2024 Health Care Affordability State Policy Snapshot

CONNECTICUT

CURB EXCESS PRICES IN THE SYSTEM	**PREMIUM RATE REVIEW**	**HEALTH CARE SPENDING BENCHMARKS**	**HOSPITAL PRICE REGULATION**	**PUBLIC OPTION**
IMPROVE OVERSIGHT, ACCOUNTABILITY AND TRANSPARENCY	**HEALTH SPENDING OVERSIGHT ENTITIES**	**ALL-PAYER OR MULTI-PAYER CLAIMS DATABASE**	**PRICE TRANSPARENCY**	**MEDICAL DEBT COLLECTION REGULATIONS**
ADDRESS CONSOLIDATION AND PROMOTE COMPETITION	**CONSOLIDATION ASSESSMENT AND AUTHORIZATION**	**BALANCE BILL PROTECTIONS**	**FACILITY FEE LIMITS**	**ANTI-COMPETITIVE CONTRACT PROVISIONS**
MAKE OUT-OF-POCKET COSTS AFFORDABLE	**REDUCED COST-SHARING: PRESCRIPTION DRUGS**	**REDUCED COST-SHARING: HIGH VALUE SERVICES**	**MEDICAL DEBT PREVENTION**	**EXPANDED COVERAGE**

State Has Active Legislation

State Does Not Have Active Legislation

HEALTHCARE VALUE HUB

The Health Care Value Hub ("the Hub") is proud to launch the 2024 Health Care Affordability Policy Snapshot ("Affordability Snapshot") which replaces the annual Healthcare Affordability Scorecard ("Scorecard"). The Affordability Snapshot provides legislators, consumer advocates, regulators and other stakeholders a tool to compare their state's health policies across other states.

The categories examined in this resource explore a variety of policy options that have previously appeared in the Scorecard, as well additional policies that impact health care affordability. Policies were selected based on whether they have the potential to impact health care affordability or access to health care at the state level, whether a reputable source was available for review, and whether evidence was current within the past ten years.

Policies were examined for whether they were active, implemented to a limited degree, or not active as of July 1, 2024. Sources for this information can be found in the downloadable Data and Source Document available on the **Dashboard** page.

The Hub offers both online and hands-on support, with a staff dedicated to monitoring, translating, and disseminating evidence and connecting advocates, researchers, and policymakers to build communities and galvanize action around creating a patient-centered, high-value healthcare system. As a research-based organization, the Hub takes a comprehensive approach to improving affordability through policy analysis, translation, visualization, and collaborative engagement. We encourage advocates, legislators, and other stakeholders to share our findings to improve consumer health care affordability across the states.

Curb Excess Prices in the System

Premium Rate Review

States can control excessive health insurance premium increases through premium rate review, where state insurance regulators scrutinize proposed rate hikes for the upcoming year to ensure that the increases are based on accurate data and realistic projections of health care costs and utilization. The Affordable Care Act (ACA) set standards for these efforts, and states meeting these standards are recognized by the Centers for Medicare and Medicaid Services (CMS) as having an effective rate review process. States may also establish the authority to approve or deny rate increases and incorporate affordability criteria into their evaluations. This section examines whether a state has an effective rate review program, as defined by CMS, the power to approve or deny rate increases, and if affordability criteria are integrated into the rate review process.

Health Care Spending Benchmarks

Health spending benchmarks aim to limit annual health care spending growth by establishing a maximum limit, or "benchmark." Benchmarks may examine overall spending or spending for specific hospitals or insurers. If the benchmark is surpassed, the overseeing state entity will often collaborate with providers to curtail spending, and some states authorize the entity to mandate performance improvement plans or impose penalties. This section examines whether a state has established a benchmark, and if so, whether the state has statutory authority to enforce the benchmark.

Hospital Price Regulation

This section assesses state efforts to reduce hospital service costs through reference-based pricing, global budgets, or a comparable program that regulates hospital pricing. Unlike reference-based benefits, which set a maximum allowed benefit for specified drugs or services, reference-based pricing establishes set service costs based on a predetermined reference rate. As of publication, each state that has implemented this model has set reimbursement as a multiple of the Medicare reimbursement rate.

