MinnesotaCare

Public Assistance Programs: A Series

November 2025

Public Assistance Programs is a series of publications that describe state and federal programs that provide assistance in the form of healthcare, income, food, housing, and child care. Each work in the series describes an individual program. Please see the list on the last page for other works in this series.

Overview

MinnesotaCare is a program that provides subsidized health coverage to eligible, low-income Minnesotans. MinnesotaCare is for individuals who are not eligible for Medical Assistance (MA)—Minnesota's Medicaid and state Children's Health Insurance Program—and who do not have access to other types of health insurance coverage. As of March 2025, about 103,000 Minnesotans were covered under MinnesotaCare.

MinnesotaCare was first established as a state program in 1992, and since 2015 it has operated under federal law as a Basic Health Program (BHP). The overarching goal of the program—to provide subsidized health coverage to low-income individuals who are ineligible for MA and without access to other health insurance coverage—has remained the same. However, as a BHP, MinnesotaCare must operate within the standards and requirements set forth in federal law and regulations for a BHP, and Minnesota receives federal funding for individuals covered under the program.

This publication describes various aspects of MinnesotaCare, including eligibility requirements, covered services, and premium and cost-sharing requirements for the program. The content of this publication does not reflect federal enactment of Public Law 119-21.[1]

[1] Sometimes referred to as the One Big Beautiful Bill Act.

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MinnesotaCare has operated as a Basic Health Program (BHP) under federal law since 2015.[2] The BHP was established by the U.S. Congress under the Affordable Care Act (ACA) to give states the option to provide subsidized health insurance to low-income state residents in lieu of offering the individuals the opportunity to purchase coverage through the state's health insurance exchange with the assistance of federal subsidies.[3] If a state chooses to operate a BHP, then it must do so within the framework provided in federal law, regulations, and guidance. In general, the federal framework provides that BHP coverage must be as comprehensive and affordable as coverage an individual could obtain in the individual market through the state's health insurance exchange. A state that establishes a BHP receives federal funding for each federally eligible individual that is covered under the BHP.

The Centers for Medicare and Medicaid Services (CMS), an agency within the U.S. Department of Health and Human Services, administer BHPs for the federal government. CMS is responsible

[2] Prior to operating as a BHP, MinnesotaCare was a state program that received a federal match for enrollees under the Prepaid Medical Assistance Project Plus (PMAP+) waiver. Initially approved by the federal government in April 1995, the PMAP+ waiver exempts Minnesota from various federal requirements and gives the state greater flexibility to expand access to health care through the MA program. Earlier versions of the waiver allowed the state to receive a federal match for the cost of services provided to MinnesotaCare enrollees.

[3] The BHP is codified in federal law at 42 U.S. Code, section 18051, with implementing regulations at 42 Code of Federal Regulations, section 600, et seq. In addition to Minnesota, New York implemented a basic health program on April 1, 2015, and suspended operation of the program on April 1, 2024, moving that program to a section 1332 state innovation waiver under which eligibility for coverage is expanded. Oregon received federal approval on June 7, 2024, to implement a basic health program beginning July 1, 2024.

for certifying state BHPs; ensuring state compliance with federal laws, regulations, and guidance related to the BHP; and reviewing state compliance at least annually. Additionally, CMS is responsible for developing the formula that determines the amount of federal funding available for a state's BHP.

State Government

The Department of Human Services (DHS) administers MinnesotaCare. DHS is responsible for administering the provision of MinnesotaCare services through a managed care system, complying with federal BHP requirements, and submitting an annual report to the federal government documenting compliance with these requirements. DHS, in cooperation with MNsure, the state's health insurance exchange, is also responsible for processing applications and determining eligibility for MinnesotaCare. MinnesotaCare law is found in chapter 256L of Minnesota Statutes.

Eligibility Requirements

To be eligible for MinnesotaCare, individuals must meet financial requirements, not be eligible for Medical Assistance (MA) or have access to other types of health insurance, and satisfy requirements related to citizenship and immigration status and state residency.

