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A Leader With a Long Road Ahead: Evaluating the Implementation of Connecticut's Health Insurance Exchange

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Evaluating the Implementation of Connecticut's Health Insurance Exchange

PBPL Senior Thesis

Alison M. Caless
Class of 2014

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Introduction: Setting the Stage

“It took a hundred years for us to even get to the point where we could start talking about and implementing a law to make sure everybody got health insurance. And my pledge to the American people is, is that we're going to solve the problems that are there, we're going to get it right, and the Affordable Care Act is going to work for the American people.” –President Barack Obama

On March 23, 2010, President Barack Obama signed into law the Patient Protection and Affordable Care Act (the “Affordable Care Act,” or “ACA”), which has altered the health care landscape in the United States. The implementation of the ACA has been a roller coaster: a Supreme Court decision, a government shutdown, and a continuing battle over whether it will lead to better health or disaster for this country. The focal point of the ACA was increasing both the quality and affordability of health insurance for citizens or lawfully present people – a “coverage first” strategy for overarching health care reform. The Act combined an individual mandate with subsidies to boost affordability, and included health insurance exchanges to foster coverage options. Health insurance exchanges are marketplaces where individuals and businesses can shop for and buy health insurance (National Association of Insurance Commissioners, 2011, 1). These marketplaces are web portals that consumers can visit to get informed and compare their insurance plan options. Health plan options are checked and certified to comply with federal, and sometimes more stringent, state standards for coverage and price. However, individuals do not have to purchase through the exchanges; the private insurance market remains as an option for buying coverage.

The health insurance exchanges are the vehicle driving the ACA reform – the front line and contact point to residents of the United States. When the law was designed, federal policymakers incorrectly assumed that most states would create their own state-run health exchanges (Scotti, 2013). In fact, more than half ended up using the option written within the

law that allowed them to have the federal government run and operate an exchange for their state. A handful also ended up partnering with the federal government – leaving only seventeen states establishing their own design (“State Decisions For Creating Health Insurance Marketplaces,” 2014). This decision alone vastly differentiated the implementation pathways of states, and resulted in tremendously different outcomes for residents depending on what state they live in. The federal exchange, HealthCare.gov, had disastrous problems including an utter failure in its launch on October 1, 2013. Many states have had technology breakdowns and abysmal enrollment numbers; such as Maryland who was still only accepting paper applications at the end of the first enrollment period, or Oklahoma whose enrollment percentage stands at 4.5% of the eligible population after the first enrollment period (Speights, 2014). By comparison, Connecticut’s percentage is approximately 30% (Speights, 2014). Many states are struggling in a similar position to Oklahoma and Maryland, while others like Connecticut have soared and experienced relative success. The question is, why?

Argument

This thesis will focus on the implementation of a state-designed health insurance exchange in Connecticut, called Access Health CT. The first round of enrollment for residents, which ran from October 1, 2013 until March 31, 2014, is now complete. State and federal officials have publicly stated that Connecticut is a leader in ACA health insurance exchange implementation. As of April 1, 2014, Access Health CT had signed up 208,301 people, or approximately 30% of its eligible population (Whipple, 2014). By comparison, Hawaii’s state-designed exchange enrolled just 3.2% of those eligible, and Oklahoma’s federally-facilitated exchange enrolled 4.5% (Speights, 2014). Connecticut has also been praised for its functional

and fast technology and system, as well as a high satisfaction rate among enrollees (Whipple, 2014).

This thesis will argue that political focus on and support for health reform, as well as an existing health policy infrastructure within Connecticut, enabled the state to enjoy early success with ACA exchange implementation. Political willingness backed by a network of advocates and experts drove Connecticut to the front of the pack and led to many smart structural design and implementation choices. However, even a triumph in the first sprint does not mean a victory for the marathon that is the ACA's implementation. Connecticut still has to fix problems that have plagued its past efforts for health reform. The two most prevalent issues include cost, with regards to health care services and affordability for consumers, as well as ensuring a solid health care system within the state to back up the large influx of newly insured individuals.

Theoretical Background

The ACA employs cooperative federalism: two levels of government, federal and state, working together to implement policy. There is a particular set of literature that applies to policy implementation and federalism. Numerous scholars have concurred that specific requirements, such as the willingness of each level to work together and structural capacity, are essential for implementation to succeed. McLaughlin (1987) describes the difficulty of making policy changes happen, particularly across layers of government and multiple institutions (172). He boils policy success down to two key ingredients: local capacity and will. Capacity, he says, can be difficult, but it is possible to build over time (172). Will, on the other hand, cannot be altered so easily and is a necessary foundation for successful policy change. Particularly with a mandate from the federal government, policymakers cannot dictate what matters to a specific state (172).

Also recognized by scholars is the fluidity of implementation – the idea that implementation problems are never “solved,” (Majone and Wildavsky, 1977). Implementation evolves through a multistaged, iterative process. A balance of pressure and support on decision-makers from advocacy groups throughout the process is essential to focus and enable implementation.

O’Toole and Montjoy (1984) build on this, adding that when two or more agencies or levels of government are coordinating to implement a policy, productive relations between the two are imperative, particularly when there is mandated cooperation (494). This parallels Thompson’s (1986) argument that examines the commitment, capacity, and progressivity of states with regards to health care policy. Thompson focuses on a gap of political will and administrative capacity between many states and Washington, D.C. Years before the ACA was even passed, concerns were raised about having such substantial variation among the states with respect to their views on health care reform.

The ACA challenges the federalist roots of the United States described by these policy implementation scholars. The U.S. Department of Health and Human Services (DHHS) and the National Association of Insurance Commissioners (NAIC) can draft regulations and issue guidance for health reform, but the states have the power to truly make them work. Jost (2010) predicted that the wide variety of choices would create unique exchange models within each state, allowing opportunities for experimentation, comparison, and learning (22). That is precisely what has happened. No state has made the exact same implementation decisions.

With respect to health policy reform, a subsection of implementation scholars have suggested specific tactics and mechanisms to support state-level implementation. Many have pointed to the importance of advocacy efforts within states. While the depth and breadth of the advocacy community will inevitably differ from one state to another, developing the capacity of

existing state organizations has been identified as imperative for implementation success (McLaughlin, 1987). Advocacy groups are seen to be important for tasks such as analyzing policy options, conducting legal analysis, building coalitions, developing communication efforts, monitoring, and providing feedback on implementation efforts (Dash, 2013, 8). The California Endowment (2011) emphasizes the need for these advocacy groups to create a consumer implementation “table” that brings together organizations working on implementation, such as health care and low-income advocacy groups, state fiscal policy groups, and children advocacy organizations (5). Also discussed is the need for relationships with the elected, appointed, and career state officials in order to have access to the leaders who are influential in driving implementation efforts. As the implementation literature suggests, political will and capacity in the form of advocacy networks proved key to CT’s successful health care exchange.

Methods

When implementing the ACA, each state made choices that drove it closer or further from the ideal structures established by the scholars above. Assessing these choices enables us to single out Connecticut and make conclusions as to how those choices have affected the level of success. To do so, I conducted a complete overview of the health insurance exchange implementation literature. This review led to a distinct group of principal decisions necessary for formulating an exchange. To determine the breakdown of structural choices in Connecticut, I examined publications by multiple foundations and organizations within the state. Further, I reviewed agendas, minutes and presentations from Exchange Board meetings. To assess how these decisions were made and why, I interviewed seven key actors in Connecticut’s Exchange

implementation. Drawing on connections from professors and relatives, I purposively identified initial informants across the range of key actors associated with health insurance exchanges.

These key roles included consumer and small business advocates, officials working at the Exchange itself, a media representative, and an insurance policy analyst. Additional informants were reached using a snowball procedure, where an informant would recommend a particular individual who he or she believed would be insightful. Drawing on a semi-structured interview guide, interviews asked informants their opinion on certain decisions made by the Board, their own opinion on successes and failures of the Exchange, as well as a few specific questions related to their area of expertise. Their answers were collected and organized to find patterns of opinions, as well as any contradicting viewpoints. A few informants received follow-up emails to clarify their statements and probe their reasoning if their comments disagreed with something stated in another interview. Interviews were also used to get a better perspective of the ground-level implementation, including the unique nuances of Connecticut's policy infrastructure that framed the choices that were made within the state.

The Path Ahead

Using this strategy, I have pieced together an in-depth case study of Connecticut's health insurance exchange implementation that reflects on the past and projects to the future. The first chapter of this thesis will explore the past: a health reform that Massachusetts started in 2006 and was a model for the ACA. The impact of comparable decisions made by Massachusetts's policymakers shapes predictions of how implementation in Connecticut will play out. While Massachusetts's reform was a model for the ACA, it was not an exact replica. Chapter two will outline the different options states had during the implementation of the ACA exchanges, and

will demonstrate the wide spectrum of alternatives. These options are the forks, decisions where Connecticut branched off from other states' decisions and paved their unique pathway of implementation. Lastly, chapter three will focus on the specific pathway of Connecticut's implementation, giving a detailed breakdown of the process. Most importantly, I will draw conclusions as to whether Connecticut has truly succeeded in exchange implementation as the media has portrayed. Success in Connecticut will be attributed to two overarching elements: a strong history of health reform that fostered a policy infrastructure and advocacy networks, coupled with political will. It will become clear that these two factors facilitated a number of important structural choices made by Connecticut policymakers – the sequence of choices that has allowed Connecticut to be seen as one of the nation's leaders in ACA implementation.

The 2006 Health Reform in Massachusetts: Takeaways From a State-Level Model for the ACA

“A group of people across the state that is larger than the entire population of the city of Boston, which used to not have insurance, that group now has health insurance. It worked in Massachusetts.” – Jonathan Gruber, Professor of Economics at MIT

Before health reform was a top priority on the national agenda, Massachusetts’s policymakers were designing their own comprehensive state reform in April of 2006. The coverage and insurance market reform provisions of the ACA were modeled after those implemented in Massachusetts. Because of its comparability to the ACA, the experiences of Massachusetts offer lessons, expectations, and possible consequences of certain provisions of the ACA. Even when the ACA was first passed in March 2010, the Bay State already had four years of knowledge and experience with a similar law that policymakers continue to study to predict the ACA’s impacts.

