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Agency of Administration
Health Care Reform
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REPORT TO THE VERMONT LEGISLATURE

Consumer Protection Report

In accordance with Act 171 (2012), Section 26a

Submitted to
House Committee on Health Care
Senate Committee on Health and Welfare
Senate Committee on Finance

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Summary

The legislature created the Green Mountain Care Board (GMCB) under Act 48 of 2011. The GMCB has broad regulatory powers over Vermont's health care system, and currently shares responsibility for health insurer rate review and approval with the Department of Financial Regulation (DFR). The statute contemplates an even broader role for the GMCB if Vermont implements Green Mountain Care (the universal, publicly-funded program of coverage described in Act 48). Due to the breadth and importance of decisions of the GMCB's and other health care regulatory agencies and the critical need for effective public input into their work, the legislature requested in Act 171 of 2012 that the DFR, in collaboration with the state health care ombudsman (HCO) and the agency of human services (AHS), provide:

- recommendations on how best to represent the public interest before the GMCB and other regulatory agencies and estimates of resource needs;
- recommendations on how best to coordinate, and/or consolidate the consumer protection efforts of the ombudsman's office, the department, and the agency;
- recommendations on the ombudsman's current and projected funding and resource needs to meet existing statutory responsibilities;
- recommendations on funding mechanisms to meet existing statutory responsibilities.

The GMCB systematically incorporates public input in its decision-making processes through:

- Weekly public meetings that include time for public comment;
- Special public hearings on particularly significant decisions;
- Solicitation of public comment through a website and other means;
- Regular input from several broadly-representative advisory committees; and
- Incorporation of input from the state's Health Care Ombudsman in formal regulatory processes.

These mechanisms have resulted in valuable public input to the GMCB's decisions, but have not resulted in robust consumer representation in some areas, particularly health insurance rate review. Moreover, as the role of the GMCB expands to review of certificates of need and potentially expands in the future to overall health care budgeting and coverage decisions, the need for well-informed and effective representation of consumers will greatly increase.

In accordance with the requirements of Act 171, this report reviews current mechanisms for public input, with a particular focus on the role and funding of the HCO. The report concludes:

- Other models of consumer protection have proven effective within Vermont for other regulatory arenas and in other states for health care regulation. These models could enhance

consumer protection and representation in Vermont's health care policy-making and regulatory processes.

- At this point it is not clear that any particular model used elsewhere or used in Vermont for other policy areas is ideal. This is an area worthy of continued discussion as Vermont's regulatory processes and the role of the GMCB evolve.

- Current statutes and regulations provide significant protection to individual consumers against potential adverse impacts of health care regulatory processes and actions of regulated entities.

- Current statutes and regulations also provide significant advocacy for and representation of consumers in public policy discussions related to health care in Vermont.

- The current mechanism for consumer protection and representation relies very heavily on the HCO. In theory this could foster coordination and effectiveness, but in practice it has resulted in fragmentation and some limitations on effectiveness. Models from other states may result in more effective targeting of resources, more realistic assessments of the cost of these activities and better coordination of consumer protection.

- The link between individual consumer advocacy (case work) performed by the HCO and their work on public policy should be strengthened.

- The HCO receives just over $1 million in state and federal funding annually. These funds have varying renewal and end dates and pay for multiple advocacy efforts. This disjointed funding system has left the HCO overwhelmed and some state agencies dissatisfied with the HCO's public advocacy efforts.

- The HCO believes that any lack of public advocacy on its part should be remedied with increased funding.

- The State should review its contracts with the HCO across all agencies and redesign contractual requirements and assess contract amounts to assure that funds flowing to the HCO are better-coordinated and correlate with the highest priorities for consumer protection and advocacy, to assure that funds are adequate to support the expected activities and to better-specify performance expectations.

- There is broad agreement that better consumer protection in the health insurance rate review process is desirable.

- The HCO has proposed some short-term measures to address the limitations on their work in the current rate review process. DFR is not in agreement that these are appropriate steps at this time.

- There is a broad agreement that, for the future, consolidation of the two-step rate review process into a one-step process should be explored.

Potential models of consumer protection

In order to determine how to best represent the public interest before the Green Mountain Care Board and other regulatory agencies, this report looks towards models of consumer advocacy in other states and within Vermont. Health care advocacy programs in Connecticut, Oregon, and Maine were explored. Within Vermont, the Attorney General's Consumer Assistance Program, the Public Service Department, and DFR's Medicare supplemental health insurance rate review process were also examined.

Connecticut: Government Agency Public Advocacy Model

Connecticut's Office of the Healthcare Advocate is a state agency that provides advocacy to individuals who have been denied coverage or a claim by their insurance company; educates consumers in the insurance plan selection process; and proposes new legislation to remove barriers to health care access under managed care plans.[1] Whereas Vermont's HCO deals with all health care related issues, including state and federal programs, Connecticut's OHA is more closely aligned with the DFR's Consumer Service Specialists because it serves individuals with private health insurance. Connecticut's Office of the Healthcare Advocate has twelve advocates, including case managers with a nursing background.[2] For SFY 2013, OHA's budget is $1,478,865. In 2011, Connecticut's OHA opened 5,515 cases and took almost 9,000 calls. In a typical year, the office recoups around $6 million in insurance pay-outs.[3]

In 2010, OHA received a one-year Consumer Assistance Program (CAP) grant of $396,400 from the federal government. OHA used this funding for a Nurse Consultant Case Manager, a Licensed Clinical Social Work Case Manager, and an Outreach Coordinator/Data Analyst. The funding also allowed OHA to conduct 100 outreach events and conduct a large media campaign, complete with commercial, transit advertising, and mailings to physicians.

