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April 2018

SHADAC Announcements

April 19th Webinar: Estimates from the 2017 Minnesota Health Access Survey

Join us for a webinar on April 19th with experts from the Minnesota Department of Health (MDH) and SHADAC, who will explore new estimates from the 2017 Minnesota Health Access Survey (MNHA) showing an increase in uninsurance from 4.3% to 6.3% between 2015 and 2017. The MNHA is administered biennially by MDH and SHADAC to assess health insurance coverage and access to care across the state. Register now.

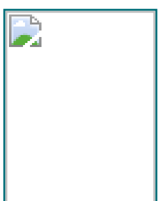
Analysis Finds Lower Access to Care among Adults with Less Education

A SHADAC analysis of data from the Behavioral Risk Factor Surveillance System (BRFSS) shows the extent to which adults (25 years and older) with different levels of education skipped needed care due to cost and did not have a personal doctor in 2016. Nationally, adults with less than a high school education were more than three times as likely to skip care due to cost in 2016 than were adults with a bachelor's degree or higher (22.9% vs. 7.3%) and twice as likely to report that they did not have a personal doctor (31.8% vs. 15.2%). Other indicators on coverage and access are available from SHADAC at State Health Compare.

Minnesota Care Coordination Cost Study: Final Report

SHADAC researchers recently completed an analysis of the costs of care coordination for adults in Minnesota's Health Care Homes (HCH) program. Under a contract with the Minnesota Departments of Health and Human Services, SHADAC used a case study approach and collected information about the costs associated with care coordination activities at six non-acute, primary care clinics. The research team found that costs for care coordination varied considerably across sites, from $1 to $12 per HCH adult panel in a typical month. Staff across sites reported the high value of care coordination to patients, with many noting that care coordination improved the efficiency of care delivery and likely saved costs and resources.

Brief Examines Context and Core Components of Minnesota's Accountable Communities for Health



A new SHADAC brief describes the development and implementation of Minnesota's 15 Accountable Communities for Health (ACHs), which were implemented under the federal Center for Medicare and Medicaid Innovation's State Innovation Models (SIM) Initiative. The brief focuses on ACH collaborative leadership structures, community-based care coordination care teams, and population-based health prevention plans. ACHs implemented a range of care coordination approaches that varied in their institutional anchor point (i.e., medical vs. non-medical) and frequently leveraged existing prevention work in the

community for their population-based prevention plans.

Health Data, Results, & Trends from the States

Kansas: KanCare Expansion and Work Requirements

The Kansas Health Institute published an issue brief that explores how Medicaid work requirements proposed by the Kansas Department of Health and Environment might apply if Kansas were to expand Medicaid to nonelderly adults (19 to 64 years old) with household incomes below 138% of the federal poverty level (FPL). The brief shows that expanding Medicaid would add an estimated 145,000 new beneficiaries, including about 95,000 adults and nearly 50,000 children, to the KanCare program. About two-thirds of projected newly enrolled adults (about 64,000) were already employed at some point during the previous year.

Oregon: Early Release Results from the Oregon Health Survey

Early release results are now available from the biennial 2017 Oregon Health Insurance Survey (OHIS). The survey results show an uninsurance rate of 6.2% (just over 245,000), with no significant change from 2015. In 2017, 47.5% of Oregonians had private group health insurance, 26% had Medicaid through the Oregon Health Plan, 15.1% had Medicare, 5.2% had individual private insurance, and 6.2% were uninsured.

Payment & Delivery System Advancement in the States

Oregon: Coordinated Care Organization Incentive Metrics through Mid-2017

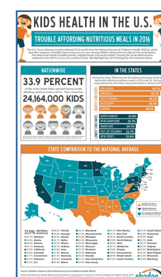
The Oregon Health Authority has published its annual mid-year progress report on Coordinated Care Organization (CCO) incentive metrics and other state quality measures. The report examines three measures: adolescent well-care visits, effective contraceptive use, and emergency department (ED) utilization. Statewide, adolescent well-care visits continued to improve, increasing by 4.0% from 2016 to 2017, with 12 CCOs improving in this area. ED utilization in the state declined when CCOs were first implemented, and use has remained fairly stable, decreasing by 1.5% from 2016 to 2017. In all, 14 CCOs have improved in the area of childhood immunizations, with overall childhood immunizations rates increasing by 2.8% since 2016.

Design, Funding, and 1332 Waiver Considerations for State Reinsurance Programs

A new issue brief from Manatt, State Reinsurance Programs: Design, Funding, and 1332 Waiver Considerations for States, provides a roadmap of policy, program design, and financing considerations for states that are contemplating development of a state-based reinsurance program under 1332 waiver authority. The brief's state policy highlight gives an overview of approved 1332 reinsurance waivers to date and spotlights a new 1332 application template developed by State Health and Value Strategies.

