VERMONT LEGAL AID, INC.

OFFICE OF HEALTH CARE OMBUDSMAN

264 NORTH WINOOSKI AVE.
P.O. BOX 1367
BURLINGTON, VERMONT 05402
(800) 917-7787 (VOICE AND TTY)
FAX (802) 863-7152
(802) 863-2316

OFFICES:

BURLINGTON
RUTLAND
ST. JOHNSBURY

OFFICES:

MONTPELIER
SPRINGFIELD

QUARTERLY REPORT
April 1, 2013 – June 30, 2013
to the
DEPARTMENT OF FINANCIAL REGULATION
and the
DEPARTMENT OF VERMONT HEALTH ACCESS
submitted by
Trinka Kerr, Vermont Health Care Ombudsman
July 17, 2013

I. Overview

This is the Office of Health Care Ombudsman's (HCO) report to the Department of Financial Regulation (DFR) and the Department of Vermont Health Access (DVHA) for the quarter April 1, 2013, through June 30, 2013. In addition to operating a hotline to provide individual consumer assistance, the HCO also does policy work and represents the public in Green Mountain Care Board activities and rate review proceedings.

There are six parts to this report: this narrative section which includes a table of all calls the HCO hotline received, broken out by month and year; a website update; and four data reports. One data report has the HCO statistics for all of the calls. The other three data reports are based on the insurance status of the client at the time the case was initiated, i.e. the client was a commercial plan beneficiary, a DVHA program beneficiary or uninsured. We don't get a caller's insurance status in every case. In the interests of efficiency, sometimes we don't ask if it is not relevant to the caller's issue.

Note that the most accurate information about eligibility for state programs is in the All Calls data report because callers who had questions about the DVHA programs fell into all three insurance status categories.

The HCO database allows us to track more than one issue per case, so that we can see the total number of calls that involved a particular issue. In each section of this narrative we note whether we are referring to data on primary issues, or both primary and secondary issues. One call can involve multiple secondary issues.

A. Total call volume decreased by 14% from last quarter, but was about the same as the second quarter in 2012.

All Calls

The HCO received 721 calls this quarter, compared to 835 in the first quarter of this year. In 2012 we received 717 calls in the second quarter. In 2011 we received 788, and in 2010, we received 677. April's call volume of 253 was similar to the 252 in April 2012. May's was lower, 228 as compared to 242 last year, and June's was higher, 240 as compared to 223. There was no identifiable reason for the decrease in May.

B. The top issues generating calls

This section includes **both** primary and secondary issues. The affordability of health care, information about applying for state programs, complaints about providers and access to prescription drugs continue to be the most common reasons for calls

All Calls (721, compared to 835 last quarter)

1. Affordability 116 (compared to 135 last quarter)
2. Information about applying for DVHA programs 113 (112 last quarter)
3. Complaints about Providers 104 (89 last quarter)
4. Access to Prescription Drugs 73 (94 last quarter)
5. Eligibility for VHAP 69 (82 last quarter)
   Communication Problems with DCF 69 (69 last quarter)
6. Eligibility for Medicaid 57 (68 last quarter)
7. Access to Mental Health treatment 38 (28 last quarter)
8. Consumer Education about Fair Hearings 31 (35 last quarter)
9. Eligibility for Premium Assistance 30 (50 last quarter)
   Transportation to medical care 30 (26 last quarter)
10. Access to Specialty Care 29 (26 last quarter)
11. Consumer Education about Medicare 28 (42 last quarter)
12. Access to Substance Abuse treatment 22 (24 last quarter)
13. Access to Durable Medical Equipment & Supplies 19 (13 last quarter)
14. Access to Dental Care 18 (23 last quarter)
15. DCF Eligibility Mistake 17 (35 last quarter)

DVHA Beneficiary Calls (363, compared to 441 last quarter)

