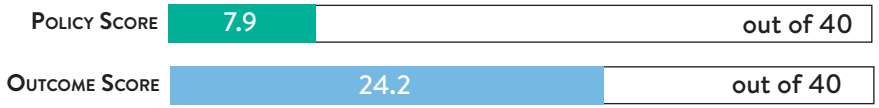
2022 Healthcare Affordability State Policy Scorecard

This Scorecard looks at both policies and related outcomes across four affordability-related areas that were implemented as of Dec. 31, 2021. Lawmakers, regulators, consumer advocates, and the public can use the Scorecards to understand how their state performs when it comes to healthcare affordability policies and outcomes relative to other states and identify opportunities to improve.

STATE: ARKANSAS **RANK: 23** out of 50 states + DC



TOTAL
32.1 OUT OF 80 POSSIBLE POINTS

Setting the stage: According to SHADAC, 23% of Arkansas adults experienced healthcare affordability burdens as of 2020. According to the Personal Consumption Expenditure, healthcare spending per person in Arkansas grew 41% between 2013 and 2021, totaling $6,943 in 2021. Please note some of the outcome measures in this Scorecard include data from 2020, which may have been impacted by the COVID-19 pandemic.

	POLICY SCORE	OUTCOME SCORE	RECOMMENDATIONS
CURB EXCESS PRICES IN THE SYSTEM	**3.0 OUT OF 10 POINTS** This section reflects policies the state has implemented to curb excess prices, outlined below.	**9.9 OUT OF 10 POINTS** AR is among the least expensive states, with inpatient/outpatient private payer prices at 149% of Medicare prices. Ranked 3 out of 50 states, plus DC.	***AR should consider building a strong price transparency tool, establishing a health spending oversight entity and creating health spending targets.***

THIS CHECKLIST IDENTIFIES THE POLICIES THAT WERE EVALUATED FOR THIS SECTION.

✓	***Create an all-payer or multi-payer claims database to analyze healthcare price inflation, price variation and utilization*** The Arkansas all-payer claims database (APCD) includes claims data from Medicaid, Medicare and fully insured private plans operating in Arkansas with at least 2,000 Arkansas enrollees. The Arkansas APCD will soon add hospital discharge and emergency department data for the uninsured. The Arkansas APCD was created under a voluntary claims submission model and subsequently gained authority for mandatory data submission. Data was used in a case study by the state to explore the number of days until claims are paid in various settings to assess revenue management.
✗	***Create a permanently convened health spending oversight entity*** Arkansas did not have a permanently convened health spending oversight entity as of Dec. 31, 2021. Still, Arkansas does have the Health Care Payment Improvement Initiative, the only statewide payment reform that involves all major public and private payers. The initiative aligns bundled payments across Medicare, Medicaid, private insurers and some self-insured employers, and is designed to reward physicians, hospitals and other providers who give patients high-quality care at an appropriate cost.
✗	***Create all-payer healthcare spending and quality benchmarks for the state*** Arkansas did not have active health spending benchmarks as of Dec. 31, 2021.
✗	***Implement free, public-facing healthcare price transparency that reflects negotiated rates and features treatment- and provider-specific prices*** Arkansas did not have a tool that met the criteria to receive credit. To receive credit, a state's tool has to be public-facing, searchable by specific procedure and hospital and show the negotiated rate paid by insurance plans/patients (not chargemaster rate).

KEY: ✓ = implemented by state ✗ = not implemented by state ··· = the state has implemented policies, but could be enhanced

Full report and additional details at **www.HealthcareValueHub.org/Affordability-Scorecard/Arkansas**

ALTARUM HEALTHCARE VALUE HUB

Healthcare Affordability State Policy Scorecard

STATE: ARKANSAS **RANK:** 23 out of 50 states + DC

REDUCE LOW-VALUE CARE

POLICY SCORE	OUTCOME SCORE	RECOMMENDATIONS
0.4 OUT OF 10 POINTS	2.9 OUT OF 10 POINTS	*AR should consider using claims and EHR data to identify unnecessary care and enact a multi-stakeholder effort to reduce it.*
AR has not yet measured the extent of low-value care being provided. 83% of hospitals have adopted antibiotic stewardship.	19% of Arkansas residents have received at least one low-value care service, placing them in the middle range of states. Ranked 35 out of 50 states, plus DC.	

THIS CHECKLIST IDENTIFIES THE POLICIES THAT WERE EVALUATED FOR THIS SECTION.

☒	***Analyze claims and electronic health records data to understand how much is spent on low- and no-value services*** Arkansas did not measure the provision of low-value care as of Dec. 31, 2021.
☒	***Require validated patient-safety reporting for hospitals*** Central line-associated bloodstream infections (CLABSI) and catheter-associated urinary tract infections (CAUTI) are two common forms of hospital-acquired infections. Data on patient safety reporting is not available for Arkansas.
☒	***Universally implement antibiotic stewardship programs using CDC's 7 Core Elements*** Improper use of antibiotics is another type of low-value care. Antibiotic stewardship is the effort to measure and improve how antibiotics are prescribed by clinicians and used by patients, and states were scored on what share of their hospitals follow the CDC's stewardship program. 83% of Arkansas hospitals have adopted antibiotic stewardship. States with 90% adoption or more get the most credit.