That said, the 2006 reform in Massachusetts was not identical to the ACA. Massachusetts has different demographics than other states where the ACA applies, and a few specifics, such as the insurance subsidies offered to low-income families, were different in its reform (Gruber, 2013, 185). However, its basic structure can be used to gather a picture of what life might look like in the ACA’s future. Considering Connecticut and Massachusetts’s similarities in political climate, population, and uninsured rates pre-reform, it is wise of Connecticut policymakers to pay close attention to outcomes in Massachusetts, and to hopefully learn valuable lessons from their successes and setbacks.

This chapter will first report the structural and implementation choices made by Massachusetts’s legislators. These will include decisions regarding decision-making bodies, the plans and subsidies established for consumers, and the actions taken to increase awareness and public support for the reform. The efficacy of these decisions will be assessed based on whether

they successfully lowered the uninsured rate and increased access to health care, while minimizing negative concerns such as cost and long-term sustainability. Most importantly, the applicable lessons from Massachusetts for Connecticut's implementation of the ACA will be highlighted. Perhaps most valuable will be exploring the changes that Massachusetts's policymakers made once certain problems arose with implementation. As a "learning organization," the Massachusetts Exchange was able to use a cycle of feedback to make the changes needed to further its health care goals. However, despite the success of some of these adaptations, cost and difficulties reaching the remaining uninsured population have continued to afflict the Massachusetts Exchange today. The totality of initial snags, modifications made, as well as the lasting problems will all be necessary for Connecticut to understand if they are to successfully implement a health insurance exchange.

An Act Providing Access to Affordable, Quality, Accountable Health Care

Health reform was a top priority on the Massachusetts agenda back in 2006. Many proposals were suggested and altered. Although legislators disagreed on the specifics of *how* to reach their goals, most agreed on some basic objectives they wanted to achieve. These included near-universal health insurance coverage, and improved access to affordable, high-quality health care that included shared responsibility between individuals, employers, and the government (Holahan and Blumberg 2006, 436). All of these were predicted to be beneficial for improving the health status and overall welfare of state residents.

Massachusetts's legislation, like the ACA, set up a health insurance exchange for the purchase of non-group coverage, established a program to subsidize insurance for lower-income

families, and mandated that all adult residents purchase what is deemed affordable health insurance (Holtz-Eakin, 2011, 178).

Policymaker Goals

The overarching, long-term goal for the Massachusetts health reform improved health care for its citizens. However, to do so, the state set objectives specifically to measure success of the Act's implementation. First and foremost, Massachusetts aimed to reduce the rate of uninsured people in the state to achieve the goal of near-universal coverage. But in order to link increased coverage with further extended health care success, other goals had to be addressed as well. The second goal was to improve access to affordable, high-quality health care. Improved access could be demonstrated in the average number of doctor visits and resident-reported satisfaction levels. High quality could also be a self-reported satisfaction level and perhaps the number of specialty care visits. Finally, policymakers also wanted to ensure a sense of shared responsibility between individuals, employers, and the government.

Massachusetts's policymakers knew that focusing so much effort on getting people health insurance was not going to be possible forever. In fact, they knew that this was just the first step in improving overall health care for residents. They made the decision to channel a lot of energy into getting people health insurance, and determined they would make adjustments later. To do so, the Exchange defined itself as a "learning organization," where they constantly reconsidered and revised their policies based on the experience of consumers, carriers, and employers (Kingsdale, 2009, 592). This feedback mechanism would address health care problems as they arose throughout the reform.

Structure and Implementation Decisions

The health insurance exchange for the state was named the Commonwealth Health Insurance Connector, or “the Connector.” This was established as a quasi-independent state agency with ten senior staff members and approximately fifty employees (Lischko, Bachman & Vangeli, 2009, 2). An eleven-member Board of Directors governed the Connector. The Board included representatives from business, labor and consumer backgrounds, as well as content experts (Kaiser Family Foundation, 2012, 2). The Board and the Connector worked together on determining the interworking of the marketplace. For example, the Board set the minimum creditable coverage (MCC) standards, mandated an individual mandate, and defined an “affordable premium,” (McDonough et al., 2008). However, the Connector defined the boundaries of that mandate and decided the precise numbers and insurance plans that would fit the outlines decided by the Board. Many decisions were a cooperative effort between the two. The Connector also approved the sliding scales of subsidized health coverage provided by the state, as well as non-subsidized insurance that meets certain coverage and cost standards (Kingsdale, 2009, 591). Basically, the Connector has the power to decide what category of insurance residents fall into, and how much each of those categories will pay.

Another job of the Connector was making sure awareness and public support were widespread. Enrollment in the subsidized and non-subsidized programs required an “active response” by residents. If the uninsured were confused about coverage or too anxious about the financial commitment, the policy was not going to succeed (SOURCE? 590). In addition to residents, employer-backing is consistently a huge issue for health reforms. In Massachusetts, business groups had blocked prior legislation, so it was imperative that they “buy in” to the rules of the new policy.

To do so, Massachusetts's legislators and policymakers ran a campaign. The process included many public events. The law was signed in historic Faneuil Hall, with political leaders, advocacy groups, business executives and the public all in attendance (SOURCE? 590). Other milestone celebrations were held at the State House, community health centers, the Kennedy Presidential Library, Harvard University, and the University of Massachusetts. Even the Boston Red Sox baseball team was on board, with events held at Fenway Park (Raymond, 2011, 15). Publicity created by these events was also important when spreading the word for a new coverage option launch.

The state also funded community outreach efforts, a public information office, hundreds of educational meetings, and advertising (Kingsdale, 2009, 590). Legislators made sure their communities knew about the program. Politicians used radio, television, social media, signs at grocery stores, fliers at the Department of Motor Vehicles, postcards, and even ads on subways and busses (Raymond, 2011, 15). Not only did they make sure residents were aware, but they were constantly reaching out for suggestions and educating citizens about their options. This engagement was used to justify the burdens of shared responsibility and make sure the population was informed. Although what individuals, employers, and the government were taking on with this reform may have seemed daunting, the idea that it was a collective effort lessened this load. This collective spirit was reflected in this statistics of public support: more than two-thirds of likely voters supported the legislation even a few years after the reform was initiated (Kingsdale, 2009, 591).

Evaluation of Outcomes: What Went Right

When evaluating the outcomes of the Massachusetts health reform, we seek to compare the results under reform to the results that would have occurred in the absence of reform. Fortunately, many foundations sponsored research that provided baseline data on coverage, access to needed care, racial and ethnic disparities, as well as the effect of the health reform on the state's population over time. All of this information and data is key for determining the success of implementation.

An overwhelming majority of sources share common statistics and determinations regarding the health reform in Massachusetts. Long (2008) conducted a survey of 10,000 respondents over a 3-year time period (272). The surveys collected information on insurance status, access to care, out-of-pocket spending, medical debt, and more general financial problems. The report compares outcomes for a cross-sectional sample of adults in periods following the implementation of health reform to the outcomes for a similar cross-sectional sample of adults prior to the reform (Long and Masi, 2009, 579).

In terms of lowering the uninsured rate the data shows that after implementation of the 2006 health reform, uninsurance is at historically low levels. These findings were again verified by annual studies; in 2011, the uninsurance rate in Massachusetts was 3.9 percent, while the national average was 15.1 percent (Long, Goin, and Lynch, 2013, 2).

With respect to the goal of increasing access to health care, there have been improvements in access for working-age adults. Adults are more likely to have a primary source of care, doctor visits, preventative care visits, and dental care visits than before the reform. Working-age adults were more likely to report that they had a usual place to go when sick or in need of advice about their health, which indicates a continuity of care in the system (Long and

Masi, 2009, 580). All of these positive gains reflect increases in both insurance coverage and in the enhancements of existing coverage.

Another goal established by policymakers was to ensure shared responsibility between individuals, employers, and the government. This was achieved when many implementers focused on strong coordination between all levels, from policymakers to ground-level workers. For example, the Secretary of Health and Human Services held weekly meetings with leaders across the state to share information and report progress and challenges (Raymond, 2011, 8). This communication led to an effective collaboration between multiple agencies working on the policy. Legislators were sure to start the program with mostly existing programs to maintain continuity during initial implementation. The Health and Human Services Department in Massachusetts worked with the Connector on joint training sessions, and the Connector also worked with the Division of Insurance to design certain policies(SOURCE 8). This coordination was so important because it reduced redundancy and administrative costs. Coordination also contributed to a smoother transition for people switching to a different type of coverage. Other strategic decisions were designing a common application and placing people automatically in the program they qualify for (10). This alleviated the need for residents to understand any unnecessary, complicated details.

While Massachusetts excelled in furthering its health care goals, not every aspect of the proposal worked smoothly from the beginning. As expected when the state defined itself as a “learning organization,” the Connector had to tweak its plan a bit for the reform to reach its full potential.

Evaluation of Outcomes: What Needed to Be Fixed

With all of these successes, any policymaker has to keep sustainability in mind. For the Massachusetts health reform, there were some difficulties. For example, there were indications that some adults were having a more difficult time obtaining care in the fall of 2008 than in fall of 2007. Although this may reflect many factors, its likely that the influx of newly insured adults combined with those now having additionally covered benefits created an increased demand for follow-up care that was not anticipated or prepared for by the medical providers (Kaiser Family Foundation, 2012, 5).

Another issue was the fact that one in five adults reported being told the doctor's office was not accepting patients with their type of coverage or was not accepting any new patients (Andrews, 2014). These difficulties were more common for lower-income individuals with public coverage than for higher-income adults with private insurance. This could be the result of lower reimbursements to providers from public versus the private programs.

Risk selection and free riding has been difficult for Massachusetts because of the "coverage first" strategy – similar to the ACA. Generally speaking, people are incentivized to take on coverage when they have expensive medical care costs, then drop coverage after treatment. Big picture, this means insurance companies are taking on costs for all these costly procedures, but there are not enough healthy people to balance out the costs of paying for that treatment. A study by the main insurance provider for the Connector, Blue Cross Blue Shield, demonstrated that there was a large portion of the population that would sign up for coverage for three months or less, undertake medical spending four times the average, then drop coverage soon after (Holtz-Eakin, 2011, 179).

