The MCHA program will not meet the needs of all persons who are refused standard health insurance because of their health status. While the premiums are subsidized by the State, some individuals will not be able to afford their share of the premiums as well as the deductible and copayment provisions. As with standard insurance and HMO policies, the MCHA coverage of psychosocial services and alternative care may not be adequate to meet the needs of some persons who have AIDS, AIDS-related conditions, or are HIV positive.

3. Publicly-Funded Health Care Programs
Minnesota's final set of mechanisms for ensuring access to

health care coverage are our publicly funded health care programs for low income persons. The two major programs are the Medical Assistance (MA) program, which is Minnesota's Medicaid program, and the General Assistance Medical Care (GAMC) program. Approximately 50% of Medical Assistance funding comes from the federal government, with about 45% coming from the state and about 5% from the county. The GAMC program is 90% state funded and 10% county funded.

As a result of Federal Regulations issued in February 1985, persons who have a CDC-defined diagnosis of AIDS are considered to have a "presumptive disability" for purposes of qualifying for the Supplemental Security Income (SSI) program; such persons automatically qualify for SSI if they meet the financial eligibility requirements. [15] Since most SSI recipients qualify for Medical Assistance (MA) in Minnnesota, these individuals would have coverage under the MA program. Some individuals who are severely disabled by AIDS-related symptoms but who do not have an AIDS diagnosis may also qualify for Medical Assistance coverage on a case-by-case basis; others may receive General Assistance Medical Care (GAMC) coverage. Due to the rapid development of the disease in certain individuals, the amount of time it takes to determine eligibility for MA and GAMC coverage may be a problem. The MA and GAMC programs do, however, have three month retroactive eligibility (payment can be made for medical services received up to three calendar months before application for eligible individuals).

Like health insurance and HMO policies, the MA program covers basic medical care services such as hospitalization and physicians' services. It also covers some alternative care, including home health care, nursing home care, and some support services. The GAMC program covers basic medical care services, but it does not cover home health care, nursing home care or other types of alternative care.

In addition to mechanisms which provide access to health care coverage, Minnesota also has mechanisms which directly provide care on an episodic basis to individuals without health care coverage. Some care at the University of Minnesota Hospital is funded by counties and the state through the University Papers program. Most hospitals in Minnesota provide a certain amount of "uncompensated" care; some of this care is given to satisfy obligations incurred as a result of the hospital receipt of federal Hill-Burton funds in the past; some is written off as "bad debt;" the rest is considered "charity" or donated care. County or public hospitals in Minnesota are legally obligated to provide services to patients regardless of their ability to pay. Only 37 of Minnesota's 87 counties have a public hospital; however, some low income residents of the remaining counties do receive care from the county hospitals in other counties. An unknown quantity of free or donated care is also provided to individuals without health care coverage by physicians, community clinics, and other health care providers. [14]

Access to long term care, particularly nursing home care, is another aspect of the access to care issue. A nursing home may be the most appropriate placement for some persons who have AIDS or conditions resulting from HIV infection such as dementia or neurological complications and require 24 hour care on a long term basis. However, states are experiencing difficulty in getting nursing homes to accept persons with AIDS and AIDS-related conditions as patients. Factors cited as contributing to this problem include high occupancy rates in nursing homes, reluctance of providers to place persons with AIDS in facilities where all the residents are elderly, and providers' assessment that AIDS patients require "heavy" care that is not adequately covered by Medicaid reimbursement rates. [7,17]

Further study is needed to determine whether access to nursing home care is or will be a problem in Minnesota for persons with AIDS and related conditions. Occupancy rates in Minnesota nursing homes are high (about 95% overall) but have been dropping. Minnesota has a moratorium on licensure and certification of new nursing home beds and a Pre-Admission Screening/Alternate Care Grants program to provide alternatives to nursing home placements for elderly persons. Inadequate Medicaid nursing home reimbursement rates for "heavy" care patients should not be a problem in Minnesota since each facility's rate reflects the "case mix" of its residents.

Questions that need to be addressed about long term care and persons with AIDS and AIDS-related conditions include:
1) the projected need for skilled nursing facility/intermediate care facility (SNF/ICF) level of care, the characteristics of patients needing it (neurological complications etc.), and the number of these persons are likely to be MA eligible;
2) whether a nursing home is the best place to provide that level of care, considering what alternatives to nursing home care are available or could be developed for these persons;
3) whether the State needs to encourage nursing homes or alternative facilities/providers to take AIDS patients through the MA program or other means;
5) whether patients should be concentrated in a limited number of nursing homes, and whether the MA program should contract with a limited number of nursing homes or alternative facilities/providers to serve AIDS patients;
6) whether replacement of hospital care with nursing home care or alternative long term care for some persons with AIDS would result in a shift of financial burden from private insurers/HMOs to the State; and
7) how any future need for nursing home care for AIDS patients will be handled under the nursing home moratorium.

Summary of Access to Care Issues
Through private health insurance and HMO policies, the MCHA, MA and GAMC programs, and the charity care system, many persons with AIDS, AIDS-related conditions, and HIV infection in Minnesota will have access to basic medical care, such as

hospital and physician services. Private organizations such as the Minnesota AIDS Project use grants and donations to provide some support services for persons with AIDS, AIDS-related conditions, and HIV infection. Local social services and public health agencies also provide some support services to eligible persons.

