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

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MinnesotaCare

MinnesotaCare is a jointly funded, federal-state program administered by the Minnesota Department of Human Services that provides subsidized health coverage to eligible Minnesotans. This information brief describes eligibility requirements, covered services, and other aspects of the program.

Note: Individuals who have questions about MinnesotaCare eligibility or are interested in applying for MinnesotaCare should call the Minnesota Department of Human Services at 651-297-3862 (in the metro area) or 1-800-657-3672.

Contents

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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. Some county human services agencies have elected to process MinnesotaCare applications and manage MinnesotaCare cases.

Eligibility Requirements

To be eligible for MinnesotaCare, individuals must meet income and asset limits and satisfy other requirements related to residency and lack of access to health insurance. MinnesotaCare eligibility must be renewed every 12 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. The 2009 Legislature allowed children with incomes greater than 275 percent of the FPG to be eligible for MinnesotaCare if they meet all other eligibility requirements. This elimination of the income limit for children was approved by the federal government on July 1, 2011, and DHS is in the process of implementing this change.[2] Parents, legal guardians, foster parents, and relative caretakers are not eligible if their gross annual income exceeds $57,500[3], 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 200 percent of FPG.

Adults without children are eligible for MinnesotaCare if their gross household incomes do not exceed 250 percent of FPG and they meet other eligibility requirements. Adults without children with incomes less than or equal to 75 percent of FPG have been eligible for Medical Assistance (MA) coverage since March 1, 2011. Under MA, these individuals pay no premiums, are not subject to an asset limit, and receive coverage for a broader set of services. The vast majority of adults without children eligible for MA coverage have therefore enrolled in that program, rather than MinnesotaCare.

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[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.

[2] DHS implemented this change on July 1, 2012, for new enrollees and plans to implement the change for all enrollees by the end of calendar year 2012. Prior to the implementation date of this change, children whose income exceeds program limits after initial enrollment can remain on MinnesotaCare if 10 percent of their gross annual household income is less than the annual premium of the $500 deductible policy offered by the Minnesota Comprehensive Health Association.

[3] The federal government approved an increase in the income limit from $50,000 to $57,500 in July 2011. DHS implemented this change on July 1, 2012, for new enrollees and plans to implement the change for all enrollees by the end of calendar year 2012.

Adult enrollees whose incomes rise above program income limits after initial enrollment are disenrolled from the program.

Table 1 lists categories of persons eligible for MinnesotaCare, eligibility criteria, and enrollee cost. Table 2 lists program income limits for different family sizes.

Table 1
Eligibility for MinnesotaCare[a]

Eligible Categories	Household Income Limit	Other Eligibility Criteria	Cost to Enrollee
Lower income children	200% of FPG	Not otherwise insured or insurance is considered underinsured; residency requirement	Exempt from premiums (pending DHS implementation)[b]
Other children	201% - 275% of FPG[c]	No access to employer-subsidized coverage; no other health coverage; residency requirement	Premium based on sliding scale
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 or $57,500,[d] whichever is less	No access to employer-subsidized coverage; no other health coverage; residency requirement; asset limit	Premium based on sliding scale
Adults without children (through June 30, 2012)	250%	No access to employer-subsidized coverage; no other health coverage; residency requirement; asset limit	Premium based on sliding scale
Adults without children not eligible for defined contribution program[e] (beginning July 1, 2012)	< 200%	No access to employer-subsidized coverage; no other health coverage; residency requirement; asset limit	Premium based on sliding scale

Eligible Categories	Household Income Limit	Other Eligibility Criteria	Cost to Enrollee
Adults without children eligible for defined contribution program (beginning July 1, 2012)	≥ 200% and ≤ 250% FPG	No access to employer-subsidized coverage; no other health coverage; residency requirement; asset limit	Cost of private sector policy that exceeds the defined contribution

[a] Exceptions to these requirements are noted in the text.

[b] DHS plans to implement this change by mid-October 2012. Prior to implementation, premiums are $4 per month.

[c] The 2009 Legislature allowed children with household incomes greater than 275 percent of FPG to be eligible, effective upon federal approval, which was received on July 1, 2011. DHS implemented this change on July 1, 2012, for new enrollees and plans to implement the change for all enrollees by the end of calendar year 2012. These children will pay the maximum premium.

