ALTARUM
HEALTHCARE VALUE HUB

Healthcare Affordabililty State Policy Scorecard

Methodology

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This methodology report was authored by Alexandra Allen (Health Policy Analyst), Amanda Hunt (Hub Director), and Lynn Quincy (Hub Senior Advisor).

All materials produced as part of the 2021 Healthcare Affordability State Policy Scorecard, including the Executive Summary and scorecards for individual states, are available on our website at: www.HealthcareValueHub.org/Affordability-Scorecard.

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Healthcare Affordability State Policy Scorecard

ABOUT THIS SCORECARD

Polling data repeatedly shows that healthcare affordability is a top issue—often the number one issue—that healthcare consumers on both sides of the political aisle want their policymakers to work on. The Altarum Healthcare Value Hub's 2021 Healthcare Affordability State Policy Scorecard ranks states' performance on a broad set of actions to make healthcare more affordable and allows users to: (1) do a quick and easy assessment of actions their state has already taken and (2) identify actions policymakers can take to further improve.[1]

As described in detail below, this policy scorecard is unique in two ways. First, it combines publicly available data with custom dataset to provide a comprehensive picture of healthcare affordability. Additionally, it scores states on both policies and outcomes across four key affordability domains.

Note: this scorecard is retrospective and only scores states on policies that were implemented as of Dec. 31, 2020 and were impacting the lives of state residents at that time. Policies that were passed, but not implemented, before this date will be factored into next year's scores. Nevertheless, we do our best to acknowledge these accomplishments on the back of each state's scorecard.

This methodology document is accompanied by two key reports: (1) an Executive Summary report discussing key findings and trends and (2) an extended Summary Report including case studies and links to supporting research to help states move forward with policy development.[2]

Regarding the COVID-19 pandemic, this scorecard focuses exclusively on permanent policy changes implemented as of Dec. 31, 2020. It does not include any temporary policies enacted in response to the COVID-19 pandemic. However, we acknowledge that the pandemic also spurred permanent policy progress, which has been captured in the scores or notes based on date of implementation. In addition, several scorecards include notes about permanent policies for which implementation was delayed by the pandemic. Regarding outcome measurements, data used in this iteration was drawn from 2015-2019 (the most current data available at time of collection) and therefore does not reflect pandemic conditions.

WHAT STATE POLICIES MAKE HEALTHCARE AFFORDABLE FOR RESIDENTS?

Myriad data show that evidence-based policies can have a profound impact on how state residents experience the healthcare system, including their ability to afford coverage and care. State policymakers have a robust policy toolset they can use to address healthcare affordability by tackling the underlying drivers of affordability problems—most notably, excess prices—and ensuring that all residents can access coverage options with affordable premiums and cost-sharing provisions.

For purposes of this scorecard, state policy actions are grouped into four key categories:

- **Curb Excess Healthcare Prices**—The healthcare prices that Americans pay are unrelated to the cost of providing services because providers charge inflated rates to secure profits in negotiation, thus prices for a single service can vary widely irrespective of quality. This pricing problem is particularly troublesome for uninsured people (8% of the U.S. adult population) and those with private health insurance (approximately 65% of the U.S. population). Even people with generous insurance coverage are affected, as high prices for services are embedded in health insurance premiums that consumers pay, either directly through high-deductible health plans or indirectly in the form of increased taxes and/or lost wages when employers shoulder the burden of paying employees' premiums.
- **Reduce Low-Value Care**—A shocking amount of healthcare services delivered are considered unnecessary. Several large studies estimated that 7-15 percent of total healthcare spending has been driven by unneeded services or inefficient care delivery (for example, duplication of medical tests when the results are not shared between care providers).[3] Failure to limit wasteful spending raises insurance premiums, passes unnecessary out-of-pocket costs on to patients, is inconvenient and can even cause medical harm.
- **Extend Coverage to All Residents**—Without insurance, affording healthcare is impossible for the vast majority of American families. Across the U.S., roughly 8.6 percent of residents were uninsured in 2020;[4] however, this rate varies widely across states. Variations also exist within states, across sub-groups of the state population.
- **Make Out-of-Pocket Costs Affordable**—Even if all U.S. residents had some form of healthcare coverage, patients could still face affordability problems if their cost-sharing provisions or the scope of covered services left them underinsured (i.e., unable to afford their share of a healthcare expense after a health plan pays the bill).

