CHARLES SMITH

Executive Commissioner
Texas Health and Human Services Commission
PRESENTATIONS & DISCUSSION
Affordability of Care & Coverage
Trends & Impacts

March 29, 2018
John Rother, President & CEO
National Coalition on Health Care
This event is made possible by a generous grant from the Gordon and Betty Moore Foundation.
Summit Goals

We will examine the underlying causes of escalating health care costs -- and a wide range of options for cutting costs while increasing the quality of care. Among the topics:

• how to improve the coordination, delivery, and efficiency of care
• how to make markets for insurance and health care services more competitive and efficient
• how to slow the rates of increase in prescription drug prices
• how to provide better and more efficient care to high-need, high-cost patients
• how to reduce the demand for care by decreasing and treating unhealthy behaviors
3 Major Challenges

• Changing demographics of the patient population in TX & nationally

• Social determinants of health that contribute to the rising incidence of chronic conditions

• Children’s health care and health
  • Lifelong impacts of adverse childhood practices
  • Early onset of chronic diseases
8 risks and behaviors:

- Poor Diet
- Physical Inactivity
- Excessive Alcohol Consumption
- Insufficient Sleep
- Poor Standard of Care
- Poor Stress Management
- Lack of Health Screening
- Smoking

Drive 15 chronic conditions, accounting for 80% of total costs for all chronic illnesses worldwide.

- Diabetes
- Coronary Artery Disease
- Hypertension
- Back Pain
- Obesity
- Cancer
- Asthma
- Arthritis
- Allergies
- Sinusitis
- Depression
- Congestive Heart Failure
- Lung Disease (COPD)
- Kidney Disease
- High Cholesterol

Source: AON Health Care Survey
Our health care cost problem is getting bigger
### $1 trillion of wasteful spending

#### Types of Waste in U.S. Health Care Spending

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>DESCRIPTION</th>
<th>PERCENT OF HEALTH CARE SPENDING</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLINICAL WASTE</td>
<td>Spending that could be reduced with better prevention or higher-quality initial care; replacing services with less-resource-intensive alternatives; or improving processes by standardizing best practices</td>
<td>14%</td>
</tr>
<tr>
<td>ADMINISTRATIVE COMPLEXITY</td>
<td>Spending that could be eliminated with simpler, more-standardized processes for billing and collections, credentialing, compliance, and oversight</td>
<td>9%</td>
</tr>
<tr>
<td>EXCESSIVE PRICES</td>
<td>Overspending resulting from paying high prices charged by inefficient suppliers (including providers), which could be eliminated by tying prices to efficiency, outcomes, and a fair profit</td>
<td>5%</td>
</tr>
<tr>
<td>FRAUD AND ABUSE</td>
<td>Spending associated with illicit schemes to extract payments for the illegitimate delivery of health care services</td>
<td>7%</td>
</tr>
</tbody>
</table>

**NOTE** THE THREE DESCRIPTIONS OF CLINICAL WASTE ARE AN AGGREGATION OF BERWICK AND HACKBARTH'S ORIGINAL ANALYSIS.

**SOURCE** “ELIMINATING WASTE IN U.S. HEALTH CARE,” BY DONALD M. BERWICK AND ANDREW D. HACKBARTH, 2012

Total U.S. Healthcare Spending by Number of Chronic Conditions in 2010

**DATA HIGHLIGHTS**

- 86% of healthcare spending is for patients with one or more chronic conditions.
- 71% of healthcare spending is for patients with multiple chronic conditions.

- Said another way, 71¢ of every dollar of healthcare spending goes to treating people with multiple chronic conditions.

Premiums growing for employers & workers

Average Annual Health Insurance Premiums and Worker Contributions for Family Coverage, 2006-2016

- 58% Total Premium Increase
- 78% Worker Contribution Increase

Individual market premium growth

Appendix B. Average Monthly Premiums in the Individual Market for Healthcare.gov states

Note: Earned premiums are equal to premium revenue collected by issuers. Individual market calculations are based on Medical Loss Ratio (MLR) data from 2013 to 2015. These data represent the entire individual market – including on- and off-exchange plans, as well as ACA-compliant and non-ACA-compliant plans. Healthcare.gov calculations are based on enrollee plan selections during the annual Open Enrollment Periods from 2014 to 2017. These data do not take into account premium tax credits.

