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Healthcare Affordability State Policy Scorecard

Summary Report

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All materials produced as part of the Healthcare Affordability State Policy Scorecard project, including the methodology report 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

EXECUTIVE SUMMARY

Polling data repeatedly shows that healthcare affordability is the number one issue that state residents on both sides of the political aisle want their policymakers to work on.[1] To inform policy conversations and support policymaker responsiveness, this *Healthcare Affordability State Policy Scorecard* details a variety of approaches to addressing the burden of healthcare affordability.

While there is more than one path to healthcare affordability, core elements include:

- Enacting policies to ensure affordable coverage options for all;
- Ensuring coverage options feature affordable cost-sharing and don't leave consumers underinsured or create barriers to high-value care; and
- Addressing the underlying causes of high healthcare costs by reducing spending on low-value care and curbing excess prices.

In addition to examining policies in each of these areas, the scorecard looks at related outcomes, giving states credit for strong outcomes even if the policy environment is missing some key policy actions.[2]

KEY FINDINGS:

- No state earned a perfect score overall. The highest ranked state, **Massachusetts**, performed well on many policy measures, but still needs to enact stronger protections against surprise medical bills and pursue additional strategies to reduce the cost of high-value care.
- **Massachusetts**, **Vermont** and **Oregon** were the highest scoring states in terms of policy actions to extend affordable coverage to all state residents, while **Massachusetts**, the **District of Columbia** and **Vermont** scored the highest in terms of coverage *outcomes* (i.e., reducing the portion of the population that is uninsured).[3] Unlike our other domains, almost all states have taken one or more actions to improve access to coverage.
- **New York**, followed by **New Jersey** and **Colorado**, scored the highest in terms of policies to make out-of-pocket (OOP) costs affordable. However, **Maryland** residents (followed by MA, NY, CA, CT, and DC) reported the lowest levels of healthcare affordability burden (i.e., struggles paying for out-of-pocket healthcare costs).
- This measure—overall affordability burdens among adults—reveals that, even in high scoring states like **Maryland**, one quarter of adults still report healthcare affordability burdens.[4] These burdens can impact as many as 57 percent of a state's adult residents, as reported in **Mississippi**.

- Policies to reduce the provision of low-value care were difficult to tabulate at the state level, as were outcomes related to low-value care. For this category, **Massachusetts** and **Maryland** once again received the highest policy scores, but **Alaska** and **Idaho** scored best in terms of the outcome measures for low-value care. As discussed below, we were surprised to see how similarly states scored across the two outcome measures for this category.
- Our examination of policy measures to address excess prices assigned the top score to **Oregon**, followed by **Massachusetts**. However, **Arkansas**—followed by **Maryland**—performed best in terms of keeping private payer prices below the national median.

The unique dataset complied for this scorecard exercise allows us to look at correlations between the measured outcomes and policies.

- The coverage *policies* were fairly well correlated with coverage *outcomes* (R=.63;[5] 50 states, plus DC) and with *OOP affordability outcomes* (R=.70; 49 states, plus DC). Similarly, policies to address OOP costs were well correlated with OOP affordability outcomes (R=.58; 49 states, plus DC).
- Policies and outcomes were poorly correlated for the "reduce low-value care" and "curbing prices" categories—which is likely due (at least in part) to the challenge of identifying outcome measures that are available for most states and that reliably signal the desired outcome. In addition, there is likely a time lag involved that is beyond the scope of this report to incorporate. Time lag accounts for the time for needed for policy actions to alter provider treatment patterns and to rein in market dynamics that have allowed unfettered price growth for years or sometimes decades.

Some data was included in the scorecard for informational purposes but not scored, including: per capita state healthcare spending (a low value could be positive or negative, depending on whether residents are getting the services they need) and private payer prices relative to Medicare (only 25 states had this data). An interesting finding in this data is that:

- **Michigan** reported the best performance (out of 25 states) in terms of keeping private payer prices close to what Medicare pays.[6]

Incorporating this unscored data on per capita state healthcare spending reveals that:

- Some states have historically high healthcare spending per person, but existing policies appear to be working to address healthcare affordability as evidenced by scorecard outcomes (see, for example, **Massachusetts**, **District of Columbia**, **Connecticut** and **New York**). **Massachusetts** exemplifies a small cadre of states that have relatively high healthcare spending per person, but a comparatively low percentage of residents reporting affordability problems. Additionally, recent spending growth in Massachusetts has moderated, suggesting that policy efforts are achieving some success.[7]
- Occasionally, historically low-spending states have parlayed that advantage into good affordability outcomes for their residents (see, for example, **New Mexico**).

But a far more common outcome is that the residents of both high- and low-spending states are reporting grave healthcare affordability burdens.[8] As noted above, fully one quarter of adults report healthcare affordability burdens in our best performing states, rising to 57% of adults in our worst performing states. This scorecard is a call-to-action and road map for people and policymakers to strengthen efforts to address state residents' top priority.

INTRODUCTION

Poll after poll shows that healthcare costs are often the top issue that consumers, *on both sides of the political aisle*, want their policymakers to work on.[9] Moreover, survey data shows that people are delaying or forgoing care due to concerns about cost—or getting care but struggling to pay the resulting bill—and that these affordability burdens affect 50 percent or more of adults in some states.[10] Healthcare affordability problems cause stress and anxiety for families, crowd out other critical family spending, and lead to poorer and less equitable health outcomes. Evidence of widespread problems goes far up the income ladder and affects people of every stripe, functioning as a strong call for action that must be met with a comprehensive approach to improve the affordability of healthcare.

The Altarum Healthcare Value Hub's *Healthcare Affordability State Policy Scorecard* examines areas where states are doing well on healthcare affordability and areas where they can improve. The scorecard identifies a wide variety of state approaches to making healthcare more affordable and, in a few cases, highlights inaction that financially harms consumers. While there are numerous actions that states must take to lower healthcare costs for their residents, the scorecard finds that every state has made some degree of progress. Importantly, this scorecard identifies a robust tool set that state policymakers can use to ensure that all residents have affordable healthcare coverage, featuring consumer-friendly cost-sharing and premiums that reflect efficient care delivery and fair pricing.

Unique features of the scorecard include:

- **Comprehensiveness**—the scorecard examines the full spectrum of healthcare affordability policy domains including:
  - Extending affordable coverage to all residents;
  - Ensuring that cost-sharing is affordable and evidence-based;
  - Reducing the provision of low- and no-value care;
  - Curbing excess healthcare prices.
- **Balance**—the scorecard looks at outcomes in addition to policy efforts, giving states credit for strong outcomes even if the policy environment lacks some key actions.
- **A unique dataset** that compiles state-level activity with respect to both policy and outcome measures across the four domains of healthcare affordability.
- **Highly actionable information**—includes an easy-to-use state checklist showing the progress each state has already made toward addressing healthcare affordability, as well as steps the state still needs to take.[11]
- This report provides **case study examples** of states across the country that are enacting the recommended policies and provides links to **the evidence** to support the recommended policies.

