



Volume 10  
Issue 1  
February/March 2004

SERVING THE COMMUNITY  
SINCE 1983

# MINNESOTA AIDS PROJECT AIDSLINE BRIEF

A MAP journal providing you with information to strengthen your awareness in the fight against HIV.

## BY THE NUMBERS

A person infected with HIV is not the only person affected by the disease. In one case in Minnesota, an individual with HIV has 41 family members, 19 friends, 57 community members, and 60 co-workers totaling 177 people all aware of and affected by her diagnosis. **If every HIV infected person had similar relationships, of the 4,598 Minnesotans infected with HIV, an estimated 813,846 Minnesotans are affected by someone diagnosed with HIV.** Subsequently, in the United States 529,035 people are known to be living with HIV and 93,639,195 people are affected. Projecting this example on a global level, with 40 million people infected, most of the world's population is affected by HIV.



1400 Park Avenue  
Minneapolis, MN 55404

#### MISSION

Minnesota AIDS Project envisions a world free of AIDS. Our mission is to lead Minnesota's fight to stop HIV and enhance the well being of those affected.

**Executive Director** Lorraine Teel

#### Staff Editorial Board

Robyn Behrens  
Colleen Bjerke  
Jenny Maxted  
Cathy Strobel  
Lorraine Teel  
Bob Tracy  
Amy Weiss, Editor  
Lauri Wollner

**Graphic Designer** Robyn Behrens

#### Contributing Writers

Colleen Bjerke  
Kim Lieberman  
Dori Makundi  
Jenny Maxted  
Ann Seguin  
Lorraine Teel  
Bob Tracy

The contributions of guest writers are credited through published by-lines.

Self-Care Update features, Prevention Update features and the MAP AIDSLine HIV Resource section are published with the financial assistance of the Minnesota Department of Health (MDH) with funds provided through Title II of the Ryan White CARE Act and the Centers for Disease Control and Prevention, as administered by MDH. These articles are subject to review by MDH prior to publication.

Housing Happenings is published with the financial assistance of Hennepin County Community Health Department with funds provided through Title I of the Ryan White CARE Act, as administered by the Department.

This newsletter is mailed at non-profit bulk rates under permit number 2772. MAP AIDSLine Brief is distributed as a free community service. To subscribe, call MAP AIDSLine.

#### Readers Notes:

Minnesota statistics reported on the cover in "By The Numbers" are based on data collected by the Minnesota Department of Health.

#### MAP RATING LEVEL 3:

Children ages 13-17, educators, adults.

© 2004 Minnesota AIDS Project

A message from Bob Tracy, MAP community affairs director



## Can We Trust Public Health?

Public health depends upon public trust. When there is an outbreak of food poisoning, public health depends upon the public to heed their words of caution – quickly. Then they depend upon the public to come forward with information to help track the spread as well as get the word out to keep others out of harm's way.

Without trust, it's hard to do good public health. Without trust, the public feels it is left wondering who is looking out for its well-being. And without trust, the public is not apt to move quickly when it needs to.

To gain trust, public health works hard day-in and day-out to collect and share reliable information with the public. There's no room for playing with the facts if public health is going to build the trust it needs.

### But that's exactly what's happening.

At the national level, we have seen the Centers for Disease Control and Prevention play with the truth about condom efficacy when it comes to reducing the risk for teen pregnancy, HIV and other sexually transmitted diseases. Sure, they still share information about condoms, but with an ideological slant and some political play to cast more doubt than confidence in what we know to be the truth about condoms. Unfortunately, and to be clear, it is only by default, this same message has crept into how the Minnesota Department of Health puts out information to the general public about condoms through vehicles such as its Web site.

More seriously however, is the recent debate over information that the Minnesota Department of Health is sharing regarding the question of abortion and breast cancer. In this case, the Department put the imprimatur of public health on information that is dated and has been shown to be false. It put politics over the facts and did so in a highly visible way.

It has also chosen to put a spin on a recently released evaluation of its federally funded abstinence-only education program, ENABL. The evaluation, in no uncertain terms clearly stated that the program did not work and that a comprehensive sexual health education strategy is what should be considered. But that's not what official spokespeople from the Department are saying. Or is this a case of molding the facts to fit the politics?

Minnesota's Department of Health has been recognized as one of the nation's best -- a leader in public health. We trust that this long-held reputation doesn't simply become a fond memory. Our public health depends upon this good group of professionals always having our trust. Call upon these officials to promote health, not politics.