Most of MinnesotaCare's eligibility requirements align with federal eligibility requirements for BHPs, which allows the state to receive federal funding for the participants. However, in some cases, Minnesota has expanded eligibility for MinnesotaCare beyond what is federally allowed, and such individuals are covered under MinnesotaCare with state-only funds. The two primary groups that receive state-only funding are adults over 64 years old who are not eligible for Medicare and noncitizens with certain immigration statuses, as described in more detail in the section, "Citizenship and Immigration Status."

Income Limits

In general, to be eligible for MinnesotaCare, individuals must have incomes greater than 133 percent of the federal poverty guidelines (FPG) but not exceeding 200 percent of FPG. The FPG vary with family size and are adjusted annually for inflation. See Table 1 for the minimum and maximum program income limits for different family sizes for 2026.

Individuals with incomes that are below the MinnesotaCare income floor may be eligible for the program if they are: lawfully present noncitizens not eligible for MA due to immigration status;[4]

[4] See Minn. Stat. § 256L.04, subd. 10, para. (b). These lawfully present noncitizens are generally nonpregnant adults falling under certain immigration classifications who have resided in the United States for less than five years.

not eligible for MA due to excess income;[5] or as of January 1, 2025, undocumented noncitizens under age 18.[6]

Table 1: Annual Household Income Limits for MinnesotaCare, 2026

Household Size	133% of FPG	200% of FPG
1	$20,815	$31,300
2	28,130	42,300
3	35,445	53,300
4	42,760	64,300

Source: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, 2025 Poverty Guidelines: 48 Contiguous States (all states except Alaska and Hawaii).
Note: Federal regulations require that states use the FPG figures that applied during open enrollment to determine eligibility for coverage in the coming calendar year. The FPG figures in this table used to determine eligibility for 2026 coverage are therefore based on the 2025 FPG figures.

Income Determination

Federal law requires that modified adjusted gross income (MAGI) is used as the income methodology for BHPs, like MinnesotaCare. MAGI is defined as adjusted gross income increased by: (1) the foreign earned income exclusion; (2) tax-exempt interest; and (3) an amount equal to the value of Social Security benefits not subject to tax.[7] Federal law also requires a standard 5 percent of FPG income disregard when determining eligibility for groups for whom MAGI-based income is required. This standard disregard has the effect of raising the FPG income limit by five percentage points.

Asset Limits

No asset limits apply for MinnesotaCare eligibility.

No Other Health Coverage

To be eligible for MinnesotaCare, an individual cannot be *enrolled* in minimum essential health coverage, as defined in federal law.[8] Minimum essential coverage includes: coverage under

[5] These are generally groups of individuals with incomes greater than the MA income limit but less than the MinnesotaCare income floor, due to differences in how the two programs calculate income. The groups include children under age 19 living with two unmarried parents, persons with lump sum or sponsor income, or persons whose current income (used under MA) differs from projected income (used under MinnesotaCare).

[6] See the section, "Citizenship and Immigration Status" for information about undocumented noncitizens age 18 and older.

[7] 26 U.S.C. § 36B. MAGI-based income excludes certain scholarships, awards, or fellowship grants used for educational purposes and certain types of income received by American Indians and Alaska Natives, and counts lump sums as income only in the month received.

[8] Minimum essential coverage is defined in federal law at 26 U.S. Code, section 5000A(f).

government-sponsored programs (including but not limited to Medicare, Medicaid, TRICARE, and other coverage for members of the armed services, and veterans health benefits); coverage under an employer-sponsored plan; individual market coverage; and other coverage recognized by the federal government.

Additionally, an individual is not eligible for MinnesotaCare if they have *access* to certain types of minimum essential coverage, even if they are not enrolled. This includes MA and employer-sponsored insurance that meets certain qualifications, as described below.[9]

Access to MA. Individuals who are eligible for MA are not eligible for MinnesotaCare.[10] This means that the vast majority of pregnant women and children under age 19 are covered under MA rather than MinnesotaCare, since the MA income limit for these eligibility groups (278 percent and 275 percent of FPG, respectively) is higher than the MinnesotaCare income limit (200 percent of FPG).

