RURAL HEALTH ADVISORY COMMITTEE

October 9, 2015

Lucinda Jesson
Co-Chair, Health Care Financing Task Force
Commissioner, MN Dept of Human Services
PO Box 64946
St Paul MN 55164-0998

Sahra Noor
Co-Chair, Health Care Financing Task Force
CEO, People's Center Health Services
425 20th Ave South
Minneapolis MN 55454

Dear Commissioner Jesson and Ms. Noor:

The Rural Health Advisory Committee (RHAC) is a Governor-appointed statewide body that advises the commissioner of health and other state agencies on rural health issues, pursuant to Minnesota Statutes section 144.1481. Our membership comes entirely from Greater Minnesota and includes House and Senate members of each party, health care providers and consumers.

As part of its charge, the Committee monitors health care coverage and access in rural Minnesota. It has had a long-standing interest in MinnesotaCare, which serves rural communities to an even greater degree than urban ones. This is because rural areas have a higher proportion of Minnesotans who need and qualify for MinnesotaCare: Minnesota's rural communities have a greater proportion of their population with incomes between138-200% of federal poverty limits (12.7% in rural counties compared to 9% in urban ones), and are less likely to have access to employer-based coverage, often because they work for smaller employers, are self-employed, work part-time, or work more than one job.

The Committee recently examined MinnesotaCare enrollment as part of an overall analysis of coverage changes in rural Minnesota since the adoption of the Affordable Care Act, and would like to share its key findings with the Task Force:

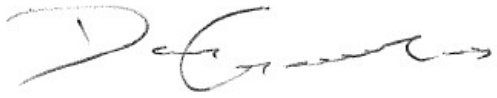
- **If MinnesotaCare were not available, many of the more than 26,000 rural MinnesotaCare enrollees would likely become uninsured or underinsured**. This estimate is based on enrollment data as of April 2015.
- **If MinnesotaCare were not available, rural Minnesota and the rural health system would face the challenges of higher uninsurance and underinsurance rates – including poorer health outcomes, higher use of emergency care, and more delayed care**. This would, for example, contribute to increases in uncompensated care for rural Minnesota's small hospitals and clinics, which already experience higher rates of such care compared to urban providers. In other states, significant numbers of rural hospitals are closing or are at risk of closing. MinnesotaCare and expanded MA have likely helped prevent this from happening more in Minnesota.

Given the important role MinnesotaCare plays in rural health in Minnesota, the Rural Health Advisory Committee recommends the following:

1. That the Health Care Financing Task Force make recommendations to preserve MinnesotaCare; and
2. That the Health Care Financing Task Force make recommendations to ensure a dedicated, stable source of revenue supports this vital program into the future, in light of the history of diverting the provider tax for non-health care uses.

Thank you for your consideration of these recommendations, and please let us know if we can provide any assistance to the Task Force as it considers these major issues for Minnesota.

Sincerely,



Daron Gersch, MD, Chair
On behalf of the Rural Health Advisory Committee

cc: Ed Ehlinger, MD, MPH, Commissioner, Minnesota Department of Health