

Minnesota Department of Health Fact Sheet: **Title V (MCH) Block Grant**
Pregnant Women, Mothers and Infants
Children and Adolescents
Children and Youth with Special Health Care Needs

September 2009

Health Insurance

About the Title V Block Grant

The federal Title V Maternal and Child Health (MCH) Block Grant helps states ensure the health of all mother and children. As part of Minnesota's Title V Block Grant activity requirements, the MDH conducts a statewide needs assessment every five years. The needs assessment provides guidance to Title V activities for the next five years by identifying priority issues. This fact sheet describes one of Minnesota's priority issues.

Seriousness of the Issue

Insurance Coverage

In 2006, nearly 93% of all Minnesotans had some type of health care coverage.¹ This included:

- 67.5% were insured through employer-sponsored coverage or purchase individual policies
- 24.6% were insured through a public program (e.g., Medicare, Medical Assistance (MA), General Assistance Medical Care (GAMC), or MinnesotaCare)
- 7.4 % (374,000 people) were uninsured, and
- 11.3% were uninsured at some point during the year.¹

In 2007, 71.3% of the uninsured in Minnesota were employed. Of those, 33% held temporary or seasonal jobs, 44.9% worked 31-40 hours per week and 28.8% worked more than 40 hours.¹

According to the Kaiser Family Foundation, 81% of the uninsured in the US had either part-time or one or more full-time workers.²

Insurance Coverage for Children

Over 19% of children aged 0-17 are covered by public insurance and 6% are uninsured. For the 18-24 age group, 16.5% are covered by a public program and 18.7% are uninsured.¹

Fewer Minnesota children aged 0-5 years were uninsured in 2007 (4.8%) than in 2004 (7%). The trend was the same for public insurance. However, the

opposite trend occurred for children aged 6-17 years with 4.6% uninsured in 2004 and 6.6% uninsured in 2007. The percentage of children in this age group on public insurance remained the same.¹

According to the National Survey of Children's Health for children aged 0-17, in 2007 87% of Minnesota's uninsured children were uninsured for the entire year and 13% were either currently uninsured or had periods of no coverage during the year.³

Families with children make up 70% of the Medical Assistance enrollment. This has remained stable over the last 10 years.¹

Disparities

As the following table shows, disparities in insurance coverage exist for Minnesota's racial and ethnic populations. This table shows trends in health insurance coverage by race and ethnicity from 2004 to 2007.¹

| | Yr | Private | Public | Uninsured |
|-----------------|----|---------|--------|-----------|
| White | 04 | 70.1% | 23.7% | 6.2% |
| | 07 | 69.2% | 24.4% | 6.4% |
| Black | 04 | 40% | 45.2% | 14% |
| | 07 | 46.5% | 38.8% | 14.7% |
| Asian | 04 | 63.5% | 26.5% | 10.1% |
| | 07 | 75% | 18.8% | 6.3% |
| American Indian | 04 | 38.1% | 39.9% | 22% |
| | 07 | 32.2% | 51.9% | 16% |
| Hispanic/Latino | 04 | 38.8% | 32.2% | 31% |
| | 07 | 47.4% | 33.5% | 19% |
| All | 04 | 67.2% | 25.1% | 7.4% |
| | 07 | 67.6% | 25.2% | 7.2% |

As noted earlier, 6% of Minnesota's children age 0-17 had no insurance coverage in 2007. However, when looking at race, 4.8% of White children had no insurance, while 12.8% of non-White children were uninsured.¹

Insurance and Prenatal Care

As part of the Minnesota Pregnancy Risk Assessment Monitoring System (PRAMS) survey, women are



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asked about their health and health care prior to and following pregnancy. In 2007, 19.4% of all women who recently had a live birth indicated that they did not have public or private insurance prior to their pregnancy. However, when looking at race/ethnicity 13.6% of White women, 20.5% of Black women, 70.1% of Hispanic women, and 39.3% of American Indian women indicated they did not have insurance prior to their pregnancy. In women under that age of 24, approximately 2 out of 5 did not have insurance prior to pregnancy.⁴

Access and Adequacy of Care

The uninsured were less likely than those with private insurance to get their care at a private clinic or doctor's office (72% compared to 97%) but significantly more likely than those with private coverage to get care at a free or public health clinic (15% vs. 1.5%) or an emergency room (11% vs. 1.5%). These findings from the 2007 Minnesota survey are similar to findings for prior years.⁵

The National Survey of Children's Health found that of those Minnesota children 0-17 that were currently insured, 31.3% said that the insurance was not adequate. In contrast, when asked if their insurance benefited the child's needs, 92.4% responded "usually" or "always." When asked if the insurance allowed them to see the needed health providers, 94.9% responded "usually" or "always." However, when asked if the out-of-pocket expenses were reasonable for the child's care, only 45.4% responded "usually" or "always" with the remainder indicating that the cost were never/sometimes reasonable (26.7%) or they either had no out-of-pocket expenses (27.9%).³

According to the 2005 National Survey of Children with Special Health Care Needs (CSHCN) (latest available data), 30% of Minnesota insured CSHCN had inadequate insurance.⁶ Estimates of inadequate insurance in this survey were derived by responses to three questions: Does the child's health insurance offer benefits or cover services that meet the child's needs? Are costs not covered by the child's health insurance reasonable? Does the child's health insurance allow him/her to see the providers he/she needs?

