

# Vermont Office of Health Care Ombudsman



## SFY 2013 Annual Report

July 1, 2012 – June 30, 2013

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## BACKGROUND

In 1998 the Vermont legislature created the Office of Health Care Ombudsman (HCO) to provide advice and advocacy for Vermonters with health care and health insurance concerns. The HCO is not a state agency. It is part of Vermont Legal Aid (VLA), a statewide nonprofit law firm. We are funded by two state agencies: the Department of Financial Regulation (DFR) and the Department of Vermont Health Access (DVHA).

In the past two years, we received six overlapping grants through the federal Affordable Care Act for consumer assistance, outreach, representation of the public in rate review proceedings, and preparations for the state's Health Benefit Exchange. The HCO provides individual consumer assistance and acts as a voice for consumers with the state and federal government.

### Consumer Assistance

The HCO helps individuals navigate the complexities of the health care system. We advise and assist Vermont residents, regardless of their income, resources or insurance status. Our services are free. As part of VLA, we are able to utilize the expertise of the attorneys in the other VLA projects.

Individuals contact us through our Burlington-based statewide hotline, the Vermont Legal Aid and Vermont Law Help websites, and by walking into one of the five VLA offices located around the state. HCO advocates analyze the client's situation, provide information and advice, directly intervene or make a referral.

One of our main goals is to help individuals get access to care. We give highest priority to individuals who are having difficulty getting immediate health care needs met, who are uninsured or who are about to lose their insurance. We give information and advice about the insurance options in Vermont and assist if there are problems with enrollment. We also educate consumers about their rights and responsibilities and provide information about and assistance with appeal processes.

Our cases involve commercial insurance (Blue Cross Blue Shield, CIGNA, and MVP) as well as public programs (Medicaid, Dr. Dynasaur and Medicare.)

### Public Advocacy

Part of the HCO's statutory mandate is to act as a voice for consumers in health care policy matters and as their advocate before government agencies. Our hotline conversations with Vermonters inform our public policy and public advocacy efforts. The HCO pushes for improved access to health care through administrative and legislative advocacy and represents the public in rate review proceedings and other matters before the Green Mountain Care

Board (the Board). Pursuant to Act 48 of 2011 and Act 171 of 2012, the Board is required to consult with the HCO about its policies and activities.

## HIGHLIGHTS

### SFY 2013

#### Introduction

From July 1, 2012, through June 30, 2013, State Fiscal Year (SFY) 2013, the HCO consumer assistance hotline received 3,167 calls.<sup>1</sup> About 49% of these callers involved state health care (DVHA) programs, 16% involved commercial health insurance plans, 27% involved Medicare<sup>2</sup>, and 11% were from uninsured individuals.<sup>3</sup>

#### Overall HCO call volume increased slightly.

This year's call volume of 3,167 was about 3% more than the 3,060 we received in SFY 2012. The distribution of issues was very close to last year's: Access to Care (27%), Billing and Coverage (14%), Buying Insurance (1%), Consumer Education (9%), Eligibility for Government Programs (27%), and Other (22%). Complex cases increased by 96%.<sup>4</sup>

#### The HCO saved individual consumers \$205,811.28 in SFY 2013.

HCO advocates got claims paid, written off or otherwise covered in 153 cases, prevented 89 households from losing their insurance and got 178 households onto insurance.

#### The high cost of health care continued to be a growing problem.

This year we received more complaints about the unaffordability of health care than ever before: 527 calls, when both primary and secondary issues were counted.<sup>5</sup> This was a 32% increase over the previous year, which had an increase of 26% over SFY 2011. Individuals increasingly have told the HCO that they cannot afford the cost of medical care, their insurance premiums, or their plan's cost-sharing. Many told us they were foregoing care because they could not afford it, even though they had insurance.

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<sup>1</sup> The term "call" also includes individuals who come to us through our website or as walk-ins.

<sup>2</sup> Medicare beneficiaries may also be on DVHA programs, like Medicaid or VPharm.

<sup>3</sup> These percentages do not add up to 100% because we do not ask callers what type of insurance coverage they have if it is not relevant to the issue they are calling us about. Also, some individuals have more than one type of insurance.

<sup>4</sup> A complex case is one that requires more than two hours of an advocate's time.

<sup>5</sup> The HCO assigns every case a primary issue. If more than one issue is raised in the call, we code the ones that are not the primary focus of the call as secondary. There can be multiple secondary issues in one call and thus the data on secondary issues can overlap.

**More callers wanted information about DVHA programs.**

After affordability, the next biggest issue was the need for information about state Medicaid programs. This year we had 473<sup>6</sup> callers who wanted more information about DVHA programs, an **82% increase** over last year's 260 calls. Some callers had insurance they couldn't afford and wanted to know if they qualified for state health plans, some needed health care services and didn't know about state programs, and some were having problems understanding the programs' rules or navigating the eligibility determination process.

**Problems with mental health care access increased 49%.**

We received 121<sup>7</sup> calls regarding problems accessing mental health treatment, compared with 81 last year. The number of mental health-related calls was about the same in each of the first three quarters of SFY 2013, then jumped in the last quarter. We examined the problem in more detail in the report for that quarter.

The problems included difficulties finding psychiatrists and therapists and denials of coverage by insurers, but the most frequently cited problem was that uninsured individuals could not find affordable treatment. It is not clear what event or events caused the call volume to jump in that particular quarter.

**The HCO worked with other consumer advocates this legislative session to improve the affordability of health insurance to be sold through Vermont's Health Benefit Exchange.**

Health insurance for many Vermonters will change significantly beginning in January 2014 as a result of the federal Affordable Care Act. The HCO collaborated with other health care advocates to press state legislators for additional subsidies to make the cost of insurance through the state's new health benefits marketplace, Vermont Health Connect (VHC), more affordable for Vermonters. Although we did not get everything we wanted, ultimately the legislature authorized both significant financial assistance for premiums and reduced out-of-pocket costs for eligible individuals purchasing plans through VHC.

