

CHAPTER 256L

MINNESOTACARE

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MINNESOTACARE PROGRAM

256L.01 DEFINITIONS.

Subdivision 1. **Scope.** For purposes of sections 256L.01 to 256L.10, the following terms shall have the meanings given them.

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. 4. **Gross family income.** "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.

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

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. The commissioner must make a quarterly 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 deposited 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.

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

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 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, or 256L.13, 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. 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 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) Beginning July 1, 1993, 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. Effective July 1, 1997, the inpatient hospital benefit for adult enrollees who qualify under section 256L.04, subdivision 7, or who qualify under section 256L.04, subdivisions 1 to 6, or 256L.13 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) Enrollees who qualify under section 256L.04, subdivision 7, or who qualify under section 256L.04, subdivisions 1 to 6, or 256L.13 with family gross income that exceeds 175 percent of the federal poverty guidelines and who are not pregnant, and are determined by the commissioner to have a basis of eligibility for medical assistance shall apply for and cooperate with the requirements of medical assistance by the last day of the third month following admission to an inpatient hospital. If an enrollee fails to apply for medical assistance within this time period, the enrollee and the enrollee's family shall be disenrolled from the plan and they may not reenroll until 12 calendar months have elapsed. Enrollees and enrollees' families disenrolled for not applying for or not cooperating with medical assistance may not reenroll.

(c) 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.

(d) Any enrollee or family member of an enrollee who has previously been permanently disenrolled from MinnesotaCare for not applying for and cooperating with medical assistance shall be eligible to reenroll if 12 calendar months have elapsed since the date of disenrollment.

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, and shall apply to the secretary of health and human services for any necessary federal waivers or approvals.

Subd. 5. Copayments and coinsurance. The MinnesotaCare benefit plan shall include the following copayments and coinsurance requirements:

(1) ten percent of the paid charges for inpatient hospital services for adult enrollees not eligible for medical assistance, 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) effective July 1, 1998, 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, or 256L.13, with income equal to or less than 175 percent of the federal poverty guidelines.

Prior to July 1, 1997, enrollees who are not eligible for medical assistance with or without a spenddown shall be financially responsible for the coinsurance amount and amounts which exceed the \$10,000 benefit limit. Effective July 1, 1997, adult enrollees who qualify under section 256L.04, subdivision 7, or who qualify under section 256L.04, subdivisions 1 to 6, or 256L.13 with family gross income that exceeds 175 percent of the federal poverty guidelines and who are not pregnant, and who are not eligible for medical assistance with or without a spenddown, shall be financially responsible for the coinsurance amount and amounts which exceed the \$10,000 inpatient hospital benefit limit.

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 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 authorized agents of the state agency.

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

NOTE: The amendment to subdivision 7, clause (1), now renumbered as subdivision 5, clause (1), by Laws 1997, chapter 225, article 1, section 3, is effective July 1, 1998. Laws 1997, chapter 225, article 1, section 22.

256L.04 ELIGIBLE PERSONS.

Subdivision 1. Children; expansion and continuation of eligibility. (a) Children. Prior to October 1, 1992, "eligible persons" means children who are one year of age or older but less than 18 years of age who have gross family incomes that are equal to or less than 185 percent of the federal poverty guidelines and who are not eligible for medical assistance without a spenddown under chapter 256B and who are not otherwise insured for the covered services. The period of eligibility extends from the first day of the month in which the child's first birthday occurs to the last day of the month in which the child becomes 18 years old.

(b) Expansion of eligibility. Eligibility for MinnesotaCare shall be expanded as provided in subdivisions 3 to 7, except children who meet the criteria in this subdivision shall continue to be enrolled pursuant to this subdivision. The enrollment requirements in this paragraph apply to enrollment under subdivisions 1 to 7. 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. For purposes of this section, 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. Proof of school enrollment will be required.

(c) Continuation of eligibility. Individuals who initially enroll in the MinnesotaCare program under the eligibility criteria in subdivisions 3 to 7 remain eligible for the MinnesotaCare program, regardless of age, place of residence, or the presence or absence of children in the same household, as long as all other eligibility criteria are met and residence in Minnesota and continuous enrollment in the MinnesotaCare program or medical assistance are maintained. In order for either parent or either spouse in a household to remain enrolled, both must remain enrolled, unless other insurance is available.

