According to a 2007 report from the United Health Foundation, *America’s Health Rankings*, Minnesota ranked second (after Vermont) as one of the healthiest states in the nation. These rankings are based on an evaluation of a variety of health outcomes and determinants, including personal behaviors, community environment, public-health policies, and clinical access. A large factor in Minnesota’s positive ranking is likely its high level of access to healthcare and its well-developed healthcare system.

Currently, 47 million people nationwide—about 15% of the U.S. population—lack health insurance coverage. Without meaningful healthcare reform, the number of uninsured Americans is expected to grow. Compared with other states, Minnesota has a relatively high proportion of individuals with health insurance coverage. According to the Minnesota Department of Health, in 2007 nearly all Minnesotans (92.8%) were insured. Of those insured, more than two-thirds (67.6%) received their health insurance coverage from private sources, and another one-fourth (25.2%) received their health insurance coverage from public programs.

Not all Minnesotans are fortunate enough to have health insurance coverage. The cost of health insurance has skyrocketed during the last decade, making it relatively unaffordable and significantly impairing the ability of many families to access high-quality healthcare services. Substantial disparities in rates of health insurance coverage exist across demographic groups. According to the U.S. Census Bureau’s

**Latina Mothers’ Perceptions of the Minnesota Healthcare System: Examining the Spillover Effects of Uninsurance on Healthcare Access, Quality, and Cost**

*by Carolyn García, José A. Pagán, Rachel Hardeman, and Alyssa Banks*

Among the many barriers to healthcare access for Latinos, language differences are particularly salient as the Spanish-speaking population in Minnesota continues to grow. Some Minnesota Latina mothers reported seeking out healthcare facilities where they know their language needs will be met.
2007 American Community Survey, about 374,000 individuals in Minnesota (roughly 7.2% of the state’s population) are uninsured, and they tend to be young (nearly 20% are 18–24 years old), poor (18% report income levels below 100% of the family poverty level), and from an ethnic/racial minority group.

Minnesota is home to a growing community of Latino immigrants. Latinos are the second largest minority group in Minnesota, representing about 4% of the state’s population. According to the U.S. Census Bureau, in 2000 the Latino population in the Twin Cities metropolitan area was 98,337; by 2006, that figure had increased nearly 42% to 139,539 (Figure 1). Nearly three-quarters of Minnesota Latinos reside in the metro area. The Latino population in Minnesota is projected to grow significantly during the coming decades, and Latinos are expected to become the largest ethnic/racial minority group in the state in less than 20 years.1 Their health status trends and low rates of health insurance coverage will likely have a substantial impact on access to healthcare, quality of care, and overall public health in Minnesota in the coming decades. According to the Urban Institute and Kaiser Commission on Medicaid and the Uninsured, as of 2007, 18% of Latinos in Minnesota are uninsured.

To better understand how access to health insurance impacts access to healthcare for Latinos, we interviewed Latina mothers in Minneapolis–St. Paul, Minnesota (a low uninsurance community) and McAllen-Edinburg, Texas (a high uninsurance community). We sought to identify any differences in access to, use of, cost of, and quality of healthcare services in these two communities for the insured versus the uninsured, as well as the barriers to healthcare system access in each community. We report the results of our analysis here.

The research upon which this article is based was supported in part through a grant from CURA’s New Initiatives program. Additional funding was provided by the Agency for Healthcare Research and Quality and the Centers for Disease Control and Prevention.

Why Health Insurance Coverage Matters
Lack of health insurance coverage has been linked to lower healthcare utilization rates as well as poorer health outcomes.2 For example, using national data from the Health and Retirement Study from 1992 to 1996, Dor et al. showed that the health of continuously uninsured adults declined more rapidly than the health of continuously insured adults during this four-year period.3 Uninsured persons are also less likely to have a regular source of care, and they report more delays in obtaining healthcare than insured persons.4 Health insurance coverage facilitates

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access to healthcare by reducing the out-of-pocket cost of obtaining medical services and reducing delays in obtaining healthcare. Insurance-related continuity of care and the timely use of healthcare services result in improved health outcomes.

