Medicaid's Impact In Minnesota:

Helping People with Serious Health Care Needs

American Cancer Society Cancer Action Network,
American Diabetes Association, American Lung Association, and
Families USA

American Cancer Society Cancer Action Network
901 E Street NW, Suite 500
Washington, DC 20004
Phone: 202-661-5754
www.acscan.org

American Diabetes Association
1701 North Beauregard Street
Alexandria, VA 22311
Phone: 1-800-DIABETES
www.diabetes.org

American Lung Association
1301 Pennsylvania Avenue NW, Suite 800
Washington, DC 20004-1725
Phone: 1-800-LUNG-USA (1-800-586-4872)
www.LungUSA.org

Families USA
1201 New York Avenue NW, Suite 1100
Washington, DC 20005
Phone: 202-628-3030
Email: info@familiesusa.org
www.familiesusa.org

Cover Design: Nancy Magill, Families USA

Medicaid, the state and federally funded health insurance program for low-income people, covers many vulnerable Minnesotans. It helps Minnesota children get a healthy start in life. It helps Minnesota's seniors and people with disabilities who need long-term care. It also helps Minnesotans with serious health conditions get the care they need—for them, Medicaid coverage can truly be the difference between life and death.

To get a sense of how important Medicaid is for Minnesotans with serious health care needs, this report looks at a subset of that group: the number of Minnesotans with cancer, diabetes, chronic lung disease, or heart disease or stroke who rely on Medicaid for their health coverage. (All of the individuals whose conditions are captured in the data in this report have received a diagnosis of their condition from a health care professional.) The conditions were defined as follows:

- Cancer: Includes all cancers except for non-melanoma skin cancers;
- Diabetes: Includes type 1 and type 2 diabetes;
- Chronic lung disease: Includes a range of lung diseases such as asthma, chronic obstructive pulmonary disease (COPD), and cystic fibrosis; and
- Heart disease or stroke: Includes a range of cardiovascular conditions, such as heart attacks, heart valve disorders, and stroke.

These are people whose health care needs require regular medical attention. Often, these conditions can be managed, or sometimes even cured, if treated in a timely manner. Medicaid helps make it possible for these Minnesotans to see a doctor when they need to, fill prescriptions, and keep up with screenings and other preventive care so that they can act quickly if their illness gets worse or recurs. Without Medicaid, many of these seriously ill people would not be able to afford the care they need. For them, Medicaid coverage is critical. Federal or state cuts to the Medicaid program would truly put them at risk.

To better understand the importance of Medicaid for people with serious health care needs, Families USA contracted with The Lewin Group to develop national and state-level estimates of the number of Minnesotans with the health conditions listed above, as well as their insurance status. For this analysis, The Lewin Group analyzed data from the Medical Expenditure Panel Survey (MEPS), which is administered by the Agency for Healthcare Research and Quality, and the Census Bureau's Current Population Survey (CPS).[1] A detailed methodology is available online at www.familiesusa.org.

Key Findings

Minnesotans with Cancer In Medicaid

Medicaid provides vitally important health care services to an estimated 13,250 Minnesotans with cancer (Table 1). Of those Minnesotans:

- 390 are children,
- 8,460 are adults, and
- 4,400 are seniors.

Table 1.
Minnesotans with Cancer Who Rely on Medicaid

Age Group	Total Number With Cancer	Number with Cancer Who Rely on Medicaid
Children (18 and under)	1,150	390
Adults (19-64)	69,640	8,460
Seniors (65+)	69,120	4,400
All Ages*	**139,910**	**13,250**

Source: Estimates for Families USA by The Lewin Group. See the methodology for details.

* Numbers may not add due to rounding.

Minnesotans with Diabetes In Medicaid

Medicaid helps an estimated 44,940 Minnesotans with diabetes get the care they need to manage their diabetes and treat any complications (Table 2). Of those Minnesotans:

- 2,020 are children,
- 29,940 are adults, and
- 12,990 are seniors.

Table 2.
Minnesotans with Diabetes Who Rely on Medicaid

Age Group	Total Number With Diabetes	Number with Diabetes Who Rely on Medicaid
Children (18 and under)	4,410	2,020
Adults (19-64)	200,380	29,940
Seniors (65+)	146,420	12,990
All Ages*	**351,210**	**44,940**

Source: Estimates for Families USA by The Lewin Group. See the methodology for details.

