

MinnesotaCare

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

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

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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) and General Assistance Medical Care (GAMC) eligibility for applicants for those programs. County human services agencies are also responsible for determining MinnesotaCare eligibility and managing MinnesotaCare cases for GAMC enrollees who transition to MinnesotaCare (see [page 7](#)). Some county human services agencies have elected to process additional MinnesotaCare applications and manage additional MinnesotaCare cases.

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.¹

Income Limits

Children² and parents, legal guardians, foster parents, or relative caretakers residing in the same household are eligible for MinnesotaCare, if their gross household income does not exceed 275 percent of the federal poverty guidelines (FPG) and if other eligibility requirements are met. The 2009 Legislature allowed children with incomes greater than 275 percent of the FPG to be eligible for MinnesotaCare if they meet all other eligibility requirements. This elimination of the income limit for children is effective upon federal approval, which has not yet been received. 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. This annual income cap will increase to \$57,500, effective July 1, 2010, or upon federal approval, whichever is later. 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 250 percent of FPG³ and they meet other eligibility requirements.

¹ The statutory change increasing the renewal period from six to 12 months was effective July 1, 2007; the change codified existing practice. Effective upon federal approval, which has not yet been received, children with family incomes that do not exceed 275 percent of FPG who fail to submit renewal forms and related documentation in a timely manner shall remain eligible. The commissioner is still required to verify income and determine premiums based on income, and to disenroll children for nonpayment of premiums.

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.

³ The income limit for adults and households without children was increased from 200 percent to 250 percent of FPG on July 1, 2009.

Extended Coverage for Children

On October 31, 2008, the federal Centers for Medicare and Medicaid Services (CMS) denied a request by the state to allow children age one through 18 who become ineligible for Medical Assistance (MA) due to excess income to be eligible for two additional months of MA⁴ and be automatically eligible for MinnesotaCare until the next MinnesotaCare renewal. These children would have been exempt until renewal from the MinnesotaCare income limit and from the requirement that MinnesotaCare enrollees have no current access to employer-subsidized coverage, no access to employer-subsidized coverage through the current employer for 18 months prior to application or reapplication, and no other health coverage while enrolled or for at least four months prior to application or renewal. These children would have been required to pay the standard MinnesotaCare sliding scale premiums to enroll and remain enrolled.

The coverage extension was authorized by the 2007 Legislature in [Laws 2007, chapter 147](#), article 13, and was to have been effective October 1, 2008, or upon federal approval, whichever was later. The Minnesota Department of Human Services resubmitted the request on September 30, 2009.

Enrollees whose incomes rise above program income limits after initial enrollment are disenrolled from the program. Children are exempt from this requirement and can remain enrolled in MinnesotaCare if 10 percent of their gross annual household income is less than the annual premium of the \$500-deductible policy offered by the Minnesota Comprehensive Health Association (MCHA).⁵

Table 1 lists categories of persons eligible for MinnesotaCare, eligibility criteria, and enrollee cost (see table on page 4 for sample sliding scale premiums). Table 2 lists program income limits for different family sizes.

⁴ These two additional months would have been in addition to the transitional MA coverage that is available to persons who lose MA eligibility due to increased earned or unearned income.

⁵ The MCHA offers health insurance to Minnesota residents who have been denied private market coverage due to pre-existing health conditions.

Table 1
Eligibility for MinnesotaCare^a

| Eligible Categories | Household Income Limit | Other Eligibility Criteria | Cost to Enrollee |
|--|---|---|--------------------------------|
| Lower income children | 150% of FPG | Not otherwise insured or insurance is considered underinsured; residency requirement | \$4 per child per month |
| Other children | 151% - 275% of FPG ^b | No access to employer-subsidized coverage; no other health coverage; residency requirement | Premium based on sliding scale |
| Pregnant women | 275% of FPG | No access to employer-subsidized coverage; no other health coverage; residency requirement | Premium based on sliding scale |
| Parents and relative caretakers | 275% of FPG or \$50,000, ^c whichever is less | No access to employer-subsidized coverage; no other health coverage; residency requirement; asset limit | Premium based on sliding scale |
| Single adults, households without children | 250% of FPG | No access to employer-subsidized coverage; no other health coverage; residency requirement; asset limit | Premium based on sliding scale |

^a Exceptions to these requirements are noted in the text.

