HEALTHCARE AFFORDABILILTY STATE POLICY SCORECARD

Methodology

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CONTENTS

Healthcare Affordability State Policy Scorecard

ABOUT THIS SCORECARD

The Healthcare Affordability State Policy Scorecard examines how well state policymakers steward their healthcare systems to address healthcare affordability—state residents' top priority.[1] As described in detail below, this policy scorecard is unique in two ways.

First, it combines publicly available data with custom data creation to provide a comprehensive picture of healthcare affordability.

Additionally, it scores states on both policies and outcomes across four domains.

Note: this scorecard is retrospective and only scores states on policies that were implemented as of December 31, 2019 and were impacting the lives of state residents at that time. State policies slated for implementation from 2020 on are noted, but not (yet) factored into states' scores.

This methodology document is accompanied by a "Summary Report" that looks across our unique dataset to identify state trends and provides case studies/links to supporting research to help states move forward.[2]

WHAT STATE POLICIES MAKE HEALTHCARE AFFORDABLE FOR RESIDENTS?

Myriad data show that evidence-based policies can have a profound impact on how state residents experience the healthcare system, including their ability to afford premiums and healthcare services. State policymakers have a robust policy toolset they can use to ensure that all residents have affordable coverage that: (1) features consumer-friendly cost-sharing, and (2) has premiums that reflect efficient care delivery and fair pricing.

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

▲ **Extend coverage to all residents**—Without insurance, affording healthcare is impossible for the vast majority of American families. Across the U.S., roughly 9 percent of residents are uninsured;[3] however, this rate varies widely across states. Variations also exist within states, across sub-groups of the state population.

▲ **Make out-of-pocket costs affordable and use evidence-based cost-sharing design**—Even if all U.S. residents had some form of healthcare coverage, patients could still face affordability problems if their cost-sharing provisions or the scope of covered services left them underinsured (i.e. unable to afford their share of a healthcare expense after a health plan pays the bill).

▲ **Reduce low-value care**—A shocking amount of the healthcare services delivered is considered unnecessary. Several large studies estimated that 7-15 percent of total healthcare spending has been driven by unneeded services or inefficient care delivery (e.g., test duplication when the results are not shared).[4] Failure to limit this waste raises insurance premiums, forces patients to pay unnecessary out-of-pocket costs, is inconvenient and can even cause medical harm.

▲ **Curb excess healthcare prices**—For well-documented reasons, the healthcare prices that Americans pay are unrelated to the cost of providing the services. Moreover, prices for a single service can vary widely (irrespective of quality) and often reflect excessive profit-taking. Our pricing problem is particularly acute for uninsured people and those with private health insurance (approximately 65% of the U.S. population). Even people with generous insurance coverage are affected, as high prices for services are embedded in health insurance premiums that all Americans pay, either directly or indirectly (in the form of increased taxes and/or lost wages when employers shoulder the burden of paying employees' premiums).

While a state's policy environment can be critically important in terms of improving healthcare affordability, some states have good outcomes (for example, with respect to lower prices or fewer low-value services) despite an absence of evidence-based affordability policies. This scorecard accounts for this by examining these outcomes and scoring states on the outcomes they have achieved, in addition to the policies they have put in place.

A summary of the policies and outcomes within each of our four high-priority areas scored can be found in **Table 1**. The measures are discussed in greater detail below.

EXTEND COVERAGE TO ALL RESIDENTS: HOW STATES WERE SCORED

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

▲ **Expand Medicaid** to populations that became newly eligible under the Affordable Care Act (ACA).[5] Restrictive state eligibility rules (e.g., work requirements) can undermine enrollment in Medicaid and are noted in our descriptive material, but do not currently negatively impact states' scores. Policy scores for this measure were assigned as follows:

  • 1 (full credit) = single adult eligibility expanded to at least 138% of FPL

  • 0.5 = single adult eligibility expanded to 100% of FPL

  • 0 = single adults or others are only eligible if their incomes are less than 100% of FPL

▲ Whether a state provides more affordable (but still protective) **coverage options for individuals with incomes above Medicaid eligibility thresholds** purchasing insurance in the non-group market. Examples include: [6]

  • Supplemental premium subsidies for individual market coverage;

  • Individual market reinsurance programs that meaningfully lowered premiums; and

  • Basic Health Plan[7]

States that offered any of these options were awarded full points.

