



Chartbook Section 5: Public Health Insurance Programs

Section 5: Public Health Insurance Programs

- Medicare
- Medical Assistance (Medicaid)
- MinnesotaCare

Previous versions of this chartbook included data for General Assistance Medical Care (GAMC, a state-based program) which ended in early 2011, and the Minnesota Comprehensive Health Association (MCHA, the state's high risk pool) which ended in 2014. Please contact the Health Economics Program at 651-201-4520 or health.hep@state.mn.us for these data.

This slide deck is part of Minnesota's Health Care Markets Chartbook, an annual review of key metrics in health care access, coverage, market competition, and health care costs ([MN Statutes, Section 144.70](#); <https://www.revisor.mn.gov/statutes/cite/144.70>).

An accessible summary of the charts and graphs contained in this deck is available on the [MDH website](#) (<https://www.health.state.mn.us/data/economics/chartbook/summaries/section5summaries.html>). Direct links are listed on each page.

Please contact the Health Economics Program at health.hep@state.mn.us if additional assistance is needed for accessing this information.

Key Terms

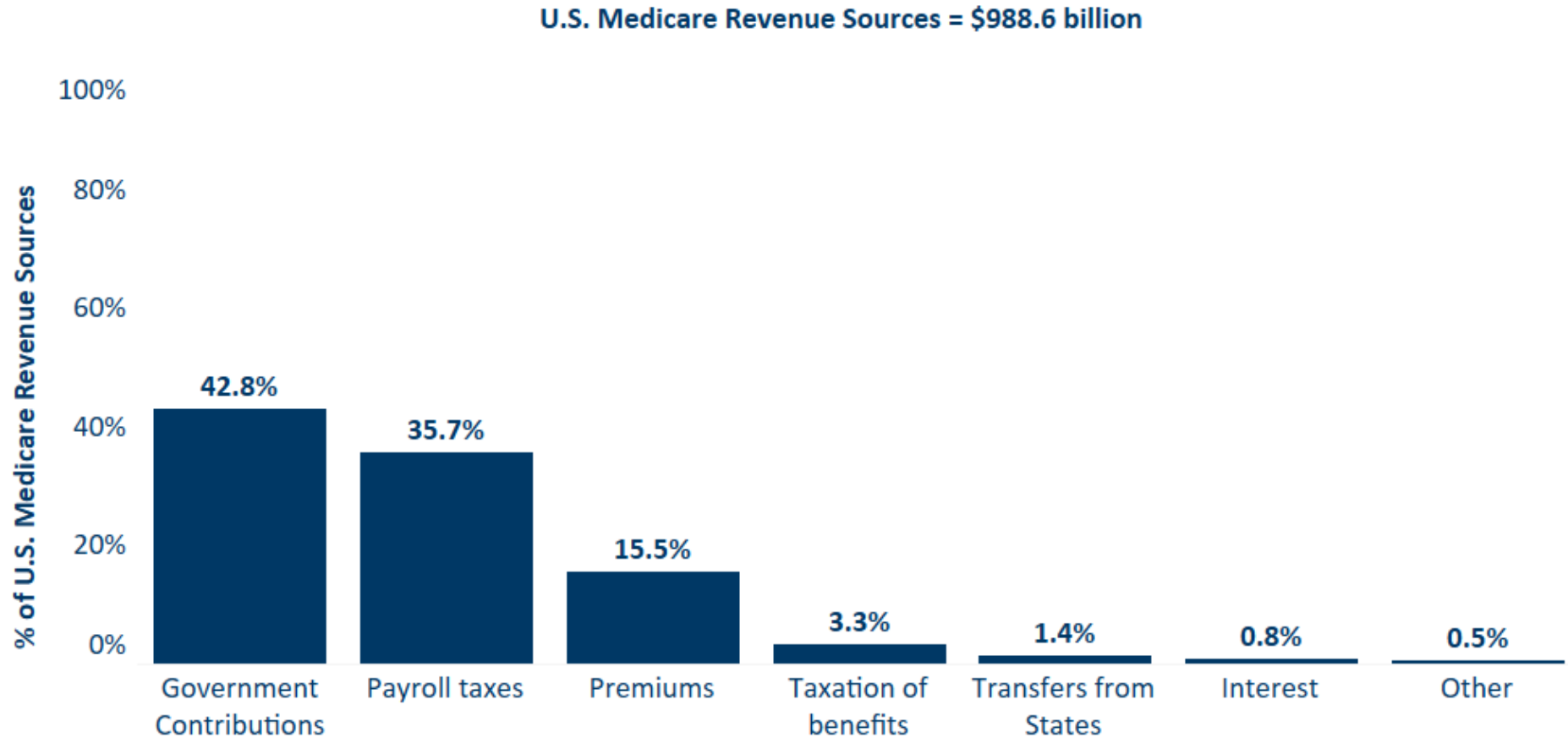
Listed in the order they are used in the chartbook

- **Medicare** – Medicare is focused on covering people aged 65 and older, as well as people with disabilities and end-stage renal disease (kidney disease). Options for receiving Medicare benefits and Medicare Prescription Drug benefits are explained in greater detail later in this chartbook.
 - **Private Medicare** is representative of Medicare Advantage and Medicare Cost Plans; these plans cover Medicare hospital and provider benefits (Part A and Part B) and may cover Part D (drug). There are two primary types:
 - **Medicare Advantage Plan (Medicare Part C):** Medicare pays the private insurance company a set amount per month to cover all services regardless of the actual services used (capitation), putting the insurer at risk if costs exceed expectations. The plan has a set provider network, and the enrollee may be responsible for paying for services that are received from providers outside the network.
 - **Medicare Cost Plan:** Medicare pays plan based on actual enrollee costs. While the plan does have a provider network, Medicare-covered services received from providers outside the network are paid by Original Medicare.
 - **Original Medicare** is the traditional fee-for-service Medicare health care system. Enrollees can go to any provider that accepts Medicare. These do not include stand-alone Medicare Part D (drug) plans, or other Medicare Supplement (Medigap) plans.
 - **Dual eligible Medicare enrollees** – full-benefit MMEs (Medicare – Medicaid Enrollees) and Qualified Disabled working individuals.
- **Medical Assistance** – Minnesota’s Medicaid program, focused on covering eligible low-income adults, children, pregnant women, elderly adults and people with disabilities; it includes both enrollment and spending.
- **MinnesotaCare** – provides health care coverage for people with low incomes; it has higher income limits than Medical Assistance. It includes both enrollment and spending.
- **Premiums** – the amount paid for health insurance each month.

Medicare

Data presented on a calendar year basis, unless otherwise specified.

Medicare Financing in the U.S., 2022



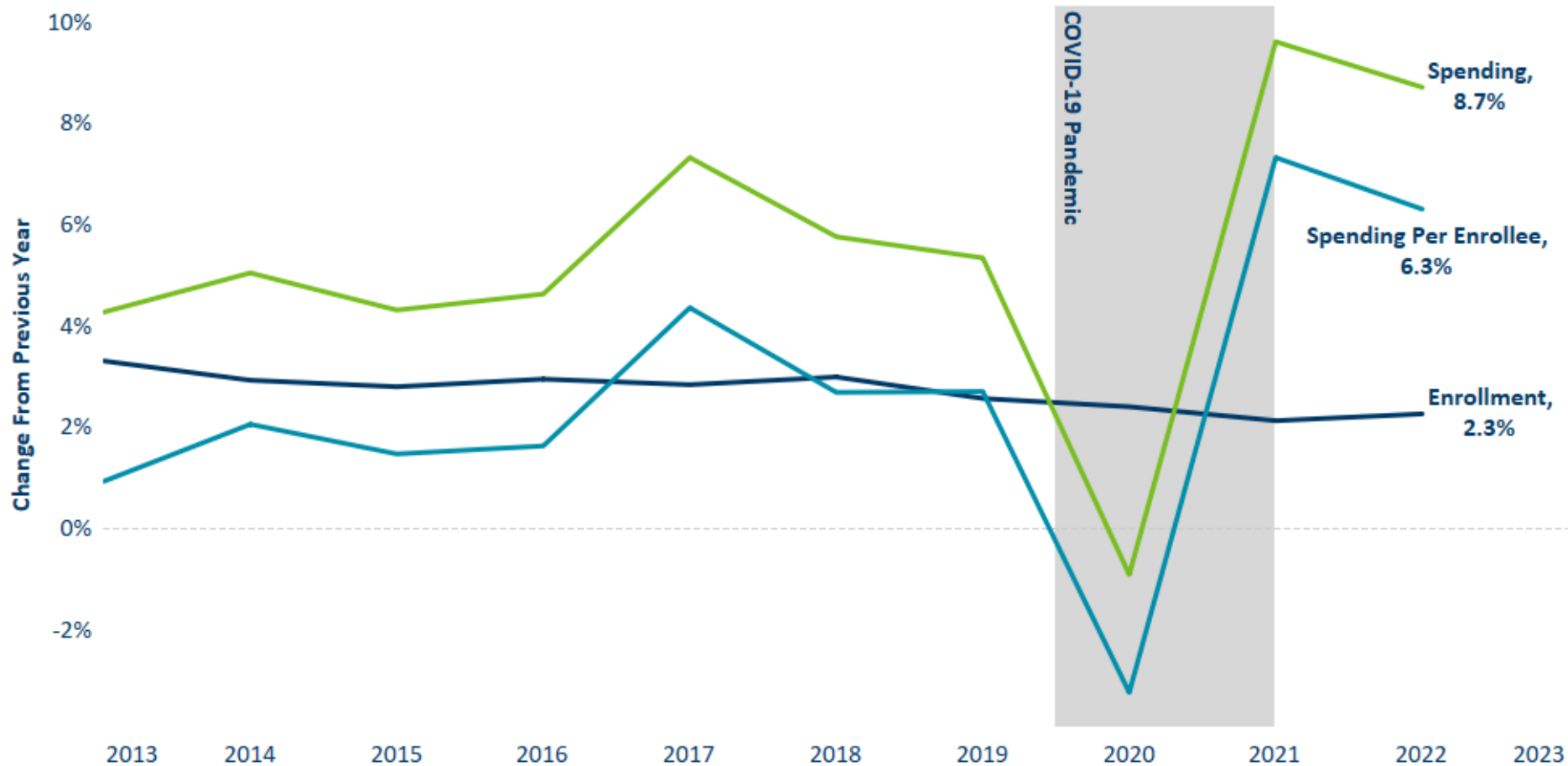
Source: 2023 Annual Report of The Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, Table II.B1, Medicare Data for Calendar Year 2022. Medicare has two separate trust funds – Hospital Insurance (Part A) and Supplementary Medical Insurance (Parts B and D) – funded by a few main revenue streams. Payroll tax based on covered earnings – including both employer and employee taxes. [Summary of graph](#)

Trends in Medicare Enrollment and Spending, Minnesota and the United States

Calendar Year	Enrollment		Expenditures (\$ millions)		Spending per Enrollee	
	MN	U.S.	MN	U.S.	MN	U.S.
2013	863,414	51,283,097	\$8,438	\$588,856	\$9,773	\$11,482
2014	888,702	52,840,291	\$8,864	\$617,327	\$9,974	\$11,683
2015	913,586	54,298,274	\$9,246	\$647,704	\$10,121	\$11,929
2016	940,548	55,760,921	\$9,675	\$675,870	\$10,286	\$12,121
2017	967,270	57,233,842	\$10,383	\$704,972	\$10,735	\$12,317
2018	996,224	58,743,029	\$10,982	\$749,612	\$11,023	\$12,761
2019	1,021,819	60,243,353	\$11,569	\$802,260	\$11,322	\$13,317
2020	1,046,400	61,552,240	\$11,464	\$832,243	\$10,955	\$13,521
2021	1,068,690	62,590,748	\$12,566	\$892,087	\$11,758	\$14,253
2022	1,092,890	63,782,878	\$13,661	\$944,318	\$12,500	\$14,805

Sources: CMS Program Statistics; June 2023 and March 2024. U.S. expenditure data are from the Health Consumption Expenditures of the National Health Expenditure Accounts (NHEA) for 2013 to 2022. U.S. population estimates are based on the United States and do not include territories, Puerto Rico, or other/outlying areas. Enrollment estimates include dual-eligible Medicare and Medical Assistance enrollees. Minnesota expenditure estimates are based on MDH annual spending report data for Medicare – public payer data (updated through 2022). All expenditures exclude out-of-pocket expenditures (including member deductibles and cost-sharing).

Change in Medicare From Previous Year, Enrollment and Spending

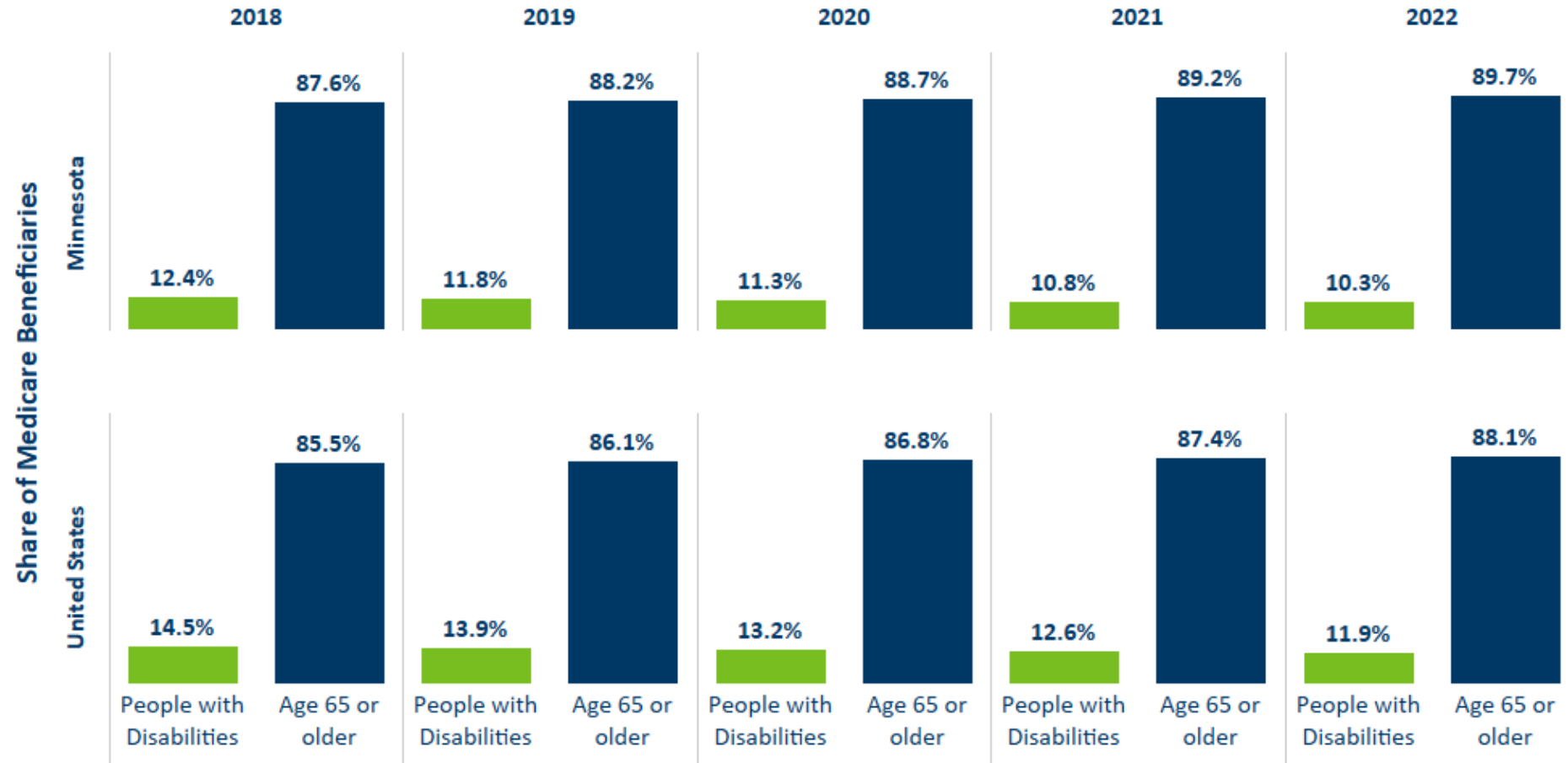


Source: CMS Program Statistics; downloaded June 2023. Minnesota spending estimates are based on MDH annual spending report data for Medicare – public payer data and exclude out-of-pocket expenditures (updated through 2022). Enrollment estimates include dual-eligible Medicare and Medical Assistance enrollees.