The complete methodology is available in a separate report,[12] but we note here: this scorecard is retrospective and only scores states on policies that were implemented Dec. 31, 2019 or earlier. If a state has a recommended policy slated for implementation in 2020 or later, it will not (yet) impact the score for that state (although we do our best to acknowledge these accomplishments in the notes section of each scorecard).

WHY FOCUS ON STATES?

State policymakers are close to the unique, local market conditions that influence healthcare affordability for state residents. Moreover, these policymakers are familiar with the state's policy environment that may include historic reasons for favoring or disfavoring certain policies. Finally, state policymakers are often (but not always) more capable of responding to residents' needs as compared to often politically gridlocked national legislators.

DIGGING INTO THE DATA—WHAT DID WE LEARN?

Overarching Findings

State policymakers have a robust policy tool set they can use to ensure all residents have affordable healthcare coverage that features consumer-friendly cost-sharing and premiums that reflect efficient care delivery and fair pricing.

While no state earned a perfect score in any affordability domain, selected states are leading the way, providing examples that other states can follow.

> The highest ranked state, **Massachusetts**, performed well on many policy measures but should enact stronger protections against surprise medical bills and pursuemore strategies to reduce the cost of high-value care. Massachusetts is a state with relatively high healthcare spending per person, but a comparatively low percentage of residents report affordability problems. Additionally, recent spending growth has moderated, suggesting that policy efforts are achieving some success.[13]

Gratifyingly, a few states that have had historically high healthcare spending per person[14] have used their policy tool set to address healthcare affordability as evidenced by scorecard outcomes (see, for example, **Massachusetts**, **District of Columbia**, **Connecticut** and **New York**).

At the other end of the spectrum, at least one historically low-spending state, **New Mexico**, has combined that advantage with selected policy actions to achieve good affordability outcomes for residents.

But a far more common outcome is that the residents of both high- and low-spending states are reporting grave healthcare affordability burdens.[15] Indeed, our unique data showing the extent of healthcare affordability burdens—ranging from 23 percent of adults (**Maryland**) to 57% of adults (**Mississippi**)—shows how shockingly prevalent these problems are.

EXTENDING COVERAGE TO ALL RESIDENTS: POLICY AND OUTCOME FINDINGS

Without healthcare coverage, affording healthcare is almost impossible for the vast majority of American families. Across the U.S., roughly 9% of residents are uninsured, although this rate varies widely across states and by sub-population within states. Health insurance makes a difference in whether and when people receive necessary medical care, where they get their care and, ultimately, how healthy they are. Uninsured people are far more likely than those with insurance to postpone healthcare or forgo it altogether.[16]

State policy decisions have a profound impact on enrollment into coverage. While outreach strategies, enrollment assistance, website design and other factors influence enrollment, this scorecard domain looks at policies that reduce the cost of coverage, since cost is the most frequently cited reason for being uninsured.[17] This section of the scorecard examined the following policy approaches:

- Medicaid expansion implemented by Dec. 31, 2019;
- Supplemental premium subsidies, reinsurance, Medicaid Buy-In, Basic Health Plan or other options for families that earn too much to qualify for Medicaid;
- Coverage options for recent or undocumented immigrants; and
- Strong rate review for fully insured, private market coverage options.

The *outcome* score for this category reflects the percent of the state's population that was uninsured in 2018. States received higher scores for lower rates of uninsurance. Interestingly, the coverage policies tabulated for this scorecard were fairly well correlated with coverage outcomes (R=.63;[18] examining 50 states, plus DC). Moreover, coverage policies were correlated with *OOP affordability outcomes* as well (R=.70; 49 states, plus DC).

Appendix Table A-1 shows the coverage policy scores for all states, along with their state rank for this scorecard component. As Table A-1 shows, almost all states have taken one or more actions to improve access to coverage. Only **Oklahoma** scored zero points in this policy area, and even its score reflects the lightly weighted action of providing modest coverage options to recent and undocumented immigrants. **Massachusetts, Vermont** and **Oregon** were scored highest in terms of *policy actions* to extend affordable coverage to all state residents while **Massachusetts**, the **District of Columbia** and **Vermont** scored highest in terms of coverage *outcomes* (i.e., reducing the portion of the population that is uninsured).

A CLOSER LOOK AT THE RECOMMENDED POLICY ACTIONS:

Expand Medicaid to 138% of the Federal Poverty Level: Some of the most profound disparities that exist across states affect residents with incomes below 138% of the federal poverty level (FPL).[19] Nationally, more than two million low-income, uninsured adults fall into the "coverage gap" that results from state decisions not to expand Medicaid.[20] In these states, residents whose income are above current Medicaid eligibility but below the lower limit for Marketplace premium tax credits face a dearth of coverage options. Strong evidence suggests that expanding Medicaid to all residents improves health outcomes, financial security and contributes to economic prosperity in a state.[21]

The data tabulated for the scorecard shows that **Wisconsin** has made Medicaid eligible to residents up to 100% of FPL and 34 states have made Medicaid available to residents at higher incomes. The remaining states have residents that fall into the so-called "coverage gap," although several of these states are poised to expand eligibility (**Idaho**, **Utah** and **Nebraska**).

> **Wisconsin** provides Medicaid to 100% of FPL. However, research examining the population with incomes between 100-138% of FPL in expansion and non-expansion states finds that Medicaid expansion coverage produced better outcomes than subsidized Marketplace coverage in terms of lower out-of-pocket premium spending and lower cost-sharing spending.[22,23,24]

Coverage options for residents with incomes above 138% of FPL: Many of the uninsured (as well as those who struggle to afford premiums) have incomes above 138% FPL—although they are not nearly as common as Medicaid expansion, states are using a variety of approaches to help families with incomes above Medicaid thresholds that lack an employer-provided coverage option. All told, 13 states took one of the policy actions described in the box below.

While no state has implemented a "public option" approach to lower premiums for those that purchase coveragein the non-group market, **Washington** plans to introduce a public option hybrid model (called Cascade Care) in 2021, whereby the state will dictate the terms of health plans but contract with private insurers to administer those plans. Because provider rates will be tied to Medicare rates, premiums are expected to decrease.

> **Reinsurance** was the most common approach to reduce the cost of non-group premiums (6 states). As an example, in 2018, **Maryland** implemented a reinsurance program to stabilize its individual insurance market. For 2019, the state reimbursed insurers for 80 percent of enrollee claims, capped at $250,000.[25] 2020 premium rates for CareFirst plans, which cover 109,000 residents, decreased by 11 percent. As a result, state actuaries predict that enrollment will rise by 5 percent.[26]
>
> Two states (**Vermont** and **Massachusetts**) augment Marketplace tax credit subsides with **state-provided subsidies** to further lower the cost of coverage. For example, Massachusetts offers subsidies that greatly reduce premiums for marketplace enrollees with incomes below 300% percent of the FPL. Researchers found that this policy increased take-up of individual market coverage among eligible people by 14 to 24 percent.[27]
>
> Two states (**New York** and **Minnesota**) implemented a **Basic Health Plan** option, which gives states the ability to provide more affordable coverage for low-income residents and improves continuity of care for people whose incomes fluctuate above and below Medicaid and Children's Health Insurance Program (CHIP) eligibility levels. States can provide coverage to individuals who are citizens or lawfully present noncitizens who do not qualify for Medicaid, CHIP or other minimum essential coverage if they meet the income criteria.[28]

Coverage for recent and undocumented immigrants. In 2017, 22 million noncitizens resided in the U.S., constituting about 7 percent of the total population.[29] Noncitizens include both lawfully present and undocumented immigrants. Noncitizens are significantly more likely than citizens to be uninsured—among the nonelderly population, 23 percent of lawfully present immigrants and 45 percent of undocumented immigrants are uninsured compared to 8 percent of citizens**.** In general, lawfully present immigrants must have a "qualified" immigration status to be eligible for Medicaid or CHIP and many must wait five years after obtaining qualified status before they may enroll. Moreover, although these families include workers, they are unlikely to be in industries that offer health coverage to employees.[30] Barriers to coverage cause significant hardship for these families and harm public health.

