
Vermont Legal Aid
Office of the Health Care Advocate

Quarterly Report
January 1, 2018- March 31, 2018
to the
Agency of Administration
submitted by
Michael Fisher, Chief Health Care Advocate
Office of the Health Care Advocate



April 23, 2018



TABLE OF CONTENTS

Introduction	3
Individual Consumer Assistance	4
Case Examples	4
Overview	6
Priorities	8
A. The HCA worked with VHC and other stakeholders to make sure that grace period notice envelopes are properly marked.	8
B. The HCA collaborated with stakeholders to support ‘silver loading’ QHPs to help stabilize the market and maintain access to affordable healthcare.	8
C. HCA expanded its partnership with Kinney Drugs.	9
D. Access to Breast Cancer Screening	9
E. Overall call volume increased for the third consecutive quarter.	9
F. Calls concerning Vermont Health Connect increased significantly.	10
G. Medicaid eligibility calls represented 21% of all our cases (220 calls/ 1046 total calls). Consumers need assistance with all types of Medicaid.	11
Consumer Protection Activities	14
A. Rate Review	14
B. Certificate of Need	15
C. Hospital Budget Review	15
D. Oversight of Accountable Care Organizations	16
E. Other Green Mountain Care Board Activities	16
F. Affordable Care Act Tax-related Activities	17
G. Other Activities	18
Outreach and Education	21
A. Increasing Reach and Education through the Website	21
B. Other Outreach and Educational Activities	23
C. Promoting Plain Language in Health Communications	24

Introduction

The Office of the Health Care Advocate (HCA) advocates for all Vermonters through both individual consumer assistance and systemic advocacy on health care issues. We work to increase access to high quality, affordable health care for all Vermonters through individual advocacy and representing the public before Green Mountain Care Board, state agencies, and the state legislature. The HCA saw a significant jump in its calls this quarter (18%). Consumers again had particular issues and questions about Medicaid eligibility (220 cases) and access to prescriptions drugs (90 cases). With the start of tax season, we also saw an increase in our tax related cases (ACA Tax Issues, 48 cases, and 1095-A & B problems, 56 cases). We continued to work on making notices more transparent and understandable to all consumers, and in particular ensuring that consumers recognize their grace period notices.

Due to new actions from the Federal Government, efforts to maintain stability in the marketplace were an important part of the HCA's advocacy this quarter. The HCA will also be working closely with stakeholders to develop an outreach strategy to help consumers understand changes to the marketplace plans for 2019.

The HCA is committed to helping Vermonters navigate the health care system during this confusing and anxious time. Our goal remains the same: to increase access to affordable, high quality health care for all Vermonters. Today's uncertainty makes the role of the HCA even more essential.

The HCA supports Vermonters through individual advocacy as well as at the legislative and administrative policy levels. Our policy priorities are informed by our daily work with Vermonters struggling with a health care system that often does not meet their needs, such as Tim's experience described in the case narrative at right. 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.

Tim's Story

Tim called the HCA because he could not afford his employer sponsored insurance. He was paying nearly \$10,000 a year for coverage for himself and his family. That was the minimum cost for a year without any major health problems. Because his employer plan was considered "affordable," he was not eligible to get APTC to help pay for a plan on VHC. An employer plan is considered affordable if it does not cost more 9.56% of the household income to get an employee only plan. The affordability test does not consider how much it costs to cover your family. This is called the "family glitch." It means that you could be spending much more than 9.56% of your household income to cover your family, but you would still be ineligible for APTC. When the advocate reviewed Tim's household income, he found that if Tim started to contribute about \$400 a month to his 401(K), the family would reduce its taxable income and become eligible for Medicaid. Since the family was already paying \$10,000 a year for the employer insurance, this cut the costs by more than half. Plus, Medicaid has very limited out of pocket costs while Tim's employer plan had a nearly \$2000 deductible and expensive copayments. Tim was also relieved to have affordable coverage, and to start saving more money for retirement.

Individual Consumer Assistance

Case Examples

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

Maddie's Story

Maddie called the HCA because she could not afford the premium for her new health plan on Vermont Health Connect (VHC). She did not want to go without insurance but did not think that she could afford the increased monthly premium. She did not understand why her premium had increased so quickly. When the advocate investigated, she discovered that Maddie was not receiving the correct amount of Advance Premium Tax Credit (APTC) for her current income. The APTC is applied monthly to reduce the premium, and how much you are eligible for depends both on your household size and your income. When the advocate called VHC, she found that it was using incorrect yearly income. VHC had Maddie's income listed as almost \$10,000 more than what she was currently earning, and that was reducing the amount of APTC she qualified for. When the income was corrected, Maddie's monthly APTC increased and her premium decreased by about \$100 a month. Maddie was able to make the payments and stay on the coverage.

Cora's Story

Cora was desperate when she called the HCA. She had cancelled two doctor's appointments and was not able to pick up four prescriptions because her new health plan on VHC was not active. She has signed up for a new health plan on VHC for January, and sent her payment at the end of December. Because her first payment for the new plan had been sent towards the end of the month, it meant that Cora's coverage was not active on the first day of the month. Cora had called VHC to request that her case be expedited, but her coverage was still not active. When the advocate intervened, she found that Cora's request that her case be expedited had not yet been communicated to the right team at VHC. The advocate submitted another request that the coverage be expedited, and also contacted the carrier which worked to speed up the process. Once the coverage was activated, the advocate contacted the pharmacy, which was able to fill the prescriptions immediately. Cora picked up the prescriptions and was able to re-schedule her doctor's appointments.

Liam's Story

Liam called the HCA because he had Hepatitis C and wanted to get treatment. The new treatment had an excellent chance of curing his disease. When his provider submitted a prior authorization request to Medicaid, it was denied because he had not met the treatment criteria. According to the Medicaid treatment criteria, his disease was not advanced enough for Medicaid to cover the direct-acting antiviral treatment. The HCA helped Liam with an internal appeal with Medicaid. He lost at that stage. He then filed a fair hearing to contest the denial. He also lost at the fair hearing stage. At the same time the HCA also worked to change the treatment criteria, so people like Liam could get curative treatment before the disease did more damage. Ultimately, Medicaid expanded the

treatment criteria for Hepatitis C. This meant that people like Liam could get treatment before they had further liver damage due to the disease. The process had taken more than a year, but Liam was finally able to start treatment.

