Office of the Healthcare Advocate
STATE OF CONNECTICUT

"This was a fantastic service. Someone responded to me almost immediately to let me know that my forms had been received. Within a few days, I was contacted by an attorney, who was amazing. We talked briefly, I sent along documents, she was able to understand the issue and took action right away. It took some time back and forth with the insurance company, but it was completely resolved. Prior to contacting OHA, I had been trying on my own for over a year."

2023 Annual Report

Pursuant to Section 38a-1050 of the Connecticut General Statutes

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A MESSAGE FROM THE ACTING HEALTHCARE ADVOCATE

The year 2023 was extremely busy for OHA's case managers. In January, insurance companies began displaying OHA's contact information more prominently on the notices sent to consumers when an insurer denies coverage of a drug or service. As a result, OHA experienced its highest overall case volume, and highest ratio of complex, resource-intensive cases, since the early implementation of the ACA and the rollout of the Access Health CT state insurance exchange. Through it all, the nurses, paralegals, attorneys, consumer information representatives and other professionals at the State Office of the Healthcare Advocate held steady, continuing their focus on delivering free, expert advice and assistance to Connecticut families struggling with health insurance denials and other coverage issues.

In 2023, we fielded 5000 calls and complaints, and helped consumers save over $4.5 million in medical expenses they otherwise would have owed, bringing the total consumer savings that OHA has achieved since its inception to over $132 million.

In 2024 and beyond, OHA hopes to build upon this increased public awareness of its services. A resource as critical and needed as free assistance and representation for claim denials and all other health coverage issues should be well-known to all Connecticut residents. To that end, we continued our series of online Lunch 'n Learn sessions, during which OHA experts spend 30 minutes at midday sharing and teaching on a variety of topics of critical importance to health insurance consumers, such as: General Information Members should know about their Health Insurance, Open Enrollment Policies and Provisions, New Connecticut Mandates (i.e., items required to be covered) and the federal No Surprises Act.

With the end of the public health emergency associated with the COVID-19 pandemic, hundreds of thousands of HUSKY members saw their eligibility for benefits redetermined for the first time since 2020. While the vast majority of these members have been able to maintain their HUSKY benefits, a substantial percentage have been placed into alternative categories of coverage, such as employer sponsored coverage or individual coverage through the Covered Connecticut program and the Access Health CT marketplace. This "unwinding" of pandemic era continuous eligibility has led to record enrollment in qualified health plans offered through Access Health CT. Despite all of the challenges presented by a pandemic, the economic impacts of high inflation, increased cybersecurity risks, rising healthcare prices and growing scarcity of providers in certain fields, Connecticut has maintained its rank among the states with lowest rates of uninsured residents.

To be sure, much more can be done – and must be done – to ensure that residents not only maintain insurance coverage, but also are able to access timely, high quality health care services and pharmaceuticals at affordable costs. OHA will continue to be the voice of Connecticut's healthcare consumers as our state and our nation continue to address each of these challenges. It has been OHA's pleasure to serve, advise and represent you and your family in 2023, and we look forward to extending this tradition into 2024 and beyond.

Sean King
Acting State Healthcare Advocate

OHA'S MISSION

OHA's mission 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 healthcare plans. OHA staff is dedicated not only to serving and assisting Connecticut's healthcare consumers, but also to ensure that the products and services available are adequate. This effort requires a multifaceted approach, including direct consumer advocacy and education, interagency coordination, and a voice in the legislative process.

A fundamental element of OHA's mission is education and outreach to consumers. Without a solid knowledge base about their rights, opportunities, and obligations as they engage with Connecticut's healthcare system, there is the chance consumers will pay more for their care, forego treatment, or fail to utilize the comprehensive series of no-cost, preventative services available. Failure to identify an easily managed health condition may lead to a significantly greater impact on the consumer in the form of a more serious illness, a longer course of treatment, complications, or much higher out-of-pocket costs.

OHA is devoted to providing consumers, and your constituents, information about and support engaging with the complexities of this system, and ensuring they are aware of the host of resources available to them when they need help.

What OHA Does

The Office of the Healthcare Advocate provides guidance and assistance to Connecticut consumers about all types of health coverage, including private and public plans. While a prime focus of OHA's work is direct client advocacy and appeals of healthcare plan denials, also fundamental to our work are activities such as educating consumers about their rights, and coaching consumers on how to navigate the healthcare system, including how to advocate on their own behalf. OHA works tirelessly to give Connecticut consumers a voice, incorporating their stories, experiences, challenges, and successes into our advocacy. OHA staff actively participate in many forums where the consumer's experience is essential to the formulation of effective and meaningful policy. Some examples of OHA's staff activities promoting community engagement and collaboration during the past year include:

Access Health CT Board of Directors

All Payer Claims Database Advisory Council

Behavioral Health Partnership Oversight Council

Behavioral Health Partnership Oversight Council Coordination of Care Committee

Connecticut Children's Behavioral Health Plan Implementation Advisory Board

Covering Connecticut Kids and Families Steering Committee

Covering Connecticut Kids and Families Quarterly Meetings

Connecticut Clearinghouse

Connecticut Health Foundation Kitchen Cabinet

Connecticut Parity Coalition

Connecticut Partners for Health

Connecticut Strong State Level Transition Team

DCF Children's Behavioral Health Task Force Implementation Plan

Health Disparities Institute Equal Coverage to Care Coalition

Explanation of Benefits Confidentiality Ad Hoc Work Group

Health Care Cabinet

Health Information Technology Advisory Council

Medical Assistance Program Oversight Council (i.e., Medicaid/HUSKY oversight)

Medical Assistance Program Oversight Council Complex Care Committee

Medical Assistance Program Oversight Council Developmental Disabilities Working Group

Medical Assistance Program Oversight Council Care Coordination Committee

Personal Care Attendant Workforce Council

Protect Our Care Coalition

OHA OUT AND ABOUT

The challenge of connecting with consumers, often at difficult moments in their life as they struggle with health issues, is rewarding and allows the agency to witness the direct results of its work. Generally, we strive to educate consumers about the need to be familiar with their health insurance policy, terms, and conditions – and then empower them to use that knowledge, along with our expert help, to harvest the benefits of having health insurance that pays for well-care but also for curative treatments that can help them live longer, healthier and more stress-free lives.

