Office of the Healthcare Advocate
STATE OF CONNECTICUT

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ANNUAL REPORT
TWO THOUSAND TEN

OHA

A Message from the Acting Healthcare Advocate

I am pleased to issue the Office of the Healthcare Advocate's 2010 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 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. OHA has also taken on additional responsibilities, 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 newsletter, website and Facebook page 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.

Finally, we note that Kevin Lembo, the former Healthcare Advocate, has moved on to become Comptroller for the State of Connecticut. This report reflects his efforts in 2010, as well as those of the dedicated staff at OHA.

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

Victoria Veltri
Acting Healthcare Advocate & General Counsel

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

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 plan. We can answer questions and assist consumers in understanding and exercising their right to appeal a managed care plan's denial of a benefit or service.

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 November, 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 certain individual insurance policies by 20%. The request was ultimately rejected by the Insurance Department. OHA also requested information from Connecticut insurers on their implementation of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA). This Federal Law prohibits certain managed care plans from imposing financial and treatment limits on mental health and substance abuse disorder benefits not imposed on medical/surgical benefits.

Staff

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Staff Notes

Kevin Lembo left OHA at the end of 2010 after six years as the Healthcare Advocate to become Connecticut's State Comptroller.

Michael Mitchell left OHA in 2010 to take a position at the HHS Office of consumer Information and Insurance Oversight.

The Case for OHA - Legislative Summary

OHA's support by the legislature in 2010 was critical to OHA's continued success. In 2010, the number of legislative referrals rose to 211. The number of referrals reflects the confidence legislators have in OHA.

Responsible Rate Review Practices

OHA's major piece of proposed legislation was HB 5090, as amended by House Schedules A and B. The bill passed the House but with very little time left, did not get raised in the Senate. This bill would have made the rate review process for individual insurance plans more open and more scrutinized. The bill would have:

- Required the Insurance Department to make the full filing available on the website
- Required a rate hearing if the rate requested was greater than a trigger amount
- Required the Insurance Department to allow OHA and the Attorney General's office to intervene in a hearing, if either or both so chose to intervene
- Prohibited the Insurance Department from limiting OHA's and the Attorney General's scope of intervention
- Required the Insurance Department to examine in more detail whether a rate request was excessive.

Though HB 5090 did not get called in the Senate, at least one of its components was adopted by the Insurance Department—filings are now available on the web. OHA has asked the Insurance Committee to re-introduce the content of HB 5090, as amended, in the 2011 legislative session.

P.A. 10-24 –An Act Requiring the Providing of Certain Information upon Certain Denials of Health Insurance Coverage

More health insurance consumers in Connecticut will know that they can access OHA when they are denied a service or treatment by their insurers. P.A. 10-24, introduced by Rep. Andrew Fleischmann, requires insurers that deny services because they are not medically necessary or not covered, to notify consumers of OHA's availability to help with an appeal. OHA looks forward to this opportunity to help more Connecticut consumers enforce their healthcare rights and to educate consumers about OHA's services.

P.A. 09-148 – SustiNet

The SustiNet Board of Directors completed its report to the legislature. OHA staff provided substantial administrative and policy reports to the SustiNet Board throughout 2009. The Healthcare Advocate is co-chair of the Board of Directors. The Board made the following recommendations on policy features for SustiNet:

- The SustiNet health plan will implement delivery system and payment reforms
- The plan will be administered by a quasi-governmental agency
- SustiNet will begin by serving state employees and retirees along with Medicaid and HUSKY beneficiaries
- SustiNet will become a new health insurance choice for municipalities, private employers and households
- HUSKY will expand to cover all adults with incomes up to 200 percent of the Federal Poverty Level.

Hospital & 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. In 2009 OHA made recommendations to the legislature to ensure that future reports would be of more value and consistency to legislators, the Governor and the public. In late 2010, OHA sent the biennial survey to managed care organizations and hospitals. Responses are due on March 1, 2011.

Other State Legislative Activities

OHA also testified in support of bills that: ensure that oral chemotherapy medications are covered at least as favorably as intravenous chemotherapy medications; require fairer rental network contracting arrangements with healthcare providers; allow small employers to obtain health insurance premium quotes; establish a Connecticut Clearinghouse to provide health insurance information to individuals and small employers; create an extension of mini-COBRA coverage from 18 to 30 months; require managed care organizations to report claims denial data to be included in the managed care report card on the Insurance Department's web site; allow non-state employers to purchase prescription drugs through the state's bulk drug purchasing authority.

OHA appeared before the following committees during the 2010 Legislative session: Insurance and Real Estate, Planning and Development, Human Services and Public Health.

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 plus one outreach coordinator/data analyst. One grant was awarded to each state. Congressional officials supported OHA's application.