Art's story

Art had lost his job and his health care coverage. Because he had lost his employer health care coverage, he had a 60 day special enrollment period to apply on VHC. With the help of an assistor at his provider's office, he had applied for a special enrollment period on VHC. He called the HCA, however, because he had never gotten a VHC plan and still needed coverage. The advocate discovered that Art had applied within the 60 day special enrollment period, so he should have been able to sign up for a plan. When the assistor had submitted the application, however, she had not marked that Art had lost his employer coverage. This meant that VHC had denied his request for a special enrollment period. Since he had applied within the 60 day period and the denial was due to an error on the application by the assistor, VHC granted Art another special enrollment period. He was able to sign up for a plan and get active coverage.

Edward's story

Edward had ten prescriptions to pick up, and the pharmacy was telling him that it was going to cost several hundred dollars. Edward thought that he had Medicaid, but when he gave the pharmacy his card, he was told that he had Healthy Vermonters. Healthy Vermonters is another state health care program that gives Vermonters a discount on prescriptions. But if you have Medicaid, your drug copayments are much lower--only \$1 to \$3. The advocate reviewed Edward's case and found that he had applied for Medicaid, but had used the wrong application. He had applied for Medicaid for the Aged, Blind and Disabled and filled out a paper application. He was actually eligible for Medicaid for Children and Adults. For that type of Medicaid, you can apply online or over the phone with VHC. The advocate helped Edward apply and expedited his application. Once the coverage was active, he was able to pick up all of his prescriptions for about \$20 instead of several hundred dollars.

Annette's Story

When Annette turned 65, she had not signed up for Medicare. She did not qualify for free Part A and did not believe she could afford it. She called the HCA to see if there were any affordable health care options for her. The advocate explained that Annette qualified for Medicaid. She also qualified for a Medicare Savings Program (MSP). If she was on an MSP, the State of Vermont would pay for her Medicare Part A & B premiums, and the Medicare cost-sharing. The state could also sign her up outside of the general Medicare enrollment times. That meant she could get on right away instead of waiting about six months for Part B coverage to start. The advocate helped her fill out the application for an MSP and Medicaid. The State approved her for both programs. By being on an MSP and Medicaid, she also qualified for what is called Low Income Subsidy (LIS). This federal program helps pay for Part D prescription drug coverage. It meant that Annette was able to sign up for a Part D plan, and LIS would cover the monthly premium. Now Annette was fully covered on Medicare, with programs to help cover the cost-sharing for Medicare Part A, B, & D.

Eloise's story

Eloise called because she got a notice from the State of Vermont telling her that her Medicaid and her Medicare Savings Program (MSP) were closing because she was now over-income for the programs. Her income had not changed, so Eloise did not understand why the programs were closing. When the advocate looked into the issue, he found that Eloise's husband was on Long Term Care Medicaid. This meant that when the State of Vermont calculated whether Eloise was eligible for Medicaid, it should have excluded her husband's income from the eligibility calculation. When the State found her ineligible, it had erroneously included her husband's Social Security income. The advocate pointed out the error, and the State agreed that it made a mistake. When the income was calculated correctly, Eloise was found eligible for both Medicaid and an MSP.

Shannon's story

Shannon called because both she and her new husband had received closure notices from Medicaid. Both Shannon and her husband had been on Medicaid for the Aged, Blind and Disabled (MABD). They each received monthly disability payments. They had just gotten married and did not realize that when they married, their incomes would count together. When their incomes were combined, they were significantly over-income for Medicaid. For MABD, the income limits for a household of one and household of two are the same. For example, in Chittenden County, the limit for a household of one and a household of two is \$1125 a month. The Medicaid coverage was particularly important because both relied on Medicaid transportation to get to their medical appointments. When the advocate researched the situation with them, he realized that they could qualify for another program. The couple had started a small business together. This meant that they could be eligible for Medicaid for the Working Disabled. That program has a higher income and resource limit, and the couple would still be income eligible for that program. The advocate helped submit the application and the necessary documentation about their business, and the State found them eligible for Medicaid for the Working Disabled. This meant that they would be able to get rides to their medical appointments once again.

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 1046 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:

- **23.42%** (245) about **Access to Care**
- **12.52 %** (131) about **Billing/Coverage**

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

- **0.86%** (9) about **Buying Insurance**
- **13.00%** (136) about **Consumer Education**
- **25.24%** (264) about **Eligibility** for state and federal programs
- **24.95%** (261) 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 264 of our cases had eligibility for state and federal healthcare programs listed as the primary issue, a total of 521 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.

The full quarterly report for January 11- March 31, 2018 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:** 1046 calls (compared to 890 last quarter)
 - **Department of Vermont Health Access (DVHA) beneficiaries:** 319 calls (257 calls last quarter)
 - **Commercial plan beneficiaries:** 221 calls (212 calls last quarter)
 - **Uninsured Vermonters:** 100 calls (78 calls last quarter)
 - **Vermont Health Connect (VHC):** 325 calls (254 calls last quarter)
 - **Reportable Activities (Summary & Detail):** 121 activities and 11 documents

Priorities

A. The HCA worked with VHC and other stakeholders to make sure that grace period notice envelopes are properly marked.

The HCA advocates talked to many consumers who had not realized that they were in a grace period for being behind on their monthly premiums. By the time they called the HCA, they were outside of their grace period and their coverage had been terminated. When the advocates investigated, they found that most of the time the grace period notices had been sent to the consumers. The problem was that consumers did not recognize that they were receiving an important notice. Because some of the grace periods notices were sent in blank envelopes, consumers assumed that they were junk mail and recycled them without opening the notice. By the time they called the HCA, they were often outside their grace period and in danger of being without insurance for the rest of the year. The HCA worked with VHC and stakeholders to ensure that the envelopes were marked with a return address to alert consumers that this was an important notice. This will allow consumers to quickly recognize that they are in a grace period, and give them an opportunity to catch up on their premiums and maintain their coverage.

B. The HCA collaborated with stakeholders to support ‘silver loading’ QHPs to help stabilize the market and maintain access to affordable healthcare.

After the Federal Government decided to stop funding the Cost Sharing Reduction (CSR) payments in 2017, the HCA immediately started working with other stakeholders to develop a strategy to protect consumers from cost increases and also support and stabilize the individual market for the future. The HCA joined with stakeholders to support changing the marketplace to allow Vermont Health Connect (VHC) to offer “silver-loaded” plans and for the carriers to offer “reflective” silver plans. The VHC “silver-loaded” plans mean that Premium Tax Credit (PTC)-eligible households will be eligible for more PTC to offset the increased cost of plans due to the loss of CSR. Consumers will be able to use the additional PTC to maintain their coverage or purchase a QHP with lower cost-sharing, or a QHP with a lower premium. Households who are not eligible for PTC can purchase “reflective” silver plans directly from the carriers and be protected from premium increases due to the “silver-loading” strategy while maintaining the same level of coverage. The HCA is actively working with other stakeholders to develop an outreach strategy to help consumers understand the changes and find what plan makes the most sense for them.