Subd. 2. Cooperation. To be eligible for MinnesotaCare, individuals 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.

Subd. 3. Families with children. Beginning October 1, 1992, "eligible persons" means children eligible under subdivision 1, and parents and dependent siblings residing in the same household as a child eligible under subdivision 1.

Subd. 4. Continuation of eligibility. Beginning October 1, 1992, individuals who initially enrolled in the MinnesotaCare program under the eligibility criteria in subdivision 1 or 3 remain eligible even if their gross income after enrollment exceeds 185 percent of the federal poverty guidelines, subject to any premium required under section 256L.07, as long as all other eligibility requirements are met and continuous enrollment in the MinnesotaCare program or medical assistance is maintained.

Subd. 5. Families with children; eligibility based on percentage of income paid for health coverage. Beginning January 1, 1993, "eligible persons" means children, parents, and dependent siblings residing in the same household. Children who meet the criteria in subdivision 1 or 6 shall continue to be enrolled pursuant to those subdivisions. Persons who are eligible under this subdivision or subdivision 3, 4, or 7 must pay a premium as determined under sections 256L.07 and 256L.08, and children eligible under subdivision 1 must pay the premium required under section 256L.06, subdivision 1. Individuals and families whose income is greater than the limits established under section 256L.08 may not enroll in MinnesotaCare.

Subd. 6. Children with lower incomes. Beginning July 1, 1993, the definition of "eligible persons" is expanded to include children who are one year of age or older but less than 18 years of age who have gross family incomes that are equal to or less than 150 percent of the federal poverty guidelines and who are not eligible for medical assistance without a spenddown under chapter 256B and who are not otherwise insured for the covered services. The period of eligibility extends from the first day of the month in which the child's first birthday occurs to the last day of the month in which the child becomes 18 years old. The commissioner shall exclude all earned income of dependent children who:

- (1) are full-time or part-time students;
- (2) are employed for less than 37.5 hours per week; and
- (3) earn less than \$10,000 a year in total from all sources of employment, when calculating gross family incomes for applicants who would otherwise be eligible under this subdivision.

Subd. 7. Addition of single adults and households with no children. (a) Beginning October 1, 1994, the definition of "eligible persons" is expanded to include all individuals and households with no children who have gross family incomes that are equal to or less than 125 percent of the federal poverty guidelines and who are not eligible for medical assistance without a spenddown under chapter 256B.

(b) Beginning July 1, 1997, the definition of eligible persons is expanded to include 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 and who are not eligible for medical assistance without a spenddown under chapter 256B.

(c) All eligible persons under paragraphs (a) and (b) are eligible for coverage through the MinnesotaCare program but must pay a premium as determined under sections 256L.07 and 256L.08. Individuals and families whose income is greater than the limits established under section 256L.08 may not enroll in the MinnesotaCare program.

Subd. 8. Applicants potentially eligible for medical assistance. Individuals who apply for MinnesotaCare who qualify under section 256L.04, 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 such individuals to their county social service agency. 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 apply for and cooperate with medical assistance within the 60-day enrollment period, and

their other family members, 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 for the family member or members who were referred to the county agency. 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. The commissioner shall re-determine 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.

Subd. 10. Sponsor's income and resources deemed available. When determining eligibility for any federal or state benefits under sections 256L.01 to 256L.16, 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.

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 the MinnesotaCare program enrollment.

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

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. 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 family income, earned and unearned, including the most recent income tax return, wage slips, or other documentation that is 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. The effective date of coverage for eligible newborns or 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 eligi-

bility is approved and the first premium payment has been received. 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.10 are secondary to a plan of insurance or benefit program under which an 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. 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.

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 to all families and individuals enrolled in the MinnesotaCare program whose gross family income is equal to or more than 200 percent of the federal poverty guidelines. This information must be provided upon initial enrollment and annually thereafter.

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

256L.06 PREMIUM FEES AND PAYMENTS.