Similarly, global budgeting involves setting a fixed prospective payment for a specified range of services over a defined period, rather than being paid for each service. By establishing a limit on annual spending, this model shifts the financial responsibility to providers and payers and encourages managing service delivery within the set budget. Some states have established state-specific insurance models which mirror select aspects of these strategies, which are also highlighted under "alternative hospital price regulation strategies."

Public Option

A Public Option is a state-managed health insurance model designed to enhance competition and control costs through negotiated rates. States possess a degree of flexibility in designing these coverage options, resulting in variations in cost-containment measures and provisions related to network adequacy and reimbursement. This section highlights states that have an active Public Option and those with provider participation mandates to ensure consistent access to in-network providers.

Policy	Status as of July 1, 2024	Summary
Premium Rate Review	● Has an effective rate review process. ● Has the authority to modify or reject premium rate increases. ⊗ Does not incorporate affordability criteria into premium rate review.	Connecticut has the authority to approve or deny proposed premium rate increases in the individual and small group markets, with authority to hold public hearings to solicit stakeholder engagement in the process. For the large group market, the state has the authority to approve or deny for HMO's only.
Health Care Spending Benchmarks	● Has health care spending benchmark for providers and/or insurers. ● Has enforcement mechanism for healthcare spending benchmark.	Connecticut's Cost Growth Benchmark was set at 3.4% for 2021 and set at 2.9% from 2023-2025. The benchmark applies to health insurance companies and healthcare providers with a minimum of 5,000 attributed lives. OHS has recommended, but not yet implemented, phasing in performance improvement plans ("PIP") for entities that exceed the benchmark and allowing civil penalty if they neglect to file a PIP", as well as incorporating the Benchmark into the review of annual insurer rate filings. Notably, Connecticut's benchmarking uses the state's Healthcare Affordability Index to estimate the policy's impact on the number of Connecticut households that will have access to quality health care coverage and be able to meet their basic economic needs. The state also has a primary care spending target of 8.5% in 2024 increasing to 10% in 2025.
Hospital Price Regulation	⊗ Has not implemented hospital reference-based pricing or rate-setting. ⊗ Has not implemented hospital global budgets. ● Has implemented alternative hospital price regulation strategies.	Connecticut was selected to participate in the "States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Innovation Model," facilitated by the Centers for Medicare and Medicaid Services (CMS). Under this program, the state will establish a voluntary hospital global budget payment model extending to all payers including Medicare fee-for-service, Medicaid and commercial insurance. Connecticut is in the second cohort, which includes a 30-month pre-implementation period, from July 2024 – December 2026.
Public Option	⊗ Does not have an active Public Option. ⊗ Does not offer a state-wide Public Option, with or without a provider participation mandate.	

● State Has Active Policy or Program ◉ Policy or Program Partially Implemented ⊗ State Does Not Have an Active Policy or Program ✱ No Source, or Limited Information Found

Improve Oversight, Accountability, and Transparency

Health Spending Oversight Entities

Health Spending Oversight Entities monitor and track health care spending systematically, offering data and research support to ensure efficient resource use. While many states set population health priorities, few have established oversight entities with enforcement powers. This section examines whether a state has a health spending oversight entity reviewing primary care, hospital, or prescription drug spending, and if upper payment limits for prescription drugs have been implemented.

All-Payer or Multi-Payer Claims Database

All-payer claims databases (APCDs) compile diverse health care data, that may include health, dental, and pharmacy claims from private insurers, state employee health programs, Medicare, and Medicaid. In instances where a database includes only some of these payers, it is referred to as a multi-payer claims database. Typically created through legislation, APCDs are often subject to state oversight and regulation. However, some claims databases have been voluntarily developed by independent entities, limiting oversight.

