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OFFICE OF THE HEALTH CARE ADVOCATE

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QUARTERLY REPORT
April 1, 2015 – June 30, 2015
to the
Agency of Administration
submitted by
Trinka Kerr, Chief Health Care Advocate
July 21, 2015

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 April 1, 2015 - June 30, 2015 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**: 1,008 calls
  - **Department of Vermont Health Access (DVHA) beneficiaries**: 298 calls or **30%** of total calls
  - **Commercial plan beneficiaries**: 350 calls or **35%**
  - **Uninsured Vermonters**: 85 calls or **8%**
  - **Vermont Health Connect (VHC)**: 508 calls or **50%** (this data report draws from the All Calls data set)
  - **Two Reportable Activities (Summary & Detail):** 168 activities, 33 documents

Overall call volume decreased 26% from last quarter, mainly due to a drop in calls in June. This halted a steady increase in calls since the launch of Vermont Health Connect.

Vermont Health Connect calls decreased 28%, but many problems continued. The technology fix at the end of May made a small dent in June's call volume. Change of circumstance cases fell 30%, and billing and invoice cases fell 22% for the quarter. Problems with invoicing and billing are the number one complaint about VHC.

We saved individual consumers $54,412 this quarter, and $600,233 in SFY 2015.

Four new rate review cases were filed, including the exchange filings, which are set for hearing on July 28th and 29th. The HCA and its independent actuary are currently analyzing those filings and preparing for the hearings.

One major Certificate of Need case went to hearing this quarter, the University of Vermont Medical Center's Replacement of Inpatient Beds. The HCA participated fully in the proceedings as an interested party.

The HCA worked hard to help Vermonters sort through many health insurance-related tax problems this quarter as the tax consequences of the Affordable Care Act went into effect. In addition to working with individual consumers, the HCA's tax attorney worked with VHC and with the Vermont Tax Professionals Association. We also created two form letters for consumers to request IRS penalty relief under two different ACA provisions. These letter templates are posted on our website.

Our website is getting more and more hits. Pageviews increased 78% over the same quarter last year. Two commonly viewed pages related to access to dental services and Medicaid income limits.

See our **recommendations** to the state at the end of the Individual Consumer Assistance section, on pages 13-15.

II. Individual Consumer Assistance

The HCA provides assistance to consumers mainly through our statewide hotline (**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.

The HCA received 1,008 calls[1] 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:

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

- **18.95%** (191) about **Access to Care**;
- **14.68%** (148) about **Billing/Coverage**;
- **1.09%** (11) about **Buying Insurance;**
- **13.19%** (133) about **Consumer Education**;
- **30.46%** (307) about **Eligibility** for state and federal programs; and
- **18.87%** (218) 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 307 of our cases had eligibility for state health care programs as the primary issue, there were actually a total of 884 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 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 decreased 26% due to a drop in calls in June, halting the steady increase in calls since the launch of Vermont Health Connect in October 2013.

This quarter we received 1,008 calls, compared to last quarter's record high of 1,367, a 26% drop. Previous totals for this quarter were: 1,022 in 2014, 721 in 2013, and 717 in 2012. This quarter's decrease was mainly due to a 12% drop in calls in June (303), compared to June 2014 (344). April and May calls were still record highs for those months. June 2015 was the first time since November 2013 that we didn't break a monthly call volume record.

Also note that our call volume for the first six months of this calendar year is more than the total call volume we had for a full year ten years ago!

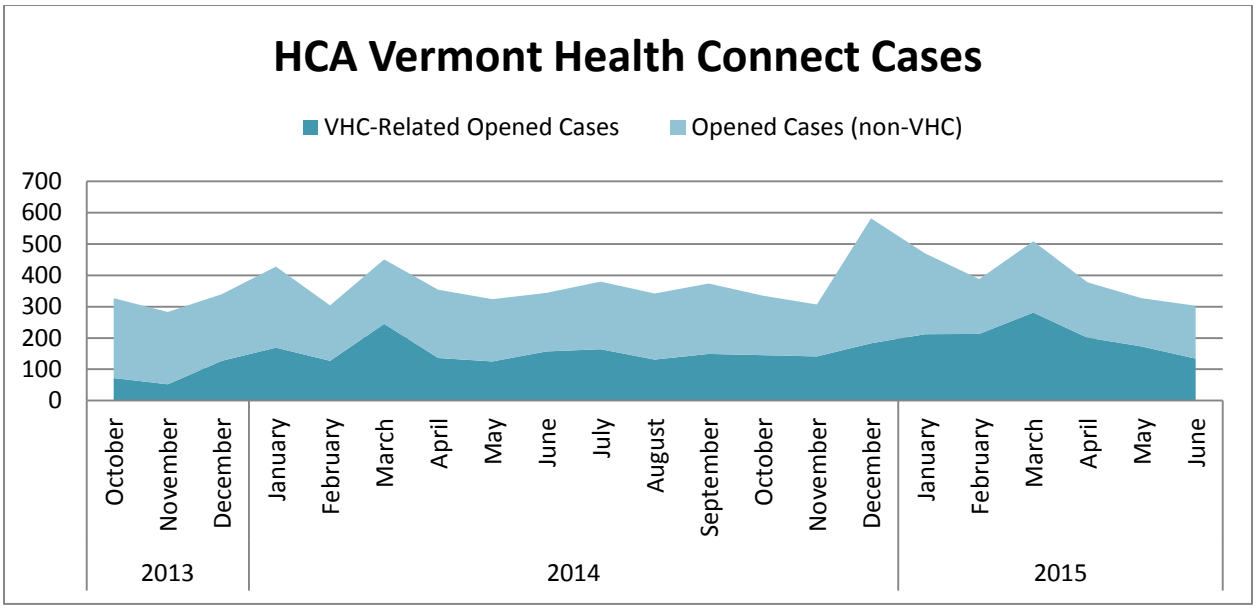
All Cases (2005-2015)											
	2005	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
January	178	313	280	309	240	218	329	282	289	428	470
February	160	209	172	232	255	228	246	233	283	304	388
March	188	192	219	229	256	250	281	262	263	451	509
April	173	192	190	235	213	222	249	252	253	354	378
May	200	235	195	207	213	205	253	242	228	324	327
June	191	236	254	245	276	250	286	223	240	344	303
July	190	183	211	205	225	271	239	255	271	381	n/a
August	214	216	250	152	173	234	276	263	224	342	n/a
September	172	181	167	147	218	310	323	251	256	374	n/a
October	191	225	229	237	216	300	254	341	327	335	n/a
November	168	216	195	192	170	300	251	274	283	306	n/a
December	175	185	198	214	161	289	222	227	340	583	n/a
Total	**2200**	**2583**	**2560**	**2604**	**2616**	**3077**	**3209**	**3105**	**3257**	**4526**	**2375**

B. Vermont Health Connect calls decreased 28%, but many problems continued.

Problems with VHC continued, but since the technology upgrades of the Release 1 deployment at the end of May, which included the change of circumstance functionality, there has been some improvement. Our call volume did drop in June. We will have to wait and see whether the decrease in calls was the beginning of a trend or just a temporary blip.

