Testimony of Kevin P. Lembo, State Healthcare Advocate
Before the Government Administration and Elections Committee
Connecticut General Assembly
In Opposition to Provisions of Senate Bill 840 and House Bill 6375
March 16, 2009

Good morning Senator Slossberg, Representative Spallone, Senator McLachlan, Representative Hetherington and members of the Government Administration and Elections Committee, for the record I am Kevin Lembo the State Healthcare Advocate and I am here to testify in strong opposition to Governor M. Jodi Rell's proposal to close the Office of the Healthcare Advocate (OHA), legislative provisions of which are contained in both SB 840 and HB 6375.

Sections 56, 62-67 and 75 of SB 840, *An Act concerning the Elimination of the Office of Consumer Counsel, the Office of the Healthcare Advocate, the Office of Ombudsman for Property Rights and Certain Legislative Commissions*, eliminate the Office of the Healthcare Advocate entirely.[1] These provisions must be stripped from SB 840. Section 43 of HB 6375, *An Act Concerning Review and Termination of Certain Boards and Commissions*, eliminates the advisory committee of the Office of the Healthcare Advocate, a critical component to maintaining the independence of OHA.

It is critical to note that if OHA is restored--requiring the revisions of SB 840 stated above--section 43 of HB 6375 must not survive. The OHA advisory committee plays a vital role and importantly, is chiefly responsible for ensuring the nomination of an independent and non-partisan Healthcare Advocate. For these reasons, section 43 of HB 6375 must be deleted.

The Office of the Healthcare Advocate was created by you, the Legislature, in 1999 as part of the much larger Managed Care Accountability Act. While we have made strides together to protect consumers over the years, the job is far from finished. The insurance market is more confusing than ever; fewer employers and individuals can find coverage that is meaningful and affordable; and, the denials get more troubling every day.

I share your concerns, and those of the Governor, about the challenging financial condition of our state and nation. The looming budget deficit of the biennium will require clear and innovative thinking on all our parts. The easy answers, the quick cuts, however will simply not be enough. The OHA is a Special Fund Agency. We receive our budget allocation from the Insurance Fund (like the Insurance Dept.). The Insurance Fund, as you know, is created based on an assessment on insurance companies. Cuts to OHA do not help to close the General Fund deficit. In fact, cuts to

[1] Section 67 of the SB 840 actually retains the Commission on Health Equity, but does not house it in any agency.

OHA would go back to the insurance industry. All rescissions, lapses and cuts are backed out as credits when the new fiscal year assessment is calculated.

The OHA and Insurance Dept. (CID) while sharing funding, have very different roles. CID is the regulator. OHA is the consumer advocate. The Insurance Department ensures that there is a healthy insurance marketplace. The Office of the Healthcare Advocate makes sure the market is healthy for consumers.

The Insurance Department does not, can not, and arguably, should not do what we do. CID only helps a limited number of consumers who are in state-regulated plans, but about 50% of insured Connecticut residents are in federally regulated plans. The Insurance Department is prevented from helping them. Without OHA, they will have nowhere else to turn. Besides referrals from legislators and CID, state entities, including among others, the Office of the Governor, the Office of Health Care Access, the Department of Social Services, have referred cases to us, because of our expertise.

The OHA ensures that health insurance companies meet their contractual obligations and that they pay for the medically necessary, sometimes life-saving, treatment patients need. We help patients and providers to build and document the case for medical necessity, and it is based on that information that denials are reversed on appeal. This is a core consumer protection of function of government that is not performed by any other state agency.

In 2008, the OHA helped more than 2,000 patients to resolve problems with their health insurance coverage. OHA's assistance resulted in more than $5,000,000 in consumer savings last year – the value of those claims for surgeries, cancer treatment, transplants, mental health care, and other needs, that we helped to overturn.

The OHA's budget for this fiscal year is slightly over $1,000,000. For every dollar we spend from the Insurance Fund, we return more than $5 directly to the pockets of patients. (OHA data follows this testimony.) The Office of Fiscal Analysis often cites OHA's performance measurement, "For every dollar we spend from the Insurance Fund, we return $5.20 to the pockets of patients," as a high-quality performance measurement example in their Results-Based Accountability (RBA) trainings, done in partnership with the Charter Oak Group, LLC.