Access to employer-sponsored coverage. To be eligible for MinnesotaCare, an individual must not have *access* to employer-subsidized health coverage that is affordable and provides minimum value, as defined in federal regulations.[11] Coverage is defined as "affordable" for an employee and dependents if the portion of the annual premium the employee must pay for both employee and dependent coverage does not exceed 9.96 percent of income for 2026.[12] Coverage provides "minimum value" if it has an actuarial value of 60 percent, or in other words, pays for at least 60 percent of medical expenses on average.

State Residency

MinnesotaCare enrollees must meet the state residency requirements that apply in the Medicaid program.[13] In general, an individual age 21 and older must live in Minnesota and demonstrate intent to reside in the state or have entered the state with a job commitment or to seek employment. Individuals under age 21 who are not emancipated are considered residents if they live in Minnesota or reside with a parent or relative caretaker who is a Minnesota resident. The Medicaid program does not include a durational residency requirement (a requirement that an individual live in a state for a specified period of time before applying for the program); as such, neither does MinnesotaCare.

[9] For more details about how various types of coverage affect MinnesotaCare eligibility, see Department of Human Services, Minnesota Health Care Programs Eligibility Manual – MinnesotaCare – Health Care Coverage Barriers, section 3.2.3.1 at https://hcopub.dhs.state.mn.us/epm/3_2_3_1.htm.

[10] Minn. Stat. § 256L.04, subd. 17.

[11] 26 C.F.R. § 1.36B-2.

[12] IRS, Rev. Proc. 2025-25. This definition of affordability took effect January 1, 2023. Prior to this date, affordability was based on what the employee would pay for self-only coverage and did not take into account the cost of covering any dependents. This was sometimes referred to as the "family glitch."

[13] See Minn. Stat. § 256L.09, subd. 2, which references 42 Code of Federal Regulations § 435.403.

Citizenship and Immigration Status

Under federal law, an individual must be a U.S. citizen or a lawfully present noncitizen to be eligible for coverage with under a BHP.[14] Individuals with a variety of different immigration statuses are considered "lawfully present," including refugees, asylees and applicants for asylum, lawful permanent residents, and Cuban and Haitian entrants.[15]

Minnesota has extended MinnesotaCare coverage using state-only funds to some noncitizens who do not meet the definition of "lawfully present" but otherwise meet MinnesotaCare eligibility requirements.

- **Deferred Action for Childhood Arrivals (DACA) grantees.** DACA grantees first became eligible for MinnesotaCare on January 1, 2017, and they continue to be eligible.[16]
- **Undocumented noncitizens age 18 and older.** Undocumented noncitizens became eligible for MinnesotaCare beginning January 1, 2025. The 2025 Legislature capped enrollment for undocumented noncitizens age 18 and older as of June 15, 2025, and provided that undocumented noncitizens age 18 and older are ineligible for MinnesotaCare beginning January 1, 2026.
- **Undocumented noncitizens under age 18.** As noted above, undocumented noncitizens became eligible for MinnesotaCare beginning January 1, 2025. Eligibility for undocumented noncitizens under age 18 has not been capped or modified like it has for undocumented noncitizens age 18 and older, and undocumented noncitizens under age 18 remain eligible for MinnesotaCare.

[14] 45 C.F.R. § 155.20. The term "lawfully present" is also used to identify who is eligible to purchase health insurance coverage through a state health insurance exchange and receive premium tax credits and cost-sharing reductions. It is different from the term (and corresponding definition) that is used to determine eligibility for Medicaid and the state Children's Health Insurance Program (or Medical Assistance, as those programs are collectively called in Minnesota).

[15] For a more comprehensive list of immigration statuses that are eligible for MinnesotaCare, see DHS, Immigration Status and Minnesota Health Care Programs Eligibility, at https://hcopub.dhs.state.mn.us/epm/assets/docs/Immigration_Chart.pdf.