Connecticut's OHA provides public advocacy at the state and federal level. The director and general counsel typically do this work. In 2010, the OHA partnered with the Attorney General to oppose a 19 percent rate increase.[4] With the help of funding from the Attorney General, an actuary was hired to examine the rate increase and raise insufficiencies. The state's insurance department later denied the rate request. In 2011, the OHA tried to push legislation for public hearings on insurance rate increases, but the legislation was vetoed by Connecticut's governor. Subsequently, OHA and the state's insurance

[1] State of Connecticut, Office of Healthcare Advocate, *Report to the Governor on Fiscal Year 2012 Activities*, Aut. 1, 2012, available at: http://www.ct.gov/oha/lib/oha/documents/combined_fiscal_year_12_report_with_2011_annual_report.pdf.

[2] Victoria Veltri, Health Care Advocate, Connecticut Office of the Health Care Advocate, telephone conversation with author, Jan. 8, 2013.

[3] Michael Ollove, Stateline, *Connecticut Health Agency Fights Desperation Among the Insured*, Dec. 24, 2012, available at: http://www.kaiserhealthnews.org/stories/2012/december/24/connecticut-uninsured.aspx.

[4] Families USA, *States Making Progress On Rate Review*, Oct. 2011, available at: http://familiesusa2.org/assets/pdfs/health-reform/State-Progress-on-Rate-Review.pdf.

department came to an agreement that OHA could request up to four public hearings per year for rate increases of 15 percent or more in individual and small employer plans.[5] The OHA does not anticipate state funding for an actuary and is looking into other sources of funding for assistance with rate review.[6]

Maine: Rate Review Process

The attorney general's office and insurance division of Maine contracted with the non-profit Consumers for Affordable Health Care (CAHC) in 2010 to provide consumer assistance and in-depth reviews of rate filings. In order to ensure efficiency while having the greatest impact, CAHC looked at the rate increases from an insurance company that controlled 91 percent of the individual market. CAHC contracted with an actuary to review the filings, prepare analyses of the insurance company's rates, including contracts, high claims pool costs, administrative costs and profit load, and prepare reports.[7] Rate review hearings functioned much like a court trial, with the insurance division acting as judge, the attorney general's office representing the general public, and CAHC representing rate payers. For the one filing CAHC worked on, each party had at least one actuary, and CAHC hired an economist. The entire process took two to three months, including the five to six weeks to gather evidence before the hearing, preparation for the hearing, and a one to two day hearing. As a result of one of CAHC's hearings, an insurance company that proposed a 9.7 percent increase to its individual policies lowered its rate to 5.2 percent, saving Maine residents an estimated $3 million.

In addition, CAHC worked with the Attorney General's office and the insurance division to perform outreach and education on rate review issues, including holding forums in several locations around the state after business hours. CAHC also worked on outreach addressing consumers' rights and responsibilities, consumer questions about health insurance coverage, and health insurance enrollment.

For the rate review project, the CAHC's staff included 1.25 FTE attorneys and 0.35 FTE in administrative support.[8] The budget for the six-month contract was $106,818, and primarily consisted of the one case which actually lasted closer to eight months due to the insurance company's appeal. About $20,000 of the funding went to an economist and $60,000 went towards the actuary, with the rest of the money

[5] State of Connecticut, Office of Healthcare Advocate, *Report to the Governor on Fiscal Year 2012 Activities*, Aut. 1, 2012 available at: http://www.ct.gov/oha/lib/oha/documents/combined_fiscal_year_12_report_with_2011_annual_report.pdf.

[6] Victoria Veltri, Health Care Advocate, Connecticut Office of the Health Care Advocate, telephone conversation with author, Jan. 8, 2013.

[7] Joe Ditre, Executive Director, Consumers for Affordable Health Care, telephone conversation with author, Sept. 5, 2012.

[8] Joe Ditre, Executive Director, Consumers for Affordable Health Care, e-mail to author, Oct. 30, 2012.

funding CAHC's legal support.[9] Due to a change in the administration in 2011, CAHC's six-month contract was not renewed.

Oregon: Rate Review Process

According to Families USA, "Oregon is leading the pack in eliminating unreasonable rate hikes."[10] Oregon's insurance division received a $5 million dollar grant from the U.S. Department of Health and Human Services for 2010 through 2014 to improve their rate review of health insurance rate requests.[11] Grants fund two actuaries, a market analyst, a rate filing intake coordinator, an administrative assistant, a grant coordinator, a rate liaison to answer consumer questions about rate filings, and a health reform/exchange coordinator in the insurance division.

In January 2012, Oregon's insurance division contracted with the Oregon State Public Interest Group Foundation (OSPIRG) for $314,448 from January 2012 to September 2014 to represent the public in rate filings.[12] OSPIRG's staff for rate review includes a health care advocate, a fellow/community outreach organizer, and a contracted actuary.

When new rates are filed, the insurance division contacts OSPIRG by e-mail and describe the basic facts about the filing. If the increase is above 10% or anticipated to affect a large amount of people, it is likely that OSPIRG will do an in-depth analysis of the rate request. During its analysis, OSPIRG may provide the insurance division with interrogatories to pass on to the insurer.[13] Once the file is deemed complete, the insurance division posts all information, including interrogatories and responses, on its website. If the increase is above 10% or anticipated to affect a large amount of people, it is likely that OSPIRG will do an in-depth analysis of the rate request. During its analysis, OSPIRG may produce interrogatories for the insurer to answer. The insurer has 10 days to answer. The website is updated with any subsequent interrogatories or responses. OSPIRG found incomplete filings to be a point of delay during the rate review process, so OSPIRG worked with the state to develop a form with a comprehensive checklist for determining whether filings are complete.

[9] Joe Ditre, Executive Director, Consumers for Affordable Health Care, telephone conversation with author, Jan. 15, 2012

[10] Families USA, *States Making Progress On Rate Review*, Oct. 2011, available at: http://familiesusa2.org/assets/pdfs/health-reform/State-Progress-on-Rate-Review.pdf.

[11] Department of Consumer and Business Services, *Health Insurance in Oregon,* Jan. 2012, available at: http://www.cbs.state.or.us/external/ins/health_report/3458-health_report-2012.pdf.

