American College of Rheumatology
Empowering Rheumatology Professionals

Rheumatic Disease REPORT CARD

RAISING THE GRADE on RHEUMATOLOGY CARE in AMERICA

SEPTEMBER 2022

2022

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Rheumatic Disease
REPORT CARD

Preface

In 2018, the American College of Rheumatology (ACR) created the *Rheumatic Disease Report Card: Raising the Grade on Rheumatology Care in America* to help answer the question: **How easy is it to live well with a rheumatic disease in my state?** Using data from public sources, this report grades each U.S. state and the District of Columbia on the access, affordability, and activity/lifestyle factors associated with an individual's ability to live well with a rheumatic disease.

In this updated version for 2022, the ACR included additional indicators to reflect new policies enacted since 2018 to improve conditions for people living with a rheumatic disease. As a result of these policies, some states saw substantial changes in their scores for 2022. Only two states' grades improved from 2018 to reflect recent efforts by policymakers to enact laws that improve access and affordability of rheumatology care. Many states saw their grades remain the same or decline – not necessarily due to changing population characteristics – but because those states have not enacted new policies to improve the quality of life for individuals living with rheumatic diseases.

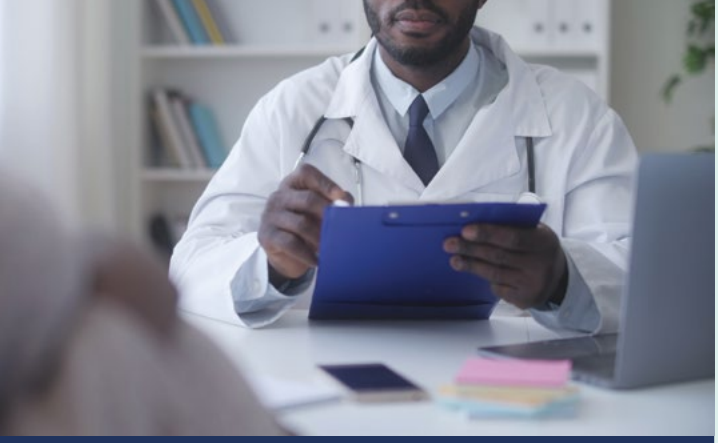
The goal of this project remains the same: to inform and empower the public and policymakers to address the healthcare access, affordability, and lifestyle factors that impact the quality of life for the millions of Americans living with a rheumatic disease.

RHEUMATIC DISEASE IN AMERICA

Rheumatic diseases are autoimmune, inflammatory, and degenerative diseases that affect a person's joints, muscles, bones, and organs. There are more than 100 rheumatic diseases and conditions, including more commonly known diseases like osteoarthritis, rheumatoid arthritis, lupus, and gout. The Centers for Disease Control and Prevention (CDC) estimates that 58.5 million adults in the United States have been told by a doctor they have some form of a rheumatic disease[1], and that number is expected to grow to 78.4 million by 2040[2]. Furthermore, there are an estimated 300,000 children in the U.S. diagnosed with juvenile arthritis, a disease that can cause permanent damage to joints and requires specialized care from a pediatric rheumatologist.[3]

The personal and economic toll of rheumatic diseases is significant. Rheumatic diseases are more than just "aches and pains" and are not simply a normal part of aging. Rheumatic diseases can result from one's own internal defense system, the immune system, producing antibodies and attacking healthy tissue. Without early intervention and effective treatment from a rheumatologist, rheumatic diseases can cause pain, long-term physical disability, organ damage, emotional and mental distress, and even premature death. According to the latest estimates, the total annual cost of rheumatic disease to the United States is $304 billion when accounting for medical costs, lost wages, and productivity.[4]

Health and demographic disparities among individuals living with rheumatic disease in the United States are well documented. Approximately 1 in 12 women will develop an autoimmune or inflammatory rheumatic disease in their lifetime, compared to 1 in 20 men.[5] Black, Latino, and Indigenous Americans are also affected disproportionately, having a significantly higher prevalence of arthritis-attributable activity limitations than non-Hispanic whites, despite all groups having a similar overall prevalence of arthritis.[6] Additionally, veterans have a significantly higher prevalence of rheumatic disease, particularly arthritis, which is the second leading cause of discharge from the U.S. Army.[7] [8]



The ACR's Workforce Solutions Initiative

Facing a looming workforce shortage that threatens to undercut the delivery of care for people living with rheumatic diseases, in 2021 the ACR's Board of Directors approved a three-year plan to work towards reversing this trend. The initiative will focus on five core interventions:

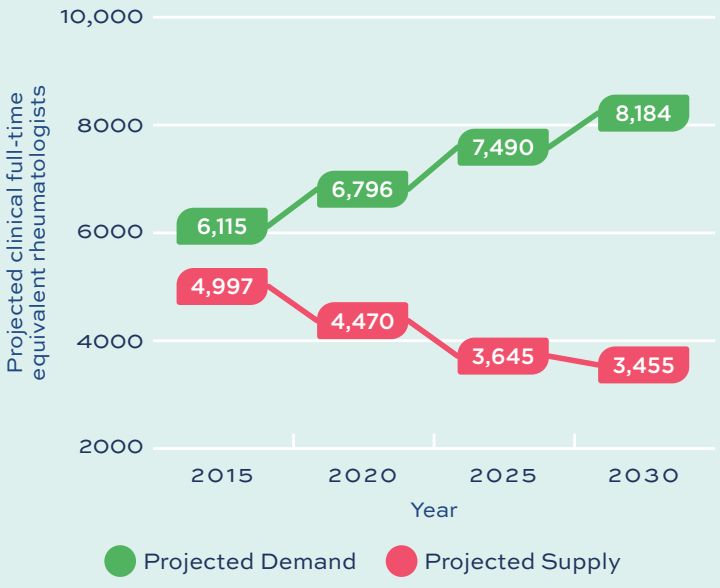
- Supporting fellowship positions in underserved regions
- Sustaining workforce recruitment
- Fostering patient-centered communities of care
- Implementing virtual training programs for clinicians
- Supporting training and research through grants

The plan recognizes that, while the rheumatology workforce shortage is a problem across the United States, it is more acutely felt in underserved areas in the Northwest, South Central, and Southwest regions of the country. Thus, the plan aims to direct resources and expertise to these areas.

To learn more about what the ACR is doing to address the rheumatology workforce shortage, please visit https://www.the-rheumatologist.org/article/the-acr-launches-initiative-to-tackle-workforce-shortage/.

While significant progress has been made over the last several decades to understand and effectively treat rheumatic diseases in the United States, notable healthcare challenges remain for Americans living with these diseases. A growing shortage of rheumatology health professionals in many parts of the country – particularly in rural areas – combined with insurance barriers and rising drug costs make it difficult for the millions of individuals living with rheumatic diseases to receive timely and quality care. There is an average of only one practicing rheumatologist for every 40,000 people and the demand for care far outpaces the supply of practicing rheumatologists. High rates of retirement within the specialty and a rapidly aging population mean that the U.S. will need thousands more adult rheumatologists by 2030 to meet growing patient demand.[9] The shortage of pediatric rheumatologists is even more acute, with only 300 pediatric rheumatologists estimated to be currently practicing in the United States.[10] Combined with insurance barriers like step therapy and prior authorization, and median out-of-pocket costs alone more than doubling from 2019 to 2020 to $1,000 annually[11], it's clear that rheumatology care remains difficult to access for many Americans.