C. The HCA expanded its partnership with Kinney Drugs.

This quarter the HCA advocacy team visited Kinney drugstores throughout the state to educate pharmacists about how the HCA can help consumers. The HCA is now getting a steady stream of referrals from the drugstores. Most of the referrals are emergency cases where the consumer cannot pick up a prescription because their coverage is not active or because the prescription that they need is not covered by their Medicare Part D plan.

D. Access to Breast Cancer Screening

This quarter, the HCA supported legislation to further reduce the out pocket costs for breast cancer screening. Although Vermont law already waives cost-sharing for screening mammograms, the HCA often spoke with consumers who needed additional ultrasounds because of the screening mammogram. Many were left with large bills from the ultrasound. The bills made them reluctant to do annual screenings. The proposed law will waive cost-sharing for medically necessary breast imaging.

E. Overall call volume increased for the third consecutive quarter.

The total call volume increased by 18% (1045 this quarter vs. 890 last quarter). About 15% of those calls involved getting consumers onto new coverage, preventing the loss of coverage, or obtaining coverage for services. We saved consumers \$186,529.15 this quarter.

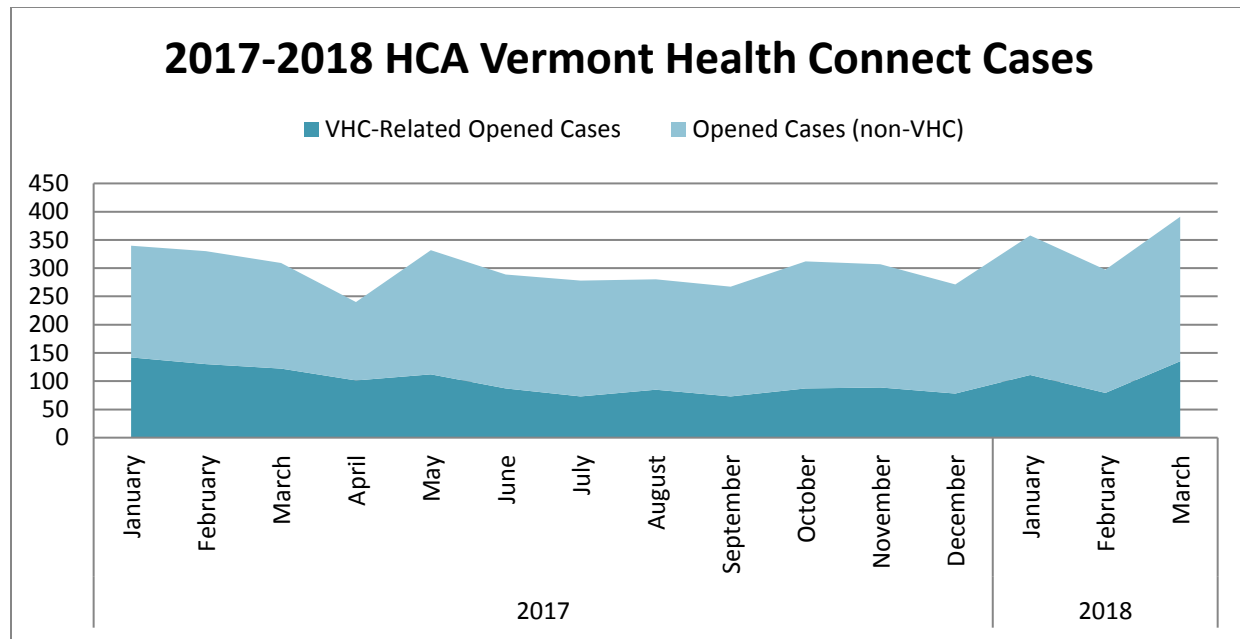
	All Calls (2008-2018)										
	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
January	309	240	218	329	282	289	428	470	411	340	358
February	232	255	228	246	233	283	304	388	511	330	297
March	229	256	250	281	262	263	451	509	416	308	391
April	235	213	222	249	252	253	354	378	333	240	-
May	207	213	205	253	242	228	324	327	325	332	-
June	245	276	250	286	223	240	344	303	339	289	-
July	205	225	271	239	255	271	381	362	304	278	-
August	152	173	234	276	263	224	342	346	343	280	-
September	147	218	310	323	251	256	374	307	372	267	-
October	237	216	300	254	341	327	335	311	312	312	-
November	192	170	300	251	274	283	306	353	287	307	-
December	214	161	289	222	227	340	583	369	284	271	-
Total	2604	2616	3077	3209	3105	3257	4526	4423	4237	3554	1046

F. Calls concerning Vermont Health Connect increased significantly.

The volume of calls concerning Vermont Health Connect increased by 28%, compared to the previous quarter (325 vs. 254). With the opening of tax season, we saw an expected jump in our tax related calls (ACA Tax issues, 43 vs. 13 calls, and 1095-A & B issues, 46 vs. 10 calls). The number of calls related to eligibility for Special Enrollment Periods and the Termination of Insurance both doubled (37 vs. 16 for SEPS and 48 vs. 19 for Termination). With a shorter Open Enrollment this year, some consumers missed their opportunity to switch plans and called to see if they would qualify for a Special Enrollment Period. Another group of consumers were terminated at the start of 2018, and called the HCA for help. This quarter, 94 VHC cases required complex interventions that took more than two hours of an advocate's time to resolve, and 49 required a direct intervention to resolve the case.

The HCA continues to resolve its cases by working directly with Tier 3 Health Access Eligibility Unit (HAEU) workers, who are 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. This quarter we had a significant increase in our escalated cases (83 vs. 73 last quarter). Of the 83 escalated cases, 71 were resolved within the quarter.

Tier 3 also now works on resolving Green Mountain Care cases (VPharm, Medicaid for Aged Blind and Disabled (MABD), Medicare Saving Programs, and Medicaid Spenddowns). This quarter we had a jump in cases for consumers having issues with Medicare Savings Programs (65 vs. 52), MABD (68 vs. 43), and VPharm eligibility (40 vs. 29).



