Written Testimony to Human Services Finance & Policy Committee

February 10, 2025

Re: Opposition to Governor Walz's budget proposal

Chair Joe Schomacker and Committee members,

I am writing in opposition to Governor Walz's Budget proposal because it balances the budget on the backs of people with disabilities – some of the most vulnerable citizens in the state.

As the parent of two adult daughters who receive Medicaid waivered services and rely on service providers for their support, many of the cuts proposed by the Governor are untenable. For example, capping inflationary adjustments and reducing the inflation rate from 6% to 2%. This will severely damage any progress that has been made over the past few years to help stabilize the direct care workforce. The U.S. Bureau of Labor Statistics shows that direct care workers who are primarily women, people of color and immigrants make an average of $17/hour. A 2% inflationary increase will make it impossible to find and retain critical direct care workers. A 2017 Workgroup between the Olmstead subcabinet and DHS/DEED had as their #1 priority to increase direct care support professional wages and benefits. This budget proposal flies in the face of this important priority.

It is also impractical to expect providers to be financially sound if they are receiving a 2% inflationary increase when inflation is 6%.

I propose we find alternative ways to cover the budget deficit. In the human services world, here are 3 ideas:

1. DHS Appeals – often DHS spends more on waiver appeals than the amount of the item being appealed.
2. 3-Year psychological evaluation for recipients of Developmental Disabilities waiver - Many people with intellectual disabilities are going to have an IQ<70 for life and that is not going to change.
3. Annual MNChoices assessment – Change from annual to every three years. If a recipient needs a more frequent assessment due to change in need, they can request it.

Thank you for reading my testimony.

Lisa Vala

Disability Advocate
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Lisa_v3@yahoo.com

Driving Excellence in Addiction Care

To: Chairs Schomacker; House Human Services Finance and Policy Committee

From: Brian Zirbes, MARRCH Executive Director

Subject: Public Testimony of the 2025 Governor's Budget

Date: February 12, 2025

MARRCH, the statewide trade association for Substance Use Disorder (SUD) programs and professionals, represents thousands of dedicated individuals and organizations committed to providing life-saving care to Minnesotans. Through education, training, advocacy, and public policy engagement, we support the critical work of our members and the countless lives they touch each year.

After reviewing the proposed 2025 Governor's budget, we recognize several thoughtful proposals, such as extending audio-only telehealth options and the effort to maintain a balanced budget for FY 28-29. However, we are deeply alarmed and disappointed that the budget fails to address the dire need for rate adjustments for SUD services, as recommended in the January 2024 Outpatient Services Rate Study

For over a decade, SUD providers have endured numerous rate studies, each shining a spotlight on the chronic underfunding of these essential services. The most recent study by Burnes & Associates offered a glimmer of hope, with data-backed recommendations reflecting the true cost of delivering care under the American Society of Addiction Medicine (ASAM) Levels of Care. Despite broad consensus on the accuracy of these findings and the urgent need for change, this budget overlooks the crisis.

The study revealed that 8 of the 9 SUD rates require increases, with the most critical—low-intensity residential care (ASAM 3.1)—needing a staggering 171.7% adjustment. **On average, a 68% rate increase is necessary across services to ensure that providers can continue delivering high-quality care.** Ignoring these recommendations means that more programs are going to close and clients will be denied access to services.

We appreciate the willingness of the Governor's office and DHS to continue to meet with us on the Governor's proposals. We have another meeting next week to get clarification on some of the proposals including changes to SUD treatment service changes, enhanced regulations, and changes to the Behavioral Health Fund eligibility and timelines.

There needs to be a balanced approach to regulation and rates. The ongoing workforce challenges are compounding the crisis. Clinical services are strained, providers are overwhelmed, and the ripple effects are felt by families and communities across the state. Each day that passes without action deepens the crisis and places more lives at risk. Another year of inaction is not just a missed opportunity—it's a failure to meet the needs of thousands of Minnesotans who depend on these services.

We urge legislators to identify and prioritize funding to begin implementing the rate recommendations without delay. With a projected $355 million surplus in FY 28-29, there is a clear opportunity to invest in the sustainability of SUD programs—a critical lifeline for individuals, families, and communities. A study of California's SUD treatment programs found every dollar spent on drug and alcohol treatment saves the public seven dollars through reduced crime. When averted health care costs are included, the savings increase to $12 for each dollar invested. Taking a balanced approach to this investment is not just fiscally responsible; it is morally imperative.

SUD treatment saves lives, strengthens families, and rebuilds communities. By addressing the funding disparities and supporting the dedicated providers on the frontlines, Minnesota can reaffirm its commitment to the health and well-being of its citizens. We ask for your leadership and action to ensure that these life-saving programs are not just sustained but strengthened for the future.

Thank you for your time and consideration. We stand ready to assist and provide any further information to support these critical changes.

Minnesota Hospital Association

161 Rondo Ave., Ste. 915
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www.mnhospitals.org

February 12, 2025 *Submitted Electronically*

Chair Schomacker and members of the House Human Services Finance and Policy Committee,

We are writing to you today on behalf of the Minnesota Hospital Association (MHA) regarding the recently released Governor's Human Services Budget proposal.

MHA opposes the Pharmacy Carve-Out (HC-91) and its unnecessary negative impacts to the Federal 340B Drug Pricing Program. Although we support making improvements to the operations of Pharmacy Benefit Managers (PBMs) used by Minnesota's managed care organizations (MCO), this budget proposal triggers a federal rule that would unnecessarily and negatively impact disproportionate share and children's hospitals, critical access hospitals, federally qualified health centers, Ryan White HIV clinics, family planning clinics, and other critical safety-net providers across Minnesota. These safety net providers would collectively lose roughly $86M+ in annual savings on outpatient drugs from the Federal 340B Drug Pricing Program (340B) that are used today to help provide access to health care and community support services across Minnesota.

The federal government created 340B to help offset Medicaid underpayments, reduce exorbitant prices from pharmaceutical companies, and stretch scarce federal resources to support more patients. The program requires pharmaceutical manufacturers participating in Medicaid to sell outpatient drugs at significantly discounted prices to specific safety net health care providers that serve many uninsured and low-income patients. The proposed exclusion of the Medical Assistance (MA) outpatient prescription drug benefit from MCOs and moving it to fee-for-service (FFS) will mean a significant loss of funding for 340B hospitals and other safety net providers.

While this proposal increases the state's ability to get Medicaid rebate revenue, it is at the greater expense of safety net providers and offers no clarity or transparency on how the Department of Human Services (DHS) would better serve patient care needs. Further, transparency does not currently exist for the hundreds of millions of dollars in Medicaid drug rebate revenue that DHS receives annually. However, information from recent MA rate studies clearly shows that MA reimbursement rates chronically lag below actual costs and do not adequately support patient care – this is one of the reasons why 340B is crucial in Minnesota.

Lastly, the negative impacts to safety net providers that will result from this proposal are not necessary. States such as Kentucky and Ohio have implemented single PBM models in their Medicaid programs that remain in managed care, control and limit negative PBM practices, optimizes 340B, and does not negatively harm patient access to care. We urge the legislature to pursue the models that Kentucky and Ohio have implemented.

MHA supports Extending Access to Audio-only Telehealth (HC-54). Medical Assistance (MA) coverage for audio-only telehealth services has been invaluable in expanding access to critical health care services and helping mitigate the provider workforce shortage. A study released by the

Minnesota Department of Health (MDH) in September 2024 found that telehealth expanded access to patient care without increasing health care spending. Specifically, MDH outlines how audio-only telehealth is an important tool to increase availability of equitable care to patients with behavioral health and chronic care conditions and individuals with limited broadband access. According to the Minnesota Office of Broadband Development, only 78% of non-metro households have access to adequate broadband services to accommodate audio-visual telehealth. In addition, many hospitals and health systems in both rural and urban areas rely on audio-only telehealth services to provide ongoing care coordination services, which helps prevent health complications and more costly care.

Lastly, the MDH report explicitly recommends audio-only telehealth to be included in the definition of telehealth in Minnesota statute and therefore be subject to payment parity and coverage requirements. MHA encourages the legislature to support the Governor's proposal to preserve patient access to telehealth services in all geographic areas of the state by extending patient access to audio-only telehealth services.

Thank you for your consideration for our comments.

Sincerely,

Mary Krinkie
Vice President of Government Relations
mkrinkie@mnhospitals.org

Danny Ackert
Director of State Government Relations
dackert@mnhospitals.org

February 12, 2025

House Human Services Finance and Policy Committee

RE: Governor Walz's Budget Recommendations

Chair Schomacker and members of the House Human Services Finance and Policy Committee:

The Minnesota First Provider Alliance (the "Provider Alliance") is a trade association of personal care assistance (PCA)/Community First Services and Supports (CFSS) agencies and waiver service providers. The PCA/CFSS program is a critical service that assists over 47,000 Minnesotans in their home and community. We are writing to provide comments on the Governor's budget recommendations.

The Provider Alliance is supportive of the Governor's proposal to increase the enhanced PCA/CFSS rate from 7.5% to 12.5% as part of the ratification of the state's collective bargaining agreement with Service Employees International Union of Minnesota (SEIU). Minnesotans with the highest support needs often have a greater level of difficulty in recruiting and retaining staff. This has forced individuals to relinquish their preferred choice of living in the community or even going without the care they need. Increasing the enhanced rate will ensure people with disabilities can pay higher wages to attract and retain staff and therefore maintain their choice of living in their communities. In the same vein, the Provider Alliance supports the proposed modest CFSS rate and budget increase as well as the improved benefits and other investments in the CFSS workforce.

Simultaneously, the Provider Alliance is concerned that the proposed budget for the Minnesota Department of Human Services (DHS) does not appear to address, or even acknowledge, the chaotic and disjointed implementation of the PCA/CFSS program. Following nearly 12 years of engagement with DHS on issues related to the PCA/CFSS transition, the Provider Alliance is dismayed by what we have seen in the last four months. Between the stagnant enrollment of CFSS providers and consultation services providers, miscommunication with lead agencies about service authorizations and client choice, and countless other systemic and process issues, we are not sure how this could have been ignored. Our only hypothesis is that DHS believes it can address the ongoing problems without legislative involvement. While we hope that the problems are easily resolved, we believe that DHS' failure to collaborate with stakeholders, including this committee, is a large reason the transition has been so problematic.

Lastly, the Provider Alliance would like to note the program integrity initiatives in the DHS budget proposal. We have historically brought forward ideas for how to increase oversight of PCA agencies and have been frustrated by the reluctance of DHS to accept those suggestions. The Provider Alliance is looking forward to reviewing the legislative language behind these proposals as we adamantly believe that any increase in provider oversight needs to be coupled with meaningful due process and a focus on actual fraud versus imperfect compliance with program rules. We look forward to learning more about the proposal as the legislative session moves along.

Thank you for the opportunity to provide comments on Gov. Walz's budget recommendations. Please let us know if you have any questions or if we can be a resource in the budget process this session.

Sincerely,

Dena Belisle, President
Minnesota First Provider Alliance

SEIU Healthcare MN & IA

February 11, 2025

Chair Joe Schomacker
Centennial Office Building, 2nd Floor
St. Paul, MN 55155

Dear Chair Schomacker:

SEIU Healthcare MN & IA represents over 50,000 Minnesotans who work in hospitals, clinics, nursing homes, and self-directed homecare. We write to inform you about two important elements in Governor Walz's Health and Human Services Budget proposals.

First, Investments in Community First Service and Supports (AD-54) reflects the recent tentative agreement between our union and the State. The two-year agreement covers over 30,000 homecare workers in PCA Choice, the Community First Service and Supports (CFSS) budget model program, Consumer Directed Community Supports (CDCS), and the Consumer Support Grant. We and the state reached a settlement that reflects the current budget environment, making progress for the workforce and the people they serve in a number of areas while only increasing wages modestly for some members. Please note that, unlike some other long-term-care programs, the programs in our bargaining unit have no built-in rate increases. Much of the spending for this tentative agreement comes in the form of one-time money for annual $1,200 stipends to help homecare workers cover their out-of-pocket health care costs. There are 40-cent-per hour increases to the wage scale for some workers in the PCA Choice and CFSS budget model programs, and an increase in the Enhanced Rate (from 7.5% to 12.5%) for those workers serving the highest-need clients in any of the covered programs. There are concrete steps towards creating a defined-contribution retirement program for this workforce in the future, but without any ongoing funding for workers to begin accruing retirement benefits; funding for retirement benefits will need to be pursued through future rounds of collective bargaining. For further details on the agreement, which invests $68 million in F7Y 26-27, please see pages 112-116 of the Department of Human Services Budget change pages. Our members are in the process of reviewing and voting to ratify the tentative agreement and, when they are done, we look forward to discussing further details with you and all members. Please note that although the legislature is no longer required to ratify the tentative agreement, the contract is still contingent upon an appropriation of these funds by the legislature.

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Second, Nursing Home Workforce Standards Board Rules (AD-91) provides about $15 million in FY 28-29 to fund a recent minimum wage rule from the Nursing Home Workforce Standards Board. Per last session's legislation, the minimum wage rule is contingent on the legislature appropriating funds to cover the increased costs to the nursing home funding system (i.e. Value Based Reimbursement). The rule provides an industry-wide minimum wage for all workers of $19 an hour in 2026 and $20.50 in 2027. There are higher minimum wages for Certified Nursing Assistants ($22.50/$24), Trained Medication Aides ($23.50/$25), and Licensed Practical Nurses ($27/$28.50). For further details please see p. 120-123 of the Department of Human Services Budget change pages. By funding this proposal, the legislature can have absolute confidence that the money will go directly to workers and will help insure quality care for our seniors.

We encourage all members to support these two critical proposals. In a tight budget environment, both proposals directly fund wage and benefit increases for the critical frontline workers who provide essential services for seniors and the disabled. Funding for these programs has always received strong bipartisan support and we hope to work with you and all members to continue that tradition.