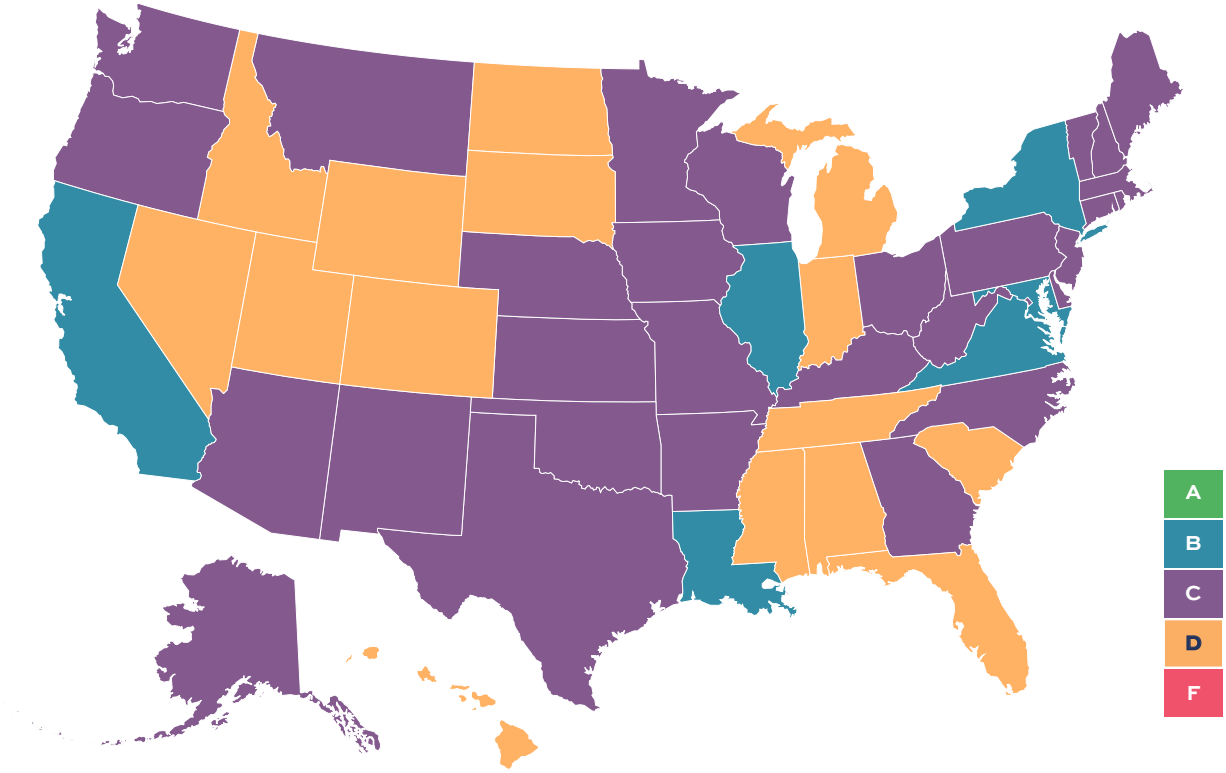
U.S. RHEUMATOLOGIST SHORTAGE PROJECTED TO WORSEN OVER THE NEXT SEVERAL DECADES



Demand for rheumatic disease care is far outpacing supply, according to the ACR's 2015 Rheumatology Workforce Study. High rates of retirement within the specialty and a rapidly aging population mean that the U.S. will need an additional 4,729 adult rheumatologists by 2030 to meet growing patient demand. [22]

Findings: A State-by-State Ranking

OVERALL GRADES



Alabama	D	Kentucky	C	North Dakota	D
Alaska	C	Louisiana	B	Ohio	C
Arizona	C	Maine	C	Oklahoma	C
Arkansas	C	Maryland	B	Oregon	C
California	B	Massachusetts	C	Pennsylvania	C
Colorado	D	Michigan	D	Rhode Island	C
Connecticut	C	Minnesota	C	South Carolina	D
Delaware	C	Mississippi	D	South Dakota	D
District of Columbia	C	Missouri	C	Tennessee	D
Florida	D	Montana	C	Texas	C
Georgia	C	Nebraska	C	Utah	D
Hawaii	D	Nevada	D	Vermont	C
Idaho	D	New Hampshire	C	Virginia	B
Illinois	B	New Jersey	C	Washington	C
Indiana	D	New Mexico	C	West Virginia	C
Iowa	C	New York	B	Wisconsin	C
Kansas	C	North Carolina	C	Wyoming	D

OVERALL GRADES: THE HIGHEST & LOWEST IN 2022

The top five highest and lowest scoring states are shown here with their respective grades and score out of 150 possible points.

TOP FIVE

NEW YORK

B 111/150

VIRGINIA

B 106/150

MARYLAND

B 105/150

CALIFORNIA

B 93/150

ILLINOIS

B 92/150

BOTTOM FIVE

WYOMING

D 37/150

S. CAROLINA

D 38/150

NEVADA

D 38/150

MISSISSIPPI

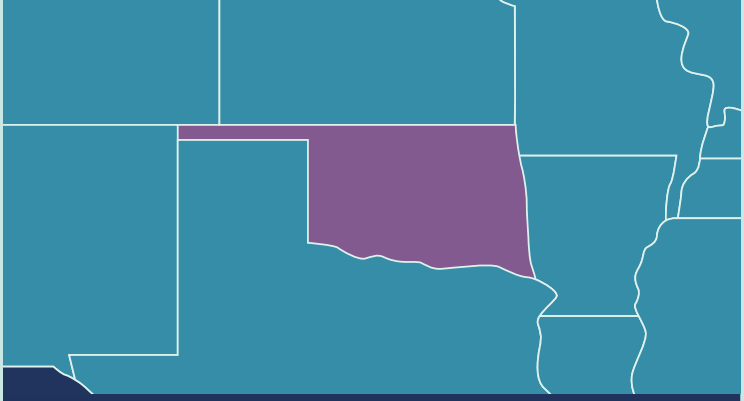
D 39/150

IDAHO

D 42/150

2018'S TOP SCORERS
MD / NY / VT / CO / CT

2018'S BOTTOM SCORERS
SC / WY / MS / AL / OK



And the Award for Most Improved Goes To . . . Oklahoma!

While most states failed to improve their rankings from 2018, one state stood apart from the rest. This year, Oklahoma increased its score by 31 points and earned an overall grade of "C," moving up from the lowest scoring state in 2018 to ranking 20th in 2022.