While a state's policy environment can be critically important in terms of improving healthcare affordability, some states have good outcomes (for example, with respect to lower prices or fewer low-value services) despite an absence of evidence-based affordability policies. This scorecard accounts for this by examining these outcomes and scoring states on the outcomes they have achieved, in addition to the policies they have put in place. A summary of scored policies and outcomes within each of our four key affordability domains can be found in **Table 1**. The measures are discussed in greater detail below.

Important Note: Do Not Compare Scores Between Years

In an effort to improve the scorecard, data sources and/or calculations were changed for two policy measures and three outcome measures in the 2021 scorecard. As a result, many changes in scores/ranks between this 2021 scorecard and last year's 2020 scorecard are due to changes in methodology, rather than changes in state policies or outcomes. **Therefore, we strongly recommend against comparing scores/ranks between years.** Instead, the 2021 Scorecard should be used as a "point in time" assessment of each state based on the improved measures, rather than a continuation of the state's score/rank from the previous year. Details on changes to policy and outcomes measures are included in the sections below.

TABLE 1: AFFORDABILITY POLICIES AND OUTCOMES SCORED

Curb Excess Prices in the System	Policy Score:	All-payer or multi-payer claims database to inform policy actions	All-payer healthcare spending and quality benchmarks or price ceilings	Permanently convened health spending oversight entity	Strong price transparency tool that is: free; public-facing; and features negotiated rates that are treatment- and provider-specific
	Outcome Score:	Private payer inpatient prices relative to Medicare prices for 25 most frequent DRGs* *(state rate relative to the best performing state)*			
Reduce Low-Value Care	Policy Score:	Require validated patient-safety reporting	Universally implement hospital antibiotic stewardship	Measure low-value care in claims and EHR data	
	Outcome Score:	Johns Hopkins University Overuse Index* *(standardized relative to national average, not relative to best state)*			
Extend Coverage to All Residents	Policy Score:*	Medicaid expansion implemented by Dec. 31, 2020	Support for families earning too much to qualify for Medicaid: Basic Health Plan, subsidies, reinsurance, Medicaid buy-in, public option, etc.	Coverage options for recent and/ or undocumented immigrants	Strong rate review for fully insured, private market coverage options
	Outcome Score:	Percent of residents who are uninsured *(state rate relative to the best performing state)*			
Make Out-of-Pocket Costs Affordable	Policy Score:	Surprise out-of-network medical bill protections	Limit short-term, limited-duration health plans	Waive or reduce cost-sharing for high-value services	Use standard plan design in the Exchange, if state-based
	Outcome Score:	Percent of adults who could not get medical care due to cost* *(state rate relative to the best performing state)*			

* These measures were changed from the 2020 Scorecard interation. See relevant sections below for details.

CURB EXCESS PRICES: HOW STATES WERE SCORED

While high expenditures in some regions of the country can be partially explained by high local input costs (like labor and electricity) and utilization, most price variation occurs irrespective of these factors.[5] Moreover, a 2019 *JAMA* study found that approximately six percent of overall healthcare spending was associated with excess prices. The burden of excess prices falls disproportionately on those with private health insurance coverage and the uninsured.[6]

Policy Score: The "excess prices" policy score reflects:

- Whether the state has an **all-payer or multi-payer claims database (APCD)**—State scores depend on whether their APCD provides actionable information for state residents, researchers, payers, regulators and legislators, with partial credit if the APCD development is in process. Both voluntary and mandatory efforts receive full points, as do multi-payer claims databases that lack claims from some payers. APCD efforts that are completely stalled do not receive any credit.
  - 1 (full credit) = APCD or multi-payer claims database produces actionable data
  - 0.5 = APCD or multi-payer claims database development is in process
  - 0 = the state does not have an APCD or multi-payer claims database
- Whether the state uses **all-payer spending benchmarks** to rein in price growth—States are scored based on whether existing spending targets address all healthcare spending or only a subset of spending (for example, spending by hospitals) and whether they are mandatory or voluntary:[7,8]
  - 1 (full credit) = mandatory spending benchmark that applies to all spending
  - 0.8 = voluntary spending benchmark that applies to all spending
  - 0.5 = mandatory spending benchmark that applies to hospital spending only
  - 0 = the state has no broad spending benchmarks
- Whether the state has a **permanently convened, health spending oversight entity**—States are scored based on the proportion of overall spending that is tracked by their oversight entity:[9]
  - 1 (full credit) = oversight entity monitors all spending
  - 0.33 = oversight entity monitors hospital spending
  - 0.1 = oversight entity monitors drug spending
  - 0 = the state has no meaningful health spending oversight entity
- Whether the state has implemented a **free, public-facing healthcare price transparency tool** that reflects negotiated rates and displays prices that are treatment- and provider-specific. While "shopping" by patients is unlikely to drive down excess healthcare prices, transparent data can be used by researchers, payers, regulators and legislators to identify pricing outliers and advance targeted solutions like reference pricing, rate setting and more, depending on the level of provider competition in the market.[10]

