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. The 2013 Legislature made significant changes to the program; most of these changes take effect January 1, 2014. This information brief describes eligibility requirements, covered services, and other aspects of the program, as the program will exist on January 1, 2014. For a description of program prior to that date, refer to the August 2012 version of this information brief.

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, or MNsure, the state's health insurance exchange, at 1-855-366-7873.

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.

Since October 1, 2013, applicants have been able to apply for MinnesotaCare through MNSure, the state's health insurance exchange, for coverage that will take effect January 1, 2014. Applications may be submitted online, by telephone, by mail, or in person.

MinnesotaCare as Basic Health Program

Under the federal Affordable Care Act (ACA), states have the option of operating a basic health program to provide health coverage to persons with incomes greater than 133 percent but not exceeding 200 percent of FPG, beginning January 1, 2015. States will receive 95 percent of the amount the federal government would otherwise have spent on premium tax credits and cost-sharing subsidies for these individuals under the insurance exchange.

The 2013 Legislature directed the Commissioner of Human Services to seek federal approval to operate the MinnesotaCare program as a basic health program. The legislature also authorized changes in MinnesotaCare eligibility, covered services, and service delivery that are consistent with federal requirements for a basic health program. Many of these MinnesotaCare changes are effective January 1, 2014. (Laws 2013, ch. 108/H.F. 1233, article 1)

Eligibility Requirements

To be eligible for MinnesotaCare, individuals must meet income limits, not be eligible for MA, and satisfy other requirements related to residency and lack of access to health insurance. MinnesotaCare eligibility must be renewed every 12 months.

Effective January 1, 2014, most MinnesotaCare enrollees will be parents and caretakers, children ages 19 to 20, and adults without children. Most children under age 19, and pregnant women, who would have been eligible for MinnesotaCare prior to January 1, 2014, will be eligible for Medical Assistance and will therefore, under the new MinnesotaCare eligibility rules, not be eligible for MinnesotaCare.

Income Limits

Effective January 1, 2014, MinnesotaCare coverage is available to persons with incomes greater than 133 percent of FPG but not exceeding 200 percent of FPG, if other program eligibility requirements are met. Children under age 19 with household incomes not exceeding 200 percent of FPG are eligible for MinnesotaCare (even if their income does not exceed the 133 percent of FPG income floor), if they are ineligible for Medical Assistance solely due to application of the

household composition rule for MA.[1] In addition, legal noncitizens ineligible for MA due to immigration status, with household incomes not exceeding 200 percent of FPG, are eligible for MinnesotaCare.[2]

Through December 31, 2013, parents and caretakers are eligible if their household income does not exceed 275 percent of FPG (subject to a maximum income of $57,500), and adults without children are eligible if their income does not exceed 250 percent of FPG. There is no income limit for children.

The table below lists the minimum and maximum program income limits for different family sizes.

Table 1
Annual Household Income Limits for MinnesotaCare
(effective January 1, 2014)

Household Size	133% of FPG	200% of FPG
1	$15,281	$22,980
2	20,628	31,020
3	25,974	39,060
4	31,321	47,100
Each additional person add	$5,346	$8,040

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Effective January 1, 2014, modified adjusted gross income (MAGI)[3] is used as the income methodology for MinnesotaCare applicants and enrollees. The use of MAGI is required by the ACA for state basic health programs. Prior to this date, a state-specific gross income calculation is applied.

[1] The MA household composition rule counts the income of both unmarried parents when determining eligibility for a minor child in the household. Beginning January 1, 2014, MinnesotaCare, as part of the switch to the modified adjusted gross income (MAGI) income methodology, will use the tax definition of household, under which only the income of one unmarried parent is counted when determining eligibility for a minor child (this is the income of the parent claiming the child as a dependent). This difference in methodology could lead to situations in which a child's income under MA (given the counting of income of both unmarried parents) is too high for that program, but is too low to qualify for MinnesotaCare (given the counting of income of only one parent and the program's income floor). This MinnesotaCare eligibility provision is intended to allow children in this situation to be eligible for MinnesotaCare.

[2] These legal noncitizens are generally those falling under certain immigration classifications who have resided in the United States for less than five years. The cost of health care services provided to these individuals is funded through MinnesotaCare without a federal match (state-only MinnesotaCare).

[3] MAGI is defined as adjusted gross income increased by: (1) foreign earned income excluded; (2) tax-exempt interest; and (3) an amount equal to the value of Social Security benefits not subject to tax. (I.R.C. § 36B)

Asset Limits

Effective January 1, 2014, no asset limit applies to MinnesotaCare enrollees.

Through December 31, 2013, parents and caretakers and adults without children are subject to an asset limit of $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.[4] Pregnant women and children are exempt from the MinnesotaCare asset limit.

Not Eligible for Medical Assistance

Effective January 1, 2014, persons who are eligible for Medical Assistance are not eligible for MinnesotaCare. Through December 31, 2013, persons eligible for both MA and MinnesotaCare can enroll in either program. This change has the effect of shifting the vast majority of pregnant women and children under age 19 from MinnesotaCare to MA, since the MA income limit for these eligibility groups (275 percent of FPG)[5] is the higher than the MinnesotaCare income limit (200 percent of FPG).