Affordability is another significant concern for policymakers. Per capita health spending in the state is 15% higher than the national average (Kingsdale, 2009, 589). During the first year

of reform, the financial burden of health care on individuals dropped significantly. But slowly the gains trailed off. This led to increases in unmet need for care because of costs over that period. There was also difficulty finding providers and getting timely appointments (Long and Masi, 2009, 585). Thus, the growing health care costs were jeopardizing affordability and affecting the successes of the entire health reform.

Addressing The Issues: Response by Legislators & Policymakers

The strong communication channels opened by policymakers enabled them to be fully aware of the problems discussed above. As a “learning organization,” the Connector took a number of initiatives to address these issues. The structural set-up of the reform allowed for a constant evolution of policy.

For example, to increase provider capacity, they started primary care physician recruitment programs. These expanded medical school enrollments for students committed to primary care, and even started a program that repaid loans for medical students who agreed to practice in underserved areas (Kaiser Family Foundation, 2012, 6). When applications were coming in too fast for workers to process them, the Connector adopted enrollment simplifications and made greater use of technology (Raymond, 2011, 12). Additional health reform legislation was also passed in 2008 to initiate cost containment and delivery system improvements. It included new regulations for electronic medical records by 2015 and a uniform billing and coding procedure among health care providers and insurers (Kaiser Family Foundation, 2012, 7). Furthermore, legislators have noticed other issues and enacted solutions; they have banned gifts to physicians from pharmaceutical companies and implemented a program that educates providers on the cost-effective utilization of prescription drugs (7). Taking this a step further,

providers are encouraged to investigate cost themselves and make recommendations to reduce excess expenses during annual public hearings.

Sticking with the strategy of listening to the front line, the legislature also created a Special Commission on the Health Care Payment System. This Commission released recommendations in 2009 suggesting a transparent payment methodology that made significant changes to the system (7). New legislation was passed based on these recommendations, and introduced in May of 2012. All of these adaptations prove that the policy and structure in place for the health reform in Massachusetts was flexible in a way that made successful implementation a much more likely outcome.

When legislators in Massachusetts made the decisions to start with an individual mandate and focus on universal coverage, they knew that this would mean adjustments. The Connector's persistent acknowledgment of areas for improvement has been a significant reason for its success. But no matter how successful a policy, it cannot be perfect. This next section will address long-term problems that the Connector has faced, despite changes made by legislators.

Remaining Issues: Long-Term Problems Connecticut Should Understand

Massachusetts has been heavily criticized during the more recent implementation of the ACA due to its "largely non-functional exchange website" (Archambault, 2014). This website, however, is completely different from the website used for the original 2006 health reform due to certain requirements from the federal government. These changes include incorporating an exchange for small businesses, connecting technology to federal databases, and adjusting subsidies and plan designs to ensure they are conforming to federal standards (Gruber, 2013,

185). Setting aside the well-known struggle with technology, there are also a few long-term problems of the Connector that Connecticut should actively try to combat.

Cost Containment

The cost of health care in Massachusetts was the highest in the country before reform law was passed – and remains so as of 2013 (Vestal, 2013). The Connector emphasized that its main focus in the original phases of implementation would be on lowering the uninsured rate. Rising costs quickly became an apparent problem that needed to be addressed. Cost of health care is a double-edged sword: (a) prices of services are rising, which means (b) corresponding premiums and deductibles paid by consumers are raised accordingly. Many people in the Massachusetts health care industry are worried that this “death spiral” will unravel the state’s nearly universal health care coverage, bankrupt businesses, and have severely detrimental effects on the state’s budget (Vestal, 2013).

Rising health care costs are not unique to Massachusetts. While they are proportionally higher in the Bay State, nationwide health care costs per person are higher in the United States than in any other country in the world (Holtz-Eakin et al., 2011, 180). In August 2013, Massachusetts passed Chapter 224 designating a budget for the health care industry in the Commonwealth. The central idea behind the law is price transparency – to require all of the state’s insurers and health care providers to provide to the public the prices of the services they offer (Vestal, 2013). The hope is that this will arm consumers to make informed choices about their care, forcing providers to respond to this competitive pressure by offering cheaper services. Quality, however, is thought to be controlled by consumer pressure; therefore providers would have incentives to deliver less expensive care by becoming more efficient (Vestal, 2013).

Governor Deval Patrick said of the law, “I’m confident that just as we showed the nation how to deliver universal care, Massachusetts will be the place that cracks the code on cost containment,” (Vestal, 2013).

The effects of Chapter 224 will not be seen for many years. Cost of health care will continue to be a battle for Massachusetts. Skeptics of the new law question its enforceability. If the industry does not limit annual growth to the state’s designated regulations, will providers be issued penalties; will they be shut down? Many worry that providers are not working with a margin that is attainable for them to contain, therefore the law will “have no teeth” when it comes to enforcement (Vestal, 2013).

Reaching the Remaining Uninsured Population

In addition to cost containment, similar issues continue with reaching the remaining uninsured population. According to the Urban Institute and Kaiser Commission on Medicaid, the average state health uninsurance rate is 15%. The highest uninsured rate is Nevada at 23%. The lowest is Massachusetts, where only 4% of the population remains without health insurance (Kaiser Commission on Medicaid 2013). However, this means that some residents of the state continue to go without health insurance coverage. These remaining uninsured are disproportionately younger, male, Hispanic, and non-citizens (Long, Goin, and Lynch, 2013, 1). The \$20 million statewide outreach and awareness campaign discussed was not successful in signing up this portion of the population. As seen in Figure 1, the relatively high uninsurance for non-elderly adults (8 percent or more) in the state in 2010 was concentrated in the Greater Boston area and in pockets across the state, including areas around Lowell and Springfield and in the southeastern part of the state.

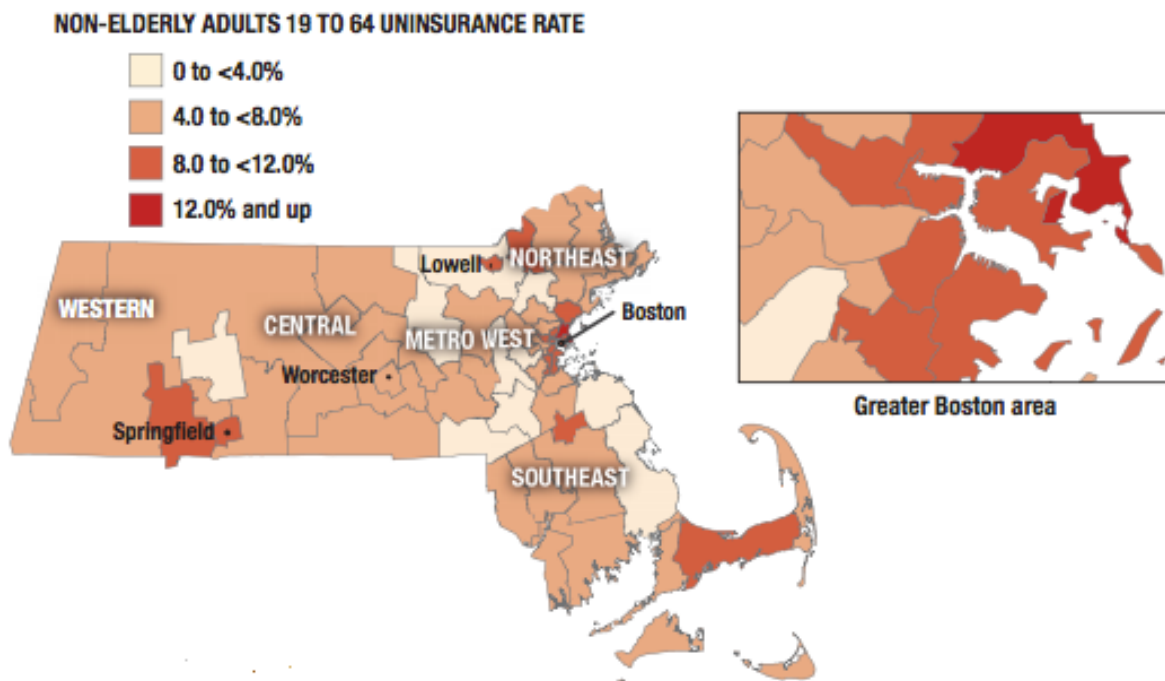


Figure 1: Uninsurance Rates for Non-Elderly Adults and Children Across Communities in Massachusetts, 2010

Source: *Blue Cross Blue Shield 2013, page 25*

Not all of those uninsured are eligible for coverage options, particularly due to new provisions implemented from the ACA. Undocumented immigrants are ineligible for Medicaid. Literacy, language and culture issues among the uninsured also were not addressed satisfactorily. Maxwell et al. (2011) corroborates that Hispanics are more likely than any other racial or ethnic group in the United States to lack health insurance. New outreach strategies are being employed to target the communities with the largest numbers of uninsured individuals, especially those lacking connections to the health care system. Additional changes include simplified enrollment processes and extended assistance for finding providers within the health care system (Maxwell et al., 2011). The lesson to be learned from Massachusetts in this area is that in initial outreach efforts, the younger, male, Hispanic populations will be more difficult to inform.

Concluding Remarks

The Massachusetts health reform has provided us with a valuable example of what ACA implementation might be like. This chapter outlined the pathway that Massachusetts took and drew out both successes and failures. Having this model to analyze can be beneficial to Connecticut – both to replicate the Commonwealth’s successes and to avoid its mistakes.

As would be expected from a state-initiated reform, it has been clear throughout this chapter that political support in Massachusetts was imperative to its success. Proper funding and manpower to carry out implementation efforts such as outreach and plan design was crucial. Clear goals, a varied group of knowledgeable representatives on the Board, and cooperation between involved agencies also helped Massachusetts succeed in moving towards universal health insurance coverage. These decisions made possible a commendable outreach campaign that has successfully signed up enough citizens that Massachusetts now has the lowest uninsured rate of any state. Research has shown that this coverage has opened the door for many residents of Massachusetts, allowing them access to health care that was unattainable before the reform.

Additionally, a significant quality of the exchange in Massachusetts was its own definition of itself as a “learning organization.” Policymakers and legislators have consistently been open to making modifications based on funneled feedback from ground-level workers, consumers, and researchers. A perfect example of this was mentioned when the shortage of providers problem started. The learning organization heard the struggles and made a number of changes to combat them, even starting a program that repaid loans for medical students who agreed to practice in underserved areas. This cyclical reform process supported the Massachusetts reform and has been a large component of its continued success.

