



December 2017

## SHADAC Announcements

### SHADAC's Evaluation of Minnesota's State Innovation Model (SIM): Key Findings



The executive summary of SHADAC's final evaluation report on the SIM initiative in Minnesota is [now available](#). SHADAC conducted the state-level evaluation between 2015 and 2017. The executive summary highlights Minnesota's progress with its Medicaid Accountable Care Organization (ACO) program, electronic health information exchange, practice transformation, community-based care coordination, ACO multi-payer alignment, and community engagement.

### Lynn Blewett in Health Affairs: Minnesota's 1332 Dilemma



SHADAC Director Lynn Blewett discussed Minnesota's 1332 reinsurance waiver request in [a recent post on the Health Affairs Blog](#). Minnesota submitted a 1332 reinsurance waiver request to the Centers for Medicare and Medicaid Services (CMS) in May 2017, asking for pass-through funding to support a reinsurance program and to support the state's Basic Health Program, MinnesotaCare. CMS approved the pass-through funding for the state's reinsurance program but not for the BHP, resulting in an estimated \$369 million loss to the state over two years. [Read our overview of Dr. Blewett's blog.](#)

### SHADAC Comments on New Direction for Center for Medicare and Medicaid Innovation

The federal Center for Medicare and Medicaid Innovation (Innovation Center) issued a [request for stakeholder feedback](#) in September on a proposed new direction for the Center, which is shifting its focus toward testing new models of patient-centered care that emphasize choice and competition. Drawing on our experience providing evaluation services to states implementing innovative ways to deliver and pay for health care, [SHADAC provided feedback](#) on the principles of transparent model design and evaluation as well as small-scale testing; identified lessons from our work with states that can inform future state-based models; and identified opportunities and challenges for states implementing new models of health care payment and delivery.

### Health Plans for Employees at Large Firms Paid for Smaller Portion of Medical Expenses in 2016 (Infographic)

A [new SHADAC infographic](#) illustrates the recent decline in the share of medical expenses paid by health plans for employees at large firms. Data from the Medical Expenditure Panel Survey (MEPS) show that this share dropped by 1.3 percentage points nationwide between 2014 and 2016. Across the country, health plans for employees at large firms paid for 80.4% of the medical expenses of their enrollees in 2014, compared with 79.1% in 2016. In all, 13 states saw significant decreases on this measure from 2014 to 2016, and Rhode Island is the only state that saw a significant increase.



## Health Data, Results, & Trends from the States

### California: 2016 California Health Interview Survey (CHIS) Data Now Available

Researchers can now access a variety of publicly available [2016 data files and web tools from the California Health Interview Survey](#) (CHIS). The CHIS is the nation's largest state health survey and provides annual estimates a variety of topics related to health and health care. The publicly available CHIS data products enable



researchers to customize and run their own statistical code, and they include downloadable data sets and PDF documents.

### Massachusetts Employer Survey (MES): Employer Offer Rates above National Average

Results from the [2016 Massachusetts Employer Survey](#) (MES) are now available. The survey tracks and monitors employer health insurance offerings, employee take-up rates, cost-sharing, plan characteristics, and employer decision-making. The 2016 results show that 65% of Massachusetts employers offered health insurance, which was higher than the national offer rate of 56%. Among employees who were eligible for their employer's health plans, 74% chose to enroll, which was slightly below the national rate of 79%.

### Minnesota: Chronic Disease Costs Projected to Grow Quickly between 2014 and 2023

The Health Economics Program at the Minnesota Department of Health (MDH) recently released its annual report to the Minnesota legislature, [Treated Chronic Disease Costs in Minnesota — A Look Back and a Look Forward](#). The analysis found that spending on chronic disease, particularly for the elderly, accounts for a significant share of total current and future healthcare spending by state-administered health care programs; state health care spending for all conditions rose from 2009 to 2014, while per-person spending fell for a number of categories; and ten-year projections of state healthcare spending show considerable cost growth from 2014 to 2023 (ranging from 24.8% for smoking exposure to 65.1% for all chronic conditions among individuals ages 60 and older).