1. Complaints about Providers 56 (55 last quarter)
2. Affordability 49 (57 last quarter)
3. Information about applying for DVHA programs 43 (52 last quarter)
   Access to Prescription Drugs 43 (40 last quarter)
4. Communication Problems with DCF 37 (33 last quarter)
5. Eligibility for VHAP 34 (40 last quarter)
6. Fair Hearings 28 (26 last quarter)

7. Transportation to medical care 27 (24 last quarter)
8. Eligibility for Medicaid 25 (38 last quarter)
9. Access to Mental Health treatment 20 (17 last quarter)
10. Access to Specialty Care 16 (18 last quarter)
11. Access to Substance Abuse treatment 15 (17 last quarter)
12. Eligibility for Medicaid Spend Down 13 (13 last quarter)
    Medicaid Billing 13 (8 last quarter)

[See the table at the end of this narrative for monthly detail related to total call volume.]

C. Lack of affordability remains the largest barrier to consumer access to health care, even for the insured, and especially for DVHA beneficiaries.

The high cost of health care continued to be the most-identified barrier to access to health care. The HCO had 116 calls, about 16% of all calls, in which the consumer said that cost was making it difficult for them to get care. This is the same percentage of callers with this problem as last quarter. Of these 116 calls, 49 or 42 % were from DVHA beneficiaries. The inability to access care due to the cost of a service, or the cost of insurance, is an issue for consumers across all groups, those insured by state programs, federal programs, private companies, and the uninsured.

D. Desire for more information about DVHA programs remains high.

The HCO continues to provide consumer education about DVHA programs to a high percentage of callers, which is related to the affordability problem. It was once again the second most common issue overall, with 113 calls. Interest in DVHA's programs is due to a number of factors: the cost of commercial plans and health care generally, the high degree of complexity of the programs which results in questions about the rules and navigating the requirements for eligibility, confusing notices from DCF, and insufficient education provided by DCF eligibility staff or Member Services.

E. Complaints about providers continue, especially from DVHA beneficiaries.

Calls about problems with providers increased to 104 from 89 last quarter, or about 15% of all calls. Of those, 56 calls or 53% were from DVHA beneficiaries, compared to 55 last quarter. The reasons for these calls are varied. They range from claims of rude treatment to medical malpractice.

F. Problems with mental health treatment increased by 36%.

More callers had problems related to mental health care this quarter, 38 calls compared to 28 last quarter. More than half of the callers (22) were on DVHA programs. Although 38 calls is only 5% of All Calls, we decided to look more deeply at the reasons for the calls. This closer examination revealed the following issues:

- 7 callers couldn't get mental health treatment because they were uninsured
- 5 callers couldn't find a psychiatrist
- 4 involved commercial plan denials of residential treatment or inpatient hospitalization
- 4 callers couldn't find a therapist
- 3 couldn't get to MH appointments due to transportation problems
- 2 who had Medicaid and Medicare were having trouble getting care because their therapists did not have the right credentials for Medicare payment
- 2 were going to be discharged from a psych ward in a hospital and needed help finding outpatient care and a place to live
- 2 involved commercial plan denials of psych meds
- 1 wanted help finding care after leaving the Emergency Department of a hospital, which he had visited because he was suicidal
- 1 was having a problem getting psych meds that were court ordered
- 1 wanted help finding aftercare because he was about to leave residential treatment
- 1 wanted to know how to find residential treatment
- 1 wanted help getting Medicaid to pay for an emotional support dog
- 1 wanted help getting an airline to allow her emotional support dog to fly with her
- 1 said her psychiatrist was not managing her medications properly
- 1 had a complaint about the food on the psych ward at a hospital
- 1 complained of treatment at a psych ward at a hospital (he said he was being tortured)

G. More consumers are asking questions about the marketplace.

The HCO is starting to get more callers asking for information about health care reform and what the new marketplace for health benefits in Vermont will mean for them. We are currently coding these cases as "Info re the ACA". This quarter we received 24 such inquiries. Last quarter we received 10. We expect the call volume about the marketplace to increase next quarter and will be adding codes to track new issues as they come up. In addition to receiving more inquiries through our hotline, the HCO's new health care reform section on our website received 47 pageviews, with an average viewing time of 7:56 minutes (which, I am told, is an amazingly long time). See section III below for more information about our website changes.