State policy options to cover recent immigrants include:

- Eliminating the five-year wait and extending Medicaid and CHIP coverage to lawfully present immigrant children and pregnant women without qualified status. In 2019, 24 states did both; 10 states covered only immigrant children and one state, **Wyoming**, covered only immigrant pregnant women);
- Providing prenatal care to women regardless of immigration status by extending CHIP coverage to the unborn child (19 states); and
- Using state funds to provide coverage options for undocumented immigrants, as **California**, **Illinois**, **New York** and **D.C.** have done for selected populations.

Coverage options that don't require state action include:

- Lawfully present immigrants can purchase coverage through the ACA Marketplaces and may receive subsidies for this coverage.
- In addition, lawfully present immigrants with incomes below 100% of FPL may receive marketplace subsidies if they are ineligible for Medicaid based on immigration status.
- Medicaid payments for emergency services may be made on behalf of individuals who are otherwise eligible for Medicaid but for their immigration status. These payments cover costs for emergency care for lawfully present immigrants who remain ineligible for Medicaid as well as undocumented immigrants.

Stronger Rate Review. Rate review is the process by which insurance regulators review health carriers' proposed insurance premiums to ensure they are based on accurate, verifiable data and realistic projections of healthcare costs and utilization. A majority of states conduct what is termed "effective" rate review, as designated by CMS's Center for Consumer Information and Insurance Oversight. This designation reflects consideration of basic factors like medical cost trends, expected utilization of services, and determinations about the reasonableness of rate increases.

However, the "effective" rate review designation does not take affordability, high-value care, or the scrutiny of provider contracts into account. Only six states in our scorecard (**California**, **Massachusetts**, **Oregon**, **Rhode Island**, **Vermont** and **Washington**) take some of these additional factors into account during their rate review process. Ensuring that insurer rates are affordable has a direct impact on consumers' out-of-pocket costs.[31]

Rhode Island's Office of the Health Insurance Commissioner established a comprehensive set of standards designed to encourage insurance companies and hospitals to reduce costs by creating more efficient systems, not by lowering the quality of care provide or reducing coverage. Strategies include requiring insurers to invest more in primary care providers and services, encouraging primary care practices to transform into Patient Centered Medical Homes and reducing costs through the adoption of payment reform strategies.[32]

Washington state has the authority to review provider contracts—critical for learning how monopoly power might be affecting rates in local markets.

MAKE OUT-OF-POCKET COSTS AFFORDABLE: POLICY AND OUTCOME FINDINGS

Even if everyone has insurance coverage, patients could still face affordability problems if their cost-sharing provisions or the scope of covered services leaves them underinsured (i.e., unable to afford their share of needed care after their health plan pays the bill). The Commonwealth Fund's biennial survey reveals that 29% of insured adults, ages 19-64, were underinsured in 2018.[33] It is well established that underinsured people mimic those without coverage by forgoing needed care.[34]

State policy decisions can have a profound impact on the affordability of out-of-pocket (OOP) costs, particularly in the fully insured market.[35] This section of the scorecard examined the following policy approaches:

- Protecting consumers from inadvertent, surprise out-of-network medical bills;
- Protecting consumers from skimpy, confusing short-term, limited-duration plans;
- Waiving or reducing cost-sharing for high-value services; and
- Deploying standard plan designs in the state-based Exchange.

The outcome score for OOP costs examines the overall prevalence of one or more healthcare affordability burdens in the state's adult population (aged 18+), including:

- Forgoing needed care
- Delaying needed care
- Skimping on care (like cutting pills in half)
- Getting care but struggling to pay the resulting medical bill

NOTE: *Outcome data was insufficient to create an estimate for Hawaii.*

Appendix Table A-1 shows the OOP policy scores for all states, along with their state rank for this scorecard component. As Table A-1 shows, unlike our scan of coverage efforts, we found much less policy activity

designed to ease the burden of healthcare out-of-pockets costs, with eight states taking no action at all. **New York**, followed by **New Jersey** and **Colorado**, scoreed highest in terms of policy actions to make out-of-pocket costs affordable, but **Maryland** residents (followed by **Massachusetts** and **New York**) reported the lowest levels of healthcare affordability burden (i.e., struggles paying out-of-pocket healthcare costs).

This measure—overall affordability burdens among adults—reveals that, even in high scoring states like **Maryland**, one in four adults still report healthcare affordability burdens.[36] These burdens affect up to 57% of adult state residents, as reported in **Mississippi**.

A CLOSER LOOK AT THE RECOMMENDED POLICY ACTIONS:

Protect Consumers from inadvertent, surprise out-of-network medical bills. Surprise medical bills (SMBs) include any medical bill for which a health insurer paid less than the patient expected. One form of SMB receiving a lot of attention is when patients receive a bill from an out-of-network provider that would have been difficult to avoid: for example, they needed urgent, emergency care or they received care from an out-of-network provider in an in-network hospital. The resulting billing issues are particularly acute for those with private health insurance which often features more limited provider networks and few balance billing protections. Moreover, these types of surprise medical bills can be quite prevalent in certain metropolitan areas, at certain institutions and for certain types of medical care.[37]

While states cannot protect consumers enrolled in self-insured plans, they can protect consumers in fully insured plans. State SMB policy efforts are considered comprehensive when they:[38,39]

- Extend protections to both emergency department and in-network hospital settings;
- Apply laws to all types of insurance, including both HMOs and PPOs;
- Protect consumers both by shielding them from harm resulting from extra provider charges—meaning they are not responsible for the charges—and prohibiting providers from balance billing; and
- Adopt an adequate payment standard—a rule to determine how much the insurer pays the provider—or a dispute-resolution process to resolve payment disputes between providers and insurers.

In this Scorecard, 13 states had comprehensive protections against surprise out-of-network bills and 14 states had partial protections (see box on page 12).