### Oregon Health Insurance Survey (OHIS): Early Release Results Show General Coverage Stability between 2015 and 2017



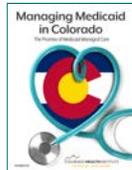
The [early release results of the 2017 Oregon Health Insurance Survey](#) (OHIS) are now available. The OHIS is an annual survey of health insurance coverage and access to and use of health care in Oregon. The early release results show that, after significant shifts in health insurance coverage from 2013 to 2015, there was no significant change in the state's insured rate between 2015 and 2017. According to the data, 93.8% of Oregonians (about 3.75 million people) had health insurance coverage in 2017, and 88.9% were insured for all 12 months preceding the survey.

## Payment & Delivery System Advancement in the States

### CMCS Informational Bulletin for States: Delivery System and Provider Payment Initiatives under Medicaid Managed Care Contracts

The Centers for Medicaid and CHIP Services (CMCS) released an [informational bulletin](#) describing states' ability to implement delivery system and provider payment initiatives under Medicaid managed care contracts under 42 CFR 438.6(c). The bulletin presents approval criteria for state directed payment arrangements, including that the payments must advance the state's Medicaid managed care quality strategy and that there must be an evaluation plan to assess the degree to which the payment arrangement achieves its objectives.

### Colorado: Managing Medicaid



A [new report](#) from the Colorado Health Institute outlines the key elements of managed care and initiatives in Colorado Medicaid that already draw upon managed care principles using a variety of approaches. The report is the first in a series that will also look at other states' experiences with Medicaid managed care and quantify the potential risks and rewards of a new approach to control costs without cutting services for the growing number of Coloradans covered by the program.

## Federal Data: News & SHADAC Resources

### State Health Compare: New 2016 Estimates of Coverage, Spending Burden, and Social Determinants of Health

SHADAC's [State Health Compare](#) has been updated to include 2016 state estimates of health insurance coverage, people with high medical care cost burden, unemployment rate, adult educational attainment, and children considered to be poor. State Health Compare allows users to explore insurance coverage status and type across a wide range of socioeconomic factors such as age, citizenship, education, income, health status, and race/ethnicity. State estimates for high medical spending and adult educational attainment are available by income and race/ethnicity; estimates of children in poverty are available by race/ethnicity; and unemployment and income inequality are available



for states as a whole. Users can create and download customized graphics for these estimates and export the underlying data.

Several updated measures in State Health Compare come from the 2016 Behavioral Risk Factor Surveillance System (BRFSS), which was released last month by the Centers for Disease Control and Prevention (CDC). [Access the full BRFSS dataset and documentation.](#)

### NHIS Estimates for First Half of 2017 Released, Uninsurance Held Mostly Steady



[New coverage estimates from the National Health Interview Survey](#) (NHIS) indicate that uninsurance rates for nonelderly adults held steady in the first half of 2017. According to the new numbers, 12.5% of nonelderly adults nationwide were uninsured during the first half of 2017, which is statistically unchanged from 12.4% during the first half of 2016. The new NHIS estimates also show that uninsurance rates were mostly stable across age, race/ethnicity, and income groups when comparing the first half of 2016 to the first half of 2017, with one exception to this stability: Among nonelderly adults with incomes between 250% and 400% of the federal poverty level (FPL), the uninsurance rate increased significantly from 10.2% to 12.2%. [Read our blog post for more details.](#)

### ACS 5-Year Estimates for 2012-2016 Released, SHADAC Tables for All States & Counties Now Available

SHADAC tables of state and county uninsurance estimates for 2012 to 2016 are [now available via clickable map](#). Users can click a state to access a table of 5-year uninsurance estimates for the state and all counties using data from the American Community Survey (ACS). With the 5-year pooled data, estimates are available even for counties with a population below 65,000 (for which estimates are not available with a single year of ACS data).



## Recommended Reading

[Value-Based Reimbursement State-by-State: A 50-State Review of Value-Based Payment Innovation](#)  
*White Paper*, Change Healthcare, 2017

[Searching for New Insurance Options, States Consider Medicaid Buy-In and Other Strategies](#)  
*State Health Policy Blog*, National Academy for State Health Policy, December 12, 2017

[Comparing Estimates of the Uninsurance Rate in Massachusetts from Survey Data](#)  
*Research Brief*, Massachusetts Center for Health Insurance and Analysis, November 2017

[Medicaid Payment and Delivery System Reform: Early Insights from 10 Medicaid Expansion States](#)  
*Issue Brief*, Commonwealth Fund, October 2017

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