[12] Jesse Ellis O'Brien, Health Care Advocate, OSPIRG, telephone conversation with author, Sept. 26, 2012.

[13] Jesse Ellis O'Brien, Health Care Advocate, OSPIRG, e-mail to author, Jan. 9, 2013.

OSPIRG contracts with an actuary to do analyses of selected rate filings. Each analysis examines the rate increases impact on consumers, the insurer's trend lines, as well as unusual administrative costs. OSPIRG often requests that insurers report detailed information on cost-containment and quality improvement initiatives.

Within 25 days of the file being deemed complete, the insurance division holds a hearing on the filing. There is also a public comment period that is open for 30 days after the file is deemed complete. OSPIRG testifies at the public hearing and presents their analysis at the end of the hearing. The public hearings are streamed live online and consumers can testify by phone. OSPIRG reported that hundreds of people watch the public hearings live online. In order to facilitate public comments, OSPIRG has a website where the public can submit their comments and OSPIRG will package up the comments and submit them to the insurance regulators.

In addition to representing the public on rate filings, OSPIRG also engages the public and other consumer organizations to promote participation by consumers in the rate review process. OSPIRG created a rate watch webpage on their website, which provides consumers with copies of the foundation's analyses, reports, and news releases. These activities are not included in OSPIRG's rate review contract with Oregon.

<u>Vermont</u>

The Office of the Attorney General's Consumer Assistance Program

Through a partnership with UVM, the Office of the Attorney General's Consumer Assistance Program (CAP) operates a consumer hotline for consumer disputes with businesses. Students at UVM, under the supervision of an attorney and two staff members, answer calls and resolve consumer complaints through a "letter-mediation" process. At the same time, complaints are logged and tracked in the CAP database. Using the database, the Consumer Protection Unit of the Attorney General's Office will investigate major consumer protection violations or a pattern of consumer protection violations and pursue legal action, if necessary. The Consumer Protection Unit also appears before the legislature on consumer protection matters and issues consumer fraud regulations.

The Department of Public Service

The Department of Public Service is an agency within the executive branch of Vermont state government charged with representing the public interest in matters regarding energy, telecommunications, water and wastewater. The Department is a separate agency from the Vermont Public Service Board, which serves as a decision-making authority in utility regulatory cases. The Department serves the public interest through its seven divisions: Consumer Affairs and Public Information, Energy Efficiency, Engineering, Finance and Economics, Planning, Public Advocacy, and Telecommunications. The divisions that best translate over to the health care context are: Consumer

Affairs and Public Information, Public Advocacy, and Finance and Economics. The total requested appropriations for DPS for SFY 2013 is $16,163,445, including $10,345,714 in special funds.[14]

The Consumer Affairs and Public Information (CAPI) division assists consumers with complaints against utilities, advocates for policies that protect consumer interests, and educates consumers about utility issues. The division is comprised of one director and four specialists. The staff handles 5,000 to 7,000 public inquiries each year. In 1996, CAPI helped develop service quality standards for energy, telecommunications and cable companies within the state. As part of its educational outreach, CAPI maintains the Department of Public Service website and provides consumer with newsletters, press releases and brochures. The CAPI division consists of one chief and four consumer affairs specialists.

The Public Advocacy Division represents the public interest in cases before state and federal courts as well as federal administrative agencies. Responsibilities of the Public Advocacy Division include reviewing and commenting on proposed utility tariff changes and special contracts and complex investigations involving deregulation, expanded competition, alternative regulatory plans, electric facility siting, and power purchase contracts. The Public Advocacy Division includes one director, five staff attorneys, and one legal secretary.

The Finance and Economics division has four responsibilities: (1) supervising rates and financial performance of regulated companies; (2) establishing the financial regulatory reporting information requirements of regulated entities; (3) administering wholesale power purchases for the state; and (4) collecting Vermont's Gross Revenue Tax. As part of its rate supervision, the division reviews new rates, changes in rates, and new services to ensure that charges by utility companies meet the statutory definition for "just and reasonable." In addition to rate supervision, the division supervises utility financing requirements, including debt or other obligations that may encumber or place the assets of regulated companies at risk. The Finance and Economics Division consists of one director, one financial administrator, two utilities finance and economics analysts, one utilities rate analyst, one utilities financial analyst, and one case project manager.

Medicare Supplemental Health Insurance Rate Reviews

The commissioner of the Department of Financial Regulation (DFR) reviews rate increases for Medicare supplemental insurance rates. In addition to its own analysis, the DFR hires an actuary to provide an independent analysis when the composite average rate increase requested by a Medicare supplemental insurer with 5,000 or more lives in Vermont exceeds three percent; or when the commissioner determines it is in the best interest of the insured. During the analysis, the independent analyst is available to the public. The independent analyst provides a recommended composite average rate increase. If this recommended increase differs by more than two percentage points, or the recommended increase by the DFR's actuary differs from the proposed rate by more than two

[14] State of Vermont Department of Public Service, *FY 2013 Budget Request*, available at: http://publicservice.vermont.gov/sites/psd/files/About_Us/PSDFY13BudgetPackage.pdf

percentage points, the commissioner shall hold a public hearing on the matter. The independent analyst may also provide assistance with testimony on rate increase proposals at the rate review hearing.

For rate review hearings, any "intervenor" approved by the commissioner of DFR may attend. Currently, the Community of Vermont Elders (COVE) intervenes in rate review hearings through as-needed representation of a staff attorney from the Senior Citizens Law Project at Vermont Legal Aid. The intervenor has access to the independent analyst. The cost of intervention is paid for by the affected policyholders or certificate holders, with the maximum payment being $2,500, which may be adjusted to reflect inflation or at the discretion of the commissioner of DFR.

Vermont's existing consumer protections for health care

In examining other models of consumer protection, it becomes clear that Vermont currently has a structure similar to other consumer assistance models of in-person assistance through the HCO, DFR, and DVHA. This in-person assistance provides a knowledge base for public advocacy. At the same time, the GMCB and DVHA provide numerous platforms for consumer advocacy by individuals and organizations.

