

Vermont Legal Aid

Office of the Health Care Advocate

Quarterly Report

January 1, 2017-March 31, 2017

to the

Agency of Administration

submitted by

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Office of the Health Care Advocate



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CONTENTS

Introduction	1
Individual Consumer Assistance	2
Overview	2
Highlights	3
Case Examples	4
Priorities	6
Case Results	12
A. Dispositions of Closed Cases	12
A. All Calls Case Outcomes	13
Consumer Protection Activities	13
A. Rate Reviews	13
B. Certificate of Need	14
C. Other Green Mountain Care Board Activities	14
D. All-Payer Model	15
E. Vermont Health Care Innovation Project (SIM Grant)	15
F. Affordable Care Act Tax-related Activities	15
G. Other Activities	16
Outreach and Education	18
A. Website	18
B. Education/Outreach	20
C. Promoting Plain Language in Health Communications	20

Introduction

The Office of the Health Care Advocate (HCA) provides individual consumer assistance as well as consumer advocacy on issues related to health insurance and health care. We 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 to promote improvements in health care access, quality and affordability.

Helping Vermonters navigate Vermont Health Connect (VHC) has been a significant task for the HCA over the last 3 and a half years. This report shows continued improvement at VHC. VHC calls, however, still represent 40% of the calls to the HCA, and the number of consumer calls for help at the HCA has not returned to pre-VHC levels.

During this time period, the HCA has also seen increased usage of our website, particularly the Medicaid eligibility pages. It is clear to us that there are many Vermonters who have real struggles with access to care, but who do not know about our services. We continually assess how to best reach more Vermonters.

This continues to be a precarious time for consumers, health care providers, and carriers given the ongoing discussions at the federal level of possible repeal of the ACA, changes to Medicaid funding, and administrative changes that could have a real impact on Vermonters. We regularly receive calls from Vermonters who express anxiety about how these possible changes will affect their families' access to care. Today's uncertainty has an impact on Vermont consumers and makes the role of the HCA even more essential.

A key strength of the HCA is our continued support for Vermonters through individual advocacy as well as at the legislative and administrative policy level. We are able to provide policy makers with feedback informed by our daily work with Vermonters facing challenges accessing the care they need such as Lisa's experience described in the case narrative above. We work to control unnecessary costs and make the health care system sustainable, and to ensure that Vermont consumers are heard by providers and policy-makers.

Lisa's Story

Lisa called the HCA in a panic. She was on Medicaid, but VHC had withdrawn the full cost of a Qualified Health Plan (QHP), over \$500, from her bank account. The withdrawal amounted to over half of her monthly income and overdrew her checking account. She was left without enough money to pay for rent or food.

Lisa had been enrolled in a QHP with Premium Tax Credit (PTC), paying about \$30 a month for her premium. When she transitioned to Medicaid, her QHP was supposed to close but that did not happen. Lisa had been paying for her QHP with automatic withdrawal from her bank account. Because her QHP was still active and she was no longer eligible for PTC due to her Medicaid coverage, VHC withdrew the full premium payment for the QHP.

Lisa was told that it would take 4 to 6 weeks to get her payment refunded. She could not afford to wait that long. The HCA spent over 8 hours investigating Lisa's case and advocating on her behalf. Ultimately, we were able to help Lisa get her QHP closed and expedite the refund.

The full quarterly report for January 1 – March 31, 2017 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**: 978 calls (compared to 883 last quarter)
 - **Department of Vermont Health Access (DVHA) beneficiaries**: 274 calls (269 calls last quarter)
 - **Commercial plan beneficiaries**: 223 calls (178 calls last quarter)
 - **Uninsured Vermonters**: 110 calls (127 calls last quarter)
 - **Vermont Health Connect (VHC)**: 393 calls (360 calls last quarter)
 - **Reportable Activities (Summary & Detail)**: 106 activities and 17 documents (75 activities, 15 documents)

Individual Consumer Assistance

Overview

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

The HCA received 978 calls¹ this quarter. We divided these calls into five issue categories. The figures below are based on the All Calls data. The percentage and number of calls in each issue category, based on the caller’s primary issue, were as follows:

- **21.78 %** (213) about **Access to Care**
- **11.96%** (117) about **Billing/Coverage**
- **3.17%** (31) about **Buying Insurance**
- **11.86%** (116) about **Consumer Education**
- **28.73%** (281) about **Eligibility** for state and federal programs
- **22.49%** (220) 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

¹ The term “call” includes cases we get through the intake system on our website.

281 of our cases had as the primary issue eligibility for state and federal healthcare programs, a total of 486 cases had eligibility listed as a secondary concern.

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. Determining which issue is the “primary” issue is sometimes difficult 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 breakdowns 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.

Highlights

- ✦ Total hotline call volume increased (978 this quarter vs. 883 last quarter).
- ✦ The HCA advised on 31 appeals this quarter. Of the 31 appeals, 22 were fair hearings.
- ✦ The HCA saved consumers \$46,785.61 this quarter.
- ✦ The HCA successfully advocated for implementation of Medicaid’s new, less-restrictive coverage criteria for hepatitis C. Medicaid’s Drug Utilization Review Board (DURB) voted in December to recommend covering treatment for patients with less severe liver disease, and for patients regardless of their substance use history, and DVHA accepted the DURB’s recommendations. This quarter, DVHA implemented the new criteria, allowing more Vermonters to access curative treatments for hepatitis C.
- ✦ The HCA assembled a stakeholder group of representatives from payers, provider organizations and consumer groups as well as representatives from the Scott Administration, to facilitate better communication for the purpose of understanding each organization’s positions on prospective policies on both the State and Federal level. This group has been meeting weekly during the second half of the legislative session.
- ✦ The HCA continued to promote the use of plain language in VHC notices, so the information is more accessible and understandable to consumers. The HCA provided comments on plain language and content on 10 different VHC notices.
- ✦ The total number of health pageviews increased by 27% in the reporting quarter ending March 31, 2017 (11,839 pageviews), compared with the same quarter in 2016 (9,322 pageviews). This is especially noteworthy because traffic to the Vermont Law Help website as a whole was nearly even when compared with the same period last year.
- ✦ The Health home page again had the second largest number of pageviews (1,182), slightly higher than last year’s 1,040. The home page tells consumers how we can help them and provides several ways to contact us, including an online form that can be filled out and submitted 24/7.
- ✦ In this quarter, as in the previous six quarters, we saw a large increase in the number of people seeking information about Medicaid Income Limits (3,960 pageviews this quarter, compared with 2,639 in the same quarter in 2016 – an increase of 50%). The consistently high numbers indicate that search engines are delivering this page as a high-ranking source of information about Medicaid income limits, and are indicative also of the increasing age of Vermont’s population.