Sincerely yours,

Rick Varco

RV:klh/opeiu#12

Position Statement on the Governor's Budget Proposal – February 10, 2025

elder voice ADVOCATES

DIVA DISABILITY VOICE ADVOCATES

Negative Impacts of the 2026-27 Budget on Elders and People with Disabilities

Overview

The proposed 2026-27 Minnesota Department of Human Services budget includes funding reductions and programmatic changes that jeopardize the well-being of elders and people with disabilities. This fact sheet highlights the key areas of concern and the potential consequences if these issues are not addressed.

Key Concerns

1. Home and Community-Based Services (HCBS) Waivers

- **Rising Demand:** Increased reliance on HCBS waivers by elders and people with disabilities.
- **Funding Gap:** The budget fails to account for the growing demand and rising costs, which have increased by approximately $3,000 per individual over the past decade.
- **Impact:** Longer waiting lists and reduced service quality, risking the independence and well-being of vulnerable populations.

2. Long-Term Services and Supports (LTSS)

- **Shifts in Care Preferences:** More individuals are choosing to remain in their homes rather than institutional settings.
- **Underfunding Risk:** Insufficient allocations could lead to unmet care needs and decreased quality of life.
- **Impact:** Increased hospitalizations and higher costs to the state in the long term.

3. Workforce Challenges in Care Services

- **Staffing Shortages:** The demand for direct care workers continues to grow, but funding does not support competitive wages or adequate training.
- **Impact:** Reduced care quality, higher caregiver burnout, and risks of neglect for those requiring assistance.

4. Economic Assistance Programs

- **Strained Resources:** Limited funding could lead to reduced benefits or stricter eligibility criteria.
- **Impact:** Financial instability for elders and people with disabilities, increasing their vulnerability to poverty and housing insecurity.

5. Special Education Services

- **Rising Enrollment:** The number of students requiring special education services is projected to grow significantly.
- **Funding Constraints:** Without adequate investment, schools may struggle to provide necessary resources and support.
- **Impact:** Educational setbacks for students with disabilities, hindering their long-term opportunities and growth.

Economic and Human Costs

- **Increased Long-Term Expenses:** Cutting funds for preventative and community-based care leads to higher costs in institutional care, emergency services, and hospitalizations.
- **Loss of Independence:** Reduced access to essential services forces individuals into institutional settings, contrary to their preferences and dignity.
- **Social Inequity:** Elders and people with disabilities bear a disproportionate burden of budget cuts, exacerbating existing disparities.

Call to Action

To protect the well-being of Minnesota's elders and people with disabilities, legislators must:

1. **Restore and Increase Funding** for HCBS waivers, LTSS, and direct care services to meet rising demand and costs.
2. **Support Competitive Wages** for direct care workers to address staffing shortages and improve care quality.
3. **Safeguard Economic Assistance Programs** to prevent financial hardships for vulnerable populations.

4. **Engage Stakeholders** in crafting sustainable solutions that prioritize dignity, independence, and equity.

Conclusion

Investing in programs for elders and people with disabilities is not just a moral imperative; it is a smart economic decision that reduces long-term costs and ensures a healthier, more equitable Minnesota.

For more information, please contact: Kristine Sundberg, Executive Director, Elder Voice Advocates & Disability Voice Advocates, kris@eldervoicefamilyadvocates.org, 952-239-6394

MID-MINNESOTA LEGAL AID
Minnesota Disability Law Center

February 11, 2025

The Honorable Joe Schomacker
Chair, Human Services Finance and Policy Committee
Minnesota House of Representatives
2nd Floor, Centennial Office Building
St. Paul, MN 55155

The Honorable Mohamud Noor
DFL Lead, Human Services Finance and Policy Committee
Minnesota House of Representatives
5th Floor, Centennial Office Building
St. Paul, MN 55155

Re: Governor's Human Services Budget

Dear Chair Schomacker, DFL Lead Noor, and Members of the Committee:

Legal Aid and the Minnesota Disability Law Center (MDLC) thank you for the opportunity to provide written testimony regarding the Governor's budget. We understand the need to balance the budget and appreciate the herculean task you are presented with. However, this should not be done by compromising the lives and wellbeing of Minnesota's most vulnerable citizens. Although we are opposed to the majority of these cuts, we will limit this letter to our four biggest concerns

The worst is the cap on inflation. In a presentation to the Senate Human Services Committee last month, Direct Care and Treatment staff stated that Minnesota was short 58,000 healthcare worker positions. The largest part of healthcare budgets are salaries. Most people can earn more at entry-level jobs at Target now than they can at a more stressful job as a PCA or home health care worker. Capping inflation will exacerbate the staffing crisis. Some facilities are already paying their workers more than they are being reimbursed in order to keep their facilities open. In the financial impact statement of who will be affected, the Governor noted that "[d]irect care workers in this field are disproportionately women and people of color." Capping inflation will create unsafe situations at home and force people who can no longer find homecare workers to move to group homes and institutional settings. It will create unsafe situations in institutional settings. It will force facilities to close.

The “next worst” cut is the 351-day cap on residential services. We believe that the resulting budget fallout will also have a dire effect on staffing. Facilities will close, services will decline, and people who need residential placement will stay in hospitals until beds are available.

Likewise, we believe the changes to the absence and utilization factor in day services will also have a tremendous negative impact on staffing and force facilities to close.

The daily time limitation of eight hours on Individualized Home Supports (IHS) with training services will have a profound effect on the ability of Minnesotans with disabilities to either move to their own homes or remain in their own homes, especially for Minnesotans in rural areas. Creating an arbitrary limit of 8 hours of IHS with training per day will likely create a staffing nightmare for many individuals who wish to receive services in their own homes. IHS and PCA are not handled by the same organizations, so service recipients will be forced to find two agencies to get their staffing needs met. If someone qualifies for 8 hours of IHS services and just a few hours of PCA staffing, it will be next-to-impossible to get the PCA staffing needs met, especially if that person is in greater Minnesota where staffing needs are highest.

If the Governor’s cuts take place, they will harm Minnesotans with disabilities by taking away needed services. The cuts limit payment for waiver services, which will likely force people with disabilities to go without services. These budget cuts threaten to further exacerbate the staffing shortages that already exist. Cutting these vital services will negatively impact other parts of our healthcare system, including placing additional strain on our already overtaxed hospitals and emergency rooms.

Thank you for the opportunity to submit written testimony on the Governor’s budget. We urge this committee to reject these cuts and ensure that Minnesotans with disabilities do not see a rollback of services and living conditions.

Sincerely,

Jennifer Purrington
Legal Director/Deputy Director
Minnesota Disability Law Center

Ellen Smart
Staff Attorney
Legal Services Advocacy Project

This document has been formatted for accessibility. Please call Ellen Smart at 612/746-3761 if you need this document in an alternative format.

Public Testimony
Minnesota House of Representatives
Human Services Policy and Finance Committee
February 12, 2025

RE: Analysis of FY2026-27 Human Services Budget and MA LTC Waiver Growth

Dear Chair Schomacker and Members of the Human Services Policy and Finance Committee:

I am Katrin Bachmeier, a minister, qualified developmental disabilities professional, and disability community advocate with 25 years of experience. As administrator of the Minnesota's largest support groups including the MNChoices Disability Services Assessment support group and through our work with nationwide agencies providing federal policy interpretation, we bring both direct experience with how these programs function and understanding of federal compliance requirements.

Understanding the Budget Numbers in Context

The November 2024 forecast presents numbers that, at first glance, might seem to indicate expanding disability services. The forecast shows the CADI (Community Access for Disability Inclusion) waiver program growing substantially over the next few years. To understand what these numbers mean, we first need to understand what CADI waivers were designed to do.

CADI waivers were originally created to help people with disabilities who would otherwise need nursing home care to live in their communities instead. These waivers were intended to serve people with significant medical needs or disabilities who require comprehensive support to live safely at home. However, what we're seeing in the current budget forecast isn't actually an expansion of these crucial disability services.

When the forecast shows CADI enrollment growing from 83,689 people to 113,545 people over four years, we need to understand exactly what this growth represents. This dramatic increase isn't primarily serving more people with disabilities who need nursing-home level care. Instead, the program is increasingly being used to serve populations that should likely be under Department of Justice oversight and funding.

Let me be specific: A significant portion of new CADI waiver recipients are registered sex offenders and others with criminal histories who require monitoring and supervision. These individuals are being classified as case mix A or B participants - the lowest levels of medical need - yet they're receiving the same waiver funding as most minors with profound and complex medical disabilities who requires around-the-clock nursing care.

To put this in perspective: Department of Justice programs typically provide supervision, monitoring, and reintegration services through halfway houses and supervised living programs. These programs have specific staffing ratios, security requirements, and oversight mechanisms

appropriate for supervising individuals with criminal histories. Instead of funding these services properly through criminal justice budgets, we're now seeing them funded through disability waivers - a program designed and intended for people with medical/behavioral needs and disabilities requiring nursing-home level care.

This shift has serious implications. When we look at the budget forecast showing increased waiver spending, we're not seeing an expansion of disability services - we're seeing disability funding being used to patch holes in our criminal justice system. While someone with complex medical needs struggles to get funding for basic medical supplies or adequate nursing care, we're using these same limited disability funds to provide what amounts to halfway house supervision.

The financial impact is significant. Traditional Department of Justice programs have their own funding streams, staffing requirements, and oversight mechanisms. By shifting these costs to disability services, we're not only conflating and misusing funds intended for medical and disability support, but we're also obscuring the true costs of both criminal justice supervision and disability services. This makes it impossible to accurately assess and budget for either program's actual needs.

This redirection of disability funding has created a particularly troubling situation: individuals with profound disabilities who require intensive medical support are essentially competing for resources with individuals who need criminal justice supervision. When we see the average cost per CADI recipient increasing from $46,814 to $67,188, these numbers mask the fact that we're comparing fundamentally different types of services that should never be funded from the same CADI Waiver source.

The True Cost of Inadequate Rates: A Matter of Life and Death

Instead of looking to other states for rate comparisons, we need to confront the deadly disparities that exist right here in Minnesota between home care rates and market rates for identical positions. We are in the midst of a lethal home care crisis- yet we continue to ignore the glaring wage disparities within our own state.

Let me be clear about these disparities:
- A nurse providing critical home care services makes $27-30 per hour without benefits
- That same nurse, with identical credentials, licenses, and required continuing education, earns $100 per hour plus comprehensive benefits in a hospital setting
- DHS advertises Direct Support positions performing the same functions approximately 2X more annually with inclusion of benefits compared to current Homecare wage floor rates without benefits.

This isn't about comparing Minnesota to other states - it's about the fact that we're paying people 50-75% of the market healthcare rates to provide life-sustaining care. The consequences of these disparities are not theoretical - they are deadly. I ask you to consider the

case of Denis Plothow, a United States veteran and pastor who served both his country and his community. Denis lost his limbs and ultimately his life as a direct result of our catastrophic home care staffing crisis. His death wasn't just a tragedy - it was the predictable outcome of a system that refuses to fund home care at rates that can attract and retain qualified staff. When a man who dedicated his life to serving others, both in military uniform and as a spiritual leader, dies because we won't properly fund basic care, we have fundamentally failed as a society.

When we fail to meet market parity for these positions in Minnesota, we aren't just increasing staffing shortages - we are signing death warrants for our most vulnerable citizens. The deployment of the National Guard to address our staffing crisis should have been a wake-up call, but instead, we continue to focus on inappropriate interstate comparisons while people die from lack of basic care.

As you consider the human services budget, remember that these numbers represent actual lives. The growing gap between home care compensation and market rates for identical positions in Minnesota will continue to deteriorate health outcomes and result in more preventable deaths. This isn't about complex economic theory - it's about whether we're willing to pay Minnesota market rates to keep Minnesotans alive in their homes.

Closing Statement

This budget committee holds an extraordinarily important responsibility. Your decisions are not just about balancing numbers on a spreadsheet - they are about preventing the further deaths of Minnesota participants. Each budget allocation, each rate decision, each policy choice directly determines whether people will live or die in their homes or facilities. The life and death of every participant rests in your hands.

We've already lost too many Minnesotans like Dennis Plothero - a veteran and pastor who served his country and community, only to die because our system failed to provide basic care. These deaths were preventable. As you consider this budget, remember that you aren't just allocating funds - you are deciding who lives and who dies. The power and responsibility to prevent further deaths lies squarely with this committee.

As a society, we are all diminished when we fail to protect our most vulnerable members. Every time we lose someone like Dennis, we lose a piece of our collective humanity. The responsibility to prevent these deaths belongs to all of us, but the power to make immediate change sits with this committee today.

This is about more than money - it is about who we are as a community and what we stand for as human beings. I ask you to remember that behind every number in this budget is a human being who’s life-sustaining services hang in the balance.

Thank you for your consideration of this testimony. I remain available to provide any additional information that will help you make these life-saving decisions.

Respectfully submitted,

Katrin Bachmeier
Minister, Qualified Developmental Disabilities Professional
Disability Voice Advocates in Minnesota

Market Rates:

$30.43/hour x2080 1.0 FTE = $63,294.40
$2,500 sign on bonus
$25,000.00 annually cash equivalent of benefits

$63,294.40 annual pay
$2,500.00 sign on bonus
$25,000.00 cash equivalent benefits

$90,794.40 annually =$43.65/hour

*****Current Homecare rates don't pay even 50% of market rates for the SAME positions*****

This position equal to or the same as;
PCA Personal Care Attendant
HST Human Services Technician
DSP Direct Support Professional

These are all the same jobs - just different job titles.