^b The 2009 Legislature allowed children with household incomes greater than 275 percent of FPG to be eligible, effective upon federal approval, which has not yet been received. These children must pay the maximum premium.

^c The 2008 Legislature increased the income limit for parents and relative caretakers to \$57,500, effective upon federal approval, which has not yet been received.

Table 2
**Annual Household Income Limits for MinnesotaCare
(Effective July 1, 2009)**

| Household Size^a | Lower Income Children 150% of 2009 FPG | Adults Without Children 250% of 2009 FPG | Families and Children 275% of 2009 FPG^b |
|-----------------------------------|---|---|---|
| 1 | \$16,248 | \$27,084 | \$29,784 |
| 2 | 21,864 | 36,444 | 40,080 |
| 3 | 27,480 | Not eligible | 50,376 |
| 4 | 33,096 | Not eligible | 60,672 |
| Each Additional Person | Add \$5,616 | Not applicable | Add \$10,296 |

^a Pregnant women are households of two.

^b 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 following:

- the homestead
- household goods and personal effects
- a burial plot for each member of the household
- life insurance policies and assets for burial expenses, up to the limits established for the Supplemental Security Income (SSI) program
- capital and operating assets of a business up to \$200,000
- insurance settlements for damaged, destroyed, or stolen property are excluded for three months if held in escrow
- a motor vehicle for each person who is employed or seeking employment
- court-ordered settlements of up to \$10,000
- individual retirement accounts and funds
- assets owned by children
- workers' compensation settlements received due to a work-related injury⁶

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

No Access to Employer-Subsidized Coverage

A family or individual must not have access to employer-subsidized health care coverage. A family or individual must also not have had access to employer-subsidized health care coverage through a current employer for 18 months prior to application or 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 contributes 50 percent or more towards the cost of coverage for an employee but does not contribute 50 percent or more towards the cost of covering that employee's dependents, the employee is not eligible for MinnesotaCare but the employee's dependents are eligible.

The requirement of no current access to employer-subsidized coverage does not apply to the following:

1. Children from households with incomes that do not exceed 150 percent⁷ of FPG
2. Children enrolled in the Children's Health Plan as of September 30, 1992 (the precursor program to MinnesotaCare) who have maintained continuous coverage

⁶ This asset exclusion was approved by the federal government on October 31, 2008, and became effective January 1, 2009.

⁷ The 2009 Legislature increased this income limit to 200 percent of FPG, effective upon federal approval, which has not yet been received.

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, GAMC, and CHAMPUS (Civilian Health and Medical Program of the Uniformed Service, also called TRICARE) are not considered health coverage for purposes of the four-month requirement; and
2. Medicare coverage is considered health coverage, and an applicant or enrollee cannot refuse Medicare coverage to qualify for MinnesotaCare.

Children from households with incomes that do not exceed 150 percent⁸ 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 the children are considered "underinsured." A child is underinsured if:

1. The coverage lacks two or more of the following:
 - basic hospital insurance
 - medical-surgical insurance
 - major medical coverage
 - prescription drug coverage
 - preventive and comprehensive dental coverage
 - preventive and comprehensive vision coverage

⁸ The exemption from the four-month uninsured requirement is found only in rule. See [Minnesota Rules, part 9506.0020](#), subpart 3, item A. The 2009 Legislature expanded the exemption from the four-month uninsured requirement to include children from families with incomes less than 200 percent of FPG, and also increased to this level the income limit below which children can have other health coverage if they are uninsured. These changes are effective upon federal approval, which has not yet been received.

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.