OHA commented on proposed regulations issued by the U.S. Departments of Health and Human Services pursuant to the ACA on the following topics: new medical loss ratio requirements, easier access to preventive healthcare services, stronger oversight of insurer rate setting practices through premium rate reviews, protections against unwarranted rescissions and consumer assistance grants.

Congressional offices consulted OHA on the issue of the elimination of child-only insurance policies–the response of some insurers to the elimination of exclusions of pre-existing conditions for children under the ACA or federal healthcare reform. OHA provided the congressional offices with the number of policies that were impacted by the insurers' change in policy.

Congressional officials also reached out to OHA on the Insurance Department's approval of one insurer's premium rate review for non-grandfathered insurance plans. OHA provided congressional officials with access to an expert on rate review issues who supplied the delegation and the Health and Human Services Office of Insurance Information and Oversight (OCIIO) with information about the insurer's Connecticut experience.

Mental Health

OHA continues to work on improving our state's mental health parity law. On the federal level, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) went into effect on January 1, 2010, and implementing regulations went into effect on July 1, 2010.

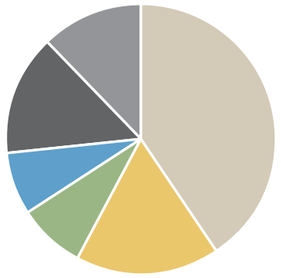
In response to the regulations, OHA convened a work group to ensure that Connecticut takes full advantage of the new protections of the MHPAEA. The work group prepared legislation to be introduced during this legislative session, an Editorial published in a statewide newspaper, received extensive coverage in an online newspaper, and contacted every large insurer in the state to track their compliance with the MHPAEA.

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 access and to appropriately review cases based on an individual's needs. Mental health issues continue to dominate OHA's case load.

Top Complaints by Issue - 2010 Compared to Previous Years

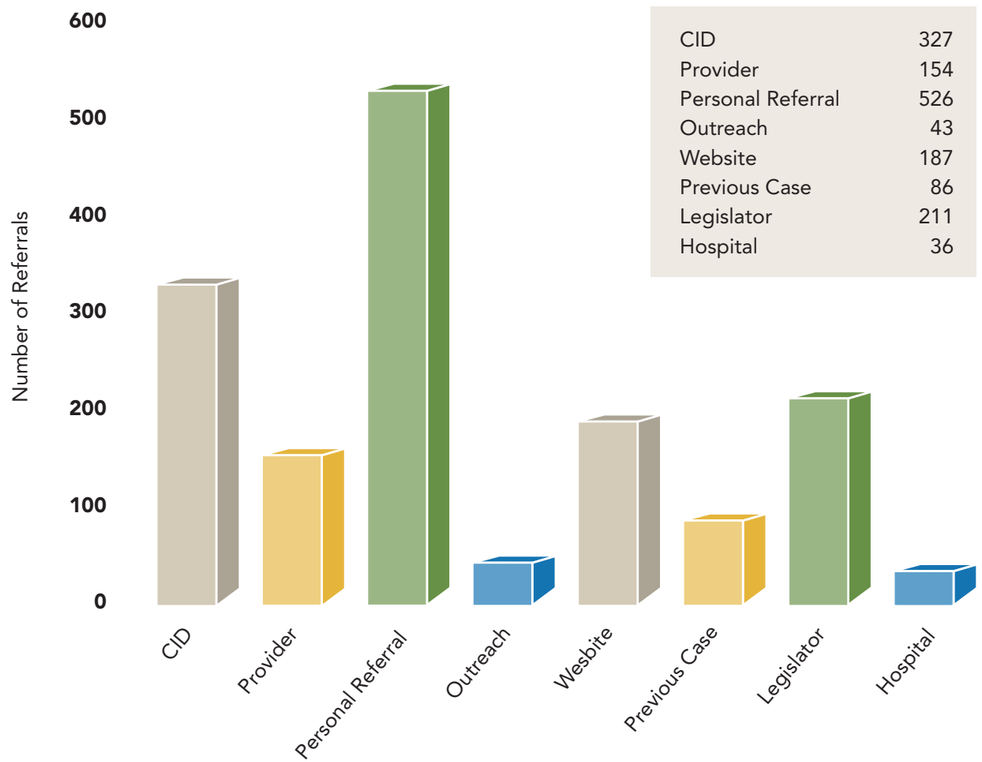
	2010	2009	2008	2007	2006
Denied Service/Treatment	374	510	232	274	286
Education/Counseling	362	356	127	142	136
Billing Problem	138	265	177	119	115
Enrollemt/Eligibility	228	254	147	176	118
Benefit Design	94	118	92	85	107
Service Not Covered	90	81	69	51	63
Denial of Claim	64	102	96	86	75
Other (Client)	136	141	225	168	96
Delay of Care (Client)	84	117	44	28	12

