

HEALTHCARE AFFORDABILITY STATE POLICY SCORECARD

Methodology



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All materials produced as part of the 2022 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 show 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 2022 Healthcare Affordability State Policy Scorecard ranks states’ performance on a broad set of actions to make healthcare more affordable and allows users to: (1) conduct 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 data 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, 2021. Policies that were passed, but not implemented, before this date will be factored into future scores. Nevertheless, we do our best to acknowledge these accomplishments in the notes of each state’s Scorecard.

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

Regarding the COVID-19 pandemic: This Scorecard focuses exclusively on permanent policy changes implemented as of Dec. 31, 2021. 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 states’ Scorecards include notes about permanent policies for which implementation was delayed by the pandemic. Some of the outcome measures in this Scorecard include data from 2020, which may have been impacted by the COVID-19 pandemic.

WHAT STATE POLICIES MAKE HEALTHCARE AFFORDABLE FOR RESIDENTS?

This Scorecard examines state policy actions in four key categories:

- ▲ **Curb Excess Healthcare Prices**—The healthcare prices that Americans pay tend to be unrelated to the cost of providing services and therefore can vary widely. This can be particularly troublesome for uninsured people (8.7% of the U.S. adult population²) and those with private health insurance (approximately 67% of the U.S. population³).
- ▲ **Reduce Low-Value Care**—Several large studies estimated that 7-15% of total healthcare spending has been driven by services providing little or no clinical benefit to the patient (for example, duplication of medical tests when the results are not shared between care providers).⁴
- ▲ **Extend Coverage to All Residents**—Across the U.S., roughly 8.7% of residents were uninsured in 2020;⁵ however, this rate varies widely across states. Variations also exist within states across sub-groups of the population.
- ▲ **Make Out-of-Pocket Costs Affordable**—Even if all U.S. residents had some form of healthcare coverage, patients could still face affordability burdens 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, outcome measures are equally important. This Scorecard scores 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 various policy measures and outcome measures in the 2022 Scorecard. As a result, many changes in scores/ranks between this 2022 Scorecard and last year's 2021 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 2022 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.

A Note on Citations

The citations included in this Methodology report are intended to provide references for resources that shaped how scoring criteria were developed, rather than being used to determine individual state scores. While some sources formed the baseline for state scoring, extensive research was conducted on individual states beyond these sources, which can be provided upon request.

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/outpatient prices relative to Medicare prices from the RAND 4.0 hospital prices dataset.* (state rate relative to the best-performing state)			
Reduce Low-Value Care	Policy Score:	Measure low-value care in claims and EHR data	Require validated patient-safety reporting	Universally implement hospital antibiotic stewardship	
	Outcome Score:	Altarum Analysis of 2020 Medicare Fee-for-Service claims data (a 5% sample) using a variation on the Johns Hopkins University Overuse Index method.* (state rate relative to the best-performing state)			
Extend Coverage to All Residents	Policy Score:*	Medicaid expansion implemented by Dec. 31, 2021	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 faced one or more of the five affordability burdens:* 1) Did not get care due to cost 2) Delayed seeking medical care because of worry about the cost 3) Made changes to medical drugs due to cost 4) Problems paying or unable to pay medical bills 5) Uninsured because cost too high (state rate relative to the best-performing state)			

* These measures were changed from the 2021 Scorecard iteration. See relevant sections below for details.

CURB EXCESS PRICES: HOW STATES WERE SCORED

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 APCD development is in process. Both voluntary and mandatory efforts receive points, as do multi-payer claims databases that lack claims from some payers.⁶
 - 1 (full credit) = state-affiliated APCD or multi-payer claims database producing actionable data
 - 0.5 = state-affiliated APCD or multi-payer claims database development in process; or non-state-affiliated APCD in process or operational and producing actionable data; or state-affiliated APCD that was at one point operational but no longer operational as of Dec. 31, 2021
 - 0 = the state does not have an APCD or multi-payer claims database

Note on Measure Change from Previous Scorecard: In the 2021 Scorecard, states received 1 point if they had any operational APCD producing data and 0.5 points if they had any APCD in progress.