Individuals who are receiving a state premium subsidy for COBRA continuation coverage for unemployed individuals, and their qualified beneficiaries, are exempt from the four-month uninsured requirement, if the individual or qualified beneficiaries apply for MinnesotaCare coverage after COBRA continuation coverage ends (see [Laws 2009, chapter 79](#), article 5, section 78).

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.

Enrollment of Certain GAMC Applicants and Recipients

Since September 1, 2006, certain GAMC applicants and recipients have been enrolled in the MinnesotaCare program as adults without children, immediately following approval of GAMC coverage. These individuals are exempt from MinnesotaCare premiums, income and asset limits, and eligibility requirements related to not having other health coverage and not having access to employer-subsidized health insurance for up to six months until their next six-month renewal. County agencies are required to pay the enrollee share of MinnesotaCare premiums for these individuals up to the six-month renewal and have the option of continuing to pay for these premiums beyond this period. At the six-month renewal, all MinnesotaCare eligibility criteria apply.

GAMC applicants and recipients are exempt from the MinnesotaCare enrollment requirement if they are any of the following:

- eligible for GAMC as General Assistance or Group Residential Housing recipients
- awaiting a determination of blindness or disability
- unable to meet the MinnesotaCare residency requirement
- homeless
- end-stage renal disease beneficiaries in the Medicare program
- persons enrolled in private health coverage
- certain persons detained by law for less than one year in a county correctional or detention facility or admitted to a hospital on a criminal hold order
- persons who receive treatment funded through the Consolidated Chemical Dependency Treatment Fund

- persons residing in the Minnesota sex offender program

Elimination of GAMC Funding

On May 14, 2009, the governor line-item vetoed the \$378,000,000 fiscal year 2011 general fund appropriation for the GAMC program in the health and human services finance bill ([Laws 2009, ch. 79/H.F. 1362](#)). The fiscal note⁹ for the line-item veto assumes that coverage for GAMC services will need to be terminated April 1, 2010, due to the lag in provider billing for services and the need to pay program expenditures out of the fiscal year 2010 appropriation. Coverage would be eliminated for the regular GAMC program; DHS is currently determining whether coverage would need to be eliminated for GAMC enrollees required to transition to the MinnesotaCare program.

In June 2009, the governor announced that he would reduce the fiscal year 2010 general fund appropriation for GAMC by \$15,000,000 through unallotment. DHS projects that the GAMC program, given this action, will have sufficient funding available to pay for coverage up to March 1, 2010, and is examining whether the GAMC appropriation, after unallotment, will be sufficient to continue the program until April 1, 2010.

DHS is assessing and analyzing options under current law (subject to any action by the legislature) to provide health care services to current GAMC enrollees and individuals who otherwise would have been eligible for the program. Final decisions on a number of issues have not been made at the time of writing.

MinnesotaCare for Persons Otherwise Eligible for GAMC

The MinnesotaCare program is a potential coverage option for individuals who would otherwise be covered under GAMC. One reason is that the MinnesotaCare income and asset limits are higher than the respective limits for GAMC. However, some MinnesotaCare program features may make that program less than an ideal fit for the former GAMC population, in part because MinnesotaCare: (1) requires enrollees to pay premiums; (2) does not allow coverage from the date of application as does GAMC; and (3) applies a \$10,000 annual limit on inpatient hospital services provided to adults without children.

The fiscal note for the line-item veto of GAMC funding states that more than 90 percent of GAMC enrollees will be eligible for MinnesotaCare. The fiscal note projects that about 75 percent of GAMC managed care capitation payments will shift to MinnesotaCare. The fiscal note assumes that most of the 25-percent reduction in capitation payment is due to former GAMC enrollees failing to pay MinnesotaCare premiums (mainly because they are unable to afford the premiums or unable to complete the MinnesotaCare application process). The estimate of a 25-percent reduction assumes that counties and other entities will assist individuals who would otherwise have been eligible for GAMC in paying MinnesotaCare premiums. To the extent that this does not occur, the percentage of individuals in this group who do not switch to MinnesotaCare will probably increase. Also, about 2 percent of former enrollees are projected as

⁹ Consolidated Fiscal Note – 2009-10 session, H.F. 1362-4E, May 15, 2009, Omnibus HHS line-item veto provision.

being unable to meet the MinnesotaCare 180-day residency requirement and a small number of additional individuals will not enroll in MinnesotaCare because they are eligible for Medicare, have other health coverage, or are ineligible for the program due to incarceration.¹⁰

The table below summarizes some of the differences between the GAMC and MinnesotaCare programs.