Lunch and Learn – OHA's popular Zoom sessions are another tool to inform, educate, and inspire consumers and advocates. These are posted on OHA's YouTube channel found here. In 30 minutes or less, OHA introduces attendees to a short PowerPoint presentation on the monthly subject. The presentation is followed by a public discussion and question/answer period. While each session is just 30 minutes long, it is not short on information The next Lunch and Learn is always featured in the newsletter and marketed through social channels.

Digital Targeting – Connecting with and providing services for Connecticut's urban centers continues to be a goal for OHA. This initiative is reflected our first line targeting metrics. We try to reach communities where the population density and the number of underserved is the highest. It's also where there are large populations who benefit from the Access Health CT marketplace, Covered Connecticut, and the Affordable Care Act and its safeguards, but also where there can be continuing confusion about coverage and how to address claim denials.

Social – Facebook and Twitter are our preferred social channels. OHA posts several times per week, and the feed is live monitored for potential abuse and consumer feedback and questions. The news feed features health news, tips, recommended reading, and strong advocacy. We deploy infographics and curate content of others where it can benefit consumers.

Facebook – The growing OHA audience is largely female, which makes sense because statistically women dominate the healthcare decisions of their families from doctors to medicines. There are also organizations and policy makers that follow OHA, so our goal is to be relevant and informative to as many as possible, and encourage readers to like, share and follow our feed. You can follow the OHA feed here.

X (Twitter) - OHA uses X (Twitter) as an additional tool to broaden our audience and reach more people. We repurpose our Facebook content to boost our community impressions and drive traffic to our website

Newsletter – Along with news, information and celebrations of our work with clients, OHA newsletters are packed with insightful observations about the state of our ever- challenging healthcare world. In short, it's worth the time to read it.

The agency makes a concerted effort to provide timely, informative, and educational content to our subscribers. OHA discusses health and medical issues that affect Connecticut families and how those issues intersect with OHA's ability to help consumers. Content begins with a personal observation and insights from State of Connecticut Acting Healthcare Advocate Sean King, followed by news links to timely healthcare related content and developments. It also includes an expanded article on a health

focus of the month and other helpful information. Each newsletter is also posted to the agency website. Through the growing database of consumers and organizations that receive our publication, the OHA newsletter has become an important tool to help get the word out about the free help available for consumers with health insurance problems. It also provides real stories of people aided by OHA along with strong educational content. See our newsletters here.

Public Relations – Under Acting Healthcare Advocate Sean King, OHA is a trusted news source to give an unvarnished assessment of healthcare insurance issues. Shortly after being named Acting Healthcare Advocate, Mr. King was called on to participate in a forum sponsored by Stamford Health. Here's the link. More opportunities will be coming.

OHA and the Department of Children and Families

Since 2012 the Department of Children and Family (DCF) and the Office of the Healthcare Advocate (OHA)have worked in collaboration with a goal of ensuring that state funds are accessed appropriately when commercial insurance coverage is available. Carelon Behavioral Health (formerly Beacon Health Options) joined this collaboration in May 2020 as the administrator retained by DCF to administer the Voluntary Care Management Program (VCMP).

Throughout 2023 Carelon, OHA, and DCF have worked together to assist Connecticut families with connecting to the services their child needs, navigating commercial healthcare insurance, and resolving issues within the consumer's healthcare insurance plan. OHA educates and advocates for these families on how to effectively utilize their commercial health insurance plan. OHA researches the commercial insurance benefits for the services requested from the family or those services that Carelon may have identified for the family. This provides the family and their providers the information needed to pursue commercial insurance as the primary funding if benefits are available and state monies are reserved as the payor of last resort.

OHA and the Albert J Solnit Facilities also continued their work together to access and navigate commercial insurance whenever available before state resources are tapped. Referrals from the DCF Solnit Facilities have resulted in the highest savings amount for this project. When OHA can successfully overturn a denial by the commercial carrier for a child's continued stay at Solnit or identify when commercial insurance is available to pay for the services needed, this can result in a savings for the state and consumers. OHA also assists with the navigation of the commercial plan by researching in-network providers for lower levels of care for purposes of discharge planning. This helps the treatment team with consistency in care as well as removing treatment barriers.

OHA's involvement and knowledge with navigating the healthcare system and working with commercial insurance can also help the family with ensuring that their child continues to receive the treatment they need at the appropriate level of care. The continuing goal of this collaboration is to provide advocacy and education to these families. By supplying families with the power of knowledge regarding their rights and ability to navigate within their commercial healthcare plans, we help ensure state funding is used appropriately by accessing commercial insurance when available. In addition to providing education on healthcare insurance, we strive to identify barriers to access to care.

Behavioral Health Clearinghouse (BHC)

The Behavioral Health Clearinghouse (BHC) was created pursuant to Public Act 14-115. The mission of the BHC is to provide a comprehensive, accurate, state-wide resource for Connecticut residents seeking access to behavioral health care and additional information related to behavioral health. The vision for the BHC includes a website that offers: an exhaustive glossary of terms, conditions, treatments, and more; a search tool for consumers to find behavioral health providers and other resources based on a variety of factors; and educational resources regarding mental illness or substance abuse. Optimally, the BHC would also incorporate a call center with clinical staff available to answer consumer questions, conduct brief screenings of consumer needs and, when appropriate, identify and arrange an appointment with a behavioral health provider who can address the needs identified. Currently, funding remains a barrier to a full realization of this vision, and OHA continues to remain vigilant for appropriate funding sources to further this initiative. In the meantime, several of the functions envisioned by the BHC are incorporated into the websites of other state agencies and partner organizations such as the Dept. of Mental Health and Addiction Services and 211 of CT.

During the 2023 legislative session, OHA tracked 240 unique bills related to healthcare and healthcare insurance policy. Of the 240 bills tracked, 69 bills received a public hearing, 19 received public testimony from OHA, and 13 eventually became law.
Some of the more important initiatives, which OHA proactively supported, include:

Public Act 23-79 (HB 699) – An Act Concerning Cannabis Regulation

Establishes an Office of the Cannabis Ombudsman (within the Office of the Healthcare Advocate for administrative purposes only) and designates the Healthcare Advocate as the appointing authority for the Cannabis Ombudsman.

Public Act 23-94 (SB 977) – An Act Concerning Medical Assistance for Surgery and Medical Services Related to Treatment of Obesity

Expands Medicaid benefits to include coverage for bariatric surgery and medical services for the treatment of obesity (BMI > 30).