**The HCO represented the public before the Green Mountain Care Board in 41 rate review proceedings.**

The HCO began representing consumers in health insurance rate reviews in March 2012. In SFY 2013 we appeared in 41 contested cases before the Board. Fourteen of these cases went to hearing. We submitted written memoranda in 27 cases, which were decided based on the

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<sup>6</sup> This number includes both primary and secondary issues.

<sup>7</sup> This number includes both primary and secondary issues.

documents. In twelve cases the Board reduced rates as we requested and, in twelve others, the Board adopted part of our recommendations to lower rates.

**The HCO, the Green Mountain Care Board and insurers worked collaboratively to improve the rate review process.**

No one has been happy with the rate review process in effect this year. As a result, all of the parties worked together with legislators to get Act 79 of 2013 passed, which will shorten and simplify the rate review process. It will take effect in January 2014. One of the improvements suggested by the HCO will give us access to more information, which will improve our ability to represent the public. A notification system for consumers who want to know when rate requests are filed will be created to facilitate public comment on rates.

**The HCO is improving its website and expanding its outreach efforts.**

Since November 2012, the HCO has worked to improve the quality and quantity of information on the current website (including a new section focused on Vermont health care reform), to develop a new website, and to expand outreach efforts. Google Analytics statistics show that views of the improved health home page increased by almost 400%, and the time users spent on the page more than doubled.

We engaged in five direct outreach efforts, reaching 113 community partners who serve approximately 280,000 Vermonters. We created audio and video PSAs and distributed flyers that encouraged Vermonters to file income tax returns to ease the process of applying for insurance through Vermont Health Connect and produced a brochure about Fair Hearings.

**The HCO's role is evolving as the health care system in Vermont changes.**

The HCO received additional funding to expand our staff to prepare for the huge changes which will occur in Vermont's insurance market in January 2014: the elimination of VHAP and Catamount Health; the expansion of and eligibility changes to Medicaid; and the sale of commercial insurance plans to individuals, families and small businesses through VHC.

The HCO continues to develop our expertise in rate review cases and began using our own actuary this year. As the Board increases its regulatory activities to bend the curve on health care costs, the HCO is expanding our ability to represent the public in those diverse activities. In addition to a host of other changes to the health care system, Act 79 of 2013 changed the name of the Health Care Ombudsman to the Health Care Advocate beginning in January 2014.

Trinka Kerr  
State Health Care Ombudsman  
August 2013

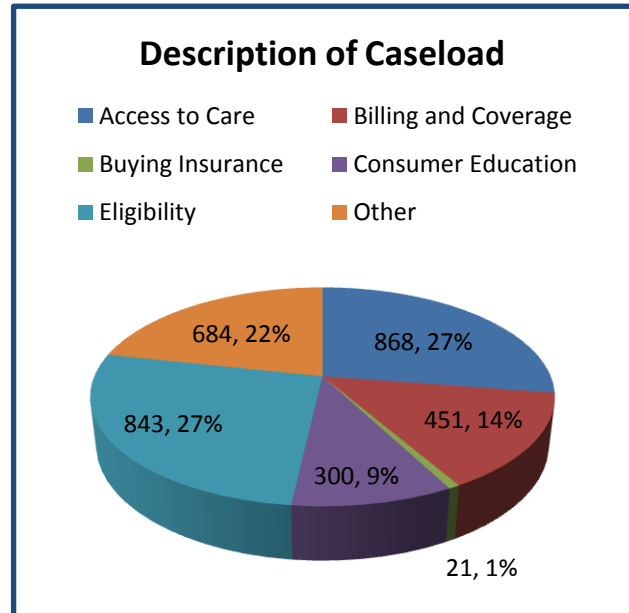
## CONSUMER ASSISTANCE

### DESCRIPTION OF CASELOAD

In State Fiscal Year (SFY) 2013 we received 3,167 calls to our statewide hotline, compared to 3,060 in SFY 2012 and 3,348 in SFY 2011. We closed 3,190 cases during this period, and had 60 cases pending at the end of June 2013. The HCO keeps data on the issues raised by callers.

We subdivide the issues into six categories: *Access to Care, Billing and Coverage, Buying Insurance, Consumer Education, Eligibility, and Other.* Every case is assigned to one of these categories. While some cases span multiple categories, the case numbers in this section are based on the **identified primary issue** from each caller in order to avoid counting the same case more than once.

The pie chart illustrates the comparative volume of calls for each category. Details are provided in the descriptions below.



#### Access to Care

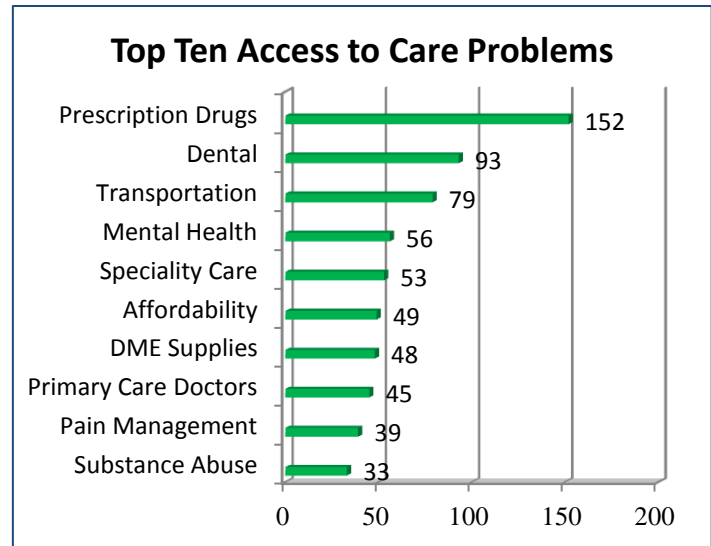
*Access to Care* cases are those in which individuals are seeking care. The number of calls related to difficulties getting access to health care was the same as last year, 868. This category constituted 27% of our call volume this year, 1% more than last year. An additional 1,208 callers cited access issues as secondary to their primary problem.

