

We had never heard of OHA before, but I'm so glad a colleague told us about their services! After we had received written authorization from the insurance company, they refused to pay for all claims we submitted stating that the services weren't covered by the policy. OHA stepped in and worked with the family and the insurance company to resolve the issue and all the claims were paid. Thank you so much!



2019 ANNUAL REPORT

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A MESSAGE FROM THE HEALTHCARE ADVOCATE

The year 2019 was challenging for Connecticut health care consumers. Continuing attempts out of Washington, D.C. to repeal of the Affordable Care Act, and a slew of regulatory proposals designed to limit the ACA, have created uncertainty around consumer rights and protections. On the state front, rising health insurance premiums and other costs continued to provoke anxiety among Connecticut families trying to access health care. Internally, the Office of the Healthcare Advocate welcomed several new employees, and currently our team is stable, with no vacancies.

Last year, the General Assembly as part of its enacted budget directed OHA to administer a High Deductible Health Plan Reform Task Force, with 12 members appointed by Governor Lamont and General Assembly leadership. The Task Force was directed to provide a report to the General Assembly by February 2020, including findings and recommendations for possible improvements to high-deductible health plans (HDHPs). The Task Force began meeting in August, and selected me to chair the Task Force. By the time you read this, the Task Force will have concluded its work and delivered its final report to the General Assembly. The Task Force benefited from a number of presentations, and written and oral comment from a distinguished array of national experts and organizations, including Dr. Victor Villagra of UConn's Health Disparities Institute, the Universal Healthcare Foundation of Connecticut, Kevin McKechnie of the American Bankers Association's HSA Council, Lynn Quincy of Altarum's Health Care Value Hub, Dr. Mark Fendrick of the University of Michigan's Center for Value-Based Insurance Design, and many others.

OHA in 2020 intends to provide an independent report discussing HDHPs and the findings and learnings from the Task Force process, but it is clear that the reason deductibles have escalated so much in the United States over the past 20 years is that the prices of the underlying healthcare have risen and continue to rise at a rate well over inflation. While everyone would like deductibles to be lower, the money has to come from somewhere.

The ultimate solution to drive deductibles lower will be to reduce the underlying cost of healthcare: to this end, OHA will continue its advocacy for reforms in pharmaceutical, hospital, and other healthcare costs and price. At the same time, there is a need for the nation and the state to take a fresh look at how deductibles are administered and deployed, and consider fair, common-sense reforms like making sure that consumers who join a plan mid-year or near the end of the year are not subjected to the full-year deductible, as is the case now.

Turning to our core mission of assisting consumers struggling with healthcare coverage issues, OHA worked hard to provide quality advice and representation to Connecticut individuals and families facing difficulties choosing or enrolling in health insurance, or facing health insurance denials. The OHA staff, including nurses, paralegals, attorneys, consumer information representatives and other professionals, fielded 4,341 calls or complaints, and achieved consumer savings of over \$6 million for the residents of Connecticut, bringing the total consumer savings that OHA has achieved since its inception in 2005 to over \$112 million.

In addition, our outreach and education activities remain critical. Our services are needed, but we find that many Connecticut residents are not aware of our office. In 2019, OHA did 119 events during the year, including health fairs, senior centers, and other key community venues and events. We are ramping up our outreach and education efforts in 2020, with a number of outreach initiatives planned or under way, including a program to work with hospitals to get OHA's message into the video loops that are played in public spaces and waiting areas at the hospitals, as well as making sure that OHA brochures and other materials are available in those facilities.



Ted Doolittle

State Healthcare Advocate

OHA'S MISSION

We 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 striving 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 the 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, forgo 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 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. In 2019, OHA participated in 119 outreach events, assisted over 4,000 consumers with specific issues and saved more than \$6 million for those we helped. We are actively working to expand the outreach that we do so that more people know that OHA is available to help. Our ongoing collaboration with legislators and state partners has made this easier. By working together on topics of importance to our state, we can ensure that Connecticut's health care consumers have every opportunity to optimize their health and wellbeing.

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 provides Connecticut consumers with 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 important to the formulation of effective and meaningful policy. Some examples of OHA's staff activities promoting community engagement and collaboration during the past year follows:

- Access Health CT Board of Directors
- All Payer Claims Database Advisory Council
- Behavioral Health Partnership Oversight Council
- Behavioral Health Working Group
- Covering Connecticut Kids and Families Steering Committee
- Covering Connecticut Kids and Families Quarterly Meetings
- Connecticut Cancer Partnership Committee
- Connecticut Choosing Wisely Collaborative
- Connecticut Health Foundation Kitchen Cabinet
- Connecticut Parity Coalition
- Connecticut Partners for Health
- Better Health Conference Planning Committee
- Connecticut Strong State Level Transition Team

- Department of Mental Health and Addiction Services Alcohol and Drug Advisory Council
- DCF Children’s Behavioral Health Task Force Implementation Plan
- DCF Three Branch Institute
- DPH National Standards for Culturally and Linguistically Appropriate Services in Health and Healthcare
- Equal Coverage to Care Coalition
- Explanation of Benefits Confidentiality *Ad Hoc* Work Group
- Family Support Council Board of Directors
- Health Acquired Infections Committee
- Health Care Cabinet
 - Healthcare Cabinet Cost Containment Study
- Health Information Technology Council
- Legislative Behavioral Task Force Under PA 13-3
- 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
- National Parity Implementation Coalition
- Opioid Stakeholder Regional Group
- Personal Care Attendant Workforce Council
- Protect Our Care Coalition
- State Opioid Plan

OHA Out and About – CY 2019

The effort to Engage, Empower and Educate consumers marches on this calendar year even as the direct intervention in claims denials continues. The political discourse about the Affordable Care Act and changes, pending changes and lawsuits, court decisions has contributed greatly to confusion among healthcare consumers. At the same time, they are being assaulted by rising costs for policies, drugs and medical care; greater deductibles and co-pays. OHA invests in strategic daily communication aimed at calming the market while educating and empowering our residents with knowledge of their rights, responsibilities and protections under state and federal law. This year, our marketing to consumers was active on all platforms social, broadcast, digital and public relations to drive awareness and personal action.

