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CONNECTICUT: BASELINE REPORT

State-Level Field Network Study
of the Implementation of the
Affordable Care Act

October 2014

Rockefeller Institute of Government
State University of New York

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University of Pennsylvania

Field Research Associates



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Part 1 – Setting the State Context

1.1 and 1.2. Decisions to Date and Goal Alignment

Connecticut's population of 3.5 million has a median household income substantially above the U.S. average, making it the third wealthiest state in the country. It ranks fourth nationally in health care spending per capita and in health insurance costs per worker.

From the start, there was no doubt that Connecticut would create its own insurance exchange, now called Access Health CT. Similarly, there was never any doubt that Connecticut would expand Medicaid. Its government leaders, all Democrats, support the Affordable Care Act. Also, Hartford, its capital, is the historic home to a number of large insurance companies, including Aetna, and this constituency favors more state-based rather than federal oversight of insurance markets.

In fall 2010, Connecticut received a \$1 million planning grant (through its State Office of Policy and Management) to design and implement a state health insurance exchange. Less than a year later, on July 1, 2011 (a year before the Supreme Court's ruling), Connecticut enacted its exchange legislation, with support from the governor and key legislative leaders. The primary debates were over how governance of the exchange board should be structured – in particular, whether to follow more of an interest group model, with various constituencies represented, or more of an expertise model, with fairly strict conflict of interest provisions. (As described below, the state opted for somewhat of a hybrid, but the governance question still remains controversial.)

For a while, Connecticut debated whether to go beyond the ACA and embrace the "public option" that Congress had rejected.

Building on preexisting efforts in Connecticut to expand toward universal coverage, a proposal known as Sustinet was advanced that would have allowed private individuals and small businesses to purchase the same self-funded coverage provided to state workers and retirees. Governor Dannel Malloy, however, did not support creation of this public option, but the idea is still capable of being revived, possibly through the advisory Health Care Cabinet, headed by Lieutenant Governor Nancy Wyman.

Connecticut opted for a conventional exchange and market structure that keeps the individual and small group markets separate, defines small groups as those fifty and under, and has a single statewide exchange selling individual and small group plans through separate web portals. Other details are described below.

Part 2 – Implementation Tasks

2.1, 2.2, and 2.3. Exchange Governance and Operations

The state's exchange, Access Health CT, is a quasigovernmental entity whose governing board is comprised of fourteen members, chaired by Wyman. Three members are the commissioner of social services, secretary of policy and management, and the state healthcare advocate. Three nonvoting ex-officio members represent state departments of insurance, public health, and mental health and addiction services. The remaining eight members (including the chair) are appointed by a variety of government leaders (the governor and the majority and minority leaders of the House and Senate), based on designated areas of expertise, which include: health care finance and economics; health care benefits plan administration; health care delivery systems; and health insurance for small employers, individuals, and self-employed, respectively.

Conflict of interest rules prohibit board members currently affiliated with an insurer, broker, or provider. However, people who previously had such affiliations, including retirees, are not prohibited, and several board members have had such affiliations. This has led to ongoing criticism that the current board includes industry perspectives disproportionately. Also of ongoing controversy is the absence of designated consumer representatives on the board, including either consumer advocates or small business firms that are designated as such.

Defenders argue that current members do represent these perspectives, and that designating a range of interest groups rather than areas of expertise would lead to more industry involvement.

Connecticut has among the greatest number of mandated benefits in the country – all of which it decided to include in its definition of essential health benefits. This made it difficult for the exchange board and staff to settle on the standard plan designs that meet the prescribed actuarial values for the different metal

tiers (bronze, silver, gold, platinum). Difficult tradeoffs between coverage and costs were discussed through a series of long board meetings that involved a variety of interest groups.

The exchange delayed hiring its chief executive officer (CEO) until June 2012, almost a year after it was formed. But the person it hired, Kevin Coughlin, is recognized as one of the country's leading experts in exchange administration, having helped to launch the initial exchange in Massachusetts, known as the Connector. Recently, he was appointed as director of the federal Center for Consumer Information and Insurance Oversight, which operates healthcare.gov, the federal exchange. At Access Health CT, Coughlin strove to create a vibrant start-up culture and energy among the staff, which appears to have succeeded. Access Health CT is recognized as one of the best functioning exchanges in the country, having enrolled more than twice the number of people initially projected by the end of open enrollment in March 2014. It is now offering to outsource some of its functions and expertise to other states.

Interestingly, in selecting the major vendor for enrollment and various "back office" functions, the Connecticut exchange did not contract with the Connecticut Business and Industry Association (CBIA), which already operates a successful private exchange for small employers, perhaps because its current business connections and political positions created potential conflicts of interest.

The exchange's operating budget is approximately \$35 million. This is financed with a combination of federal grants and a 1.35 percent assessment marketwide (both inside and outside the exchange) on all small group and individual insurance (including dental coverage). The state received a Level Two Establishment Grant for \$107.3 million to fund exchange development through December 2014. The state has received additional grants to fund IT development and enrollment assistance.

2.4 and 2.5. Outreach, Education, and Navigational Assistance

The Connecticut exchange has impressive marketing/outreach strategies. Its CEO's background is in insurance marketing (previously with the Massachusetts Connector). He instituted about a dozen different sales distribution channels, including some retail outlets set up to function like Apple stores, with insurance "genius bars" and kiosks staffed by different insurers. The exchange hosted 100 "health chats" across the state to answer questions, and seventy-eight enrollment fairs.

