

CHAPTER 256L

MINNESOTACARE

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256L.01 DEFINITIONS.

Subdivision 1. **Scope.** For purposes of sections 256L.01 to 256L.18, the following terms shall have the meanings given them.

Subd. 1a. **Child.** "Child" means an individual under 21 years of age, including the unborn child of a pregnant woman, an emancipated minor, and an emancipated minor's spouse.

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of human services.

Subd. 3. **Eligible providers.** "Eligible providers" means those health care providers who provide covered health services to medical assistance recipients under rules established by the commissioner for that program.

Subd. 3a. **Family with children.** (a) "Family with children" means:

(1) parents, their children, and dependent siblings residing in the same household; or

(2) grandparents, foster parents, relative caretakers as defined in the medical assistance program, or legal guardians; their wards who are children; and dependent siblings residing in the same household.

(b) The term includes children and dependent siblings who are temporarily absent from the household in settings such as schools, camps, or parenting time with noncustodial parents.

(c) For purposes of this subdivision, a dependent sibling means an unmarried child who is a full-time student under the age of 25 years who is financially dependent upon a parent, grandparent, foster parent, relative caretaker, or legal guardian. Proof of school enrollment is required.

Subd. 4. **Gross individual or gross family income.** "Gross individual or gross family income" for farm and nonfarm self-employed means income calculated using as the baseline the adjusted gross income reported on the applicant's federal income tax form for the previous year and adding back in reported depreciation, carryover loss, and net operating loss amounts that apply to the business in which the family is currently engaged. Applicants shall report the most recent financial situation of the family if it has changed from the period of time covered by the federal income tax form. The report may be in the form of percentage increase or decrease.

Subd. 5. **Income.** "Income" has the meaning given for earned and unearned income for families and children in the medical assistance program, according to the state's aid to families with dependent children plan in effect as of July 16, 1996. The definition does not include medical assistance income methodologies and deeming requirements. The earned income of full-time and part-time students under age 19 is not counted as income. Public assistance payments and supplemental security income are not excluded income.

History: 1986 c 444; 1987 c 403 art 2 s 63; 1988 c 689 art 2 s 137; 1989 c 282 art 3 s 33; 1990 c 568 art 3 s 14; 1992 c 549 art 4 s 2,19; 1993 c 345 art 9 s 1; 1998 c 407 art 5 s 7; 2000 c 444 art 2 s 5

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256L.02 PROGRAM ADMINISTRATION.

Subdivision 1. Purpose. The MinnesotaCare program is established to promote access to appropriate health care services to assure healthy children and adults.

Subd. 2. Commissioner's duties. The commissioner shall establish an office for the state administration of this plan. The plan shall be used to provide covered health services for eligible persons. Payment for these services shall be made to all eligible providers. The commissioner shall adopt rules to administer the MinnesotaCare program. The commissioner shall establish marketing efforts to encourage potentially eligible persons to receive information about the program and about other medical care programs administered or supervised by the department of human services. A toll-free telephone number must be used to provide information about medical programs and to promote access to the covered services.

Subd. 3. Financial management. (a) The commissioner shall manage spending for the MinnesotaCare program in a manner that maintains a minimum reserve in accordance with section 16A.76. As part of each state revenue and expenditure forecast, the commissioner must make an assessment of the expected expenditures for the covered services for the remainder of the current biennium and for the following biennium. The estimated expenditure, including the reserve requirements described in section 16A.76, shall be compared to an estimate of the revenues that will be available in the health care access fund. Based on this comparison, and after consulting with the chairs of the house ways and means committee and the senate finance committee, and the legislative commission on health care access, the commissioner shall, as necessary, make the adjustments specified in paragraph (b) to ensure that expenditures remain within the limits of available revenues for the remainder of the current biennium and for the following biennium. The commissioner shall not hire additional staff using appropriations from the health care access fund until the commissioner of finance makes a determination that the adjustments implemented under paragraph (b) are sufficient to allow MinnesotaCare expenditures to remain within the limits of available revenues for the remainder of the current biennium and for the following biennium.

(b) The adjustments the commissioner shall use must be implemented in this order: first, stop enrollment of single adults and households without children; second, upon 45 days' notice, stop coverage of single adults and households without children already enrolled in the MinnesotaCare program; third, upon 90 days' notice, decrease the premium subsidy amounts by ten percent for families with gross annual income above 200 percent of the federal poverty guidelines; fourth, upon 90 days' notice, decrease the premium subsidy amounts by ten percent for families with gross annual income at or below 200 percent; and fifth, require applicants to be uninsured for at least six months prior to eligibility in the MinnesotaCare program. If these measures are insufficient to limit the expenditures to the estimated amount of revenue, the commissioner shall further limit enrollment or decrease premium subsidies.

Subd. 4. Funding for pregnant women and children under age two. For fiscal years beginning on or after July 1, 1999, the state cost of health care services provided to MinnesotaCare enrollees who are pregnant women or children under age two shall be paid out of the general fund rather than the health care access fund. If the commissioner of finance decides to pay for these costs using a source other than the general fund, the commissioner shall include the change as a budget initiative in the biennial or supplemental budget, and shall not change the funding source through a forecast modification.

History: 1986 c 444; 1987 c 403 art 2 s 63; 1988 c 689 art 2 s 137; 1989 c 282 art 3 s 34; 1992 c 549 art 4 s 3,19; 1993 c 4 s 28; 1993 c 247 art 4 s 11; 1993 c 345 art 9 s 2; 1994 c 625 art 8 s 72; art 13 s 1; 1995 c 234 art 6 s 3; 1997 c 225 art 3 s 3; 1998 c 407 art 5 s 8,9

256L.03 COVERED HEALTH SERVICES.

Subdivision 1. Covered health services. "Covered health services" means the health services reimbursed under chapter 256B, with the exception of inpatient hospital

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services, special education services, private duty nursing services, adult dental care services other than preventive services, orthodontic services, nonemergency medical transportation services, personal care assistant and case management services, nursing home or intermediate care facilities services, inpatient mental health services, and chemical dependency services. Effective July 1, 1998, adult dental care for nonpreventive services with the exception of orthodontic services is available to persons who qualify under section 256L.04, subdivisions 1 to 7, with family gross income equal to or less than 175 percent of the federal poverty guidelines. Outpatient mental health services covered under the MinnesotaCare program are limited to diagnostic assessments, psychological testing, explanation of findings, medication management by a physician, day treatment, partial hospitalization, and individual, family, and group psychotherapy.

No public funds shall be used for coverage of abortion under MinnesotaCare except 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.

Covered health services shall be expanded as provided in this section.

