OHA

Office of the Healthcare Advocate

STATE OF CONNECTICUT

ANNUAL REPORT

CALENDAR YEAR 2011

A Message from the Healthcare Advocate

I am pleased to issue the Office of the Healthcare Advocate's 2011 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.

OHA had a record setting year in 2011, in both the recoveries we've made for healthcare consumers, $11.5 million, and the number of cases we opened - 5,515. With the assistance of a federal grant and support from Governor Dannel P. Malloy, Lieutenant Governor Nancy Wyman, and the General Assembly, we hope to achieve this level of success through 2012 and beyond.

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

Victoria L. Veltri, JD, LLM
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 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 (OHA) 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.

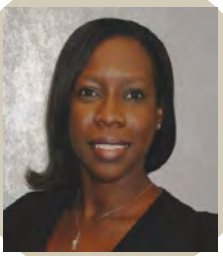
OHA also takes on matters that affect large groups of insurance consumers. By law, OHA is authorized to represent Connecticut's healthcare consumers in administrative matters. For example, in 2011 OHA participated in administrative advocacy to prevent the denial of medically necessary behavioral services for children with autism spectrum disorders, who are protected by the Medicaid Early Periodic Screening Diagnostic Treatment Program (EPSDT). OHA also engaged the Insurance Department on behalf of the consumers seeking mental health treatment when one insurer was repeatedly denying needed mental health treatment based on criteria that conflicts with Connecticut's mental health parity law.

Staff

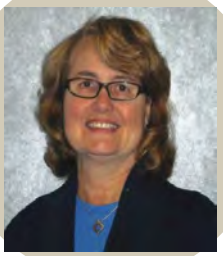
Victoria L. Veltri
State Healthcare Advocate

Maureen Smith
Director | Consumer Relations

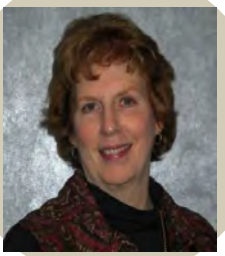
Demian Fontanella
General Counsel



Africka Hinds-Ayala
Health Program Associate

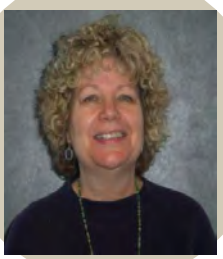


Candice Kohn
Nurse Case Manager

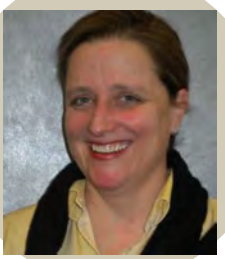


Liz Lemiska
Nurse Case Manager

Laura Morris
Health Program Associate



Marilyn Rice
Administrative Assistant



Jody Rowell
Case Manager

Darlene West
Case Manager

Vanessa Wimberly
Secretary II

OHA | 2011 Legislative Summary

The 2011 Legislative Session had two major and sixteen minor Public Acts that affect the Office of the Healthcare Advocate. These Public Acts either mandate the involvement of the Office of the Healthcare Advocate and/or seeks its support and advocacy for compliance.

PUBLIC ACT 11-53 | AN ACT ESTABLISHING A STATE HEALTH INSURANCE EXCHANGE

This legislation creates the Connecticut Health Insurance Exchange (CT-HIE) for the purposes of covering uninsured individuals in Connecticut. This Public Act implements the Exchange Board, establishes its duties, and empowers the Board to recommend a CEO candidate to the governor to run the Health Insurance Exchange. The State Healthcare Advocate serves on the CT-HIE as an ex-offico, non-voting member, and advocates for quality and affordable health plans. P. A. 11-53 includes a provision for enrollees to receive referrals for consumer assistance from the Office of the Healthcare Advocate directly or through the Navigator Grant program.

PUBLIC ACT 11-58 | AN ACT CONCERNING HEALTHCARE REFORM (SECTIONS 13 AND 14)

Public Act 11-58 also creates the Governor's Health Care Cabinet, a twenty-nine member board charged with ensuring an adequate healthcare workforce in Connecticut. This includes considering implementation of a basic health program option pursuant to the Affordable Care Act (Section 1331), coordinating healthcare delivery system reforms, providing a business plan that recommends adequate health insurance products, and advising the Governor on the affordability and sustainability of a state-wide healthcare system. In addition, the Governor's Health Care Cabinet must convene several workgroups to address service delivery, payment reforms, multi-payer initiatives, patient centered medical homes, and healthcare quality improvement. The State Healthcare Advocate serves as a board member with the Governor's Health Care Cabinet and employees of the Office of the Healthcare Advocate provide staffing and support services. P. A. 11-58 also contains numerous provisions affecting the appeal rights of consumers. By law, insurers must include OHA's contact information on denial letters so that consumers can seek assistance with those appeals.

