

# The Insurance Safety Net

## Minnesota's Public and Private Programs

By Janet Silversmith

### ABSTRACT

More than 725,000 people in Minnesota get their health insurance coverage through safety-net programs. This article describes the four safety-net insurance programs operating in Minnesota—Medical Assistance, MinnesotaCare, General Assistance Medical Care, and the Minnesota Comprehensive Health Association—their eligibility guidelines, coverage limitations, and financing mechanisms.

Approximately 11% of Minnesotans received their health care coverage in 2007 through one of Minnesota's three publicly funded health insurance programs—Medical Assistance, General Assistance Medical Care (GAMC), and MinnesotaCare. That was up from about 9% in 1998.<sup>1</sup> Another 30,000 Minnesotans (0.5%) were covered by the Minnesota Comprehensive Health Association (MCHA) plan, a private option for people who are unable to get coverage in the individual market because of pre-existing conditions. Together, these programs make up Minnesota's health insurance safety net. Unlike the strong safety net in a circus ring that is always there to catch the trapeze artist who loses her grip, Minnesota's health insurance safety net is somewhat less reliable. It is made up of a series of patches and thus has gaps, the ropes and support beams are showing signs of wear and stress, and the netting itself is tattered. This article provides a brief overview of Minnesota's safety-net insurance programs, outlining both their benefits and their limitations.

### Medical Assistance

Medical Assistance is Minnesota's version of the federal Medicaid program and is Minnesota's largest and most expensive

public health insurance program. With nearly 560,000 enrollees, expenditures were \$6.8 billion, or approximately 24% of total state spending in fiscal year 2009.<sup>2</sup> Medicaid was created by Congress in 1965 as Title XIX of the Social Security Act. It is a means-tested, individual entitlement program. Although state participation is voluntary, Medicaid is offered in all 50 states. As originally conceived, the program had three distinct features: 1) joint federal-state financing; 2) state administration in accordance with broad federal standards; and 3) linkage of eligibility to state standards for cash welfare benefits.<sup>3</sup> (Medicaid and family cash assistance were decoupled in 1996 after passage of the Personal Responsibility and Work Opportunity Reconciliation Act.)

The program is financed jointly by the federal and state governments, with each state receiving federal funding based on a formula reflecting its per capita income relative to U.S. per capita income.<sup>4</sup> The formula is designed so states with a lower per capita income relative to the national average receive a higher Federal Medical Assistance Percentage (FMAP) and those with a higher per capita income relative to the national average receive a lower FMAP. The federal contribution can be no less than 50% and no greater than 83%. In fiscal year 2010, the FMAP rates range from 50% in Minnesota and 10 other states to 75.67% in Mississippi.<sup>5</sup> An important consideration with respect to Medicaid financing is that, as an entitlement program, there is no cap on federal spending. The more a state spends, the more it receives from the federal government. This provides an incentive for states to maximize health care spending through their Medicaid programs.

One of the ways that Minnesota has sought to maximize the federal dollars it

receives is through the use of the Medical Assistance surcharge. In 1991, in response to a state budget deficit and proposed cuts to state public programs, the Legislature adopted a 10% surcharge on hospitals' total Medicaid inpatient revenue and a 5% surcharge on their Medicaid outpatient revenue. The surcharge, when matched with federal dollars, provided enough funds to offset the proposed cuts and increased hospital Medicaid rates. Recognizing the potential drain of such policies on the federal budget, Congress adopted legislation in late 1991 that required state surcharges to be "broad-based and generally redistributive in nature."<sup>6</sup> Minnesota's program did not meet this standard because the surcharge applied only to Medicaid revenue and essentially ensured that all hospitals would receive increased payment rates at least equivalent to the amount they paid, thereby violating the redistribution requirement. The Legislature subsequently modified the state surcharge by reducing the rate, expanding the surcharge to all revenue with the exception of Medicare, requiring some intergovernmental transfers from Hennepin County Medical Center and other hospitals, and adopting changes to the payment methodology (known as the Medicaid disproportionate population adjustment). Currently, the total hospital surcharge is approximately \$60 million. When combined with the intergovernmental transfers and the matching federal dollars, the available revenue approaches nearly \$170 million.<sup>6</sup> Further modifications to the surcharge have been proposed as a means for financing the state's GAMC program.