We received 508 VHC calls this quarter compared to 706 for the previous quarter, a 28% decline. However, the VHC-related call volume was still higher than in three out of the four quarters in 2014 (541, 418, 444, and 469), and was 22% higher than the same quarter last year (508 versus 418). A real spike in VHC calls occurred in the previous quarter, specifically in March (281). VHC calls have steadily decreased since then: 201 in April, 173 in May, and 134 in June.

Half of all our calls were VHC-related, which was about the same percentage as last quarter. They involved the same types of problems described in earlier HCA reports. These mainly related to issues carrying out requested changes and billing hassles, both mostly due to VHC's inadequate technology. Some cases involved problems carried over from 2014 that had not yet been resolved; others were new. Many were complex. About 26% of the cases closed during this period were complex, i.e. took more than two hours of an advocate's time. This is the same percentage of complex cases as last quarter.



C. Change of circumstance cases fell 30% due to a drop off in June.

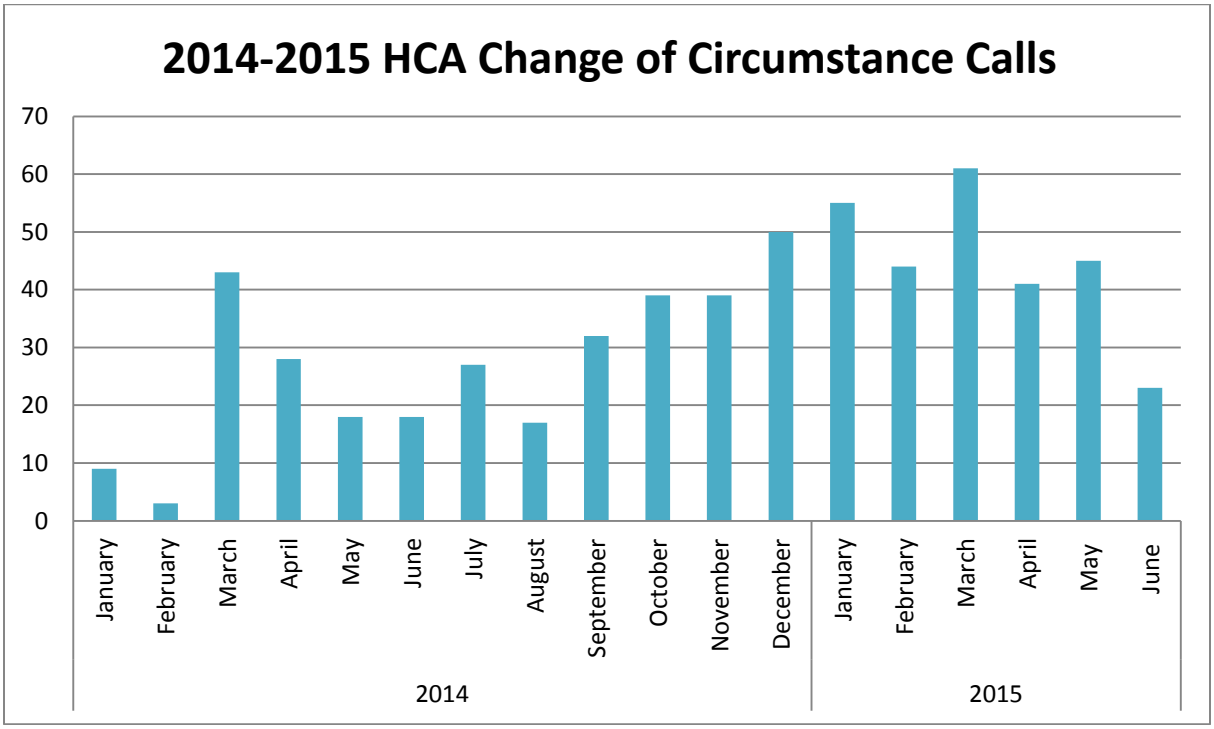
The total number of COC cases fell this quarter from 155 to 109: 41 in April, 45 in May, and June saw a 49% decrease to 23 COC calls! Last quarter the breakdown was: 55 in January, 44 in February, and 61 in March. For the sake of comparison: in all of the April to June quarter last year we only received a total of 64 COC calls, and just 18 in June 2014. The number of COC problems steadily rose after August 2014, to its apparent peak in March 2015. Since March the number of COC calls has been dropping.

VHC deployed the long awaited COC functionality as promised by May 31st. Up until that time all COCs had to be done manually, which was a difficult, time consuming and error prone process. VHC accumulated a large (about 10,000 cases) backlog of COCs which it is now steadily reducing.

Although the new COC functionality was activated starting June 1st, VHC and Member Services staff had to be trained on how to use it. Testing and training continued all through June, and VHC gradually had staff start to use the automated system. By the end of the month the new functionality seemed to be decreasing the number of newly created problems and contributing to our drop in call volume. However, there are still situations where workarounds need to be developed.

Our experience throughout June was that getting many types of COCs completed continued to be very difficult. VHC worked closely with us to expedite access to care and resolve our pending COC cases. We began to have weekly meetings with VHC staff to work through the more complex cases. By the end of June, we slowly started to see the impact of VHC's technology improvements. Some cases that had been "stuck" were finally able to be resolved.

