INFORMATION BRIEF
Research Department
Minnesota House of Representatives
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MinnesotaCare

MinnesotaCare is administered by the Minnesota Department of Human Services under federal guidance as a Basic Health Program 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, or MNsure, the state's health insurance exchange, at 1-855-366-7873.

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Administration

MinnesotaCare is administered by the Minnesota Department of Human Services (DHS) as a Basic Health Program (BHP), a state coverage option authorized by the federal Affordable Care Act (ACA). DHS, in cooperation with MNsure, the state's health insurance exchange, is responsible for processing applications and determining eligibility for MinnesotaCare. DHS is also responsible for contracting with participating entities for the provision of MinnesotaCare services, complying with federal BHP requirements, and submitting an annual report to the federal government documenting compliance with these requirements.

The federal government is responsible for certifying state BHPs, ensuring state compliance with federal laws, regulations, and guidance related to the BHP, and reviewing state compliance at least annually.

Applicants can apply for MinnesotaCare coverage online through the Minnesota eligibility system, defined in Minnesota Statutes, section 62V.055, subdivision 1, and also referred to as the Minnesota Eligibility Technology System (METS).[1] Paper applications may also be submitted, and application assistance is available from county agencies, community organizations serving as navigators, and other entities.

MinnesotaCare as Basic Health Program

The ACA gives states the option of operating a BHP to provide health coverage to persons with incomes greater than 133 percent but not exceeding 200 percent of Federal Poverty Guidelines (FPG). States receive 95 percent of the amount the federal government would otherwise have spent on advanced premium tax credits and cost-sharing subsidies for these individuals had they received coverage through the state's insurance exchange. BHP coverage must include at least the essential health benefits included in qualified health plans that are offered through the state's insurance exchange. Premiums for a BHP enrollee must not exceed the amount the enrollee would otherwise pay for qualified health plan coverage through the exchange, after application of advanced premium tax credits.

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

DHS submitted its proposal to operate MinnesotaCare as a BHP to the federal government for approval in November 2014. This proposal, referred to in federal law as the BHP Blueprint, was approved December 15, 2014, and implementation began January 1, 2015.

[1] In addition to being used for MinnesotaCare eligibility determination, METS is used by county human service agencies and tribal governments to determine MA eligibility for families and children, pregnant women, and adults without children.

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 other health insurance. MinnesotaCare eligibility must be renewed every 12 months. Renewals of eligibility occur throughout the year, with the 12-month eligibility period beginning the month of application.

Most MinnesotaCare enrollees are 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, are now eligible for Medical Assistance (MA) and therefore, under the new MinnesotaCare eligibility rules, are not eligible for MinnesotaCare.

Income Limits

MinnesotaCare coverage is available to persons with incomes greater than 133 percent of FPG but not exceeding 200 percent of FPG,[2] 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 MA solely due to application of the household composition rule for MA.[3] In addition, lawfully present noncitizens ineligible for MA due to immigration status, with household incomes not exceeding 200 percent of FPG, are eligible for MinnesotaCare.[4]

Table 1 on the next page lists the minimum and maximum program income limits for different family sizes.

[2] Before January 1, 2014, parents and caretakers were eligible if their household income did not exceed 275 percent of FPG (subject to a maximum income of $57,500), and adults without children were eligible if their income did not exceed 250 percent of FPG. There was no upper income limit for children.

[3] The MA household composition rule counts the income of both unmarried parents who live together when determining eligibility for a minor child in the household. Since January 1, 2014, MinnesotaCare, as part of the switch to the modified adjusted gross income (MAGI) income methodology, has used the tax definition of household for people expecting to file taxes, 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 who live together) 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.

[4] These lawfully present noncitizens are generally nonpregnant adults falling under certain immigration classifications who have resided in the United States for less than five years.

Table 1
Annual Household Income Limits for MinnesotaCare
(Effective January 1, 2018)

Household Size	133% of FPG	200% of FPG
1	$16,039	$24,120
2	21,599	32,480
3	27,158	40,840
4	32,718	49,200
Each additional person add	5,559	8,360
Note: Income limits are adjusted annually to reflect changes in the Federal Poverty Guidelines.		

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Since January 1, 2014, modified adjusted gross income (MAGI)[5] has been the income methodology used to determine eligibility 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 was applied.

Asset Limits

There are no asset limits for MinnesotaCare enrollees.

Not Eligible for Medical Assistance (MA)

Persons who are eligible for MA are not eligible for MinnesotaCare.[6]

No Access to Subsidized Health Coverage

To be eligible for MinnesotaCare, a family or individual must not have access to employer-subsidized health coverage that is affordable and provides minimum value, as defined in federal regulations.[7] 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 9.56 percent of income for 2018.[8] Coverage provides "minimum value" if it

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

[6] Before January 1, 2014, persons eligible for both MA and MinnesotaCare could enroll in either program. This change had 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) is higher than the MinnesotaCare income limit (200 percent of FPG). 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.

