INFORMATION BRIEF
Minnesota House of Representatives
Research Department
600 State Office Building
St. Paul, MN 55155

Randall Chun, Legislative Analyst
651-296-8639

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MinnesotaCare

The MinnesotaCare (MNCare) program, administered by the Minnesota Department of Human Services, provides subsidized health coverage for eligible Minnesotans. This information brief describes eligibility requirements, covered services, and other aspects of the program.

Contents

Administration

MinnesotaCare is administered by the Minnesota Department of Human Services (DHS). DHS is responsible for processing applications and determining eligibility, contracting with managed care plans, monitoring spending on the program, and developing administrative rules. County human services agencies are responsible for determining Medical Assistance (MA) eligibility for MinnesotaCare applicants who apply for MA. County human services agencies have the option of processing applications and managing cases for MinnesotaCare.

Eligibility Requirements

To be eligible for MinnesotaCare, individuals must meet income limits and satisfy other requirements related to residency and lack of access to health insurance. MinnesotaCare eligibility must be renewed every six months.

Income Limits

Children[1] and parents, legal guardians, foster parents, or relative caretakers residing in the same household are eligible for MinnesotaCare, if their gross household income does not exceed 275 percent of the federal poverty guidelines (FPG) and if other eligibility requirements are met. However, parents, legal guardians, foster parents, and relative caretakers are not eligible if their gross annual income exceeds $50,000, regardless of whether their income exceeds 275 percent of FPG. Different eligibility requirements and premiums apply to children from households with gross incomes that do not exceed 150 percent of FPG.

Single adults and households without children are eligible for MinnesotaCare if their gross household incomes do not exceed 175 percent of FPG and they meet other eligibility requirements.

Enrollment of Certain GAMC Applicants and Recipients

Effective September 1, 2006, certain General Assistance Medical Care (GAMC) applicants and recipients will be enrolled in the MinnesotaCare program as adults without children, immediately following approval of GAMC coverage. These individuals will be exempt, until their six-month renewal, from MinnesotaCare premiums, income and asset limits, and MinnesotaCare eligibility requirements related to not having other health coverage and not having access to employer-subsidized health insurance. County agencies will be required to pay the enrollee share of MinnesotaCare premiums for these individuals until their six-month renewal and have the option of continuing to pay for these premiums past the first six-month renewal period. GAMC applicants and recipients who are: (1) eligible for GAMC as General Assistance or Group Residential Housing recipients; (2) awaiting a determination of blindness or disability; or (3) fail to meet the MinnesotaCare residency requirement, are exempt from the MinnesotaCare enrollment requirement.

[1] A child is defined in the law as an individual under 21 years of age, including the unborn child of a pregnant woman and an emancipated minor and that person's spouse.

Enrollees whose incomes rise above program income limits after initial enrollment are disenrolled from the program. Children are exempt from this requirement and can remain enrolled in MinnesotaCare if 10 percent of their annual gross income is less than the annual premium of the $500 deductible policy offered by the Minnesota Comprehensive Health Association (MCHA).[2]

The table below lists categories of persons eligible for MinnesotaCare, eligibility criteria, and enrollee cost (see table on page 11 for sample sliding scale premiums). The table on the following page lists program income limits for different family sizes.

Table 1
Eligibility for MinnesotaCare*

Eligible Categories	**Household Income Limit**	**Other Eligibility Criteria**	**Cost to Enrollee**
Lower income children	150% of FPG	Not otherwise insured for the covered services; residency requirement	Annual premium of $48 per person
Other children; pregnant women	275% of FPG	No access to employer-subsidized coverage; no other health coverage; residency requirement	Premium based on sliding scale
Parents and relative caretakers	275% of FPG	No access to employer-subsidized coverage; no other health coverage; residency requirement; asset limit	Premium based on sliding scale
Single adults, households without children	175% of FPG	No access to employer-subsidized coverage; no other health coverage; residency requirement; asset limit	Premium based on sliding scale
* Exceptions to these requirements are noted in the text.			

[2] The MCHA offers health insurance to Minnesota residents who have been denied private market coverage.