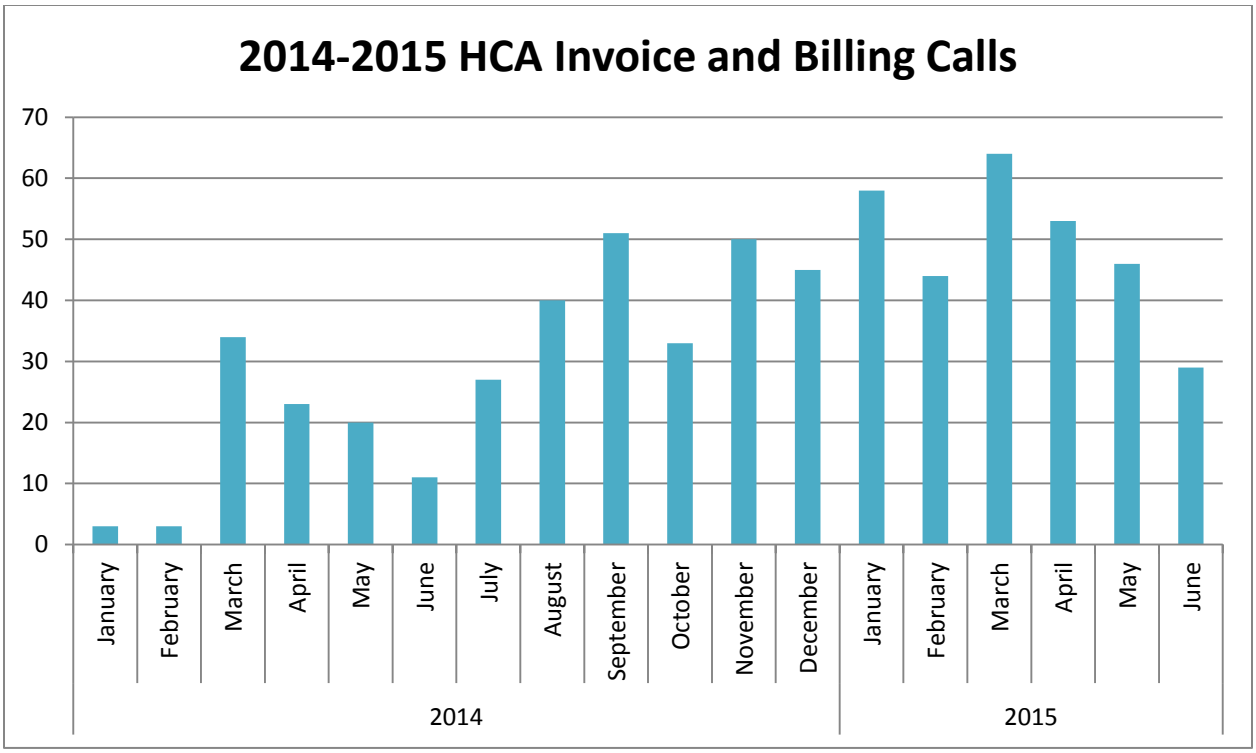
We are cautiously optimistic that in the next quarter we will see continued improvement, and Vermont consumers will, too.



D. Vermont Health Connect invoice, billing and payment problems decreased 22%.

Many consumers who purchased Qualified Health Plans (QHP) from VHC continued to have invoicing and billing problems. This was the number one complaint about VHC. The problems included non-receipt of invoices, multiple invoices in one month, delays in processing, delays in applying premiums to the correct account, delays in actually getting coverage, 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 of these cases involved problems from 2014 that were not completely resolved, and many were related to COC difficulties.

This quarter we received 128 calls involving invoices, billing and premium processing, compared to 164 last quarter, and 125 the quarter before, when primary and secondary issues are counted. In June 2015 we received 29 billing problem calls, compared to 11 in June 2014.



E. The top issues generating calls

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

All Calls 1,008 (compared to 1,367 last quarter)

1. VHC complaints 151 calls (compared to 204 last quarter)
2. VHC Invoice/billing Problem 128 (164)
3. VHC Change of Circumstance 109 (155)
4. Complaints about providers 99 (96)
5. Information about VHC 96 (197)
6. MAGI Medicaid eligibility 79 (101)
7. VHC Premium Tax Credit eligibility 78 (137)
   Information about DVHA programs 78 (122)
8. DVHA/VHC Premium billing 65 (103)
9. Access to Prescription Drugs 58 (87)
10. VHC Renewals 56 (160)
11. Affordability issue that created an access problem 56 (117)
12. Premium Billing 54 (38)
13. IRS Reconciliation consumer education 46 (82)
14. Special Enrollment Periods 43 (43)
15. Grace Periods-VHC 42 (17)

Vermont Health Connect Calls 508 (compared to 706 last quarter)

1. VHC complaints 150 (202)
2. VHC Invoice/Payment/Billing problem 126 (164)
3. Change of Circumstance 109 (155)
4. Information about VHC 91 (196)
5. Premium Tax Credit Eligibility 78 (136)
6. MAGI Medicaid eligibility 65 (94)
7. DVHA/VHC Premium billing 62 (101)
8. VHC Renewals 55 (160)
9. Premiums billing 48 (38)
10. IRS Reconciliation consumer education 46 (82)
11. Grace Periods –VHC 42 (17)

DVHA Beneficiary Calls 298 (compared to 414) last quarter)

1. Information about DVHA programs 46 (58)
2. Complaints about Providers 43 (57)
3. MAGI Medicaid eligibility 37 (39)
4. Medicaid Billing 30 (41)
5. Access to Prescription Drugs 28 (52)
6. Medicaid eligibility 22 (23)
7. Change of Circumstance 21 (19)
8. Affordability 18 (44)
   Information about VHC 18 (21)
9. Balance billing-Medicaid 16 (13)
10. Problem with Medicaid PBM 14 (42) [Note this sharp decline in the complaints about DVHA's new pharmacy benefit manager, although there are still some problems.]

Commercial Plan Beneficiary Calls 350 (compared to 492 last quarter)

1. VHC complaints 105 (129)
2. VHC invoice/payment problem 96 (119)
3. Change of Circumstance 68 (102)
4. Information about VHC 57 (108)
5. DVHA/VHC premiums billing 54 (78)
6. Premium Tax Credit eligibility 47 (81))
7. QHP Renewals 40 (123)
8. Premium billing 38 (38)
   Grace Periods-VHC 38 (17)
9. IRS Reconciliation consumer education 37 (66)
10. Notices-confusing 31 (39)

F. Hotline call volume by type of insurance:

The HCA received 1,008 total calls this quarter. Callers had the following insurance status:

- **DVHA program beneficiaries** (Medicaid, VPharm, or both Medicaid and Medicare aka "dual eligibles") insured **30%** (298 calls), compared to 30% (414) last quarter;
- **Medicare**[2] **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 **18%** (184), compared to 19% (264) last quarter;
- **Commercial plan beneficiaries** (employer sponsored insurance, small group plans, or individual plans) insured **35%** (350), compared to 36% (492) last quarter; and
- **Uninsured** callers made up **8%** (85) of the calls, compared to 11% (150) last quarter.
- In the remainder of calls insurance status was either unknown or not relevant.