# MINNESOTA AIDS PROJECT

## 2004 Legislative Action Agenda

<p><b>Education &amp; Prevention</b></p>	<p><b>Increase effective HIV prevention &amp; education</b></p> <ul style="list-style-type: none"> <li>• Introduce legislation for comprehensive sexual health education in schools, social services and public health.</li> <li>• Support reinstatement of health education graduation requirement.</li> <li>• Protect funding for HIV prevention. Oppose content restrictions and new CDC guidelines.</li> <li>• Support development of statewide networks for planning and capacity development, including reinstatement of K-12 Regional Training Sites.</li> </ul>
<p><b>Health Care &amp; Social Services</b></p>	<p><b>Expand access to health care and support services</b></p> <ul style="list-style-type: none"> <li>• Support confidential access to health care and mental health services for minors.</li> <li>• Advocate for adequate funding for drug and insurance reimbursement through state and federal programs (ADAP).</li> <li>• Promote access to universal health and social services by advocating for universal health care and reauthorization of the Ryan White Care Act.</li> <li>• Monitor and document impact of Minnesota's health care cuts.</li> </ul>
<p><b>Fair Treatment</b></p>	<p><b>Ensure fair treatment of people affected by HIV</b></p> <ul style="list-style-type: none"> <li>• Support legislation to change discriminatory application of medical assistance repayment requirements for unmarried couples.</li> <li>• Support MN Human Rights Act provisions related to sexual orientation and people with disabilities. Oppose restriction on health information and services based on sexual orientation.</li> <li>• Introduce legislation to increase health data privacy in workplaces.</li> </ul>
<p><b>Global Impact</b></p>	<p><b>A partner in response to the global epidemic</b></p> <ul style="list-style-type: none"> <li>• Promote awareness about impact of global epidemic in Minnesota. Introduce legislation requesting one-time prevention funding to address emerging epidemic in Minnesota.</li> <li>• Support follow-through on federal funding commitments, and global policies that advance comprehensive and culturally appropriate prevention services, affordable treatments and coordination through global partnerships.</li> </ul>

MAP Legislative Action Agenda is adopted annually by the MAP board of directors, with advice from its public policy committee. For more information and to keep track of what happens during the legislative session, visit MAP Public Policy at [www.mnaidsproject.org](http://www.mnaidsproject.org)



## I Could Call the MAP AIDSLine, Right?

Yes! If you need to learn more about HIV, need answers about reducing risky behaviors, or need help finding out where to get HIV medical care or services – calling the MAP AIDSLine is a smart thing to do. We don't claim to have all the answers, but we are committed to understanding the history and the ever-changing information related to HIV prevention and care. And, if we don't have the answer immediately, we will find it for you!

The MAP AIDSLine is the state's leading HIV information and referral phone line. This MAP service is funded by Minnesota Department of Health, Hennepin County and the Minnesota AIDS Project. We average approximately 500 calls per month. Calls range from basic questions about transmission, to helping HIV-positive individuals find needed services. Our callers are all ages, from all backgrounds, and live in small communities throughout Minnesota as well as the metro area. We've recently begun utilizing on-line translation services for our callers who have a primary language other than English.

The phone line has been operating at MAP for nearly two decades now but it is clear from the calls we get that many people still have basic questions about HIV. People still wonder if one can become infected from a mosquito bite. People still question the fact that HIV is not spread through casual contact, such as sneezing or sharing a drinking glass. Some employers are still skeptical of hiring someone with HIV. In some cases staff at medical facilities are still learning about and are frightened of working with a patient with HIV. There are many myths and misconceptions about HIV and our job is to help educate the general public,

those individuals at highest risk of becoming infected and persons living with HIV.

If you have had a risk and need to know where to get tested, call the MAP AIDSLine. Staff is knowledgeable about the different types of HIV tests available and will do an assessment to find out if testing is needed. We maintain a database of HIV testing sites throughout Minnesota to provide you with choices depending on your location and needs. Testing is also available at Minnesota AIDS Project.

Becoming infected with HIV is no longer the "death sentence" that it was once considered. There are medical treatments available and tests that can help determine how effective these medications are. However, there is still no cure and living with HIV continues to have unique challenges. Call the MAP AIDSLine if you or someone you know needs help accessing medical care, paying for their HIV medications or finding services for other needs related to having HIV. Our regularly updated on-line resource database allows us to access information on organizations statewide that provide HIV care and prevention services.