We have over 40 subcategories in *Access to Care*. As has been the case for years, the largest access issue was Prescription Drugs. We received calls from 152 Vermonters unable to promptly get necessary medications, compared to 148 last year. Adding the 6 Medicare Part D calls brings the total to 158. While other Prescription Drug access calls remain high, Medicare Part D calls decreased by a dramatic 57%, from 14 to 6, a trend we have observed over several years.



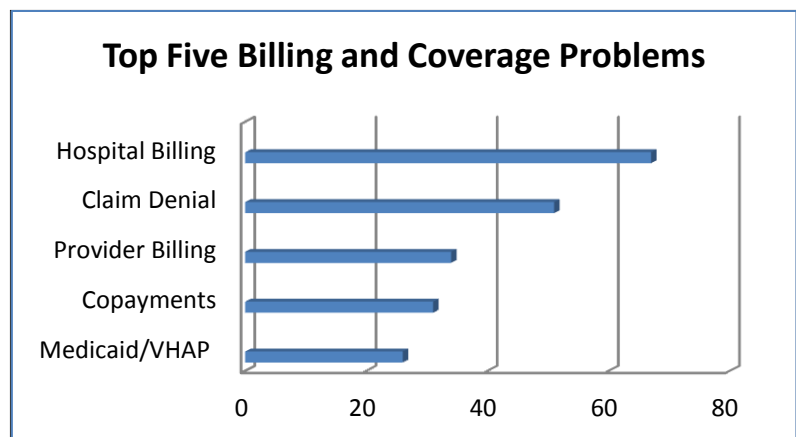
The top ten *Access to Care* issues were the same as last year, in slightly different order:

- prescription drugs (152, compared to 148 in SFY 2012)
- dental care, dentures, orthodontia (93, compared to 87)
- transportation (79, compared to 89)
- mental health treatment (56, compared to 44)
- specialty care (53, compared to 41)
- affordability (49, compared to 77)
- durable medical equipment, supplies and wheelchairs (48, compared to 64)
- primary care doctors (45, compared to 27)
- pain management treatment (39, compared to 60)
- substance abuse treatment (33, compared to 35)



**Billing and Coverage**

Calls in this category are from Vermonters who received the care they needed, but subsequently experienced problems getting their insurance to pay for that care or had other problems with the billing process. We received 451 calls in this category, compared to 429 last year. *Billing and Coverage* cases constituted about 15% of our calls, the same as SFY 2012.



As a general rule, individuals who call about billing problems no longer get direct intervention from us. Instead, we provide advice on ways to handle the situation, which enables us to give higher priority to *Access to Care* and *Eligibility* calls.

*Billing and Coverage* calls are broken down into more than 35 subcategories. The top five most common types of billing calls were the same as last year, in a slightly different order. They were:



- hospital billing (67, compared to 85 in SFY 2012)
- claim denials (51, compared to 62)
- provider billing (34, compared to 42)
- copayments (31, compared to 11)
- Medicaid/VHAP billing (26, compared to 30)

### Eligibility

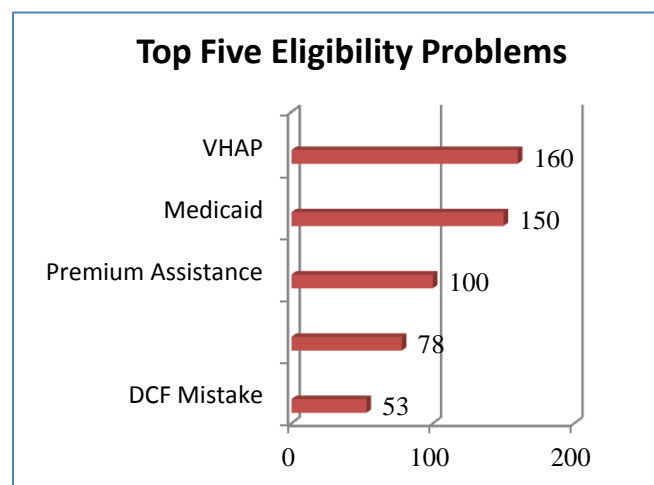
*Eligibility* calls increased slightly in 2013. We received 843 calls about eligibility for state health care (DVHA) programs in SFY 2013, compared to 815 in SFY 2012 and 1,041 in SFY 2011. Calls regarding *Eligibility* made up 27% of our calls this year, the same as last year. Notably, we had an additional 834 calls in which *Eligibility* issues were raised as a secondary issue, for a total of 1,677 calls in which *Eligibility* was an issue.

*Eligibility* calls came from individuals who were uninsured, who had commercial insurance they couldn't afford, or who were on state programs but faced termination of that coverage or other barriers to enrollment. The top five subcategories, out of more than 28, were:

- Medicaid (150 calls, compared to 171 last year)
- VHAP (160, compared to 152)
- Medicaid Spend Down Program (78, compared to 74)
- Premium Assistance (100, compared to 66)
- DCF Mistake (53 calls, compared to 22)

Although there was a spike in DCF mistakes during the third quarter of SFY 2013, resulting in an increase in the primary issue count, overall complaints about DCF decreased. Looking at both primary and secondary issues:

- DCF mistakes decreased from 119 to 53
- Application delays decreased from 43 to 22
- Lost paperwork decreased from 43 to 25



- Member Services errors decreased from 13 to 9
- Problems with the mail increased from 19 to 22

### Types of Coverage

The HCO receives calls from Vermonters with all types of health insurance and from the uninsured. The chart below breaks down our calls by the caller's type of coverage. State health care programs include Medicaid, Dr. Dynasaur, VHAP, VHAP-ESIA, VHAP Pharmacy, VScript, VPharm, and combinations of Medicaid and Medicare. Commercial insurance includes both individuals with small and large group coverage and those with individual coverage. In some cases the caller's insurance status is not relevant to the problem or is unknown, and the HCO does not get the information.

The breakdown this year, as compared to the previous two years is shown in this table.