Working Title:
Direct Support Professional
Job Class: Behavior
Modification Assistant
Agency: Human Services Dept

Salary Range: $23.76 - $30.43 / hourly with a $2,500
hiring bonus

Paid vacation and sick leave
12 paid holidays each year
Annual pay increases
Low-cost medical, dental, vision, and prescription drug plans
Dental and orthodontic care for adults and children
6 weeks paid leave for parents of newborn or newly adopted children
Pension plan that provides income when you retire (after working at least three years)
Employer paid life insurance to provide support for your family in the event of death
Short-term and long-term disability insurance that can provide income if you are unable to work due to illness or injury
Tax-free expense accounts for health, dental, and dependent care

NO minimum education requirements - so not high school diploma needed - must be at least 18 years old

To estimate the total cash equivalent of a typical State of Minnesota job benefits package, let's sum up the individual components. The values will vary depending on the specific job and individual circumstances, but here is a general estimation:

(An example of what PCA's should be paid, benefits, etc but are not who work with the disabled)

1. Health Insurance: $5,000 - $15,000
2. Dental Insurance: $300 - $1,000
3. Retirement Plans: $3,000 - $10,000 (depends on employer contributions and employee salary)
4. Paid Leave: $3,000 - $6,000 (based on 20 days of paid leave and a salary range of $40,000 to $80,000)
5. Life Insurance: $100 - $500
6. Disability Insurance: $200 - $600
7. Flexible Spending Accounts (FSAs): $300 - $1,000 (tax savings)
8. Employee Assistance Programs (EAPs): $200 - $500
9. Tuition Reimbursement: $500 - $3,000
10. Wellness Programs: $100 - $500

Adding these estimates together:

- Low End: $12,700
- High End: $38,100

Therefore, the total cash equivalent of a typical State of Minnesota job benefits package is estimated to be in the range of $12,700 to $38,100 annually.

Let's say $25,000.00 additionally annually

Check out this job at Minnesota Department of Human Services:

12:20

Often responds within 2 days

Human Services Technician

State of Minnesota
Rochester, MN

$20.91 - $28.02 an hour

Full-time · Weekends as needed +3

View similar jobs with this employer

12:18

menu Search

- **Pay:** $31.92 - 47.05 /hour

Direct Support Professional Senior - Behavior Modification Asst

Candidates may be eligible for up to a $2,500 hiring bonus!* This posting will be used to fill multiple permanent, full-time (80 hours), part-time ...

Behavioral Health • **Location:** Virginia

- **Job ID:** 81868 • **Closing Date:** 04/04/2025
- **Part-Time** • **Pay:** $23.76 - 30.43 /hour

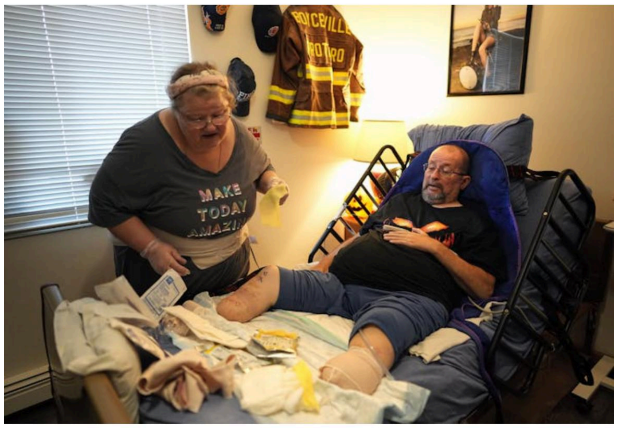
OBITUARIES

Dennis Prothero, a firefighter, veteran and quadriplegic who sought better home care, dies at 68

His plight inspired hearings and proposals at the Legislature.

By Chris Serres

FEBRUARY 17, 2023 AT 10:37AM



Dennis Prothero with caregiver, Julie Britton. (Brian Peterson, Star Tribune/The Minnesota Star Tribune)

Minnesota Alliance of Rural Addiction Treatment Programs

February 12, 2025

Dear Chair Schomacker and members of the House Human Services Finance and Policy Committee,

The Minnesota Alliance of Rural Addiction Treatment Programs (MARATP) is a 501(c)(6) non-profit organization that seeks to bring together diverse rural interests to address and advocate for strong addiction treatment programs throughout Greater Minnesota. Formed in 2017, MARATP advocates for legislation and policies that strengthen the health and well-being of rural Minnesotans, and improve rural access to higher quality, lower cost health care. We are writing you today to provide our comments on Gov. Walz's budget recommendations and the impact on rural substance use disorder (SUD) treatment providers across the state.

First, MARATP would like to express our immense disappointment in the absence of SUD or broader behavioral health services rate increases while there are general fund dollars on the bottom line. While we understand the difficulties the November forecast presents for significant, ongoing investments in Medical Assistance (MA), it was disheartening to see billions of dollars left unappropriated. A recent rate study commissioned by the Department of Human Services (DHS) noted how significantly MA rates for SUD and mental health services fall below the cost of providing care. Inadequate funding, along with workforce shortages, leads to lower access to care for Minnesotans. This crisis is especially prevalent in rural Minnesota where resources are already much more limited. MARATP members are committed to serving those in need of services, but providers continue to struggle to meet the growing demand. Minnesotans, especially those in Greater Minnesota, need SUD and behavioral health services rate increases to be a priority of this committee.

Second, MARATP would like to express its support for the proposed change to the Housing Support program that would create better, more uniform access to state housing dollars for certified recovery residences. We all know the importance of stable housing to an individual's recovery and believe the ability for more providers to access Housing Support funds will simplify and disentangle the various workarounds that have become untenable from a regulatory compliance perspective. The ability for certified recovery residences to access Housing Support agreements directly from DHS is a significant step forward. This will not only ensure stable housing for those in recovery, and therefore more success in recovery, but it will separate an individual's ability to access housing from the time they may spend in a treatment program.

Lasty, we appreciate the attention DHS and Gov. Walz has paid to program integrity and fraud prevention in the proposed budget. MARATP is committed to ensuring that the limited resources available for SUD treatment are appropriately employed to the greatest extent possible. We do have questions, however, as to whether additional resources for investigators to operate under the same practices and authorities previously will improve program integrity and we want to make sure that as the Legislature considers providing DHS additional authority, it also ensures due process for providers. We look forward to the release of the bill language for such proposals and continued discussion throughout the legislative session.

Thank you in advance for your consideration and your support of the recovery community.

Sincerely,
Marti Paulson, President
Minnesota Alliance of Rural Addiction Treatment Programs

660 18th Street ◆ PO BOX 116 ◆ Granite Falls, MN 56241

HEALTH CARE TAXES IN MINNESOTA

Minnesota Center For Fiscal Excellence

March, 2024

ACKNOWLEDGEMENTS

MCFE wishes to thank to the following organizations who made this guide possible:

Minnesota Association of Health Underwriters

Minnesota Business Partnership

Minnesota Chamber of Commerce

Minnesota Council of Health Plans

National Federation of Independent Business: Minnesota

Derrick J. Miedaner was the principal investigator and author of this report.

"Fiscal Excellence" consists of three simple yet fundamental ideas:

1. Revenue collection should reflect the principles of sound tax policy.
2. Government spending should be efficient, transparent, and accountable.
3. Spending outcomes should be measured and evaluated.

The mission of the Minnesota Center for Fiscal Excellence is to make this concept the foundation of Minnesota state and local government. We pursue this mission by

- educating and informing Minnesotans about sound fiscal policy
- providing state and local policy makers with objective, non-partisan research about the impacts of tax and spending policies
- advocating for the adoption of policies reflecting principles of fiscal excellence

MCFE does not actively lobby legislators but provides analysis, consultation, and legislative testimony on issues and specific bills on a requested or as-needed basis to ensure that principles of sound tax policy and public finance are recognized.

MCFE generally defers from taking positions on levels of government taxation and spending believing that citizens, through their elected officials, are responsible for determining the level of government they are willing to support with their tax dollars. Instead, MCFE seeks to ensure that revenues raised to support government adhere to good tax policy principles and that the spending supported by these revenues accomplishes its purpose in an efficient, transparent, and accountable manner.

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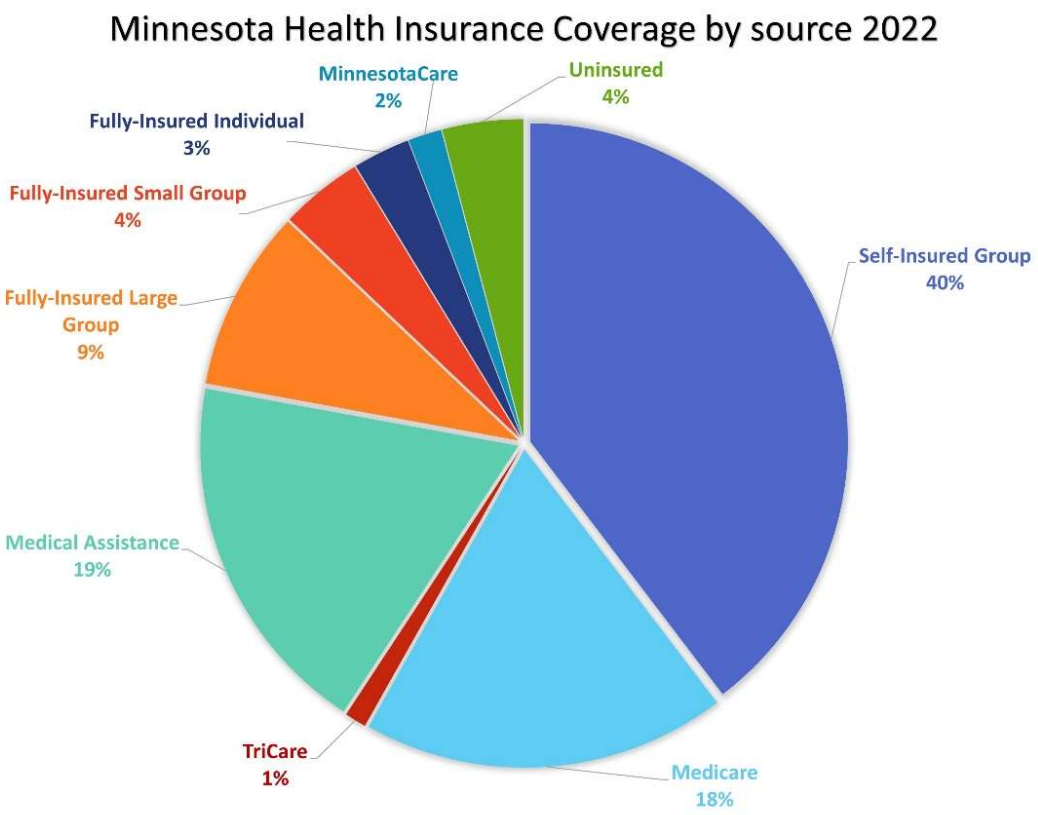
1. INTRODUCTION

The purpose of this review is to provide a contemporary summary of health care taxes and health care expenditures in Minnesota. The state, its agencies, and health care marketplace have made efforts in recent years to provide transparency to the consumer concerning their health care costs. However, much of the revenues derived from taxes, and expenditures thereof, remains largely opaque to the public. Minnesota has a number of different tax and fee structures which pertain to health care providers, insurers, employers, and individuals.



It is in the public interest to describe and visualize the incidence of tax-based revenues and the laws and entities which govern them. To this end, this report seeks to simplify the inflows and outflows of health care taxes and to illustrate the scope and use of those funds.

Minnesota is unique as a state for health care in a couple of factors. First, Minnesota has a significant concentration of large employers, including 16 Fortune 500 companies[1]. Minnesota ranks 5th in Fortune 500 concentration per capita, while the Twin Cities ranks 1st per capita among the 30 largest metro areas. Large employers typically self-insure, offering coverage to their employees that to a great extent operates outside of state regulation, including most state taxes. Minnesota is also one of only two states nationally operating a Basic Health Program, known as MinnesotaCare. MinnesotaCare provides subsidized public program coverage for eligible individuals who would otherwise would seek coverage through private health insurance.

As illustrated in the figure above, the majority of Minnesotans obtain health care coverage through their employer (represented by the self-insured group and the fully-insured large and small groups) at 53% of total state coverage[2]. The remaining individuals receive coverage from a selection of public health care programs (39.9%), purchase coverage on their own (2.9%) or are uninsured (about 4.1%).

[1] Source: MN DEED
[2] Chart Source: MN Commerce Dept.

2. MINNESOTA HEALTH CARE TAXES

2(A) State Jurisdiction

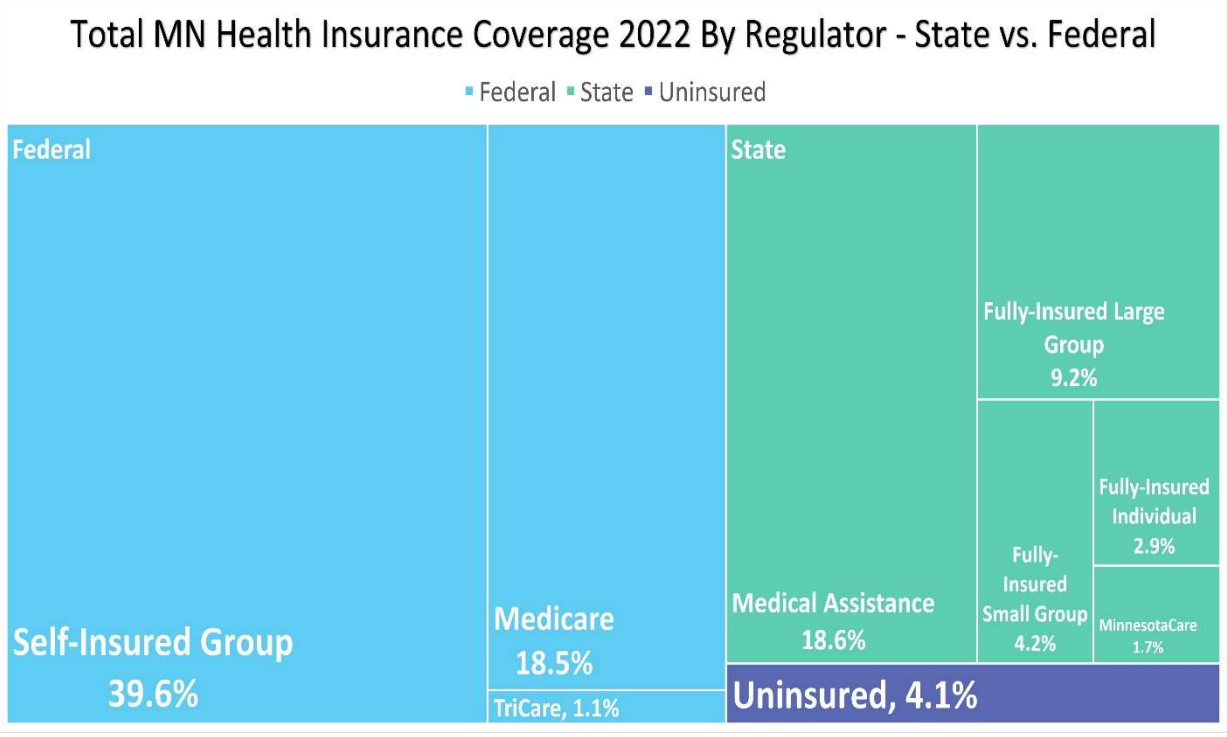
Minnesota's public programs are funded by a series of taxes applied on providers, insurance companies, and HMOs. There are two important caveats to note about state health care taxes.