Subdivision 1. Premium fees. An annual premium fee of \$48 is required from all MinnesotaCare enrollees eligible under section 256L.04, subdivision 1.

Subd. 2. Premium payments. The commissioner shall require MinnesotaCare enrollees eligible under section 256L.04, subdivisions 3 to 7, to pay a premium based on a sliding scale, as established under section 256L.08. The following applicants are exempt from this requirement until July 1, 1993:

(1) applicants who are eligible under Minnesota Statutes 1992, section 256.9354, subdivision 1, if the application is received by MinnesotaCare staff on or before September 30, 1992; and

(2) children who enroll in the MinnesotaCare program after September 30, 1992, pursuant to Laws 1992, chapter 549, article 4, section 17.

Subd. 3. Administration and commissioner's duties. Premiums are dedicated to the commissioner for MinnesotaCare. The commissioner shall make an annual redetermination of continued eligibility and identify people who may become eligible for medical assistance. The commissioner shall develop and implement procedures to: (1) require enrollees to report changes in income; (2) adjust sliding scale premium payments, based upon changes in enrollee income; and (3) disenroll enrollees from MinnesotaCare for failure to pay required premiums. 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. Premium payment is required before enrollment is complete and to maintain eligibility in MinnesotaCare. Nonpayment of the premium will result in disenrollment from the plan within one calendar month after the due date. Persons disenrolled for nonpayment may not reenroll until four calendar months have elapsed. Persons disenrolled for nonpayment 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

256L.07 ELIGIBILITY FOR SUBSIDIZED PREMIUMS BASED ON SLIDING SCALE.

Subdivision 1. **General requirements.** Families and individuals who enroll on or after October 1, 1992, are eligible for subsidized premium payments based on a sliding scale under section 256L.08 only if the family or individual meets the requirements in subdivisions 2 and 3. Children already enrolled in the children's health plan as of September 30, 1992, eligible under section 256L.04, subdivision 1, paragraph (a), children who enroll in the MinnesotaCare program after September 30, 1992, pursuant to Laws 1992, chapter 549, article 4, section 17, and children who enroll under section 256L.04, subdivision 6, are eligible for subsidized premium payments without meeting these requirements, as long as they maintain continuous coverage in the MinnesotaCare plan or medical assistance.

Families and individuals who initially enrolled in MinnesotaCare under section 256L.04, and whose income increases above the limits established in section 256L.08, may continue enrollment and pay the full cost of coverage.

Subd. 2. **Must not have access to employer-subsidized coverage.** (a) To be eligible for subsidized premium payments based on a sliding scale, a family or individual must not have access to subsidized health coverage through an employer, and must not have had access to subsidized health coverage through an employer for the 18 months prior to application for subsidized coverage under the MinnesotaCare program. The requirement that the family or individual must not have had access to employer-subsidized coverage during the previous 18 months does not apply if: (1) employer-subsidized coverage was lost due to the death of an employee or divorce; (2) employer-subsidized coverage was lost because an individual became ineligible for coverage as a child or dependent; or (3) employer-subsidized coverage was lost for reasons that would not disqualify the individual for unemployment benefits under section 268.09 and the family or individual has not had access to employer-subsidized coverage since the loss of coverage. If employer-subsidized coverage was lost for reasons that disqualify an individual for unemployment benefits under section 268.09, children of that individual are exempt from the requirement of no access to employer subsidized coverage for the 18 months prior to application, as long as the children have not had access to employer subsidized coverage since the disqualifying event. The requirement that the family or individual must not have had access to employer-subsidized coverage during the previous 18 months does apply if employer-subsidized coverage is lost due to an employer terminating health care coverage as an employee benefit.

(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, excluding dependent coverage, 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 as qualified employer subsidies toward the cost of health coverage for employees for purposes of this subdivision.