	2013	2012	2011
State Programs	1,053 (33%)	1,262 (41%)	1,345 (40%)
Catamount & Premium Assistance	149 (5%)	108 (4%)	204 (6%)
Commercial Insurance	355 (11%)	371 (12%)	398 (12%)
Medicare	400 (13%)	414 (14%)	364 (11%)
Dual Eligible <sup>8</sup>	405 (13%)	316 (10%)	309 (9%)
Uninsured	340 (11%)	283 (9%)	345 (10%)
Other	100 (3%)	71 (2%)	79 (2%)
Irrelevant/Unknown	365 (12%)	622 (20%)	692 (21%)

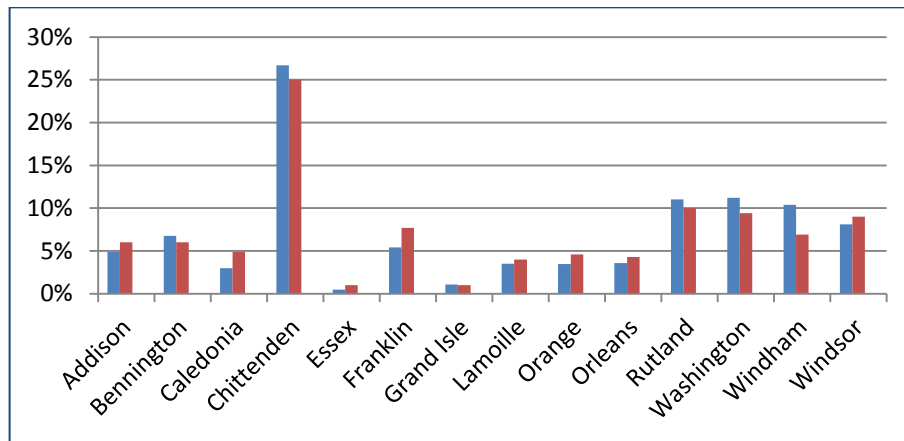
It is notable that when beneficiaries who are Dual Eligible or VPharm are added into the Medicare total, **27% of the calls were from Medicare beneficiaries**. The number of Medicare beneficiaries calling us has steadily been increasing, a trend that is likely tied to the aging of the population.

### Geographic Distribution of Calls

The HCO provides services statewide. While there was some variation by county, our calls are spread across the state in almost direct proportion to the population of the state. The chart below shows a

<sup>8</sup> Dual Eligible is also known as Medicaid plus Medicare

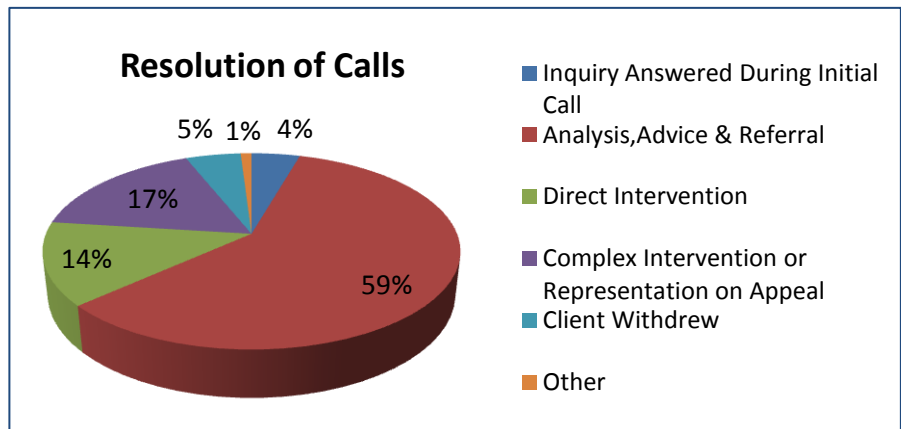
comparison of the calls received (first column, in blue) to the general population by county (second column, in red).



**Resolution of Calls**

In SFY 2013, the HCO closed 3,190 cases, compared to 3,086 last year. When each case is closed, we document how we resolved the case, where we referred the individual, and what materials we sent. We use the following categories to track how we resolve calls:

- *Inquiry Answered During Initial Call*: 143 calls, 4%, compared to 64, 2%, in SFY 2012
- *Analysis, Advice and Referral* (advice and/or referral after analysis for cases that are slightly more complex): 1,894 calls, 59%, compared to 2,062, 67%



- *Direct Intervention* (made calls or took other action on behalf of the client, up to two hours of work per case): 439 calls, 14%, the same as last year
- *Complex Intervention* (direct intervention that took more than two hours to resolve case): 545 calls, 17%, compared to 278 calls, 9%. *Complex Intervention* cases increased more than 96% compared with last year.
- *Client Withdrew*: 163 calls, 5%, compared to 226, 7%
- *Other*: 6 calls, less than 1%, compared to 17 calls, 1%

**Appeals:** The HCO helped individuals with 155 appeals, 98 (63%) of which were DVHA Fair Hearings. We represented one individual in a Fair Hearing, one in a commercial plan internal Appeal, and one in a DVHA MCO internal appeal.

### Outcomes

The HCO records outcomes whenever we know them. Frequently when we give advice, we do not know the ultimate result of that advice. However, we make every effort to track our outcomes when possible.

**The HCO saved individual consumers \$205,811.28 in SFY 2013.**

Outcome Summary		
	SFY 2013	SFY 2012
Advice or Education	1,814	2,017
Assisted with Application for Insurance	11	31
Bill Written Off	18	26
Claim Paid as a Result of HCO Intervention	28	42
Client Not Eligible for Benefit	14	23
Client Responsible For Bill	30	13
Estimated Eligibility for Insurance	108	98
Got Client onto Insurance	178	114
Obtained Coverage for Services	64	55
Other Access/Eligibility Outcome	199	209
Other Billing Assistance	71	28
Other Outcome	523	332
Patient Assistance Provided	9	11
Prevented Termination or Reduction in Coverage	89	66
Reimbursement Obtained	32	11
Service Excluded Under Contract	1	7
Service Not Medically Necessary	1	2
<b>Grand Total</b>	<b>3,190</b>	<b>3,085</b>

## Case Examples

Here are two case examples that demonstrate the kind of work we do:

### **Helped a working individual stay insured and maximized his coverage, allowing him to continue his substance abuse treatment and his employment.**

When Mr. A learned he was losing his VHAP insurance because his employer had failed to return a form, he contacted the HCO for assistance. His HCO advocate learned that DCF had in fact already received the form. However, DCF then determined that Mr. A was over income for VHAP due to a pay increase. This meant he would go onto premium assistance for Catamount (CHAP), which was more expensive.