* Numbers may not add due to rounding.

Minnesotans with Chronic Lung Disease in Medicaid

Medicaid provides health coverage to an estimated 111,560 Minnesotans with chronic lung disease, helping them manage their health conditions (Table 3). Of those Minnesotans:

- 50,500 are children,
- 51,520 are adults, and
- 9,550 are seniors.

Table 3.
Minnesotans with Chronic Lung Disease Who Rely on Medicaid

Age Group	Total Number With Chronic Lung Disease	Number with Chronic Lung Disease Who Rely on Medicaid
Children (18 and under)	154,510	50,500
Adults (19-64)	314,480	51,520
Seniors (65+)	106,850	9,550
All Ages*	**575,840**	**111,560**

Source: Estimates for Families USA by The Lewin Group. See the methodology for details.

* Numbers may not add due to rounding.

Minnesotans with Heart Disease or Stroke in Medicaid

An estimated 123,940 Minnesotans with heart disease or stroke depend on Medicaid (Table 4). Of those Minnesotans:

- 7,380 are children,
- 83,350 are adults, and
- 33,210 are seniors.

Table 4.
Minnesotans with Heart Disease or Stroke Who Rely on Medicaid

Age Group	Total Number With Heart Disease or Stroke	Number with Heart Disease or Stroke Who Rely on Medicaid
Children (18 and under)	16,460	7,380
Adults (19-64)	651,450	83,350
Seniors (65+)	474,110	33,210
All Ages*	**1,142,010**	**123,940**

Source: Estimates for Families USA by The Lewin Group. See the methodology for details.

* Numbers may not add due to rounding.

The Medicaid Program: A State and Federal Partnership

Medicaid is the national health insurance program for low-income individuals. It is jointly funded by states and the federal government through a unique partnership. Each state administers its own Medicaid program, building on minimum requirements set by the federal government. Every state must cover certain low-income children, pregnant women, parents with dependent children, and seniors and people with disabilities. States may—but do not have to—cover childless adults. In addition to covering certain groups, states must also provide Medicaid enrollees with a set of basic health care benefits. States have broad authority to expand their programs and to determine what kinds of services will be covered and how those services will be delivered.

The federal government “matches” every dollar that states invest in Medicaid. For every dollar Minnesota puts into its Medicaid program, the federal government puts in $1.00. If Minnesota’s Medicaid expenditures go up or down, the federal share does as well. This federal matching structure makes it easier for state Medicaid programs to continue covering people during tough economic times, or when health crises or natural disasters strike. Without a guaranteed federal match that moves in tandem with state spending, states would have more difficulty operating their Medicaid programs in hard times, making Medicaid a much less reliable health care safety net.

Cuts to the Medicaid program, whether cuts in federal Medicaid funding or cuts at the state level, would mean the loss of essential health care for Minnesotans who rely on Medicaid, including thousands of Minnesotans with serious health care needs.

Discussion

Thousands of Minnesotans with serious health care needs rely on Medicaid for their health coverage. There are several reasons why many of these Minnesotans have Medicaid coverage, which include the nature of the Medicaid program and some of the ways people become eligible for it. Medicaid is limited to low-income individuals. And people with low incomes are more likely to have poorer health, even when educational levels and health behaviors are taken into account.[2] There are many reasons for this: Low-income people often have greater exposure to occupational and environmental health hazards, the stresses of being poor exact a physical toll, and their health coverage is frequently sporadic.[3]

Not everyone who is eligible for Medicaid is enrolled in the program.[4] Among those who are eligible, sicker individuals are more likely to enroll than healthier ones.[5] In part, that's because many people do not enroll in Medicaid until they seek care for an illness.[6] For example, if an uninsured patient receives a diagnosis of cancer or heart disease, doctor and patient may work together to explore insurance options, including Medicaid. This means that quite a few of the individuals who have the health problems that are reflected in our data were likely already sick when they enrolled in Medicaid.

People with a serious illness may also become eligible for Medicaid because they use up their financial resources paying for medical care. Each of the diseases that is profiled in this report can lead to extremely high medical costs. For example, in Minnesota, the average hospital charge for a stay associated with a heart attack is more than $47,000.[7] For people without health insurance or with inadequate insurance, those kinds of costs can drive them into poverty, to the point that they qualify for Medicaid.