**If it is at all related to HIV, it is an appropriate call.**

# A Day in the Life of the MAP AIDSLine

This is a very small sample of the kinds of calls received on the MAP AIDSLine. If you, or anyone living with HIV has any questions about HIV, please contact MAP AIDSLine at 612-373-2437, 1-800-248-2437, 612-373-2465 (TTY), 1-888-820-2437 (TTY) or visit [www.mnaidsproject.org](http://www.mnaidsproject.org).

## 9:30 AM

A young, gay man newly diagnosed with HIV called the MAP AIDSLine looking for services. Following his diagnosis, the caller had just moved to Greater Minnesota from out of state to be closer to his family and friends. At the time of the call, he had not seen a doctor about his HIV. The caller said he is considering moving to the Twin Cities because he feels isolated in rural Minnesota. The MAP health educator offered several Greater Minnesota referrals and information to the caller. He did not have health insurance so staff explained what was available from the Department of Human Services (DHS) HIV/AIDS program to him and made that referral. The health educator also explained what a case manager does and how to access a Greater Minnesota case management program. He asked about support groups and GLBT-related groups. He was given a referral for a group in his area and staff discussed options for him in the Twin Cities should he decide to move here. He was also informed about the on-line HIV Resource Guide available through the Minnesota AIDS Project Web site. Staff sent him a printed copy of the HIV Resource Guide as well as program brochures about Positive Link and The Aliveness Project. He was also sent informational brochures describing medical care, medications and issues surrounding a new diagnosis. Staff discussed the Quick Connect program available through the MAP AIDSLine and let him know that if he decides to move to the Twin Cities this would be available for him until he gets other services set up. He was encouraged to call the MAP AIDSLine as needed for additional referrals or questions about his HIV status.

## 11 AM

A non-English speaker called and asked if we had someone who could speak his language. MAP AIDSLine staff called the new phone interpreter service and got an interpreter on the line. Once connected, we learned the caller was HIV-positive but had not accessed medical care in over a year because no one at the clinic he went to spoke his language. MAP AIDSLine staff recommended that the caller use a program that had a case manager who spoke his language. Caller was given the direct number for the case manager at that clinic. MAP AIDSLine staff asked permission to contact the clinic to inform them about this caller contacting them. Caller thanked staff and ended the call. A couple minutes later, staff called the referral clinic and spoke with the case manager who told the MAP health educator that she had just finished speaking with our caller, and that they had set up an appointment for him to come in that afternoon.

## 1:45 PM

The caller was crying when the MAP AIDSLine health educator answered the phone. The caller said she was tired, frustrated and didn't know where to turn. She had no family, friends or other support in the area. The caller was a woman who was diagnosed with HIV a decade ago. She was employed and living in stable housing with her son, but she did not have much money for food. She believes her health is deteriorating. She had not seen an HIV doctor in several years. She said she did not have the energy to figure out her new insurance information. She had been case managed and on anti-viral medication in the past. She said she was feeling okay so she stopped both services. She had no idea what her current T-cell count or viral load was. She was beginning to use street drugs again because she was so frustrated and upset. MAP AIDSLine gave her information about food resources, support groups, transportation to and from medical appointments, the number for Crisis Connection and contact information for getting back into case management. A Quick Connect appointment was set up for the client to get help sorting out her insurance, get set up with an HIV doctor, and get into a case management program.

## What MAP and Minnesota Parents Want: Keeping Our Kids Healthy

We all want our kids to be healthy. We want them to have every opportunity to grow into adults with healthy relationships and sexual lives. But to get there, we need to grow with them through adolescence – the time of their lives when they are challenged to change their relationships with parents, families and friends and test different ways of defining themselves as a unique adult. They need good information and our care along the way. Some of what they need is comprehensive information about sexuality, and at times, access to confidential health services.

### Comprehensive Sexual Health Education

Few issues have the kind of consensus support we see for providing comprehensive sexual health education for Minnesota's teens. Both state and national surveys consistently show that 70 to 75 percent of respondents want comprehensive sexual health education for teens. What people want also happens to be what works. Study after study shows that if you want to help teens delay the initiation of sexual activity or teach them to use protection if they become sexually active, the best way to do that is to help them make responsible decisions by delivering facts and respect. A one-size-fits-all, abstinence-until-marriage approach does not work. No credible research has shown this approach to work. In 2003, a five-year evaluation of ENABL, a state-funded, abstinence-only initiative in Minnesota, showed that the program failed in getting participants to delay sexual activity and the evaluators recommended a comprehensive sexual health education approach.