Eligibility for Medical Assistance is generally limited to low-income families, pregnant women, seniors, and people with disabilities. The eligibility income limits in Minnesota are higher than the federal

Table 1

**Medical Assistance Eligibility**

Population	Income Limit (% of Federal Poverty Guidelines)	Asset Limit
Pregnant women	At or below 275%	
Children younger than age 2	At or below 280%	\$1,000 per household
Children 2 to 18 years	At or below 150%	\$10,000 for one \$20,000 for two or more
Adults 19 to 20 years	At or below 100%	
Parents with children younger than 19 years	At or below 100%	\$10,000 for one \$20,000 for two or more
People who are elderly, blind, or have disabilities	At or below 100%	\$3,000 for one \$6,000 for two plus \$200 for each dependent

Source: Minnesota Department of Human Services (<http://edocs.dhs.state.mn.us/lfsrserver/Legacy/DHS-4346-ENG>)

limits, which are between 100% and 133% of poverty, depending on the population. The Minnesota income and asset limits for eligibility are listed in Table 1.

Children, their parents, and pregnant women make up 71% of Medical Assistance enrollees but account for only 25% of expenditures; the remaining 75% of spending goes for the care of people who are elderly or have a disability.<sup>2</sup>

Compared with national average Medicaid spending, Minnesota spends more per enrollee—\$7,129 a year compared with \$4,575 per year.<sup>7</sup> The higher spending is driven by more comprehensive coverage, higher eligibility levels, and a higher proportion of spending on both long-term care services and services to persons with disabilities.<sup>7,8</sup> Medical Assistance benefits in Minnesota are very comprehensive compared with those offered through the other state public programs. (A comparison of covered benefits for Medical Assistance, MinnesotaCare, and General Assistance Medical Care is online at [www.minnesotamedicine.com/clinical-silversmith](http://www.minnesotamedicine.com/clinical-silversmith).)

Minnesota has been contracting with managed care organizations on a capitated basis to provide health care services to Medical Assistance enrollees since the

early 1980s as part of its Prepaid Medical Assistance Program (PMAP). Today, approximately two-thirds of enrollees, with the exception of those who are elderly, disabled, and institutionalized, are enrolled in a PMAP plan.<sup>8</sup>

**MinnesotaCare**

MinnesotaCare is a state-funded program for low- and moderate-income working Minnesotans who do not otherwise have access to health insurance coverage. Created in 1992, the program was the successor to the state's Children's Health Plan,

which began in July 1987 and was phased out in July 1993.<sup>9</sup>

At the outset, MinnesotaCare covered families with children who had incomes at or below 185% of the federal poverty guidelines (FPG). In January 1993, the program was expanded to cover families with children whose income was at or below 275% of poverty. In October 1994, MinnesotaCare extended coverage to single adults and couples without children whose incomes were at or below 125% of the FPG. The income eligibility guideline for this group was increased in July 1996 to at or below 135% of the FPG, in July 1997 to 175%, in 2007 to 200%, and on July 1, 2009, to 250% of poverty.<sup>10</sup> Current income and asset eligibility details are listed in Table 2.

Unlike Minnesota's other public health insurance safety net programs, MinnesotaCare requires participants to pay premiums based on family size and income. The average monthly premium in 2009 was \$24 per month, with a minimum monthly premium of \$4.<sup>2</sup>

One of the early concerns about the creation of the MinnesotaCare program was that it would crowd out private coverage—that is, employers, employees, or individuals would drop their private coverage in favor of publicly subsidized coverage. The MinnesotaCare program established eligibility requirements to minimize the chance of crowd out occurring. In particular, a family or individual must not

Table 2

**MinnesotaCare Eligibility**

Population	Income Limit (% of Federal Poverty Guidelines)	Asset Limit
Adults without children	At or below 250%	\$10,000 for one \$20,000 for two or more
Pregnant women and children younger than 21	At or below 275%	No asset limit
Parents, legal guardians, foster parents, and relatives caring for children younger than 21	At or below 275%	\$10,000 for one \$20,000 for two or more