"The OHA plays a vital role and contributes to the citizens of Connecticut." ~ Consumer

"Thank you for the professional staff and quick resolve to my issue. I am so very grateful to this agency." ~ Consumer

ADDITIONAL PUBLIC ACTS | The Office of the Healthcare Advocate provided testimony for Public Acts listed in **bold**.

PA No.	Title	Summary	Effective
11-2	An Act Concerning The Provision Of Prophylactic And Emergency Care To Hospital Patients	• Hospitals can administer emergent care to anyone and prophylactic care to newborns without a physician's order in compliance with 42 CFR 482. (Amends CGS Section 19a-470k)	10-01-2011
11-44	An Act Concerning The Bureau Of Rehabilitative Services And Implementation Of Provisions Of The Budget Concerning Human Services And Public Health	There are many provision in this Public Act that has state-wide effects; the following are related to OHA's work to assist with providing consumer education and advocacy: • Reduces reimbursement to pharmacies for Rx by 2% • Excludes anyone with a pre-ex from enrolling in Charter Oak—now requires them to enroll in the CTPCIP and reduces subsidies for those in the program as of 5/31/10 • Changes adult coverage for dental services for adults in Medicaid to one cleaning, one exam, and one set of bitewings per year. There is an exception if there is a dental condition that is an aggravating factor to overall health, but this is not defined. • Restores podiatry coverage in Medicaid by 10/1/11 • ConnPACE changes and MSP – sections 88-91 • Changes eyeglasses coverage to one pair every other year • Coverage for smoking cessations treatments – effective 7/1/12 • Birth to three services for children with Autism Spectrum Disorders – expands group and individual coverage for kids with ASDs to $50K per year up to an aggregate of $150K over three years. (This is a change to insurance law.) Effective 1/1/12. See sections 147 & 148 • Expansion of violations of False Claims Act – sections 153-159 • Council to oversee DSS programs – change from MMCOC to Council on Medical Assistance Program Oversight – expands powers and range of programs that the council oversees. See sections 167-172	Bill effective July 1, 2011 Sections have various effective dates

ADDITIONAL PUBLIC ACTS | The Office of the Healthcare Advocate provided testimony for Public Acts listed in **bold**.

PA No.	Title	Summary	Effective
11-67	An Act Concerning Coverage for Breast Magnetic Resonance Imaging	• Requires coverage for breast MRI under the same conditions as ultrasound was required (Amends CGS Sections 38a-503 and 38a-530)	01-01-2012
11-76	An Act Concerning Patient Access And Control Over Medical Test Results	• Providers communicate to patients test results in the provider's possession • Upon request of the patient, requires clinical lab to share test results with patient's other providers • Allows provider who requires patient to undergo repeated testing to authorize in a single release the communication of repeated results directly to the patient	10-01-2011
11-83	An Act Concerning Health Insurance Coverage And Certain Cancer Screenings	• The American College Of Gastroenterology to consult with The American College Of Radiology For Colorectal Cancer Screening Recommendations (Amends CGS Sections 38a-492k and 38a-518k); • No individual or group policy shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for any additional colonoscopy ordered in a policy year by a physician for an insured. The provisions of this subsection shall not apply to a high deductible health plan as that term is used in subsection (f) of section 38a-493.	01-01-2012
11-88	**An Act Requiring Health Insurance Coverage for Bone Marrow Testing**	• Individual and group insurers cover bone marrow testing with maximum 20% copayment for each test. • Allows restriction of coverage to a lifetime max of one test • Consumer signs informed consent that the sample will enter the bone marrow registry.	01-01-2012
11-132	An Act Prohibiting Most Favored Nations Clauses in Health Care Provider Contracts	• Prohibits MCO contracts with providers, hospitals, or dentists from including any provision that prohibits a provider, dentist, or hospital from contracting with another MCO or PPN at a lower payment or reimbursement rate. • Prohibits contracts from (1) containing provisions requiring a provider, dentist, or hospital to disclose the payment or reimbursement rates of another MCO or PPN with which it contracts or (2) being renegotiated before renewal if a lower payment or reimbursement rate is agreed to between the provider, dentist, or hospital and another MCO or PPN. (Adds subsections (c) & (d) to CGS 38a-479b)	10-01-2011
11-163	An Act Concerning Unfair Insurance Practices And Insurance Coverage For Mental Or Nervous Conditions	• Mandates an unfair insurance practice to refuse to insure, refuse to continue to insure or limit the amount, extent, or kind of coverage available to an individual or charge a different rate for the same coverage because such individual has been diagnosed with a mental or nervous condition, as defined in sections 38a-488a and 38a-514 of the general statutes.	10-01-2011
11-169	An Act Concerning Health Insurance Coverage for Prescription Drugs for Pain Treatment	• No policy that provides coverage for prescription drugs shall require an insured to use, prior to using a brand name prescription drug prescribed by a licensed physician for pain treatment, any alternative brand name prescription drugs or over-the-counter drugs, but such policy may require an insured to use, prior to using a brand name prescription drug prescribed by a licensed physician for pain treatment, a therapeutically equivalent generic drug. (Replaces CGS section 38a-492i)	01-01-2012
11-170	**An Act Concerning the Rate Review Approval Process for Certain Insurance Policies** **REPLACED BY COMPROMISE AGREEMENT WITH OHA & CID** Individual and small employer policies, four hearings a year upon request by OHA, request must be for 15% or more per year.	• Requires small employer group health insurers to file risk classifications and premium rates with the insurance commissioner; increases the amount of time required before a new rate can go into effect; requires the Insurance Department to post rate filings on its website and provide a 30–day public comment period; from January 1, 2012 to December 31, 2013, requires a symposium on a proposed rate filing if specified criteria are met and the healthcare advocate and attorney general request it; limits the number of symposia for LTC to 5 and individual rate requests to 10; requires advanced and subsequent notice of rate increases; establishes disclosure and record retention requirements for rate filings; and requires the insurance commissioner to adopt regulations to prescribe standards to ensure that small employer group, HMO, and hospital and medical service corporation rates are not excessive, inadequate, or discriminatory. (Current practice)	01-01-2012