However, serious access to care problems do exist. Some persons with health care coverage and those without coverage will have difficulty obtaining the type and amount of psychosocial support services they need. Coverage of alternative care such as home health care and long term care, including nursing home care, may be a problem. Some persons will be unable to either afford private health care or MCHA coverage or qualify for publicly-financed health care programs. Individuals with AIDS, AIDS-related conditions, or HIV infection whose employers are self-insured may also face coverage problems.

Additional discussion is needed to further define what the role of the State and local governments in Minnesota should be in ensuring access to psychosocial support services and alternative care for persons with AIDS, AIDS-related conditions, and HIV infection who can not afford to purchase these services and are not eligible for publicly-financed programs. The extent to which virus transmission will be curtailed will depend on how successful individuals are in changing their behavior. As was mentioned earlier, many individuals, particularly those who are aware that they are already infected with a life-threatening disease, may need professional counseling and assistance in order to change their behavior. Some degree of public subsidization of such services may save the State money in the long run by reducing transmission of the HIV and specifically by reducing the number of persons with AIDS and AIDS-related conditions who become eligible for MA and GAMC.

Selected Access to Care Activities in Other States

Nationally, many individuals with AIDS and severe AIDS-related conditions have received a large portion of their care in inpatient hospital settings as a result of their complex medical needs and the traditional emphasis of third party payers on institutional care. More recently, quality of life and cost considerations have created greater interest in alternative care services such as home health care and hospice care for these persons. Recognition is growing of the need that many persons with AIDS and AIDS-related conditions have for services that go beyond what is traditionally thought of as "health care." These services may include counseling, case management and other social and support services.

San Francisco has used home health care, hospice care, and various support services to minimize the amount of time persons with AIDS and AIDS-related conditions spend in inpatient hospitalization. Implementation of this system of care has been accomplished through the joint efforts of the State of California, the County and City of San Francisco, and numerous

voluntary organizations. State, county, and city funds have gone to start-up programs to recruit, train, and supervise volunteers to provide support services; to train home health care workers in the care of persons with AIDS and AIDS-related conditions; and to subsidize the actual provision of home health care, hospice and support services for persons who do not have third party or Medicaid coverage and cannot pay for these services. For fiscal year 1985-86, the City and County of San Francisco provided almost $9 million for AIDS related services. These funds included $975,000 for general education and risk reduction activities, $1.8 million for outpatient clinics, $1.1 million for home health care, and $1.26 million for support services (housing, emotional support, practical support for daily living, mental health and substance abuse services). [16-18]

Data on the San Francisco model of care has shown overall cost savings. [6] Other local and state governments are attempting to replicate elements of the San Francisco model of care. New York State is trying to shift hospitals from providing intensive inpatient care to more appropriate levels of outpatient care by designating hospitals that receive financial incentives to provide a full range of services for AIDS patients. Reductions in inpatient hospital stays allow the hospitals to spend additional funds on outpatient treatment and home care services. The Robert Wood Johnson Foundation recently announced a $17.2 million grants initiative to improve health and supportive services for people with AIDS and AIDS related disorders. The focus of the program is on out-of-hospital care; grantees are metropolitan areas with the largest numbers of AIDS cases. [19]

Elements of the San Francisco model of care and models of care in use and under development in other cities and states could potentially be adapted for Minnesota.

<u>Planning for the Care of Persons with AIDS and AIDS-Related Conditions in State Financed Health Care Programs</u>

Planning for the future impact of AIDS on state financed health care programs should include projecting the financial impact on the MA and GAMC budgets as well as assessing the appropriateness and cost-effectiveness of the services being provided to persons with AIDS and AIDS-related conditions by the MA and GAMC programs.

New ICD-9 codes for AIDS and AIDS-related conditions were recently published. Medicare, Medicaid and other insurers are expected to begin using the new codes. The lack of a specific ICD-9 diagnosis code for AIDS up until now has complicated the process of tracking the number of persons with AIDS and AIDS-related conditions who are receiving Medicaid and expenditures associated with their care. Therefore, there is a very limited amount of information available regarding other states' experiences with AIDS and Medicaid.

The federal government currently estimates that about 40% of AIDS patients are being served under Medicaid at any one time. [20] Limited data from Maryland on the state's first 88 AIDS cases showed that 28 persons or about 30% of the 88 cases in the study became Medicaid eligible during the course of their illness. A Massachusetts study of one hospital's 41 AIDS and ARC cases over a one year time period found that 20% of the cases were covered by Medicaid; an additional 15% had no coverage. [7]

The California Department of Health Services recently completed an extensive study on the health care costs of AIDS in California. [6] Paid claims data from the Medi-Cal (California's Medicaid) program from July 1983 through August 1985 were reviewed. The study found that about 12% of California's AIDS cases were covered by Medi-Cal, and that the proportion of AIDS patients covered by Medi-Cal had not changed significantly over time. The average lifetime Medi-Cal cost per patient was $59,000. Treatment costs varied considerably by region within the state, with costs being lower in the San Francisco area than elsewhere.

