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# Reforming Connecticut Healthcare after COVID

# About the Author

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# Reforming Connecticut Healthcare after COVID

Along many dimensions, America offers the finest healthcare available in the world. That said, numerous aspects of American healthcare have long been problematic. The COVID-19 pandemic tossed quite a few new lemons into the basket (or revealed some older ones), but the pandemic also created an unprecedented array of new opportunities to improve healthcare. As the old adage goes, if you have lemons, make lemonade — and the Nutmeg State is primed to take advantage of that bit of folk wisdom.

Most observers can rattle off a menu of complaints about American healthcare. These include constricted supplies (particularly in rural areas and inner cities), fragmented provision and varying quality of care, high prices, lack of transparency, surprise medical bills, varying health status across demographic groups, unevenly distributed outcomes and sizable uninsured populations. There's even widespread agreement across party lines about these problems.

"Great system" and "all of the above problems" are not mutually inconsistent. It does suggest the need to try some unconventional approaches to solving those problems — approaches that differ from those that dominated the debate from the end of World War II to the passage of the Affordable Care Act (ACA) and after. Deciding what to do — and what not to do — is the challenge.

The problem comes in finding unconventional solutions to the problems. Politically, the American establishment has been fractured sharply along party lines when it comes to healthcare, particularly due to debate being focused on insurance rather than delivery systems. Each party has pursued what it perceives to be a radically different approach from that advocated by the other party, leading to a rancorous debate. The key is to aim for solutions that are not zero-sum games. The debate over the ACA and alternative proposals was contentious because they were largely redistributive in nature — improving the care and coverage for one segment of society required worsening the situation for another. Expanding coverage for some, for example, led to higher deductibles for others. Debate over redistribution is always rancorous.

The alternative to redistribution is to seek changes in production techniques that, at least in theory, benefit the entire population. Rather than asking, "How can we increase coverage?" we can ask, "How can we provide better health to more people at lower cost, year after year?" Toward that end, this paper is based around several questions:

I. How does Connecticut's healthcare compare to other states'?
II. How did the COVID-19 pandemic induce a shift in the healthcare debate?
III. What are some specific policies by which Connecticut could improve its healthcare system?

# How does Connecticut's healthcare compare to other states'?

Evaluating Connecticut's healthcare system is a task fraught with difficulties — let alone comparing the state's system with those of 49 other states (and the District of Columbia). Nevertheless, it's an effort worth making, starting with a pre-COVID baseline.

In 2016, 2018 and 2020, the Mercatus Center at George Mason University published the *Healthcare Openness and Access Project (HOAP)*.[1] HOAP was designed as a set of indicators suggesting the relative capacity of patients and providers (physicians, nurses, etc.) to craft healthcare to meet the desires of patients in consultation with providers.[2] Below is an explanation of how HOAP worked and how Connecticut scored in each of these categories in 2020.[3]

In the 2020 version, data were collected on 41 indicators (variables). On each indicator, states were rated between 1 (the least open and accessible) to 5 (most open and accessible). The 41 indicators were grouped into five categories: professional regulation, institutional regulation, patient regulation, payment regulation and delivery regulation. For each state, indicators in a given category were averaged to provide an index *for that category*. Finally, for each state, the five categories were averaged to provide an overall index.

The indicators, category indices and overall index were intended only as approximations for the qualities of a state's healthcare system. Below is the overall index, followed by the five categories. Beneath each are its component indicators, along with some narrative for each:

| U.S. Median | CT |
|---|---|
| 3.26 | 2.94 |

Overall HOAP Index

In the 2020 HOAP data, Connecticut trailed the U.S. median index for openness and access. Connecticut's score of 2.94 put the state at #46 among the 51 jurisdictions (50 states plus D.C.). Its #46 ranking was a fairly significant indicator that Connecticut lagged the other states according to these criteria.

