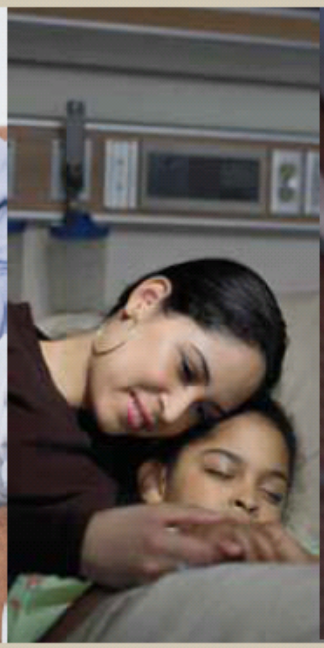
OHA

Office of the
Healthcare
Advocate

STATE OF CONNECTICUT



ANNUAL REPORT
2012

A Message from the Healthcare Advocate

I am pleased to issue the Office of the Healthcare Advocate's 2012 Annual Report. The Office of the Healthcare Advocate (OHA) was created in 1999 as part of the Managed Care Accountability Act. We have worked with tens of thousands of policyholders, patients and families to explain their rights and responsibilities in their health plans, and to advocate for patients when they are denied treatment or reimbursement by their health plans. OHA has also taken on additional responsibilities, aimed at recovering state funds, which we highlight in the report.

OHA 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 website, Facebook, Twitter and YouTube accounts give timely information about consumer rights in health insurance and updates on legislative, consumer and industry activities. We welcome your feedback and suggestions as we take on our challenges.

The report refects the dedication of OHA's staff, which continues to provide outstanding service to the residents of Connecticut. As of the date of this report, OHA reached over $50 million in savings for consumers since the office opened in 2001.

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

My Warmest Wishes for a Healthy 2013,

Victoria Veltri
State 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 provided, 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 individual and commercially insured, employer-sponsored segment of the Connecticut population has been joined by many Medicare beneficiaries who have enrolled in managed care plans.

The Office of the Healthcare Advocate helps individual Connecticut consumers who have all types of health coverage, including private and public plans. While 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 healthcare plan. We can answer questions and assist consumers in understanding and exercising their rights to appeal a managed care plan's denial of a benefit or service.

By law, OHA is authorized to represent Connecticut residents in adminstrative matters, monitor implementation of state and federal laws, and facilitate comment on those laws.

On the state and national levels, OHA has been very active in promoting healthcare consumer interests in Medicaid and fully-insured and self-insured plans. The Healthcare Advocate is a member of the Connecticut Health Insurance Exchange Board, assuming the position of Vice-Chair of the board. OHA pushes for systemic reforms based on sound data and health policy, and as the state's healthcare watchdog, OHA continues to push for accountability and transparency in healthcare costs and spending.

OHA continues to focus on implementation and enforcement of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, conducting multiple outreach efforts throughout Connecticut and a public hearing in October 2012, and issuing a report on barriers to access to behavioral health preventive and treatment services in Connecticut. OHA continues to work with national and state partners and our federal delegation to address long-term remedies that must be implemented.

Federal Involvement and Consumer Assistance Program Grant

Congressional offices consulted with OHA on the establishment of consumer assistance program grants under the Affordable Care Act (ACA). OHA stressed the importance of the independence of consumer assistance programs. After passage of the ACA, OHA secured a one year $396,400 consumer assistance program grant from the Department of Health and Human Services' Office of Consumer Information and Insurance Oversight (OCIIO). The grant supports two additional case managers and one out reach coordinator/data analyst. One grant was awarded to each state. Congressional officials supported OHA's application.

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In 2012, OHA received two more Consumer Assistance Program (CAP) grants , a limited competition grant of $127,967 and a full competition grant of $408,155. With those grants, OHA was able to replace three previous grant positions and to make some improvements in its data systems and reporting capabilities.

Under the ACA, all plans, whether self-funded or fully insured, are required to include OHA's contact information on every denial issued, informing consumers that OHA can assist with grievances and appeals. This requirement, in addition to Connecticut's similar law, led to 1328 referrals to OHA in CYs 2011 and 2012.

OHA conducted two television spot campaigns, running spots in English and Spanish in portions of the state in varying time slots. The spots have generated a heavy call volume of individuals who need help understanding insurance or selecting a health plan. OHA will be airing the spots in prime time in all areas of the state beginning in the spring of 2013.