The HCO advocate assured that Mr. A would receive continuing coverage during the transition to the new plan. In addition, the advocate recommended that Mr. A enroll in the Catamount Blue Chronic Care Management Program so he could continue to get his daily substance abuse treatment. Without CCMP he would have had a copayment of \$15 a day for his treatments.

The advocate then helped him enroll in the CCMP. Mr. A called the advocate back later because the CCMP enrollment had not been completed as expected. The advocate contacted the carrier, successfully enrolled Mr. A in the CCMP, and got the enrollment backdated so that the drug treatment clinic could be paid, as it had been treating Mr. A without payment for six weeks. This saved Mr. A \$660.

### **Worked with DFR to get an uninsured couple onto commercial insurance quickly, avoiding pre-existing condition exclusions.**

A husband and wife moved to Vermont for work and attempted to purchase health insurance. Vermont carriers refused to sell them an individual plan because the husband's employer offered insurance to its employees. However, the employer's out of state insurance carrier did not offer coverage to Vermont residents. Thus, the couple was unable to get insurance and was uninsured.

After struggling for more than two months to resolve this conundrum on their own, the couple contacted the HCO for help. By that time, they were dangerously close to being uninsured for more than 62 days, making them vulnerable to pre-existing condition exclusions even if they were able to get insurance. The HCO immediately contacted DFR. DFR determined that the couple was eligible to purchase individual insurance in Vermont and worked with a Vermont carrier to enroll them quickly. By coordinating with DFR, the HCO was able to resolve the problem within two weeks, enabling the couple to get insurance and avoid any pre-existing condition exclusions.

## QUALITY ASSURANCE AND CONSUMER SATISFACTION

The satisfaction of our clients is extremely important to us. To monitor how consumers feel about the way we provide our services, we send a Client Satisfaction Questionnaire (CSQ) with a list of questions to every client on whose behalf we intervene directly. We try to contact every client who requests follow up via returned CSQ in order to resolve complaints or outstanding issues, but sometimes that is not possible.

This year we sent out 932 CSQs and 281 (30%) were returned. Of those returned, 95% said they were Satisfied or Very Satisfied with the service they received from our office. About 86% reported they were Very Satisfied. Sixteen individuals said they were not satisfied. Most of these individuals had cases that lacked sufficient merit to obtain the outcome they desired.

Here is a sampling of the comments on this year's CSQ's:

- *Leave it to Vermont to have such a great program, to help ordinary people. Bet you wouldn't find this in Texas.*
- *I'm quite impressed with the help I received. I would have had to go to the hospital for care if I had not gotten such quick action on my case. Thank you so much.*
- *[My HCO advocate] has been very knowledgeable in my case. She does an excellent job researching and making sure that I get proper information. I also like the way she talks to me, in explaining how things work with the state of Vermont. She has always treated me and my husband with dignity and respect. My husband says she treats him like the President of the United States! As for myself, I feel like the President's Wife!*
- *Faced with numerous health issues and overwhelmed with mounting medical bills, your office has compassionately and professionally guided me through a difficult period.... I can now devote more time to getting well. [I am] eternally grateful.*
- *I hope that your office will always be available for many, many years to come. You have no idea of how rude some of these people in the offices of these hospitals and clinics can be when we are unable to pay our deductibles... Our son almost lost his hand because he had no insurance and they tried to refuse him medical attention.*
- *I was treated like a real person, not a number. I could not believe how [my HCO advocate] listened to me without patronizing me. She understood me. She did not promise or give me unreasonable expectations. Her honesty and sincerity gave me hope that my problem would be addressed. She communicated with me in easy language. She not only kept her word on my one problem of not having medicine for months, but referred me for [help with my other] issues.*
- *This is truly a great service. We were being stonewalled by the health insurance companies and you were able to resolve the problem.*

- *[My HCO advocate] was awesome. She was professional, attentive and seemed genuinely to care about helping me resolve my problem. I am genuinely impressed with and grateful to her, and to the state of Vermont for making this service available. Experiences like this one... make me proud to be a Vermonter.*
- *My case was a brief episode in which a pharmacy withheld my diabetic supplies for more than a week because I could not pay \$15. I knew they were in error, but couldn't budge them. A call to them from [my HCO advocate] cleared things up the same day.*
- *[My HCO advocate] was very helpful.... We people are new to the United States. Sometimes we feel that we are neglected because of the language barrier and other reasons. But when I contacted the [HCO], I didn't feel that way. I am very satisfied with the services provided.*
- *Keep up this most needed service. Wading through all the options is very daunting and to make an informed decision without all your help could lead to disaster [for] a person's health and financial hardship. Thank you so much for your expertise and caring.*
- *I suffer from an unusual disorder... that affects my vocal chords, so [my HCO advocate] literally became my "voice." I used to be able to handle things quite well myself but in the past five years my confidence eroded along with my voice. I approached [my pharmacy] myself on the phone but got nowhere because I lacked voice and confidence.*

*[My advocate] stepped in as my old self, she became my champion and it cost me nothing! I want her to know that this has had a great impact on me and has given me a little more faith in my fellow man. I will never forget. I was positive I would lose, [but with your help we won! Yet] winning the small settlement was not the important part. What was important was the idea that there is someone out there that will stand up for the "small people" that generally go unheard, but have been treated unfairly with no recourse. Wining this case gave me a sense of empowerment that improved my life.*

- *I'm happy that this organization exists. The health care system in this country is so complex that it's beyond the ability of ordinary citizens to navigate on their own.*



## PUBLIC ADVOCACY

### GREEN MOUNTAIN CARE BOARD ACTIVITIES

#### Rate Reviews

In March 2012, the HCO began work under a contract with DFR to represent the public in rate review proceedings and to increase public participation in the health insurance rate review process.

