

OFFICE OF THE HEALTHCARE ADVOCATE

2009 Annual Report



IS TO ASSIST CONSUMERS WITH HEALTHCARE ISSUES THROUGH THE ESTABLISHMENT OF EFFECTIVE OUTREACH PROGRAMS AND THE DEVELOPMENT OF COMMUNICATIONS RELATED TO CONSUMER RIGHTS AND RESPONSIBILITIES AS MEMBERS OF MANAGED CARE PLANS. THE OFFICE FOCUSES ON ASSISTING CONSUMERS TO MAKE INFORMED DECISIONS WHEN SELECTING A HEALTH PLAN; ASSISTING CONSUMERS TO RESOLVE PROBLEMS WITH THEIR HEALTH INSURANCE PLANS; AND IDENTIFYING ISSUES, TRENDS AND PROBLEMS THAT MAY REQUIRE EXECUTIVE, REGULATORY OR LEGISLATIVE INTERVENTION.

A MESSAGE FROM THE HEALTHCARE ADVOCATE...

I am pleased to issue this 2009 Annual Report on the activity of the Office of the Healthcare Advocate. The Office of the Healthcare Advocate was created by the General Assembly in 1999 as part of the Managed Care Accountability Act. Since that time, we have worked with thousands of policyholders, patients and families to explain their rights and responsibilities in a health plan, and to advocate for patients when they are denied treatment or reimbursement by their health insurance company. We've also taken on additional responsibilities, which we highlight in the report.

The office also focuses on assisting consumers to make informed decisions when selecting a health plan and on identifying issues, trends and problems that may require executive, regulatory or legislative intervention. It is my hope that the information provided in this report will inform the community on our activity, and empower Connecticut residents to become more informed consumers and effective self-advocates. Our seasonal newsletter launched in the autumn of 2007, daily news and other timely issues are posted on our web site and circulated electronically. The newsletter and our web site give timely information about consumer rights in health insurance, as well as updates on legislative, consumer and industry activities. Your feedback and suggestions are always welcome as we take on all of our new challenges.

If you have a specific question, or feel you have been unfairly denied care by your health insurance company, please contact us by phone at (866) 466-4446 or by e-mail at healthcare.advocate@ct.gov.

*Kevin Lembo
Healthcare Advocate*



WHAT OHA DOES...



Managed Care is a health care system involving the active coordination of, and the arrangement for, the provision of health services and coverage of health benefits. Managed care usually involves three important components: oversight of the medical care given, contractual relationships and organization of the providers giving care, and the covered benefits.

Managed care continues to dominate the health care financing and delivery system in the United States. In Connecticut, over 2.5 million health insurance consumers are enrolled in managed care plans. During the past several years, the commercially insured, employer-sponsored segment of the Connecticut population has been joined by Medicare and Medicaid managed care enrollees.

The Office of the Healthcare Advocate helps individual Connecticut consumers who have health insurance provided by a managed care organization (MCO). The office was created to promote and protect the interests of covered persons under MCO health plans in Connecticut. A major responsibility of the office involves educating consumers about their

rights and how to advocate on their own behalf when they have a problem or concern about their managed care health plan. We can answer questions and assist consumers in understanding and exercising their right to appeal a denial of a benefit or service made by the managed care plan.

The Office also takes on matters that affect large groups of insurance consumers. By law, OHA is authorized to represent Connecticut's healthcare consumers in administrative matters. Last July, OHA and the Office of the Attorney General participated in an Insurance Department hearing after an insurer filed a request to increase its premiums for individual policyholders by up to 30%. The Healthcare Advocate also demanded information from two other insurers, after it was found that the insurers understated their profits to Congress, and that they correct their reporting to Connecticut consumers about the actual amount of money each company spent on healthcare versus administration and profit. OHA also challenged the tactics of some of the Medicare Advantage plans that allegedly misrepresented the impact that federal healthcare reform would have on Medicare enrollees.

FOLLOW OHA ON FACEBOOK & TWITTER

OHA recently joined the social media world by initiating a fan page on Facebook and opening a Twitter Account. Both Facebook and Twitter offer OHA the option to communicate important information about healthcare in Connecticut, including changes in insurance coverage to a large audience, with the possibility that the information will reach more of the millions of members of both services. OHA has also linked its Facebook site to the agency web site, providing web surfers with a direct line to more detailed information. You can access OHA's Facebook page and become a fan, and follow the OHA on Twitter by entering our site at www.ct.gov/oha and clicking on the Facebook or Twitter icons.