Case Examples

These case summaries illustrate the types of problems we helped Vermonters resolve this quarter:

Anne recently immigrated to the United States and was living with her son. She suddenly became ill and had to go to the Emergency Room. She had almost no monthly income and no way to pay her bills. When she applied with Vermont Health Connect (VHC), she was told she was not eligible for Medicaid. VHC also told her that she was not eligible for a Premium Tax Credit (PTC) to help reduce the cost of her insurance coverage. This would mean that she would need to pay the full cost of a plan by herself—which would be nearly \$500 a month for a silver plan. She could not afford to do this, so she called the HCA for help. VHC had been correct when they told Anne that she was not eligible for Medicaid. A rule called the “five year bar” generally means that qualified lawful immigrants like Anne are not eligible to get Medicaid for a five-year waiting period. VHC had been wrong, however, when they told her she was not eligible for PTC. The HCA advocate showed that the “five year bar” did not apply to Anne’s eligibility for PTC. This meant that Anne was eligible to get PTC to help reduce her monthly costs. The HCA asked VHC to screen her again for PTC. VHC found her eligible, and the final cost of her plan was less than \$25 per month.

When Charlie received his health insurance bill for January 2017, it was over a thousand dollars, almost double what he had been paying. Charlie could not afford to pay the bill, and his family was in danger of losing health insurance for non-payment. The HCA discovered that VHC had removed Charlie’s subsidies because IRS data showed he had not filed his 2015 taxes. (People with subsidized health insurance must file their taxes to keep getting subsidies.) HCA determined the information that the IRS sent to VHC had not been accurate. Charlie had filed his taxes well before the deadline. Charlie’s case was not unusual. A recent Treasury Department study of the 2016 open enrollment period found that the IRS provided erroneous data about tax filing in 25% of the cases reviewed. (See <https://www.treasury.gov/tigta/auditreports/2017reports/201743022fr.pdf>) This erroneous data can delay or prevent an individual from getting the subsidies that they are eligible for. The HCA advocate showed VHC that Charlie had filed his taxes in time, and was able to get his subsidies reinstated for January.

Denise was at the pharmacy to pick a prescription for her son’s ear infection, and she was told by the pharmacist that Dr. Dynasaur (Dr. D) was not active. She could not afford to pay for the medication. When the HCA advocate investigated, he found that Dr. D had been closed for several months because Denise had not completed the renewal application. The advocate discovered, though, that Denise had tried to complete the application. The first time she had tried to do it on the phone, her call had been cut off. She had completed the application on a second try, but that application had not been processed yet. The HCA was able to get the application processed quickly and Dr. D re-activated. In the meantime, Denise was able to tell the pharmacist that Dr. D was being activated, and the pharmacy gave her a partial fill of the prescription. This meant that Denise’s son was able to get his medication right away.

Frank called the HCA because he did not have any insurance. He had been on a Qualified Health Plan (QHP) with VHC, but his income had dropped. Because he was unable to pay the premiums, his coverage had closed. When Frank tried to apply for Medicaid he was told he would be eligible. But he did not receive any documentation confirming that he was insured. When the HCA called to

check on the application, it discovered that VHC was erroneously counting income from a job that Frank no longer had. The HCA was able to correct the error, and get Frank's application expedited. He was found eligible for Medicaid back to January when he had originally applied. While Frank was uninsured, he had been paying for prescription and medical costs out of pocket. Now that he had Medicaid he was able to ask providers to re-bill Medicaid and get that money reimbursed.

Gerry called the HCA because she had received a notice saying her V-Pharm was closing at the end of the month. She would not be able to afford her medication without it. When the advocate looked into it, she found that Gerry had already paid for the next month's V-Pharm. However, she had been delayed in sending in her renewal paperwork and had missed the deadline. Gerry lived by herself and had difficulty doing paperwork on her own; she had needed someone to assist her with the paperwork, but had not been able to get help before the deadline. The HCA explained the circumstances to the State of Vermont, which agreed to extend Gerry's V-Pharm by one month. This gave her time to complete the application so she was able to afford her medication.

Victor called the HCA because he needed to get bloodwork but had no insurance coverage. He had received a transplant and needed medication and monitoring to make sure that he was healthy. The HCA advocate researched the problem and found that Victor had been on Medicaid until his income went over the Medicaid limit. Victor had met with a navigator and had completed a VHC application for a Qualified Health Plan (QHP), doing everything except the last step of enrolling in a plan. At that point, however, the navigator stopped answering Victor's calls, and failed to call VHC to enroll him in the plan that they had selected. The HCA advocate argued that Victor was eligible for a special enrollment period because of the navigator's error. VHC granted the special enrollment period. The HCA was able to help get Victor on a QHP with a Premium Tax Credit (PTC), which meant that Victor did not have any interruption in his medical care.

Beth discovered that she did not have any health care coverage when she received a large bill from her provider. By that time her coverage had been closed for months, and she had missed her chance to enroll in her employer's plan. The HCA reviewed Beth's history and found that Beth's Medicaid had been closed without any advance notice. VHC is required to send Medicaid beneficiaries a notice before they close their Medicaid. Because of the lack of notice, the HCA advocate argued that VHC needed to reinstate the Medicaid. VHC agreed and reinstated Beth's Medicaid coverage. Beth was able to ask her provider to re-bill Medicaid for that time period. This meant she would not owe the large bill to her provider. When VHC reviewed Beth's eligibility again and found that she was over-income for Medicaid, they sent a proper and timely notice. Beth was able to take that notice to her employer and enroll in her employer's plan.

[Back to Table of Contents](#)

Priorities

A. The HCA's overall call volume increased this quarter.

Total call volume was higher than last quarter (978 vs. 883). Our call volume is usually high from January to March because most healthcare plans end on December 31, with a new plan year starting on January 1. The renewal process can trigger problems. We also had calls related to VHC's open enrollment period which ended on January 31 as well as a jump in calls related to tax issues.

	All Calls (2007-2017)										
	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
January	280	309	240	218	329	282	289	428	470	411	340
February	172	232	255	228	246	233	283	304	388	511	330
March	219	229	256	250	281	262	263	451	509	416	308
April	190	235	213	222	249	252	253	354	378	333	-
May	195	207	213	205	253	242	228	324	327	325	-
June	254	245	276	250	286	223	240	344	303	339	-
July	211	205	225	271	239	255	271	381	362	304	-
August	250	152	173	234	276	263	224	342	346	343	-
September	167	147	218	310	323	251	256	374	307	372	-
October	229	237	216	300	254	341	327	335	311	312	-
November	195	192	170	300	251	274	283	306	353	287	-
December	198	214	161	289	222	227	340	583	369	284	-
Total	2560	2604	2616	3077	3209	3105	3257	4526	4423	4237	978

B. Vermont Health Connect call volume increased 9% compared with last quarter. The increase was likely due to the Open Enrollment Period which ended on January 31, 2017.

