



Artwork by Lorien Olive

The Road Not Traveled:

Universal Children's Health Care Coverage in Minnesota

Children's Defense Fund Minnesota
April 2006

Funding for this report was provided by
the Ford Foundation Family Assets Initiative Fund
and the Joyce Foundation.

*Note: The family stories in this report were submitted
to Children's Defense Fund Minnesota between August 2003 and March
2005. The stories reflect real Minnesota families' lives and their situa-
tions (including eligibility for public programs) at the time the stories
were submitted. All names have been changed.*

Introduction



All children deserve access to stable, affordable health care. Access to health care gives them the opportunity to be healthy and develop properly so they can achieve in school and succeed in life. Ensuring our children's health is a vital investment in Minnesota's future workforce, but also a critical component of a cost-effective health care system. And yet we are failing at this goal, leaving tens of thousands of Minnesota children without a clear path to stable health care because they have no health insurance.

Historically, Minnesota has been a national leader in children's health. We have promoted access to good prenatal care, provided safe and healthy environments for our children, and encouraged them to eat properly and exercise regularly. Minnesota was one of the first states to embrace the concepts of well-child check-ups and preventive care and we were pioneers in recognizing the importance of affordable, stable health care coverage. For decades, our collective work paid off—Minnesota has consistently shown very low children's uninsurance rates along with some very healthy outcomes for most of its youngest residents.

But the road to affordable, stable health care coverage for all Minnesota children has never been smooth. Too many of our children get lost in the complicated tangle of the health care system, and the road has become rockier in recent years. Between 2001 and 2004, the uninsurance rate for Minnesotans increased. **An estimated 68,000 Minnesota children now lack health insurance—the equivalent of more than twice the population of Mankato.**¹ That number increases to almost 100,000 uninsured youth if 18- to 20-year-olds are included.

Most troubling are the numbers for Minnesota's youngest children. From 2001 to 2004, their uninsurance rate grew significantly from 3.9 to 6.8 percent. That means an additional 11,000 Minnesota children ages birth to 5 are now cut-off from a stable, affordable path to access health care. This is of grave concern because access to health care for well-child visits and immunizations is especially crucial during children's earliest years.

How did this happen? In short, the current approach of cobbling together public programs in hopes that they will comple-

Health Care Coverage and Children's Health

Many factors influence the overall health of a child, but decades of research and practice affirm the importance of health insurance. Simply put, when children are uninsured, they are less likely to access professional care to meet their health needs. Often regardless of race or ethnicity, income, or health status, uninsured children are:

- More likely to develop eye and ear infections, viral sore throats, lead poisoning, serious dental problems, and chronic conditions such as asthma and diabetes;
- More than 5 times as likely to have had an unmet need for medical care;
- Nine times more likely to not have a regular pediatrician or family doctor;
- Almost twice as likely to not have received a well-child checkup within the past year; and
- Four times more likely to use the emergency room.

The tragedy is that many of these ailments are preventable or treatable, yet we allow many of our state's children to suffer simply for lack of health insurance.

SOURCES: Paul W. Newacheck, Dana Hughes, et al., The Unmet Health Needs of American's Children, *Pediatrics* 105 (2000): 989-997. J.J. Stoddard, et al., Health Insurance Status and Ambulatory Care for Children, *New England Journal of Medicine* 330 (1994): 1421-25. The Urban Institute, *Key Findings from the 2002 National Health Interview Survey Access to Care Among Uninsured Children: Well-Child Check-ups, Usual Source of Care and Unmet Needs, Covering Kids and Families*, 2003. William G. Johnson and Mary E. Rimza, The Effects of Access to Pediatric Care and Insurance Coverage on Emergency Department Utilization, *Pediatrics* 113 (2004): 483.

Health Care Coverage and Children's and Families' Success

Research documents that children's health care coverage is associated with:

- Better school attendance and academic performance,
- More opportunities for children to participate in the normal activities of childhood, such as sports and other activities,
- Improved financial security for families, and
- Improved emotional stability for parents.

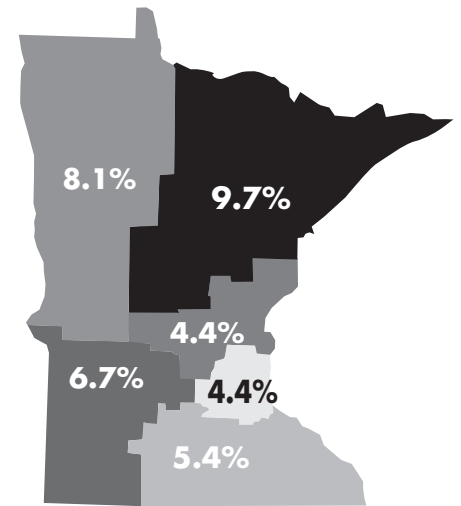
When children are healthy, parents experience less absenteeism at work. Keeping children healthy is vital for their future success as well, when they will comprise tomorrow's workforce. According to neuroscience and medical research, there is a strong relationship between early physical well-being and later cognitive functioning.

SOURCES: Donna Cohen Ross and Meg Booth, *Enrolling Children in Health Care Coverage Programs: Schools Are Part of the Equation*, Center on Budget and Policy Priorities, 2001. Ellen O'Brien and Cindy Mann, *Maintaining the Gains: The Importance of Preserving Coverage in Medicaid and SCHIP*, Health Policy Institute at Georgetown University, 2003. David K. Shipler, *The Working Poor Invisible in America*, 2005. Fragile Families Research Brief, *Parents' Labor Force Participation: Does Child Health Matter?* Bendheim-Thoman Center for Research on Child Wellbeing at Princeton University and Social Indicators Survey Center at Columbia University, 2004.

ment employers' ability to offer health care coverage for their employees' dependents (or parents' ability to afford private pay plans) does not successfully protect Minnesota children from becoming uninsured. This system is highly sensitive to market factors such as recession and skyrocketing health care costs, and lacks accountability for children's health. The growing uninsurance rate for Minnesota children is largely attributable to fewer Minnesota families accessing employee-based coverage. Meanwhile the state government reduced eligibility and erected additional barriers to prevent families from accessing public coverage. **Today, more than 3 out of 4 uninsured Minnesota children are believed to be eligible for a public health care coverage program, but are unable to access it for one reason or another.**²

Minnesota can do better for its children, but we need systemic change. The current way of providing children's health care coverage has resulted in some marked periods of progress, but also backward movement. Regardless of the changes, the health care system has remained complicated, fragmented, and unstable for children, and health care costs continue to escalate.

2004 Uninsurance Rates for Children by Geographic Region



Source: 2004 Minnesota Health Care Access Survey

Minnesota's uninsured families are left with few options short of keeping their fingers crossed that their children stay healthy or taking on enormous personal debt to access health care. It is time for Minnesotans to once again be national leaders, and to think differently about how to provide health care coverage for its youngest citizens. All Minnesota children must be guaranteed health care coverage.

Large Disparities for Minnesota's Children of Color

In 2001, Minnesota's black children were more than three times more likely to be uninsured than its white children. For Hispanic children, the uninsurance gap was more than four times their white counterparts. Yet many minorities who lacked insurance appeared eligible for public coverage programs. To address these disparities, outreach efforts successfully targeted non-white populations to help them enroll their children in public health care programs. By 2004, the insurance disparities between black and white children in Minnesota were essentially eliminated. While these were welcome changes,

additional outreach efforts are still desperately needed within the Hispanic population. More than 80 percent of Hispanic uninsured Minnesotans were potentially eligible for, but not accessing, public health care coverage in 2004.