[d] The 2008 Legislature increased the income limit for parents and relative caretakers to $57,500, effective upon federal approval, which was received in July 2011. DHS implemented this change on July 1, 2012, for new enrollees and plans to implement the change for all enrollees by the end of calendar year 2012.

[e] This program is described later in this document.

Table 2

Annual Household Income Limits for MinnesotaCare
(Effective July 1, 2012, through June 30, 2013)

Household Size[a]	Children at or Below 150% of FPG	Adults Without Children 200% of FPG[b]	Adults Without Children 250% of FPG	Families and Children 275% of FPG[c]
1	$16,764	$22,344	$27,936	$30,720
2	22,704	30,264	37,836	41,616
3	28,644	Not eligible	Not eligible	52,512
4	34,584	Not eligible	Not eligible	63,408
Each Additional Person	Add $5,940	Not applicable	Not applicable	Add $10,896

[a] Pregnant women are households of two.

[b] Updated poverty guidelines will apply upon the July 1, 2012, implementation of the MinnesotaCare defined contribution program.

[c] Parents are not eligible once income exceeds $57,500 (see text above on DHS implementation).

Asset Limits

MinnesotaCare adult applicants and enrollees, who are not pregnant, are subject to an asset limit. 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
- workers' compensation settlements received due to a work-related injury

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

No Access to Employer-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 reapplication. 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 contributes 50 percent or more towards the cost of coverage for an employee but does not contribute 50 percent or more towards the cost of covering that employee's dependents, the employee is not eligible for MinnesotaCare but the employee's dependents are eligible.

The requirements of no access to employer-subsidized coverage do not apply to the following:

1. Children from households with incomes that do not exceed 200 percent[4] of FPG

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

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

[4] The 2009 Legislature increased this income limit from 150 to 200 percent of FPG, effective upon federal approval, which was received in July 2011. DHS implemented this change on July 1, 2012, for new enrollees and plans to implement the change for all enrollees by the end of calendar year 2012.

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 and 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 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.

The four-month uninsured requirement does not apply to the following:

1. Children from households with incomes that do not exceed 200 percent[5] of FPG

2. Children enrolled in the Children's Health Plan as of September 30, 1992, who have maintained continuous coverage

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

Children described in clauses (1) and (2) also may have other health coverage, if they are considered "underinsured." A child is underinsured if:

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

   - basic hospital insurance
   - medical-surgical insurance
   - major medical coverage
   - prescription drug coverage
   - preventive or comprehensive dental coverage

[5] The 2009 Legislature expanded the exemption from the four-month uninsured requirement to include children from families with incomes less than 200 percent of FPG, and also increased to this level the income limit below which children can have other health coverage if they are underinsured (the prior income limit was 150 percent of FPG). These changes were effective upon federal approval, which was received in July 2011. DHS implemented this change on July 1, 2012, for new enrollees and plans to implement the change for all enrollees by the end of calendar year 2012.

- preventive or comprehensive vision coverage

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

3. The coverage excludes services for a particular diagnosis or a preexisting condition; or

4. The child lacks coverage because the maximum coverage for a particular diagnosis has been exceeded.

Residency Requirement

MinnesotaCare enrollees 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).

The 2011 Legislature eliminated a 180-day durational residency for adults without children, effective August 1, 2011. This elimination was related to the receipt of a federal match for this eligibility group.

Automatic Eligibility for Certain Children

Effective upon federal approval, which was received in July 2011, children who resided in a foster care or juvenile residential correctional facility at the time of their 18th birthday are automatically eligible for MinnesotaCare upon termination or release until the age of 21. These children are exempt from the MinnesotaCare income limit, insurance barriers, and premiums. This change is pending implementation by DHS. DHS plans to implement the change by mid-October 2012.

Benefits

MinnesotaCare enrollees are covered by several different benefit sets. Pregnant women and children have access to the broadest range of services and are not required to pay copayments. Parents and adults without children are covered for most services, but are subject to benefit limitations and copayments.

Since July 1, 2012, adults without children with incomes greater than or equal to 200 percent of FPG but not exceeding 250 percent of FPG, have received defined contributions provided by the state to purchase private sector coverage. Covered services and cost-sharing (e.g., deductibles, copayments) are as provided under the terms of the private sector policy.

