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Exploring Disparities Using New and Updated Measures on SHADAC'S State Health Compare

February 6, 2019 - 1:00 PM CDT

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SHADAC Director

Lynn Blewett, PhD, MPA

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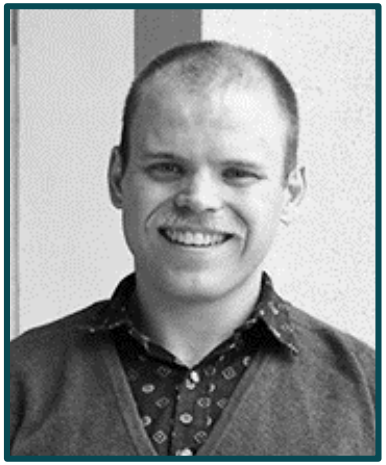
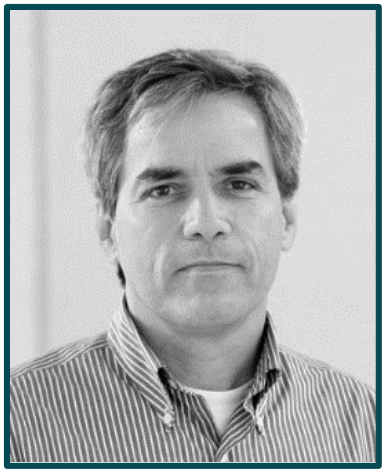
Presenters



Robert Hest, MPP
SHADAC Research Fellow



Brett Fried, MS
SHADAC Senior Research Fellow

State Health Compare Overview

Robert Hest, MPP
Research Fellow, SHADAC

SHADAC's State Health Compare -- 40+ State-level Measures of:

- Health Insurance Coverage
- Cost of Care
- Health Behaviors
- Outcomes
- Access to Care
- Utilization of Care
- Quality of Care
- Public Health
- Social and Economic Factors

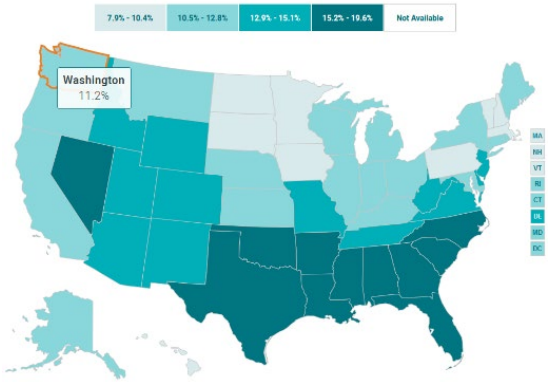
SHADAC's State Health Compare

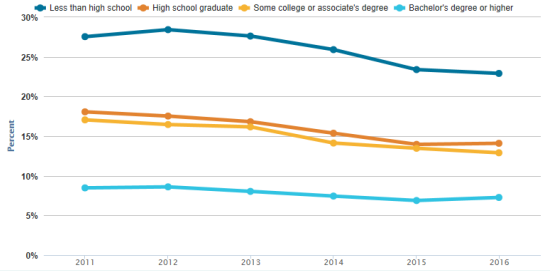
Access Policy-relevant breakdowns available for most measures

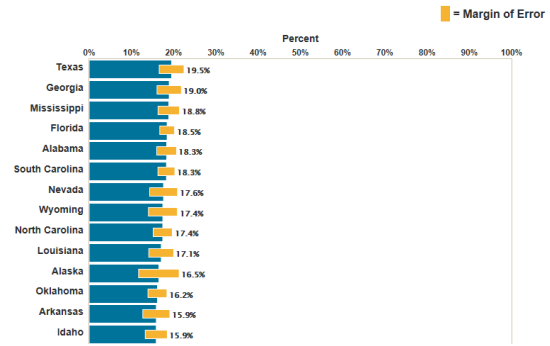
Generate tables, maps, bar charts, trends, and state rankings

Margins of error in addition to point estimates allows for significance testing

Data can be downloaded in spreadsheet format







Hest, Robert. "Significance Testing Using State Health Compare." May 2017. SHADAC. Available at: www.shadac.org/publications/significance-testing-using-state-health-compare

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16 Data Sources

- American Community Survey (ACS)
- Current Population Survey (CPS)
- Behavioral Risk Factor Surveillance System (BRFSS)
- National Health Interview Survey (NHIS)
- Healthcare Cost and Utilization Project (HCUP)
- Medical Expenditure Panel Survey (MEPS-IC)
- Other sources

Background on New Measures:

UNAFFORDABLE RENTS

Why add the unaffordable rents measure to State Health Compare?

Policy Relevant:

"There is strong evidence characterizing housing's relationship to health. Housing stability, quality, safety, and affordability all affect health outcomes."

- ✓"Nearly Half of American Renters are Cost Burdened" - *Joint Center for Housing Studies at Harvard University*

"In the United States, a chronic shortage of affordable housing is a barrier to improved health and well-being."

- ✓To Keep You Healthy, Health Insurance May Soon Pay Your Rent - *Forbes*

Sources: T. R. Goldman, "Using The Low-Income Housing Tax Credit To Fill The Rental Housing Gap," Health Affairs Health Policy Brief, June 7, 2018. DOI: 10.1377/hpb20180313.398185, https://www.healthaffairs.org/do/10.1377/hpb20180313.398185/full/; B. Japsen, August 14, 2018. "To Keep You Health, Health Insurers May Soon Pay Your Rent." Forbes. https://www.forbes.com/sites/brucejapsen/2018/08/14/to-keep-you-healthy-health-insurers-may-soon-pay-your-rent/#1ca9617b67ce . L. Taylor, "Housing and Health: An Overview of the Literature," Health Affairs Health Policy Brief, June 7, 2018. DOI: 10.1377/hpb20180313.398185, https://www.healthaffairs.org/do/10.1377/hpb20180313.398185/full/; Joint Center for Housing Studies of Harvard University, 2017. Nearly Half of American Renters are Cost Burdened." http://harvard-cga.maps.arcgis.com/apps/MapSeries/index.html?appid=ea1929b8f2bf482dadad173a3f62c27e

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Why add the unaffordable rents measure to State Health Compare (cont'd)?

Other reasons for adding this measure:

- Available for all states and for key subpopulations
- Allows for statistical testing
- Data comes out annually
- Customizable because it is microdata
- Available over time

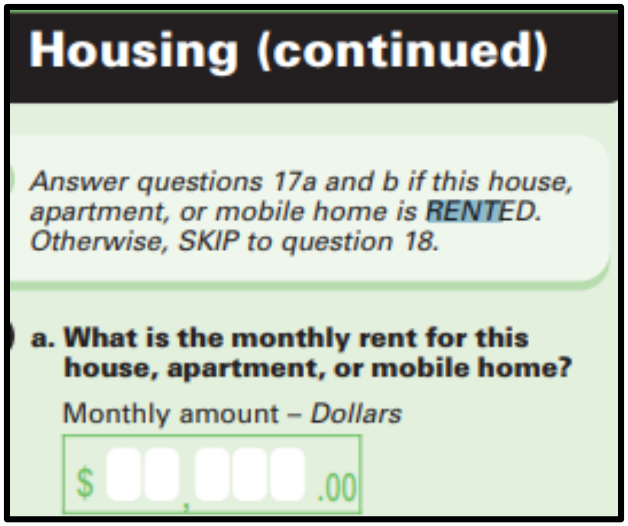
Source: T. R. Goldman, "Using The Low-Income Housing Tax Credit To Fill The Rental Housing Gap," Health Affairs Health Policy Brief, June 7, 2018. DOI: 10.1377/hpb20180313.398185, https://www.healthaffairs.org/do/10.1377/hpb20180313.398185/full/

Data Source for Unaffordable Rents: The American Community Survey (ACS)

- **Primary Focus:** General household survey; replaced decennial census long form
- Administered by the Census Bureau
- Conducted annually in all states and DC
- Target Population for Webinar: Households that rent
- Sample size: 3,200,000 individuals in 2017