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STATE: ARKANSAS **RANK:** 23 out of 50 states + DC

EXTEND COVERAGE TO ALL RESIDENTS

POLICY SCORE	OUTCOME SCORE	RECOMMENDATIONS
4.5 OUT OF 10 POINTS AR Medicaid coverage for childless adults extends to 138% of FPL. Only some immigrants can access state coverage options (see below).	6.2 OUT OF 10 POINTS 8% of AR residents are uninsured. Ranked 30 out of 50 states, plus DC.	*AR should consider options for residents earning too much to qualify for Medicaid, like a Basic Health plan, premium subsidies, Medicaid buy-in and a Public Option. AR should also consider offering coverage options for undocumented children, pregnant people and adults, should expand their unborn child option to offer comprehensive services and consider adding affordability criteria to rate review.*

THIS CHECKLIST IDENTIFIES THE POLICIES THAT WERE EVALUATED FOR THIS SECTION.

✓	***Expand Medicaid to cover adults up to 138% of the federal poverty level*** Arkansas expanded Medicaid. The state charges premiums to enrollees earning over 100% FPL, although CMS has notified them that they had to phase out premiums by December 2022. On Jan. 1, 2022, the old work requirements program, Arkansas Works, was replaced by the Arkansas Health and Opportunity for Me program, or ARHOME, which uses Medicaid dollars to buy healthcare coverage for enrollees from qualified health plans. Unlike its predecessor, ARHOME does not include work requirements. The state has requested that ARHOME enrollees who do not participate in "health and economic independence activities" be reassigned into the state's traditional fee-for-service Medicaid program, pending CMS approval.
✗	***Provide high-quality, affordable coverage options for people whose incomes are too high to qualify for Medicaid, e.g., Basic Health Plan, reinsurance or augmented premium subsidies*** Arkansas did not offer any additional coverage options for residents earning too much to qualify for Medicaid as of Dec. 31, 2021.
···	***Provide options for immigrants that don't qualify for the coverage above*** Arkansas provides Medicaid coverage for eligible lawfully residing immigrant pregnant women and children without a 5-year wait. Some level of prenatal care is available, regardless of immigration status, through CHIP's "unborn child" option, although the coverage is not comprehensive and only covers pregnancy-related services such as prenatal care, delivery and postpartum care. Arkansas offers no coverage options for undocumented children and non-pregnant adults.
···	***Conduct strong rate review of fully insured, private market options*** Arkansas has effective rate review as classified by CMS but does not incorporate affordability criteria into rate review.

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MAKE OUT-OF-POCKET COSTS AFFORDABLE

POLICY SCORE

0.0 OUT OF 10 POINTS

AR has not enacted any of the policies to reduce out-of-pocket costs, outlined below.

OUTCOME SCORE

5.2 OUT OF 10 POINTS

AR ranked 21 out of 50 states, plus DC on affordability burdens—23% of adults faced an affordability burden: not getting needed care due to cost (7%), delaying care due to cost (9%), changing medication due to cost (7%), problems paying medical bills (15%) or being uninsured due to cost (sample size too small).

RECOMMENDATIONS

AR should consider a suite of measures to ease consumer burdens, such as: protections against short-term, limited-duration health plans; surprise medical bill protections not addressed by the federal No Surprises Act; waiving or reducing cost-sharing for high-value services; and requiring standard plan design on their exchange.

THIS CHECKLIST IDENTIFIES THE POLICIES THAT WERE EVALUATED FOR THIS SECTION.

☒	***Limit the availability of short-term, limited-duration health plans*** Arkansas has no protections against short-term, limited duration health plans (STLDs) beyond federal regulations. Some people choose STLD health plans for their lower monthly premiums compared to ACA-compliant plans. However, they offer poor coverage, can discriminate against people with pre-existing conditions and pose financial risks for consumers. States received credit depending on how much they limit these plans.
☒	***Protect patients from inadvertent surprise out-of-network medical bills*** Arkansas has no state-level protections against surprise medical bills (SMBs). The federal No Surprises Act prohibits SMBs in most plans effective January 2022. However, it does not cover ground ambulances. States can still implement protections in this area—67% of ground ambulance rides in AR charged to commercial insurance plans had the potential for SMBs (2021). (AR had a small sample size [1,247] compared to other states, so interpret percentage with caution.)
☒	***Waive or reduce cost-sharing for high-value services*** Arkansas did not require waiving or reducing cost-sharing for high-value services as of Dec. 31, 2021. Arkansas requires any payment/discount made for the patient to be applied to their annual OOP cost-sharing requirement.
☒	***Require insurers in a state-based exchange to offer evidence-based standard plan designs*** Arkansas has a state-based exchange but has not implemented standard plan design. Standard plan design makes cost-sharing the same across plans within metal tiers, making it easier for consumers to compare plans. They also help regulators and exchanges negotiate or set rates with insurance carriers, which may translate to lower prices for consumers.

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