This section examines whether a state has an active all-payer or multi-payer claims database, if the database is facilitated and managed by the state or by third-party entities, if the data is free and accessible without institutional review board approval, and if the database is required to capture race and ethnicity demographic information.

Price Transparency

This section evaluates state efforts to provide access to health care price data through a publicly available and easily accessible tool. To be credited, the tool must show negotiated prices for various services and be accessible without fees, IRB approval, or legislative restrictions. Additionally, this section reviews whether a state requires prescription drug price data to be reported to a state entity and if a state has another form of price transparency regulation.

Medical Debt Collection Regulations

This section examines how a state regulates providers' ability to collect medical debt once it has been incurred. It reviews whether a state: prohibits providers from sending debts to collections while a patient is actively pursuing efforts to address the bill (e.g., appealing to insurance, applying for financial assistance, negotiating the bill, in a payment plan); prohibits spouses or other persons from being held liable for another adult's debt; limits collections' ability to garnish wages; prohibits collections from initiating home foreclosure; prohibits collections from initiating actions that would lead to an individual's arrest due to medical debt; prohibits collections from seizing a bank account.

Policy	Status as of July 1, 2024	Summary
Health Spending Oversight Entity	⊗ Does not have a Prescription Drug Affordability Board reporting on prescription drug prices. ⊗ Does not have a Prescription Drug Affordability Board, with or without Upper Payment Limits. ● Monitors and reports on hospital spending. ● Monitors and reports on primary care spending.	Connecticut's Healthcare Benchmark Initiative Steering Committee (HBISC) and Office of Health Strategy, established in 2020, review hospital and primary care spending. This includes setting targets for primary care spending, set to reach 10% of total health care expenditures by 2025.
All-Payer or Multi-Payer Claims Database	● Has a(n) all-payer or multi-payer claims database. ● Database is operated by the state. ● Database does not include access restrictions. ● Database is required to capture demographic information.	Connecticut's APCD captures social and economic demographics such as age, sex, race, gender, household size, and income.
Price Transparency	⊗ Does not have a price transparency tool.* ● Has a Prescription Drug price transparency reporting requirement. ⊗ Does not have any other price transparency regulation.*	The executive director of the Office of Health Strategy (OHS) must annually report a list of ten outpatient drugs that have been provided at a significant cost to the state or are critical to public health. Manufacturers of drugs on the executive director's list must submit all of the factors that caused the increase in the wholesale acquisition cost of the drug to OHS.
Medical Debt Collection Regulations	⊗ Does not prohibit providers from sending debts to collections while patient is actively pursuing means to pay the bill.* ⊗ Does not prohibit other persons being held liable for another adult's medical debt. ● Prohibits collections from initiating home lien or foreclosure due to medical debt. ● Exceeds federal wage garnishment protections. ⊗ Does not prohibit actions that would lead to an individual's arrest due to medical debt. ⊗ Does not prohibit collections from initiating bank account seizure due to medical debt.	Connecticut law prevents creditors from initiating foreclosure placing a lien on a patient's primary residence if that lien was filed for the purpose of collecting medical debt. The state also prohibits wage garnishment to collect medical debts when the patient is eligible to received subsidized care through the state hospital bed fund.

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Address Consolidation and Promote Competition

Consolidation Assessment and Authorization

This section examines whether relevant parties are required by law or statute to notify the state of hospital consolidation transactions beyond the federal requirements, and whether the state has the authority to review these transactions; to approve, reject, or modify conditions of the transaction; and if consumer affordability or price growth are included in the review criteria

Balance Bill Protections

The federal No Surprises Act (NSA) protects patients from balance bills, which are unexpected costs from out-of-network providers. Under the federal legislation, patients receiving emergency care or who are unknowingly treated by out-of-network providers during an in-network procedure are only required to pay the in-network cost-sharing amount for services provided. Effective January 1, 2022, the No Surprises Act applies to most health plans but not all care sites and services. States can legislate additional protections for balance bills not covered under the NSA, such as for ground ambulances, or services provided at urgent care locations, hospice facilities, and birthing centers.