High deductible plans are becoming common

Percentage of Covered Workers Enrolled in an HDHP/HRA or HSA-Qualified HDHP, 2006-2016

*Estimate is statistically different from estimate for the previous year shown (p < .05).

NOTE: Covered Workers enrolled in an HDHP/SO are enrolled in either an HDHP/HRA or a HSA-Qualified HDHP. For more information, see the Survey Methods Section. The percentages of covered workers enrolled in an HDHP/SO may not equal the sum of HDHP/HRA and HSA-Qualified HDHP enrollment estimates due to rounding.

Substantial growth in deductibles too

15% increase in the last year in the average deductible for silver plans

Source: https://www.healthpocket.com/healthcare-research/infostat/2017-obamacare-premiums-deductibles/#WW-a9oWcGe8
Federal Spending on the Major Health Care Programs, by Category

The projected rise in federal spending for the major health care programs results from the aging of the population and the expectation that health care costs per person will continue to grow more quickly than potential GDP per person.

Source:
Total employer + consumer costs (as measured by the MMI) equals 45% of Median US Household Income.
Impact on family finances

Health Affairs

September 2011
David I. Auerbach and Arthur L. Kellermann

Source:
http://content.healthaffairs.org/content/30/9/1630.abstract
“Overall, 25 percent of respondents report going without one of these types of [medical] care [in the prior 12 months] because they could not afford it.”

-Board of Governors, Federal Reserve System

Categories of Cost Drivers

• Factors that increase the demand for care (e.g., social determinants, behaviors, and environmental characteristics)

• The costs of inputs (e.g., hospital care, physician and clinical services, and prescription drugs)

• Delivery system coordination and efficiency

• The structure and competitive dynamics of markets for health care services

• The structure and competitive dynamics of markets for health insurance

• Incentives for employers and employees

• Cost-sharing practices and patterns

Source: Rother & Goldberg, A Portfolio Strategy For Affordable Coverage: Disaggregating Problems, Aggregating Solutions, Health Affairs Blog
CYNTHIA OSBORNE

Associate Professor, LBJ School of Public Affairs
Director, Center for Health and Social Policy
March 29, 2018

THE TRAIN HAS LEFT THE STATION

Texas Health Care Summit: Health Today, Health Care Tomorrow

CYnthia osborne, phd
Director, Center for Health and Social Policy
Associate Professor, LBJ School of Public Affairs
Setting the Stage

• Our earliest life experiences predict our subsequent well-being
• The prevalence of early adversity is high, and growing for many
• The population that is growing fastest are the most disadvantaged
• These trends have important consequences for the future of our health care systems
• Prevention today may help stem the tide
The Adverse Childhood Experiences (ACE) Study

• Original ACE study includes data from more than 17,000 individuals living in Southern California between 1995-1997

• Largely white, middle class sample, insured by Kaiser Permanente

• One of the largest investigations of childhood abuse and neglect and later-life health and wellbeing

• Major Findings: ACEs are common and have a dose-response relationship with negative health and wellbeing outcomes across the life course
The Three Types of ACES Include:

**ABUSE**
- Physical
- Emotional
- Sexual

**NEGLECT**
- Physical
- Emotional

**HOUSEHOLD DYSFUNCTION**
- Mental Illness
- Incarcerated Relative
- Mother treated violently
- Substance Abuse
- Divorce

Source: rwjf.org/aces
Of 17,000 ACE Study Participants:

- 26% have experienced 1 ACE
- 16% have experienced 2 ACEs
- 9.5% have experienced 3 ACEs
- 12.4% have experienced 4+ ACEs
- 36% have experienced 0 ACEs

64% have at least 1 ACE

Estimates from the ACE study. Sources: [http://cdc.gov/ace/prevalence.htm](http://cdc.gov/ace/prevalence.htm); [rwjf.org/aces](http://rwjf.org/aces)
Of 17,000 ACE Study Participants:

**ABUSE**
- Physical Abuse: 26.3%
- Sexual Abuse: 20.7%
- Emotional Abuse: 10.6%

**NEGLECT**
- Emotional Neglect: 14.8%
- Physical Neglect: 9.9%

**HOUSEHOLD DYSFUNCTION**
- Household Substance Abuse: 26.9%
- Parental Divorce: 23.3%
- Household Mental Illness: 19.4%
- Mother Treated Violently: 12.7%
- Incarcerated Household Member: 4.7%

Sources: [http://cdc.gov/ace/prevalence.htm](http://cdc.gov/ace/prevalence.htm); [rwjf.org/aces](http://rwjf.org/aces)
As the number of ACEs increases, so does the risk for negative health outcomes.

Source: rwjf.org/aces
### Possible Risk Outcomes

<table>
<thead>
<tr>
<th><strong>BEHAVIOR</strong></th>
<th><strong>PHYSICAL &amp; MENTAL HEALTH</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of physical activity</td>
<td>Severe obesity</td>
</tr>
<tr>
<td>Smoking</td>
<td>Diabetes</td>
</tr>
<tr>
<td>Alcoholism</td>
<td>Depression</td>
</tr>
<tr>
<td>Drug use</td>
<td>Suicide attempts</td>
</tr>
<tr>
<td>Missed work</td>
<td>STDs</td>
</tr>
<tr>
<td>Heart disease</td>
<td>Cancer</td>
</tr>
<tr>
<td>Stroke</td>
<td>COPD</td>
</tr>
<tr>
<td>COPD</td>
<td>Broken bones</td>
</tr>
</tbody>
</table>

Source: rwjf.org/aces
Why do ACEs impact health and wellbeing?

Mechanism by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

Source: Centers for Disease Control and Prevention. https://www.cdc.gov/violenceprevention/acestudy/about.html
ACEs and the Risk for Early Death

LIFE EXPECTANCY

People with six or more ACEs died nearly 20 years earlier on average than those without ACEs.

Source: Centers for Disease Control and Prevention. https://www.cdc.gov/violenceprevention/acestudy/resources.html
2016 National Survey of Children’s Health

• Child-level, household survey conducted with parents or guardians; implemented through the U.S. Bureau of the Census

• In 2016, 34 million children, (nearly half of all U.S. children ages 0-17), had at least one ACE

• More than 20 percent of children experienced two or more

• ACEs are common across all income groups, though 58 percent of U.S. children with ACES live in homes with incomes < 200% FPL

• Black children are disproportionately represented among children with ACEs

• 2016 findings replicate those using the 2011-12 NSCH data

Percent of Children Age 0-17 with 1+ ACEs in the US

Nationwide: 46.3%

Percent of Children Age 0-17 with 2+ ACEs in the US

Nationwide: 21.7%

# State and National Prevalence of ACEs

<table>
<thead>
<tr>
<th>Adverse Child or Family Experiences (ACEs) Items</th>
<th>Texas</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extreme economic hardship</td>
<td>29.0%</td>
<td>25.7%</td>
</tr>
<tr>
<td>Family disorder leading to divorce/separation</td>
<td>20.0%</td>
<td>20.1%</td>
</tr>
<tr>
<td>Has lived with someone who had an alcohol/drug problem</td>
<td>9.8%</td>
<td>10.7%</td>
</tr>
<tr>
<td>Has lived with someone who was mentally ill/suicidal</td>
<td>8.0%</td>
<td>8.6%</td>
</tr>
<tr>
<td>Witnessed domestic violence in the home</td>
<td>7.9%</td>
<td>7.3%</td>
</tr>
<tr>
<td>Has been a victim/witness of neighborhood violence</td>
<td>7.3%</td>
<td>8.6%</td>
</tr>
<tr>
<td>Parent served time in jail</td>
<td>6.9%</td>
<td>6.9%</td>
</tr>
<tr>
<td>Treated or judged unfairly due to race/ethnicity</td>
<td>3.6%</td>
<td>4.1%</td>
</tr>
<tr>
<td>Death of a parent</td>
<td>2.6%</td>
<td>3.1%</td>
</tr>
<tr>
<td>Child had &gt;1 ACEs (1/more of above items)</td>
<td>48.1%</td>
<td>47.9%</td>
</tr>
</tbody>
</table>