Federal Data: News & SHADAC Resources

SHADAC Data Highlight: The National Survey of Children's Health



SHADAC has published the first of a series of blogs and infographics that will highlight state-specific findings from the 2016 National Survey of Children's Health (NSCH). These results were recently released by the U.S. Census Bureau and provide an ideal data source for monitoring social determinants of health among children. Our first blog and accompanying infographic explore access to nutritious meals. According to the new data, 33.9% of children nationwide (approximately 24,164,000 children) had trouble affording nutritious meals in 2016. The five states with the highest percentages of children who had trouble affording nutritious meals in 2016 were Oklahoma (46.1%), Arkansas (45.1%), West Virginia (43.5%), Mississippi (43.4%), and Florida (40.5%).

Census Bureau Releases 2016 County Health Insurance Estimates

Small Area Health Insurance Estimates: 2016

Small Area Estimates

Current Population Reports

P30-03

March 2018

INTRODUCTION

This report provides a summary of the 2016 release of the U.S. Census Bureau's Small Area Health Insurance Estimates (SAHIE) program. The SAHIE program is partially funded by the Centers for Disease Control and Prevention's (CDC) Division of Cancer Prevention and Control (DCPC). The DCPC's National Breast and Cervical Cancer Early Detection Program and their stakeholders use SAHIE to determine the number of low-income uninsured women who may be eligible for their program at the state and county level.

SAHIE are the only source of data for single-year estimates of health insurance coverage status for all counties in the United States by selected economic and demographic characteristics (see text box "Small Area Health Insurance Estimates (SAHIE)").[1] The 1-year American Community Survey (ACS) only provides detailed estimates of health insurance coverage for counties with populations of 65,000 or more.[2] As a data enhancement to the ACS, the SAHIE model-based estimates are a vital source of information for measuring year-to-year change in health insurance coverage at the county level. The data presented in this report show changes in health insurance coverage between 2015 and 2016, as well as changes in health insurance between 2013 and 2016. In addition, it presents results on the differences in coverage among selected demographic groups.

HIGHLIGHTS

- Among the population under age 65, the estimated uninsured rate decreased between 2015 and 2016 for 629 counties, or 20.0 percent of all U.S counties.
- In 2016, for the population under age 65, the estimated uninsured rate was less than 10 percent in 1,213 counties, or 38.6 percent of all U.S. counties.
- In 2016, working-age adult males had a higher estimated uninsured rate than females in 1,662 counties, or 52.9 percent of all U.S. counties.

OVERVIEW OF SAHIE

Each year, the SAHIE program releases timely, reliable estimates of health insurance coverage for both the insured and uninsured populations in the

United States Census Bureau

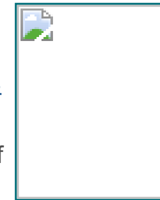
U.S. Department of Commerce
Economics and Statistics Administration
U.S. CENSUS BUREAU
census.gov

The U.S. Census Bureau released Small Area Health Insurance Estimates (SAHIE) for 2016, providing estimates of health insurance coverage for all counties and states. The SAHIE program is the only source of single-year health insurance estimates for every county in the U.S. Estimates are available for each county by age, sex, and Federal Poverty Level (FPL). Race/ethnicity information is available at the state level. County uninsured rates for the nonelderly population (i.e., under age 65) ranged from 2.1% to 33.5% nationwide in 2016, with a median county uninsured rate of 10.4%. Learn more about the 2016 SAHIE information on the SHADAC blog.

National Health Interview Survey (NHIS): January to September 2017 Early Release Estimates

The National Center for Health Statistics released coverage estimates from the National Health Interview Survey for the first three quarters of 2017, which show few significant changes when compared with the first three quarters of 2016. At 12.7%, the uninsurance rate for nonelderly adults (ages 18 to 64) at the time of interview remained stable, as were the rates of public (19.5%) and private coverage (69.3%). Among the few significant changes that did occur, public coverage decreased from 55.0% to 51.3% and private coverage increased from 20.6% to 25.6% for those with incomes below 100% of the federal poverty level.

State Health Compare: Estimates on State Funding for Public Health



A new brief provides an overview of the most recent estimates for state public health funding on SHADAC's State Health Compare, using data collected by Trust for America's Health. There is a wide gap between state public health funding among states, ranging from $4 per capita in Nevada to $221 per capita in West Virginia. The national average of state-funded public health activities for 2015 was $44 per capita.

Recommended Reading

What to Know about the Citizenship Question the Census Bureau is Planning to Ask in 2020
Pew Research Center, March 30, 2018

A Framework for Evaluating Medicaid Buy-In Proposals
Health Affairs, March 23, 2018

There's a Lot to Learn from State Medicaid Experiments, but Only If They're Carefully Evaluated
Health Affairs, March 19, 2018

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