Protect Consumers from short-term, limited-duration (STLD) health plans. STLD health plans are intended to provide temporary coverage to enrollees and are not required to offer many of the protections provided by ACA-compliant plans. As a result, out-of-pocket limits may not include what consumers pay for deductibles and copays; the plans may limit coverage for doctor visits and prescription drugs; and theydo not cover pre-existing conditions. Consumers can even be declined coverage if they have certain pre-existing health conditions. Moreover, STLD health plans typically do not cover maternity care or mental health services.[45] Most worrisome is that consumers are often in the dark about these skimpy and confusing plans and may not understand plan limitations. Though the duration of these plans was capped at three months in 2016, the Trump administration extended this time limit to 364 days in 2018.[46]

New York enacted one of the first comprehensive protections prohibiting balance billing in cases of surprise out-of-network bills, required insurers and physicians to enter binding arbitration to settle disputed bills. A 2017 assessment determined that the law reduced out-of-network billing by 34% and reduced the level of in-network emergency department physician payments in the state by 9%.[40] A 2019 study found that provider and insurer stakeholders view the dispute resolution process as fair, with arbitration decisions roughly evenly split between the two sides.[41] However, another 2019 assessment found that the law's guidance to arbiters (they should consider the 80th percentile of billed charges when making their determination) may be raising costs compared to a lower benchmark.[42]

Typically, surprise medical bill protections do not extend to large, self-insured employers. A **New Jersey** law addressed this by creating an option for self-funded groups to opt in, extending state protections to employees in these plans.[43] For self-funded groups to opt in, they must provide an annual notice to the Department of Banking and Insurance which attests to being bound by the applicable provisions of New Jersey's law, and then incorporate terms into their benefit plans via an amendment.[44]

Some states are working to limit the amount of time residents can stay on STLD plans and/or require insurers to provide certain protections and benefits. **California** bans STLD plans altogether and **Colorado, Connecticut**, **District of Columbia**, **Hawaii** and **Rhode Island** regulate plans so heavily that no insurers offer them in the state. Many states default to federal rules for STLD plans, which limit the initial plan term limit to 364 days and cap the maximum duration to 36 months.

State mandates that waive or reduce cost-sharing for high-value services. Failure to receive high-value care like flu vaccines, certain cancer screenings and other select services not only worsens health outcomes but can result in higher spending on medical care.[47] Available evidence suggests that multicomponent approaches (which align financial and non-financial incentives for both providers and patients) have the most success but, for the purposes of this section, we assess whether a state has waived or reduced cost-sharing for high-value services.

New Jersey requires health plans to waive the deductible for immunizations and lead screening for children; preventive care; maternity care; and second surgical opinions for people enrolled in fully insured plans.

Colorado and **Illinois** cap cost-sharing for insulin at $100 per month for fully insured plans.

Standard Plan Design in the state-based Marketplace. Standardizing cost-sharing obligations into a few basic plan designs can reduce barriers to high-value services and accomplish other goals as well. Standard plan designs are the ideal vehicle for deploying evidence-based practices with respect to cost-sharing design. For example, consumers strongly prefer copays, which are predictable and easy to understand, compared to deductibles and co-insurance.[48] Moreover, study after study has shown high-deductible health plan

designs are difficult for consumers to understand and create barriers to care. Further, standard benefit designs reduce the amount of variation consumers have to take into account when health plan shopping, making it easier to make a good selection. Finally, by prescribing the deductibles and cost-sharing for specific services, this policy approach reduces insurers' ability to use benefit design to select favorable risk and deter enrollment by those who are sick.[49]

We find that six states have policies aimed at lowering cost-sharing for specified healthcare services in the individual and small-group markets through state-prescribed standard plan designs: **California**, **Connecticut**, **Massachusetts**, **New York**, **Oregon**, and **Vermont.** In most cases, standardized plans for the individual and small-group markets are similar, if not identical. The **District of Columbia** has pursued a policy of standardized plan designs but applies it only to the individual market (D.C. is considering extending standardized plans to the small-group market in the future). **New York**'s standardized plan design is more limited than other states' because it only provides access to prescription drugs (generic and brand name) pre-deductible.[50]

> **Massachusetts**, whose marketplace was the first to implement plan standardization in 2010, found that standardizing plan designs made consumers more likely to accurately differentiate among plans.[51] Uniquely, the state requires an additional layer of standardization by defining three types of provider networks ("broadest commercial," "narrow," and "tiered").
>
> **Connecticut** limits cost-sharing in most plans for certain high-value services, such as primary care, and limits the number of services subject to co-insurance.[52]

REDUCE LOW VALUE CARE: POLICY AND OUTCOME FINDINGS

A shocking amount of healthcare is considered unnecessary. Across several large studies, it is estimated that 3% or more of total healthcare spending is driven by unneeded services or delivery inefficiencies (for example, test results not being shared).[53] Failure to curtail this "waste" raises premiums and causes patients to endure unnecessary cost-sharing for services, inconvenience and, occasionally, medical harm.

Policies that reduce the provision of low-value care were difficult to tabulate at the state level, as were outcomes related to low-value care. While the data is clear that significant spending is associated with low- and no-value care, evidence is still being developed with respect to the state policy actions that can reduce the provision of low- and no-value care.[54]

This section of the scorecard examined the following policy approaches:

- Whether the state requires validated reporting for four types of medical errors;
- Whether the state refuses to pay for "never events," serious reportable events (as identified by the National Quality Forum) that should never occur in a healthcare setting;

- Whether hospitals have adopted the CDC's 'Core Elements' of antibiotic stewardship; and
- Whether states are measuring low value in claims data and/or electronic health records (EHRs)

Measuring outcomes with respect to low-value care was also challenging. The prevalence of unnecessary care, and the resulting potential financial and health consequences, are rarely measured in a uniform way across states. Reflecting this dearth of information, the outcome score relied on two signals of low-value care:

- Cesarean section rates among births to first-time, low-risk mothers
- Antibiotic prescribing per 1,000 residents

Only one state (**North Dakota**) had a true zero for this policy area, but six other states took actions so minimal that their score rounded to zero. For this category, **Massachusetts** and **Maryland** once again received the highest policy scores but **Alaska** and **Idaho** scored best in terms of outcomes.

We were surprised to see how similar states scored across the two outcome measures—measures that don't seem like they should be correlated. Nevertheless, the correlation coefficient (or "r" value) was .63.

A CLOSER LOOK AT THE RECOMMENDED POLICY ACTIONS:

Validated reporting for medical errors. Medical harm is a particularly egregious form of healthcare waste and there is little debate about the need to increase efforts to reduce it.[55] Medical harm can take many forms, inclucluding:

- Serious Reportable Events—more commonly called "never events;"
- Healthcare-acquired conditions;
- Healthcare-acquired infections;
- Medication errors; and
- Diagnostic errors.