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

[8] This percentage is indexed annually; the percentage for 2017 used by DHS is 9.69. This is the first time the percentage has been reduced.

pays for at least 60 percent of medical expenses on average. A family or individual is not eligible for MinnesotaCare if they are enrolled in employer-subsidized coverage, even if this coverage does not meet the affordability and minimum value standards.

No Other Health Coverage

To be eligible for MinnesotaCare, a family or individual must not have minimum essential health coverage, as defined in the Internal Revenue Code.[9] 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 veteran's health benefits), coverage under an employer-sponsored plan, individual market coverage, coverage under a grandfathered health plan,[10] and other coverage recognized by the federal government. A family or individual is not eligible for MinnesotaCare if they have access to certain types of minimum essential coverage, even if they are not enrolled.

Residency Requirement

MinnesotaCare enrollees must meet the residency requirements of the Medicaid program. The Medicaid program generally requires an individual to live in Minnesota and demonstrate intent to reside, or to have entered the state with a job commitment or to seek employment. The Medicaid program 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).

Benefits

Adults who are not pregnant are covered under MinnesotaCare for most, but not all, services covered under MA. Covered services are summarized in Table 2.

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 3), can access the full range of MA services without enrolling in MA, except that abortion services are covered as provided under the MinnesotaCare program.[11] These individuals are exempt from MinnesotaCare benefit limitations and cost-sharing.

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

[10] 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.

[11] 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)).

Table 2
Covered Services Under MinnesotaCare

Service	Children and pregnant women	Adults who are not pregnant[a]
Acupuncture	X	X
Adult mental health rehab/crisis	X	X
Alcohol/drug treatment	X	X
Child and teen checkups	X	—
Chiropractic	X	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
Hospice care	X	X
Hospital stay	X	X
Hospital care coordination	X	X
Immunizations	X	X
Intermediate care facility for persons with developmental disabilities	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	—
Outpatient surgical center	X	X
Personal care assistance (PCA)	X	—
Physicians and clinics	X	X
Physicals/preventive care	X	X
Prescriptions	X	X
Rehabilitative therapies	X	X
Transportation: emergency	X	X
Transportation: nonemergency	X	—

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

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

Cost-sharing for Adults

Adults who are not pregnant are subject to the following cost-sharing requirements. [12]

	Effective January 1, 2017
Inpatient hospital admission	$150
Outpatient hospital visit	$25
Ambulatory surgery (per surgery)	$50
Emergency room visit (that does not result in an admission)	$50
Nonpreventive office visit (does not apply to mental health services)	$15
Radiology	$25
Eyeglasses	$25
Prescription drugs (generic/brand name – does not apply to certain mental health drugs)	$6/$20
Prescription drug out-of-pocket monthly maximum	$60
Monthly family deductible	$3.10

Children under age 21 and American Indians are not subject to cost-sharing under MinnesotaCare. Enrollees served by managed care and county-based purchasing plans are not subject to the monthly family deductible.

Enrollee Premiums

Sliding Premium Scale

Since August 1, 2015, MinnesotaCare enrollees age 21 and older have paid monthly, per-person premiums based upon the following sliding scale.

[12] MinnesotaCare cost-sharing was increased effective January 1, 2016, to comply with the 2015 Legislature's requirement that MinnesotaCare cost-sharing be increased in a manner sufficient to reduce the actuarial value of the MinnesotaCare benefit to 94 percent. Actuarial value is an estimate of the percentage of medical expenses incurred by a typical enrollee that will on average be paid by the insurer. The actuarial value of MinnesotaCare prior to the January 1, 2016, increase in cost-sharing was estimated to be 98 percent.

Table 4
Sliding Premium Scale

Federal Poverty Guidelines	Individual Premium Amount
0 – 34%	0
35 – 54%	$4
55 – 79%	$6
80 – 89%	$8
90 – 99%	$10
100 –109%	$12
110 – 119%	$14
120 – 129%	$15
130 –139%	$16
140 –149%	$25
150 –159%	$37
160 – 169%	$44
170 – 179%	$52
180 – 189%	$61
190 – 199%	$71
200%	$80

See Minn. Stat. § 256L.15, subd. 2. House Research Department

This premium scale reflects a directive from the 2015 Legislature to increase premiums by an amount sufficient to increase the projected revenue in the Health Care Access Fund by at least $27.8 million for the biennium ending June 30, 2017. Prior to this increase, premiums for enrollees with incomes between 150 percent and 200 percent of FPG ranged from $29 to $50.

The premium scale also reflects premium reductions required by the 2015 Legislature to comply with federal BHP requirements that premiums not exceed what the individual would otherwise have paid for health coverage through the state's insurance exchange, after receipt of advance premium tax credits.