The CAP grant funding also supports a partnership with a non-profit community organization to assist with outreach to underserved communities, a thirty minute PSA distributed to public access stations in the state, OHA brochures in twenty languages, including Braille, a webcast production on health reform, and a provider educational series with OHA providing training on how to conduct appeals, on health reform and on other topics.

OHA is administering the Navigator and In-Person Assister Program (NIPA) on behalf of the Connecticut Health Insurance Exchange. The NIPA program is a federally funded, grant funded program required by the ACA in order to reach residents where they live, work and play to educate them on a one-to-one basis about insurance options and to enroll individuals into coverage, beginning October 1, 2013. The NIPA is an intense grassroots outreach campaign that will assist people in enrolling into Medicaid or an Exchange plan.

The Healthcare Advocate now sits as the Vice-Chair of the CT Health Insurance Exchange Board, the co-chair of its Consumer Experience and Outreach Committee, and as a member of the Audit, Strategy and Finance committees.

Other Efforts

The Healthcare Advocate sits on the Council on Medical Assistance Program Oversight, the board of the Health Information Technology Exchange, the Healthcare Associated Infections Advisory Committee, and the Advisory Board for Healthcare Management and Insurance Studies at the UConn School of Business.

The Case for OHA - Legislative Summary

OHA received tremendous support from the Governor and the General Assembly in 2012. The number of referrals to OHA from the legisature, the Governor's office and other state agencies, including the Insurance Department totaled 464, the highest number of those types of referrals since OHA's inception.

Agency Collaborations

After OHA read in an article that the Department of Children and Families (DCF) might have to cut back services in its Voluntary Services Program, a program that provides behavioral health services for children, and DCF determined that a high number of children in the program are covered by private insurance, OHA and DCF engaged in a collaboration so that families with insurance coverage would be sent to OHA for assistance. Under the collaboration, OHA:

- Counsels families on their rights under the insurance plans, including the right to appeal denial of coverage
- Educates DCF regional office supervisors and workers about the proper use of primary healthcare coverage to prevent unnecessary state spending
- Ensures that planning for children who need out of home placement on a temporary basis is done concurrently by a provder and the Connecticut Behavioral Health Partnerhsip
- Conducts internal and external appeals for medically necessary services for all types of healthcare coverage for referred families
- Participates in ongoing planning and subsequent appeals for children referred to OHA

OHA also began a collaboration with the Department of Social Services to recover funds inappropriately spent by the Medicaid program on services that should have been covered by other healthcare coverage. An MOU was signed in October 2012 with DSS. OHA is attempting to detangle multiple errors with the submitted data. OHA has begun submitting appeals. to insurers to recover money for the general fund. OHA received approximately $8 million in claims, which is the maximum amount that OHA will be provided. However, DSS estimates that insurers will deny between $66 and $69 million in claims in the next biennium.

Legislative Work

In 2012, OHA testfied on many bills to protect consumers and to improve their chances of prevailing in the appeal process. OHA prepared a series of briefings to educate OHA staff on developments at the legislature and to tie OHA's position on proposed legislation to OHA's Principles for Policy Action.

Legislative Briefings

OHA testified in support of bills that: clarified what preventive services are subject to cost sharing under health plans in Connecticut; would have offered small business more leverage in negotiating premiums with their health insurers by allowing small business to join with the state employee pool; provided coverage for telemedicine services; require health insurers to make the entire record, including documents relied on in making a decision, to be made available to a consumer so that a consumer can prepare a proper appeal; prohibit carriers from imposing certain cost sharing for preventive colonoscopies when something is discovered during the service; and establish an All Payer Claims Database to help determine patterns in treatment, transparency in healthcare costs, and disparities in outcomes.

OHA appeared before the following committees during the 2012 legislative session: Insurance and Real Estate, Children's, Appropriations, Public Health, Human Services and Judiciary.

Read OHA's legislative briefings by clicking on the image on the right, directly below.

Hospital & Managed Care Community Benefits Report

Conn.Gen.Stat. Sec. 19a-127k requires hospitals and managed care organizations to report to OHA on the community benefit programs they offer. OHA is required to assemble these reports on a biennial basis, within available appropriations, and to make recommendations for improvement to the Governor and legislators and to make those recommendations available to managed care organizations and hospitals. OHA is currently collecting the IRS 990 tax forms from all entities from which a report will be generated.