The COVID-19 Pandemic began in late 2019. A Public Health Emergency was declared on January 27, 2020.

[Summary of graph](#)

Distribution of Medicare Beneficiaries by Reason for Eligibility¹

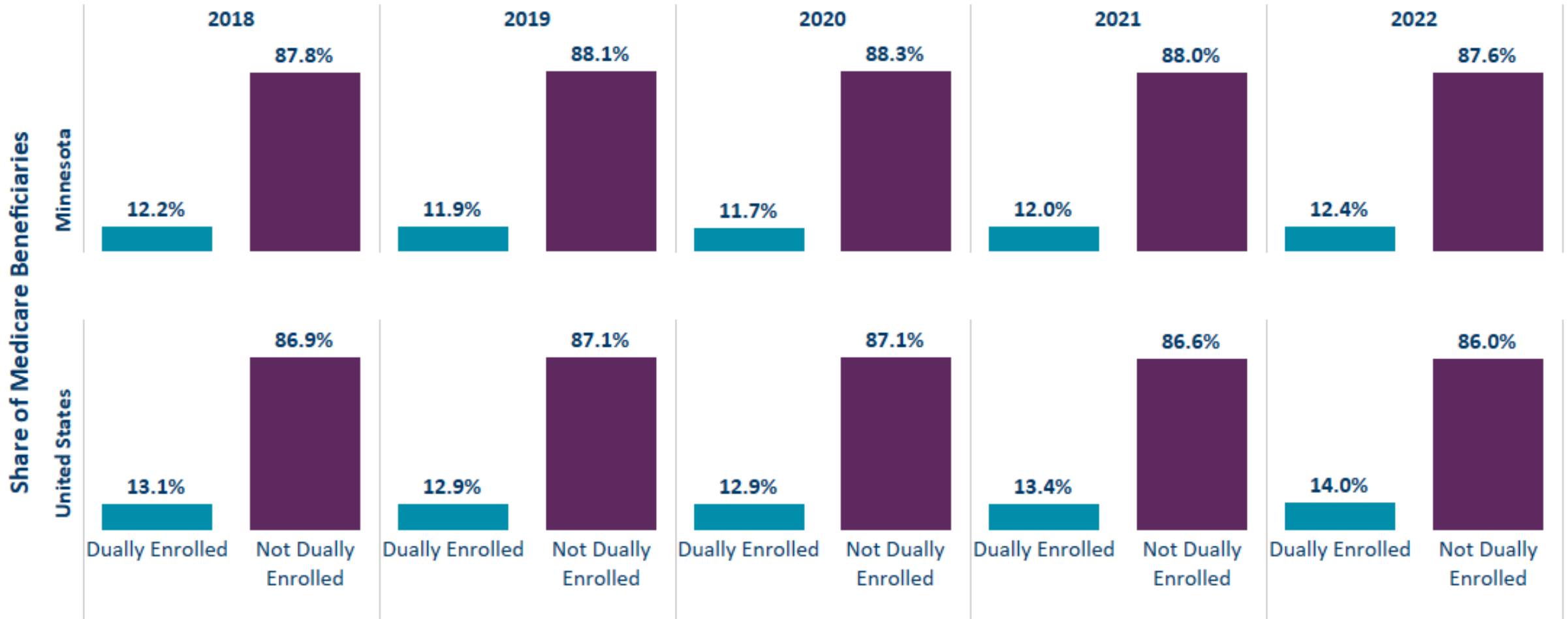


Source: CMS Program Statistics; March 2024. U.S. population estimates are based on the United States and do not include territories, Puerto Rico, or other/outlying areas. Enrollment estimates include dual-eligible Medicare and Medical Assistance enrollees.

¹People with disabilities includes enrollees with disabilities that are under age 65 and those with End-Stage Renal Disease-only. Those aged 65 or older and with ESRD or disabilities are classified as Age 65 or Older.

[Summary of chart](#)

Distribution of Medicare Beneficiaries by Dual-Enrollment Coverage¹

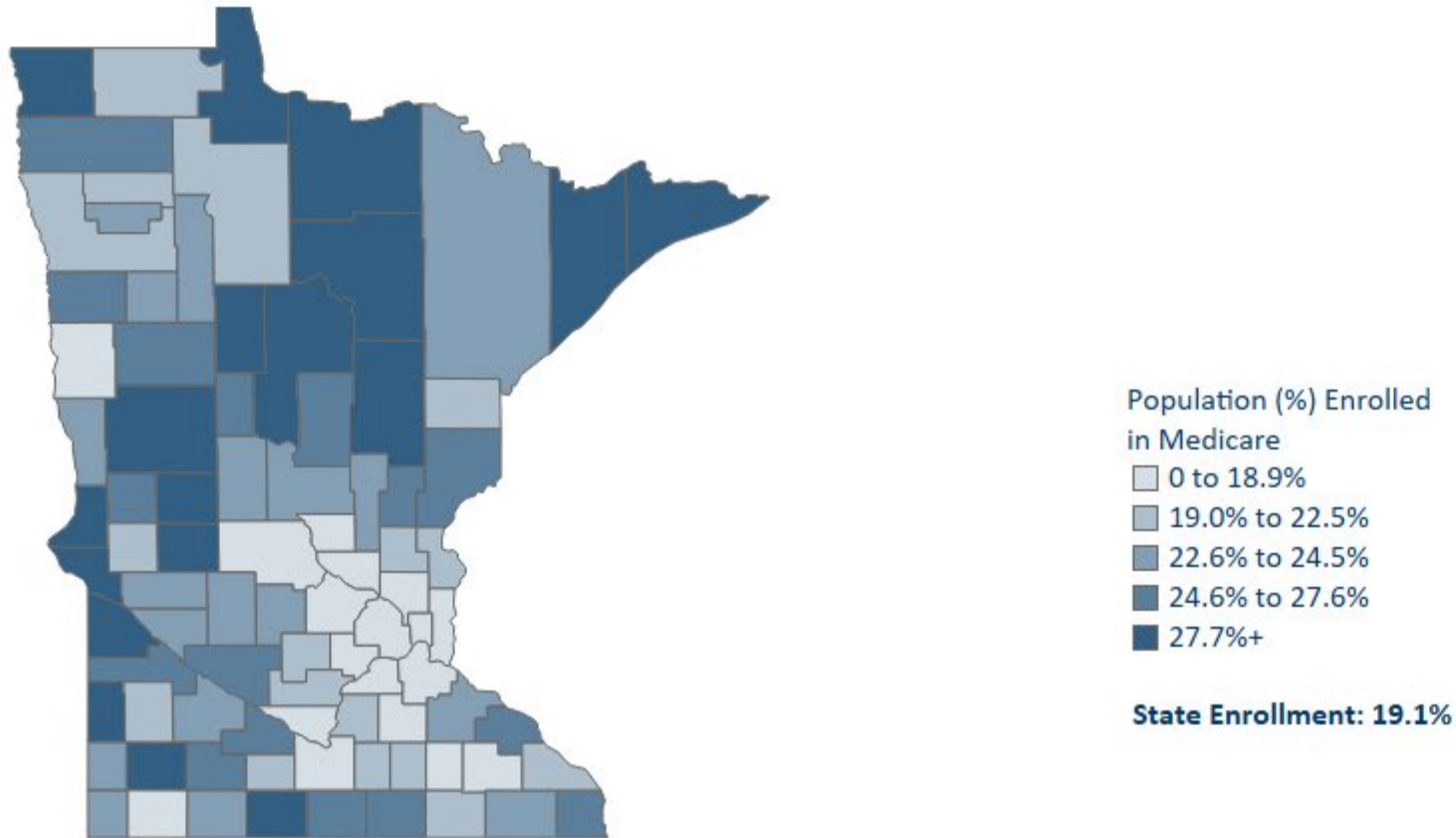


Source: CMS Program Statistics; March 2024. U.S. population estimates are based on the United States and do not include territories, Puerto Rico, or other/outlying areas.

¹Dual eligible are full-benefit MMEs (Medicare – Medicaid Enrollees). These do not include beneficiaries qualified to receive Medicare and partial Medicaid benefits.

[Summary of chart](#)

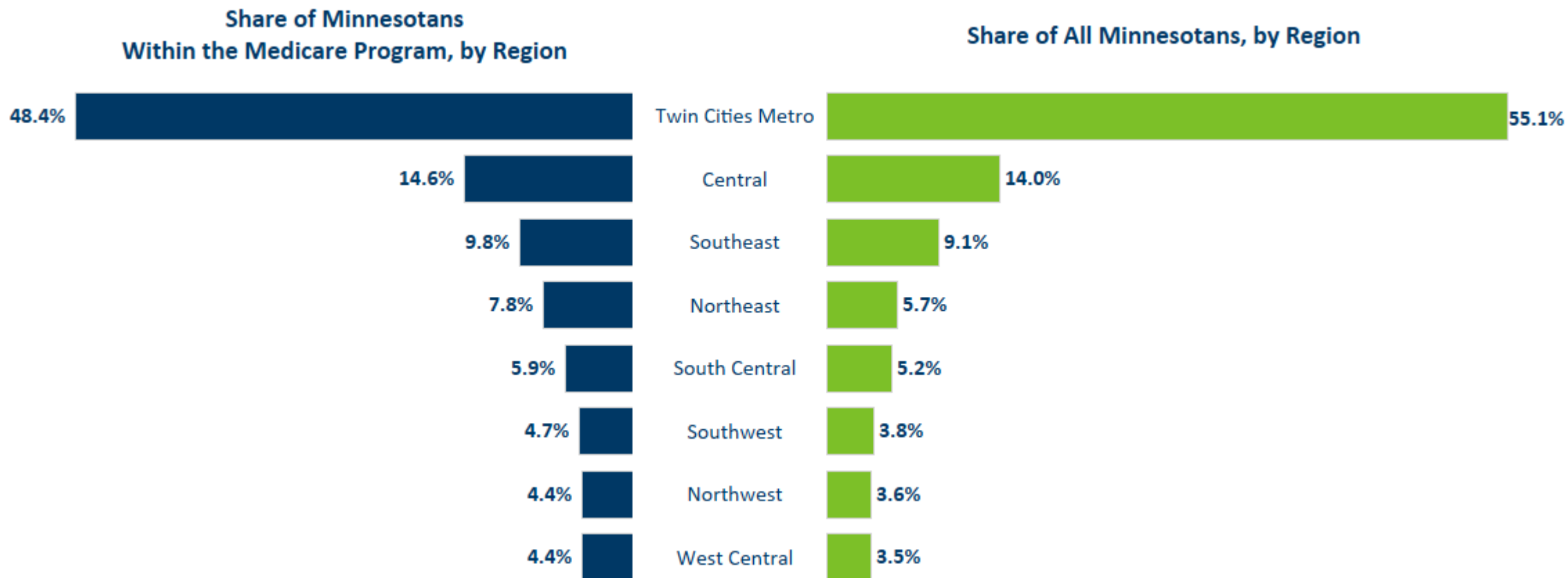
Medicare Enrollment as a Percent of Population, by County, 2022



Sources: CMS Program Statistics; March 2024; U.S. Census Bureau, Annual Estimates of the Resident Population for Counties in Minnesota: April 1, 2020 to July 1, 2022. Map shapefile from 2022 Mapbox @OpenStreetMap. Ranges are based on quintiles. Enrollment estimates include dual-eligible Medicare and Medical Assistance enrollees.

[Summary of graph](#)

Share of Medicare Population Compared to Share of Minnesota Population, by Region, 2022



For the regional boundaries, see slide 44 at the end of this chartbook.

Sources: CMS Program Statistics; March 2024; U.S. Census Bureau, Annual Estimates of the Resident Population for Counties in Minnesota: April 1, 2020 to July 1, 2022. Blue bar chart percentages are calculated by taking the Medicare enrollment in each region by the total Medicare population. Green bar chart percentages are calculated by taking the Minnesota residents in each region by the total state population. Medicare enrollment estimates include dual-eligible Medicare and Medical Assistance enrollees.