Cases by Carrier - Highest Frequency



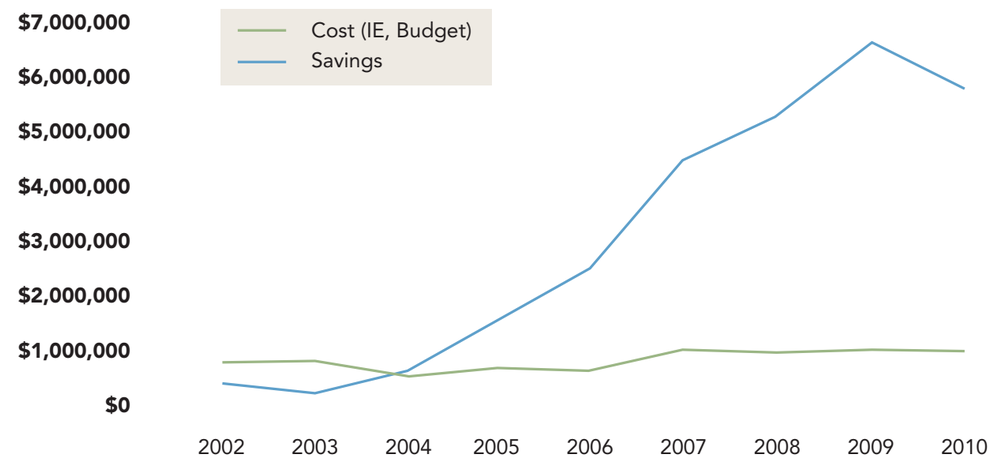
Wellpoint	469
Aetna	200
ConnectiCare	92
HealthNet	86
United Health Care/Oxford	168
CIGNA	138

Referral Source - Highest Frequency



CID	327
Provider	154
Personal Referral	526
Outreach	43
Website	187
Previous Case	86
Legislator	211
Hospital	36

2010 Agency Cost vs Consumer Savings



	Cases Closed	Savings
2002	643	$410,294.00
2003	546	$205,665.00
2004	731	$531,823.00
2005	1,468	$1,487,895.00
2006	1,480	$2,514,825.00
2007	1,702	$4,391,353.00
2008	1,989	$5,191,613.56
2009	2,613	$6,578,895.00
2010	2,119	$5,664,905.23
Total	13,291	$26,977,268.79

Consumer Relations

The number of cases referred from legislators increased in 2010. 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. Mental health continues to be the biggest clinical category of cases OHA handles; one insurer accounts for a disproportionate number of denials and appeals. Fortunately, OHA's advocacy resulted in reversals of nearly all of the denials of treatment or services that involve consumers needing treatment for serious, debilitating, or life-threatening illnesses.

Despite tough economic times, OHA's advocacy returned almost $5.7 million to residents of Connecticut in 2010.

Consumer Stories

1

AC was in need of knee surgery that could only be performed by a Specialist in New York City. The surgery was needed because two previous procedures had not produced a positive outcome. In fact, AC could not work as an Advanced Nurse Practitioner and was forced to resign from her position at an acute care hospital in Connecticut. The hospital in New York was in-network, but the surgeon was not in network.

OHA advocated with the mother to request the surgeon and anesthesia be reimbursed as if in-network, leaving AC to focus on getting well. The procedure was successful, but unfortunately an infection developed post operatively. AC required IV antibiotics and several re-admissions to the hospital.

Once again, OHA worked with the mother on AC's behalf to assure that claims were paid correctly. The mother has informed OHA that our intervention was very helpful. If the surgeon were not reimbursed as if in-network, AC would have had over $30,000 dollars in medical expense to deal with.

2

CP is a cancer survivor. Beating cancer was easy compared to battling her insurance company to get the the follow up surveilance studies recommended by her oncologist and the professional societies that monitor the research studies used to set up treatment guidelines.

CP was denied a PET scan, a part of her five year monitoring program. Prior to the request for the PET scan , she was following her program, and was reassured that her remission process was right on course. She was surprised when her insurance provider decided that this scan was not medically necessary. Thinking that this must be a mistake, she initiated an appeal on her own only to have the denial upheld. She then contacted OHA.

Her case manager reviewed the issue, and using her clinical experience gathered both the pertinent medical records and a letter of medical necessity from her physician. OHA added a collection of current peer reviewed literature to CP's second level appeal submission. Her insurer overturned the denial and authorized her PET scan.

3

SF contacted his provider, requested pre-authorization and received approval to treat a debilitating migraine condition. SF thought he had done everything right.

SF received successful treatment, and everything was great until his medical claims were denied by the insurance company-- "excluded" as experimental. SF appealed the case on multiple levels but the appeals were denied in spite of requesting and receiving authorization for his treatment.

SF was threatened with being "sent to collections" by his provider. SF reached out to the Office of the Healthcare Advocate. OHA's case manager was able to stop the collections activity and get the insurance company to honor their pre-authorization and pay for all the claims in question.