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Advocacy *for* Individuals *with* Mental Health *and/or* Substance Use Service Needs

OHA is charged under Conn.Gen.Stat. Section 38a-1041(e) with establishing a "process to provide ongoing communication among mental health providers, patients, state-wide and regional business organizations, managed care companies and other health insurers to assure: (1) Best practices in mental health treatment and recovery; (2) compliance with the provisions of sections 38a-476a, 38a-476b, 38a-488a and 38a-489; and (3) the relative costs and benefits of providing effective mental health coverage to employees and their families."

As part of its meeting its missions to analyze and monitor the development and implementation of federal, state and local laws, regulations and policies relating to healthcare coverage and recommend changes it deems necessary and facilitate public comment on laws, regulations and policies, including policies and actions of health insurers, OHA held a public hearing on October 17, 2012 to hear from consumers, providers, state agencies and others about barriers to access. The goal was to reset the current status of the delivery of mental health and substance use prevention and treatment services, while ensuring maximization and streamlining of existing resources and full explanation of insurance coverage.

OHA seeks to address the need for all Connecticut residents to have access to a mental health and substance use service delivery system that is integrated with overall healthcare, addresses healthcare disparities and improves overall outcomes.

OHA is working with its community partners, state agencies and Senator Blumenthal's office to push for the fulfillment of the promise of the Mental Health Parity and Addiction Equity Act of 2008.

OHA issued a report with its findings and recommendations on mental health and substnace use services in Connecticut. OHA will work will all its partners, especially the consumers of Connecticut, to push for long-term, sustainable change. Our report is available online at www.ct.gov/oha/lib/oha/documents/publications/report_of_findings_and_recs_on_oha_hearing_1-2-13.pdf.

FINDINGS AND RECOMMENDATIONS

Findings

1. **Connecticut lacks an overall vision of how to recognize, evaluate and provide services for individuals with mental health and substance use delivery services**
2. **Connecticut's current delivery system for mental health and substance use services is fragmented and inconsistent—benefits and access depend upon eligibility for healthcare coverage and whether the coverage is private or public**
3. **Capacity for delivery of services is insufficient for the delivery of needed services-community-based services are available on a small scale only to those in public coverage, the workforce is insufficient and there are inadequate provider networks for insured individuals covered by private coverage.**
4. **Health insurer or administrator processes for evaluation of the need for services, appeals of those decisions and peer-review for insurance denials do not always reflect the need for prompt and accurate decision-making**
5. **Mental health and substance use prevention services are largely unknown and not targeted broadly enough**
6. **Mental health and substance use care largely is not integrated into overall healthcare models nor is it designed to improve outcomes and reduce racial and ethnic disparities**

Recommendations

1. **Connecticut should adopt an overall vision for health that integrates and coordinates access to effective, timely, high quality and affordable mental health and substance use prevention and treatment services into overall healthcare**
2. **Connecticut's mental health and substance use delivery system should be synchronized by an coordinating entity**
3. **Prevention, awareness and screening programs must be enhanced**
4. **Residents covered by self-funded and fully-insured plans should have access to community-based services**
5. **Mental Health Parity and Addiction Equity must be enforced**
6. **The recommendations of the 12/18/12 Program Review and Investigation Committee report should be adopted in full**
7. **State programs must be evaluated for cost effectiveness, and should be streamlined**
8. **Cost shifting to the state should be evaluated and minimized.**

"I rely on you for insurance issues for my son. You are invaluable" - K.M.

Consumer Relations

The number of cases referred from legislators has steadily increased. We continue to encourage legislators to refer cases directly to OHA for high-quality real time services. OHA experienced a significant increase in the number of referrals from consumers and providers we've helped in the past: 526 personal referrals in 2010 up from 408 in 2009. Legislators, providers and 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. Consumers are very satisfied with our services.

Though denials of services or treatment remains the highest category of complaints OHA receives, the number of cases involving education and counseling continues to increase because of health reform activities. Mental health continues to be the biggest category of cases OHA handles; one insurer accounts for a disproportionate number of denials and appeals. Fortunately, OHA's advocacy resulted in reversals of denials of treatment or services that involve consumers needing treatment for serious, debilitating, or life-threatening illnesses.