Subd. 1a. Covered services for pregnant women and children under MinnesotaCare health care reform waiver. Beginning January 1, 1999, children and pregnant women are eligible for coverage of all services that are eligible for reimbursement under the medical assistance program according to chapter 256B, except that abortion services under MinnesotaCare shall be limited as provided under subdivision 1. Pregnant women and children are exempt from the provisions of subdivision 5, regarding copayments. Pregnant women and children who are lawfully residing in the United States but who are not "qualified noncitizens" under title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Public Law Number 104-193, Statutes at Large, volume 110, page 2105, are eligible for coverage of all services provided under the medical assistance program according to chapter 256B.

Subd. 1b. Pregnant women; eligibility for full medical assistance services. Beginning January 1, 1999, a woman who is enrolled in MinnesotaCare when her pregnancy is diagnosed is eligible for coverage of all services provided under the medical assistance program according to chapter 256B retroactive to the date the pregnancy is medically diagnosed. Copayments totaling \$30 or more, paid after the date the pregnancy is diagnosed, shall be refunded.

Subd. 2. Alcohol and drug dependency. Beginning July 1, 1993, covered health services shall include individual outpatient treatment of alcohol or drug dependency by a qualified health professional or outpatient program.

Persons who may need chemical dependency services under the provisions of this chapter shall be assessed by a local agency as defined under section 254B.01, and under the assessment provisions of section 254A.03, subdivision 3. A local agency or managed care plan under contract with the department of human services must place a person in need of chemical dependency services as provided in Minnesota Rules, parts 9530.6600 to 9530.6660. Persons who are recipients of medical benefits under the provisions of this chapter and who are financially eligible for consolidated chemical dependency treatment fund services provided under the provisions of chapter 254B shall receive chemical dependency treatment services under the provisions of chapter 254B only if:

- (1) they have exhausted the chemical dependency benefits offered under this chapter; or
- (2) an assessment indicates that they need a level of care not provided under the provisions of this chapter.

Recipients of covered health services under the children's health plan, as provided in Minnesota Statutes 1990, section 256.936, and as amended by Laws 1991, chapter 292, article 4, section 17, and recipients of covered health services enrolled in the children's health plan or the MinnesotaCare program after October 1, 1992, pursuant

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to Laws 1992, chapter 549, article 4, sections 5 and 17, are eligible to receive alcohol and drug dependency benefits under this subdivision.

Subd. 3. Inpatient hospital services. (a) Covered health services shall include inpatient hospital services, including inpatient hospital mental health services and inpatient hospital and residential chemical dependency treatment, subject to those limitations necessary to coordinate the provision of these services with eligibility under the medical assistance spenddown. Prior to July 1, 1997, the inpatient hospital benefit for adult enrollees is subject to an annual benefit limit of \$10,000. The inpatient hospital benefit for adult enrollees who qualify under section 256L.04, subdivision 7, or who qualify under section 256L.04, subdivisions 1 and 2, with family gross income that exceeds 175 percent of the federal poverty guidelines and who are not pregnant, is subject to an annual limit of \$10,000.

(b) Admissions for inpatient hospital services paid for under section 256L.11, subdivision 3, must be certified as medically necessary in accordance with Minnesota Rules, parts 9505.0500 to 9505.0540, except as provided in clauses (1) and (2):

(1) all admissions must be certified, except those authorized under rules established under section 254A.03, subdivision 3, or approved under Medicare; and

(2) payment under section 256L.11, subdivision 3, shall be reduced by five percent for admissions for which certification is requested more than 30 days after the day of admission. The hospital may not seek payment from the enrollee for the amount of the payment reduction under this clause.

Subd. 3a. Interpreter services. Covered services include sign and spoken language interpreter services that assist an enrollee in obtaining covered health care services.

Subd. 4. Coordination with medical assistance. The commissioner shall coordinate the provision of hospital inpatient services under the MinnesotaCare program with enrollee eligibility under the medical assistance spenddown.

Subd. 5. Copayments and coinsurance. (a) Except as provided in paragraphs (b) and (c), the MinnesotaCare benefit plan shall include the following copayments and coinsurance requirements for all enrollees:

(1) ten percent of the paid charges for inpatient hospital services for adult enrollees, subject to an annual inpatient out-of-pocket maximum of \$1,000 per individual and \$3,000 per family;

(2) \$3 per prescription for adult enrollees;

(3) \$25 for eyeglasses for adult enrollees; and

(4) 50 percent of the fee-for-service rate for adult dental care services other than preventive care services for persons eligible under section 256L.04, subdivisions 1 to 7, with income equal to or less than 175 percent of the federal poverty guidelines.

(b) Paragraph (a), clause (1), does not apply to parents and relative caretakers of children under the age of 21 in households with family income equal to or less than 175 percent of the federal poverty guidelines. Paragraph (a), clause (1), does not apply to parents and relative caretakers of children under the age of 21 in households with family income greater than 175 percent of the federal poverty guidelines for inpatient hospital admissions occurring on or after January 1, 2001.

(c) Paragraph (a), clauses (1) to (4), do not apply to pregnant women and children under the age of 21.

(d) Adult enrollees with family gross income that exceeds 175 percent of the federal poverty guidelines and who are not pregnant shall be financially responsible for the coinsurance amount, if applicable, and amounts which exceed the \$10,000 inpatient hospital benefit limit.

(e) When a MinnesotaCare enrollee becomes a member of a prepaid health plan, or changes from one prepaid health plan to another during a calendar year, any charges submitted towards the \$10,000 annual inpatient benefit limit, and any out-of-pocket expenses incurred by the enrollee for inpatient services, that were submitted or

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incurred prior to enrollment, or prior to the change in health plans, shall be disregarded.

Subd. 6. Lien. When the state agency provides, pays for, or becomes liable for covered health services, the agency shall have a lien for the cost of the covered health services upon any and all causes of action accruing to the enrollee, or to the enrollee's legal representatives, as a result of the occurrence that necessitated the payment for the covered health services. All liens under this section shall be subject to the provisions of section 256.015. For purposes of this subdivision, "state agency" includes prepaid health plans under contract with the commissioner according to sections 256B.69, 256D.03, subdivision 4, paragraph (d), and 256L.12; and county-based purchasing entities under section 256B.69.

History: 1986 c 444; 1992 c 549 art 4 s 4,19; 1992 c 603 s 31; 1993 c 247 art 4 s 2-4,11; 1993 c 345 art 9 s 3; 1993 c 366 s 26; 1994 c 625 art 8 s 50,51,72; 1995 c 207 art 6 s 12; 1995 c 234 art 6 s 4,5; 1997 c 225 art 1 s 1-3; 1998 c 407 art 5 s 10-16; 1999 c 245 art 4 s 89,90; 2000 c 340 s 15

256L.04 ELIGIBLE PERSONS.