ADDITIONAL PUBLIC ACTS | The Office of the Healthcare Advocate provided testimony for Public Acts listed in **bold**.

PA No.	Title	Summary	Effective
11-171	**An Act Concerning Insurance Coverage For Breast Magnetic Resonance Imaging And Extending The Notification Period To Insurers Following The Birth Of A Child**	• Requires coverage for Breast MRI and extends notification period to 61 days for newborn coverage.	01-01-2012
11-172	**An Act Concerning Health Insurance Coverage For Routine Patient Care Costs For Certain Clinical Trial Patients**	• Requires coverage for routine care costs for clinical trials for patients with: disabling, progressive, or life-threatening medical conditions" includes cancer, multiple sclerosis, Parkinson's disease, amyotrophic lateral sclerosis, acquired immunodeficiency syndrome (AIDS), and muscular dystrophy. • Covers other phases of clinical trials, even if not preventive, and Medicare trials. • Requires coverage for off-label drug use for FDA-approved drugs to treat the designated disabling, progressive, or life-threatening medical conditions. The drug must be recognized for the treatment of such a condition in the: U. S. Pharmacopoeia Drug Information Guide for the Health Care Professional; American Medical Association's Drug Evaluations, or American Society of Hospital Pharmacists' American Hospital Formulary Service Drug Information. • Specifies no required coverage for experimental or investigational drugs or any drug that the FDA has determined to be contraindicated for the treatment of a specific disabling, progressive, or life-threatening medical condition covered by the bill. This is already law with respect to cancer drugs. (Amends CGS Sections 38a-504 et seq. and 38a-542a et seq.)	01-01-2012
11-199	**An Act Concerning The Listing Of Advanced Practice Registered Nurses In Managed Care Organization Provider Listings, And Primary Care Provider Designations**	• Requires participating APRNs to be included in MCO directories. • Requires MCOs that require enrollees to select a PCP that APRNs are listed under the PCP heading (Amends CGS Section 38a-478d)	10-01-2011
11-204	An Act Concerning Health Insurance Coverage for Ostomy Supplies	• Raises coverage for ostomy supplies from $1,000 to $2,500 per year (Amends CGS Sections 38a-492j and 38a-518)	01-01-2012
11-225	An Act Concerning Insurance Coverage For The Screening And Treatment Of Prostate Cancer And Prohibiting Differential Payment Rates To Health Care Providers For Colonoscopy Or Endoscopic Services Based On Site Of Service	• Require health insurance coverage for (1) Lab tests for diagnosis of prostate cancer and (2) medically necessary treatment of prostate cancer. (Amends CGS Sections 38a-492g and 38a-518g) • Creates a new section that also requires insurers to establish fee schedules for colonoscopies that do not vary based on the site of service.	01-01-2012 (sunsets December 2013)
11-228	An Act Concerning Misrepresentation As A Board Certified Behavior Analyst	• Prevents persons from fraudulently using the title of certified behavioral analyst. Fines imposed for violations	10-01-2011

We are thrilled!
Everyone went above and beyond. What a wonderful gift to have this available at no charge to the public.
~ 2011 Consumer

Consumer Assistance Program Grant

In 2010, OHA received a one-year $396,400 Consumer Assistance Program Grant from the U.S. Department of Health and Human Services' Center for Consumer Information and Insurance Oversight. The purposes of this grant are to educate Connecticut consumers about the Affordable Care Act, their rights and responsibilities, where they can get assistance if needed; and to assist consumers with grievances and appeals of insurance coverage denials. This grant funded three positions at OHA: a Nurse Consultant Case Manager, a Licensed Clinical Social Worker Case Manager, and an Outreach Coordinator/Data Analyst. OHA was able to conduct over 100 outreach events in 2011 because of funding from this grant. OHA also conducted a large media campaign, which included a transit campaign for banners to be placed on buses in Connecticut, a 30-second commercial that aired on WTNH, now on OHA's website, and mailings to all licensed physicians in Connecticut. The number of cases referred to OHA because of outreach efforts has increased substantially. OHA is committed to its outreach efforts to the consumers of Connecticut.

