Health Care Affordability State Policy Snapshot

2024 GLOSSARY

This glossary is a component of the **Healthcare Value Hub State Policy Snapshot** project, available at www.healthcarevaluehub.org/affordability-snapshot

Introduction

The Health Care Value Hub ("**the Hub**") is proud to launch the 2024 Health Care Affordability Policy Snapshot ("**Affordability Snapshot**") which replaces the annual Healthcare Affordability Scorecard ("**Scorecard**").

The Affordability Snapshot provides legislators, consumer advocates, regulators and other stakeholders a tool to compare their state's health policies across other states. The categories examined in this resource explore a variety of policy options that have previously appeared in the Scorecard, as well additional policies that impact health care affordability.

Policies were selected based on whether they have the potential to impact health care affordability or access to health care at the state level, whether a reputable source was available for review, and whether evidence was current within the past ten years. Policies were examined for whether they were active, implemented to a limited degree, or not active as of July 1, 2024. Sources for this information can be found in the downloadable Data and Source Document available on the **Dashboard** page.

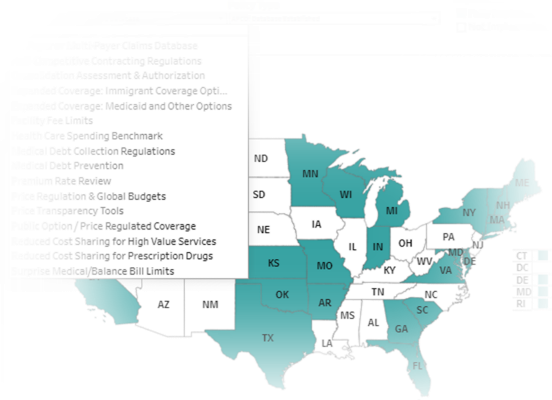
The Hub offers both online and hands-on support, with a staff dedicated to monitoring, translating, and disseminating evidence and connecting advocates, researchers, and policymakers to build communities and galvanize action around creating a patient-centered, high-value healthcare system.

As a research-based organization, the Hub takes a comprehensive approach to improving affordability through policy analysis, translation, visualization, and collaborative engagement. We encourage advocates, legislators, and other stakeholders to share our findings to improve consumer health care affordability across the states.

The Snapshot Dashboard

The Dashboard is designed to empower legislators, consumer advocates, and policy makers with a comprehensive view of state-level health care affordability policies.

Dashboard users are able to examine multiple states and policies simultaneously, including details on each state's approach and degree of implementation. Users can filter by state, category, policy, and implementation status when comparing different states and results may be viewed in both a table and map format.



Glossary: Key Terms Used Throughout the Snapshot

TERM	ACRONYM	DEFINITION
All-or-Nothing Clauses		When health systems require plans to contract with all providers in their system or none of them, even if those providers are low-value or high-cost.
All-Payer Claims Database	APCD	APCDs are large databases that can include claims data from private insurance companies, state employee health benefit programs, Medicare and Medicaid. APCDs provide a wide range of payment, utilization and disease pattern information that can be used to monitor healthcare spending and identify price variation in healthcare systems, among other activities. When the database does not include data from all provider types, it is referred to as a multi-payer claims database.
Anti-Tiering & Anti-Steering Clauses		Contract provisions that require insurers to place favored providers in higher tiers regardless of cost or quality (anti-tiering) and restrict directing patients to higher value care from competitors (anti-steering).
Basic Health Plan	BHP	Section 1331 of the Affordable Care Act (ACA) grants states the ability to create a Basic Health Plan, which is a coverage option for low-income residents who would otherwise be eligible to purchase coverage through the Marketplace. This enables states to provide more affordable coverage for low-income residents and improve continuity of care for people whose income fluctuates above and below Medicaid and CHIP levels.
Centers for Medicare and Medicaid Services	CMS	The federal agency within the Department of Health and Human Services, responsible for providing health coverage to residents through Medicare, Medicaid, the Children's Health Insurance Program and the federal Marketplace.
Children's Health Insurance Program	CHIP	The Children's Health Insurance Program provides health coverage to children whose family income is above Medicaid eligibility levels. CHIP is a federal-state partnership that is administered by states, according to federal requirements.
Consolidation		When hospitals and other health care entities join together under common ownership through a change of ownership (CHOW), such as a merger or acquisition.
Continuous Eligibility	CE	Effective January 1, 2024, states are required to provide twelve-months of continuous eligibility (CE) for children under the age of nineteen in Medicaid and the Children's Health Insurance Program (CHIP). States have the authority to expand continuous eligibility to other populations.
Copay Accumulator Programs	CAP	An insurance plan feature where third-party payments, such as payments made by a manufacturer's patient assistance program, don't count toward a patient's deductible or out-of-pocket maximum, resulting in increased out-of-pocket costs and delays in reaching required deductibles.
Facility Fees		Facility fees are extra charges hospitals bill patients after outpatient services, on top of professional service costs, to cover operational expenses. As hospitals acquire more outpatient practices, these fees are increasingly applied, raising patient costs and disproportionately affecting communities already facing financial challenges, such as rural and minority populations.