The Minnesota Department of Human Services has done a preliminary analysis of data covering MA and GAMC inpatient hospital care for potential cases of AIDS and AIDS-related conditions. The Department's payment system has identified approximately 50 people who are likely to have AIDS or AIDS-related conditions who have received care paid for by MA or GAMC.

The Department of Human Services is including projected costs for services to persons with AIDS and AIDS-related conditions as part of its overall MA budget, rather than as a separate item. Given the magnitude of the MA budget, expenditures associated with the care of persons with AIDS are not expected to represent a large share of MA expenditures during the next biennium (FY 1988-89). However, unless great strides are made in preventing the development of AIDS and AIDS-related conditions in persons who are already HIV infected, the financial impact of AIDS on the MA program will be much greater in future bienniums.

The State has a fiscal incentive to ensure that all persons who are eligible for MA receive it rather than GAMC, since the Federal government provides about 53% of the funding for the MA program, while the GAMC program is 90% state and 10% county funded. The Department of Human Services' preliminary data analysis indicated that it was necessary to take specific actions to ensure that all MA eligible persons with AIDS receive MA rather than GAMC. The Department has developed a computer program to identify GAMC cases that are MA eligible because of an AIDS diagnosis, and is working with counties to facilitate the timely transfer of such persons to the MA program.

Minnesota's Medical Assistance program provides all of the services mandated by the Federal government. Minnesota has also

chosen to provide all of the services designated as optional Medicaid services by the Federal government prior to the enactment of the Consolidated Omnibus Reconciliation Act of 1985 (COBRA). Therefore, a wide range of services, including home health care services, private duty nursing, and nursing home care are available to MA eligible persons with AIDS and AIDS-related conditions who have a medical need for the service.

The basic medical care needs of persons with AIDS and AIDS-related conditions can be met with the services currently offered under the MA program. However, it may be possible for the MA program to provide more appropriate and cost-effective services to these persons. Available options include covering case management and hospice care, which were authorized by COBRA as additional optional services that states can choose to provide under Medicaid programs, and applying for Medicaid waivers.

Federal Medicaid regulations prohibit expanded benefits to recipients with a particular disease under the regular Medicaid program. States that chose to make hospice care available must make it available to all appropriate recipients, i.e. all terminally ill Medicaid recipients. [7] The Omnibus Reconciliation Act of 1986 exempted states from this requirement for case management; states are allowed to provide case management services to individuals with AIDS or AIDS-related conditions without providing them to other Medicaid recipients.

Case management and hospice care are services that could potentially benefit many persons with AIDS and related conditions. Many of these persons have complex medical and psychosocial needs; a case manager could be quite useful in ensuring that an individual obtains all of the appropriate services to meet those needs. Case management could also serve a public health function by providing needed services that would assist HIV-infected persons in refraining from activities that spread the virus.

The Department of Human Services is currently analyzing proposals received in response to an RFP issued for the provision of medical case management services for Medical Assistance recipients with complex medical needs, including persons with AIDS and AIDS-related complex. Case management provided as an optional service would need to be coordinated with both this medical case management and the case management efforts of other groups (the Minnesota AIDS Project, county social workers, etc.).

Broadly defined, hospice services are "a program of palliative and supportive services which provides physical, psychological, social, and spiritual care for dying persons and their families." [21] AIDS is a fatal disease; most individuals with AIDS die within two years of diagnosis. Many of those individuals could probably benefit from hospice services.

Studies have shown that hospice care can be a cost saving as well as humane way to care for terminally ill patients. [21,22] While the vast majority of patients in these studies have had terminal cancer, data from Hospice of San Francisco indicates that hospice care of persons with AIDS also yields cost savings and beneficial results. [23]

Both case management and hospice care can be defined in various ways, and provided by various types of providers in various settings. Analysis of the costs and benefits of these services will depend heavily on Federal regulations to implement the COBRA provisions, which were not yet available when the Health Care Financing Subgroup was discussing these issues. For example, hospice care has been covered by the Medicare program on an experimental basis since 1982. However, the Federal Medicare regulations governing hospice are very restrictive, and have resulted in few hospice providers seeking Medicare certification. [24] A similar situation could occur with Medicaid.

Freedom of choice waivers allow the Secretary of Health and Human Services to waive Medicaid State Plan requirements, including the requirement that recipients be allowed to choose among qualified providers. This waiver can be for one of four specific purposes, all focused on increasing the cost effectiveness and efficiency of the services provided to recipients. The State must document the cost effectiveness of the project and the effect on recipients regarding access to care and quality of services. A freedom of choice waiver could allow a state to contract with the most cost effective and efficient providers for a category of Medicaid recipients, such as AIDS patients. The waiver could be applied to a variety of health care providers, including physicians, hospitals, and home health agencies. [7] With such a waiver, Minnesota could, for example, contract with a limited number of hospitals to serve Medical Assistance patients with AIDS as New York State has done.

