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Information Brief

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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.

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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. County human services agencies are responsible for determining Medical Assistance (MA) eligibility for MinnesotaCare applicants who apply for MA. Since January 1, 2000, county human services agencies have had 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 12 months. Beginning October 1, 2004, eligibility will need to be renewed every six months.

Income Limits

Children¹ 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 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.

Definition of Income for the Farm Self-Employed

Effective July 1, 2002, the definition of income used to determine MinnesotaCare eligibility for the farm self-employed was changed to require only reported depreciation to be added back to adjusted gross income. Prior law required carryover loss and net operating loss also to be added back. (See Minn. Stat. § 256L.01, subd. 4, para. (b).)

¹A 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 after an 18-month notice period. Effective October 1, 2003, families are exempt² 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).³ This exemption does not apply to parents if annual gross household income exceeds \$50,000.

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 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 and relative caretakers	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.

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² Prior to October 1, 2003, this exemption also applied to single adults and households without children. Effective February 1, 2004, the exemption will be limited to children and the notice period will be reduced from 18 to 12 months. Effective on that date, enrollees who are not children will be disenrolled on the last day of the month following the month in which it is determined that the enrollee's income exceeds the program limits.

³ 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, 2003)

Household Size*	Lower Income Children 150% of 2003 FPG	Adults Without Children 175% of 2003 FPG	Families and Children 275% of 2003 FPG**
1	\$13,476	\$15,720	\$24,696
2	18,180	21,216	33,336
3	22,896	Not eligible	41,976
4	27,600	Not eligible	50,604
5	32,316	Not eligible	59,244
6	37,020	Not eligible	67,872
7	41,736	Not eligible	76,512
8	46,440	Not eligible	85,140
9	51,156	Not eligible	93,780
10	55,860	Not eligible	102,420
Each Additional Person	4,716		8,640

* 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 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, and
- 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),⁴ 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

⁴ Since January 1, 2000, GAMC adult applicants and recipients, with dependent children and gross family incomes not exceeding 275 percent of FPG, or those without children with gross incomes between 75 percent and 175 percent of FPG, have been referred to the MinnesotaCare program and terminated from GAMC upon enrollment in MinnesotaCare.

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 percent⁵ 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.

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

Effective October 1, 2003, 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 limit on outpatient services, and must pay copayments. These differences are summarized in Table 3 below and are described in more detail in the text.

⁵ The exemption from the four-month uninsured requirement is found only in rule. See Minnesota Rules, part 9506.0020, subpart 3, item A.

Table 3
Overview – MinnesotaCare Covered Services and Cost-Sharing

Eligibility Category	Covered Services ⁶	Benefit Limitations	Cost-Sharing
Pregnant women and children	MA benefit set	None	None
Parents ≤ 175% of FPG	Most MA services	-- Limits on dental services; \$500 cap -- Limits on outpatient mental health services	\$25 eyeglasses \$3 prescriptions 50% restorative dental
Parents > 175% and ≤ 275% of FPG	Most MA services	-- Limits on dental services; \$500 annual cap -- \$10,000 annual limit for inpatient hospital -- Limits on outpatient mental health services	\$25 eyeglasses \$3 prescriptions
Adults without children ≤ 75% of FPG	Most MA services	-- Limits on dental services; \$500 annual cap -- \$10,000 annual limit for inpatient hospital -- Limits on outpatient mental health services	\$25 eyeglasses \$3 prescriptions 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)

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.⁷ These individuals are exempt from MinnesotaCare benefit limitations and copayments,⁸ but still must pay MinnesotaCare premiums. Pregnant women and

⁶ See Table 4 for a list of covered services.

⁷ 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.

⁸ This change in MinnesotaCare was approved by the federal government in April 1995 as part of the state’s health care reform 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

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 limited to diagnostic and preventative services, basic restorative services, and emergency services, subject to a \$500 annual limit. 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, and prescription drugs, subject to an aggregate \$5,000 annual limit.⁹

FFP) for services provided to MinnesotaCare enrollees who are children, pregnant women, or parents and relative caretakers of children under age 21.

⁹ This cap has been 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, sec. 72 and art. 13C, sec. 1, subd. 1 – federal contingency appropriation rider.