Table 2
Annual Household Income Limits for MinnesotaCare
(Effective July 1, 2005)

Household Size*	Lower Income Children 150% of 2005 FPG	Adults Without Children 175% of 2005 FPG	Families and Children 275% of 2005 FPG**
1	$14,364	$16,752	$26,328
2	19,260	22,464	35,304
3	24,156	Not eligible	44,280
4	29,052	Not eligible	53,256
5	33,948	Not eligible	62,232
6	38,844	Not eligible	71,208
7	43,740	Not eligible	80,184
8	48,636	Not eligible	89,160
9	53,532	Not eligible	98,136
10	58,428	Not eligible	107,112
Each Additional Person	4,896		8,976

* Pregnant women are households of two.
** Parents are not eligible once income exceeds $50,000.

Asset Limits

MinnesotaCare adult applicants and enrollees who are not pregnant are subject to an asset limit, identical to the Medical Assistance program's asset limit for parents. This asset limit is $10,000 in total net assets for a household of one person, and $20,000 in total net assets for a household of two or more persons. Certain items are not considered assets when determining MinnesotaCare eligibility, including the following:

- the homestead
- household goods and personal effects
- a burial plot for each member of the household
- life insurance policies and assets for burial expenses, up to the limits established for the Supplemental Security Income (SSI) program
- capital and operating assets of a business up to $200,000
- insurance settlements for damaged, destroyed, or stolen property are excluded for three months if held in escrow
- a motor vehicle for each person who is employed or seeking employment
- court-ordered settlements of up to $10,000
- individual retirement accounts and funds
- assets owned by children

Pregnant women and children are exempt from the MinnesotaCare asset limit.

No Access to Subsidized Coverage

A family or individual must not have access to employer-subsidized health care coverage. A family or individual must also not have had access to employer-subsidized health care coverage through a current employer for 18 months prior to application or re-application. Employer-subsidized coverage is defined as health insurance coverage for which an employer pays 50 percent or more of the premium cost. This requirement applies to each individual. For example, if an employer offers subsidized coverage to an employee but not to the employee's dependents, the employee is not eligible for MinnesotaCare but the employee's dependents are eligible.

The requirement of no current access to employer-subsidized coverage does not apply to:

1. Children from households with incomes that do not exceed 150 percent of the federal poverty guidelines;

2. Children enrolled in the Children's Health Plan as of September 30, 1992 (the precursor program to MinnesotaCare) who have maintained continuous coverage; and

3. Children who enrolled in the Children's Health Plan during a transition period following the establishment of MinnesotaCare.

Children referred to in clauses (1) and (2) are, in some cases, also exempt from the no other health coverage requirement (see section below).

Families or individuals whose employer-subsidized coverage was lost because an employer terminated health care coverage as an employee benefit during the previous 18 months are also not eligible for MinnesotaCare.

A family or individual disenrolled from MinnesotaCare because of the availability of employer-subsidized health coverage, who reapplies for MinnesotaCare within six months of disenrollment because the employer terminates health care coverage as an employee benefit, is exempt from the 18-month enrollment restriction related to access to subsidized coverage.

No Other Health Coverage

Enrollees must have no other health coverage and must not have had health insurance coverage for the four months prior to application or renewal. For purposes of these requirements:

1. MA, General Assistance Medical Care (GAMC), and CHAMPUS (Civilian Health and Medical Program of the Uniformed Service, also called TRICARE) are not considered health coverage for purposes of the four-month requirement; and

2. Medicare coverage is considered health coverage, and an applicant or enrollee cannot refuse Medicare coverage to qualify for MinnesotaCare.

Children from households with incomes that do not exceed 150 percent[3] of FPG and children enrolled in the original Children's Health Plan who have maintained continuous coverage are not subject to the four-month uninsured requirement and may have other health coverage, if this coverage is considered "under-insurance." Under-insurance means:

1. The coverage lacks two or more of the following:

   - basic hospital insurance
   - medical-surgical insurance
   - prescription drug coverage
   - preventive and comprehensive dental coverage
   - preventive and comprehensive vision coverage

2. The coverage requires a deductible of $100 or more per person per year; or

3. The child lacks coverage because the maximum coverage for a particular diagnosis has been exceeded, or the policy of coverage excludes coverage for that diagnosis.