There are no comprehensive assessments of the total cost that medical harm adds to our nation's healthcare bill.[56] Most studies are limited to the examination of a particular type of event, a particular population or a particular healthcare setting. Nonetheless, a compilation of available studies found that around 1 in 20 (6%) of patients are affected by preventable harm in medical care, which leads to disability or death around 12% of the time. Moreover, we know that the limited resources devoted to prevention—by hospitals, other healthcare providers and governmental agencies at the state and federal levels—are dwarfed by the resources spent to treat the consequences of this mostly preventable problem.[57] Beyond finances, the human cost is staggering.[58]

The strategies to reduce patient harm are fairly well understood but unevenly implemented. In part, this stems from a lack of public reporting. Tracking medical harm at the state level is an important component of comprehensive approach to improving patient safety.[59] There is broad agreement that the goal of reporting is not to "shame and blame" but to work across stakeholders to identify patterns and craft data-driven interventions that prevent future harm. Errors leading to preventable harm are almost always multifactorial.[60]

States that require reporting typically require reporting for just a few types of harm, such as selected healthcare-acquired conditions and/or healthcare-acquired infections. In this scorecard, we used a national database that showed whether states required hospitals to report two common types of infections: central line-associated bloodstream infections and catheter-associated urinary tract infections. We also looked at whether reports were validated, as studies have identified serious problems with under-reporting of medical harm.[61] In 2017, thirty-seven states plus DC required reporting for at least one of these infections.[62]

Refusing to pay for "never events." "Never events" (also known as adverse events) are serious reportable events, as identified by the National Quality Forum, that should never occur in a healthcare setting.[63] In addition to reporting requirements,[64] nonpayment for preventable, adverse events is a visible, relatively noncontroversial step that states can take to promote patient safety yet 30 states, plus DC, do not have this policy.[65] Moreover, aligning federal and state nonpayment policies can increase momentum toward broader system change.[66]

Antibiotic stewardship in acute care hospitals. A national analysis finds that at least 30 percent of antibiotics prescribed in the outpatient setting are unnecessary, contributing to unnecessary spending and the rise of antibiotic resistant bacteria.[67] Most of these unnecessary antibiotics are prescribed for respiratory conditions caused by viruses—including common colds, viral sore throats, bronchitis and sinus and ear infections—which do not respond to antibiotics. State health agencies play a role in addressing resistance because they are responsible for protecting patients across the healthcare system and serve as a bridge between healthcare organizations and the community. State health agency roles in addressing antimicrobial resistance include coordinating and facilitating prevention activities, monitoring resistance across the state, leveraging existing partnerships and resources, and developing policies to address improved antimicrobial prescribing and use (stewardship).[68]

As a means of assessing progress, this scorecard compares hospital progress on antibiotic stewardship with overall rates of antibiotic prescribing per 1,000 residents. We don't have a dataset that tells us precisely how many antibiotic prescriptions are unnecessary but the overall rate in the population can be viewed as a crude signal.

Several states in the scorecard, like **District of Columbia**, perform well on hospital stewardship yet reveal high rates of prescribing in the general population, reinforcing the CDC's finding that primary attention must be paid to the outpatient setting.

Measuring low value in claims data and/or electronic health records. For the most part, states and even individual providers are typically in the dark with respect to how often healthcare services depart from recommended clinical guidelines. More than 500 services have been identified as low- or no-value, according to the Choosing Wisely campaign.[69]

The first national study to examine spending on a subset of just 28 low-value health services among adults with commercial health insurance finds there is considerable potential for cost savings. Studying insurance claims from more than 1.46 million adults, researchers found that spending on the 28 low-value medical services totaled $32.8 million during 2013. That accounted for 0.5% of total spending or more than $22 per person annually.[70]

While purchasers and providers play key roles in reducing the provision of low- and no-value care,[71] there are steps that states can take to facilitate coordinated, multi-stakeholder action on this front, including: prioritizing the reduction of low-value care; building a culture of trust, innovation and improvement; establishing a shared language and purpose; and committing resources to measurement.[72]

A critical first step is to measure the extent of low- and no-value care in claims data. While not all forms of low-value care can be successfully measured using claims data,[73] researchers have found that the use of different types of low-value services generally correlate with each other, suggesting that the provision of low-value services may be driven by common factors.[74] This scorecard finds that only five states have taken this step: **Maryland**, **Massachusetts**, **Minnesota**, **Virginia** and **Washington**.

> The nonprofit **Virginia** Center for Health Innovation (VCHI) analyzed claims data and found that providers in the state ordered 5.4 million services that were considered low-value, resulting in over $586 million, or $9.09 per beneficiary per month, in wasteful spending in 2015.[75] Subsequently, the VCHI received a $2.2 million grant from Arnold Ventures to create a statewide pilot aimed at reducing the provision of low-value care. The pilot will create a large-scale health system learning community and an employer task force on low-value healthcare. A latter part of the project will develop a set of consumer-driven measures.

CURB EXCESS PRICES: POLICY AND OUTCOME FINDINGS

For well documented reasons, the healthcare prices that many Americans pay are unrelated to the cost of providing those services, and often exhibit unwarranted variation and excessive profit-taking.[76] This pricing problem is particularly acute for the uninsured and those with private health insurance (about 65% of the population). Even for people with generous, protective health coverage, high prices are embedded in the premiums they pay. A 2019 study found that approximately 6% of total spending was associated with excess prices.[77]

A key reason for excess prices is the market leverage of hospitals and drug and device manufacturers. Being the only provider in an area, having all hospitals owned by the same system or lack of generic drug competition are all market conditions that allow prices to rise. A 2019 report found that most Americans live in areas with concentrated healthcare markets and that consolidation has been increasing.[78]

Due to the profound impact of prices on affordability and the role of market concentration, policymaker action in this area is vital.

This section of the scorecard examined the following policy approaches:

- Free, public-facing healthcare price transparency that reflects negotiated rates and displays prices that are treatment- and provider-specific;
- All-payer or multi-payer claims database (APCD);

- All-payer spending benchmarks; and
- A permanently convened health spending oversight entity

The outcome score looks at private payer price data for the state relative to the national median. Unfortunately, this outcome was only available for metropolitan areas and therefore excludes rural providers.

Note: Outcome values were not available for the following states: AL, WV, HI, MT, ND, SD, WY and VT.

"Curbing Excess Prices" was the area of greatest state inaction, with 23 states not taking a single one of the recommended actions. Our examination of policy measures to address the excess prices assigned the top score to **Oregon**, followed by **Massachusetts**. **Arkansas**, followed by **Maryland**, received the highest score in terms of outcomes (keeping private payer prices below the national median).

We acknowledge that price levels vis-à-vis the national median is not a perfect benchmark, as the national median for private payer prices undoubtedly reflects excess prices. We also examined (but did not score) data on private payer prices relative to Medicare rates. Medicare prices, while imperfect, are developed on a cost-basis and are adjusted based on a variety of factors, including geographic region and hospital type, indicating that they are less affected by local market conditions that may give rise to excessive private payer prices. A study from the RAND corporation found that the prices paid to hospitals for privately insured patients was 2.4 times higher than the rates Medicare paid in 2017. The study, which examined prices in 25 states, also found that price levels varied widely between states. While hospitals in **Kentucky**, **Michigan**, **New York** and **Pennsylvania** had average prices that were 150 to 200 percent of what Medicare paid, hospitals in **Colorado**, **Indiana**, **Maine**, **Montana**, **Wisconsin** and **Wyoming** had average prices that were closer to 250 to 300 percent of what Medicare paid.[79]

We compared these 25 states' performance vis-à-vis the national median with their performance vis-à-vis Medicare and did not find the two to be strongly correlated.[80] Studies that have examined the relationship between private payer and Medicare spending have found that when utilization in the private payer market is high, utilization also tends to be high in the Medicare population. Yet when prices in private insurance markets are high, Medicare expenditures are low (although, according to our data, not consistently).[81] It is likely that myriad market forces at the local level preclude a consistent relationship between these two indicators of pricing levels.