Medicaid Helps Minnesotans Get the Care They Need

Medicaid makes it possible for Minnesotans to get the care they need. People with Medicaid have better access to health care than do the uninsured. A recent study that used a randomized, controlled design—the gold standard in medical research—found that, compared to the uninsured, people with Medicaid had better access to outpatient and hospital care and prescription drugs.[8] They were also more likely to have a regular source of care.[9] For people with serious health care needs, having access to care and having a regular source of care can improve health and lower rates of costly, and sometimes deadly, complications, or it can keep a disease from progressing.

- Uninsured adults with cancer have poorer outcomes and die sooner than those with insurance.[10]
- Adults with diabetes who have health insurance and a regular source of care are much more likely to receive all the recommended preventive services than people with diabetes who do not have insurance or a regular source of care.[11] And higher

use of recommended screenings among seniors with diabetes is associated with reduced rates of hospitalization.[12]

- Children with asthma who have access to a primary care doctor are more likely to get asthma-controlling medications and to have fewer asthma-associated emergency room visits.[13]
- Insured people with hypertension who have a regular source of care are more likely to be aware of their condition, to receive treatment, and to have their hypertension controlled than those without insurance.[14] Treating and controlling hypertension reduces the risk of stroke, coronary heart disease, congestive heart failure, and premature death.[15]

Medicaid Makes It Possible for Low-Income Seniors and People with Disabilities to Get the Care They Need through Medicare

Most Minnesota seniors with Medicaid will also have Medicare. Likewise, some of the adults in Medicaid who are under the age of 65 and who have a disability may also qualify for Medicare. People with both Medicare and Medicaid, who are referred to as "dual eligibles," generally have higher health care needs and lower incomes than others who are covered by either program.[16]

The standard premium for Medicare's outpatient insurance, Medicare Part B, is $1,385 a year.[17] Patients may also have to pay 20 percent of the cost of doctor visits.[18] And the deductible for a hospital stay is $1,132.[19] Most people with Medicare purchase Medicare supplemental policies to help cover these out-of-pocket costs. It would be nearly impossible for a very low-income person with a serious medical condition to be able to afford all the premiums, cost-sharing, and deductibles that are associated with Medicare without the help of Medicaid. Such a person would also be very unlikely to be able to afford a Medicare supplemental policy. By helping cover cost-sharing and premiums, Medicaid makes it possible for residents to get the care they need through Medicare.

Cutting Medicaid Would Put Minnesotans with Serious Health Care Needs at Risk

Cuts to the Medicaid program would put Minnesotans with serious health care needs at risk—at risk of not being able to get the care they need when they need it, at risk of incurring higher medical costs when they do get care, at risk of getting sicker, and even at risk of dying prematurely.

It's easy to understand how reducing Medicaid eligibility would mean that many Minnesotans with serious illnesses like cancer would lose coverage and not be able to afford medical care. But even reducing benefits or passing more out-of-pocket costs on to patients can affect their ability to get the care they need.

When states increase Medicaid cost-sharing or reduce benefits, people who depend on the program report having difficulties getting the care they need. When one state increased its Medicaid cost-sharing by adding sliding-scale premiums and other costs, 31 percent of the adults who were enrolled in Medicaid lost their coverage entirely, and another 15 percent reported disruptions in their care. Those who lost coverage had greater unmet health care needs, including an inability to get needed medications.[20] For those with serious medical conditions, such as those profiled in this report, unmet medical needs can carry a high price—both physically and financially.

Cutting Medicaid Would Shift Costs to the Health System and to Minnesota Consumers

While cutting Medicaid might offer some short-term savings, there is a clear human cost in terms of unmet medical needs and increased sickness, as well as higher risk of premature death, for those who lose coverage. There is also a cost to other Minnesotans, who often end up paying higher premiums to cover a share of the cost of care that is provided to the uninsured.