Table 1

| U.S. Median 3.00 | CT 3.00 | Professional Regulation |
|---|---|---|
| 3 | 1 | State allows medical licensure reciprocity with other states. |
| 3 | 3 | State has fewer continuing medical education requirements. |
| 3 | 5 | State grants nurse practitioners broad scope of practice. |
| 5 | 1 | State has fewer optician licensing requirements. |
| 5 | 5 | State grants behavioral health providers broad scope of practice. |
| 3 | 5 | State grants midwives broad scope of practice. |
| 4 | 5 | State grants pharmacists broad scope of practice. |
| 3 | 3 | State grants dental hygienists broad scope of practice. |
| 1 | 1 | State has less restrictive licensing of certified registered nurse anesthetists. |
| 3 | 1 | State limits liability for charity caregivers. |





In the category of professional regulation, Connecticut in 2020 was right at the U.S. median. It ranked #25 among the 51 jurisdictions. Now, we can examine specific actions that the state might have taken at that time. If a state had wanted to improve its position in this particular ranking, the optimal place to start would have been in those categories where it received a 1: medical licensure reciprocity, reducing optician licensing requirements, moving toward less restrictive nurse anesthetist licensing and further limiting liability for charity caregivers. Those with 3s (reducing medical education requirements and broadening scope of practice for dental hygienists) have room for improvement but are already toward the middle of the states. Regarding the 5s, the state was already in good shape on those indicators. (Even with a score of 5, of course, there is always room for improvement).

Table 2

| U.S. Median 3.17 | CT 2.17 | Institutional Regulation |
|---|---|---|
| 4 | 2 | State has fewer certificate-of-need restrictions. |
| 1 | 1 | State puts fewer restrictions on compounding pharmacies. |
| 5 | 1 | State does not mandate payers submit data to an all-payer claims database. |
| 2 | 1 | State has fewer provider taxes. |
| 3 | 3 | State allows entrepreneurial business structures. |
| 5 | 5 | State does not have mandatory generic substitution laws. |

In the category of institutional regulation, Connecticut scored 2.17 versus the nationwide median of 3.17. In this category, the state was tied with Florida for #39 among the 51 jurisdictions. There was room to improve the score in all but one category (mandatory generic substitution laws). There was also considerable opportunity to increase the score by reducing restrictions on compounding pharmacies, reducing mandates regarding an all-payer claim database and reducing provider taxes. Lessening certificate-of-need restrictions was also a significant opportunity for improvement.

Table 3

| U.S. Median 3.00 | CT 2.50 | Patient Regulation |
|---|---|---|
| 4 | 4 | State allows access to cannabidiol (CBD) oil. |
| 1 | 1 | State allows access to oral contraceptives without physician prescription. |
| 5 | 5 | State has lower excise taxes on e-cigarettes. |
| 4 | 3 | State allows access to naloxone. |
| 5 | 1 | State offers protection for Good Samaritans. |
| 1 | 1 | State has Free Speech in Medicine law. |

In patient regulation, Connecticut scored 2.50 versus 3.00 for the median state, and tied five other states for the #43 slot. The state had strong pickup opportunities related to CBD oil, Good Samaritan laws and loosening restrictions on free speech in medicine. (The definitions of all of these are found in the original HOAP document).

Table 4

| U.S. Median 3.56 | CT 3.22 | Payment Regulation |
|---|---|---|
| 3 | 3 | State mandates fewer health insurance benefits. |
| 5 | 5 | State does not expand on federal age rating limitations. |
| 5 | 5 | State has fewer health savings account (HSA) taxes. |
| 3 | 3 | State has less medical taxation. |
| 5 | 5 | State does not mandate that individuals buy health insurance. |
| 4 | 1 | State does not restrict short-term renewable health plans. |
| 5 | 5 | State allows drug manufacturer copay coupons. |
| 1 | 1 | State allows insurers in other states to issue health insurance in the state. |
| 1 | 1 | State allows prescription drug reimportation. |

Under payment regulation, Connecticut again lagged the U.S. median — 3.22 versus 3.56. The state was tied with five other states for #43 in the nation. The most significant opportunities for improvement in 2020 lay in restrictions on short-term renewable health plans, out-of-state insurers and drug reimportation.

