

# ACCESSING HEALTH INSURANCE IN MINNESOTA

*Report of Focus Group Discussions with American Indian,  
Hmong and Somali Community Members*

**December 2001**



*Completed by  
The Center for Cross-Cultural Health  
for the  
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*The following lists of individuals contributed their time, talent, and energy as individuals or agency representatives. Moderators and community coordinators were involved in planning and recruiting for the focus groups, collecting information in the focus groups, and summarizing themes. Their efforts are appreciated greatly. Most importantly, gratitude is extended to the 106 people who participated in the focus groups. Their willingness to share their personal experiences and beliefs with us contributes to our collective ability to improve health insurance access for all residents of Minnesota.*

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# EXECUTIVE SUMMARY

This report summarizes 14 focus groups conducted in spring 2001 with a total of 106 participants from American Indian, Hmong, and Somali communities of Minnesota. The purpose was to gather information on their experiences with health insurance, specifically public health insurance programs offered by the state. This is the first time that many of these individuals and communities have ever been asked to share their experiences with health insurance, and they had much to offer in the discussions.

Focus group participants said health insurance is very beneficial, regardless of the type of insurance or who provides it. However, they also shared many barriers to having health insurance. Listed below are some recurring themes from the focus groups.

***Not knowing what options are available, how to access them, or for some, not understanding the need for insurance is a barrier.***

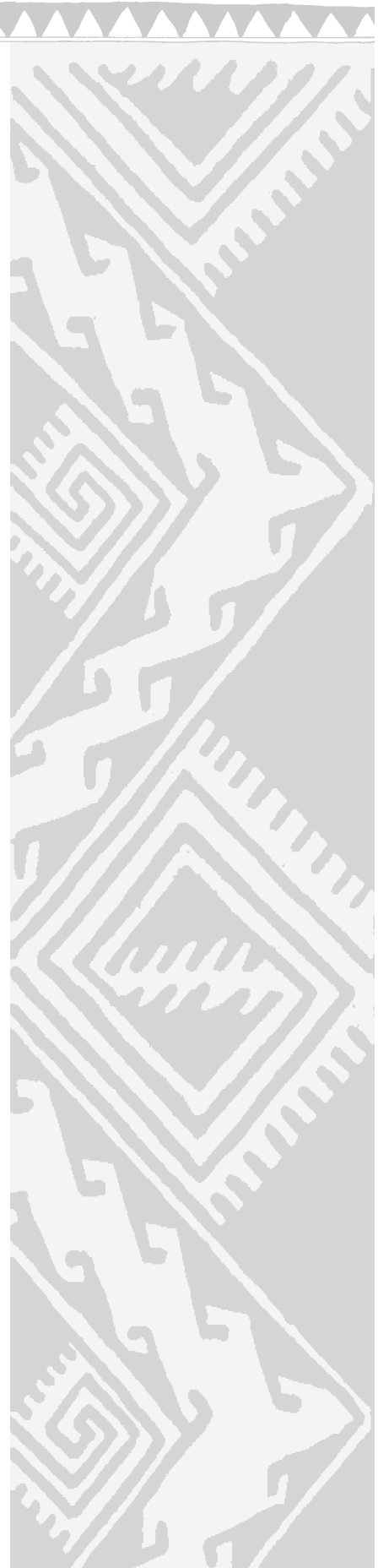
- Some people are unfamiliar with public programs, especially MinnesotaCare.
- Public health insurance programs can be difficult to understand and navigate, such as multiple insurance cards or limits on clinic choices.
- New immigrant groups may be unfamiliar with health insurance systems.
- Some American Indians do not see a need for health insurance because they believe that Indian Health Service can provide for all of their needs.

***Financial constraints keep people from having health insurance.***

- Some self-employed persons and small businesses can't afford coverage.
- Many people, particularly those with less formal education or experience are employed at jobs that do not offer any insurance.
- Some employers hire people, such as new immigrants, on contract or through temporary agencies, to avoid offering any benefits.
- Young people not in school may lack both parental and employer coverage.
- Expenses for premiums, co-pays, deductibles and prescriptions are too high.
- Many people earn too much for public programs but cannot afford private insurance.
- Purchasing insurance is unfeasible because of financial trade-offs, or because the cost of premiums or deductibles outweigh any benefit.

***Beliefs, feelings and past experience deter people from accessing insurance.***

- Some people, particularly the young, do not think they need health insurance.
- Some people are focused on immediate priorities, such as housing or jobs, rather than insurance.
- There is distrust of the government and public programs in general.
- The stigma of using public programs is embarrassing for some people.
- Negative past experiences cause some people to avoid public health insurance, such as encounters with condescending intake workers.
- Some people believe that public insurance is inferior to private in terms of clinic and product choice, quality of care, and treatment options.
- Some community members prefer to use traditional healers.





***Rules and procedures make it difficult for some people to get and keep insurance.***

- Extensive paperwork and re-certification processes are cumbersome.
- Many people feel the information required on forms is invasive and unnecessary.
- Long waiting time for approval causes a period of uninsurance.
- Non-refugee immigrants do not automatically qualify for Medical Assistance and are not covered while their cases are pending.

Aside from these barriers, participants also offered numerous suggestions to improve public health insurance programs and insurance systems of all types. They spoke of many similar issues but also offered specific insights into needs for their communities.

***Bring information to communities and help people understand insurance.***

- Educate young people about insurance in high schools and at teen clinics.
- Provide a one-to-one orientation to tell people how their insurance works.
- Offer more in-home education, particularly for elderly and non-English speakers.
- Increase outreach about insurance options, particularly to reservation residents.
- Distribute information at community events and frequented locations.

***Make it easier for people in different communities to access services.***

- Hire bilingual and bicultural staff to act as advocates and intake workers.
- Provide a multi-lingual toll-free line for information and referrals as needed.
- Hire medical social workers who can explain things in lay terms.
- Offer tours and have liaisons at hospitals and clinics.

***Use a variety of techniques to inform, educate, and assist people.***

- Use many media including trained community liaisons, community-specific television, radio programs, and newspapers, forums, and peer education.
- Translate materials into multiple languages and use multi-lingual videos.
- Provide information through employers about programs that employees may qualify for while working, or in case they should lose their job.

***Improve the enrollment process.***

- Create a simple form for pre-approving eligibility.
- Revise the forms to include fewer and less intrusive and repetitive questions.
- Reconsider the asset requirements and use family size and income instead.
- Require re-certification much less frequently.
- Shorten the processing time for applicants and cover emergencies during that time.
- Allow enrollees to charge premiums to credit cards if necessary.

***Expand who is covered.***

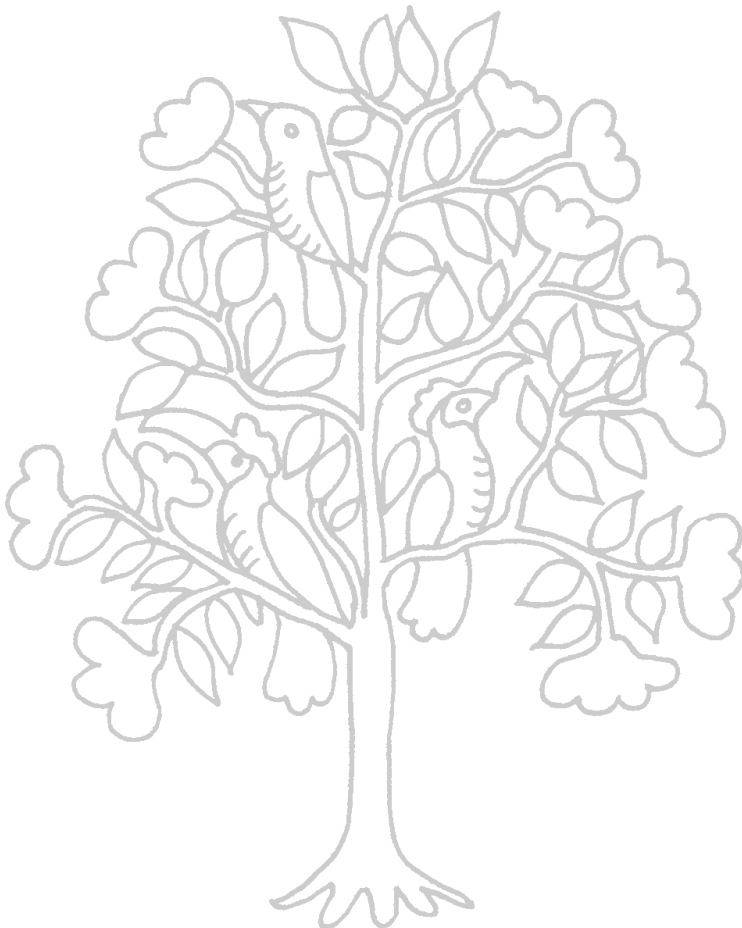
- Provide universal coverage.
- Set up programs to assist the self-employed or small employers.
- Work with employers to provide more insurance benefits to more people, including new immigrants often employed through temporary agencies.
- Offer coverage that can be activated quickly for those who are between jobs.
- For American Indians, honor the existing treaties and laws and provide adequate funding for Indian Health Service (IHS) facilities.