Facility Fee Limits

Facility fees are charges for services provided in outpatient and physician office settings that hospitals own. These fees increase the out-of-pocket costs for care and are becoming increasingly more common as the rate of health system consolidation has accelerated. This section explores whether a state prohibits facility fees under certain circumstances, if they have imposed regulations to protect consumers against out-of-pocket costs from facility fees, and if they require hospitals to report facility fee data.

Anti-Competitive Contract Provisions

Anti-competitive contracting is a pattern of contracting between health care providers and insurers where one party gains unfair advantages over potential competitors. States can enact regulations that limit dominant health systems from abusing their market power in ways that increase prices. This section evaluates whether states prohibit four types of anti-competitive contracting practices in the health system:

- Most Favored Nation Clauses: Health systems agree not to offer lower prices to competing insurers, preventing them from offering the same service at a lower price. These provisions may allow insurers and providers to collude to raise prices.
- All-or-Nothing Clauses: Health systems require plans to contract with all providers in their system or none of them, even if those providers are low-value or high-cost.
- Non-Compete Clauses: Doctors are prohibited from working at competing hospitals within a certain distance for a certain period of time.
- Anti-Tiering or Anti-Steering Clauses: Insurers must place favored providers in higher tiers regardless of cost or quality (anti-tiering) and restrict directing patients to higher value care from competitors (anti-steering).

Policy	Status as of July 1, 2024	Summary
Consolidation Assessment & Authorization	● Requires certain healthcare providers to notify the state of consolidation transactions. ● Has authority to approve, set conditions, or disapprove consolidation transactions. ● Includes consumer affordability and/or price growth in review criteria or approval conditions.	Connecticut requires the Attorney General be notified of material change of group practices, transactions qualifying to the Federal Trade Commission, and hospital affiliations or nonprofit hospital conversions, with authority to approve, apply conditions, or disapprove transactions for nonprofit hospitals. The Executive Director of the Office of Health Strategy (OHS) also has authority to approve nonprofit hospital transfers of assets to for-profit hospitals. Post-transaction oversight is requires if transaction is over a certain size. The Certificate of Need program also has authority to approve, set conditions, or disapprove transfers of ownership of hospitals or providers with 8+ physicians with criteria including whether increased prices or total health care spending may negatively impact affordability of care.
Balance Bill Protections	⊗ Does not prohibit balance billing for out-of-network ground ambulance services. ● Prohibits balance billing for out-of-network services at specific facilities not included in the NSA (see notes).	Connecticut prohibits balance billing for pediatric mental and behavioral health services provided at an "urgent crisis center," which is a facility certified by the Department of Children and Families that is dedicated to treating children's urgent mental or behavioral health needs.
Facility Fee Limits	● Prohibits facility fees for specified procedures and/or care settings. ● Has codified protections against out-of-pocket costs from facility fees (see notes). ● Requires hospitals to report facility fee data.	Connecticut prohibits facility fees for evaluation and management services provided in an off-campus location (excluding freestanding emergency departments) and for telehealth services. Additionally, the state prohibits a separate copayment for off-campus outpatient facility fees and requires hospitals to report facility fee data on an annual basis. Beginning July 1, 2024, facility fees will be prohibited for evaluation and management services provided in an on-campus location, excluding emergency departments and certain observation stays.
Anti-Competitive Contract Provisions	● Law restricts Most Favored Nation contract provisions. ● Law restricts all-or-nothing contract provisions in all or some situations. ● Law restricts anti-tiering or anti-steering contract provisions. ◉ Non-competes for physicians limited by statute.	Connecticut prohibits including Most Favored Nation, All-or-Nothing, Anti-Tiering, and Anti-Steering clauses in contracts between health organizations and healthcare providers. The Most Favored Nation prohibition specifically prevents provisions that guarantee one insurer the most favorable rates, require providers to certify that an insurer is receiving the best rate, or mandate the disclosure of rates with other entities. Connecticut also limits the scope and enforceability of physician noncompete agreements, restricting them to one year and within a fifteen-mile radius of the physician's previous practice. Physician noncompete agreements are also unenforceable in certain circumstances, such as if the physician's employment is terminated by the employer.