Table 3
Comparison of the GAMC and MinnesotaCare Programs

| | GAMC (full coverage) | MinnesotaCare (adults without children) |
|----------------------------------|---|---|
| Income limit | 75% FPG | 250% FPG |
| Asset limit, after exclusions | \$1,000 (\$2,000 for Group Residential Housing recipients) | \$10,000 household of 1/\$20,000 household of 2 or more |
| Durational residency requirement | 30 days | 180 days |
| Premiums | None | Sliding scale ^a |
| Effective date of coverage | Date of application (allows limited retroactive coverage, e.g., if individuals apply as part of an inpatient stay) | First day of month following month in which premium payment received; limited retroactive coverage ^b for persons terminated from GAMC |
| Other health coverage | May have other health coverage; program pays enrollee premiums, deductibles, and cost-sharing for cost-effective coverage | May not have other health coverage; four-month uninsured requirement; no current access to employer-subsidized insurance and no access through current employer in past 18 months |
| Covered services | No inpatient hospital annual limit Covered by GAMC but not MinnesotaCare: <ul style="list-style-type: none"> • Common carrier transportation/mileage reimbursement • Limited orthodontia | \$10,000 inpatient hospital annual limit Covered by MinnesotaCare but not GAMC: <ul style="list-style-type: none"> • Certain home care services • Hospice care |

¹⁰ Individuals who apply for GAMC or MinnesotaCare while residing in a correctional facility are not eligible for those programs. GAMC enrollees who are incarcerated after GAMC enrollment can remain on that program if they are expected to be detained for less than one year and continue to meet program requirements, but would not be eligible for MinnesotaCare if they apply for that program (due to GAMC termination) while residing in a correctional facility.

| | GAMC (full coverage) | MinnesotaCare (adults without children) |
|--------------|--|---|
| Cost-sharing | <ul style="list-style-type: none"> • \$25 nonemergency visit to ER • \$3 brand-name, \$1 generic prescriptions/\$7 monthly limit | <ul style="list-style-type: none"> • \$6 nonemergency visit to ER • \$3 all prescriptions, no monthly limit • \$25 eyeglasses • \$3 nonpreventive visits • 10% coinsurance for inpatient hospital charges, up to \$1,000 per adult |

^a At 75 percent of FPG (the GAMC income limit for full benefits), the MinnesotaCare premium for one individual is \$11 per month. At 25 percent of FPG, the MinnesotaCare premium for one individual is \$4 per month (92 percent of GAMC enrollees have incomes under 25 percent of FPG, according to a DHS analysis of individuals enrolled in GAMC for at least one month in fiscal year 2008). County agencies and other entities have the option of paying the MinnesotaCare sliding scale premiums for MinnesotaCare enrollees.

^b MinnesotaCare provides limited retroactive coverage for individuals who are terminated from GAMC or MA. For these individuals, coverage is effective the first day of the month following termination, if the individual submits a written request for retroactive MinnesotaCare coverage and a completed application, within 30 days of the mailing of the termination notice. The applicant must provide all required verifications within 30 days of submitting the written request for retroactive coverage and must pay premiums for the retroactive month, current month, and next month within 30 days of the premium billing.

Automatic Eligibility for Certain Children

Effective upon federal approval, which has not yet been received, children who resided in a foster care or juvenile residential correctional facility at the time of their 18th birthday are automatically eligible for MinnesotaCare upon termination or release until the age of 21. These children are exempt from the MinnesotaCare income limit, insurance barriers, and premiums.