In 2012, OHA fielded 9,400 calls on its toll free line and 925 referrals directly to the agency staff. OHA's advocacy returned $6.3 million to the residents of Connecticut in 2012.

Consumer Stories

Daniel requires adaptive equipment for sitting and standing. He outgrew his prone stander and required a new one. A claim was submitted to his insurer for a new one. The carrier denied the request stating that the prone stander was investigational. OHA filed an appeal on behalf of Daniel with the support of his pediatrican, physical medicine specialist and physical therapist. OHA also supplied peer reviewed literature to support the argument that the prone stander was medically necessary to assist Daniel in sitting, standing and other position changes.

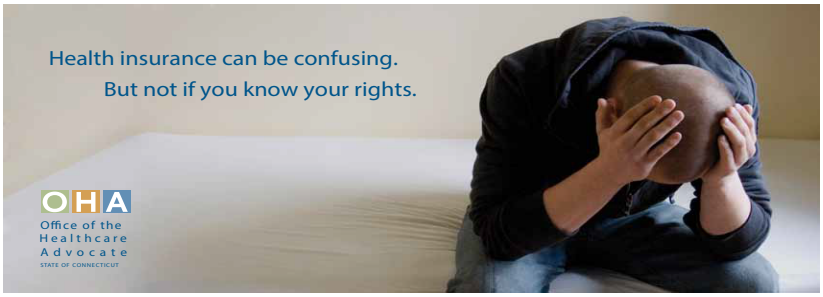
Based on OHA's arguments, the the insurer overturned the denial, and Daniel received his prone stander three days after Christmas. Daniel's mother reports that Daniel is getting used to his new stander. The stander provides the safety and support he needs for position changes.

KNOW YOUR RIGHTS
PROTECT YOUR RIGHTS

OHA

L.J. is a four year old boy with autism. He was receiving occupational therapy (OT) services that were denied by his insurer. L.J.'s provider file an appeal on behalf of L.J. Hi family paid for the OT services while the appeal was pending, but they quickly realized that paying for the services was unaffordable. The family contacted OHA.

The OHA case manager contacted the provider and provided education and counseling on the need for detailed documentation on progression from OT services and education. As a result of the case manager's coordination of the appeal, the carrier overturned its denial and approved an additional 24 visits for L.J.



CHOOSE YOUR PLAN

OHA

The family of a seventeen year old young man whose continued inpatient hospital level of care was denied by his carrier sought OHA's help in securing coverage for needed services. In five months, the young man made a significant suicide attempt and escalated his threats of harm toward others.

In denying coverage for step down care, the insurer called the young man's situation chronic although his situation began only five months ago with self-harm, threats against peers at school, increased isolation, his being bullied by peers at school and destruction of property.