The HCO represented the public in the 41 contested health insurance rate review cases that came before the Board in SFY 2013. Fourteen of these cases went to hearing. In the other 27 we submitted written memoranda and the cases were decided on the documents. In twelve cases the Board reduced rates as we requested, and in twelve others it adopted part of our request. The HCO did not appear in two cases which involved extremely small numbers of covered lives or involved no actuarial dispute. Prior to November 29, 2012, we did not have the discretion not to appear in cases.

The HCO is increasingly getting complaints from Vermonters about the cost of health care benefits. Our data show that we received 22 complaints that premiums were unaffordable and five complaints about specific rate increases this fiscal year. We helped one consumer file a comment in a rate review proceeding.

#### Examples of significant rate filings

In the Blue Cross and Blue Shield of Vermont First Quarter through Third Quarter 2013 Non-Group Rate Filing, the carrier proposed increasing rates by an average of 11.4% over 2012 rates for policy holders renewing in the first quarter of 2013, 19.6% for those renewing in the second quarter and 19.5% for those renewing in the third quarter. The Commissioner of DFR recommended modifying the rate increases by eliminating a proposed 2% contribution to surplus, resulting in quarterly rates of 9.4%, 17.6%, and 17.5%. The HCO's independent actuary testified that the increases were not supported by the information included with the filing. The Board decision disapproved the requested rate increases, based largely on this testimony.

In other cases, the HCO requested that the Board lower rates in order to make the products more affordable to consumers and to promote access to health care by accepting modifications recommended by DFR or by reducing rates beyond DFR's suggested modifications.

- In the TVHP 2013 small group filing, the Board lowered the rates beyond DFR's recommendations as requested by the HCO.
- For MVP's 2013 third and fourth quarter PPO filing, DFR recommended a reduction in the carrier's requested 3% contribution to surplus. The HCO asked the Board to remove the

entire contribution to surplus. The Board removed the entire contribution to surplus, thus lowering the rate.

- In the TVHP third and fourth quarter 2013 trend filing, the Board agreed with the HCO's request to go beyond the DFR recommendation and lower the requested medical and pharmacy trends to the lowest point in the ranges calculated by DFR's actuary. The Board decision lowered the medical trend from the requested 5.6% to 4.1% and the pharmacy trend from the requested 8.3% to 6.8%.

### Health Benefit Exchange Filings

The HCO invested substantial time and resources during the final quarter of SFY 2013 reviewing the two filings for products to be offered on the state's health benefit exchange by BCBSVT and MVP. These exchange product filings were filed on March 27, 2013. Due to the complex nature of the exchange filings, the carriers, the HCO and the Board spent much more time than is usual preparing for the hearings prior to DFR's recommendations to the Board. The Board held three pre-hearing conferences for each filing. At the HCO's suggestion, and in advance of the hearings, BCBSVT and MVP provided the HCO and the Board with interrogatories posed by the DFR's contracted actuary to the carriers and with the carriers' responses to these interrogatories.

The MVP exchange filing was complicated by MVP's amending the filing to include a pediatric dental benefit as part of the MVP plans. MVP had originally planned to rely on a supplemental dental product but this was not offered.

The Board issued its decisions for the exchange filings on July 8, 2013<sup>9</sup>. It modified the rate requests from both carriers. Major factors in the modifications included reduction of the proposed medical trend for MVP, rate adjustments based on assumed changes in morbidity (health status) of the Exchange population for both carriers, and reductions in pharmacy trend and proposed levels of contributions to surplus for both carriers.

The Board's decision in the BCBSVT filing reduced the cost of the non-standard silver copayment plan by 4.3%. The reduction in the BCBSVT rate due to changes in morbidity was consistent with testimony and arguments supplied by the HCO.

The Board's decision in the MVP filing reduced the proposed rate by 5.3%. DFR had recommended that MVP's medical trend be lowered from 5.2% to 4.8% and the pharmacy trend be approved at the requested 5.7%. The HCO had argued that MVP's medical trend should be lowered to 4.7%, and the pharmacy trend lowered to 3.4%. The Board's decision lowered MVP's medical trend to 4.7% and lowered MVP's pharmacy trend to 4.5%.

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<sup>9</sup> This is outside of SFY 2013 but is included in this report because of the high interest in the outcomes to these proceedings.

## Other Green Mountain Care Board Activities

Pursuant to Act 48 of 2011 and Act 171 of 2012, the Board must consult with the HCO about various health care reform efforts and policies. Our work in this area in SFY 2013 included:

- Comments on rate review and Certificate of Need regulations (Rate review rule 2.000, CON rule 4.000):
  - Exchanged information with other consumer groups about the section on opportunities for public participation in the draft rate review regulations
  - Participated in public hearing about the rate review regulations
  - Submitted formal written comments on proposed Board regulations.
  - Attended LCAR meeting on rate review regulations
  - Reviewed draft CON regulations and submitted comments to ensure that the HCO can intervene in CON cases and that there is public notice when a CON application is filed
- Work to improve the Board's public participation process
  - Meeting with the Stakeholder Engagement Coordinator for the Board to discuss ideas for improving public participation and sent comments on the new public comments section of the Board web site to the Coordinator
  - Coordinating with consumer groups interested in commenting on the Exchange benefits package.
  - Meeting with VPIRG to review the process for commenting on rate review cases and ways to increase public participation.
  - Feedback on the draft Board brochure on Health Insurance Rate Review prepared by the Stakeholder Engagement Coordinator.
  - Recommendations that the State develop materials explaining the timing of the rate review process for plans offered through VHC. The Board's Stakeholder Engagement Coordinator subsequently worked with DFR and DVHA to develop a summary of the process of approving qualified health plans for the Exchange and of helping consumers to review and enroll in plans. This summary was posted in March on different state agency web sites.
  - Worked with VPIRG, the Vermont Campaign for Health Care Security and AARP to explain the public comment process for comments for the two Exchange rate filings and for comments on the proposed rate increase for Catamount Health. The HCO successfully advocated with the Board to extend the public comment period for

comments on the Exchange filings for an additional week. Almost 100 people filed public comments about the Exchange filings.