Cutting Medicaid does not make anyone's health care needs go away: The people with heart disease and diabetes who lose Medicaid coverage will still need to fill the same prescriptions, those with cancer will still need treatment, and those with chronic lung disease will still need medication so that they can breathe more easily. Cutting Medicaid just shifts the cost of care to the people who had depended on the program and who suddenly find themselves uninsured. Without insurance, they will not be able to afford much of the care they need. Critical cancer treatments may be delayed. Manageable health problems may deteriorate and ultimately lead to hospitalizations and emergency room visits that could have been prevented.[21] And treatment costs will be higher when those who've lost coverage finally do get care. Often, a portion of those costs goes unpaid.

Even at public hospitals and other safety net providers, the uninsured may receive substantial bills for their medical care.[22] For the low-income uninsured, paying those bills can be impossible. To make up for the cost of this uncompensated care, hospitals and doctors charge insurers more for services that are provided to patients with health coverage. Insurers then pass those costs on by charging higher premiums to consumers and to businesses that purchase health insurance. It is estimated that, in 2008, family coverage cost $1,017 more because of higher premium charges that resulted from insurers passing along the costs of uncompensated care.[23]

Cutting Medicaid Would Hurt Minnesota's Economy in Other Ways

Higher premiums for Minnesota families are not the only cost of cutting Medicaid.

- **Cutting Children's Opportunities Short**

  Children who lose Medicaid coverage pay the price not only in terms of going

without needed health care, but also in terms of facing limitations on their future opportunities. Children with health insurance are generally healthier throughout their childhood and into their teens.[24] Better health correlates with better school performance and greater success later in life.[25] For children without health insurance, health problems may interfere with school performance, which, in turn, may result in fewer employment opportunities later in life.

For children with serious health conditions like asthma, the consequences of losing insurance can be quite stark. Asthma is a leading cause of school absences. In 2008 alone, children with asthma missed 10.5 million school days.[26] With regular medical care and medication, persistent asthma can be managed.[27] However, when children lose Medicaid coverage, they often lose their regular source of medical care. That can lead to more frequent asthma-related school absences and poorer school performance, which can ultimately affect overall educational attainment and employment opportunities.[28]

Asthma is just one example of how losing health coverage can interfere with education and limit employment opportunities. The same holds true for a host of other childhood diseases. Cutting Medicaid coverage can reduce children's opportunities. If it cuts Medicaid, Minnesota may save money today, but it will come at a substantial cost to its children and its future.

- **Lost Worker Productivity**

  Many people with Medicaid work.[29] For them, having access to medical care leads to better health, which can mean fewer days lost from work, better job performance, and higher productivity.

  For the diseases profiled in this report, there are many ways that access to health care can improve individuals' health and work productivity. Diabetes management is just one example. Appropriate management of diabetes can reduce the incidence of vascular disease (also called hardening of the arteries), a complication that is associated with an increase in missed work days and lost productivity.[30] However, a person needs access to medical care to manage diabetes optimally.[31] For thousands of Minnesotans with diabetes, Medicaid makes that possible. Having Medicaid can mean that workers with diabetes are healthier and have fewer complications. For working Minnesotans with Medicaid, that can mean fewer missed work days and higher productivity. That is good for Minnesota businesses and Minnesota's economy.

- **Pushing People into Debt and Hurting Communities**

  When people lose Medicaid coverage, they are more likely to incur medical debt.[32] The burden of medical debt is particularly hard on those with serious health care needs.

  Medical debt is a leading cause of bankruptcies and home foreclosures.[33] But even if they don't go as far as declaring bankruptcy, people with medical debt must often

make gut-wrenching decisions about the basic necessities: They may be forced to delay making rent or utility payments, may accumulate credit card debt, or may be unable to pay for food.[34] Low-income people who lose Medicaid, especially those with serious health care needs, can quickly reach the point where they have to make these tough choices—choices that have an effect on communities as well. When more individuals in a community miss paying bills, accumulate debt, and curtail spending, it is a drag on local economies.

Cutting Medicaid would hurt Minnesota communities in other ways, too. The federal Medicaid matching funds that flow into the state represent new money that generates economic activity and creates jobs. Cuts at either the state or federal level would reduce the federal dollars that flow into the state, and that would place jobs at risk. For example, a cut in federal Medicaid funding of as small as 5 percent could cost Minnesota an estimated 5,070 jobs in 2011.[35]

Conclusion

Thousands of Minnesotans with serious health care needs rely on Medicaid—it makes it possible for them to get the health care they need. For Minnesota's children, that can mean better performance in school and greater success later in life. For workers, that can mean better job performance. For everyone with Medicaid, it can mean a chance at leading a longer, healthier life.