In conjunction with these positive takeaways, Massachusetts has also illustrated a few long-term problems of concern. This chapter has demonstrated that both the containment of health care costs and bringing in the hardest to reach uninsured populations have been difficult for Massachusetts. These are issues that all those implementing exchanges through the ACA should be aware of so they can actively attempt to combat these problems.

ACA Pathways: Structural and Implementation Options for States

“States must make complex decisions about how to design their exchanges in ways that reflect the unique needs of their consumers and insurance market. [These decisions] affect key outcomes, such as enrollment, cost, consumer experience, and sustainability.” – Sarah Dash, Kevin W. Lucia, Katie Keith, and Christine Monahan, Georgetown University

The ACA directs states to establish health insurance marketplaces, or exchanges, to facilitate purchasing by both individuals and employers. In contrast to the Act’s other provisions such as broader reforms for the private insurance market and Medicaid expansion, the implementation of the exchanges rests heavily on the efforts of the states. Similar to Massachusetts in its 2006 health reform, states have made decisions regarding structure, governance, operations, and how to ensure a seamless, quality experience for their future consumers – citizens. This chapter will outline the different options states faced when implementing exchanges. Since no two states followed the exact same pathway, each can be seen as its own “state experiment” of the ACA. Although in-depth comparisons between states regarding these decisions will take years and numerous rounds of data collection, it is important to outline the differences now to formulate predictions regarding what decisions are principal to success.

The Big One: What Type of Exchange

The first decision states made shaped the entirety of their ACA implementation. Their options were (a) to design their own state exchange, (b) to partner with the federal government or (c) to defer to the federal government to set up an exchange for them.

The ACA passed through Congress without a single vote from a Republican representative. For most of its provisions, the lack of Republican support was immaterial because the new policies were to be implemented nationwide. For the exchanges, however, the lack of Republican support caused problems. The bill that ended up passing through Congress required states to “opt-in” to exchanges. This “opt-in” meant administering the law themselves, and the alternative was turning responsibility over to the federal government. To design their own exchanges, states had to put in active effort that indicated the state was making progress on implementation. States with political environments opposed to the ACA typically did not take action to show compliance with a law they did not want to pass in the first place. But this inaction meant they deferred to a federally-facilitated exchange that the Secretary of the Department of Health and Human Services would set up for them.

Twenty-seven states defaulted to the federally operated exchange option as an intentional snub to the Act, while others did not feel they had the capacity to operate an exchange themselves. In Texas, Governor Rick Perry, a Republican, announced that Texas would not create a state exchange because it would not result in better “patient protection” or in more “affordable care” (ThinkProgress, 2012). As a result, Texas is served by the federal government exchange. In Maine, public officials made the decision that they could not establish their own exchange due to fiscal constraints of the state. Thus, they too relied heavily on the federal government to set up their exchange. However, unlike Texas, Maine’s proposal letter to the Center for Medicare and Medicaid Services stated, “the State of Maine is open to exploring options for coordination as described in your proposal” (State of Maine Bureau of Insurance, 2013). An additional seven states opted for a Partnership exchange, a hybrid model where the state and federal governments work together.

The remaining sixteen states, and the District of Columbia, chose to establish an Exchange themselves (CCIIO, 2013). Requesting permission from the Secretary of the U.S. Department of Health and Human Services to establish a state-run exchange was a bit like applying to college. In Connecticut, Governor Dannel Malloy sent a letter to Secretary Kathleen Sebelius on July 10, 2012. The deadline for submission was December 14, 2012. Governor Malloy had to update Sebelius on the CT Exchange: what the structure, board and plans were for the future. The Governor's letter ended with, "On behalf of everyone involved in the Exchange, we look forward to working with your office to realize the goals of the ACA and to develop an Exchange by 2014 that meets the unique market and coverage needs here in Connecticut" (Malloy, 2012). The CT Exchange workers received a response from Secretary Sebelius on December 7, 2012. She congratulated Governor Malloy and informed him that the state had received conditional approval to establish a state-based exchange. These conditions included being able to perform all required Exchange activities projected in the CT Exchange Blueprint Application, *and* ongoing compliance with future guidance and regulations (Sebelius, 2012).

With this major milestone out of the way, a whole slew of other decisions came to the forefront. States all over the country were granted permission to continue working on their exchanges, and hastily went to work in order to meet the deadlines assigned by Secretary Sebelius.

Organizational Form

States created structural designs for their exchanges to specify the exchange's relationship with the government.

For the states that decided to establish their own exchanges, they had a few structural options: assign the tasks of the Exchange to an existing state office, establish a new independent entity, or create a nonprofit entity (NAIC, 2011, 3). There are benefits and drawbacks to each of these choices. In particular, there is an important trade-off to weigh when selecting a structure: accountability versus flexibility. A state agency would have high accountability because it is made up of elected officials that have to adhere to public scrutiny and retain the threat of not being re-elected. However, there is a trade-off because this agency would also have less flexibility due to state administrative and government operation laws. Something as small as the maximum salary for a civil service job might not be a huge deal until policymakers are trying to recruit the best talent for the Exchange and the best candidate will not accept such low pay. The flip side may have more flexibility, but would not have the accountability, mandated transparency and public participation that a government agency would. A more technical issue of an Exchange is related to funding. State agencies are subject to political and economic cycles, which might affect their stability. These nuances had to be considered by states when weighing the placement of an exchange. These trade-offs are described in the table below.

Table 1: Advantages and Disadvantages of Exchange Structure Types

Type	Advantages	Disadvantages
State Agency	<ul style="list-style-type: none"> • Direct link to State administration • Potentially easier coordination with other State agencies • More accountability to actors involved • Streamlining 	<ul style="list-style-type: none"> • Politicized decision-making • Budgetary issues • Bureaucratic hoops to jump through • Difficulty hiring and contracting practices due to procurement rules

Independent Public Entity	<ul style="list-style-type: none"> • Possible exemption from State personnel and procurement laws • More independence from existing State agencies 	<ul style="list-style-type: none"> • Difficult coordinating with key State agencies (i.e. state Medicaid, insurance department, etc.) • Expenses to establish new entity • Confusion over responsibilities
Non-Profit Entity	<ul style="list-style-type: none"> • Flexibility in decision-making • Less likely for decisions to be politicized. 	<ul style="list-style-type: none"> • Isolation from State policymakers and key State agency staff • Potential for decreased accountability • Potential for regulatory duplication, conflict and confusion. • Expenses to establish new entity

Having weighed these options, states set off on different trajectories in terms of the structures of their exchanges. Hawaii and Idaho opted to set-up their exchanges as non-profits. This decision has given the implementers a relaxed reign for making decisions. In Hawaii, however, some opponents of the non-profit structure have stated that its exemption from the state’s open meetings law has been detrimental to the transparency and accountability of the exchange (McCambridge, 2012). Kentucky, New York, Rhode Island, Utah and Vermont have exchanges running within state agencies. In New York, the Exchange is within the Department of Health and has authority to work in conjunction with the Department of Financial Services to carry out its responsibilities (Kaiser Family Foundation New York State Marketplace Profile, 2013).

Connecticut was one of twelve states that created a quasi-governmental organization for its exchange: the Office of Health Reform & Innovation. Lieutenant Governor Nancy Wyman headed the statewide approach to federal health reform, and she directed the Sustinet Health

Care Cabinet to advise the Governor and the Office on issues related to the ACA implementation (NCSL, 2013). She said of the appointed 14 members of the Board, “We have assembled a wide variety of experts who I am confident will achieve the goals of the Exchange - expanding access to affordable, high quality health care coverage while reducing costs.” She explained that as a quasi-public, the exchange would ensure transparency and accountability while still being nimble enough to move swiftly like a private-sector company (Stewartson, 2011).

After the first board meeting was delayed in the aftermath of Hurricane Irene, the Cabinet first met on September 12, 2011 to discuss the role of the office (Connecticut Health Reform Central, 2011). They established that in order to provide a meaningful and proactive statewide approach to federal health reform, they needed to establish partnerships, facilitate action plans, and provide expertise, while respecting the sovereignty of other agencies and partners. Each cabinet member was assigned a work group in the first meeting – everything from health technology to business plan development. Connecticut had chosen a structure and officially started implementation efforts.

Board Composition

States also had to determine who they wanted to be a part of their exchange’s Board – in other words, who would be best to govern this new body?

The composition of the board is imperative, as these individuals will be determining policy, voting on the issues, and driving the force of implementation. Among advocates of health reform, board diversity is seen as essential to achieving good governance and efficiency (Jost, 2010, 7). A variety of interests, fields of expertise, and political perspectives are

beneficial. This could mean representatives of other state agencies that the board interacts with (insurance division, Medicaid agency, etc.); consumers, especially representatives from lower-income and minority communities; and small businesses.

Although insurers, producers, and providers should be represented, this should be achieved by avoiding specific conflicts of interest. Health insurers, brokers who sell health insurance products, and health care providers should be barred from receiving unfair advantages over competitors or swaying policy decisions to aid their own side concerns (NAIC, 2011, 5). Avoidance could mean enacting legislation or provisions that would, for instance, prohibit exchange board members from currently working at or moving directly to or from the insurance industry (4). This is a delicate balance to achieve; the board must get the politics right and remain fair, but also ensure that the exchange succeeds and that they are capable of understanding every aspect of necessary implementation action. Generally, the goal should be a group of people who can work together to run an exchange, be impartial, and remain committed to efficient and professional management.

State-run exchange boards range from five to nineteen members. In Maryland, legislation defines that a seven-member board will govern their Exchange. The Governor appoints six of those members with the advice and consent of the Senate and House of Representatives. The last member is ex officio, the Commissioner of Human Services. There are also rules dictating what groups must be represented on the Board, and limitations on affiliations of members (Kaiser Family Foundation Connecticut Marketplace Profile, 2013).

The Connecticut board consists of fourteen individuals, including six ex-officio members, or members that are part of the Board due to their position in another office (such as Benjamin Barnes from the Office of Policy and Management). On the board are many experts – such as

Dr. Robert Scalettar in health care delivery systems, and Dr. Robert Tessier, in health care benefits plan administration (Wyman, 2011). There are two non-voting members, and eight of the twelve voting members are appointed by elected officials. Table two presents the current members of the Exchange Board.