Public Act 23-97 (SB 9) – An Act Concerning Health and Wellness for Connecticut Residents

Establishes protections for individuals seeking access to assisted reproductive technology or assisted reproduction services.

Provides for Medicaid funding of same-day access to long-acting reversible contraceptives at FQHCs.

Establishes and revises limitations on the use of covenants not to compete within physician, physician assistant and APRN employment contracts entered, amended or renewed on or after October 1, 2023.

Establishes and appoints the Healthcare Advocate to a working group to advise the Commissioner of Public Health regarding methods to alleviate emergency department crowding and to address the lack of emergency department beds.

Establishes a task force to study rural health issues.

Public Act 23-101 (SB 2) – An Act Concerning the Mental, Physical and Emotional Wellness of Children

Establishes an Office of the Behavioral Health Advocate (within the Insurance Department for administrative purposes only) modeled after OHA. The OBHA will assist mental and behavioral health providers to resolve disputes with health insurers and will coordinate with OHA to assist consumers in accessing mental and behavioral health services.

Public Act 23-137 (HB 5001) – An Act Concerning Resources and Support Services for Persons with an Intellectual or Developmental Disability

Expands the Medicaid autism waiver program to reduce the number of individuals on the waiting list.

Directs the Commissioner of Social Services to apply for a Medicaid waiver to provide for compensation of family caregivers of Medicaid waiver program participants.

Public Act 23-148 (HB 6643) – An Act Concerning Insurance Coverage for the Provision of Mental Health Wellness Examinations

Amends the mental health wellness exam mandate to eliminate coverage requirements when the exams are performed by a primary care provider instead of a licensed mental health professional.

Public Act 23-171 (SB 6669) – An Act Protecting Patients and Prohibiting Unnecessary Health Care Costs

Directs the Comptroller to establish a Drug Discount Card Program for state residents.

Directs OHS and CID to issue a report and recommendations regarding regulation of pharmacy benefits managers and reduction of prescription drug costs.

Amends the facility fee statute to further limit when a hospital may collect a facility fee for services provided on campus and to provide additional authority to OHS to take enforcement action in response to violations of the facility fee statute or Chapter 368z of the General Statutes.

Make various revisions to the certificate of need (CON) process.

Prohibits pharmacy benefits managers from including certain unfavorable terms into their contracts with entities participating in the 340B Drug Pricing Program.

Directs the Commissioner of Social Services in consultation with other agencies and stakeholders to develop a strategy to improve health care outcomes, community health and health equity for HUSKY members.

Directs the Insurance Department in consultation with other agencies to study utilization management and provider payment practices of Medicare Advantage plans.

Prohibits network provider agreements from including all-or-nothing clauses, anti-steering clauses, anti-tiering clauses or gag clauses.

Requires insurers to make documents available to consumers electronically upon request.

Public Act 23-172 (SB 228) – An Act Concerning Employees' Loss of Health Care Coverage as a Result of a Labor Dispute

Establishes a special enrollment period on the Access Health exchange for individuals whose health care coverage is terminated by an employer as a result of a labor dispute.

Public Act 23-204 (HB 6941) – An Act Concerning the State Budget for the Biennium Ending June 30, 2025, and Making Appropriations Therefore, and Provisions Related to Revenue and Other Items Implementing the State Budget

Increases maximum rates for ambulance and paramedic intercept services by 10%.

Prohibits (with minor exceptions) prospective or concurrent review of a recurring prescription drug for treatment of autoimmune disorders, multiple sclerosis or cancer after the drug has already been certified through utilization review.

Reduces from fifteen to seven days, the time period for an insurer to complete an initial non-urgent prospective or concurrent coverage determination, and reduces from fifteen to five days the amount of time by which such time period may be extended. Insurers must acknowledge receipt of such request within 24 hours. (Retrospective review timelines remain unchanged at thirty days with up to a fifteen day extension.)

Further reduces from 48 to 24 hours the time period for a health carrier to respond to an initial urgent request for a prospective or concurrent coverage determination.

Extends from 61 to 91 days the time for a subscriber to enroll a newborn on the subscriber's individual or group health plan.

Revises step therapy limitations from a maximum of sixty days to a maximum time period of thirty days and further prohibit step therapy for drugs used for treatment of schizophrenia, major depressive disorder or bipolar disorder.

Establishes a task force to study step therapy data collection efforts.

Requires insurers to include additional information, including a list of services requiring prior authorization, percentages of services requiring prior authorization, and an estimate of premium savings that resulted from utilization review, among the data reported to the Insurance Department for the consumer report card.

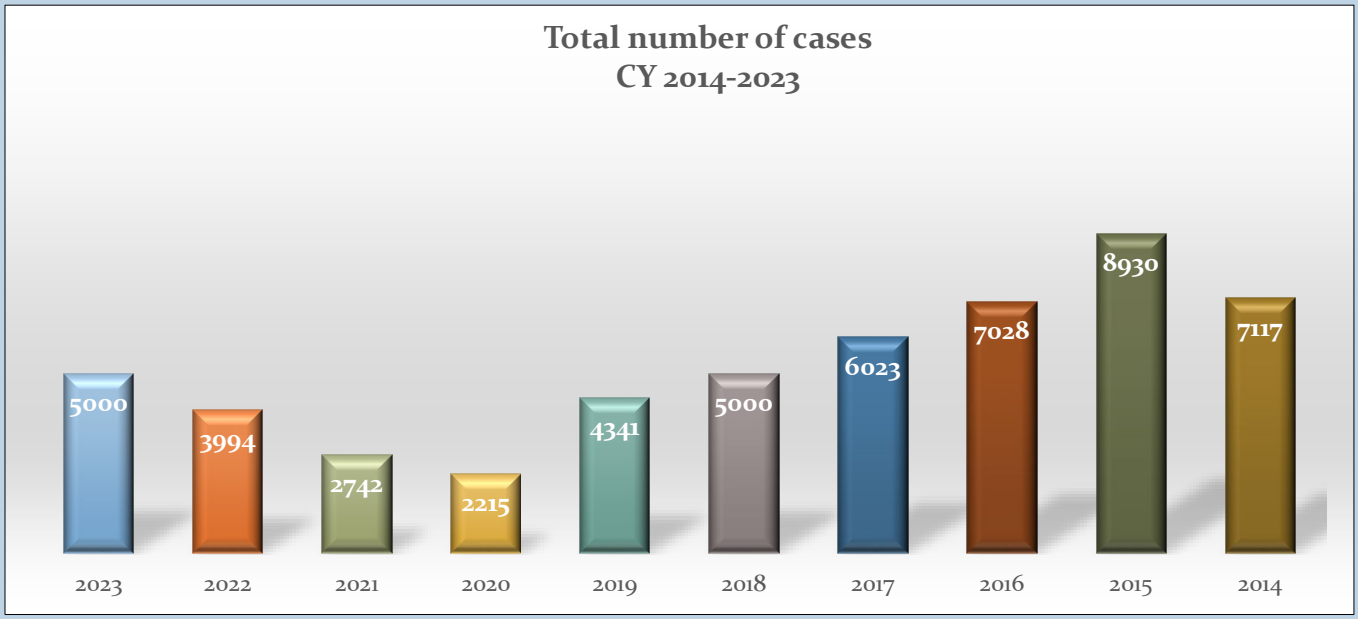
Requires network providers to submit utilization review requests electronically.