***Expand what is covered.***

- Provide coverage for items needed by the elderly, such as incontinence products, hearing aids, and eyewear with frequent prescription changes.
- Offer more coverage for traditional healers and holistic health services.
- Make dental services more available to those on public health insurance.
- Increase mental health coverage, particularly for refugees.

***Improve customer service provided by state, county, and clinic employees.***

- Provide sensitivity training and education to state, county, and clinic workers.
- Provide medical social workers, advocates, interpreters, and transportation.





# PROJECT DESCRIPTION AND PARTICIPANT DEMOGRAPHICS

## *Agency and Project Background*

In autumn 2000, the Health Economics Program of the Minnesota Department of Health began a comprehensive study of health insurance in Minnesota, specifically the barriers to achieving coverage for all residents in the state. As part of this larger study, one vital component was identified as focus group research with specific communities in the state who were underrepresented in other data collection methods, and whose experiences might explain further the data generated from the general population.

In their initial work, the Minnesota Department of Health determined that four communities had particularly large disparities in health insurance coverage from the overall state population, including Hmong, Somali, American Indian, and Hispanic/Latino residents. The Center for Cross-Cultural Health (CCCH) was contracted to carry out focus groups within three of these communities, the American Indian, Hmong, and Somali communities.

CCCH, a non-profit, 501(C) 3 organization based in Minneapolis, was formed in 1997 in response to demographic changes in the state and the need to strengthen healthcare institutions' services to culturally diverse populations. The Center now provides services to all types of health and human service providers and educators, and conducts research on culture and health. Other key project areas include training and organizational consulting in cultural competency, information and referral for providers and the general public, and educational programming. For more information, please see our website at [www.crosshealth.com](http://www.crosshealth.com).

## *Focus Group Research*

Focus group research was identified as an appropriate, systematic method for obtaining insight and understanding of the personal experiences of individuals from the selected communities. The data that is gathered in focus groups is qualitative in nature; it reflects subjective experiences but in an objective setting. For example, the questions are standardized and written as neutrally as possible and the moderator is trained to be a neutral facilitator of the process so as not to lead or mislead the responses of the groups.

Furthermore, the same procedures and analysis are used for each group, so that the experience differs as little as possible and results can be compared across groups. Methods for standardizing procedures include replication of the environmental setting, incentives for participants, note-taking and tape-recording strategies, report writing format, and team analysis for

each group. The questions were developed with community-wide input, including suggestions from the moderators, agencies involved in the project (please see acknowledgements), and individuals who were similar to potential participants (see Appendix A for final questions).

Another important feature of focus group research is that it provides in-depth information from participants on a complex topic by observational interaction among participants without controlling their responses. This type of response provides valuable information about decision-making, life circumstances, and beliefs that influence people. Participants are not randomly selected for focus groups because the goal is to find out how specific groups of people that share something in common (in this case, a cultural or ethnic background) react to the topic at hand. However, during recruitment, a wide variety of individuals is identified based upon age, gender, geographic location, and level of familiarity with the topic so that the groups represent a cross-section of the communities.

Although focus group data cannot necessarily be generalized to the larger community, the information may be transferable to other environments or situations. The specific information from these focus groups may be used in several capacities, including helping to identify gaps in coverage, barriers to accessing health insurance, and policies that could address the problem of the uninsured or underinsured. It is also useful to inform future research, program design and implementation, education, and outreach.

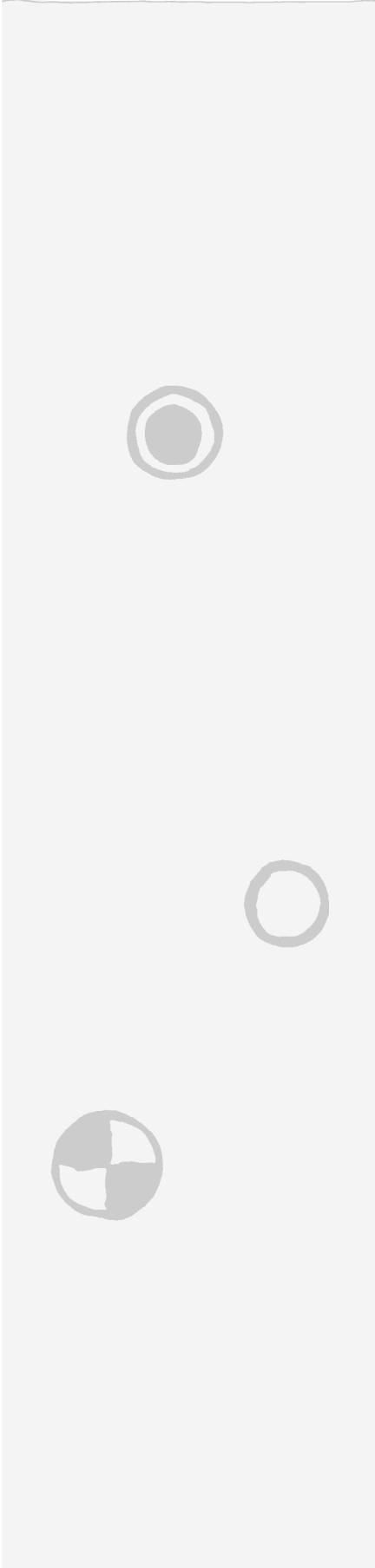

### ***Project Description and Demographics***

From February through April of 2001, community-specific agencies and individuals recruited focus group participants through general flyers, personal communication, and via client relationships. Participants were asked to attend one of fourteen focus groups. Four Hmong groups were conducted in the Twin Cities; four Somali groups were held, including one in Rochester and three in the Twin Cities, and six American Indian groups met, including two in the Twin Cities and four on reservations in Greater Minnesota (Fond du Lac, White Earth, Leech Lake, and Red Lake).

Moderators from each community were trained by two leading focus group researchers and trainers, Dr. Richard Krueger of the University of Minnesota, and Dr. Mary Anne Casey, an independent consultant. The training took place on two evenings, totaling 7 hours. Moderators were chosen from each community to lead the groups in the native or most commonly used language of the community in order to reduce language barriers and increase trust, familiarity, and sensitivity.

Focus groups were conducted between late April and late June of 2001. A total of 106 individuals participated in the groups, with an average of 8 people per group, including 33 Hmong, 33 Somali, and 40 American Indian participants. The groups were composed of adults of both genders (with the exception of one all female group and one all male group in the





Somali community). Participants were a mix of those currently insured and those currently uninsured. They represented a wide variation in knowledge and experience with different types of health insurance.