▲ **Coverage options for recent immigrants** who don't qualify for the coverage options above.[8] Scores in this section are cumulative. States were awarded:[9,10]

  • 0.5 points for offering Medicaid coverage to lawfully residing immigrant children and pregnant women without a 5-year wait

  • 0.07 points for providing a coverage option for undocumented children (weight reflects relatively small population size)

TABLE 1: AFFORDABILITY POLICIES AND OUTCOMES SCORED

Extend Coverage to All Residents	Policy Score:	Medicaid expansion implemented by Dec. 31, 2019	Support for families earning too much to qualify for Medicaid: Basic Health Plan, subsidies, reinsurance, Medicaid buy-in, etc.	Coverage options for recent and/or undocumented immigrants	Strong rate review for fully insured, private market coverage options	
	Outcome Score:	Total uninsured (*state rate relative to the best state*)				
Make Out-of-Pocket Costs Affordable	Policy Score:	Surprise out-of-network medical bill protections	Limit skimpy and confusing 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:	*Overall prevalence of adults who:* (*state rate relative to the best 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	Had trouble paying medical bills
Reduce Low-Value Care	Policy Score:	Require validated patient-safety reporting	Decline payment for never events	Universally implement hospital antibiotic stewardship	Measure low-value care in claims data and EHR	
	Outcome Score:	Cesarean section rates among births to first-time, low-risk mothers	Antibiotic prescribing per 1,000 residents	(*state rate relative to the best state*)		
Curb Excess Prices in the System	Policy Score:	Strong price transparency: free; public-facing; negotiated rates; treatment- and provider-specific	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	
	Outcome Score:	Private payer prices relative to national median (*state rate relative to the best state*)				

- 0.18 points for providing a coverage option for undocumented pregnant women (can be just prenatal care or complete coverage)

- 0.25 points for providing a statewide coverage option for undocumented, non-pregnant adults

▲ Rate review is a process by which state insurance regulators review health insurers' proposed insurance premiums for the coming year to ensure that they are based on accurate, verifiable data and realistic projections of healthcare costs and utilization. The final component of the coverage section assesses whether state regulators are authorized to incorporate **affordability factors into rate review**. Approaches include requiring insurers to demonstrate cost-containment efforts; scrutinizing provider contracts and/or requiring an emphasis on high-value care.[11]

- 1 (full credit) = rate review includes 1 or more affordability approaches

- 0.5 = basic rate review present

- 0 = rate review deemed "ineffective" by the federal government[12]

Outcome Score. The outcome score for this area assesses how well each state performs, relative to the best performing state, in terms of reducing the percentage of the population that remains uninsured.[13] States receive higher scores for lower rates of un-insurance.

MAKE OUT-OF-POCKET COSTS AFFORDABLE AND USE EVIDENCE-BASED COST-SHARING DESIGN: HOW STATES WERE SCORED

Expanding health coverage is critical to ensuring that healthcare is affordable, but is an insufficient strategy on its own. It is well documented that families' ability to afford their out-of-pocket (OOP) costs varies with income and cost-sharing obligations frequently exceed what their budget can bear.[14]

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 policy score for OOP costs considers:

▲ **Out-of-network surprise medical bill protections**—Although out-of-network surprise medical bills (SMBs) constitute a relatively small portion of overall healthcare spending, they are quite prevalent in certain metropolitan areas, at certain institutions and for certain medical specialties and services.[15] The resulting expense can be financially devastating for individuals and families. While states cannot protect consumers enrolled in self-insured plans (regulated by the U.S. Department of Labor),[16] they can protect consumers enrolled in fully insured plans (regulated by state Departments of Insurance). The score given to each state reflects the following levels of protection:[17,18]

