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QUARTERLY REPORT

January 1, 2016 – March 31, 2016

to the

Agency of Administration

submitted by

Trinka Kerr, Chief Health Care Advocate

April 21, 2016

NARRATIVE

I. Executive Summary

The Office of the Health Care Advocate (HCA) provides consumer assistance to individual Vermonters on questions and problems related to health insurance and health care. We also engage in a wide variety of consumer protection activities on behalf of the public, including before the Green Mountain Care Board, other state agencies and the state legislature.

The full quarterly report for January 1, 2016 - March 31, 2016 includes:

- This Narrative, which contains sections on **Individual Consumer Assistance, Consumer Protection Activities** and **Outreach and Education**
- Seven data reports, including three based on the caller's insurance status:
 - **All calls/all coverages:** 1,338 calls (compared to 1,033 last quarter)
 - **Department of Vermont Health Access (DVHA) beneficiaries:** 354 calls or **26%** of total calls (compared to 288 and 28% last quarter)
 - **Commercial plan beneficiaries:** 435 calls or **33%** (281 and 27%)
 - **Uninsured Vermonters:** 150 calls or **11%** (146 and 14%)
 - **Vermont Health Connect (VHC):** 737 calls or **55%** (461 and 46%; the VHC data report draws from the All Calls data set)
 - **Two Reportable Activities (Summary & Detail):** 225 activities, 47 documents (141 and 46)

Highlights

- Total call volume was 30% higher than last quarter (1,338 versus 1,033), but slightly lower (2%) than the same quarter last year (1,367). The first quarter of the calendar year usually has the highest call volume of the year because most health care plans end on December 31st and new plans years begin January 1, and this turnover related to renewals can trigger problems.
- Vermont Health Connect (VHC) call volume was 60% higher than last quarter (737 versus 461). Again, this was mostly due to problems with renewals and the start of the plan year. Volume was just slightly higher than the same quarter last year (706).
- VHC change of circumstance calls increased by 68% over the previous quarter, but were 25% lower than the same quarter last year.
- Calls about problems with VHC billing and premium processing more than doubled, and were the number one reason Vermonters called the HCA. The trend line for this issue appears to be going in the wrong direction.
- VHC and Medicaid complaints resulting from mistakes made by the Health Access Eligibility Unit almost doubled over the previous quarter, increasing from 28 to 58. Most of the errors were made in 2015.
- Calls regarding tax form 1095-A were just slightly up over last year (90 compared to 86). Some consumers who had difficulties enrolling in coverage with VHC last year are now facing tax penalties for not having coverage. Tax preparers also reported seeing consumers in this situation. VHC must enroll and effectuate coverage more promptly this year. The tax penalty for going uninsured in 2016 will be even higher.
- The Green Mountain Care Board followed our recommendation to reduce the contribution to surplus in a large group filing. This modification resulted in rates that were 2.5% lower than the rates originally requested.
- In the legislature the HCA advocated for numerous bills with provisions beneficial to consumers, including: improving access to dental care through licensing of mid-level dental providers (S.20); streamlining rules governing insurers including additional reporting of consumer complaints (S.255); and requiring regulation of Vermont's Accountable Care Organizations by the GMCB and creating consumer protections for patients attributed to ACOs (H.812).
- The number of people who used our website to find information and guidance on health care issues continued a pattern of strong growth with 40% more pageviews this quarter, compared with the same period in 2015.
- The number of people seeking information from our website about [dental services](#) increased significantly (128%), as it has the past four quarters, and our Vermont Dental

Clinics Chart rose to the third most frequently downloaded of all PDFs downloaded from the Vermont Law Help website.

- We conducted outreach through three published articles, provided information at two events, and gave three presentations to audiences ranging from mental health staff to tax professionals and lawyers to an advisory board for seniors. Additionally, we worked to lower the reading grade level and improve the readability score of 11 State communications to consumers regarding VHC and other health-related issues.

II. Individual Consumer Assistance

The HCA provides assistance to consumers through our statewide helpline (**1-800-917-7787**) and through the Online Help Request feature on our website, www.vtlawhelp.org/health. We have a team of advocates located in Vermont Legal Aid's Burlington office which provides this help to any Vermont resident free of charge, regardless of income.

The HCA received 1,338 calls¹ this quarter. We divided these calls into five issue categories. The figures below are based on the All Calls data. The percentage and number of calls in each issue category based on the caller's primary issue were as follows:

- **19.36%** (259) about **Access to Care**;
- **12.41%** (166) about **Billing/Coverage**;
- **1.87%** (25) about **Buying Insurance**;
- **11.51%** (154) about **Consumer Education**;
- **30.49%** (408) about **Eligibility** for state and federal programs; and
- **24.36%** (326) were categorized as **Other**, which includes Medicare Part D, communication problems with providers or health benefit plans, access to medical records, changing providers or plans, confidentiality issues, and complaints about insurance premium rates, as well as other issues.

We have a customized case management system that allows us to track more than one issue per case. This enables us to see the total number of calls that involved a particular issue. For example, although 408 of our cases had eligibility for state health care programs as the primary issue, there were actually a total of 1,142 cases that had some eligibility issue. This is because it is possible to have multiple types of issues in a single case.

In each section of this Narrative we indicate whether we are referring to data based on just primary issues, or primary and secondary issues combined. Sometimes it is difficult to determine which issue is the "primary" issue when there are multiple causes for a caller's problem. This has proven to be particularly true for Vermont Health Connect (VHC) cases. See the breakouts of the issue numbers in the individual data reports for a more detailed

¹ The term "call" includes cases we get through our website.

look at how many callers had questions about issues in addition to the “primary” reason for their call.

The most accurate information about **eligibility for state programs** is in the All Calls data report because callers who had questions about Vermont Health Connect and Medicaid programs fell into all three insurance status categories.

A. The HCA’s overall call volume was 30% higher than last quarter, but about the same as the same quarter last year.

Total call volume was 30% higher than last quarter (1,338 versus 1,033), but slightly lower (2%) than the same quarter last year (1,367). The first quarter of the calendar year usually has the highest call volume of the year because most health care plans end on December 31st and new plans years begin January 1, and this turnover can trigger problems. (This was true even before VHC began.) In 2014 we received 1,184 calls for this quarter; in 2013 (pre-VHC) we received 835. This year’s call volume for the first calendar quarter is thus 60% higher than the year before the launch of VHC.