Expands Medicaid coverage of undocumented children from age twelve to age fifteen beginning July 1, 2024, and require a study of costs and benefits for further expanding coverage of undocumented immigrants to age twenty-five.

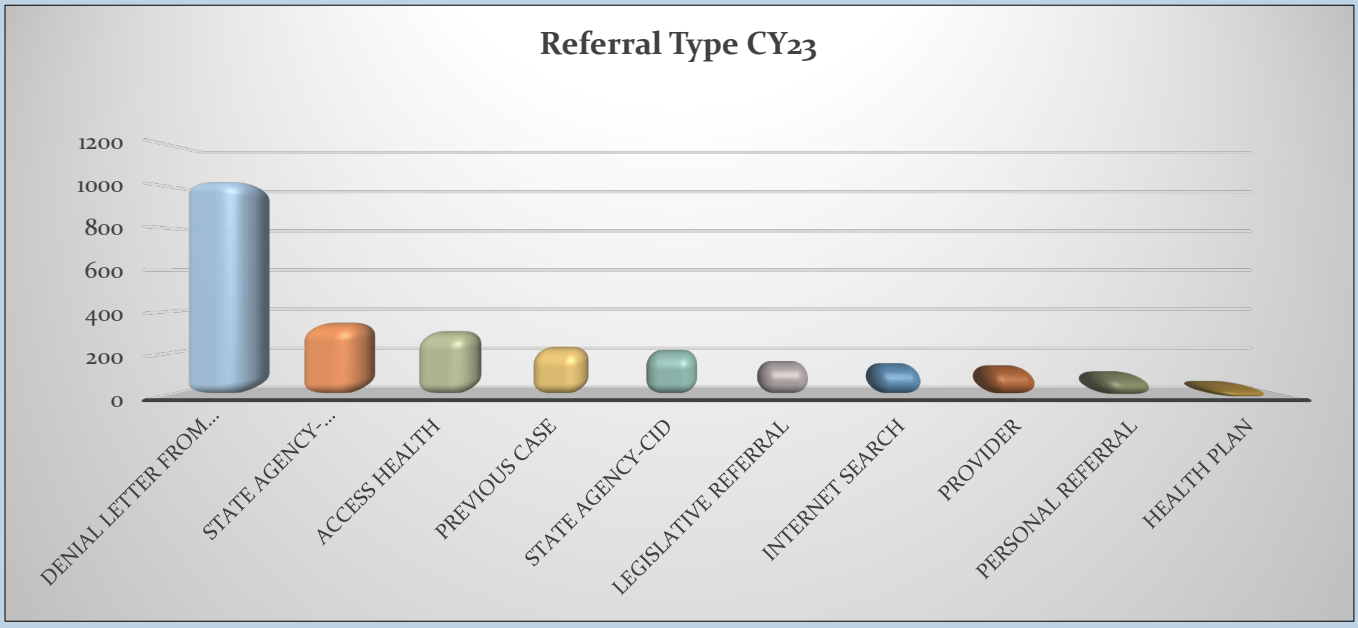
Requires DSS to update its policies regarding coverage of gender-affirming care.

Consumer Relations

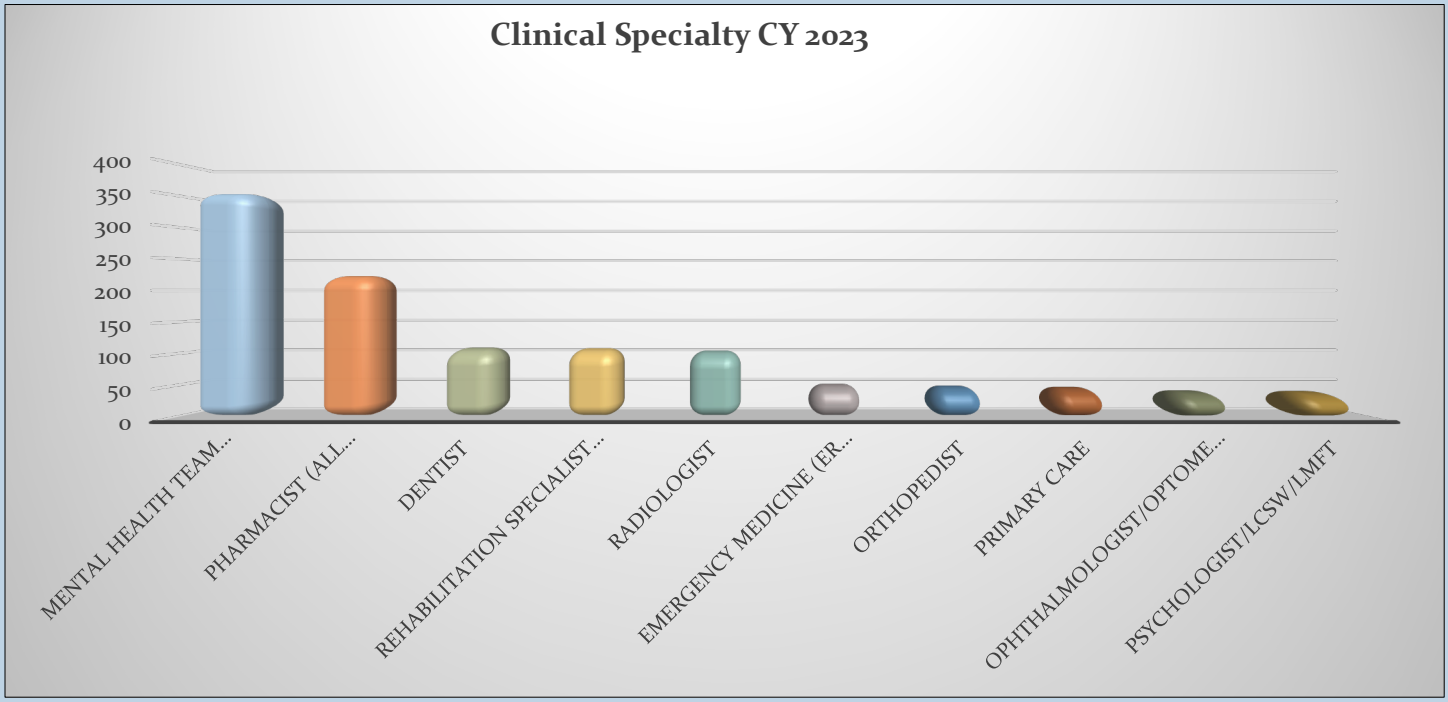
For 2023, the total number of cases is the highest since 2018. This increase can be attributed to a return to a normal post-pandemic environment, with consumers returning to doctors, having surgeries, and preventive care that they otherwise put off during COVID. In addition, OHA's contact information is now listed prominently on the 1st page of all denial letters making it more noticeable, thereby enabling consumers to contact OHA more quickly and easily.