Table 5

| U.S. Median 3.60 | CT 3.80 | Delivery Regulation |
|---|---|---|
| 1 | 5 | State reimburses Medicaid providers at parity for store-and-forward telemedicine. |
| 1 | 1 | State has less restrictive tele-presenter requirements. |
| 5 | 4 | State reimburses Medicaid providers at parity for remote monitoring. |
| 5 | 5 | State allows online prescribing. |
| 2 | 2 | State allows broad Medicaid reimbursement by provider type. |
| 3 | 3 | State has less restrictive tele-pharmacy location laws. |
| 5 | 5 | State allows online eye exams. |
| 5 | 3 | State does not treat direct primary care (DPC) as insurance. |
| 4 | 5 | State allows DPC drug dispensing. |
| 5 | 5 | State allows DPC wholesale lab pricing. |

Delivery regulation was the one category where Connecticut's score exceeded that of the U.S. median, tying Vermont for #21 in the nation. The strongest opportunity for improving this category's score came from reducing tele-presenter requirements, since that was the only variable with a score of 1.

Although these are four-year-old data that preceded the world-changing pandemic, they demonstrate where the state was lagging or ahead according to different variables pre-COVID. These tables are useful as tools for sparking conversation and presenting areas where reform might be attainable and valuable.





# How did the COVID-19 pandemic induce a shift in the healthcare debate?

For many, the arrival of COVID-19 was the most destructive, disruptive, unsettling event in living memory. Lives, business, education and mental health suffered dramatically. But even in the darkness, the pandemic had an upside in terms of medical care. Consider the following, written roughly 25 days into the pandemic's tour of destruction through America:[4]

> *"COVID-19 has thrust us into the worst of times and the best of times. … It's the worst of times because the virus has sheathed the globe in a slurry of death, suffering, privation, inquietude and isolation. … It's the best of times because practically everyone of consequence appears suddenly to recognize that: (1) delivery systems (resources and how we use them) matter more than insurance schemes; (2) legal and regulatory constraints paralyze the delivery system during crises; and (3) improving that delivery system depends on private agents who can nimbly and rapidly innovate."*

And, of course, the public sector played a massive role in the changes. The same article noted that state governments played an outsized role in the rapid rounds of innovation, including:

- Hospitals wishing to spend their own money to add ICU beds no longer need to beg governments for permission (through certificate of need processes).
- Doctors licensed in one state who wish to rush to another state … to join the fray no longer need to obtain additional licenses when they arrive.
- Patients who wish to consult with doctors in other states via telemedicine can now do so. They can use conventional apps like Skype and FaceTime rather than proprietary health care portals.
- Retired doctors and nurses are being welcomed back with minimal licensure obstacles.
- Nurse practitioners and other professionals are being allowed to practice up to the limits of their training.
- The Food and Drug Administration is — to some extent — expediting approval processes for ventilators, surgical masks, mask-cleaning devices, drug treatments, etc.

Significantly, states had enormous latitude to experiment and improvise. Florida and South Dakota reacted in their ways, New York and California in theirs. The difference in choices reflected the preferences of each state's electorate. The results, in terms of infection rates, death rates, income shocks and personal interactions could be observed in real-time and now, in hindsight. We can observe which states performed best, and why, and adjust policy accordingly. A balanced assessment does not yield a simplistic red-states-did-better or blue-states-did-better answer. The different approaches across the states reflect the federalism built into the Constitution by the Founders. In a true sense, the states were, as Justice Louis Brandeis said in 1932, "laboratories of democracy."[5]

In this way, COVID launched one of history's greatest and fastest unintended scientific experiments. State legislatures today are acting on a combination of observations from COVID and pre-COVID points of view.

# What are some specific policies by which Connecticut could improve its healthcare system?

The following are seven specific healthcare reforms available to Connecticut. They include expanding physician licensure, expanding nursing licensure, offering greater autonomy to nurse anesthetists, offering prescriptive authority to qualified psychologists, dropping certificate of need laws, making COVID emergency telehealth provisions permanent and authorizing association health plans.

## 1) Expanding Physician Licensure

The COVID emergency demonstrated the importance of having a nimble, expandable workforce. In the early days of the pandemic, emergency orders allowed physicians, nurses and other medical professionals to practice in states other than those where the practitioners were licensed. This included both cross-border telehealth and temporary relocation across state lines, for example, when Colorado doctors traveled to New York City to relieve pressure on the healthcare system there.[6] For many localities, this flexibility was a godsend.

In coming years, aging Baby Boomer patients and retirements by nurses are projected to increase, leaving some communities short on care.[7] And in all likelihood, individual states will experience temporary pressures like those seen during COVID. Therefore, it behooves states to make themselves as inviting to caregivers as possible.