G. Medicaid eligibility calls represented 21% of all our cases (220 calls/ 1046 total calls). Consumers need assistance with all types of Medicaid.

Medicaid eligibility was again the top issue generating calls. We had 115 calls about eligibility for MAGI (expanded) Medicaid, 68 about eligibility for Medicaid for the Aged Blind and Disabled (MABD), 24 about Medicaid Spenddowns, and 13 about Medicaid for Working Disabled. 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.

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 1046 (compared to 890 last quarter)

1. MAGI Medicaid eligibility 115 (97)
2. Access to prescription drugs/pharmacy 90 (44)
3. Complaints about providers 81 (80)
4. Information/applying for DVHA programs 77 (60)
5. Medicaid eligibility (non-MAGI) 68 (63)
6. Buy-in programs/Medicare Savings Programs 65 (52)
7. Premium Tax Credit eligibility 63 (70)
8. Termination of Insurance 58 (28)
9. Information about VHC 58 (50)

10. 1095-A and 1095-B problems 56 (10)
11. Special Enrollment Periods eligibility 54 (23)
12. Consumer education about Medicare 52 (31)
13. Fair hearing appeals 50 (36)
14. ACA Tax issues 48 (15)
15. VPharm eligibility 40 (27)
16. Eligibility for VHC grace periods 40 (29)

Vermont Health Connect Calls 325 (compared to 254 last quarter)

1. MAGI Medicaid eligibility 97 (84)
2. Premium Tax Credit eligibility 57 (67)
3. 1095-A & 1095-B problems 46 (10)
4. Information about VHC 53 (47)
5. Termination of insurance 48 (19)
6. ACA Tax Issues 43 (13)
7. Eligibility for VHC grace periods 40 (29)
8. Fair hearing appeals 39 (24)
9. Special Enrollment Periods 37 (16)
10. Change of Circumstance 32 (33)
11. VHC invoice/payment/billing problem affecting eligibility 32 (26)

DVHA Beneficiary Calls 319 (compared to 259 last quarter)

1. MAGI Medicaid eligibility 44(36)
2. Medicaid eligibility (non-MAGI) 29 (33)
3. Access to prescription drugs/pharmacy 28 (21)
4. Complaints about providers 24 (25)
5. Buy-in programs/Medicare Savings Programs 22 (19)
6. Information/applying for DVHA programs 23 (17)
7. VPharm eligibility 16 (9)
8. Access to transportation 15 (13)
9. Medicaid/VHAP Managed Care Billing 15 (13)
10. PA Denial 14 (4)

Commercial Plan Beneficiary Calls 221 (compared to 209 last quarter)

1. Premium Tax Credit eligibility 35 (48)
2. Eligibility for VHC grace periods 28 (18)
3. MAGI Medicaid eligibility 27 (26)
4. 1095-A & 1095-B problems 25 (6)
5. ACA Tax issues 23 (8)
6. VHC invoice/payment/billing problem related to eligibility 21 (14)
7. Information about VHC 17 (25)
8. Consumer education about Medicare 17 (13)
9. Change of circumstance 13 (13)
10. DVHA/VHC premium billing 14 (13)
11. Termination of Insurance 14 (4)

12. Fair Hearings 14 (8)

The HCA received 1046 total calls this quarter. Callers had the following insurance status:

- **DVHA program beneficiaries** (Medicaid, Medicare Savings Program also called Buy-In program, VPharm, or both Medicaid and Medicare also known as “dual eligible”): 30.5% (319 calls), compared to 28.8 % (257 calls) last quarter
- **Medicare² 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): 28.01% (293 calls), compared to 28.7% (255 calls), last quarter
- **Commercial plan beneficiaries** (employer-sponsored insurance, small group plans, or individual plans 21.1% (221 calls), compared to 23.5% (209 calls) last quarter
- **Uninsured:** 9.56% (100 calls), compared to 8.7% (77 calls last quarter)

Case Results

A. Dispositions of Closed Cases

All Calls

We closed 981 cases this quarter, compared to 890 last quarter:

- 35% (340) were resolved by brief analysis and advice
- 27% (269 cases) were resolved by brief analysis and referral
- 24% (237) of the cases were complex interventions involving complex analysis, usually direct intervention, and more than two hours of an advocate’s time
- 9% (85) were resolved by direct intervention, including calling an insurance company, calling providers, writing letters, gathering supporting medical documentation, etc.
- In the remaining cases (49), clients withdrew, resolved the issue on their own, or had some other outcome.

Appeals: The HCA assisted 32 individuals with appeals: 24 Fair Hearings, 1 Commercial Insurance – Internal 1st Level appeal, 1 Commercial External Appeal, 2 Medicare Part D appeal, and 4 Medicaid MCO Internal appeal.

DVHA Beneficiary Calls

We closed 301 DVHA cases this quarter, compared to 257 last quarter:

- 35% (105) were resolved by brief analysis and/or advice
- 26% (80) were considered complex intervention, which involves complicated analysis, usually direct intervention, and more than two hours of an advocate’s time
- 26% (78 cases) were resolved by brief analysis and/or referral
- 9% (29) were resolved by direct intervention on the caller’s behalf, including advocacy with the carrier and providers, writing letters, and gathering medical information

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

- In the remaining cases clients withdrew, resolved the issue on their own, or had some other outcome.

Appeals: The HCA assisted 10 DVHA beneficiaries with appeals: 5 Fair Hearings, 2 Medicare Part D appeal, and 3 Medicaid MCO Internal appeal.

Commercial Plan Beneficiary Calls

We closed 214 cases involving individuals on commercial plans, compared to 199 last quarter:

- 35% (74 cases) were resolved by brief analysis and/or advice
- 30% (65) were considered complex intervention, which involves complicated analysis, usually direct intervention, and more than two hours of an advocate's time
- 17% (36) were resolved by brief analysis and/or referral
- 15% (33) 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: 19 Fair Hearings, 1 Commercial Insurance – Internal 1st Level appeal, 1 Commercial Insurance – External appeal, 2 Medicare Part D appeals, and 1 Medicaid MCO Internal appeal.

B. All Calls Case Outcomes

The HCA helped 99 people get enrolled in insurance plans and prevented 20 insurance terminations or reductions. We obtained coverage for services for 31 people. We got 14 claims paid, written off, or reimbursed. We estimated VHC insurance program eligibility for 37 more. We provided other billing assistance to 16 individuals. We provided 538 individuals with advice and education. Twelve people were not eligible for the benefit they sought, and nine were responsible for the bill they disputed. We obtained other access or eligibility outcomes for 106 more people.