Another potential effect of lack of insurance coverage is an overall reduction in healthcare quality. In a 2007 article in *Health Affairs* titled “Spillovers and Vulnerability: The Case of Community Uninsurance,” Pauly and Pagán argued that lower rates of health insurance coverage could impact a community not only financially by increasing the cost of care, but also by reducing the quality of care available in the local healthcare market. The uninsured demand lower quality healthcare at the local level than do the insured, and this “preference externality” impacts the quality of care available to the insured population.

**Research Methodology**

We conducted focus groups to seek out the perspectives of insured and uninsured Latina mothers living in Minneapolis–St. Paul, Minnesota, and McAllen-Edinburg, Texas. These communities were selected because they represent substantially disparate communities with respect to health insurance coverage rates. In Minneapolis–St. Paul, more than 90% of individuals report having health insurance coverage, and only 10.8% report being unable to see a physician during the past year because of cost. This compares to only 41% of McAllen residents who report having insurance, and 48.6% who report being unable to see a physician because of cost during the past year.

We were interested in gaining the insights of mothers because they are typically the primary healthcare seekers for children. Based on health disparities data, demographic trends in Minnesota, and the high rates of Latinos who lack health insurance coverage, we chose to focus this project on Latina mothers who indicated that they were currently caring for at least one child in their household.

We divided our sample into two groups, one with mothers who had health insurance coverage and one with those without. The uninsured mothers were those who had not had health insurance coverage of any kind for at least the past six months, but had been residing in the state for at least that period. Demographic data for study participants are provided in Table 1.

In Minnesota, a community liaison recruited insured Latina mothers with the help of staff from metro area community agencies. The liaison identified uninsured participants through her personal relationships in the community, and participants referred friends who qualified. In Texas, project staff identified insured participants primarily from within the local community. A community liaison assisted in recruiting the uninsured participants. All study procedures, including recruitment, were approved by the Institutional Review Boards of the University of Minnesota and the University of Texas–Pan American.

An interview guide (see sidebar on page 16) was developed to help moderators lead the discussions. Staff from Hispanic Advocacy and Community Empowerment through Research (HACER) moderated focus groups in both states; all focus groups were conducted in Spanish. We conducted a total of eight focus groups (two each of insured or uninsured mothers in each location) between December 2007 and February 2008; group sizes ranged from 5 to 12. Ultimately, 28 Latinas participated in the Minnesota focus groups, and 30 participated in Texas. Each focus group lasted approximately two hours. We provided refreshments and childcare, and we gave each participant a $50 gift card from the retail company Target for their participation.

Experienced HACER staff translated into English and transcribed all recorded dialogues. After all the transcripts had been descriptively coded, we organized the codes into broad descriptive categories that provided a framework for assessing the similarities and differences between the participant subgroups (uninsured/insured and Minnesota/Texas).

**Results**

General themes that emerged from the focus group discussions were access to care, quality of care, and financial concerns. With respect to access, an underlying theme for those with health insurance was perceived constraints on which clinic, doctor, or hospital they might access. For the uninsured, issues of healthcare access focused on delays in obtaining healthcare, use of “safety net” clinics, and use of home remedies. In terms of quality of care, on the whole participants expressed negative perceptions of the quality of healthcare they received, citing experiences such as long wait times in the doctor’s office and perceived discrimination. Overall, Latinas in Minnesota perceived their healthcare system to be of higher quality than did Latinas in Texas. With respect to financial concerns, the overall recurring theme for both the insured and uninsured mothers was affordability of care.

More detailed findings on the Minnesota Latina mothers are presented below, stratified by health insurance status. Where useful, comparisons with participants from Texas are also provided.

**The Insured in Minnesota**

**Access to Care.** Although having health insurance facilitates access to healthcare by removing or lessening many of the financial barriers faced by individuals and families seeking health services, responses from insured mothers suggested that barriers to access persist. Such barriers include financial barriers (lack of financial resources), systemic barriers (obstacles within the system), and sociological barriers (discrimination or language differences). Focus group participants cited examples of all of the above as factors that influenced their access to healthcare.

Insured mothers identified a number of systemic barriers, including obtaining an appointment with a physician, the wait time at clinics, difficulty obtaining timely appointments with specialists, and the cumbersome referral process necessary to receive care from a specialist. One Minnesota who described her frustration with obtaining an appointment with a specialist noted:

> If we can have the appointments sooner, because imagine if you are sick and if they give you the appointment in two weeks, by the time you go to the appointment the sickness is gone.