Connecticut is a member of the Interstate Medical Licensure Compact (IMLC), which allows reciprocal licensure across the member states. There are two further actions available to the state that would enhance the mobility of physicians:

First, as the map on the next page shows, Connecticut does not participate in certain aspects of the IMLC. Specifically, the Connecticut Department of Public Health, as of Fall 2022, has been issuing licenses to out-of-state licensed physicians through the IMLC. However, Connecticut will not be acting as a state of principal license until additional legislation is passed. Such legislation would put Connecticut's IMLC participation on par with most of the other member states.

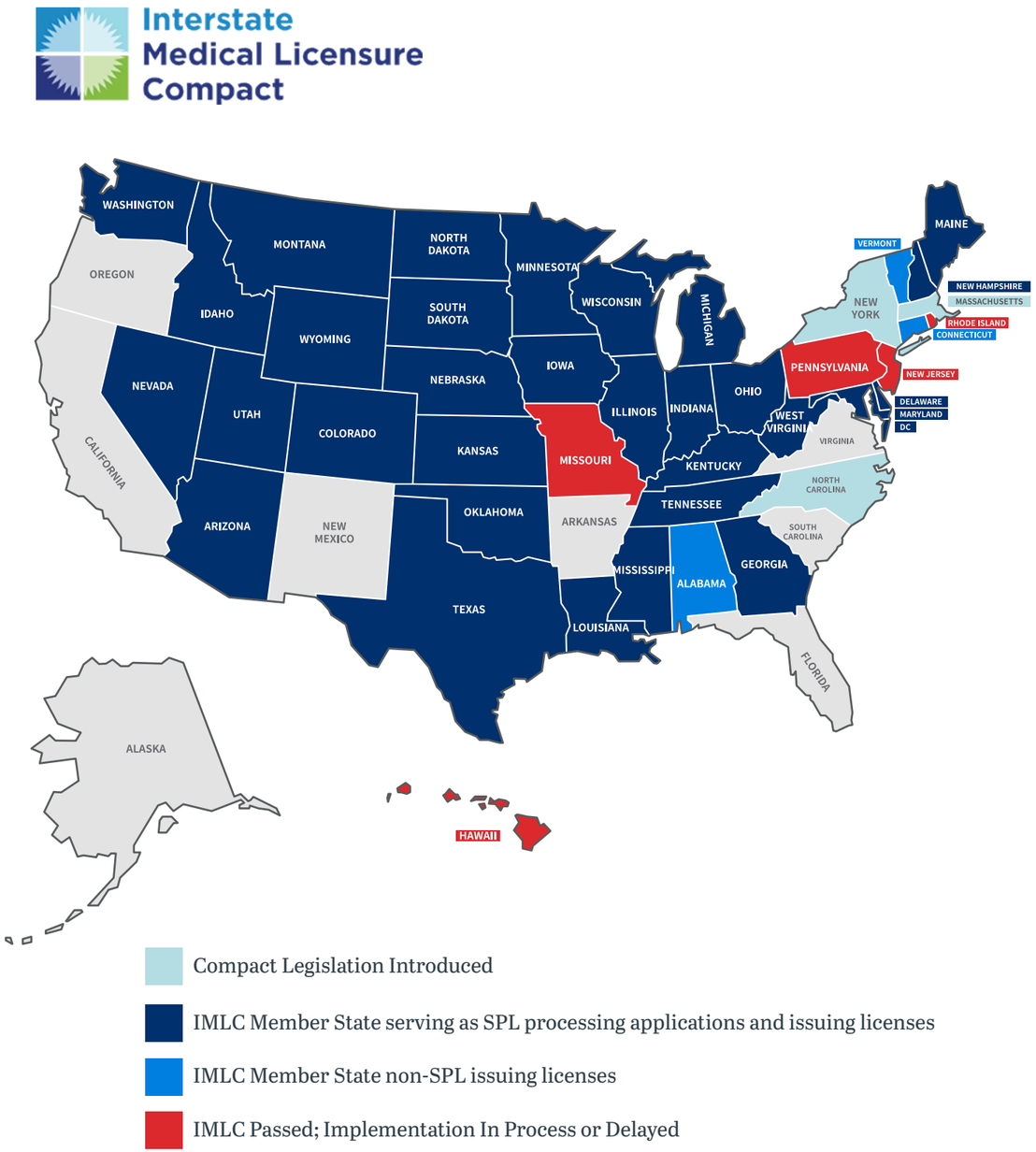
Second, Connecticut could go farther in inviting qualified physicians to enter the state and provide care to state residents. Arizona offers "Licensure by Universal Recognition." This means that licensed physicians (and other professionals, healthcare and nonhealthcare) can move to the state and begin practicing immediately — regardless of whether the physician is licensed in an IMLC member state. To do so, a physician must:[8]