Consumer Protection Activities

A. Rate Review

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

One new rate filing was decided during the quarter covering January 2018 through March 2018. The HCA filed a Notice of Appearance and a Memorandum in Lieu of Hearing in the matter. Additionally, five rate filings were pending at the end of the quarter.

The one decided filing involved the premium rates that the Cigna Health and Life Insurance Company (CHILIC) will charge large employer groups in 2018. Roughly 500 Vermont members will be affected by this rate filing. CHILIC proposed an average 6.2 percent increase for its large group book of business. CHILIC's proposed rate was reduced to 2.7 percent.

The five pending rate filings are Blue Cross and Blue Shield of Vermont's 2019 large group filing, The Vermont Health Plan's 2019 large group filing, MVP's 2018 large group HMO 3Q/4Q filing, MVP's 2018 POS large group 3Q/4Q filing, and MVP's 2018 small group 3Q/4Q filing. These five filings collectively

impact approximately 17,800 Vermont members. The HCA has filed Notices of Appearance in all five of these matters and we intend to file all appropriate memoranda and other documents and to represent the interests of Vermonters affected by these filings.

This quarter, the HCA also devoted substantial effort to modify the rate review process to allow the HCA to better represent the interests of Vermonters. We engaged multiple stakeholders in this effort including Green Mountain Care Board staff, Blue Cross and Blue Shield of Vermont staff, MVP staff, and state legislators. The HCA is hopeful that its efforts will result in meaningful changes to the rate review process although we have laid the groundwork for a possible statutory solution next legislative session should that be necessary.

B. Certificate of Need

The HCA participates in Certificate of Need (CON) processes as an “interested party” to ensure that approved health care investments are in the best interests of Vermonters. During the last quarter, the Green Mountain Care Board (Board) asked the legislature to make changes to the state statute governing its certificate of need review process. The HCA testified before the House Health Care Committee and asked for several changes to the Board’s proposal: 1) The Board’s proposal asked for the statute to allow the Board to index CON thresholds at the rate of medical inflation. The HCA asked the committee to retain the current statutory language, limiting indexing to the rate of general inflation; 2) Currently, facilities such as urgent care centers are excluded from CON review. The HCA asked for a statutory change to bring within the Board’s CON jurisdiction freestanding walk-in clinics; 3) The Board’s proposal excluded routine replacement of non-medical equipment. The HCA asked for these terms to be clearly defined if this exclusion is added to the statute; 4) The HCA asked for the statute to require more transparency on the process for CON expedited review. Currently, if a CON project goes under expedited review, the Board can follow any process it chooses and does not publicly disclose what the process will be, making it difficult for the public and other stakeholders to participate; 5) The Board proposed removing projects that repair, renovate, or replace infrastructure from CON review. The HCA asked for this type of CON application to continue to be subject to CON review or for the exclusion to be narrowed to those projects that do not involve new construction, is unlikely to significantly increase the cost of medical services to patients, and will not impact the provision of medical services to patients; 6) The Board’s proposal removed the option for potential interested parties to apply during the 20 day period following the close of a CON application, leaving just the first 20 days after a CON application is filed for someone to apply for interested party status. The Board argued that the period after the application has closed delayed the process unnecessarily. The HCA opposed this change because the initial 20 day period is too short for many potential applicants to reasonably assess whether they want to intervene. Often CON reviews take more than a year and large amounts of information on the project are not made available until well after the first 20 days. The HCA asked for potential interested parties to be allowed to apply any time within the Board’s review of a CON application, ending 5 days after the application closes; and 6) The HCA asked for the statute to require a more robust review of energy efficiency measures to ensure potential energy efficiency financial savings are maximized. The Board and the HCA worked together to modify the Board’s proposal and came to a consensus that satisfied most of the HCA’s concerns. The bill is currently pending at the legislature.

C. Hospital Budget Review

The HCA participates in the Board’s annual hospital budget review process. This quarter, we worked with Board staff to improve our role in the process. We met with Board staff and together determined that asking our standard questions as early in the process as possible would help the summer review period go more smoothly for the Board, the HCA, and the hospitals. We submitted a set of questions to

the Board, and the Board incorporated some of our questions into its own budget guidance. Additionally, the Board voted to include our full set of questions as an attachment to the hospital budget guidance, which was sent out to all hospitals in March. We look forward to receiving the written answers to our questions when the hospitals submit their budget materials in June or July, and anticipate that having these answers earlier in the process will allow us participate more meaningfully in the review process and to use the hearing time more efficiently.

D. Oversight of Accountable Care Organizations

This quarter, the Board and the HCA received the Blue Cross Blue Shield of Vermont 2018 contract with OneCare Vermont (deemed confidential by the Board). Submission of payer contracts is one of the conditions imposed by the Board in its approval of OneCare Vermont's 2018 budget. The HCA also continued to track the Board's ACO certification process and other budget contingencies, including attribution numbers which were released this quarter.

Additionally, this quarter the HCA participated in two meetings convened by the Board related to development of the OneCare Vermont measure set for 2019. We continue to advocate for measures that look at the patient experience and adequately capture quality of care and access. This work is ongoing.

E. Other Green Mountain Care Board Activities

During the last quarter, the HCA participated in several stakeholder groups organized by the Green Mountain Care Board in addition to attending weekly Green Mountain Care Board meetings. The Federal Issues Work Group was organized to discuss state issues that could arise as a result of changes made by the federal government. The HCA has been an active member of this group. The first issue the group worked on was the loss of federal cost sharing reduction funding for health insurance exchange plans. The group agreed on a solution to this issue, which required a statutory change. The HCA and other stakeholders supported the statutory change before the legislature and the bill passed. The group also did some work related to both proposed and final federal rule changes to short-term insurance plans and association health plans, and again supported a bill to address the issues in Vermont. During the current legislative session, the legislature passed a bill that tasked the federal issues working group with addressing whether Vermont would benefit from a state mandate requiring all Vermonters to have health insurance, and if so, how such a mandate should be structured. The bill required the group to include a representative from the HCA.

During this time the HCA also submitted public comments to the Board regarding the Board's approval of 2019 qualified health plan benefits and the Board staff's proposed changes to the Board's Data Governance Council Charter. For the qualified health plan benefits, we asked the Board to increase the benefit richness of silver plans to the maximum allowed by the federal government. This would allow individuals who receive subsidies to have the richest plans possible with no increased premium costs. It also would minimize the financial losses health insurers will experience from paying for cost sharing reductions, because richer plans would require less cost sharing subsidization. Ultimately, the Board decided to consider this argument in future years but did not make the change this year.