Table 4
Covered Services Under MinnesotaCare

Service	Children; Pregnant Women	Parents; Adults without children $\leq 75\%$ of FPG*	Adults without children $>75\%$ and $\leq 175\%$ of FPG*
Alcohol/drug treatment	X	X	
Chiropractic	X	X	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	
Mental health	X	X	X
Outpatient surgical center	X	X	X
Physicians and clinics	X	X	X
Prescriptions	X	X	X
Physicals/preventive care	X	X	X
Rehabilitation/therapy	X	X	
Transportation: emergency	X	X	
Transportation: special	X		
Adult mental health rehab/crisis	X		
Child and teen checkup	X		
Case management	X		
Common carrier transportation	X		
Nursing home/ICF/MR	X		
School-based services	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
- 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 physician 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, 2003)

Gross Monthly Income	Household Size (assumes all household members enroll)				
	1	2*	3	4	5
\$250	\$4	\$8	\$12	\$12	\$12
\$500	9	8	12	12	12
\$1,000	31	23	18	18	18
\$1,500	89	57	47	35	35
\$2,000	176	118	76	62	62
\$2,500	N.E.	185	148	120	95
\$3,000	N.E.	N.E.	222	177	144
\$3,500	N.E.	N.E.	N.E.	259	207
\$4,000	N.E.	N.E.	N.E.	352	296

NOTE: N.E. means **not eligible** to enroll in MinnesotaCare at this income level.
* The maximum income limits for households without children are \$1,293 (household of one) and \$1,742 (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. Since January 1, 1997, all MinnesotaCare enrollees have received health care services through prepaid health plans and not through fee-for-service.

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,

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, sec. 84.)

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 \$435 million in fiscal year 2003. Fifty-eight percent of this amount was paid for through state payments from the health care access fund. Enrollee premiums and copayments and federal funding received under the health care reform waiver and a recently approved waiver for the State Children's Health Insurance Program (SCHIP)¹¹ pay for the remainder.

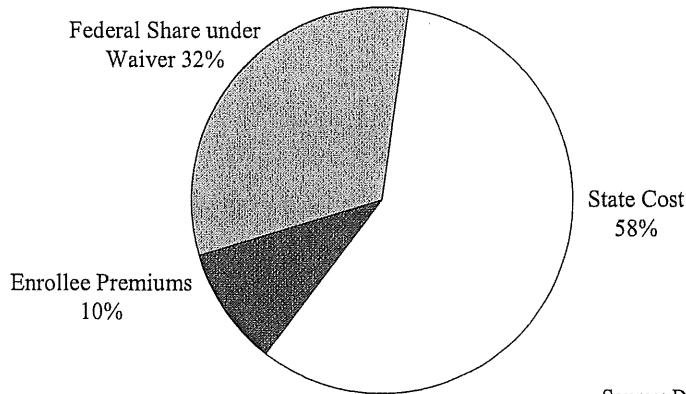
Funding for the state share of MinnesotaCare costs, and for other health care access initiatives, is provided by:

- A tax on the gross revenues of health care providers, hospitals, surgical centers, and wholesale drug distributors (sometimes referred to as the "provider tax"). The tax percentage is 1.5 percent of gross revenues for calendar years 1998 through 2003. The tax will revert back to 2 percent of gross revenues effective January 1, 2004.
- Effective January 1, 2004, a 1 percent premium tax on health maintenance organizations, nonprofit health service plan corporations, and community integrated service networks.

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.

¹¹ The health care reform waiver is described in footnote 8 on page 7. 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 66.5 percent for parents and relative caretakers on MinnesotaCare with incomes greater than 100 percent but not exceeding 200 percent of FPG.

MinnesotaCare Funding (FY 2003)

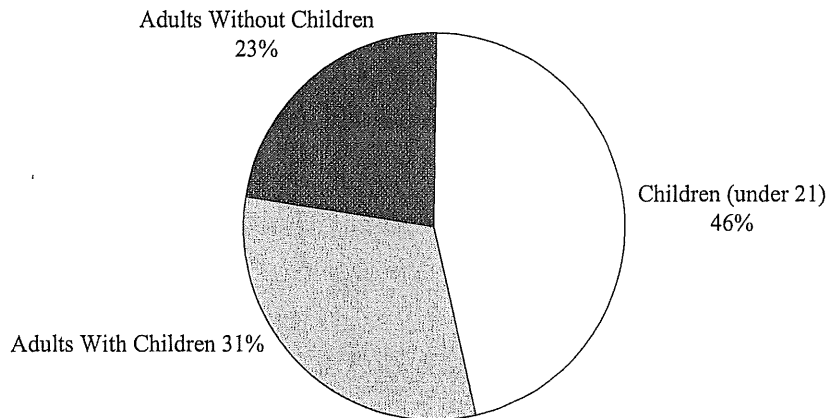


Source: DHS Reports and Forecasts Division

Recipient Profile

As of October 1, 2003, 154,790 individuals were enrolled in the MinnesotaCare program. As of September 2, 2003, just under one-half of MinnesotaCare enrollees were children.

MinnesotaCare Enrollment (September 2, 2003)



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.

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