Percentage of Children with No Adverse Experiences, and with Three or More Adverse Experiences, by Race and Hispanic Origin: 2011/12

Source: Child Trends Data Bank (chart recreated). Original source note: Child Trends' original analyses of data from the National Survey of Children's Health.
Percentage of Children with No Adverse Experiences,* and with Three or More Adverse Experiences,* by Poverty Level: 2011/12

*Persistent economic hardship was excluded as an experience for this analysis.

Child Poverty in the U.S. and Race/Ethnicity

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Average</td>
<td>21%</td>
</tr>
<tr>
<td>African American</td>
<td>36%</td>
</tr>
<tr>
<td>American Indian</td>
<td>34%</td>
</tr>
<tr>
<td>Asian and Pacific Islander</td>
<td>13%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>31%</td>
</tr>
<tr>
<td>Non-Hispanic White</td>
<td>12%</td>
</tr>
<tr>
<td>Two or More Races</td>
<td>21%</td>
</tr>
</tbody>
</table>

Source: U.S. Census Bureau, 2015 American Community Survey.
Child Poverty in Texas and Race/Ethnicity

Child poverty (percentage), 2008-2014

Child Maltreatment

Figure 3

Child Maltreatment Rate (Unique Victims per 1,000 Population), by Race¹ and Hispanic Origin, 2014

¹Estimates for specific race groups have been revised to reflect the new OMB race definitions, and include only those who are identified with a single race. Hispanics may be of any race.

Births to Unmarried Mothers

Percentage of All Births that Were to Unmarried Women, by Race and Hispanic Origin: Selected Years, 1960-2014

Family Structure

Figure 2

Living Arrangements of Children, by Race and Hispanic Origin: 2015

Exposure to Violence

Figure 2

Children's Exposure to Violence:
Percentage Victimized in the Past Year: Selected Years, 2008-2014

*Excludes indirect exposure to violence
**Includes hearing about or seeing violence; excludes witnessing violence, household theft, and school threat of bomb or attack

Incarcerated Parents

Children who had a parent who was ever incarcerated by race and ethnicity – 2011-2012

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic or Latino</td>
<td>7%</td>
</tr>
<tr>
<td>Black or African</td>
<td>12%</td>
</tr>
<tr>
<td>White</td>
<td>6%</td>
</tr>
</tbody>
</table>

Source: Annie E. Casey Foundation. KIDS COUNT data center. Children who had a parent who was ever incarcerated by race and ethnicity. Child Trends analysis of data from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, National Survey of Children’s Health.
U.S. Child Population Projection

Percentage Distribution of Children Under Age 18, by Race and Hispanic Origin, 2000, 2010, and Projected 2020

Source: Child Trends Data Bank (chart recreated and adapted).

Original note: Data reflect new race categories from the 2000 decennial census and only include those respondents who identified with a single race. Those who chose multiple races are included in "all other races" (not shown). Other races also includes American Indians and Pacific Islanders. Those of Hispanic origin may be of any race.

Texas Child Population Projection

Child population projections by race and ethnicity (percentage), 2010-2050:
- 2015: 6%, 11%, 33%, 50%
- 2020: 8%, 9%, 22%, 61%
- 2025:
- 2030:
- 2035:
- 2040:
- 2045:
- 2050:

Child population projections by race and ethnicity (number), 2010-2050:
- 2010: 808,211
- 2015: 804,714
- 2020: 742,185
- 2025:
- 2030:
- 2035:
- 2040:
- 2045:
- 2050: 5,625,799

Key Takeaways

• Early adversity has life-long consequences
• Prevalence of adversity is high – especially for some subgroups of the population
• Population is increasing among children with highest exposure to adversity
• Our systems need to “get on board” to address the needs coming their way
Center for Health and Social Policy

chasp.lbj.utexas.edu
chasp@austin.utexas.edu
MARK HAYWARD

Professor, College of Liberal Arts-Sociology
Director, UT Austin Population Health Initiative
Does the Body Forget?  
The Long Arm of Childhood