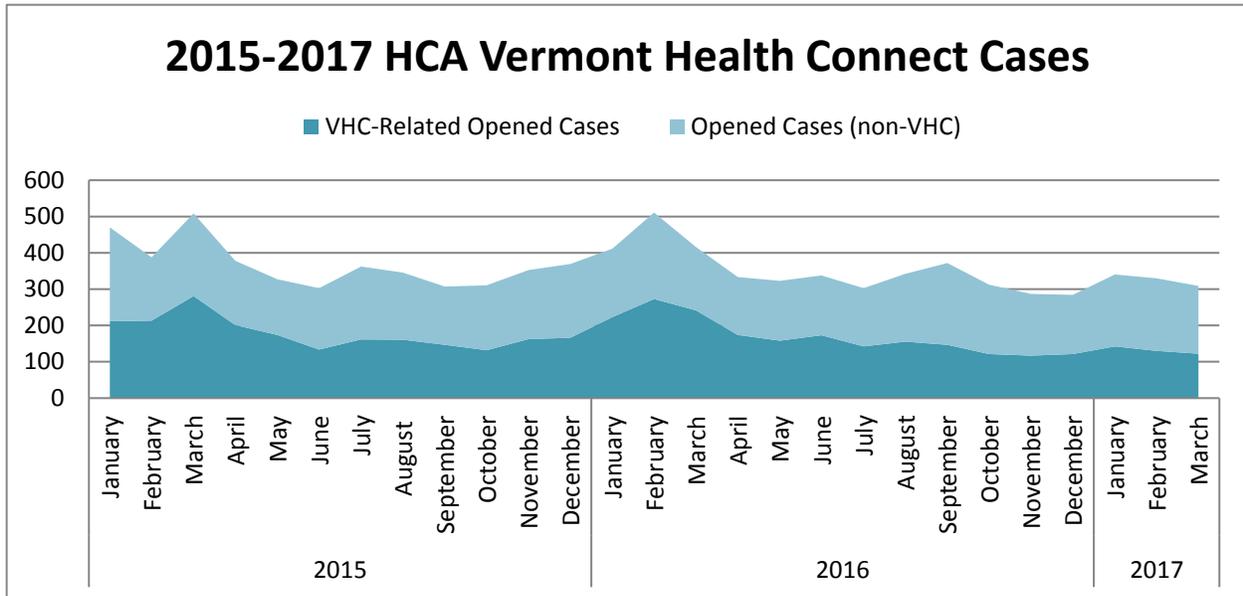
VHC call volume increased 9% this quarter compared to the previous quarter (393 vs. 360). With Open Enrollment closing at the end of January, consumers were calling about eligibility and plan selection. The HCA also had an increase of tax calls this quarter, as consumers started to file their taxes. The call volume for the quarter, however, represented a 46% decrease from the same quarter last year (393 vs. 737). This decrease in VHC cases reflects that VHC is functioning better and more consistently.

Even though VHC call numbers dropped from 2016, consumers are still having difficulties. The HCA had 64 calls this quarter about VHC complaints, and 50 calls about mistakes made by the VHC eligibility unit. Overall 29% of our VHC cases this quarter involved a mistake or complaint (114 calls about a mistake or complaint vs. 393 total VHC calls).

VHC cases still represent 40% of all HCA calls. Of all VHC cases, 30% required complex interventions that took more than two hours of an advocate's time to resolve (116 complex interventions out of 393 total VHC cases). We remain concerned about consumers who are trying to navigate VHC to resolve problems on their own.

The HCA continues to resolve its cases by working directly with a Tier 3 Health Access Eligibility Unit (HAEU) worker, who is trained to resolve all aspects of complex cases. In addition, the HCA meets with

VHC each week to discuss cases as needed, and has regular email contact with Tier 3. During the first quarter of 2016, before the escalation path was launched, the HCA was carrying 75-80 complex cases per week. That number gradually decreased to 40-50 per week, and now, because the new escalation process allows complex cases to be resolved more quickly and efficiently, the HCA generally carries fewer than 20 unresolved complex cases per week. This quarter, the HCA escalated 52 complex cases, and 44 were resolved within the quarter.



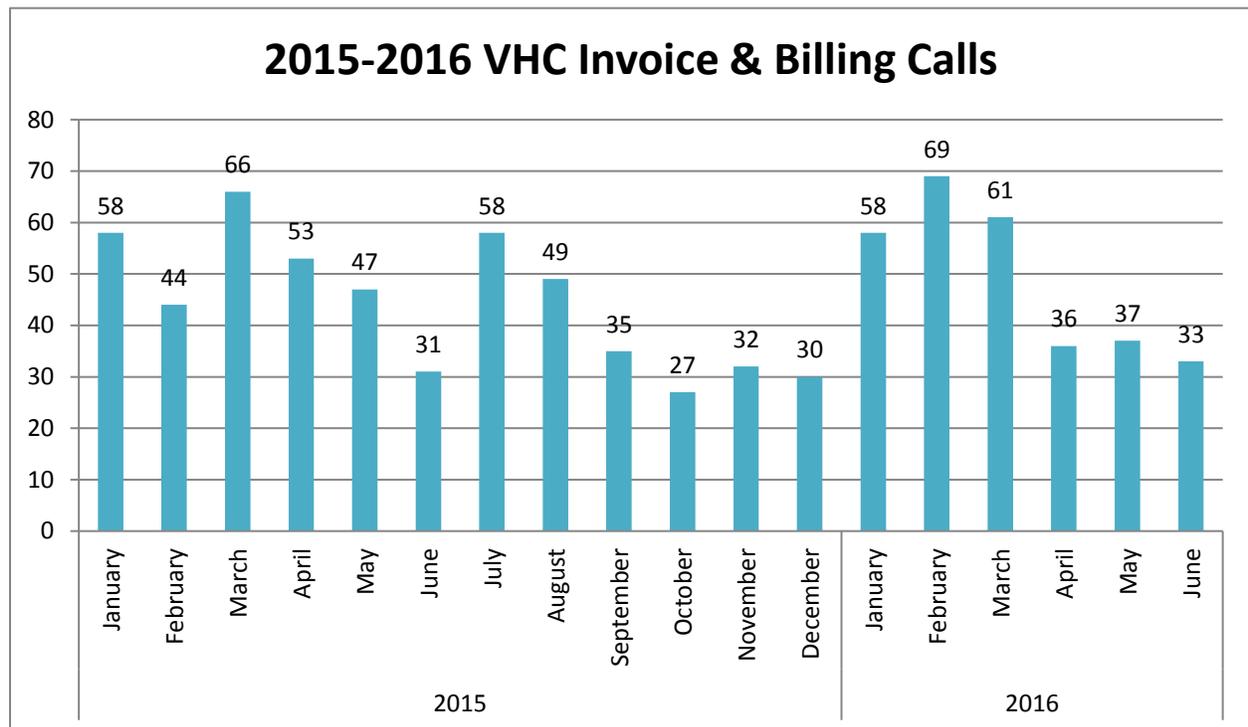
C. With the start of tax season, calls about tax issues increased. Tax calls represented 36% of all VHC calls (142 out of 393 total VHC calls).