- Suggestions to DFR about changes to its website that would make its consumer information more complete and user-friendly. Recommended to DFR and the Board that they develop a joint web site with information about the entire rate review process and allow rate payers to ask for electronic notification about relevant rate filings. DFR and the Board worked with a contractor to design a single web site to make these changes.
- Participation in the Accountable Care Organization (ACO) Measures workgroup convened by the Board's Director of Payment Reform. This workgroup is one of three working to support the Board's initiative to establish population-based payment pilots with ACO's. The group seeks to identify standardized measures that will be used for commercial plans and Medicaid to evaluate the performance of Vermont's ACOs, qualify and modify shared savings payments and guide improvements in health care delivery. The HCO advocated for more measures that specifically might improve patient experience.
- Work with the Board and insurers on legislative revisions to the rate review process eventually included as part of Act 79 in the 2013 session. The new statutory provisions which will take effect in 2014 shorten and simplify the process by having the Board, rather than DFR, conduct the initial actuarial review of filings. They also improve the transparency of the process for the public by allowing the HCO to suggest questions the Board should pose to the carriers to supplement information in the filing, by providing the HCO with supplemental information obtained during the review process and by creating a notification system for consumers who want to know when rate requests are filed.
- Attendance at and participation in numerous Board meetings.

## OTHER PUBLIC ADVOCACY

In addition to providing services to individuals, the HCO works for systemic change. Because we talk to consumers every day and track data, we can serve as a sentinel to policy makers. We see trends in problem areas and try to get them fixed. We inform public agencies and the legislature about the health care concerns of consumers, and we make recommendations for changes. We monitor, analyze, and comment on federal and state laws and regulations. We collaborate with federal and state advocacy organizations in order to strengthen the voice of consumers in the public debate. We strive to promote the development of consumer organizations and to educate citizens about their rights and responsibilities.

## Legislative Advocacy

HCO staff frequently speak to state legislators, submit reports on the trends and cases we are seeing, and provide written and oral testimony to standing committees. When the legislature is not in session, we report regularly to the Health Care Oversight Committee. Some of the legislative areas we worked on this year:

- The HCO worked with other consumer advocates to improve the affordability of health insurance to be sold through the Health Benefit Exchange or marketplace. Together we pressed legislators to for additional subsidies to make the cost of insurance through the state's new health benefits marketplace, Vermont Health Connect (VHC), more affordable for Vermonters. Although we did not get everything we wanted, ultimately the legislature authorized both significant state financial assistance for premiums and reduced out-of-pocket costs.
- The HCO, the Board and insurers worked collaboratively to get the legislature to pass an improved rate review process. As a result of this collaboration, Act 79 of 2013 will take effect in 2014 to shorten and simplify the rate review process from a two-step process to a one-step process by having the Board, rather than DFR, conduct the initial actuarial review of filings with a stricter timeline. Among other improvements suggested by the HCO, we will have access to more information under the new process, increasing our ability to represent the public. A system will be created to facilitate public comment on rates by notifying consumers who want to know when rate requests are filed.
- We successfully advocated for increased funding for the HCO for SFY 2014. These additional resources will help us to assist consumers using VHC and provide better representation of the public in Board activities.

## Administrative Advocacy

The HCO works for systemic change through state and federal agencies. This year we:

- Provided extensive comments on Agency of Human Services proposed regulations during the VHC Health Benefits, Eligibility, and Enrollment rulemaking process
- Commented on DVHA's proposed Dental Coverage for Pregnant and Postpartum Women regulations
- Reviewed all proposed Medicaid program regulations
- Provided extensive comments on the Essential Health Benefits to be provided in the exchange plans to be sold through VHC
- Provided extensive comments on the Plan Designs for the exchange plans

- Provided extensive comments, along with other VLA attorneys, on the state's Global Commitment waiver request to CMS
- Participated in the stakeholder workgroup for a demonstration project to integrate and improve the care for individuals who are dually eligible for Medicaid and Medicare, as well as the subgroup which is working to change the appeals process for these beneficiaries
- Worked with other VLA advocates to improve Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services
- Participated in the stakeholder workgroup on surrogate decision-making rules, specifically regarding Clinician Orders for Life Sustaining Treatment (COLST) and Do Not Resuscitate orders
- Kept up an ongoing dialogue with DVHA regarding issues that arose from specific consumer cases
- Submitted comments to CMS about the three day observation status problem for Medicare coverage. CMS requires inpatient hospitalization for three days before it will pay for nursing home level care. This is a growing problem nationally.
- Submitted comments to CMS on the federal reporting requirements for Consumer Assistance Programs under the ACA
- Participated in the Medicaid Exchange Advisory Board

### Other Efforts

- Participated in the legislatively created state Palliative Care and Pain Management Task Force to improve access to such care
- Provided Vermont's Congressional delegation with information regarding the health care and health insurance concerns of Vermonters
- Conferred regularly with other state and national health care consumer programs about ways to improve the implementation of the exchanges and how to better serve consumers

## COORDINATION

The HCO works closely with the Long Term Care Ombudsman and other VLA attorneys. In addition, we coordinate our efforts with many consumer and advocacy groups to expand access to health care, especially the Vermont Campaign for Health Care Security, Disability Rights Vermont and the Vermont Public Interest Research Group (VPIRG).



## OUTREACH

Since November 2012, the HCO has worked to improve the current website (including adding a section focused on Vermont health care reform), to develop a new website, and to expand outreach efforts.