OHA STAFF

- Kevin Lembo, Healthcare Advocate
- Maureen Smith, Director of Consumer Relations
- Victoria Veltri, General Counsel
- Darlene West, Case Manager
- Candice Kohn, Case Manager
- Africka Hinds-Ayala, Health Program Associate
- Michael Mitchell, Health Program Analyst
- Marilyn Rice, Administrative Assistant
- Vanessa Wimberly, Support Staff

NOW YOU'LL BE HEARD

The Office of the Healthcare Advocate is dedicated to serving Connecticut's health insurance consumers by resolving conflicts with their insurance plans. We take a multifaceted approach: direct consumer advocacy with insurance companies, education, interagency coordination, and a voice in the legislative process. We are a free service of the state of Connecticut.

THE CASE FOR OHA

OHA's most important legislative victory in 2009 was the preservation of the office. OHA is an independent state agency that is funded through assessments on Connecticut insurers. OHA maintained its critical place in state government because of overwhelming legislative support and significant public testimony on its impact on individual consumers: OHA has had enormous success in assisting and advising consumers—recovering almost \$6.6 million for consumers. OHA is more committed than ever to helping Connecticut's health insurance consumers access the care promised in their health insurance coverage.

PUBLIC ACT 09-135 – AN ACT CONCERNING POSTCLAIMS UNDERWRITING PROTECTION AGAINST LOSS OF INSURANCE

OHA proposed a major piece of legislation that passed nearly unanimously in the 2009 legislative session, but was ultimately vetoed by the Governor. Public Act 09-135 would have provided more protection for consumers against unwarranted rescissions or cancellations of insurance policies, leaving the consumer with no insurance and unpaid medical bills. The legislature sent a clear message that Connecticut's public policy should be directed at saving consumers from the potentially predatory actions of some individual insurance companies. The co-chairs of the Insurance Committee of the legislature have re-introduced the bill again in the 2010 session. OHA will marshal its resources to ensure passage of the bill. This postclaims underwriting bill is necessary legislation, even in the event of passage of federal healthcare reform. It will provide Connecticut consumers with significant protections against the loss of their insurance and unpaid medical expenses.

P. A. 09-115 AN ACT CONCERNING HEALTH INSURANCE COVERAGE FOR AUTISM SPECTRUM DISORDERS (ASDs)

OHA was involved in drafting and reviewing language of this bill, which requires coverage for diagnosis and treatment of ASDs as well as behavioral therapies for children age 14 or younger, psychological and psychiatric services, and certain prescription drugs. The bill was a compromise bill between autism advocates, providers, insurers and legislators.



SENATE BILL 958 – AN ACT CONCERNING UTILIZATION REVIEW

OHA and the Office of the Attorney General worked collaboratively on this bill, designed to improve the process by which consumers can appeal denials of requested care. The bill provided for a formal hearing at which consumers could directly ask questions of the insurance company's providers to challenge the insurer's reason(s) for concluding that treatment was not medically necessary. The bill also required the insurer to make a recording of the hearing that the consumer could use to appeal the denial to a higher level. It required that a peer reviewer of the insurer or an outside company be of the identical specialty as that of the consumer's provider. Finally, the bill guaranteed payment of claims when representatives of the insurer misrepresented coverage of a service.

This bill did not make it out of the Insurance Committee. OHA is committed to ensuring that the process of medical necessity determinations becomes stronger and fairer to consumers. OHA will seek alternate routes to improve this process until the bill is re-introduced.

P. A. 09-148 - SustiNET

OHA played a major role in the refinement and passage of the SustiNet Health Partnership, a bill designed to plan for Connecticut's healthcare future. The SustiNet bill established a Board of Directors, naming Kevin Lembo, Healthcare Advocate, and Nancy Wyman, State Comptroller, as co-chairs. The Board is responsible for ultimately reporting to the legislature in 2011 a recommended plan for comprehensive, self-insured healthcare reform in Connecticut. To assist the board, five advisory committees - medical home, provider advisory and healthcare quality, preventive healthcare, health information and technology, and disparities and health equity were established. Three task forces—childhood and adulthood obesity, tobacco and smoking cessation, and healthcare workforce - were also established.