Separately, we submitted comments arguing that the Data Governance Council Charter did not include sufficient details to ensure that the Board functioned efficiently. We pointed out that the charter gave very little information about the purpose and powers of the Council as a whole and allows almost all decisions to be dictated by the chair, a position which is automatically held by the director of the Board. It does not require the chair to have any experience or expertise in data governance. We asked the

Board to take its role as a steward for Vermont’s health care data seriously and ensure that the Council is well designed. The Board adopted some of our suggestions including requiring the full Council to vote on any changes to Council members, instead of allowing the chair to make these changes unilaterally.

F. Affordable Care Act Tax-related Activities

Due to the tax filing season, our tax-related calls from consumers increased this quarter as detailed above. HCA advocates helped consumers get corrections made to their tax forms including 1095-As from VHC but also 1095-B forms from government plans and private insurance companies. Advocates answered questions about the individual shared responsibility provision and available exemptions, especially in light of the December 2017 tax legislation. VHC was able to correct forms 1095-A much more quickly than in past filing seasons. We are pleased to report that we heard from significantly fewer people this year who needed to file an extension on their taxes because they were waiting for a corrected 1095-A.

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. In this quarter, the HCA’s tax attorney spent significant time parsing the December 2017 federal tax legislation (the so-called Tax Cuts and Jobs Act) and advising the HCA policy team on its impact as they pursued administrative and legislative priorities.

Our tax technical assistance also increased with the filing season. 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 17 technical assistance questions (vs. 15 last quarter). She also responded to 43 technical assistance questions (vs. 30 last quarter) from Vermont tax preparers and legal aid attorneys. Common question topics included shared responsibility exemptions, advance premium tax credit reconciliation and repayment, and various questions about Modified Adjusted Gross Income (MAGI).

In December, the HCA’s tax attorney met with the IRS Office of Chief Counsel’s Healthcare Counsel to discuss emerging issues including how tax privacy restrictions affect consumers’ ability to find out why their VHC premium subsidies are ending. In late December the federal government changed its position and allowed the Marketplace to explicitly notify consumers that they are scheduled to lose subsidies due to failure to file taxes. This should help consumers avoid confusion and needless delay in fixing the problem.

In January, we learned through a Vermont Department of Taxes legislative presentation that a significant number of very low income Vermonters had paid an individual shared responsibility penalty in prior years. This group of Vermonters very likely should not have owed a penalty. We submitted an informal information request to the IRS Taxpayer Advocate for the State of Vermont. The IRS Taxpayer Advocate investigated and found that the IRS had sent letters to those taxpayers who it identified as likely eligible for an affordability exemption from the individual mandate. We will continue to monitor this issue and encourage government agencies to engage in proactive outreach when they have information suggesting that taxpayers are being harmed by tax filing confusion.

The HCA also engages in tax-related outreach and educational activities. This quarter we developed a fact sheet to educate consumers and tax preparers on ways to reduce MAGI in order to qualify for more affordable health insurance or minimize APTC repayment. This effort is described below in the **Outreach and Education** section.

G. Other Activities

Administrative Advocacy

❖ Access to Screening Mammography

This quarter the HCA continued to advocate for implementation of Act 25 of 2013, which requires first-dollar coverage of screening mammography including additional views. We believe that hundreds of women have been and continue to be charged cost-sharing and deductibles for call-back mammograms that should be fully covered under Vermont law. This law had an implementation date of over three and a half years ago, and yet it continues to not be followed. We are actively pursuing full implementation, which would save many Vermont women hundreds of dollars each year and reduce the financial barriers that make it harder for Vermonters to access these preventative cancer screenings.

❖ Access to Treatment for Hepatitis C Virus

On January 1 Vermont Medicaid implemented new treatment guidelines for Hepatitis C Virus (HCV) based on the Drug Utilization Review Board (DURB) recommendation from October 2017. The new guidelines allow Medicaid beneficiaries with HCV to be treated regardless of their disease stage. This quarter the HCA worked with providers at the University of Vermont Medical Center and submitted a data and information request to DVHA to ensure that the new guidelines are fully implemented. This quarter we also submitted a data and information request to the Vermont Department of Corrections (VTDOC) to determine if people in the custody of VTDOC are receiving comparable HCV care to people in the community.

The HCA continues to actively participate in the Vermont Department of Health Hepatitis C Task Force, and our Policy Analyst is a member of the Task Force Steering Committee. We attended two meetings of the Task Force Steering Committee this quarter.

❖ Health Care Stop Loss Insurance

The Chief Advocate testified before the Legislative Committee on Administrative Rules about the Department of Financial Regulation's proposed modifications to stop loss insurance regulations (H-2009-02), which make it easier for companies to offer self-insured health plans. The HCA submitted written comments in the prior quarter. HCA's LCAR testimony repeated our written concerns that making it easier for small employers to self-insure undermines the State of Vermont's health care reform agenda. Increased self-insurance could hurt the small group market and consumers and places additional health insurance plans beyond the state's regulatory reach. Self-insured plans are not subject to many of the consumer protections of the Affordable Care Act, yet the offer of insurance can disqualify low and moderate-income consumers from subsidized ACA-regulated plans. We remain concerned about DFR's approach to this issue.

❖ Health Care Administrative Rules (HCAR)

The Agency of Human Services (AHS) continued its gradual and systematic revision of Medicaid rules known as the Health Care Administrative Rules (HCAR) project. HCA supports the project and has committed significant resources to leading VLA's review of all HCAR rules, both in draft form and when officially proposed.

This quarter we submitted substantial formal public comments on AHS's proposed HCAR rule on Internal Appeals, Grievances, Notices and State Fair Hearings on Medicaid Services. We raised significant concerns about how federal managed care reforms are implemented in Vermont in light of the unique

nature of Global Commitment. The comments were a joint effort with the Elder Law Project, the Disability Law Project, and the Vermont Ombudsman Project of VLA.

In January we also submitted formal public comments on Medicaid Cost-Sharing and Medicaid Benefit Delivery. These comments were a joint effort with the Elder Law Project and the Vermont Ombudsman Project of VLA.

Some HCAR rules on which we previously commented were finalized this quarter including Non-covered Services, which was substantially improved from the first draft on which we commented in 2017. This quarter we attended the Legislative Committee on Administrative Rules meeting at which this rule was reviewed.