Section 2176 home and community based Medicaid waivers allow states to provide home and community based services to person who would otherwise require care in a skilled nursing facility (SNF) or intermediate care facility (ICF). The services can include services not covered under the regular Medicaid program, such as social services. The cost of providing these services must not exceed the costs of caring for the person in an SNF or ICF. Minnesota may want to consider applying for this type of waiver for persons with AIDS and related conditions after more historical data on service costs is available.

Summary of Health Care Financing Recommendations

1. The Minnesota Departments of Health and Commerce should continue to make information about health maintenance organization and health insurance coverage, and the Minnesota Comprehensive Health Association (MCHA) program available to persons who have AIDS, AIDS-related conditions, HIV infection,

or are at increased risk of infection. These Departments should also monitor their complaint systems and data on the MCHA program to determine if additional problems are arising with access to care for persons who are HIV antibody positive, or have AIDS or AIDS-related conditions.

2. Persons with AIDS, AIDS-related conditions, or HIV infection who are not eligible for Medical Assistance or General Assistance Medical Care but lack the financial means to purchase health care coverage are part of a larger problem of financial access to care. For public health as well as humanitarian reasons, the Health Care Financing Subgroup recommends that consideration be given to including persons with AIDS, AIDS-related conditions, and HIV infection as a priority group in efforts undertaken to increase financial access to care.

3. The State of Minnesota should consider seeking a limited exemption from the federal Employee Retirement and Income Security Act (ERISA) preemption of state regulation of employer-provided health plans. A limited exemption would allow the State to monitor all health plans and to protect enrollees of all plans equally.

4. The Department of Human Services should continue to monitor data from the Medical Assistance and General Assistance Medical Care programs on the number of persons with AIDS and AIDS-related conditions and expenditures made on their behalf for budget projection and program planning purposes.

5. The Department of Human Services should continue its efforts to ensure that all Medical Assistance (MA) eligible persons with AIDS and AIDS-related conditions are covered under the MA program rather than the General Assistance Medical Care (GAMC) program. These efforts may include periodic review of program data and implementation of procedures to expedite transfer of cases to the MA program, education of physicians and patients on the benefits of the MA program in comparison to GAMC, and training of county social services personnel on this issue.

6. The Department of Human Services should analyze options that may make it possible for the MA program to provide more appropriate and cost-effective services to persons with AIDS and AIDS-related conditions, including the addition of case management and hospice care and applying for a Medicaid waiver. Analysis of each option should include an assessment of whether the addition of the service or the waiver will be beneficial for persons with AIDS and related conditions and what net financial impact the addition of the service or the waiver would have on the MA program and other state expenditures. Input should be sought from the Health Care Financing Subgroup, MDH, the Minnesota AIDS Project, other concerned members of the community, medical professionals, and health care providers.

7. The Departments of Health, Human Services, Finance, and Commerce, and the State Planning Agency should continue to meet

on a periodic basis to analyze health care financing issues identified as requiring further study, to monitor implementation of the Health Care Financing Subgroup's recommendations, and to work on biennial budget issues such as forecasting for the Medical Assistance budget. Issues requiring further analysis include 1) defining what further role the State of Minnesota and local governments should take in ensuring access to psychosocial support services and alternative care for persons with AIDS, AIDS-related conditions, and HIV infection who do not have private or public health coverage, or whose coverage does not include needed services; 2) determining whether access to long term care, including nursing home care, is or will be a problem for persons with AIDS and AIDS-related conditions; 3) evaluating the cost effectiveness and appropriateness of Medical Assistance options for persons with AIDS and AIDS-related conditions, including case management, hospice care, and waivers; and 4) interagency monitoring of additional AIDS issues that may affect or be related to health care financing issues.

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C. EDUCATION ISSUES

AIDS Policies for Schools

School districts in several states have experienced problems in implementing policies regarding school attendance of children with AIDS. As of October 1986, there were no known cases of AIDS among children or adolescents in Minnesota; however, there are children and adolescents infected with HIV and some AIDS cases in the school age population are expected to occur in Minnesota in the near future.

In response to national concern about the placement in schools of children infected with HIV, the Centers for Disease Control issued Recommendations for Education and Foster Care of Children Infected with HTLV-III in August 1985. Minnesota Department of Health Guidelines for the Placement In Schools of Children and Adolescents Infected with HTLV-III (based on the CDC recommendations) were developed with input from the Minnesota Department of Education, teachers' associations, school officials, and interested others, and issued in September 1985.

The Minnesota Department of Education (MDE) Commissioner and Minnesota State Board of Education concurred with the guidelines, and distributed copies of the guidelines to all local school districts, along with sample local school district policies developed by Minnesota Department of Education staff. The policies address not only attendance of children with HIV infection, but also continued employment of faculty with HIV infection, provision of instruction to learners of all ages and development of an individualized health plan with students and parents. Upon request, the Department of Education has reviewed policies developed by local school districts.

Inservice Education of School Personnel on Educational Implications of AIDS

The Minnesota Department of Education has communicated information about the educational implications of AIDS to school personnel in a variety of ways. Articles about AIDS were published in Education Update in November 1985 and May 1986. School administrators have been sent an issues paper, state guidelines and sample local district polices, notice of inservice resources for staff and community, and instructional resources for learners of all ages. They have also been notified about plans for a "First Response Team" composed of Minnesota Department of Education and Department of Health officials who are prepared to assist the school districts that have the first AIDS cases deal with the situation.