- 1 (full credit) = state has comprehensive SMB protections

- 0.5 = state has partial SMB protections

- 0 = state has minimal or no SMB protections

▲ **Protections against skimpy, confusing short-term, limited-duration health plans**—Short-term, limited-duration (STLD) health plans are not required to provide the standard ACA protections for non-group

coverage. Although they are relatively low cost, STLD plans cover little, are not well understood by consumers[19] and only a small percentage of the premiums collected are ultimately spent on beneficiaries' medical care.[20] Scoring for this policy reflects the level of consumer protection:[21,22]

- 1 = state bans STLD health plans
- 0.8 = STLD plans are heavily regulated; few or no plans are for sale in the state
- 0.5 = state imposes maximum term limits in addition to renewal restrictions that preclude enrollment in these plans for more than 364 days AND provides at least one of the following consumer protections: pre-existing conditions protections, benefit requirements or requiring a medical loss ratio of 80 or above
- 0.3 = state imposes maximum term limits in addition to renewal restrictions preclude enrollment in these plans for more than 364 days, however, other consumer protections are absent or modest (like requiring consumer disclosure or prohibiting gender rating)
- 0 = state defaulted to federal rules or extended the amount of time a person can be enrolled in a STLD plan

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 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,[23] but for the purposes of this section, we assess whether a state has waived or reduced cost-sharing for high-value services. Examples are rare but include:

- New Jersey, which has mandates that 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, which capped cost-sharing for insulin at $100 per month for fully insured plans.

States get full credit for this measure if they have taken any action to waive or reduce cost-sharing for high-value services.[24]

Deploy standard plan designs in a state-based exchange—Standardizing cost-sharing obligations into a few basic plan designs can incorporate the goals of reducing barriers to high value services but accomplish other goals as well.[25] While states have the authority to require standard plan designs in the fully insured marketplace, in practice the few states that have deployed this approach have done so in their state-based insurance marketplace.[26] This section awards credit to states that have implemented any type of standard plan designs in their state-based insurance marketplace.[27] States lacking a state-based exchange received no credit for this measure.

Outcome Score. As several studies have identified, difficulty affording OOP costs can manifest itself in several ways:

- Forgoing needed care;
- Delaying needed care;
- Skimping on care (for example, cutting pills in half); and
- Getting care but struggling to pay the resulting medical bill.

The outcome score for this high-priority area examines the overall prevalence of one or more of the above affordability problems among members of the state's adult population (aged 18+).[28] State scores are based on how well they perform relative to the highest performing state. States with the lowest OOP affordability burdens receive the highest scores.

REDUCING 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.[29] In other words, roughly 25 percent of healthcare spending does not result in better health.[30] The study examines several categories of healthcare waste, including:

▲ Overuse of services (a.k.a. low- and no-value care) and coordination failures (discussed in this section) and

▲ Pricing failures (discussed in the next section).

Policy Score: While approaches to reducing low-value care can be controversial, reducing medical errors is a widely accepted strategy that is ripe for action.[31] In this category, state scores depend on two factors:

▲ Whether the state requires reporting[32] for two types of medical errors (central line-associated bloodstream infections and catheter-associated urinary tract infections) and whether the reports are validated.[33] (The highest score in this policy area would mean that both types of medical errors were reported and validated.); and

▲ Whether the state followed Medicare's lead in refusing to pay for services related to "never events"— serious reportable events, as identified by the National Quality Forum, that should never occur in a healthcare setting.[34] Scores for this measure are as follows:

  • 1 (full credit) = all payers decline payment for 'never events'

  • 0.5 = selected payers decline payment for 'never events'

  • 0 = all state payers continue to pay for services connected to 'never events'

The low-value care policy score also assesses:

▲ **Antibiotic stewardship**, measured by the percentage of a state's acute care hospitals that have adopted the CDC's 'Core Elements' for hospital antibiotic stewardship.[35] Proven benefits include protecting patients from unintended consequences, improving the treatment of infections and helping combat antibiotic resistance.[36] State scores reflect their relative progress (vis-a-vis other states) towards 100 percent of acute care hospitals adopting the CDC's standards.[37]