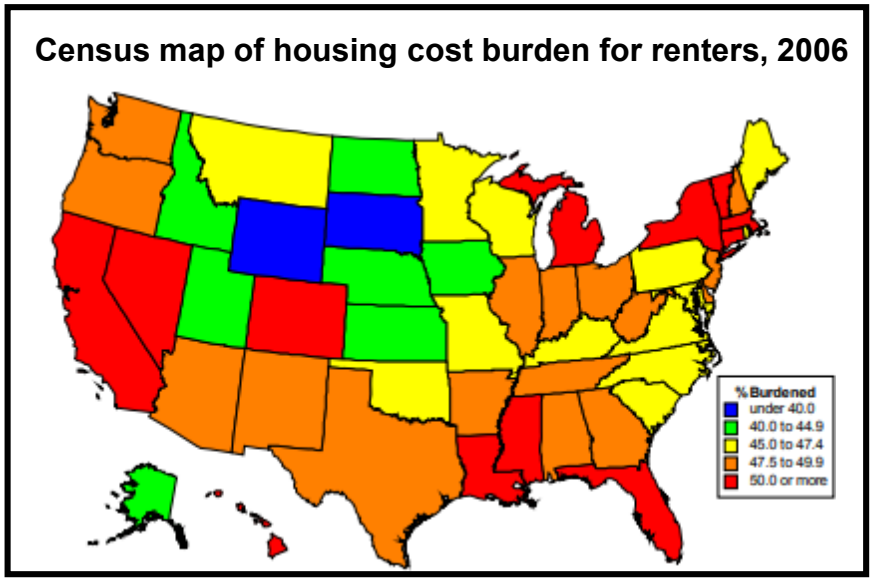
Variables/Questions in the ACS for Unaffordable Rents?

- **Housing Tenure:** Is this house, apartment or mobile home rented?
- **Gross Rent:** Recoded variable from census that reports the gross rental costs of the housing unit, including contract rent plus additional costs for utilities
- **Household Income:** Recoded and includes the income of the householder and all other individuals 15 years old and over in the household.



Why use the 30% affordability rule?

- HUD and the USDA use the 30% affordability rule in the rental programs they administer:
  - Section 8 voucher program and project based rental assistance
  - Public Housing
  - Section 202 Housing for the elderly
  - Section 521 Rental Assistance
- It is used by the Census Bureau and other research organizations to define housing cost burden



Sources: Brennan, M and M. Galvez. 2017. "Housing as a Platform, Strengthening the Foundation for Well-Being," Urban Institute, Washington, D. C. https://www.urban.org/sites/default/files/publication/.../housing-as-platform_1.pdf

Schwartz, M. & Wilson E. 2007. Who Can Afford to Live in a Home?: A look at data from the 2006 American Community Survey." Washington D.C, U.S. Census Bureau. https://www.census.gov/housing/census/publications/who-can-afford.pdf

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Limitations to the Unaffordable Rents measure?

- As a measure of financial burden it doesn't account for neighborhood school quality, public safety and access to jobs and amenities.
- Does not take into account family size
- Higher income households can pay more for housing and still have enough left over for necessities

Source: Herbert, C., Hermann, A., McCue, D. 2018. Joint Center for Housing Studies of Harvard University, Measuring Housing Affordability: Assessing the 30% of Income Standard http://www.jchs.harvard.edu/research-areas/working-papers/measuring-housing-affordability-assessing-30-percent-income-standard

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Breakdowns available for unaffordable rents on State Health Compare

Medicaid Enrollment

- Rental households with a Medicaid enrollee (Medicaid rental households)
- Rental households without a Medicaid enrollee (Non-Medicaid rental households)

Household Income

- Rental households with incomes less than $25,000
- Rental households with incomes from $25,000 to $49,999
- Rental households with incomes $50,000 or greater

Disability Status

- Rental households with a person that has a disability
- Rental households without a person that has a disability

Race/Ethnicity

- Rental households with a person of color in the household
- Rental households without a person of color in the household

Variation Between States in Unaffordable Rents for Rental Households, 2017

Among Rental Households: Percent with Unaffordable Rents	
TOP FIVE STATES	
1. Florida	53.8%
2. California	53.1%
3. Hawaii	51.7%
4. New York	50.3%
5. New Jersey	49.6%
BOTTOM FIVE STATES	
1. North Dakota	36.0%
2. Nebraska	37.4%
3. South Dakota	37.5%
4. Iowa	38.2%
5. Montana	39.3%
United States	***46.8%***

Among rental households in Florida: 53.8% have unaffordable rents

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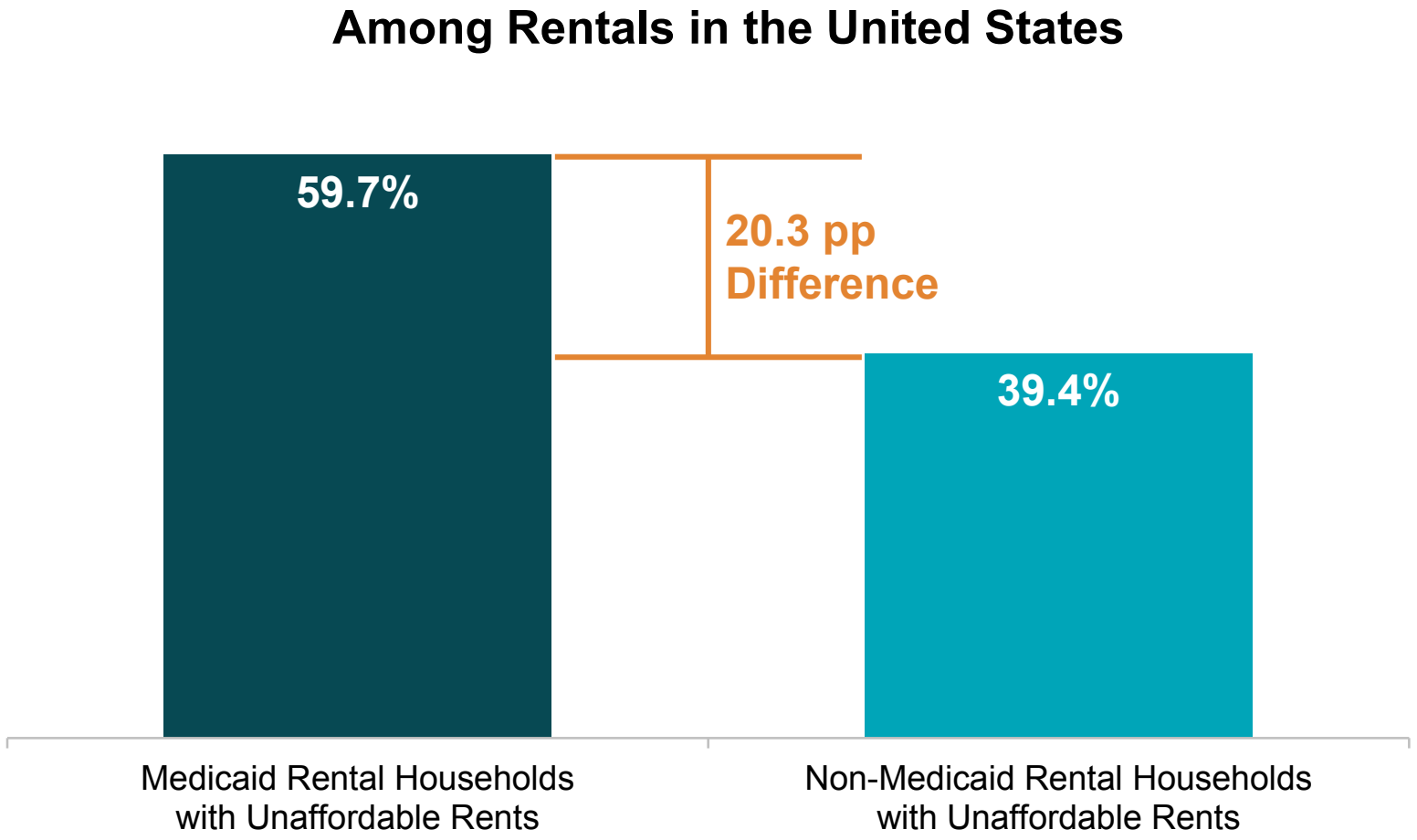
Percentage Point Difference: Medicaid Breakdown of Unaffordable Rents in the U.S, 2017