A brief anonymous survey of participants was conducted at the beginning of each focus group (see Appendix B for the English version). From this survey it was determined that the age range was very broad (18-89 years) and the average age was 42. Female participants outnumbered male participants (73 vs. 33). Those who currently have insurance also outnumbered those who do not (86 vs. 20), although focus group discussions revealed that many people have had times when they were uninsured and that coverage can be very transitory. Participants indicated that they first heard about insurance from a variety of sources, most notably their employer, a social worker, or through a welfare agency or office. Those with current insurance coverage said they had obtained it through their employer (52) or the State of Minnesota (31) (there were three non-respondents).

Of those currently insured, the average length of insurance coverage was just under four years. Nearly half of those currently covered said their family is also eligible for coverage and that their current insurance meets most of their needs. Eleven of the twenty people currently uninsured previously had insurance of some type, ranging from one month to thirty-three years ago. Reasons for no insurance include job loss, reliance on Indian Health Service, earning too much money to qualify for public programs, and loss of parental coverage. The uninsured said that they avoid doctor or hospital visits, or if necessary, take payroll deductions or rely on reservation clinics.



# COMMUNITY PROFILES

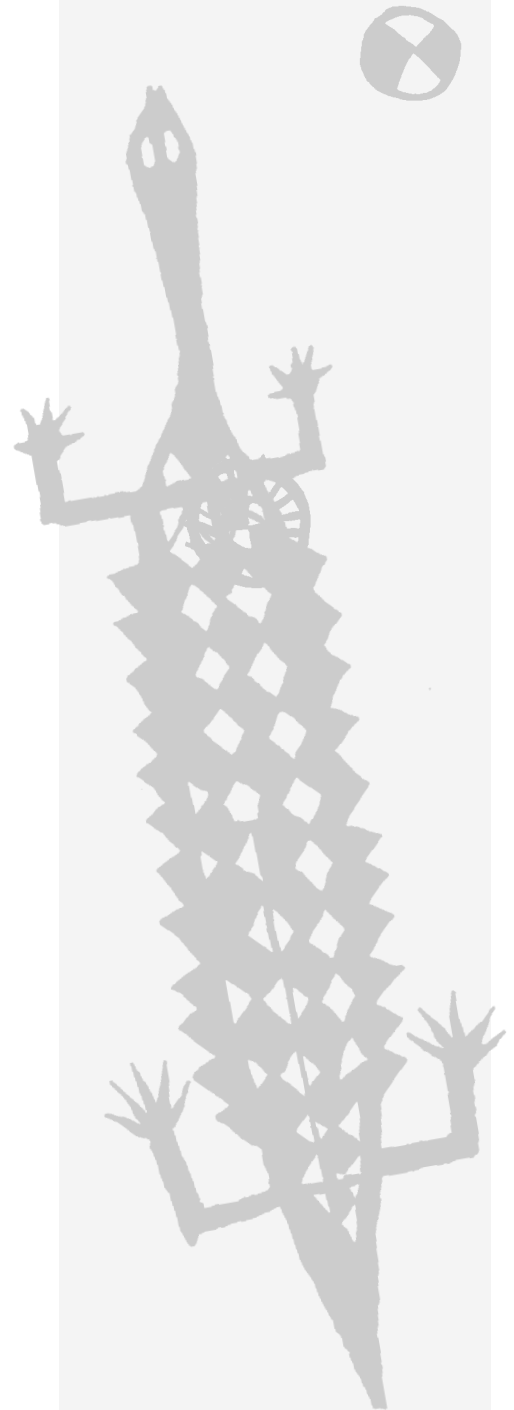
## *American Indian*

According to 2000 Census data, approximately 45,000 people in Minnesota identify themselves as American Indian. Of these, over 18,000 currently live on a reservation in Minnesota, with total reservation population being over 35,000 for the state. Fond du Lac has the lowest percentage (40%) of its residents who are American Indian while Red Lake has the highest percentage of its residents that are American Indian (98%).

Minnesota has seven Anishinaabe (Chippewa, Ojibwe) and four Dakota (Sioux) reservations. The focus groups for this project were all conducted on Anishinaabe reservations because these reservations are more populated than Dakota reservations in Minnesota. The four reservations involved in this project were Fond du Lac near Duluth, with approximately 3,500 enrolled members; Red Lake in Northern Minnesota, which has 8,000 members (about 5,000 on reservation); White Earth in Northwestern Minnesota with 21,000 members; and Leech Lake in North Central with 6,200 members. Two other focus groups were conducted in Minneapolis with the assistance of the Indian Health Board, and participants represented a variety of tribes. Approximately 12,700 American Indians reside in Minneapolis.

The provision of health services to federally recognized Indians grew out of a special relationship between the federal government and Indian tribes. This government-to-government relationship is based upon Article I, Section 8, of the United States Constitution and has been given form and substance by numerous treaties, laws, Supreme Court decisions and executive orders. Indian Health Service, which operates as an agency of the U.S. Department of Health and Human Services (DHHS), is responsible for and administers health services in three ways: through IHS facilities, through tribally operated facilities and by contracting out for health services.

All Indian Health Service facilities in Minnesota fall under the Bemidji Area Indian Health Service, which covers Minnesota, Wisconsin, Michigan and Indiana and is one of 13 regional offices under the umbrella of the Federal Indian Health Service. Each of the reservations in this project operates a clinic or hospital on site (Fond du Lac also operates a facility in Duluth). American Indians are eligible for services at these facilities and public and private insurance is also accepted. Each reservation also has tribal health insurance available for those who are employed by the tribe. Access to Indian Health Service or tribal facilities is not guaranteed for individuals, however, and funding for these sites may be inadequate to serve the needs of the communities. American Indians living off-reservation, such as in an urban area like the Twin Cities, still have access to Indian Health Service facilities nationwide. However, the Indian Health Board in Minneapolis is the only facility in the Twin Cities area and it does not offer comprehensive services, such as urgent care. Although Indian Health Board does not turn away any patient, the cost is not reimbursable by IHS. Thus, American





Indians living off-reservation may have fewer opportunities for services by IHS facilities, and even greater need for additional health insurance coverage.

### ***Hmong***

Census 2000 data for Minnesota indicates 41,800 Hmong residents, the largest single Asian group in the state. Local community agencies believe that these numbers may still underestimate the population due to fear or resistance to filling out the Census forms. Although Minnesota and California have historically been home to the two largest Hmong populations in the United States, recent Census data shows Minnesota and Wisconsin now have the largest populations.

The Hmong began to arrive in Minnesota as primary refugees in 1979 following the Vietnam War. The number of Hmong refugees in Minnesota peaked in the early 1980s as many came from refugee camps in countries such as Thailand. They continue to arrive in small numbers even today, with a cumulative total of over 16,000 coming as primary refugees to the state and thousands more through secondary migration.

In Laos, Hmong people were primarily subsistence farmers and used many herbal and spiritual health remedies. Formal health facilities and insurance did not exist. Hmong people have said they came to Minnesota for family reunification and the public programs and services, job opportunities, and lifestyle that Minnesota offers. Although it has been many years since the first Hmong arrived in Minnesota, many continue to face challenges in becoming accustomed to the language and the health systems here. According to a 2000 report by the Wilder Research Center, 77% of Hmong participants they surveyed in the Twin Cities said they either speak no English or just a little bit, and 43% said language barriers are one of their greatest stressors in Minnesota.

### ***Somali***

Somali people began arriving in the United States in the early 1990s as refugees due to war in their homeland. Most Somali people now living in Minnesota spent at least some time, if not years, in refugee camps in third countries or in other states prior to coming to Minnesota. Like the Hmong, they were exposed to health hazards and challenges at home and in refugee camps, including violence from war, infectious diseases, and inadequate nutrition. Stressors are numerous with the change in environment and climate and the loss of home, family, language, and some elements of their culture.

Somalis are the fastest growing refugee group in Minnesota. Community leaders estimate as many as 60,000 Somalis now reside in the state. According to the Minnesota Department of Health Refugee Health Program, 2151 Somalis arrived as primary refugees in 2000, the largest single group in that year (54% of the total). Like the Hmong, family reunification and quality of life in Minnesota are major factors for locating in the state.