### Current Website

Within the limitations of the current Vermont Law Help platform and design, we have applied significant effort to improve the quality and quantity of information available on the Health home page. Google Analytics statistics show an increase of 310% (1,211 in SFY 2013, compared with 286 in SFY 2012) in Health home page views. When you view the statistics for the period from January (when many improvements to the site had begun to be implemented) through June 2013, compared with the same period the previous year, the results are even more dramatic: 868 page views, compared with 176 in 2012 – an increase of 393.18%. The average time spent on the page doubled. The bounce rate (the number of users accessing the Health page and leaving quickly) decreased from 57.89% to 34%, a 47% decrease.

On March 19, we added a page focused on health care reform in Vermont, which we have continued to update regularly to inform consumers about current information and upcoming changes. Between March 19 and the end of SFY 2013, the page had been viewed 198 times and the average time spent on the page was 4:09. (By comparison, the average amount of time Americans spent on a web page in January 2013 was 01:12.)

### New Website Development

We anticipate launching the new Vermont Law Help website in early September. We paid close attention to improving consumers' ability to easily find the information they are seeking and to navigate through the site to find additional information that is relevant to their respective issues. The site utilizes an advanced search function, and we have the ability to identify the top resources that should be returned for a given search.

Our web analysis tells us that 21,933 users accessed our site via a mobile device in SFY 2013, compared with 8,291 in SFY 2012. The current site is not mobile-friendly, and the bounce rate for mobile users is high. The new website is device-responsive – that is, the software will detect the type of device and shift the presentation of the contents to provide consumers with a highly readable view of the site, whether they are using a PC, a tablet or a smart phone.

The new site includes easy-to-find tools to adjust the font size and to translate the entire site, including navigation buttons and sidebars, into the seven languages that are most common to the population we serve. The new site will feature an online intake form to make it easier for Vermonters across the state to reach out for assistance at a time that is convenient for them.



## Direct Outreach

In the past six months, the HCO engaged in five direct outreach efforts, reaching 113 community partners who, in turn, serve approximately 280,000 Vermonters. We have eight outreach events scheduled for upcoming months, including staffing information tables at the Burlington Farmers' Market and on Church Street and presentations at an AmeriCorps training, Refugee & Immigrant Service Providers Network meeting, the Burlington Neighborhood Planning Assembly Meeting, and a retirement community.

We created audio and video PSAs and distributed flyers that encouraged Vermonters to file income tax returns to ease the process of applying for insurance through Vermont Health Connect. We published a brochure that explains how to request a Fair Hearing and what to do once the hearing is scheduled.

## OTHER ACTIVITIES

- Prepared a Consumer Complaints Report<sup>10</sup> for DVHA to assist with preparation for the Health Benefits Exchange. It examined three years of HCO calls and made recommendations based on them for implementation of the Exchange.
- Prepared the HCO Implementation Plan<sup>11</sup> outlining the steps the HCO will take to prepare for the implementation of the Exchange.
- Participated in a state workgroup which developed the Consumer Protection Report<sup>12</sup> required by Act 171 of 2012 with DFR, DVHA and Agency of Administration Office of Health Care Reform.
- Presented information about Vermont's ombudsman programs on a national conference call for the Integrated Care Resource Center, which is a joint technical assistance initiative of CMS.
- Reported data about complaints the HCO received about residential substance abuse treatment services to the Vermont Department of Health, Division of Alcohol and Drug Abuse Programs, at their request.
- Assisted Community Oriented Correctional Health Services (COCHS) for the Vermont Department of Corrections in its assessment of the options for delivering health care to the criminal justice population.

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<sup>10</sup> [HCO Consumer Complaints Report](#)

<sup>11</sup> [HCO Implementation Plan](#)

<sup>12</sup> [Consumer Protection Report](#)

**EXPENDITURES****Vermont Legal Aid, Inc.**

HCO ANNUAL REPORT SFY 2013 YTD

July 1, 2012 to June 30, 2013

<b>Personnel</b>	<b>SFY 2013 Total</b>
<b><u>Salaries</u></b>	
Project Director	\$71,486.94
Attorneys	\$152,013.83
Lay Advocates and Para Professional Staff	\$189,439.77
Management Professional Staff	\$74,912.03
Clerical Support	\$39,101.75
	<i>Total Salaries:</i> <b>\$526,954.32</b>
	<i>Fringe Benefits:</i> <b>\$267,710.14</b>
	<b>Total Personnel: \$794,664.46</b>
<b><u>Operating Costs</u></b>	
Occupancy	\$72,250.01
Office Supplies and Other Office Overhead	\$10,501.99
Equipment Rental, Repair and Maintenance	\$6,436.33
Computer Services and Support	\$19,056.15
	<b>Total Operating: \$108,244.49</b>
<b><u>Grant or Contract Specific Expenses</u></b>	
Travel	\$3,528.52
Training	\$12,823.92
Law Library	\$4,453.59
Website Redesign	\$978.44
Online Intake	\$393.40
Outreach	\$156.99
Other Specific Costs	\$8,220.00
	<b>Total Specific Expenses: \$30,554.85</b>
<b><u>Overhead</u></b>	
Administrative Support Expenses	\$14,648.58
Depreciation	\$15,879.84
	<b>Total Overhead: \$30,528.42</b>
Expert Witnesses, Consultants and Actuaries	\$37,495.00
Exchange Implementation	<b>\$130,500.00</b>
	<b>TOTAL COSTS: \$1,131,987.22</b>

SFY 2013 INCOME**Advocacy**

Department of Vermont Health Access	\$307,246.00
Vermont Department of Financial Regulation	\$215,700.00
Vermont Department of Financial Regulation (federal grant)	\$160,291.27

**Outreach and Website**

Vermont Department of Financial Regulation (federal grant)	\$81,962.55
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**Rate Review**

Vermont Department of Financial Regulation (federal grant)	\$235,162.40
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**Exchange Implementation**

Vermont Department of Vermont Health Access (federal grant)	\$131,625.00
	<b>\$1,131,987.22</b>