Benefits

MinnesotaCare enrollees are covered by several different benefit sets. Pregnant women and children have access to the broadest range of services and are not required to pay copayments. Parents and adults without children are covered for most services, but are subject to benefit limitations and copayments. These differences are summarized in Table 4 below and are described in more detail in the text.

Table 4
Overview – MinnesotaCare Covered Services and Cost-Sharing

| Eligibility Category | Covered Services ^a | Inpatient Hospital Limit | Cost-Sharing |
|----------------------------------|-------------------------------|--|---|
| Pregnant women and children | MA benefit set | None | None |
| Parents ≤ 215% of FPG | Most MA services | None | <ul style="list-style-type: none"> • \$25 eyeglasses • \$3 prescriptions • \$3 nonpreventive visit • \$6 nonemergency visit to hospital ER |
| Parents > 215% and < 275% of FPG | Most MA services | \$10,000 annual limit for inpatient hospital services ^b | <ul style="list-style-type: none"> • \$25 eyeglasses • \$3 prescriptions • \$3 nonpreventive visit • \$6 nonemergency visit to hospital ER |
| Adults without children | Most MA services | \$10,000 annual limit for inpatient hospital services | <ul style="list-style-type: none"> • \$25 eyeglasses • \$3 prescriptions • \$3 nonpreventive visit • \$6 nonemergency visit to hospital ER • 10% inpatient hospital, up to \$1,000 |

^a See Table 5 for a list of covered services.

^b The state recently received federal approval to raise the income limit above which patients are subject to this annual limit (see [footnote 14](#)).

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.¹¹ These individuals are exempt from MinnesotaCare benefit limitations and copayments,¹² but still must pay MinnesotaCare premiums. Pregnant women and

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)). 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.

¹² This change in MinnesotaCare was approved by the federal government in April 1995 as part of the state’s health care reform waiver (now referred to as the Prepaid Medical Assistance Project Plus or PMAP+ waiver). The waiver, and subsequent waiver amendments, exempt Minnesota from various federal requirements, give the state greater flexibility to expand access to health care through the MinnesotaCare and MA programs, and allow the state to receive federal contributions (referred to as “federal financial participation” or FFP) for services provided to MinnesotaCare enrollees who are children, pregnant women, or parents and relative caretakers of children under age 21. After protracted negotiations, the PMAP+ waiver was reauthorized by the federal Centers for Medicare and Medicaid Services for the period October 31, 2008, through June 30, 2011.

children up to age two are not disenrolled for failure to pay MinnesotaCare premiums and can avoid MinnesotaCare premium charges altogether by enrolling in MA.

Parents and adults without children, who are not pregnant, are covered under MinnesotaCare for most, but not all, services covered under MA.¹³ Parents with household incomes greater than 215 percent of FPG, and all adults without children, are subject to an annual benefit limit for inpatient hospital services of \$10,000.¹⁴

Table 5
Covered Services Under MinnesotaCare

| Service | Children; Pregnant Women | Parents; Adults without children^a |
|----------------------------------|---------------------------------|---|
| 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 |
| Immunizations | x | x |
| Interpreters (hearing, language) | x | x |
| Lab, x-ray, diagnostic | x | x |
| Medical equipment and supplies | x | x |
| Mental health | x | x |

¹³ Effective October 1, 2003, through December 31, 2007, adults without children with incomes greater than 75 percent but not exceeding 175 percent of FPG received coverage under MinnesotaCare for a limited benefit set. The limited benefit set covered inpatient hospital services (subject to a \$10,000 annual limit), physician services, outpatient hospital and ambulatory surgical center services, chiropractic services, lab and diagnostic services, diabetic supplies and equipment (added January 1, 2006), and prescription drugs. This coverage was subject to a \$5,000 annual limit on outpatient services, which was eliminated January 1, 2006. The limited benefit set was eliminated by the 2007 Legislature, effective January 1, 2008. Prior to January 1, 2008, outpatient mental health coverage for parents and adults without children was limited to diagnostic assessments, psychological testing, explanation of findings, day treatment, partial hospitalization, psychotherapy, and medication management. This restriction was eliminated January 1, 2008, except that coverage for mental health case management did not take effect until January 1, 2009.