Table 2: The Board of Directors of Connecticut’s Health Insurance Exchange as of March 2013

Name	Position	Type
Nancy Wyman – Chair	Lieutenant Governor	Governor's Appointee
Mary Fox	Retired Senior VP of Aetna Product Group	Governor's Appointee
Paul Philpott	Principal Consultant, Quo Vadis Advisors LLC	Legislative Leadership Appointee
Grant A. Ritter	Senior Scientist, Schneider Institutes for Health Policy	Legislative Leadership Appointee
Robert E. Scalettar	Former Chief Medical Officer, Anthem Blue Cross Blue Shield	Legislative Leadership Appointee
Robert F. Tessier	Executive Director, CT Coalition of Taft-Hartley Health Funds	Legislative Leadership Appointee
Cecilia J. Woods	Former Vice-Chair, Permanent Commission on the Status of Women	Legislative Leadership Appointee
Maura Carley	President and CEO, Healthcare Navigation, LLC	Legislative Leadership Appointee
Roderick L. Bremby	Commissioner, Department of Social Services	Ex-Officio Member (Voting)
Vicki Veltri - Co-Chair	State Healthcare Advocate, Office of the Healthcare Advocate	Ex-Officio Member (Voting)

Benjamin Barnes	Secretary, Office of Policy & Management	Ex-Officio Member (Voting)
Anne Melissa Dowling	Deputy Commissioner, Connecticut Insurance Department	Ex-Officio Member (Non-Voting)
Jewel Mullen	Commissioner, Department of Public Health	Ex-Officio Member (Non-Voting)
Patricia Rehmer, MSN	Commissioner, Department of Mental Health and Addiction Services	Ex-Officio Member (Non-Voting)

Source: Connecticut Health Reform Central 2013

Connecticut decided that Board members cannot have affiliations with insurers, insurance producer or brokers, or associations of health care providers, health care facilities or clinics, or related trades for these entities while serving on the Board. Board Members are also prohibited from working for a health care carrier that offers a plan through the Exchange for a year after serving on the Board (Kaiser Family Foundation Connecticut Marketplace Profile, 2013). Despite these provisions, the Board has a substantial representation of members with ties to the insurance industry.

Some consumer groups are concerned about the absence of representation for underinsured or uninsured consumers in Connecticut's Exchange. In fact, Small Businesses for a Healthy Connecticut pushed for the removal of retired health insurance executives from the Board and pushed for more representation of consumers and small businesses. Small Businesses for a Healthy Connecticut sent a letter to Secretary Sebelius asking for her help "in addressing the problematic composition of Connecticut's Health Insurance Exchange Board which has over-representation by insurance industry interests and under-representation by individual and small business consumers" (Bordonaro, 2012). Consumer advocates particularly took issue with the appointment of insurance executive Mary Fox (former senior VP for Aetna Product Group).

Others, however, disagree and insist the appointments were given to people with real expertise and “demonstrated concern about and sensitivity to consumer issues and to the needs and desires of purchasers” (Bordonaro, 2012). Nevertheless, barring any immediate changes to the make-up of the board, the group that will have the most influence over how Connecticut’s Exchange will operate is in place.

Regulatory Authority of the Marketplace

Once the board is in place, it must make crucial regulatory decisions about the functioning of the state health marketplace. The Board has final say on all decisions – everything from choosing to put a limit on the health plans allowed to be sold through the exchange, to whether to merge the individual and small employer health insurance markets. Each state designing its own exchange made its own choices regarding aspects of regulatory authority of the marketplaces. Two important regulatory considerations when working with health insurance are **adverse selection** and the design of **certified qualified health plans**.

I. Adverse Selection

State exchanges have to face the threat of adverse selection. This phenomenon is when individuals purchasing insurance through an exchange are categorically unhealthier and incur high health care costs (Jost, 2010, 3). For example, in Connecticut, the Exchange creates a market for health insurance and allows people to sign up for certain health insurance plans. However, there is still the option of purchasing an insurance plan through a company that is not sold on an exchange. These two groups of people signing up for insurance are called “pools.” Adverse selection is a potential problem because the pool of people purchasing insurance

through an exchange can essentially become a “high-risk” pool that becomes destructive to insurers (SOURCE 3). This natural selection is destructive because if many new customers buying through an exchange have high medical bills (“high-risk”), insurers then have to drive up costs to unaffordable levels for all individuals and employers. This would alienate the pool within the exchange and result in a flood out – everyone looking only to purchase outside the exchange because of the great cost difference. Fortunately, the ACA does provide some mechanisms to discourage this phenomenon. First, the individual mandate ensures a larger pool of individuals, including healthy individuals who otherwise may have stayed out of the insurance market. Additionally, certain regulations on insurance plans offered through the exchange can make them more attractive to consumers. “Essential health benefits” also exist within and outside of the exchanges – such as keeping patient out-of-pocket expenses for medical care the same for plans purchased within or outside the exchange (NCSL, 2013).

For states, the ACA does not have any provisions in place that prevent them from actively trying to discourage adverse selection (Jost, 2010, 4). Indeed, unlike the federal government, states possess unique authority to prohibit the sale of insurance to individuals and small groups outside the exchange. This measure, however, would be considered an extreme action to eliminate the outside market and avoid adverse selection. An alternative to this would be to require plans outside the exchange to comply with regulations imposed within the exchange (Jost, 2010, 8).

Adverse selection *within* the exchanges is also a significant risk. If there is a pattern of preference for high-risk enrollees to pick a particular insurer within the Exchange, that insurance company is being adversely selected and will likely not continue offering plans through the Exchange. An option for states to avoid this challenge is to develop a risk-adjustment program.

These programs move funds from health plans and insurers with lower-actuarial-risk enrollees to plans and insurers with higher-actuarial-risk enrollees (6). But systems like this require actively collecting data and the ability to be flexible and responsive to changes within the market. State exchanges must be sure they have the capacity to take on this task.

California's Exchange law requires that all plans offered outside the Exchange market must be offered in the Exchange as well (Cantor, 2012, 11). Connecticut has historically had a very concentrated, uncompetitive health insurance market. Furthermore, these companies have enjoyed a low level of regulation by the Connecticut Insurance Department (Andrews, 2014). This trend continued with the implementation of the ACA. The healthy relationship with insurance companies that chose not to sell plans through the Exchange was maintained – they were not prohibited from selling insurance to force consumers to look to the exchange. Instead, the Board chose to rely on the individual mandate, expecting that the large influx of newly insured will have a balanced risk pool.

II. Certified Qualified Health Plans

Design and Cost

Linked to adverse selection is the states' power to control their standards of price and value within their exchanges. Though there are general federal regulations for what needs to be included in insurance plans and how much it can cost, states still have a significant amount of leeway to design these plans. For example, states can approve any and all plans that meet the ACA's minimum requirements, or they can set high certification standards that weed out some carriers' plans. The ACA does require that all plans within the exchanges be divided into tiers in order to structure choice and help consumers sort through price and value. But a silver tiered

plan from Aetna may not be the same as a silver tiered plan from Blue Cross Blue Shield. In New York, for example, any insurer may participate in the Exchange as long as it offers a plan on these federally required “metal levels” (typically designated Bronze, Silver, and Gold plan types). Exchanges can encourage or require insurers to offer just a limited number of options to encourage competition based on price and value. Exchanges could limit the variability in benefit design beyond what the federal law requires to limit adverse selection and, if authorized, negotiate aggressively with health plans on price (The California Endowment, 2011, 41). Internet tools, quality ratings, and satisfaction surveys can help guide plan selection for consumers (Jost, 2010, 12). States could also implement a policy where plan designs are periodically reviewed and re-approved for participation in the exchanges.

In Connecticut, a committee within the Board helped design outlines of plans, including what specific services were needed in each of the plans. For example, consumer advocates argued heavily against having deductible payments apply to regular appointments. Deductibles are a set amount the individual pays usually before the insurance company starts paying. For example, the patient pays the first \$1,000 before the insurance company starts chipping in. The reason insurance companies like this is it drives down cost – people avoid unnecessary medical care especially while they are still under the \$1,000 amount. The fact that consumer advocates made sure this deductible did *not* apply for routine visits means that a newly insured individual will not have to pay the full expense of their first doctor visit – that is exempt from the deductible. However, insurance companies are still covered in the event of a very expensive emergency room bill – the customer pays the full deductible there. These plans were then sent to insurance companies so they could sort out the specifics and pricing. The Connecticut Insurance

Department (CID) reviews and approves changes in these plans by carriers (Kaiser Family Foundation Connecticut Marketplace Profile, 2013).

Negotiation with Insurance Companies

States have the option of having insurers submit bids to participate, or a general negotiating strategy with insurers (Jost, 2010, 20). States can act as an active purchaser, essentially managing the competition and negotiating product offerings with insurers. This would entail a back-and-forth between the Board and insurers – almost bartering to find a compromised system of pricing that works for affordability to consumers and profit to insurers. Alternatively, the exchanges can be open marketplaces, or clearinghouses where all qualified insurers are welcome to join. This model relies more on market forces to generate product offerings (NCSL, 2014). States must consider the size of the exchange, the number of insurers, and bargaining power when weighing these options.

California's Exchange, for instance, acts as an active purchaser, selectively contracting health coverage. Bids from insurers were evaluated based on their goals of affordability, competition, alignment of delivery systems, and long-term partnerships (Kaiser Family Foundation New York Marketplace Profile, 2013). Unlike California, Connecticut has operated as a clearinghouse, accepting plans from all qualified insurance companies. No negotiating with insurance companies took place. The plan skeleton designs went to carriers, and the carriers filled in the details themselves. However, legislation has been passed that acknowledges that for 2015 and later the Exchange can opt to utilize a competitive bidding process and develop selective contracting criteria (CT Health Plan Benefits & Qualifications Advisory Committee Memo, 2012, 2).

Concluding Remarks

This chapter discussed the paramount decisions states had to make while implementing the exchanges of the ACA. If the coverage reforms are to serve their true purpose, the exchanges are paramount to success. If the exchanges function as planned, they will expand coverage, improve the quality of health insurance coverage and, eventually, reduce costs in the health care sector. Determinants that seem small, such as the make-up of the board, or how they interact with insurance companies, will make a difference in each state-designed exchange. The long-term effects of these decisions obviously have not reached fruition; however, it is possible at this stage to look at a particular state and determine its initial successes and struggles with implementation and tie these outcomes to specific decisions made by legislators and policymakers that formed its pathway. Next, we turn to Connecticut to do just this.