The differences in covered services and cost-sharing are summarized in Table 3 below and are described in more detail in the text. The defined contribution program is described in a separate section that follows.

Table 3
Overview of MinnesotaCare Covered Services and Cost-Sharing

Eligibility Category	Covered Services[a]	Inpatient Hospital Limit	Cost-Sharing
Pregnant women and children	MA benefit set	None	None
Parents ≤ 215% of FPG	Most MA services	None	• $25 eyeglasses • $3 prescriptions • $3 nonpreventive visit • $3.50 nonemergency visit to hospital ER
Parents > 215% and ≤ 275% of FPG	Most MA services	$10,000 annual limit for inpatient hospital services	• $25 eyeglasses • $3 prescriptions • $3 nonpreventive visit • $3.50 nonemergency visit to hospital ER
Adults without children < 200% of FPG (effective July 1, 2012)	Most MA services	$10,000 annual limit for inpatient hospital services	• $25 eyeglasses • $3 prescriptions • $3 nonpreventive visit • $3.50 nonemergency visit to hospital ER • 10% inpatient hospital, up to $1,000
Adults without children ≥ 200% and ≤ 250% of FPG (effective July 1, 2012)	Services covered under the private sector policy purchased	None, unless private sector policy has a limit	As provided in the private sector policy

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

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 under the MinnesotaCare program.[6] These individuals are exempt from MinnesotaCare benefit limitations and copayments,[7] but still must pay MinnesotaCare premiums. Pregnant women and

[6] 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.

[7] 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 or PMAP+ 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

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.

Parents and adults without children who are not pregnant are covered under MinnesotaCare for most, but not all, services covered under MA. Parents with household incomes greater than 215 percent of FPG, and all adults without children, are subject to an annual benefit limit for impatient hospital services of $10,000.

Since July 1, 2012, covered services for adults without children with incomes ≥ 200 percent of FPG up to the program limit of 250 percent of FPG have varied, depending upon the private sector coverage that is purchased with the defined contribution.

Table 4
Covered Services Under MinnesotaCare

Service	Children; Pregnant Women	Parents; Adults without children[a]
Acupuncture[b]	x	x
Adult mental health rehab/crisis	x	x
Alcohol/drug treatment	x	x
Child and teen checkup	x	
Chiropractic	x	x
Common carrier transportation	x	
Dental[c]	x	x
Emergency room	x	x
Eye exams	x	x
Eyeglasses	x	x
Family planning	x	x
Hearing aids	x	x
Home care	x	x[d]
Hospice care	x	x
Hospital stay	x	x
Hospital care coordination[b]	x	x
Immunizations	x	x
Interpreters (hearing, language)	x	x
Lab, x-ray, diagnostic	x	x
Medical equipment and supplies	x	x
Mental health	x	x
Mental health case management	x	x

21. Since August 1, 2011, the state has also received under the waiver FFP for services provided to MinnesotaCare enrollees who are adults without children with incomes above 75 percent but not exceeding 250 percent of FPG. The PMAP+ waiver was recently reauthorized by the federal Centers for Medicare and Medicaid Services for the period July 1, 2011, through December 31, 2013.

Service	Children; Pregnant Women	Parents; Adults without children[a]
Outpatient surgical center	x	x
Physicians and clinics	x	x
Physicals/preventive care	x	x
Prescriptions	x	x
Rehabilitative therapies	x	x
School-based services	x	
Transportation: emergency	x	x
Transportation: special	x	

[a] Benefit limitations and cost-sharing requirements apply.

[b] This benefit became effective January 1, 2012.

[c] MinnesotaCare covers the dental services covered under MA. Effective January 1, 2010, MA coverage of dental services for adults who are not pregnant (and therefore MinnesotaCare coverage of dental services for this category of individuals) was limited to specified services (see Minn. Stat. § 256B.0625, subd. 9).

[d] Personal care attendant and private duty nursing services are covered for children and pregnant women, but are not covered for parents and adults without children.