[16] Effective November 1, 2024, the federal government had determined that DACA grantees were eligible for a BHP under federal law, thus allowing a state to receive federal funding for DACA grantees that are covered under a BHP. The federal government revisited that determination and reversed it in 2025, making DACA grantees ineligible for federal funding under a BHP effective August 25, 2025.

Eligibility Process and Policies

Applicants can apply for MinnesotaCare coverage online via MNsure or by submitting paper applications. Either way, an applicant's eligibility is determined using the Minnesota eligibility system, also referred to as the Minnesota Eligibility Technology System (METS).[17] Application assistance is available from county agencies, community organizations serving as navigators, and other entities. DHS must make eligibility determinations within 45 days of receiving an application.

MinnesotaCare eligibility is renewed on a calendar-year basis, with eligibility redeterminations for coverage for a coming calendar year occurring at the end of the previous calendar year, during the annual MNsure open enrollment period for qualified health plan coverage.[18]

Covered Services

Federal law requires that BHP coverage include at least the essential health benefits that are covered by qualified health plans offered through the state's health insurance exchange. The requirement is effectuated in Minnesota by basing MinnesotaCare coverage on MA covered services.[19] Under MinnesotaCare, adults who are pregnant are eligible for coverage of all MA covered services retroactive to the date of conception. Children under age 19 and adults who are not pregnant are eligible for most, but not all, services that are covered under MA. See Table 2 for details.

Table 2: Covered Services under MinnesotaCare

Service	Children under Age 19	Adults Who Are Not Pregnant
Acupuncture	X	X
Adult mental health rehab/crisis	X	X
Alcohol/drug treatment	X	X
Child and teen checkups	X	—
Chiropractic	X	—[20]
Dental	X	X

[17] Minn. Stat. § 62V.055, subd. 1. In addition to being used for MinnesotaCare eligibility determination, METS is used to determined eligibility for premium tax credits and by county human service agencies to determine MA eligibility for families and children, pregnant women, and adults without children.

[18] Minn. Stat. § 256L.05, subd. 3a.

[19] Minn. Stat. § 256L.03.

[20] Beginning January 1, 2026, or upon federal approval, whichever is later, MinnesotaCare coverage for chiropractic services will change from being available to all enrollees to being available only to children and adults under the age of 21.

Service	Children under Age 19	Adults Who Are Not Pregnant
Early intensive developmental and behavioral intervention (EIDBI)	X	—
Emergency room	X	X
Eye exams	X	X
Eyeglasses	X	X
Family planning	X	X
Hearing aids	X	X
Home care	X	X
Hospice care	X	X
Hospital stay	X	X
Hospital care coordination	X	X
Immunizations	X	X
Interpreters (hearing, language)	X	X
Lab, X-ray, diagnostic	X	X
Medical equipment and supplies	X	X
Mental health	X	X
Mental health case management	X	X
Nursing facility care	X	—
Outpatient surgical center	X	X
Personal care assistance (PCA)	X	—
Physicians and clinics	X	X
Physicals/preventive care	X	X
Prescriptions	X	X
Rehabilitative therapies	X	X
Transportation: emergency	X	X
Transportation: nonemergency	X	—

Source: Minn. Stat. § 256L.03.

Notes: Adults who are pregnant are eligible to receive all MA covered services under MinnesotaCare retroactive to the date of conception.

Premiums

Federal law provides that an enrollee's premium for BHP coverage cannot exceed the amount the enrollee would have paid for a silver level qualified health plan (QHP) purchased through the state's health insurance exchange with the assistance of a premium tax credit. In keeping with this requirement, Minnesota has developed a sliding scale for premiums, as shown in Table 3. MinnesotaCare enrollees who are not exempt from paying premiums must pay monthly, per-person premiums according to the scale (see the next section for information about individuals who are exempt from paying MinnesotaCare premiums).