- ▲ 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
 - 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:⁸
 - 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. State scores for this measure are as follows:⁹
- 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 charge master 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 that meets Hub criteria

Outcome Score: The “excess prices” outcome score examines each state’s combined inpatient and outpatient relative price—the ratio of the actual private insurer allowed amount for an inpatient or outpatient service divided by the Medicare allowed amount for the same service provided by the same hospital—for claims from more than 4,000 hospitals and ambulatory surgical centers in all states from 2018 to 2020. The data was drawn from the RAND 4.0 study, “Prices Paid to Hospitals by Private Health Plans: Findings from Round 4 of an Employer-Led Transparency Initiative.”¹⁰ State scores reflect how each state performs, relative to the highest performing state. States with lower relative prices received higher scores. Although data from Maryland were excluded from the RAND 4.0 study, we have included Maryland in the ranking and taken into account their unique rate-setting system.¹¹

Note on Measure Change from Previous Scorecard: The previous iteration of this Scorecard used a different metric for this outcome, comparing each state’s inpatient-only private payer prices versus Medicare rates (Private-to-Medicare Ratio) for a basket of the top 25 most frequently provided inpatient services. These numbers were calculated by Johns Hopkins University using 2018 MarketScan claims data.

REDUCE LOW-VALUE CARE: HOW STATES WERE SCORED

Building on ground-breaking work conducted by the Institute of Medicine and Berwick and Hackbarth, a 2019 study found that approximately one-quarter of healthcare spending is wasted.¹² The study examined several categories of healthcare waste, including overuse of services (a.k.a. low- and no-value care) and pricing failures (discussed in the previous section).

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

- ▲ Whether the state (or multi-sector collaboratives in the state) has attempted to measure low-value care in claims data and/or EHRs and subsequently works with providers to reduce the provision of low-value care.^{13,14} State scores for this measure are as follows:
 - 1 (full credit) = 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
- ▲ Whether the state requires medical error reporting¹⁵ 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 Scores in this section are cumulative.
 - +0.25 = Reporting for CLABSI is mandatory;
 - +0.25 = CLABSI reports are validated;
 - +0.25 = Reporting for CAUTI is mandatory; and
 - +0.25 = CAUTI reports are validated.
 - 0 = neither medical error is reported nor validated (states that did not report this information to the CDC received a 0)
- ▲ The percentage of the state’s acute care hospitals that practice antibiotic stewardship by adopting the CDC’s *Core Elements for Hospital Antibiotic Stewardship*.¹⁷ State scores reflect their progress, relative to other states, towards 100% of acute care hospitals adopting the CDC’s standards.¹⁸

Outcome Score. The “low-value care” outcome score captures the percentage of Medicare beneficiaries in each state who received one or more low-value care services identified from a list of 20 low-value services.^{19,20} State scores reflect how each state performs, relative to the highest performing state. States with lower percentages of adults receiving low-value care services received higher scores.

Estimates of low-value care prevalence by state were determined by applying algorithms to physician and outpatient facility Medicare Fee-for-Service claims data (a 5% sample) from 2020. The low-value care services used in these calculations were selected for their relevance to the Medicare population and sourced from a variety of previously published sources.^{21,22} Table 2 shows a list of the 20 individual services used. The primary outcome in each measure was the proportion of Medicare recipients receiving each low-value care service, excluding individuals and cases where the low-value care service was likely warranted. The 20 individual service prevalence rates were then added together to get a state total.

Note on Measure Change from Previous Scorecard: The previous iteration of this Scorecard used a different metric for this outcome measure based on the Johns Hopkins Overuse Index using 2015-2018 data. The outcome was a standard deviation of each state’s overuse of low-value care relative to an unknown national average.