State scores for this measure are as follows:[11]

- 1 (full credit) = state has a price transparency tool that includes all of the following features:
  - Free
  - Public facing
  - Prices reflect private payer-negotiated rates (not chargemaster or list prices)
  - Prices are provider and procedure specific (states received credit even if the tool reflected only a few services)
- 0 = state does not have a price transparency tool meeting our criteria

Outcome Score: The "excess prices" outcome score compares each state's inpatient private payer prices versus Medicare rates—a measure known as the Private-to-Medicare Ratio (PMR)—for a basket of the top 25 most frequently provided inpatient services. The score reflects how each state performs relative to the highest performing state.

State-level PMRs were calculated by Johns Hopkins University using 2018 MarketScan claims data. Estimates were obtained by dividing the average hospital inpatient Diagnostic Related Group (DRG) allowed amount in private claims (including both insurance payment and patient out-of-pocket payments) by the average hospital inpatient DRG allowed amount in Medicare for each state. The table below lists the basket of 25 inpatient services in order of DRG number. Note: this analysis is entirely different from the widely used Whaley-RAND study on the same subject.[12]

> **Sampling Methods/Limitations:** MarketScan data is a convenience sample, not a random/probability sample, and is therefore susceptible to sampling biases and may not accurately represent the entire population. In addition, roughly 75 percent of state-level MarketScan sample sizes used in this analysis were less than 15 percent of the total number of people with employer-sponsored insurance in each state. ***For these reasons, one CANNOT make general statements about entire states' exposure to excess prices based on this convenience sample. Instead, findings should be discussed as a single sample within the state.***
>
> **Exclusions:** Hawaii was excluded due to insufficient data and South Carolina was excluded due to data limitations within MarketScan, therefore these states received an N/A for total score and overall rank. The top 1 percent of admissions with highest and lowest payments were excluded. For states with missing Medicare DRGs, the research team replaced missing values with that DRG's national average allowed amount. MarketScan is a convenience sample and is more representative in some states than in other states, therefore it should not be taken as absolute but rather a potential signal of a pattern.

Note on Measure Change from Previous Scorecard: The previous iteration of this scorecard used a different metric for this outcome measure based on private payer prices relative to the national median. In an effort to improve the rigor and usefulness of the scorecard, this metric was replaced by the new measure described above.

TABLE 2: TOP 25 INPATIENT DRG BASKET USED FOR EXCESS PRICE SCORE

25	CRANIOTOMY AND ENDOVASCULAR INTRACRANIAL PROCEDURES WITH MCC
64	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W M
219	CARDIAC VALVE AND OTHER MAJOR CARDIOTHORACIC PROCEDURES WITHOUT CARDIAC CATHETERIZATION WITH MAJOR COMPLICATION OR COMORBIDITY (MCC)
220	CARDIAC VALVE AND OTHER MAJOR CARDIOTHORACIC PROCEDURES WITHOUT CARDIAC CATHETERIZATION WITH COMPLICATION OR COMORBIDITY (CC)
246	PERCUTANEOUS CARDIOVASCULAR PROCEDURES WITH DRUG-ELUTING STENT WITH MCC OR 4+ VESSELS OR STENTS
247	PERCUTANEOUS CARDIOVASCULAR PROCEDURES WITH DRUG-ELUTING STENT WITHOUT MAJOR COMPLICATION OR COMORBIDITY (MCC)
329	MAJOR SMALL AND LARGE BOWEL PROCEDURES WITH MCC
330	MAJOR SMALL AND LARGE BOWEL PROCEDURES WITH COMPLICATION OR COMORBIDITY (CC)
392	ESOPHAGITIS, GASTROENTERITIS AND MISCELLANEOUS DIGESTIVE DISORDERS WITHOUT MAJOR COMPLICATION OR COMORBIDITY (MCC)
454	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION WITH COMPLICATION OR COMORBIDITY (CC)
455	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION WITHOUT COMPLICATION OR COMORBIDITY (CC)/MAJOR COMPLICATION OR COMORBIDITY (MCC)
460	SPINAL FUSION EXCEPT CERVICAL WITHOUT MAJOR COMPLICATION OR COMORBIDITY (MCC)
470	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY WITHOUT MAJOR COMPLICATION OR COMORBIDITY (MCC)
472	CERVICAL SPINAL FUSION WITH COMPLICATION OR COMORBIDITY (CC)
621	O.R. PROCEDURES FOR OBESITY WITHOUT COMPLICATION OR COMORBIDITY (CC)/MAJOR COMPLICATION OR COMORBIDITY (MCC)
743	UTERINE AND ADNEXA PROCEDURES FOR NON-MALIGNANCY WITHOUT COMPLICATION OR COMORBIDITY (CC)/ MAJOR COMPLICATION OR COMORBIDITY (MCC)
765	CESAREAN SECTION WITH COMPLICATION OR COMORBIDITY (CC)/MAJOR COMPLICATION OR COMORBIDITY (MCC)
766	CESAREAN SECTION WITHOUT COMPLICATION OR COMORBIDITY (CC)/MAJOR COMPLICATION OR COMORBIDITY (MCC)
774	VAGINAL DELIVERY WITH COMPLICATING DIAGNOSES
775	VAGINAL DELIVERY WITHOUT COMPLICATING DIAGNOSES
853	INFECTIOUS AND PARASITIC DISEASES WITH O.R. PROCEDURE WITH MCC
871	SEPTICEMIA OR SEVERE SEPSIS WITHOUT MV >96 HOURS WITH MCC
872	SEPTICEMIA OR SEVERE SEPSIS W/O MV >96 HOURS W/O M
885	PSYCHOSES
897	ALCOHOL, DRUG ABUSE OR DEPENDENCE WITHOUT REHABILITATION THERAPY WITHOUT MAJOR COMPLICATION OR COMORBIDITY (MCC)