Cuts to Medicaid would take that away from many who rely on the program. Cuts would also affect Minnesotans who don't directly rely on the program. For example, an increase in the amount of uncompensated care (a likely consequence of a rise in the number of uninsured) would translate into higher premiums for those with health insurance. Lost worker productivity, worse performance in school for sick children who can't get the care they need, and increased medical debt would all be byproducts of cutting Medicaid—byproducts that would be a drag on Minnesota's economy. Medicaid is vital to all the Minnesotans it covers, but its benefits are particularly clear to people with conditions like cancer, heart disease, diabetes, and chronic lung disease who need ongoing medical care. Unfortunately, because of current limits on Medicaid eligibility, thousands of low-income Minnesotans with serious health care needs remain uninsured. The Affordable Care Act will expand Medicaid eligibility in 2014, and that will give many of these individuals an opportunity to get Medicaid coverage and to be able to afford the care they need.

Keeping Medicaid intact and fully implementing the Affordable Care Act are clearly important to low-income Minnesotans with serious health care needs—but they're important to the rest of Minnesota as well.

The Affordable Care Act: Better Access to Health Care for Minnesotans with Serious Health Care Needs

All of the provisions of the Affordable Care Act will be in place in 2014. For low-income people with serious health care needs, that will mean greater access to health coverage, including Medicaid. Today, not everyone who is low-income is eligible for Medicaid. Eligibility levels for adults can often be quite low, which excludes many people with very low incomes from the program. In fact, in most states, a childless adult can literally be penniless and not qualify for Medicaid.

Beginning in 2014, all state Medicaid programs will cover individuals with incomes at or below 133 percent of the federal poverty level (about $25,000 for a family of three in 2011).[36] For the first three years, the federal government will pay for all of the associated costs for those who are newly eligible for Medicaid. In the following years, the percentage that the federal government covers will gradually decline until, by 2019, the federal government will pay 90 percent of these costs and states will pay 10 percent.

For many Minnesotans with serious health care needs, this expanded coverage will mean better access to the health care they need. There are thousands of uninsured Minnesotans with incomes at or below 133 percent of poverty who've been diagnosed with serious medical conditions and who are not currently eligible for the state's Medicaid program but who would be eligible in 2014.[37] These include the following:

- 1,100 who've been diagnosed with cancer,
- 4,500 who've been diagnosed with diabetes,
- 11,800 who've been diagnosed with chronic lung disease, and
- 13,600 who've been diagnosed with heart disease.

With the Affordable Care Act in place, thousands of Minnesotans with serious health care needs who do not currently have health insurance will have the opportunity to get coverage that will make it easier for them to see a doctor, get the medicines and treatment they need, and lead more productive lives.

Endnotes

[1] For this analysis, The Lewin Group took national Medical Expenditure Panel Survey (MEPS) data to the state level by running a logistic regression to U.S. Census Bureau Current Population Survey (CPS) data. Because the CPS provides a conservative estimate of Medicaid enrollment compared to other estimates, such as those using Centers for Medicare and Medicaid Services Medicaid Statistical Information System (MSIS) data, these disease-specific estimates for Medicaid are conservative.

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[3] Paula Lantz et al., op. cit.; Ann Case and Christina Paxson, op. cit.; G. W. Evans and P. Kim, "Childhood Poverty and Health: Cumulative Risk Exposure and Stress Dysregulation," *Psychological Science* 18, no. 11 (November 2007): 953-7.

[4] Kaiser Commission on Medicaid and the Uninsured, *Medicaid: A Primer 2010* (Washington: Kaiser Family Foundation, June 2010).

[5] Ibid.

[6] Institute of Medicine, *Care without Coverage: Too Little, Too Late* (Washington: Institute of Medicine, 2002).