Mark D. Hayward  
University of Texas at Austin

Texas Health Care Summit  
LBJ School of Public Affairs  
University of Texas at Austin  
March 29, 2018
Childhood is the foundation for adult health

- More than a quarter of US children are born into poor families
- Adverse childhood experiences are common and have major consequences for adult health and mortality
  - People with 6+ ACES have a life expectancy 20 years less than persons with no ACES
- Early life family conditions and health also influence adult health through a myriad of adult achievement, relationship, and behavioral pathways
Prevalence of ACEs by Category for Participants Completing the ACE Module on the 2010 BRFSS

**ABUSE**

- Emotional: 35%
- Physical: 16%
- Sexual: 11%

**HOUSEHOLD CHALLENGES**

- Intimate Partner Violence: 15%
- Substance Abuse: 25%
- Mental Illness: 16%
- Separation/Divorce: 23%
- Incarcerated Household Member: 6%
Determinants of Adult Age-Related Losses in Capacity (e.g., occupation, marriage, disease, genes)

Capacity over the Life Course (15 = hypothetical level below which limitations in adulthood occur)

Determinants of Gains in Capacity (e.g., nutrition, education, family resources, genes)

Developmental phase of human life course

Aging phase of the human life course
AN EXAMPLE OF THE CONNECTIONS BETWEEN CHILDHOOD AND A HEALTH LIFE

"Can a good education overcome a bad childhood?"

Source: Montez & Hayward (2014, *Demography*)
Measuring Childhood & Adult Conditions

Index of Cumulative Childhood SES Adversities

- Father had <8 years education: 35.2%
- Mother had <8 years education: 25.6%
- Family was poor: 28.2%
- Moved for financial reasons: 17.1%
- Received help from relatives: 13.0%
- Never lived with father: 7.3%
- Father had blue collar occupation: 77.6%

Childhood Health

- 1=fair/poor; 0=good, very good, excellent

Educational attainment

- Less than HS, HS, Some College, BA+
Connections between childhood and a healthy life

Educational Attainment
- Key indicator of overall adult lifetime environment
- Numerous & changing mechanisms
- Temporally and causally prior to other dimensions of SES
- More stable than income or occupation
- Policy intervention
Active Life Expectancy at Age 50, Males (life free of functional limitations and disability)
Active Life Expectancy at Age 50, Males (life free of functional limitations and disability)
Active Life Expectancy at Age 50, Males (life free of functional limitations and disability)
Active Life Expectancy at Age 50, Males (life free of functional limitations and disability)
Active Life Expectancy at Age 50, Males (life free of functional limitations and disability)
Childhood has a very long arm

- The health effects of childhood socioeconomic conditions and health reverberate far into the life course
- Childhood SES also sets in motion a cascade of experiences that reinforce childhood’s influence
- Adult conditions matter too!
- Childhood SES, health, and education all combined in an additive & cumulative way to influence healthy life expectancy
Does your body forget?
Does your body forget?

• No

• But, that does not mean that people with disadvantaged childhoods are doomed

• Improving adult conditions can help dampen the long arm of childhood disadvantage
GEORGES BENJAMIN

Executive Director
American Public Health Association
Creating The Healthiest Nation: A Population Approach

Texas Health Care Summit: Health Today, Health Care Tomorrow

National Coalition on Healthcare & The Center for Health & Social Policy

LBJ School of Public Affairs

Austin, Texas
March 29, 2018
America Is Not Getting Good Value for Its Health Dollar

The U.S. spends more money per person on health than any other country, but our lives are shorter—by nearly four years—than expected based on health expenditures.