Another stated:

> Imagine how frustrating it is to have your son sick and knowing that you have to wait a whole month, or two weeks, to have an appointment because there are no people that can see your son. That’s very frustrating. For us as mothers it is exasperating to see that your child has something and you cannot do anything about it.
<table>
<thead>
<tr>
<th>Demographic Characteristics</th>
<th>Minneapolis–St. Paul, Minnesota</th>
<th>McAllen-Edinburg, Texas</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Insured (11 participants)</td>
<td>Uninsured (17 participants)</td>
</tr>
<tr>
<td>Age (mean)</td>
<td>37.55</td>
<td>33.18</td>
</tr>
<tr>
<td>Primary Language</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spanish</td>
<td>64%</td>
<td>82%</td>
</tr>
<tr>
<td>English</td>
<td>36%</td>
<td>17.65%</td>
</tr>
<tr>
<td>Number of Children in Household (mean)</td>
<td>2.18</td>
<td>1.76</td>
</tr>
<tr>
<td>Employment Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed</td>
<td>82%</td>
<td>29%</td>
</tr>
<tr>
<td>Self-employed</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Unemployed</td>
<td>18%</td>
<td>12%</td>
</tr>
<tr>
<td>Homemaker</td>
<td>0%</td>
<td>59%</td>
</tr>
<tr>
<td>Student</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Unable to work</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Income Total</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than $10,000</td>
<td>0%</td>
<td>35%</td>
</tr>
<tr>
<td>$10,000 to less than $30,000</td>
<td>45%</td>
<td>59%</td>
</tr>
<tr>
<td>$30,000 to less than $50,000</td>
<td>36%</td>
<td>6%</td>
</tr>
<tr>
<td>$50,000 to less than $70,000</td>
<td>18%</td>
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</tr>
<tr>
<td>$70,000 or more</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
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<td></td>
</tr>
<tr>
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<td>0%</td>
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<tr>
<td>Very Good</td>
<td>27%</td>
<td>13%</td>
</tr>
<tr>
<td>Good</td>
<td>45%</td>
<td>25%</td>
</tr>
<tr>
<td>Fair</td>
<td>27%</td>
<td>44%</td>
</tr>
<tr>
<td>Poor</td>
<td>0%</td>
<td>19%</td>
</tr>
<tr>
<td>Personal Doctor or Provider</td>
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<td></td>
</tr>
<tr>
<td>Yes</td>
<td>30%</td>
<td>53%</td>
</tr>
<tr>
<td>No</td>
<td>70%</td>
<td>47%</td>
</tr>
<tr>
<td>Number of Doctor Visits in United States in Past Year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>1–3</td>
<td>64%</td>
<td>41%</td>
</tr>
<tr>
<td>4–6</td>
<td>9%</td>
<td>29%</td>
</tr>
<tr>
<td>7–11</td>
<td>18%</td>
<td>12%</td>
</tr>
<tr>
<td>12 or more</td>
<td>9%</td>
<td>18%</td>
</tr>
<tr>
<td>Number of Doctor Visits in Mexico in Past Year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>91%</td>
<td>62%</td>
</tr>
<tr>
<td>1–3</td>
<td>9%</td>
<td>13%</td>
</tr>
<tr>
<td>4–6</td>
<td>0%</td>
<td>13%</td>
</tr>
<tr>
<td>7–11</td>
<td>0%</td>
<td>13%</td>
</tr>
<tr>
<td>12 or more</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Number of Uses of Complementary or Alternative Medicine in Past Year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>64%</td>
<td>56%</td>
</tr>
<tr>
<td>1–3</td>
<td>9%</td>
<td>31%</td>
</tr>
<tr>
<td>4–6</td>
<td>0%</td>
<td>6%</td>
</tr>
<tr>
<td>7–11</td>
<td>18%</td>
<td>6%</td>
</tr>
<tr>
<td>12 or more</td>
<td>9%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Note: Response totals may sum to more than 100% due to rounding.
Another respondent explained:

I needed to have an appointment and I waited for four months because those specialists don’t have appointments for the next day, but they did not tell me that I had to wait for four months.

Insured mothers often reported feelings of limited access to healthcare providers due to restrictions in their health plans or a lack of knowledge about their health insurance network. Participants often mentioned the complexity of their health plans or explained their struggle with understanding the limitations of their coverage. One mother said:

I don’t know, with my insurance, I can go somewhere else.