- First, taxes, surcharges and fees are often passed on to consumers in the form of higher costs.

The amount of tax "passed-through" to the consumer in health care can vary depending on which type of tax, which insurance plan, and where the individual or organization obtained coverage. This report does not attempt to establish a pass-through calculation and presents each health care tax at their respective statutory rate.

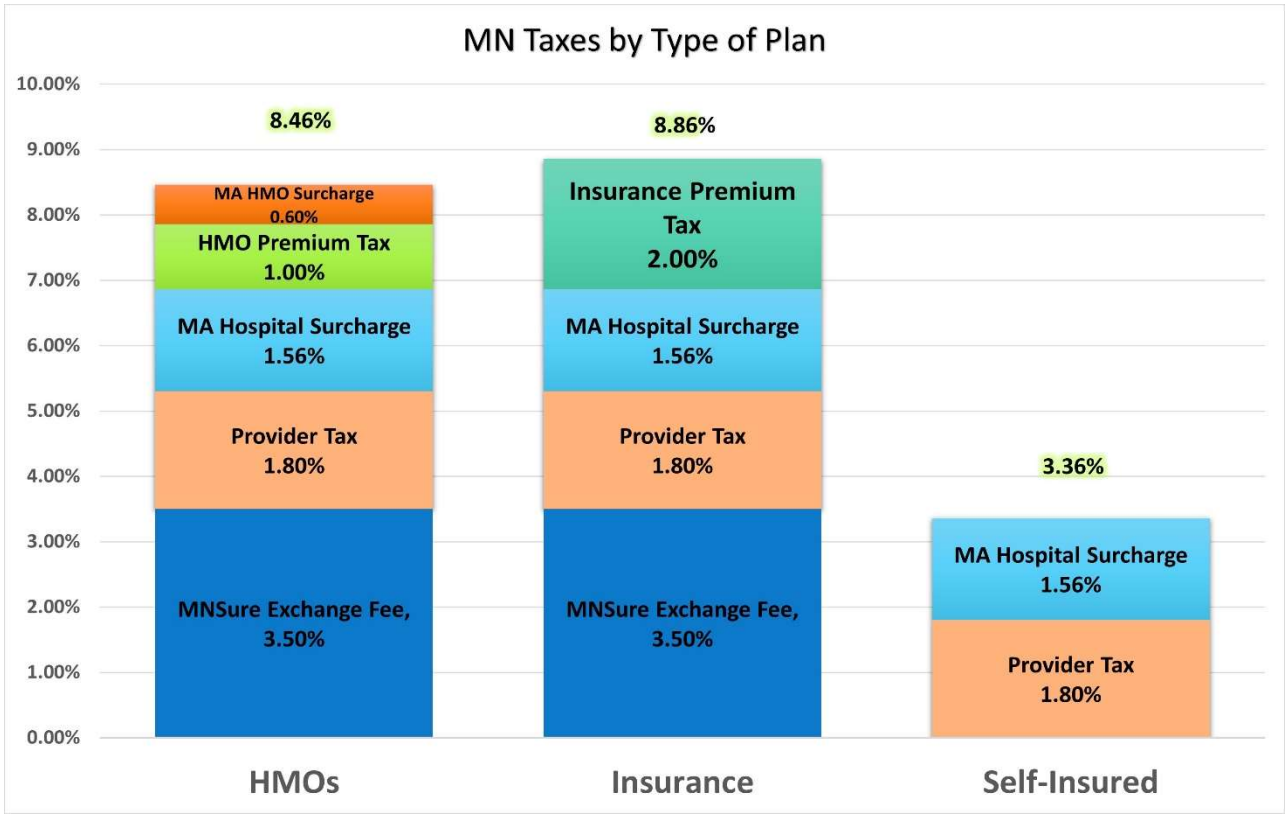
- Second, state health care taxes do not apply equally to all types of coverage.

That is because self-insured health plans, representing nearly 40% of all coverage in the state, operate under the federal Employee Retirement Income Security Act of 1974, or "ERISA." Under ERISA, self-insured health plans are regulated exclusively by the federal government. The figure below illustrates the scope of state regulatory jurisdiction, including taxing authority.



2(B) Overview of Taxation for Minnesota Health Care

Under ERISA, the current regime of health care taxes does not apply equally to all types of coverage. The state also levies different taxes and surcharges relative to the service being provided. The figure below illustrates the different tax rates as applied to different segments of coverage. A total percentage of taxes is shown above each bar and represents the aggregate tax rate applied to each type of coverage.



The figure demonstrates that the self-insured group, the largest source of health care coverage for Minnesotans, has the lowest health care tax rate of any market. Under ERISA, the provider tax and MA surcharge are only effectively applied to self-insured organizations when the tax is "passed-through" in the form of a higher payment to providers for their services. Minnesota law expressly incorporates this practice by authorizing providers to transfer the tax expense to third-party contracts on behalf of a patient or consumer[3].

On the other hand, private markets, which include large group, small group, and individual coverage, are directly subject to state taxation and pay the highest tax rate of any marketplace. This is because in addition to the provider tax and MA hospital surcharge, they also pay an insurance premium tax, with individuals purchasing insurance through MNsure also subject to a 3.5% exchange fee.

HMOs similarly pay a higher tax rate than self-insured organizations through the applied HMO premium tax and surcharge, with individuals purchasing HMO coverage through MNsure also subject to the 3.5% exchange fee, but maintaining a slightly lower overall tax rate than the private insurance market.

[3] 295.582

2(C) Overview of Taxation for Minnesota Health Care

The chart below further explores each tax described in the preceding charts. It describes the remittance of each tax, or who is assessed, followed by the rate, total amount taxed in 2022, the destination of tax revenues, and finally the statutory authority governing the tax.

Type	Who Pays	Rate	Amount Paid in 2022[4]	Destination	Relevant Statute
Health Care Provider Tax	Hospitals and surgical centers; health care providers that furnish directly to a patient or consumer medical, surgical, optical, visual, dental, hearing, nursing services, drugs, laboratory, diagnostic or therapeutic services. Nursing homes and pharmacies are not included.	1.8% gross revenues on patient services	Providers: $266,416,000 Wholesale drug distributors: $167,500,000 Hospitals and Surgical Centers: $265,686,000	Health Care Access Fund	295.52 taxes imposed
HMO Premium Tax	Health maintenance organizations (HMOs) and nonprofit health service plan corporations.	1.0% on gross premium revenues	$122,708,000	Health Care Access Fund	297i.05 tax imposed
Insurance Premium Tax	Non-HMO Health Care Insurance Companies	2.0% on gross premium revenues	N/A*	State General Fund	297i.05 tax imposed
HMO Medicaid Surcharge	Health maintenance organizations and community integrated service networks.	0.6% of total premium revenues	$257,835,000**	State General Fund	9510.2020 medical care surcharge
MNSure Exchange Fee(withheld premiums)	Insurance companies indirectly: MNsure shall retain or collect up to 3.5 percent of total premiums for individual and small group market health plans and dental plans sold through MNsure	3.5% of total premiums	$22,240,000	Retained by MNSure	62v.05 responsibilities and powers of MNSure
Medical Assistance Hospital Surcharge	1.4 %of net patient revenues excluding net Medicare revenues reported by that provider to the health care cost information system according to the schedule in subdivision 4.	1.56% of net patient revenues	N/A**	State General Fund	256.9657 provider surcharges

* Disaggregated collections from health insurance companies versus all insurance providers, including life, health, homeowners, and others is not available. Total 2% gross premiums taxes on all insurers were $624.050,000 in FY22.

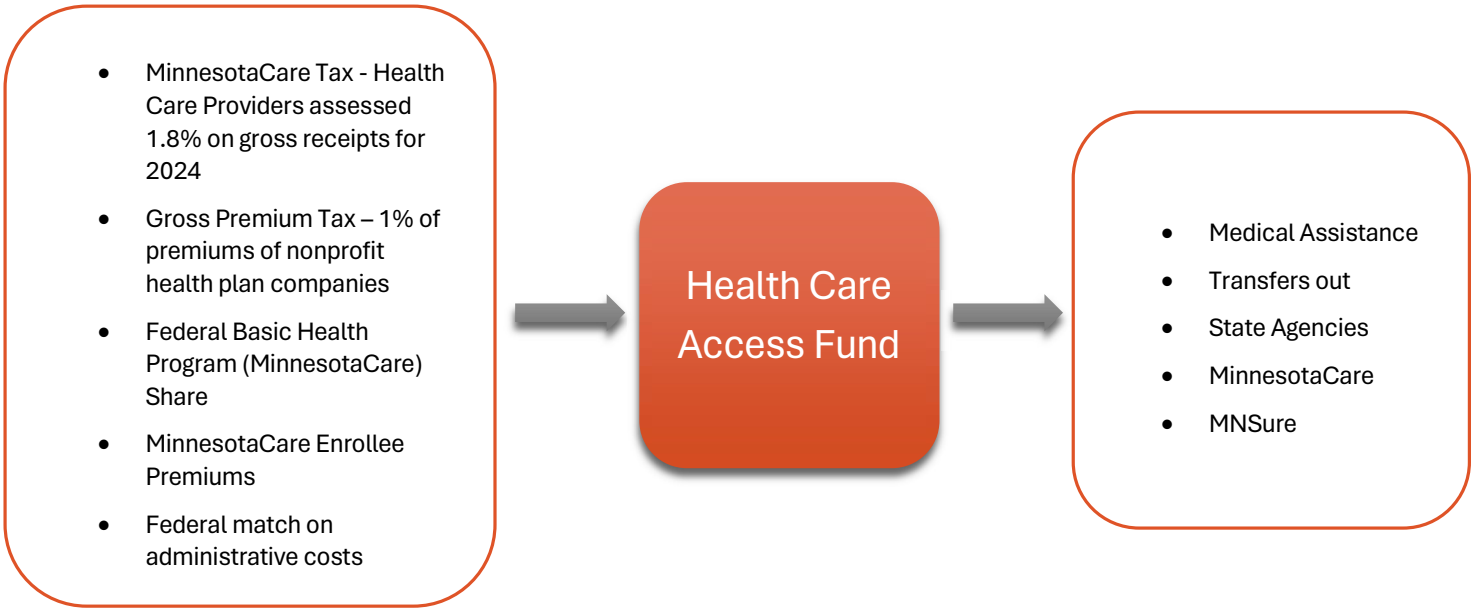
**Similarly, disaggregated surcharge totals from HMOs, licensed nursing homes, hospitals, and intermediate care facilities are not available. The surcharge total was $257,835,000 in FY 22

[4] Source: 2022 MN Tax Handbook

3. HEALTH CARE FUNDING ACCOUNTS

As noted in the chart on the previous page, Minnesota has a regime of taxes which are assessed on health care and insurance providers. The revenues from some of these taxes are placed into dedicated state funds or accounts. The source of taxes used to fund these accounts, and the expenditures out of the accounts are codified in state statute, which is listed on the chart above.

HEALTH CARE ACCESS FUND



PURPOSE OF THE HEALTH CARE ACCESS FUND

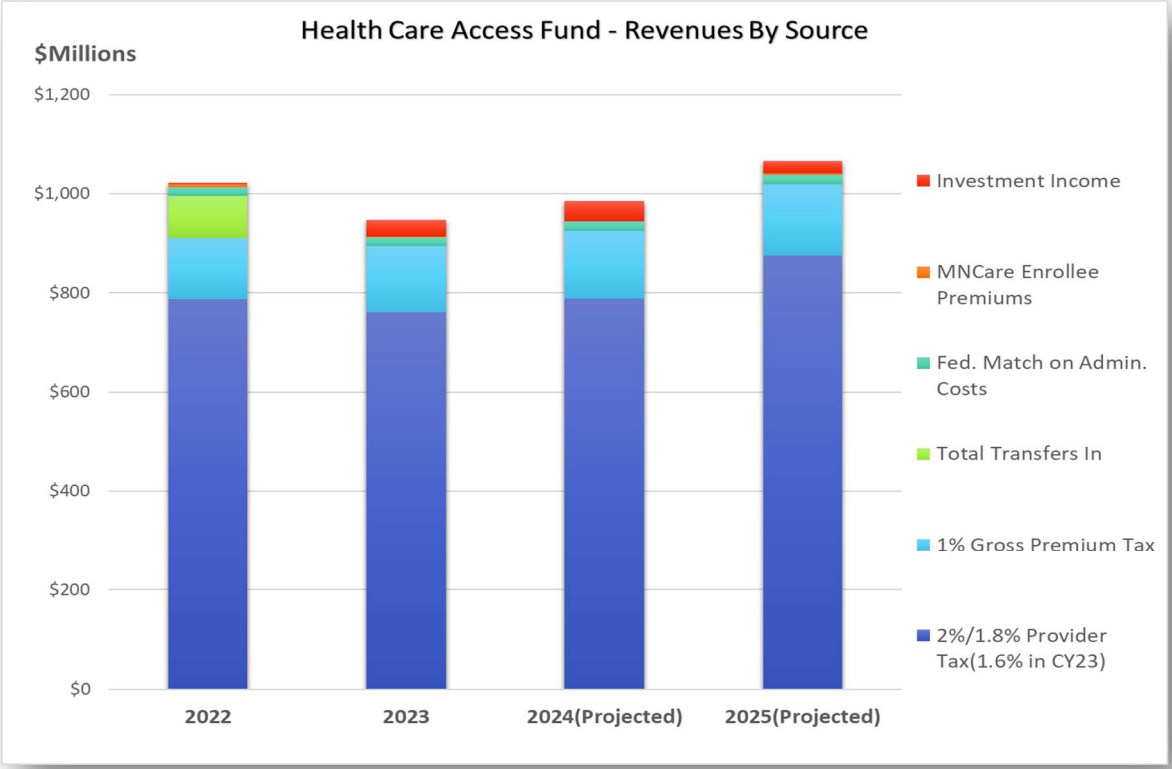
The health care access fund (HCAF) was created to increase access to health care, contain health care costs, and improve the quality of health care services for Minnesotans. The fund covers portions of the cost of both the Medical Assistance (MA) and MinnesotaCare/Basic Health Program (BHP) programs.