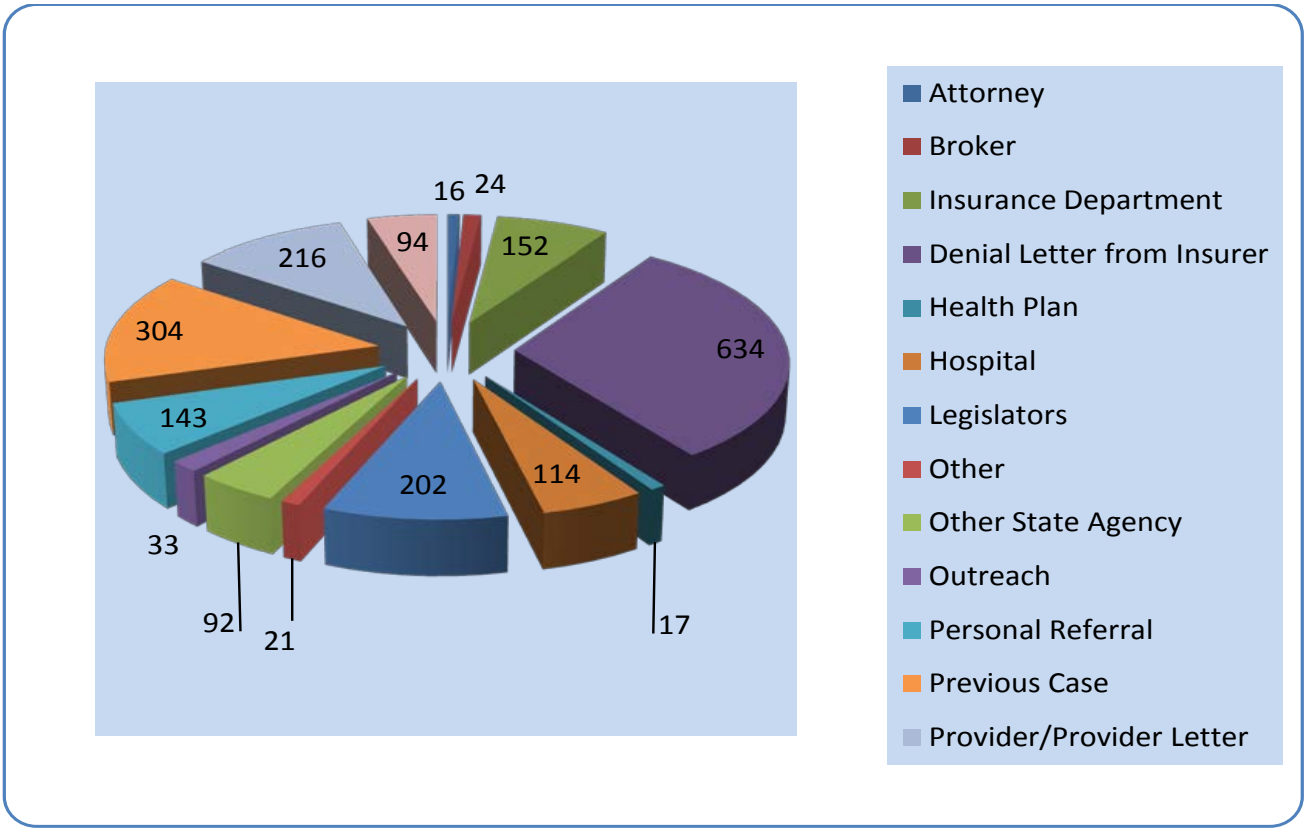
In collaboration with another state agency, OHA argued to the insurer that continued inpatient coverage was required, followed by a step-down treatment option. OHA filed an external appeal, and the insurer's decision was overturned, providing coverage for a continued inpatient coverage an initial thirty day stay in the step down facility. OHA continues to pursue coverage for ongoing needs for this young man.

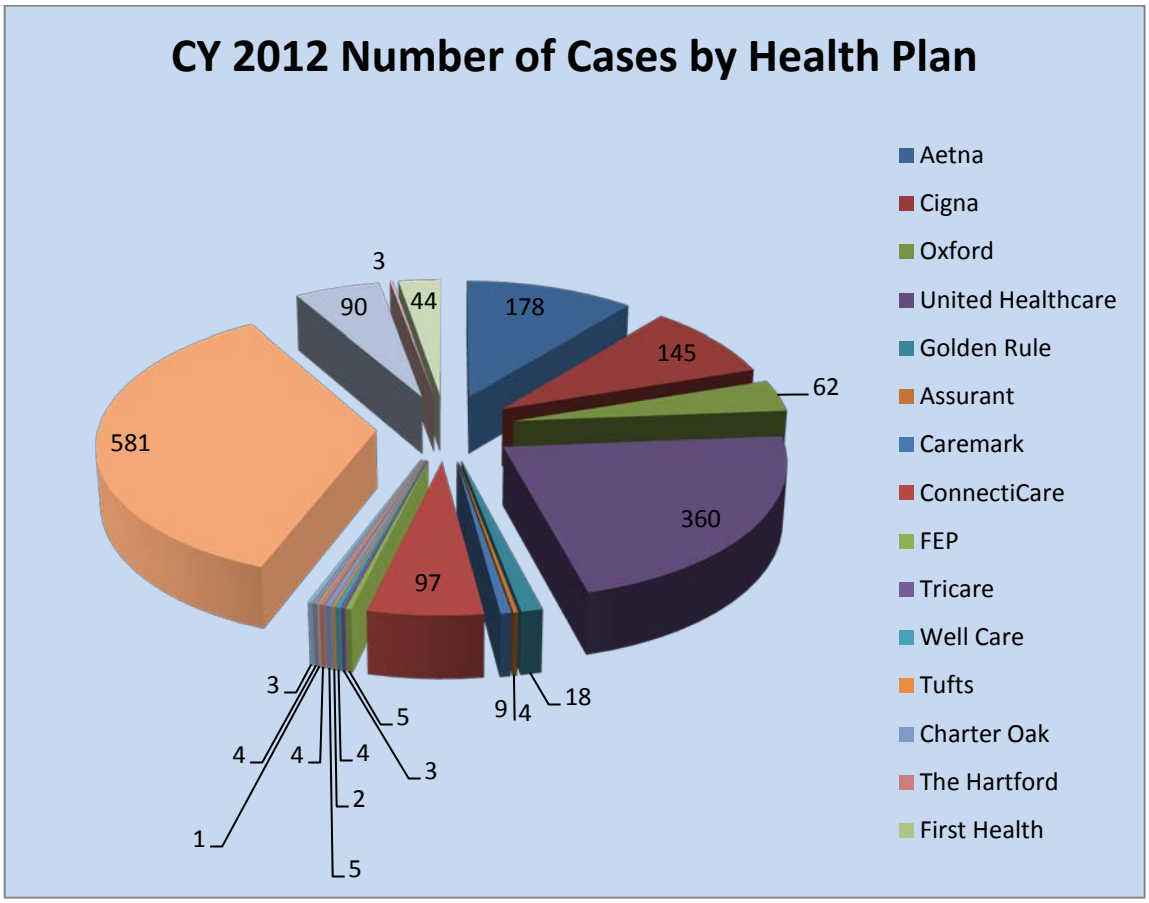
OHA Cases by Highest Frequency of Clinical Category and Calendar Year