No Access to Subsidized Health Coverage

Effective January 1, 2014, in order to be eligible for MinnesotaCare, a family or individual must not have access to subsidized health coverage that is affordable and provides minimum value, as defined in federal regulations.[6] These regulations define coverage as "affordable" for an employee and related individuals, if the portion of the annual premium the employee must pay for self-only coverage does not exceed 9.5 percent of income. Coverage provides "minimum value" if it pays for at least 60 percent of medical expenses on average.

Through December 31, 2013, a family or individual must not have access to employer-subsidized health care coverage, and 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 was defined as health insurance coverage for which an employer pays 50 percent or more of the premium cost. The requirement of no access to employer-subsidized coverage does not apply to certain low-income children.

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[4] Exempt assets included: 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 (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; and workers' compensation settlements received due to a work-related injury.

[5] The 2013 Legislature increased the MA income limit for children ages 2 through 18 from 150 percent to 275 percent of FPG, effective January 1, 2014.

[6] See Code of Federal Regulations, title 26, section 1.36B-2.

No Other Health Coverage

Effective January 1, 2014, in order to be eligible for MinnesotaCare, a family or individual must not have minimum essential health coverage, as defined in the Internal Revenue Code.[7] The Internal Revenue Code defines minimum essential coverage as coverage under government-sponsored programs (including but not limited to Medicare, Medicaid, TRICARE and other coverage for members of the armed services, and veterans health benefits), coverage under an employer-sponsored plan, individual market coverage, coverage under a grandfathered health plan,[8] and other coverage recognized by the federal government.

Through December 31, 2013, enrollees must not have other health coverage and must not have had health coverage for the four months prior to application or renewal. Low-income children and children meeting other specified criteria were exempt from these requirements.

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.

Benefits

Parents and adults without children who are not pregnant are covered under MinnesotaCare for most, but not all, services covered under MA. Effective January 1, 2014, the $10,000 annual limit on inpatient hospital benefits that applied to certain parents and caretakers, and adults without children, is eliminated. Covered services are summarized in Table 2.

Through December 31, 2013, this annual limit on inpatient hospital benefits applies to parents with household incomes greater than 215 percent of FPG, and adults without children with incomes below 200 percent of FPG. Adults without children with incomes equal to or greater than 200 percent of FPG are able to purchase private sector coverage without the $10,000 annual inpatient limit, through the Healthy Minnesota Contribution Program—the MinnesotaCare defined contribution program. This program, eliminated January 1, 2014, is described later in this publication.

[7] See Internal Revenue Code, section 5000A.

[8] Under the ACA, most health insurance plans that existed on March 23, 2010, are eligible for grandfathered status. Grandfathered plans do not have to meet all of the ACA requirements related to the regulation of health insurance. However, grandfathered status is lost and compliance with the ACA is required, if significant changes are made to the plan's benefits or premiums and cost-sharing.

Children ages 19 and 20, and children under age 19 not eligible for MA solely due to the MA household composition rule (described in footnote 1), can access the full range of MA services without enrolling in MA, except that abortion services are covered as provided under the MinnesotaCare program.[9] These individuals are exempt from MinnesotaCare benefit limitations and cost-sharing.

Table 2
Covered Services Under MinnesotaCare

Service	Children	Parents; Adults without children[a]
Acupuncture	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[b]	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[c]
Hospice care	X	X
Hospital stay	X	X
Hospital care coordination	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
Nursing facility care	X	

[9] 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.

Service	Children	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/common carrier	X	

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

[b] 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).

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

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Cost-sharing for Adults

Parents and adults without children, who are not pregnant, are subject to the following cost-sharing requirements:

- $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
- A family deductible, effective January 1, 2012

The family deductible is waived for MinnesotaCare enrollees served by managed care and county-based purchasing plans.

Effective January 1, 2014, the copayment of 10 percent for inpatient hospital services, up to an annual maximum of $1,000 per adult, is eliminated (tied to elimination of the $10,000 annual limit on inpatient hospital services).

Children under age 21 are not subject to cost-sharing under MinnesotaCare.

Elimination of the Healthy Minnesota Contribution Program

The 2013 Legislature eliminated the Healthy Minnesota Contribution Program, effective January 1, 2014. MinnesotaCare enrollees who are adults without children with incomes equal to or exceeding 200 percent of FPG but not exceeding 250 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. Through December 31, 2013, these enrollees receive a monthly defined contribution based on a sliding scale to purchase private sector individual coverage. Enrollees are financially responsible for any cost-sharing required by the private sector policy and for any premium amounts that exceed the defined contribution.

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 were as provided under the terms of the private sector coverage purchased by the enrollee.