[7] Hospital charges are from a customized report Families USA created using online data available from the Agency for Healthcare Research and Quality (AHRQ), Health Care Cost and Utilization Project, available online at http://hcupnet.ahrq.gov/. Using AHRQ's online database, Families USA generated a report on average hospital charges for all discharges in 2009 with a primary diagnosis of acute myocardial infarction (heart attack). For the purposes of creating that report, we defined acute myocardial infarction as including ICD-9-CM diagnosis codes 410.0-410.9.

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[15] Thomas J. Wang et al., "Contemporary Reviews in Cardiovascular Medicine: Epidemiology of Uncontrolled Hypertension in the United States," *Circulation* 112, no. 11 (2005): 1,651-1,662.

[16] Kaiser Commission on Medicaid and the Uninsured, *Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries* (Washington: Kaiser Family Foundation, May 2011), available online at http://www.kff.org/medicaid/upload/4091-08.pdf.

[17] Centers for Medicare and Medicaid Services, *Medicare and You, 2011* (Washington: Department of Health and Human Services, 2011).

[18] Ibid. The 20 percent cost-sharing applies to individuals in the original Medicare program. The amount is based on Medicare-approved charges and applies to physicians who accept Medicare. Patients in Medicare Advantage plans may have different cost-sharing.

[19] Centers for Medicare and Medicaid Services, op. cit.

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[26] Lara J. Akinbami, Jeanne E. Moorman, and Xiang Liu, "Asthma Prevalence, Health Care Use, and Mortality: United States, 2005-2009," *National Health Statistics Reports* no. 32 (January 12, 2011): 1-15; See also Sheniz Moonie et al., "The Relationship between School Absence, Academic Performance, and Asthma Status," *Journal of School Health* 78, no. 3 (March 2008): 140-148.

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[28] Anne Case and Christina Paxson, op. cit.

[29] Kaiser Commission on Medicaid and the Uninsured, *Medicaid: A Premier, 2010*, op. cit.

[30] Managing blood glucose can reduce the incidence of macrovacsular disease, a type of vascular disease that affects the large blood vessels. Coronary artery disease is an example of macrovascular disease. C. Stettler et al., "Glycemic Control and Macrovacsular Disease in Types 1 and 2 Diabetes Mellitus: Meta-Analysis of Randomized Trials," *American Heart Journal* 152, no. 1 (July 2006): 27-38; Alex Z. Fu et al., "Health Care and Productivity Costs Associated with Diabetic Patients with Macrovascular Comorbid Conditions," *Diabetes Care* 32, no. 12 (December 2009): 2,187-2,192, available online at http://care.diabetesjournals.org/content/32/12/2187.full. This study focuses on the productivity losses and economic costs associated with macrovascular disease.

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[33] David Himmelstein et al., "Medical Bankruptcy in the United States, 2007: Results of a National Study," *The American Journal of Medicine* 122, no. 8 (June 2009): 741-746; Christopher Tarver et al., "Get Sick, Get Out: The Medical Causes of Home Mortgage Foreclosures," *Health Matrix* 18, no.1 (Winter 2008): 65-105.

[34] Sara Collins et al., *Losing Ground: How the Loss of Adequate Health Insurance Is Burdening Working Families* (New York: The Commonwealth Fund, August 2008).

[35] Kathleen Stoll and Kim Bailey, *Jobs at Risk: Federal Medicaid Cuts Would Harm State Economies* (Washington: Families USA, 2011).

[36] Under the Affordable Care Act, individuals with a modified adjusted gross income that is at or below 133 percent of poverty will be eligible for Medicaid. Adjusted gross income is based on the Internal Revenue Code definition, modified to disregard 5 percent of income, which essentially increases income eligibility to 138 percent of poverty.

[37] These estimates are based on modified adjusted gross income as defined in the Affordable Care Act.

Acknowledgments

This report was written by:

Kim Bailey
Senior Health Policy Analyst

Dee Mahan
Director, Medicaid Advocacy

Kathleen Stoll
Deputy Executive Director,
Director of Health Policy

with

Christine Sebastian
Health Policy Analyst

The following Families USA staff assisted in the preparation of this report:

Ron Pollack, Executive Director

Peggy Denker, Director of Publications

Ingrid VanTuinen, Deputy Director, Publications

Tara Bostock, Editor

Rachel Strohman, Editorial Assistant

Nancy Magill, Senior Graphic Designer

Special thanks to Randy Haught,
Senior Director, The Lewin Group

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