The sliding scale is specified in statute,[21] and statute gives DHS the authority to adjust MinnesotaCare premiums to ensure that enrollees do not pay more than they would if they were to purchase a QHP through MNsure with the assistance of a premium tax credit. MinnesotaCare's sliding scale was adjusted for 2021 through 2025 because the federal government increased the premium tax credit amount during that period and thereby reduced the amount that individuals receiving premium tax credits would pay for coverage through an exchange.[22] The increased federal tax credits are set to expire at the end of calendar year 2025, and it is expected that MinnesotaCare will return to the statutorily required premiums for 2026.

Table 3: MinnesotaCare Premiums, 2020 through 2026

Federal Poverty Guidelines	Individual Premium Amount 2020 and 2026	Individual Premium Amount 2021 through 2025
0 – 34%	0	0
35 – 54%	$4	0
55 – 79%	$6	0
80 – 89%	$8	0
90 – 99%	$10	0
100 –109%	$12	0
110 – 119%	$14	0
120 – 129%	$15	0
130 – 139%	$16	0
140 – 149%	$25	0
150 – 159%	$37	0
160 – 169%	$44	$4

[21] Minn. Stat. § 256L.15, subd. 2.

[22] The federal American Rescue Plan Act of 2021 increased premium tax credits for 2021 and 2022; the Inflation Reduction Act of 2022 (Pub. Law No. 117-169) extended the higher premium tax credits for 2023 through 2025.

Federal Poverty Guidelines	Individual Premium Amount 2020 and 2026	Individual Premium Amount 2021 through 2025
170 – 179%	$52	$9
180 – 189%	$61	$15
190 – 199%	$71	$21
200%	$80	$28

Sources: Minn. Stat. § 256L.15, subd. 2; DHS, MinnesotaCare Premium Estimator Table, Effective January 1, 2025 – December 31, 2025.
Notes: See the body of this publication for information about the different premium schedules in 2020 and 2026 as compared to 2021 to 2025.

Premium Exemptions

The following groups of individuals are exempt from paying MinnesotaCare premiums:[23]

- individuals with household income less than 160 percent of FPG, for 2021 through 2025, and less than 35 percent of FPG for 2026
- individuals under age 21
- American Indians and Alaska Natives, and members of their households
- members of the military and their families who are determined eligible for MinnesotaCare within 24 months of the end of the member's tour of active duty

Nonpayment of Premiums

In general, nonpayment of premiums results in disenrollment from MinnesotaCare coverage, effective the calendar month following the month for which the premium was due.[24] Individuals who do not pay their premium for a month therefore receive a "grace" month. Individuals who decide to re-enroll in MinnesotaCare following disenrollment generally must pay premiums to cover this grace month, except that no premium for the grace month is required for individuals re-enrolling in coverage that begins in the fourth month following disenrollment.

Cost-sharing

Federal law provides that an enrollee's cost-sharing for coverage obtained through a BHP must meet the standards required for cost-sharing for QHPs offered through health insurance exchanges. For MinnesotaCare, children under age 21 and American Indians are not subject to any cost-sharing under the program, but other adults are subject to cost-sharing. The dollar amounts for MinnesotaCare cost-sharing are not specified in statute. Instead, DHS is required to adjust MinnesotaCare cost-sharing in a manner sufficient to maintain the actuarial value of

[23] Minn. Stat. § 256L.15.

[24] 45 C.F.R. § 600.525.

the MinnesotaCare benefit at 94 percent.[25] See Table 4 for selected cost-sharing requirements for 2026.

Certain services are identified in state statutes as being exempt from cost-sharing. They are: additional diagnostic services or testing following a mammogram; drugs used for tobacco and nicotine cessation; certain medications used for the prevention or treatment of the human immunodeficiency virus (HIV); and mobile crisis intervention or crisis assessment (effective January 1, 2026, or upon federal approval, whichever is later).[26]

Table 4:
MinnesotaCare Cost-sharing Requirements for 2026

Service	Cost
Inpatient hospital admission	$250
Emergency room visit (that does not result in an admission)	$100
Nonpreventive care office visit (does not apply to mental health services)	$28
Radiology visit	$45
Eyeglasses	$10
Prescription drugs (generic/brand name – does not apply to certain mental health drugs); out-of-pocket maximum of $70/month	$10/$25

Source: HRD communication with DHS, October 2025.