Cases continue to come to OHA from a variety of sources. The highest category of referrals to OHA is from Denial Letters from insurers. This is consistent with what was mentioned above on the recent change of OHA's contact information now being more noticeable to consumers when they get a denial letter, and as a result OHA has received a significant rise in cases. The second highest category is from State Agency DCF, followed by Access Health CT (AHCT). Our AHCT referrals come from two sources: direct letters from clients, as well as phone calls to our agency generated by AHCT.

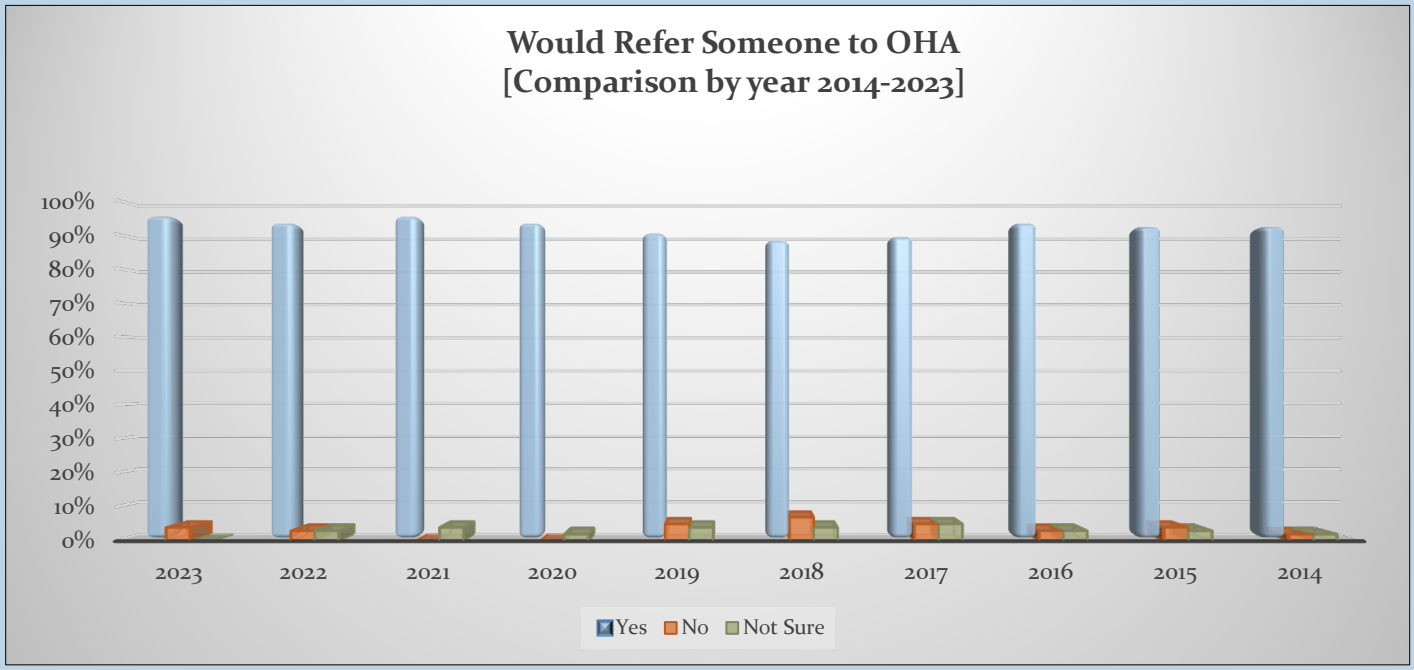


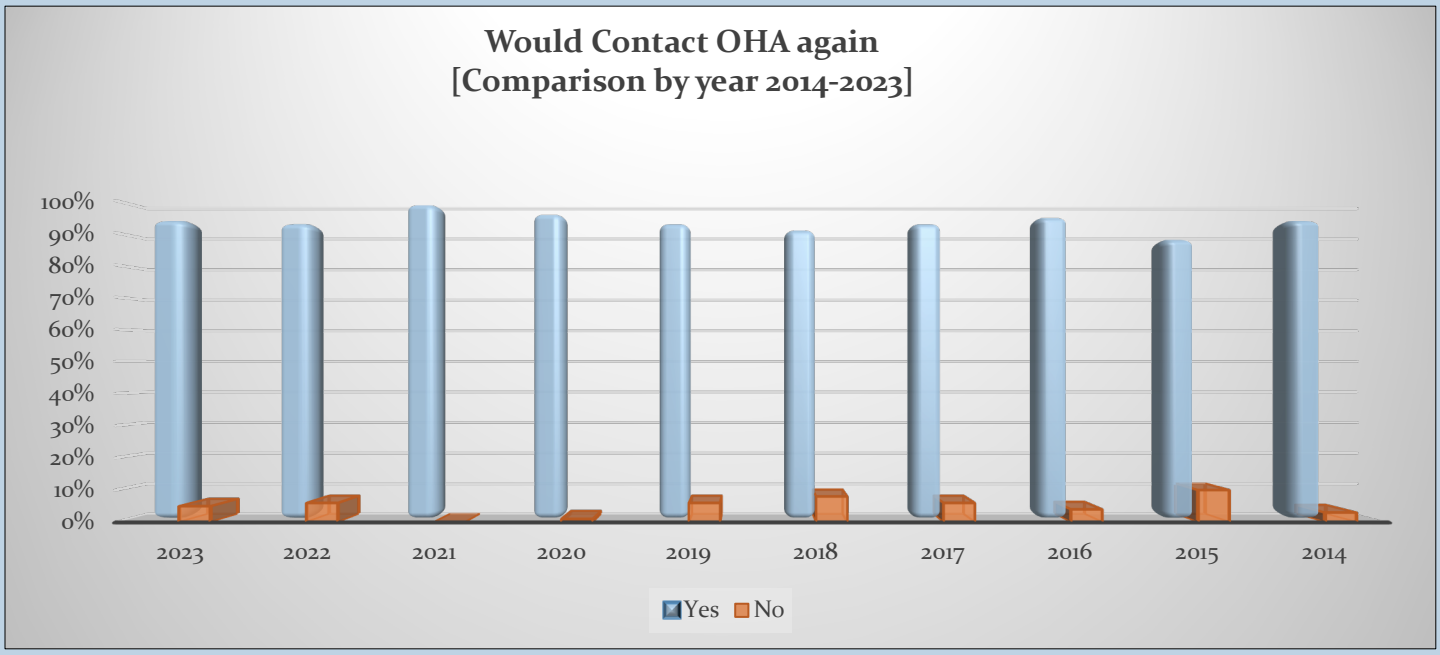
OHA continued to receive a wide range of cases representing many clinical categories, with Mental Health as the predominant case type for assistance. Fortunately, OHA's advocacy resulted in many reversals of denials of treatment or services that involve consumers in need of treatment for serious, debilitating, or life-threatening illnesses.