Minnesotans speak with the voice of consensus in support of efforts to reduce teen pregnancies, reduce abortions, reduce STD and HIV infections, and promote lifelong healthy decisions about sexuality. They want teens to get sexual health education that talks about values, relationships, personal responsibility, sexual health, abstinence, AND what we know about reducing risk for unplanned pregnancy and sexually transmitted infections such as HIV. They want their kids to have the facts – all of the facts. And, young people want the facts – the real facts. Parents want precious limited public money spent on what works.

What parents do not want is to have the health and well-being of their kids traded for politics driven by a small but vocal, socially-conservative minority that puts ideology over facts, good science, and good public health. However, you can expect the abstinence-only push to come back to the Minnesota Legislature during 2004, and to continue on the national scene.

### Minor's Consent

MAP will also be fighting back efforts to weaken the State's minor's consent law that allows teens to get health care related to concerns such as STDs or substance abuse without parental consent. It also extends the care confidentially.

In 2003, socially conservative lawmakers tried to effectively repeal the confidentiality provision. They'll try it again in 2004.

Imagine sitting in your doctor's exam room and he or she asks you about your health concerns, but first says, "nothing you tell me will be kept confidential." Now imagine yourself as a teen concerned that you might have an STD or a young man asking questions about being gay.

Forget the studies (even though they support this point); just ask any teen if they are going to start this kind of conversation with their health care provider without being able to ask that it be kept confidential?

The reality is that once young people seek out confidential care for an STD, or contraception, substance abuse or questions about sexual orientation, the health care provider then works with them to involve their parents or guardian in the care plan.

What social conservatives want to do is put a "Do Not Enter without a note from your parents" sign on adolescent care clinics. Just like the abstinence-only push, it will have the exact opposite of the intended effect on the good health of our young people and the healthy relationships we want them to have with their parents.

MAP, as a co-convenor, along with Minnesota Organization on Adolescent Pregnancy Prevention and Parenting, of the Sexuality Education for Life coalition, will make comprehensive sexual health education and protecting minor's consent, top priority for its public policy advocacy in 2004. Be sure to visit the Public Policy Page at [www.mnaidsproject.org](http://www.mnaidsproject.org) to track these issues through the legislative session.

CLINI

DO NOT ENTER

without a note  
from your parents.

# HIV, Immigration and Public Benefits

Living with HIV is no picnic regardless of who you are, but for immigrants to the U.S. diagnosed with HIV, there can be the additional burden of navigating a public benefits system that has special provisions for immigrants.

Immigration status and public benefits were linked in the 1996 welfare reform act that created the federal TANF (Temporary Assistance to Needy Families) and Minnesota's MFIP (Minnesota Family Investment Plan). As passed, legal immigrants were not eligible to receive TANF cash assistance, childcare, transportation, or other non-cash benefits. In addition to barring what the Congress termed "unqualified" legal immigrants from all federal public benefits such as Social Security and food stamps, this law required counties to report individuals 'suspected' of being illegal immigrants to the INS (now known as Bureau of Citizenship and Immigration Services (BCIS)). Minnesota is currently exempted from this requirement because it has a thorough verification process when administering public assistance.

One of the driving forces behind barring immigrants from health care is the misperception that immigrants over-utilize public benefits programs and that new immigrants were eagerly coming to the United States to access social service programs. However, a study conducted by the National Academy of Sciences dispels that myth, showing that the

average immigrant contributes \$1,800 more in taxes annually than s/he receives in benefits and services provided by the government. In 1997, the US government received \$50 billion from taxes paid by immigrants. The idea that individuals immigrate to the United States in search of public benefits is not supported by research on migration patterns. In fact, the National Immigration Law Center reports that between 1995 and 2000, the number of immigrant families with children increased four times faster in states that have the least generous safety nets than in states such as California and Massachusetts where immigrants can more easily access state programs.

Many parents who are not eligible for benefits because of their immigration status, but whose children qualify for MFIP, food stamps, and medical benefits, have been afraid to access services. Between 1994 and 1999 participation in the Food Stamp Program by children who are United States citizens living in mixed status households fell by 42 percent. People who have a family member not here legally are often afraid to even inquire about eligibility out of fear of deportation.