Another respondent explained:

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Another said:

Oftentimes [it] is lack of information because you don’t know if you can go see this doctor or that one, and if your insurance will pay.

Ultimately, this confusion or paucity of information about coverage may delay individuals from seeking the care they need.
In terms of sociological barriers, language differences are particularly salient as the Spanish-speaking population in Minnesota continues to grow and the healthcare system attempts to respond to the needs of this population. Insured mothers frequently cited the issue of language barriers when accessing the healthcare system. One participant said:

I don’t speak English … I tell [the doctor], it hurts in here, and they don’t understand much.

Other participants have learned to seek out care at healthcare facilities where they feel confident their language needs will be met. For example, one participant said:

I just go to Westside. I know there is someone always there to translate.

Another mother expressed relief that her daughter would be having her surgery at Hennepin County Medical Center, because she had greater confidence in their staff’s ability to communicate with her and her daughter:

[W]hen they told me the surgery was going to be in the Hennepin, I felt better because it was better for me that they send me to Hennepin where there are interpreters.

Another issue related to language barriers is the training of interpreters. A few participants expressed an overall lack of confidence in their interpreters. One mother said:

[A]nother thing is that oftentimes the interpreters do not speak Spanish well. They believe they are interpreters, but when you talk to her, you know that she is not saying what you are saying.

Another sociological barrier to accessing the healthcare system for Latina mothers in Minnesota is perceived discrimination. The majority of insured mothers related at least one anecdote about a time when they felt discriminated against for being Latina or for not being able to speak English. One participant stated:

[M]y experiences have been negative because for looking Latina, they talk to me differently, like I am stupid.

Although none of the insured mothers reported opting out of the healthcare system because of perceived discrimination, some did mention changing providers as a way to deal with this issue.

**Quality of Care.** Assessing healthcare quality is difficult because quality may mean different things to different people. Whereas some people may consider quality healthcare to mean seeing the doctor right away, being treated courteously by the doctor’s staff, or having the doctor spend a lot of time with them, others may focus on the clinical aspects of quality. With this caveat in mind, the insured mothers were asked to rank the quality of their healthcare on a scale of 1 to 10 (with 1 being lowest and 10 being highest). On average, Minnesota participants rated the quality of their healthcare an 8; the Texas participants consistently rated the quality of their healthcare much lower, ranging from 1 to 3 using the same scale. Nevertheless, Minnesota participants shared stories that expressed concern about healthcare quality, such as this one:

I feel that the doctors don’t give us much time. They are very exact that the appointment is only for a half an hour and no more than that…. 15 minutes and nothing more. We have to arrive early and wait.

**Financial Concerns.** The overall cost of healthcare was a recurring theme for the insured mothers, including high-priced premiums, deductibles, and copayments. One participant explained that she has to delay care at times due to the expensive deductible.

Sometimes, you know, the kids might be sick and I still don’t take them to the doctor, because I’m like, “ugh, I’ve gotta pay a deductible,” and I’ll just wait…. [T]hey send me a note from school like, “your kid, you know, is sick” or whatever. I feel like they’re probably thinking, “man, this parent doesn’t even take them to the doctor,” but I feel like we have to pay a deductible …

Insured mothers reported paying upwards of $600 per paycheck toward their health insurance. Time and time again, they expressed frustration with the high costs, with some wondering aloud if it was worth it. One participant stated:

In my case, I am working. I have a decent job and still I don’t make enough to feel secure in case I get sick. This is an absurd situation.

Health insurance premiums and deductibles continue to increase. The Kaiser Family Foundation’s Employer Health Benefits Annual Survey (2006) reported that the cost of health insurance premiums and deductibles for workers and employers had increased.
to more than double the 1999 cost. According to a 2008 publication from the National Coalition on Healthcare titled *Facts on Health Care Costs*, the average worker in 2007 paid $3,354 out of his or her paycheck to cover health insurance premiums. The insured mothers frequently voiced frustration with the high costs of premiums and deductibles, and the notion that it is not realistic for working families to pay such high costs for healthcare.