Premium Exemptions

Children under age 21 are exempt from MinnesotaCare premiums.

American Indians and Alaska Natives, and members of their households, are also exempt from premiums.

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 following the month for which the premium was due. Persons who end their MinnesotaCare coverage therefore receive a "grace" month. Persons who decide to re-enroll in MinnesotaCare following disenrollment generally must pay premiums to cover this grace month, except that no premium for the grace month is required for persons re-enrolling in coverage that begins in the fourth month following disenrollment.

Prepaid MinnesotaCare

The Commissioner of Human Services contracts on a prepaid basis with participating entities to deliver health care services to MinnesotaCare enrollees. Participating entities include health maintenance organizations and other health carriers, county-based purchasing plans, certain accountable care organizations and county integrated health care delivery networks, and networks of health care providers (see definition in Minn. Stat. § 256L.01, subd. 7).

MinnesotaCare enrollees receive health care services from these participating entities, rather than through a fee-for-service system. Participating entities 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.

The 2014 Legislature required DHS to enter into contracts, as part of a statewide procurement, with participating entities to serve MinnesotaCare enrollees, beginning January 1, 2016. The ACA requires MinnesotaCare, as a BHP, to offer enrollees a choice of at least two participating entities in each county.

Funding and Expenditures

Since January 1, 2015, the state has received, for each MinnesotaCare enrollee, a federal BHP payment equal to 95 percent of the subsidy the person would have received through MNsure, the state's health insurance exchange, had the state not operated MinnesotaCare as a BHP. This BHP payment has replaced the federal match that had been received through December 31, 2014, for MinnesotaCare enrollees under the Prepaid Medical Assistance Project Plus (PMAP+)

waiver.[13] Federal BHP funding was $334.0 million for fiscal year 2016 and is projected to be $425.2 million for fiscal year 2017.[14]

Total payments for health care services provided through MinnesotaCare were $479.9 million in fiscal year 2016. Fifty-four percent of this amount was paid for through state payments from the health care access fund. The remainder was paid from enrollee premiums (this category also includes enrollee cost-sharing), federal funding received under the PMAP+ waiver, and federal BHP funding.

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

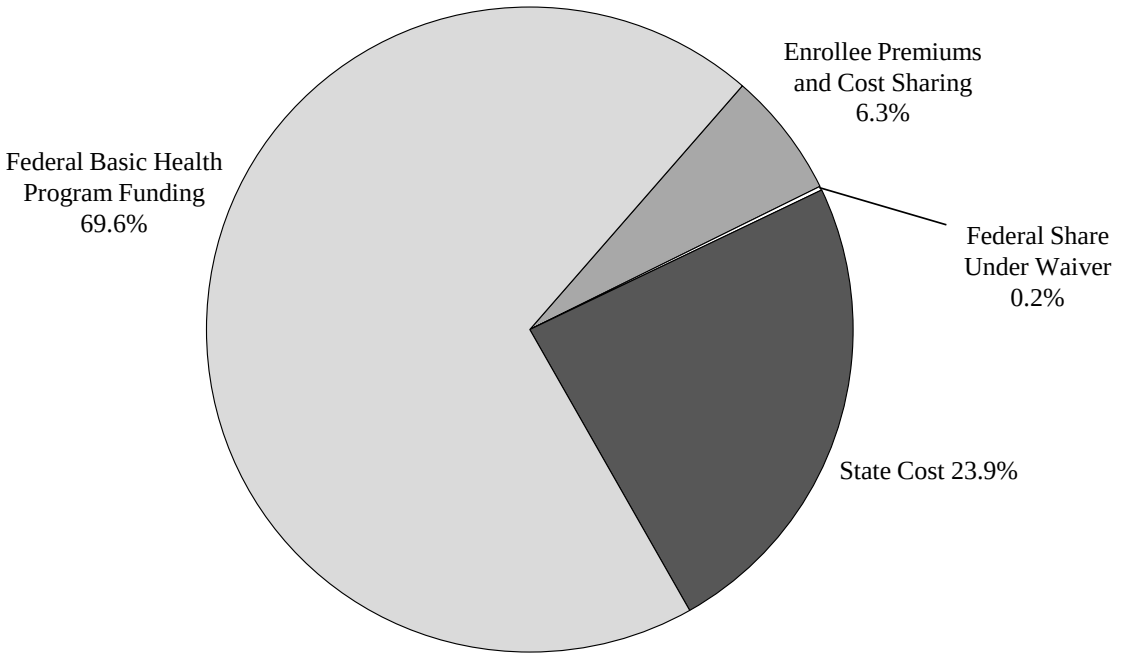
- A 2 percent tax on the gross revenues of health care providers, hospitals, surgical centers, and wholesale drug distributors (sometimes referred to as the "provider tax"); and
- A 1 percent premium tax on health maintenance organizations and nonprofit health service plan corporations.