It was not until this organization got involved that I saw results. Thank you for your hard work in advocating for me!

~ 2011 Consumer / Patient

OHA and DCF Collaboration

OHA and the Department of Children and Families (DCF) are beginning collaborations on a project regarding children and DCF Voluntary Services. OHA will assist DCF in appealing denials from insurers for families entering DCF Voluntary Service program. There are approximately 780 children serviced through DCF's Voluntary Services and DCF spends approximately $14 million on Voluntary Services mental and behavioral health treatment. Of those 780 children, 19% have private insurance. Families entering DCF Voluntary Services will benefit from the expertise of OHA staff to help with appeals and coverage with their private insurance. This collaboration could potentially save the State of Connecticut and DCF substantial funding that it currently pays out under the Voluntary Services program.

Hospital and Managed Care Community Benefits Report

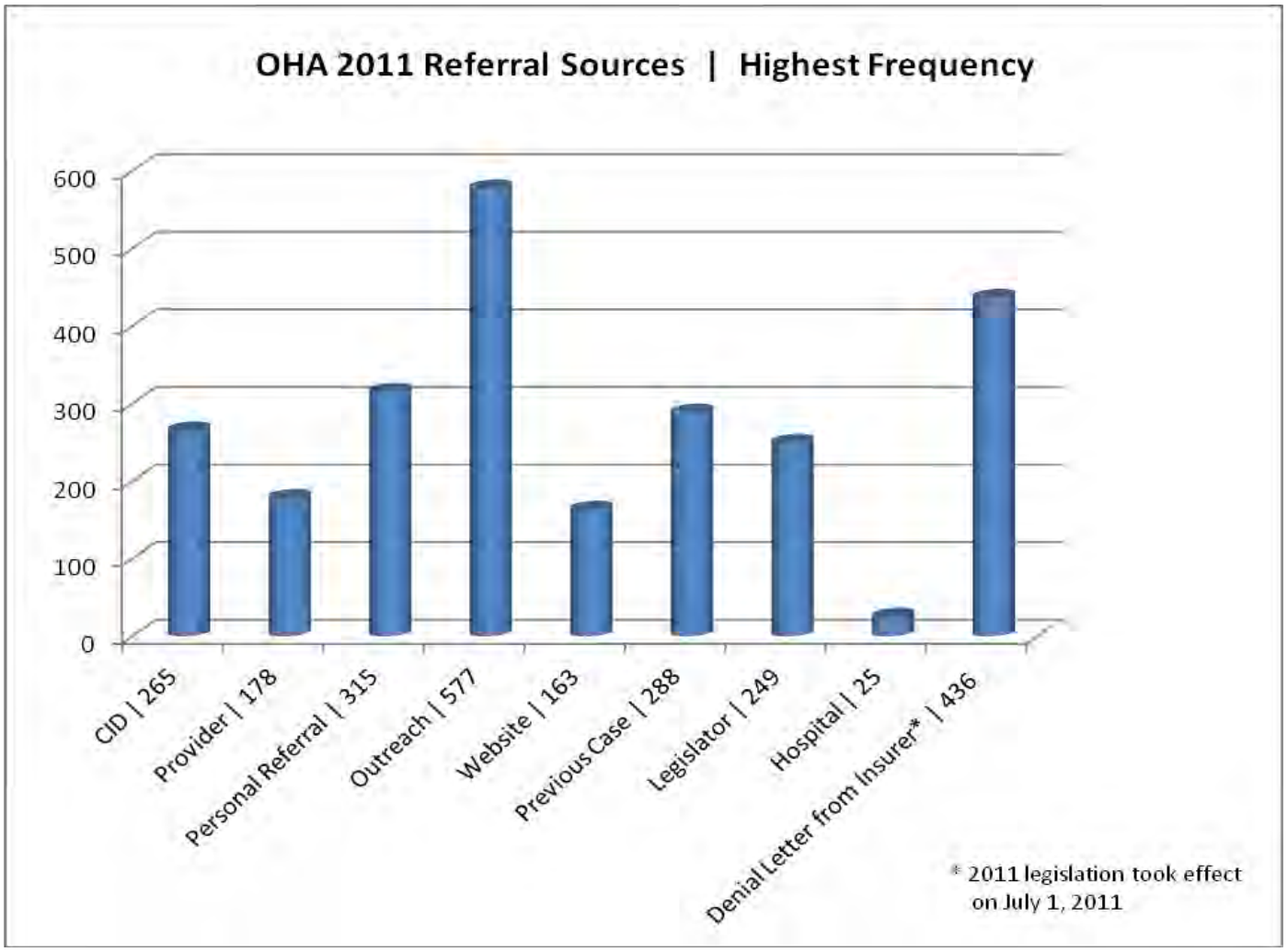
Connecticut General Statutes § 19a-127k requires hospitals and managed care organizations to report on a biennial basis the community benefits programs they have in place to OHA. In late 2010, OHA sent the biennial survey to managed care organizations and hospitals. These reports were returned in 2011 and are available from OHA.