Some participants also expressed concern with how comprehensive coverage that they were receiving was, given the high cost of coverage. One woman summarized her concerns by stating:

> Really it is a guessing game. The guessing is for you because you don’t know exactly what they are going to cover, but they know exactly how much they are going to charge you. … [B]ut you can’t go buy a medicine and say we can only pay this percentage. How can they know exactly how much they can take from our check for health insurance?

Overall, insured mothers in both Minnesota and Texas believed that both health insurance and healthcare were costly and unaffordable. Participants in both states expressed frustration with high copayments, deductibles, and premiums. Including children on health insurance plans made the cost an even greater burden for families. One mother said:

> [I]f I put my daughters in the plan I have to pay almost $500 a month. Imagine—I would just earn [money] to pay the insurance.

An interesting idea that emerged from discussions among the insured mothers was the concept of a payment plan or pay arrangement. Several mothers talked about the fact that although they were insured, they found themselves facing high medical bills that they could not afford to pay. Several women who found themselves in this predicament explained how grateful they were to have the option to set up a pay arrangement in which they made monthly payments toward their total bill. One woman explained:

> I had a cut in my hand. I got the bill and I told my husband to call and ask if we could have a payment arrangement and pay a small amount each month. They said yes. Thanks to God, they said yes.

One participant mentioned the idea of a payment plan in the context of discussing the difficulty she has paying her premiums and deductibles for her employer-based health insurance. As she explained:

> You are put into a stressful situation. It may be easier to go to the emergency room and don’t think about the bill and get into a payment arrangement.

Interestingly, in Texas, insured mothers discussed the notion of a payment plan far less than those in Minnesota.

Specific plan benefits and differences between plans were superficially discussed among the insured mothers. Although all of the participants had health insurance coverage, the packages of benefits provided varied substantially among them. Copayments for women in these groups ranged from $20 to $40. Premiums and deductibles ranged from $500 to $1,500. Within these discussions, the comprehensiveness of coverage also was addressed. For example, one woman said:

> The deductibles are so high, they only really cover preventative medicine. But if a person gets sick or has a medical condition in which they need hospitalization, or that requires something more than what they call office visits, they charge for the deductible. In my case, it is $1,500 per person per family. From my check, one-third is going to the family insurance plan, and even though I am paying so much each month, if one of us gets sick and has to go to the emergency [room] or has to be hospitalized, the first $1,500 comes out of our pocket.

One participant summed up the overall sentiment about health insurance plans among the insured mothers.

> In the United States, health is not a right. It is a privilege for some people to have a good medical service and quality. Health is a right that all people have—that is what you see in other countries such as in Canada, where everybody, even [the] homeless, are able to receive medical services. Here in the United States, one of the richest countries, you can’t do that because if you do it, you need to think how much is it going to cost me, and that is just only the beginning, because later the bills come and you have to pay everything else that the insurance does not cover.

**The Uninsured in Minnesota Access to Care.** The uninsured mothers offered a variety of reasons for why they were uninsured, including affordability and lack of clear information about how to apply for and obtain health insurance coverage. Some participants reported that they had delayed care because of difficulty understanding the application process for public health insurance; others indicated they had income levels that were barely above the Medicaid eligibility guidelines for their state. Additionally, some reported that being an immigrant (documented or undocumented) influenced their ability to access health insurance. Our findings from the focus groups indicated that the high cost of care, lack of services in Spanish, and lack of culturally appropriate healthcare are all potential barriers to access. Participants also discussed alternative care options such as use of safety net clinics and home remedies (complementary and alternative medicine).

Safety net clinics are a loosely organized collection of publicly subsidized hospitals, local health departments, clinics, and individual medical facilities that provide free or low-cost care to the uninsured. Minnesota’s safety net clinics include Federally Qualified Health Centers (FQHC). According to the Minnesota Association of Community Health Centers, Minnesota has 17 FQHCs—11 in the metro area and 6 others throughout the state. These centers provide healthcare services to anyone regardless of the ability to pay. Sliding-scale fees are used to accommodate different income levels. Many of Minnesota’s uninsured seek care at these centers. Since 2001, the number of uninsured served by the 17 Minnesota FQHCs rose 61%, from 36,385 to 58,606. In addition, since 2001, the amount contributed by patients who are on a sliding-scale fee plan has declined by 33%.