The SustiNet Board of Directors, its advisory committees and task forces have been meeting since September, exchanging ideas and formulating preliminary recommendations.

OTHER STATE LEGISLATIVE ACTIVITIES

OHA also testified in support of bills that would have: banned or otherwise restricted pharmaceutical gift giving; prohibited prescription data-mining for sale to third parties; established an academic counter-detailing program to independently educate providers on scientifically supported use of prescription drugs; and required cultural competency education for physicians. OHA testified in support of an insurance bill, now P. A. 09-179, that requires an independent review of the costs and benefits of the insurance mandates.

In front of the Appropriations Committee, OHA suggested restraint in the cutting of healthcare sections of the social services budget without detailed examination of the need for services, success of programs and down-stream impact. During a hearing on the submission of a renewal of a federal waiver governing HUSKY A, CT's Medicaid managed care program for families, OHA offered substantial comment on the need for increased accountability in the program. OHA provided suggestions to the Human Services Committee on combing through projected expenses in the human services budget that appeared to be inordinately high, given past performance of those programs. OHA also supported an independent review of the \$800 million HUSKY program.

OHA testified in support of a bill, now law, that allows more individuals to become eligible for Medicare Savings Programs, provides assistance with access to prescription drugs and helps with Medicare premiums.

OHA appeared before the following committees during the session: Insurance and Real Estate, Public Health, Government Administration and Elections, Human Services, Labor and Public Employees, and Appropriations.

FEDERAL INVOLVEMENT

Congressional offices consulted OHA on the issue of improper insurance policy rescissions, in an attempt by Congress to create protections for consumers against this devastating practice. OHA provided congressional committees with information from Connecticut, and the conduct of insurers across several states. OHA's advocacy included work with several other state and advocacy organizations.

As part of the National Healthcare Reform Effort, OHA staff were consulted by the offices of U.S. Sen. Dodd and Rep. Rosa DeLauro on issues of consumer protection, including the proposal of consistent and consumer-friendly definitions of insurance terms in all policies, and the inclusion of a section in one of the bills that would create independent governmental agencies like OHA in every state to assist consumers with healthcare issues, and offered federal grant funding for the creation of the offices. OHA maintains close contact with Connecticut's congressional delegation in an effort to ensure that strong consumer protections are built into any reform measure.

The 2009 Connecticut Legislative Session was a success for OHA and health insurance consumers statewide. The ongoing development of SustiNet, our continued involvement with federal reform developments, and our daily efforts to improve healthcare access, bode well for Connecticut's healthcare consumers.

MENTAL HEALTH

OHA continues to work on improving our state's mental health parity law (P. A. 08-125). On the Federal level, the Wellstone-Domenici Mental Health Equity and Addiction Parity Act, went into effect on January 1, 2010. OHA staff worked with Senator Dodd's office, offices of other U.S. Senators, attorneys general and consumer advocates from states across the country to ensure final passage of the legislation. You can find details of that legislation at: www.dol.gov/ebsa.

Access to medically necessary mental health treatment at appropriate levels of care continues to be a major issue under managed care. OHA will continue to press insurers to improve provider access and to appropriately review cases based on an individual's needs. The office saw a large jump in insurer denials of coverage for the treatment of eating disorders associated with other mental health conditions. OHA will also push insurers to defer to mental health providers in their recommendations of care.

SOME BIG CHANGES

In 2009, OHA worked on over 2,600 cases, twenty-three percent more than last year. Because of the economic downturn from last year, OHA staff educated and assisted more consumers than ever before on insurance options and changes to COBRA. OHA worked directly with COBRA administrators and employers to ensure laid-off employees received the COBRA extensions and subsidies available under federal and state law.

<i>Total Complaints Closed 2002 thru 2009</i>	
Year	Number of Complaints Closed
2009	2,613
2008	2,143
2007	1,749
2006	1,865
2005	1,468
2004	731
2003	546
2002	643

REPEAT CUSTOMERS

The number of consumer cases referred from legislators doubled from last year (from 98 to 188), following OHA's informal campaign encouraging legislators to make direct referrals to our office. We also experienced a significant increase in the number of referrals from providers and consumers we've helped in the past. Legislators, providers and individual consumers know that OHA operates in real time and via direct contact with consumers on: educational cases, medical and behavioral health issues, and legal matters. Legislators can be certain that OHA will let them know the outcome of matters they refer, without compromising their constituents' confidentiality.