Subdivision 1. Families with children. (a) Families with children with family income equal to or less than 275 percent of the federal poverty guidelines for the applicable family size shall be eligible for MinnesotaCare according to this section. All other provisions of sections 256L.01 to 256L.18, including the insurance-related barriers to enrollment under section 256L.07, shall apply unless otherwise specified.

(b) Parents who enroll in the MinnesotaCare program must also enroll their children and dependent siblings, if the children and their dependent siblings are eligible. Children and dependent siblings may be enrolled separately without enrollment by parents. However, if one parent in the household enrolls, both parents must enroll, unless other insurance is available. If one child from a family is enrolled, all children must be enrolled, unless other insurance is available. If one spouse in a household enrolls, the other spouse in the household must also enroll, unless other insurance is available. Families cannot choose to enroll only certain uninsured members.

Subd. 2. Cooperation in establishing third-party liability, paternity, and other medical support. (a) To be eligible for MinnesotaCare, individuals and families must cooperate with the state agency to identify potentially liable third-party payers and assist the state in obtaining third-party payments. "Cooperation" includes, but is not limited to, identifying any third party who may be liable for care and services provided under MinnesotaCare to the enrollee, providing relevant information to assist the state in pursuing a potentially liable third party, and completing forms necessary to recover third-party payments.

(b) A parent, guardian, relative caretaker, or child enrolled in the MinnesotaCare program must cooperate with the department of human services and the local agency in establishing the paternity of an enrolled child and in obtaining medical care support and payments for the child and any other person for whom the person can legally assign rights, in accordance with applicable laws and rules governing the medical assistance program. A child shall not be ineligible for or disenrolled from the MinnesotaCare program solely because the child's parent, relative caretaker, or guardian fails to cooperate in establishing paternity or obtaining medical support.

Subd. 3. [Repealed, 1998 c 407 art 5 s 48]

Subd. 4. [Repealed, 1998 c 407 art 5 s 48]

Subd. 5. [Repealed, 1998 c 407 art 5 s 48]

Subd. 6. [Repealed, 1998 c 407 art 5 s 48]

Subd. 7. Single adults and households with no children. The definition of eligible persons includes all individuals and households with no children who have gross family incomes that are equal to or less than 175 percent of the federal poverty guidelines.

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Subd. 7a. Ineligibility. Applicants whose income is greater than the limits established under this section may not enroll in the MinnesotaCare program.

Subd. 8. Applicants potentially eligible for medical assistance. (a) Individuals who receive supplemental security income or retirement, survivors, or disability benefits due to a disability, or other disability-based pension, who qualify under subdivision 7, but who are potentially eligible for medical assistance without a spenddown shall be allowed to enroll in MinnesotaCare for a period of 60 days, so long as the applicant meets all other conditions of eligibility. The commissioner shall identify and refer the applications of such individuals to their county social service agency. The county and the commissioner shall cooperate to ensure that the individuals obtain medical assistance coverage for any months for which they are eligible.

(b) The enrollee must cooperate with the county social service agency in determining medical assistance eligibility within the 60-day enrollment period. Enrollees who do not cooperate with medical assistance within the 60-day enrollment period shall be disenrolled from the plan within one calendar month. Persons disenrolled for nonapplication for medical assistance may not reenroll until they have obtained a medical assistance eligibility determination. Persons disenrolled for noncooperation with medical assistance may not reenroll until they have cooperated with the county agency and have obtained a medical assistance eligibility determination.

(c) Beginning January 1, 2000, counties that choose to become MinnesotaCare enrollment sites shall consider MinnesotaCare applications to also be applications for medical assistance. Applicants who are potentially eligible for medical assistance, except for those described in paragraph (a), may choose to enroll in either MinnesotaCare or medical assistance.

(d) The commissioner shall redetermine provider payments made under MinnesotaCare to the appropriate medical assistance payments for those enrollees who subsequently become eligible for medical assistance.

Subd. 9. General assistance medical care. A person cannot have coverage under both MinnesotaCare and general assistance medical care in the same month. Eligibility for MinnesotaCare cannot be replaced by eligibility for general assistance medical care, and eligibility for general assistance medical care cannot be replaced by eligibility for MinnesotaCare.

Subd. 10. Sponsor's income and resources deemed available; documentation. When determining eligibility for any federal or state benefits under sections 256L.01 to 256L.18, the income and resources of all noncitizens whose sponsor signed an affidavit of support as defined under United States Code, title 8, section 1183a, shall be deemed to include their sponsors' income and resources as defined in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, title IV, Public Law Number 104-193, sections 421 and 422, and subsequently set out in federal rules. To be eligible for the program, noncitizens must provide documentation of their immigration status.

Subd. 11. MinnesotaCare outreach. (a) The commissioner shall award grants to public or private organizations to provide information on the importance of maintaining insurance coverage and on how to obtain coverage through the MinnesotaCare program in areas of the state with high uninsured populations.

(b) In awarding the grants, the commissioner shall consider the following:

- (1) geographic areas and populations with high uninsured rates;
- (2) the ability to raise matching funds; and
- (3) the ability to contact or serve eligible populations.

The commissioner shall monitor the grants and may terminate a grant if the outreach effort does not increase enrollment in medical assistance, general assistance medical care, or the MinnesotaCare program.

Subd. 12. Persons in detention. Beginning January 1, 1999, an applicant residing in a correctional or detention facility is not eligible for MinnesotaCare. An enrollee

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residing in a correctional or detention facility is not eligible at renewal of eligibility under section 256L.05, subdivision 3b.

Subd. 13. Families with relative caretakers, foster parents, or legal guardians. Beginning January 1, 1999, in families that include a relative caretaker as defined in the medical assistance program, foster parent, or legal guardian, the relative caretaker, foster parent, or legal guardian may apply as a family or may apply separately for the children. If the caretaker applies separately for the children, only the children's income is counted and the provisions of subdivision 1, paragraph (b), do not apply. If the relative caretaker, foster parent, or legal guardian applies with the children, their income is included in the gross family income for determining eligibility and premium amount.

History: 1986 c 444; 1992 c 549 art 4 s 5,19; 1993 c 247 art 4 s 5; 1993 c 345 art 9 s 4-6; 1994 c 625 art 8 s 52-55,72; art 13 s 2; 1995 c 234 art 6 s 6-9; 1997 c 85 art 3 s 9; 1997 c 203 art 12 s 1; 1997 c 225 art 1 s 4-8; 1998 c 407 art 5 s 17-25; 1999 c 245 art 4 s 91-94

256L.05 APPLICATION PROCEDURES.