# CITIZEN, NON-CITIZEN, QUALIFIED NON-CITIZEN: *What does it all Mean?*

Non-citizens are persons who live in the United States but have not yet become U.S. citizens. This includes legal permanent immigrants, immigrants living here on a temporary basis (students and visitors) as well as immigrants without legal status (came without status or their visa expired). For federal public benefits, non-citizens are considered “qualified non-citizens” if they are lawful permanent residents, refugees and asylees (person who came to the US and were granted permission to remain in the US based on a claim of persecution or feared persecution in their home countries), persons paroled into the country for at least one year, persons whose deportation has been withheld, Cuban-Haitian entrants, Amerasians, and certain battered women and children. “Qualified non-citizens” may or may not be eligible for SSI, TANF/MFIP, Medicaid/MA, and food stamps or other cash assistance depending, for example, on which category of non-citizen they are, how long they have been in the United States, or even whether they entered the U.S. before enactment of the 1996 welfare reform law and whether they were already receiving assistance when the law went into effect.

Non-citizens who do not fall within the above-mentioned groups are referred to as “not qualified” and include individuals in the United States with BCIS permission for a temporary period such as visitors, students, temporary workers and also people without BCIS permission or documents (either never had or no longer have permission to be in the US). In general this group of people only qualify for free medical assistance for emergencies if they are elderly, disabled or under 18, pregnant, and for testing and treatment for symptoms of communicable diseases.

## **What is Available for Immigrants Living in Minnesota?**

In 1996 when the federal law cut nearly all benefits for legal immigrants, many states decided to work to keep immigrant benefits intact. The state of Minnesota supplied funds to provide cash assistance and food stamps to some immigrants who no longer

qualified for federal benefits. For most immigrants receiving assistance, work was prioritized before education, and all were strongly encouraged to gain citizenship.

Prior to July 2003, immigrants with HIV who did not qualify for Medical Assistance and Emergency Medical Assistance (EMA) might have been eligible for health care coverage through General Medical Assistance Care (GAMC) and Emergency General Medical Assistance Care (E-GAMC). This all changed with the cuts to Minnesota’s human service budget that went into effect in July of 2003. There were major changes for immigrants including elimination of GAMC eligibility for people who are undocumented non-citizens, immigrants here on a temporary (students and visitors) visa and sponsored immigrants who are not categorically eligible for EMA. Cancellation of E-GAMC will result in loss of public health care coverage for many immigrants, effectively leaving them with no public health care coverage.

Today, immigrants with HIV not eligible for Medical Assistance can receive some health care coverage through Minnesota Comprehensive Health Association and get assistance with monthly premium payment through the Department of Human Services. They may also participate in clinical trials, and receive care through public hospitals and community health centers. With the current situation, in which public health care facilities and programs are severely under-funded, and with no visible change in the horizon, it is only a matter of time before this option also runs out.

Immigration and public benefits eligibility is very complex and confusing. Minnesota immigrants with HIV face special challenges in accessing medical care and the other public benefits they need to manage their HIV disease. Minnesota currently has over 300 African-born immigrants identified as having HIV. Their immigration status dictates their ability to access medical care, housing, food stamps and other public benefits.



# The Role of **HIV** CASE MANAGEMENT

## CASE MANAGEMENT

Living well with a long-term chronic illness like HIV takes a lot of work. It can require educating yourself not only about the illness itself, but also tests, medications and other treatments. And, given the sad fact that stigma still complicates the lives of those with HIV, it also means deciding whom to tell about your HIV status, when to tell and even what to tell.

It means finding a physician who knows how to treat HIV, and making and keeping up with a complicated schedule of medical appointments. Just figuring out what your health insurance does and does not pay for can be a never-ending job. And meanwhile, the rest of life rolls along – there are jobs to go to, bills to pay, relationships to maintain, kids to raise – it's a lot and it can be overwhelming.

Managing HIV in many ways means not only learning to take care of your self physically, but also learning to manage and negotiate systems (like health care insurance) and resources (like assistance in paying for medications) that can help you manage your physical health.

Case managers are experts in many of the systems and resources that can help people living with HIV. This expertise can provide you with information and options that are going to help you decide what will work

best for you. In addition when you run into a brick wall, a case manager can help either directly by advocating on your behalf, or by finding experts in the field who can advocate for you. Also, their experience in working with many clients means they can often troubleshoot for you.

One myth about case management is that it is only for people who are either really sick or who face many other serious problems. Case management provides support in many ways:

- If you are recently diagnosed, a case manager can help you find a doctor, get health insurance, and provide support to help you integrate HIV management into your life.
- If you recently moved to Minnesota, or from one part of the state to another, case management can help you learn about available resources until you are settled.

- If you used to go to the doctor for HIV-related treatment and stopped, but want to start again, a case manager can help you find a physician.
- If you are having a hard time managing your medications, remembering to take them for example, a case manager can help you with various medication adherence tools.
- If other things in your life – chemical use, depression, ending or beginning employment – make it difficult to manage living with HIV, a case manager can help get you the resources you need.