G. Dispositions of closed cases

All Calls

We closed 1,065 cases this quarter, compared to 1,340 last quarter.

- 28% (299 cases) were resolved by brief analysis and advice;
- 24% (254) were resolved by brief analysis and referral;
- 26% (278) of the cases were complex interventions involving complex analysis, usually direct intervention, and more than two hours of an advocate's time;
- 16% (168) were resolved by direct intervention, including calling an insurance company, calling providers, writing letters, gathering supporting medical documentation, etc.;
- Just 2 cases were 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: 2 commercial plan appeals, 17 Fair Hearings, 2 VHC expedited internal hearings, 5 DVHA internal MCO appeals and 1 Medicare appeal. Most of our cases involving VHC and DVHA problems are resolved without using the formal appeals process.

DVHA Beneficiary Calls

We closed 329 DVHA cases this quarter, compared to 395 last quarter.

- 30% (99 cases) were resolved by brief analysis and advice;
- 26% (84) were resolved by brief analysis and referral;
- 21% (70) were considered complex intervention, which involves complex analysis, usually direct intervention, and more than two hours of an advocate's time;

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

- 22% (72) 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.
- In the remaining cases, clients withdrew, resolved the issue on their own, or had some other outcome.

- Appeals: 24 cases involved appeals: 17 Fair Hearings, 2 VHC expedited internal hearings, and 5 internal MCO appeals.

Commercial Plan Beneficiary Calls

We closed 381 cases involving individuals on commercial plans, compared to 488 last quarter.

- 27% (104 cases) were resolved by brief analysis and advice;
- 15% (56) were resolved by brief analysis and referral;
- 35% (132) were considered complex intervention, which involves complex analysis, usually direct intervention, and more than two hours of an advocate's time;
- 19% (74) were resolved by direct intervention on the caller's behalf, including advocacy with the carrier and providers, writing letters, and gathering medical information;
- Just one call from a commercial plan beneficiary was resolved in the initial call.
- In the remaining cases clients withdrew, resolved the issue on their own, or had some other outcome.

- Appeals: 2 cases involved commercial plan appeals: one Level 1 appeal, and one Level 2. No external reviews.

H. Case outcomes

All Calls

The HCA helped 102 people get enrolled in insurance plans and prevented 16 insurance terminations or reductions. We obtained coverage for services for 30 people. We got 31 claims paid, written off or reimbursed. We helped 2 people complete applications and estimated VHC insurance program eligibility for 26 more. We provided other billing assistance to 62 individuals. We obtained hospital patient assistance for 1 person. We provided 534 individuals with advice and education. We obtained other access or eligibility outcomes for 103 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 $54,412.07** in cases opened this quarter**.** In SFY 2015, we saved Vermonters **$600,223.56.**

I. Case examples

Here are a few case summaries of the problems we helped Vermonters resolve this quarter:

1. When Ms. A filed her tax return, she learned she owed the IRS $9,000. The IRS said this was because she had received too much Premium Tax Credit (PTC) in 2014 based on her income. The IRS gave her twenty days to respond. In a panic because she did not have the $9,000, Ms. A called the HCA for help. She told the HCA advocate that she had started 2014 on a Qualified Health Plan (QHP) purchased through Vermont Health Connect, and received PTC to help pay the monthly premiums. In the spring of 2014, her husband started a new job that offered insurance, and he added her to his plan. She reported the change to VHC and stopped paying her VHC premiums, but her QHP was never terminated. At the end of the year VHC generated a 1095-A, a tax form which showed which months she had marketplace coverage and the premium tax credit received for each month. Ms. A's 1095-A incorrectly showed that she had QHP coverage and received tax credits for the entire year. She had sent this form in with her tax return, as required. After hearing her story, the HCA advocate contacted VHC and requested retroactive termination of Ms. A's QHP back to when she went on her husband's insurance. The advocate also requested a corrected 1095-A. VHC made the changes and sent Ms. A the corrected Form 1095-A. Ms. A sent the new information to the IRS and did not have to pay the $9,000.

2. A problem with the application of a grace period caused an incorrect coverage termination. Mr. B called the HCA because he did not understand why his QHP had been closed. He had paid late a few times, but knew that he had caught up on all of his monthly premium payments. The HCA advocate reviewed his payment record and found that when he had paid late, he was put into a grace period and never taken out. Individuals who receive premium tax credits get a three month grace period if they make a late payment. The only way to get out of a grace period is to get completely caught up on payments. If at the end of the three months payments are not completely up to date, then coverage can be terminated. When several late payments are made, the status of the grace period can get confusing. The advocate determined that Mr. B had indeed caught up on his payments within the three month grace period, but VHC had not taken him out of the grace period and had incorrectly closed his plan. The HCA advocate contacted VHC and pointed out the error and VHC had Mr. B's coverage reinstated the next day.

3. Ms. C called the HCA because she did not have any health care coverage for the second year in a row. In 2014 Ms. C had paid for insurance for seven months through VHC, but was never able to get the coverage activated. After a lot of back and forth, ultimately

VHC refunded her 2014 premium payments. When she filed her tax return she learned that she had to pay a tax penalty for the months that she did not have insurance. To avoid having this problem again, she tried to sign up for 2015 coverage during the open enrollment period. Because she had some issues with the VHC website, she began to worry that her application might not have actually gone through. She called VHC in March to double check the status of her application and was told that, indeed, she did not have any coverage, and that it was now too late to enroll. She called the HCA. When the HCA advocate investigated, she realized that Ms. C was eligible for a Special Enrollment Period (SEP). Because this was the first year that health insurance was tied to tax liability under the Affordable Care Act , the IRS created a new SEP for individuals who had to pay a tax penalty for not having coverage in 2014. Because Ms. C had had to pay such a penalty, she was eligible for this new SEP. The HCA advocate contacted VHC and argued that Ms. C should have been told about her eligibility for the SEP when she had called to double check her coverage. She requested that Ms. C be given the SEP with an April 1 start date, which is when she would have been able to enroll if she had been properly advised. VHC agreed. Ms. C was relieved that she finally had active coverage after more than a year of trying.