A CLOSER LOOK AT THE RECOMMENDED POLICY ACTIONS:

Free, public-facing healthcare price transparency. It is well established that prices for the same healthcare service can differ significantly across providers—even within the same geographic area.[82] Yet, it is almost impossible for consumers and policymakers to get reliable information about this pricing landscape. While "shopping" by patients is unlikely to drive down excess prices,[83] transparent pricing data can be used by researchers, payers, regulators and legislators to identify outliers and embrace targeted solutions like reference pricing, strategic network construction, rate setting and more (though success will depend on the level of provider competition in the market). For maximum impact, healthcare price transparency tools should reflect negotiated rates and display prices that are treatment- and provider-specific. Ideally price transparency would be accompanied by consumer-friendly quality information and the website interface will have been thoroughly tested for consumer friendliness and usability, however states were not scored on these dimensions.

Given that increasing price transparency is a broadly acceptable policy approach, we were surprised how few states scored well in this area. Just nine states received credit for this policy action: **Colorado**, **Connecticut**, **Maine**, **Maryland**, **Massachusetts**, **Minnesota**, **New Hampshire**, **Oregon** and **Washington**.

> **Maine**'s award winning CompareMaine.org is a user-friendly healthcare transparency website and is one of the only in the nation to present quality ratings alongside cost information.[84] Consumers can compare the costs and quality of more than 220 procedures at more than 280 facilities in the state.
>
> **Maryland**'s "Wear the Cost" price transparency website has data for just four procedures (and has not been updated in several years), but the site uniquely shows the portion of total cost that is associated with potentially avoidable complications.[85]

All-payer or multi-payer claims databases. APCDs are large-scale databases created by states that contain diverse types of healthcare data, including claims data from private insurance companies, state employee health benefit programs and, in some cases, Medicare and Medicaid.[86] These databases are critical tools for addressing excess prices. APCDs (or their near cousin, multi-payer claims datasets) can provide useful information on payment, utilization and disease patterns, which can be used by a wide range of stakeholders to aid in health system transformation efforts.

This was the area of greatest state action on excess prices, with 27 states having an active APCD or an APCD in process.[87]

> **Oregon** published a report summarizing 54 use cases for its APCD (the Oregon All-Payer All-Claims database, or APAC), including: healthcare spending and cost trends; healthcare delivery system performance; healthcare utilization; population health; disease prevention; and insurance coverage.[88]

All-payer spending targets or benchmarks. As healthcare spending continues to increase faster than wages and the rest of the economy, establishing overall spending targets are an important tool for addressing high healthcare spending. While data from **Massachusetts** shows us that even voluntary targets are helpful, mandatory targets may be even more impactful. Quality benchmarks, such as those being developed in **Delaware**, are also important to ensure that efforts to reduce growth in healthcare costs does not negatively impact health outcomes.

Only six states have made use of this strategy thus far: **Delaware**, **Maryland**, **Massachusetts**, **Oregon**, **Rhode Island** and **Vermont.** A novel idea in Massachusetts is setting benchmarks to limit the growth in out-of-pocket health spending.

Massachusetts was the first state to create an annual cost growth benchmark to monitor total per capita healthcare spending. If the annual growth of total healthcare expenditures across all payers (public and private) exceeds the benchmark, the state's Health Policy Commission can require healthcare entities to implement Performance Improvement Plans and submit to strict monitoring. The Commission's 2018 Cost Trends Report found that total healthcare expenditures grew 3 percent in 2016 and 1.6 percent in 2017—a rate significantly lower than the benchmark.[89] Additionally, Massachusetts's spending growth was well below the national rate (approximately 4 percent in 2017).

In 2018, **Delaware** became the first state to both set a healthcare spending growth target and a suite of associated quality benchmarks.[90] These quality measures include: emergency department use, opioid overdose deaths and risk factors, and a suite of cardiovascular health measures.

A permanently convened, health spending oversight entity. All states regulate some parts of their healthcare systems, but many lack a comprehensive, inter-agency, multi-payer plan to address this enormous segment of their economies. In order to systematically and comprehensively address the healthcare affordability burdens of state residents (and inform health system transformation efforts more generally), states need an entity empowered to look across various types of health and social spending, and to identify where the state needs to be more efficient in terms of value for each dollar spent, quality short-comings and affordability problems for residents. State oversight entities can take a variety of forms, but all monitor healthcare spending in a comprehensive and systematic way. These entities provide data and research support to the state and other stakeholders in determining if state, employer and resident resources are being used efficiently.[91]

Only seven states have made use of this strategy thus far: **Delaware**, **Maryland, Massachusetts**, **Oregon**, **Pennsylvania**, **Rhode Island** and **Vermont.**

This strategy typically goes hand-in-hand with establishing health spending targets. **Pennsylvania** was the only state to have an oversight entity (for hospital spending) but no accompanying spending targets.[92]

Maryland's Health Services Cost Review Commission monitors the efficiency and effectiveness of hospitals using financial data (revenue, expenditures and utilization) to inform the commission's recommendations on global hospital spending targets, uncompensated care and community benefits.

Vermont's Green Mountain Care Board has one of the most extensive portfolios of all the oversight entities we reviewed.[93] This oversight entity is empowered to: monitor spending and quality of care across sectors; operate the state's all-payer claims database; review health insurance rates and identify drivers of rate increases; oversee pilots and innovations; align activity across payers and make legislative recommendations.

CONCLUSION

This scorecard makes use of a unique dataset that compiles state-level activity with respect to both policy and outcomes measures across the four domains of healthcare affordability. This data shows promising correlations across the policies and outcomes that contribute the affordability of healthcare but also significant areas of inaction where states are falling short in terms of meeting the needs of state residents.

The scorecard shows that state policymakers have a robust tool set they can use to ensure all residents have affordable coverage that features consumer-friendly cost-sharing and premiums that reflect the efficient delivery of healthcare and fair healthcare pricing.

By providing a language, a tool set and a set of state-specific case studies. This report helps policymakers more closely tie the recommended evidence-based policy actions to state residents' top priority—healthcare affordability. Moreover, this scorecard and related products empower healthcare consumers to hold their elected officials accountable for addressing the burden of healthcare affordability.