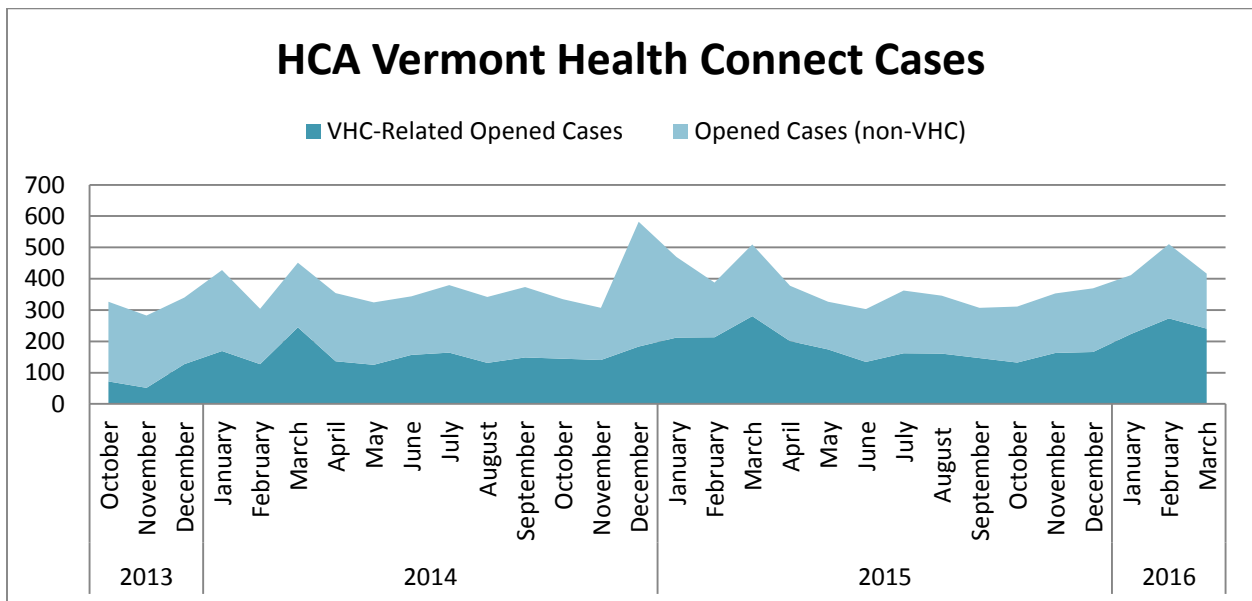
All Cases (2006-2016)											
	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
January	313	280	309	240	218	329	282	289	428	470	411
February	209	172	232	255	228	246	233	283	304	388	511
March	192	219	229	256	250	281	262	263	451	509	416
April	192	190	235	213	222	249	252	253	354	378	-
May	235	195	207	213	205	253	242	228	324	327	-
June	236	254	245	276	250	286	223	240	344	303	-
July	183	211	205	225	271	239	255	271	381	362	-
August	216	250	152	173	234	276	263	224	342	346	-
September	181	167	147	218	310	323	251	256	374	307	-
October	225	229	237	216	300	254	341	327	335	311	-
November	216	195	192	170	300	251	274	283	306	353	-
December	185	198	214	161	289	222	227	340	583	369	-
Total	2583	2560	2604	2616	3077	3209	3105	3257	4526	4423	1338

B. Vermont Health Connect call volume was 60% higher than last quarter, and 4% higher than the same quarter last year.

VVHC call volume was 60% higher than last quarter (737 versus 461). This was mainly due to renewals and plan turnover. It was just slightly higher (4%) than the same quarter last year (706). In 2014 we received 541 VHC calls in this quarter. VHC did not exist in this quarter in 2013.

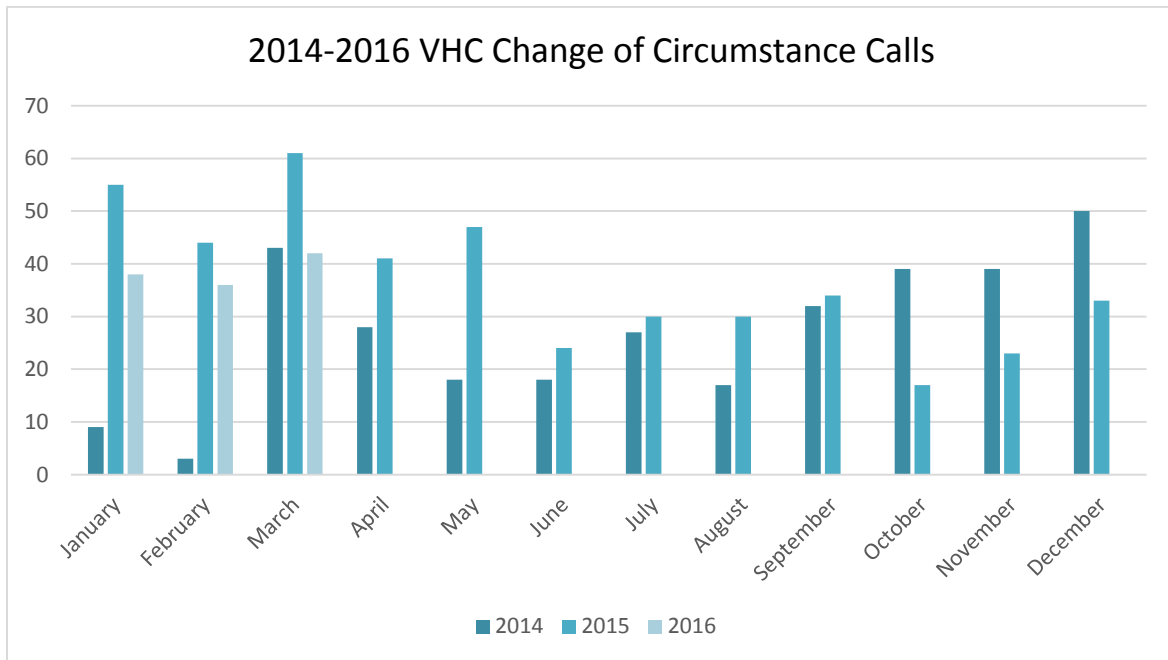
Although VHC continues to improve its functionality and performance, many Vermonters are still having serious problems. Call volume has not decreased as hoped or expected. VHC-related call volume had been trending downward at the end of 2015, but that trend appears to have reversed. We are also disheartened by the number of very complex problems we are still seeing. This quarter, of the 650 VHC calls we resolved with VHC, 38% of them were complex, and 80% of our total complex cases involved VHC.