¹⁴ The increase in the income limit at or above which the annual inpatient hospital benefit limit applies (from 200 percent to 215 percent of FPG) took effect July 1, 2009.

| Service | Children; Pregnant Women | Parents; Adults without children^a |
|-------------------------------|---------------------------------|---|
| Mental health case management | x | x |
| Nursing home/ICF/MR | x | |
| Outpatient surgical center | x | x |
| Physicians and clinics | x | x |
| Physicals/preventive care | x | x |
| Prescriptions | x | x |
| Rehabilitative therapies | x | x |
| School-based services | x | |
| Transportation: emergency | x | x |
| Transportation: special | x | |

^a Benefit limitations and cost-sharing requirements apply.

^b MinnesotaCare covers the dental services covered under Medical Assistance (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) will be limited to specified services (see [Minn. Stat. § 256B.0625](#), subd. 9 (Supp. 2009)).

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

Copayments for Adults

Parents and adults without children, who are not pregnant, are subject to the following copayments:

- Copayment of 10 percent of paid charges for inpatient hospital services, up to an annual maximum of \$1,000 per adult. (This copayment does not apply to parents and relative caretakers of children under age 21.)
- \$3 copayment per prescription
- \$25 copayment per pair of eyeglasses
- \$3 per nonpreventive visit (does not apply to mental health services)
- \$6 for nonemergency visits to a hospital emergency room

Enrollee Premiums

Minimum Premium

Children enrolling in MinnesotaCare are charged a minimum monthly premium of \$4 per child, if they are from households with incomes that do not exceed 150 percent of FPG.

Effective upon federal approval, which has not yet been received, children with family incomes at or below 200 percent of FPG will not be charged premiums.

Sliding Premium Scale

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

Table 7
Sliding Premium Scale

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

Premium Exemption

Members of the military and their families who are determined eligible for MinnesotaCare within 24 months of the end of the member's tour of active duty are exempt from premiums for 12 months.¹⁵

¹⁵ Federal approval for this provision was obtained on October 31, 2008. The provision took effect February 1, 2009, and will expire June 30, 2010.

Nonpayment of Premiums

Unless an exemption applies, nonpayment of premiums results in disenrollment from MinnesotaCare effective the calendar month for which the premium was due.¹⁶ If an enrollee who is pregnant fails to pay the premium, MinnesotaCare coverage continues until the last day of the month in which 60 days postpartum occurs. If the premium is not paid for an enrollee who is a child under age 2, MinnesotaCare coverage continues to the last day of the month following the month in which the child turns 2 years of age.

Prepaid MinnesotaCare

The legislature has authorized the Commissioner of Human Services to contract with health maintenance organizations and other prepaid health plans to deliver health care services to MinnesotaCare enrollees. All MinnesotaCare enrollees receive health care services through prepaid health plans and not through fee-for-service.

Prepaid health plans (sometimes referred to as managed care 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.

¹⁶ The 2008 Legislature provided a grace month extending the enrollment of a person who fails to pay the premium to the first day of the calendar month following the calendar month for which the premium was due. This provision is effective upon federal approval, which has not yet been received.