During this health care reform process, the coordination from individual assistance to public advocacy has not always been smooth. All parties agree that the rate review process in particular requires further examination.

Green Mountain Care Board

The Green Mountain Care Board provides several channels through which individual consumers and advocates can represent the interests of Vermonters. Public engagement is a requirement of Act 48, specified in key passages such as:

- "It is the intent of the general assembly to achieve health care reform through the coordinated efforts of an independent board, state government, and the citizens of Vermont, with input from health care professionals, businesses, and members of the public."
- "The health care system must be transparent in design, efficient in operation, and accountable to the people it serves. The state must ensure public participation in the design, implementation, evaluation, and accountability mechanisms of the health care system."

In November, the GMCB released a public outreach and final engagement plan, highlighting its goal "[t]o educate, engage and listen to Vermonters regarding health system reform so that they understand what reform means for them and can take an active role in shaping the Board's work to improve health care and moderate cost." In order to achieve this goal, the GMCB will:

- Focus on informative dialogue with Vermonters about what health system reform means for them so that more Vermonters understand reform and can be active participants in the public discussion about it.

- Utilize the advisory committee/technical advisory groups, including consumers and consumer advocates, by seeking their assistance in planning and implementing engagement efforts.
- Create a steady flow of information/dialogue on the GMCB's roles, upcoming events and ongoing activities.
- Create clear processes for collecting feedback from residents across the state – and for linking public input with GMCB decisions and actions in a way that shows the GMCB heard public comments.
- Ensure that materials and presentations use language, contextual examples, and graphics that are accessible to a broad range of Vermonters.
- When appropriate, collaborate with other state offices on efforts such as engagement events.

The specific ways in which the GMCB will interact with consumers or consumer advocates include: advisory committees and public meetings, events and activities, and publications and digital media.

Advisory committees and public meetings

The GMCB's general advisory committee is made up of consumers, businesses, and health care providers to provide information to the GMCB on hospital budgets and health system finances. In addition, the GMCB's weekly board meetings are open to the public and provide opportunities for public comment. As a result, consumer advocates and individuals can provide their feedback directly to the board. The GMCB also holds public forums twice a year to specifically discuss rate review. The GMCB's forum in November on rate review was well-attended.

Events and activities

In addition to its public meetings, the GMCB has created a speakers' schedule and calendar of board events that ensure full geographic coverage, special attention to consumers, and the best match between specific audiences' interests and Board members' areas of expertise. The GMCB also tracks events and proactively seek events in any geographic or socioeconomic areas that are underrepresented.

Publications and digital media

As further part of its outreach, the GMCB will continue to develop simple, brief Green Mountain Guides on GMCB issues and will make these guides available in print, online, and via e-mail. The GMCB continues to create a streamlined user experience on the website by organizing content in a way that is easy to navigate and understand. The website includes a "dashboard" with key indicators of health care costs and quality. The GMCB also intends to provide a glossary to explain technical terms and stories from Vermonters on its website.

Most importantly for consumers, the website has many opportunities for users to submit comments. The GMCB collected 1500 written comments from Vermonters when it considered the benefit package for Vermont Health Connect and expects to continue, if not exceed, this level of direct dialogue with Vermont consumers and advocates throughout the health care reform process. The GMCB also plans to

have a listserv in order to inform Vermonters directly about upcoming events and opportunities for comment.

The GMCB is committed to ensure high quality interactions with consumers by measurements of participation rate and consumer satisfaction in each area of engagement. The GMCB's public meetings, advisory board, and outreach efforts provide many opportunities for advocates to represent consumers and consumers to represent themselves in front of the GMCB.

Department of Vermont Health Access

Since 2011, DVHA has been engaging consumers and advocates in order to smoothly transition individuals and businesses through Vermont Health Connect (VHC) in October 2013. DVHA's current work consists of various methods of outreach and request for consumer participation. These activities inform DVHA's planning for extensive individual assistance for Vermonters during the implementation of VHC.

Outreach and consumer feedback

Forums: In the late summer and fall of 2012, Vermont Health Connect hosted five public forums in major locations around the state, four of which were dedicated to the general public and one targeted small businesses. Each forum garnered between twenty and eighty attendees as well as local media and public access stations coverage.

Medicaid and Exchange Advisory Board (MEAB): Created by Act 48, the Medicaid and Exchange Advisory Board advises DVHA on policy development and program administration for the state's Medicaid-funded programs and the Exchange. The MEAB is comprised of consumer advocacy organizations, health care professionals, self-employed individuals and representatives of small businesses eligible for enrollment, and the thirty members bring diverse perspectives. To comply with Act 48, the State of Vermont merged the Health Benefit Exchange Advisory Group with the Medicaid Advisory Board on July 1, 2012. The monthly MEAB meetings are open to the public. DVHA staff helps the MEAB chairs set the agenda, and regularly present on the development of Vermont Health Connect components in order to obtain constructive feedback. Meeting agendas and meeting documents are available online. Collectively, the members provide a wealth of expertise to inform the design and implementation of the Exchange.

Outreach Working Group: DVHA has assembled an outreach working group consisting of both internal and external stakeholders. All representatives offer a unique perspective on conducting outreach to Vermonters and/or providing health coverage support services. This group aids with strategic development and outreach implementation to support successful enrollment in the Exchange. Examples of stakeholders include non-profit organizations and business associations currently serving Exchange-eligible populations.

Stakeholder Training: DVHA has contracted with consultant group GMMB to develop a training curriculum for stakeholders and to educate them on how to conduct Vermont Health Connect outreach. Stakeholders will be able to attend a training session in person or take the training on their own by following the presentation materials available on the website. In the coming months, this training will be promoted throughout DVHA's networks to reach as many consumers as possible.