Enrollee Premiums

Sliding Premium Scale

Effective January 1, 2014, MinnesotaCare enrollees age 21 and older pay monthly, per-person premiums based upon the following sliding scale:

Table 3
Sliding Premium Scale

Federal Poverty Guideline Greater than or Equal to	Less than	Individual Premium Amount
0%	55%	$4
55%	80%	$6
80%	90%	$8
90%	100%	$10
100%	110%	$12
110%	120%	$15
120%	130%	$18
130%	140%	$21
140%	150%	$25
150%	160%	$29

Federal Poverty Guideline Greater than or Equal to	Less than	Individual Premium Amount
160%	170%	$33
170%	180%	$38
180%	190%	$43
190%		$50

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This premium scale is intended to reduce average premiums paid by enrollees. Under the premium scale in effect through December 31, 2013, households pay premiums ranging between $4 per person per month and 7.2 percent of income, with household premiums varying with the number of persons covered. Children with incomes under 200 percent of FPG pay no premiums.

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.

Nonpayment of Premiums

Unless an exemption applies, nonpayment of premiums results in disenrollment from MinnesotaCare coverage, effective the calendar month for which the premium was due. 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.

Prepaid MinnesotaCare

The Commissioner of Human Services contracts with health maintenance organizations and other prepaid health plans to deliver health care services to MinnesotaCare enrollees. MinnesotaCare enrollees receive health care services through these prepaid health plans, rather than 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.

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.

Funding and Expenditures

Total payments for health care services provided through MinnesotaCare were $549 million in fiscal year 2012. 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,[10] and the Minnesota's Children's Health Insurance Program (CHIP)[11] 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

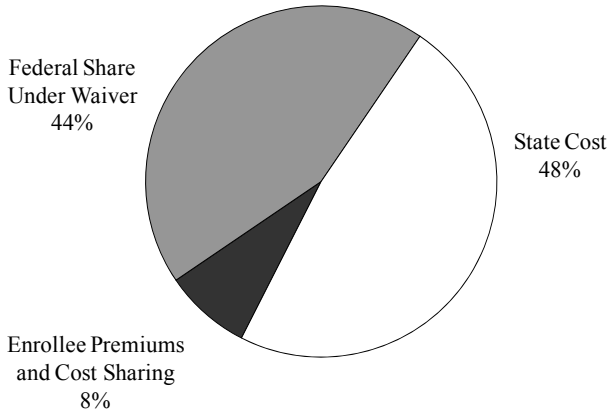
- A 1 percent premium tax on health maintenance organizations and nonprofit health service plan corporations.

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.

[10] The state's health care reform waiver (now referred to as the Prepaid Medical Assistance Project Plus or PMAP+ waiver) was approved by the federal government in April 1995. The waiver, and subsequent waiver amendments, exempted Minnesota from various federal requirements, gave the state greater flexibility to expand access to health care through the MinnesotaCare and MA programs, and allows 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. 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 (through June 30, 2012) or 200 percent of FPG (beginning July 1, 2012). The PMAP+ waiver was reauthorized by the federal Centers for Medicare and Medicaid Services for the period July 1, 2011, through December 31, 2013. DHS is seeking reauthorization of the waiver for the period January 1, 2014, through December 31, 2017, revised as necessary to reflect program eligibility changes.

[11] 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 is greater than 133 percent of FPG.

MinnesotaCare Funding
(FY 2012)



Source: DHS Reports and Forecasts Division

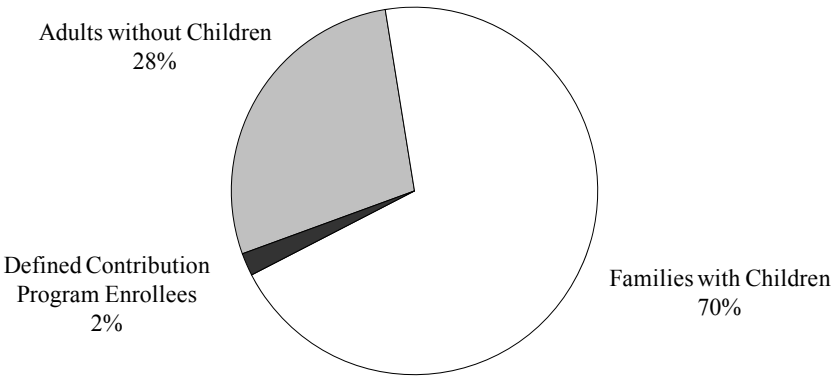
The 2011 Legislature directed the Commissioner of Management and Budget to reduce the tax rate on health care providers, if the commissioner determines by December 1 of each year that the ratio of revenues to expenditures and transfers for the health care access fund for the biennium will exceed 125 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 July 2013, 131,979 individuals were enrolled in the MinnesotaCare program. Over two-thirds of MinnesotaCare enrollees are children, parents and caretakers, or pregnant women.

MinnesotaCare Enrollment
(July 2013)



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)

Persons can also apply for MinnesotaCare through MNsure, the health insurance exchange (1-855-366-7873 or online at www.mnsure.org).

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/.