DENIALS ARE INCREASING

Last year also brought an increase in denials, with insurers ratcheting their medical necessity criteria ever tighter, but OHA's reversal rate remains impressive. Mental health continues to be the biggest clinical category of cases OHA handles; one insurer accounts for a disproportionate number of denials and appeals, particularly for the treatment of Eating Disorders. Fortunately, OHA's advocacy resulted in reversals of nearly all of the denials of treatment or services those that involve consumers needing treatment for serious, debilitating, or life-threatening illnesses.

Despite tough economic times, OHA's advocacy returned almost \$6.6 million to residents of Connecticut in 2009.

CONSUMER COMPLAINTS FALL INTO A FEW MAJOR ISSUE CATEGORIES:

TOP TEN COMPLAINTS BY ISSUE

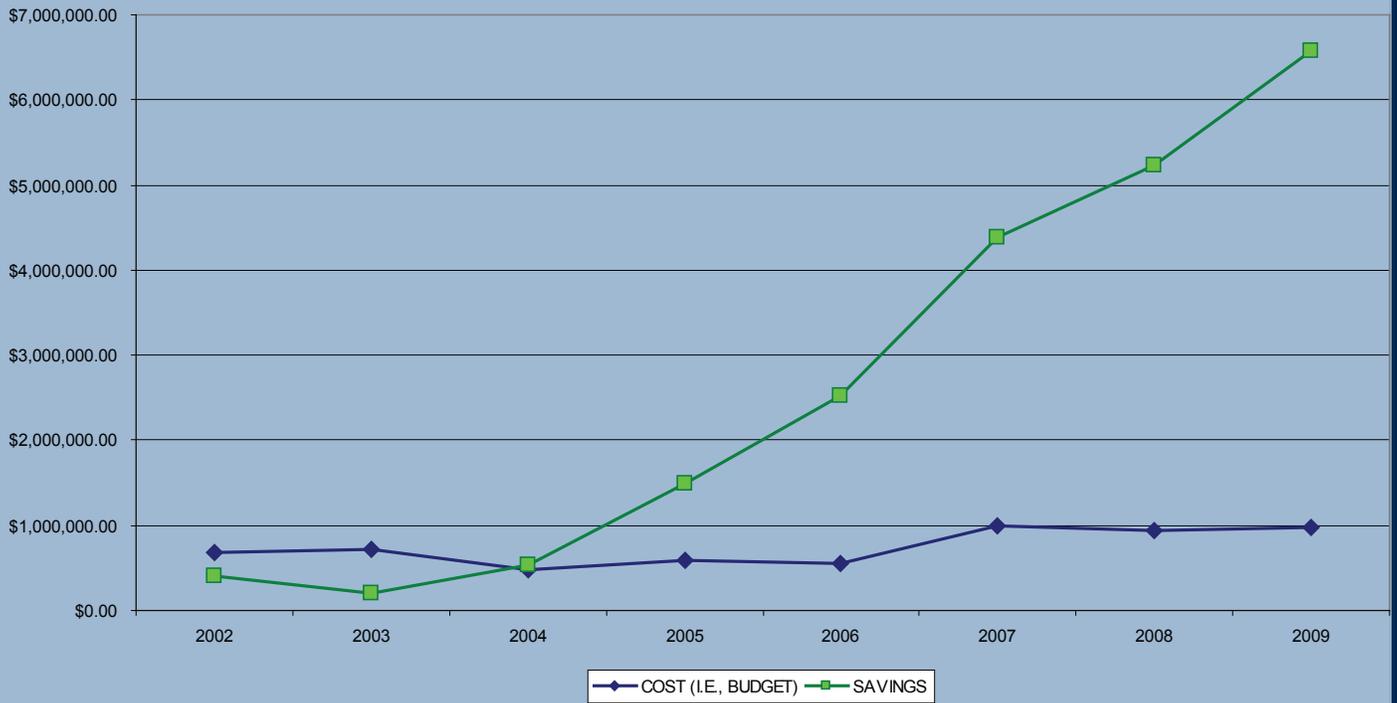
2009 Compared with Previous Years

Complaint	2009	2008	2007	2006
Consumer Denied Service or Treatment	510	232	274	286
Education/Counseling	356	127	142	136
Billing Problem	265	177	119	115
Consumer Enrollment or Eligibility	254	147	176	118
Consumer - Other	141	225	168	96
Clarification - Benefit Design or Legal Issue	118	92	85	107
Delay of Care	117	44	28	12
Provider Denial of Claim	102	96	86	75
Service Not Covered	81	69	51	63
Poor Customer Service	69	55	44	41