REDUCE LOW-VALUE CARE: HOW STATES WERE SCORED

Building on groundbreaking work conducted by the Institute of Medicine and Berwick and Hackbarth, a 2019 study found that approximately one-quarter of healthcare spending is wasted.[13] In other words, roughly 25 percent of healthcare spending does not result in better health.[14] The study examined several categories of healthcare waste, including overuse of services (a.k.a. low- and no-value care) and coordination failures (discussed in this section) as well as pricing failures (discussed in the previous section).

Policy Score: In this category, state scores depend on three factors:

- Whether the state requires **medical error reporting**[15] for two types of medical errors—central line-associated bloodstream infections (CLABSI) and catheter-associated urinary tract infections (CAUTI)—and whether the reports are validated.[16] While approaches to reducing low-value care can be controversial, reducing medical errors is a widely accepted strategy that is ripe for action.[17]
  - 1 = both types of medical errors are reported and reports are validated
  - 0.25 to 0.75 = some partial combination of reporting/validation is required
  - 0 = neither medical error is reported nor validated (states that did not report this information to the CDC received a 0)
- The percentage of a state's acute care hospitals that practice **antibiotic stewardship** by adopting the CDC's 'Core Elements' for hospital antibiotic stewardship.[18] Proven benefits include protecting patients from unintended consequences, improving the treatment of infections and helping combat antibiotic resistance. State scores reflect their relative progress (vis-à-vis other states) towards 100 percent of acute care hospitals adopting the CDC's standards.[19]
- Whether the state (or multi-sector collaboratives in the state) has attempted to **measure low-value care in claims data and/or Electronic Health Records (EHRs)** and subsequently work with providers to reduce the provision of low-value care.[20,21] State scores for this measure are as follows:
  - 1 = any attempt to broadly assess the provision of low-value care in the state
  - 0 = no attempt to broadly assess the provision of low-value care in the state

Note on Measure Change from Previous Scorecard: The previous 2020 iteration of the scorecard scored states on whether they followed Medicare's lead in refusing to pay for services related to "never events"—serious reportable events, as identified by the National Quality Forum, that should never occur in a healthcare setting.[22] However, this measure was removed from the current scorecard based on findings that, since Medicare issued that rule, all state Medicaid programs and many private insurance plans and hospitals have independently issued their own rules disallowing payment for never events, reducing the need to encourage state governments to implement further protections. However, it is worth noting that Maine, New Jersey, Connecticut and Pennsylvania passed laws explicitly prohibiting hospitals from billing patients for never events.