▲ Whether the state (or multi-sector collaboratives in the state) have attempted to **measure low-value in claims data and/or EHRs** and subsequently work with providers to reduce the provision of low-value care.[38,39] State scores for this measure are as follows:

  • 1 = any attempt to broadly assess the provision of low-value care in the state

  • 0 = no attempt to broadly assess the provision of low-value care in the state

Outcome score: The receipt of unnecessary care, and the potential financial and health consequences, are rarely measured at the state-level. Reflecting this dearth of information, the "low-value care" outcome score assesses only two (of many) examples of low-value care:

▲ **Cesarean section rates among births to first-time, low-risk mothers**[40]—Although we cannot directly measure unnecessary c-sections performed in each state, we can score states based on their c-section rates relative to other states.[41,42]

▲ **Antibiotic prescribing per 1,000 residents**—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.[43] While we cannot directly measure unnecessary antibiotic prescribing in each state, we can score states based on their prescription rates relative to other states.[44]

Each of the above outcome measures was given equal weight in creating the overall "low-value care" outcome score for the state.

CURB EXCESS PRICES: HOW STATES WERE SCORED

While high expenditures in some regions of the country can be partially explained by high local input costs (like labor and electricity) and utilization, most price variation occurs irrespective of these factors.[45] Moreover, a 2019 *JAMA* study (mentioned previously) found that approximately 6 percent of overall healthcare spending was associated with excess prices. The burden of excess prices falls disproportionately on those with private health insurance coverage and the uninsured.[46]

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

▲ Whether the state has implemented **free, public-facing healthcare price transparency** that reflects negotiated rates and displays prices that are treatment- and provider-specific. While "shopping" by patients is unlikely to drive down excess healthcare prices, transparent data can be used by researchers, payers, regulators and legislators to identify pricing outliers and advance targeted solutions like reference pricing, strategic network construction, rate setting and more—depending on the level of provider competition in the market.[47] State scores for this measure:[48]

- 1 (full credit) = state has a price transparency tool that includes all of these features:

  - Free

  - Public-facing

  - Prices reflect private payer negotiated rates (not charge master or list prices)

  - Prices are provider and procedure specific

  - Note: states received credit even if the pricing tool reflected only a few services. While it did not affect their score, we tried to note where these tools had other desirable features like pairing prices with quality data, distance calculators, etc. Laws that require entities to justify drug price increases above a certain percent are helpful but do not get credit in this section.

- 0 = state did not have a price transparency tool meeting our criteria

▲ Whether the state has an **all-payer or multi-payer claims database (APCD)**—State scores will depend on whether the APCD provides actionable information for state residents, researchers, payers, regulators and legislators, with partial credit if the APCD development is in process. Both voluntary and mandatory efforts receive full points, as do multi-payer claims databases that lack claims from some payers. APCD efforts that are completely stalled do not receive any credit.

  - 1 (full credit) = APCD or multi-payer claims database produces actionable data

- 0.5 = APCD or multi-payer claims database development is in process
- 0 = the state does not have an APCD or multi-payer claims database

▲ Whether the state uses **all-payer spending benchmarks** to rein in price growth—States are scored based on whether existing spending targets address all spending or only a subset of spending (for example, spending by hospitals) and whether they are mandatory versus voluntary:[49,50]

- 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:[51]

- 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

Outcome Score. The "excess prices" outcome score compares states' private payer prices to the national median. The score reflects how each state performs relative to the highest performing state.

Using data from the Health Care Cost Institute's (HCCI) Health Marketplace Index,[52] the Healthcare Value Hub created 2018 state estimates for overall health prices, relative to the national median. The methodology for this calculation is as follows:

▲ Using private payer claims data, HCCI calculated metropolitan area-specific healthcare price levels as a percent of the national median for several categories of healthcare services.