H. Recommendations to DVHA

- *Ask DCF eligibility workers to return HCO advocate calls promptly.* We have noticed that it seems to be taking longer and longer for eligibility workers and supervisors to get back to us. We try to resolve as many problems as we can without going to Health Care Operations (AOPS), but that is becoming harder to do.

- *Assign designated workers to assist individuals with Medicaid Spenddowns.* This is a repeated request from last quarter, as the processing of spenddowns actually seems to be getting slower. The same number of people called this quarter regarding spenddowns as last quarter, 13. Individuals on spenddowns frequently have problems understanding and navigating the program.
- *Encourage DCF staff and Member Services to make sure their clients understand how the DVHA programs work. Provide applicants and beneficiaries with written materials that explain the programs and checklists.* This is a repeat recommendation from last quarter because we continue to get calls from individuals who are confused about the requirements of the programs.
- *Improve notices to make them readable and clear.* This is also a repeat recommendation from last quarter as the current notices remain a big problem. We recently agreed to comment on the proposed Vermont Health Connect notices, which we are hoping will be more understandable.

I. The following information is included in this quarterly report:

- A table showing monthly totals for All Calls at the end of this narrative
- Four data reports based on type of insurance coverage:
  - **All calls/all coverages**: 721 calls;
  - **DVHA beneficiaries**: 363 calls or **50%** of total calls;
  - **Commercial plan beneficiaries**: 111 calls or **15%**;
  - **Uninsured Vermonters**: 67 calls or **9%** and
- Health Website Usage Report

II. Green Mountain Care Board activities

Pursuant to Act 48 of 2011 and Act 171 of 2012, the Green Mountain Care Board is required to consult with the HCO about various health care reform issues. HCO activities for the past quarter included:

- Attending nine regular Board meetings and one Board Advisory Committee meeting
- Participating in five meetings of the Accountable Care Organization (ACO) Measures Work Group convened by the Board's Director of Payment Reform and one meeting of the Patient Experience Survey Subgroup. This ACO work group is one of three groups working to support the Board's initiative to establish population-based payment pilots with ACO's. The group has been working to identify standardized measures that will be used for commercial plans and Medicaid to: evaluate the performance of Vermont's Accountable Care Organizations (ACOs), qualify and modify shared savings payments and guide improvements in health care delivery.
- Working with the Board and insurers on legislative revisions of the rate review process.

The Health Care Ombudsman is also a member of the State Innovation Model (SIM) grant steering committee, which held its first meeting this quarter.

Rate Reviews

While there were relatively few rate filings which were ready for review by the Green Mountain Care Board in this calendar quarter, the quarter included the two Vermont 2014 exchange product filings on which the HCO invested substantial time and resources. The HCO filed notices of appearance in ten new rate filing cases, appeared at the two contested hearings for the exchange filings and filed ten memoranda. At the end of June there were ten rate filings pending at either the DFR initial review stage or the DFR recommendation stage of the review process.

The HCO spent most of its time during the quarter reviewing the two filings for products to be offered on the state's health benefit exchange, Vermont Health Connect, by BCBSVT and MVP. These exchange product filings were filed on March 27th.

Due to the complex nature of the exchange filings, the carriers, the HCO and the Board spent much more time than is usual preparing for the hearings prior to DFRs recommendations to the Board. The Board held three pre-hearing conferences for each filing. At the HCO's suggestion, and in advance of the hearings, BCBSVT and MVP provided the HCO and the Board with interrogatories posed by the DFR's contracted actuary to the carriers and with the carriers' responses to these interrogatories.

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

The HCO worked with its contracted actuary, Allan I. Schwartz of AIS Risk Consultants in Freehold, New Jersey in reviewing the two filings. Mr. Schwartz prepared reports identifying issues with the filings and testified by phone at the June 18, 2013 and June 21, 2013 hearings. He recommended modifications to the rates based on an anticipated decrease in morbidity (health status) for the BCBSVT filing, and reduced medical and pharmacy trend assumptions in the MVP filing.