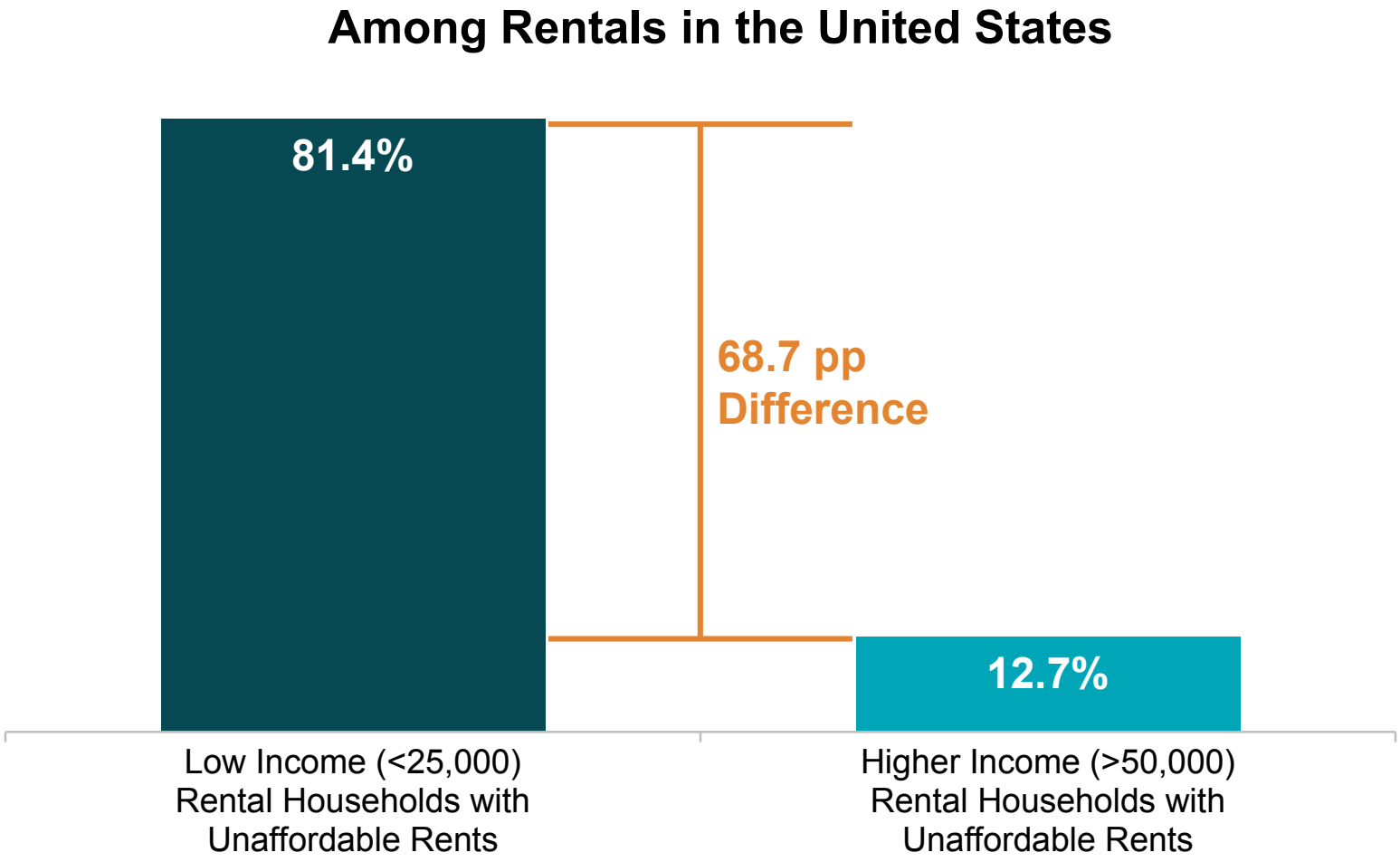


Percentage Point Difference: Medicaid Breakdown of Unaffordable Rents by State, 2017

TOP FIVE STATES	Medicaid Rental Households	Non-Medicaid Rental Households	Percentage-Point Difference
1. Nevada	63.5%	38.4%	25.1 pp
2. Michigan	60.2%	35.6%	24.6 pp
3. Ohio	56.2%	32.0%	24.2 pp
4. New York	63.8%	39.6%	24.2 pp
5. Wisconsin	58.8%	34.7%	24.1 pp

BOTTOM FIVE STATES	Medicaid Rental Households	Non-Medicaid Rental Households	Percentage-Point Difference
1. Hawaii	55.1%	50.4%	4.7 pp
2. South Dakota	45.6%	34.4%	11.1 pp
3. South Carolina	54.8%	42.5%	12.3 pp
4. Alaska	50.0%	37.3%	12.7 pp
5. Delaware	56.9%	42.8%	14.1 pp

Percentage Point Difference: Household Income Breakdown of Unaffordable Rents in the U.S, 2017



Percentage Point Difference: Income Category Breakdown of Unaffordable Rents by State, 2017

TOP FIVE STATES	Low Income (<25,000) Rental Households	High Income (>50,000) Rental Households	Percentage-Point Difference
1. Nevada	89.2%	8.3%	80.9 pp
2. Indiana	81.4%	2.4%	79.1 pp
3. Wisconsin	82.0%	3.6%	78.4 pp
4. Arizona	85.8%	7.4%	78.4 pp
5. Texas	85.3%	8.2%	77.1 pp

BOTTOM FIVE STATES	Low Income (<25,000) Rental Households	High Income (>50,000) Rental Households	Percentage-Point Difference
1. Hawaii	75.6%	31.9%	43.7 pp
2. Dist. of Columbia	79.7%	21.8%	57.9 pp
3. Massachusetts	75.8%	16.0%	59.8 pp
4. Rhode Island	68.9%	6.7%	62.1 pp
5. Maine	68.7%	6.5%	62.2 pp

Background on New Measures:

UNHEALTHY DAYS

Why add the Unhealthy Days Measures to State Health Compare?

Policy Relevant:

"Because Healthy Days captures broad dimensions of health from the individual's perspective, it is a simple way to holistically measure the health and well-being of a population and its trend over time."

“The Healthy Days measures have broad applications for federal, state, and local governments to better understand the needs of their communities and to identify vulnerable subpopulations.”

“It baffles me that not everyone is using this as a standard tool of measuring progress within communities.” – Humana CMO, Mary Caffrey

Sources: S. Lane Slabaugh, Mona Shah, Matthew Zack, Laura Happe, Tristan Cordier, Eric Havens, Evan Davidson, Michael Miao, Todd Prewitt, Haomiao Jia “Leveraging Health-Related Quality of Life in Population Health Management: The Case for Healthy Days.” Population Health Manag. 20(1): 13–22. doi: 10.1089/pop.2015.0162. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5278802/; Caffrey, M. (2018). Humana’s “Bold Goal” update finds more healthy days for Medicare Members in 4 cities. *American Journal of Managed Care, “In Focus” Blog.* Available at https://www.ajmc.com/focus-of-the-week/humanas-bold-goal-update-finds-more-healthy-days-for-medicare-members-in-4-cities

Why add the Unhealthy Days Measures to State Health Compare (cont'd)?

Other reasons for adding this measure:

- Available for all states and for subpopulations
- Allows for statistical testing
- Data comes out annually
- Customizable because it is microdata
- Available over time

Data Source for Unhealthy Days: The Behavioral Risk Factor Surveillance System (BRFSS)

- **Primary Focus:** Health-related risk behaviors, chronic health conditions and use of preventive services
- Administered by the Centers for Disease Control and Prevention (CDC)
- Conducted annually in all states and DC
- Target Population: Civilian non-institutionalized population 18 years of age and over
- Sample size: ~ 450,000 individuals in 2017

Questions on the BRFSS for Unhealthy Days?

- **Physically Unhealthy Days:** “Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?”

- **Mentally Unhealthy Days:** “Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?”

How are estimates for unhealthy days created?