[Summary of chart](#)

Options for Receiving Medicare Benefits

Medicare benefits have four parts:

Part A:
Federal Hospital
Insurance

Part B:
Federal Medical
Insurance

Part C:
Medicare
Advantage Plans

Part D:
Prescription
Drug Coverage

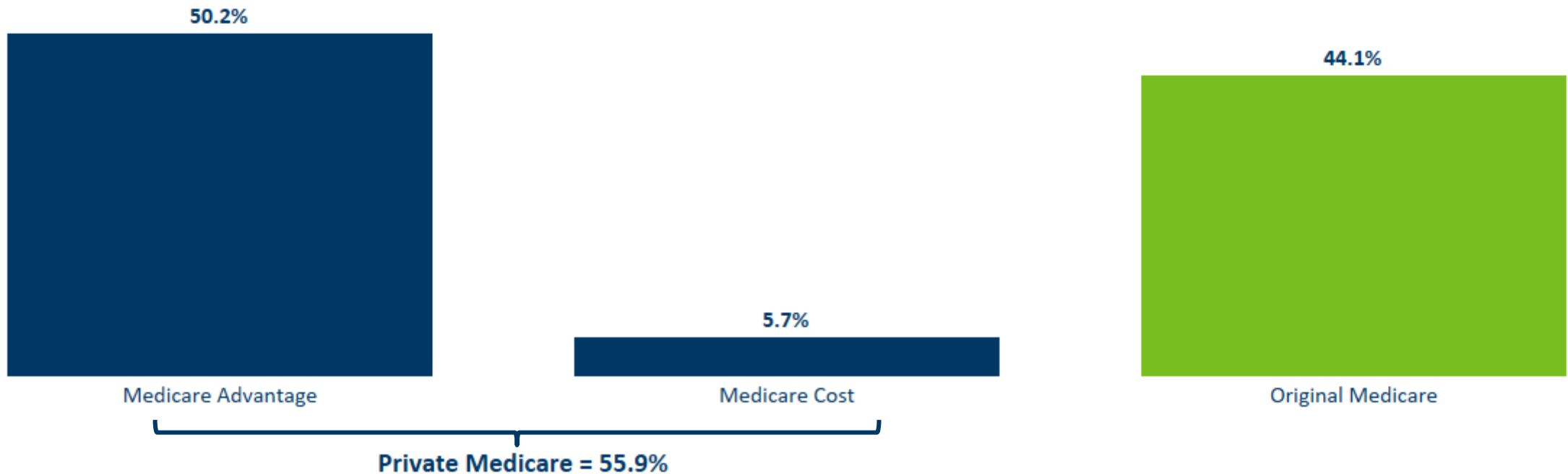
Original Medicare (With Options Below to Fill Original Medicare's Gaps)

- Consumer selects if they want either option that are provided by private health plans.
- Part D (outpatient prescription drug coverage).
- Medigap policy (pays Medicare coinsurance, copayments, deductibles).

Private Medicare (Two Options)

- **Part C:** private plan provides all Medicare Parts A and B benefits. *May* include Part D.
- **Medicare Cost:** private plan provides Medicare benefits for consumer within plan network; out-of-network services paid by Original Medicare. Available in limited counties. *May* include Part D.

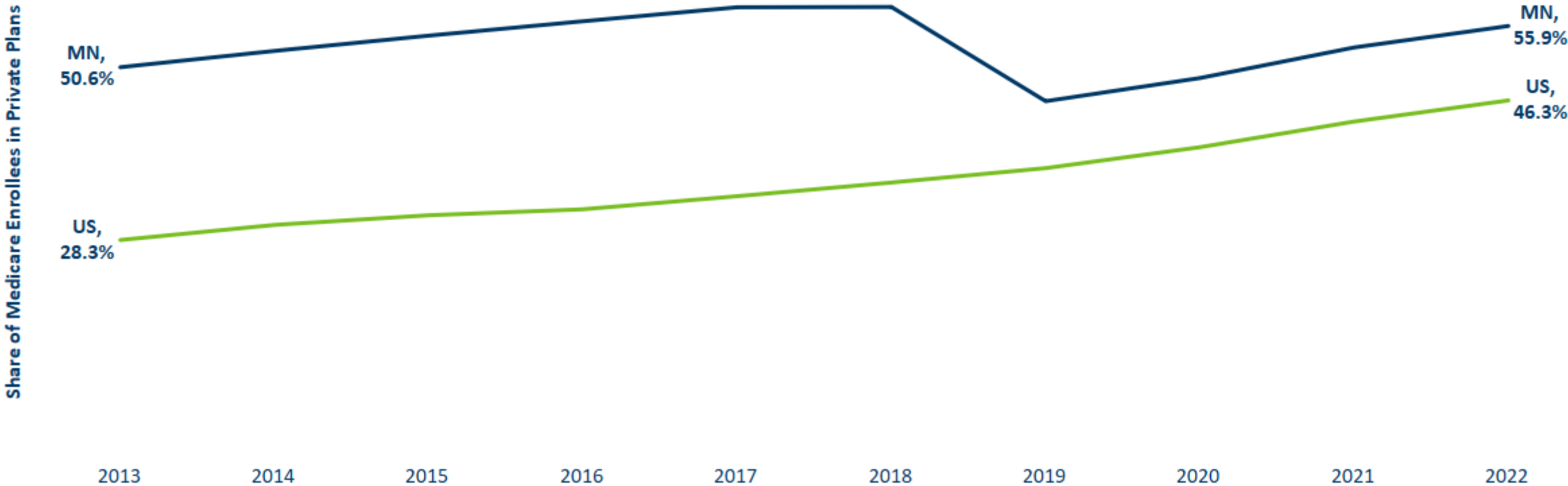
Medicare Enrollment, as of December 2022



Source: CMS, Medicare Advantage Monthly Enrollment by State/County/Contract as of December 2022. Total Medicare enrollment is based off CMS Enrollment Dashboard 2022, calendar year. Private Medicare is representative of Medicare Advantage and Medicare Cost Plans. Medicare Advantage and Medicare Cost Plans cover Medicare hospital and provider benefits (Part A and Part B) and may cover Part D (drug). Original Medicare is the traditional fee-for-service Medicare health care system. Private Medicare enrollment estimates include dual-eligible Medicare and Medical Assistance enrollees. These do not include stand-alone Medicare Part D (drug) plans, or other Medicare supplement plans. As this is a point in time estimate, results may differ from data reported on a calendar year basis.

[Summary of graph](#)

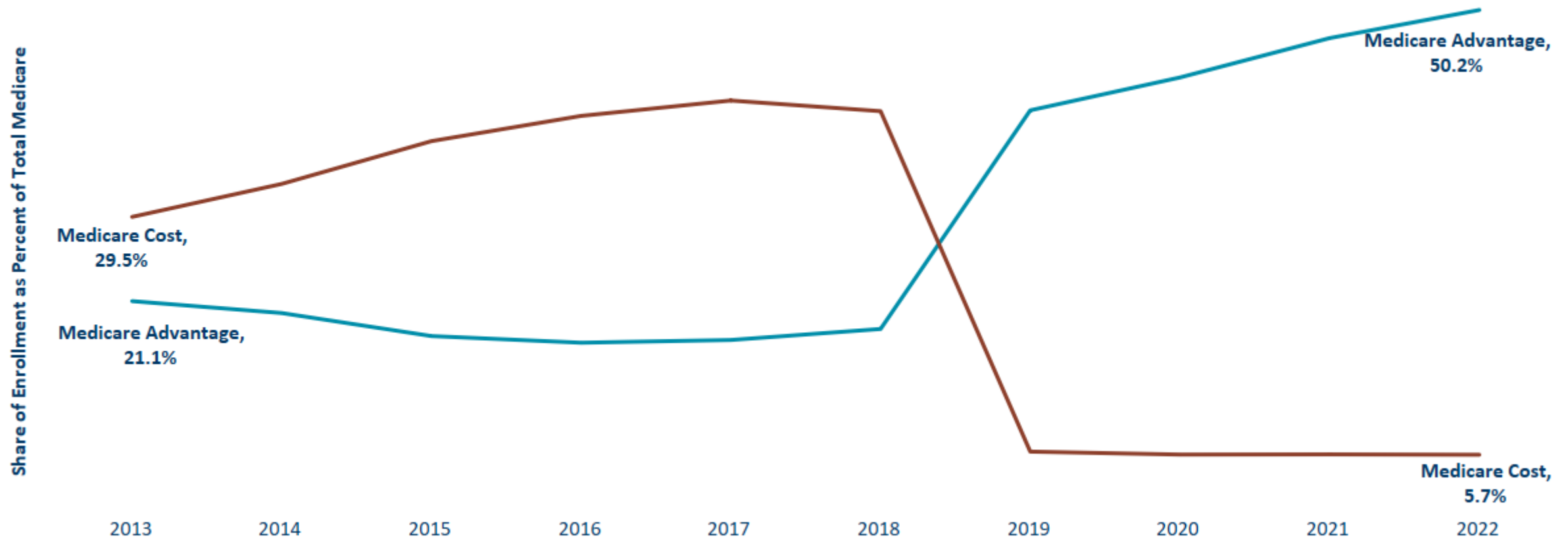
Total Medicare Private Plan Enrollment as a Percent of Population, Minnesota and the United States



Source: CMS, Medicare Advantage Monthly Enrollment by State/County/Contract as of December of each year. Total Medicare enrollment is based off CMS Enrollment Dashboard 2022, calendar year. CMS Medicare private plans include Medicare Advantage and Medicare Cost Plans that cover Medicare hospital and provider benefits (Part A and Part B) and may cover Part D (drug). These estimates include dual-eligible Medicare and Medical Assistance enrollees. It does not include stand-alone Medicare Part D (drug) plans, or other Medicare supplement plans. U.S. population estimates are based on the United States and do not include territories, Puerto Rico, or other/outlying areas.

[Summary of graph](#)

Medicare Private Plan Enrollment as a Percent of Total Enrollment in Minnesota



Source: CMS, Medicare Advantage Monthly Enrollment by State/County/Contract as of December as of each year. Total Medicare enrollment is based off CMS Enrollment Dashboard 2022, calendar year. Medicare private plans include Medicare Advantage and Medicare Cost Plans that cover Medicare hospital and provider benefits (Part A and Part B) and may cover Part D (drug). These estimates include dual-eligible Medicare and Medical Assistance enrollees. It does not include stand-alone Medicare Part D (drug) plans, or other Medicare supplement plans.

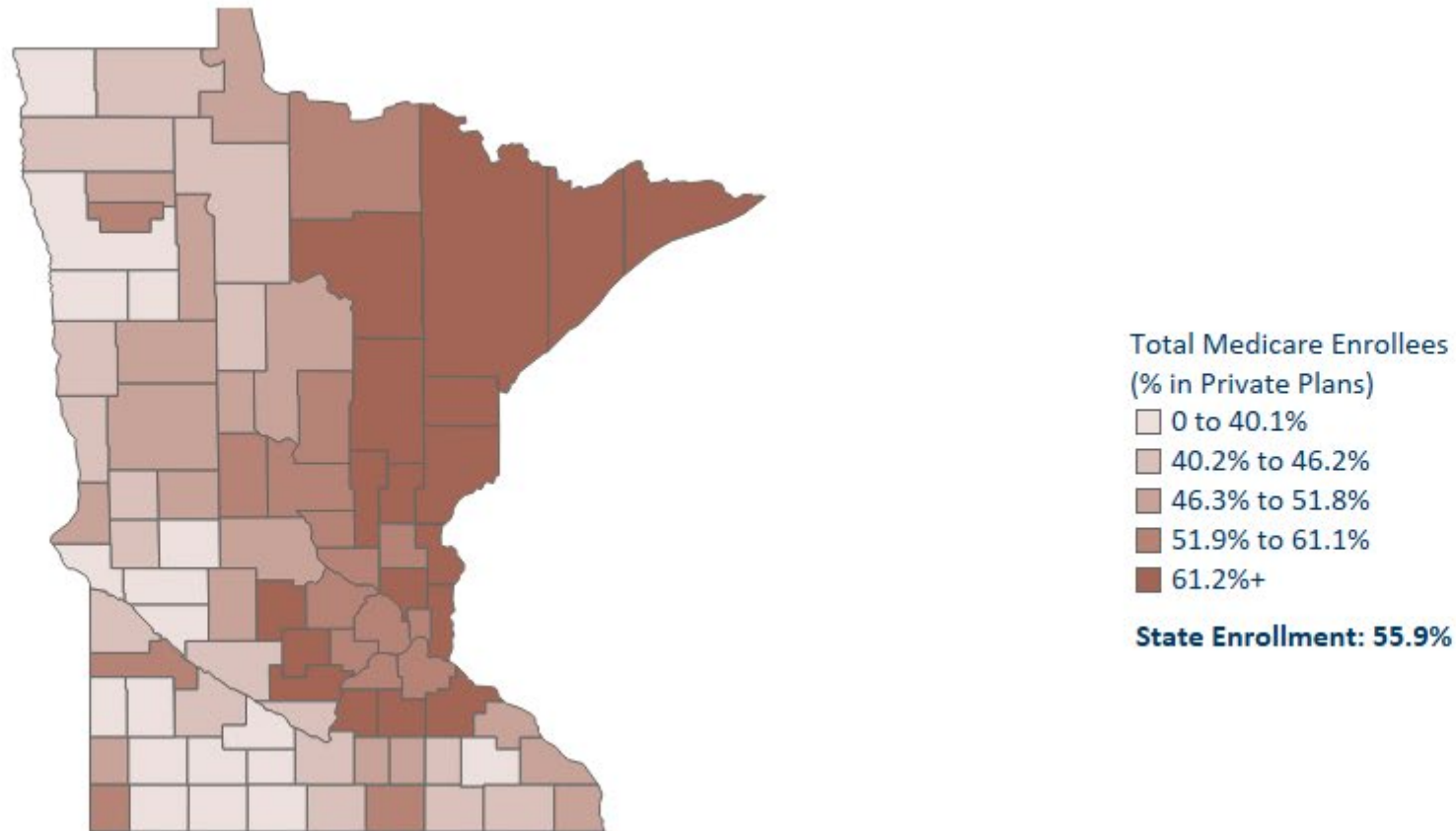
[Summary of graph](#)

Medicare Enrollment by Plan Type

Calendar Year	Total Medicare Enrollment	Original Medicare	Private Medicare		
			Total	Medicare Cost	Medicare Advantage
2013	863,414	426,461	436,953	254,814	182,139
2014	888,702	420,247	468,455	291,571	176,884
2015	913,586	413,972	499,614	338,771	160,843
2016	940,548	408,726	531,822	372,493	159,329
2017	967,270	402,871	564,399	397,900	166,499
2018	996,224	414,551	581,673	399,243	182,430
2019	1,021,819	549,544	472,275	61,926	410,349
2020	1,046,400	531,486	514,914	60,345	454,569
2021	1,068,690	500,599	568,091	61,814	506,277
2022	1,092,890	481,640	611,250	62,813	548,437

Source: MDH analysis of CMS, Medicare Advantage Monthly Enrollment by State/County/Contract reports as of December as of each year and CCW reporting. Medicare private plans include Medicare Advantage and Medicare Cost Plans that cover Medicare hospital and provider benefits (Part A and Part B) and may cover Part D (drug). Private Medicare and Medicare Advantage enrollment estimates include dual-eligible Medicare and Medical Assistance enrollees. It does not include stand-alone Medicare Part D (drug) plans, or other Medicare supplement plans.