FUNDING DETAIL OF THE HEALTH CARE ACCESS FUND

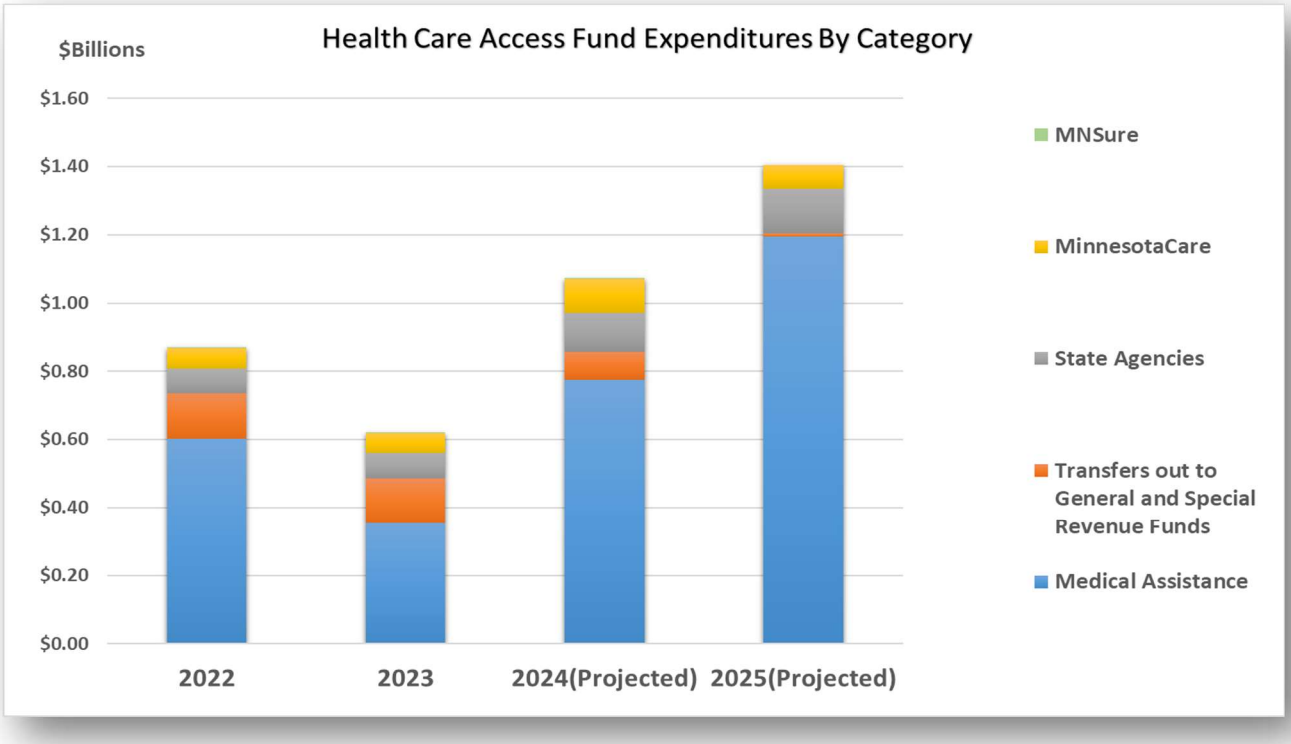
The largest source of funding for the HCAF is a 1.8 percent provider tax, accounting for more than 80% of the funds revenue each year. Prior to January 1, 2020, the provider tax was 2.0 percent. The tax was temporarily reduced to 1.6 percent for calendar year 2023 and will return to 1.8 percent on January 1, 2024. The second major source of revenue for the HCAF is federal basic health program (BHP) payments to support the MinnesotaCare program. The federal payment accounts for 95% of what the enrollees would have otherwise received in federal premium tax credits if they had purchased insurance through the health care marketplace[5].

The 1.0 percent gross premium tax accounts for nearly 15% of the HCAF revenue, with MinnesotaCare enrollee premiums, investment income earned on the balance of the fund, and a federal match on administrative costs comprising the remaining revenue.

[5] Minnesota Department of Human Services: MinnesotaCare Basics



The figure below depicts expenditures from the Health Care Access Fund (HCAF) between 2022-2025. HCAF expenditures are projected to increase substantially due to the state increasing the HCAF share of Medical Assistance funding by more than $1.2 billion over three state fiscal years. The change lowers the General Fund obligation by the corresponding amount. Increased federal payment during the federal pandemic emergency period have also created wide fluctuations in revenue and expenditures. These fluctuations will be further discussed in **Section 5: Current Challenges.**



THE PREMIUM SECURITY PLAN ACCOUNT

- Transfers from State General Fund
- Federal Pass-Through Funds

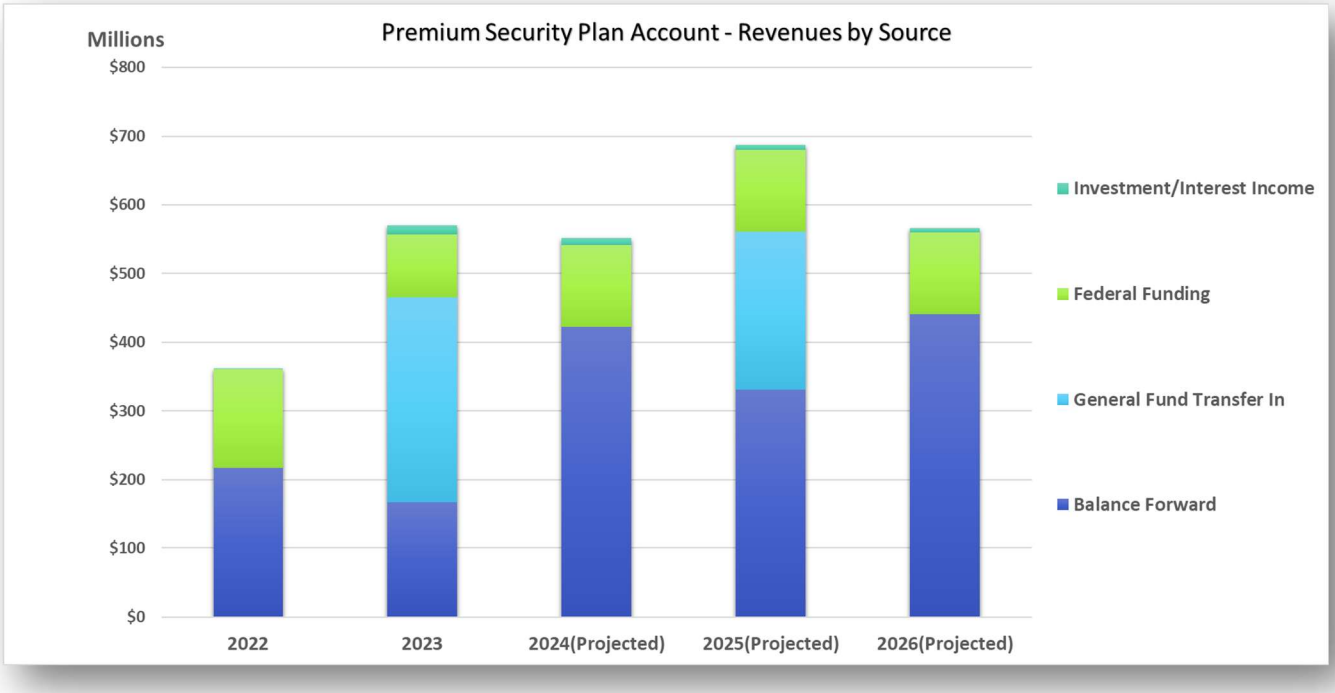
→ **Premium Security Plan Account** →

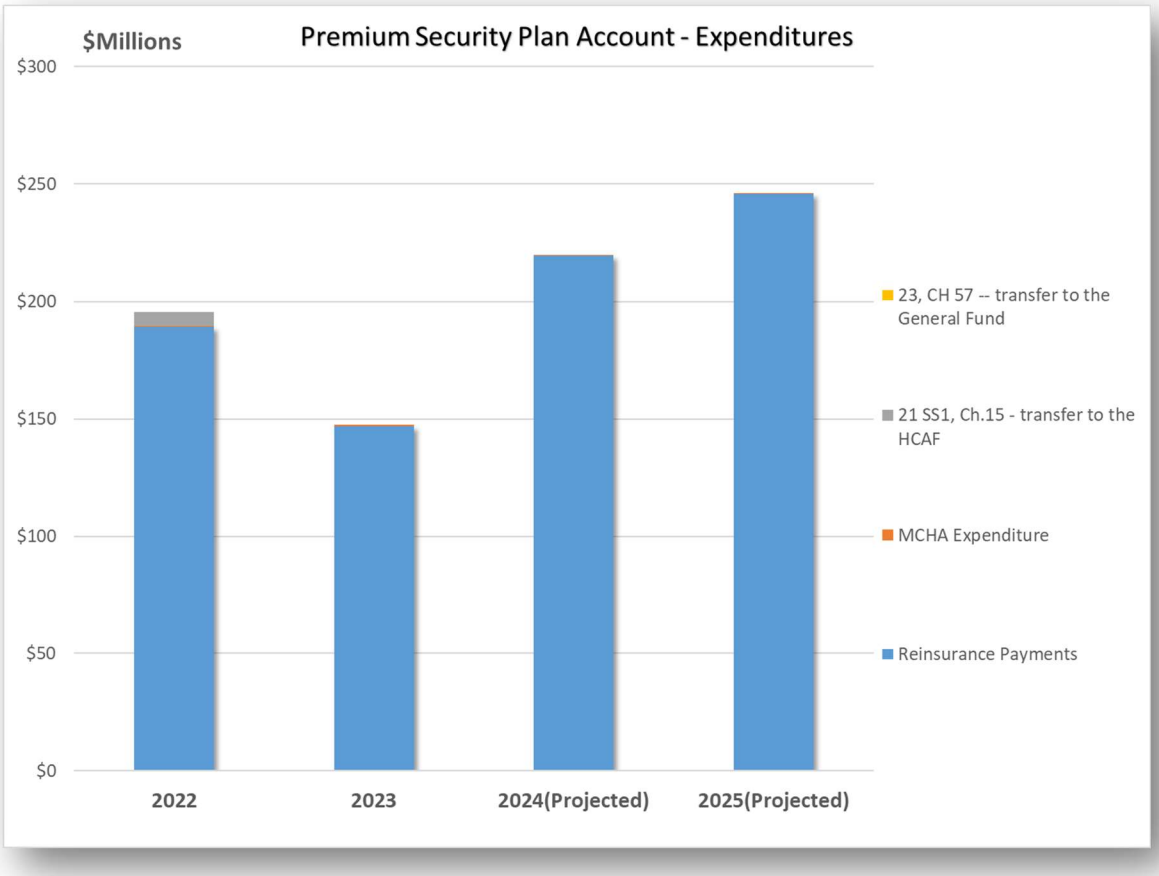
- Reinsurance Payments
- Transfers to General and HCAF funds
- MCHA Expenditure

PURPOSE OF THE MINNESOTA PREMIUM SECURITY PLAN

The Minnesota Premium Security Plan (MPSP), also known as the reinsurance program, helps to protect the affordability and availability of individual health insurance by providing stabilizing secondary insurance for health plans offering individual insurance policies in Minnesota. The MPSP covers a portion of the cost for people with significant healthcare expenses – 80% of the cost of claims between $50,000 and $250,000. The program accordingly lowers the amount of total financial liability for health plans offering individual insurance policies. This translates into lower health insurance premiums and more health insurance options for people who purchase their health insurance in the individual market throughout Minnesota.

The MPSP was created by state law in 2017. The Plan was originally scheduled to sunset in 2019, but has been extended twice. Most recently, the Minnesota Legislature authorized the MPSP to operate through 2027. Laws of Minnesota 2023, Chapter 57 transfers $275.775 million from the Premium Security Plan Account in fiscal year 2026 to the general fund, leaving funds sufficient to operate the program only through the 2025 plan year.




