How Health Reform Helps Communities of Color In Minnesota

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The historic health reform law moves our nation toward a health care system that covers many more people, reforms the insurance industry, improves the quality of care, and curbs rising costs. The benefits and protections in the new law also lay a critical foundation for eliminating racial and ethnic health disparities and promoting health equity. This is especially important for Minnesota, where people of color make up 14 percent of the state's population.[1, 2]

Communities of color in Minnesota stand to gain from the new health care law—both from those provisions that will affect all communities but have a disproportionate impact on communities of color and from those that are designed specifically to eliminate health disparities. We describe these provisions in more detail below.

Expands Access to Coverage

Health reform will increase coverage and reduce the number of uninsured by doing the following:

- **Expanding Medicaid**

  In 2014, Medicaid coverage will be expanded to cover children and adults with incomes up to 133 percent of the federal poverty level, roughly $14,403 for an individual and $24,352 for a family of three in 2010. Approximately 18 percent of those who will be newly eligible for Medicaid in Minnesota in 2014 will be people of color.[3] This Medicaid expansion will provide coverage to many racial and ethnic minority individuals and families who would otherwise go without quality, affordable health coverage, particularly adults without dependent children.

Creating New Marketplaces

Also beginning in 2014, the new law will further expand coverage through the creation of state health insurance exchanges for Minnesotans who do not qualify for Medicaid or who cannot get affordable coverage from their employer. These exchanges will allow individuals to shop for insurance and easily compare prices and benefits. To ensure that health insurance is affordable within the exchanges, the law will provide tax credits to offset the cost of premiums. These tax credits will be available to Minnesotans whose incomes fall between 133 percent and 400 percent of poverty and who purchase coverage through an exchange. It is estimated that 17 percent of those who will be eligible for these premium tax credits in Minnesota in 2014 (the first year these tax credits will be available) will be people of color.[4]

Number Eligible for Medicaid Expansions and Tax Credits in 2014, By Race/Ethnicity in Minnesota

	Eligible for Medicaid	Eligible for Subsidies	Total Eligible
African American	25,500	22,100	47,600
American Indian and Alaska Native	4,100	4,200	8,300
Asian	23,500	22,700	46,200
Latino	34,600	30,000	64,600
Native Hawaiian and Other Pacific Islander	0	300	300
White	395,500	389,000	784,500
All Populations*	483,200	468,200	951,400

Source: Special data run for Families USA by The Lewin Group, June 30, 2010, on file at Families USA.

* Numbers may not add due to rounding.

Helps Minority-Owned Small Businesses

According to the latest data, there are approximately 22,382 minority-owned small businesses in Minnesota.[5] Small businesses often find it difficult to provide health coverage to their workers. Typically, coverage for small businesses is more expensive than it is for larger businesses.[6] In 2008, less than one-third (29.2 percent) of Minnesota businesses with fewer than 10 workers (and 70.5 percent of those with 10 to 24 workers) offered health insurance to their employees, whereas nearly all firms with 50 or more workers (95.3 percent) offered coverage.[7]

Starting in 2010, small businesses in Minnesota will be eligible to receive tax credits to help with the cost of providing health coverage to their workers, and the size of those credits will increase over time. For 2010-2013, small business owners who offer employee coverage will be eligible to receive a credit that will cover up to 35 percent of the cost of coverage. For 2014 and thereafter, the credit will cover up to 50 percent of the cost of coverage. To be eligible for these tax credits, small business must have no more than 25 employees and average annual wages of less than $50,000.

In addition to the help that will be provided by these tax credits, the new exchanges will provide a one-stop shop where small businesses can purchase coverage that is comprehensive and affordable. Exchanges will make premiums more reasonable and predictable for small businesses, which are currently left to fend for themselves with few protections in the private market.

Eliminates Discrimination Due to Pre-existing Conditions

The new law offers critical protections to Minnesotans who have pre-existing conditions today as well as to those who are healthy now but may develop a health problem as they grow older. Under health reform, no individual with a pre-existing condition will be denied coverage, charged a higher premium, or sold a policy that excludes coverage of essential health benefits simply because he or she has a pre-existing condition, such as cancer, obesity, or heart disease.

Nearly one-quarter of Minnesotans (23.1 percent) have a pre-existing condition, but because of health reform, they will now find it easier to purchase and keep health coverage. While this will help all racial and ethnic groups, groups that are more likely to have pre-existing conditions stand to gain even more. For example, approximately one-quarter (24.3 percent) of non-Hispanic whites have a pre-existing conditions in Minnesota, followed by 23.2 percent of American Indians and Alaska Natives, 20 percent of African Americans, 14.7 percent of Latinos, and 10.2 percent of Asian Americans.[8]

It is important to note that these data include only those who have been *diagnosed* with a pre-existing condition. This *may* result in an undercount for racial and ethnic minorities, since research shows that there are significant disparities in access to care and the delivery of care across racial and ethnic groups, which may in turn lead to differing rates of diagnosis.

Increases Funding for Community Health Centers

Community health centers play a critical role in expanding access by serving as a trusted safety net. Typically located in medically underserved areas, community health centers provide culturally and linguistically appropriate care to all residents regardless of insurance coverage, citizenship status, or ability to pay. Minnesota has 14 federally funded qualified health centers (FQHC) with 76 delivery sites that serve approximately 154,000 patients.

People of color disproportionately use community health centers as their source of primary and preventive care compared to all other populations. For example, of those who use community health centers in Minnesota, approximately 60 percent are racial and ethnic minorities.[10]

Beginning in fiscal year 2011 and continuing through 2015, the health reform law will appropriate $11 billion to community health centers for the services they provide and for construction and renovation. It is important to note that undocumented immigrants will remain ineligible for Medicaid and other public benefits and will be barred from purchasing insurance through the exchanges. Community health centers, therefore, will continue to play a critical role as the safety net for our most vulnerable populations, including those who will continue to lack access to care.