Most important, however, are the patients we serve; those who otherwise would have spent down their retirement savings, max-ed out their credit cards, refinanced their homes, or borrowed from friends and family members to get the care they needed. Even worse, there are those who could do none of those things and who simply go home and wait. This is dramatic, but it is a frightening reality for our neighbors every day.

Since 1/1/05, OHA has helped about 7,500 patients and returned nearly $14 million in savings directly to patients and their families. We share some of their stories with you in attachments to our testimony. With higher unemployment, and an anticipated increase in denials for those lucky enough to have insurance, the need for OHA will only increase in the coming years. In fact, our caseload this year is already tracking significantly higher than last year's.

Beyond individual cases and in the last year, OHA took on the unfunded task of becoming the administrative home of the newly established Commission on Health Equity, which is now undertaking its strategic planning. We also completed data gathering for, and hope to have for you

in April, the Hospital and Managed Care Organization's Community Benefits Report, a task transferred to OHA last year.

OHA pursues a strong public policy agenda. In the last few years, we proposed and secured passage of legislation: codifying the definition of medical necessity; prohibiting postclaims underwriting[2]; eliminating the coverage requirement of a three-day acute hospital stay prior to receiving medically necessary residential treatment under mental health parity; and, removing the barrier to the coverage of physical, occupational and speech therapies for children with autism spectrum disorders We've been deeply involved also in policy discussions on reforming and improving Connecticut's public insurance programs and private sector offerings and in ensuring that the federal stimulus money directed at preserving Medicaid and SCHIP hits its target. We've testified in support of many bills that would ensure accountability in both public and commercial insurance programs. Recently, OHA lent its name on behalf of the state to a federal lawsuit, joined by a wide variety of states and organizations, to challenge the so-called "conscience rule". This rule could have jeopardized billions of federal dollars that Connecticut relies on for healthcare funding.[3]

At the federal level, by request of congressional officials, OHA staff participated directly in negotiations on the final language of the Wellstone-Domenici Mental Health Parity Act in order to ensure that strong state mental health parity laws were not jeopardized. We also were asked to provide expertise and support for congressional investigations into the proliferation of the often egregious process of postclaims underwriting.

In closing, OHA is a multi-faceted entity with a variety of expertise that's proven to be effective and efficient. It is a model envied by other states. We provide crucial, sometimes life-saving assistance while insisting on improvements in the healthcare arena and in the insurance market. OHA needs not only to remain standing, but to remain independent.

I urge you to reject sections 56, 62-67 and 75 of SB 840 and section 43 of HB 6375.

Thank you for your attention to these comments, the attached data and the consumer and other advocate communications about our work. I look forward to our continued work together.

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1. Cutting OHA does not help solve the fiscal crisis.
2. Cutting OHA only enriches the insurance companies.
3. Cutting OHA means direct and immediate harm to consumers.