$Millions
Premium Security Plan Account - Expenditures
$300
$250
$200
$150
$100
$50
$0
2022
2023
2024(Projected)
2025(Projected)
23, CH 57 -- transfer to the General Fund
21 SS1, Ch.15 - transfer to the HCAF
MCHA Expenditure
Reinsurance Payments

4. PUBLIC HEALTH CARE PROGRAMS

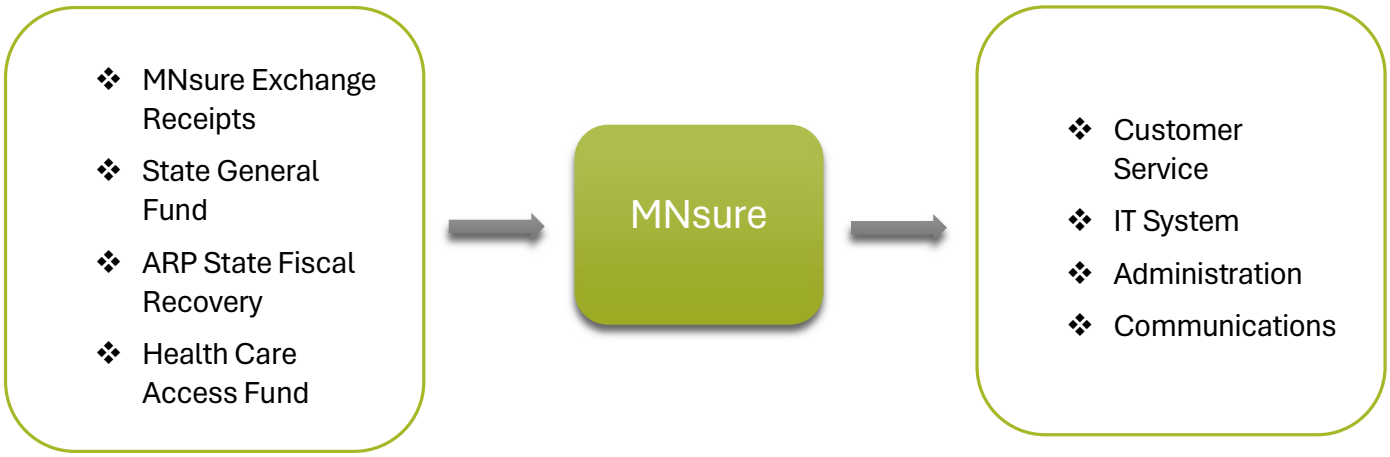
Minnesota Health Care Programs are generally administered through managed care. Managed care organizations provide health care services to enrollees in return for a capitated payment. Roughly 85% of Minnesota public program enrollees are in managed care with the reminder enrolled under fee-for-service (FFS) arrangements. FFS involves the state paying providers directly for each covered service. Through the managed care system, enrollees can obtain coverage through the MNSure exchange, depending on their eligibility.

Managed care organizations operate subject to significant withholds and payment delays. Five percent of managed care plan payments are withheld pending satisfactory attainment of performance targets. If calendar year performance targets in the contract are achieved, managed care organizations must still wait at least six months – no sooner than July of the following year – to receive withheld funds. The projected Medical Assistance amount to be withheld during CY2025 is approximately $651 million, including both state and federal share.

An additional three percent (for a total of 8%) is withheld and support state budget balancing efforts. This withhold is akin to the accounting shifts that previously occurred in education aids and related areas which move costs from one fiscal year into the next in difficult budgetary times. However, unlike other revenue recognition shifts which are reversed as budget conditions permit, this shift has persisted regardless of budgetary circumstances. The projected amount of this payment delay is approximately $786 million, including both state and federal share. Together, these managed care shifts in Medical Assistance and MinnesotaCare total roughly $1.5 billion.

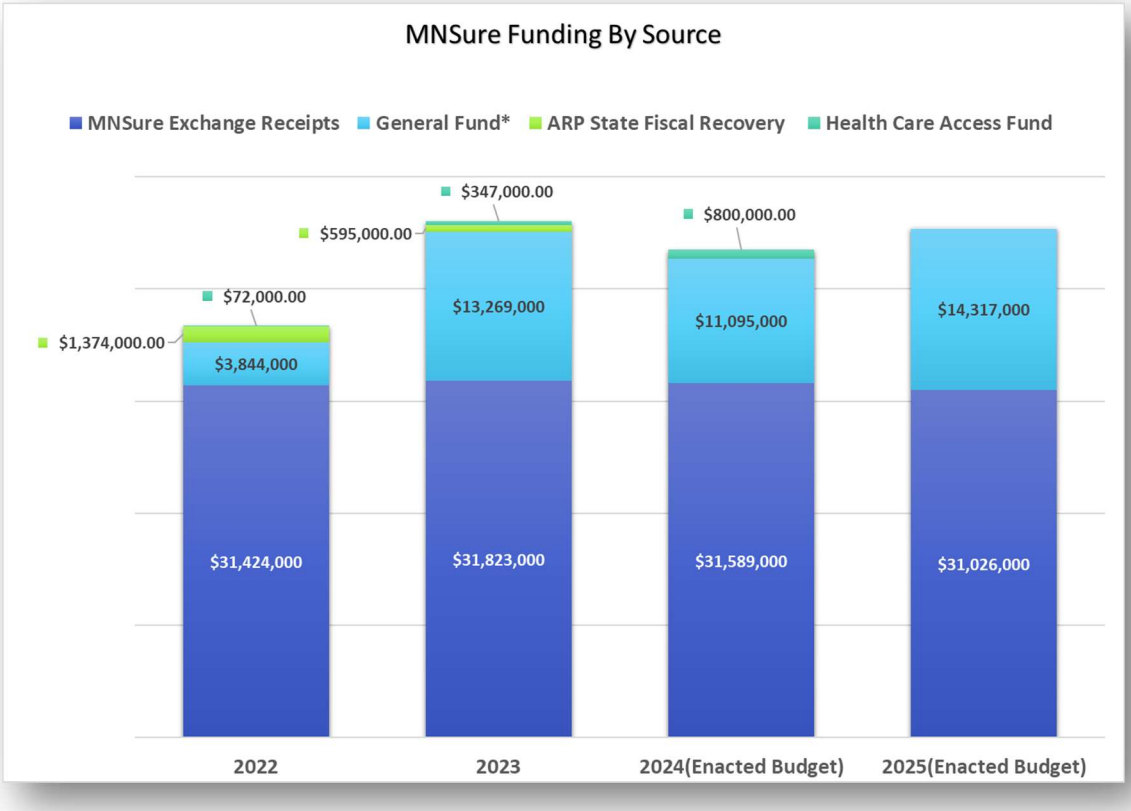
Citation: Minnesota Council of Health Plans, Minnesota Department of Human Services, 256B.69 PREPAID HEALTH PLANS (c)

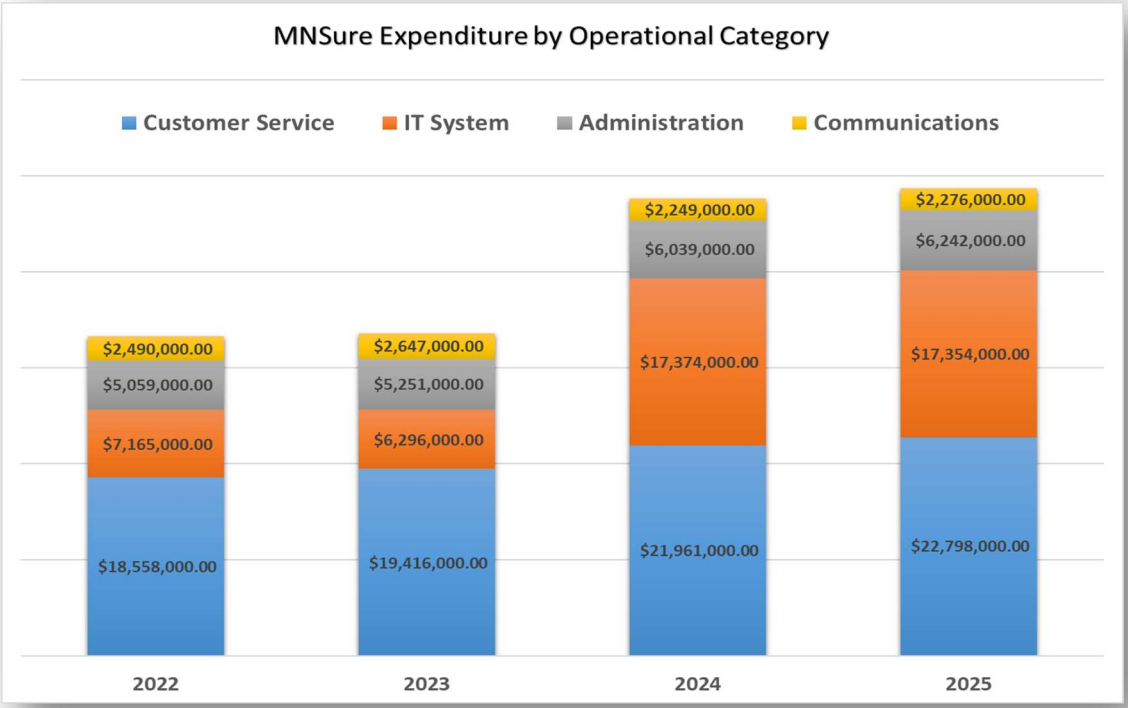
4(A) MNsure



PURPOSE OF MNSURE

MNsure is Minnesota's health insurance marketplace, and provides a platform for individual consumers to purchase insurance coverage. The marketplace serves individuals who do not receive health insurance through their employer or a government program. Minnesotans who purchase coverage through MNsure are eligible to receive federal premium assistance in the form of a premium tax credit.


MNSure Funding By Source
MNSure Exchange Receipts
General Fund*
ARP State Fiscal Recovery
Health Care Access Fund
$1,374,000.00
$72,000.00
$3,844,000
$31,424,000
$595,000.00
$347,000.00
$13,269,000
$31,823,000
$800,000.00
$11,095,000
$31,589,000
$14,317,000
$31,026,000
2022
2023
2024(Enacted Budget)
2025(Enacted Budget)


MNSure Expenditure by Operational Category
Customer Service
IT System
Administration
Communications
$2,490,000.00
$5,059,000.00
$7,165,000.00
$18,558,000.00
$2,647,000.00
$5,251,000.00
$6,296,000.00
$19,416,000.00
$2,249,000.00
$6,039,000.00
$17,374,000.00
$21,961,000.00
$2,276,000.00
$6,242,000.00
$17,354,000.00
$22,798,000.00
2022
2023
2024
2025

4(B) MinnesotaCare

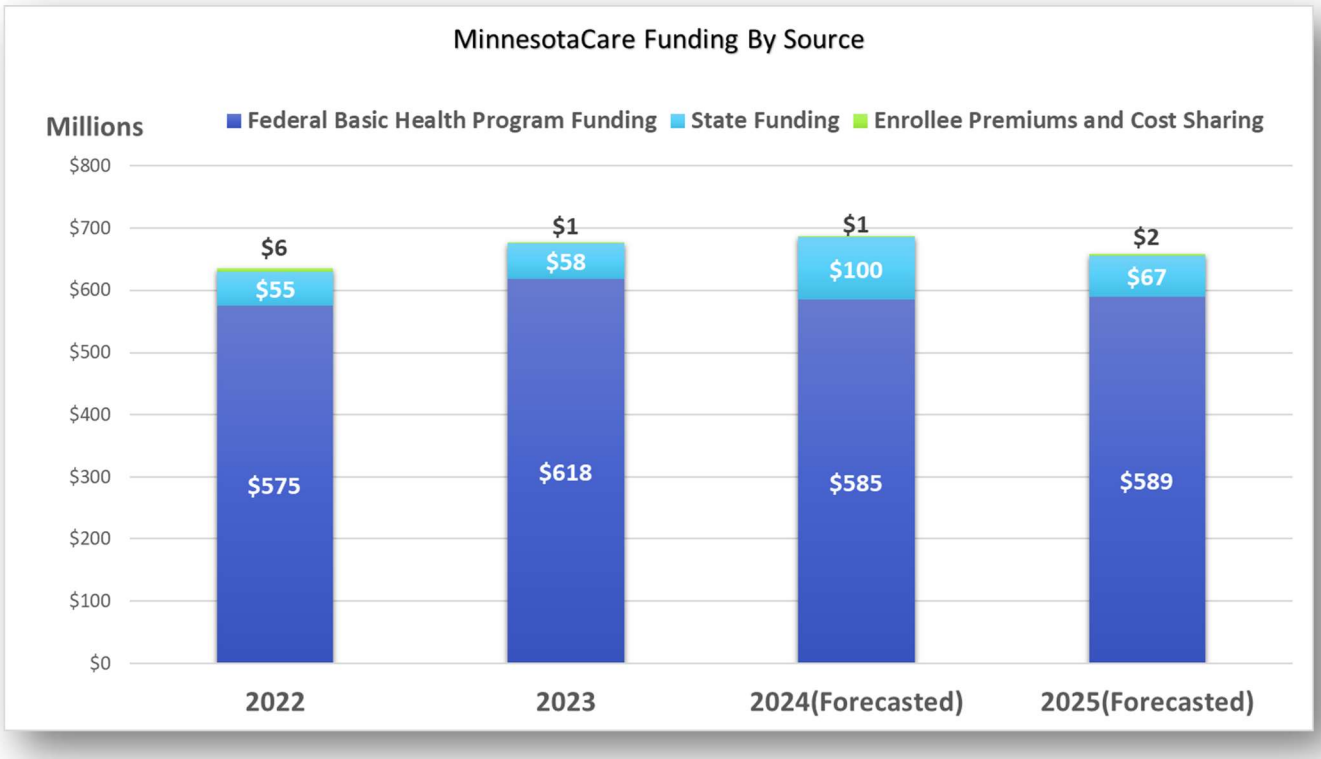
- Federal Basic Health program (BHP) funding
- State-based funding through the Health Care Access Fund
- Enrollee premiums
- Cost sharing