The HCA advises consumers on multiple tax issues related to the Affordable Care Act. These calls are complex and represent a significant portion of our VHC calls. We had 33 calls about general tax questions related to the Affordable Care Act, and 41 calls specifically about reconciliation (74 calls this quarter vs. 52 last quarter). Reconciliation is the process by which consumers must figure their actual Premium Tax Credit (PTC). If too much PTC was received from VHC, consumers must pay the IRS some or all of the excess they received.

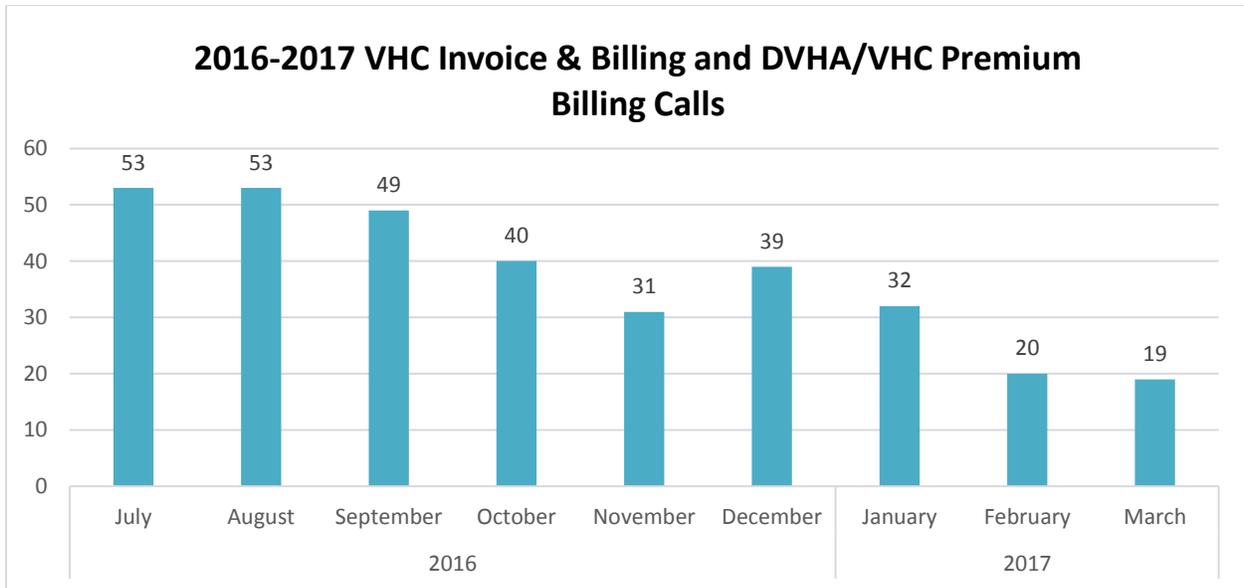
The HCA received 30 calls about the Individual Shared Responsibility Payment (ISRP), which consumers may have to pay for not having healthcare coverage (30 this quarter vs. 23 last quarter). In addition, we started to see more calls concerning Form 1095-A problems (38 this quarter vs. 11 last quarter). 1095-A is the tax form that documents the months a consumer had private insurance through VHC, and the advance PTC they received. If the form is not accurate, it can unfairly increase a consumer’s tax liability.

D. Vermont Health Connect invoice and premium cases decreased by 40%.

VHC continued to improve its ability to generate accurate and timely invoices and resolve billing problems. This quarter the HCA received 71 calls about billing issues (35 about DVHA/VHC premium issues, and 36 about VHC invoice/billing problems affecting eligibility). Last quarter the HCA received 117 calls about billing issues (52 about DVHA/VHC premium issues, and 65 about VHC invoice/billing problems affecting eligibility). When we combine these two billing issue categories, billing is the fourth most common issue this quarter.² This shows significant improvement in an area which has been particularly frustrating for consumers for the past three years.



² In 2016, the HCA revised how we code VHC billing cases. Now cases with general VHC billing problems are recorded as DVHA/VHC premium issues. If the billing problem directly impacts eligibility, it is recorded under VHC invoice/billing problems affecting eligibility. This change resulted in a drop in the number of cases coded for VHC invoice/billing problems affecting eligibility and an increase in the cases coded for general VHC billing problems. Both codes represent VHC billing problems. As a result, the historical data can no longer be represented in separate charts.



E. Calls about Premium Tax Credit (PTC) eligibility stayed about the same.

The HCA received 94 calls from consumers concerning their eligibility for the Premium Tax Credit (PTC), compared to 95 last quarter. These cases represent 24% of our total VHC cases. With the Open Enrollment Period still ongoing, consumers were reviewing plan selections and reporting changes impacting eligibility for PTC. These calls are relatively complex because the HCA advises consumers regarding their eligibility for PTC, which can involve multiple issues and calculations. If consumers are eligible, the HCA also calculates how much PTC they should be receiving. If consumers receive more PTC than they are eligible for, they may have to pay some or all of it back when they file their taxes. This process is called reconciliation. The HCA received 41 calls involving reconciliation this quarter.

F. Consumers need assistance with all types of Medicaid eligibility. Medicaid eligibility calls represented 20% of all our cases. (203 calls/ 978 total calls).

For the second quarter in a row, Medicaid eligibility was the top issue of all calls. We had 126 calls about eligibility for MAGI (expanded) Medicaid, 44 about eligibility for Medicaid for the Aged Blind and Disabled (MABD), and 30 about Medicaid Spenddowns. MAGI Medicaid and MABD Medicaid have different eligibility and income rules, and HCA advocates assess and advise on eligibility for both programs. Consumers frequently have questions about what counts as income; who should be counted in their household; what expenses can be used to meet a Spenddown; how to complete renewal paperwork, and whether their eligibility decision is correct.