SOURCES: Health Economics Program, *Minnesota's Uninsured: Findings From the 2001 Health Access Survey*, Minnesota Department of Health and University of Minnesota School of Public Health, 2002. Health Economics Program, *Health Insurance Coverage in Minnesota: Trends from 2001 to 2004*, Minnesota Department of Health and University of Minnesota School of Public Health, 2006.

Rough Terrain, Complicated Paths:

How Are Minnesota Children Covered?

Like most Americans, Minnesota families and children rely on many different types of health insurance coverage. Private employer-based coverage provides access to health care for the majority of Minnesota children. A small percentage is also covered through individual private-pay plans.

Approximately one-fifth of Minnesota children are covered through public health care programs. The primary programs that serve children are:

- **Medical Assistance (MA).** MA is Minnesota's version of the federal Medicaid program and as such provides free health care coverage to the lowest-income Minnesota families.
- **MinnesotaCare.** MinnesotaCare is a reduced-cost, premium-based health coverage program for working families who do not have access to employer-based insurance and cannot afford private insurance.



While Minnesota's public programs have more generous income limits than many states, they still fall short of providing coverage for all Minnesota children. Moreover, they have complex rules that prevent many income-eligible families from accessing the programs.

For a detailed explanation of the different types of coverage and public programs, see Appendix A.

REALITY CHECK #1

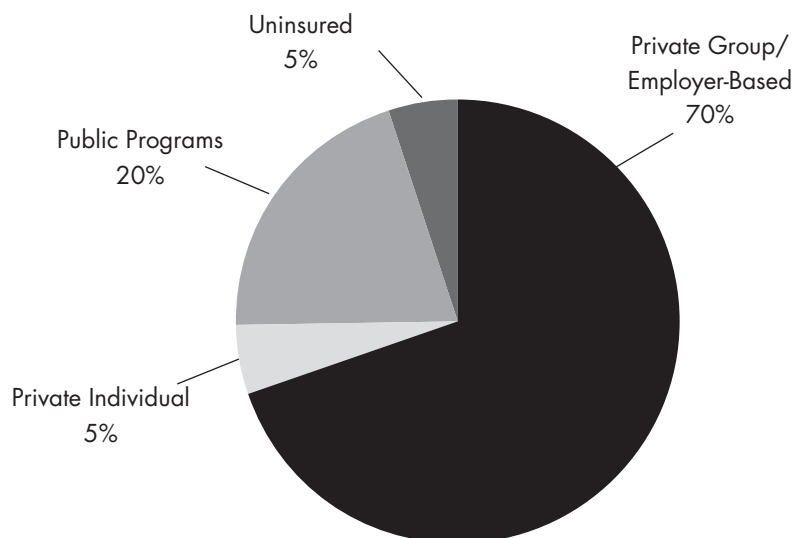
The Uninsured Can Face Overwhelming Medical Debt

Each month, Mark and Joan Erickson plunge deeper into medical debt while the health of their sick child worsens. The Ericksons have four children. Mark is self-employed as an auto mechanic and the family lives paycheck-to-paycheck. Their two youngest children are covered under Medical Assistance but the rest of the family is uninsured.

In 2004, Mary, their 16-year-old daughter, was diagnosed with an aggressive form of Lupus and hospitalized. Her medical bills totaled \$38,000. She recently experienced more health problems but refused to be hospitalized because she knew her parents could not afford the bills.

On a recent visit with the family, a health care outreach worker reported, "the family was beside themselves when discussing Mary's illness." Overwhelmed and stressed about the growing medical debt, Mark said he works so hard but feels like it's all for nothing because he can't break even each month. The Ericksons are in danger of losing their house because they can't pay their medical bills.

Sources of Health Care Coverage for Minnesota Children, 2004



SOURCE: Health Economics Program, *Health Insurance Coverage in Minnesota: Trends from 2001 to 2004*, Minnesota Department of Health, University of Minnesota School of Public Health, 2006

Building Bridges To Access:

Past Work Toward Universal Coverage for Children (late 1980s–early 2000s)

MinnesotaCare: Millions in Savings

Increasing coverage for Minnesota families through MinnesotaCare had a significant impact on the budgets of Minnesota's hospitals. A 1 percentage-point increase in MinnesotaCare enrollment during the mid-'90s was associated with a \$2.19 decrease in the hospitals' uncompensated care spending per capita. Over its first four years, MinnesotaCare enrollment reduced uncompensated care costs for Minnesota hospitals by \$58.6 million.

SOURCE: University of Minnesota School of Public Health, *Expanding Access to Health Insurance Coverage Lessons the Burden of Uncompensated Care*, 2003.

Reducing Barriers Trims Costs

Simplifying the application and renewal process for health care coverage saves government administrative costs by increasing the efficiency of eligibility workers. One study found that extending eligibility periods can reduce administrative costs by 2 to 12 percent. Similarly, enrollment costs in New York were reduced by an estimated 40 percent with a simplified system (which included a one-page application and a process similar to Minnesota's delayed verification).

SOURCES: Ku and Rose, *Staying Covered: The Importance of Retaining Health Insurance for Low-Income Families*, Center on Budget and Policy Priorities, 2002. Fairbrother, Dutton et al., *Costs of Enrolling Children in Medicaid and SCHIP*, *Health Affairs* 23 (2004): 237-243.

Minnesotans have successfully come together to address the number of uninsured within our community before. Like today, the late-1980s in Minnesota were marked by rapidly increasing health care costs and frequent public calls to control them. Simultaneously, estimates from the University of Minnesota

suggested a relatively large number of Minnesotans lacked affordable, stable health coverage. Many Minnesotans were especially troubled by how the lack of insurance compromised

children's health and the financial impact this had on the rest of the health care system. State leaders proclaimed children's health to be a crucial community resource and they set goals to ensure that all Minnesota children could access affordable health care coverage.

Progress toward this goal was aided by the impact of health care cost-control measures like managed care and price regulations in the early-1990s and a healthy state economy at the end of the decade. More Minnesota employers offered health care coverage to a greater percentage of Minnesota workers and their families. As a result, an increasing number of Minnesota children were covered by employer-based plans by the end of the decade.

But even as these changes occurred in the private market, tens of thousands of Minnesota children remained uninsured. State policymakers took two sets of actions to ameliorate the situation:

- **Expanded Access to Public Health Care Coverage.** It was apparent that

some working Minnesotans and their children fell into a gap and could not access private coverage. Some were paid hourly or were part-time workers who were not eligible for benefits; some

worked for employers that

were too small to afford offering insurance; and some were self-employed and could not afford individual coverage.

This group of Minnesotans earned more than the income limits for coverage through Minnesota's Medicaid program, Medical Assistance.

Consequently, they remained uninsured. Answering this need, policymakers and legislators created one of the nation's first reduced-cost, sliding-scale premium public health coverage program, MinnesotaCare. When implemented in 1993, MinnesotaCare covered families with incomes less than 275 percent of the federal poverty line (about \$32,700 for a family of 3 in 1993).^a As the program was refined, state policymakers also expanded children's access to affordable coverage

"It is the goal of the State of Minnesota to make continuous progress toward reducing the number of Minnesotans who do not have health coverage."

—Minnesota Department of Human Services, 1998

^aThe federal poverty line is an official national measure of poverty for differing family sizes. It is updated each year by the U.S. Department of Health and Human Services. A family of 3 is currently considered to live under the federal poverty line if their income is less than \$16,090. The measure has been criticized extensively for underestimating the real costs of meeting a family's most basic needs, and thus eligibility for an array of federal and state programs is based on percentages of the poverty line.



through eligibility changes to Medical Assistance. (For a description of these changes, see Appendix B).