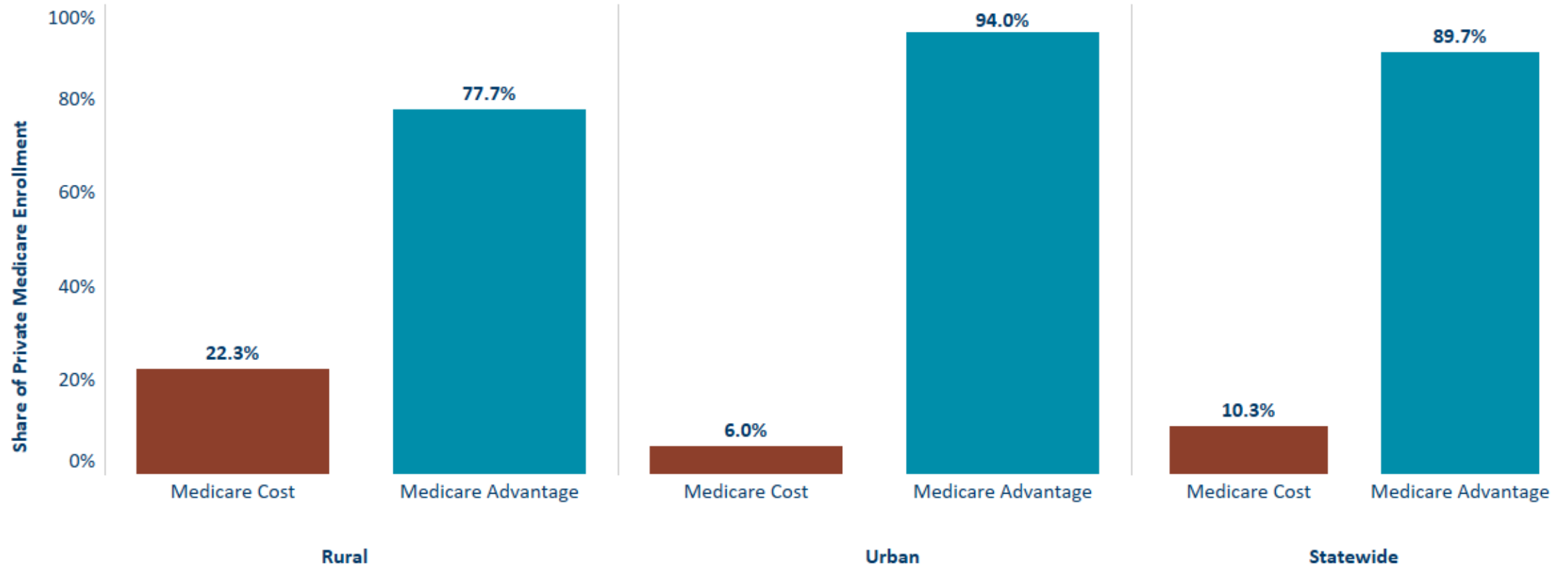
Medicare Private Plan Enrollment as a Percent of Medicare Population, by County, as of December 2022



Sources: CMS, CMS Enrollment Dashboard 2022, calendar year; U.S. Census Bureau, Annual Estimates of the Resident Population for Counties in Minnesota: April 1, 2020 to July 1, 2022. Map shapefile from 2022 Mapbox @OpenStreetMap. Ranges are based on quintiles. Medicare private plans include Medicare Advantage and Medicare Cost Plans that cover Medicare hospital and provider benefits (Part A and Part B) and may cover Part D (drug). It does not include stand-alone Medicare Part D (drug) plans, or other Medicare supplement plans. These estimates include dual-eligible Medicare and Medical Assistance enrollees. Distribution is based on Private Medicare Plan Enrollees as a percent of total Medicare enrollees.

[Summary of graph](#)

Distribution of Minnesota Medicare Private Plan Enrollees, by Region & Type of Plan, December 2022



Source: CMS, Medicare Advantage Monthly Enrollment by State/County/Contract Report as of December 2022.

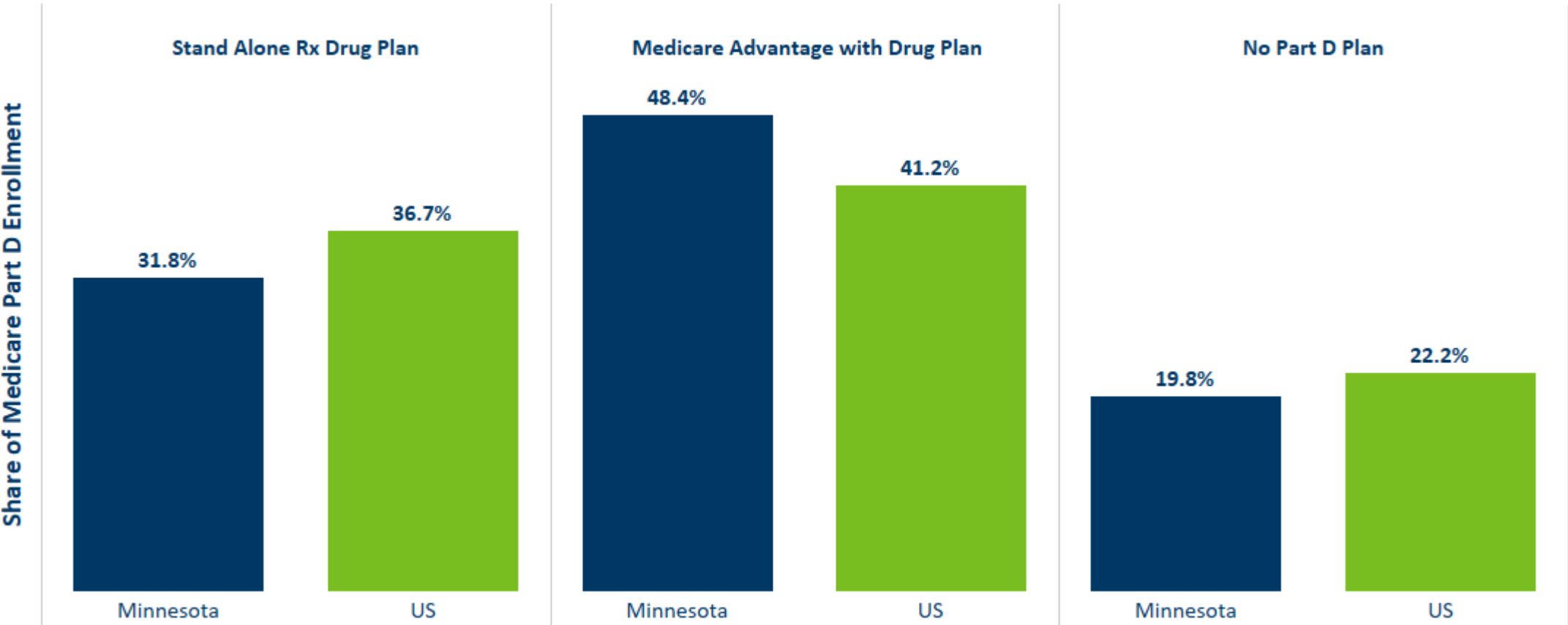
These plans cover Medicare hospital and provider benefits (Part A and Part B) and may cover Part D benefits (prescription drugs). These do not include stand-alone Medicare Part D (drug) plans, or other Medicare supplement plans. Medicare Cost plans represented are 1876 Cost Plans; Medicare Advantage plans represented are local Coordinated Care Plans (CCPs). Due to low populations, Private Fee For Service Plans and Medicare MSA plans are including within Medicare Advantage; each have less than 0.1% of Medicare enrollees enrolled. These estimates include dual-eligible Medicare and Medical Assistance enrollees.

[Summary of graph](#)

Options for Receiving Medicare Prescription Drug Benefits

- Prescription drug benefits are offered through Medicare Part D plans. Medicare Part D is an optional benefit; Medicare enrollees are not automatically enrolled in these plans.
- There are multiple options for Medicare Part D plans:
 - **Stand-alone Medicare Part D Plan** – Plan covers Medicare Part D benefits only, separate from other Medicare benefits.
 - **Medicare Part D Coverage with Medicare Health Plan** – Medicare Part D benefits are included in a private Medicare plan (Medicare Advantage or Medicare Cost).
 - **Employer Plan** – a health plan sponsor, such as an employer, creates a Medicare Part D Plan for their Medicare-eligible retirees.
- For more information, visit [Minnesota Health Care Choices \(http://www.mnhealthcarechoices.com/\)](http://www.mnhealthcarechoices.com/). This annual publication provides detail on all plan offerings for Minnesota residents.

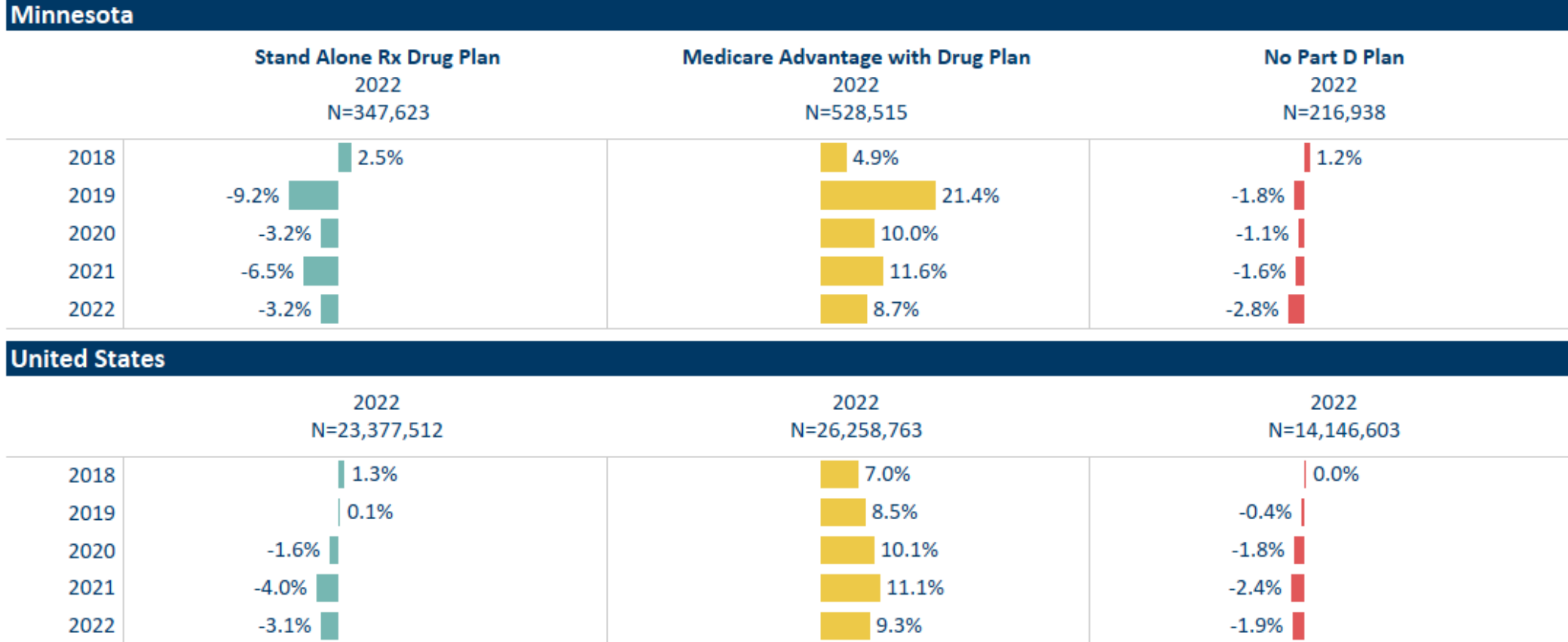
Distribution of Prescription Drug Coverage for Medicare Enrollees, by Type, 2022



Source: MDH analysis of CMS Program Statistics; March 2024. MDH has calculated “No Part D Plan” by subtracting Medicare Advantage Drug Plan Enrollment and Medicare Part D enrollment from Total Medicare enrollment. “No Part D Plan” may include participants enrolled in a Retiree Drug Subsidy (RDS) plan, other prescription drug coverage not included in the other categories, or participants without drug coverage. Medicare Advantage CMS definition does not implicitly indicate this includes Medicare Cost plans. U.S. population estimates are based on the United States and do not include territories, Puerto Rico, or other/outlying areas.

Change in Annual Prescription Drug Coverage, by Type

Change from Previous Year



Source: MDH analysis of CMS Program Statistics; March 2024. MDH has calculated “No Part D Plan” to be based off subtracting Medicare Advantage Drug Plan Enrollment and Medicare Part D enrollment from Total Medicare enrollment. “No Part D Plan” may include participants enrolled in a Retiree Drug Subsidy (RDS) plan, other prescription drug coverage not included in the other categories, or participants without drug coverage. Medicare Advantage CMS definition does not implicitly indicate this includes Medicare Cost plans. U.S. population estimates are based on the United States and do not include territories, Puerto Rico, or other/outlying areas.

[Summary of graph](#)

Medical Assistance

Minnesota's Medicaid program – jointly financed by the state and the federal government – provides health insurance to people with low incomes and people with disabilities. [U.S. Department of Health & Human Services, Office of the Assistant Secretary for Planning and Evaluation, Poverty Guidelines: https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines/prior-hhs-poverty-guidelines-federal-register-references](https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines/prior-hhs-poverty-guidelines-federal-register-references)

In 2014, under the Affordable Care Act (ACA), Medical Assistance eligibility was increased to all childless adults, parents and caretakers, and children (aged 19 to 20) with incomes at or below 133% of Federal Poverty Guidelines (FPG), and children (aged 2 to 18) with incomes at or below 275% of FPG.

The Public Health Emergency related to the COVID-19 pandemic began on January 27, 2020 ([U.S. Department of Health & Human Services, Office of the Assistant Secretary for Planning and Evaluation: https://aspr.hhs.gov/legal/PHE/Pages/2019-nCoV.aspx](https://aspr.hhs.gov/legal/PHE/Pages/2019-nCoV.aspx)) and allowed continuous enrollment for anyone enrolled on or after March 31, 2020. The continuous enrollment provision ended on March 31, 2023 and after that time, Minnesota began to disenroll Minnesotans (either those who are no longer eligible or do not complete the renewal process).