G. The top issues generating calls

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

All Calls 978 (compared to 883 last quarter)

1. MAGI Medicaid eligibility 126 (130)
2. Complaints about providers 103 (75)
3. VHC Premium Tax Credit eligibility 94 (95)
4. VHC Change of Circumstance 64 (54)
5. VHC complaints 64 (59)
6. Access to prescription drugs 55 (56)
7. HAEU mistake 50 (43)
8. Medicaid eligibility (non-MAGI) 44 (44)
9. Other: Not health related 41 (24)
10. Information/applying for DVHA programs 41 (59)
11. Consumer education about IRS reconciliation 41 (39)
12. Buy-in programs/Medicare Savings Programs 40 (55)
13. Termination of insurance 38 (58)
14. 1095-A problems 38 (11)
15. Affordability affecting access to care 37 (38)
16. VHC invoice/billing problem affecting eligibility 36 (65)
17. Special enrollment periods (eligibility) 36 (32)
18. Fair hearing appeals 36 (26)
19. DVHA/VHC premium billing 35 (52)
20. Information about VHC 34 (33)
21. VPharm eligibility 33 (42)
22. ACA Tax issues 33 (13)
23. Consumer education about Medicare 30 (36)
24. Consumer education about IRS penalty 30 (23)
25. Medicaid spend down (eligibility) 30 (31)
26. Buying QHPs through Vermont Health Connect 26 (15)
27. Hospital billing 25 (20)
28. Provider billing problems 24 (23)
29. Access to transportation 23 (11)

Vermont Health Connect Calls 393 (compared to 359 last quarter)

1. MAGI Medicaid eligibility 120 (121)
2. Premium Tax Credit eligibility 92 (94)
3. VHC complaints 64 (59)

4. Change of Circumstance 61 (52)
5. HAEU mistake 44 (39)
6. Consumer education about IRS reconciliation 39 (39)
7. 1095-A problems 38 (11)
8. VHC invoice/payment/billing problem affecting eligibility 36 (65)
9. Information about VHC 32 (32)
10. DVHA/VHC premium billing 28 (48)

DVHA Beneficiary Calls 274 (compared to 269 last quarter)

1. MAGI Medicaid eligibility 44 (58)
2. Complaints about providers 41 (27)
3. Information/applying for DVHA programs 21 (29)
4. Access to transportation 19 (9)
5. Change of Circumstance 18 (15)
6. Pain management (access to care) 17 (3)
7. Medicaid eligibility (non-MAGI) 16 (20)
8. VHC Premium Tax Credit eligibility 14 (16)
9. Medicaid balance billing 13 (4)
10. Access to dental care 12 (10)
11. Medicaid/VHAP Managed Care Billing 12 (14)

Commercial Plan Beneficiary Calls 223 (compared to 178 last quarter)

1. Premium Tax Credit 50 (51)
2. Change of Circumstance 32 (22)
3. 1095-A problems 27 (3)
4. VHC complaints 27 (24)
5. MAGI Medicaid eligibility 27 (19)
6. VHC invoice/payment/billing problem related to eligibility 26 (36)
7. HAEU mistake 22 (14)
8. DVHA/VHC premium billing 20 (30)
9. Consumer education about IRS reconciliation 16 (26)
10. Access to prescription drugs 12 (6)
11. Consumer education about Medicare 11 (4)
12. Cost sharing too high 10 (5)
13. ACA Tax issues 10 (7)
14. Information about VHC 10 (11)

H. The top issues generating calls

The HCA received 978 total calls this quarter. Callers had the following insurance statuses:

- **DVHA program beneficiaries** (Medicaid, Medicare Savings Program also called Buy-In program, VPharm, or both Medicaid and Medicare also known as “dual eligible”): 28% (274 calls), compared to 30% (265 calls) last quarter

- **Medicare³ beneficiaries** (Medicare only, Medicare Advantage Plans, Medicare and a Medicare Supplemental Plan aka Medigap, Medicare and Medicaid also known as “dual eligible,” Medicare and Medicare Savings Program also called Buy-In program, Medicare and Part D, or Medicare and VPharm): 22% (217 calls), compared to 30% (316 calls) last quarter
- **Commercial plan beneficiaries** (employer-sponsored insurance, small group plans, or individual plans): 23% (223 calls), compared to 18% (159 calls) last quarter
- **Uninsured:** 11% (110 calls), compared to 14% (124) of calls last quarter

Case Results

A. Dispositions of Closed Cases

All Calls

We closed 981 cases this quarter, compared to 913 last quarter:

- 32% (311 cases) were resolved by brief analysis and advice
- 22% (213) of the cases were complex interventions involving complex analysis, usually direct intervention, and more than two hours of an advocate’s time
- 25% (245) were resolved by brief analysis and referral
- 13% (128) were resolved by direct intervention, including calling an insurance company, calling providers, writing letters, gathering supporting medical documentation, etc.
- In the remaining cases (84), clients withdrew, resolved the issue on their own, or had some other outcome.

Appeals: The HCA assisted 31 individuals with appeals: 22 Fair Hearings, 3 Medicaid MCO Internal appeals, 1 Commercial Insurance – Internal 2nd Level appeals, 2 Commercial Insurance – Internal 1st Level appeals, 1 Commercial Insurance – External appeals, 1 Medicare Part D Appeal, and 1 Medicare Part A, B, or C Appeal.

DVHA Beneficiary Calls

We closed 266 DVHA cases this quarter, compared to 274 last quarter:

- 33% (89 cases) were resolved by brief analysis and/or advice
- 19% (50) were resolved by brief analysis and/or referral
- 23% (61) were considered complex intervention, which involves complicated analysis, usually direct intervention, and more than two hours of an advocate’s time
- 20% (52) were resolved by direct intervention on the caller’s behalf, including advocacy with the carrier and providers, writing letters, and gathering medical information
- In the remaining cases clients withdrew, resolved the issue on their own, or had some other outcome.

Appeals: The HCA assisted 7 DVHA beneficiaries with appeals: 4 Fair Hearings and 3 Medicaid MCO Internal appeals

³ Because Medicare beneficiaries can also have commercial or DVHA coverage, these Medicare numbers overlap with the figures for those categories.

Commercial Plan Beneficiary Calls

We closed 218 cases involving individuals on commercial plans, compared to 284 last quarter:

- 34% (74 cases) were resolved by brief analysis and/or advice
- 15% (33) were resolved by brief analysis and/or referral
- 30% (65) were considered complex intervention, which involves complicated analysis, usually direct intervention, and more than two hours of an advocate's time
- 17% (38) were resolved by direct intervention on the caller's behalf, including advocacy with the carrier and providers, writing letters, and gathering medical information
- In the remaining cases clients withdrew, resolved the issue on their own, or had some other outcome.

Appeals: The HCA assisted 24 commercial plan beneficiaries with appeals: 1 Commercial Insurance – External appeals, 2 Commercial Insurance – Internal 1st Level appeals, 1 Commercial Insurance – Internal 2nd Level appeals, 18 Fair Hearings, 1 Medicaid Part D appeal, and 1 Medicaid Part A, B, or C appeal.

B. All Calls Case Outcomes

The HCA helped 89 people get enrolled in insurance plans and prevented 16 insurance terminations or reductions. We obtained coverage for services for 24 people. We got 11 claims paid, written off, or reimbursed. We estimated VHC insurance program eligibility for 35 more. We provided other billing assistance to 12 individuals. We provided 583 individuals with advice and education. One person was not eligible for the benefit they sought, and four were responsible for the bill they disputed. We obtained other access or eligibility outcomes for 84 more people.