Why The U.S. Performs So Poorly

Lowest rank for health outcomes for high income countries

Lack of universal coverage

Complex service delivery & payment

Focus on treatment over primary care & prevention

Inadequate focus on social determinates
### Figure 2

**Social Determinants of Health**

<table>
<thead>
<tr>
<th>Economic Stability</th>
<th>Neighborhood and Physical Environment</th>
<th>Education</th>
<th>Food</th>
<th>Community and Social Context</th>
<th>Health Care System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment</td>
<td>Housing</td>
<td>Literacy</td>
<td>Hunger</td>
<td>Social integration</td>
<td>Health coverage</td>
</tr>
<tr>
<td>Income</td>
<td>Transportation</td>
<td>Language</td>
<td>Access to healthy options</td>
<td>Support systems</td>
<td>Provider availability</td>
</tr>
<tr>
<td>Expenses</td>
<td>Safety</td>
<td>Early childhood education</td>
<td></td>
<td>Community engagement</td>
<td>Provider linguistic and cultural competency</td>
</tr>
<tr>
<td>Debt</td>
<td>Parks</td>
<td>Vocational training</td>
<td></td>
<td>Discrimination</td>
<td>Quality of care</td>
</tr>
<tr>
<td>Medical bills</td>
<td>Playgrounds</td>
<td>Higher education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support</td>
<td>Walkability</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Health Outcomes**
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations
Health Reform Was Designed To Address Many of These Issues

- Expanding health insurance coverage
- Enhance the system focus on prevention
- Increase attention to Social determinants of health & health disparities
- Reform the delivery and payment system to pay for results vs volume
- Bend the cost curve and make insurance affordable for individuals and families
- Improve the U.S. health outcomes
Moving Upstream To Improve Population Health
Broad Understanding Your Zip Code Matters: It Determines Access To

- High-quality schools
- Job opportunities
- Healthy housing
- Nutritious food
- Safe communities
- Green space

- Toxic exposures
- Quality healthcare
- Good public transit
- Social cohesion
- Social capital
Building Systems Across Sectors To Improve Health
Asthma: A Common Clinical Condition

- Asthma is a common environmental sensitive condition
- Minorities disproportionally impacted
- Asthma attacks a significant barrier to school attendance
- Must know root cause of poor control by clinical & social determinates
- Allows one to craft broad solutions that address both
A Unrecognized Epidemic

- Hospital ED - A
  - 1 case poorly controlled
  - Asthma
  - Uninsured

- Hospital ED - B
  - 3 cases poorly controlled
  - asthma
  - Aetna - Insurer

- Hospital ED - C
  - 4 cases poorly controlled
  - Asthma
  - BC/BS - insurer

- Hospital ED - D
  - 2 cases poorly controlled
  - Asthma
  - Medicaid - Insurer

10 Hospital ED Asthma Cases
Enter Public Health

- Health department notified
- Epidemiological investigation occurred
  - All occurred in kids going to the same school
  - Variance in where they lived
  - All resulted in school absence on similar days
- No single hospital or insurer would pick this up because of small sample size in each ED
All Kids Ride On Same Bus
Coordinated Community Resources
Using Hero’s Beyond Health Care

- School system
- Private hospital
- Public health
- Transportation

- Reduced ER visits
- Dollars saved
- Health Improved & less disparity
- Less school absenteeism
- Transportation safer
Ensuring Prevention & Population Health Is A Shared Value

We are Generation Public Health
Together, we can create the healthiest nation.
About APHA

APHA is a global community of public health professionals and the collective voice for the health of the public. APHA is the only organization that combines 140 years of perspective, a broad-based constituency and the ability to influence federal policy to advocate for and improve the public’s health.

- Founded – April 18, 1872
- 501C(3) & Nonpartisan
- Over 50,000 individual & affiliate members
TRICIA BROOKS

Senior Fellow, Center for Children and Families
Georgetown University McCourt School of Public Policy
Changing the Trajectory of Children’s Health: Medicaid’s Leadership Role

NCHC Texas Health Care Summit: Health Today, Health Care Tomorrow
Austin, Texas
Tricia Brooks
3-29-18
Historical Health Insurance Rates for Children

Source: American Community Survey
Correlate to Increased Participation of Eligible Children in Medicaid/CHIP

Source: Various Urban Institute Analyses, see https://www.insurekidsnow.gov/campaign/participation-rates/index.html
Medicaid is the Largest Single Source of Health Insurance for Children