Service Delivery

Most MinnesotaCare enrollees receive health care services through a managed care system rather than through fee-for-service (FFS).[27] Under the managed care system, participating entities receive a capitated payment from DHS for each MinnesotaCare enrollee, and in return are required to provide enrollees with all covered health care services for a set period of time. Participating entities are health maintenance organizations[28] and other health carriers, county-based purchasing plans, certain accountable care organizations and county-integrated health

[25] Minn. Stat. § 256L.03, subd. 5. Actuarial value is an estimate of the percentage of medical expenses incurred by a typical enrollee that will on average be paid by the insurer.

[26] Minn. Stat. § 256L.03, subd. 5.

[27] MinnesotaCare services are delivered through fee-for-service only in limited circumstances—e.g., to Deferred Action for Childhood Arrivals grantees, to eligible undocumented noncitizens, to comply with decisions related to DHS appeals that require retroactive coverage, or in cases of agency or technology system errors.

[28] As of January 1, 2025, health maintenance organizations delivering services to MinnesotaCare enrollees must be organized as nonprofits.

care delivery networks, and networks of health care providers.[29] MinnesotaCare must offer enrollees a choice of at least two participating entities in each county.[30]

Competitive Procurement

DHS uses a competitive procurement process to contract with participating entities to serve MinnesotaCare and MA enrollees in different regions of the state. Under this process, as currently implemented, participating entities submit proposals that are scored on technical qualifications. Based on these scores, DHS chooses two or more entities to serve each county for MinnesotaCare. Under competitive procurement, not all entities are selected to serve MA and MinnesotaCare enrollees, and there may be changes in the entities selected over different cycles of competitive procurement. In the latest round of contracting, in January 2022, DHS issued a request for proposals and selected entities to serve MinnesotaCare and MA enrollees in greater Minnesota beginning in calendar year 2023.

Provider Payment

DHS does not generally regulate how participating entities pay the health care providers under contract to serve MinnesotaCare enrollees, and for most service categories, the participating entities may establish their own rates. However, for some service categories, statute specifies payment rates. For example, participating entities are required to pay dental providers under MinnesotaCare at levels at least equal to the MA FFS rate and must also increase reimbursement to critical access dental providers by at least the amount of the critical access dental provider rate.

With respect to MinnesotaCare's FFS system, provider payment rates are generally the same as they are under MA, with a few exceptions identified in statute.[31]

Funding and Expenditures

MinnesotaCare is financed with federal funding, state funding, and enrollee premiums. Total payments for health care services provided through MinnesotaCare were $663 million in fiscal year 2024.[32] Most of the spending was financed with federal funds, with state funds and revenue from enrollee premiums making up smaller shares (see Table 5).

[29] Minn. Stat. § 256L.01, subd. 7.

[30] 42 C.F.R. § 600.420.

[31] Minn. Stat. § 256L.11.

[32] Data in this section are from DHS Reports and Forecasts Division, Background Data Tables for February 2025 Forecast.

Table 5:
MinnesotaCare Spending on Health Care Services
by Funding Source, 2024

Funding Source	Amount	Percent of Total Spending
Total spending	$663,018,392	—
Federal funding	$582,867,887	87.9%
State funding	$79,759,288	12.0%
Revenue from enrollee premiums	$391,216	0.06%

Source: DHS, background forecast tables for the February 2025 forecast.
Notes: Numbers may not add to totals due to rounding.

Federal Funding

A state that operates a BHP receives a federal payment intended to reflect the amount the federal government would otherwise spend on subsidies had the BHP enrollees received coverage through the state's health insurance exchange. The state receives a federal BHP payment based on each enrollee that meets federal BHP eligibility requirements. The payment is currently equal to 95 percent of the premium tax credits a person would have received through a health insurance exchange, had the state not operated a BHP, and includes an adjustment factor to reflect the federal government ending direct reimbursement to insurers for cost-sharing reductions.[33]

Federal law requires that federal funding for a BHP is deposited into a trust fund established by the state. The trust funds may only be used to reduce premiums and cost-sharing for BHP enrollees or expand covered services for the enrollees.