OHA RETURN ON INVESTMENT

2009 Agency Cost vs. Consumer Savings



OHA: A GOOD INVESTMENT

YEAR	Investment (i.e., budget)	SAVINGS	Return on Investment
2009	\$981,577.00	\$6,578,895.00	6.70
2008	\$947,685.96	\$5,238,893.00	5.53
2007	\$993,119.00	\$4,391,353.00	4.42
2006	\$544,672.00	\$2,514,825.00	4.62
2005	\$581,414.00	\$1,487,895.00	2.56
2004	\$479,328.00	\$531,823.00	1.11
2003	\$709,271.00	\$205,665.00	0.29
2002	\$686,253.00	\$410,294.00	0.60
Total		\$21,359,643.00	



OHA handled a number of unusual consumer cases. We assisted two managed care consumers with nearly identical cases who had thousands of dollars of treatment at local hospitals, and were sued by those hospitals for unpaid medical bills. Each hospital was in-network with the consumer's insurance plan. For providers to get reimbursement, they must comply with the insurers' contracts and file their claims within the required time frame. Failure to do so, consistently results in denials of coverage from the insurer, and by contract and state law, relieves the consumer from any responsibility for the charges. Both hospitals failed to file a claim with their consumer's insurance plan in a timely manner. As a result, the insurers denied each hospital's claim for reimbursement.

Despite the insurers' denials clearly informing the hospitals that their patients were not responsible for the costs of their treatment, both hospitals referred their respective unpaid bills to their collections attorneys who then filed collections actions against the patients.

Both hospitals obtained judgments against the patients, requiring the patients to pay charges they should not have paid.

OHA sent letters to the attorneys requesting a detailed look at the cases. Once we reviewed the cases, we realized these two hospitals did not include in their representations to the court that: 1) the patients were insured; 2) the hospital submitted their claims to the insurers after the filing deadline; and 3) the result of the untimely filing erases any patient responsibility for the medical bills.

After we notified the respective collection attorneys about Connecticut state law on unfair billing practices, both hospitals went back to court to reopen the judgments against the consumers so the hospitals could withdraw the cases. That action erases the existence of the cases. For one consumer, it resulted in the refund of the thousands dollars of payments he had paid to the hospital, even though he never owed the money. Both consumers were deeply grateful.

We resolved a similar case for a consumer who received emergency medical treatment outside the United States. The hospital never submitted a legible bill to the insurer within the timely manner, despite repeated requests by the consumer and the insurer. When the foreign hospital tried to collect from the consumer the charges for his visit, OHA contacted the hospital and the hospital withdrew its collection activity.

These cases have triggered additional research into hospital billing and collection practices and the need for better education of hospital billing staff on unfair billing practices. The lesson for consumers is to call us no matter how unusual you think your case is. We may fix it and find a deeper problem that we need to address.

Case Example II

C.H. is a vibrant, articulate woman in her mid 50's. Because she is disabled with life threatening medical issues, she is covered by Medicare. She knew what kind of treatment decisions she would be facing, so before she chose a Medicare Advantage plan, she did her homework, and met with a representative of a Medicare Advantage Plan that she thought would best meet her needs. They discussed what the co-payments and co-insurance amounts would be for her anticipated treatments. Based on the information and guidance she received at this meeting, she signed up for a specific plan with that company. By paying more in premium, she was assured that she would virtually have no out of pocket expenses. However, when her claims were processed for her first two months of coverage, she found out that under her policy, her co-payments and coinsurance liabilities added up to well over \$ 1,000, far exceeding what the insurer represented. She was on the verge of being sent to a collection agency.