The Green Mountain Care Board issued its decisions for the exchange filings on July 8th. It modified the rate requests from both carriers. Major factors in the modifications included reduction of the proposed medical trend for MVP, and rate adjustments based on assumed changes in morbidity, reductions in pharmacy trend, and proposed levels of contributions to surplus for both carriers.

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

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

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

- In the TVHP 2013 small group filing, the Board lowered the rates beyond DFR's recommendations as requested by the HCO.
- For MVP's 2013 third and fourth quarter PPO filing, DFR recommended a 2% reduction in the carrier's contribution to surplus. The HCO asked the Board to remove the entire contribution to surplus. The Board removed the entire contribution to surplus, thus lowering the rate.
- In another TVHP filing, the Board agreed with the HCO's request to go beyond the DFR recommendation and lower the requested medical and pharmacy trends to the lowest point in the ranges calculated by DFR's actuary, thus lowering the rate.

The HCO worked with the Vermont Public Interest Research Group (VPIRG), the Vermont Campaign for Health Care Security and AARP to explain the public comment process for the two exchange rate filings and the proposed rate increase for Catamount Health. The HCO also persuaded the Board to extend the exchange filings public comment period for an additional week.

The HCO added additional staff to work on rate reviews this quarter. A law school intern, Kroopa Desai, began working with staff attorneys Lila Richardson and Kaili Kuiper in late May. She has assisted with research, writing memoranda and hearing preparation for rate review cases, particularly the two filings for the exchange.

III. Website update

This is a new section of our quarterly report. The HCO currently has funding from the federal government through the Affordable Care Act to update its website. The new website is under development, and we expect to launch it within the next few weeks. All of the health contents from the current site have been reviewed, revised or deleted and new contents have been created. Great efforts have been made to enhance consumer experience with the site, including improved search and navigation functions. A new platform and underlying structure will help us to obtain more accurate and specific information about website usage via Google Analytics. The new site is device-responsive, which means that the 12% of visitors who access

our site from mobile devices will find a site that is both readable and navigable on those devices.

We received 1,766 health-related views to the Vermont Law Help website this quarter, compared to 490 for the same period last year, an increase of more than 260%. Vermont Law Help is Vermont Legal Aid and Law Line's current joint website, which includes a Health section The average time viewers spent on a health page increased by more than 12% over last year. The number of health pageviews resulting from Google searches increased from 16 to 80, a 400% gain. We also are developing a new section on health care reform. That page received 47 pageviews, with 7:56 minutes average time on a page. We expect even greater viewing increases after we launch the new site and further improve the health care content.

[See the attached report called Health Website Usage Report for more detail.]

IV. Hotline call volume by type of insurance:

The HCO received 721 total calls this quarter. Callers had the following insurance status:

- **DVHA programs** (Medicaid, VHAP, VHAP Pharmacy, Premium Assistance, VScript, VPharm, or both Medicaid and Medicare aka dual eligibles) insured **50%** (363 calls), compared to 53% (440) last quarter;
- **Medicare** (Medicare only, Medicare and a Medicare Supplemental Plan aka Medigap, Medicare and Medicaid aka dual eligibles, Medicare and Medicare Savings Program aka Buy-In program, Medicare and Part D, or Medicare and VPharm) insured **29%** (209), compared to 30% (249) last quarter;
    - **Commercial carriers** (employer sponsored insurance, individual or small group plans, and Catamount Health plans) insured **15%** (111), compared to 16% (133) last quarter; and
    - **Uninsured** callers made up **9%** (67) of the calls, compared to 10% (84) last quarter.
    - In the remainder of calls the insurance status was either unknown or not relevant.

V. Disposition of closed cases

<u>All Calls</u>
We closed 745 cases this quarter, compared to 813 last quarter.