4. Mr. D was in pain and needed surgery, but he had no health care coverage. He called the HCA because he did not know what to do. He had very little income. Although he was over 65, he had not worked enough quarters to qualify for free Medicare Part A. He had not signed up for Medicare Part B either because he could not afford the monthly premiums. He had applied for Medicaid for the Aged Blind and Disabled (MABD), but was denied because he had savings in the bank over the $2,000 resource limit. He was also not eligible for MAGI Medicaid because of his age. When the HCA advocate reviewed his situation, she realized that Mr. D would be eligible for a Medicare Savings Program as a Qualified Medicare Beneficiary (QMB). The MSPs do not have resource limits, which meant that Mr. D's savings would not prevent him from getting on one of the programs. The advocate helped Mr. D fill out another application, and this time he was approved for QMB. QMB covers the costs of Medicare Part A and Part B premiums, Medicare cost-sharing and late-enrollment penalties. With QMB, Mr. D was able to get onto both Medicare Part A and Part B. The MSP also qualified him for a Special Enrollment Period for Part D, so he could get prescription drug coverage. Mr. D will now be able to have his surgery to alleviate his pain.

5. Mr. E called the HCA because he was in debt, and unable to afford care for his many medical conditions. Although he had Medicare, he was struggling to afford the premiums and the cost-sharing. He was over income for MABD, but could not afford a

supplemental plan. Medicare generally covers 80% of medical expenses, but he had to pay the remaining 20%. He was also having trouble paying his Medicare Part B premiums of $104.90 per month. His income was too high to qualify for any of the state programs that would help pay for his Part B premium, the Medicare Savings Programs. In fact, he had been on an MSP but had been terminated from the program because his earned income increased slightly. The HCA advocate realized that Mr. E should have been screened for another program that would cover his cost-sharing and also give him more complete coverage. Because he had a part-time job, Mr. E was eligible for Medicaid for the Working Disabled, which has a higher income limit than MABD. The advocate helped him with the application and requested a rush on it. Mr. E was found eligible for MWD within days. Medicare will continue to cover 80% of his medical expenses, and Medicaid will cover the remaining 20%. Having Medicaid coverage also means that Mr. E can now have some dental coverage which will allow him to start seeing a dentist again, and the cost-sharing savings will make it easier for Mr. E to afford his Part B premiums.

6. Mother has difficulty getting continuous glucose monitor for child with diabetes. Ms. F's school age child had diabetes, and his doctor wanted him to switch from an insulin pump to a continuous glucose monitor. The doctor believed that the new monitor would be better for managing his diabetes. Ms F had been working for almost six months to get the glucose monitor approved by Medicaid. The provider said they submitted the prior authorization request numerous times, but still had not gotten a decision. DVHA was telling Ms. F that it had not received any prior authorization requests. Ms. F felt she was going around in circles so she called the HCA. The HCA advocate contacted DVHA on the family's behalf and asked it to review its prior authorization requests to see if any had been submitted by this provider. DVHA found and approved the prior authorization request that day. Ms. F was finally able to get the new monitor for her child.

J. Recommendations to the State of Vermont

1. Fix the Vermont Health Connect invoice and billing system.

We are still seeing many problems with invoicing and billing. This was the second quarter that the number of invoice and billing complaints exceeded the number of COC complaints. It is not clear whether these problems are due to issues with VHC or Benaissance (VHC's premium processer), or both. In any case, for many people the system is not working well. The problems included non-receipt of invoices, multiple invoices in one month, delays in processing, delays in applying premiums to the correct account, delays in actually getting coverage, 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. Sometimes there is a time lag and lack of accuracy in the transmittal of payment information from VHC to the carriers, which affects whether the carriers are willing to provide coverage. This has become more critical now that all three carriers (BlueCross Blue Shield of Vermont, MVP, and Northeast Delta Dental) are making greater attempts to enforce premium payment grace periods and are terminating coverage more frequently based on payment information from VHC.

VHC should consider eliminating the middleman premium processor, and allowing payment directly to the carriers

2. *Review the carriers' grace period notices and require clarifications and improvements as necessary.*

Consumers have reported confusion about the meaning of the grace period notices they have received when they fail (or VHC or the carriers think they've failed) to make timely premium payments. Grace period notices are sent by the carriers and not VHC, even though VHC is responsible for processing and tracking premium payments. VHC should review these notices and work with the carriers and stakeholders to make sure they are in plain language, clear, and consistent with the Health Benefit Eligibility and Enrollment (HBEE) regulations.

3. *Follow through on the implementation of the proper Federal Poverty Levels for MAGI Medicaid and Dr. Dynasaur.*

This year the State of Vermont did not begin determining eligibility for MAGI Medicaid and Dr. Dynasaur using 2015 FPLs until June 17, 2015.[3] The federal Department of Health and Human Services issued the 2015 FPLs in February. The HCA and the Medicaid and Exchange Advisory Board pressed VHC to implement the new FPLs for several months.

VHC's failure to use the 2015 FPLs until four months after they were issued means that some individuals who may have been eligible for Medicaid and Dr. Dynasaur could have been found ineligible, and may not be getting the benefits to which they are entitled. They could be unnecessarily paying premiums and cost sharing for QHPs, when they could be on Medicaid.

We know VHC is working on how to identify these applicants and make them whole, but we want to make sure it happens as quickly as possible. And, we want to make sure that in the

[3] This delay did not affect the determination of Premium Tax Credits because PTC for 2015 coverage is based on 2014 FPLs. Medicaid for Children and Adults (MCA, aka MAGI Medicaid) uses the current year's FPLs.

future the FPLs are implemented in a timely manner. VHC has said that it will implement the new FPLs by April 1 each year starting in 2016, and we want to make sure that happens as well.

4. *Work with stakeholders to improve and clarify the processes and regulations for eligibility for long term care services and supports.*

As the SOV knows, Vermont Legal Aid had some concerns about the most recent round of Health Benefit Eligibility and Enrollment (HBEE) regulations. At the Legislative Committee on Administrative Rules (LCAR) meeting in June, the SOV agreed to work with us to clarify how eligibility and coverage is supposed to work for all the waiver programs in light of the new HBEE rules. We are mentioning this ongoing effort here as a "recommendation" in order to emphasize the importance of the SOV's commitment to work with us to clarify these eligibility processes and improve the HBEE or other regulations.

III. Consumer protection activities

A. Rate review work

The HCA monitors insurance carrier requests for premium rates, which are usually rate increases. Carriers filed four new rate review cases with the Green Mountain Care Board in this quarter. The HCA entered Notices of Appearance in three of these cases. None of the cases was ready for hearing during the quarter.