- **Reduced Red-Tape for Minnesota's Public Programs.** Even though expanded program eligibility offered more inroads to universal coverage for Minnesota children, additional barriers stood between eligible uninsured families and public coverage. According to research, “administrative hassles” are the primary reason parents do not enroll their eligible children in public health care programs, and Minnesota’s programs had many.³ To reduce the impediments and streamline the process for families, Minnesotans identified the barriers, and then effectively removed many of them. Changes included shortening and simplifying the public health care coverage application form from 24 to 4 pages; allowing families who appeared eligible to begin using their health care benefits immediately as long as they provided needed information within 30 days of enrollment (known as “delayed verification”); and automatically enrolling newborns for the first two years of their lives in Medical Assistance if their mothers were enrolled on MA while they were pregnant. (For a more complete description of these changes, see Appendix B.)

Despite all of the significant progress made in changing public policies to meet Minnesota’s families’ needs, not all of the plans fully came to fruition. For example, MinnesotaCare was to be phased in over

“The legislation that created MinnesotaCare in 1992 would have provided universal care through public programs and private insurance by 1997, and it included cost-cutting strategies. Both elements were repealed when it seemed to some people that the market was working, and we didn’t need that much government intervention.”

—Jan Malcolm, former Minnesota Department of Health Commissioner, 2005

10 years, covering children and families first and then expanding to cover adults without children in their homes, self-employed individuals, and small employers, but these expansions never took place. Nonetheless, the collective drive to ensure all Minnesota children were covered began to have an effect—by 2001, the uninsurance rate for Minnesota children ages 0 to 17 was believed to be at a historic low at less than five percent.⁴ Still, approximately 60,000 Minnesota children were uninsured.

REALITY CHECK #2

Cuts to Public Programs Leave Some Families without Options

Joanne Walker has three sons under the age of 14 who are without health insurance for the first time in their lives. Joanne is a full-time county employee and earns slightly more than \$2,650 (gross) a month (just over 150 percent of the federal poverty line). She had been covering her family through insurance provided by her employer. However, her monthly health insurance premium was raised to \$650 for family coverage, of which she is required to pay 50 percent.

By the time she pays for her family’s basic needs of rent, utilities, food, and car, she has \$356 left each month for all other expenses. Paying her share of the monthly premium offered by her employer to cover dependents would leave her with \$31 each month. Instead, Joanne dropped her employer’s coverage.

The 2003 legislative changes to public health care programs that reduced eligibility for Medical Assistance from 170 to 150 percent of the federal poverty line made Joanne’s sons ineligible for the program. Their income would qualify them for MinnesotaCare, but they are ineligible for this program because Joanne’s employer offers to pay at least 50 percent of health insurance premiums.

Detours:

Roadblocks To Universal Children's Coverage (early 2000s–present)

At the turn of the millennium, two national trends dramatically influenced local efforts to provide affordable health care coverage to all Minnesota children. First, the national economy weakened and entered a recession. Revenues for Minnesota employers and the state budget were lower than forecasted. Simultaneously, health care costs were rising dramatically: from 1997 to 2002, the average monthly premium for family coverage in Minnesota increased by more than 10 percent annually, more than three times the annual rate of inflation.⁵ The concurrent influences affected employers and the state government alike. To contain costs, both reduced their previous commitment to providing stable, affordable coverage to Minnesota families.

More Minnesota Children Lost Employer-Based Coverage

From 2001 to 2004, the percent of Minnesota children covered by their parents' employer decreased from roughly 77 to 69 percent.⁶ The sluggish economy induced many Minnesota employers to lay-off employees and without a job, parents cannot access employer-based coverage for themselves or their children. Then, many of the jobs created since 2000 have been temporary or seasonal, which are less likely to include health



benefits, or positions at small companies, which struggle to provide health insurance. In 2002, only 34 percent of Minnesota employees in the smallest firms (with fewer than 10 employees) had access to employer-based health care coverage, whereas 74 percent of those working for the largest firms (with more than 200 employees) did.⁷

Employer-Based Coverage Grew More Expensive for Minnesota Families

Also in reaction to the ballooning health

care costs, many employers shifted more of the financial responsibility of the increases to their employees.^b From 1997 to 2002, the average monthly amount Minnesota employees paid in health care premiums increased by 75 percent, from \$121 to \$212.⁸ During the same period, the average deductible and the average co-payment for office visits each increased 50 percent. HealthPartners, Medica, and BlueCross BlueShield of Minnesota reported these patterns continued at least through 2004.

^b The Minnesota Department of Health reports that parents' "take-up rate," the rate at which employees who are offered employer-based health care coverage enroll in it, did not change from 2001 to 2004, suggesting the increased costs working Minnesota families were required to pay for their health care did not contribute to the increased children's uninsurance rate during this time period. However, the costs of employer-based coverage have always been an issue for lower income Minnesotans. In both 2001 and 2004, the take-up rate for children whose family incomes were less than 200 percent of the federal poverty line was only about 75 percent, but the number of Minnesota children whose family income fell below this threshold increased significantly from 2001 to 2004. In other words, the higher costs of employer-based coverage affected Minnesota children's uninsurance rate because by 2004 there were more lower-income Minnesota families who could not afford the increased expenses of employer-based coverage.

Affordable Public Coverage Became Less Accessible

Minnesota families who could not access affordable employer-based coverage during the economic downturn and its aftermath should have been able to turn to their government for protection. Many of the families of Minnesota's poorest children successfully did. The number of Minnesota children living in poverty increased from 2001 to 2004, and concurrently children's enrollment in MA, the public coverage program for the lowest-income Minnesota families, increased by approximately 15 percent.⁹ However, child enrollment in MinnesotaCare, the public coverage program for the next income tier of Minnesota families, did not change from 2001 to 2004. **The lack of an increase in the MinnesotaCare numbers for Minnesota children during this time period is of concern because an increased number of Minnesota children became uninsured during the same time period. MinnesotaCare enrollment should have increased to protect these children.**

To understand why more seemingly eligible uninsured Minnesota children were not enrolled in the public programs, it is important to understand program changes that occurred since 2003. The market forces that affected employer-based coverage influenced Minnesota's state budget as well. In 2003, a massive budget deficit was projected for the state's upcoming biennium—a shortfall of more than \$4.5 billion. Growing enrollment numbers in Medical Assistance coupled with the rising health care costs made the public health care programs a target for state leaders. They turned away from the volumes of research that demonstrated the



importance of health insurance in ensuring healthy children and lowering long-term health care costs. Rather than a statewide shared goal, lawmakers perceived children's health care coverage as a fiscal burden.

Touting the need to “reform the health care system” in 2003, state leaders enacted legislative changes that served to increase the ranks of the uninsured.

Achieved through numerous smaller maneuvers that masked the true impact, the health care cuts totaled \$340 million. The Minnesota Department of Human Services predicted that 15,500 Minnesota children and 5,000 parents would no longer be covered by 2007 as a result.¹⁰ The cuts were an utter reversal of the state's actions during the 1990s and early 2000s to expand health care coverage for Minnesota children. Policymakers sought to reduce access to public health care coverage by reducing eligibility for children and adults, and reinstating and creating administrative roadblocks proven to hinder eligible families' access to public coverage. (For a detailed description of the changes that most affected Minnesota children, see Appendix C.)

Who Are Minnesota's Uninsured Children?

- Nearly 80 percent of them live in households where one or both of the parents work full or part-time jobs.
- They are most likely to have parents who work for small employers (with less than 50 employees).
- Nearly 84 percent were born in the United States.
- They are more likely (57 percent of them) to live in Greater Minnesota than in the Twin Cities.
- They most likely live in households with incomes under 300 percent of the federal poverty line (about \$48,000 for a family of 3). Less than 10 percent of uninsured children live in household with incomes higher than this.
- They are most likely to be white children (more than 68 percent of uninsured children are white), although a disproportionate number of them are children of color. For example, only 4.3 percent of Minnesota's total population of white children are uninsured compared to 6.8 percent of the total black children population, 25.5 percent of the total Hispanic children population, and 6.3 percent of populations for other races.
- They are slightly more likely to be female than male.