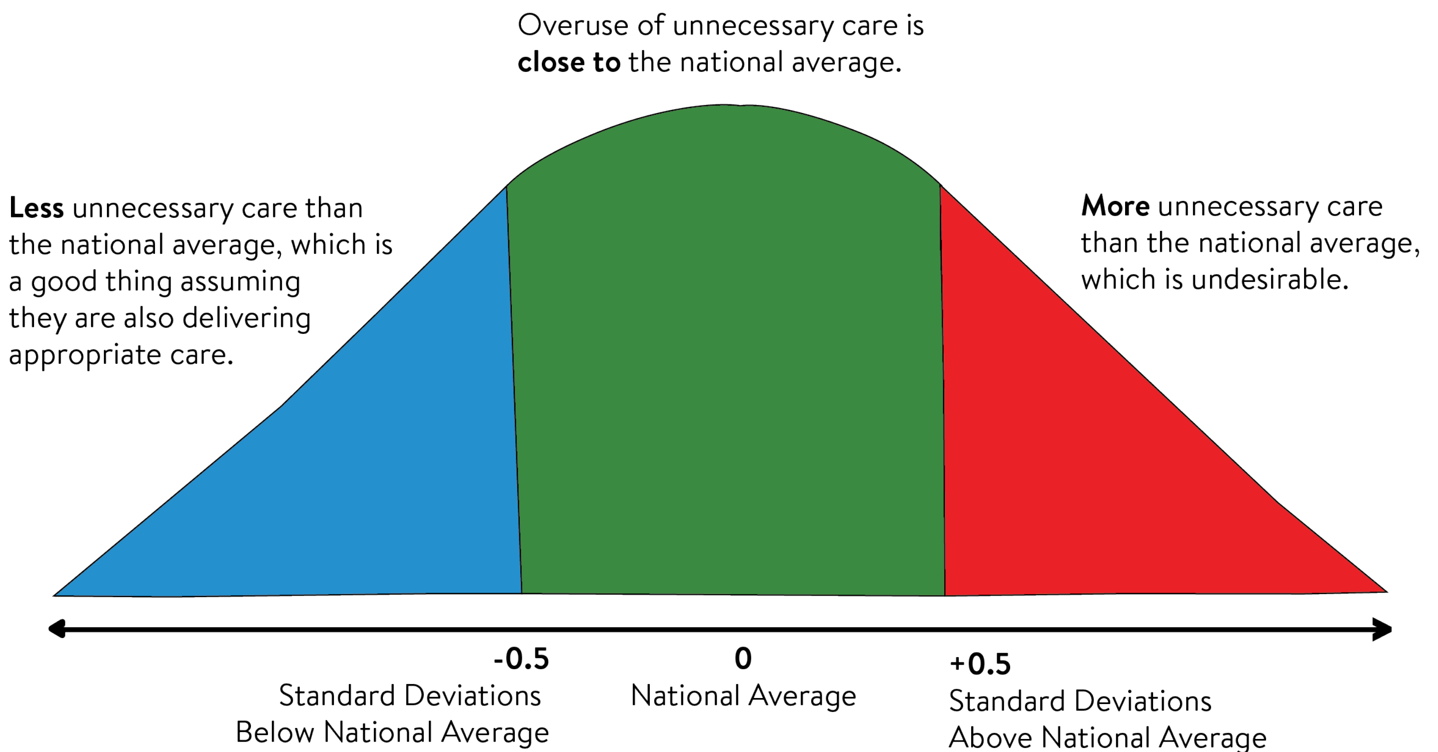
Outcome Score. The receipt of unnecessary care, and the potential financial and health consequences, are rarely measured at the state-level. Scores are based on an estimate of each state's overuse of low-value care compared to the national average, using a custom analysis produced by Johns Hopkins University.[23]

Johns Hopkins' Overuse Index (OI) was originally developed using Medicare claims data and combined 20 clinical "bellwether" procedures to indicate whether a region is using healthcare services that are not expected to produce better health. Some low-value procedures in the index were invasive procedures that put patients at unnecessary risk for complications with little health benefit, like nasal endoscopy for sinusitis. Others were expensive tests that create financial burdens and often lead to unnecessary procedures, like MRI scans for new low back pain. See the full list of original indicators here.[24] The custom analysis done for the 2021 Healthcare Affordability State Policy Scorecard includes seventeen indicator procedures, including five new indicators, drawn from 2015-2018 claims data. The investigators retired eight indicators.

While the OI cannot directly measure the extent of overuse comprehensively, it creates a relative measure of systemic overuse of low-value care and allows the comparison of overuse in each state relative to the national average. Each state's index value represents how many standard deviations that state's level of low-value care overuse is above or below the national average, which is represented by the value "zero" in the middle of the scale. For the sake of easy interpretation, the actual standard deviations are not listed on the front of the scorecard. The scorecard language reflects the interpretation of the Overuse Index below.