TERM	ACRONYM	DEFINITION
Federal Poverty Level	FPL	The federal government's measure of income, used to determine eligibility for certain programs and benefits.
From Conception to End of Pregnancy (FCEP) Option	FCEP	Formerly the CHIP Unborn Child Option, this program extends CHIP low-income pregnant people, regardless of immigration status, to improve birth outcomes. Coverage may be limited to prenatal care or states may provide comprehensive benefits similar in scope to pregnancy related Medicaid.
Global Budgets		Global budgets are an alternative payment model in which providers—typically hospitals—are paid a prospectively-set, fixed amount for the total number of services they provide during a given period of time. Providers are responsible for expenditures in excess of the set amount, creating an incentive to reduce unnecessary utilization and invest in prevention.
Health Spending Benchmarks		Annual targets for health care spending that can be established at a state level or for other subsets of spending. These targets are used to both measure and constrain aggregate health care spending.
Health Spending Oversight Entity		An agency that keeps track of health care spending in a comprehensive and systematic way, provides data and research support to the state and other stakeholders to track health care prices and quality to determine if resources are used efficiently.
High-Value Care		Healthcare services that are of proven value and have no significant tradeoffs—that is, the benefits of the services so far outweigh the risks that all patients in a given population should receive them.
Immigrant Five-Year Bar		Federal regulations prohibit certain lawfully residing immigrants from receiving Medicaid and CHIP without waiting five years. States have the option to cover lawfully residing children under age 21 and/or pregnant people with an exemption from the five-year bar.
Medicaid Expansion		When states increase Medicaid eligibility to allow all adults with incomes at or below 138% FPL to enroll in Medicaid. Prior to the ACA, Medicaid coverage was limited to low-income adults with dependents, qualified pregnant women and children and individuals receiving Supplemental Security Income (SSI).
Medicaid for Justice Involved People		A justice-involved individual is a person who is currently or formerly incarcerated in a correctional facility. States have historically been unable to provide Medicaid coverage to individuals when they are incarcerated (known as the "inmate exclusion"). However, CMS recently issued guidance allowing states to provide Medicaid services to justice-involved individuals while they are in a correctional setting to support their reentry into the community under a 1115 demonstration waiver.
Most Favored Nation Clauses	MFN	When health systems agree not to offer lower prices to competing insurers, preventing them from offering the same service at a lower price. These provisions may allow insurers and providers to collude to raise prices.
No Surprises Act	NSA	Federal legislation that protects people covered under group and individual health plans from receiving surprise medical bills when they receive most emergency services, non-emergency services from out-of-network providers at in-network facilities and services from out-of-network air ambulance service providers effective January 2022.

TERM	ACRONYM	DEFINITION
Non-Compete Clauses		Contact provisions that prohibit employees, including physicians, from working at competing health care facilities within a certain distance and/or for a certain period of time following the end of their employment.
Out-of-Pocket Costs	OOP	Costs that consumers are responsible for and are not covered by insurance. Can include co-payment, coinsurance and deductibles.
Prescription Drug Affordability Board	PDAB	A prescription drug affordability board is a state-level entity tasked with evaluating the prices of high-cost medications to ensure they are reasonable and do not create barriers to access. These boards often have the authority to review price increases, set upper payment limits, and recommend strategies to contain drug costs while maintaining patient access to necessary treatments.
Price Transparency Tool		A website that displays price information on healthcare services, allowing consumers to "shop" for the best price and budget for expected services.
Public Option		Coverage directed and operated by a state that is designed to provide residents a high-value, affordable health insurance option that can be purchased in the individual and small-group market, typically on a state-based exchange.
Rate Review		The scrutiny of proposed premium rates by state health insurance departments, or occasionally the federal government. This scrutiny is intended to help moderate premium hikes and lower costs for individuals, families and businesses that buy insurance in these markets.
Reference-Based Pricing		When health costs—typically, charges from providers—are evaluated against the Medicare reimbursement rate for the same service.
Retroactive Medicaid		Retroactive Medicaid provides coverage for medical expenses incurred up to three months before a person applies for Medicaid, as long as they meet eligibility requirements during that time. This ensures that individuals, particularly those facing sudden illnesses or injuries, can receive care and have their bills covered even before applying. Retroactive coverage is especially beneficial for costly services like nursing home care, offering a financial safety net for those in need.
Short-Term, Limited Duration Health Plans	STLD	Health plans that only provide coverage for a limited term, typically less than 365 days, and are not subject to consumer protections under the ACA. They are less expensive, but offer poor coverage and limited consumer protections, and pose financial risks for consumers.
State-Based Exchange		Also referred to as a state-based Marketplace. Under the ACA, states have three Marketplace options: a state-based exchange; a state-based exchange that is hosted on the federal platform, where states are responsible for many of the Marketplace functions, and the federal government is responsible for eligibility and enrollment functions; or a federally-facilitated Marketplace, where the federal government performs all Marketplace responsibilities.
Surprise Medical Bills	SMB	Also referred to as "Balance Bills." A medical bill for which a health insurer paid less than the patient expected, leaving the patient to pay for the remaining, unexpected balance. Surprise medical bills often come from healthcare services that the patient did not know was out-of-network until the service was billed.