▲ To calculate state averages, the Hub created a weighted sum of the percent-of-national-median-price values in the metropolitan areas of the state. The Hub weighted the 2018 percent-of-national-median-price values by county population, using 2018 estimate data from the U.S. Census Bureau.

▲ Because metropolitan areas, also known as core-based statistical areas (CBSAs),[53] often span multiple states, the Hub determined the counties located in each CBSA using data from the National Bureau of Economic Research.[54] For CBSAs that spanned state borders, the Hub used the percent-of-national-median price values for the relevant counties in both states.

▲ Rural areas were not included in the state average because price values were unavailable. Price values were also unavailable for the following states: AL, HI, MT, ND, SD, VT and WY.

WEIGHTING THE SCORECARD POLICY AND OUTCOME COMPONENTS

The value of this scorecard lies, in part, in the actionable policy and outcomes data provided for each state. However, in order to produce an overall score and an accompanying state rank, the Hub weighted individual components to reflect their relative burden on consumers. The Hub also weighted sub-components, using either a percent-of-the-population-affected approach or percent-of-spending approach as needed. In some cases, these initial weights were rounded to make it easier to explain the underlying rationale or to ensure that a policy action had enough weight to generate a minimum score. Component and sub-component weights are summarized in **Table 2**.

ACTING ON THE SCORECARD DATA

Our companion report *Healthcare Affordability: How do States Compare When It Comes to Addressing Residents' Top Priority?* discusses variation across states. Additionally, our state profiles provide customized recommendations for important next steps, given the state's unique policy and outcome environment, in order to meaningfully address state residents' top concern: healthcare affordability.

TABLE 2: WEIGHTING THE SCORECARD POLICY AND OUTCOME COMPONENTS

Extend Coverage to All Residents	Policy Score:	Medicaid expansion implemented by Dec. 31, 2019	Support for families earning too much to qualify for Medicaid: Basic Health Plan, subsidies, reinsurance, Medicaid buy-in, etc.	Coverage options for recent and/or undocumented immigrants	Strong rate review for fully insured, private market coverage options		x 2 for overall score
	Component weights:	1	3	2	4	= 10 possible points	
	Outcome Score:	Total uninsured in state (*No component weights*)				= 10 possible points	
Make Out-of-Pocket Costs Affordable	Policy Score:	Surprise out-of-network medical bill protections	Limit skimpy and confusing 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		x 1 for overall score
	Component weights:	4	2	3	1	= 10 possible points	
	Outcome Score:	Healthcare OOP affordability burdens (*No component weights*)				= 10 possible points	
Reduce Low-Value Care	Policy Score:	Require validated patient-safety reporting	Decline payment for never events	Universally implement hospital antibiotic stewardship	Measure low-value care in claims data and EHR		x .75 for overall score
	Component weights:	1.5	2	1	5.5	= 10 possible points	
	Outcome Score:	Cesarean section rates among births to first-time, low-risk mothers	Antibiotic prescribing per 1,000 residents				
	Component weights:	5	5			= 10 possible points	
Curb Excess Prices in the System	Policy Score:	Strong price transparency	All-payer or multi-payer claims dataset to inform policy actions	All-payer healthcare spending benchmarks	Permanently convened health spending oversight entity		x 1.25 for overall score
	Component weights:	1	3	3	3	= 10 possible points	
	Outcome Score:	Private payer prices relative to national median (*No component weights*)				= 10 possible points	

ENDNOTES

1. The Scorecards themselves, along with all other products associated with this project, can be found at HealthcareValueHub.org/Affordability-Scorecard. See also: Quincy, Lynn, Amanda Hunt and Sabah Bhatnagar, *Healthcare Affordability: How do States Compare When It Comes to Addressing Residents' Top Priority?*, Healthcare Value Hub (January 2020).

2. Quincy, Lynn, Amanda Hunt and Sabah Bhatnagar, *Healthcare Affordability: How do States Compare When It Comes to Addressing Residents' Top Priority?*, Healthcare Value Hub (January 2020).