**United States**
- Medicaid/CHIP: 36%
- Employer: 47%
- Direct Purchase: 6%
- Other: 8%
- Uninsured: 5%

**Texas**
- Medicaid/CHIP: 38%
- Employer: 41%
- Direct Purchase: 6%
- Other: 9%
- Uninsured: 4%

Source: American Community Survey 2016
Medicaid Covers the Lowest Income and Most Vulnerable Children

<table>
<thead>
<tr>
<th></th>
<th>United States</th>
<th>Texas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children living in or near poverty</td>
<td>80%</td>
<td>77%</td>
</tr>
<tr>
<td>Infants and young children (under age 3)</td>
<td>45%</td>
<td>47%</td>
</tr>
<tr>
<td>Children with disabilities or special health care needs</td>
<td>41%</td>
<td>40%</td>
</tr>
<tr>
<td>Children in foster care</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Births</td>
<td>48%</td>
<td>54%</td>
</tr>
</tbody>
</table>
Medicaid Contributes to Children’s Success in School and in Life

Medicaid helps children grow up to reach their full potential. Children enrolled in Medicaid:

- Miss fewer school days due to illness or injury
- Do better in school
- Are more likely to graduate high school and attend college
- Grow up to be healthier as adults
- Earn higher wages
- Pay more in taxes

Medicaid Strengthens Families

• Parents with Medicaid are healthier and better able to support their children’s healthy development

• Families with Medicaid have greater economic security and are less likely to have medical debt or bankruptcy

• Coverage provides peace of mind that reduces family stress

But...Coverage and Medical Care Are Not Enough

It is widely accepted that the desired health outcomes cannot be addressed by medical care alone; health is impacted by many more factors.

<table>
<thead>
<tr>
<th>Economic Stability</th>
<th>Education</th>
<th>Health and Health Care</th>
<th>Neighborhood and Environment</th>
<th>Social and Community Context</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Poverty</td>
<td>• High school graduation</td>
<td>• Access to health care</td>
<td>• Access to healthy food</td>
<td>• Social cohesion</td>
</tr>
<tr>
<td>• Employment</td>
<td>• Language and literacy</td>
<td>• Access to primary care</td>
<td>• Quality of housing</td>
<td>• Civic participation</td>
</tr>
<tr>
<td>• Food security</td>
<td>• Early childhood education</td>
<td>• Health literacy</td>
<td>• Crime and violence</td>
<td>• Incarceration</td>
</tr>
<tr>
<td>• Housing stability</td>
<td></td>
<td></td>
<td>• Environmenal conditions</td>
<td>• Discrimination</td>
</tr>
</tbody>
</table>

*Source: Healthy People 2020*
A Leadership Opportunity for Medicaid

“The debate about ...<the ACA>... has drawn attention to the central role that the Medicaid program plays in providing coverage and access to health care for millions of Americans. This central role positions Medicaid as an ideal platform on which to build an integrated system that simultaneously addresses health care and social needs.”

Katherine Witgert

<table>
<thead>
<tr>
<th>Leveraging Medicaid to Address SDOH</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Optional benefits</td>
</tr>
<tr>
<td>• Value-based purchasing</td>
</tr>
<tr>
<td>• Newer models of care</td>
</tr>
<tr>
<td>• Data collection and measurement</td>
</tr>
<tr>
<td>• Multi-benefit applications</td>
</tr>
<tr>
<td>• Integrated eligibility systems</td>
</tr>
<tr>
<td>• Bright Futures – pediatrician recommended guidelines</td>
</tr>
</tbody>
</table>

## NQF and CMS Recommendations

<table>
<thead>
<tr>
<th>Community and Healthcare System Linkages</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Acknowledge that Medicaid has a role in addressing social determinants of health.</td>
</tr>
<tr>
<td>• Create a comprehensive, accessible, routinely updated list of community resources.</td>
</tr>
</tbody>
</table>

### Information Sharing and Measurement

- Harmonize tools that assess social determinants of health.
- Create standards for inputting and extracting social needs data from electronic health records.
- Increase information sharing between government agencies.