Glossary: Categories and Policies Examined

Improve Oversight, Accountability, & Transparency

Health Spending Oversight Entities

Health spending oversight entities monitor and track health care spending systematically, offering data and research support to ensure efficient resource use. While many states set population health priorities, few have established oversight entities with enforcement powers. This section examines whether a state has a health spending oversight entity reviewing primary care, hospital, or prescription drug spending, and if upper payment limits for prescription drugs have been implemented.

All-Payer or Multi-Payer Claims Database

All-payer claims databases (APCDs) compile diverse health care data, that may include health, dental, and pharmacy claims from private insurers, state employee health programs, Medicare, and Medicaid. In instances where a database includes only some of these payers, it is referred to as a multi-payer claims database. Typically created through legislation, APCDs are often subject to state oversight and regulation.

However, some claims databases have been voluntarily developed by independent entities, limiting oversight. This section examines whether a state has an active all-payer or multi-payer claims database, if the database is facilitated and managed by the state or by third-party entities, if the data is free and accessible without institutional review board approval, and if the database is required to capture race and ethnicity demographic information.

Price Transparency

This section evaluates state efforts to provide access to health care price data through a publicly available and easily accessible tool. To be credited, the tool must show negotiated prices for various services and be accessible without fees, IRB approval, or legislative restrictions. Additionally, this section reviews whether a state requires prescription drug price data to be reported to a state entity and if a state has another form of price transparency regulation.

Medical Debt Collection Regulations

This section examines how a state regulates providers' ability to collect medical debt once it has been incurred. Specifically, it reviews what protections states have established to ensure that a patient is not liable to lose their home or wages due to the inability to afford health care by evaluating whether a state limits collections' ability to garnish wages, prohibits collections from initiating home foreclosure or placing a lien on a property, or prohibits collections from seizing a bank account.

Curb Excess Prices in the System

Public Option

A Public Option is a state-managed health insurance model designed to enhance competition and control costs through negotiated rates. States possess a degree of flexibility in designing these coverage options, resulting in variations in cost-containment measures and provisions related to network adequacy and reimbursement. This section highlights states that have an active Public Option and those with provider participation mandates to ensure consistent access to in-network providers.

Premium Rate Review

States can control excessive health insurance premium increases through premium rate review, where state insurance regulators scrutinize proposed rate hikes for the upcoming year to ensure that the increases are based on accurate data and realistic projections of health care costs and utilization.

The Affordable Care Act (ACA) set standards for these efforts, and states meeting these standards are recognized by the Centers for Medicare and Medicaid Services (CMS) as having an effective rate review process. States may also establish the authority to approve or deny rate increases and incorporate affordability criteria into their evaluations. This section examines whether a state has an effective rate review program, as defined by CMS, the power to approve or deny rate increases, and if affordability criteria are integrated into the rate review process.

Curb Excess Prices in the System

Health Care Spending Benchmarks

Health care spending benchmarks aim to limit annual health care spending growth by establishing a maximum limit, or "benchmark." Benchmarks may examine overall spending or spending for specific hospitals or insurers. If the benchmark is surpassed, the overseeing state entity will often collaborate with providers to curtail spending, and some states authorize the entity to mandate performance improvement plans or impose penalties. This section examines whether a state has established a benchmark, and if so, whether the state has statutory authority to enforce the benchmark.

Hospital Price Regulation

This section assesses state efforts to reduce hospital service costs through reference-based pricing, global budgets, or a comparable program that regulates hospital pricing. Unlike reference-based benefits, which set a maximum allowed benefit for specified drugs or services, reference-based pricing establishes set service costs based on a predetermined reference rate. As of publication, each state that has implemented this model has set reimbursement as a multiple of the Medicare reimbursement rate.

Similarly, global budgeting involves setting a fixed prospective payment for a specified range of services over a defined period, rather than being paid for each service. By establishing a limit on annual spending, this model shifts the financial responsibility to providers and payers and encourages managing service delivery within the set budget. Some states have established state-specific insurance models which mirror select aspects of these strategies, which are also highlighted under "alternative hospital price regulation strategies."