The HCA works with VHC staff to resolve problems and escalate cases in which Vermonters need immediate access to care. We have weekly meetings with VHC staff to resolve the more complex cases. When we first started these meetings last summer, our list of cases to be resolved was usually 40-50 each week. This quarter the complex cases increased dramatically to 70-80 cases. Although VHC staff work incredibly hard to resolve these cases, many still take weeks to resolve. (Access to care cases are resolved much more quickly.)



C. Vermont Health Connect change of circumstance calls increased by 68%, but were 25% lower than last year's first quarter.

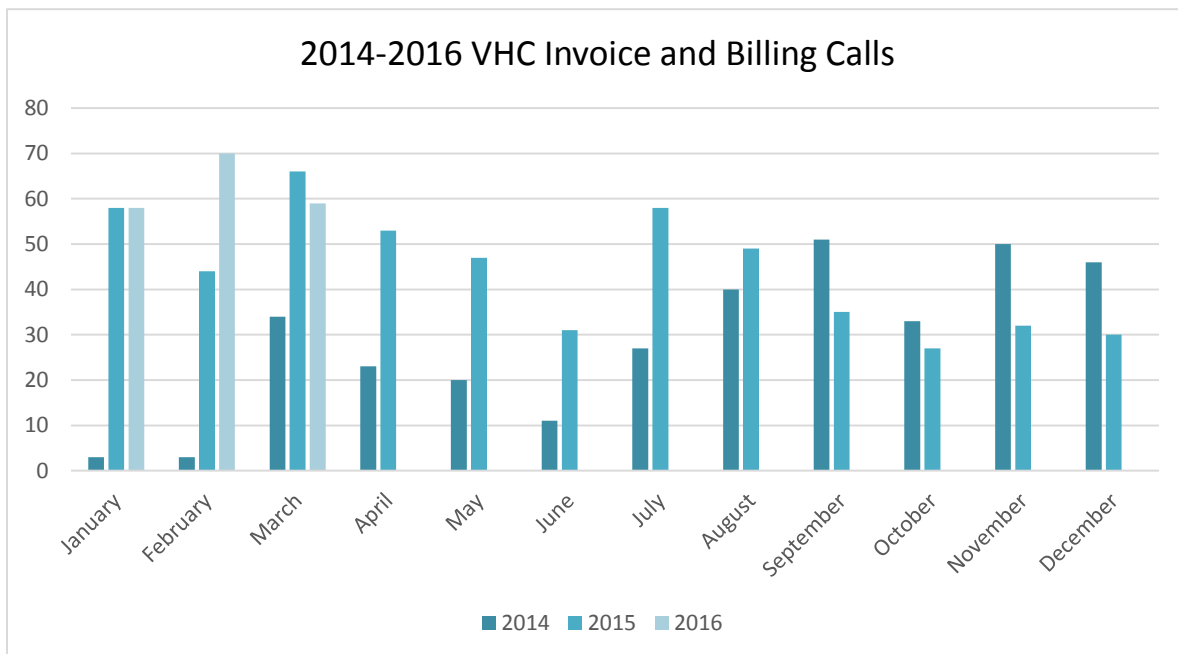
Change of Circumstance calls this quarter increased by more than 68% over last quarter: 38 in January, 36 in February, and 42 in March. COCs had been declining in 2015: 155 in Q1, 109 in Q2, 94 in Q3, and 69 in Q 4 (when primary and secondary issues are counted). The low was 17 calls in October. This quarter these calls shot up to 116 calls. However, it should also be noted that the COC calls this quarter were 25% lower than the same quarter last year, in which we received 155.



D. Vermont Health Connect billing and payment problems more than doubled over the previous quarter, and were the number one reason people called the HCA.

Many consumers who purchased Qualified Health Plans (QHP) from VHC continued to have billing and payment problems. This is the number one complaint about VHC and the number one complaint overall. The problems include: invoices showing the wrong amount due or lack of credit for consumer payments; delays in processing payments, especially payments made by check; delays in applying premiums to the correct account, causing delays in getting active coverage; not receiving invoices, and lost payments. In some cases, the premium problems caused a consumer’s coverage to incorrectly be closed because they were not credited for payments they had actually made. Many were related to 2015 COC difficulties and problems with renewals.

This quarter we received 187 calls involving invoices, payment and premium processing, compared to 90 last quarter, and 141 for the quarter before that. In February we received a record high number of complaints on this issue: 70. Problems related to billing and payment appear to be trending in the wrong direction.



E. Health Access Eligibility Unit mistakes almost doubled.

VHC and Medicaid complaints resulting from mistakes made by HAEU almost doubled over the previous quarter, increasing from 28 to 58. Examples of mistakes we saw were: COCs that were not completed—or completed inaccurately, mistakes in renewals, mistakes in closures, premium tax credit amount mistakes, and incorrect advice. The increase may be partly the result of renewals, and some mistakes were brought to light because it was tax season. Some of the mistakes were not actually made this quarter but in previous quarters, and surfaced now as people got their tax forms. We had one case where the mistake was made in 2014. Some human errors were compounded by technology issues.

F. Problems with tax Form 1095-A increased just slightly this year.

We received 90 calls this quarter about problems with 1095-As, compared to 86 for the same quarter last year. Many of the calls involved consumers seeking a 1095-A that accurately reflected both the premiums that they paid and the APTC they received for 2015. Some also called because they had not received a -A and wanted to file their taxes. The HCA helped consumers avoid or minimize a tax penalty by resolving 2015 coverage issues. The HCA's tax attorney provided the HCA advocates with technical assistance on 27 cases.

See more about the HCA's work on tax issues in the **Affordable Care Act Tax-related Activities** section below.

G. The top issues generating calls

The listed issues in this section include both primary and secondary issues, so some of these may overlap.