Digital Targeting – OHA's key target are the urban centers as pinpoints for its digital outreach with an expanding radius of 25 miles to insure that the majority of the state is covered. The urban centers also have large representation of underserved healthcare consumers. Our primary delivery vehicles were banner ads, content association and news websites.

Social – As in previous years, Facebook and Twitter remain our preferred social channels which are deployed almost daily. We populate these venues with information about the OHA, helpful healthcare tips and the latest developments in the on-going discussions regarding the ACA, Medicare for all and are policy initiatives aimed at making healthcare accessible and affordable. We use a lot of infographics to explain developments. OHA curates and shares content developed by others that we think has ramifications and benefits for our consumers. In short, we create, harvest and boost content predicated on impact. Posts are vetted, planned

and scheduled each day along with real time monitoring of consumer feedback and engagements so we can answer questions and supervise interactions.

Facebook – The profile of our consumers has remained largely the same. An overwhelming number of them, nearly 80 percent are female in ages 25 to 65. But the trend in age is skewing a bit older this year averaging 30 to 64. This demographic is to be expected. Women dominate the healthcare decisions of their families from doctors to medicines. Men tend to weigh in on healthcare policies but not healthcare per se. Independent data also points to female dominance in the health space. Consequently, we use a combination of data points to guide our content but also any advertising that we do. Programming tends to fall in female friendly radio programs, cable and news programming with dominate female skews.

Twitter - The OHA twitter strategy is to continue to re-purpose what we post on FB so it has a similar feel on the Twitter feed. OHA also uses Twitter for live posts and re-tweets important information from other sources.

Public Relations – Healthcare Advocate Ted Doolittle spent considerable effort on health policy, advocating for change and working at improving the working knowledge of public officials and consumers. He had two articles published in The Hill. One debunked the notion that there is a significant difference between Private vs. government Medicare. In the article, Mr. Doolittle argues that Medicare is essentially run by private enterprise. <https://thehill.com/opinion/healthcare/457248-private-sector-vs-medicare-theyre-basically-the-same-thing>

In a sister opinion article, Mr. Doolittle made the point that if policy advocates want to expand Medicare, they will need to hire private insurance companies to run it because they've got the tools and expertise needed to execute. He also notes that in reality, the Medicare program has been one of the most successful public

private partnerships ever. <https://thehill.com/opinion/healthcare/466576-want-to-expand-medicare-youll-need-to-hire-the-insurance-companies-not>

In other news. Mr. Doolittle and the OHA received news coverage for work on high deductible health plans through the task force he chairs; advocating for the public option health policy with Comptroller Kevin Lembo and news coverage of a forum by OHA in New Britain. The OHA received significant exposure for participation in an hour long program on the award winning WNPR program: *Where We Live* that asked “What’s the fix for our Ailing Health Care System?”

<https://www.wnpr.org/post/whats-fix-ailing-health-care-system>

Television – Radio The advertising campaign OHA started in 2018 was continued in the first and second quarter of CY 2019. The spots were radio versions of the two 15-second television advertisements. OHA also ran the television spots in the first half the year. The thrust of both commercials is that Connecticut’s residents can expect compassionate, expert healthcare advice and help by accessing the OHA on the telephone or online. The television version aired statewide on Comcast Cable and also on WTNH.

High Deductible Health Insurance Plan (HDHP)

In the 2019 budget, Governor Lamont and the Connecticut Legislature asked for a Task Force to look at how health insurance plans with high deductibles (HDHPs) were affecting consumers. (A deductible is money that the consumer has to pay for their health care before the insurance will begin to pay for care.)

The Task Force heard from many experts about issues with high deductibles. Deductibles which are too high can lead people to avoid necessary care because they cannot afford to pay for it. Some people avoid care even when it will be completely paid for by the insurance company. Some do not understand or trust that their care will be paid for by the insurance company, and some do not want to pay for follow up care that may be necessary. Insurance companies use deductibles to lower monthly premiums by shifting more of the costs directly to consumers. Both premiums and deductibles have grown over the years because the price of medical care has gone up a lot.

The Task Force heard how high deductibles prevent people from getting health care that they need even when they have health insurance. At the same time, deductibles do help some people to save money, especially people who are able to put money into a Health Savings Account, which is one the best tax shelters in the tax code. The Internal Revenue Service has put forth rules on which HDHPs allow people to put money into an HSA. Not all HDHPs qualify.

The Task Force heard about how high deductibles lead to medical debt, especially for people who do not have a lot of money to begin with. Medical debt is a problem for both consumers and providers. Consumers tend to avoid going back to doctors when they owe money and are not able to pay. Providers have to choose between serving the needs of the patient who owes them money, and making sure they can stay in business to serve all of their patients.

The Task Force considered many possible changes to HDHPs that could address some of the problems that high deductibles contribute to. Those changes are described in this report, as well as what the Task Force thinks about each change. The possible changes fall into five basic categories:

1. Helping people understand their insurance better
2. Changing how deductibles work
3. Making HSAs work for more people
4. Helping people pay for health care
5. Bringing health care prices down

A majority of the Task Force adopted many of the recommendations that had been considered, while several other proposals were rejected. None of the recommendations had unanimous support from the Task Force membership. In general, Task Force members looked favorably on efforts to teach consumers about their health plans, while at the same time noting that the complexity of health insurance is itself an issue. The Task Force further supported reforms to encourage people who qualify for HSAs to fund them, and to encourage the state to consider funding the HSAs of people who qualify but do not have the income to fund their own. Task Force members also recognized that a main cause for the growth of HDHPs is the growth of the underlying health care costs, and expressed its support for existing efforts to identify a Healthcare Affordability Standard and a Health Care Cost Benchmark. Finally, Task Force members supported certain cost sharing reforms intended to mitigate consumer and provider concerns that necessary or high-value care is cost-prohibitive due to a high deductible.