TABLE 2: LOW-VALUE CARE SERVICES USED FOR OUTCOME SCORE

Imaging for low back pain within the first six weeks, unless red flags are present
Routine pre-operative testing before low-risk surgical procedures
Population-based screening for 25-OH-Vitamin D deficiency
PSA testing for prostate cancer screening in men with no symptoms of the disease when they are expected to live less than 10 years.
Routinely repeating DXA scans more often than once every two years
Electroencephalography (EEG) for headaches
Annual electrocardiograms (EKGs) or any other cardiac screening for low-risk patients without symptoms
Screening for breast, colorectal, or prostate cancer if life expectancy is estimated to be less than 10 years
Screening for cervical cancer in low-risk women aged 65 years or older and in women who have had a total hysterectomy for benign disease.
MRI of the peripheral joints to routinely monitor inflammatory arthritis
Arthroscopic lavage and debridement for Knee Osteoarthritis
Coronary Artery Calcium Scoring for Coronary Artery Disease (CAD)
Sinus computed tomography (CT) or indiscriminately prescribe antibiotics for uncomplicated acute rhinosinusitis
Hysterectomy for benign disease
Electroencephalogram (EEG) monitoring in individuals presenting with syncope
Meniscectomy in patients with DJD of the knee
Routine monitoring of digoxin in patients with congestive heart failure
Imaging in acute foot trauma
Laminectomy and/or spinal fusion
Screening for asymptomatic carotid artery stenosis (CAS) in adults aged 80 years and older

EXTEND COVERAGE TO ALL RESIDENTS: HOW STATES WERE SCORED

Policy Score: The policy score for this area reflects:

- ▲ Whether the state has expanded Medicaid under the Affordable Care Act (ACA).²³ Restrictive state eligibility rules (e.g., work requirements) 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:²⁴
 - Premium subsidies for individual market coverage
 - Individual market reinsurance programs*
 - Medicaid Buy-In
 - Public Option
 - Basic Health Plan²⁵

*The 2021 American Rescue Plan Act (ARPA) temporarily increased marketplace subsidies, rendering reinsurance programs less effective than in the past.²⁶ If ARPA subsidies are made permanent (as of October 2022, they are set to expire in 2025²⁷), the Healthcare Value Hub may re-evaluate how reinsurance programs are credited in future Scorecard iterations. For the 2022 Scorecard, states with reinsurance programs received credit for this measure, but establishing a reinsurance program was not recommended for states without an existing program.

- ▲ Whether the state offers coverage options for immigrants who don't qualify for the coverage options above.²⁸ Federal guidelines prohibit lawfully residing immigrants from receiving Medicaid and the Children's Health Insurance Program (CHIP) without waiting five years. However, states can remove this five-year bar for pregnant women and children. In addition, states generally must provide separate state-funded premium subsidies and insurance purchasing options for undocumented immigrants and other immigrants groups ineligible for federal subsidies. States can also opt into CHIP's "Unborn Child" option to provide certain services to undocumented immigrant pregnant people. Scores in this section are cumulative. States were awarded:^{29,30}
 - +0.2 points for providing Medicaid coverage for lawfully residing immigrant children without a 5-year wait;
 - +0.2 points for providing Medicaid coverage for lawfully residing immigrant pregnant women without a 5-year wait;
 - +0.2 points for providing coverage options for undocumented immigrant children;

- +0.2 points for providing comprehensive coverage options for undocumented immigrant pregnant women, including through CHIP’s “Unborn Child” option and other programs (only +0.1 points were given if the state provides non-comprehensive care that only covers pregnancy-related services such as prenatal care, delivery and postpartum care and excludes other services³¹); and
- +0.2 points for providing coverage options for undocumented, non-pregnant adults of all ages (only +0.1 points were given if the state limits coverage to certain age ranges)

Note on Measure Change from Previous Scorecard: The 2021 iteration of the Scorecard awarded different point values for each of the above immigrant populations in an attempt to capture the different proportions of the total immigrant population, based on age and pregnancy status. However, in part because population composition is likely unique to each state, the 2022 Scorecard was changed to equally award 0.2 points for each subpopulation. In addition, the previous year’s Scorecard awarded full credit for providing coverage only to certain age groups for adult undocumented immigrants as well as for providing non-comprehensive coverage for pregnant immigrants (both lawfully residing and undocumented) that excluded non-pregnancy related services.

