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HOUSE RESEARCH

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Information Brief

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The MinnesotaCare Program

The MinnesotaCare 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 MinnesotaCare program, including changes made by the 1998 Legislature.

Contents

Applying for MinnesotaCare. Applications for the program, and additional information, can be obtained from the Department of Human Services by calling 1-800-657-3672 or (651) 297-3862 (in the metro area).

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 social service agencies are responsible for determining Medical Assistance (MA) eligibility for MinnesotaCare applicants who apply for MA.[1]

Eligibility

To be eligible for MinnesotaCare, individuals must meet income limits and satisfy other requirements related to lack of access to health insurance and residency. MinnesotaCare eligibility must be reviewed every 12 months.

Income Limits

Minor children, parents, and dependent siblings[2] residing in the same household are eligible for MinnesotaCare, if their gross household income does not exceed 275 percent of the federal poverty guidelines and other eligibility requirements are met. Different eligibility requirements and premiums apply to children from households with gross incomes that do not exceed 150 percent of the federal poverty guidelines.

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

Prior to January 1, 1999, enrollees whose incomes rise above program income limits after initial enrollment may remain enrolled, but must continue to pay the full (unsubsidized) cost of the premium. Effective January 1, 1999, enrollees whose incomes rise above program income limits after initial enrollment will be disenrolled from the program after an 18-month notice period. Individuals and families will be exempt from this requirement and will be allowed to 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).[3]

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[1] Beginning January 1, 2000, county social service agencies will have the option of processing applications and determining eligibility for all MinnesotaCare applicants.

[2] 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. Dependent siblings are defined in the law as unmarried children under age 25 who are full-time students and financially dependent upon their parents.

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

Table 1 lists categories of persons eligible for MinnesotaCare, eligibility criteria, and enrollee cost (see Table 4 on page 10 for sample sliding scale premiums). Table 2 on page 4 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 the federal poverty guidelines	Not otherwise insured for the covered services; residency requirement	Annual premium of $48 per person
Other Children; Pregnant Women	275% of the federal poverty guidelines	No access to employer-subsidized coverage; no other health coverage; residency requirement	Premium based on sliding scale
Parents	275% of the federal poverty guidelines	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 the federal poverty guidelines	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.
** Effective upon federal approval.

Asset Limits

Effective upon federal approval, MinnesotaCare adult applicants and enrollees, who are not pregnant, will be subject to an asset limit of $15,000 in total net assets for households of one and $30,000 in total net assets for households of two or more persons. The following items will be excluded from total net assets:

- a homestead
- household goods and personal effects
- assets owned by children
- vehicles used for employment
- court-ordered settlements up to $10,000
- individual retirement accounts
- capital and operating assets of a trade or business up to $200,000 in net assets

Pregnant women are exempt from the MinnesotaCare asset limit. Effective September 30, 1998, children will also be exempt from the asset limit.[4]

Table 2

Annual Household Income Limits for MinnesotaCare			
Household Size*	150% of 1998 Federal Poverty Guidelines	175% of 1998 Federal Poverty Guidelines	275% of 1998 Federal Poverty Guidelines
1	$12,072	$14,088	$22,140
2	16,272	18,984	29,832
3	20,472	23,892	37,536
4	24,672	28,788	45,240
5	28,872	33,684	52,932
6	33,072	38,592	60,636
7	37,272	43,488	68,340
8	41,472	48,384	76,032
9	45,672	53,292	83,736
10	49,872	58,188	91,440
Additional	4,200	4,896	7,704
*Pregnant women are households of two.			

No Access to Subsidized Coverage

A family or individual must **not** have access to employer-subsidized health care coverage. 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.

This 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;

[4] The 1998 Legislature exempted children from the asset limit in order to comply with federal requirements for receiving funding under the State Children's Health Insurance Program. In July 1998 the federal Health Care Financing Administration denied a state waiver request to retain the asset limit for children. Pregnant women were exempted in the original legislation establishing the asset limit.

(2) children enrolled in the Children's Health Plan as of September 30, 1992 (the precursor program to MinnesotaCare); 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).

Prior to January 1, 1999, a family or individual not otherwise exempt must also not have had access to employer-subsidized coverage during the 18 months prior to application. This requirement 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; (3) children who enrolled in the Children's Health Plan during a transition period following the establishment of MinnesotaCare; (4) persons losing employer-subsidized coverage as a result of the death of an employee or divorce, or who "age-out" and become ineligible for coverage as a child or dependent; (5) persons losing coverage for reasons that would not disqualify them from receiving unemployment benefits (i.e. those who lose their jobs due to a layoff or leave for cause); and (6) children of an employee who loses employer-subsidized coverage due to misconduct or voluntary separation.