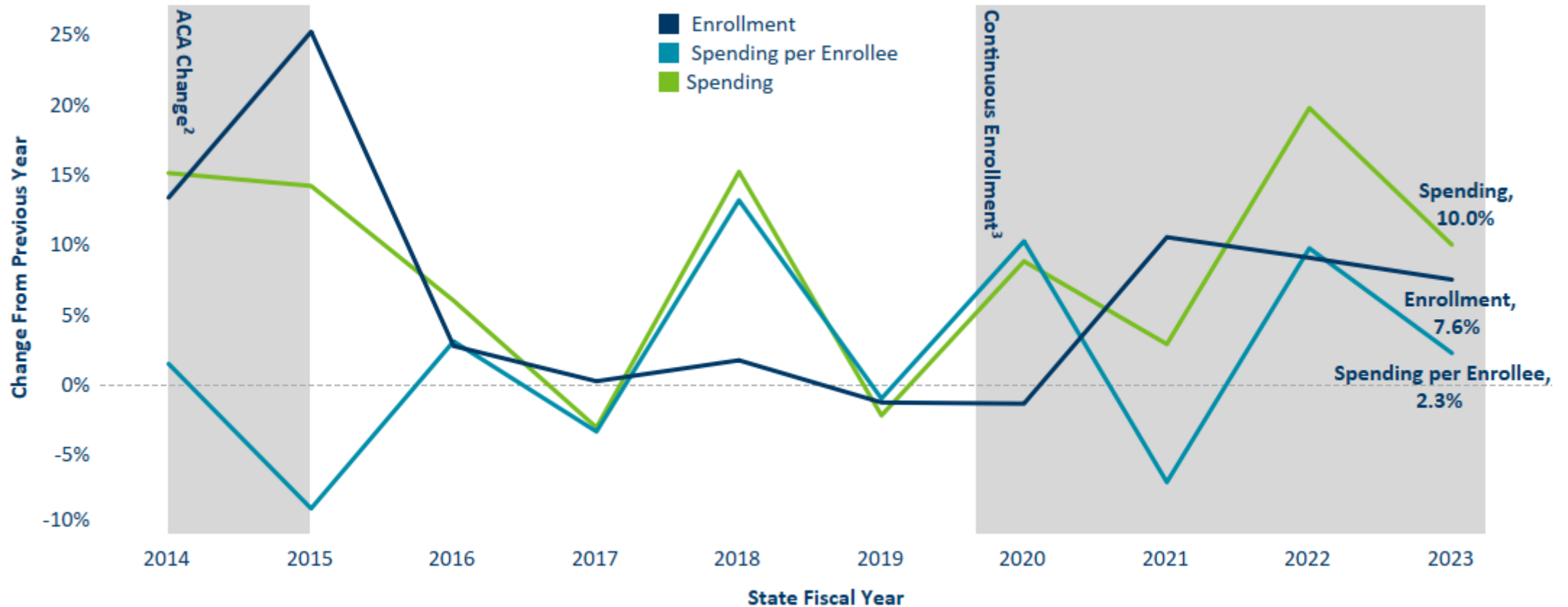
Data presented on a state fiscal year (SFY) basis, unless otherwise specified.

Trends in Medical Assistance Enrollment and Spending

State Fiscal Year	Avg. Monthly Enrollment	Spending (\$ millions)	Avg. Monthly Spending per Enrollee	Growth in:		
				Enrollment	Total Spending	Spending per Enrollee
2014	838,256	\$9,265	\$921	13.4%	15.2%	1.5%
2015	1,049,819	\$10,585	\$840	25.2%	14.2%	-8.8%
2016	1,079,400	\$11,225	\$867	2.8%	6.1%	3.1%
2017	1,082,654	\$10,888	\$838	0.3%	-3.0%	-3.3%
2018	1,102,087	\$12,549	\$949	1.8%	15.2%	13.2%
2019	1,088,692	\$12,280	\$940	-1.2%	-2.1%	-0.9%
2020	1,074,566	\$13,369	\$1,037	-1.3%	8.9%	10.3%
2021	1,188,285	\$13,763	\$965	10.6%	3.0%	-6.9%
2022	1,296,590	\$16,488	\$1,060	9.1%	19.8%	9.8%
2023	1,394,535	\$18,143	\$1,084	7.6%	10.0%	2.3%

Source: Minnesota Department of Human Services, February 2024 Expenditure Forecast, data for state fiscal years. Lower enrollment in SFY 2020 is a result of lower enrollment for the first three quarters of 2020, making the average monthly enrollment in SFY2020 lower than the average in SFY2019.

Change in Medical Assistance From Previous Year, Enrollment and Spending¹⁻³



Source: Minnesota Department of Human Services, February 2024 Expenditure Forecast, data for state fiscal years. Lower enrollment in SFY 2020 is a result of lower enrollment for the first three quarters of 2020, making the average monthly enrollment in SFY2020 lower than the average in SFY2019.

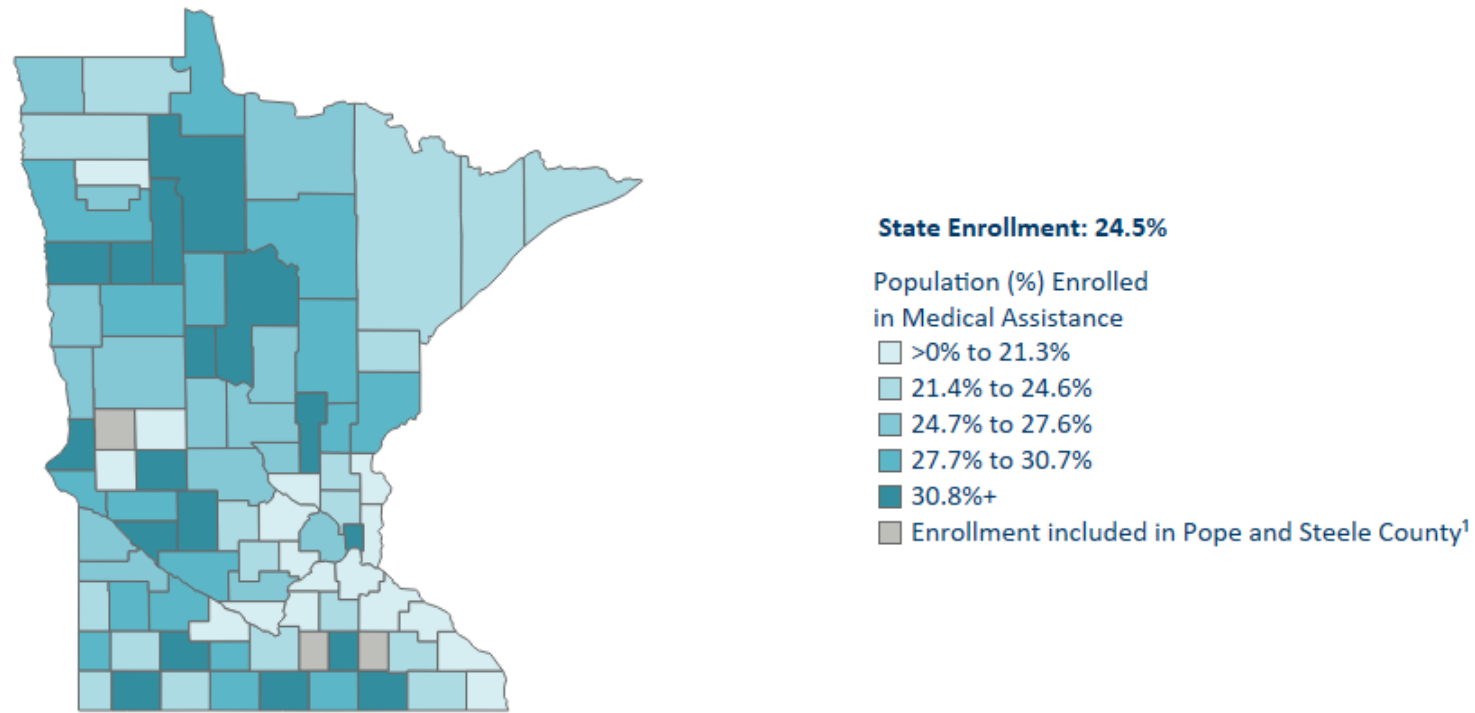
¹Some MinnesotaCare enrollees qualified for Medical Assistance (MA) following the March 2011 MA eligibility expansion to include childless adults with incomes at or below 75% of the Federal Poverty Guidelines (FPG).

²In 2014, under the ACA, eligibility was increased to all childless adults, parents and caretakers, and children (aged 19 to 20) with incomes at or below 133% FPG, and children (aged 2 to 18) with incomes at or below 275% FPG.

³The Public Health Emergency related to the COVID-19 pandemic began on January 27, 2020 ([ASPE: https://aspr.hhs.gov/legal/PHE/Pages/2019-nCoV.aspx](https://aspr.hhs.gov/legal/PHE/Pages/2019-nCoV.aspx)) and allowed for continuous enrollment for anyone enrolled on or after March 31, 2020. The continuous enrollment provision ended on March 31, 2023.

[Summary of graph](#)

Medical Assistance Enrollment as a Percent of Population, by County, Calendar Year 2023

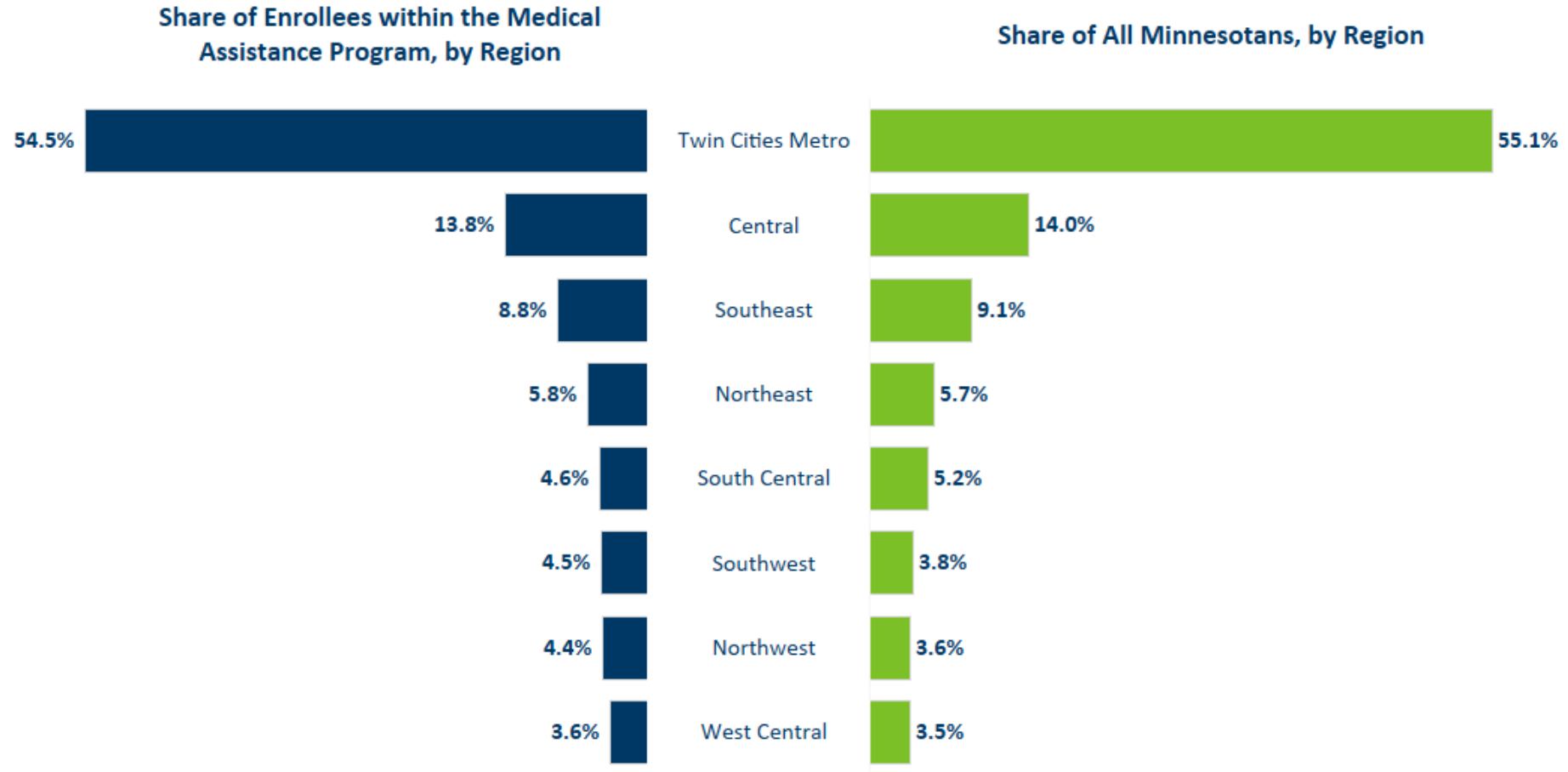


Source: Minnesota Department of Human Services, enrollment data for calendar year 2023; County estimates from U.S. Census Bureau, Annual Estimates of the Resident Population for Counties: April 1, 2020 to July 1, 2023; map shapefile from 2022 Mapbox @OpenStreetMap. Ranges are based on quintiles. Enrollment excludes “other” with no known category. Includes all enrollees, even those with dual-coverage (Medicare or private coverage) during the year.

¹DHS does not separate out Grant county enrollment and it is instead included in Pope county; Dodge and Waseca counties enrollment is combined into enrollment for Steele county.

[Summary of graph](#)

Share of Medical Assistance Enrollees Compared to Share of Minnesota Population, by Region, Calendar Year 2023



For the regional boundaries, see slide 44 at the end of this chartbook.

Source: Minnesota Department of Human Services, enrollment data for calendar year 2023; County estimates from U.S. Census Bureau, Annual Estimates of the Resident Population for Counties: April 1, 2020 to July 1, 2023. Enrollment excludes “other” with no known category. Blue bar chart percentages are calculated by taking the Medical Assistance enrollment in each region by the total Medical Assistance population. Green bar chart percentages are calculated by taking the Minnesota residents in each region by the total state population.