Subdivision 1. Application and information availability. Applications and other information must be made available to provider offices, local human services agencies, school districts, public and private elementary schools in which 25 percent or more of the students receive free or reduced price lunches, community health offices, and Women, Infants and Children (WIC) program sites. These sites may accept applications and forward the forms to the commissioner. Otherwise, applicants may apply directly to the commissioner. Beginning January 1, 2000, MinnesotaCare enrollment sites will be expanded to include local county human services agencies which choose to participate.

Subd. 1a. Person authorized to apply on applicant's behalf. Beginning January 1, 1999, a family member who is age 18 or over or who is an authorized representative, as defined in the medical assistance program, may apply on an applicant's behalf.

Subd. 2. Commissioner's duties. The commissioner shall use individuals' social security numbers as identifiers for purposes of administering the plan and conduct data matches to verify income. Applicants shall submit evidence of individual and family income, earned and unearned, such as the most recent income tax return, wage slips, or other documentation that is determined by the commissioner as necessary to verify income eligibility. The commissioner shall perform random audits to verify reported income and eligibility. The commissioner may execute data sharing arrangements with the department of revenue and any other governmental agency in order to perform income verification related to eligibility and premium payment under the MinnesotaCare program.

Subd. 3. Effective date of coverage. The effective date of coverage is the first day of the month following the month in which eligibility is approved and the first premium payment has been received. As provided in section 256B.057, coverage for newborns is automatic from the date of birth and must be coordinated with other health coverage. The effective date of coverage for eligible newly adoptive children added to a family receiving covered health services is the date of entry into the family. The effective date of coverage for other new recipients added to the family receiving covered health services is the first day of the month following the month in which eligibility is approved or at renewal, whichever the family receiving covered health services prefers. All eligibility criteria must be met by the family at the time the new family member is added. The income of the new family member is included with the family's gross income and the adjusted premium begins in the month the new family member is added. The premium must be received eight working days prior to the end of the month for coverage to begin the following month. Benefits are not available until the day following discharge if an enrollee is hospitalized on the first day of coverage. Notwithstanding any other law to the contrary, benefits under sections 256L.01 to 256L.18 are secondary to a plan of insurance or benefit program under which an

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eligible person may have coverage and the commissioner shall use cost avoidance techniques to ensure coordination of any other health coverage for eligible persons. The commissioner shall identify eligible persons who may have coverage or benefits under other plans of insurance or who become eligible for medical assistance.

Subd. 3a. **Renewal of eligibility.** Beginning January 1, 1999, an enrollee's eligibility must be renewed every 12 months. The 12-month period begins in the month after the month the application is approved.

Subd. 3b. **Reapplication.** Beginning January 1, 1999, families and individuals must reapply after a lapse in coverage of one calendar month or more and must meet all eligibility criteria.

Subd. 3c. **Retroactive coverage.** Notwithstanding subdivision 3, the effective date of coverage shall be the first day of the month following termination from medical assistance or general assistance medical care for families and individuals who are eligible for MinnesotaCare and who submitted a written request for retroactive MinnesotaCare coverage with a completed application within 30 days of the mailing of notification of termination from medical assistance or general assistance medical care. The applicant must provide all required verifications within 30 days of the written request for verification. For retroactive coverage, premiums must be paid in full for any retroactive month, current month, and next month within 30 days of the premium billing.

Subd. 4. **Application processing.** The commissioner of human services shall determine an applicant's eligibility for MinnesotaCare no more than 30 days from the date that the application is received by the department of human services. Beginning January 1, 2000, this requirement also applies to local county human services agencies that determine eligibility for MinnesotaCare. Once annually at application or reenrollment, to prevent processing delays, applicants or enrollees who, from the information provided on the application, appear to meet eligibility requirements shall be enrolled upon timely payment of premiums. The enrollee must provide all required verifications within 30 days of notification of the eligibility determination or coverage from the program shall be terminated. Enrollees who are determined to be ineligible when verifications are provided shall be disenrolled from the program.

Subd. 5. **Availability of private insurance.** The commissioner, in consultation with the commissioners of health and commerce, shall provide information regarding the availability of private health insurance coverage and the possibility of disenrollment under section 256L.07, subdivision 1, paragraphs (b) and (c), to all: (1) families enrolled in the MinnesotaCare program whose gross family income is equal to or more than 225 percent of the federal poverty guidelines; and (2) single adults and households without children enrolled in the MinnesotaCare program whose gross family income is equal to or more than 165 percent of the federal poverty guidelines. This information must be provided upon initial enrollment and annually thereafter. The commissioner shall also include information regarding the availability of private health insurance coverage in the notice of ineligibility provided to persons subject to disenrollment under section 256L.07, subdivision 1, paragraphs (b) and (c).

History: 1986 c 444; 1987 c 403 art 2 s 63; 1988 c 689 art 2 s 137; 1992 c 549 art 4 s 6,19; 1993 c 247 art 4 s 6; 1994 c 625 art 8 s 72; art 13 s 3; 1995 c 234 art 6 s 10; 1996 c 451 art 5 s 10; 1997 c 225 art 1 s 9-11; 1997 c 251 s 26; 1998 c 407 art 5 s 26-31; 1999 c 245 art 4 s 95,96; 2000 c 488 art 9 s 27

256L.06 PREMIUM FEES AND PAYMENTS.

Subdivision 1. [Repealed, 1998 c 407 art 5 s 48]

Subd. 2. [Repealed, 1998 c 407 art 5 s 48]

Subd. 3. **Administration and commissioner's duties.** (a) Premiums are dedicated to the commissioner for MinnesotaCare.

(b) The commissioner shall develop and implement procedures to: (1) require enrollees to report changes in income; (2) adjust sliding scale premium payments,

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based upon changes in enrollee income; and (3) disenroll enrollees from MinnesotaCare for failure to pay required premiums. Failure to pay includes payment with a dishonored check, a returned automatic bank withdrawal, or a refused credit card or debit card payment. The commissioner may demand a guaranteed form of payment, including a cashier's check or a money order, as the only means to replace a dishonored, returned, or refused payment.

(c) Premiums are calculated on a calendar month basis and may be paid on a monthly, quarterly, or annual basis, with the first payment due upon notice from the commissioner of the premium amount required. The commissioner shall inform applicants and enrollees of these premium payment options. Premium payment is required before enrollment is complete and to maintain eligibility in MinnesotaCare.

(d) Nonpayment of the premium will result in disenrollment from the plan within one calendar month after the due date. Persons disenrolled for nonpayment or who voluntarily terminate coverage from the program may not reenroll until four calendar months have elapsed. Persons disenrolled for nonpayment who pay all past due premiums as well as current premiums due, including premiums due for the period of disenrollment, within 20 days of disenrollment, shall be reenrolled retroactively to the first day of disenrollment. Persons disenrolled for nonpayment or who voluntarily terminate coverage from the program may not reenroll for four calendar months unless the person demonstrates good cause for nonpayment. Good cause does not exist if a person chooses to pay other family expenses instead of the premium. The commissioner shall define good cause in rule.