> **Sampling Methods/Limitations:** The data used in this analysis was drawn from 100 percent of inpatient and outpatient Medicare claims and the Master Beneficiary Summary files of Medicare beneficiaries through the Center for Medicare and Medicaid Services' (CMS) Virtual Research Data Center (VRDC). **This data does not verify whether low-value care in Medicare claims extends to the entire healthcare market, but for the purposes of this scorecard, we inferred that it does indicate patterns of overuse.**

Interpretation of Overuse Index Values for Low-Value Care Score



Note on Measure Change from Previous Scorecard: The previous iteration of this scorecard used a different metric for this outcome measure based on cesarean section rates among births to first-time, low-risk mothers and antibiotic prescribing per 1,000 residents. In an effort to improve the rigor and usefulness of the scorecard, these measures were removed and replaced by the Overuse Index described above.

EXTEND COVERAGE TO ALL RESIDENTS: HOW STATES WERE SCORED

Policy Score: There are a number of ways to ensure coverage for most state residents. The policy score for this area reflects the presence or absence of the following actions:

- Whether the state has **expanded Medicaid** to populations that became newly eligible under the Affordable Care Act (ACA).[25] Restrictive state eligibility rules (e.g., work requirements) can undermine enrollment in Medicaid and are noted in our descriptive material, but do not currently negatively impact states' scores. Policy scores for this measure were assigned as follows:
  - 1 (full credit) = childless adult eligibility expanded to at least 138 percent of Federal Poverty Level (FPL)
  - 0.5 = childless adult eligibility expanded to 100 percent of FPL
  - 0 = childless adults or others are only eligible if their incomes are less than 100 percent of FPL
- Whether the state offers **additional coverage options** for residents with incomes above Medicaid eligibility thresholds to purchase insurance in the non-group market. States that offered any of the following options were awarded full points for this measure:[26]
  - Premium subsidies for individual market coverage
  - Individual market reinsurance programs*
  - Medicaid Buy-In
  - Public Option
  - Basic Health Plan[27]

*The 2021 American Rescue Plan Act (ARPA) temporarily increased marketplace subsidies, rendering reinsurance programs less effective than in the past.[28] If ARPA subsidies are made permanent, the team may re-evaluate how reinsurance programs are credited in future scorecard iterations. For this year's scorecard, states with reinsurance programs received credit for this measure, but it was not recommended to states.

- Whether the state offers **coverage options for immigrants** who don't qualify for the coverage options above.[29] Scores in this section are cumulative. States were awarded:[30,31,32]
  - 0.2 points for offering Medicaid coverage to lawfully residing immigrant children without a 5-year wait
  - 0.3 points for offering Medicaid coverage to lawfully residing immigrant pregnant women without a 5-year wait
  - 0.07 points for providing coverage options for undocumented immigrant children (weight reflects relatively small population size)
  - 0.17 points for providing coverage options for undocumented immigrant pregnant women (can be solely prenatal care or additional coverage)
  - 0.25 points for providing coverage options for undocumented, non-pregnant adults

- Whether the state has **rate review that includes affordability criteria**. Rate review is a process by which state insurance regulators review health insurers' proposed insurance premiums for the coming year to ensure that they are based on accurate, verifiable data and realistic projections of healthcare costs and utilization. The final component of the coverage section assesses whether state regulators are authorized to incorporate affordability factors into rate review. Existing approaches include requiring insurers to demonstrate cost-containment efforts, scrutinizing provider contracts and/or requiring an emphasis on high-value care.[33]
  - 1 (full credit) = rate review process includes 1 or more affordability approaches
  - 0.5 = basic rate review process present (as defined by the federal government[34])
  - 0 = rate review deemed "ineffective" by the federal government[35]

Outcome score: The outcome score for this category assesses how well each state performs, relative to the best-performing state, in terms of reducing the percentage of the population that remains uninsured. States receive higher scores for lower rates of un-insurance.[36]

> **Sampling Methods/Limitations:** Uninsurance rates were drawn from the American Community Survey (ACS). The ACS is a probability sample with large sample sizes, allowing one to make statements about entire state populations.[37] For information on sampling error and coverage, see "American Community Survey Accuracy of the Data (2019)."[38]

MAKE OUT-OF-POCKET COSTS AFFORDABLE: HOW STATES WERE SCORED

Expanding health coverage is critical to ensuring that healthcare is affordable, but is an insufficient strategy on its own. It is well documented that families' ability to afford their out-of-pocket (OOP) costs varies with income and cost-sharing obligations frequently exceed what their budgets can bear.[39]

Policy Score: States can take a number of actions to ensure that health coverage is truly protective (i.e., does not include large coverage gaps); reflects a family's ability to afford costs; and adheres to best-practices with respect to cost-sharing designs that remove barriers to high-value care.