DVHA has used its interaction with consumers and advocates to develop an outreach plan. The plan addresses individuals who will be eligible for Vermont Health Connect and specifically targets young adults (18-34), who make up the largest portion of the uninsured population in Vermont, and Catamount Health beneficiaries, because they will transition to the Exchange in 2014. Additionally, the underinsured population is a priority for the DVHA. The plan explores a variety of tactics for reaching these populations with the goal of engaging them and driving them to the VHC website or an in-person assistor where they can learn more about the Exchange and get assistance enrolling. The plan includes the following components:

- Materials development
- Earned media
- Paid media (advertising)
- Social media
- Stakeholder engagement
- Partnerships and grassroots engagement
- State employee communications

Individual Assistance: Call Center

Currently, DVHA is working with the existing outsourced Medicaid call center to explore the possibility of expanding its services to VHC customer contacts for the October 1, 2013 enrollment launch. Key priorities include:

- Standardizing execution of change, issue, and knowledge management across all support organizations;
- Developing a standard approach to measuring and reporting on customer satisfaction;
- Establishing a methodology for identifying trends in customer frustration; and,
- Establishing a cross departmental evaluation and response team for addressing customer identified process, information and website issues in order to improve the customer experience and the efficiency of our services.
- Decreasing costs through a single point of contact for all support services and consolidate technology, resources and facilities;
- Developing a formal quality assurance review program for management of all policies and procedures used within all support organizations, and establish metrics for evaluating quality within the service delivery model;
- Implementing workforce management practices to increase staffing efficiencies, reduce customer wait time and expand hours of operation; and,
- Establishing formal performance targets for all support organizations including quality, service levels and customer satisfaction.

Individual Assistance: Navigators & In-Person Assistors

The ACA created the Navigator function to educate individuals and families about the availability of qualified health plans, provide them with fair and impartial information regarding plans that best fit their needs, and help them enroll in their plan of choice. Vermont's Act 48 includes the duties of Navigators required by the ACA, and also requires Navigators to facilitate enrollment in Medicaid, Dr. Dynasaur, VPharm, and other public health benefit programs.

Using the guidelines and standards noted above, the State will use an RFP process to select at least two Vermont entities to serve as Navigators. Using previous grant funding, Vermont has identified the Navigator Program's certification criteria and process. Criteria for Navigator entities includes, but is not limited to:

- Experience with enrollment-eligible populations (e.g., uninsured, under 400% FPL, individuals with private insurance, and small businesses);
- Experience with the health care system in Vermont;
- An organizational mission that is consistent with providing outreach, education, and enrollment assistance;
- Existing infrastructure in place to reach a broad range of Exchange-eligible populations; and
- Services accessible in person and over the phone, and have computer and internet skills to assist populations in the state who are less familiar with computer technology and might not have access to the internet.

Using previous grant funding, DVHA contracted with GMMB to develop a Navigator training program that meets federal guidelines and ensures that individuals are appropriately trained, including material on Vermont Health Connect's conflict of interest, accessibility, and privacy and security standards. The proposed training components for Navigators are presented below in Table 1.

Table 1. Navigator Training Curriculum

Component	Content
Train-the-Trainer	1 Overview of the Program 2 Trainer Essentials 3 Review of Content using Leaders' Guide 4 Demonstrations 5 Post Course Evaluation
Navigator training	1 Pre and Post Tests before each content area 2 Principles of Customer Service 3 Use of "Plain Language"

	4 Affordable Care Act 5 Vermont Health Connect structure 6 Vermont’s Blueprint 7 Needs of underserved and specific populations 8 Eligibility and enrollment rules and procedures 9 The range of QHP options and insurance affordability programs 10 Privacy and security standards 11 Digital literacy and website navigation 12 Financial assistance 13 Outreach and education 14 Conflicts of interest 15 Sources of information and referral 16 Scenarios 17 Post Course Evaluation
Refreshers & Updates	1 Changes to the program or approach 2 Exchange Updates 3 Experiences, Problem Solving, & Trouble Shooting

To identify the amount of enrollment assistance that may be needed across the State, Wakely Consulting completed a geographic resource allocation assessment. The analysis helped determine how Vermont should disperse consumer assistance resources geographically to ensure Vermonters receive the support they need.

The In-Person Assistance program is an optional resource announced in August of 2012 by the Center for Medicare & Medicaid Services (CMS). It is distinct from the Navigator program and may be funded through Exchange Establishment grants. Though there will be different sources of funding for these to programs, DVHA believes there are strengths in designing and presenting to the public a unified program with a single name and entity. Given that familiarity already exists with the Navigator name, and that stakeholders and consumers are used to the concept of assistance being provided by a "navigator" in other social service settings, we proposed to use the name "Navigator" to describe the in-person assistance offered by Vermont Health Connect.

The ACA allows states to use federal funding to design VHC's Navigator program and conduct training, but state dollars must be used to fund the actual grants to organizations providing this service. Vermont is seeking $400,000 in state funding for the Navigator program in 2014 and on an ongoing basis for future years as a part of the state budget process . Vermont is seeking approximately $1,600,000 in federal funding as a part of its Level One Establishment Grant application, to be distributed to

contracted organizations for the In-Person Assistance program to support in-person enrollment support for Exchange-eligible Vermonters in 2013 and 2014 .

A competitive Request for Proposals (RFP) process, combined for both State-funded "Navigators" and federally-funded "In-Person Assistors," will help identify the most qualified organizations to provide assistance functions across the State for specific populations. To best accommodate the need for assistance across the state, DVHA plans to implement a tiered grant system. Having three tiers of assistors allows the State flexibility in the amount awarded to each qualified entity. The size of the grant and the distinction between tier levels will reflect the organization's targeted population size and estimated volume of enrollment assistance they would provide.

Due to its extensive consumer engagement and preparation for the call center, Navigators, and In-Person Assistors, DVHA anticipates a successful transition to Vermont Health Connect.