All too often, OHA hears from our clients that high deductible impinge on their ability to access care. While high deductibles are directly driven by the high and rising underlying price of healthcare, which was beyond the scope of the Task Force, nevertheless there is opportunity for substantial improvements in the HDHP

structure. For instance, there would seem to be very few barriers to implementing a common-sense requirement that members joining part-way through the plan year be subject to a pro-rated annual deductible, instead of the full annual deductible; and while this would possibly impact premiums, given the small number of enrollees who ever hit the deductible, the impact on premium should not be large. OHA will continue to work on this and other common-sense reforms to the HDHP structure in 2020.

OHA and the Department of Children and Families

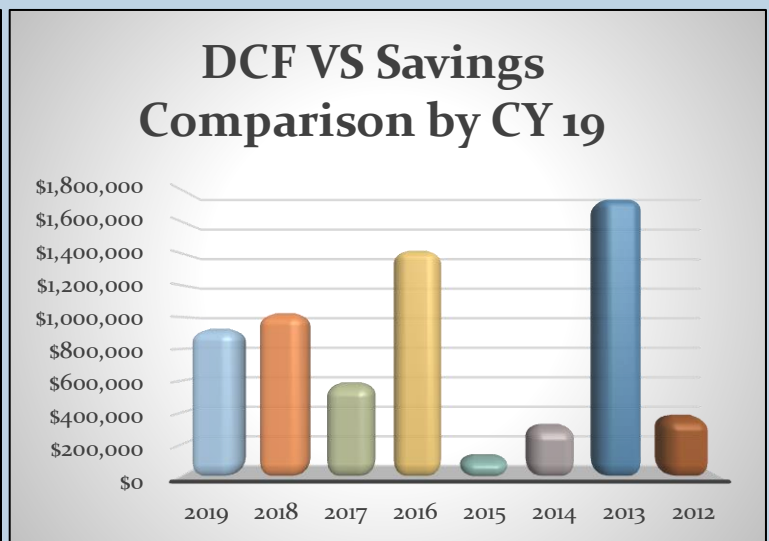
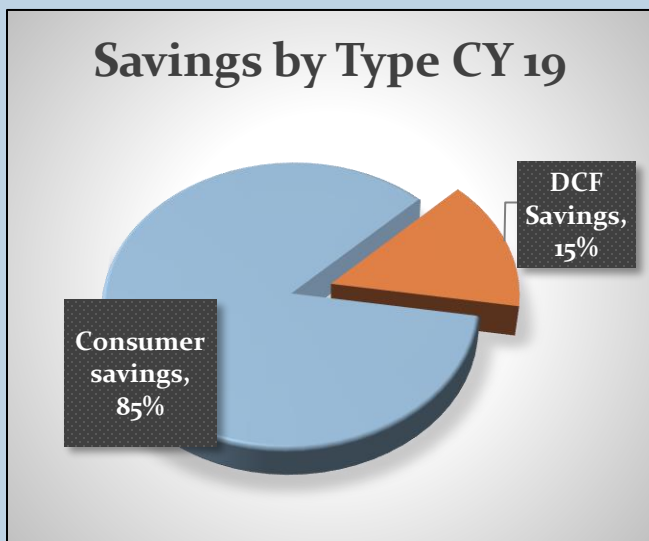
This project continues to be a positive example of collaboration among state agencies. This collaboration started in 2012 with an idea to save state monies within the DCF Voluntary Services Program by ensuring that any commercial insurance coverage held by families being assisted by DCF is utilized before any state funds are expended, or if state funds had been expended, to insure reimbursement from commercial carriers where appropriate. The program subsequently expanded to other DCF programs and facilities. This ongoing partnership with DCF's Careline phone intake system, DCF Area Offices and the DCF Solnit Facilities for inpatient adolescent behavioral healthcare have allowed for data collection regarding the amount of state monies saved, as well as allowing us to find trends and patterns, and to identify barriers to behavioral health services. The data reports are utilized to educate consumers and state agencies. The educational awareness efforts by the OHA staff as a result of this collaboration have included the following:

1. Information on OHA services available to clients, staff and other agencies
2. Training and education to DCF clients, providers and staff on insurance navigation
3. How to utilize health coverage effectively and the questions to ask regarding benefits
4. How to submit a pre-authorization of service for treatment
5. Assistance with insurance companies' peer-to-peer review and concurrent reviews
6. Coordination of benefits between different healthcare plans
7. How to utilize commercial insurance before or after state funding
8. Identification of denial of claims, exclusions and other possible violations of insurance regulations

OHA's immediate involvement upon identification of consumers and DCF clients in need of OHA assistance and services leads to the ability to appeal denials of services and treatments in a timely way. The ability to have OHA involved from the beginning often can obviate the need to unnecessarily rely on HUSKY coverage at state

expense. Appeals overturned by OHA can lead to reimbursement by commercial insurance, thus saving the state money. This collaboration has provided many clients with the appropriate continued coverage under their commercial plan when transition from acute levels of treatment to lower levels of care. Coordination and collaboration efforts for these clients enables their care to continue with more services and less barriers. Trends and patterns in needed care for different populations and age groups were identified and addressed with other state.