Copayments for Adults

Parents and adults without children, 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. (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 (does not apply to mental health services)
- $3.50 for nonemergency visits to a hospital emergency room (reduced from $6.00, effective January 1, 2011)
- A family deductible, effective January 1, 2012

The commissioner may allow managed care and county-based purchasing plans to waive the family deductible.

Enrollee Premiums

Premium Exemption for Children

Children with family incomes at or below 200 percent of FPG are not charged premiums.[8]

Sliding Premium Scale

MinnesotaCare enrollees (who are not children exempt from premiums) pay premiums equivalent to the percentages of gross monthly income specified in Table 5. This premium scale became effective July 1, 2009, and replaced a premium scale under which the enrollee contribution ranged from 1.8 percent to 8.8 percent of monthly gross household income.

Table 5
Sliding Premium Scale

Federal Poverty Guideline Range	Average Percentage of Gross Monthly Income Paid as Premium
0% – 45%	Minimum premium of $4/month
46 – 54	$4/month or 1.1%, whichever is greater
55 – 81	1.6%
82 – 109	2.2
110 – 136	2.9
137 – 164	3.6
165 – 191	4.6
192 – 219	5.6
220 – 248	6.5
249 – 275	7.2

Premium Exemption

Members of the military and their families who are determined eligible for MinnesotaCare within 24 months of the end of the member's tour of active duty are exempt from premiums for 12 months.[9]

[8] Federal approval for this provision was received in July 2011; this change is pending implementation by DHS. DHS plans to implement the change by mid-October 2012. Prior to implementation, children from households with incomes that do not exceed 150 percent of FPG are charged a minimum premium of $4 per month.

[9] The 2011 Legislature eliminated the sunset of this provision.

Nonpayment of Premiums

Unless an exemption applies, nonpayment of premiums results in disenrollment from MinnesotaCare effective the calendar month for which the premium was due.[10] If an enrollee who is pregnant fails to pay the premium, MinnesotaCare coverage continues until the last day of the month in which 60 days postpartum occurs. If the premium is not paid for an enrollee who is a child under age two, MinnesotaCare coverage continues to the last day of the month following the month in which the child turns two years of age.

Enrollees who are disenrolled due to nonpayment of premiums may reinstate their coverage retroactively to the first day of disenrollment by paying all billed premiums within 20 days of disenrollment. Individuals who do not reinstate their coverage cannot reenroll in MinnesotaCare until four calendar months have elapsed, unless the individual demonstrates good cause for nonpayment.

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.

Prepaid health plans (sometimes referred to as managed care organizations) 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. Five percent of each plan's capitation rate is withheld annually, and returned pending the plan's completion of performance targets related to various process, quality, and clinical measures.

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.

Effective for admissions occurring on or after July 1, 2011, inpatient hospital services provided to adults without children enrolled in MinnesotaCare have been delivered on a fee-for-service basis, with DHS making payments directly to hospitals.

The 2011 Legislature authorized a two-year competitive bidding pilot to serve nonelderly, nondisabled adults and children in the seven-county metropolitan area beginning January 1, 2012. The 2012 Legislature allowed the commissioner to continue the use of competitive bidding for managed care contracts effective on or after January 1, 2014.

[10] The 2008 Legislature provided a grace month extending the enrollment of a person who fails to pay the premium to the first day of the calendar month following the calendar month for which the premium was due. This provision was subject to federal approval, which had not been received by the time the 2011 Legislature repealed the language authorizing a grace month.

The 2011 Legislature also made a number of changes related to managed care payment rates. These include:

- adding as performance targets, subject to payment withholds, measures related to reducing a plan's hospital admission rate and rate of hospital readmission within 30 days of a previous hospitalization; and
- reducing capitation rates by 6 percent for families and children, beginning September 1, 2011, and for the calendar years 2013 through 2015, setting limits on trend (inflation) increases to capitation rates of 3 percent or 4 percent, depending upon the enrollee group and year.

MinnesotaCare Defined Contribution Program

The 2011 Legislature directed DHS to implement, beginning July 1, 2012, a defined contribution program for certain MinnesotaCare enrollees who are adults without children. Enrollees can use the defined contribution to purchase private sector individual health coverage. Defined contribution program enrollees are exempt from paying MinnesotaCare sliding scale premiums and cost-sharing, but must pay any portion of their premium that exceeds the monthly defined contribution and are subject to the deductible and cost-sharing requirements of the private sector coverage they purchase.