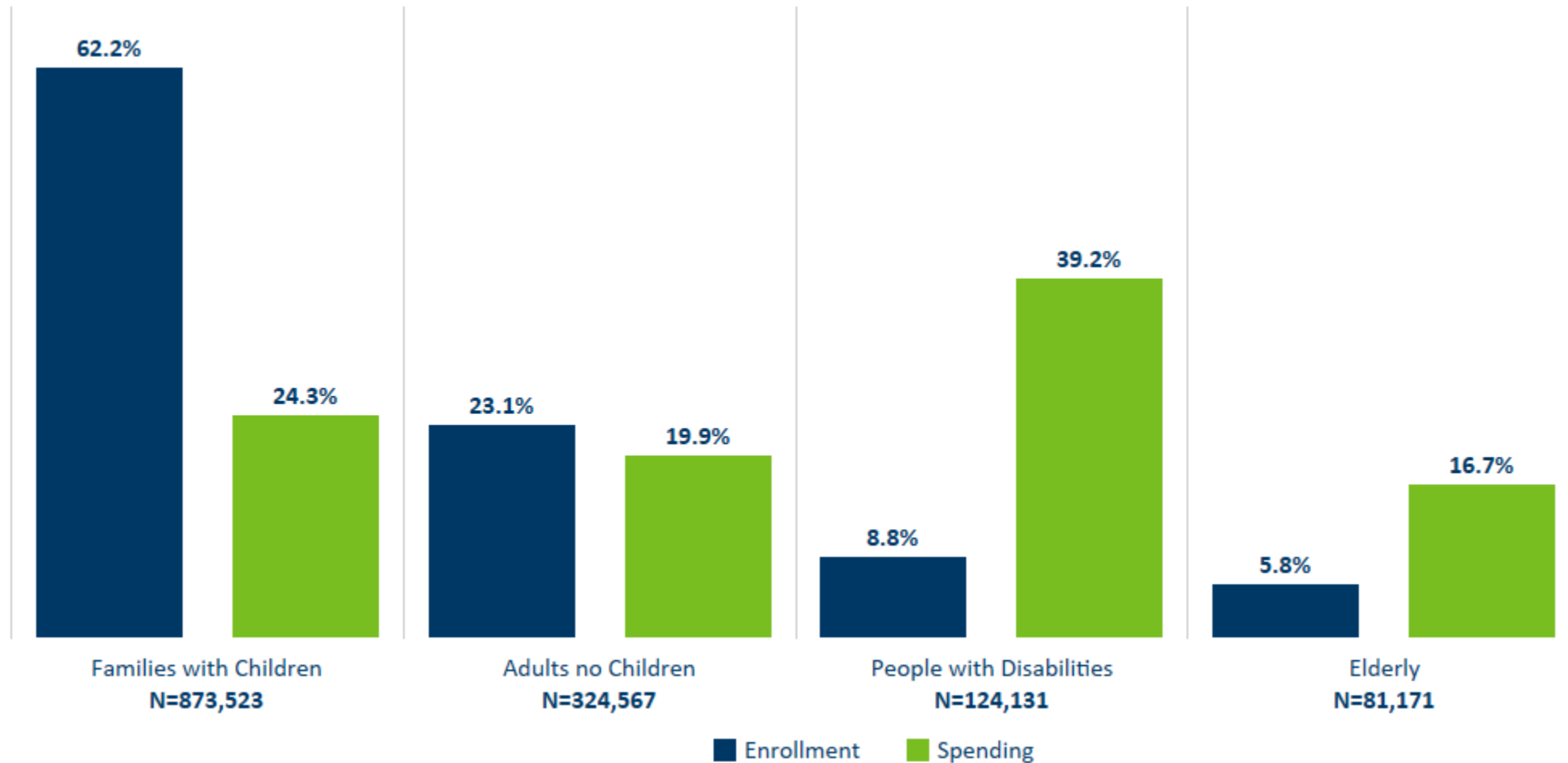
[Summary of chart](#)

Medical Assistance Enrollment, by Eligibility Category



Source: Minnesota Department of Human Services, February 2024 Expenditure Forecast.
[Summary of graph](#)

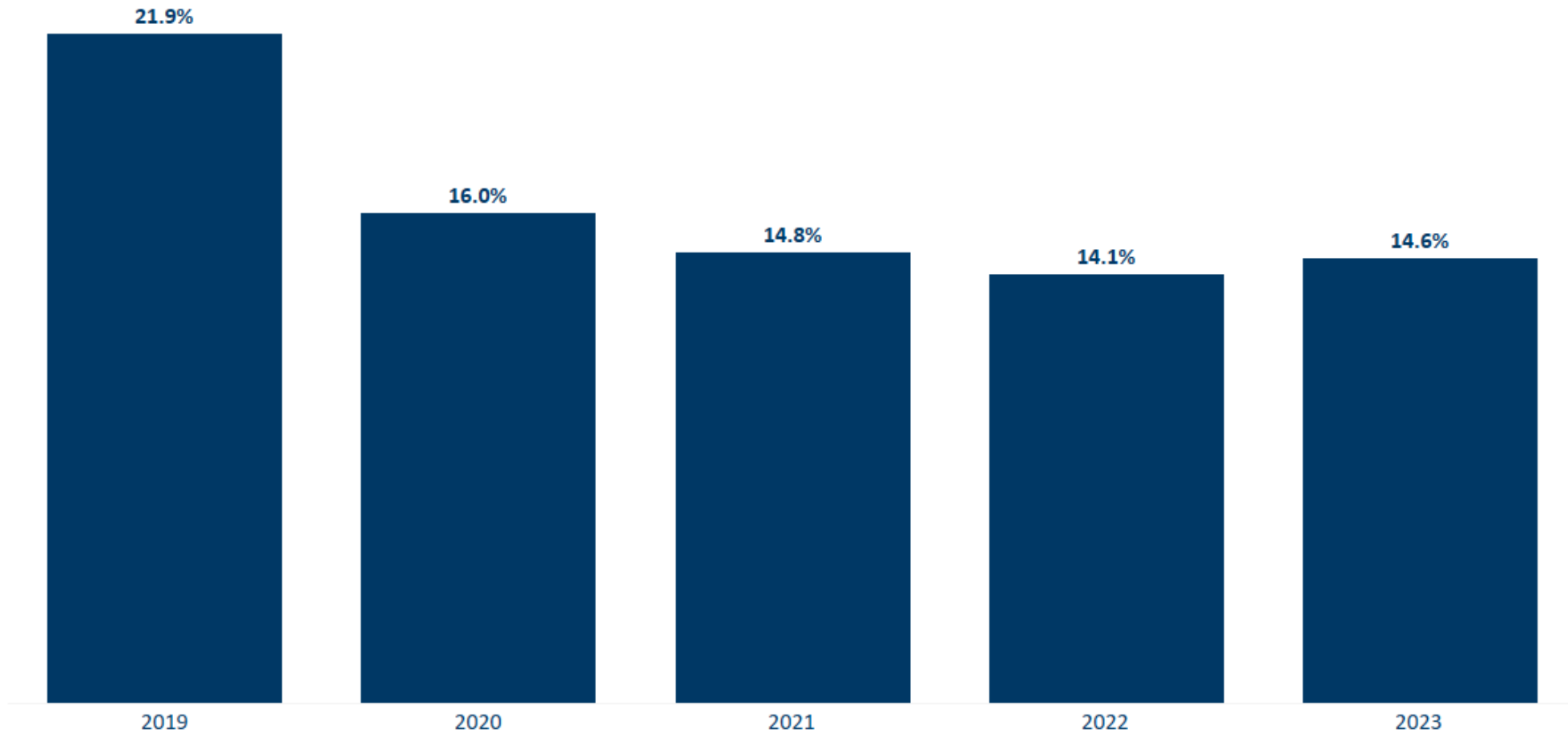
Distribution of Medical Assistance Enrollment and Spending, by Eligibility Category, Calendar Year 2023



Source: Minnesota Department of Human Services, data for calendar year 2023. Data source is different than prior slide, which data is based on state fiscal years. Enrollment within eligibility labels is rounded.

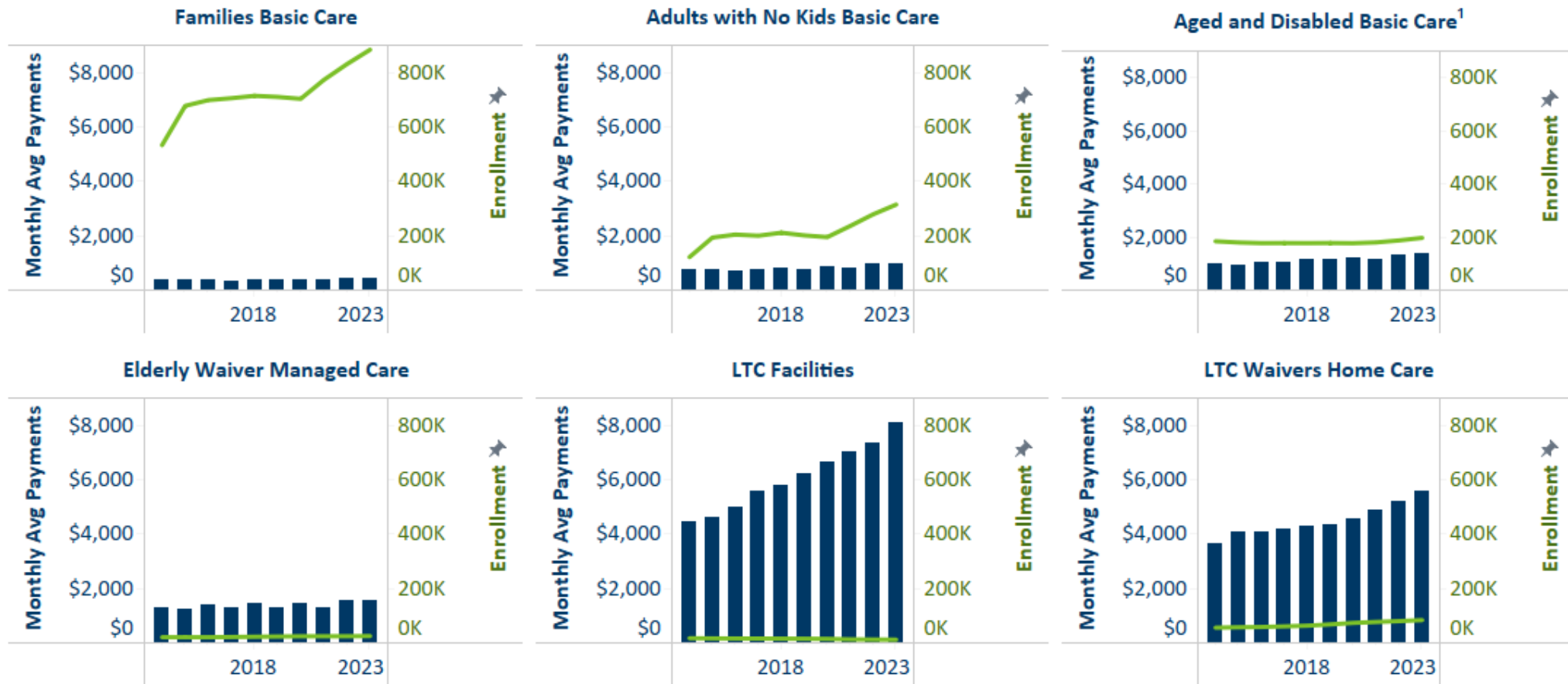
[Summary of graph](#)

Proportion of Fee-for-Service Medical Assistance Enrollment, as of December



Source: Minnesota Department of Human Services monthly enrollment files and December Managed Care Enrollment files. Data are based on a point of time (December) for each calendar year.
[Summary of graph](#)

Medical Assistance Spending, per Recipient State Fiscal Year

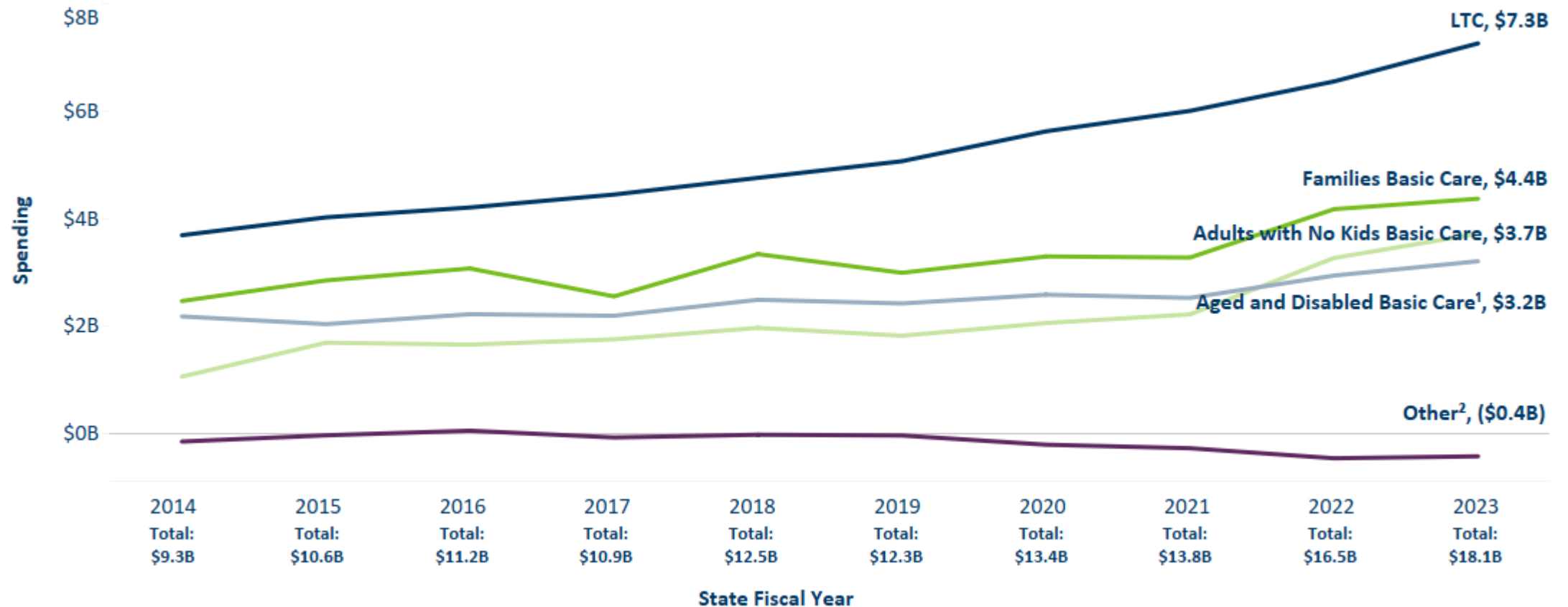


Source: Minnesota Department of Human Services, February 2024 Expenditure Forecast – State Fiscal Years. This excludes several categories of service that do not have “monthly average spending” data within the forecast; these include categories such as: breast and cervical cancer coverage, family planning services, pharmacy rebates, adjustments, and special funding items.

¹The “Aged and Disabled Basic Care” has had the “Elderly Waiver Managed Care” expenditures removed; instead “Elderly Waiver Managed Care” expenditures are included in its own category and based on taking the total annual payments by the average monthly service recipients by 12 months.