The Somali community is young, with approximately 85% between the ages of 20 and 40, and many families have been separated due to refugee camp placement, lack of sufficient housing for larger families, or job opportunities in different areas. Unlike the Hmong, 39% of the Somali people surveyed by the Wilder Research Center said they speak and understand English very well, and only 11% said they speak no English. They indicated their greatest stressor as separation from family and friends, due to the many reasons listed above. Because there was no formal health insurance system in Somalia, familiarity with the system is lacking. As refugees, Somalis are automatically signed up for Medical Assistance upon arrival and are guaranteed that insurance for eight months.

### ***Selected Resources on Communities***

American Indian Policy Center. *To Build A Bridge: Working with American Indian Communities*, 2000. [www.airpi.org](http://www.airpi.org) (provides an overview of treaties, acts, and court decisions)

Indian Health Service [www.ih.gov](http://www.ih.gov)

Kaiser Family Foundation [www.kff.org](http://www.kff.org)

Minnesota Department of Health, Refugee Health  
[www.health.state.mn.us/refugee](http://www.health.state.mn.us/refugee)

Minnesota Department of Human Services. *Tribal Resource Book*.  
October 1998. [www.dhs.state.mn.us](http://www.dhs.state.mn.us)

Office of Minority Health, U.S. DHHS [www.omhrc.org](http://www.omhrc.org)

State of Minnesota Planning/State Demographic Center  
[www.mnplan.state.mn.us/](http://www.mnplan.state.mn.us/)

Wilder Research Center. *Speaking for Themselves: A survey of Hispanic, Hmong, Russian, and Somali immigrants in Minneapolis-Saint Paul*. November 2000.  
[www.wilder.org](http://www.wilder.org)





*For the most part, you can choose to be healthy by being good to yourself.*  
—Hmong participant

*Back home, we never concerned ourselves with our health conditions, but it became important that we take great care of our health in the new environment. The air here is different and the food is not quite as natural. Here we should be careful with what we eat, the environment we work in and where we sleep. We have many problems and pressure that we didn't have before.*

—Somali participant

## FOCUS GROUP FINDINGS

### *What does it mean to be healthy?*

Participants were first asked what it means to be healthy, and a variety of responses surfaced with many repeated themes. Common responses included:

- Balancing physical, spiritual, mental and emotional health
- Having a good diet including eating a variety of fresh (not processed) foods, staying hydrated, avoiding salt, sugar and fried foods, and practicing vegetarianism
- Exercising and avoid being overweight
- Maintaining healthy relationships
- Getting regular check-ups
- Staying chemical-free and tobacco-free
- Being happy
- Living in a clean environment, including home
- Having good genetics
- Creating a sense of balance in life
- Getting plenty of rest
- Being disease-free
- Being around healthy activity
- Feeling good about myself
- Taking medications as prescribed
- Trying to live as our ancestors taught us
- Practicing good hygiene

Several participants said access to affordable health insurance is essential to being and staying healthy. During some reservation groups, participants noted that one reason they live where they do is the availability of Indian Health Service and the security that provides for them. Immigrants also stated that the transition to a new country is damaging to one's health and requires special efforts to remain healthy.



# FOCUS GROUP FINDINGS

## *What are the benefits of health insurance?*

Participants responded very positively to the idea of health insurance and agreed that it provides many benefits. The vast majority of participants considered health insurance a necessity, a part of a healthy life, and extremely beneficial. Some key benefits included better access to care, financial savings, and peace of mind.

### **Better Access to Care**

- Can get preventive care, such as annual physicals and screenings
- A person doesn't have to wait until there is an emergency to get care
- The quality of care received will improve with health insurance
- Will be more likely to receive health education information from clinics



### **Financial Savings**

- Fewer out-of-pocket costs for medical care
- Access to health services that you cannot afford (e.g. prescriptions)
- Protects credit history by not allowing bills to accumulate
- Allows coverage off-reservation, for example, in emergencies or when referred to other clinics or hospitals.

### **Peace of Mind**

- Less worry about the future
- More confidence and security in one's health
- The freedom to see a physician
- Allowing for choices when something goes wrong
- Protects health by relieving stress associated with high bills



*"The benefit is...being able to take my children to a physician. I didn't have insurance and had to decide if something was really an emergency or if I could fix it at home."*

*-American Indian participant*

*"Health insurance helps you when there is no one who can help you financially. You cannot work if you aren't healthy. We are low income and though it does not cover everything, health insurance helps. You know the real worth of insurance when you get sick. Good quality insurance is worth everything."*

*-Hmong participant*

*"You don't have to worry so much about what will happen to you if you were to get sick. You know that you'll be taken care of."*

*-Hmong participant*

*“When we came here we were not given health education or orientation about health programs. I don’t believe someone chooses not to have insurance, but I think this is just ignorance.”*

*-Somali participant*

*“I never even heard of MinnesotaCare until last summer. I was in the hospital and they asked me why I didn’t have it. I said “what’s MNCare? I still don’t know how to sign up for it.”*

*-American Indian participant*

*“I never worried about health insurance. I relied on Indian Health Service (IHS) until I worked outside the reservation and realized its value.”*

*-American Indian participant*

*“I don’t understand why I have two cards! I have MNCare, but I also got a U-Care card and a green card that says MN HealthCare Programs Identification. What’s the difference? Am I on two policies?”*

*-Hmong participant*



## FOCUS GROUP FINDINGS

### *What keeps people from having health insurance?*

There are many reasons that people may not have health insurance, but some major barriers surfaced in discussions with focus group participants. These include lack of awareness, including options available for health insurance, the importance of it, and how to access it; financial constraints that prove prohibitive to obtaining health insurance; beliefs, feelings, and past experiences which may deter people from accessing health insurance; and rules and procedures associated with health insurance programs that may make it difficult to get or to keep insurance coverage.

#### *Lack of Awareness and Understanding*

Each community raised lack of awareness of insurance as a potential problem. Unaware individuals may not receive regular channels of communication because they do not speak or read English or because they do not regularly access media such as television. Some individuals may also avoid going to clinics and social services and therefore do not receive flyers, brochures, or personal communication about programs that are available there. In addition, people may be aware of insurance, but not familiar with affordable, state-based options for coverage that could allow them to participate.

For those coming from a country without formal health insurance programs, as is true for both Somali and Hmong people, many are also unfamiliar with the entire concept of insurance. This means that they may not seek out health insurance at all, they may lack confidence to ask questions about something that is unfamiliar to them, or they may not understand the messages directed at them by providers and others about the importance of health insurance. Information may not be distributed widely enough in the venues that are most useful to communities, for example in local newspapers, at community events, and by trusted individuals.

Furthermore, the various health and social service systems may not be referring people as much as needed. American Indian participants shared that county agencies do not always refer them to state-based programs because they believe they are already covered under Indian Health Service and therefore do not need or are not eligible for other programs. MinnesotaCare in particular was not well known in any of the communities who participated in this project. On reservations, very few participants had even heard of the program and some said that the emphasis has been to sign people up for Medical Assistance rather than promoting MinnesotaCare or other programs.

Awareness is also a problem in the process of signing up for insurance. If people know that insurance programs exist, they still need to know how to sign up for them. One example given was that people might think that health insurance is automatic. Or they may be unaware that there are steps in the process, including re-certification, that will cause their insurance to lapse if not completed.

Participants stated that even if someone is aware that insurance exists and what their options are, they may not understand how it works. The complexity of insurance is confusing to many and leads to frustration, apathy, or embarrassment. One example is the use of private insurers through public programs, which causes confusion for individuals who are unsure if they are covered by one or both, when in fact the insurance is one and the same.