### Payment Methods and Innovative Use of Resources

- Expand the use of waivers and demonstration projects to learn what works best for screening and addressing SDOH.

### Framework for State Medicaid Programs/Health Care Organizations to Address SDOH

State Examples of Medicaid SODH Innovations

**Massachusetts**
- Developed a neighborhood stress test (based on income, education, transportation, etc.)
- Provides extra payment to providers in high needs areas
- Extra funding supports innovations to address root social and economic issues

**Oregon**
- Close collaboration between OR Health Authority and OR Department of Education
- Aligned efforts of regional coordinated care organizations and early learning hubs to transform services for children and families

**Kansas**
- Targets members with severe mental illness, substance use disorder, developmental disabilities
- Requires MCOs to conduct health risk assessment and submit quarterly data
- Medicaid quality strategy includes measurement, reporting and pay for performance incentives
Emerging Efforts Tend to Focus on High Cost Populations, Even Though More than Half of Enrollees Are Children

Per Enrollee Medicaid Cost by Eligibility Group, 2014

- United States
  - Aged: $13,063
  - Disabled: $16,859
  - Adults: $3,278
  - Children: $2,976

- Texas
  - Aged: $11,890
  - Disabled: $19,475
  - Adults: $2,577
  - Children: $2,966

Medicaid Enrollment, December 2017

- United States
  - Child Enrollment: 49.62%
  - Aged, Disabled, Adults Combined: 50.38%

- Texas
  - Child Enrollment: 26.4%
  - Aged, Disabled, Adults Combined: 73.7%

Enrollment Data Source: CMS December 2017 Medicaid and CHIP Enrollment Report;
Expenditure Data Source: Kaiser Family Foundation State Health Facts
Cutting Federal Funding by Restructuring or Capping Medicaid Will Undermine Efforts to Tackle SDOH

**Waivers**
- Section 1332 Waivers allow states to pursue new models of integrated coverage
- Section 1115 Waivers allow states to change benefits, cost-sharing and other program rules

**Block Grants**
- Set amount for each state
- Fundamental change in entitlement and financing structure
- To achieve federal savings, states would receive less funding

**Per Capita Caps**
- Set amount states receive per enrollee
- Growth factor lower than expected expenditures
President’s Budget Proposes Even Deeper Cuts to Medicaid along with Cuts to Food, Housing, and Other Assistance

While the U.S. spends 25% more on health care per capita than the next highest spending country (Switzerland), the U.S. ranks 13th in overall spending on health care and social programs combined.

Source of Medicaid Cuts: Congressional Budget Office Scores of Various Legislative Proposals; White House Budget
Source of US spending: Organisation for Economic Co-operation and Development (2016); Health Affairs Blog 9/7/17 Blog
State Would Face Hard Choices in Dealing with Cuts in Federal Funding

Boost State Spending

- Close or cap enrollment
- Impose more red tape to suppress enrollment and retention
- Reduce Eligibility
- Cut Benefits
- Increase Enrollee Costs
- Lower Reimbursement for Providers
Key Takeaways

- Investments in Medicaid, food, housing, and other basic needs are critical to children’s healthy futures, particularly low-income children.
- Medicaid is a logical platform for addressing health care and social needs but cuts would undermine emerging efforts.
- To be successful, states need stable funding from a trusted partner in the federal government.
- Innovations should embrace longer-term ROI to reverse the trends of poor health status, obesity, and chronic disease that gain a foothold in childhood.
For More Information

Tricia Brooks
• Tricia.Brooks@georgetown.edu

Center for Children and Families website
• ccf.georgetown.edu

Say Ahhh! Our child health policy blog
• http://ccf.georgetown.edu/blog/
LEADERSHIP PERSPECTIVES

Jack Lewin, National Coalition on Health Care

Frederick Cerise, Medicaid and CHIP Payment and Access Commission (MACPAC) and Parkland Health and Hospital System

Susan Distefano, Children’s Memorial Hermann Hospital

Jamie Dudensing, Texas Association of Health Plans
CLAY JOHNSTON

Inaugural Dean
Dell Medical School | The University of Texas at Austin