- prove residency in Arizona;
- be currently licensed or certified for at least one year in another U.S. state in the discipline applied for and at the same level of practice as recognized in Arizona;
- be in good standing in all states where currently licensed or previously licensed or certified;
- have met all applicable education, work, exam and/or clinical supervision requirements in the other state where originally licensed or certified;



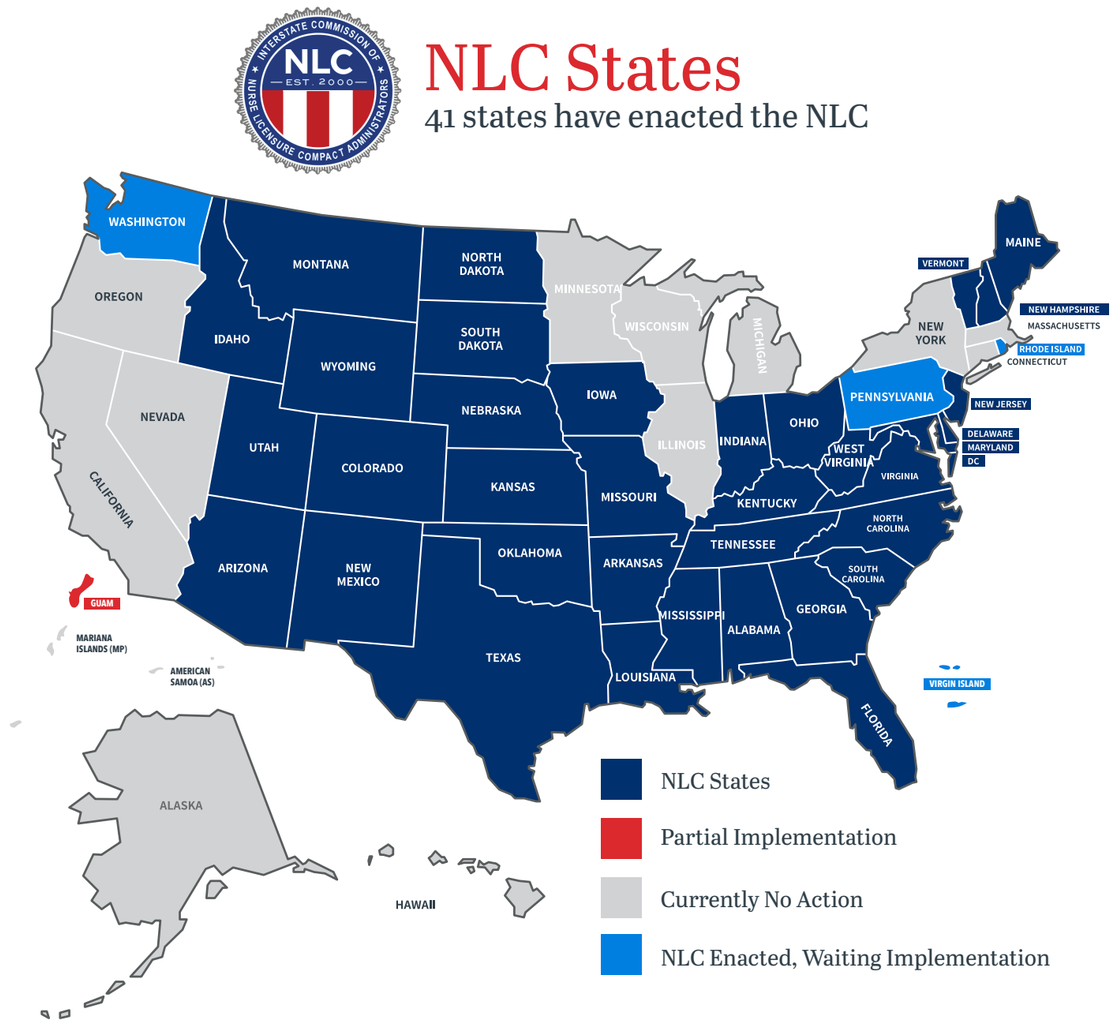


- complete a criminal background check when required by law;
- take and pass any applicable exam on Arizona state law; and
- pay all applicable fees to the AMB.