A Close-Up on Connecticut's Access Health CT

“Connecticut is well-recognized as a national leader in effectively implementing the Affordable Care Act, exceeding enrollment targets set by the nonpartisan Congressional Budget office by 136 percent and exceeding our own goals by 98 percent. This is success by any definition.”

– Connecticut Lieutenant Governor Nancy Wyman

In the media, Connecticut has been referred to as a national leader in implementing the Affordable Care Act. Connecticut's enrollment numbers validate that the state has reached a large portion of the uninsured. In February of 2014, Connecticut was at 238% of its enrollment target for the first four months. This put the state way ahead of all others. As of April 1, 2014, Access Health CT has enrolled 208,301 residents in plans with private insurance carriers and government-funded Medicaid (Access Health CT, 2014). The state has received praise from many high-ranking federal officials. Other states are even approaching Connecticut to use its proposed “exchange in a box,” which includes the technology and workflow processes that have been significant in its success (Hickins, 2014). This chapter will rewind and establish why Connecticut's implementation has been portrayed as such a triumph. This will include an overview of relevant Connecticut health reform history, reexamining structural decisions, and analyzing enrollment data. Apart from a few glitches, Access Health CT is well deserving of the praise it has received for its implementation so far. This chapter will outline factors that set Connecticut apart from other states' efforts and enabled success, like its established infrastructure for health policy. Interviews with seven key players in Access Health CT's implementation also indicate a number of areas that could use improvement. These issues will be explained, along with the potential impact they could have on Access Health CT's future.

A Step Ahead: Past Health Reform Efforts Helped Set Connecticut Up For Success

Similar to Massachusetts, Connecticut advocates and legislators had been hard at work to tackle the challenge of health care reform long before national legislation was passed. The present success of Access Health CT can be attributed in part to the efforts of advocates and public officials that had been working together on previous reform efforts. This experience working on health reform and collaborating with one another created an infrastructure within the health reform community, and these relationships were used to build an exchange structure that would work.

Organizations and advocacy groups in Connecticut have fought for changes to the system for decades. Before the ACA, state legislators in Connecticut had passed numerous health reform bills, which helped establish solid foundations for the ACA. For example, Connecticut had established solid Medicaid and Children’s Health Insurance Program (CHIP) programs called HUSKY. Membership in HUSKY is broken down into four categories, as Table 3 displays. This structured system of Medicaid that was already in place made the expansion offered by the ACA much easier to implement.

Table 3. Connecticut Children’s Health Insurance HUSKY Client Categories

HUSKY Type	Individuals Covered
HUSKY A	Children, parents, and pregnant women
HUSKY B	Children whose parents earn too much to qualify for Medicaid
HUSKY C	Disabled adults, low-income seniors, individuals receiving long-term care
HUSKY D	Covers adults who do not have minor children (this began in 2010 when Connecticut became first state in country to expand Medicaid under the ACA)

Source: CT Mirror 2013

In addition to a solid existing Medicaid structure, Connecticut also had other health reform proposals passed with help from organizations such as the Universal Health Care Foundation of Connecticut. In collaboration with many groups across the state, the Foundation built relationships with medical societies, hospitals, businesses, and labor groups to create a proposal that would help provide affordable health coverage to 98% of Connecticut residents (SustiNet Health Partnership, 2014). Public Act No. 09-148, An Act Concerning the Establishment of the SustiNet Plan, was passed in 2009 and planned to have enrollment start in July of 2012. While the reform was not a model for the ACA as Massachusetts's reform was, it still had a number of important similarities that aided Connecticut in getting a head start on implementation. SustiNet looked to provide statewide health care plans for Connecticut residents regardless of employment status, age, or pre-existing conditions (SustiNet Health Partnership, 2014).

When the ACA was passed in March of 2010, the SustiNet Board was just getting underway. Since many of the functionalities of SustiNet overlapped with those of the ACA, efforts were shifted to Access Health CT. The SustiNet Board was asked to report to the General Assembly in May of 2010 and advise how to implement the federal law in Connecticut. SustiNet board Co-Chair Kevin Lembo said of the report, it “plots a course for our future conversations and acknowledges the federal interaction in a solid way” (Stuart, 2014). The SustiNet Board of Directors issued several reports to the Governor and General Assembly with a series of recommendations for the ACA's implementation. SustiNet's structure and guidance were imperative to gathering the right experts and advisers to help structure Access Health CT. Legislators, advocates, and experts already had experience coming together on advisory committees and knew how the processes of meetings went (SustiNet Health Partnership, 2011).

The path to fight political battles to get health reform legislation through had been slightly worn and the communication channels opened.¹ In addition to having a solid foundation of knowledgeable people within the state, Access Health CT also brought in new individuals with valuable experience. For example, Access Health CT CEO Kevin Counihan served as the chief marketing officer for the Massachusetts Health Insurance Connector Authority – which helped Massachusetts in its health reform in 2006.

Set For Success: CT Has Earned Its Label as an ACA Implementation Leader

With solid experience of activism in health reform, Connecticut’s decision to establish its own state-run exchange was the clear choice. In comparison with other states, Connecticut was relatively successful in getting its exchange off the ground in part because of this head start. The trials of the national healthcare.gov demonstrate the clear challenges of implementing an exchange. When the ACA passed, DHHS did not think they would be running twenty-seven exchanges and partnering to design seven. The burden of serving so many states with the federal program meant a much more massive job than they anticipated, which resulted in catastrophe when the healthcare.gov website was finally online for open enrollment. Chad Brooker, the Director of Exchange Policy and Legal Advisor at Access Health CT, said, “Designing an exchange for one state alone is a daunting task. I cannot fathom how the Department of Health and Human Services is trying to organize designs and data processes with twenty-seven times the amount of work we’re doing.” While the federal government and other states found themselves on their heels in terms of implementing exchanges, Connecticut’s recent history of health care reform and collaboration meant that the political will and capacity were in place for effective

¹ As of September 2011, Connecticut Lieutenant Governor Nancy Wyman confirmed that Sustinet no longer effectively exists as an active policy-making body, but rather as an information source to inform the decisions of the Health Care Cabinet within the state (McQuaid, 2011).

implementation. Connecticut's jump on designing Access Health CT so quickly after the law was passed made getting everything done within the short timelines given much easier. They embraced the program, engaged their communities, and could focus on actively advertising for the change (Scotti, 2013).

Connecticut's political support also allowed it to be the first state to accept the ACA's expansion of Medicaid. Many states, particularly those with Republican-run politics, rejected the expansion as a snub to the ACA in general. In these states, a large portion of the population, those in the lowest-income bracket, were left without Medicaid as an option for health insurance. Connecticut's decision will allow a wider bracket of individuals to qualify for HUSKY, while relieving state taxpayers of the cost of the expansion. Consumer advocates and Access Health CT Board member Victoria Veltri have been vocal about the benefits this decision has had for Connecticut: "It's been a great change for coverage," said Veltri. "We have a lot of people at very low incomes in Connecticut. This has almost doubled the number of people inside the program. Luckily – and I say this almost every day – we live in Connecticut, and we understand the importance of covering our low-income population" (Campbell, 2012).

Some states, like Texas, do not even have a Board to help the federal government set up their exchange. In contrast, Connecticut has an active Board of Directors with subcommittees and advisory committees that meet at least bi-monthly. Advisory committees include consumer experience and outreach, health plan benefits and qualifications, brokers, agents, and navigators, and the small business health options programs "SHOP." The quasi-governmental structure of Access Health CT has allowed it to be efficient in decision-making.

The structure and organized nature of the Board also allowed it to be a strong leader within the ACA implementation community on a national scale. Activists from Connecticut,

such as small business advocate Kevin Galvin, have been resources for federal policymakers since before the ACA was even passed. Galvin even participated at the Small Business Financing Forum, a group called together by President Barack Obama to sketch out ideas and strategies for health reform (Galvin, 2014). The importance of this is that many Connecticut implementers were at the center of reforms from the beginning. They understood the changes, and were innovators at the front of taking action to make the program work.

Their collective role as key actors from the outset also allowed Connecticut to be resilient in fighting for implementation flexibility from the federal government. Peter Van Loon, Chief Operating Operator of Access Health CT, believes that Connecticut's ability to exercise a certain level of "creative disobedience" was imperative to the success that it has had (Van Loon, 2014). This "creative disobedience" included not following some orders from the federal government. For example, drawing on the rich experience of its principals, Access Health CT realized early on that it was not feasible for them to accommodate all of the Connecticut Medicare and Medicaid Services' regulations for the first few years of ACA implementation. They decided to scale back the functionality of Access Health CT by twenty percent, and focus more effort on the most important aspects of coverage for customers. "We wanted to build a Mercedes," CEO Kevin Counihan said. "But we've scaled back to a Ford Focus. And that has worked" (Pandey, 2014). Van Loon agrees, stressing that trying to cover all the directives from CMS would have been disastrous, and that scaling back even more could ensure fuller, guaranteed functionality.

Outreach and Awareness: Navigator and Assistors in Connecticut

"The government is going to make you – mandate – that you buy insurance from an insurance company or you pay a tax... That's five swear words in one sentence."

-Ellen Andrews, Executive Director of Connecticut Health Policy Project

Experience with health care reform also allowed Connecticut policymakers to strategize an effective outreach plan based upon what had worked or not worked in the past. In 2012, Access Health CT started to gather input to help design and market the Exchange to its customers. Many advocates were wary due to Connecticut's mixed record with similar efforts. In the early years of HUSKY, a lot of money was spent for outreach and awareness. However it was not effective in attracting new applications or getting families covered (Connecticut Health Policy Project, 2012). The CT Health Policy Project conducted focus groups with parents of uninsured children that the program was trying to reach, and found that a big factor in parents signing up for coverage was doing so through people that they trust, in formats they are used to. Moreover, it was necessary that they hear the message several times. Recommended channels were community organizations, schools, churches, and other trusted institutions.