3. Estimate from Berchick, Edward R., Jessica C. Barnett, and Rachel D. Upton, *Health Insurance Coverage in the United States: 2018,* United States Census Bureau. Washington, D.C. (November 2019). https://www.census.gov/content/dam/Census/library/publications/2019/demo/p60-267.pdf

4. Shrank, William H., Teresa L. Rogstad, and Natasha Parekh, "Waste in the US Health Care System Estimated Costs and Potential for Savings," *JAMA,* Vol. 322, No. 15: 1501-1509 (2019). https://jamanetwork.com/journals/jama/fullarticle/2752664

5. Primary source augmented by additional Healthcare Value Hub review was Kaiser Family Foundation, *Where Are States Today? Medicaid and CHIP Eligibility Levels for Children, Pregnant Women, and Adults* (March 2019). https://www.kff.org/medicaid/fact-sheet/where-are-states-today-medicaid-and-chip/

6. Other market stabilization measures such as state-level individual mandates or combining small group and individual markets are noteworthy but do not affect a state's score. A primary source augmented by additional Healthcare Value Hub review was Palanker, Dania, Rachel Schwab, and Justin Giovannelli, *State Efforts to Pass Individual Mandate Requirements Aim to Stabilize Markets and Protect Consumers,* The Commonwealth Fund (June 2018). https://www.commonwealthfund.org/blog/2018/state-efforts-pass-individual-mandate-requirements-aim-stabilize-markets-and-protect

7. Section 1331 of the Affordable Care Act gives states the option of creating a Basic Health Program, a health benefits coverage program for low-income residents who would otherwise be eligible to purchase coverage through the Health Insurance Marketplace. For more, see Quincy, Lynn, Amanda Hunt and Sabah Bhatnagar, *Healthcare Affordability: How do States Compare When It Comes to Addressing Residents' Top Priority?*, Healthcare Value Hub (January 2020).

8. In 2017, there were 22 million noncitizens residing in the US-about 7% of the total population. Noncitizens include lawfully present and undocumented immigrants. Noncitizens are significantly more likely than citizens to be uninsured. For children and pregnant women, states can eliminate the five-year wait for Medicaid. 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% FPL may receive subsidies if they are ineligible for Medicaid based on immigration status. See Kaiser Family Foundation, *Health Coverage of Immigrants* (February 2019). https://www.kff.org/disparities-policy/fact-sheet/health-coverage-of-immigrants/

9. A primary source was Kaiser Family Foundation, *Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost Sharing Policies as of January 2019: Findings from a 50-State Survey* (March 2019). https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-and-cost-sharing-policies-as-of-january-2019-findings-from-a-50-state-survey/

10. Primary source augmented by additional Healthcare Value Hub review was National Immigration Law Center, *Medical Assistance Programs for Immigrants in Various States* (August 2019). https://www.nilc.org/wp-content/uploads/2015/11/med-services-for-imms-in-states.pdf

11. Source data compiled by the Hub team from various data sources. For more on these approaches, see Healthcare Value Hub, *Improving Value: Insurance Rate Review.* https://www.healthcarevaluehub.org/improving-value/browse-strategy/rate-review.

12. For more on the characteristics of effective rate review programs, see Center for Medicare & Medicaid Services, The Center for Consumer Information & Insurance Oversight: State Effective Rate Review Programs. https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet

13. Different surveys produce different estimates of the uninsured rate. Our outcome score uses uninsured rates for the civilian, noninstitutionalized population

from the American Community Survey (ACS). Experts believe that ACS is a better source for estimates of the uninsured than another common survey, the Current Population Survey- although the latter is considered a better source for estimates of Medicaid coverage and has better income information. For more on the ACS, see Berchick, Edward R., Jessica C. Barnett, and Rachel D. Upton, *Health Insurance Coverage in the United States: 2018*. United States Census Bureau, Washington, D.C. (November 2019). https://www.census.gov/content/dam/Census/library/publications/2019/demo/p60-267.pdf