Physically or Mentally Unhealthy Days: The number of "physically unhealthy days" or "mentally healthy days" is summed across all adults in the state and then divided by the number of adults in the state

All Unhealthy Days:

1) The number of "physically unhealthy days" and "mentally unhealthy days" is summed to create an "all unhealthy days" total for each adult
2) The number of "all unhealthy days" is then summed across all adults in the state
3) It is then divided by the number of adults in the state.

Limitations of the “all unhealthy days” measure

1) Overlap between the number of “physically unhealthy days” and “mentally unhealthy days”
2) The “all unhealthy days” measure is truncated at 30 days.

Addressing the limitations

- The CDC has found that the pattern of responses to the unhealthy days questions supports using the “all unhealthy days” measure.
- SHADAC reports all three types of measures separately so that it is possible to highlight differences in physical health as well as mental health

Source: Centers for Disease Control and Prevention. Measuring Healthy Days. Atlanta, Georgia: CDC, November 2000.

Breakdowns available for the unhealthy days measures on State Health Compare

- **Household Income:** <$15,000, $15,000 to $24,999, $25,000 to $49,999, $50,000+
- **Age:** 18 to 34, 35 to 54, 55 to 64, 18 to 64, 65+
- **Coverage Type:** uninsured and insured
- **Disability Status:** with a disability and no disability
- **Education:** <HS, HS graduate, some college and BA+
- **Race/Ethnicity:** Hispanic/Latino, White, Black and Other

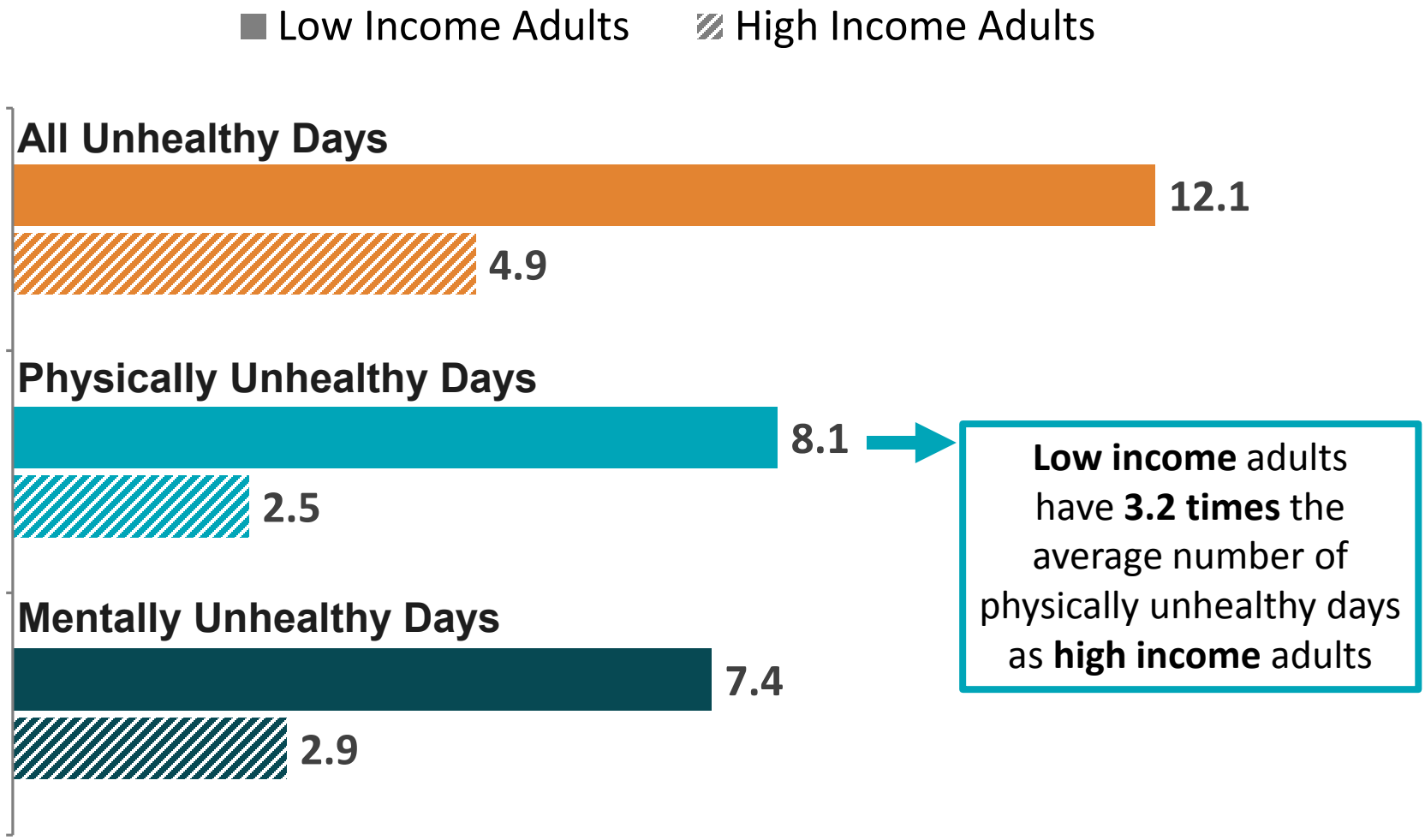
Variation Between States for the Unhealthy Days Measures, BRFSS 2017

Physically *or* Mentally Unhealthy Days	
TOP FIVE STATES	
1. West Virginia	9.0
2. Arkansas	8.6
3. Kentucky	8.5
4. Mississippi	8.2
5. Louisiana	8.2
BOTTOM FIVE STATES	
1. Minnesota	5.3
2. District of Columbia	5.4
3. Nebraska	5.9
4. South Dakota	5.9
5. Hawaii	5.9
United States	***6.8***

Physically Unhealthy Days Only	
TOP FIVE STATES	
1. West Virginia	5.7
2. Kentucky	5.4
3. Arkansas	5.3
4. Mississippi	5.1
5. Alabama	5.1
BOTTOM FIVE STATES	
1. District of Columbia	2.6
2. Minnesota	3.1
3. Nebraska	3.3
4. North Dakota	3.3
5. Connecticut	3.5
United States	***4.0***

Mentally Unhealthy Days Only	
TOP FIVE STATES	
1. West Virginia	5.2
2. Arkansas	5.1
3. Louisiana	5.0
4. Kentucky	4.9
5. Mississippi	4.9
BOTTOM FIVE STATES	
1. Minnesota	3.0
2. South Dakota	3.1
3. Hawaii	3.2
4. Nebraska	3.4
5. Connecticut	3.4
United States	***4.0***

Nationally: *How much greater are the average number of unhealthy days among low income adults (<$15,000) as compared to higher income adults (>$50,000)?*



State Level: *How much greater are the average number of unhealthy days for low income adults (<$15,000) compared to higher income adults (>$50,000)?*

Physically *or* Mentally Unhealthy Days	
TOP FIVE STATES	
1. Idaho	3.5x
2. Kentucky	3.4x
3. New Hampshire	3.4x
4. Wyoming	3.4x
5. Tennessee	3.3x
BOTTOM FIVE STATES	
1. Nevada	1.7x
2. California	1.8x
3. Hawaii	1.9x
4. New York	1.9x
5. New Jersey	2.2x

Physically Unhealthy Days Only	
TOP FIVE STATES	
1. Tennessee	5.3x
2. Kentucky	5.0x
3. Idaho	4.7x
4. North Carolina	4.6x
5. New Hampshire	4.5x
BOTTOM FIVE STATES	
1. Nevada	2.0x
2. Hawaii	2.2x
3. California	2.3x
4. New York	2.7x
5. New Jersey	2.8x

Mentally Unhealthy Days Only	
TOP FIVE STATES	
1. Idaho	4.3x
2. New Hampshire	4.2x
3. Maine	4.0x
4. Wyoming	4.0x
5. Iowa	3.7x
BOTTOM FIVE STATES	
1. California	1.8x
2. New York	1.8x
3. Nevada	2.0x
4. New Jersey	2.2x
5. Massachusetts	2.2x

Low income adults in **Idaho** have **3.5 times** the average number of unhealthy days as higher income adults

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Virtual State Health Compare Tour

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Products that use State Health Compare Data

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EDUCATION MATTERS

Two Measures on State Health Compare

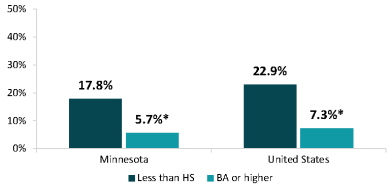
statehealthcompare.shadac.org

MN Minnesota

PERCENT OF ADULTS (25+) WHO DIDN'T GET MEDICAL CARE DUE TO COST

By Educational Attainment, 2016

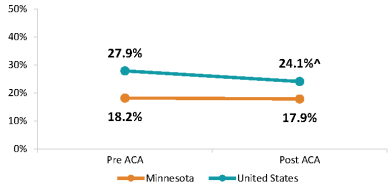
In Minnesota, adults with less than a high school education were over three times as likely as those with a Bachelor's degree or higher to forgo needed care due to cost.