SOURCE: Health Economics Program, *Health Insurance Coverage in Minnesota: Trends From 2001 to 2004*, Minnesota Department of Health, 2006.

Existing Barriers to Public Coverage Became More Pronounced

As noted, this decade has been marked by economic changes and spiraling health care costs, and this impacted the budgets of many Minnesota families. As their income declined, sometimes precipitously, many of these families became newly eligible for Minnesota's public programs and sought to gain health care coverage through them. But in doing so, they also encountered longstanding barriers that prevent otherwise eligible Minnesota families from accessing affordable coverage. For example, MinnesotaCare requires children to be uninsured for 4 months before enrolling. This means many children whose parents are laid off from a job must wait four months without any coverage (even a temporary plan like COBRA) before they can access public coverage, even if they are otherwise eligible for it. Children also are not eligible for MinnesotaCare if their parents' employer offers and pays at least half the costs of employer-based coverage for dependents, even if the family's share is unaffordable.^c Finally, the monthly premiums required of families to access public coverage through MinnesotaCare can be unaffordable—they are close to 10

On average nationwide, family health care coverage through an employer-based plan cost almost \$10,000 a year in 2004. This was only slightly less than the earnings of a full-time, minimum wage worker.

SOURCE: Kaiser Family Foundation and Health Research Educational Trust, *Employer Health Benefits 2004 Annual Survey*, 2004.

percent of some families' incomes. (For a detailed description of these barriers, see Appendix D.)

These longstanding barriers, and those introduced since 2003, effectively prevent eligible children from accessing public coverage. Today, more than 3 out of 4 of uninsured Minnesota children appear eligible for public coverage.¹¹ This clearly demonstrates that our current approach of piecing together



public programs in the hopes that they will complement employers' ability to offer health care coverage for their employees' dependents (or parents' ability to afford private pay plans) does not successfully protect Minnesota children from becoming uninsured. Too many Minnesota children are not eligible for employer-based coverage and not covered by the state's public programs because the barriers to enrollment are too high. Our current health care system is one that essentially accepts that a certain number of Minnesota children will always be uninsured.

^c Children whose family income is less than 150 percent of the federal poverty line (about \$24,000 for a family of three) are exempt from MinnesotaCare's four-month waiting and 50 Percent rules because they are eligible for Medical Assistance.

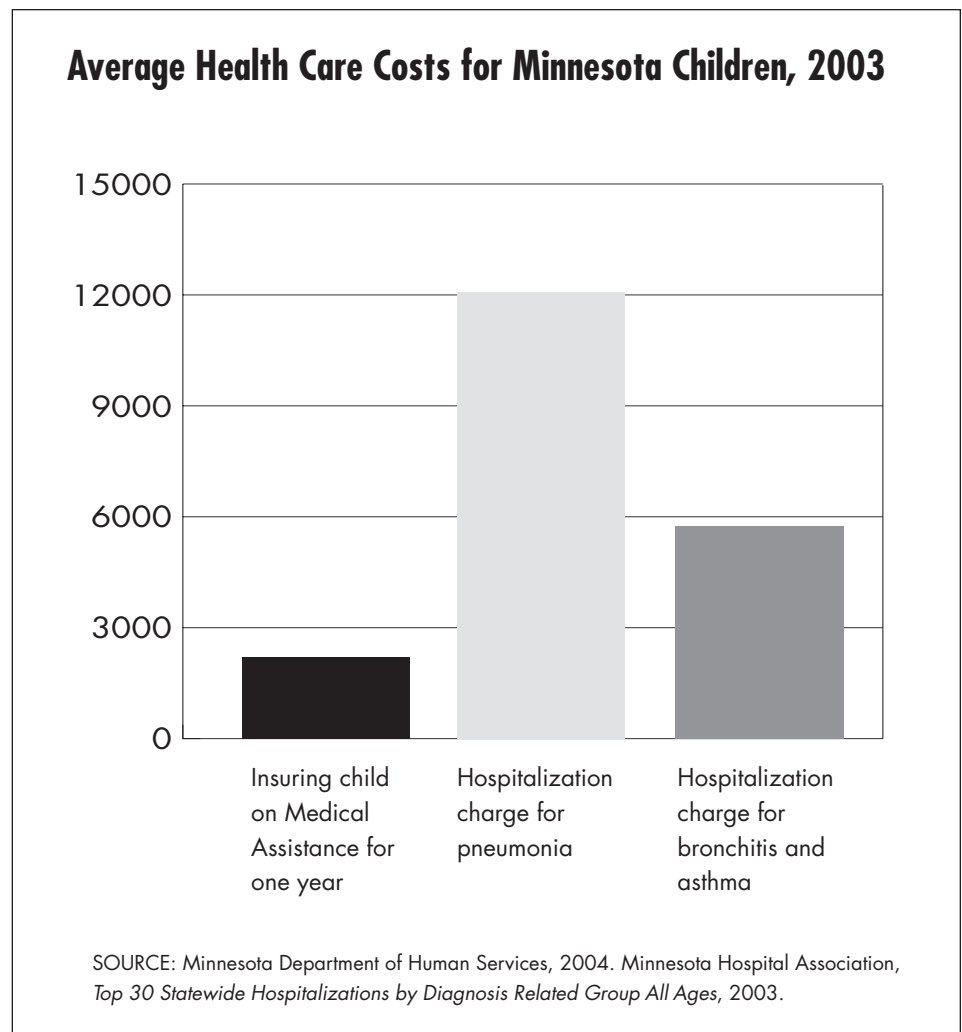
Caution:

What Happens When Children and Adults Are Uninsured?

The trend toward more uninsured children during the beginning of this decade mirrored that for all Minnesotans; in addition to the estimated 68,000 uninsured children in 2004, the number of uninsured Minnesota adults was estimated at approximately 307,000.¹² These 375,000 uninsured Minnesotans still get sick and need health care, but they simply do not have an affordable, stable avenue to access it. Instead, they seek care only when they absolutely have to and do so through a loosely defined “safety net” health care delivery system. In doing so, the uninsured put their own health and economic security at risk, and strain the capacity of the safety net providers.

Children’s Health and Families’ Economic Security Are Threatened

Fearing high health care costs, families without stable insurance often forgo or delay routine checkups and immunizations for their children. Illnesses, even minor common childhood ailments such as ear infections, are not attended to because treatment is deemed unaffordable. Without timely treatment, however, these health issues easily become medical emergencies. In the end, many uninsured families often end up using emergency room care for preventable or minor illnesses.¹³ Minnesota’s uninsured are less likely to have a usual source of care and those who do are more than three times as likely to use emergency room and urgent care settings than Minnesotans who are privately insured.¹⁴ This type of care is far more expensive than proper



treatment. The costs for a single preventable hospitalization in Minnesota in 2003 greatly surpassed the average cost of insuring a child for an entire year on Medical Assistance.

Uninsured families often bear the brunt of these more expensive costs. It is commonly believed that the uninsured can simply get free health care by visiting an emergency room or community health clinic. But the budgets of hospital emergency rooms and community health clinics are too tight to be able to absorb all of their uncompensated care costs. Consequently, these providers must

work to collect payment. **In fact, the uninsured are significant payers in the health care system—they pay approximately 35 percent of their total health care costs out-of-pocket.**¹⁵

To pay these costs, families use budgeting strategies such as rotating bills, skimping on food, and using less expensive (but often lower quality) child care to make it to the next month. They may also borrow money from family and friends, work multiple jobs, run up steep credit card debt, or take out loans or second mortgages. Recent research documents the affects medical debt has

on American families' overall financial status, housing and employment, and material and emotional well-being.¹⁶ More than 4 out of 10 uninsured American families in one study reported being in debt to the facility where they received care, whereas another study by Harvard Medical School reported that almost half of all bankruptcies filed in 2001 were due to medical debt.¹⁷ Without health care coverage, families must make painful choices between immediate household needs and the long-term health of themselves and their children.