The exchange supports six regionally based navigator organizations that implemented outreach strategies and provided support to approximately 300 enrollment assisters statewide. These assisters work mainly at community-based or social service organizations.

Hundreds of brokers have also undergone the training required to sell insurance through the exchange. Brokers' initial

resistance to the exchange largely abated when it was determined that insurers would continue to compensate brokers directly, according to their own commission schedules, rather than having standardized commissions paid only through the exchange. Commissions for individual insurance are reported to be a bit lower than in previous years, but consistent with current commission rates outside the exchange.

By the end of March 2014, Connecticut's exchange had enrolled about 75,000 people, more than twice the number initially projected.

2.6. Interagency and Intergovernmental Relations

The state's Office of Policy and Management has been actively involved in planning and oversight of the exchange and its finances and operations. The Department of Insurance reviews and approves forms and rates for policies sold through the exchange. Medicaid is administered separately by the Department of Social Services. Both departments have representatives on the exchange board (although the Insurance Department's member is nonvoting).

The exchange portal directs applicants who are eligible for Medicaid to its entirely separate application process, which is still done by paper, not electronically. As one observer put it, there may be "no wrong door" to applying, but once you enter, there are two different exit doors: one for private insurance and the other for Medicaid applicants.

2.7. QHP Availability and Market Changes

Implementing legislation allows the Connecticut exchange to be an active purchaser that negotiates with participating plans. However, the exchange board, following its staff's recommendation, opted initially to include all qualified plans, in order to ensure sufficient participation. Nevertheless, the exchange was active in giving insurers' actuaries reasons to keep their rates moderate and evaluate the rates initially filed by hiring an outside actuary to review them. Some observers believe this caused the Department of Insurance to also review the filed rates more closely, and this review process, in fact, resulted in a significant reduction in the final rates from those initially filed.

Insurers may choose separately whether to participate in the individual or small group part of the exchange. In 2014, three insurers offered individual coverage through the exchange: Anthem Blue Cross, ConnectiCare (a local HMO), and HealthyCT, a newly formed nonprofit co-op insurer funded by the ACA. In 2015, United Healthcare also joined the individual exchange market. Notably absent is Aetna, which is headquartered in Hartford. Initially, it applied to offer coverage, but then withdrew after its initial rate filing was questioned by Insurance Department and exchange actuaries. Views differ on whether or not Aetna would have withdrawn even if its proposed rates had been accepted, since it also declined to participate in, or it

withdrew applications to, several other exchanges in states where it has significant market presence.

Enrollment patterns have favored Anthem Blue Cross, with well over half. The new nonprofit insurance co-op has not fared well, enrolling only 3 percent, due to having higher prices in most markets. Although ConnectiCare has a minority share, enrolling more than a third of individuals, it has substantially increased its market share over prior years.

Connecticut has among the highest medical costs in the country, due in part to the population's relative wealth, but also in part to the fact that its provider market is fairly consolidated. As a result, insurers effectively have to include most hospitals in the state in order to provide statewide coverage. Therefore, the hospital networks for exchange plans remain largely the same as in the group market. For physicians, however, the two leading insurers formed somewhat different networks for the individual market than for their group plans, and were able to negotiate somewhat lower prices in doing so.

Part 3 – Small Business Exchanges

Access Health CT offers a separate small business health options (SHOP) exchange to small employers, defined as fifty or fewer workers. Insurers may decide separately whether to participate in SHOP versus the individual market exchange. Employers may opt to either give workers a choice of plans, or to pick a single plan or insurer.

Many observers are skeptical about whether the SHOP exchange will offer much or any advantage over existing market options. In 2014, the SHOP exchange enrolled only a few hundred people in Connecticut. Connecticut already has a successful small employer exchange, known as CBIA, for Connecticut Business and Industry Association, which also allows employers to give workers a choice of insurers. One potential advantage the SHOP might have over CBIA is the availability of tax credits for low-wage firms. But, wages tend to be higher in Connecticut than national averages, so experts doubt that many firms that want to sponsor health insurance will qualify.

Thus, the main distinguishing feature between the SHOP and the CBIA exchanges may be simply which insurers are included in each. No insurer currently participates in both. Anthem Blue Cross, UnitedHealthcare, and HealthyCT (the new nonprofit co-op insurer) sell small group coverage through SHOP but not CBIA. CBIA offers Aetna, Oxford HMO (which United owns), and ConnectiCare. Interestingly, ConnectiCare sells individual coverage through the exchange, but not small group coverage.

Part 4 – Summary Analysis

Connecticut demonstrates how well even a smaller state can do in implementing health insurance reform through its own exchange. Broad political and industry support for a state-based

exchange has resulted in one of the very best functioning exchanges in the country.

Difficult or potentially contentious issues that Connecticut may face in coming years include: 1) high health care costs and the diminished level of price competition among hospitals; 2) whether additional insurers will enter the exchange and whether the new nonprofit insurance co-op will remain financially viable; 3) whether the SHOP exchange will achieve critical mass; and 4) the appropriate level of consumer representation on the exchange board.