The Office of the Healthcare Advocate contacted the plan, and negotiated that she be able to change from the product she was encouraged to purchase, into a more appropriate plan for her medical and financial needs. OHA was also able to persuade the plan to refund the out of pocket expenses that she had incurred. C.H. remarked in an e-mail to OHA, "Thank you for your assistance with this nerve racking situation"

C.H.'s case represents how difficult it is to negotiate and evaluate any insurance plan before its purchase. OHA provides assistance to consumers who need help to select or understand any public or private insurance plan.



2009 was OHA's first in preparing the Hospital and Managed Care Community Benefits Report.

Connecticut General Statutes § 19a-127k requires hospitals and managed care organizations to report on a biennial basis the community benefits programs they have in place. The phrase community benefits is defined as "any voluntary program to promote preventive care and to improve the health status for working families and populations at risk in the communities within the geographic service areas of a managed care organization or a hospital in accordance with guidelines established pursuant to subsection (c) of this section."

Public Act 08-184 shifted responsibility for the collection of data on hospital and

Hospital and Managed Care Organization Community Benefits Report 2007 - 2008 Biennium

"Because Connecticut like most other states and the federal government is on a path to significantly improve access to preventive healthcare and the treatment of chronic conditions, hospitals and MCOs are necessarily part of the equation. The provision of community benefits programs will play an even larger role in community health education."

managed care organization community benefit programs from the Department of Public Health to the Office of the Healthcare Advocate (OHA). In keeping with the biennial reporting requirements of §19a-127k, OHA collected data for the 2007 and 2008 calendar years.

No managed care organizations reported that they have community benefit programs as defined in statute. However, some managed care organizations provide outreach services to communities or free clinics that might qualify under a clearer definition of a "community benefits program."

Because of inconsistent reporting by hospitals and managed care organizations over the past few years, and despite the use of a re-designed survey this year, true statistical comparisons among hospitals and managed care organizations across years are impossible. OHA provides the information reported by the surveyed entities, but in its report OHA made recommendations to ensure that future reports are of more value and consistency to legislators, the Governor and the public.



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Office of the Healthcare Advocate MCO39400

	Actual Expenditure FY 08	Estimated FY 09	Governor Recommended FY 10	Governor Recommended FY 11	Legislative FY 10	Legislative FY 11
POSITION SUMMARY						
Permanent Full-Time - IF	7	7	0	0	10	10
BUDGET SUMMARY						
Personal Services	437,490	541,822	0	0	713,161	757,235
Other Expenses	144,779	137,542	0	0	183,342	204,838
Equipment	8,533	1,266	0	0	2,400	2,400
Other Current Expenses						
Fringe Benefits	233,465	303,692	0	0	375,228	380,821
Indirect Overhead	14,878	23,750	0	0	20,000	24,000
Agency Total - Insurance Fund [1]	839,145	1,008,072	0	0	1,294,131	1,369,294

	Legislative FY 10		Legislative FY 11		Diff. from Governor Rec FY 10		Diff. from Governor Rec FY 11	
	Pos.	Amount	Pos.	Amount	Pos.	Amount	Pos.	Amount
FY 09 Governor Estimated Expenditures - IF	7	1,008,072	7	1,008,072	0	0	0	0
Inflation and Non-Program Changes								
Personal Services	0	15,165	0	23,413	0	0	0	0
Other Expenses	0	7,428	0	7,428	0	0	0	0
Equipment	0	1,134	0	1,134	0	0	0	0
Fringe Benefits	0	24,204	0	29,797	0	0	0	0
Indirect Overhead	0	-3,750	0	250	0	0	0	0
Total - Insurance Fund	0	44,181	0	62,022	0	0	0	0

Funding for the Commission on Health Equity

The Commission on Health Equity was established within the Office of the Healthcare Advocate (OHA), for administrative purposes only, through PA 08-171. Funds to support the Commission were not appropriated.

The Commission's mission is to eliminate disparities in health status based on race, ethnicity and linguistic ability, and to improve the quality of health for all of the state's residents.

-(Legislative) One position and funding of \$84,522 in Personal Services and \$47,332 in Fringe Benefits is provided in FY 10 and FY 11 to support the Commission on Health Equity.

Personal Services	1	84,522	1	84,522	1	84,522	1	84,522
Fringe Benefits	0	47,332	0	47,332	0	47,332	0	47,332
Total - Insurance Fund	1	131,854	1	131,854	1	131,854	1	131,854

Provide Funding for Sustinet Staffing

PA 09-148 established a Sustinet Health Partnership Board of Directors that must make legislative recommendations, by January 1, 2011, on the details and implementation of the "Sustinet Plan," a self-insured health care delivery plan.