## 2) Expanding Nursing Licensure

The nursing profession has a licensure arrangement equivalent to the IMLC — the Nurse Licensure Compact (NLC). A large majority of the 50 states (along with several territories) has enacted the NLC, though Connecticut is not among those states.[9] Under this arrangement, "Nurses holding a multistate license can practice in other NLC states/territories, without obtaining additional licenses, while maintaining their primary state of residence (PSOR). The multistate license is issued in a nurse's PSOR, but is recognized across state lines, like a driver's license."[10] Were Connecticut to join the NLC, an out-of-state nurse practicing in another state (or other jurisdiction) would have to know and follow Connecticut nursing laws and to apply for a Connecticut license if he or she planned to remain in the state beyond some specified period. Connecticut would retain the power to revoke an out-of-state nurse's privileges and would have the power to report violations to the nurse's PSOR.[11]








Connecticut already allows military spouses to obtain expedited licenses.[12]

> *"State agencies shall issue licenses to military spouses from other states so long as the military spouse holds said license in at least one other jurisdiction, has practiced under the license for at least four years, is in good standing in all jurisdictions, satisfies a background or character and fitness check if required, and pays all required fees. A military spouse may be required to take all or a portion of a licensing examination. A military spouse must furnish evidence of competency to the appropriate state agency."*

Joining the NLC would extend this practice beyond military families. However, the existence of the military spouse provision means that the state already has infrastructure in place to accommodate such an expansion of prospective licensees.

## 3) Offering Greater Autonomy to Nurse Anesthetists

In 2014, Connecticut began allowing nurse anesthetists (NAs) to practice independently. However, NAs must practice in collaboration with a physician for the first three years of such independent practice.[13, 14] Some states have dropped mandatory collaborative practice agreements (CPAs), and it is worth examining whether mandatory CPAs actually improve the quality of care and whether such mandates limit the attractiveness of Connecticut to NAs. If the three-year CPA mandate remains in place, a relevant question would be whether the state ought to recognize an NA's CPA from a previous state.

## 4) Offering Prescriptive Authority to Qualified Psychologists

Demands on mental health professionals have increased in recent years, and there is no reason to suspect that this demand will recede anytime soon. At present, psychologists in Connecticut lack prescriptive authority — the ability to prescribe medications to their patients. A number of other states, like Colorado, now offer psychologists such authority, and Connecticut could do the same.[15] For example, Colorado recently enacted a law granting such authority. In 2022, a Connecticut psychologist argued for prescriptive authority in a *CT Mirror* article:[16]

> *"Three years ago, I wrote in The CT Mirror that we in Connecticut had a growing mental health crisis on our hands: that too many people who needed psychiatric medications for behavioral health or substance abuse issues could not get them.*
>
> *I recounted that during those pre-pandemic days, my office manager tried to find services for her daughter. She called 19 psychiatrists without one return call. As I said at the time, the reasons could have been many: they were too busy, too full, or maybe they didn't accept this person's health insurance."*

The article also said:

> *"The training in clinical psychopharmacology involves a rigorous medical program designed for practicing doctoral psychologists. It's similar to how many [Advanced Practice Registered Nurse] programs are structured—a two-year, comprehensive Master of Science program in pathophysiology, clinical medicine, laboratory studies, neuroscience, neuroanatomy, pharmacology and psychopharmacology. It includes comprehensive exams and supervised clinical experience, followed by a national board exam."*

The American Psychological Association offers support for of such legislation.[17] That page also includes discussion of ongoing state legislative initiatives on prescriptive authority for psychologists. In correspondence with the author of this paper, a clinical psychologist offered the following take on the issue:

> *"Psychologists who are appropriately trained do a good job with prescribing. And the training is rigorous, basically a Masters in psychopharmacology with tons of supervision on top of their psychology doctoral degree. It also really helps increase access to care in underserved/rural areas where there aren't enough psychiatrists and psychiatric nurse practitioners. Arguably, psychologists with prescriptive authority have way more overall mental health education and training and an equal or greater amount of psychopharm[acology] training than Masters level nurse practitioners who already have the same authority."*