Subd. 3. **Period uninsured.** To be eligible for subsidized premium payments based on a sliding scale, families and individuals initially enrolled in the MinnesotaCare program under section 256L.04, subdivisions 5 and 7, must have had no health coverage for at least four months prior to application. The commissioner may change this eligibility criterion for sliding scale premiums in order to remain within the limits of available appropriations. The requirement of at least four months of no health coverage prior to application for the MinnesotaCare program does not apply to:

(1) families, children, and individuals who apply for the MinnesotaCare program upon termination from or as required by the medical assistance program, general assistance medical care program, or coverage under a regional demonstration project for the uninsured funded under section 256B.73, the Hennepin county assured care program, or the Group Health, Inc., community health plan;

(2) families and individuals initially enrolled under section 256L.04, subdivisions 1, paragraph (a), and 3;

(3) children enrolled pursuant to Laws 1992, chapter 549, article 4, section 17; or

(4) individuals currently serving or who have served in the military reserves, and dependents of these individuals, if these individuals: (i) reapply for MinnesotaCare coverage after a period of active military service during which they had been covered by the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); (ii) were covered under MinnesotaCare immediately prior to obtaining coverage under CHAMPUS; and (iii) have maintained continuous coverage.

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

256L.08 PREMIUMS.

Subdivision 1. Premium determination. Each individual or family enrolled in the MinnesotaCare program shall pay a premium determined according to a sliding fee based on the cost of coverage as a percentage of the individual's or family's gross family income.

Subd. 2. Sliding scales to determine percentage of gross family income. The commissioner shall establish sliding scales to determine the percentage of gross family income that households at different income levels must pay to obtain coverage through the MinnesotaCare program. The sliding scale must be based on the enrollee's gross family income, as defined in section 256L.01, subdivision 4, during the previous four months. The sliding scale must provide separate sliding scales for individuals, two-person households, and households of three or more.

Subd. 3. Sliding scales after June 30, 1993. Beginning July 1, 1993, the sliding scales begin with a premium of 1.5 percent of gross family income for individuals with incomes below the limits for the medical assistance program set at 133–1/3 percent of the AFDC payment standard and proceed through the following evenly spaced steps: 1.8, 2.3, 3.1, 3.8, 4.8, 5.9, 7.4, and 8.8. These percentages are matched to evenly spaced income steps ranging from the medical assistance income limit to a gross monthly income of \$1,600 for an individual, \$2,160 for a household of two, \$2,720 for a household of three, \$3,280 for a household of four, and \$3,840 for a household of five or more persons.

Subd. 4. Ineligibility. Families with children whose gross monthly income is above the amount specified in subdivision 3 are not eligible for the plan. An individual or households with no children whose gross family income is greater than the amount specified in section 256L.04, subdivision 7, are ineligible for the plan.

Subd. 5. Premium collection through wage withholding. The premium for coverage under the MinnesotaCare program may be collected through wage withholding with the consent of the employer and the employee.

Subd. 6. Exclusion from chapter 14. The sliding fee scale and percentages are not subject to the provisions of chapter 14.

Subd. 7. Minimum premium payment. Beginning with premium payments due on or after July 1, 1995, the commissioner shall require all MinnesotaCare enrollees to pay a minimum premium of \$4 per month.

History: 1986 c 444; 1992 c 549 art 4 s 9,19; 1993 c 247 art 4 s 11; 1994 c 625 art 8 s 72; art 13 s 5; 1995 c 234 art 6 s 14–16; 1997 c 225 art 1 s 13

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) Prior to July 1, 1997, to be eligible for health coverage under the MinnesotaCare program, families and individuals must be permanent residents of Minnesota.

(b) Effective July 1, 1997, to be eligible for health coverage under the MinnesotaCare program, adults without children must be permanent residents of Minnesota.

(c) Effective July 1, 1997, 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. Permanent Minnesota resident. 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.

Subd. 4. Eligibility as Minnesota resident. To be eligible, all applicants 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.

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, 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

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 aid to families with dependent children.

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 to 6, or 256L.13 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 adults who are not pregnant and are eligible under section 256L.04, subdivisions 1 to 6, or 256L.13, 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 (c), 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 to 6, or 256L.13, 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

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 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. Contracts between the department of human services and managed care plans must include MinnesotaCare, and medical assistance and may, at the option of the commissioner of human services, also include general assistance medical care.

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.