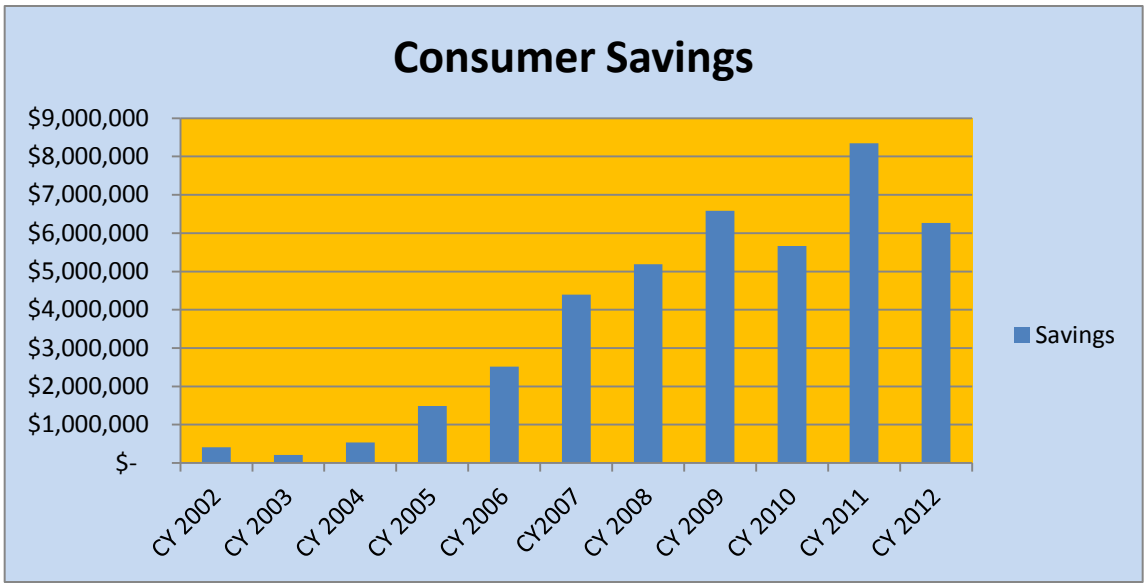
Clinical Category (Highest Frequency)	2008	2009	2010	2011	2012	Total
Mental Health*	185	207	264	407	524	1587
Medical	123	193	155	257	261	989
Pediatrics	46	65	58	87	93	349
Geriatric	41	63	40	58	24	226
Pharmacy	68	118	120	173	141	620
Surgery	66	107	76	140	151	540
Orthopedic	33	81	79	122	113	428
Oncology	74	89	50	80	90	383
Dental	84	87	56	385	267	879
Physical Therapy	42	39	53	155	110	399
OB/GYN	33	49	39	70	33	224

* Mental Health includes Substance Use. In calendar year 2013, substance use and mental health will be tracked separately, but co-occurring conditions will be tracked by primary diagnosis.