Other activities undertaken by MDE have included holding eight regional workshops around the state, making presentations at several state and regional meetings of educators, and developing a resource guide, videotape, and instructional resources for students. A total of 500 administrators, school nurses, and health educators participated in the all day regional workshops and received a packet of materials on AIDS. The resource guide,

Preventing AIDS: A Resource Guide for Inservice Education on Acquired Immune Deficiency Syndrome and Educational Implications, was a joint project of MDE and the School Nurse Organization of Minnesota (SNOM); it was distributed to all workshop attendees, all members of SNOM, and Minnesota Education Association (MEA) local chapter presidents. A 25 minute videotape of the core information from the workshops was developed by MDE, SNOM, and MEA and distributed to all local MEA presidents. A second videotape was developed that reviews components of a local school district policy and guidelines recommended for schools in dealing with AIDS - cleaning bodily fluids, responding with support, use of the First Response Team, etc. This videotape was sent to each MEA local president in September, 1986.

The instructional resources guide, Preventing AIDS Through Education, was developed by the Minnesota Department of Education under contract with the Minnesota Department of Health. This guide includes learner outcomes for all ages - early childhood through adult, a variety of options for educators to use in development of lesson plans including a lecture outline, classroom activities, sample lesson plans, and a list of audiovisual resources. It has been distributed to all local school districts.

The Department of Education has attempted to strengthen expertise and resources on AIDS in local communities. In the future, the Department plans to do more on the educational implications of AIDS with local school boards. Integration of AIDS material into schools' curriculum is a priority.

Significant groundwork has been laid for the educational community to be informed about AIDS and to have established policies so that educators, students, parents and the community will respond with support and understanding when a student or adult is known to be HIV infected. However, there continue to be areas where additional resources and inservice are needed, and reinforcement of basic principles is essential.

The importance of AIDS education in the schools was stressed in the Surgeon General's recent report on AIDS. The report notes that adolescents are a special educational concern, but further states that "Education concerning AIDS must start at the lowest grade possible as part of any health and hygiene program." [1]

Recommendation

The Minnesota Department of Education should ensure that local school boards have established policies; ensure that local educators integrate AIDS education into a variety of curriculum areas; ensure that student service staff are available and prepared to counsel students about AIDS and HIV transmission; promote the community education system as a vehicle for providing information about AIDS to the general public; and support schools and communities where children and faculty are known to be HIV infected through implementation of the First

Response Team and ongoing support as the number of children and faculty who are infected increases. Ongoing technical and scientific expertise will be provided by the Minnesota Department of Health.

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EMPLOYMENT ISSUES

The AIDS Issue Team addressed three AIDS policy issues related to employment: 1. Employment of food handlers infected with HIV; 2. Occupational Safety and Health Act (OSHA)/Employee-Right-to-Know Issues; and 3. Personnel policies affecting state employees infected with HIV. (Employment discrimination against persons with AIDS or AIDS-related conditions was addressed under Human Rights Issues.)

Employment of Food Handlers with HIV Infection

Nationally, there has been public concern about the purported risk of transmission of HIV by persons preparing and serving food and beverages. The Minnesota Department of Agriculture has also received questions about whether or not a food handling employee can continue to be employed in a direct food handling capacity after having been diagnosed with AIDS.

The Minnesota Department of Agriculture's authority covers all food handlers in Minnesota except those who are regulated by the Minnesota Department of Health, local health officials and the United States Department of Agriculture.

Minnesota Statues 31.171, "Employment of Diseased Persons," provides that: "It shall be unlawful for any person to work in or about any place where any fruit or any food products are manufactured, packed, stored, deposited, collected, prepared, produced or sold, whose condition is such that disease may be spread to his associates direct, or through the medium of milk, cream, butter, other food or food products likely to be eaten without being cooked after handling, whether such condition be due to a contagious, infectious, or venereal disease, in its active or convalescent stage, or to the presence of disease germs, whether accompanied by, or without, any symptoms of the disease itself.

It shall be the duty of the commissioner, his assistants, inspectors, or agents to report to the state commissioner of health for investigation, any person suspected to be dangerous to the public health, as provided for in this section, and immediately to exclude such persons from such employment pending investigation and during the period of infectiousness, if such person is certified by the state commissioner of health, or his authorized agent, to be dangerous to the public health."

In response to this concern, the Minnesota Department of Agriculture (MDA) requested an opinion from the Minnesota Department of Health regarding the potential health implications of direct food handling by employees diagnosed as having AIDS. Given past experience with Hepatitis B and data on HIV infection, MDH concluded that food handlers "appear to be at minimal risk in transmitting this infection." Based on this opinion, MDA adopted a policy that it would not exclude a food handling employee from employment due to AIDS. However, if such a situation came to its attention, MDA would notify the

Commissioner of Health in accordance with M.S. 31.171.