## 5) Dropping Certificate of Need Laws

Like many other states — particularly in the Eastern U.S. — Connecticut has certificate of need (CON) requirements.[18] As a Connecticut state webpage explains:[19]

> *"Certificate of Need (CON) is a regulatory program requiring certain types of health care providers to obtain state approval prior to making major changes in the health-care landscape such as mergers, substantial capital investments in new equipment or facilities, changing access to services, or discontinuing a medical service."*

Experience across the United States demonstrates that CON applications can be expensive, lengthy and prone to political pressures. Moreover, CON laws can deprive communities of vital healthcare resources. In a 2012 Virginia case, for example, an infant died because Virginia officials had refused to allow a particular hospital to add a high-tech neonatal care facility because such services were judged by officials to be unnecessary.[20]





While CON laws were once universal in the U.S., a growing number of states have repealed their laws or have been considering taking such action. Connecticut would do well to consider following suit.

NCSL
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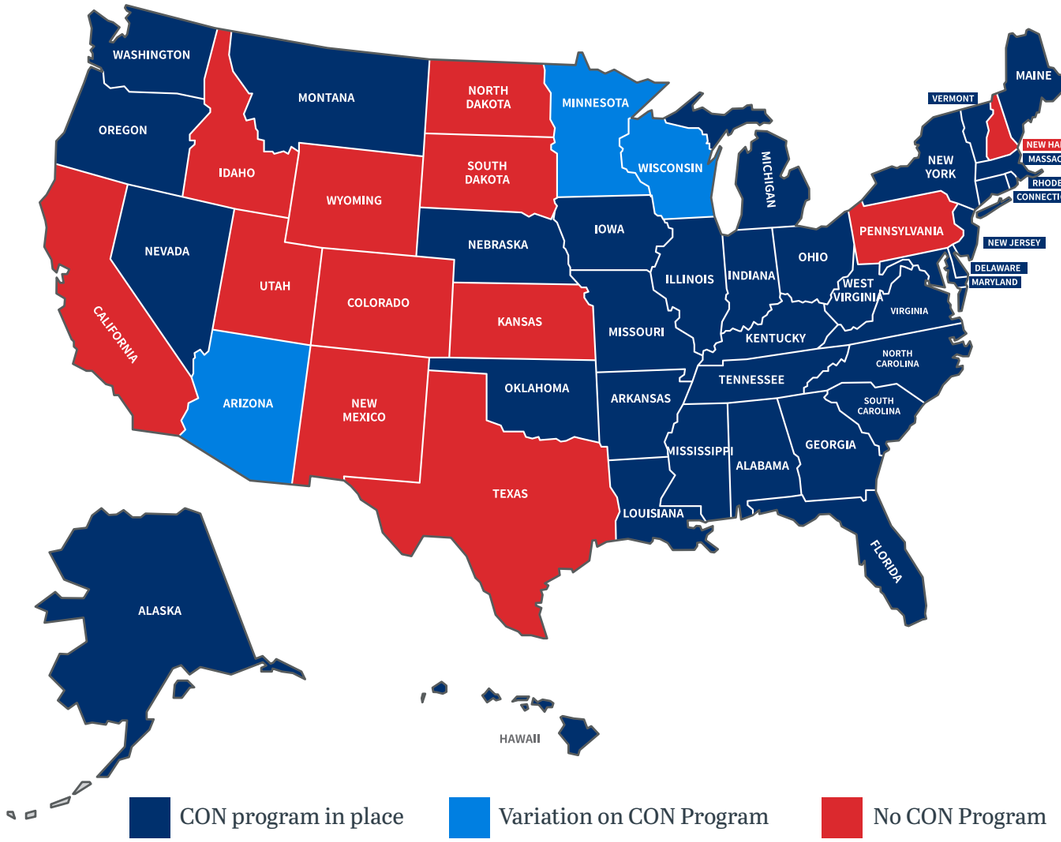
# Certificate of Need State Laws



As Matthew Mitchell explains:[21]

- In much of the country, state regulations have monopolized local health care markets.
- Certificate of Need (CON) laws have been widely studied and the evidence is overwhelming that they reduce access, limit competition and increase costs.
- State legislators could improve health care quality, lower prices and — above all — make it easier for millions of Americans to obtain care by repealing CON laws.