Savings remain highly variable from year to year due to many factors, including changes in state-mandated coverage, the number of denials referred to OHA from DCF programs and facilities, and increases in DCF staff awareness regarding the ways OHA can assist DCF clients with insurance navigation. The in-home services/IICAPS (Intensive In-Home Child & Psychiatric Service) program for behavioral health have remained the majority case type for 2019. Due to legislative changes to this mandate, OHA continues to provide ongoing educational services to consumers, providers and state agencies. Education provided to DCF and Connecticut residents regarding the nature of their healthcare insurance benefits for these services has increased in 2019 due to changes in the DCF process.



This coming year will be one of change for this collaboration between OHA/DCF. The agencies will continue to work together to strengthen this current collaboration and introduce other agencies into this partnership to benefit Connecticut residents. The goal of this growth in collaboration between agencies is to decrease barriers to access to care, save state monies and provide increasing education regarding healthcare insurance benefits.

OHA and the Department of Developmental Services (DDS)

OHA continues to collaborate with DDS to promote consumer engagement, education and options for coverage of services under private health coverage for individuals who seek help from DDS. OHA assists in collaboration efforts with other state agencies, providers, legislators and consumers to identify and access services that may be covered by the consumer's healthcare plan. OHA has answered many questions regarding health plan terms and provisions, specifically those associated with Autism Spectrum Disorder services. OHA continues to work with DDS to ensure that consumers who may be eligible for DDS services receive the additional support available to them. OHA continues to collaborate with other state agencies, providers and the public to support and promote healthcare services to this population. OHA's goal for this collaborative effort with DDS is to continue to provide education to the DDS staff and their clients in utilizing commercial insurance benefits, to work with the DDS regarding access to care and following trends and patterns, and to report to DDS as needed.

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. At this time, 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.

During the 2019 legislative session, OHA tracked 253 unique bills, 15 of which became law, provided expert insight concerning possible language for several, and testified on 36.

- OHA supported SB 838 (PA 19-117, Section 209-210), which expands insurance coverage of breast ultrasounds for women age 40 and over, and further eliminates cost sharing for all breast cancer screening procedures covered under the statute, including baseline mammograms, breast tomosynthesis, ultrasound screenings and MRIs.
- OHA advocated for SB 31 (Public Act 19-117, Section 240), which subjects out-of-network clinical laboratories to the same restrictions against surprise billing that apply to other providers.
- OHA advocated for SB 902, (Public Act 19-117, Section 247), which initially proposed various reforms to high deductible health plans (HDHPs), but upon passage, established a task force to study HDHPs and make recommendations to the Insurance Committee to address the impacts of HDHPs on their members.
- OHA supported HB 5521 (Public Act 19-134), which prohibits preexisting condition exclusions from short-term limited duration health plans, and further expands the definition of a preexisting condition (and therefore the scope of the prohibition) to include those conditions that were present before the effective date of coverage, but not diagnosed or treated.
- Finally, OHA supported HB 7125 (Public Act 19-159), which requires health insurers annually, beginning March 1, 2021, to report mental health parity compliance measures to the Insurance Commissioner, including:
 - (1) A description of the processes used to develop and select medical necessity criteria related to mental health and medical benefits
 - (2) A description of all non-quantitative treatment limitations applied to mental health and medical benefits
 - (3) An analysis of the processes, strategies, evidentiary standards and other factors that the insurer used in developing and applying its criteria and limitations, including:
 - a. the factors considered in designing non-quantitative treatment limitations
 - b. the evidentiary standards applied to the factors considered above.
 - c. the processes and strategies used to design and apply each non-quantitative treatment limitation, both as written and in actual operation



CONSUMER RELATIONS

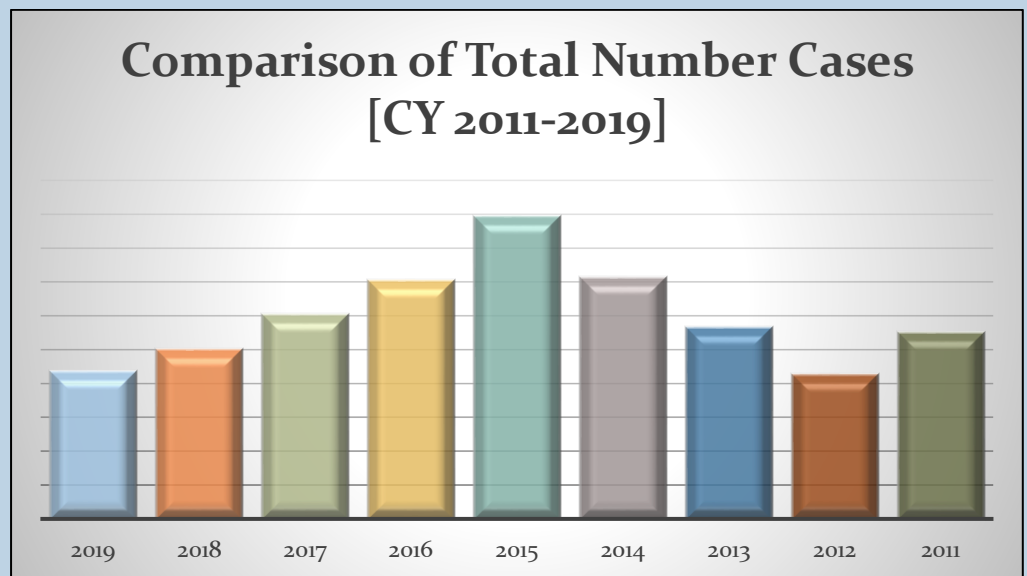
“My case worker was very responsive to me by diligently working at my case and keeping me informed. Way to go OHA!”

“My case worker was absolutely amazing and helpful during the entire process. Always pleasant and fought for my case. I am extremely grateful for OHA.”

“The advocate assigned to me was instrumental in our case. She was efficient, intelligent, professional and a lifesaver!”