Department of Financial Regulation

Assistance and information for individual consumers

The consumer services section within the Insurance Division at DFR has among its staff four consumer services specialists trained to handle a variety of insurance issues, including but not limited to health insurance-related complaints and inquiries. If a consumer with private health insurance calls the HCO with what the HCO suspects is a legal violation, the HCO will refer the consumer DFR.

DFR receives a significant number of phone inquiries from consumers with a range of questions and concerns about health insurance. Most are often resolved same day by DFR. Consumers may also file formal complaints with via mail, fax, email or in-person meeting giving DFR authorization to begin an investigation into the issue. At this point, the matter is entered into a tracking database and assigned to a staff specialist who supervises review of the complaint to completion. The consumer and insurer are notified of the process.

Year-ending 2012, DFR logged 2,137 inquiries and complaints relating to private health insurance. Major medical comprised 65% of the consumer contacts. A breakdown of those claims indicates that 65% raised potential claims issues; 59% underwriting; 15% policyholder service and 11% marketing and sales problems. The average duration for resolution of a formal health insurance consumer complaint was 42 days. DFR assisted in the return of $78,045 in benefits and coverage to policyholders during 2012.

Anticipating an increase in consumer inquiries and complaints in conjunction with the launching of the new health insurance exchange, DFR received funding under the federal grant to hire two more consumer services specialists. Recruitment is underway for those new positions.

Public Advocacy

For all health insurance plans, DFR has the power to investigate and impose administrative penalties against any person that is engaged in an unfair or deceptive act or practice. For rate proposals on health insurance plans, the commissioner must review rates to determine whether a proposed rate is

"affordable, promotes quality care, promotes access to health care and is not unjust, unfair, inequitable, misleading, or contrary to the laws of this state." The Commissioner of DFR, after review, presents a rate recommendation to the GMCB.

In addition to its current role in the rate review process, DFR and GMCB are also designing Vermont's rate review website, a single site geared towards educating consumers on the entire rate review process. This will replace the individual rate review websites currently hosted by each department and provide one location for consumers to obtain rate review information. The new website is funded by the Rate Review Grant under the ACA. The site will allow for greater consumer transparency and contain a new feature allowing consumers to subscribe to electronic notifications of rate filings and information on rate review events, such as upcoming public forums.

Office of Health Care Ombudsman

In 1998, the Vermont legislature created the Office of Health Care Ombudsman to provide health care advice and advocacy to Vermonters and to act as a voice for consumers with state policy makers. The HCO is a project within Vermont Legal Aid, a statewide non-profit law firm. It is funded by DFR and DVHA to provide services to Vermonters free of charge, regardless of income or assets.

Assistance and information for individual consumers
By statute, the HCO must assist individual health care consumers with problems, complaints, questions and appeals.[15] This is accomplished through the HCO's statewide hotline. The hotline is currently staffed with 5 advocates and a supervising attorney. For the state fiscal year (SFY) 2012, the HCO received 3,060 calls from individual Vermonters. Of these calls, 43 percent of the calls were from beneficiaries on state health care programs, 16 percent of the calls were from individuals on private health insurance plans, 25 percent of the calls from were from Medicare beneficiaries, and 9 percent of the calls were from uninsured individuals.[16] The bulk of these calls, at 2,017, are resolved through advice or education, but the hotline also assists individuals with appeals and eligibility issues. If the HCO has a client that may benefit from legal representation and the individual is eligible under Vermont Legal Aid guidelines, the HCO may refer the case to an attorney at Vermont Legal Aid for legal representation. The HCO may also assist or represent individuals in appeals of private health insurance determinations, overseen by DFR. In calendar year 2012, the HCO saved Vermont consumers $149,122.

Beginning in October 2013, health insurance plans will be offered on VHC for individuals and small employers. Under funding from DVHA, the HCO will take referrals from VHC and the Navigators to assist consumers with problems related to VHC.[17] When Catamount began, the HCO had a near 50 percent

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[15] 8 V.S.A. § 4089w(b)(1), (2) & (4).

[16] Vermont Office of Health Care Ombudsman, *SFY 2012 Annual Report*, available at: http://www.vtlegalaid.org/assets/Uploads/2012-HCO-Annual-Report-Final.pdf

[17] 33 V.S.A. §§ 1805(16), 1807(b)(4).

increase in calls during the quarter prior to implementation. The HCO predicts at least a 25% increase in call volume prior to and during the open enrollment period of Vermont Health Connect.[18] It should be noted that unlike with implementation of Catamount, where the HCO took all calls related to the new program, Navigators and In-Person Assistors will be providing the bulk of the enrollment assistance and the HCO will only receive referrals on issues where the Navigator or In-Person Assistor could not provide help.

The HCO must also provide information to the public about the Affordable Care Act, Vermont health care reform, and VHC through online information and community presentations.[19] For SFY 2012, the HCO: presented on state health care reform and VHC on public television with the Campaign for Health Care Security; provided consumer education to University of Vermont students; provided community education on health insurance to the Vermont Association for the Blind and Visually Impaired; and wrote about issues related to health care reform in Vermont Legal Aid's Justice Quarterly newsletter. These activities are funded by DFR through the Affordable Care Act and CMS Consumer Assistance Program (CAP) grants. These grants end on August 31, 2013.

Public Advocacy

Along with assisting and educating individuals, the HCO is required by statute to provide advocacy on the behalf of the Vermont public. This generally includes: promoting the development of citizen and consumer organizations;[20] providing information; recommendations to policy makers regarding consumer problems and concerns;[21] and facilitating public comment on laws, regulations, and policies.[22] For SFY 2012, HCO worked on: health care reform proposals and changes to Act 48 of 2011 and Act 171 of 2012; DVHA budget changes; health insurer reporting requirements to DFR; creation of a Mental Health Ombudsman; expansion of Medicaid for Working Persons with Disabilities; reduction in cost-sharing for prescription drug coverage for individuals receiving premium assistance for employer-sponsored health insurance; increased access to substance abuse treatment; and health care exemptions in the Public Records Act. The director of the HCO is also a member of Vermont's Medicaid and Exchange Advisory Board.