- ▲ Whether the state includes **affordability criteria** in its rate review process. 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. Existing approaches to incorporate affordability factors into rate review include requiring insurers to demonstrate cost-containment efforts, scrutinizing provider contracts and/or requiring an emphasis on high-value care.³²
 - 1 (full credit) = rate review process includes 1 or more affordability approaches
 - 0.5 = “effective” rate review process present (as defined by the federal government³³)
 - 0 = rate review deemed “ineffective” by the federal government³⁴

Outcome score: The “extend coverage to all residents” outcome score is based on the percent of each state’s population that is uninsured. States receive higher scores for lower rates of uninsurance, relative to the best-performing state.³⁵

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.³⁶ For information on sampling error and coverage, see American Community Survey Accuracy of the Data (2019).³⁷

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

Expanding health coverage is critical to ensuring that healthcare is affordable for all residents, 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, while cost-sharing obligations frequently exceed what their budgets can bear.³⁸

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 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, including the ten essential health benefits and the prohibition on medical underwriting. Although they are relatively low cost, STLD plans cover little, which can leave consumers vulnerable to high out-of-pocket costs. STLD plans can also reject/charge higher rates for women and people with pre-existing conditions, are not well understood by consumers³⁹ and ultimately spend only a small percentage of the premiums collected on beneficiaries' medical care.⁴⁰ Scoring for this policy reflects the level of consumer protection:^{41,42}
 - 1 (full credit) = state bans STLD health plans
 - 0.8 = STLD plans are heavily regulated, and no plans are available in the state
 - 0.5 = state (1) imposes maximum term limits and renewal restrictions that effectively limit STLD plan duration to LESS THAN one year 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% or more
 - 0.3 = state (1) imposes maximum term limits/restrictions that limit STLD plan duration to LESS THAN one year but have no other consumer protections OR (2) imposes maximum term limits/restrictions that limit STLD plan duration to some length GREATER THAN one year, but have some limited consumer protections (requiring consumer disclosures and/or prohibiting gender rating)
 - 0 = state defaults to federal rules
- ▲ 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 prevalent in certain metropolitan areas, at certain institutions and for certain medical specialties and services.⁴³ The resulting expense of SMBs can be financially devastating for individuals and families. The federal No Surprises Act prohibits surprise medical billing in most insurance plans nationwide as of January 2022.

However, some states should consider implementing their own additional protections for the following reasons: (1) State-based protections will remain if the No Surprises Act is ever overturned or made less comprehensive in the future and (2) The No Surprises Act does not cover some services, which often result in surprise bills for consumers, such as ground ambulance services and lab testing. 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 conducted in 2021. While states cannot protect consumers enrolled in self-insured plans (regulated by the federal U.S. Department of Labor), they can protect consumers enrolled in fully insured plans and public plans (regulated by state Departments of Insurance). The score given to each state reflects the following levels of protection. Scores in this section are cumulative:^{44,45}

- +0.4 = comprehensive SMB protections, as defined by The Commonwealth Fund;
- +0.4 = partial SMB protections, as defined by The Commonwealth Fund;⁴⁶
- +0.2 = protections for one or more loopholes in the federal No Surprises Act, including ground ambulances, lab work and services provided at certain facilities;^{47,48,49} and
- 0 = minimal or no state-level surprise medical bill protections

Note on Measure Change from Previous Scorecard: The 2021 iteration of the Scorecard awarded different points for states that had comprehensive and partial SMB protections and did not include No Surprises Act loophole protections in scoring.

*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% of state-level MarketScan sample sizes used in this analysis were less than 15% 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 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,⁵⁰ 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. Examples include:
 - Capping cost-sharing for insulin at \$25 for a 30-day supply (New Mexico⁵¹ and Texas⁵²) or \$75 for a 30-day supply (Oregon⁵³) for fully insured plans
 - 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.⁵⁴ This section awards credit to states that have implemented any type of standard plan designs in their state-based insurance marketplace.⁵⁵ States lacking a state-based exchange—and therefore, unable to implement standard plan designs—received no credit for this measure.

Outcome Score. The “make out-of-pocket costs affordable” outcome score is based on the percent of adults who experienced one or more of the following five affordability burdens:

1. Did not get medical care due to cost
2. Delayed seeking medical care due to cost concerns
3. Made changes to medical drugs due to cost
4. Trouble paying medical bills
5. Uninsured due to high cost of insurance

State-level estimates were obtained from a custom State Health Access Data Assistance Center (SHADAC) analysis of 2019–2020 National Health Interview Survey (NHIS) data from the Center for Health Statistics (NCHS). State scores reflect how each state performs, relative to the highest performing state. States with lower percentages of adults experiencing one or more affordability burdens received higher scores.