History: 1986 c 444; 1987 c 403 art 2 s 63; 1988 c 689 art 2 s 137; 1989 c 282 art 3 s 35; 1992 c 549 art 4 s 7,19; 1993 c 247 art 4 s 7; 1993 c 345 art 9 s 7; 1994 c 625 art 13 s 4; 1995 c 234 art 8 s 56; 1998 c 407 art 5 s 32; 1999 c 245 art 4 s 97

256L.07 ELIGIBILITY FOR MINNESOTACARE.

Subdivision 1. General requirements. (a) Children enrolled in the original children's health plan as of September 30, 1992, children who enrolled in the MinnesotaCare program after September 30, 1992, pursuant to Laws 1992, chapter 549, article 4, section 17, and children who have family gross incomes that are equal to or less than 150 percent of the federal poverty guidelines are eligible without meeting the requirements of subdivision 2, as long as they maintain continuous coverage in the MinnesotaCare program or medical assistance. Children who apply for MinnesotaCare on or after the implementation date of the employer-subsidized health coverage program as described in Laws 1998, chapter 407, article 5, section 45, who have family gross incomes that are equal to or less than 150 percent of the federal poverty guidelines, must meet the requirements of subdivision 2 to be eligible for MinnesotaCare.

(b) Families enrolled in MinnesotaCare under section 256L.04, subdivision 1, whose income increases above 275 percent of the federal poverty guidelines, are no longer eligible for the program and shall be disenrolled by the commissioner. Individuals enrolled in MinnesotaCare under section 256L.04, subdivision 7, whose income increases above 175 percent of the federal poverty guidelines are no longer eligible for the program and shall be disenrolled by the commissioner. For persons disenrolled under this subdivision, MinnesotaCare coverage terminates the last day of the calendar month following the month in which the commissioner determines that the income of a family or individual exceeds program income limits.

(c) Notwithstanding paragraph (b), individuals and families may remain enrolled in MinnesotaCare if ten percent of their annual income is less than the annual premium for a policy with a \$500 deductible available through the Minnesota comprehensive health association. Individuals and families who are no longer eligible for MinnesotaCare under this subdivision shall be given an 18-month notice period from the date that ineligibility is determined before disenrollment.

Subd. 2. Must not have access to employer-subsidized coverage. (a) To be eligible, a family or individual must not have access to subsidized health coverage through an employer and must not have had access to employer-subsidized coverage through a

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current employer for 18 months prior to application or reapplication. A family or individual whose employer-subsidized coverage is lost due to an employer terminating health care coverage as an employee benefit during the previous 18 months is not eligible.

(b) For purposes of this requirement, subsidized health coverage means health coverage for which the employer pays at least 50 percent of the cost of coverage for the employee or dependent, or a higher percentage as specified by the commissioner. Children are eligible for employer-subsidized coverage through either parent, including the noncustodial parent. The commissioner must treat employer contributions to Internal Revenue Code Section 125 plans and any other employer benefits intended to pay health care costs as qualified employer subsidies toward the cost of health coverage for employees for purposes of this subdivision.

Subd. 3. Other health coverage. (a) Families and individuals enrolled in the MinnesotaCare program must have no health coverage while enrolled or for at least four months prior to application and renewal. Children enrolled in the original children's health plan and children in families with income equal to or less than 150 percent of the federal poverty guidelines, who have other health insurance, are eligible if the coverage:

- (1) lacks two or more of the following:
 - (i) basic hospital insurance;
 - (ii) medical-surgical insurance;
 - (iii) prescription drug coverage;
 - (iv) dental coverage; or
 - (v) vision coverage;
- (2) requires a deductible of \$100 or more per person per year; or
- (3) lacks coverage because the child has exceeded the maximum coverage for a particular diagnosis or the policy excludes a particular diagnosis.

The commissioner may change this eligibility criterion for sliding scale premiums in order to remain within the limits of available appropriations. The requirement of no health coverage does not apply to newborns.

(b) Medical assistance, general assistance medical care, and civilian health and medical program of the uniformed service, CHAMPUS, are not considered insurance or health coverage for purposes of the four-month requirement described in this subdivision.

(c) For purposes of this subdivision, Medicare Part A or B coverage under title XVIII of the Social Security Act, United States Code, title 42, sections 1395c to 1395w-4, is considered health coverage. An applicant or enrollee may not refuse Medicare coverage to establish eligibility for MinnesotaCare.

(d) Applicants who were recipients of medical assistance or general assistance medical care within one month of application must meet the provisions of this subdivision and subdivision 2.

Subd. 4. Families with children in need of chemical dependency treatment. Premiums for families with children when a parent has been determined to be in need of chemical dependency treatment pursuant to an assessment conducted by the county under section 626.556, subdivision 10, or a case plan under section 260C.201, subdivision 6, or 260C.212, who are eligible for MinnesotaCare under section 256L.04, subdivision 1, may be paid by the county of residence of the person in need of treatment for one year from the date the family is determined to be eligible or if the family is currently enrolled in MinnesotaCare from the date the person is determined to be in need of chemical dependency treatment. Upon renewal, the family is responsible for any premiums owed under section 256L.15. If the family is not currently enrolled in MinnesotaCare, the local county human services agency shall determine

whether the family appears to meet the eligibility requirements and shall assist the family in applying for the MinnesotaCare program.

History: 1986 c 444; 1992 c 549 art 4 s 8,19; 1993 c 345 art 9 s 8; 1994 c 625 art 8 s 56,72; 1995 c 234 art 6 s 11-13; 1997 c 187 art 1 s 18; 1997 c 225 art 1 s 12; 1998 c 407 art 5 s 33; 1999 c 139 art 4 s 2; 1999 c 245 art 4 s 98

256L.08 [Repealed, 1998 c 407 art 5 s 48]

256L.09 RESIDENCY.

Subdivision 1. Findings and purpose. The legislature finds that the enactment of a comprehensive health plan for uninsured Minnesotans creates a risk that persons needing medical care will migrate to the state for the primary purpose of obtaining medical care subsidized by the state. The risk of migration undermines the state's ability to provide to legitimate state residents a valuable and necessary health care program which is an important component of the state's comprehensive cost containment and health care system reform plan. Intent-based residency requirements, which are expressly authorized under decisions of the United States Supreme Court, are an unenforceable and ineffective method of denying benefits to those persons the Supreme Court has stated may legitimately be denied eligibility for state programs. If the state is unable to limit eligibility to legitimate permanent residents of the state, the state faces a significant risk that it will be forced to reduce the eligibility and benefits it would otherwise provide to Minnesotans. The legislature finds that a durational residence requirement is a legitimate, objective, enforceable standard for determining whether a person is a permanent resident of the state. The legislature also finds low-income persons who have not lived in the state for the required time period will have access to necessary health care services through the general assistance medical care program, the medical assistance program, and public and private charity care programs.