Eligibility and Program Requirements

MinnesotaCare enrollees who are adults without children with incomes equal to or exceeding 200 percent of FPG have been eligible for the defined contribution program since July 1, 2012, and are not eligible to receive coverage under the standard MinnesotaCare program.

Defined contribution program enrollees are not charged MinnesotaCare sliding scale premiums and are not required to enroll with a managed care or county-based purchasing plan to receive coverage.

Covered services, deductibles and other cost-sharing, disenrollment for nonpayment of premium, enrollee appeal rights and complaint procedures, and the effective date of coverage are as provided under the terms of the private sector coverage purchased by the enrollee.

Requirements of the standard MinnesotaCare program related to eligibility, income and asset methods, income reporting, and program administration continue to apply to defined contribution program enrollees.

Use of the Defined Contribution; Health Plan Requirements

Enrollees will receive a monthly defined contribution to help pay premiums for private sector health plan coverage. The defined contribution program generally does not require health plans purchased by enrollees to meet specific criteria regarding covered benefits or cost-sharing, other than requiring that the health plan purchased must:

1. provide coverage for mental health and chemical dependency services; and

2. comply with the limitations on abortion coverage of the standard MinnesotaCare program.[11]

Enrollees are required to select a health plan within four months of approval of MinnesotaCare eligibility. If a health plan is not selected and purchased within this time period, the enrollee must reapply and meet all eligibility criteria. The commissioner may designate criteria under which an enrollee would have more than four months to select a health plan.

Enrollees who fail to pay a health plan premium are disenrolled by DHS from MinnesotaCare on the first day of the calendar month following the calendar month for which the premium was due. Persons who are disenrolled for nonpayment of premium or who voluntarily terminate coverage cannot enroll in MinnesotaCare until four calendar months have elapsed.

Defined Contribution Amounts

The amount of the monthly defined contribution received by an enrollee varies with the enrollee's age and income. The authorizing legislation specifies monthly base contribution amounts that vary with age. Enrollees receive a percentage of this base contribution, depending upon their income.

The monthly base contribution varies with age as provided in the following table.

Table 6
Monthly Contributions

Age	Monthly Base Contribution
19-29	$125
30-34	$135
35-39	$140
40-44	$175
45-49	$215
50-54	$295
55-59	$345
60+	$360

The monthly defined contribution received by an enrollee is calculated by multiplying the monthly base contribution by a percentage that varies inversely with income as follows:

1. Persons with household income equal to 200 percent of FPG receive a defined contribution equal to 93 percent of the base contribution

[11] Minnesota Statutes, section 256L.03, subdivision 1, limits abortion coverage under MinnesotaCare to situations "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."

2. Persons with household incomes equal to 250 percent of FPG receive a defined contribution equal to 80 percent of the base contribution

3. Persons with household incomes that fall between 200 percent and 250 percent of FPG receive a defined contribution equal to a percentage that is interpolated in evenly spaced increments from the defined contribution percentages specified in clauses (1) and (2)

The defined contribution is increased by 20 percent for enrollees who purchase coverage through the Minnesota Comprehensive Health Association (MCHA) (see below).

Administration by DHS

DHS administers the defined contribution program. DHS duties include:

1. Calculating and processing defined contributions for enrollees;

2. Paying the defined contribution to health plan companies or MCHA, as applicable, for enrollee health plan coverage;

3. Developing, in consultation with the Department of Commerce, an efficient and cost-effective method of referring eligible applicants to professional insurance agent associations; and

4. Seeking federal financial participation for adult enrollees covered under the defined contribution program.

Coverage Through MCHA

MCHA is a high-risk insurance pool that makes health coverage available to persons who are turned down for private sector coverage because of a preexisting health condition, or who meet other eligibility criteria.

If MinnesotaCare enrollees eligible for the defined contribution program are eligible for MCHA coverage, they may use the defined contribution to purchase an MCHA policy, and the MCHA six-month preexisting condition limitation is waived. DHS is required to pay MCHA any difference between the revenue received and actual coverage losses to MCHA related to implementation of this provision. This money is appropriated annually to DHS from the health care access fund.