Top Complaints by Issue | 2011 Compared to Previous Years

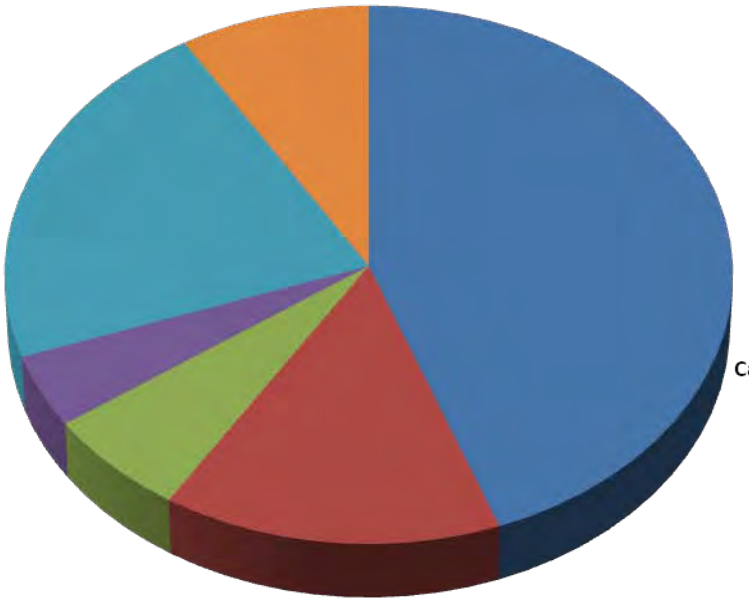
COMPLAINT | YEAR	2011	2010	2009	2008	2007	2006
Denied Service/Treatment	**649**	374	510	232	274	286
Education/Counseling	**595**	362	356	127	142	136
Billing Problem	**327**	138	265	177	119	115
Enrollment/Eligibility	**383**	228	254	147	176	118
Benefit Design	**235**	94	118	92	85	107
Service Not Covered	**177**	90	81	69	51	63
Denial of Claim	**568**	64	102	96	86	75
Other (Client)	**130**	136	141	225	168	96
Delay of Care (Client)	**103**	84	117	44	28	12
Incorrect Claim Adjudication (Client)	**75**	39	40	50	n/a	n/a

"OHA was very helpful in guiding me through the process and advocating for reasonable claim coverage."

"I am very pleased with the outcome as I was sick for so long with all the cancer and treatment side effects. Your office lit the light at the end of the tunnel. I truly believe this helped to speed up my recovery."