Consumer Protection Activities

A. Rate Reviews

The HCA monitors all commercial insurance carrier requests to the Green Mountain Care Board for changes in premium rates. These are usually requests for rate increases.

Five new cases were filed during the quarter, and the HCA has entered appearances in all of these cases. They involve rates for MVP's small group grandfathered plans, MVP's large group PPO plans, Blue Cross and Blue Shield of Vermont (BCBSVT)'s large group manual rates, The Vermont Health Plan (TVHP)'s large group manual rates and MVP's Large Group HMO plans. The Board's independent actuary and the HCA have been reviewing the rate filings during the quarter.

The BCBSVT and TVHP filings will affect 15,908 members (8,159 subscribers) in 67 groups. Because of the impact of these filings on many Vermonters, the HCA has worked with an independent actuary to review the filings. The HCA submitted suggested questions for BCBSVT and TVHP at the end of the quarter.

One rate review case was decided during the quarter. The case involves Cigna's manual rating formula for its large employer groups. The proposed rates in this filing will affect approximately 1,940

Vermonters. The HCA argued that the requested Contribution to Surplus should be reduced from 3.5% to 1%. The Board reduced the contribution to 2%.

B. Certificate of Need

The HCA participates in Certificate of Need processes as an “interested party” to ensure that approved projects are in the public’s best interest. In January, the HCA submitted a notice of intervention and began reviewing Brattleboro Memorial Hospital’s proposal to construct a four-story building to house medical offices and cardiac rehabilitation, and to replace the hospital’s operating room suite and boilers. We also submitted a notice of intervention in the University of Vermont Medical Center’s application to replace its electronic medical records at a cost of \$112.4 million. In addition, the HCA entered the final phase of the Board’s two-year review of the Green Mountain Surgery Center’s proposal to create a for-profit ambulatory surgery center which will charge lower rates than local hospitals charge for the same services. The HCA spent the last quarter assessing the positives and negatives of the proposed project from a consumer’s perspective and preparing to question witnesses at the hearing. The hearing for this matter took place in April.

C. Other Green Mountain Care Board Activities

In the past quarter, Mike Fisher met with the Green Mountain Care Board to introduce himself and discuss our role in their work. In addition, HCA staff attended nine weekly Board meetings.

Qualified Health Plan Benefits

The HCA again participated in regular stakeholder calls with the Department of Vermont Health Access (DVHA) to develop benefit designs for next year’s Qualified Health Plans. At the end of the process, the proposed benefit designs were submitted to the Green Mountain Care Board for approval. We submitted comments to the Board at that time, urging the Board to support a new bronze plan option that would provide some first dollar coverage for office visits beyond preventative care. We also stressed that DVHA needs to improve its outreach and education to the significant number of Vermonters who are income eligible for cost sharing reductions but have purchased plans that do not qualify for the reductions.

Hospital Budget Review

The HCA continues to participate in the Green Mountain Care Board’s Hospital Budget Review process. In the last quarter, we attended three Green Mountain Care Board meetings related to the hospital budget review process. We submitted formal comments on the Board’s proposed Fiscal Year 2018 Hospital Budget Guidance. In our comments we suggested that the Board break out the 0.4% net patient revenue growth allowable for new health care reform investments and that the Board clearly define “health care reform investment.” We supported the use of a dashboard of metrics in the budget review process, and advocated for inclusion of quality and access measures, payer mix, health care reform investments, bad debt, and charity care in the dashboard. We strongly supported the inclusion of pricing information in the budget review process to improve hospital price transparency. Additionally, we asked the Board to formalize its budget review hearings with standardized presentations from the hospitals. Finally, we opposed the Board waiving the hospital budget review hearing for any hospital because the hearings are essential to ensure a transparent budget review process.

Accountable Care Organization Rule

Last quarter, the Board continued to hold bi-weekly meetings with a stakeholder group including the HCA to develop the Accountable Care Organization Rules required by Act 113 of 2016. The HCA attended five stakeholder meetings during that time and submitted two sets of comments with suggestions for changes to the draft rule to enhance consumer protections. These changes increased requirements for care quality in addition to cost savings, strengthened Board oversight on issues strongly related to consumer protection, improved rule clarity, and enhanced transparency of ACO work.

D. All-Payer Model

During the last quarter the Department of Vermont Health Access entered into a contract with OneCare Vermont, the state's largest Accountable Care Organization, to manage the care of approximately 30,000 Medicaid beneficiaries. This contract was announced by Governor Scott as a "pilot" for the All-Payer Model. This quarter the HCA reviewed the contract, met with DVHA staff members, and asked questions of DHVA about the contract. We continue to advocate for robust consumer protections in the All-Payer Model, and in any pilot or other contract that involves providers taking on financial risk for Vermonters' health care. We detail our consumer protection concerns about the APM in our paper: *Consumer Principles for Vermont's All-Payer Model*.

E. Vermont Health Care Innovation Project (SIM Grant)

This quarter the HCA continued to participate in the Vermont Health Care Innovation Project (VHCIP), which is funded by a federal State Innovation Model (SIM) grant. The VHCIP is in its final stages and the work groups, in which we had been active participants, have concluded their activities. During this quarter we continued to monitor the activities of the VHCIP Core Team and attended one Core Team meeting as an interested party. The HCA is a participant in the VHCIP Self-Evaluation Committee and attended one meeting of the committee this quarter. Additionally, this quarter the HCA completed an evaluation interview with the federal State Innovation Model evaluator, RTI International.

F. Affordable Care Act Tax-related Activities

During this quarter the HCA continued tax-related assistance, advocacy, and outreach efforts. We continued to participate in a stakeholder workgroup on QHP renewals and open enrollment issues, to ensure that consumers experienced as smooth a transition as possible from 2016 to 2017 plans. In general VHC improved its renewal and enrollment operations over last year; however, the HCA did get calls from consumers who either (1) had an erroneous non-filer indicator from the IRS which endangered their subsidies, or (2) did not realize they needed to file their 2015 tax return to continue receiving PTC from VHC. Because the warning notice does not explicitly tell consumers that they have a non-filer indicator on their account, some consumers did not realize there was a problem until they received their bill for January 2017. Some consumers were not able to fix the issue by December 15, which is the deadline to make changes affecting January premiums. In January, the HCA helped several consumers demonstrate to VHC that they had filed their 2015 taxes, and helped others obtain copies of their 2015 Form 1095-A so that they could file in time to receive PTC for February. The HCA successfully advocated for consumers to receive January PTC if the non-filer indicator on their account was wrong.

The HCA has consistently advocated for tax forms to be more accessible to consumers. We are pleased that consumers can now download 1095 forms from their online account.