While this may seem like a modest improvement from the "D" grade the state received four years ago, it belies the fact that Oklahoma was one of only 13 states that have passed a law banning state-regulated insurance plans from using copay accumulators. Copay accumulators are used by insurance plans and pharmacy benefit managers (PBMs) to prevent drug manufacturer copay assistance coupons from counting toward a patient's deductible and maximum out-of-pocket spending. PBMs are companies hired by insurers and public payers to manage drug benefit programs.

However, Oklahoma still scored relatively poorly—as it did four years ago—on indicators measuring the presence of policies to place reasonable limits on prior authorization and specialty tiers, rheumatologists per capita, insurance coverage, and rates of physical inactivity and arthritis-attributable activity limitations, issues that remain a persistent problem for people living with rheumatic disease. Nevertheless, Oklahoma's recent policy efforts to control out-of-pocket cost increases for people living with rheumatic diseases merit recognition.

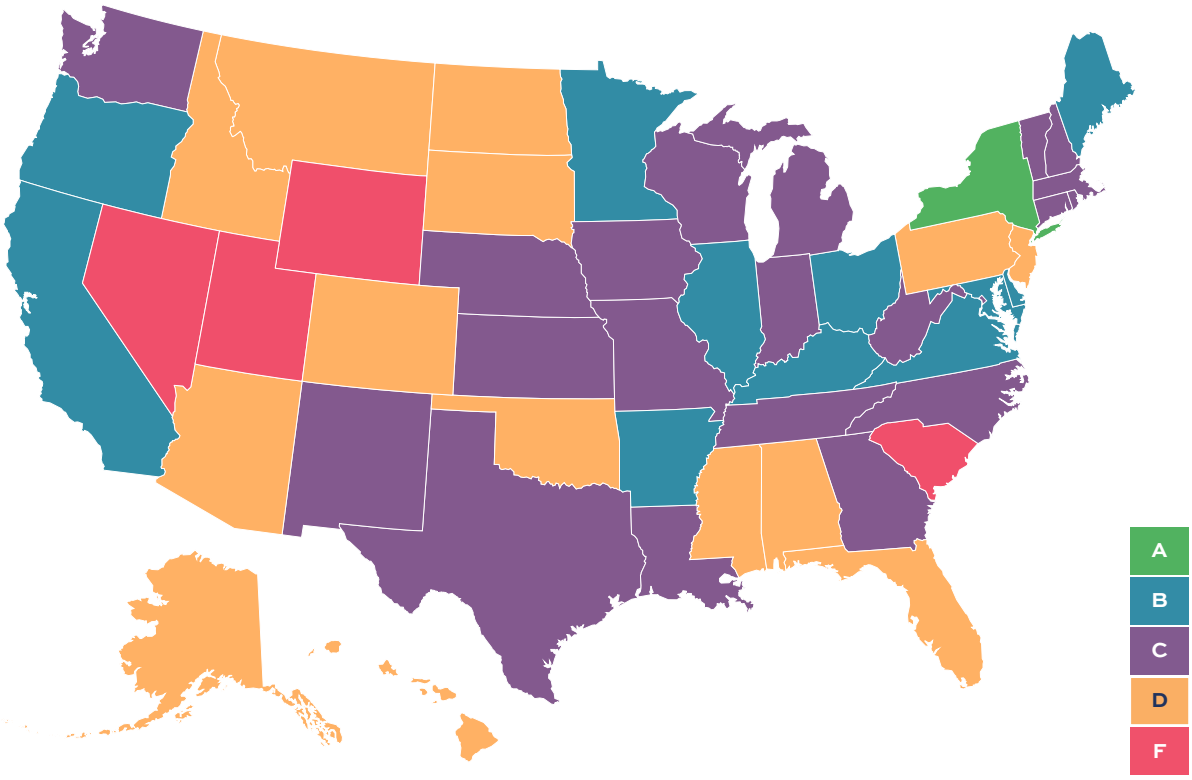
Methodology

States were graded on a point system and received points based on how they performed on each indicator. Indicators were weighted based on their importance and relevance to the quality of life for Americans living with a rheumatic disease.

For numeric indicators – the number of people per rheumatologist, the percent of residents who do not have health insurance coverage, the prevalence of arthritis-attributable activity limitations among adults, and the percent of adults who are physically inactive – the maximum number of points were awarded to states that ranked in the top quintile, while states ranking in the second quintile received 4/5 the maximum number of points, and so on.

For the indicators tracking state legislation prohibiting specialty tiers and copay accumulators, points were awarded on an all-or-nothing basis. For other indicators tracking state legislation – step therapy, prior authorization, and PBM regulations – as well as the presence of CDC-funded activity programs, states were awarded partial credit for meeting some criteria. States were then awarded a letter grade (A, B, C, D, or F) in each category based on how many points they earned as well as an overall grade consisting of the average score between the three categories.

2022 ACCESS GRADES



Alabama	D	Kentucky	B	North Dakota	D
Alaska	D	Louisiana	C	Ohio	B
Arizona	D	Maine	B	Oklahoma	D
Arkansas	B	Maryland	B	Oregon	B
California	B	Massachusetts	C	Pennsylvania	D
Colorado	D	Michigan	C	Rhode Island	C
Connecticut	C	Minnesota	B	South Carolina	F
Delaware	B	Mississippi	D	South Dakota	D
District of Columbia	C	Missouri	C	Tennessee	C
Florida	D	Montana	D	Texas	C
Georgia	C	Nebraska	C	Utah	F
Hawaii	D	Nevada	F	Vermont	C
Idaho	D	New Hampshire	C	Virginia	B
Illinois	B	New Jersey	D	Washington	C
Indiana	C	New Mexico	C	West Virginia	C
Iowa	C	New York	A	Wisconsin	C
Kansas	C	North Carolina	C	Wyoming	F

In the access category, states that received higher grades have enacted policies that limited insurance companies' use of step therapy and prior authorization, practices that make it more difficult for patients to access needed medication and have been shown to delay medically necessary treatments and contribute to adverse outcomes for patients. They also typically had fewer people per available rheumatologist and a low uninsured rate.

STEP THERAPY is when an insurer requires the beneficiary to try and "fail" insurer-preferred treatments before they can begin the therapy their doctor originally prescribed.

PRIOR AUTHORIZATION requires a prescribing physician to obtain approval from the patient's insurer before the insurer will agree to cover a prescribed treatment or service.

Since 2018, additional states have passed laws curtailing insurers' use of step therapy and prior authorization. However, there is still more work to be done to improve access to rheumatology care. In many states, there is a wide disparity in the ratio of people to rheumatologists—ranging from 19,000 in Massachusetts to 156,611 in Wyoming. Likewise, a lack of health insurance remains a persistent problem for many people living with rheumatic diseases, with some states having an uninsured rate exceeding 10 percent.

Policymakers looking to improve their state's Access grade should work to expand the rheumatology workforce, improve health insurance access, and place reasonable limits on insurers' use of step therapy and prior authorization protocols to ensure patients can access timely and medically necessary treatment.