American Indian participants are unique because many have relied upon Indian Health Service clinics almost exclusively, particularly on reservations. Thus, many are unaware or do not understand the need to sign up for health insurance coverage. However, insurance is important for American Indian individuals when they are off of the reservation or need services that the reservation does not provide. It is also important for tribes because federal and state governments will reimburse them for individuals who are enrolled in public programs.

Confusion about insurance has meant fewer people signing up for other types of coverage. In some cases, people who are tribal employees opt to take a cash benefit over insurance, believing that the IHS money should/will cover their needs. A participant also noted that healthcare workers assume that a person who appears to be Indian or has an Indian name is covered by IHS and therefore do not even ask if they have other forms of insurance coverage.



*American Indian participants said:*

*"I was enrolled in the MFIP (Minnesota Family Investment Program), and they said that I was automatically signed up for Medical Assistance, but I didn't know how to use it so I just went to IHS instead."*

*"People don't realize that there is only a small pool of contract health services dollars from IHS that serves many people."*

*"IHS told me to apply for it (MA), but I felt like they should pay for it. I am an enrollee (of the tribe) and they (the clinic) get money for it."*

*"The tribe should consider paying the cost of the premium for MinnesotaCare for people who will not sign up themselves, because it could save the tribe money in the long run."*

*"I take what I can get. I have no degree and three kids to support."*



**American Indian participants said:**

*“I didn’t have health insurance for 15 years because I was self-employed.”*

*“I know someone who has private insurance and five children. She only covers the youngest two.”*

*“Those living on a very small, fixed income of \$500 a month cannot afford premium costs.”*

**Somali participants said:**

*“When employers see that you are eagerly looking for work, they take advantage. The company asks you to sign agreements that you will not ask for benefits. When you fill out applications, if you mark that you are looking for permanent work, you will not be called.”*

*“We take jobs without health insurance because we desperately need money for our families or for our relatives back home.”*

*“I consider health insurance very important, but I will accept employment if they don’t offer health insurance. I cannot afford being without a job and sometimes there aren’t many choices.”*

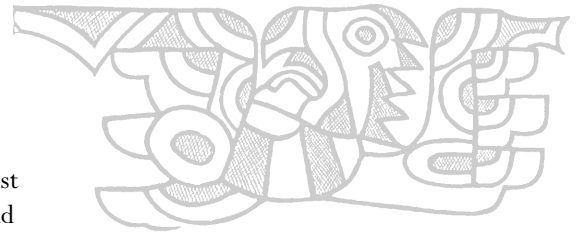
**Hmong participants said:**

*“I can be offered a job that pays \$14 an hour but when the medical bill comes, I bet it’s more than all of my checks combined, so I wouldn’t take a job that pays more but doesn’t offer me any health insurance.”*

*“It depends upon how comprehensive the policy is, for example, if the benefits do not cover much, it is not worth investing in.”*

**Financial Constraints**

One common element that emerged in all three communities was that although jobs that provide health insurance benefits are very important, the availability of such jobs is limited for people in their communities. Many people find themselves in the position of having to choose between a job and health insurance. In this case, most said that the job would be financially more important, but several Hmong participants did say they would not consider a job if it didn’t provide health benefits. American Indian participants also noted that some tribal employees prefer (and need) to take a cash option over insurance benefits.



Somali participants said that finding a job and earning income are a priority over insurance for them. Many must accept seasonal, temporary, and contract work which are all offered without health benefits for the most part. Somali participants also discussed employers who take advantage of low-skilled or non-English speaking workers. They may deliberately avoid providing benefits by stipulating in contracts that employees cannot seek benefits from the company at any time. Or, they may provide short-term contracts that allow for laying off workers or making them permanently ineligible for benefits with the company.

Those who are self-employed or work for a small business are often unable to afford health insurance, and are also in the position of having to choose between work and insurance. Age is a factor primarily for young people who have recently left their parents’ insurance but are not working full-time or have low-wage jobs that do not provide benefits.

Like employment, the cost of insurance is also a major factor contributing to a lack of health coverage. Although specific factors related to cost elasticity (how much people would be willing to pay for insurance) were not discussed in detail, participants indicated that monthly premiums, co-pays, and prescription drug costs were all significant barriers. They discussed the cost-benefit of paying premiums when clinic visits are infrequent, the policy does not cover much, or the deductible is so high that individuals end up paying the costs anyway. Participants said that young, single, healthy individuals might take the risk of not needing the insurance at all.

Participants also said that coverage might not be equal within families. Sometimes parents are only able to cover their children and not themselves, or one spouse may have insurance but not the other.

Income eligibility requirements for public programs are also a barrier to coverage. Many people said that they worked at jobs that did not offer benefits and did not pay high enough wages to afford premiums, yet they made too much money to qualify for public programs. They feel forced to choose between a job and health insurance.

Participants also stated that being cut off of public insurance programs was especially difficult because often they were not in a stable position to obtain or afford another type of insurance.

Recent immigrants said that other priorities get in the way such as basic financial survival. Immigrants who come to the United States on visas, not as refugees, do not automatically qualify for Medical Assistance as refugees do and they are not covered while their case is pending.



*“When my children were young, I was ineligible because of my income, so my family went without insurance. I saved my income tax money for four years to provide my kids with glasses.”*

*-American Indian participant*

*“The whole time I am working, I am without insurance.”*

*-American Indian participant*

*“I have to wait to make less money so that I can qualify for public insurance.”*

*-American Indian participant*

*“My baby was cut off of MA after one year because I made too much money, but I didn’t have other insurance.”*

*-American Indian participant*

*“If someone who has public health insurance takes a temporary job, the county cuts his/her benefits without giving them time to find other health coverage.”*

*-Somali participant*

*“Sometimes coverage ends without you knowing. You try to use your medical insurance card and then get told that your policy expired. You don’t know why and how you can get it again.”*

*-Hmong participant*

*“Coping with other problems and focusing on survival are the main reasons that people don’t have insurance. The county should not cut benefits before individuals get other insurance.”*

*-Somali participant*

*“Some months I skip payment on my health insurance so that I can have water and heat. After a month, I already get a letter saying health insurance is being denied. This makes everything so hard.”*

*-Hmong participant*

*“Medical Assistance is NOT viewed as health insurance. It is welfare, a handout. People don’t want anything to do with it because of pride.”*

*–American Indian participant*

*“My son didn’t want to take me to apply for MA because it was too embarrassing. We can just work and pay for it ourselves. I hate bothering other people or asking for help.”*

*–Hmong participant*

*“I have an uncle who always yells at my aunt when she goes to the hospital because he says that she’s really not sick but because she goes, she will get sick. So I know that they don’t have health insurance because he thinks it’s not worth it when people are not as sick as they think.”*

*–Hmong participant*

*“Doctors who are treating you but you don’t know anything about them makes trusting them hard. We don’t want to have health insurance with people we don’t even know.”*

*–Hmong participant*

*“Some people are ashamed of going for public assistance. I am one of those people who has a phobia of it (public assistance).”*

*–Somali participant*

*“When my child was under age 18, it was important for me to have health coverage, but now it’s just me so I don’t care.”*

*–American Indian participant*

*“My nephew has been in the U.S. for seven years and has never applied for a health card. I think the reason is because he never gets sick.”*

*–Somali participant*



### ***Beliefs, Feelings and Past Experiences***

American Indian participants expressed beliefs about health insurance related to their perception that treaty rights stipulate guaranteed access to health services administered by Indian Health Service. Because of this, some American Indians feel that they should not have to sign up for additional governmental or employer-based insurance. However, others point out that this belief has led some tribes to educate and promote health insurance options in order to increase reimbursement rates to the tribe.

Similarly, distrust of government and government programs/services may lead many American Indians to avoid signing up for insurance programs. The belief that these programs are welfare-related benefits also leads many to shy away from them.

In the Hmong and Somali communities, distrust of government programs was not mentioned as a strong factor, but mistrust of Western medicine in general, and also embarrassment in signing up for public assistance, were beliefs linked to a lack of insurance.