Access Health CT listened. The current Navigator and Assistor Outreach Program is the result of a unique partnership between Access Health CT and Connecticut's Office of the Healthcare Advocate (OHA), and has proven to play a key role in the Exchange's community outreach efforts (Eastern AHEC, Inc., 2014). Navigators and in-person assistors are organizations and individuals who are in charge of helping to educate people about the new system, understand their choices, and facilitate selection of a health insurance plan (Dash et al., 2013, 7). Six organizations have been tapped in Connecticut as Navigator organizations, and the state trained over 300 individuals to be Assisters. Training was thirty-four hours for assistors and forty for navigators, and included passing a certification exam (Kaiser Family Foundation Connecticut Marketplace Profile, 2013).

These people were the frontline workers, interacting with residents to make sure they understand what the ACA can offer them, and ensuring they can make informed decisions

regarding their health insurance coverage. Counihan said of the outreach program, “It’s a new law and we have an obligation to explain it. A lot of things that have inhibited people from buying insurance or that have made it too expensive will go away on January first. People need to know about these benefits” (Gallo, 2014). Access Health CT was also the only state exchange to open stores where residents of Connecticut could walk in and talk to trained individuals about enrollment options. The stores were opened in cities with high concentrations of uninsured people, such as New Britain and New Haven. They were inspired by Apple, Inc.’s famous storefronts, with employees greeting people at the door and knowledgeable staff to explain the process of signing up for health insurance. The effects of these stores were noteworthy; they signed up, on average, 300 to 400 people per day (Gallo, 2014).

Looking to the Future: Problems that Could Threaten CT’s Success

The *Hartford Business Journal* sums up Access Health CT’s position accurately in one of its recent headlines: “Exchange leaders deserve praise, but plenty of work remains” (Hartford Business Journal Editorial, 2014). Comparably high enrollment numbers, impeccable project management, and working technology were made possible by an infrastructure in the state that offered insight into what they needed to accomplish. That is the good news. As implementation continues in the days and months ahead, however, there are many unanswered questions and future problems to solve.

Reaching the Remaining Uninsured

As a practical matter, if an uninsured individual was not reached through the first round of outreach and open enrollment, new strategies must be employed to engage them. Access

Health CT enrollment currently stands at 208,301 enrollees (Access Health CT, 2014). It is unclear how many of the individuals signing up for coverage through the Exchange were uninsured and how many switched from other insurance plans. However, uninsured totals for Connecticut were approximately 344,582 in 2012 (CT Uninsured Profile Summary, 2012). Thus, it is clear that there is a remaining group of individuals that have not signed up for coverage.

Going forward, it is possible that Access Health CT will suffer the same problem that Massachusetts did during its reform; namely, reaching that last group of uninsured that was not brought into the system in round one. To address this challenge, the exchange should engage as many stakeholders as possible, hold meetings and forums to share best practices and spread innovative ideas, and target the message of signing up for insurance at crucial transitions when people think of insurance, such as marriage, birth of a child, illness or death in the family (Connecticut Health Policy Project, 2012).

As was the case in Massachusetts, reaching the Hispanic population in Connecticut has proven to be challenging. Barriers this community faces include language, culture, financial limitations, lack of access to the Internet, and fears of giving the federal government information in the belief it could be used to deport family members (Radelat, 2014). The fact that immigrants who lack permanent legal status are not allowed under the ACA to enroll through any state insurance exchange contributes to confusion over eligibility. However, as Elena Rios, president of the National Hispanic Health Foundation, points out, the problems Hispanics are facing with ACA enrollment are nothing new. Most public programs face the same dilemma.

A similar approach to the one Massachusetts took will be necessary in Connecticut. In order to pursue this strategy, Connecticut must identify which organizations and people are

“trusted messengers” for hard-to-reach communities. An open back-and-forth between organizations relating to constituents and policymakers, and a simple enrollment process will help sign up more of the Hispanic population (Connecticut Health Policy Project, 2012). Additionally, more work must be done on the Spanish-language Access Health CT website, which launched in late February 2014 (almost five months after the English-language site went up on October 1, 2013). Several Assistors in Connecticut have claimed that the website is difficult to read, and they end up translating and interpreting the English-language website when trying to help Latinos enroll (Radelat, 2014).

Potential Provider Shortages

Now that Access Health CT has signed up thousands of residents who have lacked coverage, these people will be searching for primary care physicians. The Connecticut State Medical Society is warning of a major shortage of physicians in the state that could lead to a lack of access to doctors for the newly insured (Bordonaro, 2012). Dr. Douglas Gerard, an internist in New Hartford, sees it as a simple supply and demand imbalance, “They are increasing the demand side of patients, but didn’t increase the supply side of physicians.” As was the case in Massachusetts, the fear for policymakers is that newly insured individuals will become frustrated with an inability to find a provider. This frustration is dangerous because it has the potential to expand to a “is coverage worth it for me” mentality.

Inaccuracy of carrier provider networks has the potential to compound this problem. New enrollees receive a list from the insurance company that that includes all providers included in the “covered network.” When they begin to call providers, however, they may be unable to schedule an actual appointment. DSS commissioned a secret shopper survey of health plan

networks in 2006 to verify Medicaid provider panels. People posing as HUSKY members called the providers listed and were only able to secure needed appointments with one in four providers listed in the plan directories (Andrews, 2013, slide twelve). This would be disastrous if the same happened to people signing up for coverage through Access Health CT.

One suggested solution has been to allow nurse practitioners to treat patients and prescribe medications independent of licensed physicians. A current proposal to the Connecticut legislature by the Malloy administration would require APRNs to work with a physician for the first three years after becoming licensed, but then would allow them to practice alone (Levin Becker, 2014). Some argue that legislators should not reduce the training and education needed to provide medical care. They worry that there has not been enough discussion about patient safety issues. Supporters of the bill claim that APRNs in Connecticut are required to have a graduate degree in nursing or a related field and certification from a national organization. They claim nurse practitioners could be a solution to the potential problem of provider shortages in the state.

Cost Containment

In addition to reaching the remaining uninsured and addressing provider shortages, cost is still the elephant in the room for the implementation of health insurance exchanges. The United States spends more of its gross domestic product (GDP) on health care than any other developed democracy. In 2008, the United States spent more than \$7,500 per capita on health care, which was more than double what Germany spent and almost three times what New Zealand spent (Orentlicher, 2011, 66). Just like Massachusetts's health reform, the ACA focuses on expanding access to coverage initially, and then defers cost containment to the following step. As a state

with the fourth highest premiums for health insurance, cost is a looming problem that Connecticut will face for a long time. First, there is the problem of health care service and goods costs rising each year. On top of this, there is the fear that the new pool of insured residents through Access Health CT will be adversely selected. If the newly insured are older and sicker and incur most health care costs, it is not worth it for insurance companies because they are not making as much money. Therefore, the response from insurance companies is to drive up prices for everyone, both sick and healthy, to make sure their profit margin is where they want it to be. This increase, combined with the natural increase in health care services and goods, make the “affordable” part of the ACA seem less and less attainable.

With respect to adverse selection within the pool of consumers buying through Access Health CT, information regarding the health status of individuals new to coverage will not be available for months. Claims from those who started coverage in January of 2014 will not even be available from carriers until May due to the lengthiness of the process. As such, risk-pool assessments will not be available until a full year of coverage has been reviewed. Only then will we know whether some degree of adverse selection has resulted in insurance companies needing to raise costs moving forward.

Adverse selection will be an ongoing assessment for Access Health CT and exchanges nationwide. With the enrollment period for many exchanges ending on March 31, 2014, the numbers are only just coming out about the age of individuals signing up through exchanges. The breakdown of numbers from the federal government is still not available. As discussed, the fear with adverse selection is a “death spiral.” This would be a possibility if the enrollment of individuals were skewed to older individuals with higher health costs, driving up costs from insurance companies and making it unaffordable for many individuals (Universal Health CT,

2014). Table 4 demonstrates that the age distribution of members signing up for insurance includes a large portion of enrollees, 30%, under the age of 35. While being younger does not automatically equate to being healthier, the aggregate group of younger individuals are likely to balance out the older and typically sicker people signing up for coverage.

Table 4. Connecticut’s Exchange Enrollment Data for October 1, 2013 – March 31, 2014

Total Enrolled CT Residents	208,301
Record in CT set on last day:	5,917 people signed up in one day
Enrolled with private insurance carriers	78,713
Enrolled in Medicaid:	129,588
Age Breakdown as of 3/27/2014	55 and older: 33% 45-54: 24% Under 35: 30%

Source: Access Health CT Website

According to data from Access Health CT, the median age of individuals signing up through the exchange is in the mid to upper 30s. More specific data will be released once the last-minute enrollees have been tabulated; however, the data in Table 4 is promising in that the age breakdown is not significantly skewed on the higher end. Additionally, a report issued by the Kaiser Family Foundation (2014) suggests that fears about a “death spiral” should not be as prominent as they are. Their study suggests that premiums are not as sensitive to the mix of enrolled individuals as some people think, particularly with respect to age (Levitt, Glaxon & Damico 2013).

Even if adverse selection is avoided, however, cost and affordability for consumers will continue to be a struggle for Access Health CT. Two important suggestions for keeping costs

down in Connecticut are stricter qualified health plans (QHPs) and active purchasing with insurance companies. QHPs are plans that are approved for sale in state exchanges. Federal guidelines have set criteria for QHPs to participate in an exchange, but states can decide to put in place additional requirements. Alta Lash, Executive Director of United Connecticut Action for Neighborhoods (UCAN), was on the eight-person Standard Plan Design Committee for Access Health CT. The committee spent twenty-nine hours drafting plan designs as to what to include in each tier of plans: bronze, silver, and gold. Lash, a consumer advocate, emphasized the importance of getting only big health care costs – i.e. expensive emergency visits, surgeries – to count towards a purchaser’s deductible (Lash, 2014). Additional victories for consumers included ensuring complete coverage for preventative care, and flat fees for co-payments so individuals know going into an appointment what they are expected to contribute for a particular service. The plan designs went through a drafting period that included public comment and editing states. Overall the plan designs themselves have not had too many objections. The real issue that has been raised is how these skeleton designs are passed along to insurance carriers who are then able to assign their own prices.