[Summary of graph](#)

Medical Assistance Spending, by Eligibility Category



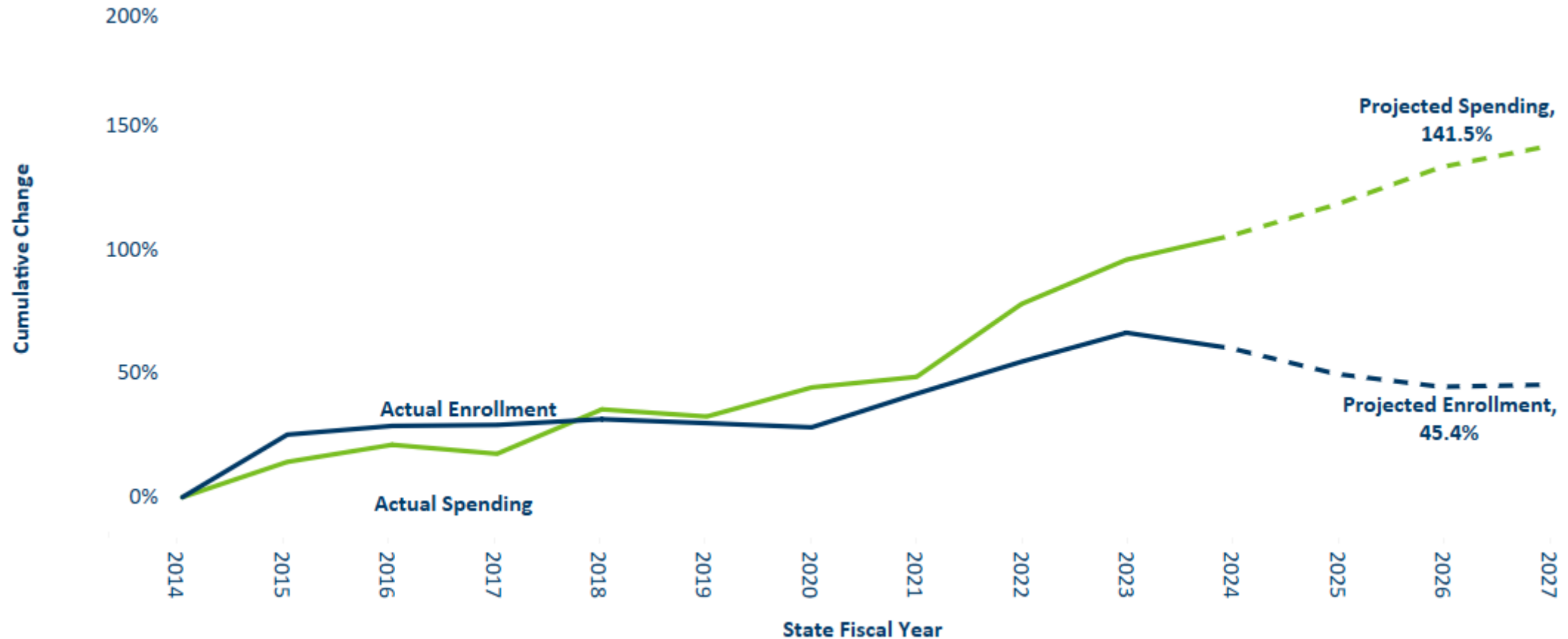
Source: Minnesota Department of Human Services, February 2024 Expenditure Forecast. Data source is different than prior slide, which data is based on calendar years.

¹The “Aged and Disabled Basic Care” has had the “Elderly Waiver Managed Care” expenditures removed; instead “Elderly Waiver Managed Care” expenditures are included in the LTC category.

²Other includes categories of service that include pharmacy rebates and adjustments, resulting in some years having negative values.

[Summary of graph](#)

Actual and Projected Cumulative Changes in Medical Assistance Spending and Enrollment¹



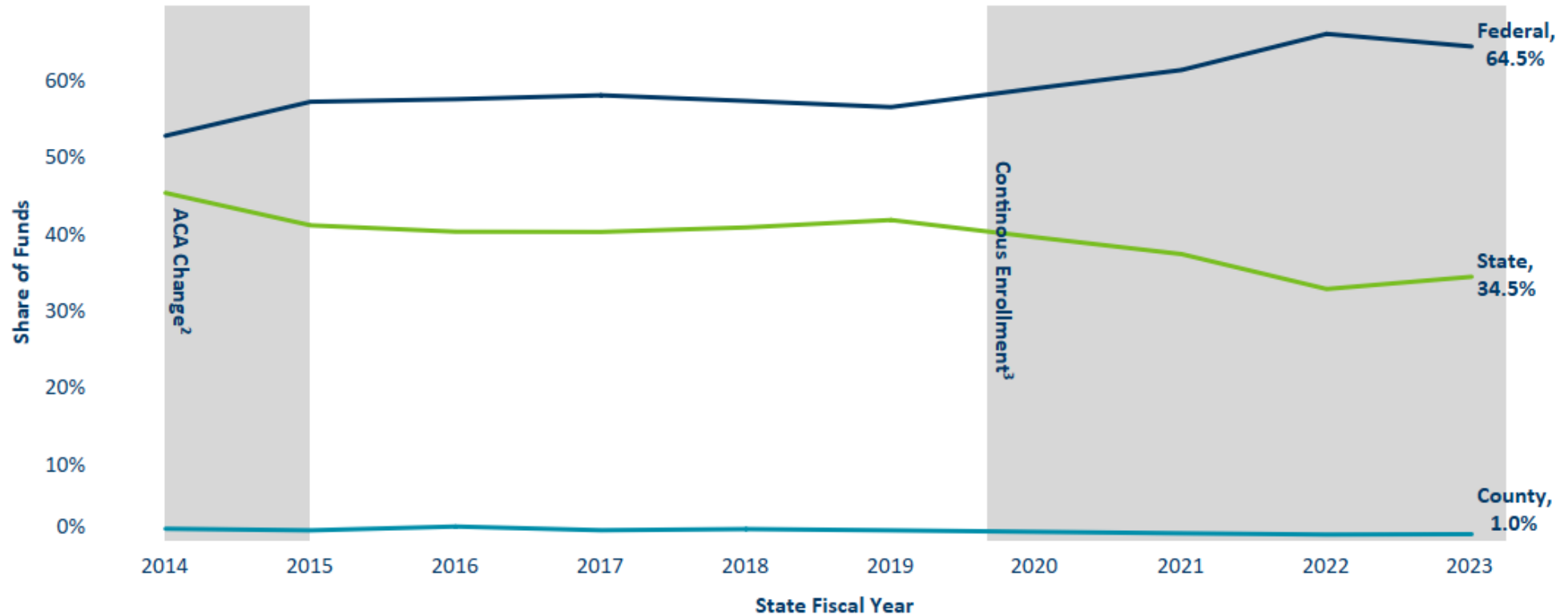
Sources: Minnesota Department of Human Services, February 2024 Expenditure Forecast, data for state fiscal years. Actual spending for fiscal years 2014 through 2023. Projected spending for 2024 through 2027.

In 2014, Medical Assistance was expanded to include childless adults, parents and caretakers, and children (aged 19 to 20) with incomes up to 133% of the Federal Poverty Guidelines (FPG), and children (aged 2 to 18) up to 275% of the FPG, in accordance with the Medicaid Expansion in the Affordable Care Act.

¹The Public Health Emergency related to the COVID-19 pandemic began on January 27, 2020 ([ASPE: https://aspr.hhs.gov/legal/PHE/Pages/2019-nCoV.aspx](https://aspr.hhs.gov/legal/PHE/Pages/2019-nCoV.aspx)) and allowed for continuous enrollment for anyone enrolled on or after March 31, 2020. The continuous enrollment provision ended on March 31, 2023.

[Summary of graph](#)

Medical Assistance Funding by Source of Funds¹⁻³



Sources: Minnesota Department of Human Services, February 2024 Expenditure Forecast, data for state fiscal years. Includes state Chemical Dependency (CD) fund share, state medical education share, state chemical dependency fund, state medical education share, and CHIP enhanced.

¹Some MinnesotaCare enrollees qualified for Medical Assistance (MA) following the March 2011 MA eligibility expansion to include childless adults with incomes at or below 75% of the Federal Poverty Guidelines (FPG).

²In 2014, under the ACA, eligibility was increased to all childless adults, parents and caretakers, and children (aged 19 to 20) with incomes at or below 133% FPG, and children (aged 2 to 18) with incomes at or below 275% FPG. Under the Affordable Care Act, the Federal Government will cover 100% of the costs of newly eligible enrollees from the Medicaid Expansion for calendar years 2014-2016, and 90% after 2016.

³The Public Health Emergency related to the COVID-19 pandemic began on January 27, 2020 ([ASPE: https://aspr.hhs.gov/legal/PHE/Pages/2019-nCoV.aspx](https://aspr.hhs.gov/legal/PHE/Pages/2019-nCoV.aspx)) and allowed for continuous enrollment for anyone enrolled on or after March 31, 2020. The continuous enrollment provision ended on March 31, 2023.

[Summary of graph](#)

MinnesotaCare

A sliding-fee-scale Minnesota health insurance program - financed by resources from the state, federal government, and enrollee premiums - for low- and moderate-income Minnesotans who are not offered insurance through their employer that meets federal guidelines. [U.S. Department of Health & Human Services, Office of the Assistant Secretary for Planning and Evaluation, Poverty Guidelines: https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines/prior-hhs-poverty-guidelines-federal-register-references](https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines/prior-hhs-poverty-guidelines-federal-register-references)

In 2015, MinnesotaCare was converted to a **Basic Health Plan (BHP)** under the ACA, which expanded benefits and reduced the maximum income requirements to 200% of Federal Poverty Guidelines (FPG).

The Public Health Emergency related to the COVID-19 pandemic began on January 27, 2020 ([U.S. Department of Health & Human Services, Office of the Assistant Secretary for Planning and Evaluation: https://aspr.hhs.gov/legal/PHE/Pages/2019-nCoV.aspx](https://aspr.hhs.gov/legal/PHE/Pages/2019-nCoV.aspx)) and allowed continuous enrollment for anyone enrolled on or after March 31, 2020. The continuous enrollment provision ended on March 31, 2023 and after that time, Minnesota began to disenroll Minnesotans (either those who are no longer eligible or do not complete the renewal process).

Data presented on a state fiscal year (SFY) basis, unless otherwise specified.

Trends in MinnesotaCare Enrollment and Spending

State Fiscal Year	Avg. Monthly Enrollment	Spending (\$ millions)	Avg. Monthly Spending per Enrollee	Growth in:		
				Enrollment	Total Spending	Spending per Enrollee
2014	101,646	\$520	\$426	-18.5%	-8.8%	11.9%
2015	91,105	\$510	\$466	-10.4%	-2.0%	9.4%
2016	115,754	\$480	\$345	27.1%	-5.8%	-25.9%
2017	89,081	\$397	\$372	-23.0%	-17.2%	7.6%
2018	83,357	\$427	\$426	-6.4%	7.4%	14.8%
2019	80,772	\$438	\$452	-3.1%	2.8%	6.1%
2020	77,594	\$453	\$486	-3.9%	3.3%	7.5%
2021	92,912	\$536	\$481	19.7%	18.4%	-1.1%
2022	105,852	\$637	\$501	13.9%	18.7%	4.2%
2023	103,657	\$676	\$544	-2.1%	6.3%	8.5%

Source: Minnesota Department of Human Services, February 2024 Expenditure Forecast, data for state fiscal years. Lower enrollment in SFY 2020 is a result of lower enrollment for the first three quarters of 2020, making the average monthly enrollment in SFY2020 lower than the average in SFY2019.

Change in MinnesotaCare From Previous Year, Enrollment and Spending¹⁻³



Source: Minnesota Department of Human Services, February 2024 Expenditure Forecast, data for state fiscal years. Lower enrollment in SFY 2020 is a result of lower enrollment for the first three quarters of 2020, making the average monthly enrollment in SFY2020 lower than the average in SFY2019.

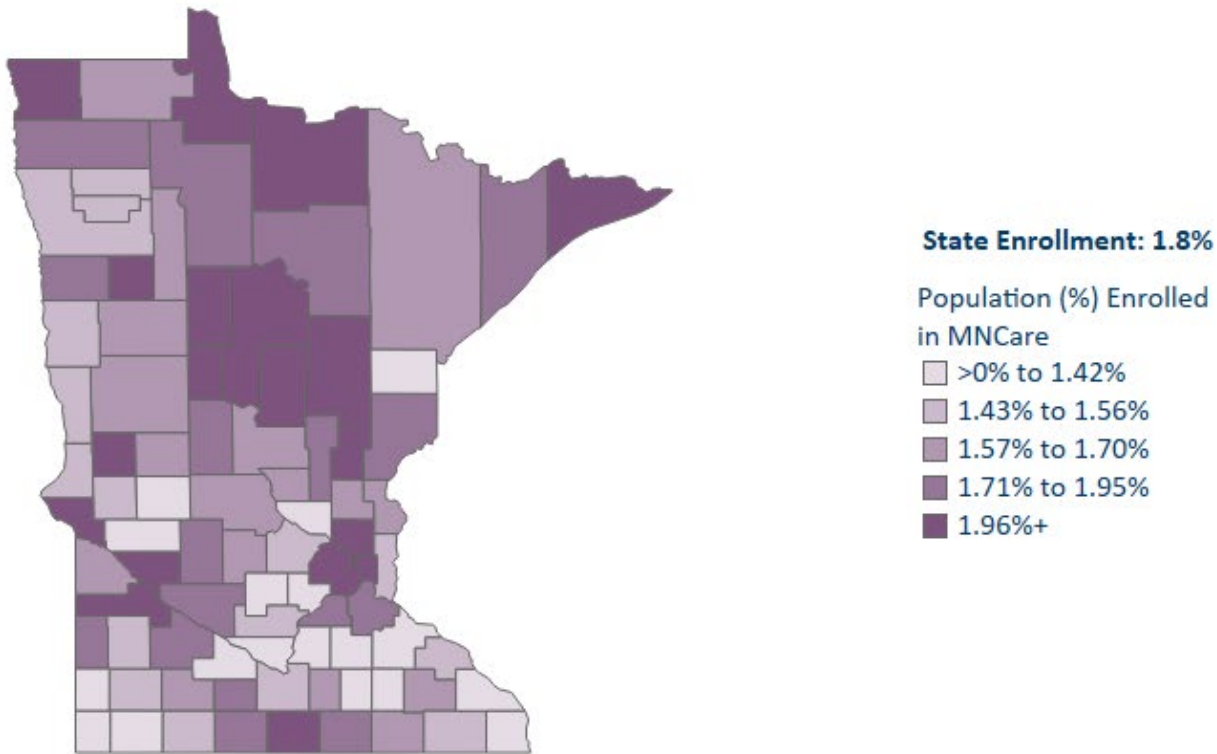
¹Enrollment and spending declines after 2010 reflect that some MinnesotaCare enrollees qualified for Medical Assistance (MA) following the March 2011 MA eligibility expansion to include childless adults with incomes at or below 75% of the Federal Poverty Guidelines (FPG).

²In 2014, under the ACA, Medical Assistance (MA) eligibility expanded and as a result some MinnesotaCare enrollees qualified for MA.

³The Public Health Emergency related to the COVID-19 pandemic began on January 27, 2020 ([ASPE: https://aspr.hhs.gov/legal/PHE/Pages/2019-nCoV.aspx](https://aspr.hhs.gov/legal/PHE/Pages/2019-nCoV.aspx)) and allowed for continuous enrollment for anyone enrolled on or after March 31, 2020. The continuous enrollment provision ended on March 31, 2023.