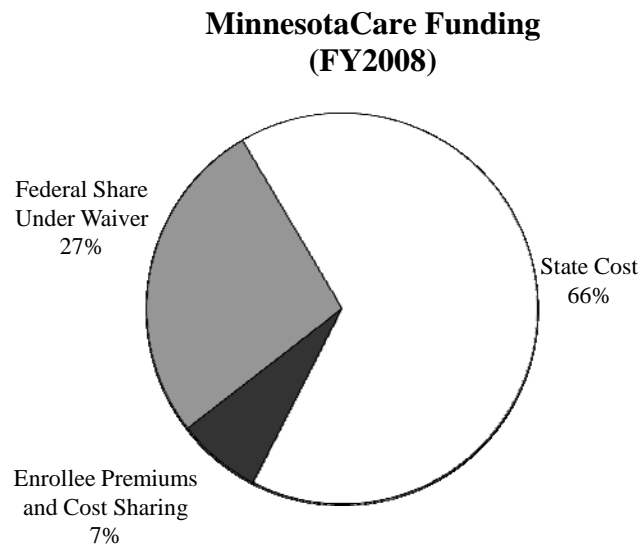
Funding and Expenditures

Total payments for health care services provided through MinnesotaCare were \$463 million in fiscal year 2008. Sixty-six percent of this amount was paid for through state payments from the health care access fund. Enrollee premiums (this category also includes enrollee cost-sharing) and federal funding received under the Prepaid Medical Assistance Project Plus (PMAP+) waiver and Minnesota's Children's Health Insurance Program (CHIP)¹⁷ allotment pay for the remainder.

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, nonprofit health service plan corporations, and community integrated service networks.

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.

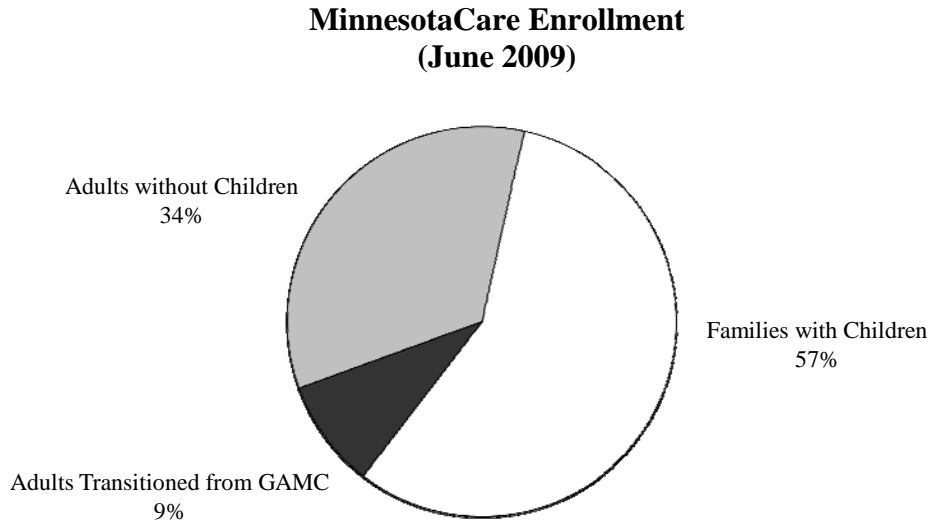


Source: DHS Reports and Forecasts Division

¹⁷ The PMAP+ waiver is described in [footnote 12](#) on page 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 equals or exceeds 133 percent of FPG but does not exceed 275 percent of FPG. Minnesota had a CHIP waiver until January 31, 2009, that provided an enhanced federal match of 65 percent for parent and relative caretakers enrolled in MinnesotaCare with family incomes greater than 100 percent but not exceeding 200 percent of FPG. Parents and relative caretakers now receive the regular MA federal match of 50 percent. There is no federal match for adults without children.

Recipient Profile

As of June 2009, 121,722 individuals were enrolled in the MinnesotaCare program. Just over three out of five MinnesotaCare enrollees are children, parents and caretakers, or pregnant women.



Source: DHS Reports and Forecasts Division

Application Procedure

Application forms for MinnesotaCare, and additional information on the program, can be obtained from DHS by calling:

**1-800-657-3672 or
651-297-3862 (in the metro area)**

Application forms are also available through county social service agencies, health care provider offices, and other sites in the community. Applications are also available on the Internet at www.dhs.state.mn.us/HealthCare.

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