Access Health CT made the decision to not negotiate plan pricing with insurance companies. The QHPs were sent out to participating carriers, who assigned prices and wrote up the details of the bronze, silver, and gold plans they would offer through Access Health CT. The language of the legislation passed for the Exchange does empower the Board to exercise active purchasing: “the exchange is authorized and empowered to [...] limit the number of plans offered, and use selective criteria in determining which plans to offer, through the exchange, provided individuals and employers have an adequate number and selection of choices” (SB921,

Connecticut's 2011 Health Insurance Exchange Act, 2011). There are two conflicting arguments made by interest groups in Connecticut regarding active purchasing.

Consumer advocates insist that Access Health CT must negotiate on behalf of consumers. To be clear, negotiation can take many forms, but the premise is that Access Health CT should have a back-and-forth with insurance companies, bargaining with proposed costs from other competitors, and have the power to say "that's not good enough" if necessary. Proponents of active purchasing compare Access Health CT to a large employer. Ninety percent of large employers negotiate with insurers on behalf of their employees to maximize both value and affordability (Andrews, 2012). Since Connecticut's goal is between 250,000 and 300,000 state residents, the idea is that the state can use this pool of potential consumers almost as if they were a group of employees at a businesses shopping for health insurance. Consumers cite the decision made by California's exchange to exercise active purchasing, and also use Massachusetts's experience as well. In 2007, the MA Connector was not satisfied with premium bids offered by carriers, so the Governor asked insurers to go back and "sharpen their pencils." Advocates also stress that Connecticut has been a leader in this reform, and although historically insurance company interests have been kneeled to, now is the time for Access Health CT to step up. They emphasize that federal regulations are meant to be a floor, not a ceiling for state exchange standards (Andrews, 2012).

Others involved in implementation see active purchasing as unnecessary, and potentially even detrimental to Connecticut's marketplace. Although no formal comment or discussion has been made of Access Health CT's decision to not negotiate with insurance companies, Chad Brooker, a policy analyst at Access Health CT, has said that active purchasing will not have the effect that consumer advocates believe it will. The bargaining power of Access Health CT with

insurance companies is not great, even with a large pool of potential consumers, because so little is known about the health and needs of that group. Many insurance companies already are not participating on the Exchange yet, partially due to how little is known about the risks that these businesses are taking. Because of this, Brooker emphasizes that negotiation would go a lot differently in reality than many advocates dream (Brooker, 2014). Furthermore, Brooker points to the naturally competitive nature of Access Health CT for insurance companies. If all insurance companies are bargained down to the same price, the natural competitive forces are driven out. Brooker pointed to Healthy CT, the non-profit carrier currently participating in Access Health CT, as an example of the benefits of natural competition. Healthy CT only has about 3% of signups in the state (Haigh, 2014). This abysmal number has been due to a number of challenges, including lack of brand recognition and plans that were priced too high to compete with other insurers. In response to this low sign-up percentage, Healthy CT will now be incentivized to lower prices during the next enrollment cycle, which Brooker confirmed the insurance company is already working on.

The battle of whether or not to active purchase could take a turn if a current bill in the legislature, An Act Concerning the Duties of the Connecticut Health Insurance Exchange, passes. This bill would direct Access Health CT to negotiate premiums with insurers on behalf of consumers. A similar bill died on the state House of Representatives calendar last year.

Concluding Remarks

This chapter makes clear that Connecticut has earned its name as a leader in the implementation of the ACA exchanges. The existing infrastructure for health reform allowed Connecticut to have a quick jump on the ACA immediately after the law was passed, and even

participate in recommendations to the federal government. This leadership role allowed them some flexibility in implementation, which officials took advantage of by scaling back some functionalities of Access Health CT for the first few years. These decisions streamlined Connecticut's focus and enabled implementers to do a comparatively smaller amount of work, better. This included better outreach, better technology, and more manpower to double-check and test-run.

While Connecticut has succeeded in comparison with other states, going forward, there are changes that have to be made. In Massachusetts, the "learning organization," the Connector, had to make a number of changes throughout the years of implementation to improve the process and overall health care sector. Connecticut faces some similar problems: in particular, reaching the remaining uninsured and cost containment. To ensure that success continues, adaptations will have to be made. Ideally, the strong infrastructure and political bandwidth that this state has developed will continue to improve Access Health CT until all residents of Connecticut have improved access to coverage and health care.

Concluding Remarks: Where Do We Go From Here?

"The hallmark of health reform has been the concept of shared responsibility, the sense of shared ownership of a common value that our nation benefits from more citizens realizing the peace of mind of health insurance coverage. We must have the patience to recognize the implementation of the ACA will take time to be fully realized." –Kevin Counihan, CEO of Access Health CT

When the ACA was passed in 2010, Connecticut was poised for success much like Massachusetts before its health reform in 2006. The state had a high uninsured rate at eight percent, with the potential to sign up a lot of residents for coverage. Connecticut also had political focus on the issue and a health reform infrastructure in place. The ACA was the big sweeping reform backed by federal start-up funds that could make a positive change in health care for Connecticut residents. The path this federal reform chose to take was modeled after Massachusetts's 2006 plan: get people quality, affordable health insurance first, then reduce the costs of health care for individuals and the government. The hope was to have the DHHS guide states through the process of building a health insurance exchange tailored to the demographics and needs of each state.

Connecticut's advantageous decision-making started with just that – designing its own exchange and committing to implementation. The state has excelled in maintaining political support, keeping focus on the issue, and selecting well when outsourcing for tasks such as technology and outreach programs. Access Health CT signed up over 200,000 people for health insurance in the first six-month enrollment period, or 30% of the eligible population in the state (Access Health CT, 2014). Other consistently successful states throughout implementation rollout are California and New York (John, 2014). Both of these states had health policy arenas established in their states, and political support. On the other hand, Maryland is a state that had political will for health reform and change, but struggled with technology and has floundered as

a result. Frozen computer screens, error codes, and web site crashes plagued most of Maryland's first enrollment period. Meredith Cohn, a reporter in Maryland, spent two days – including two calls to the exchange's call center and seven repeats of entering her personal information – buying insurance (Ornstein, 2014). This is an example of how all of the factors that came together in Connecticut were like a recipe – without one and every one, success would not have added up the way it did. While Maryland was projected to be a leader in ACA reform, the Exchange failed in transparency during implementation and did not have a structure in place that would encourage decisions-makers to assess problems and move to fix them. They did not have same recipe as Connecticut.

Connecticut has over 7,000 non-profit organizations, many of which are devoted to health-related concerns (Galvin, 2014). These organizations worked on past reform efforts – like HUSKY and Sustinet – and helped Connecticut step up their game with respect to health policies. Advocates, public engagers, leadership, experts – relationships between these groups had been already through the health reform process and were ready to operate in a way that led to successful ACA implementation. A key decision that arose from this infrastructure was the “creative disobedience” of Connecticut policymakers. Cutting back and pushing timelines out further than the federal government was asking was risky but necessary. Access Health CT's technology worked not only because the companies it contracted out to did their job, but also because the task we handed over to them was smaller and more manageable. This was the recipe – infrastructure, political support, and smart decisions – that allowed Connecticut to be commended for early implementation success.

While Connecticut should celebrate these early implementation victories, several potentially debilitating problems have arisen that threaten Connecticut's success. The experience

of Massachusetts warns us that cost containment, provider shortages, and difficulty reaching certain populations, are likely to persist as struggles for implementation efforts. Initial implementation efforts in Connecticut suggest the same will likely be true in our state. Consumer advocates still worry about the affordability of health insurance plans for consumers. Insurance companies are still assessing whether there is significant adverse selection within Access Health CT's participants, which could drive up insurance costs for all residents. All of this swirls around the steady increase in health care services and goods costs. Pair these increases with the high expectation of provider shortages in the state, and it seems surprising that policymakers in the state are still optimistic about the future of Access Health CT.

But there is a reason they are optimistic. Steps can be taken to combat these problems. Some have already been put into motion. Bills awaiting legislative action include one that requires Access Health CT to directly negotiate with health insurance companies over premium rates. Another measure proposes using a State Innovation Model (SIM) planning grant of \$2.8 million from the federal Centers for Medicare and Medicaid Services (CMS) to promote affordability, value, and eliminate inequities in health care. This plan was submitted and accepted by CMS at the end of 2013 and it encompasses a variety of changes to create a more sustainable health care system. Unlike the ACA, this reform focuses more on improving the provider and care side of public health, rather than insurance coverage and access. The plan includes measures such as requiring electronic health records, focus on preventative care, and arming consumers with the tools they need to make health decisions. The specifics of implementation are still in the works as of April 2014, but this ambitious vision for change looks promising (Universal Health Care Foundation of Connecticut, 2013). If successful, this could

help mitigate the cost concerns of Access Health CT's future insurance plans by keeping the prices of health care services and goods down.

An additional proposal from the Malloy administration would allow advanced practice registered nurses (APRNs) to work independently of doctors would change the medical landscape in Connecticut and expand access to primary care for citizens. The National Governors Association stated, "expanded utilization of [APRNs] has the potential to increase access to health care, particularly in historically underserved areas" (NGA, 2012). At the time of writing, this bill has passed the Senate and House of Representatives and is moving to Governor Malloy's desk, which he has publicly stated that he will sign. This is a positive indication that Connecticut policymakers are willing to adapt at least some changes needed to aid ACA's implementation.

The content of these proposed adjustments to exchange implementation are important; however, it is of equal importance that Connecticut will continue to benefit from the general willingness of Connecticut politicians and advocates to fight for something better. Throughout this thesis process, I have met individuals that would fight each other tooth and nail over health care reform decisions. But all were passionate and dedicated to their efforts to make change. In 2002, Gary Rose wrote that Connecticut politics has a reputation as the "land of steady habits" and "the Constitution State," due to its predictable and stable system of politics, as well as its long tradition of noble self-government. This predictability includes a stark party division in the legislature. Even so, Connecticut is a small state. Legislators, advocates, representatives of different industries and organizations know each other and many have worked together for decades. This existing infrastructure that helped Connecticut with its initial success in exchange implementation will be key for making key adaptations throughout the rest of Access Health

CT's implementation. Building on the existing reform infrastructure and the advocacy networks, Connecticut needs to be able to respond to implementation challenges as a "learning organization," in ways similar to the Massachusetts model. As long as we acknowledge when problems arise and utilize the infrastructure we have to solve that problem, we can make the best of the ACA work for our state and increase both the quality and affordability of health insurance for residents. Connecticut should continue to be a leader in ACA implementation, but must settle in for the long road ahead.

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