* Difference between BA or higher and less than HS significant at the 95% level in 2016

By Less than High School Education, Pre/Post ACA

In Minnesota, the change before and after implementation of the ACA was not statistically significant.

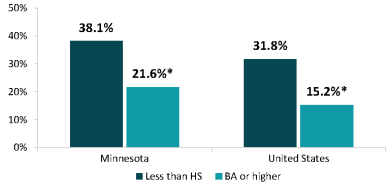


^ Difference pre/post ACA significant at the 95% level
Pre ACA is defined as 2011-2013. Post ACA is defined as 2014-2016

PERCENT OF ADULTS (25+) WHO DON'T HAVE A PERSONAL DOCTOR

By Educational Attainment, 2016

In Minnesota, adults with less than a high school education were more likely than those with a Bachelor's degree or higher not to have a personal doctor.



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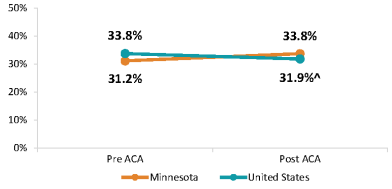
By Less than High School Education, Pre/Post ACA

In Minnesota, the change before and after implementation of the ACA was not statistically significant.



^ Difference pre/post ACA significant at the 95% level
Pre ACA is defined as 2011-2013. Post ACA is defined as 2014-2016

PERCENT OF ADULTS (25+) WITH LESS THAN A HIGH SCHOOL EDUCATION, 2016

Minnesota

PERCENT OF ADULTS WHO DIDN'T GET MEDICAL CARE DUE TO COST BY EDUCATIONAL ATTAINMENT

2011-2016 and pre/post Affordable Care Act (ACA) implementation

	2011	2012	2013	2014	2015	2016	Pre ACA	Post ACA
Less than high school (25+)	17.6%	19.8%	17.3%	18.0%	17.7%	17.8%	18.2%	17.9%
Bachelor's degree or higher (25+)	7.1%	5.9%	7.7%	5.8%	6.1%	5.7%*	6.9%	5.9%^
All education levels (18+)	10.9%	10.7%	10.3%	9.2%	8.4%	9.5%	10.6%	9%^

* Difference between BA or higher and less than HS significant at the 95% level in 2016
^ Difference pre/post ACA significant at the 95% level

PERCENT OF ADULTS WHO DON'T HAVE A PERSONAL DOCTOR BY EDUCATIONAL ATTAINMENT

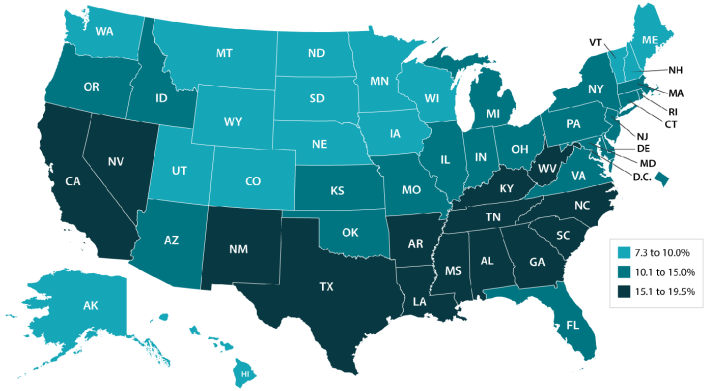
2011-2016 and pre/post Affordable Care Act (ACA) implementation

	2011	2012	2013	2014	2015	2016	Pre ACA	Post ACA
Less than high school (25+)	30.2%	29.6%	33.6%	31.0%	32.0%	38.1%	31.2%	33.8%
Bachelor's degree or higher (25+)	17.7%	19.1%	21.4%	19.6%	18.2%	21.6%*	19.4%	19.8%
All education levels (18+)	22.7%	24.2%	27.1%	24.2%	23.2%	27.3%	24.7%	24.9%

* Difference between BA or higher and less than HS significant at the 95% level in 2016
^ Difference pre/post ACA significant at the 95% level

ALL STATES AND DC: PERCENT OF ADULTS (25+) WITH LESS THAN A HIGH SCHOOL EDUCATION, 2016

US	14.1%	DC	10.5%	KY	17.0%	MT	7.8%	OH	11.7%	TX	19.5%
AL	16.9%	FL	13.9%	LA	17.3%	NE	10.0%	OK	13.9%	UT	9.1%
AK	9.0%	GA	16.1%	ME	8.3%	NV	16.3%	OR	10.1%	VT	8.0%
AZ	14.6%	HI	8.9%	MD	11.3%	NH	7.5%	PA	11.2%	VA	12.3%
AR	15.6%	ID	10.5%	MA	10.8%	NJ	12.3%	RI	13.8%	WA	9.7%
CA	19.0%	IL	13.2%	MI	10.3%	NM	17.0%	SC	15.4%	WV	15.3%
CO	9.9%	IN	12.7%	MN	7.9%	NY	14.9%	SD	9.9%	WI	9.0%
CT	11.2%	IA	8.5%	MS	18.0%	NC	15.2%	TN	15.5%	WY	7.7%
DE	13.0%	KS	10.3%	MO	11.8%	ND	7.3%				



Source: SHADAC analysis of the 2011-2016 Behavioral Risk Factor Surveillance System (BRFSS) public use files.
Notes: Estimates for "Less than HS" and "BA and higher" are for 25 years and over and estimates for "All education levels" are for 18 years and over. All estimates are for the civilian non-institutionalized population. Pre ACA is defined as 2011-2013. Post ACA is defined as 2014-2016. Less than HS is defined as any level of education below high-school graduate/GED. BA or higher is defined as any level of education equal to or greater than a bachelor's degree.

CHECK OUT THESE AND OTHER ESTIMATES AT STATEHEALTHCOMPARE.SHADAC.ORG

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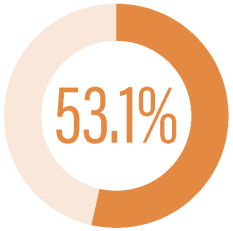
CA HOUSING AFFORDABILITY MATTERS

UNAFFORDABLE RENTS: A NEW MEASURE ON STATE HEALTH COMPARE

Housing affordability is a social determinant of health. A lack of affordable housing contributes to housing instability and homelessness, both of which are strong predictors of higher health care costs and poor health outcomes, among others.[1] Many states—especially those with high housing costs and large numbers of low-income residents—face housing affordability challenges. Unaffordable Rents, a new measure on State Health Compare, provides six years (2012-2017) of data on the percentage of rental households that spend more than 30% of their monthly income on rent, both at the national and state level, including breakdowns for Medicaid enrollment, non-white/white, disability status, and household income.

44.7% of households in California rented in 2017.

BREAKDOWN OF UNAFFORDABLE RENTS IN CALIFORNIA



of rental households in California had unaffordable rents in 2017.

AMONG RENTAL HOUSEHOLDS WITH:

A MEDICAID ENROLLEE
65.1% had unaffordable rents in 2017.

A PERSON OF COLOR
54.4% had unaffordable rents in 2017.

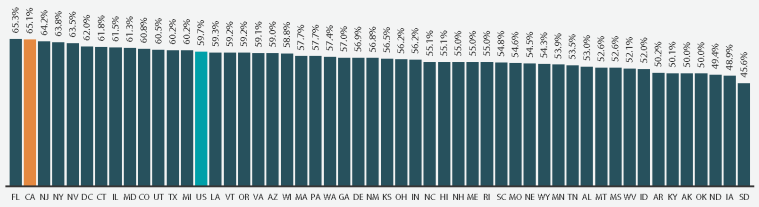
A PERSON THAT HAS A DISABILITY
60.7% had unaffordable rents in 2017.