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Make Out-of-Pocket Costs Affordable

Reduced Cost Sharing: Prescription Drugs

This section examines whether states have passed legislation reduce the amount a consumer pays out-of-pocket for select prescriptions drugs including insulin, epinephrine, oral oncology medications and asthma inhalers. This section also examines state-level legislation prohibiting copay accumulator programs, which are payer strategies that limit the impact of manufacturer cost-sharing assistance programs on consumer out-of-pocket costs.

Reduced Cost-Sharing: High Value Services

This section provides an overview of state efforts aimed at reducing consumer cost burdens for high-value services. Specifically, it identifies states which have enacted legislation mandating coverage without cost-sharing for: primary care services recommended by the United States Preventive Services Task Force (USPSTF); various cancer screening and diagnostic services; and annual mental health exams. It also evaluates state efforts to expand access to affordable maternal and reproductive health care by highlighting the states that mandate private insurers cover in-vitro fertilization, fertility preservation, doula services and abortion care. The section concludes with a review of whether a state has incorporated equity-focused initiatives in their state-regulated insurance design.

Medical Debt Prevention

This section reviews state laws aimed at preventing medical debt, including mandates for hospitals and health care providers to offer financial assistance policies, screen patients for insurance and charity care eligibility, and inform patients of charity care policies before collecting payment. It also assesses whether states have extended Medicaid benefits retroactively for 90 days; expanded general presumptive eligibility for Medicaid to all adults; prohibited short-term, limited duration health plans; and if the state has established annual reporting requirements on community benefit spending.

Expanded Coverage

This section evaluates policies aimed at expanding access to and improving the affordability of health insurance, including whether a state has expanded Medicaid eligibility to adults with incomes up to 138% of the federal poverty level (FPL); authorized 12-month continuous Medicaid eligibility for all adults; extended postpartum Medicaid coverage to 12 months following delivery; established a Basic Health Plan; initiated a program providing state-funded premium subsidies for residents ineligible for Medicaid; explicitly authorizes coverage for gender-affirming care under Medicaid; has authorized the provision of Medicaid coverage to individuals transitioning from incarceration; and if the state has extended Medicaid coverage to include dental, hearing, and vision benefits, including eye exams and glasses, beyond what is deemed medically necessary following injury or surgery. Beyond these policy options, this section also reviews state efforts to extend coverage to children, pregnant residents, and non-pregnant adults regardless of immigration status. This includes waiving the five-year required waiting period for immigrant children and legally residing pregnant residents (the "five-year bar"); offering alternative coverage options regardless of citizenship status; and opting into the From-Conception-to-End-of-Pregnancy (FCEP) option under the Children's Health Insurance Program (CHIP), previously known as the CHIP Unborn Child option.

