Dear Chair Liebling and House Human Services and Finance Committee,

Thank you for the opportunity to testify in support of HF3. My name is Catherine Harrison and I reside in New Brighton, House District 40A with my husband and 3 young children. I am a registered nurse and public health professional and a member of the Minnesota Public Health Association. I'm submitting this written testimony to accompany my verbal remarks in strong support of HF3.

Over the course of my public health career I have worked with populations ranging from mothers and babies in rural West Africa, to undocumented day laborers, to college students at the University of Minnesota, and in topic areas ranging from Adverse Childhood Experiences to climate change and health equity. Across these diverse experiences, the basic definition of public health has been my North Star: "Public health is what we do as a society to assure the conditions for people to be healthy."

Robust, democratic processes are vital for this assurance. And while our public health theories and definitions tell us this, so does the data: Research from the Health & Democracy Index found that communities with high voter participation enjoy greater social cohesion and better health outcomes, including lower infant and premature mortality, adult disability rates, fewer poor mental health days and better self-reported health.[1] Not only that, but states with better civic participation experience shrinking health disparities. In short, ensuring representative democratic decision making is also a necessary means to health equity.

But there is a cost to voting. One tool to measure how hard or easy it is for people to vote is The Cost of Voting Index (COVI) which refers to the time and effort it takes a person to vote. Minnesota is ranked 15th of all states, so while we are doing better compared to some states, there is more we can do to protect and expand democracy.[2] It is important to promote and protect inclusive policies including the ones in HF3. Including AVR within DHS would dramatically improve voter registration for low-income Minnesotans and increase opportunities for improved health and well-being. Indeed, the Kaiser Family Foundation reported the Medicaid program serves more than 1.3 million low-income Minnesotans, who are more likely to be people of color and have worse health than the general population.[3] Research has shown a negative correlation between those enrolled in

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[1] Hunter D, Ayers J, Barba Brown J. Health & Democracy Index. https://democracyindex.hdhp.us/. Published August 31, 2021.

[2] Schraufnagel S, Pomante MJ, Li Q. Cost of Voting in the American States: 2020. Election Law Journal: Rules, Politics, and Policy. Published online October 13, 2020. doi:10.1089/elj.2020.0666

[3] Kaiser Family Foundation. Medicaid in Minnesota, October 2022. Accessed February 27, 2023. https://files.kff.org/attachment/fact-sheet-medicaid-state-MN

Medicaid and voter registration– such that Medicaid beneficiaries are less likely to be registered to vote than the general population.[4] Additionally, not being registered to vote is the number one reason given for not voting. AVR would reduce the administrative burden associated with registering to vote and alleviate unnecessary barriers to inclusion.

Those of us in public health know that community health and wellbeing would be considerably improved by the passage of HF3. Just last year the Minnesota Public Health Association passed its Voter Registration and Participation Resolution which supports policies like those included in HF3. Like my fellow MPHA members, I urge the health committee to pass this bill and the provision to enact AVR because it will empower Minnesotans to assure the conditions for a healthy future for ourselves and our communities.

Sincerely,
Catherine Harrison, RN MPH
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[4] Jake Haselswerdt, Jamila Michener; Disenrolled: Retrenchment and Voting in Health Policy. J Health Polit Policy Law 1 June 2019; 44 (3): 423–454. doi: https://doi.org/10.1215/03616878-7367012