- 33% (245 cases) were resolved by brief analysis and advice;
- 24% (179) were resolved by brief analysis and referral;
- 20% (146) of the cases were complex interventions, which involves complex analysis, usually direct intervention, and more than two hours of an advocate's time;
- 15% (109) were resolved by direct intervention, including calling an insurance company, calling providers, writing letters, gathering supporting medical documentation, etc.;
- 5% (34) of the cases were resolved in the initial call.

- In the remaining cases, clients withdrew, resolved the issue on their own, or had some other outcome
- Appeals: 49 cases involved help with appeals.

DVHA Beneficiary Calls

We closed 391 DVHA cases this quarter, compared to 418 last quarter.

- 28% (109 cases) were resolved by brief analysis and advice;
- 26% (100) were resolved by brief analysis and referral;
- 20% (80) were considered complex intervention, which involves complex analysis, usually direct intervention, and more than two hours of an advocate's time;
- 20% (79) were resolved by direct intervention on the caller's behalf, including advocacy with DVHA and providers, writing letters, and gathering medical information;
- 3% of calls (11) from DVHA beneficiaries were resolved in the initial call.
- In the remaining cases, clients withdrew, resolved the issue on their own, or had some other outcome.
- Appeals: 31 cases involved help with DVHA program appeals, of which 6 were internal MCO appeals and 25 were Fair Hearings. In addition, two DVHA beneficiaries, who had Medicaid as secondary coverage, had external reviews through DFR because their primary insurance denied coverage for a service.

VI. Case outcomes

All Calls

The HCO helped 43 people get insurance and prevented 24 insurance terminations or reductions. We obtained coverage for services for 29 people. We got 21 claims paid, written off or reimbursed. We assisted 4 people complete applications for DVHA programs and estimated program eligibility for 24 more. We provided billing assistance to 18 individuals. We obtained patient assistance for 2 people. We provided 381 individuals with advice and education. We obtained other access or eligibility outcomes for 59 more people, many who will be approved for medical services and state insurance. We encourage clients to call us back if they are subsequently denied insurance or a medical service. In total, this quarter the **HCO saved individual consumers $23,299.31.**

DVHA Beneficiary Calls

The HCO prevented 22 terminations or reductions in coverage for DVHA beneficiaries, and got 7 more people onto different DVHA programs. We estimated the eligibility for other programs for 7 DVHA beneficiaries. We got 11 claims paid, written off or reimbursed. We got other billing assistance for 10 people, and hospital patient assistance for 1 individual. We obtained coverage for services for 23 individuals. We provided 192 DVHA beneficiaries with advice or education, and obtained other access or eligibility outcomes for 41 more people.

Case examples

Helped a working individual stay insured and maximized his coverage, allowing him to continue his substance abuse treatment and his employment. When Mr. A learned he was losing his VHAP because his employer had failed to return a form, he contacted the HCO for assistance. His HCO advocate learned that DCF had in fact already received the form. However, DCF then determined that Mr. A was actually over income for VHAP due to a pay increase. This meant he would go onto premium assistance for Catamount (CHAP). The HCO advocate assured that Mr. A would receive continuing coverage during the transition to the new plan. In addition, the advocate recommended that Mr. A enroll in the Catamount Blue Chronic Care Management Program so he could continue to get his daily substance abuse treatment. Without CCMP he would have had a copayment of $15 a day for his treatments. The advocate helped him enroll in the CCMP. Mr. A called the advocate back later because the CCMP enrollment had not been completed as expected. The advocate was able to get him enrolled in the CCMP and have it backdated so that the treatment clinic could be paid, as it had been treating Mr. A without payment for six weeks. This saved Mr. A $660.