The Safety Net System Is Overwhelmed

The providers that make up Minnesota's "safety net" health care delivery system cannot continue to be relied on as families' primary source of care. As the growing number of uninsured Minnesotans seek care from the safety net, these providers are less likely to be fully compensated for the services they provide. Simultaneously, the majority of Minnesota's safety net providers reported a decrease in government funding in 2004.¹⁸ **With decreased revenue and soaring demand, Minnesota's safety net providers are strained. Ultimately,**

this affects their ability to remain financially solvent and provide needed care. The following describes these providers and how they have been impacted:

- *Hospital Emergency Rooms.* According to the Minnesota Hospital Association, from 2003 to 2004, Minnesota's hospitals estimated a 28 percent increase in uncompensated care costs.¹⁹ Minnesota's largest "safety net" hospital, Hennepin County Medical Center (HCMC), accounts for the greatest amount of the state's uncompensated care costs. From 2003 to 2004, HCMC experienced a 38 percent increase in these costs.²⁰ Hospital administrators estimated HCMC would lose \$33.7 million in revenue

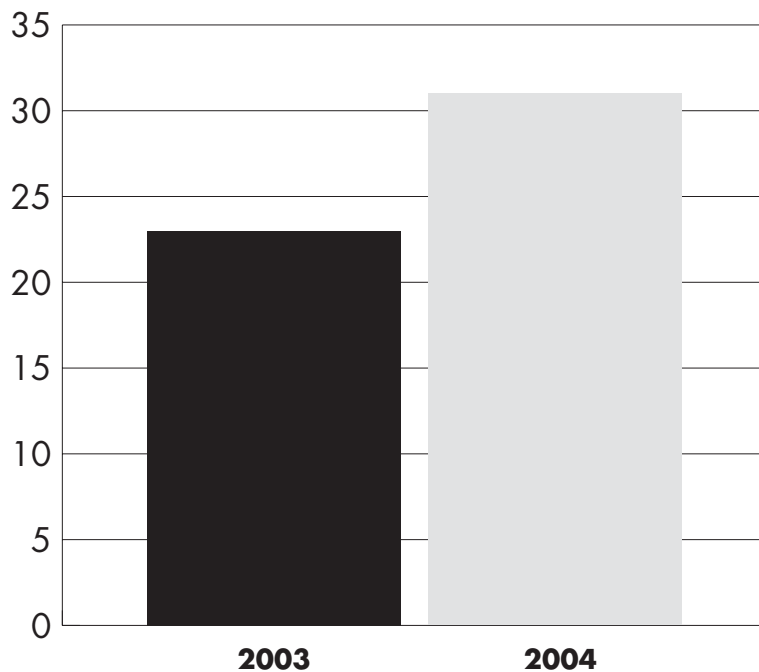
between 2003 and 2005 because of the recent changes to Minnesota's public health care programs.²¹ According to the Minnesota Department of Health, an estimated \$73.8 million in uncompensated care, including charity care and bad debt, was

incurred for health care services provided to Minnesota children in 2004.²²

- *Community Health Centers and Clinics.* By law, federally-qualified community health centers and clinics must provide comprehensive preventive and primary health care services without regard to patients' ability to pay. According to the Minnesota Association of Community Health Centers, the

According to the Minnesota Department of Health, an estimated \$73.8 million in uncompensated care, including charity care and bad debt, was incurred for health care services provided to Minnesota children in 2004.

Hennepin County Medical Center's Uncompensated Care Costs



SOURCE: Department of Human Services and Public Health, *Assessing the Impacts of Health, Human Services and Corrections Changes Enacted by the Minnesota Legislature During the 2003 Session*, Hennepin County, 2005.



number of uninsured patients requiring services at their locations increased by more than 12 percent between 2003 and 2004.²³ The number of uninsured children requiring services increased by almost 9 percent. At the same time, the number of patients

who had health care coverage decreased, resulting in reduced revenue from reimbursements. Individual clinics report dire situations. For example, Open Door Health Center in Mankato, the only sliding-fee clinic in the southern third of Minnesota, served nearly 11,000 total patients in 2005, a 78 percent increase since

2003.²⁴ Approximately three-quarters of their clients are uninsured. The Indian Health Board of Minneapolis reported a 5 percent increase in uninsured clients seeking services from 2003 to 2005. The uninsured now represent 25 percent of their client population.²⁵

- *Community Safety Net Programs.* Other safety net providers, such as non-profits whose missions are to help lower

income Minnesotans access health care but who are under no legal mandates to serve clients regardless of ability to pay, are also struggling to sustain services. Patient numbers are increasing and patient demographics are changing. These providers have witnessed an increase in the numbers of children, whites and other non-traditional population groups seeking safety net care. Simultaneously, their government funding has decreased. For example, the Salvation Army Free Clinic in Rochester, which provides care to the uninsured only, reports a spike in patients. Clients are now coming from all of southern Minnesota and overwhelming the clinic, which is open only two evenings a week. To try to sustain services, the clinic instituted a

“Despite their enormous importance, community health centers and the rest of the health care ‘safety net’ cannot offset the impact of reductions in publicly-funded health insurance, let alone absorb the fiscal pressures that they would face in that circumstance.”

—Rosenbaum and Budetti, *Low-Income Children and Health Insurance: Old News and New Realities, Pediatrics*, 2005

\$10 co-payment from patients outside of Olmsted County. Portico is a Twin Cities-based organization that helps enroll eligible individuals in public programs, and offers a unique program for uninsured persons who do not qualify. The program allows clients to receive primary care services from a group of participating clinics for a small monthly fee. Portico provides services to about 1,000 uninsured people a year on average, but reports a considerable increase in demand. In addition, the average length of time clients remain on their program has increased from about 8 months in 2003 to about 2 years now.²⁶ Portico currently has a waiting list of 600 uninsured for its program.

REALITY CHECK #3

Rising Premium Costs Make Employer-Based Coverage Unaffordable for Many

Jim and Pat Anderson have struggled for years to secure health care coverage for themselves and their children, Katie and James. Their gross family income is \$2,800 a month (about 180 percent of the federal poverty line). Both their children were covered under Medical Assistance as children under age 2 but when Katie turned 2, she lost eligibility. They cannot access insurance through Jim’s employer because the premiums for family coverage are too expensive at \$228 a month, which is nearly 10 percent of their monthly income.

Jim, Pat, and Katie are not eligible for MinnesotaCare because Jim’s employer offers family coverage and pays more than half the premium cost. If this rule didn’t exist, the Andersons would qualify for MinnesotaCare and need to pay an estimated \$149 a month in premiums to cover their family. Instead, they remain uninsured.

Shortly after her birthday, Katie landed in the emergency room at Children’s Hospital. The Andersons incurred a bill of \$1,133 for her care, nearly half of their monthly income. The average annual cost for the state to insure Katie on MinnesotaCare at the time was about \$1,700.

Traveling Together:

The Impact of the Uninsured on the Community

Having a larger proportion of children and families rely on safety net care as their primary source of care is not an efficient way to deliver comprehensive, cost-effective health care. It most immediately influences the general well-being of the uninsured and the safety net health care providers, but the consequences of the inefficiencies reverberate in the broader community as well. Local governments and taxpayers, private payers, and the general public are all impacted by a growing number of uninsured.