14. Healthcare Value Hub, *Making Healthcare Affordable: Finding a Common Approach to Measure Progress* (January 2017). https://www.healthcarevaluehub.org/advocate-resources/publications/making-healthcare-affordable-finding-common-approach-measure-progress

15. Sanger-Katz, Margot, and Reed Abelson, "Surprise! Insurance Paid the E.R. but Not the Doctor," *The New York Times* (November 2016). https://www.nytimes.com/2016/11/17/upshot/first-comes-the-emergency-then-comes-the-surprise-out-of-network-bill.html

16. A New Jersey law addressed this short-coming in state SMB protections by creating an option for self-funded groups to opt in, extending state protections to employees in these plans.

17. Primary source augmented by additional Healthcare Value Hub review was Hoadley, Jack, Kevin Lucia, and Maanasa Kona, *State Efforts to Protect Consumers from Balance Billing*, The Commonwealth Fund (January 2019). https://www.commonwealthfund.org/blog/2019/state-efforts-protect-consumers-balance-billing

18. To search for bills and statutes in all 50 states as they relate to surprise billing regulations, see The Source on Healthcare Price & Competition, The State Laws Impacting Healthcare Cost & Quality Database. https://sourceonhealthcare.org/legislation/

19. Gantz, Sarah, "A Philly woman's broken back and $36,000 bill show how some health insurance brokers trick consumers into skimpy plans," *The Philadelphia Inquirer* (November 2019). https://www.inquirer.com/health/consumer/limited-benefit-skimpy-health-plans-sales-pitch-20191114.html

20. Livingston, Shelby, "Short-term health plans spend little on medical care," *Modern Healthcare* (August 2019). https://www.modernhealthcare.com/insurance/short-term-health-plans-spend-little-medical-care

21. Primary source augmented by additional Healthcare Value Hub review was Palanker, Dania, Maanasa Kona, and Emily Curran, *States Step Up to Protect Insurance Markets and Consumers from Short-Term Health Plans*, The Commonwealth Fund (May 2019). https://www.commonwealthfund.org/publications/issue-briefs/2019/may/states-step-up-protect-markets-consumers-short-term-plans

22. Primary source augmented by additional Healthcare Value Hub review was Sullivan, Sarah, "Short Term Health Insurance Initial Term and Maximum Duration Limits by State," *Health eDeals* (September 2019). https://www.healthedeals.com/blog/save/short-term-health-insurance-state-duration-limits/

23. Healthcare Value Hub, *High-Value Care: Strategies to Address Underuse* (November 2018). https://www.healthcarevaluehub.org/advocate-resources/publications/high-value-care-strategies-address-underuse

24. Source data compiled by the Healthcare Value Hub team from various data sources.

25. For a broader discussion of this policy, see Quincy, Lynn, Amanda Hunt and Sabah Bhatnagar, *Healthcare Affordability: How do States Compare When It Comes to Addressing Residents' Top Priority?*, Healthcare Value Hub (January 2020).

26. Corlette, Sabrina; Ahn, Sandy; Lucia, Kevin; Ellison, Hannah, *Missed Opportunities: State-based Marketplaces Fail to Meet Stated Policy Goals of Standardized Benefit Designs*, Urban Institute (July 2016).

27. Primary source augmented by additional Healthcare Value Hub review was Ahn, Sandy and Sabrina Corlette. *State Efforts to Lower Cost-Sharing Barriers to Health Care for the Privately Insured*, Urban Institute (June 2017). https://www.urban.org/sites/default/files/publication/90961/2001311-state-efforts-to-lower-cost-sharing-barriers-to-health-care-for-the-privately-insured.pdf

28. Source is a custom SHADAC 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). 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. Data were suppressed if the number of sample cases was too small or the estimate had a relative standard error greater than 30%.

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The Healthcare Value Hub takes a careful look at the evidence and consults with experts in order to clarify for advocates, media and policymakers the important cost drivers and the promising policy solutions. Hub Research Briefs, Data Briefs, Easy Explainers, infographics and other products are available at our website.

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