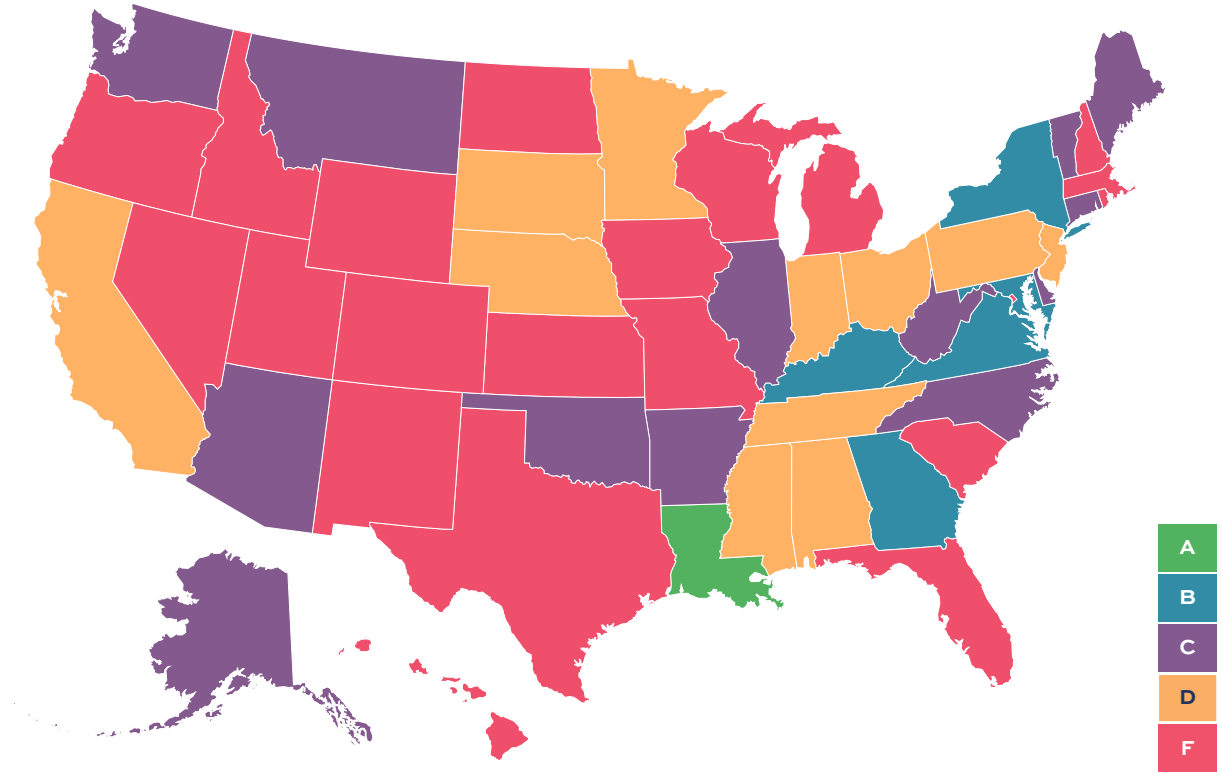
Prior Authorization Reform: Texas' "Gold Card Law"

The ACR's report card tracks various efforts by states to place limits on insurance companies' use of prior authorization – such as whether that state has enacted a maximum response time for the insurer to respond to a request for an exception or whether the state requires a standardized or electronic request form. But some state lawmakers are exploring options to make the prior authorization process even easier for patients and clinicians. A so-called "gold card" system would enable physicians to bypass insurance prior authorization requirements for certain services if they're able to demonstrate they consistently meet the criteria for prior authorization approval.

Lawmakers in Texas enacted such a law in 2021 with bipartisan support. Rheumatologists and other specialists in Texas who have a prior authorization approval rate of over 90% over a six-month period for certain services will be automatically exempt – or "gold carded" – from having to submit prior authorization requests for those services. This makes it easier for doctors who consistently meet prior authorization requirements to navigate an arduous process that delays patients' access to care.

So far, Texas is the only state to have enacted such a law, but lawmakers in other states have recently expressed interest in similar reforms.

2022 AFFORDABILITY GRADES



Alabama	D	Kentucky	B	North Dakota	F
Alaska	C	Louisiana	A	Ohio	D
Arizona	C	Maine	C	Oklahoma	C
Arkansas	C	Maryland	B	Oregon	F
California	D	Massachusetts	F	Pennsylvania	D
Colorado	F	Michigan	F	Rhode Island	F
Connecticut	C	Minnesota	D	South Carolina	F
Delaware	C	Mississippi	D	South Dakota	D
District of Columbia	F	Missouri	F	Tennessee	D
Florida	F	Montana	C	Texas	F
Georgia	B	Nebraska	D	Utah	F
Hawaii	F	Nevada	F	Vermont	C
Idaho	F	New Hampshire	F	Virginia	B
Illinois	C	New Jersey	D	Washington	C
Indiana	D	New Mexico	F	West Virginia	C
Iowa	F	New York	B	Wisconsin	F
Kansas	F	North Carolina	C	Wyoming	F

As in 2018, many states performed poorly in the Affordability category for 2022. This category measures state policy efforts to curtail health insurers' use of drug specialty tiers and copay accumulators and to regulate abusive PBM business practices that drive up costs for patients. Twenty states received an "F" grade for Affordability in 2022.

Even in states where patients can find a rheumatologist, their prescribed treatment costs are often exorbitantly expensive. While states have made substantial progress to reform PBM practices compared to 2018, fewer than half have put limits on insurers' use of specialty tiers or prohibited the use of copay accumulators that result in higher out-of-pocket costs for patients.

Medications in a specialty tier require that patients pay 20-50 percent of the drug's cost instead of the flat co-pays patients usually pay for medications in "generic" or "preferred" drug tiers. These specialty tier payments can add up to thousands of dollars in out-of-pocket costs for patients each year.

Copay Accumulators Harm Patients

Patients are being harmed by copay accumulators adjustment policies (CAAPs) that bar copay assistance from counting towards a patient's deductible or out-of-pocket maximum. These policies hurt patients who depend on medicines by:

Exposing Vulnerable Patients to Large, Unexpected Costs

CAAPs disproportionately impact patientssuffering from serious illness, particularly those who are low income or persons of color. These patients rely on copay insurance, but accumulators cut that lifeline and leave patients exposed.

Interrupting Necessary Treatment

Nearly all copay assistance is used to pay for medicines without generic alternatives. When more costs are transferred to the sick and vulnerable, those patients often lose access to needed medications—driving down drug adherence and resulting in other more costly health issues. CAAPs create an unnecessary barrier that interrupts the course of critical treatment for patients.