Subd. 2. Residency requirement. (a) To be eligible for health coverage under the MinnesotaCare program, adults without children must be permanent residents of Minnesota.

(b) To be eligible for health coverage under the MinnesotaCare program, pregnant women, families, and children must meet the residency requirements as provided by Code of Federal Regulations, title 42, section 435.403, except that the provisions of section 256B.056, subdivision 1, shall apply upon receipt of federal approval.

Subd. 3. [Repealed, 1998 c 407 art 5 s 48]

Subd. 4. Eligibility as Minnesota resident. (a) For purposes of this section, a permanent Minnesota resident is a person who has demonstrated, through persuasive and objective evidence, that the person is domiciled in the state and intends to live in the state permanently.

(b) To be eligible as a permanent resident, an applicant must demonstrate the requisite intent to live in the state permanently by:

(1) showing that the applicant maintains a residence at a verified address other than a place of public accommodation, through the use of evidence of residence described in section 256D.02, subdivision 12a, clause (1);

(2) demonstrating that the applicant has been continuously domiciled in the state for no less than 180 days immediately before the application; and

(3) signing an affidavit declaring that (A) the applicant currently resides in the state and intends to reside in the state permanently; and (B) the applicant did not come to the state for the primary purpose of obtaining medical coverage or treatment.

(c) A person who is temporarily absent from the state does not lose eligibility for MinnesotaCare. "Temporarily absent from the state" means the person is out of the state for a temporary purpose and intends to return when the purpose of the absence has been accomplished. A person is not temporarily absent from the state if another state has determined that the person is a resident for any purpose. If temporarily

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absent from the state, the person must follow the requirements of the health plan in which the person is enrolled to receive services.

Subd. 5. Persons excluded as permanent residents. An individual or family that moved to Minnesota primarily to obtain medical treatment or health coverage for a preexisting condition is not a permanent resident.

Subd. 6. 12-month preexisting exclusion. If the 180-day requirement in subdivision 4, paragraph (b), clause (2), is determined by a court to be unconstitutional, the commissioner of human services shall impose a 12-month preexisting condition exclusion on coverage for persons who have been domiciled in the state for less than 180 days.

Subd. 7. Effect of a court determination. If any paragraph, sentence, clause, or phrase of this section is for any reason determined by a court to be unconstitutional, the decision shall not affect the validity of the remaining portions of the section. The legislature declares that it would have passed each paragraph, sentence, clause, and phrase in this section, irrespective of the fact that any one or more paragraphs, sentences, clauses, or phrases is declared unconstitutional.

History: 1986 c 444; 1992 c 549 art 4 s 10,19; 1993 c 247 art 4 s 11; 1994 c 625 art 8 s 72; 1997 c 225 art 1 s 14; 1998 c 407 art 5 s 34-36

256L.10 APPEALS.

If the commissioner suspends, reduces, or terminates eligibility for the MinnesotaCare program, or services provided under the MinnesotaCare program, the commissioner must provide notification according to the laws and rules governing the medical assistance program. A MinnesotaCare program applicant or enrollee aggrieved by a determination of the commissioner has the right to appeal the determination according to section 256.045.

History: 1986 c 444; 1991 c 292 art 4 s 17; 1992 c 549 art 4 s 11,19; 1993 c 247 art 4 s 11; 1994 c 625 art 8 s 72

256L.11 PROVIDER PAYMENT.

Subdivision 1. Medical assistance rate to be used. Payment to providers under sections 256L.01 to 256L.11 shall be at the same rates and conditions established for medical assistance, except as provided in subdivisions 2 to 6.

Subd. 2. Payment of certain providers. Services provided by federally qualified health centers, rural health clinics, and facilities of the Indian health service shall be paid for according to the same rates and conditions applicable to the same service provided by providers that are not federally qualified health centers, rural health clinics, or facilities of the Indian health service.

Subd. 3. Inpatient hospital services. Inpatient hospital services provided under section 256L.03, subdivision 3, shall be paid for as provided in subdivisions 4 to 6.

Subd. 4. Definition of medical assistance rate for inpatient hospital services. The "medical assistance rate," as used in this section to apply to rates for providing inpatient hospital services, means the rates established under sections 256.9685 to 256.9695 for providing inpatient hospital services to medical assistance recipients who receive Minnesota family investment program assistance.

Subd. 5. Enrollees younger than 18. Payment for inpatient hospital services provided to MinnesotaCare enrollees who are younger than 18 years old on the date of admission to the inpatient hospital shall be at the medical assistance rate.

Subd. 6. Enrollees 18 or older. Payment by the MinnesotaCare program for inpatient hospital services provided to MinnesotaCare enrollees eligible under section 256L.04, subdivision 7, or who qualify under section 256L.04, subdivisions 1 and 2, with family gross income that exceeds 175 percent of the federal poverty guidelines and who are not pregnant, who are 18 years old or older on the date of admission to the inpatient hospital must be in accordance with paragraphs (a) and (b). Payment for

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adults who are not pregnant and are eligible under section 256L.04, subdivisions 1 and 2, and whose incomes are equal to or less than 175 percent of the federal poverty guidelines, shall be as provided for under paragraph (c).

(a) If the medical assistance rate minus any copayment required under section 256L.03, subdivision 4, is less than or equal to the amount remaining in the enrollee's benefit limit under section 256L.03, subdivision 3, payment must be the medical assistance rate minus any copayment required under section 256L.03, subdivision 4. The hospital must not seek payment from the enrollee in addition to the copayment. The MinnesotaCare payment plus the copayment must be treated as payment in full.

(b) If the medical assistance rate minus any copayment required under section 256L.03, subdivision 4, is greater than the amount remaining in the enrollee's benefit limit under section 256L.03, subdivision 3, payment must be the lesser of:

(1) the amount remaining in the enrollee's benefit limit; or

(2) charges submitted for the inpatient hospital services less any copayment established under section 256L.03, subdivision 4.

The hospital may seek payment from the enrollee for the amount by which usual and customary charges exceed the payment under this paragraph. If payment is reduced under section 256L.03, subdivision 3, paragraph (b), the hospital may not seek payment from the enrollee for the amount of the reduction.

(c) For admissions occurring during the period of July 1, 1997, through June 30, 1998, for adults who are not pregnant and are eligible under section 256L.04, subdivisions 1 and 2, and whose incomes are equal to or less than 175 percent of the federal poverty guidelines, the commissioner shall pay hospitals directly, up to the medical assistance payment rate, for inpatient hospital benefits in excess of the \$10,000 annual inpatient benefit limit.