Effective January 1, 1999, the requirement that a family or individual not have had access to employer-subsidized coverage during the 18 months prior to application will apply only to those persons whose employer-subsidized coverage was lost because an employer terminated health care coverage as an employee benefit.

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),[5] and CHAMPUS (Civilian Health and Medical Program of the Uniformed Service) are not considered health coverage; and

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

Prior to January 1, 1999, children from households with incomes that do not exceed 150 percent of the federal poverty guidelines, children enrolled in the original Children's Health Plan, and persons covered under specified local plans providing coverage to the uninsured are exempt from these requirements.

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[5] Effective January 1, 2000, GAMC adult applicants and recipients, with dependent children and family incomes not exceeding 275 percent of the federal poverty guidelines, or those without children with incomes between 75 percent and 175 percent of the federal poverty guidelines, and who meet the MinnesotaCare eligibility criteria, will be terminated from GAMC upon enrollment in MinnesotaCare.

Effective January 1, 1999, children from households with incomes that do not exceed 150 percent of the federal poverty guidelines and children enrolled in the original Children's Health Plan may have other health coverage and are not subject to the four-month uninsured requirement if they are "not otherwise insured for the covered services" as defined in rule (see Minn. Rules part 9506.0020, subpart 3, item B). A child is not otherwise insured for covered health services when one of the following criteria is met:

(1) the child lacks two or more of the following types of coverage:

- basic hospital coverage
- medical-surgical coverage
- major medical coverage
- dental coverage
- vision coverage

(2) the child's 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.

Residency Requirement

Pregnant women, families, and children must meet the residency requirements of the Medicaid program, except that the MA 30-day residency requirement in Minnesota Statutes, section 256B.056, subdivision 1, will apply upon federal approval. 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.

Covered Services and Copayments

Pregnant women and children have access to a broader range of covered services than adults who are not pregnant (services covered under MinnesotaCare for these two groups are listed in Table 3 on page 9). In addition, adults who are not pregnant are subject to benefit limitations and copayments that do not apply to pregnant women and children.

Covered Services

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 must still 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 adults other than pregnant women are covered under MinnesotaCare for most, but not all, services covered under MA. These individuals are subject to benefit limitations and copayments for certain services.

Benefit Limitations for Adults

Adults who are not pregnant are subject to the following benefit limitations. These limitations do not apply to pregnant women or children.

- Dental services for adults on MinnesotaCare who are not pregnant are limited to preventive services, except that nonpreventive dental services are covered for adults who are not pregnant with household incomes that do not exceed 175 percent of the federal poverty guidelines. These nonpreventive services are subject to a 50 percent copayment.

- Inpatient hospital services for adults who are not pregnant and who: (1) reside in households without children; or (2) are parents with household incomes greater than 175 percent of the federal poverty guidelines, 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 the federal poverty guidelines.

- Outpatient mental health services for adults who are not pregnant are limited to diagnostic assessments; psychological testing; explanation of findings; day treatment; partial hospitalization; individual, family, and group psychotherapy; and medication management.

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[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. Once the MA asset test for pregnant women is eliminated effective September 30, 1998, (see Laws 1998, ch. 407, art. 5, sec. 3) nearly all MinnesotaCare enrollees who are pregnant women will be eligible for MA.

[7] This is a change in MinnesotaCare related to approval of the health care reform waiver by the federal government in April 1995. The waiver exempts Minnesota from various federal requirements, gives 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 or pregnant women. In early 1997, the state submitted additional waiver requests to the federal government as part of Phase 2 of the health care reform waiver. One of the requests is to obtain FFP for parents on MinnesotaCare.

Copayments for Adults

Adults who are not pregnant are subject to the following benefit limitations. These limitations do not apply to pregnant women or children.

- 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.

- $3.00 copayment per prescription.

- $25.00 copayment per pair of eyeglasses.

- Copayment of 50 percent of the MA allowable charge for nonpreventive dental care services provided to adults who are not pregnant with household incomes that do not exceed 175 percent of the federal poverty guidelines.