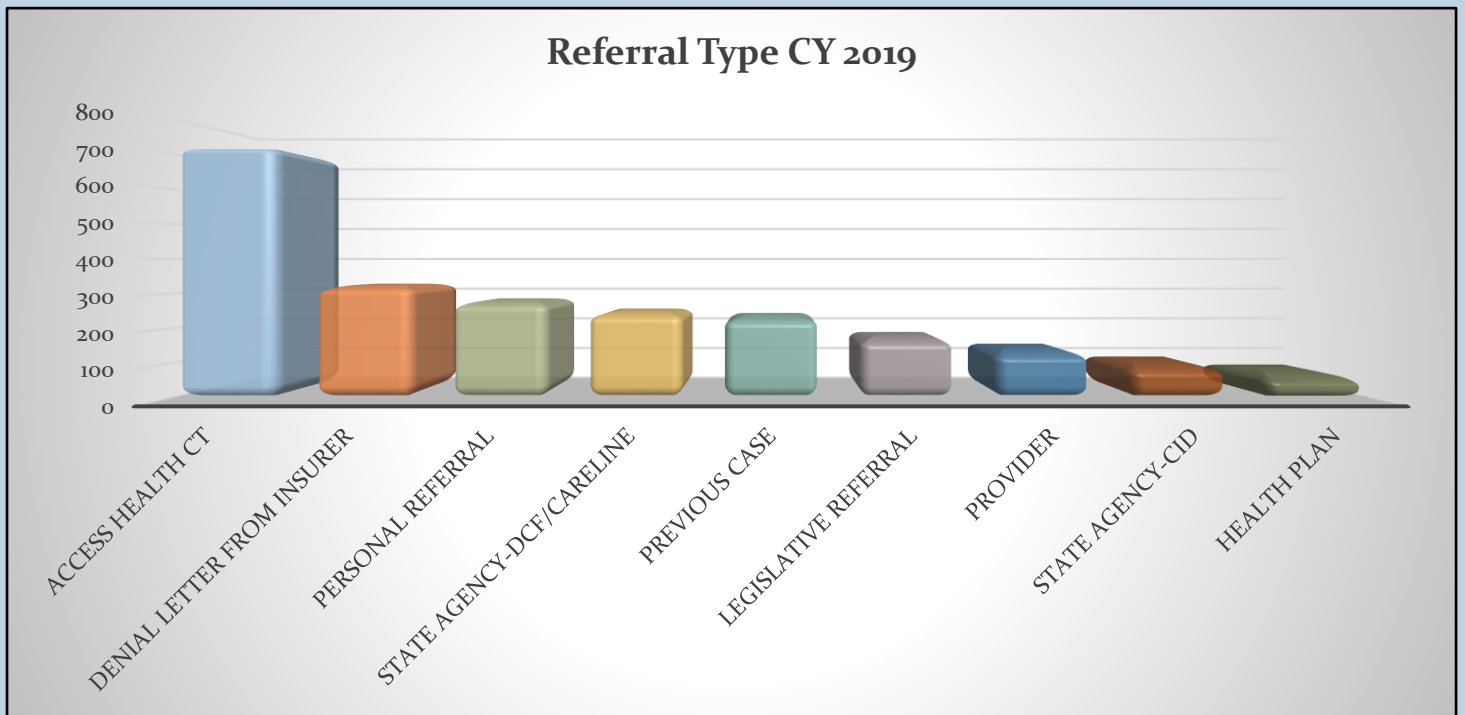
“Our case worker was our angel on earth! Not only was she intelligent but she was kind, patient, compassionate, authentic, funny and empathetic. Without her this case would have never ended. You are very lucky to have her on your team”

In CY 2019, OHA continued to receive a high volume of consumer calls on its toll-free line and hundreds of additional calls or emails directly to staff. We continue to encourage legislators and agencies to refer cases directly to OHA for high-quality real-time services. 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, claims denials and legal matters. Consumers continue to be very satisfied with our services.