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.

[13] The Prepaid Medical Assistance Project Plus or PMAP+ waiver was initially approved by the federal government in April 1995. The waiver exempts Minnesota from various federal requirements and gives the state greater flexibility to expand access to health care through the MA program. Earlier versions of the waiver allowed the state to receive a federal match for the cost of services provided to MinnesotaCare enrollees. The PMAP+ waiver was most recently reauthorized by the federal Centers for Medicare and Medicaid Services through December 31, 2020.

[14] DHS November 2016 Forecast, Background Tables. The federal Centers for Medicare and Medicaid Services (CMS) approved, on September 22, 2017, the state's request for section 1332 waiver to operate a reinsurance program in the individual market. CMS did not, however, approve the state's waiver request to receive as a pass-through those savings that would accrue to the federal government under the Basic Health Program funding formula because the reinsurance program would reduce federal subsidy costs. The Department of Commerce estimates that the pass-through savings would have totaled $177.6 million in 2018 and $191.2 million in 2019. Minnesota Department of Commerce, Division of Insurance, "Actuarial Analysis and Certification for the Minnesota Section 1332 Waiver Application" May 30, 2017.

MinnesotaCare Funding
(FY 2016)



Source: DHS Reports and Forecasts Division

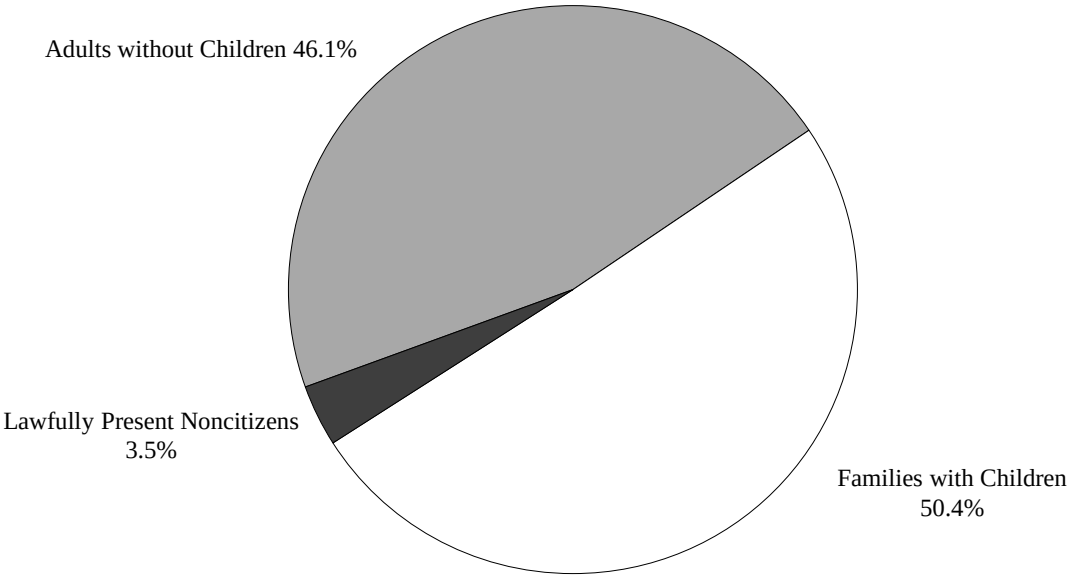
The tax rate on health care providers can be reduced, if the Commissioner of Management and Budget determines by December 1 of each year that the ratio of revenues to expenditures and transfers for the health care access fund for the biennium will exceed 125 percent. If this determination is made, the commissioner must 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 MinnesotaCare tax on the gross revenues of health care providers is scheduled to be repealed, effective for gross revenues received after December 31, 2019.

Recipient Profile

As of August 2017, 92,421 individuals were enrolled in the MinnesotaCare program. Just under one-half of enrollees were adults without children and one-half of enrollees were mainly parents and children ages 19 and 20 (most children 18 and under are eligible for MA). The remaining enrollees were lawfully present noncitizens who were not eligible for MA due to immigration status (see footnote 4).

MinnesotaCare Enrollment
(August 2017)



Source: DHS Reports and Forecasts Division

Application Procedure

There are several ways to obtain MinnesotaCare application forms and to apply for MinnesotaCare coverage. These include the following:

- Applying for MinnesotaCare through MNsure, the state's health insurance exchange (1-855-366-7873 or online at www.mnsure.org)
- Calling DHS directly at 1-800-657-3672 or 651-297-3862 (in the metro area)
- Obtaining application forms through county social service agencies, health care provider offices, and other sites in the community, or from the DHS website

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