CY 2012 Referral Sources (Highest Frequency)



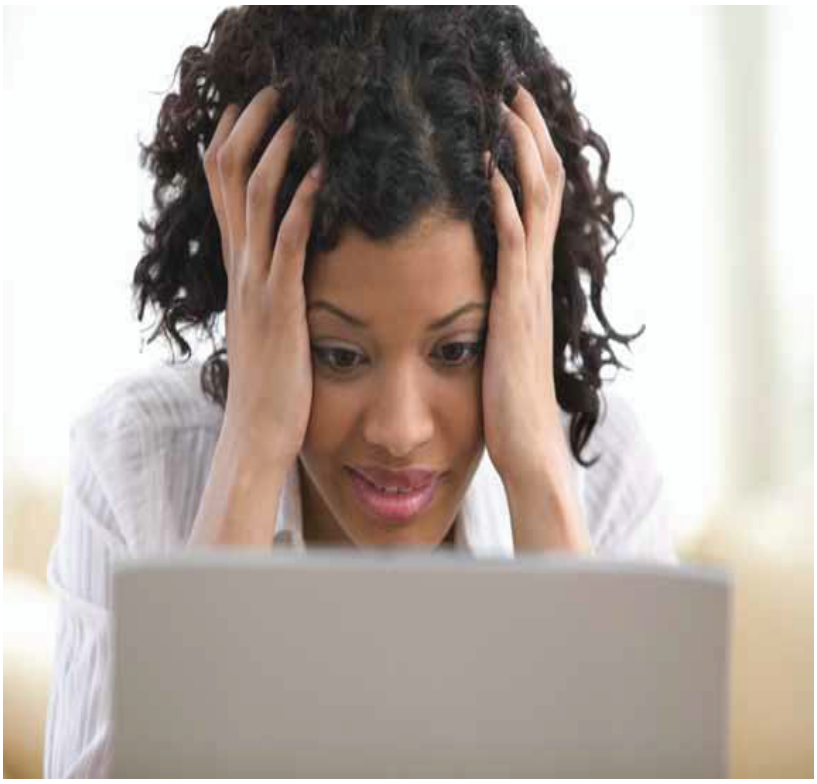




The slight loss in savings in 2012 from 2011 is attributed to lost productivity due to substantial medical leaves, the loss of a seasoned case manager and several cases in 2011 with unusually high savings.

Healthcare can be Confusing
The Answers Start at OHA

CALL OHA for help
1-866-466-4446
healthcare.advocate@ct.gov



OHA STAFF 2012

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"You do an outstanding job and provide a wonderful serivce. My thanks." - K.H.

STAFF NOTES:

Candice Kohn retired in December 2012 after seven years with OHA
Liz Lemiska left in the summer of 2012 to take a position in the private sector

Office of the Healthcare Advocate
MCO39400

	Actual Expenditures FY 11	Governor's Estimated FY 12	Original Appropriated FY 13	Governor Revised FY 13	Legislative Recommended FY 13	Difference Leg - Gov FY 13
POSITION SUMMARY						
Permanent Full-Time - IF	10	9	9	13	18	5
BUDGET SUMMARY						
Personal Services	619,209	746,398	725,540	960,256	1,268,100	307,844
Other Expenses	136,371	136,373	136,374	136,374	157,442	21,068
Equipment	1,146	1,400	700	700	6,700	6,000
Other Current Expenses						
Fringe Benefits	393,011	493,954	495,294	657,248	841,954	184,706
Indirect Overhead	(527)	117,320	120,957	19,211	19,211	0
Agency Total - Insurance Fund	**1,149,210**	**1,495,445**	**1,478,865**	**1,773,789**	**2,293,407**	**519,618**