Sampling Methods/Limitations: The NHIS sample is drawn from the Integrated Public Use Microdata Series (IPUMS) National Health Interview Survey (NHIS), analyzed by SHADAC. See Table 3 below for details on the variables selected. Data were analyzed at the University of Minnesota’s Census Research Data Center because state identifiers were needed to produce results and these variables were restricted. Notes: Estimates were created using the NHIS survey weights, which are calibrated to the total U.S. civilian non-institutionalized population. N/A indicates that data were suppressed either because the number of sample cases was too small or the estimate had a relative standard error greater than 30%.

Note on Measure Change from Previous Scorecard: The 2021 iteration of the Scorecard used an alternative measure provided by SHADAC: the percent of adults in each state who could not get needed medical care due to cost.

TABLE 3: VARIABLES USED FOR "MAKE OUT-OF-POCKET COST AFFORDABLE" OUTCOME SCORE

SCORECARD LABEL	DID NOT GET MEDICAL CARE DUE TO COST	DELAYED SEEKING MEDICAL CARE DUE TO COST CONCERNS	MADE CHANGES TO MEDICAL DRUGS DUE TO COST	TROUBLE PAYING MEDICAL BILLS	UNINSURED DUE TO HIGH COST OF INSURANCE
IPUMS Variable Name	ybarcar	delaycost	ydelaymedyr yskimpmedyr yskipmedyr	hiprobpayr	hinocostr
Survey Question	“During the past 12 months, was there any time when you needed medical care, but DID NOT GET IT because of the cost?”	“During the past 12 months, have you DELAYED getting medical care because of the cost?”	“During the past 12 months, were any of the following true for you? ...You DELAYED filling a prescription to save money. ...You took less medication to save money. ...You skipped medication doses to save money.”	“In the past 12 months did you/ anyone have problems paying or were unable to pay any medical bills? Include bills for doctors, dentists, hospitals, therapists, medication, equipment, nursing home or home care.”	Constructed Variable, Reasons for no insurance: Too expensive
Denominator	Percentage of the civilian non-institutionalized adults age 18+	Percentage of the civilian non-institutionalized adults age 18+	Percentage of the civilian non-institutionalized adults age 18+	Percentage of the civilian non-institutionalized adults age 18+	Percentage of the uninsured civilian non-institutionalized adults age 18+

WEIGHTING THE SCORECARD POLICY AND OUTCOME COMPONENTS

The Scorecard Policy components are weighted by individual components within the four categories to reflect their relative burden on consumers. Additionally, sub-components were weighted based on Hub assessment of impact. 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 4.

TABLE 4: WEIGHTING THE SCORECARD POLICY COMPONENTS

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	
	Component weights:	3	3	3	1	= 10 possible points
Reduce Low-Value Care	Policy Score:	Measure low-value care in claims and EHR data	Require validated patient-safety reporting	Universally implement hospital antibiotic stewardship		
	Component weights:	7	2	1		= 10 possible points
Extend Coverage to All Residents	Policy Score:	Medicaid expansion implemented by Dec. 31, 2021	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	3	3	2	= 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:	2	4	3	1	= 10 possible points

ENDNOTES

1. The Scorecards themselves, along with all other products associated with this project, can be found at <https://www.healthcarevaluehub.org/affordability-scorecard>
2. Estimate from American Community Survey (2020 5-year Estimates), Table S2701: Selected Characteristics of Health Insurance Coverage in the United States, United States Census Bureau, Washington, D.C. (Accessed Sept. 29, 2022). <https://data.census.gov/cedsci/table?q=Table%20S2701&tid=ACSST1Y2021.S2701>
3. Estimate from American Community Survey (2020 5-year Estimates), “Table S2703: Private Health Insurance Coverage by Type and Selected Characteristics”, United States Census Bureau, Washington, D.C. (Accessed Sept. 29, 2022), <https://data.census.gov/cedsci/table?q=Table%20S2703>
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With support from Arnold Ventures and the Robert Wood Johnson Foundation, the Healthcare Value Hub provides free, timely information about the policies and practices that address high healthcare costs and poor quality, bringing better value to consumers. The Hub is part of Altarum, a nonprofit organization with the mission of creating a better, more sustainable future for all Americans by applying research-based and field-tested solutions that transform our systems of health and healthcare.

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