As in prior quarters, we commented on notices to consumers affecting their eligibility for tax credits. The HCA also continued to receive and escalate cases with VHC involving APTC reconciliation and forms

1095-A. As described above under Priorities, a significant portion of our VHC calls this quarter were tax-related.

The HCA continued to employ a half-time tax attorney, who also staffs the Low-Income Taxpayer Clinic at VLA. This arrangement has allowed the HCA to stay up to date on tax law developments, and enables our staff to effectively field calls related to the ACA and VHC.

As in prior quarters, the HCA's tax attorney consulted with HCA advocates when particularly difficult IRS-related issues arose in HCA cases. During this quarter, the tax attorney advised the HCA on 13 technical assistance questions. She also responded to 58 technical assistance questions from nonprofit tax assisters, Vermont tax preparers, and legal services attorneys in other states. During tax season the most common technical assistance questions involved the complex IRS rules on how to reconcile advance payments of the Premium Tax Credit (PTC). The tax attorney also answered questions on a wide variety of ACA topics including unusual types of income, tax filing status, Form 1095 errors, IRS procedures, shared responsibility payment exemptions, and coverage overlaps.

As described below under **Administrative Advocacy**, the HCA submitted formal comments to the federal Department of Health and Human Services (HHS) regarding its proposed Market Stabilization rule. The HCA objected to a proposed change in actuarial value methodology for silver plans, which has the potential to reduce PTC (and thus increase the cost of coverage) for a significant number of consumers nationwide.

The HCA also engaged in tax-related outreach and education activities this quarter, particularly in the wake of the January 20, 2017 Executive Order directing federal agencies to “minimize the economic burden” of the ACA. We updated our website to include information about the Executive Order and its impact on the ACA's Shared Responsibility Provision. Further information is below in the **Outreach and Education** section.

G. Other Activities

Administrative Advocacy

❖ Access to Treatment for Hepatitis C Virus

This quarter the HCA successfully advocated for implementation of Medicaid's new, less-restrictive coverage criteria for hepatitis C. Medicaid's Drug Utilization Review Board (DURB) voted in December to recommend covering treatment for patients with less severe liver disease, and for patients regardless of their substance use history, and DVHA accepted the DURB's recommendations. This quarter the HCA met with the DVHA Commissioner and communicated with DVHA staff and health care providers to ensure that the policy change was fully implemented. DVHA implemented the new criteria during the quarter, allowing more Vermonters to access curative treatments for hepatitis C.

❖ Controlled Substance and Pain Management Advisory Council

Act 173 of 2016 created this council to advise the Commissioner of Health on matters related to the Vermont Prescription Monitoring System, the appropriate use of controlled substances in treating pain, and preventing prescription drug abuse, misuse, and diversion. This quarter the HCA reviewed the Department of Health's draft Rule for Medication-Assisted Treatment for Opioid Dependence. The rule would expand capacity for the treatment of opioid dependence by allowing advanced practice registered nurses and physician's assistants to prescribe buprenorphine to individuals requiring and seeking treatment for opioid dependence. The rule would also increase the number of patients a provider may treat.

❖ **Health Care Administrative Rules (HCAR)**

The Department of Vermont Health Access (DVHA) has begun a multi-year revision of Medicaid rules. Eventually all Medicaid rules will be amended and adopted under the title of Health Care Administrative Rules (HCAR). In January, the HCA submitted formal comments on three proposed HCAR Rules describing coverage for dental and orthodontic services. We asked for changes to the proposed rules that would clarify providers' responsibility to explain the patient's financial responsibility for non-covered services and would use the existing definition of the clinical criteria for coverage of orthodontic services. During the quarter, DVHA made changes to address our concerns in the final proposed version of the regulations. These rules were pending at the Legislative Committee on Administrative Rules (LCAR) at the end of the quarter.

DVHA also proposed new HCAR rules covering augmentative communication devices. The Disability Law Project (DLP) of Vermont Legal Aid and other advocates commented extensively on these regulations because they made substantive changes in coverage criteria for the devices. The HCA endorsed the DLP comments. As a result of the large number of public comments, DVHA rewrote the rule and held a new public comment period during the quarter. The DLP and HCA agree with the new version of the rule.

❖ **2018 Qualified Health Plan (QHP) Work Group**

The HCA participated in this stakeholder group which was convened by DVHA to help develop any recommended changes to benefit design for Qualified Health Plans (QHPs) offered on Vermont Health Connect in 2018. The legislature set up a process to discuss the effect that the maximum out-of-pocket expense limit for prescription drugs in Vermont law has on plan design, especially at the bronze plan metal level. The work group also reviewed other plan design changes. We attended one meeting of the group during the quarter. DVHA's recommendations for plan design changes were presented to the Green Mountain Care Board at the end of January.

❖ **Vermont Health Connect Escalation Path**

The HCA and VHC continued to collaborate on improving the State's escalation path for HCA cases involving complex VHC issues. We communicate with VHC multiple times a day and meet as needed to discuss the most difficult cases. **HHS Market Stabilization Rule**

The HCA submitted formal comments in response to a Notice of Proposed Rulemaking by the federal Department of Health and Human Services (HHS). HCA raised concerns with several proposals that could reduce enrollment of healthy consumers and cause hardships for consumers who experience a loss of income or other challenging situations. HCA strongly objected to any continuous coverage requirement for exchange coverage as contrary to the plain language of the Affordable Care Act. HCA requested that HHS recognize state flexibility in several areas, to allow Vermont to tailor its rules and procedures to the issues facing our exchange.

❖ **Comments on Vermont Health Connect Notices**

At VHC's request, the HCA commented on 10 notices, in an effort to make them more readable and consumer-friendly. See **Promoting Plain Language in Health Communications** below.

❖ **Medicaid and Exchange Advisory Board**

This quarter, the new Chief Health Care Advocate was appointed to Vermont's Medicaid and Exchange Advisory Board (MEAB) and continued the HCA's active participation on this board. The Chief attended 3 meetings of the MEAB during the quarter.

Legislative Activities

This quarter included the first three months of the 2017 session of the Vermont Legislature. During the quarter, the HCA advocated for legislation that would benefit health care consumers and monitored the activity of legislative committees that took up issues related to health care. We worked on legislation to improve Accountable Care Organization transparency to the public as well as reporting on ACO activities to the Legislature. The HCA also responded to legislative requests for comment on a number of other issues.

Our new Chief Health Care Advocate testified numerous times before legislative committees this quarter, including 7 times before the Senate Committee on Health and Welfare and 5 times before the House Committee on Health Care.