Case management can be short or long-term. Many people start case management and work with their case manager to resolve the difficulties they are experiencing and then leave the program when things become more controllable. If new issues arise, they can return.

There are a number of HIV case management programs in Minnesota, and while there are many common features of these programs, there are many differences as well. Some agencies are culturally specific and have created programs to meet the unique cultural needs of a racial or ethnic group including possibly having case managers who speak your language. Other programs are part of HIV medical clinics and may only see clients who receive medical care at their clinic, although most will provide case management for non-clinic patients. Several programs are located in various regions of Greater Minnesota. Some target a specific population – youth, veterans, injecting drug users; and others are community based, not targeting any specific group. The MAP AIDSLine contacts each HIV case management program every month to find out if there are openings for new clients. If you are interested in finding out more about case management or in finding a case manager, please contact the MAP AIDSLine at 612-373-2437 or 1-800-248-2437 or visit [www.mnaidsproject.org](http://www.mnaidsproject.org), and click on “HIV Resource Guide.”

**If you are interested  
in finding out  
more about case  
management or  
other HIV resources,  
contact the  
MAP AIDSLine at  
612-373-2437 or  
1-800-248-2437 or visit  
[www.mnaidsproject.org](http://www.mnaidsproject.org)  
and click on  
“HIV Resource Guide.”**



# HOUSING HAPPENINGS

## Budget Cuts Impact on Housing

### Direct Housing Cuts

Over the past year as many of us are painfully aware, significant cuts were made to affordable housing and homelessness programs, as well as many other anti-poverty and economic development programs that will impact housing development and services. At the state level, Minnesota Housing Finance Agency (MHFA) experienced a 33 percent reduction in program funding, while transitional housing and emergency services, which help fund shelters, experienced a 29 percent reduction in funding. Along with these direct funding cuts to affordable housing, there were other budget cuts that will impact affordable housing production, rehab, and services. Cuts to cities and counties are already impacting affordable housing activity.

Nationally [at the time of writing, the HUD (US Department of Housing and Urban Development) budget has not yet been approved by Congress] it is possible that for the first time in the history of the program, existing Section 8 vouchers will not be fully funded. HOPWA (Housing Opportunities for Persons with AIDS – also a HUD funded program) funds have never been sufficient to meet housing needs of those living with HIV, and even though the program will be funded at similar levels to last year, there are more people than ever living with HIV and more low-income households at risk or currently experiencing homelessness.

Closer to home, MAP has had to close its waiting list for transitional housing assistance for the first time. This is due to a combination of issues, including funding and changes in households served. While most funding sources for MAP's housing program remained, one important contract was lost this year. And though the total number of clients has remained stable, the number of families versus individuals in the program has increased from about 30 percent to over 50 percent and continues to grow. This has several implications. Unlike individuals, families can receive assistance for up to 24 months. In the past this rarely happened, as families were able to obtain permanent subsidized housing, such as Shelter Plus Care, HAP or Section 8 vouchers prior to 24 months. Those programs are now filled to or over capacity, which forces families to remain in transitional housing much longer. In addition, this drains program funds much faster since rents for families served are about double the rent for individuals. The result is fewer people being able to leave the program, thus reducing the number of new people that can come into the program. This also adds people to the waiting list.

### Cuts that Impact Housing

For individuals and families, the most obvious and, potentially overwhelming, changes in resources were those made to Public Assistance programs by the Minnesota Legislature. Changes such as counting a portion of housing subsidies and SSI (Supplemental Security Income) as income for MFIP (Minnesota Family Investment Program) families, increases in child care co-pays or a complete loss of child care assistance, changes to emergency programs, and the tightening of eligibility rules for health care programs, among others, have had and will have a profound impact on families' abilities to manage housing costs. The changes have been in effect for only a few months; so it's not entirely clear what the long-term ramifications will be. However, we have already seen some of the financial difficulties caused by cuts to childcare and Minnesota's emergency cash programs.

The 2003 Legislature eliminated the state Emergency Assistance (EA) program, meaning that counties are no longer required to spend money on EA-related services. Counties can choose to provide emergency assistance to families in crisis, but they are not required to. EA dollars which used to help prevent homelessness by aiding a person in a resolvable crisis with rent, shelter, moving expenses, mortgage and utility costs, must now compete with county administrative costs, education and training, work supports, and a myriad of other expenses.