In order to represent the public interest before the GMCB, the HCO is charged with:

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[18] The Office of Health Care Ombudsman, *HCO Implementation Plan, prepared for Vermont's Health Benefits Exchange Implementation*, Dec. 2012, available at: http://healthconnect.vermont.gov/sites/hcexchange/files/HCO%20Exchange%20Implementation%20Plan%20Final%20Report.pdf.

[19] Required for HCO's contract with DFR funded by the second Consumer Assistance Program ACA grant, which was a Limited Competition grant.

[20] 8 V.S.A. § 4089w(b)(7)

[21] 8 V.S.A. § 4089w(b)(3)

[22] 8 V.S.A. § 4089w(b)(6)

- monitoring, analyzing, and commenting on federal, state and local laws and regulations, including the activities, policies, procedures, and rules of the GMCB;[23]
- advising the GMCB regarding policies, procedures, and rules, as well as suggesting policies, procedures, or rules to the GMCB in order to protect patients' and consumers' interests;[24]
- participating in the advisory group convened by the director of payment reform, advising the director in developing and implementing the pilot projects, and coordinating with the GMCB in setting overall policy goals for payment reform.[25]

In SFY 2012, the HCO worked with DFR and the GMCB to improve consumer access to their websites and testified on the Green Mountain Care benefits package for 2017. The HCO's work in public advocacy is staffed part-time by its director with part-time assistance from its staff attorney.

Rate Review

In March 2012, the HCO began representing consumers in the health insurance rate review cases before the GMCB. Initially, the HCO represented rate payers at every hearing; however, legislative council questioned whether the GMCB had the authority to require that the HCO enter as a party for every rate review proceeding. Accordingly, the GMCB amended its rules so that the HCO has the discretion to appear as a party in selected rate review proceedings.[26] Now that the HCO has discretion to appear as a party in rate review cases, it may be able to focus its resources more closely on cases that harm Vermonters, as opposed to having to weigh in on every case.

The rate review process begins when health insurers file rate requests for major medical health insurance with DFR, using the System for Electronic Rate and Form Filing (SERFF). DFR's staff reviews the filings in conjunction with Oliver Wyman, a national consulting firm with which DFR has contracted for expert actuarial services. In the course of that review, DFR and Oliver Wyman typically interact with the insurer, requesting clarification or additional information as needed, with no statutory time limit on that process. When DFR has the information it needs to render a recommendation, it deems the filing complete. By statute, DFR then has 30 days to make a recommendation to the GMCB.[27] Upon receipt of the DFR recommendation, the GMCB has 30 days to approve, modify, or disapprove the requested rate.[28] Within this timeframe, the GMCB must hold a public hearing. The GMCB sets the hearing providing itself a minimum of ten days to review the record and write its decision, leaving, at most, and often less than, twenty days for the HCO to prepare for the hearing.

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[23] 8 V.S.A. § 4089w(b)(5)

[24] 18 V.S.A. § 9374(f)

[25] 18 V.S.A. § 722(b)

[26] GMCB Rule § 2.105(b).

[27] 8 V.S.A. § 4062(a)(2)(A).

[28] 8 V.S.A. § 4062(a)(2)(B); 18 V.S.A. § 9375(b)(6).

For 2012, there have been 54 filings, 39 written GMCB decisions, and 10 hearings. The HCO has appeared in 39 cases and at 10 hearings and have filed memoranda in 28 cases. After this experience, the HCO reports that it is difficult for them to conduct a thorough review complete with actuarial analysis, from the ground up in less than 20 days. It is also anticipated that the HCO's workload will increase significantly in a short time span once DFR provides recommendations on rates for plans to be offered in the exchange later this year.

The HCO's representation of consumers is funded by DFR through a Rate Review Grant under the Affordable Care Act. Currently, the HCO's representation in rate review hearings is staffed by one part-time attorney. The HCO has $25,000 to hire an actuary, but has had difficulty doing so due to the tight deadlines of each rate request and the requirement, until recently, that the HCO appear in every rate review hearing. The HCO has used much of this funding to pay for DFR's actuary as an expert witness at hearings. At this time, the HCO has contracted with an independent actuary for one pending filing.

Certificate of Need

The HCO is authorized to participate in certificate of need proceedings as an interested party on a discretionary basis.[29] Over the years, the HCO has monitored Certificate of Need applications and entered appearances in several, including the creation of electronic health records at Fletcher Allen Health Care. Currently, however, there is no funding source to support the HCO's activities for Certificate of Need participation from DFR or the GMCB. Historically the HCO has had the capacity to intervene in the CON process under their standard advocacy contract with DFR. Because CON review and approval authority has been solely assigned to the GMCB, no new funding source has been identified.

Assessment

In examining the structure of Vermont's current consumer protections for health care, two levels of consumer protection have emerged: individual assistance and advocacy on behalf of the public. Individual assistance informs public advocacy. Accordingly, coordination of these two areas should be examined.

Individual Assistance

Vermont's Public Service Department, Attorney General's Office, Connecticut and Massachusetts use a helpline model to provide consumer assistance to individuals. Here, DFR handles private insurance complaints. The HCO provides assistance and advice to uninsured individuals, individuals receiving health coverage through state or federal programs, or individuals with coverage by private health insurance with no income level limits. If the HCO is presented with a violation of state insurance law, they refer the call to DFR's Consumer Specialists for enforcement. The HCO will assist individuals with

[29] 18 V.S.A. § 9440(c)(9).

appeals against the state for a state-funded program or through DFR's appeal process for private insurance. The HCO's experience with all of Vermont's health care programs and health insurance plans along with its coordination with Vermont's state agencies provides consumers with effective individual assistance.