Healthcare Affordability State Policy Scorecard

Appendix Table A-1: Summary of Scorecard Results

	Overall		Extend Coverage To All Residents				Make Out-of-pocket Costs Affordable			
	Score	State Rank	Policy Score	State Rank for Policy	Outcome Score	State Rank for Outcome	Policy Score	State Rank for Policy	Outcome Score	State Rank for Outcome
	Reflects weighted category components	*(1=best)*	*Reflects policy components of different weights (Max value=10)*	*(1=best)*	*Max value=10*	*(1=best)*	*Reflects policy components of different weights (Max value=10)*	*(1=best)*	*Max value=10*	*(1=best)*
State										
Alabama	-	#N/A	2	43	5	38	0	44	4	33
Alaska	26	36	6	13	3	47	0	44	6	15
Arizona	32	23	3	33	5	42	2	24	6	18
Arkansas	31	25	4	16	6	28	0	44	5	24
California	47	6	7	8	7	22	7	6	9	4
Colorado	45	11	4	17	7	25	9	3	4	31
Connecticut	46	10	4	17	8	8	7	7	9	5
Delaware	44	13	4	17	8	14	6	8	6	17
District of Columbia	43	15	8	4	10	2	3	20	9	6
Florida	29	28	2	39	3	48	4	16	6	21
Georgia	21	41	2	43	3	49	0	44	4	35
Hawaii	-	#N/A	4	17	9	4	2	30	N/A	N/A
Idaho	24	40	2	43	4	44	0	44	1	49
Illinois	38	19	5	15	7	20	8	5	5	26
Indiana	28	33	3	33	6	30	2	24	3	39
Iowa	35	21	3	26	9	7	3	20	6	23
Kansas	29	29	2	43	6	32	1	32	3	42
Kentucky	28	31	3	26	8	13	0	44	5	29
Louisiana	28	32	3	30	7	26	4	19	3	41
Maine	46	9	7	9	7	26	6	10	5	27
Maryland	63	2	7	9	8	16	8	4	10	1
Massachusetts	66	1	10	1	10	1	5	11	10	2
Michigan	33	22	3	30	8	9	1	32	5	28
Minnesota	54	4	7	6	9	6	3	20	7	12
Mississippi	18	43	2	43	4	46	2	24	0	50
Missouri	30	27	2	41	6	34	3	20	4	34
Montana	-	#N/A	3	26	6	28	1	32	2	46
Nebraska	26	38	3	30	6	30	1	32	3	44
Nevada	25	39	3	26	4	45	1	32	3	43
New Hampshire	41	17	3	33	8	14	5	14	7	10
New Jersey	44	12	7	6	7	24	9	2	9	7
New Mexico	41	16	4	17	6	36	5	11	8	8
New York	48	5	8	5	8	9	10	1	10	3
North Carolina	29	30	3	33	5	43	2	24	4	36
North Dakota	-	#N/A	3	33	7	23	1	32	6	19
Ohio	30	26	4	17	8	19	1	31	4	30
Oklahoma	19	42	0	51	2	50	0	44	2	47
Oregon	56	3	9	3	7	21	6	9	6	22
Pennsylvania	38	20	4	17	8	11	2	24	7	11
Rhode Island	46	8	6	14	9	4	4	18	7	13
South Carolina	31	24	3	33	5	40	1	32	3	37
South Dakota	-	#N/A	2	43	5	37	1	32	7	14
Tennessee	26	37	2	41	5	39	1	32	4	32
Texas	28	34	1	49	0	51	5	14	3	40
Utah	27	35	2	39	6	34	1	32	1	48
Vermont	-	#N/A	9	2	9	3	4	16	8	9
Virginia	43	14	4	17	6	32	1	32	6	16
Washington	47	7	7	12	8	17	5	11	5	25
West Virginia	-	#N/A	4	17	8	17	2	24	2	45
Wisconsin	39	18	7	11	8	11	1	32	6	20
Wyoming	-	#N/A	1	50	5	40	0	44	3	38

Source: The Policy and Outcome scores reflect the underlying Healthcare Affordability State Policy Scorecard data, as described in the accompanying Methodology

Healthcare Affordability State Policy Scorecard

Appendix Table A-1: Summary of Scorecard Results (continued)

	Reduce Low-value Care				Address Excess Prices			
	Policy Score	State Rank for Policy	Outcome Score	State Rank for Outcome	Policy Score	State Rank for Policy	Outcome Score	State Rank for Outcome
	Reflects policy components of different weights (Max value=10)	*(1=best)*	*Reflects two outcome components of equal weight (Max value=10)*	*(1=best)*	*Reflects policy components of different weights (Max value=10)*	*(1=best)*	*Max value=10*	*(1=best)*
State								
Alabama	3	14	1	47	0	45	N/A	N/A
Alaska	1	43	10	1	0	45	0	43
Arizona	1	42	7	13	0	45	9	12
Arkansas	0	47	2	45	3	18	10	1
California	2	32	7	15	3	18	5	42
Colorado	2	23	9	3	4	11	7	31
Connecticut	3	9	3	35	4	11	7	34
Delaware	0	48	4	33	9	5	7	33
District of Columbia	2	19	3	37	0	45	8	18
Florida	2	30	3	41	2	38	8	20
Georgia	2	20	3	39	0	45	7	24
Hawaii	2	17	9	3	2	38	N/A	N/A
Idaho	0	45	9	2	0	45	7	29
Illinois	2	31	5	22	0	45	7	27
Indiana	2	33	4	28	0	45	8	21
Iowa	2	22	4	30	0	45	8	13
Kansas	2	26	4	30	3	18	9	9
Kentucky	2	16	0	48	0	45	9	4
Louisiana	2	21	0	50	0	45	9	3
Maine	4	7	7	15	4	11	7	25
Maryland	10	2	4	26	6	9	10	2
Massachusetts	10	1	5	21	10	2	7	32
Michigan	1	43	4	32	3	18	8	15
Minnesota	9	3	8	10	4	11	7	35
Mississippi	2	29	0	51	0	45	9	7
Missouri	2	27	4	25	0	45	9	6
Montana	0	46	8	12	0	45	N/A	N/A
Nebraska	2	24	3	35	0	45	8	22
Nevada	1	36	5	23	0	45	7	26
New Hampshire	2	24	6	19	4	11	6	36
New Jersey	4	6	2	46	0	45	6	39
New Mexico	1	40	9	6	2	38	8	17
New York	2	27	2	42	3	18	6	40
North Carolina	2	15	6	20	0	45	7	28
North Dakota	0	51	7	18	0	45	N/A	N/A
Ohio	1	34	4	33	0	45	9	11
Oklahoma	0	50	3	38	3	18	9	8
Oregon	4	8	9	6	10	1	6	38
Pennsylvania	3	13	5	24	1	43	8	16
Rhode Island	1	39	4	29	7	8	9	5
South Carolina	2	18	2	42	3	18	7	23
South Dakota	1	41	7	15	0	45	N/A	N/A
Tennessee	3	10	2	44	0	45	8	14
Texas	1	37	3	39	3	18	7	30
Utah	3	11	8	9	3	18	9	10
Vermont	1	38	9	3	9	5	N/A	N/A
Virginia	8	4	4	26	3	18	8	19
Washington	7	5	9	6	3	37	6	37
West Virginia	3	12	0	49	0	45	N/A	N/A
Wisconsin	1	35	8	10	3	18	6	41
Wyoming	0	49	7	14	3	18	N/A	N/A

Healthcare Affordability State Policy Scorecard

Appendix Table A-2: Percent of Adults Reporting Healthcare Affordability Burdens, by State, 2017