AN INCOME LESS THAN $25,000
87.6% had unaffordable rents in 2017.

USING MEDICAID TO ADDRESS HOUSING INSTABILITY AT THE STATE LEVEL

States have the flexibility to use Medicaid funds to help provide housing support services for individuals with disabilities, older adults needing long-term services and supports, and individuals experiencing chronic homelessness. Medicaid can be used to provide services to support individuals' housing transitions, to help individuals sustain their tenancy, and to develop strategic housing collaboratives. These services can be reimbursed through Medicaid demonstration waivers and Medicaid state plans. For example, California's most recent Medicaid 1115 Waiver includes initiatives to help enrollees who are experiencing or are at risk of homelessness access affordable, stable housing and supportive services.[2]

AMONG RENTAL HOUSEHOLDS WITH A MEDICAID ENROLLEE: PERCENT WITH UNAFFORDABLE RENTS



THE MEASURES THAT MATTER SERIES

This infographic is the second in a series highlighting measures available from State Health Compare, a resource states can use to better understand trends in health and health care in their state and compare those to other states and the nation. The previous infographic in the series, Education Matters, highlighted the role education plays in inequities in health care affordability and access.

Notes: Unaffordable rent is defined as spending more than 30% of monthly household income on rent. Medicaid households are defined as households with one or more Medicaid enrollee. Differences described in this analysis are statistically significant at the 95% confidence level unless otherwise noted.

Sources: SHADAC analysis of the 2017 American Community Survey (ACS) Public Use Microdata Sample (PUMS) files, State Health Compare, SHADAC, University of Minnesota, statehealthcompare.shadac.org.

[1] Paradise J, Ross DC. Linking Medicaid and Supportive Housing: Opportunities and On the Ground Examples. Jan 2017: Kaiser Family Foundation. https://www.kff.org/report-section/linking-medicaid-and-supportive-housing-issue-brief/. Cassidy A. Health Policy Brief: Medicaid and Permanent Supportive Housing. October 2016: Health Affairs and Robert Wood Johnson Foundation. https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf432103.

[2] Medi-Cal 2020 Demonstration. 2018: California Department of Health Care Services. Accessed July 5, 2018. http://www.dhcs.ca.gov/provgovpart/Pages/medi-cal-2020-waiver.aspx

Click here to check out these and other estimates on State Health Compare!

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The Evolving Opioid Crisis Across the States

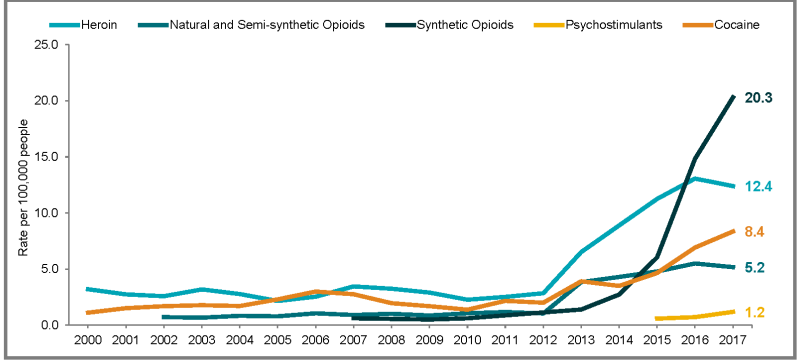
Connecticut

For nearly two decades, the United States has experienced a trend of increasing drug overdose deaths. At the national level, the growth in overdose deaths since 2000 was initially driven by natural and semi-synthetic opioids—largely prescription opioid painkillers, such as oxycodone and hydrocodone. However, in recent years the crisis has evolved. Since 2010, rapid increases in deaths from illicit opioids—including heroin and illegally manufactured and trafficked synthetic opioids (e.g., fentanyl)—have outpaced deaths from natural and semi-synthetic opioids. Additionally, data also suggest the overdose crisis may now be expanding beyond opioids. In recent years, deaths from some other illegal drugs, such as cocaine and psychostimulants (e.g. methamphetamine), also have grown sharply, which may be because traffickers often sell illicit drugs alongside each other and sometimes even mix drugs together.[1]

In addition, the data show that the impact of the overdose crisis varies across states. SHADAC has developed these state-level snapshots of data on overdose deaths as a resource for people to better understand the crisis in their states—a key step in developing and deploying effective policy solutions.

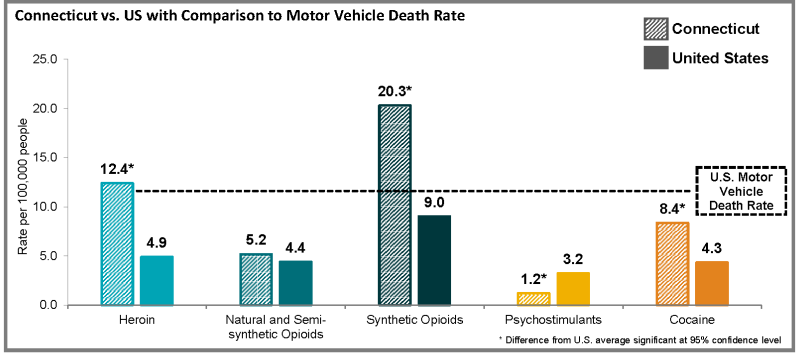
In 2017, **901** Opioid-related drug overdose deaths occurred in Connecticut.[2]

Trends in Drug Overdose Deaths per 100,000 people, by Drug Type (2000-2017)



Drug Overdose Deaths per 100,000 people in 2017, by Drug Type

Connecticut vs. US with Comparison to Motor Vehicle Death Rate



1. Hedegaard H, Bastian BA, Trinidad JP, Spencer M, Warner M. Drugs most frequently involved in drug overdose deaths: United States, 2011–2016. National Vital Statistics Reports; vol 67 no 9. Hyattsville, MD: National Center for Health Statistics. 2018. https://www.cdc.gov/nchs/data/nvsr/nvsr67/nvsr67_09-508.pdf
2. Includes drug poisoning deaths associated with natural and semi-synthetic opioids (e.g. hydrocodone, oxycodone), synthetic opioids (e.g. fentanyl), and heroin.

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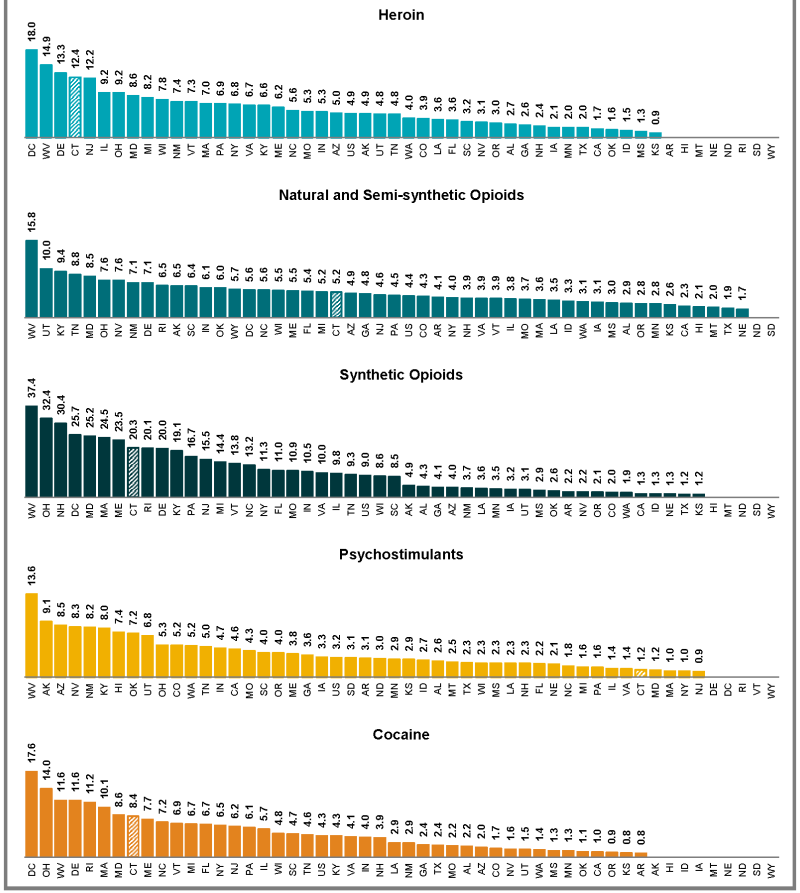
Connecticut

Exploring State Variation: Drug Overdose Deaths per 100,000 people in 2017



Definitions: Age-adjusted rates of deaths caused by drug poisoning (i.e., overdose), including those caused by natural and semi-synthetic opioids, synthetic opioids (non-methadone), the illegal opioid heroin, psychostimulants (including methamphetamine), and cocaine. For further definitions and source notes, CLICK HERE to visit SHADAC's State Health Compare.