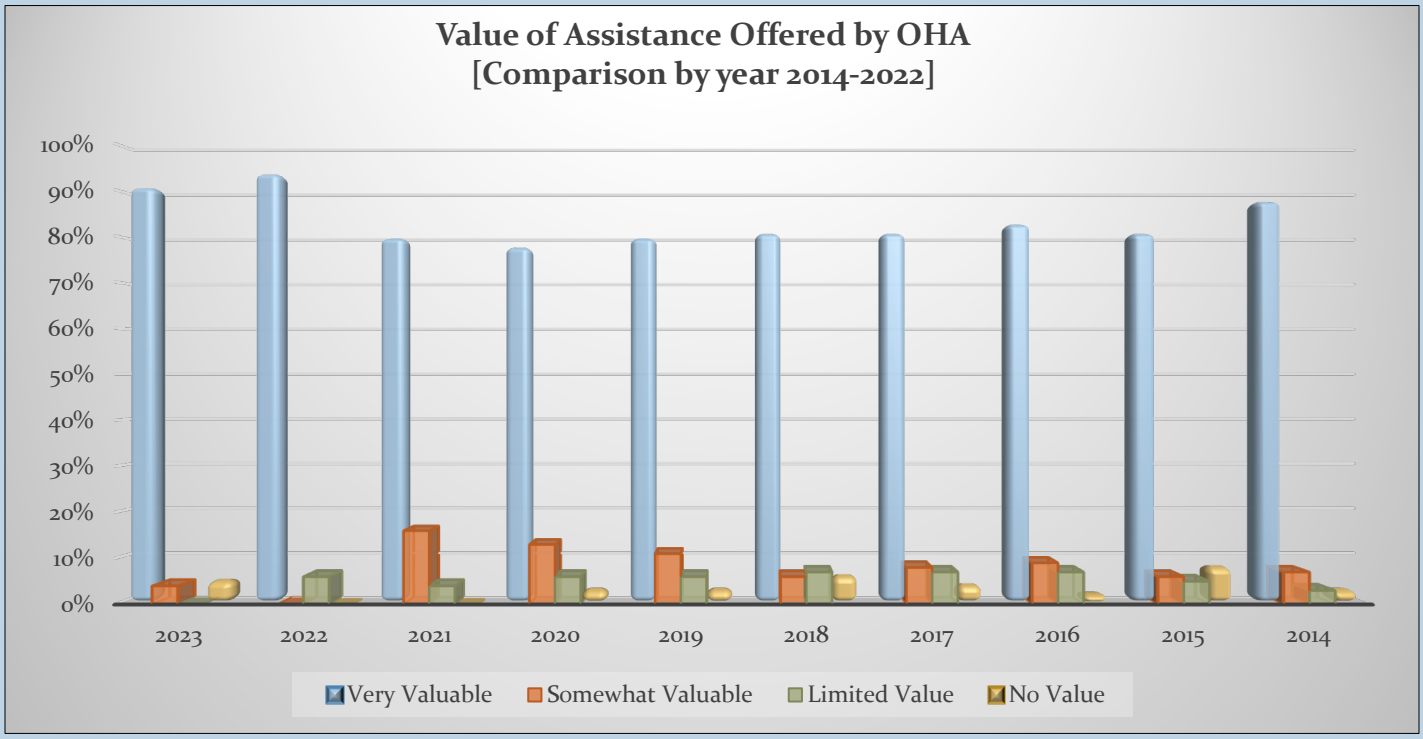


"I can't thank OHA enough for taking the lead and fixing this administrative issue. The health benefit company would "yes" me for months and not move to fix the issue. Potentially costing me $11,000. Once OHA got involved it progressed and was fixed. We owe $0 as expected."

OHA's consumers continue to give OHA very high ratings. Because of our education to consumers regarding the benefits under their health plans, the percentage of individuals reporting that they have an improved understanding of their healthcare plan after contacting OHA continues to increase. In CY 2023, 96 percent of consumers responded they would refer someone to OHA. This metric has been consistently high and favorable since 2014. OHA considers this measure the most important measure of OHA's services. The percentage of individuals reporting that they would contact OHA again also continues to remain strong and is at 95 percent while 91 percent of consumers found OHA to be valuable.