Address Consolidation and Promote Competition

Facility Fee Limits

Facility fees are charges for services provided in outpatient and physician office settings that hospitals own. These fees increase the out-of-pocket costs for care and are becoming increasingly more common as the rate of health system consolidation has accelerated. This section explores whether a state prohibits facility fees under certain circumstances, if they have imposed regulations to protect consumers against out-of-pocket costs from facility fees, and if they require hospitals to report facility fee data.

Consolidation Assessment & Authorization

This section examines: whether relevant parties are required to notify the state of hospital consolidation transactions beyond the federal requirements, and whether the state has the authority to review these transactions; to approve, reject, or modify conditions of the transaction; and if consumer affordability or price growth are included in the review criteria.

Balance Bill Protections

The federal No Surprises Act (NSA) protects patients from balance bills, which are unexpected costs from out-of-network providers. Under the federal legislation, patients receiving emergency care or who are unknowingly treated by out-of-network providers during an in-network procedure are only required to pay the in-network cost-sharing amount for services provided. Effective January 1, 2022, the No Surprises Act applies to most health plans but not all care sites and services. States can legislate additional protections for balance bills not covered under the NSA, such as for ground ambulances, or services provided at urgent care locations, hospice facilities, and birthing centers.

Anti-Competitive Contract Provisions

Anti-competitive contracting is a pattern of contracting between health care providers and insurers where one party gains unfair advantages over potential competitors. States can enact regulations that limit dominant health systems from abusing their market power in ways that increase prices. This section evaluates whether states prohibit four types of anti-competitive contracting practices in the health system, including Most Favored Nation Clauses, All-or-Nothing Clauses, Physician Non-Compete Clauses, and Anti-Tiering or Anti-Steering Clauses.

Make Out-of-Pocket Costs Affordable

Reduced Cost-Sharing: Prescription Drugs

This section examines whether states have passed legislation to reduce the amount consumers pay out-of-pocket for select prescriptions drugs including insulin, epinephrine, oncology medications, and asthma inhalers. This section also examines state-level legislation prohibiting copay accumulator programs, which are payer strategies that limit the impact of manufacturer cost-sharing assistance programs on out-of-pocket costs.

Reduced Cost-Sharing: High Value Services

This section provides an overview of state efforts aimed at reducing consumer cost burdens for high-value services. Specifically, it identifies states which have enacted legislation mandating coverage without cost-sharing for:

- Primary care services recommended by the United States Preventive Services Task Force (USPSTF);
- Various cancer screening and diagnostic services; and
- Annual mental health exams.

It also evaluates state efforts to expand access to affordable maternal and reproductive health care by highlighting the states that mandate private insurers cover in-vitro fertilization, fertility preservation, doula services and abortion care. The section concludes with a review of whether a state has incorporated equity initiatives in their state-regulated insurance design.

Medical Debt Prevention

This section reviews state laws aimed at preventing medical debt, including mandates for hospitals and health care providers to offer financial assistance policies, screen patients for insurance and charity care eligibility, and inform patients of charity care policies before collecting payment. It also assesses whether states have extended Medicaid benefits retroactively for 90 days, if a state prohibits or regulates short-term, limited-duration health plans, and if a state has established annual community benefit spending reporting requirements.

Expanded Coverage

This section evaluates policies aimed at expanding access to and improving the affordability of health insurance, including whether a state has:

- Expanded Medicaid eligibility to adults earning up to 138% FPL;
- Authorized 12-month continuous Medicaid eligibility for all adults;
- Extended postpartum Medicaid coverage to 12 months following delivery;
- Established a Basic Health Plan;
- Initiated a program providing state-funded premium subsidies for residents ineligible for Medicaid;
- Includes coverage for gender-affirming care under Medicaid;
- Provides Medicaid coverage to individuals transitioning from incarceration; and
- If the state has extended Medicaid coverage to include dental, hearing, and vision benefits, including eye exams and glasses, beyond what is deemed medically necessary following injury or surgery.

Beyond these policy options, this section also reviews state efforts to extend coverage to children, pregnant residents, and non-pregnant adults regardless of immigration status.

This includes waiving the five-year required waiting period for immigrant children and legally residing pregnant residents (the "five-year bar"), offering alternative coverage options for undocumented adults and children, and opting into the From Conception to End of Pregnancy (FCEP) option under the Children's Health Insurance Program (CHIP), previously known as the CHIP Unborn Child option.

With support from Arnold Ventures, the Healthcare Value Hub provides free, timely information about the policies and practices that address high health care 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 by applying research-based and field-tested solutions that transform our systems of health and health care.

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