Table 3

Covered Services		
Service	Children and Pregnant Women	All Other Adults *
Access services (transportation, lodging, interpreter, and other services needed to access other covered services)	X	
Chemical dependency services	X	X
Chiropractic	X	X
Dental services	X	X
Diagnostic, screening, preventive services	X	X
Family planning services	X	X
Hearing aids	X	X
Certain home care services	X	X
Hospice care services	X	X
Individualized Education Plan/Special education services	X	
Immunizations	X	X
Inpatient hospital services	X	X
Long-term care facility services	X	
Medical equipment and supplies	X	X
Nurse practitioner services	X	X
Orthodontic services	X	
Outpatient laboratory and x-ray services	X	X
Outpatient mental health services	X	X
Personal care attendant and case management services	X	
Physical therapy, occupational therapy, speech therapy, audiology	X	X
Physician and health clinic visits	X	X
Pregnancy-related services	X	X
Most prescription drugs	X	X
Private duty nursing services	X	
Public health nursing clinic services	X	X
Rehabilitative therapy services (Medicare-certified agency)	X	X
Sign and spoken language interpreter services	X	X
Transportation: emergency	X	X
Transportation: special	X	
Vision care, including prescription eyeglasses	X	X

* Benefit limitations and cost-sharing requirements apply.

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 the federal poverty guidelines.

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 8.8 percent of gross family income. The minimum premium is $4 per person per month.

Table 4 provides sample monthly 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 4

Sample Monthly Household Premiums (as of July 1, 1998)

	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	38	23	18	18	18
$1,500	111	57	46	34	34
$2,000	N.E.	148	97	75	62
$2,500	N.E.	N.E.	186	119	95
$3,000	N.E.	N.E.	265	221	145
$3,500	N.E.	N.E.	N.E.	306	257
$4,000	N.E.	N.E.	N.E.	N.E.	351

NOTE: N.E. means **not eligible** to enroll in MinnesotaCare at this income level.

* The maximum income limit for households without children (household size of two) is $1,582 per month. The sample premiums listed in the table for a household size of two reflect the higher income limit that applies 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. MinnesotaCare enrollees were switched from fee-for-service care to prepaid care in stages, between July 1, 1996, and January 1, 1997. Since January 1, 1997, all MinnesotaCare enrollees have received health care services through prepaid health plans and not through fee-for-service.[8]

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.

Enrollment, Expenditures, and Funding

As of July 1, 1998, 103,815 individuals were enrolled in the MinnesotaCare program. Total payments for medical care services provided through MinnesotaCare are estimated to be $122.5 million in FY 1999 and $137.0 million in FY 2000.[9]

Funding for MinnesotaCare premium subsidies and for other health care access initiatives are provided by:

- A tax on the gross revenues of health care providers, hospitals, surgical centers, and wholesale drug distributors. The tax percentage is 1.5 percent of gross revenues for calendar years 1998 and 1999. The tax will remain at this rate for an additional two

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[8] The 1996 health and human services supplemental appropriations act requires the Commissioner of Human Services to seek a federal waiver to allow a fee-for-service plan option for MinnesotaCare enrollees (Laws 1996, ch. 451, art. 2, § 33). This request has been included in Phase 2 of the health care reform waiver.

[9] Enrollment figures are from the April 7, 1998, MinnesotaCare enrollment reference sheet prepared by the Department of Human Services. Estimates of medical payments and the estimates for MinnesotaCare tax revenue, enrollee premium payments, and federal financial participation, are from the April 14, 1998 tracking sheet prepared by House and Senate fiscal staff.

calendar years if the Commissioner of Finance projects a positive structural balance in the health care access fund for fiscal year 2001.

- A 1 percent premium tax on health maintenance organizations, nonprofit health service plan corporations, and community integrated service networks. For calendar years 1998 and 1999, Minnesota law exempts these entities from the premium tax if the rate of increase in their expenditures for health care services in the individual and small employer markets does not exceed the MinnesotaCare cost containment goals specified in section 62J.04. For calendar years after 1999, no premium tax will be imposed if the Commissioner of Finance determines there will be no structural deficit in the health care access fund for the next fiscal year. If a deficit is projected, the Commissioner of Finance is required to reinstate the tax, in increments of 0.25 percent, at the lowest level that is sufficient to eliminate the projected structural deficit.

Medicare, MA, GAMC, and MinnesotaCare 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.

The measures listed above will raise an estimated $125.1 million in FY 1999 and an estimated $144.9 million in FY 2000. In addition to these amounts, enrollee premium payments are expected to total $26.3 million in FY 1999 and $30.1 million in FY 2000, and federal financial participation received as a result of the health care reform waiver (see footnote 7) is expected to total $66.6 million in FY 1999 and $66.8 million in FY 2000.

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:

- Health care provider offices
- Local human services agencies
- School districts
- Some public and private elementary schools
- Community health offices
- Women, Infants, and Children (WIC) sites