Effective upon federal approval, individuals under age 21 enrolled in a program of study at a postsecondary educational institution, including an emancipated minor and an emancipated minor's spouse, will not be eligible for MinnesotaCare if they have access to health coverage through the postsecondary educational institution.

Residency Requirement

Pregnant women, families, and children must meet the residency requirements of the Medicaid program. The Medicaid program requires an individual to demonstrate intent to reside permanently or for an indefinite period in a state, but it does not include a durational residency requirement (a requirement that an individual live in a state for a specified period of time before applying for the program).

In contrast, enrollees who are adults without children must have resided in Minnesota for 180 days prior to application and must also satisfy other criteria relating to permanent residency.

Benefits

MinnesotaCare enrollees are covered by one of three benefit sets. Pregnant women and children have access to the broadest range of services and are not required to pay copayments. Parents, and single adults and households without children with incomes not exceeding 75 percent of FPG, are covered for most services, but are subject to benefit limitations and copayments. Single adults and households without children with incomes greater than 75 percent but not exceeding 175 percent of FPG receive coverage for a limited set of services, are subject to a $5,000 annual

[3] The exemption from the four-month uninsured requirement is found only in rule. *See* Minnesota Rules, part 9506.0020, subpart 3, item A.

limit on outpatient services and must pay copayments. No annual limit will apply beginning January 1, 2006. These differences are summarized in Table 3 below and are described in more detail in the text.

Table 3
Overview – MinnesotaCare Covered Services and Cost-Sharing

Eligibility Category	Covered Services[4]	Benefit Limitations*	Cost-Sharing**
Pregnant women and children	MA benefit set	None	None
Parents ≤ 175% of FPG	Most MA services	-- $500 annual limit on dental services -- Limits on outpatient mental health services	$25 eyeglasses $3 prescriptions $3 nonpreventive visit $6 nonemergency visit to hospital ER 50% restorative dental
Parents > 175% and ≤ 275% of FPG	Most MA services	-- $500 annual limit on dental services -- $10,000 annual limit for inpatient hospital -- Limits on outpatient mental health services	$25 eyeglasses $3 prescriptions $3 nonpreventive visit $6 nonemergency visit to hospital ER
Adults without children ≤ 75% of FPG	Most MA services	-- $500 annual limit on dental services -- $10,000 annual limit for inpatient hospital -- Limits on outpatient mental health services	$25 eyeglasses $3 prescriptions $3 nonpreventive visit $6 nonemergency visit to hospital ER 10% inpatient hospital, up to $1,000 50% restorative dental
Adults without children > 75% and ≤ 175% of FPG	Limited benefit set: inpatient hospital, physician, and other specified services	--$10,000 annual limit for inpatient hospital -- $5,000 annual limit for all other services***	$50 emergency room 10% inpatient hospital, up to $1,000 $5 nonpreventive visits $3 prescriptions ($20 per month maximum)

* The $500 annual limit on adult dental services will not apply beginning January 1, 2006.
** The copayments for nonpreventive visits and nonemergency visits to a hospital emergency room are effective January 1, 2006.
*** No annual limit will apply beginning January 1, 2006.

Covered Services and Benefit Limitations

Pregnant women and children up to age 21 enrolled in MinnesotaCare can access the full range of MA services without enrolling in MA, except that abortion services are covered as provided

[4] See Table 4 for a list of covered services.

under the MinnesotaCare program.[5] These individuals are exempt from MinnesotaCare benefit limitations and copayments,[6] but still must pay MinnesotaCare premiums. Pregnant women and children up to age two are not disenrolled for failure to pay MinnesotaCare premiums and can avoid MinnesotaCare premium charges altogether by enrolling in MA.

All parents, and single adults and households without children with incomes not exceeding 75 percent of FPG, who are not pregnant, are covered under MinnesotaCare for most, but not all, services covered under MA. These individuals are subject to the following benefit limitations.