Helped a consumer resolve a dispute over two deductibles so she could afford her medication. Mrs. B had employer sponsored insurance (ESI). She needed an extremely expensive prescription medication. Her ESI group plan was renewed on January 1st and included a $3,000 deductible. Because of the high deductbile, Mrs. B could not afford her medication. She was able to get assistance from a foundation to help pay for the medication in January. However, in February the carrier renewed the plan again, saying it had to do so because of the new state-mandated out of pocket prescription maximum. The new plan included a new deductible set at $2,500. This meant that the insurer expected Mr. and Mrs. B to meet another annual deductible, or two deductibles in the space of two months. The foundation which had assisted them earlier would not help with two deductibles in the same year. The carrier refused to apply the previous deductible payment to the new deductible. After trying to solve the problem on her own for two months, Mrs. B called the HCO for help. The HCO advocate advised her to file a complaint against the carrier through DFR, and helped her file it. Within a month the carrier agreed to apply the first deductible to the second contract, saving Mr. and Mrs. B $2,125.

Identified and resolved a coordination of benefits problem so a child could get his medication. The mother of C called the HCO because she was having trouble getting a specialty medication for him. The medication had to be special ordered for overnight mail delivery. C had both ESI through his mother and Dr. Dynasaur. His mother's employer switched carriers and plans on January 1st. The new primary insurer's mail order pharmacy did not work properly with the Dr. Dynasaur, and C's mother was charged a copayment of about $1,000. For two weeks she tried to figure out what the problem was. Everywhere she turned she got different and conflicting answers. Eventually she called the HCO. The HCO advocate investigated and learned that the issue was that the ESI plan's specialty pharmacy was not contracted with Vermont Medicaid. Working with DVHA, the HCO was able to resolve the problem so that the family could get the medication. The ESI paid first and Dr. Dynasaur paid the coinsurance. This saved C's mother $1,000.

Got an uninsured individual in severe pain onto insurance quickly. D called the HCO following an emergency room visit the previous week. At the time of the ER visit, D was in extreme pain, which he later learned was due to a kidney stone. The ER physician referred him to a urologist for specialized care to resolve the underlying problem. Though in considerable pain, D was delaying the urology appointment because he was uninsured and could not afford it. D told the HCO he had been uninsured for seven years and had never heard of Green Mountain Care. The HCO advocate explained that he should be eligible for VHAP and helped him file an online application. Within three days Mr. D was enrolled in VHAP-Limited and able to get an appointment.

VII. Issues

The HCO divides calls into five issue categories. The breakout by issue category in this quarter based on the caller's primary issue was as follows. [See the DVHA data report for a similar breakdown for the DVHA beneficiaries who called us.]

- **29.40%** (212) of our total calls were regarding **Access to Care**;
- **13.18%** (95) were regarding **Billing/Coverage**;
- **.55%** (4) were questions regarding **Buying Insurance;**
- **9.15%** (66) were **Consumer Education**;
- **24.27%** (175) were regarding **Eligibility** for state programs, Medicare and Catamount Health plans; and
- **23.44%** (165) were categorized as **Other**, which includes Medicare Part D, communication problems with providers or plans, access to medical records, changing providers or plans, enrollment problems, confidentiality issues, and complaints about insurance premium rates.

The HCO database allows us to track more than one issue per case, so we can see the total number of calls that involved a particular problem. For example, although 175 cases had Eligibility as the primary issue, there were actually a total of 334 calls in which we spent a significant amount of time assisting consumers regarding access to health insurance. [See the breakouts of the issue numbers in the individual data reports for a more detailed look at how many callers had questions about issues other than the primary reason for their call.]

VIII. Table of all calls by month and year

All Cases

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
January	241	252	178	313	280	309	240	218	329	282	289
February	187	188	160	209	172	232	255	228	246	233	283
March	177	257	188	192	219	229	256	250	281	262	263
April	161	203	173	192	190	235	213	222	249	252	253
May	234	210	200	235	195	207	213	205	253	242	228
June	252	176	191	236	254	245	276	250	286	223	240
July	221	208	190	183	211	205	225	271	239	255	
August	189	236	214	216	250	152	173	234	276	263	
September	222	191	172	181	167	147	218	310	323	251	
October	241	172	191	225	229	237	216	300	254	341	
November	227	146	168	216	195	192	170	300	251	274	
December	226	170	175	185	198	214	161	289	222	227	
Total	2578	2409	2200	2583	2560	2604	2616	3077	3209	3105	1556