We submitted memoranda and the Board issued decisions in four pending rate filings. In all four cases, the Board reduced the requested rates. All of the Board's decisions were consistent with arguments we made for reducing the rates.

The most important pending rate review cases are the two filings for 2016 plans that will be offered on Vermont's exchange, Vermont Health Connect, by Blue Cross Blue Shield of Vermont and MVP. The carriers filed their requests for rate increases on May 15, 2015, and the Board will issue its decisions by August 13, 2015. Hearings are scheduled for July 28 and July 29, 2015 at the Green Mountain Care Board. The HCA has filed Notices of Appearance in both cases.

The HCA has been working closely with its independent actuary, Donna Novak of NovaRest, Inc., to analyze the Exchange filings, suggest questions for the Board's actuaries to pose to the carriers, and to prepare for the hearings.

B. Certificate of Need Applications

The HCA also monitors all the Green Mountain Care Board's Certificate of Need review proceedings. Between April and June of 2015, we primarily participated in two pending CONs as

an interested party: the University of Vermont Medical Center's Replacement of Inpatient Beds and the Northwestern Medical Center's Office Building.

UVMC's Replacement of Inpatient Beds CON went to hearing in May. We prepared for and participated in the two days of hearings. We reviewed and analyzed all the case materials, including the independent architectural report and financial report prepared for the Board. We met with representatives from the Vermont Federation of Nurses and Health Professionals regarding their concerns with the proposed project, and held discussions with representatives from the mental health advocacy community and consumer protection organizations to learn their perspectives on the project. These discussions included Disability Rights Vermont, which the Board gave Amicus Curiae status for the proceedings.

At the UVMC Inpatient Bed CON hearing, the HCA participated as an interested party, including cross examining the witnesses. After the hearing we submitted a post-hearing memo which presented the HCA's analysis of the project. We supported the plan to increase single patient rooms, but stated our concerns that the proposed project would increase costs for patients. We also expressed concern that UVMC did not adequately address the shortage of inpatient psychiatric beds and other shortcomings with the psychiatric unit when it developed this proposal. In addition, we urged the hospital to incorporate staff of all levels and community members in the planning process going forward, and to focus on the community issues stated in its latest Community Health Needs Assessment.

In June, we submitted questions to the Board for Northwestern Medical Center regarding their Office Building CON project. Our questions focused largely on energy efficiency measures, opportunities for staff and community involvement in the planning process, budgetary impacts of the project, the impact of the project on community issues identified in the hospital's latest Community Health Needs Assessment, what services will be provided in the new space, how all space created by the project will be utilized, and how patients can determine their insurance coverage for services out of the emergency room compared to the urgent care center.

C. Other Green Mountain Care Board activities

The HCA continues to participate in the Board's regulatory responsibilities beyond our rate review and CON work. For example:

- The HCA continued to monitor proposed legislative changes to the Board's duties as the legislative session came to a close;
- We submitted formal public comments to the Board on the Vermont Health Care Innovation Project (SIM grant) self-evaluation process. We suggested a number of ways in which the self-evaluation plan could improve its consumer component and include a broader range of consumer voices. The Board incorporated our suggestions into the plan that it passed, contingent upon renegotiation of the scope of work with the evaluation contractor.
- We also submitted formal comments suggesting changes to the Board's website. Our comments focused on ways the Board can make it easier for consumers to access

information about the Certificate of Need and Rate Review processes through the website. The Board says it is in the process of working on its website to incorporate our suggestions.

- We attended seven weekly Green Mountain Care Board meetings, reviewed the video recording from two Board meetings that we could not attend, met with the Board's staff to discuss current health care legislation proposals and other consumer protection priorities, and attended three Data Governance Committee meetings.

D. Vermont Health Care Innovation Project

The HCA continues to participate in the Vermont Health Care Innovation Project (VHCIP), which is funded by Vermont's State Innovation Model (SIM) grant. This quarter we:

- Participated in 3 meetings as a member of the VHCIP Steering Committee
- Participated, along with representatives from other projects of Vermont Legal Aid, as "active members" in 6 of the 7 VHCIP work groups:
    - Payment Models Work Group
    - Quality and Performance Measures Work Group
    - Population Health Work Group
    - Care Models and Care Management Work Group
    - Disability and Long Term Services and Supports Work Group
    - Health Information Exchange/Health Information Technology Work Group
- Attended 12 VHCIP work group meetings
- Attended 4 meetings of the VHCIP Core Team as an interested party
- Attended 1 meeting of the SIM Self-Evaluation Committee and 2 informal meetings with SIM staff about the self-evaluation plan
- Attended the VHCIP Symposium (sub-grantee reports)
- Attended the VHCIP Convening about the grant's year 2 milestones and plans for their achievement
- Completed an evaluation interview with RTI, the contractor completing the federal evaluation of Vermont's SIM grant

E. Affordable Care Act Tax-related Activities

The federal Affordable Care Act made tax law newly important to effective health advocacy. It imported tax concepts into Medicaid, created a new federal tax credit to subsidize private health insurance purchased through health benefit exchanges, and created a tax penalty for failure to have insurance coverage. In October 2014, the HCA partnered with the Low Income Taxpayer Project at Vermont Legal Aid to engage in education, outreach, and advocacy relating to the Affordable Care Act. This partnership continued during the reporting period.

During this quarter, the HCA continued to employ a half-time tax attorney, who also staffs the Low Income Taxpayer Project at VLA. This allowed the HCA to stay up to date on legal

developments and educate our staff to effectively field calls related to the ACA and Vermont Health Connect. In addition, the tax attorney consulted with HCA advocates when particularly difficult tax issues arose in HCA cases.

In 2015 we saw the first tax season where consumers had to report to the IRS on their health insurance coverage and reconcile any advance payments of the Premium Tax Credit (APTC). Vermont Health Connect (VHC) and other health insurance marketplaces sent tax form 1095-A to consumers and to the IRS. Form 1095-A reports the details of a person's health insurance coverage and the details of any advance payments of the Premium Tax Credit (APTC).

It was a rocky start for the new tax form, as detailed in HCA's previous quarterly report. Many 1095-A forms arrived late or were incorrect. Some consumers discovered when they got their 1095-A that VHC had not processed a coverage change or a plan cancellation that they'd requested in 2014. VHC staff worked hard to correct mistakes as quickly as possible, but the problems were numerous and in some cases difficult to fix. The HCA helped many consumers get account changes made and get amended tax forms from VHC. Still, some people had to file extensions, and some had their tax return processing held up.