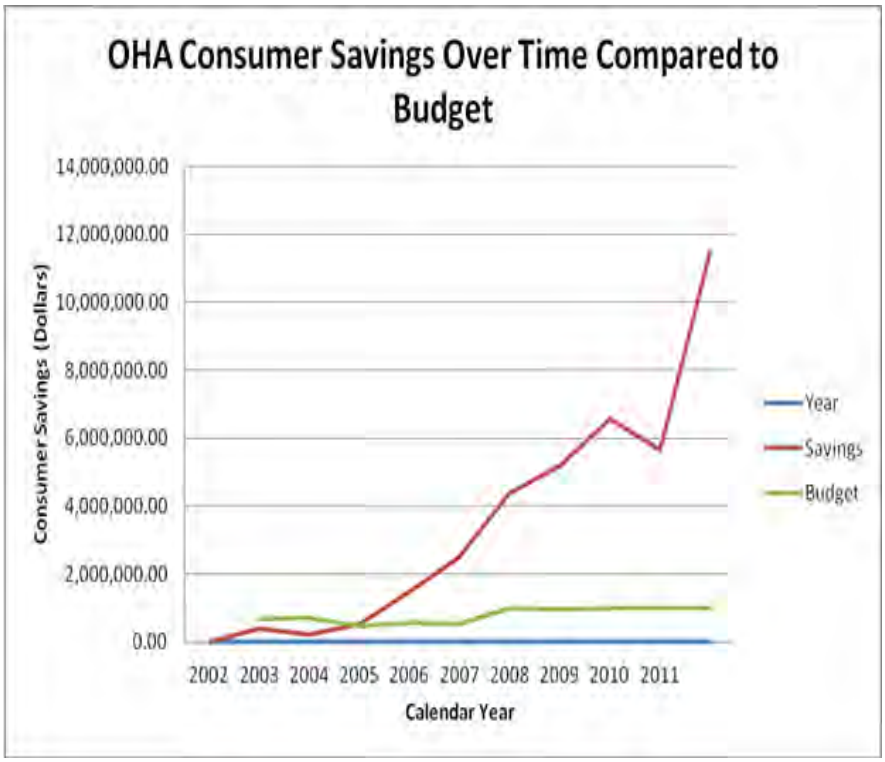


Cases by Insurance Carrier | Highest Frequency



Cases	Percentage	
1,250	44%	Wellpoint | Anthem BC-BS
412	15%	Aetna
177	6%	ConnectiCare
122	4%	HealthNet
612	22%	United Health Care/Oxford
246	9%	CIGNA

- ***"I will never be able to thank this agency enough for helping us when things were so confusing and our lives in such upheaval due to illness." ~ OHA Client***
- ***"I've been calling on you for 10+ years!" ~ Connecticut Provider***



YEAR	CONSUMER SAVINGS
2002	$410,294
2003	$205,665
2004	$531,823
2005	$1,487,895
2006	$2,514,825
2007	$4,391,353
2008	$5,191,614
2009	$6,578,895
2010	$5,664,905
2011	$11,465,080.37
TOTAL	**$38,462,349.16**

BUDGET

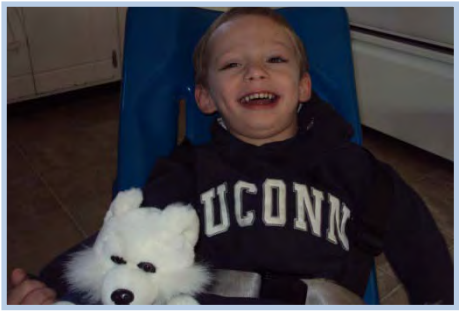
The budget for the Office of the Healthcare Advocate has remained within a range of $1.1 to $1.5 million since 2002. Over the course of this time, OHA has proven to be one of the most cost effective agencies in the state.

OHA | Consumer Relations and Outreach

Nine-year old Shane's parents were are at their wits end. Their son was diagnosed with Primary Insulin Growth Factor Deficiency (IGFD), a rare condition that affects 6,000 children in the United States, but is commonly confused with Idiopathic Short Stature. Treatment for his condition is growth hormone therapy, a treatment routinely denied by insurance companies as experimental and/or cosmetic. The doctor's appeals were denied. The parent's appeals were denied. The parents received help from the manufacturer of the drug for several months during their appeal process. The drug manufacturers' appeals were also denied. The parents, seeing an improvement in their son's physical and emotional health paid for the therapy for several months, but the $4,000+ per month cost was impossible to maintain. The family contacted OHA, who appealed the denial of treatment. Within one month of the appeal, not only was OHA able to get the treatments approved, OHA was able to get a large portion of the family's prescription drug expense reimbursed. Their son's rate of growth has more than doubled.

By the time Michelle's family called OHA, the 17 year old had a long history of failed mental health treatment. Undiagnosed with ADD until she was 15 years old, she was shunned by peers and failing academically. She became very depressed and withdrew from the few clean friends she had. In an effort to numb the rejection and isolation she felt, she began abusing alcohol and marijuana. Eventually, those substances were not enough to dull her emotional pain. Despite multiple interventions by her family, Michelle became increasingly depressed and increased the lethality of her drug use, adding heroine, opiates, and prescription sedatives. She would "use" whatever she could find in friends or family's home. When confronted by her parents, Michelle ran or became so violent that a restraining order was placed on her to protect her family members. Michelle was unreachable, out-of-control. Michelle was finally admitted to a substance abuse residential facility where she could receive treatment for her depression and substance use. The parents were relieved their daughter was finally safe and was going to get the treatment she deserved. The relief was short-lived as the insurance company informed them that Michelle's treatment was not medically necessary and would not pay it. Knowing their daughter was at a crossroads, the parents handed over their credit card to pay for their daughter's much needed treatment. With the help of OHA, after two levels of appeal, the insurance company finally agreed that Michelle's treatment was medically necessary, and they reimbursed the family $15,000. Michelle is well on her way to recovery.