Undermining Patient Protections

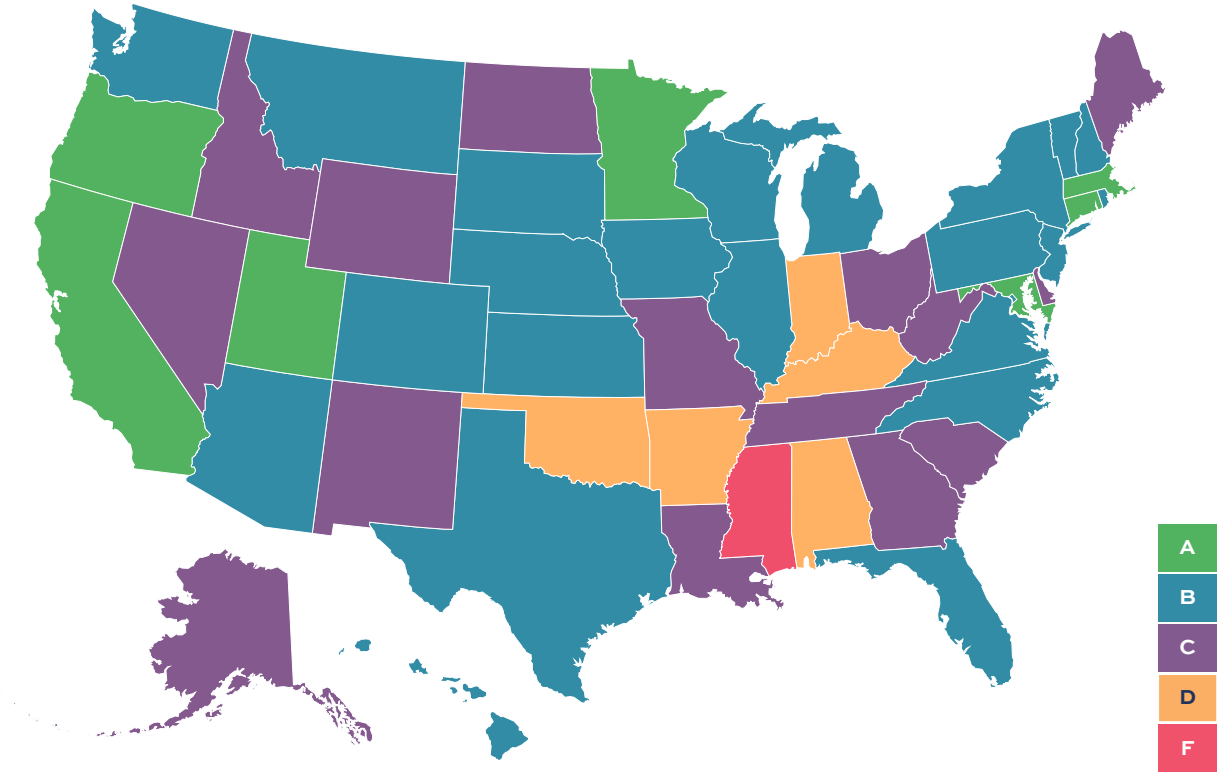
The Affordable Care Act provided minimum standards for coverage and protections against high out-of-pocket costs, particularly for those with pre-existing health conditions. CAAPs erode these protections and harm patients with serious, chronic health conditions.

Copay Accumulators Explained

Copay accumulators are used by insurance plans and PBMs to prevent drug manufacturer copay assistance coupons from counting toward a beneficiary's deductible and maximum out-of-pocket spending.

Many rheumatic disease patients must take expensive specialty medications to manage their disease. Often, they receive copay assistance coupons from drug manufacturers to cover part of the cost. However, insurance companies' copay accumulator adjustment programs now make it more difficult for patients to afford treatment. These programs disproportionately impact the most vulnerable patients. Insurers claim that copay accumulators incentivize patients to switch to lower-cost generics or biosimilar drugs, but few of these alternatives exist for people with rheumatic diseases. Approximately 95% of the medications subject to copay accumulator programs have no generic or biosimilar equivalents, leaving patients without alternative options.[12] Insurers also claim that these programs are necessary to manage drug costs, blaming manufacturers for setting high prices, but in practice, these programs simply place the financial burden on patients—not drug manufacturers.

2022 ACTIVITY/LIFESTYLE GRADES



Alabama	D	Kentucky	D	North Dakota	C
Alaska	C	Louisiana	C	Ohio	C
Arizona	B	Maine	C	Oklahoma	D
Arkansas	D	Maryland	A	Oregon	A
California	A	Massachusetts	A	Pennsylvania	B
Colorado	B	Michigan	B	Rhode Island	B
Connecticut	A	Minnesota	A	South Carolina	C
Delaware	C	Mississippi	F	South Dakota	B
District of Columbia	B	Missouri	C	Tennessee	C
Florida	B	Montana	B	Texas	B
Georgia	C	Nebraska	B	Utah	A
Hawaii	B	Nevada	C	Vermont	B
Idaho	C	New Hampshire	B	Virginia	B
Illinois	B	New Jersey	B	Washington	B
Indiana	D	New Mexico	C	West Virginia	C
Iowa	B	New York	B	Wisconsin	B
Kansas	B	North Carolina	B	Wyoming	C

Overall, states scored the highest in the Activity/Lifestyle category. Among the seven states that received an "A" grade, most had a low prevalence of activity and lifestyle limitations due to arthritis or another rheumatic disease and low rates of physical inactivity. In addition to these characteristics, the report card also tracked the presence of CDC-funded arthritis activity programs in the states. Since 2018, the CDC's funding for these programs has increased significantly, bringing on more partners alongside the YMCA and National Recreation and Park Association (NRPA). Every state plus the District of Columbia is now home to at least one CDC-funded activity program offered by the YMCA, NRPA, the Osteoarthritis Action Alliance, or the National Association of Chronic Disease Directors, or has received funding from the CDC to run an activity program directly through their state health department.

Taking an active role in one's health can make a significant difference for Americans living with a rheumatic disease, especially given the access and affordability challenges they face. Patients who want to live well with their rheumatic disease should work with their doctor to find exercises that can help them manage their health and exercise for at least 30 minutes each day. Studies show that regular exercise can reduce joint pain, improve mobility, and reduce stress levels associated with increased disease flare-ups.[13]

Patients in every state can help raise their grade on rheumatology care by exercising regularly, eating healthy foods, following their healthcare treatment plans, and keeping a positive attitude. Policymakers at all levels of government can also play a role by making funds available for evidence-based rheumatology intervention programs like those funded by the CDC and by supporting access to and participation in these programs in rural areas and underserved communities.

Activity Limitations for People Living with Rheumatic Disease

Having a rheumatic disease can cause significant physical, mental, and emotional strain. Even seemingly simple tasks – like cooking, getting dressed, or driving an automobile – can be difficult for those with rheumatic disease. Arthritis limits the activities of 23.7 million U.S. adults[14], and according to a recent survey, approximately 83% of people living with a rheumatic disease reported at least one activity limitation due to their disease, including the ability to exercise, work, continue a hobby, or even care for a child or loved one.[15] Anxiety and depression are also some of the most common co-existing conditions of rheumatic diseases, with studies suggesting anywhere between 15 and 60 percent of patients suffer from clinical depression resulting from the stress of living with a chronic disease and chronic pain.[16] These cognitive issues can also affect a person's ability to function in work, social, and family environments as well as their self-esteem and ability to communicate.