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Organizations Using State Health Compare As a Resource

State Agencies

Minnesota Department of Health, Office of Rural Health & Primary Care; New Jersey Department of Health, Center for Health Statistics and Informatics; New Mexico Human Services Department

Federal Agencies

National Academy of Medicine; NIH: National Institute on Minority Health and Health Disparities; NIH: Disaster Health Information – Opioids

Foundations

Milbank Memorial Fund Reforming States Group; Robert Wood Johnson Foundation's State Network Resource Hub

Research Organizations

Altarum: Health Care Value Hub; Georgetown University Center for Children and Families; Mathematica Policy Research, Inc.; National Academy for State Health Policy (NASHP); Patient-Centered Outcomes Research Institute (PCORI); University of Arizona Center for Rural Health

State Policy Groups

Connecticut Health Policy Project; Council of State Governments; National Organization of State Offices of Rural Health

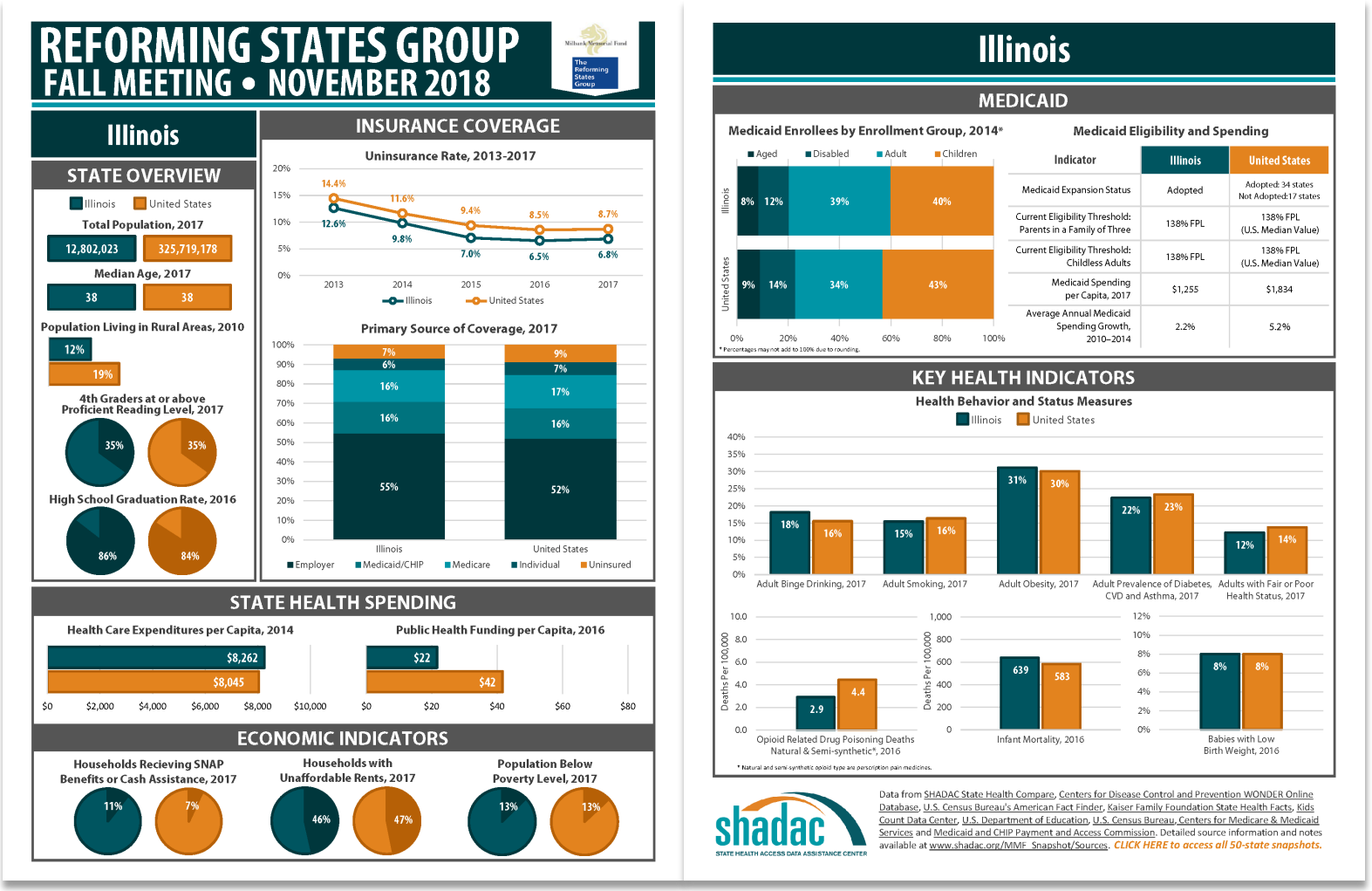
Associations

California Hospital Association; National Association of Health Data Organizations (NAHDO)

Colleges & Universities

Butler University; George Washington University; University of Illinois at Urbana-Champaign; University of Minnesota; University of South Carolina; Vanderbilt University

Millbank Memorial Fund – State Health Profiles



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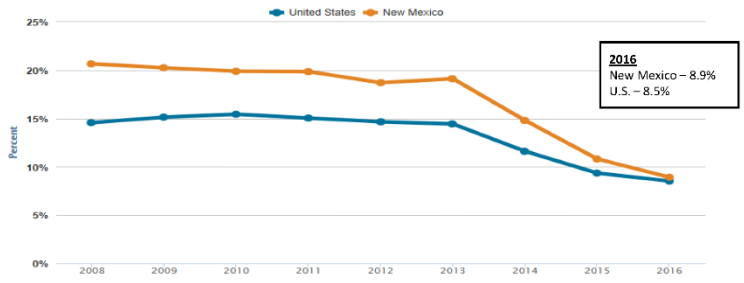
New Mexico Human Services Department

Enrollment Impacts
New Mexico Uninsured Rate



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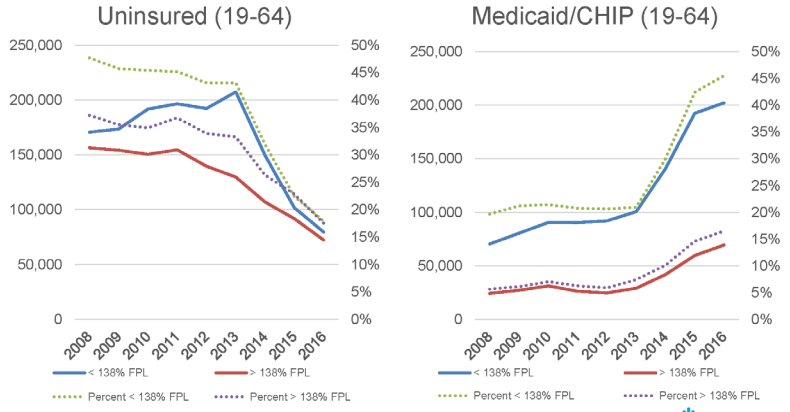
SHADAC is a multidisciplinary health policy research center with a focus on state health policy. SHADAC is supported by the Robert Wood Johnson Foundation and is affiliated with the Health Policy and Management Division of the School of Public Health at the University of Minnesota. For more information, visit www.shadac.org.