A second problem also emerged. Since a person's APTC was based on projected 2014 income, which may have been estimated as early as October 2013, many discovered that they received too much or did not qualify for APTC at all. One Vermont consumer who called the HCA had to repay over $10,000 in subsidies. Many people could not afford to pay their bill by April 15.

The IRS issued FAQ and two different forms of penalty relief to address these problems. First, IRS announced late payment forgiveness for some people who got too much APTC. Later, IRS posted FAQ and announced late payment forgiveness for people whose taxes were affected by a late or incorrect 1095-A. The HCA and Vermont Legal Aid's Vermont Low Income Taxpayer Project (LITP) developed two simple handouts to help people see if they qualify and request penalty relief if they do. When printed double-sided, the handout has instructions on one side and a form letter that clients can use on the other. These handouts are posted on the Health Insurance, Taxes and You page of Vermont Law Help (click on Late Payment Penalties).

During this quarter, the HCA frequently answered tax-related questions from VHC, tax preparers, health assisters, advocates in other states, Congressional caseworkers, and from Vermont consumers. The volume of questions addressed to the tax attorney was lower than last quarter, but still significant (64 compared to over 100 last quarter). This quarter, many of the questions involved Form 1095-A, IRS tax return processing and audit procedures, the advance Premium Tax Credit allocation rules, or the Individual Shared Responsibility Payment. Several consumers received IRS notification that their tax return could not be processed due to issues related to advance payments of the Premium Tax Credit (APTC). Some of these cases involved consumer error, e.g. a child who was named on a 1095-A unbeknownst to the parent claiming that child, and some cases involved late or incorrect forms 1095-A. Other cases were flagged by the IRS for APTC allocation issues, even where the tax return and 1095-A were correct.

The HCA tax attorney also consulted frequently with the HCA advocates as they assisted individuals with ACA tax questions and problems.

To address consumers' confusion and misunderstanding of the tax implications of the Affordable Care Act, the HCA engaged in a significant number of outreach and education activities. They are detailed below in the Outreach and Education section.

HCA continued to communicate with VHC regarding substantive issues as they arose. This quarter, one major issue was the effect of retroactive 2014 account changes on Forms 1095-A (and thus consumers' tax returns). VHC had not finished its 2014 change of circumstances backlog at the time the initial Forms 1095-A were generated, and this issue continued through the current quarter as VHC initiated retroactive coverage terminations in April and May. HCA participated in weekly 1095-A stakeholder calls through April. We also continued our advocacy on proposed revisions to DCF's Health Benefits Eligibility and Enrollment Rule, which implements the Affordable Care Act in Vermont.

F. Other Activities

Blog Post on Penalty Relief and Premium Tax Credit Reconciliation
The HCA's tax attorney authored a blog post, edited by Villanova Tax Professor T. Keith Fogg, on the IRS's penalty relief policy for individuals who received excess advance payments of the Premium Tax Credit (APTC). The post appeared on the tax procedure blog *Procedurally Taxing.* In it, the HCA criticizes the IRS's policy for its complexity and describes the barriers that may prevent deserving consumers from getting relief. The blog post also suggests improvements that could be made to the policy.

Rule 09-03 Work Group
The HCA is one of the stakeholders participating in this work group which was set up in Act 54 of the 2015 legislative session. The work group will help the Agency of Administration, the Green Mountain Care Board and the Department of Financial Regulation evaluate the necessity of maintaining provisions for regulating insurers in Rule 09-03, which contains consumer protection and quality requirements for managed care organizations, and in other regulations governing quality and consumer protection. The group will also assess which state entity is the appropriate one to be responsible for functions set forth in the regulations. The group held its first meeting during the quarter.

2017 Qualified Health Plan Work Group
The HCA is participating in this stakeholder group which was convened by the Department of Vermont Health Access to help DVHA develop any recommended changes to benefit design for Qualified Health Plans offered on Vermont Health Connect in 2017. The group met three times during the quarter.

Other Boards, Task Forces, and Work Groups
This quarter the HCA participated in:

- 2 meetings of the Gateways national consumer advocacy group for state-based marketplaces
- 3 Qualified Health Plan Stakeholder Work Group meetings
- 3 Medicaid and Exchange Advisory Board (MEAB) meetings
- 1 MEAB Improving Access Work Group meeting (a subgroup of the MEAB which works on improving access to Medicaid services, which the Chief Health Care Advocate Chairs)
- 3 MEAB Individuals and Families Work Group meetings
- 1 informal meeting with Donna Sutton Fay and Jackie Majoros about the MEAB
- 1 VHC Consumer Experience Work Group meeting
- 1 VHC Customer Support meeting with Maximus, VHC, DVHA and HAEU
- 1 meeting about VHC tax issues
- 1 Health Insurance Consumer Protection 09-03 Review Work Group meeting

Legislative Activities
This quarter the HCA actively advocated for the following legislative initiatives:

- An act relating to notification of individuals placed in hospital observation status
- An act relating to establishing and regulating dental therapists
- An act relating to surrogate decision making for do-not-resuscitate orders and clinician orders for life-sustaining treatment
- An act relating to health care

Additionally, HCA staff consistently monitored the activities of legislative committees that took up issues related to health care and health reform.

This quarter, HCA staff:

- Testified before legislative committees 9 times
- Submitted 1 set of written comments/testimony
- Met informally with legislators about legislative initiatives
- Regularly met and collaborated with other advocates on legislative initiatives, including participation in the Surrogate Decision Making working group and the Oral Health Care for All legislative team
- Met with the Speaker of the House regarding access to oral health care
- Attended:
    - 5 meetings of the Senate
    - 4 meetings of the House of Representatives
    - 1 meeting of the House Democratic Caucus
    - 4 meeting of the House Committee on Appropriations
    - 12 meetings of the House Committee on Health Care
    - 1 meeting of the House Committee on Human Services
    - 7 meetings of the House Committee on Ways and Means
    - 4 meetings of the Senate Committee on Appropriations

- 6 meetings of the Senate Committee on Finance
- 1 meeting of the Senate Committee on Government Operations
- 6 meetings of the Senate Committee on Health and Welfare

Administrative Advocacy

This quarter, the HCA:

- Submitted 1 formal comment on VHC's Special Enrollment Period rules
- Raised 3 substantive legal issues with AHS regarding proposed final VHC regulations in Bulletin B15-02FP
- Participated in weekly 1095-A check-in phone calls