The repeal of the State EA program will have a significant impact on low-income families who are experiencing a crisis due to a sudden and/or temporary loss of income. A review of the county plans by the Legal Services Advocacy Project reveals a patchwork of differing policies is already emerging. Since each county will enact their own policies and requirements, consumers and providers in each of the 87 Minnesota counties will have to determine what changes have been implemented in their county and observe the impact on the local community.

As these drastic cuts were passed, those in power stressed that we would all "share the pain". But those most vulnerable, those living with HIV and other disabilities, those experiencing or at risk of homelessness, those extremely low-income individuals and families seem to be burdened with more than their "fair share".

*Housing Happenings is a timely update of housing-related information for HIV service providers and consumers. For further information contact Kim Lieberman, MAP housing systems advocate, at 612-373-9166, 800-243-7321 or by email at [kliberman@mnaidsproject.org](mailto:kliberman@mnaidsproject.org)*

# What **BENEFITS** Actually Changed?

Laws enacted during the 2003 legislative session brought about significant changes in Minnesota's public health and welfare programs. The changes have made public health care benefits even more confusing and complicated than they already were. Generally, it is single adults without children and non-citizens who are most negatively affected by the new structure of Minnesota Healthcare programs. However, a new co-pay structure in place under General Assistance Medical Care (GAMC) and Medical Assistance (MA) has had a major impact for most people covered by those plans.

General Assistance Medical Care has now been split into two very different benefits programs. Adults with incomes below 75 percent of the Federal Poverty Guideline (\$562/month) will receive full coverage. Full GAMC benefits continue to provide comprehensive coverage for individuals living with a chronic health condition such as HIV, if their income is between \$0 and \$562 per month. But for this population, new medication co-pays of up to \$20 per medication per month can be overwhelming.

Adults with income between 75 percent and 175 percent of the Federal Poverty Guideline (\$563 to \$1310 per month) will be eligible for a drastically scaled back "Hospital-Only" benefit. The reduced "Hospital-Only" benefit does not cover any medications and requires a \$1,000 co-pay per hospitalization. For an individual living with HIV who generally takes multiple medications, this program has simply ceased to be an option. Finally, full GAMC now has only very reduced dental benefits and "Hospital-Only" provides for no dental coverage at all.

Medical Assistance, which is Minnesota's Medicaid program, has not changed as drastically. However, the co-pay structure for medications and reduced dental benefits mirror those in the GAMC program. Single disabled adults on MA may earn up to \$749 per month, and while it may seem possible for someone on MA to cover this expense, the reality is that responsibility for these co-pays may break what could already be a very tight budget.

MinnesotaCare (MNCare) has also been significantly altered to include a two-tier coverage structure. Full MNCare benefits are available for single adults earning between \$0 and \$562 per month. The only change to this program is a reduction in dental benefits. It is the newly created "Limited Benefit" MNCare program that appears to have the farthest-reaching impact. It is a program that caps outpatient coverage at \$5,000

per year. This includes doctor's visits, prescription drugs, lab tests and chiropractic care. For an individual who takes HIV medications, this benefit would be exhausted very quickly. This program has a \$10,000 annual inpatient hospital benefit with a 10 percent co-pay (of up to \$1,000) for any hospital visit. Of additional concern is the total lack of dental benefits associated with the Limited Benefit MNCare program.

Michael called the MAP benefits specialist after the Department of Human Services (DHS) notified him that he was no longer eligible for full MNCare benefits. Because of his income, he would only be eligible for Limited Benefit MNCare. Michael was very concerned to learn that Limited Benefit MNCare offers \$5,000 of outpatient coverage per year including prescription drugs, and his HIV medications alone cost around \$25,000 annually. Fortunately, he met the income and asset requirements for the AIDS Drug Assistance Program (ADAP) at DHS. Through the DHS HIV/AIDS programs, he has gotten coverage for a private insurance plan and financial assistance with his HIV medication co-pays. The DHS HIV/AIDS programs are an ongoing resource that can assist in many situations where other health care benefits are not available or are insufficient.

Because of the complexity of benefits programs available for people living with HIV, the Minnesota AIDS Project (MAP) offers assistance for exploring and accessing various benefits. Ann Seguin, MAP benefits counselor, is available to help with a variety of issues. She can be a statewide resource for information and counseling about health insurance & disability benefits, public health care and public income programs. She can be a direct source of assistance for people living with HIV or a referral/information source for service providers. Please contact her at (612) 373-2468 or (800) 248-AIDS or at [ann.seguin@mnaidsproject.org](mailto:ann.seguin@mnaidsproject.org) with questions, counseling requests/referrals or to schedule an informational meeting.