- Dental services are subject to a $500 annual limit.[7] Emergency services, dentures, and extractions related to dentures are excluded from the annual limit.
- Inpatient hospital services are subject to an annual benefit limit of $10,000. This limit does not apply to parents with household incomes that do not exceed 175 percent of FPG.
- Outpatient mental health services are limited to diagnostic assessments; psychological testing; explanation of findings; day treatment; partial hospitalization; individual, family, and group psychotherapy; and medication management.

Single adults and households without children, with incomes greater than 75 percent but not exceeding 175 percent of FPG, receive coverage for a limited benefit set of services. This limited benefit set covers:

- inpatient hospital services, subject to an annual limit of $10,000;
- physician services provided during an inpatient stay; and
- physician services not provided during an inpatient stay, outpatient hospital services, chiropractic services, lab and diagnostic services, diabetic supplies and equipment,[8] and prescription drugs, subject to an aggregate $5,000 annual limit (no annual limit will apply beginning January 1, 2006).[9]

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[5] Under MinnesotaCare, abortion services are covered "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" (Minn. Stat. § 256L.03, subd. 1). Under MA, abortion services are covered to save the life of the mother and in cases of rape or incest (see Minn. Stat. § 256B.0625, subd. 16), and as a result of a Minnesota Supreme Court decision, for "therapeutic" reasons (*Doe v. Gomez*, 542 N.W.2d 17 (1995)). MinnesotaCare enrollees must enroll in the MA program in order to obtain abortion services under the MA conditions of coverage. Nearly all MinnesotaCare enrollees who are pregnant women are eligible for MA.

[6] This change in MinnesotaCare was approved by the federal government in April 1995 as part of the state's health care reform waiver (now referred to as the Prepaid Medical Assistance Project Plus waiver). The waiver, and subsequent waiver amendments, exempt Minnesota from various federal requirements, give the state greater flexibility to expand access to health care through the MinnesotaCare and MA programs and allow the state to receive federal contributions (referred to as "federal financial participation" or FFP) for services provided to MinnesotaCare enrollees who are children, pregnant women, or parents and relative caretakers of children under age 21.

[7] The $500 annual limit on adult dental services will not apply beginning January 1, 2006.

[8] Coverage for diabetic supplies and equipment takes effect January 1, 2006.

[9] This limit was increased from the $2,000 amount specified in the authorizing legislation, due to the receipt of federal Medicaid funds under the federal Jobs and Growth Tax Relief Reconciliation Act of 2003. See Laws 2003, 1st spec. sess., art. 12, § 72 and art. 13C, § 1, subd. 1 – federal contingency appropriation rider.

- effective January 1, 2006, the limited benefit set will also cover services provided by a psychologist or licensed independent clinical social worker.

Table 4
Covered Services Under MinnesotaCare

Service	**Children; Pregnant Women**	**Parents; Adults without children ≤ 75% of FPG***	**Adults without children > 75% and ≤ 175% of FPG***
Adult mental health rehab/crisis	x		
Alcohol/drug treatment	x	x	
Case management	x		
Child and teen checkup	x		
Chiropractic	x	x	x
Common carrier transportation	x		
Dental	x	x	
Emergency room	x	x	x
Eye exams	x	x	x
Eyeglasses	x	x	
Family planning	x	x	x
Hearing aids	x	x	
Home care	x	x	
Hospice care	x	x	
Hospital stay	x	x	x
Immunizations	x	x	x
Interpreters (hearing, language)	x	x	x
Lab, x-ray, diagnostic	x	x	x
Medical equipment and supplies	x	x	Diabetic supplies and equipment only, beginning January 1, 2006
Mental health	x	x	x
Nursing home/ICF/MR	x		
Outpatient surgical center	x	x	x
Physicians and clinics	x	x	x
Physicals/preventive care	x	x	x
Prescriptions	x	x	x
Rehabilitation/therapy	x	x	
School-based services	x		
Transportation: emergency	x	x	
Transportation: special	x		

* Benefit limitations and cost-sharing requirements apply.