Local Government and Taxpayers

When the federal and state government decrease their commitments to health care costs by reducing eligibility, affordability, and access to public programs, it shifts the public commitment to more local forms of government. Local governments cannot absorb these greater costs, but nonetheless must face the consequences in local health departments and county hospitals. They in turn have little choice but to turn to local taxpayers for help. For example, to make up for the rising uncompensated care costs at Hennepin County Medical Center (HCMC), Hennepin County property taxpayers afforded HCMC a \$19.4 million property tax subsidy in 2004.

Private Health Insurance Premiums

To address their growing uncompensated care costs, providers may also turn to their privately insured clients to pay a



greater share. In effect, private premiums increase to pay for uncompensated care. While this is not the sole reason that private premiums continue to rise, it is a factor. According to Families USA, health insurance premiums for Minnesota families with private, employer-based coverage were \$386 higher in 2005 due to the unpaid cost of health care for the uninsured.²⁷ The study also estimated that if the health care crisis continues on its current path, health insurance premiums for Minnesota families with employer-based coverage will be \$650 higher by 2010.

Access to Health Care For All

Finally, the health of entire communities and their collective access to medical care is affected when communities have more uninsured individuals. National research has shown that in communities with higher rates of uninsurance:

- There are fewer hospital services because funds are diverted from disease prevention and surveillance programs to pay for uncompensated care costs;
- There is a greater likelihood that communicable diseases will be passed on, for example through children in their schools;
- Emergency rooms and trauma care centers are more likely to be overcrowded; and
- Local health services and medical practices may close because they are not being adequately reimbursed for their services, having an enormous impact on the local community's economic base.²⁸

The Road Ahead:

A Healthy Destination for All Children



The road to healthy outcomes for children is not difficult to find or navigate. It starts with stable health insurance. It is paved with affordable access to preventive care, medical treatments and inpatient services. It ends with equal access to care for all children.

Research clearly demonstrates the importance of health care to ensure good outcomes for our children. Yet over the past few years, Minnesota has turned its back on the research and reversed itself on many of the advances it had made in extending health care to its youngest residents. The current landscape—in which some purchase health insurance through their employers, some

Health care for our children needs to be a given. It cannot depend upon where a child's parents work, how much they earn, or even whether they work. It cannot depend on whether parents or caregivers can fill out a complicated application form or navigate a complex application process.

through the state, others on their own, and still others go without—will never come together to provide health care access for all Minnesota children.

Furthermore, our fragmented system, where each part is affected by the same market forces, will never be able to provide proper incentives for controlling health care costs.

Clearly, it's time for an innovative change. It's time to come together again and ask the difficult questions and find sensible answers. Health care for our children needs to be a given. It cannot depend upon where a child's parents work, how much they earn, or even whether they work. It cannot depend on whether parents or care-

REALITY CHECK #4

Safety Net Care Is Not Stable Health Care

The Steiner family lives and works in rural Minnesota. They are a family that has been bounced around in the safety net system in search of affordable health care. The Steiner's four-year-old son Luke is uninsured. Since birth, Luke has experienced chronic ear infections but because of the lack of insurance has been unable to access on-going, timely care. As a result, he now faces the possibility of permanent hearing damage. Luke's family first had his ear infections treated at a local private clinic, but due to unpaid medical bills, they were soon unable to use this as an option. When the infections reoccurred, they tried to get him treated at the local community clinic but due to high demand, Luke had to wait three to four weeks to be seen, which was unbearable for him when the infections became painful. The family finally resorted to a long bus ride to Minneapolis for treatment at a walk-in, sliding-fee clinic. However, this still was not a timely option and required more expense than the family could afford. Recently, a teacher at Luke's preschool urged the parents to get Luke's hearing tested because she suspected hearing loss. This forced the Steiners into yet another quandary over how to access needed services.

REALITY CHECK #5

Public Programs Barriers Prevent Access

John and Sharon Berg lost their health insurance because of a change in jobs. Their one-and-a-half year old son, Jack, has chronic health issues, so they feared the effects a lapse in coverage would have for him. At the time they lost coverage, they decided to pay for a temporary COBRA policy to continue coverage for Jack, despite the policy's steep costs.

By law, Jack's COBRA coverage will expire next month, so John and Sharon applied for MinnesotaCare for him. They are income-eligible for the program, but Jack's application was immediately denied because his COBRA policy counts as previous health insurance. Children must be uninsured for four months before they are able to access MinnesotaCare.

givers can fill out a complicated application form or navigate a complex application process. It cannot require parents to exhaust all of their financial resources. It cannot depend on the winds of the economy, nor the whims of policymakers. It's time to guarantee all of our children the right to a healthy present and a healthy future, by insisting that they all have health insurance.

In increasing numbers, Minnesota policymakers, advocates and health care providers are calling for universal access to health care. It's time for Minnesota to overcome the last of the obstacles and truly embrace health care reform. It's time to travel the last bit of road that we've not traveled before and ensure equal health care access to all Minnesota children. Our state's health depends on it.



Minnesota Citizens Forum on Health Care Costs

In 2003, Governor Tim Pawlenty appointed a task force to examine controlling health care costs. Former U.S. Senator Dave Durenberger (R) hosted discussions throughout the state to learn how Minnesotans felt about health care and how to create a better system. The task force urged a major overhaul of the system "based on Minnesotans' values" that focus on quality, access, and health. The final report made seven recommendations and stressed that to effectively control costs, all the recommendations should be heeded, not just one or two. It proposed:

- Allowing Minnesotans to decide what is most important to them;
- Fully disclosing costs and quality so that consumers can better understand where health care dollars go;

- Reducing costs through better quality services and elimination of ineffective and unnecessary services;
- Changing incentives to encourage health and to help Minnesotans choose healthier lifestyles;
- Supporting new models of health care education to address shortages of health care professionals throughout the state;
- Reducing the cost of overhead and administration by better use of standardization and technology; and
- Achieving universal participation in the health care system to ensure that every Minnesotan receive preventive and basic health care services and pay according to their ability.

The report advocated that universal participation start with Minnesota's children.

Learn more at www.mncitizensforum.org.

Appendix A:

Types of Health Care Coverage for Minnesota Children

Private Market Options

Group/Employer-Based: Group health insurance is usually purchased by an employer, labor union or other purchaser through a health plan to provide a negotiated set of health benefits for a defined group. Each member of the group receives the same benefits. Generally, the larger the group, the better the purchasing power for negotiating benefits and/or monthly premiums. As an alternative, groups can opt to self-insure, which means they pay for all covered health care services directly rather than purchasing them through a health plan.

- *Consolidated Omnibus Budget Reconciliation Act (COBRA):* COBRA is the federal law that provides an employee the right to continue coverage in an employer-based group plan for a limited time even though that employee is no longer eligible (e.g., they were laid off from the employer). COBRA is often prohibitively expensive because the families must pay the total share of the premium costs—both the employer and employee contribution.

Individual/Private Pay: Individuals or families that are not part of a group can purchase individual coverage through a handful of licensed health plans in Minnesota. Plans vary by the number of covered benefits, the amount of deductibles, co-pays and premiums. Because an individual or family has no purchasing power, these plans are usually more expensive than a group policy and require higher out-of-pocket expenses in the form of deductibles, co-pays and premiums. Those covered under these types of plans may be more likely to be underinsured, electing fewer benefits to cut down on premium costs.

Public Health Insurance Programs

All of the public programs that cover Minnesota children provide a comprehensive benefit set that includes preventive care, immunizations, hospitalization, and mental health, dental, and vision services.