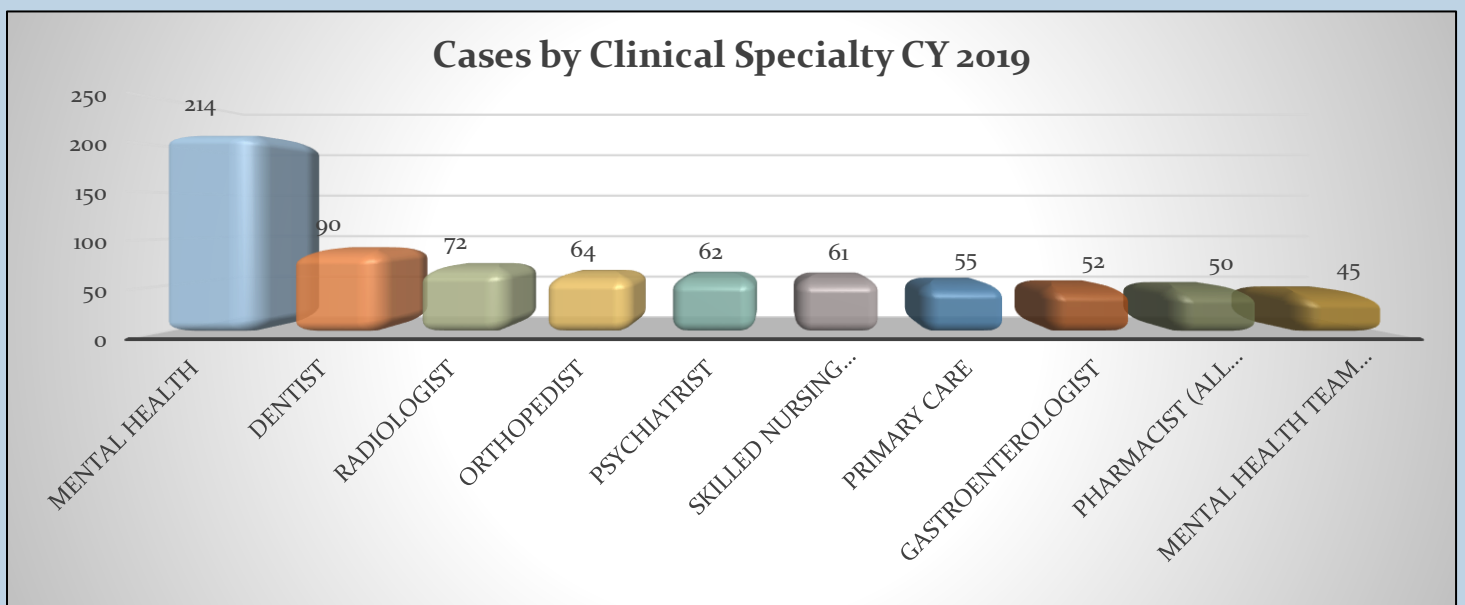


Cases continue to come to OHA from a variety of sources. The highest category of referrals to OHA are Access Health CT (AHCT) cases for consumers who have application, documentation and other issues. The referrals from AHCT come from two sources: Direct letter to clients and phone calls to our agency generated by AHCT. The second highest category is Denial Letter from insurer that consumers received from their health care plans and are required under

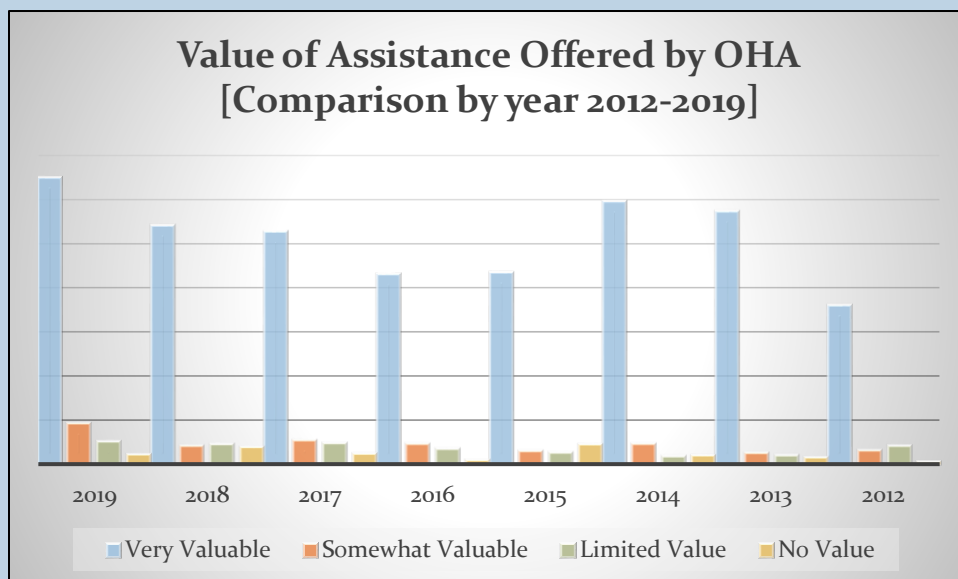
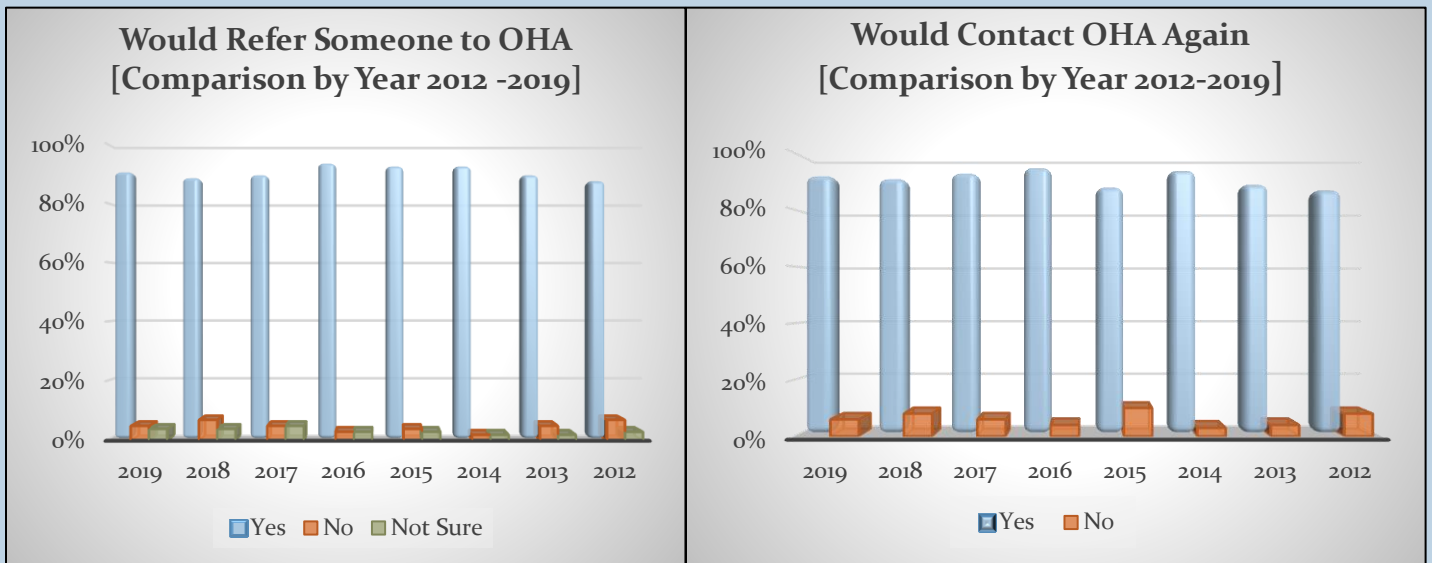
federal and state law to include OHA’s contact information. These letters were the second top source of referrals to OHA in CY 19, followed by Personal referrals, State agencies, Previous cases and Referral from Legislators.