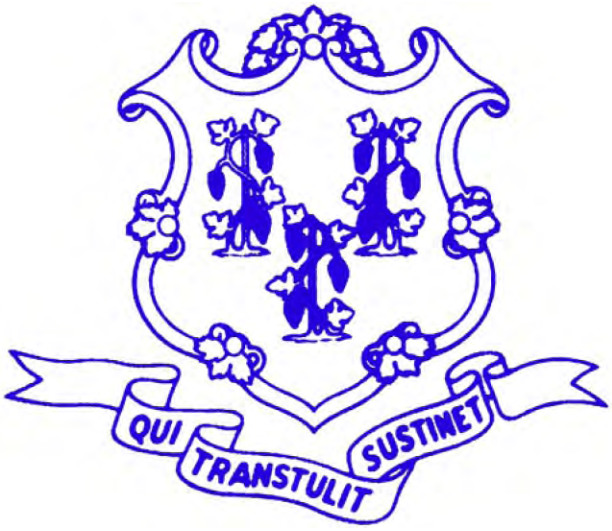
Daniel is a 3 year old with dyskinetic cerebral palsy. He requires adaptive equipment for sitting and standing. As he has grown and gotten stronger, his spasticity became an issue particularly at night in his crib. Daniel's parents feared his safety due to these uncontrolled, unpredictable spastic motor movements while in his well-padded crib which he was fast outgrowing. Because he is nonverbal and unable to reposition himself, his parents had to frequently check and reposition him during the night. They explored bed options with Daniel's pediatrician, physical medicine physician and his physical therapist. All these professionals agreed that Daniel needed a bed that would keep him safe and facilitate his care at home. His parents are devoted to him and keeping him safe, maximizing his development and abilities are a top priority. A claim was submitted to their health insurer for a safe bed. Unfortunately, the insurance company did not agree to cover the cost of this bed. Initially, the insurer failed to recognize that a special bed was medically necessary for Daniel's safety and indeed served a medical purpose. Subsequently they again failed to see that a typical adult hospital bed was not indicated or suitable for this child. Frustrated and discouraged, his mother took note of the information included at the end of the insurance denial letter indicating she could contact (OHA) for help if she did not agree with her health insurer's claim decision. Including OHA contact information on all denial claims for CT citizens was mandated in January 2011. This healthcare issue was thoroughly investigated by OHA. OHA coordinated a successful appeal process. Today, Daniel has his appropriate, safe bed and his insurer covered the claim.



CONNECTICUT STATE BUDGET

FY 12 & FY 13 BIENNIUM

Part 1: Agency Detail



OFFICE OF FISCAL ANALYSIS
CONNECTICUT GENERAL ASSEMBLY

Office of the Healthcare Advocate
MCO39400

	Actual FY 10	Governor Estimated FY 11	Governor Recommended FY 12	Governor Recommended FY 13	Legislative FY 12	Legislative FY 13
POSITION SUMMARY						
Permanent Full-Time - IF	10	10	0	0	9	9
BUDGET SUMMARY						
Personal Services	584,325	757,235	0	0	746,398	725,540
Other Expenses	119,387	136,373	0	0	136,373	136,374
Equipment	1,574	2,280	0	0	1,400	700
Other Current Expenses						
Fringe Benefits	369,479	380,821	0	0	493,954	495,294
Indirect Overhead	(2,155)	1	0	0	117,320	120,957
Agency Total - Insurance Fund	**1,072,610**	**1,276,710**	**0**	**0**	**1,495,445**	**1,478,865**
Additional Funds Available						
Private Contributions	11,850	2,000	0	0	0	0
Agency Grand Total	**1,084,460**	**1,278,710**	**0**	**0**	**1,495,445**	**1,478,865**

	Legislative FY 12		Legislative FY 13		Diff. from Governor Rec FY 12		Diff. from Governor Rec FY 13	
	Pos.	Amount	Pos.	Amount	Pos.	Amount	Pos.	Amount
BUDGET CHANGES SUMMARY								
FY 11 Governor Estimated Expenditures - IF	**10**	**1,276,710**	**10**	**1,276,710**	**0**	**0**	**0**	**0**
Current Services Adjustments	0	322,141	0	309,889	0	0	0	0
Current Services Totals	**10**	**1,598,851**	**10**	**1,586,599**	**0**	**0**	**0**	**0**
Policy Adjustments	(1)	(103,406)	(1)	(107,734)	9	1,495,445	9	1,478,865
Total Recommended - IF	**9**	**1,495,445**	**9**	**1,478,865**	**9**	**1,495,445**	**9**	**1,478,865**
BUDGET CHANGES DETAILS								
FY 11 Governor Estimated Expenditures - IF	**10**	**1,276,710**	**10**	**1,276,710**	**0**	**0**	**0**	**0**

Current Services Adjustments

Adjust Funding to Reflect Wage and Compensation Related Costs
Every eleventh year there is an additional pay period, which would result in 27 pay periods in FY 12 (currently there are 26 pay periods in a fiscal year). Turnover reflects those funds which: 1) remain after an employee leaves and is replaced by an individual at a lower salary, and 2) those funds that result from positions being held vacant.