Medical Assistance (MA): MA, Minnesota's version of the federal Medicaid program, provides free health care coverage for the lowest-income Minnesota families. The state Department of Human Services works with counties to administer the program. Eligibility is based on income, family size, children's ages, whether children are blind or disabled, financial assets, residency, and citizenship status. MA may cover each individual within a family, but eligibility guidelines differ for each family member. For children under the age of 2, family income can be up to 280 percent of the federal poverty line (about \$45,000 for a family of 3). For children 2 to 17, the income limit is 150 percent of the federal poverty line (about \$24,000 for a family of 3). For children 18 through 20 and for parents, the income limit is 100 percent of the federal poverty line (about \$16,000 for a family of 3). The average monthly enrollment for children (ages 0-17) in 2005 was slightly more than 224,000.²⁹

MinnesotaCare: MinnesotaCare is a reduced-cost, premium-based health coverage program for working families who do not have access to employer-based insurance and cannot afford private insurance. The program is administered by the state Department of Human Services. MinnesotaCare enrollees pay a

monthly premium, which is calculated based on income, family size and number of family members enrolled in the program. MinnesotaCare covers parents and children up to 275 percent of the federal poverty line (approximately \$44,000 for a family of 3). In addition to income and family size, MinnesotaCare eligibility relies on asset, residency and citizenship requirements. The average monthly enrollment for children (ages 0-17) in MinnesotaCare in 2005 was about 54,000.³⁰

Minnesota Comprehensive Health Association (MCHA): MCHA is a non-profit organization that provides comprehensive health care coverage for Minnesotans who have high-risk medical conditions. To qualify, an individual must have been denied coverage by a Minnesota insurer due to a pre-existing medical condition. There are no income requirements. By law, MCHA premiums must be set between 101 and 125 percent of the weighted average for comparable, individual, non-group policies, making it a very expensive option for families. Currently, almost 3,000 children (ages 0-19) are covered by MCHA.³¹

In addition to these programs, some of Minnesota's children were once covered through the General Assistance Medical Care (GAMC) program. Undocumented immigrant children living in dire poverty in Minnesota (those with family income below 75 percent of the federal poverty line and less than \$1,000 in assets) used to be covered through GAMC. In 2003, undocumented immigrant children were cut from this program. No replacement for these children's health coverage needs was put forward.

Appendix B:

Children's Health Care Coverage Expansion (1990s–early 2000s)

Expanded Access to Medical Assistance

In 1997, the federal government created the Children's Health Insurance Program (CHIP), a block grant that provided federal funds to encourage states' efforts to cover children. The next year, responding to renewed emphasis on the importance of immunizations and early childhood screenings, Minnesota used some of its CHIP dollars to raise the ceiling for MA eligibility for children under 2. Families could now enroll their youngest children if their income was below 280 percent of the federal poverty line (about \$38,000 for a family of 3 in 1998). This was, and remains, the highest income eligibility level for children in any public health insurance program in Minnesota.

In 2002, Governor Jesse Ventura signed legislation that expanded and streamlined the multiple eligibility guidelines for children of different age groups on MA. All children ages 2 to 18 became eligible for MA up to 170 percent of the federal poverty line (about \$25,500 for a family of 3 in 2002). Children younger than 2 were still eligible if their families' income was up to 280 percent of the federal poverty line.

Reduced Red-Tape to Minnesota's Public Programs.

Shortened and simplified forms.

Many eligible families were not successfully enrolling in public health care programs because the application was overwhelmingly long. In 2000, the Department of Human Services reduced the initial application from 24 to 4 pages and the renewal form (required at intervals to re-establish eligibility) to 2 pages.

Delayed verification. Often families do not have every piece of necessary documentation (e.g. pay stubs and other proof of income) at the time they complete the public health care programs application. Gathering these documents takes time, which extends the period that parents and their children remain uninsured. Research shows that even brief gaps in coverage can contribute to problems for families in accessing care, obtaining prescriptions, and paying medical bills.³² "Delayed verification" allowed families who appear eligible to begin using their health care benefits immediately as long as they provide needed information within 30 days of enrollment. Families applying to MinnesotaCare were given this option beginning in 1999; the next year, Medical Assistance enrollees were afforded the same benefit.

Automatic newborn renewal. Despite remaining eligible, many families fell off public programs at renewal time because of problems submitting new documents to verify their income. Within months, many of these families re-enrolled. This process is known as "churning" and creates lapses in care for children, confusion for families and increased public costs due to additional time and paperwork for program administrators. Research affirms that stable health insurance improves access to regular preventative care, which results in fewer visits to the emergency room and healthier outcomes for children.³³ Churning is especially disruptive for children under age 2 who require regular check-ups and immunizations. To ensure that children received postnatal and early childhood health care, Minnesota chose to automatically enroll newborns in Medical Assistance who were obviously eligible because their mothers were receiving MA while they were pregnant. These infants were guaranteed coverage for the first 2 years of their lives without any renewal procedures.

Appendix C:

2003 Public Health Care Coverage Changes that Most Affected Children

Reduced Children's Eligibility for MA

As of July 2004, eligibility for Medical Assistance for Minnesota children ages 2 to 18 was reduced from 170 percent to 150 percent of the federal poverty line (the equivalent of about \$26,600 and \$23,500, respectively, for a family of 3 in 2004). This terminated 2,900 children from MA.³⁴ It was assumed that children who lost coverage from MA because they were over the income limits would immediately enroll in MinnesotaCare, but program enrollment data does not demonstrate that this happened.³⁵

Eliminated Coverage for Children Who Are Non-citizens or Undocumented Immigrants

In July 2003, low-income children who are non-citizens and undocumented or non-immigrants (foreign born students, visitors, tourists, and others in the U.S. on a temporary basis) became ineligible for Minnesota's General Assistance Medical Care program, which offered these children a comprehensive benefit set including preventative care. Upon implementation, 2,200 Minnesota children under the age of 21 lost coverage.³⁶

Moved Backward on Automatic Newborn Renewal

Newborns who were automatically enrolled in MA because their mothers had been on the program when they were pregnant could no longer stay on the program until age 2. As of July 2003, re-determination was required when these children turned 1. Following this change, 3,800 Minnesota infants lost their MA coverage.³⁷

Reduced Renewal Windows

The renewal period for MinnesotaCare was shortened from once a year to every 6 months in 2003. Shorter coverage periods result in a greater number of children falling off public programs because of the complications that occur at renewal time. There are myriad reasons why families have difficulties renewing their coverage (e.g., renewal notices are only sent in English, income verifications are often difficult to gather in a timely manner, low-income families move frequently and may not receive the renewal notice on time). By converting to a 6-month eligibility period, Minnesota increased administrative costs while doubling the likelihood that

children will lose coverage simply because of paperwork. The Minnesota Department of Human Services estimated that by 2007, this change would reduce enrollment in MinnesotaCare by about 6,000 children, as well as about 4,400 parents.³⁸

Eliminated Delayed Verification

Families who appear eligible can no longer use their health care benefits immediately while gathering required documentation. This is especially problematic for those who need to access care immediately, such as pregnant mothers and children with chronic diseases.

Appendix D:

Long-Standing Barriers to Accessing Minnesota's Public Health Care Coverage Programs

MinnesotaCare's Four-Month Waiting Rule

Since its creation, MinnesotaCare has denied coverage to families who have had insurance during the previous 4 months, even if they are otherwise eligible for the program. Children lose coverage for a variety of reasons: a parent's employer may stop offering dependent coverage, the coverage may become too expensive for the family, or a parent may be laid-off. Regardless, all of these children are required to go without coverage for 4 months before they can enroll in MinnesotaCare. This can create dangerous lapses in care, especially for children with chronic conditions. Between October 2003 and September 2004, an estimated 5,900 separate MinnesotaCare applications (which included multiple family members) were denied health care coverage due to this rule.³⁹

MinnesotaCare's "50 Percent" Rule

If a Minnesota family has access to employer-based health insurance for which the employer pays at least 50 percent of the premium, the family cannot access MinnesotaCare. As health care costs have risen steeply and outpaced wage increases, 50 percent of their health care costs has become increasingly expensive for many Minnesota families, but because of this rule, they are denied an alternative affordable option for health care coverage.