# benefits counseling resource list

## Health Care Help Line

BHW Federal Building  
Suite 298  
Fort Snelling MN 55111  
Tel: 612-727-5244  
Toll Free: 866-296-4319  
[dayton.senate.gov/healthcare.html](http://dayton.senate.gov/healthcare.html)

The Health Care Help Line (HCHL) is operated by the office of Mark Dayton, United States Senator for Minnesota. HCHL assists Minnesotans of all ages in getting necessary medical treatments approved and paid for by Medicare, insurance companies, and HMOs. Assists people who believe they are being denied necessary medical treatment by their health care provider, or people whose insurance company, Medicare, or other carrier refuses to pay for treatment they have already received.

## Minnesota AIDS Project

1400 Park Ave. S  
Minneapolis MN 55404  
Tel: 612-373-2437  
Toll Free: 800-248-2437  
[www.mnaidsproject.org](http://www.mnaidsproject.org)

Provides education about benefit programs, assistance with completing forms, and advocacy in getting or keeping health and disability benefits. People living with HIV, case managers, or other HIV service providers can contact the Benefits Counseling Program for assistance.

## Minnesota Work Incentives Connection

2200 University Ave W., Suite 240  
St. Paul MN 55114  
Tel: 651-632-5113  
Toll Free: 800-976-6728  
[www.mnworkincentives.com](http://www.mnworkincentives.com)

The Minnesota Work Incentives Connection is a statewide toll-free hotline designed to help people with disabilities understand how work income affects public benefits like SSI, SSDI/RSDI, Medical Assistance, Medicare, Minnesota Supplemental Aid (MSA), Food Stamps and Public Housing. Information provided on the phone, but final benefits analysis plan can also be given in person, anywhere in the state. Get on mailing list for announcements of community meetings and newsletter with updates.

## Neighborhood Health Care Network

2550 University Ave W.  
Suite 416 - South  
St. Paul MN 55114  
Tel: 651-489-2273  
Toll Free: 866-489-4899

Neighborhood Health Care Network provides callers with information on low-cost health insurance, access to confidential medical advice, and, when possible, referrals to medical and dental clinics in their area that see uninsured patients. Uninsured callers can receive an application for Minnesota Health Care Programs (such as Medical Assistance and MNCare), as well as assistance in navigating the application and approval process.

## DHS - HIV/AIDS Program

444 Lafayette Road  
St. Paul MN 55155-3872  
Tel: 651-582-1980  
Toll Free: 800-657-3761  
TTY Toll Free: 800-627-3529  
Fax: 651-582-1989  
[www.dhs.state.mn.us/Contcare/hiv/default.htm](http://www.dhs.state.mn.us/Contcare/hiv/default.htm)

Provides assistance in finding and paying for health insurance including premiums and co-pays, and provides the dental care program, nutrition program and drug reimbursement program for HIV-positive people living in Minnesota or Pierce and St. Croix counties in Wisconsin, with incomes at or below 300% poverty level and cash assets of \$25,000 or less. Also offers educational presentations about HIV services available in Minnesota, including culturally specific presentations for African-born communities.

## Social Security

Toll Free: 800-772-1213  
TTY Toll Free: 800-325-0778  
[www.ssa.gov](http://www.ssa.gov)

Call or check the Web site for answers to questions or to find an office near you.

**To locate additional agencies throughout the state of Minnesota that may offer benefits counseling, also contact:**

## UnitedWay 2-1-1 First Call For Help - Metro Region

404 Eighth St. S  
Minneapolis MN 55404  
Tel: 2-1-1  
Alt. Tel: 651-291-0211  
Toll Free: 800-543-7709  
[www.firstcallnet.org](http://www.firstcallnet.org)



[www.mnaidsproject.org](http://www.mnaidsproject.org)

## ***Finding the Balance:*** HIV and Corrections

**Monday, March 29, 2004**

**5:30-8:30 pm**

**Minneapolis Urban League**

**2100 Plymouth Avenue North, Minneapolis**

Nationally, rates of HIV and HCV are higher in prisons than in the general population. While the recorded number of prisoners in Minnesota is low, most believe the actual numbers are much higher. MAP's recently completed needs assessment report, *Finding the Balance: HIV and Corrections*, compiles interviews, observations and research to offer recommendations for a framework to address and serve Minnesota offenders with HIV. Join us for a presentation and discussion of the report and learn about available HIV and offender resources. Dinner will be served.

**To register, contact MAP AIDSLine at  
612-373-2437 or 800-248-2437.**