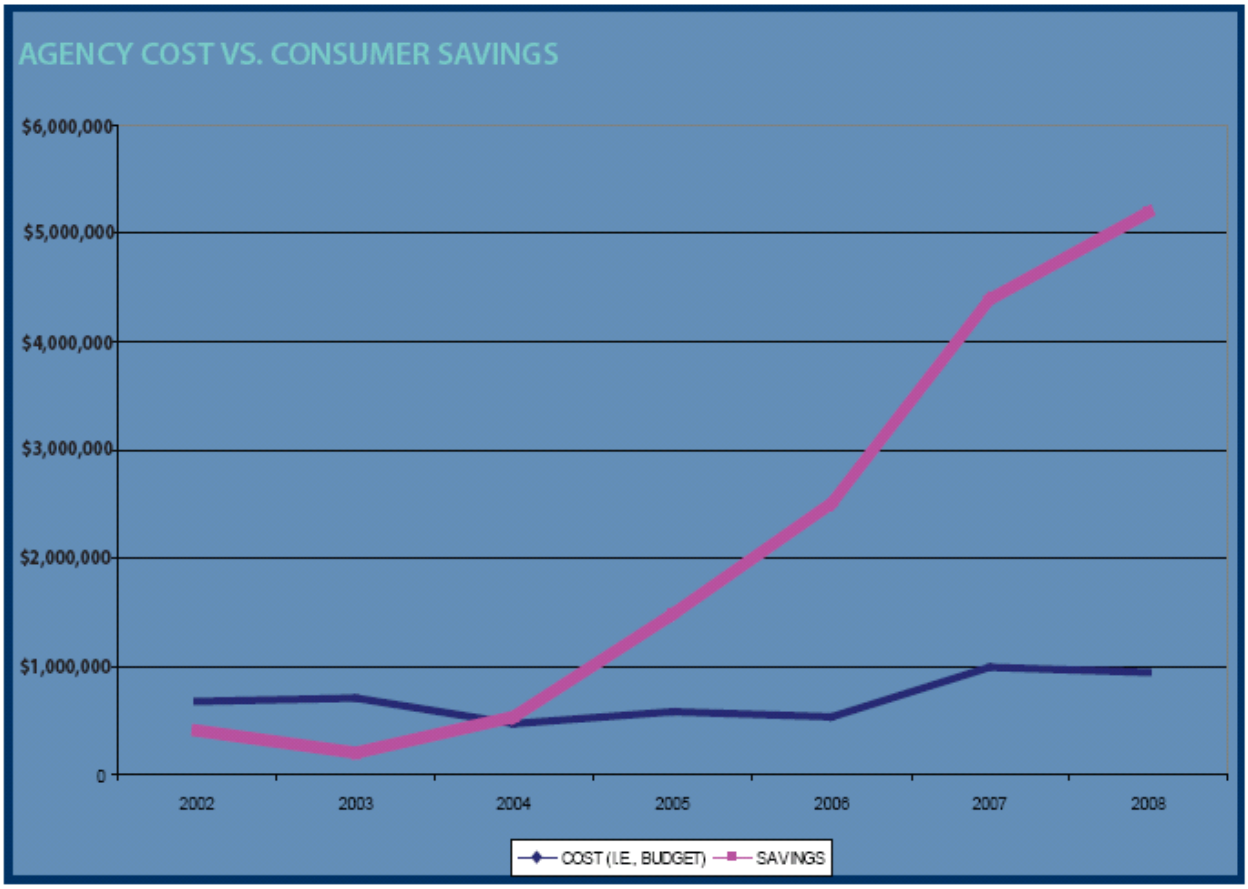
[2] We proposed legislation this year to revise the earlier bill on postclaims underwriting to tighten up the requirements on insurers in order to prevent maltreatment of consumers. That bill, HB 6531 passed out of the Insurance and Real Estate Committee on March 10, 2009.

[3] The action is now pending in federal court, awaiting the outcome of new federal rulemaking that may resolve the underlying issue in the case.

OFFICE OF THE HEALTHCARE ADVOCATE
BY THE NUMBERS

OHA: A Good Investment

YEAR	Investment (i.e., budget)	SAVINGS	Return on Investment
2008	$1,032, 611.00	$5,191,613.56	5.48
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	*$5,026,668.00*	*$14,733,468.56*	*2.93*



OFFICE OF THE HEALTHCARE ADVOCATE
BY THE NUMBERS

Total Complaints Closed 2002 thru 2008	
Year	**Number of Complaints Closed**
2008	2,143
2007	1,749
2006	1,865
2005	1,468
2004	731
2003	546
2002	643

Consumer Complaints Fall Into a Few Major Issue Categories:

TOP TEN COMPLAINTS BY ISSUE 2006 thru 2008				
ISSUE	**2006**	**2007**	**2008**	**TOTAL**
Consumer Denied Service or Treatment	295	302	324	921
Billing Problem	133	179	202	514
Consumer - Other	160	177	153	490
Consumer Enrollment or Eligibility	v178	154	156	488
Enrollment/Eligibility	178	154	156	488
Consumer Education or Counseling	133	148	205	486
Denial of Claim by MCO	84	102	95	281
Benefit Design	102	78	97	277
Service Not Covered	76	66	59	201
Denial of Payment	49	64	54	167