MinnesotaCare's Premium Scale Exceeds Families Ability To Pay

When MinnesotaCare was implemented with a sliding premium scale, the intent was to require families with higher incomes to contribute a greater amount to their coverage, but still keep the monthly premiums affordable for the families. In 1992, the high end of the premium costs for MinnesotaCare were slightly less than 7 percent of gross household income. Today, the premium is nearly 10 percent of household income for some families. For a family of 3 earning \$3,652 a month (close to the highest level of eligibility at 272 percent of the federal poverty line), premiums are as high as \$360 a month.⁴⁰ This is unaffordable, especially since other fixed household costs such as energy, housing payments and child care have also increased so markedly in recent years for Minnesota families. In a 2002 survey of former enrollees, the high cost of premiums was the second most commonly cited reason for dropping MinnesotaCare coverage (behind finding other insurance).⁴¹

References

- ¹ Health Economics Program, *Health Insurance Coverage in Minnesota: Trends from 2001 to 2004*, Minnesota Department of Health, University of Minnesota School of Public Health, 2006.
- ² *Ibid.*
- ³ Genevieve Kenney and Jennifer Haley, *Why Aren't More Children Enrolled in Medicaid or SCHIP? New Federalism National Survey of American's Families*, The Urban Institute, 2001.
- ⁴ Health Economics Program, *Health Insurance Coverage in Minnesota: Trends from 2001 to 2004*, Minnesota Department of Health, University of Minnesota School of Public Health, 2006.
- ⁵ Health Economics Program, *Employer-Based Health Insurance in Minnesota: Results from the 2002 Employer Health Insurance Survey*, Minnesota Department of Health, 2005.
- ⁶ Health Economics Program, *Health Insurance Coverage in Minnesota: Trends from 2001 to 2004*, Minnesota Department of Health, University of Minnesota School of Public Health, 2006.
- ⁷ Health Economics Program, *Employer-Based Health Insurance in Minnesota: Results from the 2002 Employer Health Insurance Survey*, Minnesota Department of Health, 2005.
- ⁸ *Ibid.*
- ⁹ Children's Defense Fund Minnesota analysis of enrollment data provided by the Minnesota Department of Human Services.
- ¹⁰ Health Care Administration, *2003 Legislative Eligibility Reductions in Minnesota Health Care Programs*, Minnesota Department of Human Services, 2003.
- ¹¹ Health Economics Program, *Health Insurance Coverage in Minnesota: Trends from 2001 to 2004*, Minnesota Department of Health, University of Minnesota School of Public Health, 2006.
- ¹² *Ibid.*
- ¹³ Jeffrey Stoddard, et al., Health Insurance Status and Ambulatory Care for Children, *New England Journal of Medicine* (1994): 1421-25. William G. Johnson and Mary E. Rimza, The Effects of Access to Pediatric Care and Insurance Coverage on Emergency Department Utilization, *Pediatrics* 113 (2004): 483.
- ¹⁴ Health Economics Program, *Variations in the Use of Health Services in Minnesota by Insurance Status: Results from the 2001 Minnesota Health Access Survey*, Minnesota Department of Health, 2004.
- ¹⁵ Jack Hadley and John Holahan, How Much Medical Care Do the Uninsured Use, And Who Pays For It?, *Health Affairs*, 2003.
- ¹⁶ The Access Project, The Champaign County Health Care Consumers, Human Services Coalition of Dade County, and Tenants' and Workers' Support Committee, *The Consequences of Medical Debt: Evidence from Three Communities*, 2003. Robert Siefert, *Home Sick: How Much Medical Debt Undermines Housing Security*, The Access Project, 2005.
- ¹⁷ The Access Project, *Paying for Health Care When You're Uninsured: How Much Support Does the Safety Net Offer*, 2003. David Himmelstien, Elizabeth Warren, Deborah Thorne, and Steffie Woolhandler, MarketWatch: Illness and Injury As Contributors To Bankruptcy, *Health Affairs*, 2005.
- ¹⁸ Minnesota Council of Non-Profits, *Survey of Minnesota Non-Profit Organizations*, 2004.
- ¹⁹ Minnesota Hospital Association, *Uncompensated Care in Minnesota*, 2005.
- ²⁰ Department of Human Services and Public Health, *Assessing the Impacts of Health, Human Services and Corrections Changes Enacted by the Minnesota Legislature During the 2003 Session*, Hennepin County, 2005.
- ²¹ Personal communication with Bruce Phyle, Hennepin County Medical Center, 7/22/2004.
- ²² Personal communication between Scott Leitz, Minnesota Department of Health and State Representative Paul Thissen, 2/9/04.
- ²³ Minnesota Association of Community Health Centers, 2004 MNACHC Chart Book: Trends From Minnesota's Health Centers, *Access Minnesota*, Fall 2005.
- ²⁴ Minnesota Association of Community Health Centers, Open Door Health Center: South Central Minnesota's Only Safety Net Provider, *Access Minnesota*, Winter 2005.
- ²⁵ Minnesota Association of Community Health Centers, MNACHC Interview: Dr. Terril Hart, Indian Health Board of Minneapolis, *Access Minnesota*, Winter 2005.
- ²⁶ Personal communication with Emily Rasmussen, Portico, 3/6/2006.
- ²⁷ Families USA, *Paying a Premium: The Added Costs of Care for the Uninsured*, 2005.
- ²⁸ Institute of Medicine, *A Shared Destiny: Effects of Uninsurance on Individuals, Families, and Communities*, 2003.
- ²⁹ Data provided by the Minnesota Department of Human Services.
- ³⁰ Data provided by the Minnesota Department of Human Services.
- ³¹ Personal communication with Peggy Zimmerman-Belbeck, Minnesota Comprehensive Health Association Director of Operations, 3/6/2006.
- ³² Institute of Medicine, *Coverage Matters: Insurance and Health Care*, 2001.
- ³³ Kalkines, Arky, Zall, & Bernstein LLP, *Coverage Gaps: The Problems of Enrollment Churning in Medicaid Managed Care and Child Health Plus*, New York Coalition of Prepaid Health Services Plans, 2000. William G. Johnson and Mary E. Rimza, The Effects of Access to Pediatric Care and Insurance Coverage on Emergency Department Utilization, *Pediatrics* 113 (2004): 483.
- ³⁴ Personal communication with George Hoffman, Minnesota Department of Human Services, 11/12/2004.
- ³⁵ Children's Defense Fund Minnesota analysis of enrollment data provided by the Minnesota Department of Human Services.
- ³⁶ Personal communication with George Hoffman, Minnesota Department of Human Services, 11/12/2004.
- ³⁷ *Ibid.*
- ³⁸ Health Care Administration, *2003 Legislative Eligibility Reductions in Minnesota Health Care Programs*, Minnesota Department of Human Services, 2003.
- ³⁹ Minnesota Department of Human Services analysis of denials between 10/13/2003 and 9/30/04.
- ⁴⁰ Minnesota Department of Human Services, *MinnesotaCare Premium Table July 2005 through June 2006*, 2005.
- ⁴¹ Health Economics Program, *MinnesotaCare Disenrollee Survey Report*, Minnesota Department of Health, 2002.



Children's Defense Fund

Children's Defense Fund Minnesota

University National Bank Building
200 University Avenue West, Suite 210
St. Paul, MN 55103
651-227-6121 • www.cdf-mn.org