While rheumatic diseases can be debilitating, it is still possible to live an active and full life. The CDC Arthritis Program is one way in which adults with rheumatic diseases can improve their quality of life and manage symptoms. The CDC's community-based physical activity programs, such as the Arthritis Foundation Aquatic Program and Active Living Everyday, teach participants to safely increase their physical activity to manage their conditions.

Conclusion & Take Action

Rheumatic disease care in the United States is at a critical juncture. As the prevalence, cost, and impact of these diseases continue to climb, the current healthcare landscape prevents too many patients from getting medically necessary care. To turn the tide on this public health crisis, it is imperative that patients, clinicians, and policymakers work together to address the access, affordability, and lifestyle factors that can mean the difference between a life cut short by pain and disability––and one that is well lived. The time for action is now and solutions must be bold in scope. Rheumatic diseases can be debilitating—but they don't have to be. By raising awareness and enacting policies that improve rheumatic disease care access and affordability, we can raise the grade on rheumatology care for millions of affected Americans.

THIS TABLE SHOWS THE INDICATORS THAT DETERMINED A STATE'S GRADE IN 2020 COMPARED TO 2018.

2018 Report Card

ACCESS

- Number of people per rheumatologist
- Percent of residents who lack insurance coverage
- Presence/strength of state legislation to limit insurer use of step therapy
  - Clear override process
  - Exclusions for previously failed steps or contraindications
  - Universal override
  - 72-hour response requirement
  - Enforcement mechanism

AFFORDABILITY

- Presence of state legislation limiting insurer use of specialty tiers
- Strength of state's laws promoting pharmacy benefit manager transparency
  - Gag clause ban
  - Claw-back ban
  - State licensure or registration
  - Fair audit provision
  - Disclosure of rates and rebates
  - Prohibit copay greater than formulary price

ACTIVITY/LIFESTYLE

- Prevalence of arthritis-attributable activity limitation among adults
- Percent of adults who are physically inactive
- Presence of CDC-funded YMCA or NPRA arthritis intervention program

2022 Report Card

ACCESS

- Number of people per rheumatologist
- Percent of residents who lack insurance coverage
- Strength of state's legislation to limit insurer use of step therapy
  - Clear override process
  - Exception for previously failed steps
  - Exception for contraindications
  - Universal override & prior authorization form
  - 72-hour or better response requirement
  - 24-hour or better emergency response
  - Applies to Medicaid
- Strength of state's legislation to limit prior authorization
  - 24-hour approval for urgent requests
  - 72-hour approval for non-urgent requests
  - Electronic submission
  - Standardized form
  - Published utilization review procedure
  - Clinical peer review requirement

AFFORDABILITY

- Presence of state legislation limiting insurer use of specialty tiers
- Strength of state's laws promoting pharmacy benefit manager transparency
  - Claw-back ban
  - State licensure or registration
  - Fair audit provision
  - Disclosure of rates and rebates
  - Spread pricing prohibition
  - Fiduciary duty requirement
  - Patient steering prohibition
- Presence of state legislation preventing insurers from implementing copay accumulators

ACTIVITY /LIFESTYLE

- Prevalence of arthritis-attributable activity limitation among adults
- Percent of adults who are physically inactive
- Prevalence of CDC-funded arthritis intervention program (Y-USA, NPRA, NACDD, OA Action Alliance, other state organization)

APPENDIX A: INDICATOR WEIGHTING

	2018	2022
ACCESS - 50 Possible Points		
Number of people per rheumatologist	**25**	**10**
Percent of residents who lack insurance coverage	**15**	**10**
Strength of state's legislation to limit insurer use of step therapy	**10** (2 points for meeting each criterion)	**15** (1 or 2 points per criterion)
Strength of state's legislation to limit prior authorization	**N/A**	**15** (1 or 2 points per criterion)
AFFORDABILITY - 50 Possible Points		
Presence of state legislation limiting insurer use of specialty tiers	**20**	**15**
Strength of state's laws promoting pharmacy benefit manager transparency	**30** (5 points for meeting each criterion)	**20** (2 or 3 points per criterion)
Presence of state legislation preventing insurers from implementing copay accumulators	**N/A**	**15**
ACTIVITY/LIFESTYLE 50 Possible Points		
Prevalence of arthritis-attributable activity limitation among adults	**20**	**15**
Percent of adults who are physically inactive	**20**	**15**
Prevalence of CDC-funded arthritis intervention program	**10** (5 points for each, Y-USA or NRPA)	**20** (4 points each for Y-USA, NPRA, NACDD, OA Action Alliance, Other State Organization)

2022 Data Sources

ACCESS

- Number of people per rheumatologist (ACR 2015 Workforce Study) [17]
- % of residents who lack insurance coverage (U.S. Census Bureau Current Population Survey 2020 – Data aggregated by the Kaiser Family Foundation) [18]
- Presence/strength of state legislation to limit insurer use of step therapy (ACR state legislation tracking)
- Presence/strength of state legislation to limit insurer use of prior authorization (ACR state legislation tracking)

AFFORDABILITY

- Presence of state legislation limiting insurer use of specialty tiers (ACR state legislation tracking)
- Strength of state's laws promoting pharmacy benefit manager transparency (ACR state legislation tracking)
- Presence of state legislation preventing insurers from implementing copay accumulators (ACR state legislation tracking)

ACTIVITY/LIFESTYLE

- Prevalence of arthritis-attributable activity limitation among adults (CDC) [19]
- Percent of adults who are physically inactive (CDC) [20]
- Presence of CDC-funded (Y-USA, NPRA, NACDD, OA Action Alliance, Other State Organization) arthritis intervention program (CDC) [21]