Out-of-Pocket Costs

The average annual health insurance premium for private insurance in Minnesota (for both single and family coverage) more than doubled between 1997 and 2006. While the employer contribution assumes much of this cost, the employee share has more than

doubled and the employer share has been increasing only slightly.¹ During that same time, wages and income increased by only 30-40%.⁷

Nearly 90% of those with incomes below 100% of the Federal Poverty Guidelines (FPG) spent 10% or more of their income on health care. In comparison, only 9% of Minnesotans with incomes above 300% FPG spent more than 10% of their income on health care.⁷

In 2007, total spending per enrollee in a private health plan increased by 5.6 % (from \$3,879 to \$4,095), which was the lowest rate of increase in the last decade. In contrast, enrollee out of pocket costs increased by 13.7%, the highest rate of increase since 2002. The share of total cost paid by enrollees represented 15.1% of total spending in 2007, compared to 10.1% in 2000.⁸

Out-of-Pocket costs for families of CSHCN also keep rising. Twice as many families with CSHCN paid more than \$5,000 for out-of-pocket costs in 2005 than in 2001; and twice as many paid more than \$1,000 in 2005 than in 2001.⁶ Affordability and adequacy of coverage become significant family policy issues because one out of five families with children have one or more children with a special health need.

Evidence-Based Strategies

There is a large body of research that is virtually unanimous in its conclusions about the impact of insurance on the health of children and adults. As stated both simply and succinctly by the Kaiser Commission on Medicaid and the Uninsured: "Health Insurance Matters".⁹ As noted in the overview of that document, lack of insurance compromise's the health of individuals because they are less likely to receive preventive care, more likely to be hospitalized for avoidable health problems, less likely to receive timely diagnoses, and more likely to delay needed treatment.

In addition, lack of insurance also affects the financial well being of families by increasing family exposure and vulnerability to the high cost of health care and out-of-pocket costs.

One strategy to address lack of health insurance and adequate health insurance is to advocate for adequate health insurance coverage in either public or private programs for all children and adolescents. Policy makers should continue to explore ways to ensure that Minnesotans have access to affordable, high quality health insurance coverage.

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Additionally, due to the significant disparities that exist in health insurance coverage among Minnesota's racial and ethnic minorities, there is a need to develop and promote health services and systems of care designed to eliminate disparities and barriers across the MCH population.

Current Resources and Capacity

Minnesota's local health departments (LHDs) work to increase the number of clients enrolled in health insurance programs. In 2008, 88% of LHD identified that "Lack of Insurance" as a barrier to health care services.¹⁰

Through interaction with clients in various programs, LHD are able to monitor those programs in which they routinely assess the health insurance status of clients; and those programs in which they refer clients without insurance to appropriate insurance resources. The following table presents the data from 2008 for programs that most significantly impact the health insurance status of women and children:

| Service | Assessed | Referred |
|--|----------|----------|
| Family planning clinics | 75% | 88% |
| Early intervention service coordination for CSHN | 91% | 93% |
| WIC clinics | 92% | 95% |
| Family home visiting | 96% | 94% |
| CTC Outreach | 88% | 88% |
| Follow-along program | 72% | 79% |

Another effort to support the adequate and appropriate use of insurance for children is the MDH MAZE training. MAZE stands for Taking the MAZE out of Funding. These materials reflect eligibility criteria and benefits coverage for Minnesota's publicly-funded health insurance programs. In 2007-08 staff trained 978 people in 45 trainings. Over the past 5 years (2003-2008) nearly 5,000 people have been trained in 213 trainings.

Minnesota participates in the Early Childhood Comprehensive System (ECCS). A key component of that system is to address the need for access to comprehensive health services and medical homes, including assuring access to insurance resources.

¹ MDH, Health Economic Program, Minnesota Health Care Markets Chartbook.

<http://www.health.state.mn.us/divs/hpsc/hep/index.html>

² Kaiser Family Foundation

<http://www.kff.org/about/kcmu.cfm>

³ National Survey of Children's Health. 2007 Data.

<http://www.nschdata.org/Content/#>

⁴ MDH, Minnesota Pregnancy Risk Assessment Monitoring System (2009). 2007 Data Tables.

⁵ MDH, Health Economic Program, Access to Care and Health Status Among Uninsured Minnesotans, 2007.

<http://www.health.state.mn.us/divs/hpsc/hep/index.html>

⁶ National Survey of Children with Special Health Care Needs. 2005 Data

<http://cshcndata.org/Content/Default.aspx>

⁷ MDH Health Economics Program, Health Insurance Affordability Study, January 2009.

⁸ Private Health Insurance Trends in Minnesota, 2007. MDH Health Economic Program Issue Brief, September 2008.

⁹ Kaiser Family Foundation. *The Uninsured: A Primer-Key Facts About Americans Without Health Insurance*. December, 2003.

¹⁰ MDH, Office of Public Health Practice, Local Public Health Planning and Performance Measurement Reporting System. 2008 Data.

<http://www.health.state.mn.us/ppmrs/analysis.html>