Funding and Expenditures

Total payments for health care services provided through MinnesotaCare were $738 million in fiscal year 2011. Sixty-eight percent of this amount was paid for through state payments from the health care access fund. The remainder is paid from enrollee premiums (this category also includes enrollee cost-sharing), federal funding received under the Prepaid Medical Assistance Project Plus (PMAP+) waiver, and the Minnesota's Children's Health Insurance Program (CHIP)[12] allotment.

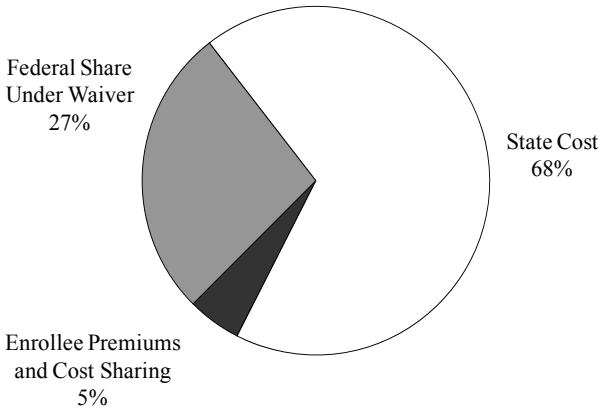
Funding for the state share of MinnesotaCare costs, and for other health care access initiatives, is provided by:

- 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"); and

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

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.

MinnesotaCare Funding (FY2011)



Source: DHS Reports and Forecasts Division

[12] The PMAP+ waiver and federal funding available through the waiver is described in footnote 7 on page 8. The state may make a claim against its CHIP allotment for the difference between the CHIP federal matching rate for Minnesota (65 percent) and the Medicaid federal matching rate for Minnesota, for the cost of services provided to children under age 21 whose family income equals or exceeds 133 percent of FPG but does not exceed 275 percent of FPG. Minnesota had a CHIP waiver until January 31, 2009, that provided an enhanced federal match of 65 percent for parent and relative caretakers enrolled in MinnesotaCare with family incomes greater than 100 percent but not exceeding 200 percent of FPG. Parents and relative caretakers now receive the regular MA federal match of 50 percent.

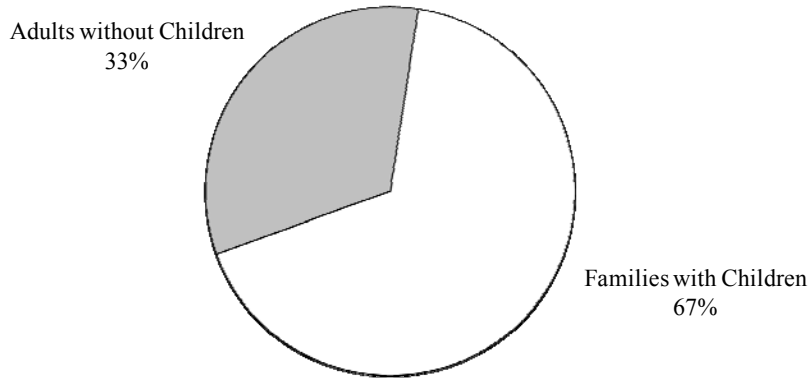
The 2011 Legislature authorized the Commissioner of Management and Budget to contingently reduce the tax rate on health care providers, if the commissioner determines by December 1 of each year that the ratio of revenues to expenditures and transfers for the health care access fund for the biennium will exceed 125 percent. If this determination is made, the commissioner is to reduce the rate so that the projected ratio of revenues to expenditures and transfers for the biennium will not exceed 125 percent. Any rate reduction expires after one year and the future rate is subject to annual redetermination by the commissioner.

The 2011 Legislature also repealed the MinnesotaCare provider taxes, effective for gross revenues received after December 31, 2019.

Recipient Profile

As of April 2012, 131,432 individuals were enrolled in the MinnesotaCare program. Just over two-thirds of MinnesotaCare enrollees are children, parents and caretakers, or pregnant women.

MinnesotaCare Enrollment
(April 2012)



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 more information about health care programs, visit the health and human services area of our website, www.house.mn/hrd/hrd.htm.