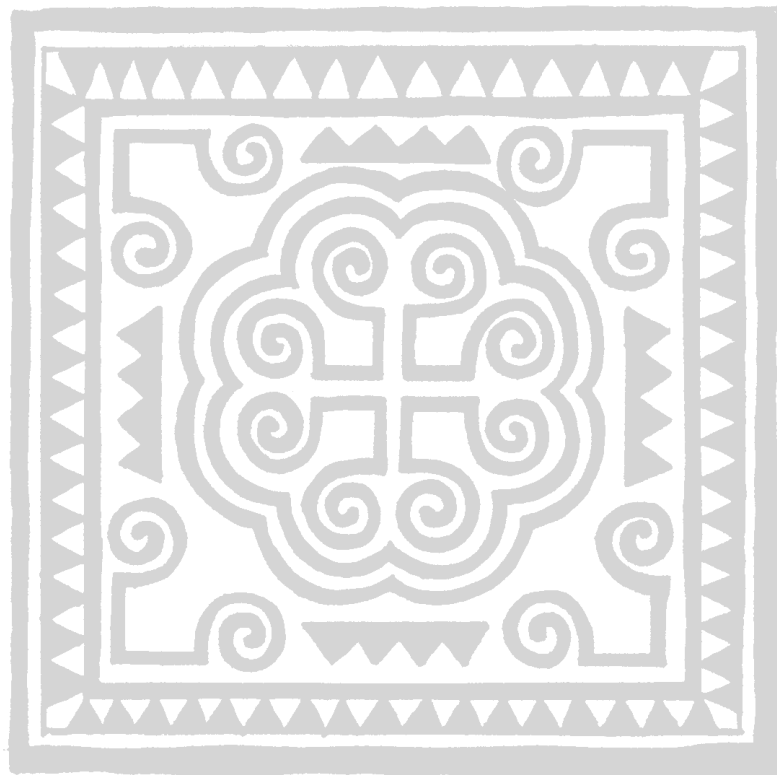
People from all three communities shared that some people simply do not value their health or do not think they need health insurance. Two examples were most prominent: those who are healthy and think that they won’t need the insurance and young people in particular who may not see the value in obtaining insurance that they may rarely use.

### ***Use of Traditional Healers***

The use of traditional healers, who are not covered by most health insurance plans, is another factor contributing to a lack of insurance. In each of the communities, individuals gave examples of using traditional healers or home remedies for illnesses and ailments. Some people said that when Western medicine fails to cure someone or they've had a negative experience, they would seek traditional healers. Others said the opposite, that people prefer to try home remedies or traditional healers first and if that fails or the issue becomes more serious, then they visit a clinic.

The Hmong participants, in particular, noted generational differences. They indicated that elders were more likely to rely upon traditional healers while younger people rely more on Western medicine, and on prayer if they are Christian.

The Somali participants had mixed opinions, some noting that the use of traditional healers is in conflict with belief in Allah and the Islamic faith,



*“Young people think they are invincible. Who needs insurance when you have always been healthy? Young people think, “We don’t need to spend all this money at this time. We’ll wait until we get older.” Perhaps some people choose not to have insurance because they do not understand the purpose to protect in case anything happens.”*

*-Hmong participant*

*“Some people don’t have children like we do. Or they don’t have to take care of their parent who is sick. Making sure they have insurance isn’t the first thing on their mind.”*

*-Hmong participant*

*“There are many things you can treat at home.”*

*-American Indian participant*

*“For example, they go to the doctor for something and that doctor was mean or treated them wrong in some way, so they turn to their shaman healer.”*

*-Hmong participant*

*“I go to the hospital first, but because nothing usually works immediately like how Hmong medicine works, I go to the traditional healer. I don’t feel the pain faster that way.”*

*-Hmong participant*

*“I prefer to use stuff out of the woods. But I don’t tell my family to avoid the clinic.”*

*-American Indian participant*

*“Yes, the older generations prefer to use these forms. If these methods have been tried and the person is still very ill, the older folks will resort to using their health insurance and going to the doctor. Some of the younger generations rely on prayers to God.”*

*-Hmong participant*

*“The younger ones want to get checked (by a physician). I think the younger ones are actually afraid to use traditional healers, just like the older ones are afraid and don’t understand modern (Western) medicine. They do what they know, that’s all.”*

*-Hmong participant*

*“I think for some people it is a cultural thing. They prefer using herbs, home remedies and religious practices. Therefore they don’t see the point of having health insurance.”*

*-Somali participant*

*“We believe in Islam and if we seek health from traditional healers rather than Allah, we are crossing the limit. Even if you try to find them, there are no traditional healers in the U.S.”*

*-Somali participant*

*“Whatever we used back home, we are not in the same situation and same environment. People have illnesses like high blood pressure and diabetes and they have to be careful. Islam teaches us to seek medicine from health experts, not magic power from fortunetellers.”*

*-Somali participant*

*“Some people prefer to use traditional healers and ways of practice, but they still have health insurance.”*

*-Hmong participant*

*“I don’t know too many people who have health insurance that would go to a traditional healer instead. But many people don’t go to either.”*

*-American Indian participant*



while others said that having health insurance is against the faith and therefore, traditional remedies and healers should be used instead. A common theme among them, however, was that access to traditional healers and remedies in the United States is limited and that the illnesses people encounter here are different from the ones they experienced in the past, requiring different care.

Given this mix of comments from participants, one clear theme that emerged is that none of the communities expressed strongly that large numbers of individuals are using healers instead of or rather than accessing Western medical systems. Many participants said they know people who use both traditional and “Western” healers. Many said that a combination of resources is most commonly used and that the use of traditional healers did not necessarily preclude most people from having health insurance.

### **Rules and Procedures**

Nearly all participants said that health insurance programs require too much paperwork and the application is too time consuming. The first challenge involves collecting all of the necessary information. Some participants expressed difficulty with transportation and childcare when trying to get to clinics or agencies to fill out paperwork, particularly on reservations where distances are often greater. They also noted the costs associated with getting copies of needed documentation are prohibitive.

Others said the paperwork was intimidating and required too much time and energy to compile. The thirty-day rule (participants must complete and submit application paperwork within 30 days or be forced to start over) seems unreasonable to some participants. They said it might take them longer than that to compile all the information, and if they are forced to start over, it will discourage them from applying.

Specific concerns about the forms are that the questions are invasive of privacy and unreasonable. American Indian participants were particularly concerned about the government knowing private information and find it intrusive. Moreover, questions about assets such as homes, cars, or land cause frustration because American Indians feel that it is irrelevant to whether or not they should have or can afford health insurance when their income is clearly minimal.

Besides paperwork, Hmong participants, in particular, felt that the waiting time to find out if one qualifies is too long and that emergencies should be covered in the meantime. The requirement of re-certifying every six months is also frustrating because it requires more time and energy to maintain the coverage. Participants also expressed how disappointing it is to go through the entire process only to find out that they don't qualify or to successfully complete the process and then have benefits terminated later because of failing to comply with procedures.