All Calls 1,338 (compared to 1,033 last quarter)

1. VHC Invoice/Billing Problem affecting eligibility 187 (compared to 90 last quarter)
2. VHC Renewals 137 (45)
3. VHC complaints 127 calls (66)
4. MAGI Medicaid eligibility 120 (82)
5. VHC Change of Circumstance 116 (69)
6. VHC Premium Tax Credit eligibility 115 (67)
7. Complaints about providers 108 (93)
8. DVHA/VHC Premium billing 93 (53)
9. 1095-A problems 90 (8)
10. Access to Prescription Drugs 82 (72)
11. Information/applying for DVHA programs 61 (40)
12. Termination of insurance 62 (68)

13. HAEU Mistake 58 (28)
14. Consumer Education on IRS Reconciliation 57 (0)
15. Special Enrollment Periods (eligibility) 52 (29)
16. Consumer Education about ACA tax issues 51 (23)
17. VHC Website/Technology 51 (17)
18. Affordability issue affecting access to care 48 (53)
19. Medicaid eligibility (non-MAGI) 43 (34)
20. Buy-in Programs/MSPs 42 (27)
21. Disenrollment at consumer request 42 (39)
22. Buying QHPs through VHC 37 (38)

Vermont Health Connect Calls 737 (compared to 461 last quarter)

1. VHC Invoice/Payment/Billing problem 185 (89)
2. VHC Renewals 136 (46)
3. Premium Tax Credit Eligibility 114 (65)
4. Change of Circumstance 113 (67)
5. MAGI Medicaid eligibility 108 (73)
6. DVHA/VHC Premium billing 92 (52)
7. 1095-A problems 89 (8)
8. Consumer Education on IRS Reconciliation 56 (18)
9. HAEU Mistake 56 (25)
10. Termination of insurance 54 (62)
11. VHC Website/Technology 50 (17)

DVHA Beneficiary Calls 354 (compared to 288 last quarter)

1. Complaints about Providers 50 (39)
2. MAGI Medicaid eligibility 47 (26)
3. Information/applying for DVHA programs 29 (24)
4. Access to Prescription Drugs 27 (27)
5. Transportation 26 (17)
6. Medicaid eligibility (non-MAGI) 25 (16)
7. Choosing/Changing Providers 21 (18)
8. Change of Circumstance 17 (9)
9. Affordability affecting access to care 16 (10)
10. Copayments 14 (1)
11. Consumer education about Fair Hearings 14 (12)

H. Hotline call volume by type of insurance:

The HCA received 1,338 total calls this quarter. Callers had the following insurance status:

- **DVHA program beneficiaries** (Medicaid, VPharm, or both Medicaid and Medicare aka “dual eligibles”) insured **26%** (354 calls), compared to 28% (286) last quarter;

- **Medicare² beneficiaries** (Medicare only, Medicare Advantage Plans, Medicare and a Medicare Supplemental Plan aka Medigap, Medicare and Medicaid aka “dual eligibles,” Medicare and Medicare Savings Program aka Buy-In program, Medicare and Part D, or Medicare and VPharm) insured **15%** (207), compared to 20% (211) last quarter;
- **Commercial plan beneficiaries** (employer sponsored insurance, small group plans, or individual plans) insured **30%** (395), compared to 27% (282) last quarter; and
- **Uninsured** callers made up **11%** (150) of the calls, compared to 14% (145) last quarter.
- In the remainder of calls insurance status was either unknown or not relevant.

I. Dispositions of closed cases

All Calls

We closed 1,262 cases this quarter, compared to 945 last quarter.

- 38% (358 cases) were resolved by brief analysis and advice;
- 25% (315) were resolved by brief analysis and referral;
- 24% (308) of the cases were complex interventions involving complex analysis, usually direct intervention, and more than two hours of an advocate’s time;
- 13% (164) were resolved by direct intervention, including calling an insurance company, calling providers, writing letters, gathering supporting medical documentation, etc.;
- 1 case was resolved in the initial call.
- In the remaining cases, clients withdrew, resolved the issue on their own, or had some other outcome.
- Appeals: The HCA assisted 27 individuals with appeals: 4 commercial plan appeals, 22 Fair Hearings, 0 VHC expedited internal hearings, 1 DVHA internal MCO appeals and 0 Medicare appeals. Most of our cases involving VHC and DVHA problems are resolved without using the formal appeals process.

DVHA Beneficiary Calls

We closed 354 DVHA cases this quarter, compared to 266 last quarter.

- 35% (123 cases) were resolved by brief analysis and advice;
- 33% (118) were resolved by brief analysis and referral;
- 13% (45) were considered complex intervention, which involves complex analysis, usually direct intervention, and more than two hours of an advocate’s time;
- 13% (45) were resolved by direct intervention on the caller’s behalf, including advocacy with DVHA and providers, writing letters, and gathering medical information;
- No DVHA cases were resolved in the initial call.

² Because Medicare beneficiaries can also have commercial or DVHA coverage, these Medicare numbers overlap with those figures.

- In the remaining cases, clients withdrew, resolved the issue on their own, or had some other outcome.
- Appeals: 9 cases involved appeals on behalf of individuals who were on a DVHA program when they called us: 8 Fair Hearings and 1 internal MCO appeal.

Commercial Plan Beneficiary Calls

We closed 386 cases involving individuals on commercial plans, compared to 245 last quarter.

- 23% (87 cases) were resolved by brief analysis and advice;
- 10% (38) were resolved by brief analysis and referral;
- 45% (174) were considered complex intervention, which involves complex analysis, usually direct intervention, and more than two hours of an advocate's time;
- 16% (63) were resolved by direct intervention on the caller's behalf, including advocacy with the carrier and providers, writing letters, and gathering medical information;
- No calls from a commercial plan beneficiary were resolved in the initial call.
- In the remaining cases clients withdrew, resolved the issue on their own, or had some other outcome.
- Appeals: 19 cases involved appeals for individuals on commercial plan: one External Review, one Level 1 internal appeal, two Level 2 internal appeals, 15 Fair Hearings, and 0 Expedited Fair Hearings.

J. Case outcomes

All Calls

The HCA helped 48 people get enrolled in insurance plans and prevented 15 insurance terminations or reductions. We obtained coverage for services for 2 people. We got 11 claims paid, written off or reimbursed. We estimated VHC insurance program eligibility for 3 more. We provided other billing assistance to 28 individuals. We provided 165 individuals with advice and education. Three people were not eligible for the benefit they sought and two were responsible for the bill they disputed. We obtained other access or eligibility outcomes for 79 more people, many of whom we expected to be approved for medical services and state insurance.

We encourage clients to call us back if they are subsequently denied insurance or a medical service after our assessment and advice, or do not have their issue resolved as expected.

In total, this quarter the **HCA saved individual consumers \$98,358.97** in cases opened this quarter.