Source: Minnesota Department of Human Services (<http://edocs.dhs.state.mn.us/lfsrserver/Legacy/DHS-4346-ENG>)

have current access to employer-sponsored health care coverage (in which their employer pays 50% or more of the premium cost) or have had access to such coverage for 18 months prior to application or re-application. In addition, enrollees must not have had health insurance coverage for the four months prior to application or renewal. Generally, children in households with incomes below 150% of poverty are exempt from both of these provisions.<sup>11</sup>

Finally, in an attempt to address concerns about individuals flocking to Minnesota from other states to enroll in the program, adults without children must be residents of Minnesota for 180 days prior to application in order to be eligible.

Benefits provided through MinnesotaCare are fairly comprehensive, with some exceptions. Initially, the program covered outpatient medical services only. Starting in July 1993, services were expanded to include inpatient hospital benefits; orthodontia for children was added in July 1995; and, starting in July 1996, children and pregnant women were able to obtain transportation services to and from medical appointments.<sup>9</sup> Among the most significant limitations of the program is the \$10,000 annual inpatient hospital benefit limit for all adults without children and for parents with household incomes greater than 215% of poverty.

MinnesotaCare has a unique financing mechanism. Although both Medical Assistance and GAMC are paid for through the state's General Fund, MinnesotaCare is supported by a dedicated fund—the Health Care Access Fund—into which various streams of revenue are deposited, including a 2% tax on health care providers' gross revenues. This accounted for 65% of funding in 2009. The Health Care Access Fund is also financed through a 1% premium tax and premiums paid by enrollees on a sliding-fee scale. In addition, beginning in 1995, MinnesotaCare began to receive funding from the federal government through waivers granted to the state. This accounted for 29% of funding for the program in 2009.<sup>2</sup> The waivers enable the state to expand access to health care through the Minneso-

taCare and Medical Assistance programs, and they allow the state to receive federal contributions for services provided to children, pregnant women, or parents and relatives who care for children younger than 21 years of age who are enrolled in MinnesotaCare.<sup>11</sup>

The 2% provider tax has been controversial since its inception and has been the target of several lawsuits.<sup>12-14</sup> One of the advantages of the tax from a financing perspective is that, as health care spending increases, so too does revenue. The tax is also somewhat invisible to the average health care consumer, as it is intended to be passed through to third-party payers who generally incorporate the cost into contractual payment arrangements with providers. There is some disagreement over the adequacy of the pass-through. Among the disadvantages of the tax, which is strongly opposed by many providers, is its somewhat regressive nature.<sup>15</sup>

Also unique to MinnesotaCare is its complete reliance on managed care. Although the program was originally operated on a fee-for-service basis, the state began moving enrollees into managed care plans in July 1996. Since January 1997, all MinnesotaCare enrollees receive services through managed care health plans.<sup>9</sup> Enrollees in Medical Assistance and GAMC also receive services through managed care plans, but not exclusively.

With approximately 118,000 people enrolled in MinnesotaCare in 2009, total spending on the program was \$526 million, with an average payment per enrollee of \$372 per month.<sup>2</sup>

## General Assistance Medical Care

Created in the early 1970s, GAMC is a state-funded program for low-income people who do not meet the requirements for Medical Assistance. These are generally adults without children. On average, 32,000 Minnesotans are covered through GAMC during any given month.<sup>8</sup> Although many GAMC enrollees would otherwise be eligible for MinnesotaCare (ie, their income and assets are within the MinnesotaCare limits), the application process, the premium structure, and the limited inpatient hospital benefit are often considered significant hurdles to enrolling them in the program. As many as 70% of GAMC enrollees have been reported to have substance abuse disorders and/or a mental illness. The GAMC income and asset eligibility requirements are listed in Table 3.