State	Needed but couldn't afford medical care	Delayed seeking medical care because of worry about the cost	Made changes to medical drugs because of cost	Trouble paying medical bills	Any healthcare affordability burden
Alabama	7.8	10.4	26.2	31.5	43.9
Alaska	5.5	8.4	22.6	28.2	36.2
Arizona	7.9	10.7	21.4	24.4	37.2
Arkansas	7.0	8.6	21.7	30.9	40.2
California	3.3	4.6	18.9	16.4	26.0
Colorado	6.6	9.5	36.7	25.4	43.4
Connecticut	3.5	5.2	20.4	18.8	26.3
Delaware	2.6	6.3	28.8	28.4	36.9
District of Colum	3.7	8.6	22.5	13.3	26.4
Florida	7.6	9.2	23.4	28.3	37.9
Georgia	7.5	9.1	30.0	34.4	44.8
Hawaii	N/A	N/A	14.2	N/A	**N/A**
Idaho	8.5	12.4	38.9	38.9	54.5
Illinois	6.3	8.4	30.7	28.4	40.8
Indiana	4.7	7.8	34.5	31.0	46.6
Iowa	3.9	6.0	28.0	26.2	38.7
Kansas	N/A	9.8	34.9	32.5	47.2
Kentucky	5.9	8.2	29.0	33.7	41.7
Louisiana	8.4	9.9	32.5	31.0	47.0
Maine	5.5	7.5	26.7	33.8	40.9
Maryland	2.6	4.4	18.4	17.8	24.3
Massachusetts	4.1	6.1	9.5	21.8	25.9
Michigan	5.8	7.4	27.6	31.6	41.2
Minnesota	3.7	7.4	23.5	22.6	34.3
Mississippi	10.9	11.0	39.8	42.7	57.2
Missouri	5.9	9.3	33.3	32.0	44.0
Montana	9.7	13.7	38.5	35.9	50.8
Nebraska	5.0	7.9	25.1	37.5	48.5
Nevada	7.0	8.4	31.1	30.4	47.7
New Hampshire	4.1	7.3	N/A	23.0	33.2
New Jersey	4.2	5.3	20.3	21.9	28.4
New Mexico	5.0	N/A	24.3	17.9	31.3
New York	3.2	4.8	18.4	15.3	26.0
North Carolina	5.8	8.0	27.2	33.0	45.5
North Dakota	5.3	8.2	27.0	N/A	37.3
Ohio	4.9	7.1	27.9	31.8	43.1
Oklahoma	7.7	9.8	28.8	39.6	51.5
Oregon	7.4	12.7	22.7	29.8	38.6
Pennsylvania	3.1	5.3	21.7	23.8	33.3
Rhode Island	5.3	N/A	20.3	24.2	35.4
South Carolina	7.0	8.1	28.9	37.4	45.8
South Dakota	N/A	N/A	21.8	23.4	35.5
Tennessee	6.8	8.7	31.5	31.6	43.6
Texas	7.8	10.4	35.8	33.3	46.8
Utah	6.4	9.6	46.8	35.2	52.7
Vermont	N/A	N/A	14.7	27.8	32.2
Virginia	3.7	7.2	21.3	28.1	36.6
Washington	5.4	9.1	29.6	26.0	40.5
West Virginia	9.0	10.1	22.1	38.0	49.4
Wisconsin	4.6	8.8	21.7	27.8	37.4
Wyoming	N/A	12.0	N/A	37.1	46.1

Source: Custom analysis of the 2017 National Health Interview Survey (NHIS) data, National Center for Health Statistics (NCHS). The NHIS sample is drawn from the IPUMS Health Surveys: National Health Interview Survey (IPUMS and SHADAC).

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 because the number of sample cases was too small or the estimate had a relative standard error greater than 30%.

ENDNOTES

1. Healthcare Value Hub, *What Do Consumers Say?* https://www.healthcarevaluehub.org/cost-and-quality-problems/what-do-consumers-say (accessed on Jan. 2, 2020).
2. A complete discussion of methodology is available at Quincy, Lynn, Sabah Bhatnagar and Amanda Hunt, *Healthcare Affordability State Policy Scorecard Methodology*, Healthcare Value Hub (January 2020).
3. See Appendix Table A-1: Summary of Scorecard Results.
4. For more information on this dataset, see Quincy, Lynn, Sabah Bhatnagar, and Amanda Hunt, *Healthcare Affordability State Policy Scorecard Methodology*, Healthcare Value Hub (January 2020).
5. In statistics, the correlation coefficient "R" measures the strength and direction of a linear relationship between two variables on a scatterplot. Value of zero means there is no relationship whereas the closer R is to +1 or –1, the stronger the relationship. The Excel function CORREL was used to calculate the R values.
6. White, Chapin, and Christopher Whaley, *Prices Paid to Hospitals by Private Health Plans Are High Relative to Medicare and Vary Widely*, Rand Corporation, Washington, D.C. (2019). https://www.rand.org/pubs/research_reports/RR3033.html
7. Healthcare Value Hub, *Healthcare Affordability Scorecard: Massachusetts*, https://www.healthcarevaluehub.org/Affordability-Scorecard/Massachusetts
8. See Appendix Table A-2: Percent of Adults Reporting Healthcare Affordability Burdens, by State.
9. Healthcare Value Hub, *What Do Consumers Say?*, https://www.healthcarevaluehub.org/cost-and-quality-problems/what-do-consumers-say
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11. Available by state on Healthcare Value Hub, *Healthcare Affordability State Policy Scorecard.* https://www.healthcarevaluehub.org/Affordability-Scorecard/
12. See Quincy, Lynn, Sabah Bhatnagar and Amanda Hunt, *Healthcare Affordability State Policy Scorecard Methodology*, Healthcare Value Hub (January 2020).
13. Healthcare Value Hub, *Healthcare Affordability Scorecard: Massachusetts*, https://www.healthcarevaluehub.org/Affordability-Scorecard/Massachusetts
14. Note, healthcare spending per person was included as information but was not a scored element. Low healthcare spending per person could be a good thing or a bad thing, depending on whether residents are getting the services they need.
15. See Appendix Table A-2: Percent of Adults Reporting Healthcare Affordability Burdens, by State.
16. Garfield, Rachel, Kendal Orgera and Anthony Damico, *The Uninsured and the ACA: A Primer—Key Facts about Health Insurance and the Uninsured Amidst Changes to the Affordable Care Act*, Kaiser Family Foundation Washington, D.C. (January 2019).
17. Tolbert, Jennifer, et al., *Key Facts about the Uninsured Population, Kaiser Family Foundation (December 2019).* https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/
18. In statistics, the correlation coefficient "R" measures the strength and direction of a linear relationship between two variables on a scatterplot. Value of zero means there is no relationship whereas the closer R is to +1 or –1, the stronger the relationship. The Excel function CORREL was used to calculate the R values. Correlation does not, by itself, indicate causation. Readers of this report may draw their own conclusions.
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20. Garfield, Rachel, Kendal Orgera and Anthony Damico, *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid*, Kaiser Family Foundation Washington, D.C. (March 21, 2019).https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/
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