Further support for the Minnesota Department of Agriculture policy came from the the Centers for Disease Control, U.S. Public Health Service, November 15, 1985 Recommendations for Preventing Transmission of Infection with HTLV-III in the Workplace. These recommendations specifically addressed concerns about food service workers (FSWs), noting that "All epidemiologic and laboratory evidence indicates that blood borne and sexually transmitted infections are not transmitted during the preparation or serving of food or beverages, and no instances of HBV (hepatitis B virus) or HTLV-III/LAV transmission have been documented in this setting." The CDC recommendations concluded that "FSWs known to be infected with HTLV-III/LAV need not be restricted from work unless they have evidence of other infection or illness for which any FSW would also be restricted." Routine serologic testing of FSWs for antibody to HTLV-III/LAV was not recommended by CDC.

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OSHA/Employee Right-to-Know Issues

The purpose of Minnesota's Occupational Safety and Health (OSHA) program is to ensure that workplaces are safe and healthful for working people. The OSHA program, which is in the Department of Labor and Industry, enforces the federal OSHA regulations, some "localizing" state OSHA standards, and the state Employee Right-to-Know Act. The program covers private and public employers. It conducts about 6000 unannounced inspections a year; it also responds to employee complaints, and investigates all significant accidents, especially those that result in a worker's death. The OSHA program can cite employers for unsafe or unhealthy conditions, levy fines, and conduct followup inspections to assure compliance with citations that are issued.

Two aspects of the OSHA program are of interest with regard to AIDS. First, OSHA regulations allow an employee who "reasonably believes" that working conditions pose an "imminent danger" to refuse to work, notify the employer, and request an OSHA inspection. Early on, during the AIDS "scare" phase, it was felt that mere exposure to an AIDS infected person might be feasibly believed to be an imminent danger. The OSHA program has determined that this provision is not now applicable to the AIDS situation, since there is enough information available through the general media that the reasonable person should be aware that AIDS is not spread through casual contact as occurs in the normal work situation.

Second, the 1983 Right-to-Know Legislation required that

hospitals and clinics provide training to employees about infectious agents to which they are routinely exposed. The training requirement covers employees who are not "technically qualified;" as a result of 1984 legislative changes, "technically qualified" individuals (RNs, physicians, etc.) must have the opportunity to participate in training sessions. Generally, the OSHA program has had good compliance from hospitals on this requirement.

The AIDS Issue Team discussed data privacy concerns related to notification of employees under the Right-to-Know law. The OSHA program has determined that the Right-to-Know legislation does not require employers to advise employees that another employee has AIDS since employees must be "routinely exposed" before they must be provided with information or trained.

State Personnel Policy on AIDS

In order to address the issues that AIDS presents to the State as an employer and as a provider of services to clients who may have AIDS, a work group within the Department of Employee Relations (DOER) was put together to develop a statewide personnel policy on AIDS.

The DOER work group determined that the State already has personnel policies for dealing with AIDS-related situations in place, including policies which address hiring, reassignment, reasonable accomodation, discipline, etc. The group felt, however, that there was a need to communicate how those policies apply in AIDS-related situations to managers and supervisors who, with guidance from personnel and labor relations directors, are responsible for implementation of personnel policies. Toward that end, a "Policy Statement Regarding AIDS in the Workplace" was developed.

The Policy Statement affirms the policy of the State of Minnesota not to discriminate against any individual applicant, employee, or client because he or she may have AIDS or an AIDS-related condition. It addresses the status of employees with such conditions, co-workers of employees with such conditions, and employees who may be required to provide services to individuals with such conditions.

DOER has distributed the policy and resource materials to the personnel office in each state agency, and has made information available to union stewards and to the Employee Assistance Program. In addition, DOER is encouraging each state agency to develop specific AIDS policies dealing with that agency's particular situation as needed.

Recommendations

1. State agency employee leave forms for sick leave should either be revised or procedures should be established that protect private medical data that the employee may furnish on

these sick leave forms. Data privacy concerns have arisen in some state agencies when employees have been asked to specify the illness for which they are taking sick leave and how that information is subsequently handled.

E. HUMAN RIGHTS ISSUES

The Minnesota Human Rights Act and Discrimination Against Persons with AIDS and AIDS-Related Conditions

Persons with AIDS as well as those who are either identified as or perceived to be members of groups at high risk for acquiring the disease have experienced various forms of discrimination throughout the United States. For some individuals, e.g. gay men, discrimination in areas such as employment and housing is a long term problem that has been exacerbated by the AIDS crisis.

Nationally, there have been legal efforts to use laws barring discrimination on the basis of physical disability to address discrimination against persons with AIDS. California and Wisconsin have passed state laws specifically prohibiting discrimination in employment against persons who are HIV antibody positive. Los Angeles has passed a city ordinance prohibiting discrimination.

On June 20, 1986, the U.S. Department of Justice issued a memorandum regarding application of Section 504 of the Rehabilitation Act to persons with AIDS, AIDS-related complex, or HIV infection. This memorandum concluded that Section 504 prohibits "discrimination based on the disabling effects that AIDS and related conditions may have on their victims." It also concluded, however, that "an individual's (real or perceived) ability to transmit the disease to others is not a handicap within the meaning of the statute and therefore, that discrimination on this basis does not fall within Section 504." [1]

The Department of Justice memorandum represents one agency's interpretation of federal civil rights law. It should be noted that the federal standard of discrimination as described in this memorandum differs from the state standard in Minnesota. For example, the Minnesota Human Rights Act will not allow an employer to discriminate against an individual based on ability to transmit a disease absent any medical evidence that the individual poses a danger to others in the employment setting.