Spending on GAMC was approximately \$288 million in fiscal year 2009, with the average payment per enrollee being \$751 per month—more than double that for MinnesotaCare enrollees.<sup>2</sup>

GAMC has garnered significant public attention following the May 2009 decision by Gov. Tim Pawlenty to line-item veto \$381 million in funding for the program for fiscal year 2011, and the decision one month later to reduce the fiscal year 2010 GAMC appropriation by \$15 million through unallotment, thereby eliminating GAMC coverage on March 1, 2010.<sup>11</sup> In an apparent response to significant concerns from enrollees, advocates, and health care providers, the Commis-

Table 3

### General Assistance Medical Care Eligibility

Benefit level	Income Limit (% of Federal Poverty Guidelines)	Asset Limit
Full medical benefits	At or below 75%	\$1,000 per household
Hospital-only benefits	75% to 175%	\$10,000 for one \$20,000 for two or more

Source: Minnesota Department of Human Services (<http://edocs.dhs.state.mn.us/lfservlet/Legacy/DHS-4346-ENG>)

sioner of Human Services, Cal Ludeman, announced on November 6 that the state would automatically enroll current GAMC enrollees in MinnesotaCare for up to six months, with counties paying the associated premiums. In order to receive ongoing coverage through MinnesotaCare, individuals would have to apply for and maintain premium payments. Since then, the democratic majorities in the Minnesota House and Senate have unveiled a joint proposal to retain GAMC for a limited period of time. Resolution of this issue is expected to be a significant topic during the 2010 legislative session.

## Minnesota Comprehensive Health Association

An important component of Minnesota's health care safety net is the nonpublic Minnesota Comprehensive Health Association (MCHA). Established by the state Legislature in 1976, the primary purpose of MCHA is to provide private insurance coverage to Minnesota residents who have been turned down for health insurance in the individual market because they have pre-existing health conditions.<sup>16</sup> There are, however, other ways by which individuals can become eligible for MCHA coverage, including loss of group insurance coverage, being ineligible for federal Medicare benefits, or having one of approximately 45 "presumptive conditions."<sup>16</sup>

Approximately 30,000 Minnesotans (0.5%) receive coverage through MCHA (which is administered by Medica), making it both the largest and most expensive high-risk pool in the nation.<sup>17</sup> Enrollment peaked at more than 35,000 in 1993 but has declined since then, in part, because of state-enacted insurance reforms.<sup>18</sup> Seven different plans (including a Medicare supplement plan) are offered through MCHA. Each has a fairly comprehensive benefit structure with deductibles ranging from \$500 to \$10,000.

Unlike Medical Assistance, GAMC, and MinnesotaCare, MCHA does not as a rule receive any direct state funding. (The state did, however, provide MCHA with \$15 million from the state's Health Care Access Fund in 1998 and 1999, and

in 2001, the state provided MCHA with \$15 million from the Workers Compensation Assigned-Risk Plan.) Instead, funding comes from enrollee premiums and an assessment on insurers. MCHA enrollees pay premiums at rates above the market average. By law, rates are set between 101% and 125% of the weighted average for comparable policies.<sup>19</sup> Given the risk profile of MCHA enrollees and the premium limits, MCHA has historically incurred costs in excess of premiums collected. The difference is covered by an assessment on state-regulated companies that sell individual and group health insurance policies in an amount equal to their proportion of premiums collected from Minnesota residents.<sup>20</sup> The assessment on insurers has been controversial because of the significant portion of Minnesotans (40%) who are covered by self-insured plans.<sup>1</sup> Federal law prohibits application of the assessment to self-insured plans, meaning that the assessment base is limited to plans in the fully insured market, which cover only 27% of Minnesotans.<sup>1</sup> On the other hand, these are the very insurers that utilize the underwriting mechanisms that cause individuals to turn to MCHA for assistance.

## Conclusion

Although Medical Assistance continues to be the most significant component, Minnesota's health insurance safety net is a patchwork. The GAMC patch provides coverage to low-income adults without children, the MinnesotaCare patch supports working families and adults without children who don't have access to employer-sponsored coverage, and the MCHA patch provides coverage for those who have been otherwise denied. Together, these programs provide a complicated, expensive web of protection for more than 725,000 Minnesotans. Federal reform could simplify Minnesota's patchwork of programs through streamlined eligibility and enhanced federal funding. **MM**

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