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 reversals of denials of treatment or services that involve consumers in need of treatment for serious, debilitating, or life-threatening illnesses.



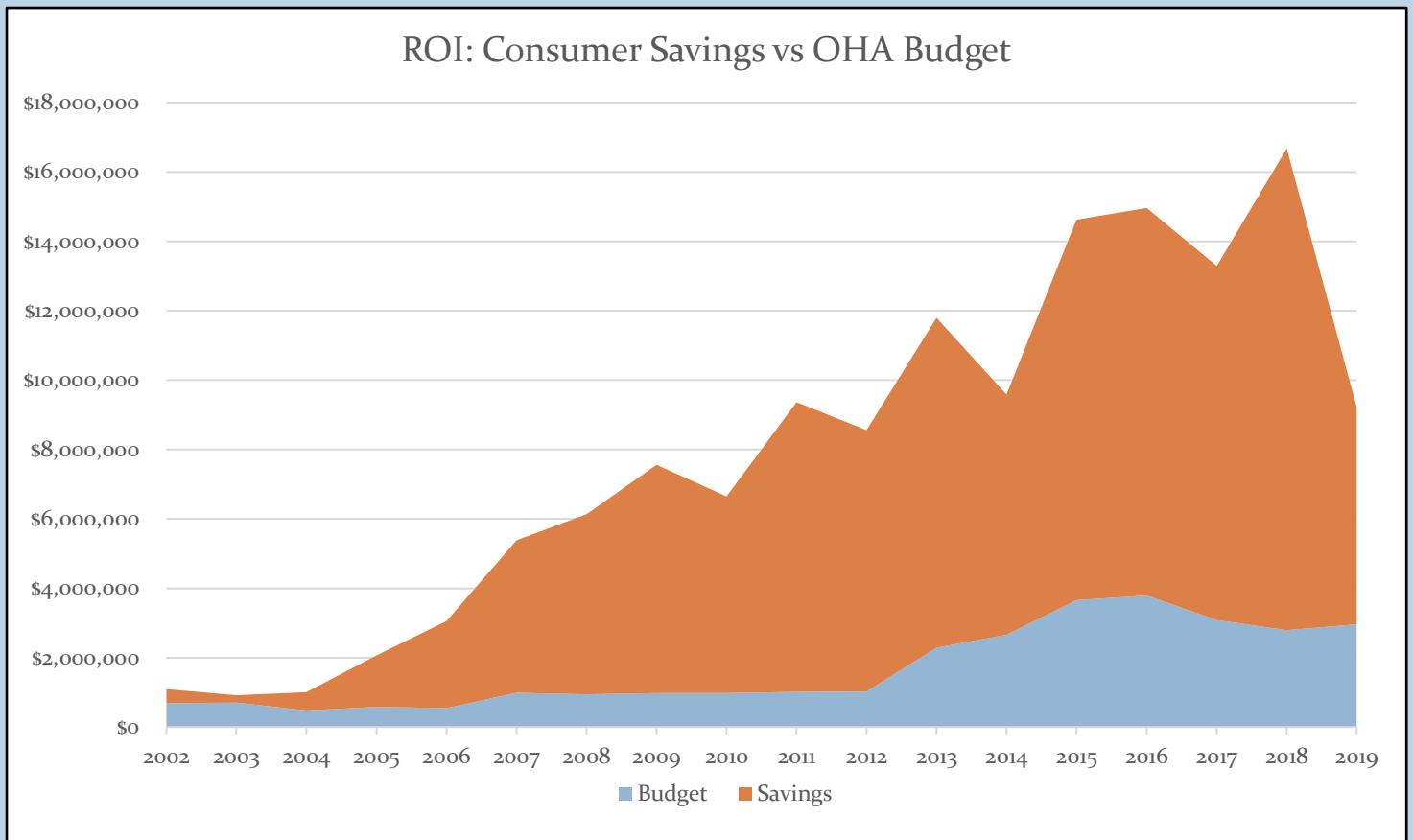
OHA's consumers continue to give OHA very high ratings. Because of our education to consumers regarding the benefits under their health plans, the percentage of individuals reporting that they have an improved understanding of their healthcare plan after contacting OHA continues to increase. In CY 2019, 91 percent of Consumers responded they would refer someone to OHA. This metric has been consistently high and favorable since 2012. 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 at 93 percent.



The chart below illustrates the total number of cases opened and savings per calendar year since OHA began operations. OHA’s advocacy returned 6 million to the residents of Connecticut in 2019. Including the amounts from CY 19, the office has now since its founding returned over \$112 million in savings for consumers.

Calendar Year	Total Number of Cases Opened	Total Calendar Year Savings
2002	774	\$410,294
2003	613	\$205,665
2004	956	\$531,823
2005	1,594	\$1,487,895
2006	2,002	\$2,934,451
2007	1,988	\$4,391,353
2008	1,475	\$5,191,613
2009	2,060	\$6,578,895
2010	2,139	\$5,664,095
2011	5,515	\$8,347,041
2012	4,271	\$7,540,211
2013	5,638	\$9,500,000
2014	7,117	\$6,924,978
2015	8,930	\$10,967,539
2016	7,028	\$11,168,483
2017	6,023	\$10,200,836
2018	5,000	\$13,884,660
2019	4,341	\$6,264,118
Total	67,464	\$112,193,949

The graph below shows OHA's annual budget over time compared to consumer savings shows that OHA's budget remains low while our work and efforts in savings to consumers continues to increase.