Copayments for Adults

All parents, and single adults and households without children with incomes not exceeding 75 percent of FPG, who are not pregnant, are subject to the following copayments:

- Copayment of 10 percent of paid charges for inpatient hospital services, up to an annual maximum of $1,000 per adult or $3,000 per family (This copayment does not apply to parents and relative caretakers of children under age 21.)
- $3 copayment per prescription
- $25 copayment per pair of eyeglasses
- $3 per nonpreventive visit (effective January 1, 2006)
- $6 for nonemergency visits to a hospital emergency room (effective January 1, 2006)
- Copayment of 50 percent of the MA allowable charge for restorative dental care services provided to adults who are not pregnant and have household incomes that do not exceed 175 percent of FPG

Single adults and households without children, with incomes greater than 75 percent but not exceeding 175 percent of FPG, are subject to the following copayments:

- Copayment of 10 percent of paid charges for inpatient hospital services, up to an annual maximum of $1,000
- $3 per prescription, subject to a $20/month maximum
- $50 per emergency room visit
- $5 per nonpreventive visit

Enrollee Premiums

$48 Annual Premium

Children enrolling in MinnesotaCare are charged an annual premium of $48 per child, if they are from households with incomes that do not exceed 150 percent of FPG.

Subsidized Premium Based on Sliding Scale

Children enrolling in MinnesotaCare who do not qualify for the $48 annual premium described above, and adults enrolling in the program, are charged a subsidized premium based upon a

sliding scale. The premium charged ranges from 1.5 percent to 9.8 percent of gross family income.[10] The minimum premium is $4 per person per month.

The following table provides sample monthly sliding scale premiums for different income levels and household sizes. These premiums apply to both families with children and to single adults and households without children. Complete premium tables are available from DHS.

Table 5
Sample Monthly Household Premiums
(as of July 1, 2005)

	Household Size (assumes all household members enroll)				
Gross Monthly Income	**1**	**2***	**3**	**4**	**5**
$250	$4	$8	$12	$12	$12
$500	9	8	12	12	12
$1,000	36	23	18	18	18
$1,500	79	65	54	34	34
$2,000	197	107	86	71	73
$2,500	N.E.	211	133	108	90
$3,000	N.E.	N.E.	252	160	128
$3,500	N.E.	N.E.	342	242	186
$4,000	N.E.	N.E.	N.E.	393	275

NOTE: Effective upon federal approval, these premiums will increase by 8 percent. N.E. means **not eligible** to enroll in MinnesotaCare at this income level.

* The maximum income limits for households without children are $1,396 (household of one) and $1,872 (household of two). The sample premiums listed in the table reflect the higher income limits that apply to families with children.

Prepaid MinnesotaCare

The legislature has authorized the Commissioner of Human Services to contract with health maintenance organizations and other prepaid health plans to deliver health care services to MinnesotaCare enrollees. All MinnesotaCare enrollees receive health care services through prepaid health plans and not through fee-for-service.

[10] Effective October 1, 2003, the percentage of income paid was increased by 0.5 percentage points for enrollees with incomes greater than 100 but not exceeding 200 percent of FPG, and by 1.0 percentage points for enrollees with incomes greater than 200 percent of FPG. (Laws 2003, 1st spec. sess., ch. 14, art. 12, § 84) Effective upon federal approval, these premiums will increase by 8 percent. (Laws 2005, 1st spec. sess., ch 4, art. 8, § 74)

Prepaid health plans (sometimes referred to as managed care plans) receive a capitated payment from DHS for each MinnesotaCare enrollee, and in return are required to provide enrollees with all covered health care services for a set period of time. A capitated payment is a predetermined, fixed payment per enrollee that does not vary with the amount or type of health care services provided. A prepaid health plan reimbursed under capitation does not receive a higher payment for providing more units of service or more expensive services to an enrollee, nor does it receive a lower payment for providing fewer units of service or less expensive services to an enrollee.

Under prepaid MinnesotaCare, enrollees select a specific prepaid plan from which to receive services, obtain services from providers in that plan's provider network, and follow that plan's procedures for seeing specialists and accessing health care services. Enrollee premiums, covered health care services, and copayments are the same as they would have been under fee-for-service MinnesotaCare.