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 non-risk 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

ELIGIBILITY FOR MINNESOTACARE FOR FAMILIES UNDER HEALTH CARE REFORM WAIVER

256L.13 ELIGIBILITY FOR MINNESOTACARE FOR FAMILIES AND CHILDREN UNDER THE MINNESOTACARE HEALTH CARE REFORM WAIVER.

Subdivision 1. Families with children; in general. 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 determined eligible for MinnesotaCare according to this section, and section 256L.04, subdivisions 3 to 6, shall no longer apply. All other provisions of sections 256L.01 to 256L.12, including the insurance-related barriers to enrollment under section 256L.07, shall apply unless otherwise specified in sections 256L.13 to 256L.16.

Subd. 2. Children. For purposes of sections 256L.13 to 256L.16, a “child” is an individual under 21 years of age, including the unborn child of a pregnant woman, and including an emancipated minor, and the emancipated minor’s spouse.

Subd. 3. Families with children. For purposes of sections 256L.13 to 256L.16, a “family with children” means a parent or parents and their children, or legal guardians and their wards who are children, and dependent siblings, residing in the same household. The term includes children and dependent siblings who are temporarily absent from the household in settings such as schools, camps, or visitation with noncustodial parents. For purposes of this section, 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. Proof of school enrollment will be required.

Subd. 4. Children in families with income at or less than 150 percent of federal poverty guidelines. Children who have gross family incomes that are equal to or less than 150 percent of the federal poverty guidelines and who are not otherwise insured for the covered services, are eligible for enrollment under sections 256L.13 to 256L.16. For the purposes of

this section, "not otherwise insured for covered services" has the meaning given in Minnesota Rules, part 9506.0020, subpart 3, item B.

Subd. 5. Residency. Families and children who are otherwise eligible for enrollment under this section are exempt from the Minnesota residency requirements of section 256L.09, if they meet the residency requirements of the medical assistance program according to chapter 256B.

Subd. 6. Cooperation with medical assistance. Pregnant women and children applying for MinnesotaCare under this section are not required to apply for the medical assistance program as a condition of enrollment. Other adults enrolled in MinnesotaCare determined by the commissioner to have a basis of eligibility for medical assistance must cooperate in completing an application for medical assistance by the last day of the third month following admission to an inpatient hospital. If an enrollee fails to complete an application for medical assistance within this time period, the enrollee shall be disenrolled and may not reenroll.

Subd. 7. Cooperation in establishing paternity and other medical support. Families and children enrolled in the MinnesotaCare program must cooperate with the department of human services and the local agency in establishing 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 of the child's parent or caretaker's failure to cooperate in establishing paternity or obtaining medical support.

History: 1995 c 234 art 6 s 18

256L.14 COVERED SERVICES FOR PREGNANT WOMEN AND CHILDREN UNDER THE MINNESOTACARE HEALTH CARE REFORM WAIVER.

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. Pregnant women and children are exempt from the provisions of section 256L.03, subdivision 5, regarding copayments.

History: 1995 c 234 art 6 s 19

256L.15 PREMIUMS.

Subdivision 1. Premium determination. Families and children enrolled according to sections 256L.13 to 256L.16 shall pay a premium determined according to a sliding fee based on the cost of coverage as 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, 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.

Subd. 2. Sliding scale to determine percentage of gross family income. The commissioner shall establish a sliding fee scale to determine the percentage of gross 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 family income during the previous four months. The sliding fee scale begins with a premium of 1.5 percent of gross family income for families with incomes below the limits for the medical assistance program for families and children 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 to 275 percent of the federal poverty guidelines for the applicable family size. The sliding fee scale and percentages are not subject to the provisions of chapter 14. If a family reports increased income after enrollment, premiums shall not be adjusted until eligibility renewal.

Subd. 3. **Exceptions to sliding scale.** An annual premium of \$48 is required for all children who are eligible according to section 256L.13, subdivision 4.

History: 1995 c 234 art 6 s 20

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.14.

History: 1995 c 234 art 6 s 21

ASSET LIMIT

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;
- (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.

History: 1997 c 225 art 1 s 17

PENALTIES

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