-(Governor) Provide funding of $49,163 in FY 12 and $28,305 in FY 13 to reflect current services wage-related adjustments such as annual increments, general wage increases, overtime, annualization, turnover, 27th payroll and other compensation-related adjustments

	Legislative FY 12		Legislative FY 13		Diff. from Governor Rec FY 12		Diff. from Governor Rec FY 13	
	Pos.	**Amount**	**Pos.**	**Amount**	**Pos.**	**Amount**	**Pos.**	**Amount**
-(Legislative) Same as Governor.								
Personal Services	0	49,163	0	28,305	0	0	0	0
Total - Insurance Fund	**0**	**49,163**	**0**	**28,305**	**0**	**0**	**0**	**0**
Apply Inflationary Increases								
Applying inflationary factors to current year expenditures provides an estimate of the cost of continuing services into the next year. The Governor's budget applies these factors:								

Description	FY 12	FY 13
General	2.5%	3.1%
Medical	4.4%	4.2%
Food & Beverage	1.8%	1.8%
Energy	4.9% - 6.2%	3.4% – 4.3%

-(Governor) Increase funding for Other Expenses by $3,406 in FY 12 and an additional $4,329 in FY 13 (for a cumulative total of $7,735 in the second year) to reflect inflationary increases.								
-(Legislative) Same as Governor.								
Other Expenses	0	3,406	0	7,735	0	0	0	0
Total - Insurance Fund	**0**	**3,406**	**0**	**7,735**	**0**	**0**	**0**	**0**
Adjust Funding for Replacement Equipment								
-(Governor) Reduce funding by $880 in FY 12 and $1,580 in FY 13 for replacement equipment for this agency.								
-(Legislative) Same as Governor.								
Equipment	0	(880)	0	(1,580)	0	0	0	0
Total - Insurance Fund	**0**	**(880)**	**0**	**(1,580)**	**0**	**0**	**0**	**0**
Adjust Fringe Benefits and Indirect Overhead								
-(Governor) Provide funding of $270,452 in FY 12 and $275,429 in FY 13 to ensure sufficient funds for fringe benefits and indirect overhead.								
-(Legislative) Same as Governor.								
Fringe Benefits	0	153,133	0	154,473	0	0	0	0
Indirect Overhead	0	117,319	0	120,956	0	0	0	0
Total - Insurance Fund	**0**	**270,452**	**0**	**275,429**	**0**	**0**	**0**	**0**
Current Services Adjustments Subtotals	0	322,141	0	309,889	0	0	0	0
Current Services Totals - IF	**10**	**1,598,851**	**10**	**1,586,599**	**0**	**0**	**0**	**0**
Policy Revision Adjustments								
Transfer Positions and Funding to Reflect Consolidation								
-(Governor) Transfer 10 positions and funding of $1,595,445 in FY 12 and $1,578,865 in FY 13 to reflect the consolidation of the Office of the Healthcare Advocate into the Department of Consumer Protection.								

	Legislative FY 12		Legislative FY 13		Diff. from Governor Rec FY 12		Diff. from Governor Rec FY 13	
	Pos.	Amount	Pos.	Amount	Pos.	Amount	Pos.	Amount
-(Legislative) Funding and positions are not consolidated.								
Personal Services	0	0	0	0	10	806,398	10	785,540
Other Expenses	0	0	0	0	0	136,373	0	136,374
Equipment	0	0	0	0	0	1,400	0	700
Fringe Benefits	0	0	0	0	0	533,954	0	535,294
Indirect Overhead	0	0	0	0	0	117,320	0	120,957
Total - Insurance Fund	**0**	**0**	**0**	**0**	**10**	**1,595,445**	**10**	**1,578,865**
Eliminate Inflationary Increases								
-(Governor) Reduce Other Expenses by $3,406 in FY 12 and an additional $4,329 in FY 13 (for a cumulative total of $7,734 in the second year) to reflect the elimination of inflationary increases.								
-(Legislative) Same as Governor.								
Other Expenses	0	(3,406)	0	(7,734)	0	0	0	0
Total - Insurance Fund	**0**	**(3,406)**	**0**	**(7,734)**	**0**	**0**	**0**	**0**
Eliminate Position and Reduce Funding								
-(Legislative) Eliminate one position and reduce funding by $100,000 in each year.								
Personal Services	(1)	(60,000)	(1)	(60,000)	(1)	(60,000)	(1)	(60,000)
Fringe Benefits	0	(40,000)	0	(40,000)	0	(40,000)	0	(40,000)
Total - Insurance Fund	**(1)**	**(100,000)**	**(1)**	**(100,000)**	**(1)**	**(100,000)**	**(1)**	**(100,000)**
Policy Adjustments Subtotals	(1)	(103,406)	(1)	(107,734)	9	1,495,445	9	1,478,865
Total Recommended - IF	**9**	**1,495,445**	**9**	**1,478,865**	**9**	**1,495,445**	**9**	**1,478,865**

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