History: 1993 c 345 art 9 s 9; 1994 c 625 art 8 s 57; 1997 c 225 art 1 s 15; 1998 c 407 art 5 s 37; 1999 c 159 s 106

256L.12 MANAGED CARE.

Subdivision 1. Selection of vendors. In order to contain costs, the commissioner of human services shall select vendors of medical care who can provide the most economical care consistent with high medical standards and shall, where possible, contract with organizations on a prepaid capitation basis to provide these services. The commissioner shall consider proposals by counties and vendors for managed care plans which may include: prepaid capitation programs, competitive bidding programs, or other vendor payment mechanisms designed to provide services in an economical manner or to control utilization, with safeguards to ensure that necessary services are provided.

Subd. 2. Geographic area. The commissioner shall designate the geographic areas in which eligible individuals must receive services through managed care plans.

Subd. 3. Limitation of choice. Persons enrolled in the MinnesotaCare program who reside in the designated geographic areas must enroll in a managed care plan to receive their health care services. Enrollees must receive their health care services from health care providers who are part of the managed care plan provider network, unless authorized by the managed care plan, in cases of medical emergency, or when otherwise required by law or by contract.

If only one managed care option is available in a geographic area, the managed care plan may require that enrollees designate a primary care provider from which to receive their health care. Enrollees will be permitted to change their designated primary care provider upon request to the managed care plan. Requests to change primary care providers may be limited to once annually. If more than one managed care plan is offered in a geographic area, enrollees will be enrolled in a managed care plan for up to one year from the date of enrollment, but shall have the right to change to another managed care plan once within the first year of initial enrollment. Enrollees may also change to another managed care plan during an annual 30-day open

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enrollment period. Enrollees shall be notified of the opportunity to change to another managed care plan before the start of each annual open enrollment period.

Enrollees may change managed care plans or primary care providers at other than the above designated times for cause as determined through an appeal pursuant to section 256.045.

Subd. 4. Exemptions to limitations on choice. All contracts between the department of human services and prepaid health plans to serve medical assistance, general assistance medical care, and MinnesotaCare recipients must comply with the requirements of United States Code, title 42, section 1396a (a)(23)(B), notwithstanding any waivers authorized by the United States Department of Health and Human Services pursuant to United States Code, title 42, section 1315.

Subd. 5. Eligibility for other state programs. MinnesotaCare enrollees who become eligible for medical assistance or general assistance medical care will remain in the same managed care plan if the managed care plan has a contract for that population. Effective January 1, 1998, MinnesotaCare enrollees who were formerly eligible for general assistance medical care pursuant to section 256D.03, subdivision 3, within six months of MinnesotaCare enrollment and were enrolled in a prepaid health plan pursuant to section 256D.03, subdivision 4, paragraph (d), must remain in the same managed care plan if the managed care plan has a contract for that population. Managed care plans must participate in the MinnesotaCare and general assistance medical care programs under a contract with the department of human services in service areas where they participate in the medical assistance program.

Subd. 6. Copayments and benefit limits. Enrollees are responsible for all copayments in section 256L.03, subdivision 4, and shall pay copayments to the managed care plan or to its participating providers. The enrollee is also responsible for payment of inpatient hospital charges which exceed the MinnesotaCare benefit limit.

Subd. 7. Managed care plan vendor requirements. The following requirements apply to all counties or vendors who contract with the department of human services to serve MinnesotaCare recipients. Managed care plan contractors:

(1) shall authorize and arrange for the provision of the full range of services listed in section 256L.03 in order to ensure appropriate health care is delivered to enrollees;

(2) shall accept the prospective, per capita payment or other contractually defined payment from the commissioner in return for the provision and coordination of covered health care services for eligible individuals enrolled in the program;

(3) may contract with other health care and social service practitioners to provide services to enrollees;

(4) shall provide for an enrollee grievance process as required by the commissioner and set forth in the contract with the department;

(5) shall retain all revenue from enrollee copayments;

(6) shall accept all eligible MinnesotaCare enrollees, without regard to health status or previous utilization of health services;

(7) shall demonstrate capacity to accept financial risk according to requirements specified in the contract with the department. A health maintenance organization licensed under chapter 62D, or a nonprofit health plan licensed under chapter 62C, is not required to demonstrate financial risk capacity, beyond that which is required to comply with chapters 62C and 62D; and

(8) shall submit information as required by the commissioner, including data required for assessing enrollee satisfaction, quality of care, cost, and utilization of services.

Subd. 8. Chemical dependency assessments. The managed care plan shall be responsible for assessing the need and placement for chemical dependency services according to criteria set forth in Minnesota Rules, parts 9530.6600 to 9530.6660.

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Subd. 9. **Rate setting.** Rates will be prospective, per capita, where possible. The commissioner may allow health plans to arrange for inpatient hospital services on a risk or nonrisk basis. The commissioner shall consult with an independent actuary to determine appropriate rates.

Subd. 10. **Childhood immunization.** Each managed care plan contracting with the department of human services under this section shall collaborate with the local public health agencies to ensure childhood immunization to all enrolled families with children. As part of this collaboration the plan must provide the families with a recommended immunization schedule.

History: 1993 c 345 art 9 s 10; 1994 c 625 art 8 s 58-60; 1995 c 234 art 6 s 17; 1997 c 225 art 1 s 16; art 2 s 56,62; 1998 c 407 art 5 s 38

256L.13 [Repealed, 1998 c 407 art 5 s 48]

256L.14 [Repealed, 1998 c 407 art 5 s 48]

256L.15 PREMIUMS.

Subdivision 1. **Premium determination.** Families with children and individuals shall pay a premium determined according to a sliding fee based on a percentage of the family's gross family income. Pregnant women and children under age two are exempt from the provisions of section 256L.06, subdivision 3, paragraph (b), clause (3), requiring disenrollment for failure to pay premiums. For pregnant women, this exemption continues until the first day of the month following the 60th day postpartum. Women who remain enrolled during pregnancy or the postpartum period, despite nonpayment of premiums, shall be disenrolled on the first of the month following the 60th day postpartum for the penalty period that otherwise applies under section 256L.06, unless they begin paying premiums.

Subd. 1a. **Payment options.** The commissioner may offer the following payment options to an enrollee:

- (1) payment by check;
- (2) payment by credit card;
- (3) payment by recurring automatic checking withdrawal;
- (4) payment by one-time electronic transfer of funds;
- (5) payment by wage withholding with the consent of the employer and the employee; or
- (6) payment by using state tax refund payments.