Collaboration with Other Organizations

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

- American Civil Liberties Union of Vermont (ACLU-VT)
- Bi-State Primary Care Association
- Blue Cross Blue Shield of Vermont
- Community Catalyst
- MVP Health Care
- National Association of Enrolled Agents
- OneCare Vermont
- Prisoners' Rights Office
- South Royalton Legal Clinic
- University of Vermont Medical Center
- Vermont Association of Hospitals and Health Systems (VAHHS)
- Vermont CARES
- Vermont Health Connect
- Villanova University Tax Clinic (Procedurally Taxing)
- Voices for Vermont's Children
- Women's Freedom Center

[Back to Table of Contents](#)

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

- The total number of health pageviews increased by 27% in the reporting quarter ending March 31, 2017 (11,839 pageviews), compared with the same quarter in 2016 (9,322 pageviews). This is noteworthy because the total number of pageviews for the entire Vermont Law Help website was nearly even when compared with the same period last year.
- The number of people who visited our [Services Covered by Medicaid](#) page increased by 221% this quarter, with 350 pageviews compared to last year's 109. Last quarter that page had 129 pageviews.
- This quarter, like the previous six quarters, we saw a large increase in the number of people seeking information about [Medicaid Income Limits](#) (3,960 pageviews this quarter, compared with 2,639 in the same quarter in 2016 – an increase of 50%). The consistently high numbers indicate that search engines are delivering this page as a high-ranking source of information about Medicaid income limits, as well as the increasing age of Vermont's population.
- The number of people seeking help finding [Dental Services](#) increased (16%) compared with the previous year. (504 pageviews this quarter, compared with 435 in the same period last year.)
- The [Health home page](#) again had the second largest number of pageviews (1,182), slightly higher than last year's 1,040. The home page tells consumers how we can help them and provides several ways to contact us including an online form that can be filled out and submitted 24/7.
- The number of people looking for information about **Prescription Drugs, Prescription Assistance and Medicare Part D** jumped significantly. All these topics together earned 302 pageviews this quarter compared to 145 pageviews in 2016. This is a 300% increase.
- 11 of the 25 health pages with the largest number of pageviews focused on **Medicaid or long-term care Medicaid (Choices for Care)**. There is almost no information about MCA Medicaid or Dr. Dynasaur available on the state websites, but there is clearly a need for information on these topics.
- There were spikes in interest in our pages on the **Ladies First Health Program** (up from 9 to 83 pageviews), **Dr. Dynasaur** (up from 24 to 77 pageviews) and the health care **Complaints** page (up from 62 to 111).
- We saw decreases in traffic over last year on the following pages: **Health Insurance, Taxes and You** (down from 476 to 396), **Medical Marijuana Registry Patient Form** (down from 318 to 172), **Tax Form 1095-B and C** (down from 197 to 78), and **VHC Appeals** (down from 29 to 14).
- The top-12 health pages on our website this quarter with change over last year:
 - Income Limits – Medicaid – 3,960 pageviews (50% ↑)
 - Health section home page – 1,182 (14% ↑)
 - Dental Services – 504 (16% ↑)
 - Vermont Choices for Care – 405 (65% ↑)
 - Health Insurance Taxes and You – 396 (17% ↓)
 - Services Covered by Medicaid – 350 (221% ↑)
 - Medicaid – 229 (70% ↑)
 - Resource Limits – Medicaid – 208 (48% ↑)
 - Medicaid and Medicare Dual Eligible – 172 (20% ↓)
 - Medical Marijuana Registry Patient Form – 172 (46% ↓)
 - Choices for Care Income Limits – 162 (22% ↑)

PDF Downloads

- 43 out of 101 or **43% of the unique PDFs downloaded** from the Vermont Law Help website were on health care topics. Of those unique health-related PDF titles:

- 23 were created for consumers. The top five consumer-focused PDF downloads were:
 - [Vermont Dental Clinics Chart](#) (135 downloads)
 - [Advance Directive, short form](#) (51 downloads)
 - [Blue Cross Blue Shield of VT Annual Report 2014](#) (24 downloads)
 - [Vermont Medicaid Coverage Exception Request - 10 Standards and Provider Request Form](#) (23 downloads)
 - [Advance Directive, long form](#) (13 downloads)
- 15 were prepared for lawyers, advocates and assisters who help consumers with tax issues related to the Affordable Care Act. The top advocate-focused downloads were:
 - [PTC rule allocation summary](#) (12 downloads)
 - [2015 Affordability Exemption Charts handout \(from September ACA Refresher presentation\)](#) (4 downloads)
 - [Low-Income Taxpayers and the Affordable Care Act – November 2014](#) (3 downloads)
- 5 covered topics related to health policy. The top policy-focused downloads were:
 - [Vermont ACO Shared Savings Program Quality Measures](#) (12 downloads)
 - [Consumer Principles for Vermont's All-Payer Model Nov 2015](#) (2 downloads)

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

The [Advance Directive, short form](#) is the **fifth most downloaded of all PDFs** downloaded from the Vermont Law Help website.

B. Education/Outreach

Immigrants' Rights Forum (March 28, 2017)

An HCA attorney attended an immigrants' rights forum presented by the Women's Freedom Center and the South Royalton Legal Clinic at the School for International Training in Brattleboro. HCA brochures were offered to 36 attendees, and the attorney announced that the HCA is available to consult with consumers of all immigration statuses who have healthcare or health insurance questions.

Procedurally Taxing (February 2, 2017)

The HCA's tax attorney analyzed the January 20, 2017 Executive Order which directed federal agencies to reduce the economic burden of the Affordable Care Act. The analysis explains the effect of the Order on the Shared Responsibility Provision and Premium Tax Credit, and discusses tax preparers' ethical obligation to prepare a complete and correct tax return. Procedurally Taxing is a blog run by Villanova University Law School professors, which has an audience of hundreds of tax professionals.

National Association of Enrolled Agents E@lert Newsletter (February 3, 2017)

The National Association of Enrolled Agents included the HCA tax attorney's article on the Executive Order in its electronic newsletter, which is sent to thousands of tax professionals nationwide.

C. Promoting Plain Language in Health Communications

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

- Provided extensive plain language edits and edits/comments to improve comprehension of message and ability to resolve the problem being addressed in the following notices/letters:
 - Notice on SHIP (State Health Insurance Assistance Program) assistance sent on 1-6-17
 - EE509-MNT Applying for Retro Medicaid sent on 1-17-17
 - EE510-MNT –Grant of Retro Medicaid sent on 1-17-17
 - EE511-MNT –Denial of Retro Medicaid sent on 1-17-17
 - EE714-Spend Down Request sent on 2-3-17
 - EE715 Spend Down Request Denial sent on 2-3-17
 - SYS712 Dr. D Premium Change Notice sent on 2-3-17
 - ADM-600-MM Direct Enrollment Notice sent on 3-6-2017
 - Automatic Medicaid Renewal Notice sent on 3-16-2017
 - Self-Service blurb sent on 3-21-17

Office of the Health Care Advocate

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