### **American Indian participants said:**

*"Many times they ask for birth certificates and social security numbers, but I don't have that kind of money to get copies first before applying."*

*"I live thirty minutes away and I have no transportation to even go and apply. I was given a lot of information when I applied. After completing forms, they needed more paperwork. I thought, 'Forget about it.' I try to comply, but sometimes it's just too much."*

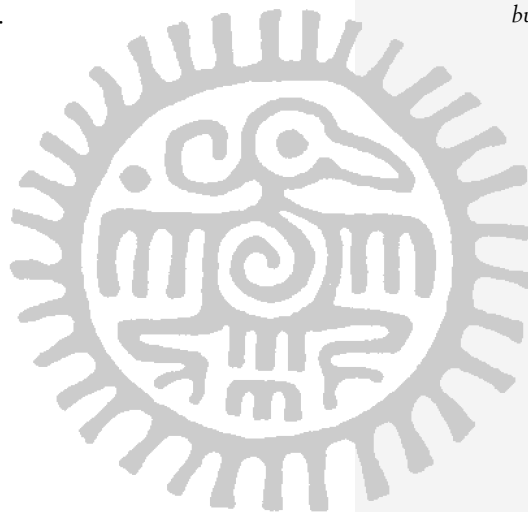
*"If I have to sell my house to get MA, then where am I going to live?"*

*"The questions are odd. You are already low income, how could you own a boat?"*

*"Are people really profiting from owning a house or a car or is that basic living?"*

*"Assets are what throw people out of the program and they are the ones who need it."*

*"I left a lot of blanks on the form for things I didn't think I should have to answer. They ask you where you got pregnant and it's none of their business as far as I'm concerned."*



*"If the clients do not return the report forms on time, the county terminates benefits. The letter says if they use their health cards anymore, they will be criminals."*

**-Somali participant**

*"You try so hard to get all the information for the application and then find out that you don't qualify. Your caseworker tells you all these reasons why you're not qualified and it gets confusing. I think that a lot of people give up on getting health insurance. It's so complicated."*

**-Hmong participant**

**American Indian participants said:**

*"I found it easy to get, but keeping it wasn't easy."*

*"If you make people jump through enough hoops, you'll discourage them from even applying. It's a form of control."*

*"People at MA are always trying to screen people out, to catch them being fraudulent."*

*"If you didn't have the need, you wouldn't be there in the first place."*

Finally in regard to the procedures in the enrollment processes, participants said that those providing services in the application process can be disrespectful (state or county employees, clinic workers). Although many participants said they are pleased with public health insurance programs overall, many also noted that they feel as though they are treated poorly in the process of applying and determining eligibility. For example, American Indian participants conveyed that the process is degrading. They commented that some insurance program employees talk down to them or are unhelpful. The entire process is viewed negatively if people feel that they are suspect just by applying.



# FOCUS GROUP FINDINGS

## *What is your view of coverage offered by Minnesota's public health insurance programs?*

Many of the participants expressed the opinion that they were not concerned with the source of their insurance coverage, just so long as they have it. Many said that all things being equal, they had no preference for public or private. Other participants did offer specific feedback on public programs.

Medical Assistance is appreciated by many because it covers nearly everything (as opposed to 80/20 coverage with many private health plans) and doesn't cost as much as private plans would. Participants also said that public insurance program coverage is more reliable because it is "guaranteed" by the government and not subject to an employer's decisions or affected by job transitions.

The shortcomings of public health insurance program coverage were also noted. MinnesotaCare is not as widely known as Medical Assistance and opinions about it were mixed; some said they preferred it to MA while others said it did not cover as much. For both programs, participants said that there is less choice for items such as eyeglasses and prescriptions. In addition, fewer clinics and hospitals will accept public health insurance, which makes it difficult to get care when needed. Finding dentists who will accept Medical Assistance, especially outside of the Twin Cities area, is very difficult.

Treatment options were also considered by some to be inferior for those with public insurance. Some perceived that doctors would treat patients better if they had private insurance rather than public, and felt that they had received fewer treatment options, less time with the physician, or that the providers cared less about the outcome because they were on public insurance.

*"Private insurance and public are about the same. I've been on both and don't see any difference."*

*-Hmong participant*

*"Health insurance is insurance regardless of who pays for it."*

*-American Indian participant*

*"It doesn't matter as long as the coverage is comparable."*

*-American Indian participant*

*"Rochester Mayo took good care of my granddaughter. My MA worker talked with them and we got a hotel and everything worked out fine."*

*-American Indian participant*

*"I have been on it (MA) for five years now and haven't run into any problems. It is free and you are covered wherever you go."*

*-Hmong participant*

*"I am a single father. My employer cannot cover all three of us, so I use private insurance (for more clinic choices), but I think the MA is better for my two boys."*

*-American Indian participant*

**Somali participants shared that:**

*"When they see you have MA, they put your name at the bottom (of the list) or say they don't take it. You do not get the service you need."*

*"Public health insurance doesn't cover everything, especially dental. When I was getting new glasses, they saw my insurance and gave me plastic ones. After an argument, I got the ones I wanted. But if you have private insurance, you get better services."*

*"My doctor sent me with a prescription and I was rejected at three places and told I had to pay. Then he sent me with a White man who speaks Somali and I was still told that I had to come up with \$45 dollars. I ripped up the paper (prescription) and didn't pay it."*

**Hmong participants shared that:**

*“Since the doctors knew that I’ve had children before and am on public assistance they treated me horribly. They didn’t pay attention to my needs and refused to let me eat the food my mother-in-law brought into me. I starved those days in the hospital.”*

*“Public insurance helps a lot, but not as much after you’ve been in the hospital for long periods of time and you have to pay out of pocket.”*

*“If I work, I would rather get private insurance. It is more valuable. You are paying for it, so therefore you have more say in your care.”*

*“My child and grandchild both had leukemia. With private insurance, my grandchild was rushed from hospital to hospital and everyone seemed to tend to him. My child had to wait longer and everything happened slower for him.”*

**American Indian participants said:**

*“When I broke my leg and went to the hospital, they said we were just looking for drugs.”*

*“When I went to the doctor for back pain, they sent me to a psychiatrist. I filled out a bunch of papers and went back and told them I wasn’t crazy.”*

*“I would love to work somewhere with insurance. What troubles me about public insurance is that they can take it away.”*

*“When you receive insurance from work, you don’t have to reveal as much.”*

Some participants deemed private insurance preferable because of coverage options and because they felt they are respected more with it. They appreciate more choices of hospitals and clinics and the anonymity or confidentiality that private insurance allows. Lastly, participants expressed that coverage should be universal and equal. Those who currently fall through the cracks such as those between jobs and non-refugee immigrants also need insurance coverage. Furthermore, participants said they want to be treated well regardless of the type of insurance coverage they have. Participants felt that assumptions are made about them and that their needs are not always taken as seriously as others.



# FOCUS GROUP FINDINGS

## *How can public health insurance programs be improved?*

### *Bring information to communities and help people understand insurance.*

- Survey people on their needs and their knowledge of insurance.
- Increase outreach for MinnesotaCare to improve awareness and enrollment.
- Educate regarding insurance early, such as in high school, and provide information at teen clinics.
- Provide a one-to-one orientation to tell people how their insurance works.
- Offer more in-home education, particularly for those who are elderly or cannot read, write, and/or speak English.
- Distribute information at community events and frequented locations (community centers, bingo, senior centers, Headstart, clinics, etc.).
- Host forums, much like focus groups, to share information and educate people and offer a small stipend, food, or daycare money to attract people to events.

### *Make it easier for people in different communities to access services.*

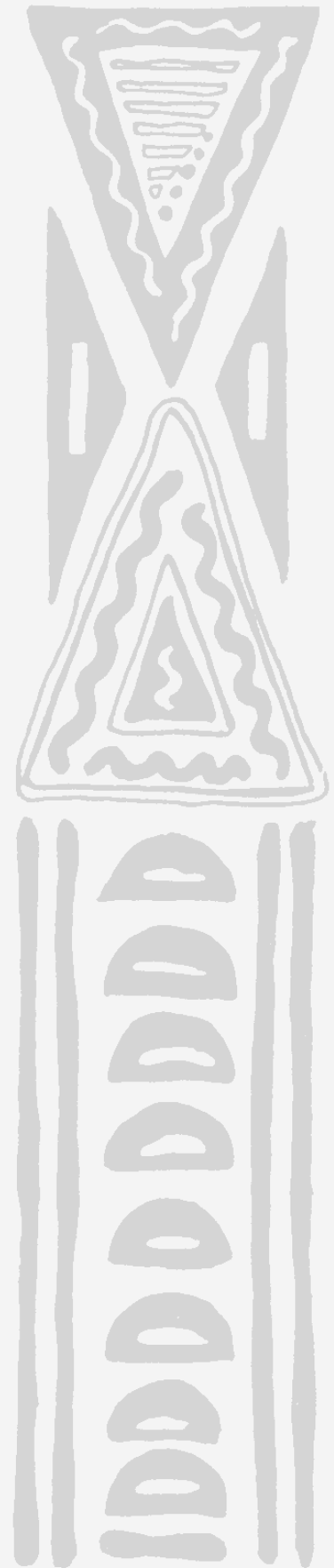
- Hire people from the community to share information and to train others.
- Hire bilingual and bicultural staff to act as advocates and intake workers.
- Provide a multi-lingual toll-free line for information and referrals as needed.
- Hire medical social workers who can explain things in lay terms.
- Offer tours and have liaisons from the community at hospitals and clinics.
- Have community-specific (e.g. Hmong) rooms at the hospital for guidance.