	Legislative FY 10		Legislative FY 11		Diff. from Governor Rec FY 10		Diff. from Governor Rec FY 11	
	Pos.	Amount	Pos.	Amount	Pos.	Amount	Pos.	Amount
-(Legislative) Funding for two positions and related expenses, a total of \$114,643 in FY 10 and \$171,965 in FY 11, is provided to support the Sustinet Health Partnership Board of Directors.								
Personal Services	2	71,652	2	107,478	2	71,652	2	107,478
Other Expenses	0	42,991	0	64,487	0	42,991	0	64,487
Total - Insurance Fund	2	114,643	2	171,965	2	114,643	2	171,965

Reduce Funding to Reflect the Rollout of the FY 09 Recisions

The Governor initiated four rounds of recisions in FY 09 totaling \$178.2 million in General Fund and \$31.4 million in Other Funds. The Governor's FY 10 - FY 11 Biennial Budget includes the rollout of some of these FY 09 recisions across various agencies.

-(Governor) Funding of \$4,000 is reduced in FY 10 and FY 11 to reflect the rollout of the Governor's FY 09 recisions.

-(Legislative) Same as Governor.

Other Expenses	0	-4,000	0	-4,000	0	0	0	0
Total - Insurance Fund	0	-4,000	0	-4,000	0	0	0	0

Achieve Other Expenses General Savings

-(Governor) Funding of \$619 is reduced in FY 10 and FY 11 to reflect a general savings due to streamlining of business operations in this agency. Savings are anticipated across various state agencies to result from a reduction in operating costs (examples include: cellular communications services, in-state travel, mileage reimbursement, food/beverage, motor vehicle rental and fuel).

-(Legislative) Same as Governor.

Other Expenses	0	-619	0	-619	0	0	0	0
Total - Insurance Fund	0	-619	0	-619	0	0	0	0

Adjust Placement of the Office of the Healthcare Advocate

The OHA serves Connecticut healthcare consumers by working to resolve consumers' conflicts with their insurance companies. OHA does this through: direct consumer advocacy with insurance companies, public education, and interagency coordination. OHA's caseload in FY 08 included approximately 2,000 patients, resulting in \$5.2 million in "consumer savings" (the value of the insurance claims overturned with OHA's assistance).

-(Governor) The elimination of OHA is provided through the reduction of \$1.0 million in funding from the Insurance Fund in FY 10 and \$1.1 million in FY 11. Seven positions under OHA are eliminated.

	Legislative FY 10		Legislative FY 11		Diff. from Governor Rec FY 10		Diff. from Governor Rec FY 11	
	Pos.	Amount	Pos.	Amount	Pos.	Amount	Pos.	Amount
-(Legislative) The elimination of OHA is not provided.								
Personal Services	0	0	0	0	7	556,987	7	565,235
Other Expenses	0	0	0	0	0	140,351	0	140,351
Equipment	0	0	0	0	0	2,400	0	2,400
Fringe Benefits	0	0	0	0	0	327,896	0	333,489
Indirect Overhead	0	0	0	0	0	20,000	0	24,000
Total - Insurance Fund	0	0	0	0	7	1,047,634	7	1,065,475
Budget Totals - IF	10	1,294,131	10	1,369,294	10	1,294,131	10	1,369,294

OTHER SIGNIFICANT 2009 LEGISLATION AFFECTING THE AGENCY'S BUDGET

PA 09-148, "An Act Concerning the Establishment of the Sustinet Plan" – This Act a Sustinet Health Partnership board of directors that must make legislative recommendations, by January 1, 2011, on the details and implementation of the "SustiNet Plan," a self-insured health care delivery plan. PA 09-3 of the June Special Session (the Budget Act) provides funding for two positions under the Office of the Healthcare Advocate to support this board.

[1] In order to achieve an aggregate FY 10 budgeted lapse, the Office of Policy and Management has programmed allotment reductions for agencies that comprise the various lapses in Section 1 of PA 09-3 JSS. A detailed list of holdbacks by agency is included in the Financial Schedules section of the book.

Office of the
Healthcare
Advocate
State of Connecticut



-- Artwork by K. S, aged 11

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