The Out-of-Pocket Cost policy score considers:

- Whether the state has **out-of-network surprise medical bill protections**—Although out-of-network surprise medical bills (SMBs) constitute a relatively small portion of overall healthcare spending, they are quite prevalent in certain metropolitan areas, at certain institutions and for certain medical specialties and services.[40] The resulting expense can be financially devastating for individuals and families. While states cannot protect consumers enrolled in self-insured plans (regulated by the U.S. Department of Labor),[41] they can protect consumers enrolled in fully insured plans (regulated by state Departments of Insurance). The score given to each state reflects the following levels of protection:[42,43]
  - 1 (full credit) = state has comprehensive SMB protections
  - 0.5 = state has partial SMB protections
  - 0 = state has minimal or no SMB protections

Note: The federal No Surprises Act passed in 2020 prohibits surprise medical billing in most insurance plans nationwide effective January 2022. However, some states should consider implementing their own protections for the following reasons: (1) the No Surprises Act does not cover some services which often result in surprise bills for consumers, such as ground ambulance services. The back of each scorecard contains details about states' prevalence of ground ambulance-related SMBs based on a custom analysis of MarketScan data by Johns Hopkins University for Altarum; and (2) state-based protections will remain if the No Surprises Act is ever overturned or made less comprehensive in future legislation. MarketScan data is a convenience sample, not a random/probability sample, and is therefore susceptible to sampling biases and may not accurately represent the entire population. In addition, roughly 75 percent of state-level MarketScan sample sizes used in this analysis were less than 15 percent of the total number of people with employer-sponsored insurance in each state. ***For these reasons, one CANNOT make general statements about entire states' exposure to ground ambulance surprise medical billing based on this convenience sample. Instead, findings should be discussed as a single sample within the state.***

- Whether the state has **protections against short-term, limited-duration health plans**—Short-term, limited-duration (STLD) health plans are not required to provide the standard ACA protections for non-group coverage. Although they are relatively low cost, STLD plans cover little, can reject/charge higher rates for women and people with pre-existing conditions, are not well understood by consumers[44] and only a small percentage of the premiums collected are ultimately spent on beneficiaries' medical care.[45] Scoring for this policy reflects the level of consumer protection:[46,47]
  - 1 = state bans STLD health plans
  - 0.8 = STLD plans are heavily regulated and no plans are for sale in the state
  - 0.5 = state (1) imposes maximum term limits and renewal restrictions that effectively prohibit residents from being enrolled in any STLD plan for more than 364 days and (2) provides at least one of the following consumer protections: pre-existing conditions protections, benefit requirements or requiring a medical loss ratio of 80 percent or more
  - 0.3 = state imposes maximum term limits and renewal restrictions that effectively prohibit residents from being enrolled in any STLD plan for more than 364 days, however, other consumer protections are absent or limited (like requiring consumer disclosure or prohibiting gender rating)
  - 0 = state defaults to federal rules or extended the amount of time a person can be enrolled in a STLD plan
- Whether the state has mandates that **waive or reduce cost-sharing for high-value services**—Failure to receive high-value care like flu vaccines, certain cancer screenings and select other services not only worsens health outcomes, but can result in higher spending on medical care in the future. Incentivizing patients to use high-value care involves a constellation of strategies,[48] but for the purposes of this section, we assess whether a state has taken any action to waive or reduce cost-sharing for high-value services to make them more affordable for patients.[49] Examples are rare but include:
  - Capping cost-sharing for insulin at $100 per month for fully insured plans (Colorado, Illinois)
  - Waiving the deductible for: immunizations and lead screening for children; preventive care; maternity care; and second surgical opinions for people enrolled in fully insured plans (New Jersey)
- Whether the state has deployed **standard plan designs on their state-based exchange**—Standardizing cost-sharing obligations into a few basic plan designs can incorporate the goals of reducing barriers to high-value services and accomplish other goals as well.[50] While states have the authority to require

standard plan designs in the fully insured Marketplace, in practice, few states have done so.[51] This section awards credit to states that have implemented any type of standard plan designs in their state-based insurance marketplace.[52] States lacking a state-based exchange received no credit for this measure.