### *Use a variety of techniques to inform, educate, and assist people.*

- Use many media including community-specific television and radio programs, newsletters and community newspapers, and flyers.
- Translate materials into multiple languages.
- Provide age-specific information, so that both young and older people understand and relate to the messages directed at them.
- Provide information via employers about programs that employees may qualify for while working without benefits or in case they should lose their job.
- Revise confusing statements that say “this is not a bill” because many people, especially elders, think it is a bill and pay it anyway.

### *Simplify the enrollment process.*

- Create a simple form that would pre-approve eligibility (before filling out paperwork in entirety).
- Revise the forms to include fewer and less intrusive and repetitive questions.
- Reconsider the asset requirements and use family size and income instead.
- Allow individuals to apply without considering the incomes of everyone in the household.



*"If Minnesota is truly a healthcare state, then they need to step up and find a way to offer universal coverage."*

*-American Indian participant*

*"I know that when my uncle came here 20 years ago, there was a lot of help to get him adjusted. Where did these people go? How come there is no one out there who will sit down and explain things here in America for us?"*

*-Hmong participant*



- Make the re-certification process much less frequent.
- Shorten the processing time once an application is submitted and cover emergencies during that time.
- Consider people on a case-by-case basis and implement sliding-scale fees.
- Lower income qualifications as the cost of living increases.
- Separate eligibility for cash assistance from medical assistance so that people who are no longer getting cash assistance can still get health insurance.

***Expand who is covered.***

- Offer universal coverage.
- Set up programs to assist the self-employed or small employers.
- Require MA or MinnesotaCare coverage for all and work with employers to provide more insurance benefits to more people.
- Give people a choice between taking their employer's coverage or state coverage and have the employer reimburse the county or state.
- Offer coverage that can be activated quickly and with minimal hassle for those who become unemployed or are between jobs.
- Offer coverage for students who are 18 years of age or older (and ineligible for parental coverage) but are not offered employer coverage.
- For American Indians, honor the existing treaties and provide adequate funding for Indian Health facilities and residents.

***Expand what is covered***

- Provide coverage for items needed by the elderly, such as incontinence products, hearing aids, and eyewear with frequent prescription changes.
- Offer a portable health card to go where you choose and eliminate the need to choose a primary clinic.
- Offer more coverage for traditional healers, spiritual and holistic healthcare.
- Make services available to those on public health insurance and increase coverage for root canals and braces.
- Cover prescriptions and eyeglasses comparatively with private insurance.
- Increase mental health coverage, particularly for those coming from traumatic situations, such as refugees.
- Make state insurance resemble military insurance (no co-pays).

***Improve customer service and work to remove the stigma of public programs.***

- Customer service is everything; state and county employees need to be friendlier.
- Provide sensitivity training and education to state, county, and clinic employees.
- Take our community's needs seriously and don't discount us.
- Interpreters and transportation are still very much needed.
- Allow people to charge their premiums to a credit card if they need to.
- Offer equal treatment for all applicants, including advocates for the poor.

# COMMUNITY-SPECIFIC THEMES

This section serves to reiterate themes already presented in the report, based upon each community, so that those who provide outreach and services to the specific communities can readily identify the most frequent and strongest concerns expressed in these focus groups.

## ***American Indian***

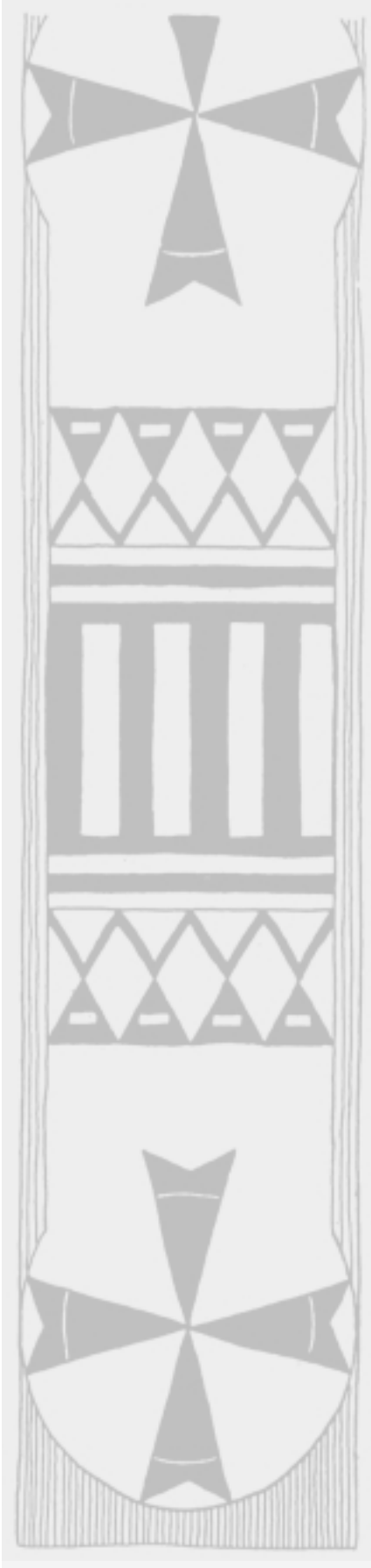
Compared to the other focus group participants, American Indians emphasized that:

- The eligibility criteria, including income and assets, are unreasonable.
- Enrollment paperwork is excessive and invasive.
- Workers who are disrespectful to applicants limit their willingness to sign up.
- Knowledge and understanding of health insurance programs, especially MinnesotaCare, is limited on reservations in particular.
- Some Indian people choose to live on reservations in order to have access to tribal clinics or hospitals that they may not have living in an urban area.
- Many people (Indian and non-Indian) assume that Indian Health Service covers all Indian people and all needs, so they do not apply for other programs or inquire if patients have other coverage.
- Mistrust of government causes people to shy away from public insurance.
- Tribes need more funding to adequately staff and equip clinics and hospitals and need to encourage participation in insurance programs to increase reimbursement rates.

## ***Hmong***

Compared to the other focus group participants, Hmong participants emphasized that:

- Cost is prohibitive to obtaining insurance in any form.
- Young people, particularly students or those working part-time, are unable to get insurance and need it greatly.
- Transportation and interpreters are vitally necessary, particularly for the elderly.
- Mistrust of Western medicine and medical systems causes hesitation to access it.
- Processes such as waiting periods and re-certification limit enrollment.
- Confusion over types of coverage is common and one-to-one orientation is needed.
- Help that was extended to the first Hmong people to arrive in Minnesota does not seem to be as readily available any longer.
- Time spent in the United States has not necessarily improved access to health insurance or health systems and there are generational differences in access.





### *Somali*

Compared to the other focus group participants, Somali participants emphasized that:

- Employment status and difficulty attaining permanent, full-time jobs with benefits is a major reason for lack of insurance, particularly for the newly arrived.
- The community is very young overall and people aged 18-24 may not realize the importance of insurance.
- Immigration status affects insurance. Those who are not refugees or whose eight months of Medical Assistance have lapsed may be uninsured and/or uninformed.
- Coverage offered by MA is not adequate, specifically as it relates to dental services, prescriptions, clinic choices, and eyeglasses.