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Most of the uninsured mothers in our study reported regularly using some form of safety net to obtain their healthcare. As one participant stated:

I have gone [to a safety net clinic] for a physical exam and they didn’t charge me anything, and that was helpful.

Some expressed dissatisfaction with the services provided at safety net clinics. Noted one mother:

[T]hey don’t check anything other than cuerpo [body], papanicolaou [pap]. They do a mammogram and all of that, but there are no blood tests or any of that.

However, most uninsured mothers had positive views of the clinics and the services they offered. The existence of sliding-scale fees was frequently mentioned as a positive feature, and many participants said they were thankful for the option. Nevertheless, others found even the sliding-scale fees to be unmanageable at times. These women explained that sometimes they felt the need to delay care for themselves due to inability to pay. Although these women were willing to delay care for themselves, many explained that they were willing to take the “risk” of a high bill, or that they would work out a payment plan, for their child or children to be seen by a doctor because they did not want to delay their care.

An interesting theme that emerged from the uninsured mothers was a “health first, pay later” mentality. Participants felt very grateful that they were able to receive healthcare services (emergency care in particular) regardless of their health insurance status. One mother explained:

[If somebody has an accident, they don’t pay attention to if you have insurance, if you have money …] For example, in the Church of Guadalupe, they didn’t notice that when there was an accident with a bus…. And I imagine that’s a good thing because they attend to them even if they don’t have insurance, and after they can arrange how to make the payments.

This response speaks not only to the idea of treatment before payment, but also to the opportunity for pay arrangements that was discussed among the insured mothers.

The health first, pay later mentality reported by the uninsured mothers in Minnesota was very different from the experiences reported by the uninsured mothers in Texas. Many of the Texas participants described experiences where they were turned down for care because of inability to pay. Another significant difference noted between the two states is the use of safety net clinics. Although many Minnesotans described their use of the safety net, Texans more often reported that they would cross the border into Mexico if they found the cost of accessing healthcare in the United States to be unaffordable.

Quality of Care. Overall, the uninsured mothers reported that they were satisfied with the quality of the healthcare they received. When asked to rank the quality of their healthcare on a scale of 1 to 10 (with 1 being lowest and 10 being highest), on average they rated the quality of their healthcare an 8.

In Texas, women rank their quality of care much lower. Some joked that their quality of care should be ranked 0, but most rankings ranged from 1 to 3. It should be noted that because this rating is based solely on perceptions of quality, a firm conclusion cannot be drawn about the actual quality of care in Texas or Minnesota healthcare systems. Ultimately, our data suggest that access to care was a more salient issue for the uninsured mothers than quality of care. As one participant explained:

[Minnesota doctors] are good; what scares us are the prices. Because of that we have to go to the [safety net] clinics…. Maybe it’s not free there, but it’s at prices that we could afford.

Financial Concerns. Accessing healthcare services can be a very expensive endeavor for the uninsured. Even with the sliding-scale fees at safety net clinics, uninsured mothers discussed their frustration with the lack of affordability of healthcare services. One participant summarized the sentiment expressed by the entire group by stating simply that “without insurance, everything is expensive.” The exorbitant cost of healthcare was so much for one uninsured mother that she was forced to take out a private loan to pay off her medical debt.

So I went to the appointment. And they told me how I could do the payments. I asked for a loan from the bank, because it’s very expensive. And so now I am paying the bank.

A large number of uninsured mothers in both Minnesota and Texas stated that they were uninsured because
they were ineligible for Medicaid. The majority of those who said they were ineligible reported that their income is only slightly higher than the federal poverty guideline eligibility requirements for Medicaid. On the other hand, they reported that their employer-based health insurance is unaffordable, leaving them without any health insurance coverage. One woman explained that the cost of health insurance for her and her family was so expensive that she preferred to use safety net clinics and pay the sliding-scale fee each time, noting:

Imagine if it’s already time for the next check up and we still haven’t finished paying the bills from previous appointments. It’s frustrating.

The idea of payment plans also emerged from the discussions among the uninsured mothers, with one participant stating:

[Safety net clinics] give you credit. You don’t have to pay in cash every time. They make a plan for you.

Another participant explained the amount of money she would have to pay from each paycheck to have employer-based health insurance.

But, like, for me in my job, I only make $400, so how am I going to pay $280 for insurance? Imagine that—if I make $400 and they take $280?