Outcome Score: As several studies have documented, difficulty affording out-of-pocket costs can manifest itself in many ways, including foregoing needed care, delaying needed care, skimping on care (such as cutting pills in half) and getting care but struggling to pay the resulting medical bills.[53] The outcome score for this category is based on the prevalence of one of these manifestations: the **percent of adults who could not get needed medical care due to cost.**

State-level estimates were obtained from a SHADAC analysis of 2019 Behavioral Risk Factor Surveillance System (BRFSS) survey data. State's scores are based on how well each state performs relative to the highest-performing state. States with the lowest percentages of adults who could not get needed medical care due to cost receive the highest "scores.

Sampling Methods/Limitations: The BRFSS is a probability sample with large sample sizes, and one can make statements about entire state populations based on BRFSS. For information on sampling methodology, see the report "Overview: BRFSS 2016."[54]

Note on Measure Change from Previous Scorecard: The previous iteration of the scorecard used a more robust outcome measure obtained from a custom analysis of the 2017 National Health Interview Survey produced by SHADAC. The custom measure assessed the overall prevalence of one or more of the following four affordability problems among the state's adult population (aged 18+):[55]

- Trouble paying medical bills
- Made changes to medical drugs due to cost
- Delayed seeking medical care due to cost concerns
- Needed but couldn't afford medical care

Due to data limitations, **the current measure is more limited in scope and only captures one of the more serious affordability burdens**—inability to get care at all—versus the previous measure which captured a broader array of affordability burdens. While the current measure may lead viewers to believe that affordability burdens affect a relatively small portion of the population, the prevalence of affordability burdens is likely far higher.

WEIGHTING THE SCORECARD POLICY AND OUTCOME COMPONENTS

The value of this scorecard lies, in part, in the actionable policy and outcomes data provided for each state. However, in order to produce an overall score and an accompanying state rank, the Hub weighted individual components within categories to reflect their relative burden on consumers. The Hub also weighted sub-components, using either a percent-of-the-population-affected approach or percent-of-spending approach as needed. In some cases, these initial weights were rounded to make it easier to explain the underlying rationale or to ensure that a policy action had enough weight to generate a minimum score. Component and sub-component weights are summarized in **Table 3**.

Note on Measure Change from Previous Scorecard: The previous iteration of this scorecard used a slightly different set of weights within the "Reduce Low-Value Care" and "Extend Coverage to All Residents" policy categories. The "Reduce Low-Value Care" policy weights were changed to accommodate the removal of the "never events" policy from the category, as described earlier in this report. The "Extend Coverage to All Residents" policy weights were changed to correct a slight distortion produced by the previous high weight on rate review and to bolster equity considerations related to expanding Medicaid and coverage for immigrant populations.

TABLE 3: WEIGHTING THE SCORECARD POLICY AND OUTCOME COMPONENTS

Curb Excess Prices in the System	Policy Score:	Strong price transparency	All-payer or multi-payer claims dataset to inform policy actions	All-payer healthcare spending benchmarks	Permanently convened health spending oversight entity	
	Component weights:	1	3	3	3	= 10 possible points
	Outcome Score:	Private payer inpatient prices relative to Medicare prices *(No component weights)*				= 10 possible points
Reduce Low-Value Care	Policy Score:	Require validated patient-safety reporting	Universally implement hospital antibiotic stewardship	Measure low-value care in claims data and EHR	*(Never events policy removed from category)*	
	Component weights:	2 (previously 1.5)	3 (previously 1)	7 previously 5.5)		= 10 possible points
	Outcome Score:	Johns Hopkins Overuse Index (*No component weights*)				= 10 possible points
Extend Coverage to All Residents	Policy Score:	Medicaid expansion implemented by Dec. 31, 2020	Support for families earning too much to qualify for Medicaid: Basic Health Plan, subsidies, reinsurance, Medicaid buy-in, Public Option, etc.	Coverage options for recent and/or undocumented immigrants	Strong rate review for fully insured, private market coverage options	
	Component weights:	2 (previously 1)	3	3 (previously 2)	2 (previously 4)	= 10 possible points
	Outcome Score:	Percent of residents who are uninsured (*No component weights*)				= 10 possible points
Make Out-of-Pocket Costs Affordable	Policy Score:	Surprise out-of-network medical bill protections	Limit short-term, limited-duration health plans	Waive or reduce cost-sharing for high-value services	Use standard plan design in the exchange, if state-based	
	Component weights:	4	2	3	1	= 10 possible points
	Outcome Score:	Healthcare OOP affordability burdens (*No component weights*)				= 10 possible points

ENDNOTES

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Contact the Hub: 2000 M Street, NW, Suite 400, Washington, DC 20036
(202) 828-5100 | www.HealthcareValueHub.org | @HealthValueHub

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