Senators Berglin, Koering, Foley, Tomassoni and Lourey introduced--

S.F. No. 255: Referred to the Committee on Health and Family Security.

A bill for an act

relating to MinnesotaCare; modifying covered health services; repealing the limited benefits for certain single adults and households without children; amending Minnesota Statutes 2004, sections 256L.03, subdivision 1; 256L.12, subdivision 6; repealing Minnesota Statutes 2004, section 256L.035.

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

Section 1. Minnesota Statutes 2004, section 256L.03, subdivision 1, is amended to read:

Subdivision 1. [COVERED HEALTH SERVICES.] ~~For individuals under section 256L.04, subdivision 7, with income no greater than 75 percent of the federal poverty guidelines or for families with children under section 256L.04, subdivision 1, all subdivisions of this section apply.~~ "Covered health services" means the health services reimbursed under chapter 256B, with the exception of inpatient hospital services, special education services, private duty nursing services, adult dental care services other than services covered under section 256B.0625, subdivision 9, paragraph (b), orthodontic services, nonemergency medical transportation services, personal care assistant and case management services, nursing home or intermediate care facilities services, inpatient mental health services, and chemical dependency services. Outpatient mental health services covered under the MinnesotaCare program are limited to diagnostic assessments, psychological testing, explanation of

findings, medication management by a physician, day treatment, partial hospitalization, and individual, family, and group psychotherapy.

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

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

Sec. 2. Minnesota Statutes 2004, section 256L.12, subdivision 6, is amended to read:

Subd. 6. [CO-PAYMENTS AND BENEFIT LIMITS.] Enrollees are responsible for all co-payments in ~~sections~~ section 256L.03, subdivision 5, ~~and 256L.035~~, and shall pay co-payments to the managed care plan or to its participating providers. The enrollee is also responsible for payment of inpatient hospital charges which exceed the MinnesotaCare benefit limit.

Sec. 3. [REPEALER.]

Minnesota Statutes 2004, section 256L.035, is repealed.

APPENDIX
Repealed Minnesota Statutes for 05-1070

256L.035 LIMITED BENEFITS COVERAGE FOR CERTAIN SINGLE ADULTS AND HOUSEHOLDS WITHOUT CHILDREN.

(a) "Covered health services" for individuals under section 256L.04, subdivision 7, with income above 75 percent, but not exceeding 175 percent, of the federal poverty guideline means:

(1) inpatient hospitalization benefits with a ten percent co-payment up to $1,000 and subject to an annual limitation of $10,000;

(2) physician services provided during an inpatient stay; and

(3) physician services not provided during an inpatient stay, outpatient hospital services, freestanding ambulatory surgical center services, chiropractic services, lab and diagnostic services, and prescription drugs, subject to an aggregate cap of $2,000 per calendar year and the following co-payments:

(i) $50 co-pay per emergency room visit;

(ii) $3 co-pay per prescription drug; and

(iii) $5 co-pay per nonpreventive physician visit.

For purposes of this subdivision, "a visit" means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary.

Enrollees are responsible for all co-payments in this subdivision.

(b) The November 2006 MinnesotaCare forecast for the biennium beginning July 1, 2007, shall assume an adjustment in the aggregate cap on the services identified in paragraph (a), clause (3), in $1,000 increments up to a maximum of $10,000, but not less than $2,000, to the extent that the balance in the health care access fund is sufficient in each year of the biennium to pay for this benefit level. The aggregate cap shall be adjusted according to the forecast.

(c) Reimbursement to the providers shall be reduced by the amount of the co-payment, except that reimbursement for prescription drugs shall not be reduced once a recipient has reached the $20 per month maximum for prescription drug co-payments. The provider collects the co-payment from the recipient. Providers may not deny services to recipients who are unable to pay the co-payment, except as provided in paragraph (d).

(d) If it is the routine business practice of a provider to refuse service to an individual with uncollected debt, the provider may include uncollected co-payments under this section. A provider must give advance notice to a recipient with uncollected debt before services can be denied.

Senate Health and Family Security Committee
Testimony of Kathy McDonough In Support of Senator Berglin's Bill to
Eliminate the $5,000 Cap on the MinnesotaCare Limited Benefit Program
January 13, 2005

My name is Kathy McDonough. I am a staff attorney at Legal Services Advocacy Project (LSAP) in St. Paul. LSAP is a statewide division of Mid Minnesota Legal Services, representing the interests of low-income Minnesotans.

- Minnesota has a rich history of providing health care coverage for low-income people. In the 1990s the Legislature implemented the MinnesotaCare program, state-subsidized health care insurance for low-income working Minnesotans who don't have access to health care through an employer. In the late 1990s, Minnesota could take pride in having one of the lowest uninsurance rates in the nation.
- MinnesotaCare enrollees pay monthly premiums, co-payments and deductibles to participate in the Program.
- As the cost of private health care insurance continues to rise and employers find it increasingly difficult to subsidize employee health care coverage, access to MinnesotaCare is vitally important.
- Many MinnesotaCare enrollees suffer from chronic illnesses such cancer, heart disease, diabetes, multiple sclerosis and mental illness.
- Many are working but their employers do not provide health care. Others have been determined disabled but must wait 2½ years for Medicare eligibility.
- In 2003 the Legislature severely cut publicly-funded health care programs to balance the budget. One such cut included putting a $5,000 cap on the amount of benefits available to enrollees.
- Since 2003, Legal Services offices throughout the State have been contacted by MinnesotaCare enrollees who have exceeded their $5,000 cap and can't access medically necessary services until the cap is renewed.
- The Bemidji Legal Services office was recently contacted by Jan DeChampeau. Ms. DeChampeau was not able to travel here from Bemidji today. She asked me to tell her story.
- Ms. DeChampeau has worked as the manager of a video store for 18 years. Her employer does not provide health care coverage. So Ms. DeChampeau is enrolled in MinnesotaCare. She pays $50 per month in premiums and copayments to participate in the program.
- Ms.DeChampeau suffers from a chronic condition, duodenal ulcers, for which she receives ongoing treatment and medication. Several months ago Ms. DeChampeau suffered a torn ligament in her knee. Her physician received approval from the MinnesotaCare program to surgically repair Ms. DeChampeau's injured knee. Subsequently, Ms. DeChampeau was notified that, due to the surgery, she had exceeded the $5,000 cap and now owes thousands of dollars for the surgery.
- Ms. DeChampeau could not continue to work if she did not receive care for her health problems. She must also live in fear of what could happen if she has additional health problems once she has exceeded the cap.
- Even though Ms. DeChampeau could not access services once she had exceeded the cap, she was required to continue paying the $50 monthly premiums or risk being dropped from the program and waiting 4 months for reinstatement.
- As Ms. DeChampeau's case demonstrates, health care needs don't just go away because a person doesn't have health insurance. Chronic conditions may become a crisis and require more expensive emergency care resulting in uncompensated care.
- I urge you to support Senator Berglin's bill to eliminate the MinnesotaCare $5,000 cap on outpatient services. Surplus funds in the Health Care Access Fund can be used to eliminate the cap.