APPENDIX B: STATE DATA TABLES

Overall Data

State	Access Score (Out of 150)	Access Grade	Affordability Score (Out of 150)	Affordability Grade	Activity Score (Out of 150)	Activity Grade	Final Score (Out of 150)	Final Grade
AK	13	D	24	C	28	C	65	C
AL	14	D	15	D	14	D	43	D
AR	37	B	27	C	14	D	78	C
AZ	19	D	21	C	33	B	73	C
CA	39	B	12	D	42	A	93	B
CO	16	D	6	F	35	B	57	D
CT	25	C	24	C	40	A	89	C
DC	20	C	9	F	31	B	60	C
DE	33	B	27	C	24	C	84	C
FL	12	D	6	F	31	B	49	D
GA	23	C	30	B	20	C	73	C
HI	14	D	3	F	35	B	52	D
IA	25	C	9	F	36	B	70	C
ID	10	D	3	F	29	C	42	D
IL	35	B	24	C	33	B	92	B
IN	24	C	12	D	17	D	53	D
KS	21	C	9	F	30	B	60	C
KY	30	B	33	B	14	D	77	C
LA	21	C	48	A	21	C	90	B
MA	27	C	0	F	40	A	67	C
MD	32	B	30	B	43	A	105	B
ME	31	B	27	C	27	C	85	C
MI	20	C	3	F	31	B	54	D
MN	31	B	15	D	42	A	88	C
MO	26	C	9	F	25	C	60	C
MS	17	D	12	D	10	F	39	D
MT	17	D	24	C	33	B	74	C
NC	25	C	24	C	32	B	81	C
ND	14	D	9	F	22	C	45	D
NE	20	C	15	D	36	B	71	C
NH	27	C	6	F	39	B	72	C
NJ	16	D	12	D	34	B	62	C
NM	26	C	9	F	29	C	64	C
NV	6	F	3	F	29	C	38	D
NY	43	A	30	B	38	B	111	B
OH	31	B	12	D	28	C	71	C
OK	16	D	27	C	18	D	61	C
OR	37	B	9	F	41	A	87	C
PA	18	D	15	D	34	B	67	C
RI	20	C	6	F	37	B	63	C
SC	8	F	9	F	21	C	38	D
SD	16	D	12	D	30	B	58	D
TN	24	C	12	D	22	C	58	D
TX	25	C	6	F	37	B	68	C
UT	9	F	6	F	42	A	57	D
VA	37	B	30	B	39	B	106	B
VT	20	C	27	C	36	B	83	C
WA	29	C	24	C	33	B	86	C
WI	29	C	9	F	36	B	74	C
WV	25	C	27	C	22	C	74	C
WY	6	F	6	F	25	C	37	D

APPENDIX B: STATE DATA TABLES

Access Data

State	People Per Rheumatologist	Points Out of 10	Percent Uninsured	Points Out of 10	Clear Override Process 2 pt	Exception for Previously Failed Steps 2 pt	Exception for Contraindication 2 pt	Exception for Stable Patients 2 pt	Universal Override and Prior Authorization Form 2 pt	72 Hour or Better Response 2 pts	24 Hour Emergency Response 2 pts	Applies to Medicaid 1 pts	Points Out of 15	24 Hour Urgent Response 3 pts	72 Hour or Better Response 3 pts	Electronic Submission 2 pts	Standardized Form 2 pts	Published Utilization Review Procedure 3 pts	Review by Clinical Peer 2 pts	Points Out of 15	Access Score	Access Grade
AK	69,306	2	12.6%	2									0	X	X			X		9	13	D
AL	50,902	4	8.9%	4									0		X			X		6	14	D
AR	28,804	10	8.5%	4	X	X	X	X		X	X		12	X	X		X	X		11	37	B
AZ	138,908	2	10.8%	2	X	X	X	X		X	X		12					X		3	19	D
CA	41,120	8	7.3%	6	X	X	X	X	X	X	X		14	X	X		X	X		11	39	B
CO	44,926	6	10.4%	2	X	X							4	72 hrs	5 days		X		X	4	16	D
CT	25,244	10	4.8%	8	X	X	X					X	7							0	25	C
DC	26,561	10	3.3%	10									0							0	20	C
DE	29,377	10	8.4%	6	X	X	X	X		X	X		12	-	5 days (procedure) 2 days (drugs)	X		X		5	33	B
FL	49,045	6	12.3%	2	X								2				X			2	12	D
GA	73,452	2	14.5%	2		X	X	X		X	X		10			X	X	X	X	9	23	C
HI	53,111	4	3.7%	10									0							0	14	D
IA	56,112	4	6.1%	8	X	X	X	X		5 days	72 hrs		8	72 hrs	5 days	X		X		5	25	C
ID	66,036	2	12.2%	2									0		X			X		6	10	D
IL	37,746	8	6.5%	6	X	X	X	X		X	X		12	X	X			X		9	35	B
IN	59,803	2	6.1%	8	X	X	X			X	X		10	72 hrs	7 days	X	X			4	24	C
KS	49,169	6	9.2%	4		X	X	X		X	X	X	11							0	21	C
KY	56,111	4	6.9%	6	X	X	X	X		X			10	X	5 days	X		X	X	10	30	B
LA	55,543	4	7.7%	6	X	X	X					X	7			X	X			4	21	C
MA	19,171	10	2.4%	10									0		X	X	X			7	27	C
MD	20,264	10	4.3%	10				X					2	X	X	X	X			10	32	B
ME	50,480	6	5.1%	8	X	X	X	X		X	X		12		X	X				5	31	B
MI	43,997	6	3.9%	10									0	72 hrs	15 days	X	X			4	20	C
MN	41,580	8	5.3%	8	X	X	X	X		5 days	72 hrs		8	72 hrs	5 days	X	X	X		7	31	B
MO	41,716	8	9.7%	4	X	X	X	X					8		X			X		6	26	C
MS	55,822	4	11.9%	2		X	X						4		X	X	X			7	17	D
MT	41,031	8	7.6%	6									0		7 days			X		3	17	D
NC	42,480	6	10.0%	4	X	X	X	X		X	X		12		X					3	25	C
ND	55,905	4	6.2%	8									0			X				2	14	D
NE	46,772	6	7.3%	6	X	X	X	X		5 days	72 hrs		8							0	20	C
NH	23,870	10	4.2%	10									0		X	X	X			7	27	C
NJ	31,085	10	6.4%	6									0							0	16	D
NM	50,178	6	11.8%	2	X	X	X			X	X	X	11	X	7 days	X	X			7	26	C
NV	71,798	2	10.2%	4									0							0	6	F
NY	32,232	10	4.6%	10		X	X	X		X	X	X	11		X	X	X	X	X	12	43	A
OH	38,729	8	6.2%	8	X	X	X	X		10 days	48 hrs		8	48 hrs	10 days	X		X	X	7	31	B
OK	73,567	2	14.5%	2		X	X	X		X	X		10				X			2	16	D
OR	39,572	8	4.7%	10	X	X	X	X		X	X		12		X	X	X			7	37	B
PA	30,749	10	5.5%	8									0							0	18	D
RI	32,281	8	3.1%	10									0	72 hrs	15 days				X	2	20	C
SC	55,939	4	8.5%	4									0							0	8	F
SD	51,101	4	9.0%	4	X	X	X	X		5 days	72 hrs		8							0	16	D
TN	51,731	4	11.4%	2	X		X	X		X	X		10		X			X	X	8	24	C
TX	55,452	4	17.5%	2	X	X	X	X		X	X		12		5 days	X	X	X		7	25	C
UT	57,287	2	9.7%	4									0					X		3	9	F
VA	42,502	6	5.5%	8	X	X	X	X		X	X		12	X	X	X		X		11	37	B
VT	35,262	8	2.6%	10									0	48 hrs	120 hrs		X			2	20	C
WA	43,044	6	7.8%	6	X	X	X	X		X	X		12	2 days	5 days			X	X	5	29	C
WI	37,730	8	4.8%	8	X	X	X	X		X	X	X	13							0	29	C
WV	66,446	2	5.1%	8	X	X	X	X					8	48 hrs	7 days	X		X	X	7	25	C
WY	156,611	2	9.6%	4									0							0	6	F