The Minnesota Human Rights Act prohibits discrimination on the basis of race, color, creed, national origin, sex, marital status, public assistance status, disability, and age in the areas of employment, selling or leasing property or housing, public accomodations, public services, and educational institutions. (Some classes are not covered in all areas). The Act does not cover discrimination on the basis of sexual preference. The provisions of the Act relating to disability are similar to federal law. A disabled person is defined as a person who (1) has a physical or mental impairment which substantially limits one or more major life activities; (2) has a record of such impairments; or (3) is regarded as having such an impairment. The disability provisions of the Act are the provisions which apply to individuals with AIDS or AIDS-related

conditions. In some circumstances, a person with AIDS might also make an allegation of discrimination based on national origin or sex.

The Human Rights Act is enforced by the Minnesota Department of Human Rights, which accepts and processes individual charges of unlawful discrimination and also works to eliminate discrimination through public education and other programs. The majority of cases processed by the Department of Human Rights are employment- related. In addition to prohibiting employment discrimination based on disability, the statute requires that an employer with 50 or more permanent, full-time employees must make reasonable accomodation to the known disability of a qualified disabled person, and defines reasonable accomodation. It also extends job protection to job applicants, prohibiting employers from requiring an applicant to furnish information on a disability, and defining four conditions that must be met in order for an employer to require a pre-employment physical examination.

The Department's process for handling discrimination complaints includes investigation of charges to determine whether there is probable cause to believe has occurred. If so, the Department tries to resolve the charge through conciliation, and the case may be referred to the Attorney General's Office for litigation. An administrative hearing is held; if the administrative law judge finds that discrimination has occurred, the administrative law judge can order that the victim be reinstated in his or her job, receive compensation, etc.

As of October 1986, the Department had docketed six AIDS-related charges. Four of these charges involve employment and two are against places of public accomodation. Of the employment cases, one settled prior to a determination, one was conciliated after a determination that discrimination had occured, and the others are under investigation. Both charges involving public accomodations are under investigation.

An individual who feels that he or she has been discriminated against can, of course, choose to go directly to the court by filing a lawsuit rather than filing a charge with the Department of Human Rights. Several individuals in Minnesota have chosen this route.

References

U.S. Department of Justice, Office of Legal Counsel. Memorandum for Ronald E. Robertson, General Counsel, Department of Health and Human Services, Re: Application of Section 504 of the Rehabilitation Act to Persons with AIDS, AIDS-Related Complex, or Infection with the AIDS Virus. Washington, D.C., June 20, 1986.

F. CORRECTIONS ISSUES

AIDS Policies for Correctional Institutions

Inmates with AIDS began to be identified in prison populations in New York and New Jersey in late 1981 and 1982, causing the Centers for Disease Control to warn in January 1983 that health care personnel for correctional facilities should be aware of the occurence of AIDS in prisoners, particularly prisoners with histories of intravenous drug use. [1] Nationally, many prison populations contain a high concentration of individuals at risk for the disease, primarily because of IV drug use and to a lesser degree, male homosexual activity. [2]

Although the Minnesota corrrections system had not had any prisoners with AIDS, the Department of Corrections believed that it was important to begin addressing AIDS issues and did so in Spring 1983. In October 1985, the Department Corrections issued a series of policy directives for all correctional facilities on the following topics: AIDS Training and Education Program; AIDS Support Team; and Prevention and Handling of AIDS.

The AIDS Training and Education Program policy requires that each correctional institution, in cooperation with the Department of Corrections training director and health care administrator, develop and implement an education program that effectively communicates to all staff and inmates current facts related to AIDS. The AIDS Support Team Policy requires that a support team of appropriate personnel be established for each person with an AIDS, ARC or HIV antibody positive diagnosis. The Prevention and Handling of AIDS policy addresses issues related to testing of inmates, and standards of care for AIDS and ARC patients.

These policies are consistent with other medical policies in Corrections. As of October 1986, no inmates with AIDS had been identified in the Minnesota correctional system; there have been two inmates with ARC. AIDS Support Teams had been established for these two individuals in accordance with the Department's policy. Confidentiality is being handled as required under the Data Practices Act; staff are not given an individual's specific diagnosis but are told that blood precautions should be observed in dealing with the individual.

References

Centers for Disease Control. Acquired Immune Deficiency Syndrome (AIDS) in Prison Inmates - New York, New Jersey. Morbidity and Mortality Weekly Report 1983; 31:700-1.

U.S. Department of Justice, National Institute of Justice. AIDS in Prisons and Jails: Issues and Options. February 1986.