K. Case Examples

Here are five case summaries which illustrate the types of problems we helped Vermonters resolve this quarter:

1. Mr. A called the HCA because he had been diagnosed with a life-threatening condition, and his doctors had told him that the best treatment was a new prescription medication. Mr. A, however, did not have a Medicare Part D plan to cover prescription drugs. In the past, he had paid out of pocket for his prescriptions. This medication cost tens of thousands of dollars, however, and Mr. A could not afford it without insurance coverage. After finding out about treatment plan, Mr. A had tried to sign up for a Part D plan. Each year, Medicare has an Open Enrollment period when you can sign up for or change your Part D plan. Mr. A had missed Open Enrollment by one day. When the advocate investigated the situation, she found that during the Medicare Part D open enrollment, Mr. A had been incapacitated by his illness, and that had limited his ability to sign up during the OEP. The HCA advocate requested a Special Enrollment Period from Medicare, so Mr. A could sign up for a Part D plan. Medicare granted the Special Enrollment Period, and Mr. A was able to sign up for a Part D plan that covered his needed medication and start his treatment.
2. Ms. B was due to deliver her baby any day when she called the HCA. She had a Qualified Health Plan (QHP) through VHC, but her plan left her with high out of pocket costs. When she first got pregnant, she had asked VHC whether she was eligible for Dr. Dynasaur for Pregnant women. The Dr. D would help cover some of the expenses not covered by her QHP. At that time, she was told that as a family of three, she was over the income guidelines for the program and not eligible. That was a mistake. When she called the HCA, the advocate told her that she was actually eligible for the program. Under the eligibility rules for Dr. D for pregnant women, the pregnant woman is counted as herself and the baby she is expected to deliver is counted as another member of the household. For Ms. B, this meant she had a family of four. When the family was counted correctly, Ms. B was found eligible for Dr. D. The HCA requested that her case be rushed, and she was able to get active coverage before she delivered her baby.
3. Ms. C called the HCA in a panic. She was a cancer survivor and needed to fill her medication. She had multiple appointments scheduled for the month. There was a problem with the renewal of her QHP with VHC for 2016. This meant that she did not have active coverage. When VHC was finally able to do the renewal, there was another problem. Ms. C was eligible for Advance Premium Tax Credit (APTC), which helped reduce her monthly premium by several hundred dollars. The VHC system, however, showed incorrectly that she was not eligible for APTC, and that she would need to pay

the full price of the plan. She could not afford to pay full price for the plan. The HCA advocate escalated the case to get the mistake fixed, and the APTC applied to Ms. C's case. This meant Ms. C was able to pay her premium to start her coverage—and was able to get her prescriptions in time.

4. Mr. D called because he needed transportation to his appointment with his substance abuse counselor. When he called to set up a ride, he was told that he did not have Medicaid coverage, and therefore, was no longer eligible for transportation. Mr. D was confused because he had just submitted an application for Medicaid and believed that he was eligible. The HCA advocate investigated and found that Mr. D had submitted an application for VHC Medicaid. Mr. D, however, had Medicare. This meant that he was eligible for a different type of Medicaid called Medicaid for Aged, Blind and Disabled (MABD). MABD and VHC Medicaid require different applications. After he was put onto VHC Medicaid, VHC had discovered the mistake and taken him off. But no one had taken the next step to put him back onto MABD Medicaid. The advocate intervened and asked that Mr. D's Medicaid be restored. It was restored the same day, and Mr. D was given time to submit the correct application. He was also able to get a ride to his appointment.
5. Ms. E called the HCA because she received a closure notice from VHC. The notice said that she was above the resource limit for Medicaid for Aged Blind and Disabled (MABD), and that her Medicaid was going to close. When the HCA advocate investigated, she found that Ms. E was over-resourced for Medicaid, and was not eligible for that program. The advocate also found that Ms. E was eligible for a Medicare Saving Plan (MSP). The MSP pays for the Part B premium, and the program has no resource limits. The advocate found that Ms. E should have been on an MSP since she had submitted her Medicaid application over a year prior because she had asked to be screened for an MSP on that application. The state put her on the MSP back to the date of her application, and Ms. E was refunded over a thousand dollars in Part B premiums.

III. Consumer Protection Activities

A. Rate Reviews

The HCA monitors all insurance carrier requests to the Green Mountain Care Board for changes in premium rates, which are usually rate increases. Six rate review cases were filed during the quarter. The HCA entered Notices of Appearance in five but did not appear in one case setting potential rates for an MVP plan that has no members. We submitted a memorandum in one and are waiting for a report from the actuary for the Green Mountain Care Board and a solvency analysis from the Department of Financial Regulation in the other new cases.

The first case considered during the quarter was the 2016 Large Group Manual Rate Filing by CIGNA Health and Life Insurance Company (Cigna). Cigna requested rates which would produce an average annual rate change of -1.1% and ranged from -3.9% to 1.1%. The filing impacts 15 policyholders with 2,586 covered lives. The HCA requested that the Board reduce the requested 3.5% contribution to surplus to 1%. The Board issued a decision modifying the requested rate with a 1% contribution to surplus. This modification resulted in an approximate -3.5% average annual rate decrease resulting in rates that were 2.5% lower than the rates originally requested.

The HCA has also been involved during the quarter in administrative and judicial review of the Board's December 2015 decision disapproving the rate request for five plans offered by the Agriservices Association, an association for farmers. Agriservices uses MVP's large group Minimum Premium Plan (MPP) funding arrangement for grandfathered plans with a contract renewing with a December 1, 2015 effective date. The average annual increase requested in the filing was 26.9%. The HCA asked the Board to disapprove the requested rates and the Board's December 2015 decision disapproved the increase. In January MVP asked the Board to reconsider its decision. The HCA opposed this request and the Board refused to change its initial decision. MVP then appealed the administrative rate review case to the Vermont Supreme Court. The insurer has filed its brief and the HCA is preparing its brief asking the Supreme Court to uphold the Board decision denying the requested rate increase.

B. Certificate of Need

The HCA has continued to monitor Certificate of Need (CON) processes before the Board. In the last quarter, we tracked University of Vermont Medical Center's compliance with the Board's terms for its Inpatient Bed Project; the Board's Decision in Copley Hospital's Surgical Suite Construction Project; and the ongoing interrogatories for Green Mountain Surgery Center's Ambulatory Surgical Center application.

C. Other Green Mountain Care Board Activities

In the last quarter, we submitted three sets of formal comments to the Board. The first addressed the Board's proposal to lift the moratorium on the VCHURES data, which would allow non-state entities to access the information. In the comments, we supported the lifting of the moratorium, but we urged the Board to only allow data releases to non-state entities when the data will be used to improve healthcare quality, affordability, and/or access to Vermonters; we asked the Board to post data requests and provide a public comment period of at least ten days before issuing a decision on a request; and we recommended that the Board require any entity that is granted access to VCHURES data to agree that the entity cannot claim

confidentiality or intellectual property rights over its research results against the state of Vermont. The Council plans to adopt all three recommendations.