Policy	Status as of July 1, 2024	Summary
Reduced Cost-Sharing: Prescription Drugs	● Prohibits copay accumulator programs. ● Caps the price of insulin or diabetes supplies. ⊗ Does not cap the price of other prescription drugs or medical devices.	Insurers in Connecticut must apply any third-party discounts or payments for prescribed medications toward the enrollee's coinsurance, copayment, deductible, or other out-of-pocket expenses. Connecticut caps the out-of-pocket cost for a 30-day supply of prescription insulin and covered diabetes-related equipment and supplies at $25.00 and $100.00, respectively.
Reduced Cost-Sharing: High Value Services	● Mandates private insurers cover USPSTF recommended preventive services without cost-sharing. ● Waives or reduces cost-sharing for an annual mental health exam in private health plans. ● Provides coverage and/or waives or reduces cost-sharing for select maternal and reproductive health services. ● Mandates coverage for some cancer screening services without cost-sharing. ● Insurance design includes cost-saving measures to mitigate health disparities.	Connecticut does not yet offer direct Medicaid reimbursement for doula services but allows reimbursement through agreements with clinical providers in the Maternity Bundle Program. This temporary measure ensures access to doula care until direct reimbursement processes are implemented, which are tentatively expected to begin January 2025. The state also requires health plans to cover in-vitro fertilization and fertility preservation. Insurers are also required to cover colorectal cancer screenings pre-deductible and the following cancer screening services without cost-sharing: follow-up colonoscopies, diagnostic and screening mammograms (including tomosynthesis), breast cancer risk assessments, biopsies, ovarian cancer screenings, BRCA1/BRCA2 genetic testing, cervical and vaginal cancer screenings, and HPV screenings. Additionally, Covered Connecticut plans provide free and discounted health coverage, including dental and non-emergency medical transportation benefits, for those earning up to 175% FPL (above the Medicaid limit).
Medical Debt Prevention	● Mandates hospitals and other health care providers provide free or discounted care with set eligibility criteria for low-income patients (see notes). ⊗ Does not mandate health care providers screen patients for insurance eligibility or charity care. ● Mandates health care providers notify patients of charity care options before collecting payment. ● Retroactively extends Medicaid benefits ninety days prior to application date for all enrollees. ⊗ Has not authorized all qualified entities to provide presumptive eligibility for all adults in Medicaid.* ● Has prohibited or effectively eliminated short-term, limited duration health plans. ● Requires transparency in spending for community benefit programs.	Connecticut requires hospitals to offer charity care and reduced cost services for low-income patients as a condition of receiving state hospital bed funds. STLD health plans aren't explicitly banned in the state, but strict regulations have effectively removed them from the market.

● State Has Active Policy or Program ◉ Policy or Program Partially Implemented ⊗ State Does Not Have an Active Policy or Program ✱ No Source, or Limited Information Found

Policy	Status as of July 1, 2024	Summary
Expanded Coverage—Medicaid and Other Options	● Expanded Medicaid income eligibility to 138% FPL. ⊗ Does not offer a basic health plan or other affordable coverage option for residents with incomes below 200% FPL.* ⊗ Has not authorized 12-month continuous eligibility for adult Medicaid enrollees. ● Includes 12 months of postpartum care in Medicaid benefits. ⊗ Does not provide select Medicaid services to justice-involved people up to 90 days before release.* ● Medicaid policy explicitly includes coverage for gender-affirming services. ● Offers extensive dental, vision, or hearing coverage in Medicaid benefits. ● Offers state-based premium subsidies.	Connecticut Medicaid covers eye exams and eyeglasses for adults; covers hearing aids and other hearing devices for adults; and offers some dental coverage for extraction, dentures, root canal, restorative (both fillings and crowns), preventive, and diagnostic services. Connecticut offers state-based premium subsidies and cost-sharing reductions for adults with income up to 175% FPL if they select a Silver plan on the exchange. The subsidies pay the remaining premiums and cost-sharing left after federal subsidies are applied. The regulations governing the Connecticut Medicaid program clearly state that the program provides coverage for gender-affirming care.
Expanded Coverage—Immigrant Coverage	● Offers coverage for lawfully residing immigrant children or pregnant people without a five-year bar. ● Covers pregnancy-related services through the CHIP "From-Conception-to-End-of-Pregnancy" (FCEP) Option. ◉ Offers an affordable coverage option for some, but not all, undocumented immigrant children (see notes). ◉ Offers an affordable coverage option for some, but not all, undocumented immigrant adults (see notes).	Connecticut's Husky A and B programs offer coverage for uninsured children 12 and under with income at or below 323% FPL regardless of immigration status (comprehensive benefits for incomes at 201% FPL and below, limited Medicaid benefits excluding Non-Emergency Medical Transportation and Early and Periodic Screening, Diagnostic, and Treatment for families with incomes between 201-323% FPL). Once enrolled, children can keep coverage through age 19. Beginning in 2025, the age limit for enrolling in this program will increase to age 15. The state also offers comprehensive Medicaid-like coverage for up to one year post-pregnancy for people with income at or below 264% FPL regardless of immigration status.

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