G. ISSUES RELATED TO STATE OPERATED AND LICENSED FACILITIES

AIDS Policies for Facilities Operated by the Department of Human Services

The Department of Human Services is responsible for the operation of eight state hospitals, which are now known as regional treatment centers or human services centers, and two state nursing homes. These facilities provide services to persons who are mentally ill, mentally retarded, or chemically dependent. The Department of Human Services faced a difficult task in developing AIDS policies for these facilities which would allow the State to fulfill its responsibility for preventing transmission of the HIV among vulnerable insitutionalized populations in its care while respecting the rights of these individuals.

Four AIDS policies for these facilities were developed and adopted in final form by the Department of Human Services in May 1986 following review by the Department of Health. The policies are AIDS Diagnosis, Infection Control Policies for AIDS Residents/Patients, Care and Treatment of AIDS Patients, and AIDS Patient Support Team.

The purpose of the AIDS Diagnosis policy is to establish consistent policy for diagnosing and handling AIDS in the regional centers. The policy establishes procedures for evaluation of patients who are HIV infected and outlines precautions to be used for such persons.

The Infection Control policy outlines in more detail the procedures to be followed by clinical and laboratory personnel and all other allied professionals working in direct patient care, with laboratory specimens, or with equipment. The purpose of the policy is to prevent the spread of HIV and other presumably transmissible agents by contact with blood and body fluids to staff, residents, and visitors at DHS residential facilities, and to protect persons with immune deficiencies from the acquisition of potential opportunistic infections.

The policy on care and treatment of AIDS patients requires each facility to develop an education/training program that will, on an ongoing basis, provide current, accurate information on AIDS to staff and residents. It also requires each facility to review and, where necessary, alter its medical practices guidelines to conform with procedures and policies established in the policy. The policy addresses screening, placement, and identification, and management of patients who are HIV antibody positive.

The purpose of the AIDS Patient Support Team Policy is to assure optimum care for patients who have been diagnosed with AIDS, AIDS-related conditions, or HIV antibody positivity. The policy requires the Chief Executive Officer of the facility to work with the medical director and the patient's case manager to put together the most appropriate support team to meet the patient's

needs.

AIDS Policies for Facilities Licensed by the Departments of Health and Human Services

Questions have arisen regarding application of the infectious disease provisions of Minnesota Department of Health health facility and program rules to prospective or current residents/patients who have AIDS, AIDS-related conditions, or HIV infection. The Department of Health is exploring rule changes and other possible alternatives for addressing these situations, including waiver and variance options and broader dissemination of information to providers. The Departments of Health and Human Services will be examining other AIDS-related issues regarding facility and program rules as needed.

AIDS Policies for Veterans' Administration Facilities

The Department of Veterans Affairs is responsible for the operation of two veterans' homes at Hastings and Minneapolis, providing nursing care and domiciliary care in the first home and domiciliary care only in the second home. These homes provide services to veterans who are elderly, have chronic medical, psychiatric, chemical dependency and financial needs.

Policies and procedures were reviewed to address concerns related to maximizing care for veterans with AIDS, supporting staff in rendering that care, and to dealing with issues relating to the employment of the person with AIDS. Policy and procedure changes were made to prevent the spread of HIV and to protect persons with immune deficiencies from acquiring opportunistic infections.

A veteran who is HIV antibody positive, or has been diagnosed with AIDS or ARC, could be admitted to the Veterans' Homes under current admission procedures unless the individual has medical needs which could not be met by the facility.

Three new policies were adopted by the Department of Veterans Affairs to address AIDS issues. The first policy, Precautions to be used in caring for patients infected with the Acquired Immunodeficiency Syndrome, addresses procedures that should be followed in caring for residents who are infected with HIV. The second policy, AIDS Support Team, outlines the procedure for setting up a support team for each resident with AIDS, ARC, or who is HIV antibody positive. The third policy, AIDS Education and Training Program, addresses the provision of education about AIDS to staff and residents.

H. LAW ENFORCEMENT ISSUES

Education of Law Enforcement Personnel About AIDS

In order to meet the need of law enforcement personnel for information about AIDS, the Minnesota Board of Peace Officer Standards and Training (POST) in the Department of Public Safety developed two informational articles on AIDS. These articles were published in three Minnesota law enforcement journals: the Minnesota Chiefs of Police Journal (August 1986), the Minnesota State Sheriffs Journal (August 1986), and the Peace and Police Officers Association Journal (May 1986). The articles covered basic information about what AIDS is; how it is transmitted; who is at risk; and what the symptoms of AIDS are. Topics of specific interest to law enforcement personnel were also covered, including coming into contact with HIV infected persons in arrest and first aid situations.

I. Data Practices Issues

The Minnesota Governmental Data Practices Act and related statutes provide statutory protection for some data collected, stored or disseminated by various state agencies. The Act specifies classifications of various types of data on individuals and terms governing its release. The Issue Team did not complete an exhaustive review of each agency's statutory basis for protecting AIDS data that it may possess on individuals. This would be a substantial effort and would be best accomplished by each agency in consultation with their legal counsel. This review would not only pertain to how AIDS-related data is protected but any medical data on individuals collected or utilized by that state agency.

Recommendations

1. State agencies that collect data on individuals should review their existing statutory basis for protecting that data to ensure that it provides adequate protection of that data. Agencies may wish to accomplish this review in conjunction with their appropriate assistant attorney general.