This quarter, the HCA:

- Submitted formal comments on VHC regulations
- Met with VHC about implementation of 2015 federal poverty levels
- Met with VHC about the escalation path for cases
- Participated in 2 Health Insurance Marketplace Statement (1095-A) calls
- Corresponded with AHS policy analysts about the proposed HBEE rule and successfully advocated for changes to the rule
- Advocated for policy changes on VHC tax issues
- Discussed VHC policies and practices regarding plan reinstatement and IRS reporting (1095-As) for certain 2014 QHPs

Collaboration with other organizations

The HCA worked with the following organizations this quarter:

- American Bar Association Section of Taxation, Individual and Family Tax Committee
- American Civil Liberties Union (ACLU)
- Campaign for Health Care Security
- Community Catalyst
- Community of Vermont Elders
- Disability Rights Vermont
- Families USA
- IRS Affordable Care Act Office
- IRS Office of Chief Counsel
- IRS Taxpayer Advocate Service
- Peoples Health and Wellness Clinic
- Planned Parenthood of Northern New England
- Vermont Association of Hospitals and Health Systems
- Vermont Oral Health Care for All Coalition
- Vermont Campaign for Health Care Security
- Vermont Dental Hygienists' Association
- Vermont Health Connect
- Vermont Information Technology Leaders
- Vermont Low Income Advocacy Council (VLIAC)

- Vermont Public Interest Research Group
- Vermont Technical College
- Villanova Law School
- Voices for Vermont's Children

Trainings

- 5/1: Consumer's Union Provider Payment Reform Webinar
- 5/12: Consumer's Union Rate Review Conference Call
- 6/5: Legislative Advocacy Training at Vermont Legal Aid Staff College
- 6/22: Legislative Council Vermont Legislative Review
- 6/22: Community Catalyst Hospital Billing Rules Webinar

IV. 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 78% in the reporting quarter ending March 31, 2015 (5,252 pageviews), compared with the same quarter in 2014 (2,952 pageviews).
- Like last quarter, the number of people seeking information about dental services increased significantly (306%) over last year. (191 pageviews this quarter, compared with 47 in the same period last year)
- This quarter, again like last quarter, showed a huge increase over last year in the number of people seeking information about Medicaid income limits (1,366 pageviews this quarter, compared with 86 in the same quarter in 2014, an increase of 1,488%). We believe that search engines are delivering this page as a high-ranking source of information about Medicaid income limits.
- Nine of the 15 pages that had the largest number of pageviews focus on Medicaid or long-term care Medicaid (Choices for Care) topics.
- Other topics presented in the top 15 pageviews include:
    - Health home page (+52%)
    - Health Insurance, Taxes and You (New this year/no comparative data)
    - Medical Decisions, Advance Directives and Living Wills (+53%)

- Buying Prescription Drugs (+132%)
- Complaints (things to consider before making a complaint against a provider) (+113%)

PDF Downloads
Thirty-eight out of 76 PDFs downloaded from the Vermont Law Help website were on health care topics. Of those 38 PDFs:

- 21 were created for consumers. The top consumer-focused downloads were:
  - Advance directive, short and long forms
  - Vermont dental clinics chart
  - Advance Premium Tax Credit (APTC) IRS penalty waiver request letter template with instructions
- 11 were prepared for lawyers, advocates and assisters who help consumers with health care matters, including tax issues related to the Affordable Care Act. The top advocate-focused downloads were:
  - Low-Income Taxpayers and the Affordable Care Act, Nov 2014
  - Tax Issues for Health Assisters Form 8965 Example
- 6 covered topics related to health policy. The top advocate-focused downloads were:
  - Accountable Care Organizations - What is the Evidence?
  - Health Literacy and Plain Language

Our Vermont Dental Clinics Chart was the seventh most downloaded of all PDFs, not limited to health, and our policy paper, Accountable Care Organizations – What is the Evidence?, was ninth.

B. Education

During this quarter, the HCA provided education materials, presentations, and public service announcements both directly to consumers and to individuals and organizations who serve populations that may benefit from the information and education provided. The materials we developed have been shared with health and tax advocates in Vermont and nationwide, and posted to our website.

Flyers, Letter Templates, Other Printed Material
In April, we developed a simple, easy-to-understand template letter that consumers can use to request IRS late-payment-penalty relief resulting from the inability to repay excess Advance Premium Tax Credit (APTC) payments by the April 15 deadline.

We wrote an article that was published in the April issue of Vermont Legal Aid's newsletter, *Justice Quarterly*, which explained the requirement to pay back excess APTC. The article included a link to the template letter consumers can use to request abatement of late payment penalties.

Also in April, the HCA wrote a guest post, *Penalty Relief and Premium Tax Credit Reconciliation*, on a widely read tax procedure blog, Procedurally Taxing.

In June, we produced another simple, easy-to-use template letter that consumers can use to request IRS late-payment-penalty relief. In this case, the letter assists those who were unable to pay their taxes by the April 15 deadline because they did not receive the required 1095-A form on time or because the form they received was wrong.

Presentations

During this quarter, the HCA provided education to more than 100 individuals who serve populations that may benefit from the information and education provided.

Fletcher Free Library (May 4)
The HCA presented at an outreach event for nonprofit and social service agencies offered by navigators from Planned Parenthood of Northern New England and the Vermont Campaign for Health Care Security Education Fund. One staff person from an addiction recovery center attended the program, which provided current information about who can enroll in VHC, how to apply, and how the HCA can help.

American Bar Association Tax Section Meeting (May 8)
The HCA's tax attorney collaborated with the IRS Taxpayer Advocate Service, IRS Office of Chief Counsel, and IRS Wage & Investment's Office of Program Coordination & Integration to present ACA: Implementation Issues Affecting Individuals and Families. The presentation, sponsored by the Individual and Family Taxation Committee, was given to 40 tax attorneys and tax professionals at the May meeting of the ABA Tax Section. Topics included tax assessment and collection issues related to the Premium Tax Credit and the Individual Shared Responsibility penalty, controversy issues for practitioners, IRS communications and partner resources, and the Taxpayer Advocate's leading concerns. The presentation PowerPoint was posted on the VT Law Help public website.

Vermont Tax Professionals Association (May 19)
The HCA announced resources available on HCA's "ACA for Assisters" site and encouraged referrals to the HCA at the May meeting of VTPA, attended by 59 CPAs, enrolled agents, unenrolled tax preparers, and attorneys.