Mitchell notes:

> *"In encouraging CON, lawmakers hoped hospitals would acquire fewer beds, fill them with fewer patients, and spend less money. The main purpose of CON was therefore to reduce health care expenditures by rationing care. [Supporters] also thought that they could reduce health care costs by encouraging 'the use of appropriate alternative levels of health care, and for the substitution of ambulatory and intermediate care.'*
>
> *Beyond costs and expenditures, [they] also hoped to ensure an adequate supply of care, especially for 'underserved populations,' including 'those which are located in rural or economically depressed areas.' Finally, they hoped to 'achieve needed improvements in the quality of health services.'"*

Mitchell concludes:

> *"These goals — cost containment, adequate and equitable access, and quality improvement — remain widely shared aims of health policy and are laudable goals. The preponderance of evidence suggests that CON fails to achieve them. In fact, CON likely increases costs, limits access, and undermines quality."*

## 6) Making COVID Emergency Telehealth Provisions Permanent

Restrictions on the use of telehealth in Connecticut were greatly reduced during the pandemic. Gov. Ned Lamont signed an emergency waiver in March 2020 temporarily relaxing restrictions. Among other provisions, the waiver allowed out-of-state providers to offer services in Connecticut and required insurers to pay the same for telehealth visits as for in-person visits.

The emergency provisions have been extended to June 30, 2024, but "a spokesperson for the Department of Public Health said the state doesn't currently have any plans to extend [these] provisions beyond June of next year."[22] There is one exception





to the sunsetting of these provisions. After June 30, 2024, out-of-state providers will still be able to provide mental health and behavioral health services.

These emergency provisions allowed the state to meet extraordinary demands during an extraordinary period. But, as noted above, critical shortages of healthcare personnel and services are expected to increase over the coming decades. Connecticut would do well to consider making these temporary provisions permanent — as some other states have done.

## 7) Authorizing Association Health Plans

During the 2023 legislative session, a bipartisan group of state legislators introduced House Bill 6710, which would authorize association health plans (AHPs). As described by State Rep. Kerry Wood:

> *"The concept is simple — allow trade associations to provide healthcare benefits for their member organizations. Pooled together, small employers would be able to purchase insurance in much the same way that large employers do, using the power of numbers to achieve savings that wouldn't otherwise be possible."*

Rep. Wood went on to debunk what she argues are myths about how AHPs would operate.[23] She assures that AHPs (1) won't exclude individuals with preexisting conditions; (2) will be robustly regulated; (3) will offer the full range of services available under ACA rules; (4) will cover conditions mandated by state law; (5) won't withdraw coverage of those who become sick; (6) won't price sick people out of their policies; (7) won't provide insurers with windfall profits; and (8) and refutes the claim that AHPs are prone to insolvency.

AHPs are absolutely worthy of consideration. Two caveats are in order, however. First, over a period of many years, some states have passed legislation enabling AHPs, and in some cases, they have had little effect on markets. Second, actuaries have warned that AHPs can lead to market segmentation and adverse selection.[24] Legislators should give both concerns a careful look.

# Conclusion

Before COVID — and very likely still — Connecticut ranked low among the states in terms of openness and access, or providers' ability to work together with patients to find solutions to health problems. Suddenly and to a significant degree, COVID offered Connecticut and the whole United States an unprecedented experiment in how openness and access could be expanded. For the most part, that experiment was a smashing success, as evidenced by the enormous success in telehealth expansion. Since the onset of the pandemic, a number of states have built on that massive experiment by relaxing prior restrictions on the provision of care.

But to build on that progress, it will be necessary to shun both the hyper-partisan approaches to reform and the healthcare myths beloved by Left and Right, and instead embrace bipartisan solutions that avoid zero-sum games.

# Endnotes

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3 It should be noted that these data were collected and aggregated in late 2019, pre-pandemic, but they are the most recent comprehensive data available. In many states, laws surrounding the delivery of health care have improved since late 2019 by, for example, improving access to telemedicine. But these data do offer a structure for analyzing and proposing reforms to Connecticut's healthcare system in 2023.

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