“My case worker was extremely helpful with my case. Thanks to her diligence and concern she was able to get me a one-time exception for my claim. I was awarded 100% coverage. I was thrilled and relieved. My only wish is that I contacted OHA sooner!”

1 SV is a 37-year old female who was diagnosed with chronic right ankle pain. Her condition required a specialized surgical procedure to her right ankle. The preauthorization request for the surgery had been denied by her Aetna healthcare plan. The reason for their denial of coverage was said to be, “clinical studies have not proven that this procedure is effective for treatment of the member’s condition.” The surgery was completed and it significantly helped the patient. SV called OHA for help to appeal the denial after the insurance’s adverse determination letter and medical bills began to arrive. OHA interviewed the patient and researched her procedure and condition. After a year-long process of appealing the denial(s) the case was won. The surgery in question was determined medically necessary by an independent medical reviewer, and the denial of coverage was reversed.

Total savings: \$44,000

2 JB contacted OHA after she was having difficulty obtaining specialty medication. Her employer recently changed insurance carriers and the member had to utilize a different pharmacy with the new carrier. Due to multiple miscommunications, the member was not able to access her medications for a chronic health condition for 6 days. OHA facilitated a conference call between the provider and pharmacy and the issue was resolved. Consumer was able to obtain medication.

Total Savings: \$97,345

3 PF contacted OHA due to her breast cancer surgery. Her insurance provider did not have an in-network breast surgeon and plastic surgeon at the same hospital. The carrier was approving the breast surgeon doctor from one hospital and plastic surgeon at another hospital. The two surgeries are usually performed simultaneously. OHA contacted the carrier and had a phone conference with their legal team. We were able to resolve the issue and the patient was able to have her mastectomy with breast reconstruction at the in-network level of coverage. We also assisted with previous bills related to her breast cancer.

Total Savings: \$74, 959

4 The consumer's father contacted OHA because his adolescent son was denied mental health treatment. The carrier denied the admission as not medically necessary. OHA filed the internal and external appeals. The appeal was overturned at external level and they paid 147 days of Psychiatric residential treatment. This allowed his son to receive the necessary mental health treatment needed. The son was able to be discharged and was doing well in an outpatient program after treatment.

Total savings: \$396,165

5 CM contacted OHA for assistance with an appeal for a denied claim for inpatient mental health services for a total of 48 days. OHA appealed internally with the health plan, but the denial was upheld. Consequently, a request was put in for an external review with an independent organization. The external reviewer determined the hospitalization as medically necessary as the member continued with trauma and anxiety, interfering with her ability to function. The carrier's denial of inpatient mental health services was reversed.

Total Savings: \$137,295

6 GS contacted OHA when he received a bill from the hospital for outpatient surgery. The claim was denied as the participant provider did not participate in the plan's network. After the review of the complaint, the hospital contacted the health plan and was given erroneous information, which was delivered to the member. The member consented to the surgery as the hospital was considered inpatient surgery. Because the health plan provided incorrect information, OHA requested to honor the information given and to reprocess the claim as a one-time exception. The carrier reprocesses the claim as in-network with no financial responsibility to GS.

Total Savings: \$28,723

7

Consumer had two back procedures to alleviate severe lumbar pain which the insurance carrier determined as not medically necessary. The consumer appealed the determination twice but her claims were still denied coverage by her insurance carrier. The consumer contacted OHA for assistance with submitting an external review which was her last recourse for insurance coverage. OHA represented the consumer in her external review and was successful in getting the denials overturned.

Total Savings: \$33,733

8

The consumer, DD, had reconstructive surgery following a double mastectomy. Her surgery required a specialized plastic surgeon. The carrier denied coverage for the specialist because he was out-of-network, and the consumer did not use the in-network provider. Faced with an unexpected bill, and while battling a second bout of breast cancer, the consumer contacted OHA. The agency was able to intervene and the carrier reversed its decision allowing an exception in her favor.

Total Savings: \$54,200.

9

For three years, KG medical treatments were improperly submitted to his secondary health insurer. The secondary insurer contacted the consumer and informed him that it would retract the payments made in error. Faced with the possibility of paying for his multiple medical treatments over the past three years, the consumer reached out to OHA for help. OHA was able to contact the primary insurer carrier and the numerous providers to coordinate the resubmission and reprocessing of his claims. Then, once the primary insurer paid its portion, the remaining balances were correctly submitted to consumer's secondary insurer. By contacting OHA, the consumer was able to avoid paying \$33,243 in stale, untimely claims.

10

The consumer was enrolled in her husband's retiree pension fund health insurance through his union. However, when he became Medicare eligible, the consumer was informed by her husband's pension fund that she should not have been on his retiree plan since she qualified for Medicare years earlier. The husband's union demanded payment for claims for the prior three years in which she was wrongfully covered. Additionally, when she was properly enrolled in Medicare Part D, she was assessed

a late enrollment penalty fee. When OHA intervened in her case, the Union retracted its demand for reimbursement. Likewise, the Medicare Part D penalties were removed.

Total Savings: \$23,186

11

Consumer contacted OHA regarding the pre authorization denial of hip surgery. OHA filed the 1st level appeal and the appeal was overturned. While hospitalized the member had complications and her stay was extended.

Total savings: \$117,673.99

Office of the Healthcare Advocate			
Position Summary Account			Actual FY 19
Permanent Full-Time-IF			17
Budget Summary Account	Total Budget	Actual FY 18	%
Personal Services	1,596,950.00	1,318,740.18	82.58%
Other Expenses	305,000.00	298,831.89	97.98%
Equipment	5,000.00	4,734.77	94.70%
Fringe Benefits	1,253,599.00	1,233,984.37	98.44%
Indirect Overhead	106,630.00	106,630.00	100.00%
Agency Total-Insurance Fund	3,267,179.00	2,962,921.21	90.69%

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