Funding and Expenditures

Total payments for health care services provided through MinnesotaCare were $409 million in fiscal year 2005. Fifty-five percent of this amount was paid for through state payments from the health care access fund. Enrollee premiums (this category also includes copayments and prescription drug rebates) and federal funding received under the Prepaid Medical Assistance Project Plus waiver and a State Children's Health Insurance Program (SCHIP)[11] waiver pay for the remainder.

Funding for the state share of MinnesotaCare costs, and for other health care access initiatives, is provided by:

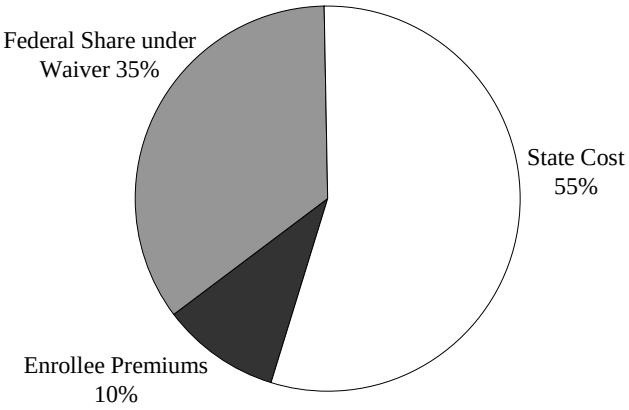
- A 2 percent tax on the gross revenues of health care providers, hospitals, surgical centers, and wholesale drug distributors (sometimes referred to as the "provider tax").

- A 1 percent premium tax on health maintenance organizations, nonprofit health service plan corporations, and community integrated service networks.

Medicare payments to providers are excluded from gross revenues for purposes of the gross revenues taxes. Other specified payments, including payments for nursing home services, are also excluded from gross revenues.

[11] The Prepaid Medical Assistance Project Plus waiver is described in footnote 6 on page 8. The SCHIP waiver, approved by the federal government on June 13, 2001, and effective for a five-year period from that date, provides an enhanced federal match of 65 percent for parents and relative caretakers on MinnesotaCare with incomes greater than 100 percent but not exceeding 200 percent of FPG.

MinnesotaCare Funding
(FY 2005)

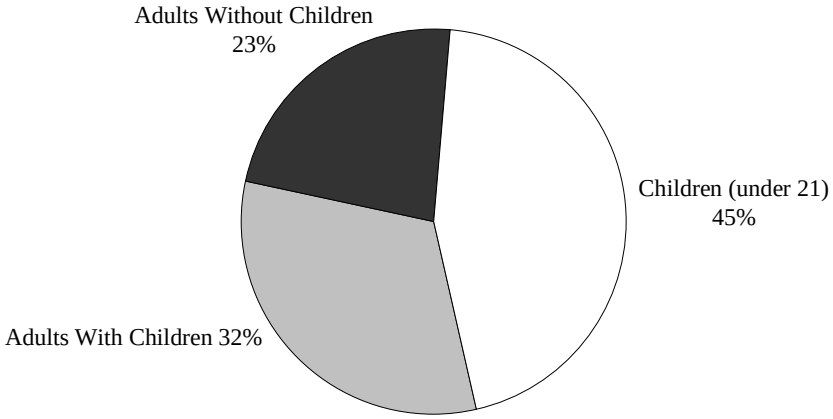


Source: DHS Reports and Forecasts Division

Recipient Profile

As of September 2, 2005, 135,586 individuals were enrolled in the MinnesotaCare program. As of September 2, 2005, just under one-half of MinnesotaCare enrollees were children.

MinnesotaCare Enrollment
(September 2, 2005)



Source: DHS Reports and Forecasts Division

Application Procedure

Application forms for MinnesotaCare, and additional information on the program, can be obtained from DHS by calling:

1-800-657-3672 or
651-297-3862 (in the metro area)

Application forms are also available through county social service agencies, health care provider offices, and other sites in the community. Applications are also available on the Internet at www.dhs.state.mn.us/HealthCare.

For copies of this publication, please call 651-296-6753. For more information about health care programs, visit the health and human services area of our web site, www.house.mn/hrd/issinfo/hlt_hum.htm.