State Funding and Enrollee Premiums

State-only funding is used to pay for coverage of MinnesotaCare enrollees who are not federally eligible for a BHP, including individuals who are age 65 and over and not eligible for Medicare and undocumented noncitizens who do not meet the definition of "lawfully present" (including DACA grantees).

The state share of MinnesotaCare costs is financed with funds from the Health Care Access Fund (HCAF) which is a special revenue fund in the state treasury. (The HCAF also finances MA and other health care initiatives.) The primary sources of revenue for the HCAF are:

[33] Initially under federal law, the payment was equal to 95 percent of the advanced premium tax credits and cost-sharing reductions the person would have received through a health insurance exchange, had the state not operated a BHP. The adjustment factor results in increased BHP payments to Minnesota and is intended to offset reductions in state BHP funding that would otherwise have occurred as a result of the federal government, beginning in calendar year 2018, excluding cost-sharing reductions from the BHP payment calculation.

- a 1.8 percent tax (for 2026) on the gross revenues of health care providers, hospitals, surgical centers, and wholesale drug distributors (sometimes referred to as the "provider tax"); and
- a 1.0 percent premium tax on health maintenance organizations and nonprofit health service plan corporations.[34]

Enrollee premiums also finance MinnesotaCare, but as shown in Table 5, they are a small part of financing the program. Combined state payments and enrollee premiums constitute about 12 percent of MinnesotaCare spending on health care services.

Recipient Profile

In March 2025, 103,047 individuals were enrolled in the MinnesotaCare program.[35] Nearly half of the enrollees were adults without children, and about one-third were parents and children (mainly ages 19 and 20, as most children 18 and under are eligible for MA). The remaining enrollees were enrollees covered under state-only funded MinnesotaCare, including 9,236 who were undocumented noncitizens.[36]

Table 6: MinnesotaCare Program Enrollment, March 2025

Category	Total Enrolled	Percent of Total Enrollment
Adults without children	50,334	48.8%
Families with children	36,760	35.7%
State-only funded enrollees	15,953	15.5%
Total	**103,047**	**—**

Source: DHS Reports and Forecasts Division, Monthly MinnesotaCare Program Enrollment Counts Statewide and by County.

[34] Minn. Stat. § 297I.05, subd. 5.

[35] The data in this section are from DHS Reports and Forecasts Division, Monthly MinnesotaCare Program Enrollment Counts Statewide and by County. Data for March 2025 as of August 2, 2025.

[36] DHS provided the enrollment number for undocumented noncitizens.

Application Procedure

There are several ways to obtain MinnesotaCare application forms and to apply for MinnesotaCare coverage. These include the following:

- Applying for MinnesotaCare through MNsure, the state's health insurance exchange (1-855-366-7873 or 651-539-2099 in the metro area), or online at https://www.mnsure.org/)
- Calling DHS directly at 1-800-657-3672 or 651-297-3862 (in the metro area)
- Obtaining application forms through county social service agencies, health care provider offices, and other sites in the community, or from the DHS website

About This Series

Public Assistance Programs is a series of publications that describe state and federal programs that provide assistance in the form of healthcare, income, food, housing, and child care. Each work in the series describes an individual program.

Current works in this series include:

- Overview of Public Assistance Programs
- General Assistance (GA)
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- Minnesota Supplemental Aid (MSA)
- Supplemental Security Income (SSI)
- Medical Assistance (MA)
- MinnesotaCare
- Subsidized health coverage through MNsure
- Child Care Assistance Program (CCAP)
- Food Support
- Housing Support

Please see the health and human services area of the House Research website for more information about these programs and related topics.

Earlier Versions

Information in the series was originally published as the *Minnesota Family Assistance: A Guide to Public Programs Providing Assistance to Minnesota Families*, which was a comprehensive guide to these programs.

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