→ Minnesota Care →

- 113,758 program enrollees

PURPOSE OF MINNESOTACARE

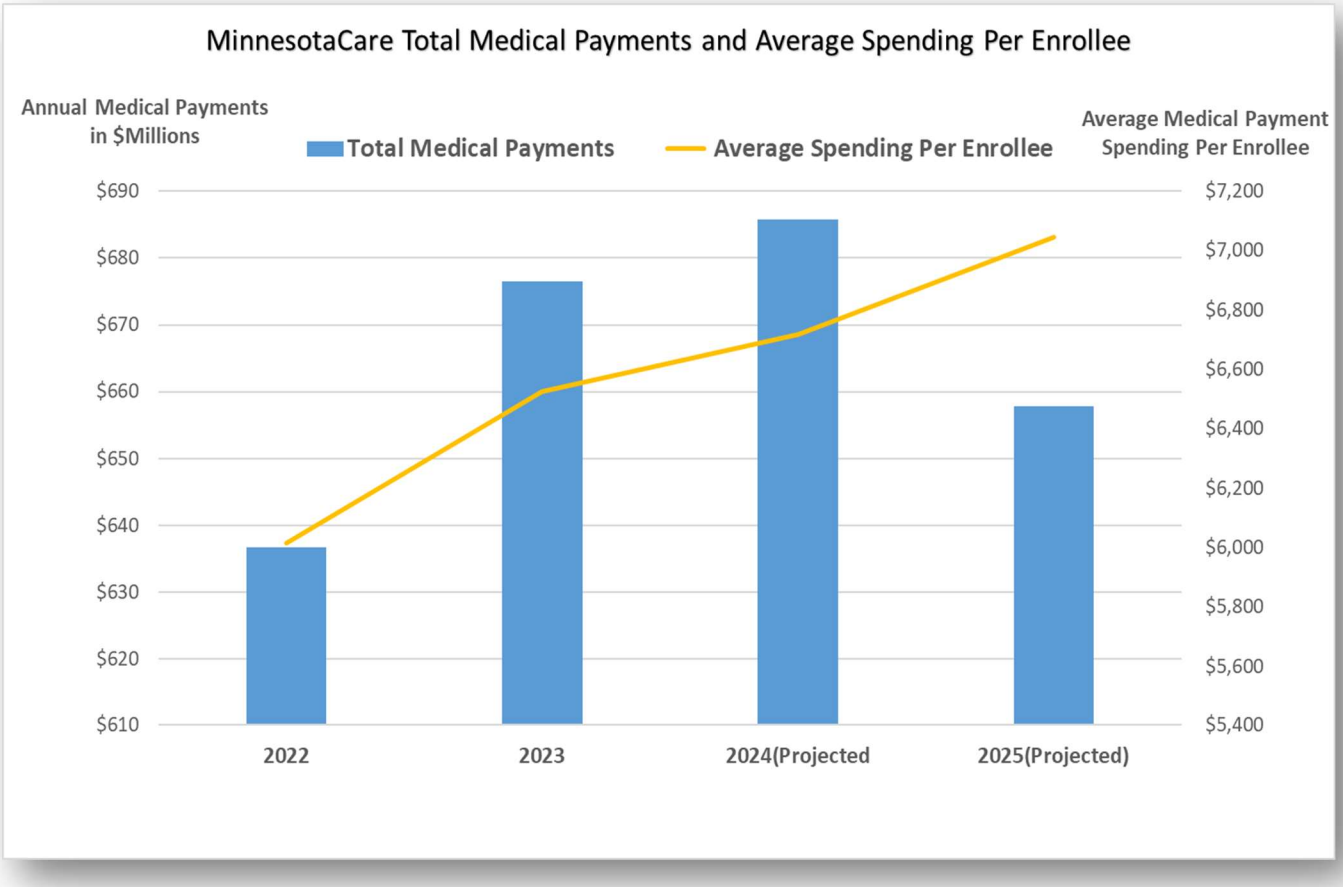
MinnesotaCare provides subsidized health care coverage to low-income individuals. The program is administered by the Minnesota Department of Human Services (DHS) under federal guidance as a basic health program under the Affordable Care Act (ACA). In compliance with federal requirements for a BHP, MinnesotaCare provides health coverage to persons with incomes greater than 133 percent, but not exceeding 200 percent, of Federal Poverty Guidelines (FPG).



A Note on MinnesotaCare and the HCAF - From the DHS November 2023 Forecast:

The November (2023) forecast produces HCAF spending increases in each year of the forecast horizon. The increase in the current biennium is the result of higher-than-expected BHP enrollment. The projected increases in the 2024-2025 and 2026-2027 biennia are the result of a change in the value of a factor in the federal BHP funding formula. The Income Reconciliation Factor (IRF) is meant to account for the year-end settle-up of prospective tax credits that happens for individuals in the private market at tax time. The value of the IRF is reduced by about 4% for 2024, and the forecast assumes this lower level persists throughout the rest of the forecast horizon. This reduction in the IRF leads to reduced federal BHP funding which ***directly increases the need for state program spending.***

Finally, the November forecast includes the impact of allowing 2024 eligibility renewals to rely on attested income. This is expected to increase caseload relative to previous forecast assumptions, but the projected state budget impact is very small because federal BHP funding is expected to cover most of the additional cost.



4(C) MEDICAL ASSISTANCE

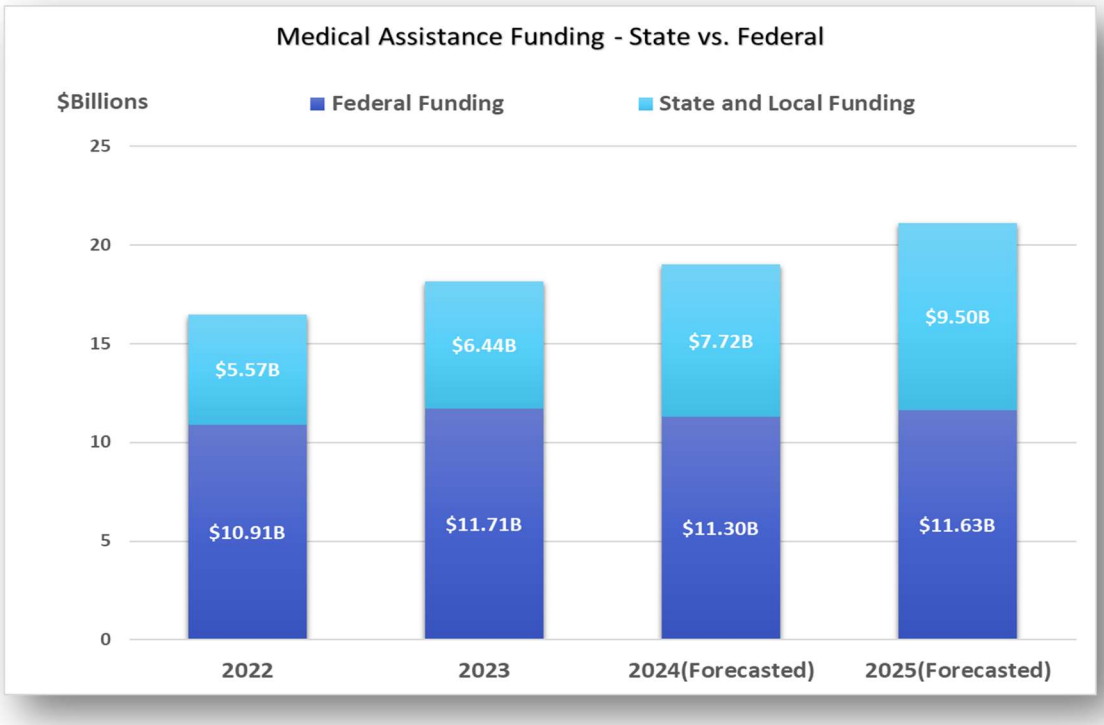
- Federal BHP funding
- State funding
- Local government funding
- Enrollee premiums

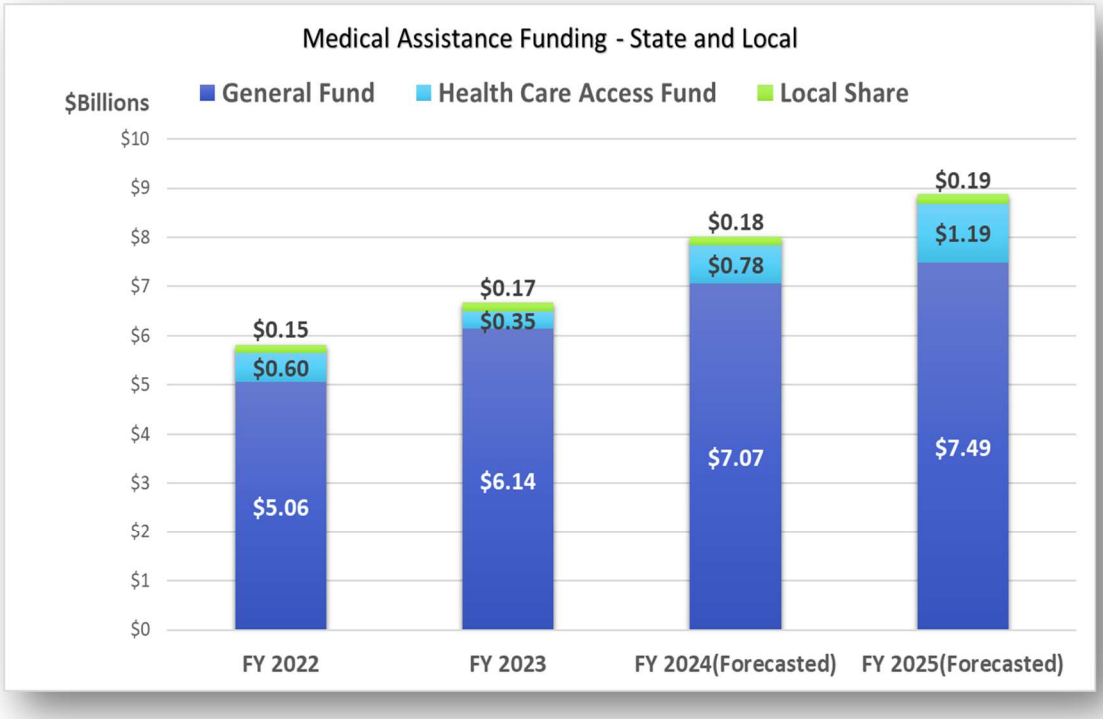
→ **Medical Assistance** →

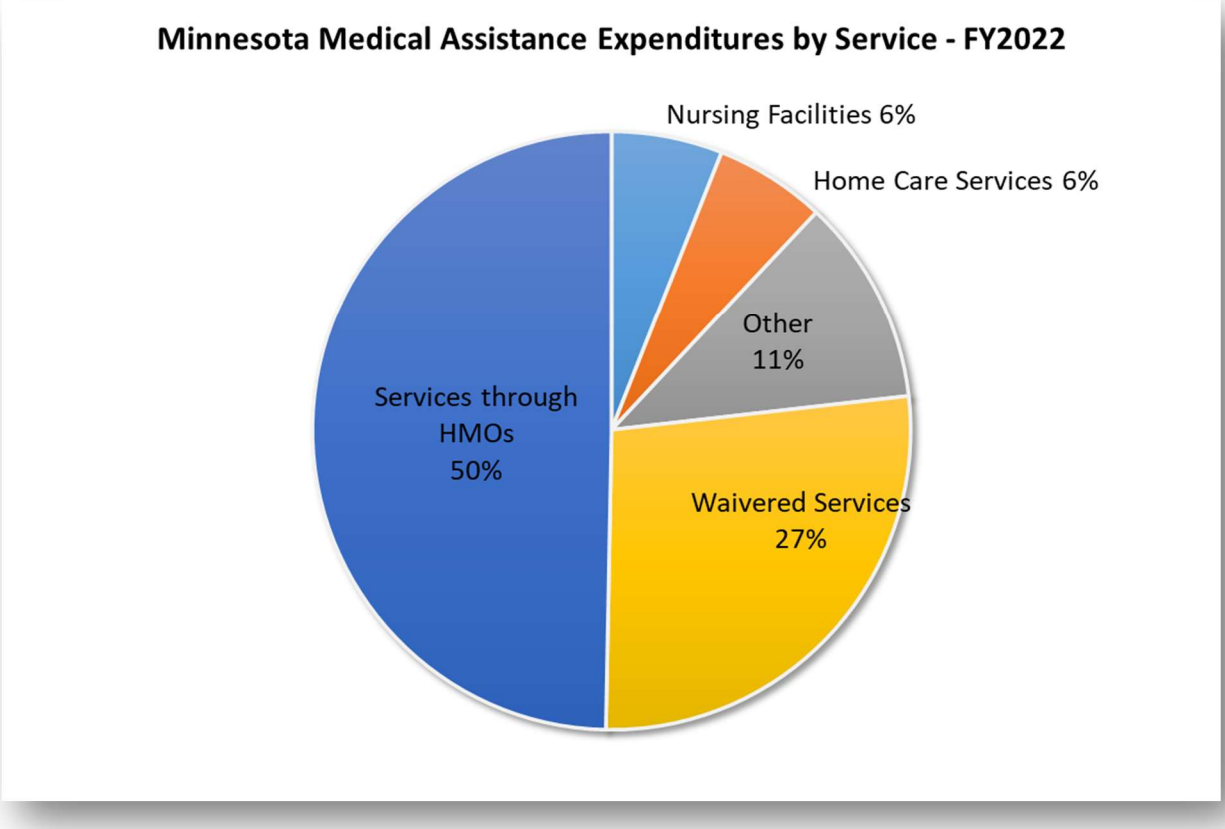
- 1,162,772 program enrollees
- HMO services
- Home care
- Nursing facilities
- Waivered services

PURPOSE OF MEDICAL ASSISTANCE

Medical Assistance (MA) is the state's Medicaid program and serves over 1 million Minnesotans. MA, under expanded eligibility adopted in Minnesota, provides health care plan and service coverage for individuals without children with incomes under 133% of federal poverty guidelines (higher income thresholds exist for families and adults with children). Whereas enrollees of MinnesotaCare may pay a premium for their health plan, MA recipients in most cases do not. Specific details of MA eligibility requirements can be found in the Appendix.