APPENDIX B: STATE DATA TABLES

Affordability Data

State	Specialty Tiering Legislation	Points Out of 15	Clawback Ban 3 pts	State Licensure or Registration 3 pts	Fair Audit Provision 3 pts	Disclosure of Discounts and Rebates 2 pts	Spread Pricing Prohibition 3 pts	Fiduciary Duty 3 pts	Patient Steering 3 pts	Points Out of 20	Copay Accumulator Ban	Points Out of 15
AK	Yes	15	X	X	X					9	No	0
AL	No	0	X	X	X		X		X	15	No	0
AR	No	0	X	X	X		X			12	Yes	15
AZ	No	0	X		X					6	Yes	15
CA	No	0	X	X	X			X		12	No	0
CO	No	0	X		X					6	No	0
CT	No	0	X	X	X					9	Yes	15
DC	No	0	X				X	X		9	No	0
DE	Yes	15	X	X	X		X			12	No	0
FL	No	0		X	X					6	No	0
GA	No	0	X	X	X		X		X	15	Yes	15
HI	No	0		X						3	No	0
IA	No	0		X	X			X		9	No	0
ID	No	0		X						3	No	0
IL	No	0	X	X	X					9	Yes	15
IN	No	0	X	X	X			X		12	No	0
KS	No	0	X	X	X					9	No	0
KY	No	0	X	X	X		X	X	X	18	Yes	15
LA	Yes	15	X	X	X		X	X	X	18	Yes	15
MA	No	0								0	No	0
MD	Yes	15	X	X	X			X	X	15	No	0
ME	Yes	15	X	X	X			X		12	No	0
MI	No	0		X						3	No	0
MN	No	0	X	X	X		X		X	15	No	0
MO	No	0	X	X	X					9	No	0
MS	No	0	X	X	X				X	12	No	0
MT	Yes	15	X	X	X					9	No	0
NC	No	0	X	X	X					9	Yes	15
ND	No	0	X	X	X					9	No	0
NE	No	0								0	Yes	15
NH	No	0	X	X						6	No	0
NJ	No	0	X	X	X			X		12	No	0
NM	No	0	X	X	X					9	No	0
NV	No	0						X		3	No	0
NY	Yes	15	X	X	X		X	X		15	No	0
OH	No	0	X	X	X		X			12	No	0
OK	No	0	X	X	X			X		12	Yes	15
OR	No	0		X	X				X	9	No	0
PA	No	0	X	X	X		X		X	15	No	0
RI	No	0		X	X					6	No	0
SC	No	0	X	X	X					9	No	0
SD	No	0	X	X	X			X		12	No	0
TN	No	0	X	X	X				X	12	No	0
TX	No	0	X		X					6	No	0
UT	No	0	X	X						6	No	0
VA	No	0	X	X	X		X		X	15	Yes	15
VT	Yes	15	X	X	X			X		12	No	0
WA	No	0	X	X	X					9	Yes	15
WI	No	0	X	X	X					9	No	0
WV	No	0	X	X	X				X	12	Yes	15
WY	No	0		X	X					6	No	0

APPENDIX B: STATE DATA TABLES

Activity/Lifestyle Data

State	Percent of Adults with an Arthritis-Attributable Activity Limitation	Points Out of 15	Percent of Adults Who Are Physically Inactive	Points Out of 15	Y-USA	NPRA	NACDD	OA Action Alliance	State Organization with CDC Funding	Points Out of 20	Activity Score	Activity Grade
AK	10.5	9	20.8	15		X				4	28	C
AL	16.3	3	30.7	3	X	X				8	14	D
AR	14.5	3	31.1	3		X			X	8	14	D
AZ	10.5	9	23.3	12	X	X		X		12	33	B
CA	8.2	15	21.2	15	X	X		X		12	42	A
CO	9.5	12	17.7	15	X	X				8	35	B
CT	9.5	12	22.6	12	X	X	X	X		16	40	A
DC	9.8	12	20.2	15	X	X				4	31	B
DE	11	6	27.2	6	X	X	X			12	24	C
FL	10.7	9	27.3	6	X	X	X	X		16	31	B
GA	11.4	6	27.4	6	X	X				8	20	C
HI	6.8	15	21.7	12	X	X				8	35	B
IA	8.8	15	24.5	9	X	X	X			12	36	B
ID	10.6	9	22.2	12	X	X				8	29	C
IL	9.5	12	24.9	9	X	X	X			12	33	B
IN	11.3	6	28.5	3	X	X				8	17	D
KS	10.1	9	24.8	9	X	X			X	12	30	B
KY	15.8	3	32.5	3	X	X				8	14	D
LA	13.1	6	30.8	3	X	X	X			12	21	C
MA	9.7	12	23.3	12	X	X		X	X	16	40	A
MD	8.3	15	23.2	12	X	X	X	X		16	43	A
ME	12.3	6	24.8	9	X	X	X			12	27	C
MI	12.5	6	24.3	9	X	X	X	X		16	31	B
MN	8.7	15	21	15	X	X			X	12	42	A
MO	14.1	3	27.8	6	X	X		X	X	16	25	C
MS	14.5	3	33.2	3		X				4	10	F
MT	11.7	6	21.5	15	X	X	X			12	33	B
NC	13.2	3	24.6	9	X	X	X	X	X	20	32	B
ND	9.5	12	25.6	6		X				4	22	C
NE	9.1	15	24.3	9	X	X	X			12	36	B
NH	9.9	12	21.5	15	X	X			X	12	39	B
NJ	8.9	15	28.7	3	X	X	X	X		16	34	B
NM	10.5	9	23.7	12		X	X			8	29	C
NV	9.2	15	26	6	X	X				8	29	C
NY	9.4	12	25.9	6	X	X	X	X	X	20	38	B
OH	11.6	6	26.9	6	X	X	X	X		16	28	C
OK	13.7	3	30.5	3	X	X	X			12	18	D
OR	12.9	6	20.7	15	X	X	X	X	X	20	41	A
PA	10.2	9	24.7	9	X	X	X	X		16	34	B
RI	10	12	25.3	9	X	X	X		X	16	37	B
SC	13.7	3	27.6	6	X	X	X			12	21	C
SD	10.3	9	25.3	9		X	X	X		12	30	B
TN	14.7	3	28.9	3	X	X	X	X		16	22	C
TX	9	15	27.5	6	X	X	X	X		16	37	B
UT	8.9	15	18.2	15		X		X	X	12	42	A
VA	9.2	15	23.4	12	X	X			X	12	39	B
VT	10.9	9	19.6	15	X	X		X		12	36	B
WA	11.3	6	18.4	15	X	X			X	12	33	B
WI	10	12	21.9	12	X	X		X		12	36	B
WV	18.7	3	30.1	3	X	X	X	X		16	22	C
WY	10.7	9	23.6	12	X					4	25	C

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