During the quarter the Board developed its guidance for hospitals to use in the next budget review cycle for the 2017 fiscal year, which begins in October 2016. The HCA submitted comments to the Board suggesting some changes to the proposed guidance and met with the Board's Director of Health System Finances to discuss the comments.

The Board also began the process of analyzing and reviewing the hospitals' actual budget amounts compared to their approved budgets for fiscal year 2015 which ended in September 2015. The Board heard presentations from the University of Vermont Medical Center and Central Vermont Medical Center (part of the same hospital network) and from Rutland Regional Medical Center about the facilities' proposed use of excess net patient revenue for 2015. The HCA submitted comments supporting UVMCMC and CVMC's proposal to spend money on investments in community resources and on reducing commercial rates.

The HCA attended the GMCB's weekly public meetings (13), Advisory Committee meeting, and Data Governance meetings (3). This quarter we also attended an additional GMCB meeting about hospital budget targets, and met with GMCB staff twice.

D. All-Payer Model

In the last quarter, the staff of the GMCB facilitated meetings of stakeholders to discuss and outline the governance structure, provider payment policies, and related parameters for an all-payer model and single Accountable Care Organization for Vermont. In order to monitor for consumer protection concerns, the HCA participated in various aspects of the planning process for the proposed new ACO. This included joining the provisional board for the new ACO in late March, of which we attended four meetings. We participated in conference calls regarding the proposed business plan (8), reviewed drafts of the plan, and submitted six sets of formal comments. The HCA also continued to participate in meetings of the ACO Payment Subgroup (2) and the ACO Rostering Subgroup (4), and successfully advocated for edits to the draft roosting agreement which make it much more readable for consumers. Finally, the HCA helped organize three informational meetings for consumer groups to learn more about the proposed All-Payer Model.

E. Vermont Health Care Innovation Project

The HCA continues to participate in the Vermont Health Care Innovation Project (VHCIP), which is funded by a federal State Innovation Model (SIM) grant. The Chief Health Care Advocate is a member of the VHCIP Steering Committee, which met one time this quarter. The HCA participated, along with representatives from other projects of Vermont Legal Aid, as "active

members” in five of the six VHCIP work groups: Payment Model Design and Implementation, Practice Transformation, Health Data Infrastructure, Disability and Long Term Services and Supports, and Population Health. This quarter we participated in six VHCIP work group meetings. Additionally, we continue to monitor the activities of the VHCIP Core Team. This quarter we attended three Core Team meetings as an interested party.

F. Affordable Care Act Tax-related Activities

During this quarter the HCA continued its tax-related assistance, advocacy, and outreach efforts. In 2016 consumers began to receive two new tax forms relating to health care: Form 1095-B from Medicaid and other providers of health insurance, and Form 1095-C from large employers. The HCA engaged in significant consumer education regarding these new tax forms. We regularly updated Vermont tax preparers on VHC policies related to tax forms and tax issues. We also engaged with VHC when potential problems related to the tax forms surfaced. For example, when consumers reported receiving Forms 1095-B with no information about the sender, we alerted VHC to verify that VHC’s forms were being generated correctly. The HCA participated in weekly VHC stakeholder calls during the tax season.

VHC’s 2016 open enrollment period ended on January 31, 2016. Throughout the quarter we assisted consumers with renewal and enrollment problems. Many consumers had errors in their 2015 coverage that affected their 2016 benefits or enrollment. Consumer calls related to forms 1095-A brought many 2015 account problems to light. Some consumers discovered that their payments had been lost or misapplied when Form 1095-A unexpectedly showed unpaid months of coverage. Also, we saw many cases in which the consumer received excess APTC after it should have been terminated according to the regulations. The HCA helped many consumers get account changes made and, where appropriate, get amended tax forms from VHC.

In this quarter the HCA continued to employ a half-time tax attorney, who also staffs the Low Income Taxpayer Clinic at VLA. This allowed the HCA to stay up to date on tax law developments and support our staff to effectively field calls related to the ACA and VHC. The tax attorney consulted with HCA advocates when particularly difficult IRS-related issues arose in individual HCA cases. Technical assistance on tax issues remains an important part of the HCA’s work in this area. During this quarter the tax attorney advised the HCA on 27 technical assistance questions. She also responded to 82 technical assistance questions from assisters, VHC personnel, Vermont tax preparers, and legal services attorneys in other states. Many technical assistance consultations involved IRS safe harbor rules for mistakes in APTC eligibility determinations, including overlapping coverage situations.

We continued to encounter consumers who reported difficulty enrolling in coverage with VHC last year and now face a tax penalty as a result of not having coverage. Tax preparers also

reported seeing consumers in this situation. We are concerned that these reports persist in VHC's third year. The tax penalty is significantly higher for 2015 than it was for 2014, and in 2016 it will be higher still. We advised consumers and tax preparers to seek Congressional help in these situations, since the federal agency with responsibility for hardship exemptions (HHS) does not recognize a hardship for penalties caused by marketplace error.

The HCA also engaged in outreach and education activities, detailed below in the Outreach and Education section. In addition to those activities, the HCA's tax attorney assisted the Open Door Clinic in Middlebury in developing a flowchart of Affordable Care Act issues for guestworkers. We plan to continue collaborating with assister organizations on educational materials in the future.

G. Other Activities

Administrative Advocacy

VHC Escalation Path

This quarter, the HCA worked extensively with VHC to develop an efficient escalation path for HCA cases, so they can be resolved more quickly. We communicated with VHC multiples times a day, and met at least once per week to discuss the most complex cases. With the new escalation path, we anticipate decreasing the number of cases on the list more rapidly in the future.

HBEE Rule

The HCA submitted formal comments to AHS on emergency amendments to Part Seven of the Health Benefits Eligibility and Enrollment rule, and on proposed amendments to other parts of the HBEE rule.

Health Care Administrative Rules (HCAR)

In March VLA and the HCA submitted formal comments on the first round of proposed Health Care Administrative Rules (HCAR), prior to formal rulemaking. We asked for clarification regarding informed consent for sterilizations, opposed the content of a rule on Medicaid Non-Covered Services, Experimental and Investigational Services, including arguing that the definitions of "services" and "experimental or investigational" be completely rewritten with input from medical professionals and other stakeholders.

Health Information Technology Plan

In February, the HCA submitted formal comments on Vermont's 2016 draft Health Information Technology Plan. Our comments focused on concerns with the costs, preparation, and other resources needed to implement the ambitious plan; the value the state will receive for the costs of health information technology; the need for experts within state government on health

information confidentiality and privacy; and the need for effective provider quality measurements. In addition, we urged VITL and the state to focus on efforts to gain patient consent for the Vermont Health Information Exchange (VHIE). Finally, we asked the state to prioritize the use of technology for care coordination.