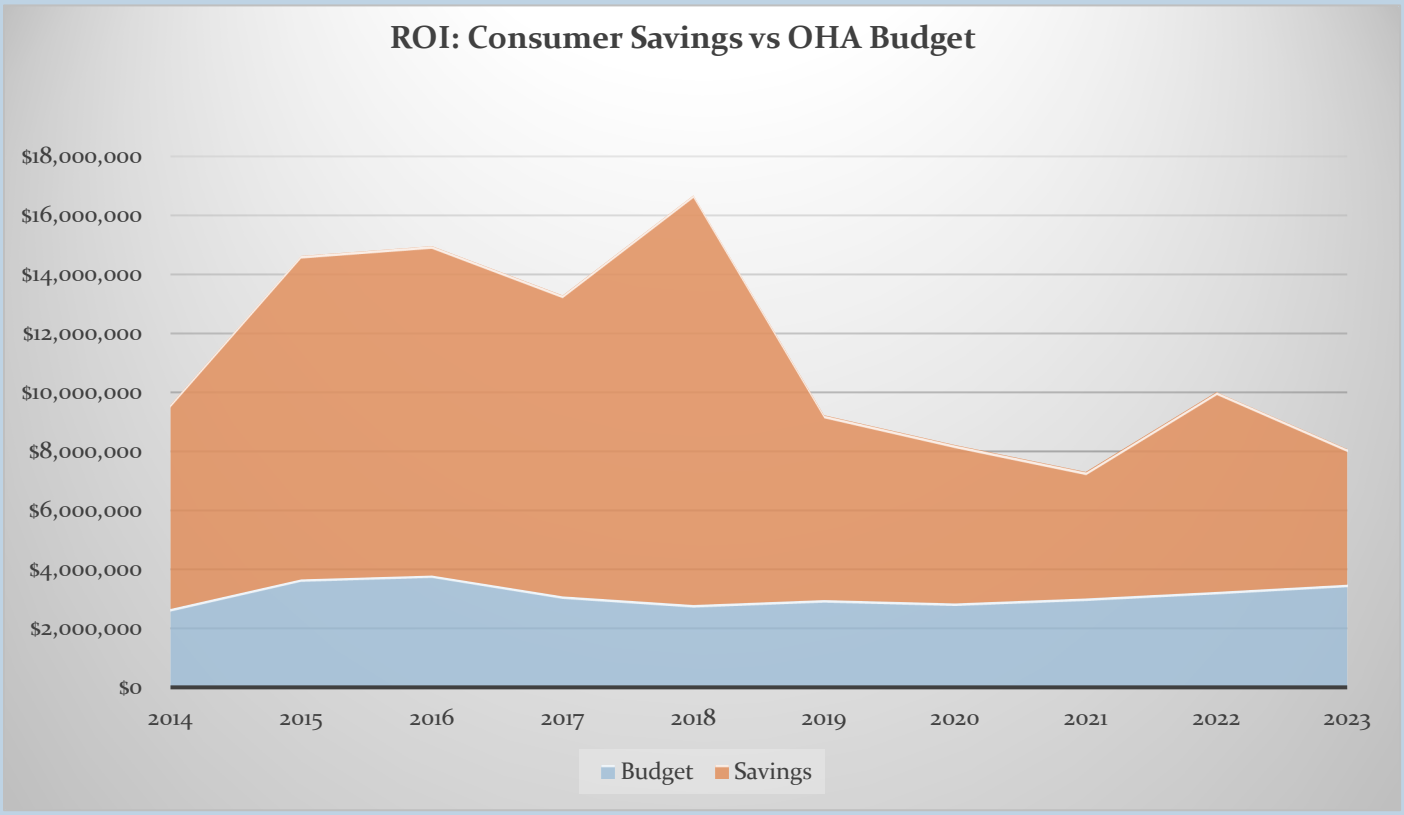
"My Advocate listened, was professional and friendly, told me what she needed from me. Took the time to understand my complaint and used her legal expertise to resolve my $3000 complaint in my favor against health insurance. I am very grateful for her efforts. Thank you."

OHA SAVINGS

The chart below illustrates the total amount of savings for consumers since 2014. OHA's advocacy returned $4.6 million to the residents of Connecticut in 2023. Since its founding in 2002, this office has returned over $132 million in savings to consumers.

Year	Budget	Savings
2014	$2,657,873	$6,924,978
2015	$3,659,826	$10,967,539
2016	$3,792,692	$11,168,483
2017	$3,087,756	$10,200,836
2018	$2,794,051	$13,884,659
2019	$2,962,921	$6,264,118
2020	$2,844,900	$5,373,038
2021	$3,016,676	$4,288,751
2022	$3,238,271	$6,775,150
2023	$3,481,636	$4,598,114

The graphic below shows OHA's annual budget over time compared to consumer savings,and demonstrates that OHA's budget remains low while our savings to consumers continues to be impressive.



"I worked with 2 separate people from OHA, and they were both very helpful, saving me literally several thousand dollars. I'm not sure that I ever thanked them properly, so I want to take the opportunity to give credit now."

CONSUMER STORIES

Connecticut resident contacted OHA for help obtaining coverage for a prescription drug medication that is prescribed to treat MS-related fatigue. The medication had been covered by her past two employer-based health plans. The patient had been taking the medication for 6-years and it significantly improves her condition. When the employer changed their employee's health benefits to a different health insurance carrier, her doctor's request for authorization of the medication was denied. The new health plan stated, "it was not medically necessary for her condition." OHA collected clinical documentation from the patient and her physician and wrote an appeal to the carrier, which demonstrated the reasons why the off-label use of the medication should be considered medically necessary for her condition. At this level of appeal, the denial was overturned so that coverage would be allowed.

Savings: $2160

Our consumer was scheduled for breast reconstruction surgery with two out-of-network surgeons. The consumer previously had a mastectomy and needed to have complex reconstruction surgery, which requires two surgeons at the same time. OHA worked with the carrier and each provider, to obtain two single-case agreements prior to the surgery. Both doctors were approved to receive $75,000 each for the 16-hour surgery.

Savings: $150,000

A concerned parent called about their young child with a malignant and incurable brain tumor. They researched surgeons and in-network coverage. The surgeon they were looking at was out-of-state. The family looked up the surgeon and the hospital to make sure they were listed in-network and took screenshots, because given the anticipated cost of the surgery, ensuring this was in network was top priority for them. The carrier assigned them a case worker confirming they looked up the provider and the facility correctly. The provider called the carrier, and was first told it would not be covered and then later on told it would be covered. They all did everything they could prior to make sure this would be covered. The carrier after the procedure classified the surgery as out-of-network, and there was a bill for $89,420. OHA worked with the carrier to review phone logs, screenshots and reference numbers that were given to the provider. Also, OHA reviewed notes from the carrier's case manager, stating this would be in-network. The carrier reviewed all notes and processed the claim as in-network with no patient responsibility. OHA helped, but this is a great example of a family under duress still doing a wonderful job documenting their communications with the carrier – a huge help in subsequent efforts to change erroneous decisions or even reverse a denial on appeal.