Another participant stated:

I was working and they offered me insurance, but it turned out to be more expensive to go see the doctor and be paying monthly for insurance than it was to just go and pay the $20 each time [at a safety net clinic].

Other uninsured mothers described other responses to the high cost of care, such as using home remedies or delaying care. As one woman explained:

Would you rather have a bill that’s super expensive or go to buy homemade remedies so that you can give them to your kids so that they are more economical? Which would your rather have? Well, the homemade remedy, that’s cheaper.

Alternatively, in Texas, some uninsured mothers mitigated the financial burden of being uninsured by traveling the short distance across the border to Mexico to seek care.

**Summary**

Findings from the focus groups illustrated the issues and experiences of insured and uninsured Latina mothers in the healthcare systems in two states, Minnesota and Texas. The results indicated that overall, Minnesotans (both insured and uninsured) are satisfied with the healthcare services they receive. The areas of dissatisfaction with the healthcare system cited most often are the lack of affordability and relatively high costs. The results from the insured mothers suggest that even with health insurance coverage, they experienced other barriers to care. One interesting idea that emerged from both the insured and uninsured mothers was the concept of a payment plan or pay arrangement as a mechanism to make healthcare services more affordable. In addition, both the insured and uninsured mothers often cited language barriers as an obstacle. Uninsured mothers most often reported delaying care for themselves or their children; others reported using home remedies as a first line of defense against illness. The uninsured mothers noted that safety net clinics played a significant role in providing healthcare. Overall, the findings from these focus groups lend credence to the oft-cited notion that our healthcare system in the United States is broken.

**Improving the Quality of Minnesota’s Healthcare System**

The results of our focus groups suggest several recommendations to help alleviate the plight of the uninsured in Minnesota and improve the care and experiences of Latinos who access the Minnesota healthcare system.

First, our results suggest that access to healthcare is becoming increasingly unaffordable. The individual, family, and community benefits of providing health insurance coverage to this underserved population are substantial. Previous research has shown that the size of the uninsured population can have a significant spillover effect on healthcare access, cost, and quality for the insured population in the same community. Texas faces daunting financial and political challenges because it has the highest proportion of uninsured children and adults in the country. Real state-based solutions to solving the
The problem of uninsurance may not be politically feasible in Texas. However, Minnesota has one of the lowest rates of uninsurance and, as such, addressing the problem is much more realistic and feasible. If the costs of healthcare continue to increase, the problem of uninsurance is likely to get worse, not better. Swift action can result in substantial benefits for everyone by not only providing more financial stability to healthcare providers, but also by improving healthcare access and quality and, ultimately, population health. At the service-delivery level, policies are needed that encourage a variety of payment plan options for those with or without insurance who cannot afford the care they need or receive.

Second, other barriers to accessibility, such as language barriers and the lack of culturally appropriate healthcare, need to be addressed. Communication difficulties between patients and healthcare providers can lead to misdiagnosis as well as unnecessary clinical tests and procedures. Lack of linguistic concordance can also result in mistrust of English-speaking providers by patients who are not proficient in English. Language and communication barriers can be overcome through the use of appropriate language and cultural training for healthcare providers. The use of professional interpreters instead of family members or minors can also be effective at reducing misunderstandings between patients and providers in clinical encounters. Lastly, the adoption of comprehensive written policies related to language access can be important to reduce disparities in healthcare access and quality.6

Finally, the comparative analysis between insured and uninsured Latina mothers in Minnesota and Texas suggests that Minnesota mothers are more likely to delay care or resort to home remedies when they cannot access the healthcare system, whereas mothers in Texas have an additional option: relatively easy access to healthcare services in Mexico. In addition, the frequent decision by the uninsured to access safety net clinics in lieu of purchasing insurance must be considered in health policy initiatives targeting access to care for this population. Providing additional resources for safety net clinics in Minnesota would allow these facilities to continue to provide basic, culturally appropriate healthcare services at a relatively low cost. Moreover, there is an evident need for new health insurance products that target the Latino immigrant population in Minnesota. These health insurance products should focus on providing access to the basic healthcare services most-needed and most-used by Latino families at an affordable price. The Latino population in Minnesota will continue to grow in the near future and, as such, this market segment will become increasingly attractive to health insurance providers with experience offering services to this population.

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