HCA also coordinates VLA's response to HCAR developments on which we do not comment. One set of informal comments was submitted this quarter on Durable Medical Equipment, written by the Disability Law Project of VLA.

❖ **Comments on HHS proposed rule, "Protecting Statutory Conscience Rights in Health Care"**

The HCA submitted comments to the federal Department of Health and Human Services (HHS) in response to its proposed rule permitting increased discrimination in health care. The proposed regulation would exacerbate the challenges that many patients --especially women, LGBTQ people, people of color, immigrants and low-income people --already face in getting the health care they need in a timely manner and at an affordable cost. The rule would expose vulnerable patients to increased discrimination and denials of medically-indicated care by broadening religious health care provider exemptions beyond the existing limited circumstances allowed by law.

❖ **Vermont Health Connect Escalation Path**

The HCA and VHC continue to collaborate to resolve complex VHC issues. The VHC escalation path now also works to resolve issues regarding Medicaid for Aged, Blind and Disabled (MABD), Medicare Savings Programs, Medicaid Spenddowns and V-Pharm. We communicate with VHC multiple times a day and meet as needed to discuss the most difficult cases.

❖ **Comments on Vermont Health Connect Notices**

At VHC's request, the HCA commented on 4 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 Chief Health Care Advocate continue to co-chair and actively participate in Vermont's Medicaid and Exchange Advisory Board (MEAB).

Legislative Activities

The HCA has put considerable time and effort into focusing on legislative advocacy this quarter. A significant theme of this work has been in response to actions or potential actions from the Federal Government that would have a negative impact on the stability of Vermont's health insurance marketplace.

- **S.19** – Silver loading bill passed both houses and has been signed by the governor. The HCA joined with other advocates to successfully change the organization of Vermont's marketplace

to allow for a silver loading with reflective silver plans to maintain Cost Sharing Supports for lower income Vermont families and focusing those costs on premiums for people who receive Premium Tax Credits.

- Advocated for **H. 696** - Individual mandate bill passed the House and has not been acted upon by Senate Finance committee at the end of the quarter. This bill established a state individual mandate and established a working group to work over the interim to develop strategies to potentially establish penalties or incentives to maintain a high rate of health insurance participation.
- **H.892** – Short Term, Limited Duration health insurance coverage and Association Health Plan regulation bill passed the House and has not been acted upon by Senate Finance at the end of the quarter. This bill establishes that Short Term Limited Duration plans cannot be longer than 3 months and cannot be renewed in Vermont. It also requires the Department of Financial Regulation to engage in rulemaking to regulate Association Health Plans.
- **H.912** - An act relating to the health care regulatory duties of the Green Mountain Care Board. Passed by the House and has not been acted upon by Senate Health and Welfare as of the close of the quarter. The HCA engaged significantly and successfully on the CON portion of this bill as well as other incidental sections including the creation of a workgroup to focus on the regulation of freestanding health care facilities. H.912 was also the context in which we engaged in an important conversation about the HCA’s ability to ask relevant questions in the Rate Review process. While this advocacy did not result in an update of the statutes, it did result in a memorandum from the Chair of Senate Health and Welfare calling on the GMCB and the HCA to improve the process to assure that the HCA is able to access the information it requests of carriers while not unjustifiably increasing the administrative burdens of the insurers.
- **S. 262** - An act relating to miscellaneous changes to the Medicaid program and the Department of Vermont Health Access. S. 262 passed the Senate and has not seen final action in the House Health Care committee as of the close of the quarter. The HCA and VLA advocated for some important changes to this bill with a focus on appropriate notice to applicants that DVHA is using electronic asset verification to review Medicaid eligibility, developing a system to give beneficiaries appropriate assistance asking for a fair hearing after an internal appeal, as well as a minor update to the factors that can lead to a secretary reversal of a HSB decision.
- **H. 905** - An act relating to the Green Mountain Care Board’s bill back formula. This bill passed the House Health Care Committee and became a part of a larger tax bill in House Ways and Means. The HCA was a member of the stakeholder group that developed this proposal and supported its passage.
- **H. 404** - An act relating to Medicaid reimbursement for long-acting reversible contraceptives was passed by the House and is awaiting final action in Senate Health and Welfare at the end of the quarter. The HCA supported this bill in each stage of action.
- **H. 639** - An act relating to banning cost-sharing for all breast imaging services. This bill passed the House and has not seen substantial action in Senate Finance. This is a bill that the HCA requested legislators introduce this year.
- **H. 914** - An act relating to reporting requirements for the second year of the Vermont Medicaid Next Generation ACO Pilot Project. This bill passed the House and is awaiting final action in Senate Health and Welfare at the end of the quarter. The HCA generally supported this bill. We testified about specific areas of concern.
- **S. 53** - An act relating to a universal, publicly financed primary care system. S.53 has passed the Senate and is awaiting action in House Health Care. The HCA testified in favor of this bill in both the Senate and the House.

- **S. 176** - An act relating to the wholesale importation of prescription drugs into Vermont, bulk purchasing, and the impact of prescription drug costs on health insurance premiums. S.176 passed the Senate and is awaiting action from House Health Care. The HCA supports this bill and tracked it through the process.

Collaboration with Other Organizations

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

- American Civil Liberties Union of Vermont
- Bi-State Primary Care
- Blue Cross Blue Shield of Vermont
- Community Catalyst
- Families USA
- IRS Taxpayer Advocate Service
- Ladies First
- MVP Health Care
- OneCare Vermont
- Planned Parenthood of Northern New England
- University of Vermont Medical Center
- Vermont Association of Hospitals and Health Systems
- Vermont Care Partners
- Vermont CARES
- Vermont Coalition of Clinics for the Uninsured
- Vermont Department of Health
- Vermont Department of Taxes
- Vermont Health Connect
- Vermont Medical Society
- Vermont Program for Quality in Health Care
- VNAs of Vermont
- Voices for Vermont's Children

Outreach and Education

A. Increasing Reach and Education through the 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 (<https://vtlawhelp.org/health>) with more than 250 pages of consumer-focused health information maintained by the HCA.

HCA advocates work diligently to keep the site updated in order to provide the latest and most accurate information to Vermont consumers.

Popular Web Pages

- The total number of **health pageviews increased by 2%** in the reporting quarter ending March 31, 2018 (11,908 pageviews), compared with the same quarter in 2017 (11,676 pageviews).

