

# HELPING CONSUMERS THROUGH THE MANAGED CARE MIRE

State advocacy office helps insured residents get the treatment they deserve

By VICTORIA VELTRI

Health reform and access to health insurance coverage are the talk of the state and the country. Extending insurance coverage to the tens of millions of Americans and the hundreds of thousands of Connecticut residents without it is certainly a widely shared goal—there are multiple bills under consideration in the state legislature that would move us much closer to that goal.

Nonetheless, we need to make it a priority to focus also on the many inconsistencies and barriers to care faced by consumers who are currently insured so we don't duplicate our mistakes on a systemic basis. Daily, Connecticut's commercially and publicly insured residents struggle to understand their insurance coverage, their financial responsibilities and how to challenge decisions that deny medically necessary care. The Office of the Healthcare Advocate (OHA) helps consumers navigate these confusing processes.

OHA is an independent, non-partisan state agency with one overriding mission: to provide assistance to consumers who may be confused about health care in general and

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need help in working through managed care issues. Since its inception, the office has provided free services to consumers in investigation of their complaints, appealing denials of coverage by insurance plans and assisting residents in the selection of plans. OHA pursues legislative or systemic remedies when individual casework identifies ongoing barriers to health care. State and national officials, and officials from other states, consult with our staff on a regular basis to discuss emerging federal health care issues and to seek our input on proposed legislation.

## Cancer Case

One person who was caught in a managed care mire is Claire, a 63-year-old woman who thought her battle with breast cancer ended more than 15 years ago. Instead, it returned with a vengeance and she needed immediate treatment to save her life. She underwent major surgery, chemotherapy and radiation during her first go-around, but one of her lungs and her heart were affected by the massive doses of radiation. Her new and experienced oncologist suggested a

newer form of focused, higher-dose radiation treatment to prevent further damage to Claire's lungs and heart. The oncologist requested prior authorization for the treatment as required by Claire's insurer. An approval would guarantee that the insurer would not argue that the treatment was not medically necessary. A denial would guarantee a delay in treatment at best, or no treatment at worst. Claire, like many others before her, hit a major roadblock. Her insurer rejected the oncologist's request for prior authorization for the procedure, calling the procedure experimental and investigational, despite its frequent and effective use for repeat cancer patients with organ damage.

After OHA convinced the insurer to reopen Claire's appeal and to have an appropriately trained provider review the request based on Claire's individual circumstances, including the compromised status of her heart and lungs, the insurer overturned its denial. Claire started her focused radiation treatment the next day and is doing very well.

The overriding concern in managed health care is whether requested health care services or treatments are "medically necessary." The concept of medical necessity has been the subject of complex litigation and multiple pieces of state legislation to protect providers and consumers, and to reinvigorate and codify the deference due to health providers when they render care to patients. However, at its core it is an individual issue affecting individual consumers.

To be sure, insurers approve the majority of requested treatments. Sadly, however, Claire's experience with a denial of medically necessary treatment was repeated over 60,000 times last year for individual health care policyholders in Connecticut. Approximately 17 percent of the 358,000 advance requests for treatment last year were denied. These statistics do not include insurers' other denials of claims based on a lack of medical necessity for services or treatments that do not require advanced approval. Nor do they include data on claim denials for other reasons such as a patient's use of an out-of-network provider.

OHA is right in the middle of the medical necessity, claim denial and other health care battles. We fight for individuals like Claire who face death or serious illness in the mirror, and whose choices are limited to either doing everything they can to get their medically necessary treatment, or going without, because their insurers fail to look at them as individuals with unique circumstances. Nowadays, an insurer not paying for promised medically necessary care is tantamount to an actual denial of care.

## Increased Demand

Skyrocketing health care costs, a rough economy, the clamping down on approvals of requests for health care coverage, and the escalating numbers of people requesting coverage for mental health services, surgical interventions and effective medications have only increased demand for the free legal, individual and systemic advocacy services that the Office of the Healthcare Advocate provides to Connecticut residents. We try each day to restore the balance between the consumer's need for health care, the provider's need for respect for his or her medical judgment and the need to control health care costs.



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Since 2001, OHA has assisted more than 8,000 people and returned \$14.5 million back to consumers when denials of care are overturned. Last year alone, OHA saved consumers \$5.2 million with an 85 percent success rate of getting care denials overturned. Referrals come to OHA from all areas of the state, from legislators, state agencies, our congressional delegation, hospitals, providers, and, most importantly, from previous consumers.

As general counsel for OHA, in addition to other duties, I have the responsibility of developing and advocating for the legislative agenda that we set each year. While we have several pieces of legislation moving through this year's legislative session, recently we succeeded in pushing these bills through the legislature or Congress:

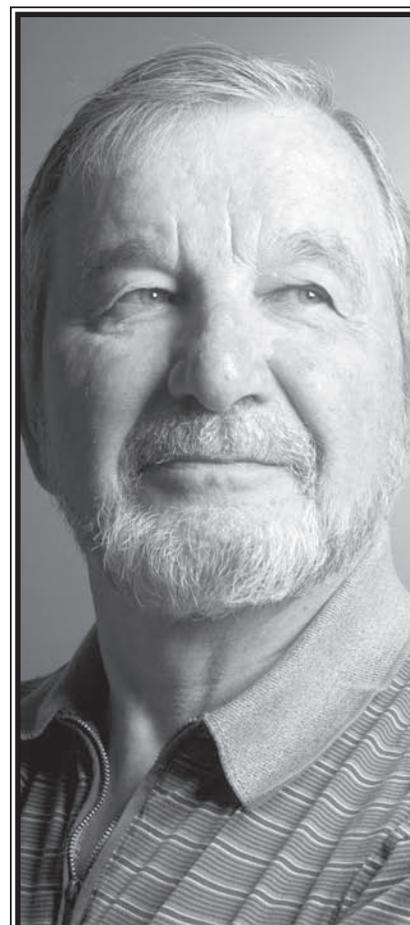
- P.A. 08-125, eliminates an arcane legal requirement prohibiting coverage for mental health residential services unless one is at an acute or crisis level of care and is

in an acute hospital for three days prior to the residential treatment.

- P.A. 08-171, established a Commission on Health Equity whose 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."
- P.A. 08-132, requires insurers to cover therapies for autism spectrum disorders to the same extent they are covered for physical illnesses.
- P.A. 07-75, incorporates a definition of medical necessity into the individual and group health insurance statutes.
- Domenici-Wellstone Mental Health Parity Act. For more information, see U.S. Sen. Christopher Dodd's comments in the *Congressional Record*: [www.govtrack.us/congress/record.xpd?id=110-s20070918-53&person=300036](http://www.govtrack.us/congress/record.xpd?id=110-s20070918-53&person=300036)

These "mini-fixes" reflected in legislation must be addressed as we take on a new health care system. One of OHA's near-term goals will be to outline the access-to-care issues insured residents now face so that these same issues are not perpetuated in any future model.

In Connecticut, if you or someone you represent is having difficulty selecting an insurance plan, getting approval for a service, challenging a denial or has general questions about health care or health care insurance, please call the State of Connecticut, Office of the Healthcare Advocate (OHA) toll-free at 1-866-HMO-4446 or contact us at [www.ct.gov/oha](http://www.ct.gov/oha) for the help or information you need. ■



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