Rule 09-03 Work Group

This quarter the HCA continued to be actively involved in this work group which was set up in Act 54 of the 2015 legislative session. The work group met twice during the quarter. The group's purpose is to help the Agency of Administration, the Green Mountain Care Board, and the Department of Financial Regulation (DFR) evaluate the necessity of maintaining provisions for regulating commercial insurers currently in Rule 09-03. The rule contains consumer protection and quality requirements for insurers in areas such as the adequacy of provider networks and the way insurers conduct prior authorization reviews for requested services. The group also reviewed reporting requirements for the insurers about the claims for covered services that are denied. The HCA advocated for provisions in the statute and rule that would maintain regulatory protections for consumers in commercial health care plans, would improve the reports insurers provide about denied claims and would require DFR to file reports showing how many complaints are filed about violations of the consumer protection standards in Rule 09-03. The work group agreed with most of our suggestions but DFR did not want to provide the reports about consumer complaints. We agreed that the legislature should determine whether the reports would be required. The Administration presented proposed language for statutory changes to implement the work group's proposals in S.255, and the HCA has testified about this bill. The HCA also met with MVP and the Vermont Medical Society about network adequacy in relation to Rule 09-03.

2017 Qualified Health Plan Work Group

The HCA is participating in this stakeholder group, which was convened by DVHA to help develop any recommended changes to benefit design for QHPs offered on Vermont Health Connect in 2017. The group met twice during the quarter. Recommendations for the 2017 QHPs were presented to the Green Mountain Care Board during the quarter.

2018 Qualified Health Plan (QHP) Work Group

The 2017 QHP Work Group recommended beginning a process to discuss the effect that the maximum out of pocket expense limit set forth in Vermont statutes has on plan design especially at the silver and bronze plan levels. A work group of stakeholders, including the HCA, was convened to discuss this issue and how the state might address it for 2018 plans. The group met four times during the quarter.

Medicaid and Exchange Advisory Board

The Chief Health Care Advocate is an active participant in Vermont's Medicaid and Exchange Advisory Board (MEAB). This quarter the MEAB met three times.

Legislative Activities

This quarter the HCA actively advocated for a number of legislative initiatives, and monitored the activities of the legislative committees that took up issues related to health care and health reform.

H.812: The HCA advocated for H.812, which would require the Green Mountain Care Board to regulate Accountable Care Organizations and would provide protections for patients attributed to ACOs, including grievance and appeals processes. Currently the state is not required to regulate ACOs. H.812 passed out of the House Health Care Committee with a vote of 11-0 and passed the House with a vote of 139-2. The bill was referred to the Senate Health and Welfare Committee.

S.20: The HCA continued to advocate for S.20, which would create a mid-level dental provider (Dental Therapist) in Vermont in order to improve access to dental care, particularly for children, seniors, and Medicaid beneficiaries. Access to dental care is a significant issue about which the HCA receives numerous consumer assistance calls and web page views. This quarter the bill, which passed the Senate in 2015, was taken up in the House Human Services Committee.

S.62: The HCA continued to advocate for S.62 which would allow, in limited circumstances, a surrogate to provide or withhold consent on a patient's behalf for a do-not-resuscitate order or clinician order for life-sustaining treatment. During this quarter the bill, which passed the Senate in 2015, resided in the House Committee on Human Services.

S.216: The HCA supported language recommended by the Administration that would allow the Green Mountain Care Board to permit some bronze plans on Vermont Health Connect in 2018 to use a prescription out of pocket maximum amount that is higher than the maximum amount allowed under current Vermont law. This would enable plan designs to lower cost sharing for other medical costs. There is concern from the actuary who works with DVHA that without adjustments to the pharmacy out of pocket maximum it may be impossible to design bronze plans that meet federal standards. The proposal for plan design changes would be developed by a stakeholder work group.

S. 245: The HCA supported the proposal in S. 245 to require hospitals to notify patients of provider acquisitions, including disclosure of any new charges resulting from hospital affiliations.

S.255: The HCA advocated for provisions in S.255 that would maintain regulatory protections for consumers in commercial health care plans and would require the Department of Financial

Regulation to file reports showing how many complaints are filed about violations of these consumer protection standards. During this quarter the bill passed the Senate with a favorable report from the Senate Health and Welfare Committee and was referred to the House Health Care Committee.

The HCA's legislative advocacy this quarter included testifying before the House Health Care Committee 17 times, testifying before the House Human Services Committee, testifying before a joint meeting of the House Health Care and Human Services Committees, testifying before the House Ways and Means committee two times, testifying before the House Government Operations Committee, and testifying before the Senate Finance Committee two times. We submitted two sets of formal comments to the House Health Care Committee on H.812, submitted formal comments to the Senate Health and Welfare Committee on H.812, and submitted formal comments to the Senate Health and Welfare Committee on consumer protections in Rule 09-03. Additionally, we regularly met with legislators and collaborated with state agencies and other advocates on legislative initiatives. The Chief Health Care Advocate gave a presentation on H. 812 at Vermont Legal Aid's Legislative Breakfast.

Collaboration with other organizations

The HCA regularly collaborates with other organizations to advance consumer-oriented policy objectives. We worked with the following organizations this quarter:

- AARP
- American Civil Liberties Union
- Bi-State Primary
- Community Catalyst
- Community Health Accountable Care
- Community of Vermont Elders
- Department of Vermont Health Access
- Families USA
- Health*first*
- Open Door Clinic
- SHIP
- Vermont Family Network
- Vermont Medical Society
- Vermont Oral Health Care for All Coalition
- Vermont Low Income Advocacy Council
- Vermont Public Interest Research Group
- Voices for Vermont's Children

Outreach and education

A. Website

Vermont Law Help is a statewide website maintained by Vermont Legal Aid and Law Line of Vermont. The site includes a substantial Health section (www.vtlawhelp.org/health) with more than 200 pages of consumer-focused health information maintained by the HCA. We work diligently to keep the site updated in order to provide the latest and most accurate information to Vermont consumers.