[Summary of graph](#)

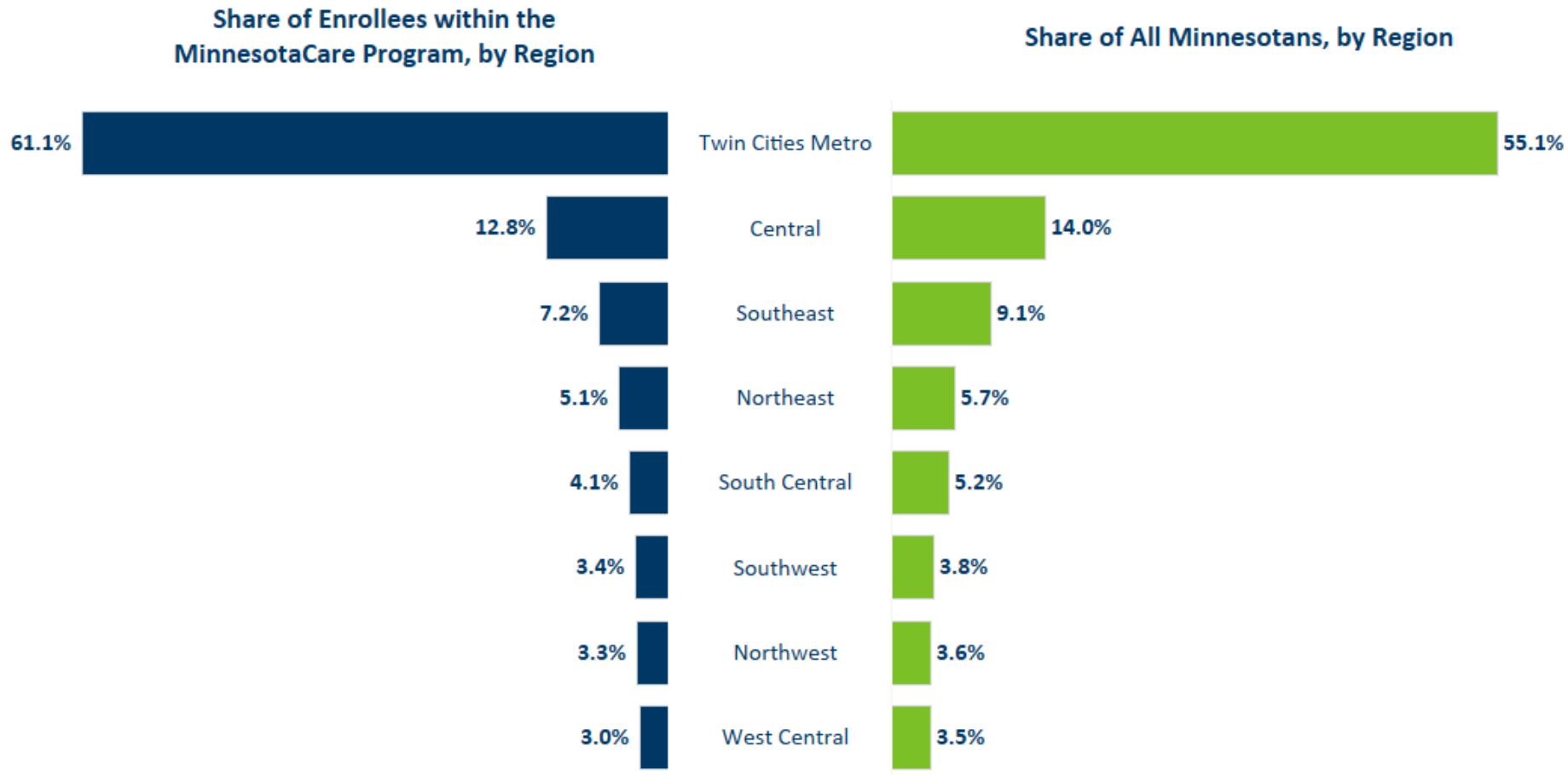
MinnesotaCare Enrollment as a Percent of Population, by County, Calendar Year 2023



Source: Minnesota Department of Human Services, enrollment data for calendar year 2023; County estimates from U.S. Census Bureau, Annual Estimates of the Resident Population for Counties: April 1, 2020 to July 1, 2023; map shapefile from 2022 Mapbox @OpenStreetMap. Enrollment excludes “other” with no known category. Includes all enrollees, even those with dual-coverage (Medicare or private coverage) during the year. Ranges are based on quintiles.

[Summary of graph](#)

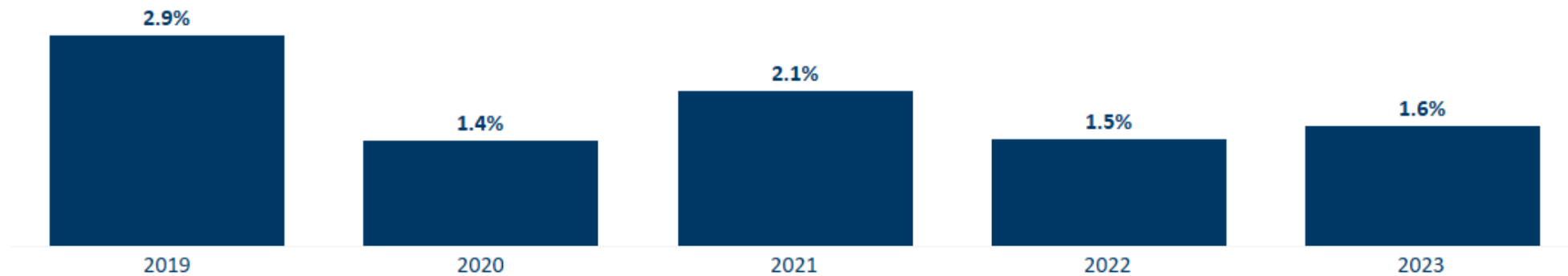
Share of MinnesotaCare Enrollees Compared to Share of Minnesota Population, by Region, Calendar Year 2023



For the regional boundaries, see slide 44 at the end of this chartbook.

Sources: Minnesota Department of Human Services, enrollment data for calendar year 2023; County estimates from U.S. Census Bureau, Annual Estimates of the Resident Population for Counties: April 1, 2020 to July 1, 2023. Enrollment excludes “other” with no known category. Blue bar chart percentages are calculated by taking the MinnesotaCare enrollment in each region by the total MinnesotaCare population. Green bar chart percentages are calculated by taking the Minnesota residents in each region by the total state population.

Proportion of Fee-for-Service MinnesotaCare Enrollment, as of December



Source: Minnesota Department of Human Services monthly enrollment. Data is based on a point of time (December) for each calendar year.

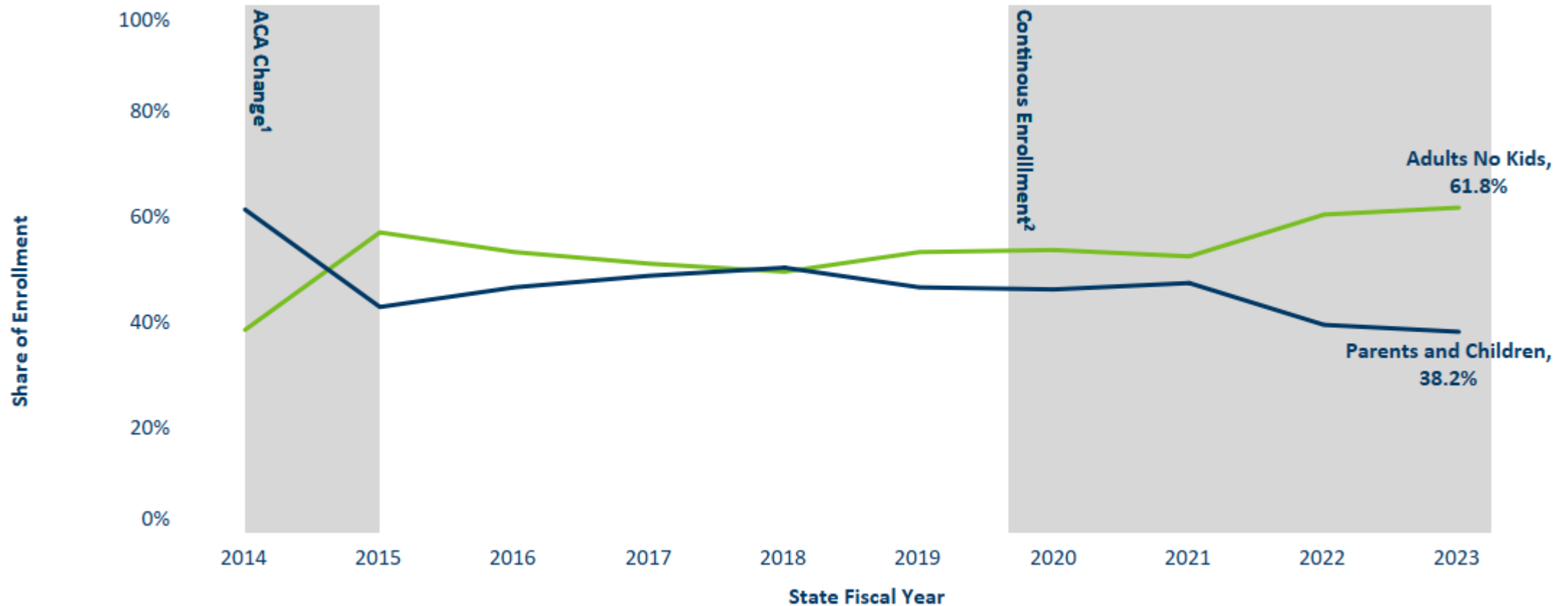
[Summary of graph](#)

MinnesotaCare Enrollment by Eligibility Category

State Fiscal Year	Average Monthly Enrollment	Parents and Children	Adults No Kids
2014	101,646	62,398	39,249
2015	91,105	39,115	51,990
2016	115,754	54,012	61,742
2017	89,081	43,526	45,555
2018	83,357	41,998	41,359
2019	80,772	37,688	43,084
2020	77,595	35,899	41,696
2021	92,912	44,110	48,802
2022	105,852	41,867	63,985
2023	103,657	39,639	64,018

Source: Minnesota Department of Human Services, February 2024 Expenditure Forecast, data for state fiscal years. Adults No Kids and Parents and Children include older adults and Deferred Action for Childhood Arrivals.

Distribution of MinnesotaCare Enrollment, by Eligibility Category



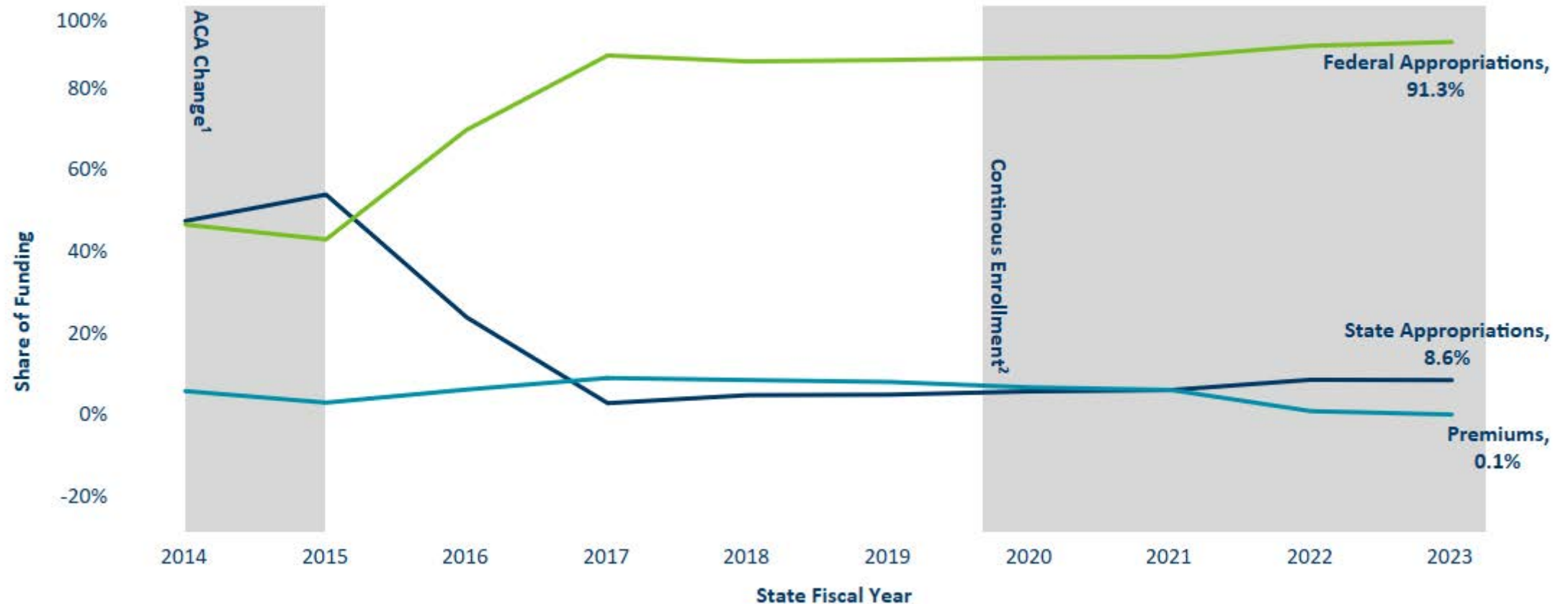
Source: Minnesota Department of Human Services, February 2024 Expenditure Forecast, data for state fiscal years. Adults No Kids and Parents and Children include older adults and Deferred Action for Childhood Arrivals.

¹In 2014, under the ACA, Medical Assistance (MA) eligibility expanded and as a result some MinnesotaCare enrollees qualified for MA.

²The Public Health Emergency related to the COVID-19 pandemic began on January 27, 2020 (ASPE: <https://aspr.hhs.gov/legal/PHE/Pages/2019-nCoV.aspx>) and allowed for continuous enrollment for anyone enrolled on or after March 31, 2020. The continuous enrollment provision ended on March 31, 2023.

[Summary of graph](#)

MinnesotaCare Funding by Source



Source: Minnesota Department of Human Services, February 2024 Expenditure Forecast, data for state fiscal years. Federal Appropriations includes Federal Basic Health Program (BHP) Funding.

¹In 2014, under the ACA, Medical Assistance (MA) eligibility expanded and as a result some MinnesotaCare enrollees qualified for MA.

²The Public Health Emergency related to the COVID-19 pandemic began on January 27, 2020 (ASPE: <https://aspr.hhs.gov/legal/PHE/Pages/2019-nCoV.aspx>) and allowed for continuous enrollment for anyone enrolled on or after March 31, 2020. The continuous enrollment provision ended on March 31, 2023.

[Summary of graph](#)

Additional Information from the Health Economics Program Available Online

- Health Economics Program Home Page
(www.health.state.mn.us/data/economics/index.html)
- Publications (publications.web.health.state.mn.us)
- Health Care Market Statistics (Chartbook Updates)
(www.health.state.mn.us/data/economics/chartbook/index.html)

A summary of the charts and graphs contained within is provided at [Chartbook Summaries – Section 5](https://www.health.state.mn.us/data/economics/chartbook/summaries/section5summaries.html) (<https://www.health.state.mn.us/data/economics/chartbook/summaries/section5summaries.html>). Direct links are listed on each page. Please contact the Health Economics Program at health.hep@state.mn.us if additional assistance is needed for accessing this information.

Appendix: Minnesota Counties and Regions Used in the Geographic Analysis



Source: Minnesota Department of Health, regional map based on State Community Health Services Advisory Committee (SCHSAC) regions.
[Summary of image](#)