Savings: $89,420

The consumer contacted OHA regarding the denial of coverage for an oral surgery. The consumer and provider repeatedly requested authorization for the surgical procedure, and the plan denied the request citing that dental services are not a covered service. OHA investigated further and discovered the plan had paid for the hospital services for the service. OHA contacted the provider and the anesthesiologist and requested they resubmit the claim forms. The plan paid the claim for the anesthesiologist but denied the coverage for the surgeon citing the service is not a covered service. OHA appealed the determination, and the determination was overturned after reviewing the medical records, which proved the surgery was a medical issue and not a dental issue.

Savings: $15,216

Our consumer contacted OHA regarding denial of reimbursement of DME. Consumer reports a new plan with the same insurer was effective 1/23. In the new plan, prior authorization was required for the specific DME that was not required with the previous plan. When the consumer went to the pharmacy to pick up the specific DME she was informed the plan denied coverage for lack of prior authorization. Due to the medical necessity of the equipment, the consumer purchased the DME out of pocket. The consumer later went to the provider and informed him of the new prior authorization request, which was eventually approved approximately 2 weeks later. Consumer requested OHA's assistance with reimbursement for the DME she picked up, which was not covered under the prior authorization. Consumer had filed 2 appeals for reimbursement prior to OHA contact, both of which were denied. OHA did an inquiry to the plan and requested reimbursement due to the medical necessity of the required device and how the member could not go without the DME. The plan agreed to reimburse the member the out-of-pocket expenses for the DME.

Savings: $438.99

A consumer contacted OHA regarding a denial of a medication. Consumer had been on the medication for a few years, and the plan denied coverage for reasons that the medication requested was over the quantity limits. Consumer filed all levels of appeal prior to OHA contact, and the appeals were upheld including the external review. OHA contacted the provider and requested another prior authorization be placed. The prior authorization was initially denied. OHA thereafter filed the external appeal, and the IRO reversed the plans previous determination.

Savings: $20,532

Consumer had difficulty enrolling with his preferred primary care provider. After contacting the carrier, OHA was able to assist the consumer with changing his PCP with the carrier. Additionally, he was charged for an eye exam and glaucoma test because he did not have a referral from his PCP. The provider would not correct or back date the claim. Consumer thereupon contacted OHA for further assistance. After reviewing the plan's policy for eye care, OHA confirmed that the consumer should not have been charged because his visit should have been coded as a routine eye exam. After discussing the issue with the provider, the balance was removed from the consumer's account.

Savings: $424.00

The parent of a 17-year-old youth who was receiving residential mental health services contacted OHA for help when their health insurance carrier decided these services were no longer "medically necessary" and ended coverage. OHA collected clinical information from the patient's family and treatment team and wrote an appeal, which demonstrated the reasons why residential level of care was the most appropriate intervention to help with the types of challenges that were occurring. The health plan's decision to deny the request was upheld on appeal. But as is the case for all adverse determinations that involve clinical decisions, the member had the right to have the health plan's decision reviewed by an independent, external medical reviewer. At this level of appeal, the denial was overturned so that coverage would be allowed.

Savings: $37,800

Consumer is an active woman diagnosed with non-paraneoplastic autoimmune retinopathy of the right eye. She had been treated with high dose steroids since her diagnosis, without improvement in her vision. Due to the rarity of this disease, there are no randomized controlled studies of treatment. Her ophthalmologist had several articles regarding the utility of IVIG, as treatment for this antibody mediated disease. Autoimmune retinopathy (AIR) is an extremely rare disease for which there are no clinical trials or specifically approved therapies. However, there was an expert consensus that high dose IVIG is generally the most effective therapy for this condition. OHA assisted with her expedited external appeal, and the denial was overturned.

Savings: $604,238.99

Consumer was admitted after surgery to a skilled nursing facility that did not have a full-time nurse on staff. Unbeknownst to him, the facility hired an independent out of network nurse to manage his medications. This resulted in a balance of 100% of the charges for the nurse. OHA pointed out to the

insurer that the federal No Surprises Act prohibited the insurer from charging the consumer on this basis. The decision to deny coverage was overturned after the second level appeal.

Savings: $640.00

Consumer had both mammography and ultrasound imaging performed, and then had the costs applied towards her deductible. The facility charged the consumer for the imaging and ultrasound services. The consumer contacted OHA for assistance. The agency referred the carrier to a newly passed CT law mandating coverage for breast cancer screening, even for diagnostic reasons and not just as a preventive measure. The carrier reversed its determination and removed the consumer's cost share responsibility.

Savings: $619.31

The consumer began treatment with a weight loss provider and was receiving injections of prescribed weight loss medication administered by the provider. After determining the proper dosage, the provider prescribed the medication to be administered at home. However, the consumer was denied coverage for the weight loss drug because it was not on the carrier's formulary. The consumer contacted OHA for assistance with an appeal. OHA gathered the medical records from the consumer's providers. Coincidently, the consumer's plan offered a new weight loss management program. Upon reviewing the consumer's medical records, the case manager suggested that the consumer apply to the program available through her health benefits plan. The consumer applied and was qualified to enroll in the program. The consumer will now be able to receive weight loss treatment as well as the medication she was originally prescribed.

Savings: $7,200 (for six months of the medication).

Consumer's IVF prior authorization was denied as having exhausted her available benefits. OHA assisted the provider with their appeal which was later overturned. However, the prescribed medications needed to begin the IVF cycle were later denied. OHA intervened with the carrier to escalate the approval of the Rx in accordance with the overturned IVF decision. With OHA's assistance, the consumer was able to receive the IVF medications in order to commence the IVF cycle on schedule.

Savings $6,500.00

OHA Budget

Budget Summary Account	Total FY23 Budget	FY23 Actual Expenses	%
Personal Services	$ 1,816,901.00	$ 1,620,031.15	89%
Other Expenses	$ 277,991.00	$ 210,302.98	76%
Equipment	$ 5,000.00	$ 4,715.04	94%
Fringe Benefits	$ 1,472,372.00	$ 1,550,652.82	105%
Indirect Overhead	$ 95,934.00	$ 95,934.00	100%
Grand Total:	**$ 3,668,198.00**	**$ 3,481,635.99**	**95%**

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