Google Analytics statistics show:

- The total number of health pageviews increased by 40% in the reporting quarter ending March 31, 2016 (9,148 pageviews), compared with the same quarter in 2015 (6,518 pageviews).
- The number of people seeking help finding [dental services](#) increased significantly (128%), as it has **the past four quarters**. (435 pageviews this quarter, compared with 191 in the same period last year). The number of pageviews this quarter (435) is 58% higher than last quarter (276).
- This quarter, like the previous three quarters, we saw a large increase in the number of people seeking information about [Medicaid income limits](#) (2,639 pageviews this quarter, compared with 1,404 in the same quarter in 2015, an increase of 126%). The consistently high numbers indicate that search engines are delivering this page as a high-ranking source of information about Medicaid income limits, as well as the increasing age of Vermont's population.
- The [health home page](#) again had the second largest number of pageviews (1,040), an increase of 12% over last year's 930. The home page tells consumers how we can help them and provides several ways to contact us including an online form that can be filled out and submitted 24/7.
- Seven of the 20 health topics with the largest number of pageviews focused on Medicaid or long-term care Medicaid (Choices for Care), while ACA-related tax topics for consumers occupied four of the top slots.
- Other popular topics included:
 - [Health Insurance, Taxes and You](#) (476 pageviews, +33%)
 - [Medical Marijuana Registry – Patient Form](#) (318 pageviews, +3,433%)
 - [Federally Qualified Health Centers \(FQHCs\)](#) (155 pageviews, +210%)
- While the number is still relatively low at 34, it is significant to note that the number of people seeking information about medical debt rose 183% over the number seeking the information during the same period last year.

PDF Downloads

Forty-eight out of 90 or 53% of the **unique PDFs** downloaded from the Vermont Law Help website were on health care topics. Of those health-related PDFs:

- 19 were created for consumers. The top consumer-focused downloads were the same as last quarter, although the Vermont dental clinics chart took the top spot this quarter:
 - Vermont dental clinics chart
 - Advance directive, short and long forms
 - Blue Cross Blue Shield of VT Annual Report 2014
 - Vermont Medicaid Coverage Exception Request – 10 Standards and Provider Request Form
- 21 were prepared for lawyers, advocates and assisters who help consumers with tax issues related to the Affordable Care Act. The top advocate-focused downloads were:
 - Low-Income Taxpayers and the Affordable Care Act
 - Tax Issues for Health Assisters Form 8965 example
- 8 covered topics related to health policy. The top policy-focused downloads, which were the same as last year's, were:
 - Consumer Principles for Vermont's All-Payer Model
 - Vermont ACO Shared Savings Program Quality Measures

Our [Vermont Dental Clinics Chart](#) rose to the **third most downloaded of all PDFs** downloaded from the Vermont Law Help website.

B. Education

During this quarter, the HCA provided education materials and presentations and maintained a strong social media presence on Facebook, reaching out directly to consumers as well as to individuals and organizations who serve populations that may benefit from the information and education provided. Materials we developed have also been shared directly with health and tax advocates in Vermont and nationwide and posted to our website.

Education/Outreach

Justice Quarterly (January 13)

The HCA published an article, Medicaid Reviews: Beneficiaries Must Respond or Risk Losing Coverage, in the winter issue of Vermont Legal Aid's quarterly newsletter. The article briefly explained the review process and the consequences of not responding. The newsletter was distributed to 347 subscribers.

Tax Notes (January 29)

The HCA's tax attorney was quoted extensively in an article, Up to a Million Face ACA Reporting Cutoff, Risk Losing Coverage, explaining to tax professionals that thousands of taxpayers, who didn't include the required 8962 when they filed their 2014 returns were at risk of not being eligible for premium subsidies. The article was available to Tax Notes Subscribers.

Cultural Awareness Day (February 17)

The University of Vermont College of Medicine's Department of Family Medicine sponsored a conference, *Coming to the USA: A Focus on Healthcare Challenges*, attended by approximately 250 medical students, along with some medical professionals and community members. The goal was to raise awareness about the issues and barriers that New Americans may face. The HCA staffed a table where they engaged in conversations, handed out approximately 100 brochures and answered questions.

Social Work Outreach (February 24)

The HCA distributed 33 brochures to students in the Biosociopolitical Issues in Social Work class at the University of Vermont.

Allocation of Premium Tax Credits Rules Summary (March 2016)

The HCA tax attorney created a short reference document, [Allocation of Premium Tax Credits Rules Summary](#), that we posted to the Vermont Law Help website. In addition, it was distributed to the 30 subscribers to the Low Income Taxpayer Clinic listserv, as well as to other tax preparers who contacted VLA with allocation questions.

Promoting Plain Language in Health Communications

During this quarter, the HCA provided feedback and revisions to promote the use of plain language and increase consumers' accessibility to and understanding of important communications from the state and other health organizations regulated by the state. The HCA:

- Revisited the Grace Period one-pager and graphic to address confusion in the latest versions and to increase readability.
- Suggested extensive revisions to various web-based and print communications from Vermont Health Connect related to the ACA and taxes, including:
 - Form 1095 FAQs for Tax Preparers and Vermont Health Connect Customers
 - Health Insurance 101 for Tax Filing: 2016
 - 3 Tips for Filing Taxes if You have Medicaid or a VHC Plan
- Suggested extensive plain language revisions to several critical consumer notices:
 - Verification notice for renewing Medicaid/Dr. Dynasaur enrollees
 - Termination notice for noncompliance with verification request
 - Notice of APTC amount change
- Suggested plain language revisions to ADA notice used by DVHA
- Suggested revisions to VHC's 1095-A call script that alerted people to the fact that they may need to file for an income tax filing extension
- Suggested plain language revisions to VHC's "right to appeal" handout
- Suggested extensive revisions to a primary care enrollment agreement prepared by the Vermont Health Care Innovation Project Rostering Workgroup

Presentations

During this quarter, the HCA provided education directly to approximately 37 individuals, many of whom serve populations that are likely to benefit from the information and education provided.

Washington County Mental Health (February 18)

The HCA presented about the HCA and what we do in addition to discussing the upcoming Medicaid reviews, then answered questions. About 11 WCMH staff members attended. We distributed HCA brochures at the presentation, and WCMH requested additional brochures.

Low Income Taxpayer Clinic Network (March 1)

The HCA tax attorney gave a presentation to the Low Income Taxpayer Clinic Network on the ACA-related problems identified in the 2015 National Taxpayer Advocate annual report to Congress. There were 14 legal services lawyers, 1 tax professor, and 1 law student in attendance.

Senior Solutions Advisory Council (March 23)

The HCA presented information about the All Payer Waiver and H.812 (an act relating to implementing an all-payer model and oversight of accountable care organizations) to approximately 10 members of the Senior Solutions Advisory Council via conference call. The Council is composed of representatives from towns in Windham and Windsor County who are interested in elder and caregiver issues.