HUMAN SERVICES DEPARTMENT

Enrollment Impacts:
New Mexico 19-64 Uninsured and Medicaid-Insured by FPL
2016: 138% FPL, $16,394 (single), $33,534 (4-person)



Source: SHADAC State Health Compare, University of Minnesota

HUMAN SERVICES DEPARTMENT

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Minnesota Department of Health

MDH Minnesota Department *of* Health
OFFICE OF RURAL HEALTH & PRIMARY CARE

Public and individual health insurance trends in rural Minnesota

ENROLLMENT DURING IMPLEMENTATION OF THE AFFORDABLE CARE ACT

Introduction

Most Minnesotans, including those living in rural areas, obtain their health insurance through an employer. However, coverage through two additional sources - public programs and the individual (or non-group) market – historically have been especially important in rural areas. This brief examines how enrollment in these types of insurance has changed since enactment of the Affordable Care Act (ACA) in 2010.

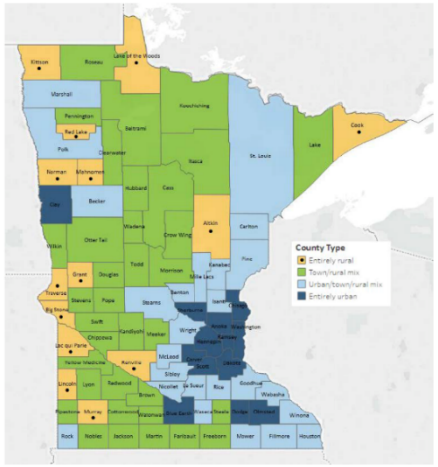
The analysis uses data from the Minnesota Department of Human Services and the Minnesota Department of Commerce.

To understand distribution, it also employs a new urban-rural classification system developed by the state demographer's office, which categorizes Minnesota's 87 counties into four groups (Figure 1):

- entirely rural
- small town/rural mix
- urban/small town/rural
- entirely urban.[1]

Companion briefs on other rural health access issues and rural hospital finance over the same period are also available.[2]

Figure 1. Minnesota rural-urban county types



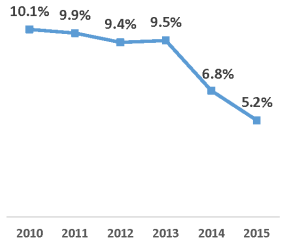
Source: Minnesota State Demographic Center, January 2017

Background

The Affordable Care Act (ACA) affected many aspects of the health care system, with insurance coverage changes among the most visible and dramatic of its impacts.

The number of Minnesotans with health insurance has grown significantly in the seven years since the law's enactment, driving down the state's uninsurance rate among the nonelderly population from 10 percent in 2010 to 5 percent in 2015, an all-time low.

Figure 2: Uninsurance rate in Minnesota, nonelderly population, 2010 to 2015



Source: SHADAC analysis of the American Community Survey (ACS) Public Use Microdata Sample (PUMS) files, State Health Compare, SHADAC, University of Minnesota, statehealthcompare.shadac.org.

Various types of insurance and supports for acquiring it have contributed to this historic shift, including the requirement to hold coverage, the availability of financial help for some to buy coverage and affording health care, resources to help Minnesotans understand their options and the availability of the new state "marketplace" (MNsure) that among other services provides a "one-stop shop" for finding both public and private health insurance plans.

This brief focuses on trends in coverage through two specific sources of insurance changed by the ACA:

1. The state's publicly funded health insurance options, also known as Minnesota Health Care Programs, and specifically its two largest programs: Medical Assistance and MinnesotaCare.
2. The individual market, which refers to insurance policies people obtain on their own and not through an employer or other source (which is why it also sometimes referred to as the private "non-group" market).

While the most common type of health insurance in Minnesota – including in rural areas – remains employer-based coverage (covering 56 percent of the state in 2015),[3] this analysis focuses on public program and non-group coverage because historically, rural residents of the state have been more likely than their urban counterparts to rely on these types of coverage.[4 5 6]

Public programs

As states implemented portions of the ACA under their jurisdiction, Minnesota made some of the earliest and most significant changes to its public insurance programs. It expanded eligibility for Medical Assistance (MA, Minnesota's version of Medicaid), first in early 2011 and again in early 2014. It was also the first state to establish a "Basic Health Plan," an option under the ACA to provide affordable coverage to those who are low-income (138-200 percent of Federal Poverty Guidelines, or FPG) but not eligible for MA. It did so by adapting the long-standing MinnesotaCare program to meet the ACA's standards.[7]

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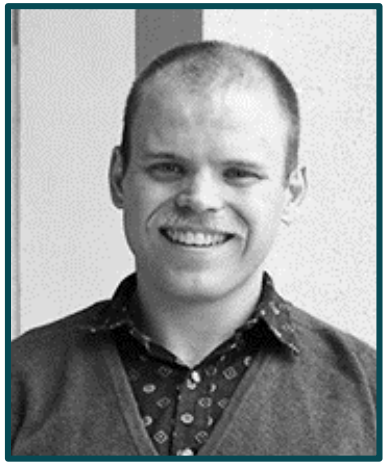
Georgetown University Health Policy Institute

Question & Answer



Robert Hest, MPP
SHADAC

Brett Fried, MS
SHADAC

Please submit question using the chat box or Tweet questions to @SHADAC.

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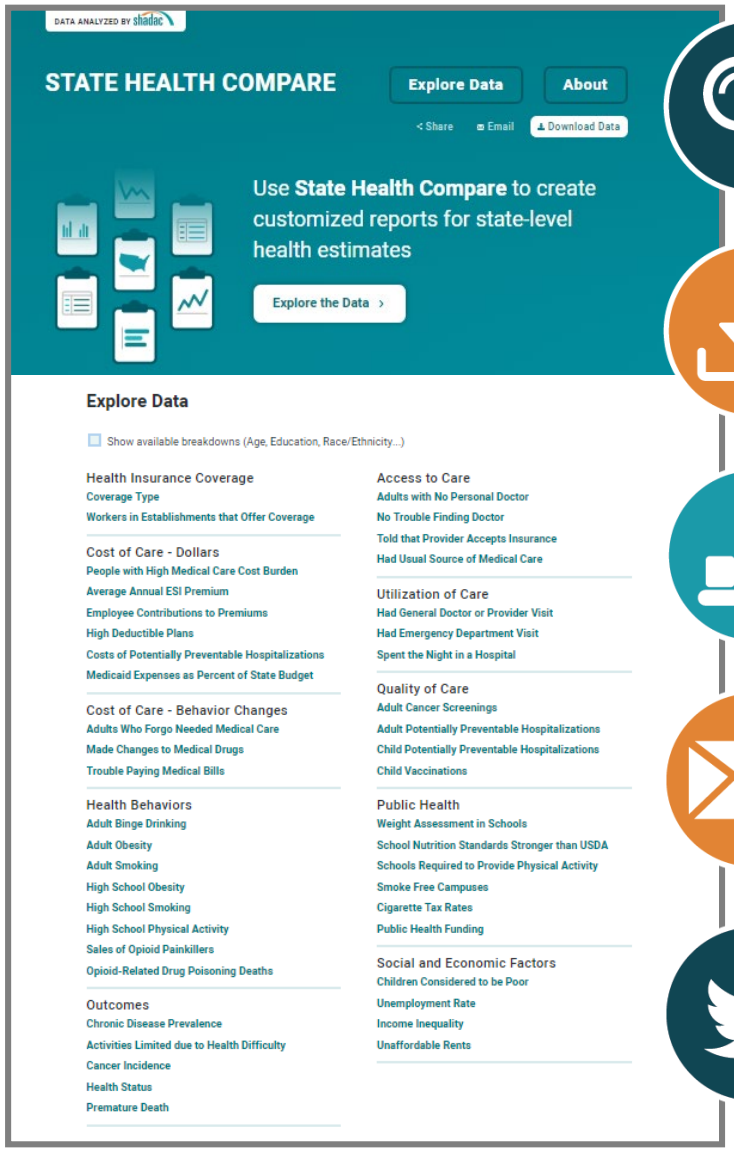

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THANK YOU!

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