	Gov Rec FY 13 Pos.	Gov Rec FY 13 Amount	Leg Rec FY 13 Pos.	Leg Rec FY 13 Amount	Difference from Gov Pos.	Difference from Gov Amount
BUDGET CHANGES SUMMARY						
FY 13 Original Appropriation - IF	9	1,478,865	9	1,478,865	0	0
Current Services Adjustments	0	(101,746)	0	(101,746)	0	0
Current Services Totals - IF	9	1,377,119	9	1,377,119	0	0
Policy Adjustments	4	396,670	9	916,288	5	519,618
Total Recommended - IF	13	1,773,789	18	2,293,407	5	519,618
BUDGET CHANGES DETAILS						
FY 13 Original Appropriation - IF	9	1,478,865	9	1,478,865	0	0
Current Services Adjustments						
Adjust Indirect Overhead This agency is charged by the State Comptroller under the Statewide Cost Allocation Plan (SWCAP) for utilizing certain centralized state agency services. **(Governor)** Reduce funding by $101,746 to reflect revised SWCAP costs. **(Legislative)** Same as Governor						
Indirect Overhead	0	(101,746)	0	(101,746)	0	0
Total - Insurance Fund	0	(101,746)	0	(101,746)	0	0
Current Services Adjustments Subtotals	0	(101,746)	0	(101,746)	0	0
Current Services Totals - IF	9	1,377,119	9	1,377,119	0	0

	Gov Rec FY 13 Pos.	Gov Rec FY 13 Amount	Leg Rec FY 13 Pos.	Leg Rec FY 13 Amount	Difference from Gov Pos.	Difference from Gov Amount
Policy Revision Adjustments						
Absorb Federally Funded Positions						
(Governor) Provide funding of $295,270 for three positions previously supported by federal resources. Of this total, $174,716 is for personal services and $120,554 is for fringe benefits. The positions are a Health Program Assistant 2, Clinical Social Worker, and a Nurse Consultant.						
(Legislative) Same as Governor						
Personal Services	3	174,716	3	174,716	0	0
Fringe Benefits	0	120,554	0	120,554	0	0
Total - Insurance Fund	3	295,270	3	295,270	0	0
Transfer One Position from the Department of Children and Families						
The Department of Children and Families' (DCF) Voluntary Service Program (VSP) provides casework, community referrals, and treatment services for children and youth with serious emotional disturbances, mental illnesses, and/or substance dependency who are not committed to DCF.						
(Governor) Transfer funding of $101,400 from DCF to support one position dedicated to appealing denials of insurance coverage for VSP clients. Of this total, $60,000 is for personal services and $41,400 is for fringe benefits.						
(Legislative) Same as Governor						
Personal Services	1	60,000	1	60,000	0	0
Fringe Benefits	0	41,400	0	41,400	0	0
Total - Insurance Fund	1	101,400	1	101,400	0	0
Enhance Medicaid Recoveries						
Currently, the Department of Social Services bills private insurance agencies for repayments when appropriate for Medicaid eligible clients.						
(Legislative) Provide funding of $447,118 and four positions to allow the Office of the Healthcare Advocate (OHA) to pursue private insurance payment for rejected claims for Medicaid eligible individuals. These positions are a health program supervisor and a registered nurse case manager.						
OHA shall provide the legislature with a Result Based Accountability report concerning the success of these efforts and the potential to expand private insurance recoveries.						
Personal Services	0	0	4	270,344	4	270,344
Other Expenses	0	0	0	8,568	0	8,568
Equipment	0	0	0	6,000	0	6,000
Fringe Benefits	0	0	0	162,206	0	162,206
Total - Insurance Fund	0	0	4	447,118	4	447,118

	Gov Rec FY 13 Pos.	Gov Rec FY 13 Amount	Leg Rec FY 13 Pos.	Leg Rec FY 13 Amount	Difference from Gov Pos.	Difference from Gov Amount
Provide Resources for the Commission on Health Equity The Connecticut Commission on Health Equity was established to eliminate disparities in health status based on race, ethnicity, gender and linguistic ability, thereby improving the quality of health for all of the state's residents. **(Legislative)** Half-year funding of $72,500 is provided for the Commission. These funds shall by used to support a Master's of Public Health level position to assist the Commission in researching and writing reports. The Commission is also provided with dedicated Other Expenses funding ($12,500).						
Personal Services	0	0	1	37,500	1	37,500
Other Expenses	0	0	0	12,500	0	12,500
Fringe Benefits	0	0	0	22,500	0	22,500
Total - Insurance Fund	0	0	1	72,500	1	72,500
Policy Adjustments Subtotals	4	396,670	9	916,288	5	519,618
Total Recommended - IF	13	1,773,789	18	2,293,407	5	519,618

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