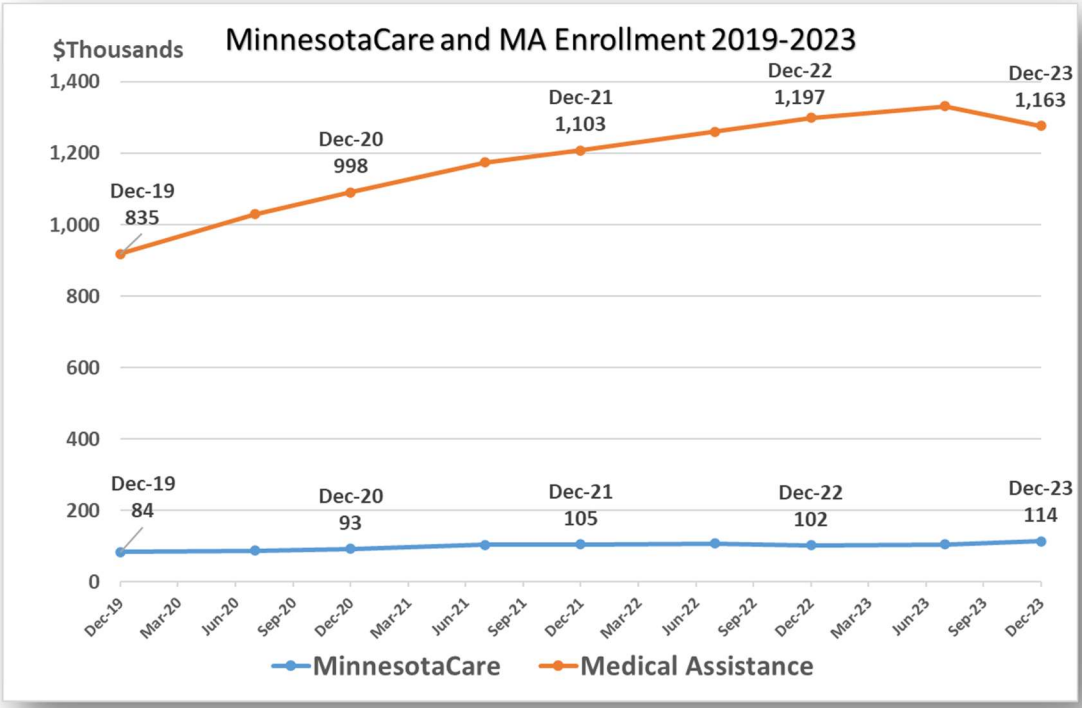



Medical Assistance Funding - State and Local
$Billions
General Fund
Health Care Access Fund
Local Share
$10
$9
$8
$7
$6
$5
$4
$3
$2
$1
$0
$0.15
$0.60
$5.06
$0.17
$0.35
$6.14
$0.18
$0.78
$7.07
$0.19
$1.19
$7.49
FY 2022
FY 2023
FY 2024(Forecasted)
FY 2025(Forecasted)


Minnesota Medical Assistance Expenditures by Service - FY2022
Nursing Facilities 6%
Home Care Services 6%
Other
11%
Services through
HMOs
50%
Waivered Services
27%

5. CURRENT CHALLENGES: Post-Covid Health Coverage

Beginning in March 2020, Minnesotans who have qualified for publicly subsidized health care (MinnesotaCare and Medical Assistance) have remained enrolled regardless of changes to their eligibility status. This continuous enrollment process was possible through federal funding as a response to the COVID-19 pandemic. Since December 2019 enrollment in Medical Assistance has accordingly grown from 835,000 to 1.16 million people. This represents a nearly 40% increase in MA enrollment. The chart below illustrates the growth in enrollment for each program.



In December 2022, congress disconnected Medicaid continuous coverage[6] requirements from federal COVID-19 relief funds. The legislation set the coverage requirements to end effective March 31, 2023, after which states would have 12 months to initial and complete renewals for enrollees who were automatically covered.

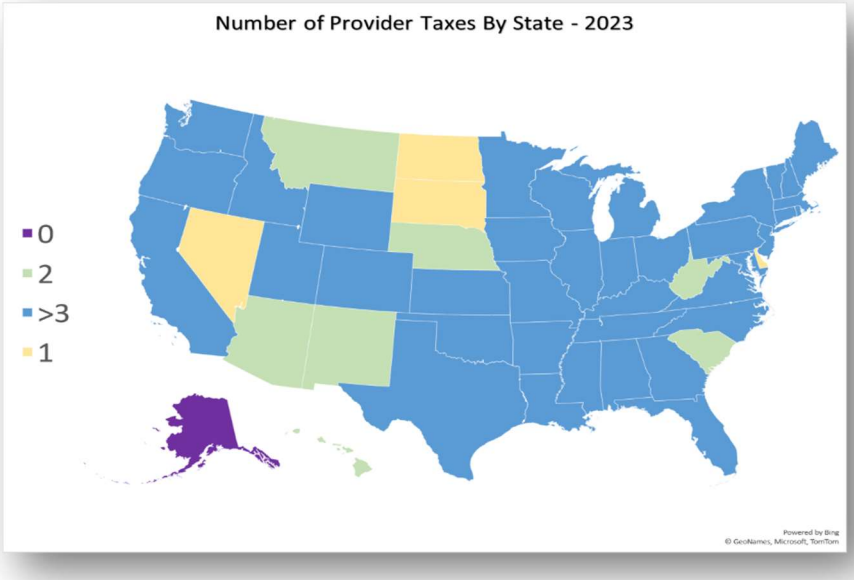
Nationally, the U.S. Department of Health and Human Services estimates a loss-of-coverage rate of 17.4% due to the sunsetting of automatic enrollment[7]. For Minnesota specifically, DHS estimates that 15-25% of people enrolled in Medical Assistance and MinnesotaCare may lose coverage when renewals resume. The Minnesota Department of Human Services (MDHS) has initiated a Mitigation Plan to reduce the number of coverage losses. The enrollment fluctuations will have a significant impact on the enrollment of both public programs and private insurance, the revenues collected, and the state expenditures involved.

[6] https://www.dhs.state.mn.us/main/groups/publications/documents/pub/mndhs-062535.pdf
[7] https://aspe.hhs.gov/sites/default/files/documents/dc73e82abf7fc26b6a8e5cc52ae42d48/aspe-end-mcaid-continuous-coverage.pdf

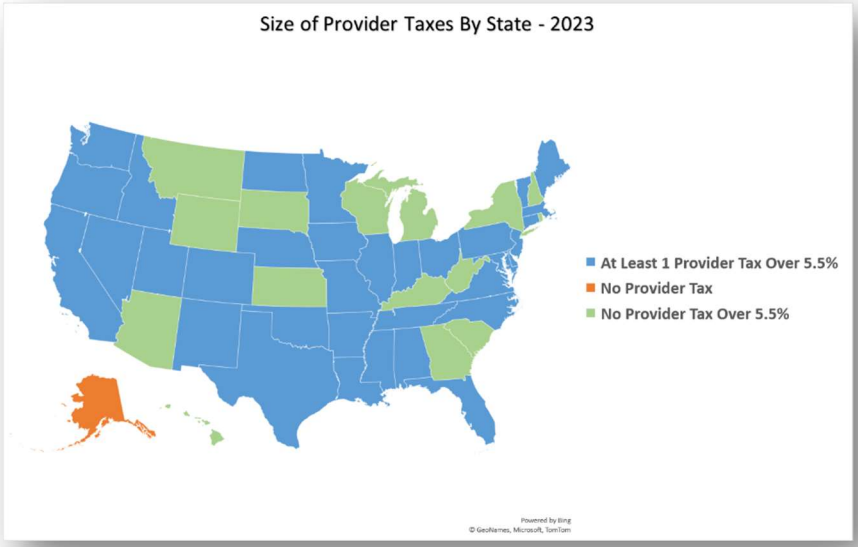
6. APPENDIX – HEALTH CARE TAXES IN OTHER STATES

6(A) Health Care Provider Taxes

NUMBER OF PROVIDER TAXES BY STATE[8]



SIZE OF PROVIDER TAXES BY STATE[9]



[8] Source: Kaiser Family Foundation Annual Survey of State Medicaid Officials conducted by Health Management Associates, November 2023

[9] Source: Kaiser Family Foundation Annual Survey of State Medicaid Officials conducted by Health Management Associates, November 2023

6(B) States by Type of Health Care Exchange[10]

States with a State-Based Exchange	States Using Federal Exchange – 1.5% Fee	State-Based Marketplace-Federal Platform
California	Alabama	Arkansas
Colorado	Alaska	Georgia
Connecticut	Arizona	Oregon
District of Columbia	Delaware	
Idaho	Florida	
Kentucky	Hawaii	
Maine	Illinois	
Maryland	Indiana	
Massachusetts	Iowa	
Minnesota	Kansas	
Nevada	Louisiana	
New Jersey	Michigan	
New Mexico	Mississippi	
New York	Missouri	
Pennsylvania	Montana	
Rhode Island	Nebraska	
Vermont	New Hampshire	
Virginia	North Carolina	
Washington	North Dakota	
	Ohio	
	Oklahoma	
	South Carolina	
	South Dakota	
	Tennessee	
	Texas	
	Utah	
	West Virginia	
	Wisconsin	
	Wyoming	

[10] Source: Kaiser Family Foundation "State Health Insurance Marketplace Types, 2024".

7. GLOSSARY

Basic Health Plan (BHP)

See: MinnesotaCare

Employer Coverage – Employers that offer health insurance either self-insure or fully insure their employee health programs. Under both types of employer plans, there is cost-sharing and premiums paid for by their employees.

Fully Insured Group Coverage

Fully insured group coverage is different from individual coverage because the employer is also part of the relationship. An employer purchases a fully-insured group policy from a health carrier to cover employees of the organization. The employer may pay all or part of an employee's premium. The policy is called fully-insured because the health carrier assumes the risk of providing coverage to the employees (in a self-insured group plan the employer assumes the risk and financial obligation to provide coverage to employees).

Fully-insured plan – Employer health insurance coverage where the health insurance company takes on the risk of medical bills for employees and their dependents (employer purchases plan from insurance company).

Group Coverage

The most common group coverage is provided by employers to employees. Group coverage may be one of two types: fully insured or self-insured. Federal law says your coverage document must tell you if your plan is self-insured.

Health Care Access Fund

The health care access fund (HCAF) was created to increase access to health care, contain health care costs, and improve the quality of health care services for Minnesotans. Historically, the provision of subsidized health care through MinnesotaCare has been the primary expenditure in the HCAF.

HMO Medicaid Surcharge

An annual medical care surcharge equal to six-tenths of one percent of the total premium revenues of that health maintenance organization. The revenues are deposited in the state general fund.

HMO Premium Tax

A 1% tax assessed on gross premiums collected by non-profit health plan companies, non-profit HMOs and non-profit health service plan companies. These taxes are used to fund the Health Care Access Fund.

Individual market coverage – private health insurance that is purchased directly to cover one person and/or their dependents (through MNsure, a broker, or directly from an insurer).

Insurance Premium Tax

A 2% tax assessed on premiums collected by health insurance companies.

Large group plan – private health insurance plans that are purchased by employers with more than 50 employees.

Medical Assistance (Minnesota Medicaid)

Medical Assistance (MA) is Minnesota's Medicaid program for people with low income. Most people who have MA get health care through health plans. You can choose a health plan from those serving MA members in your county. MA is Minnesota's largest health care program and serves children and families, pregnant women, adults without children, seniors and people who are blind or have a disability. MA does not require enrollees to pay a monthly premium.

MinnesotaCare

MinnesotaCare is a health care program for Minnesotans with low incomes. MinnesotaCare is funded by a state tax on Minnesota hospitals and health care providers, Basic Health Program funding and enrollee premiums and cost sharing. MinnesotaCare may require enrollees to pay a monthly premium.

Minnesota Comprehensive Health Association (MCHA)

MCHA is a nonprofit organization that administers the Premium Security Plan. This role entails selecting and managing the vendors that calculate reinsurance payments to health insurers, legal counsel, accounting and other administrative support to the PSP and the Board and timely management of the PSP.

Minnesota Premium Security Plan (MPSP)

The Premium Security Plan was created by the 2017 legislature to provide reinsurance payments to health insurers to help cover the cost of high claims in the individual market. These payments are intended to reduce premiums overall and to promote affordable health insurance for Minnesotans. The Premium Security Plan helps to protect the affordability and availability of individual health insurance by providing stabilizing secondary insurance for health plans offering individual insurance policies in Minnesota.

MNsure (state-based marketplace)

MNsure is Minnesota's health insurance marketplace where individuals and families can shop, compare and choose health insurance coverage that meets their needs. The insurance offered through

the exchange is for individuals and self-employed professionals. MNsure also offers coverage options for enrollees of Medical Assistance and MinnesotaCare.

MNsure Exchange Fee

During the 2013 legislative session, a law was enacted that created MNsure and detailed how it would be financed. That language is found at 62V.05, subd. 2. This language states that for the first year, MNsure will collect up to 1.5% of total premiums for individual plans, small group plans and dental plans sold on MNsure. Starting in 2015, that amount increased to 3.5% of total premiums for those plans.

Private Health Insurance

Health insurance offered by employers or purchased by individuals.

Provider Tax

The state collects tax from health care providers, hospitals, and surgical centers that provide health care goods and services in Minnesota. We also collect tax on legend drugs sold, delivered, or distributed into the state. These taxes fund the MinnesotaCare program, a state health care program for Minnesotans with low incomes. The MinnesotaCare Tax Rate will change to 1.8% (From 1.6%) in 2024 for the Provider, Hospital, Surgical Center, Wholesale Drug Distributor, and Legend Drug Use Taxes.

Self-Insured Group Coverage

Some employers provide coverage to their employees through a self-insured health care plan. This means the employer pays for its employees' health care with its own money. Many large corporations are self-insured.

A self-insured employer must file a master plan with the United States Department of Labor. The Department assigns the plan an identifying number. The employer then prepares a Summary Plan Description (SPD) for employees that details the terms of coverage. Self-insured health plans are subject to a federal law known as the Employee Retirement Income Security Act of 1974, or "ERISA." Self-insured health plans are regulated exclusively by the federal government.

Self-insured plan – Employer health insurance coverage where the employer takes on the risk of medical bills for employees and their dependents.

Small group plan – private health insurance plans that are purchased by employers with 2 to 50 employees.

State-Based Marketplace

See: MNsure