At application or reapplication, a MinnesotaCare applicant or enrollee may authorize the commissioner to use the Revenue Recapture Act in chapter 270A to collect funds from the applicant's or enrollee's state income tax refund for the purposes of meeting all or part of the applicant's or enrollee's MinnesotaCare premium obligation for the forthcoming year. The applicant or enrollee may authorize the commissioner to apply for the state working family tax credit on behalf of the applicant or enrollee. The setoff due under this subdivision shall not be subject to the \$10 fee under section 270A.07, subdivision 1.

Subd. 1b. **Payments nonrefundable.** Only MinnesotaCare premiums paid for future months of coverage for which a health plan capitation fee has not been paid may be refunded.

Subd. 2. **Sliding fee scale to determine percentage of gross individual or family income.** (a) The commissioner shall establish a sliding fee scale to determine the percentage of gross individual or family income that households at different income levels must pay to obtain coverage through the MinnesotaCare program. The sliding fee scale must be based on the enrollee's gross individual or family income. The sliding fee scale must contain separate tables based on enrollment of one, two, or three or more persons. The sliding fee scale begins with a premium of 1.5 percent of gross individual or family income for individuals or families with incomes below the limits for

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the medical assistance program for families and children in effect on January 1, 1999, and proceeds through the following evenly spaced steps: 1.8, 2.3, 3.1, 3.8, 4.8, 5.9, 7.4, and 8.8 percent. These percentages are matched to evenly spaced income steps ranging from the medical assistance income limit for families and children in effect on January 1, 1999, to 275 percent of the federal poverty guidelines for the applicable family size, up to a family size of five. The sliding fee scale for a family of five must be used for families of more than five. The sliding fee scale and percentages are not subject to the provisions of chapter 14. If a family or individual reports increased income after enrollment, premiums shall not be adjusted until eligibility renewal.

(b) Enrolled individuals and families whose gross annual income increases above 275 percent of the federal poverty guideline shall pay the maximum premium. The maximum premium is defined as a base charge for one, two, or three or more enrollees so that if all MinnesotaCare cases paid the maximum premium, the total revenue would equal the total cost of MinnesotaCare medical coverage and administration. In this calculation, administrative costs shall be assumed to equal ten percent of the total. The costs of medical coverage for pregnant women and children under age two and the enrollees in these groups shall be excluded from the total. The maximum premium for two enrollees shall be twice the maximum premium for one, and the maximum premium for three or more enrollees shall be three times the maximum premium for one.

Subd. 3. **Exceptions to sliding scale.** An annual premium of \$48 is required for all children in families with income at or less than 150 percent of federal poverty guidelines.

History: 1995 c 234 art 6 s 20; 1998 c 407 art 5 s 39; 1999 c 245 art 4 s 99-101

256L.16 PAYMENT RATES; SERVICES FOR FAMILIES AND CHILDREN UNDER THE MINNESOTACARE HEALTH CARE REFORM WAIVER.

Section 256L.11, subdivision 2, shall not apply to services provided to children who are eligible to receive expanded services according to section 256L.03, subdivision 1a.

History: 1995 c 234 art 6 s 21; 1998 c 407 art 5 s 47

256L.17 ASSET REQUIREMENT FOR MINNESOTACARE.

Subdivision 1. **Definitions.** For purposes of this section, the following definitions apply.

(a) "Asset" means cash and other personal property, as well as any real property, that a family or individual owns which has monetary value.

(b) "Homestead" means the home that is owned by, and is the usual residence of, the family or individual, together with the surrounding property which is not separated from the home by intervening property owned by others. Public rights-of-way, such as roads that run through the surrounding property and separate it from the home, will not affect the exemption of the property. "Usual residence" includes the home from which the family or individual is temporarily absent due to illness, employment, or education, or because the home is temporarily not habitable due to casualty or natural disaster.

(c) "Net asset" means the asset's fair market value minus any encumbrances including, but not limited to, liens and mortgages.

Subd. 2. **Limit on total assets.** (a) Effective April 1, 1997, or upon federal approval, whichever is later, in order to be eligible for the MinnesotaCare program, a household of two or more persons must not own more than \$30,000 in total net assets, and a household of one person must not own more than \$15,000 in total net assets.

(b) For purposes of this subdivision, total net assets include all assets, with the following exceptions:

(1) a homestead is not considered;

(2) household goods and personal effects are not considered;

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(3) any assets owned by children;
(4) vehicles used for employment;
(5) court-ordered settlements up to \$10,000;
(6) individual retirement accounts; and
(7) capital and operating assets of a trade or business up to \$200,000 in net assets are not considered.

(c) If an asset excluded under paragraph (b) has a negative value, the negative value shall be subtracted from the total net assets under paragraph (a).

Subd. 3. Documentation. (a) The commissioner of human services shall require individuals and families, at the time of application or renewal, to indicate on a checkoff form developed by the commissioner whether they satisfy the MinnesotaCare asset requirement. This form must include the following or similar language: "To be eligible for MinnesotaCare, individuals and families must not own net assets in excess of \$30,000 for a household of two or more persons or \$15,000 for a household of one person, not including a homestead, household goods and personal effects, assets owned by children, vehicles used for employment, court-ordered settlements up to \$10,000, individual retirement accounts, and capital and operating assets of a trade or business up to \$200,000. Do you and your household own net assets in excess of these limits?"

(b) The commissioner may require individuals and families to provide any information the commissioner determines necessary to verify compliance with the asset requirement, if the commissioner determines that there is reason to believe that an individual or family has assets that exceed the program limit.

Subd. 4. Penalties. Individuals or families who are found to have knowingly misreported the amount of their assets as described in this section shall be subject to the penalties in section 256.98. The commissioner shall present recommendations on additional penalties to the 1998 legislature.

Subd. 5. Exemption. This section does not apply to pregnant women. For purposes of this subdivision, a woman is considered pregnant for 60 days postpartum.

Subd. 6. Waiver of maintenance of effort requirement. Unless a federal waiver of the maintenance of effort requirements of section 2105(d) of title XXI of the Balanced Budget Act of 1997, Public Law Number 105-33, Statutes at Large, volume 111, page 251, is granted by the federal Department of Health and Human Services by September 30, 1998, this section does not apply to children. The commissioner shall publish a notice in the State Register upon receipt of a federal waiver.

History: 1997 c 225 art 1 s 17; 1998 c 407 art 5 s 40

256L.18 PENALTIES.

Whoever obtains or attempts to obtain, or aids or abets any person to obtain by means of a willfully false statement or representation, or by the intentional withholding or concealment of a material fact, or by impersonation, or other fraudulent device:

(1) benefits under the MinnesotaCare program to which the person is not entitled; or

(2) benefits under the MinnesotaCare program greater than that to which the person is reasonably entitled;

shall be considered to have violated section 256.98, and shall be subject to both the criminal and civil penalties provided under that section.

History: 1997 c 225 art 1 s 18