- The **top-20 health pages** on our website this quarter with change over last year:
 - [Income Limits – Medicaid](#) – 3,320 pageviews (16% ↓)
 - [Health](#) – section home page – 1,515 (28% ↑)
 - [Resource Limits – Medicaid](#) – 496 (138% ↑)
 - [Services Covered by Medicaid](#) – 495 (41% ↑)
 - [Vermont Choices for Care](#) – 430 (6% ↑)
 - [Dental Services](#) – 370 (27% ↓)
 - [HCA Online Help Request Form](#) – 218 (85% ↑)
 - [Health Insurance, Taxes and You](#) – 205 (45% ↓)
 - [Buying Prescription Drugs](#) – 216 (41% ↑)
 - [Long-term Care](#) – 188 (68% ↑)
 - [Choices for Care Resource Limits](#) – 186 (39% ↑)
 - [Federally Qualified Health Centers](#) – 167 (27% ↑)
 - [Medicare Savings / Buy-In Programs](#) – 165 (14% ↑)
 - [Advance Directive Forms](#) – 148 (135% ↑)
 - [Choices for Care Income Limits](#) – 148 (9% ↓)
 - [Medicaid](#) – 148 (35% ↓)
 - [Prescription Assistance – State Pharmacy Programs](#) – 143 (86% ↑)
 - [Choices for Care Requirements](#) – 135 (100% ↑)
 - [Medicaid and Medicare dual eligible](#) – 131 (24% ↓)
 - [Medicaid Transportation](#) – 127 (119% ↑)

- Besides the pages listed above, other **spikes in interest** in our pages included:
 - [Health home page](#) – 1,515 (28% ↑)
 - [Long-term Care Help](#) (new page) – 91 (100% ↑)
 - [Medical Marijuana Registry Forms](#) – 33 (450% ↑)
 - [Health Centers and Clinics](#) – 27 (800% ↑)
 - [Get Help with Part D Costs](#) – 27 (200% ↑)
 - [Understanding Health Care Costs](#) – 25 (178% ↑)

Popular PDF Downloads

26 out of 75 or 35% of the **unique PDFs downloaded** from the Vermont Law Help website were on health care topics. Of those unique health-related PDF titles:

- 16 were created for consumers. The top five consumer-focused PDF downloads were:
 - [Advance Directive, short form](#) (124 downloads)
 - [Advance Directive, long form](#) (89 downloads)
 - [Vermont Dental Clinics Chart](#) (75 downloads)
 - [Simple 5-Step Guide to Getting DME through Medicaid](#) (40 downloads)
 - [Vermont Medicaid Coverage Exception Request Form](#) (29 downloads)
 - The advance directive forms were accessed much more often this year as compared to the same period last year (213 downloads versus 64 last year).
- 4 were prepared for lawyers, advocates and assisters who help consumers with tax issues related to the Affordable Care Act. The top advocate-focused download was:
 - [PTC Rule Allocation Summary](#) (11 downloads)
- 6 covered topics related to health policy. The top policy-focused download was:
 - [VT ACO Shared Savings Program Quality Measures](#) (6 downloads)

The *Advance Directive Short Form* is the **fifth most downloaded of all PDFs** downloaded from the entire Vermont Law Help website. The *Long Form* is the **seventh most downloaded**.

The *Vermont Dental Clinics Chart* is the **eighth most downloaded of all PDFs** downloaded from the entire Vermont Law Help website.

New Online Help Tool Adds to Our Reach

In 2017 we added a new Health section to the online help tool on our website. It is found at https://vtlawhelp.org/triage/vt_triage and it can be accessed from most pages of our website. Our first Health topic was posted in June and a final section was added in October 2017.

The website visitor answers a few questions to find specific health care information they need. The new feature addresses some of the most popular questions that are posed to the HCA. In addition to our deep collection of health-related web pages, the online help tool adds a new way to access helpful information — at all hours of the day and night. The website user can also call us or fill in our online form to get personal help from an advocate.

Website visitors used this new tool to access health care information **161 times** during this quarter. That's an **18% increase** over the previous quarter.

Of the 44 health care topics that were accessed using this tool, the top topics were:

- Dental Services - I need help finding a low-cost dentist and paying for dental care.
- Dental Services - I need help with dentures.
- Long-Term Care - I have a nursing home complaint.
- Long-Term Care - I want to go over my long-term care options (nursing homes, in-home care, and more).
- Long-Term Care - How do I know if I can get Choices for Care Long-Term Care Medicaid?

B. Other Outreach and Educational Activities

Legislative Day (January 12, 2017)

HCA advocates participated in an outreach event at the Statehouse. HCA advocates talked about constituent services and distributed brochures.

Outreach at the Community Health Center (January 24, 2018)

HCA advocates visited the Community Health Center to discuss Medicaid coverage rules for transgender patients and explain how the HCA advocates for patients.

Kinney Drug Referral Program (February and March 2018)

HCA advocates visited Kinney drugstores throughout the state to discuss the HCA and our referral program and the HCA's policy initiatives for drug coverage.

Tax Time PTC Reminder Fact Sheet (March 8, 2018)

The HCA developed a simple fact sheet to inform consumers and tax preparers of the Premium Tax Credit's benefit cliff at 400% of the federal poverty line. The fact sheet tells consumers they may be able to save significantly on their health insurance and tax credits by contributing money to a retirement

plan. In some cases contributions can be made until the tax filing deadline. The HCA urged consumers to consult their tax advisor to see if they could lower their income for PTC purposes. HCA partnered with the Vermont Department of Taxes to distribute the fact sheet through the Department of Taxes' subscription email lists.

Meeting with Public Defender's Office (March 13, 2018)

HCA advocates met with the Public Defender's office and explained what the HCA does and how we can help. The advocates shared HCA cards and brochures.

Are You Leaving Money on the table? (April 9, 2018)

Mike Fisher, the Chief Health Care Advocate, went on WDEV Radio to educate Vermonters about the opportunities for tax credits and promote the HCA's Tax Time PTC Reminder fact sheet.

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 made plain language edits and edits/comments to improve comprehension of message and ability to resolve the problem being addressed in the following notices/letters:

- Macros Language Review
- Macros with Referral to VHC
- EE605-MM, Withdrawn cases-Active MCA
- Dr. D premium reduction notices

Office of the Health Care Advocate

Vermont Legal Aid
264 North Winooski Avenue
Burlington, Vermont 05401
800.917.7787

<http://www.vtlegalaid.org/health>