Increases Workforce Diversity

As health reform expands coverage, it will be increasingly important to ensure that the health care workforce is adequate, diverse, and addresses the needs of all individuals. The most recent estimates project that 5.3 percent of Minnesotans are underserved, meaning that they live in an area where there is a shortage of primary care health professionals.[11] Diversity in the health care workforce not only enhances the practice environment for all populations, but studies consistently show that minority health professionals are more likely to practice primary care in minority and underserved communities.[12, 13]

The health reform law will fund scholarships, grants, and loan repayment programs for health care professionals to increase workforce diversity. It will also provide continuing education support for health professionals who serve minority and underserved populations. In addition, it will offer grants to improve health care services, increase retention, and increase the representation of minority faculty members and health professionals.

Improves Data Collection

It is well known that disparities in health exist across racial and ethnic minority groups, but there is limited coordination, documentation, and analysis of data that examine the nature of health disparities by race and ethnicity. Collecting and reporting these data are crucial for identifying and monitoring the health problems that exist among Minnesota's communities of color, and for developing the proper solutions to eliminate health disparities in communities of color.

The health reform law requires that, by no later than 2012, data be collected and reported by race, ethnicity, sex, primary language, and disability status for participants at the smallest geographic level possible for all federally conducted or supported health care or public health programs. This is especially important for identifying and examining variations between subpopulations. Data and analyses will also be available to agencies within the Department of Health and Human Services (HHS), as well as to other federal agencies, nongovernmental organizations, and the public.

Supports Community Health Workers

Often seen as a trusted source for information among some minority communities, community health workers are able to provide a unique link between members of the community and health care services. Moreover, the community health worker's relationship with the community allows him or her to provide information and resources in a culturally appropriate manner. Currently, community health workers do not receive dedicated funding and are not provided sufficient support to carry out their work.

The health reform law provides additional support to community health workers through the appropriation of grants to divisions of a state, a public health department, a free health clinic, a hospital, or a federally qualified health center that hosts community health workers and promotes positive health behaviors and outcomes in medically underserved communities, especially communities of color. The legislation also provides funding for the training, supervision, and support of community health workers for fiscal years 2010 through 2014.

Conclusion

Although addressing disparities was not the primary focus of health reform, the legislation does take steps in the right direction to address health disparities seen in communities of color. In addition to covering millions more people, reducing costs, and improving quality, health reform addresses the widespread inequities that result in racial and ethnic health disparities. The coverage expansions, together with many other provisions, will significantly affect Minnesota's communities of color.

During the implementation process, it will be important to monitor how provisions are being implemented to ensure that reform is meeting the needs of all communities. It will also be critically important for advocates to provide public comment on federal regulations and to inform communities of the opportunities to have their voices heard. Only then can we ensure that people of color in Minnesota are able to benefit from the new law and that we continue to build upon this critical foundation to advance health equity.

Endnotes

[1] For this fact sheet, "people of color" are defined as those who self-identify as African American, American Indian/Alaska Native, Asian, Latino, Native Hawaiian, or other Pacific Islander.

[2] Kaiser Family Foundation, *Minority Health: Facts-At-A-Glance* (Washington: Kaiser Family Foundation State Health Facts Online, 2008), available online at www.statehealthfacts.org.

[3] Special data run for Families USA by The Lewin Group, June 30, 2010. On file at Families USA.

[4] Ibid.

[5] U.S. Small Business Administration, *Small Business Profile: Minnesota* (Washington: SBA Office of Advocacy, 2009), available online at www.sba.gov/advo/research/profiles/09co.pdf.

[6] Beth Levin Crimmel, *Medical Expenditure Panel Survey Statistical Brief #231: Premiums, Employer Costs, and Employee Contributions for Private Sector, Employer-Sponsored Health Insurance, Single Coverage by Firm Size, 1996-2006* (Washington: Agency for Health Care Research and Quality, January 2009).

[7] Agency for Healthcare Research and Quality, *Medical Expenditure Panel Survey—Insurance Component, 2008, Table II.A.2: Percent of Private-Sector Establishments that Offer Health Insurance by Firm Size and State: United States, 2008* (Washington: AHRQ, 2008).

[8] Christine Sebastian, Kim Bailey, and Kathleen Stoll, *Health Reform: Help for Minnesotans with Pre-Existing Conditions* (Washington: Families USA, May 2010), available online at www.familiesusa.org/assets/pdfs/health-reform/pre-existing-conditions/Minnesota.pdf.

[9] National Association of Community Health Centers, *Minnesota Health Center Fact Sheet* (Washington: National Association of Community Health Centers, 2009), available online at www.nachc.com/client/documents/research/2009-State-Fact-Sheets/COFS08.pdf.

[10] Ibid.

[11] Kaiser Family Foundation, *Minnesota: Health Professional Shortage Areas* (Washington: Kaiser Family Foundation State Health Facts Online, 2008), available online at www.statehealthfacts.org/comparemaptable.jsp?ind=682&cat=8.

[12] Fitzhugh Mullan, Candice Chen, Stephen Petterson, Gretchen Kolsky, and Michael Spagnola, "The Social Mission of Medical Education: Ranking the Schools," *Annals of Internal Medicine* 2010 152 no. 12 (June 15, 2010): 818-819, available online at www.annals.org/content/152/12/804.full.pdf+html.

[13] Kaiser Family Foundation, *Eliminating Racial/Ethnic Disparities in Health Care: What Are the Options?* (Washington: Kaiser Family Foundation, 2008), available online at www.kff.org/minorityhealth/upload/7830.pdf.

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