This system will be bolstered by the call center, Navigators, and In-Person assistors when VHC is implemented in 2013. The Navigators and In-Person Assistors will assist individuals with any basic enrollment questions or other issues with VHC, but will refer more complex issues to the HCO, creating a well-coordinated effort between DVHA and the HCO.

In addition to individual assistance, the GMCB's public meetings and opportunities for public comment provide for consumer advocacy as the individual level. This, in conjunction with the GMCB and DVHA's plans for outreach and education should provide for an effective advocacy forum for individual consumers and consumer advocates.

<u>Public Advocacy</u>

The HCO's individual consumer assistance and database allows it to identify trends for its public advocacy. Similar to the attorney general's consumer assistance program, the HCO can look for trends in its hotline calls and advocate on behalf of the public at the state and federal level. It also participates as a member of the Medicaid and Exchange Advisory Board and a consumer advocate to the Green Mountain Care Advisory Board. During its participation on these boards and in the legislature, state agencies such as DVHA and GMCB would benefit from more consumer input from the HCO in the form of concrete proposals to address the issues reported by the HCO.

The specific area where the HCO is unable to adequately represent the public interest before the GMCB is through the rate review process because of the problems mentioned above. The HCO has tried to engage actuaries for rate reviews, but due to tight deadlines and limited access to information, the actuaries say they would have difficulty completing a useful analysis.

HCO Recommendations and estimates of resource needs and funding mechanisms

When weighing consumer protection changes, the timeline of health care reform should be considered. Rate reviews for the plans offered in the VHC will begin in the spring of this year. The VHC will be implemented in October of this year and coverage will start in January 2014. In 2016, employers with 100 or fewer employees will purchase plans from the VHC, and implementation of Vermont-style single payer health care is slated to begin in 2017. Any consumer protection reforms should be made within the context of the many changes in Vermont's health care over the next few years. Accordingly, recommendations for how the HCO can meet its current statutory duties are presented along with potential long-term changes in consumer representation focused on the rate review process.

The HCO's current funding is complex and insecure. At this moment the budget is a little over one million dollars of state and federal funding and supports a staff of nine: one director, two staff attorneys, one outreach specialist and five advocates.

For its current fiscal year the HCO has six funding streams, ending at five different points in time.[30] One funding stream has already ended, two Consumer Assistance Program contracts with DFR from CMS will end on August 31, 2013 with only one having a possible renewal, and the Rate Review contract with DFR from CMS ends September 30, 2014. The core funding from DFR and DVHA is at the end of a four year contract period as of June 30, 2013, and will be renegotiated late this spring. It is unknown what additional funding will be available from CMS.

The HCO estimates that it will need three new staff members to handle its duties in state fiscal year 2014: one more staff attorney and two more health care advocates. It expects that it willl no longer have an outreach specialist once the CAP outreach contract ends on August 31, 2013. Thus, the expectation is that it will need a total of eleven staff members:

- 1 Project Director
- 1 Supervising Attorney for the hotline
- 2 Staff Attorneys to split the duties related to rate reviews, certificates of need, health policy analysis, and the Green Mountain Care Board
- 7 Health Care Advocates for the hotline, online applications for services and the website

The HCO estimates that the total cost for this staffing pattern would be almost $1.2 million for state fiscal year 2014.[31] Possible funding sources include renewed DFR and DVHA core services contracts at a higher level than the past four years, a renewed rate review contract with DFR using the federal rate review funding from HHS, a new contract with DVHA using potential additional federal funding from CMS of $300,000 for work related to the VHC,[32] and a new contract with the GMCB for work related to health care reform and required by Acts 48 and 171.

There may be additional money coming from the federal government to support consumer assistance program work under the ACA, but the state cannot rely on this coming through. DFR has received three CAP grants which have been passed through to the HCO. They total $335,000. Of this amount, $200,000 is for individual consumer assistance. For the HCO to expand its consumer services to handle issues arising from the exchange, this probable shortfall should be addressed.

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[30] See Appendix: Current and Recent HCO Grants and Contracts

[31] See Appendix: Vermont Legal Aid, Office of Health Care Ombudsman, Budget for July 1, 2013 to June 30, 2014.

[32] DVHA expects to hear about this Level 1 Exchange grant proposal in mid-January 2013. The $300,000 funds two additional advocates, part of a staff attorney and part of a health policy analyst.

In addition, there is no federal funding available for the state health care reform duties created for the HCO in Acts 48 and 171. It would seem most appropriate for those responsibilities to be funded out of the state budget.

To address the issue of rate review representation, the HCO proposes that the rate review process align more closely with the Medicare supplemental rate review process, in that DFR procure an independent actuarial analysis if the rate increase surpasses a certain threshold or affects a certain number of Vermonters. The benefit for the HCO of an independent actuary contracting with DFR for rate review hearings in front of the GMCB is that the independent actuary will receive the relevant information regarding rate increases at the same time as DFR, providing for a more thorough review process. The independent actuary would have the ability to ask questions of the carrier, a step that is missing under the current system. Under such a system, the HCO would have access to the actuary and the recommended rate much earlier in the rate review process. Furthermore, if the public has access to the actuary, as under the Medicare supplemental health insurance rate review process, then the public will be better-informed and the process will be more transparent.

The DFR has already allocated $25,000 the HCO for actuarial analysis of major medical rate increases in front of the GMCB. This funding will likely decrease in future years and will not be available for 2015 and 2016. The HCO recommends that for the short-term, the DFR could use this and additional funding to contract with an independent actuary for future rate reviews. In order to maintain administrative efficiency, it is recommended that the independent analysis is only triggered if the proposed rate increase meets a percentage threshold, including a combined percentage threshold covering annual increases, and affects a certain number of Vermonters.

Funding an independent actuary, especially for 2015 and 2016, could prove problematic. As it currently works with the Medicare supplemental insurance rate review, the DFR manages the contracts for independent actuarial review and must bill the insurance company back for the cost. The insurance company can then pass the cost onto its certificateholders as a premium increase. The cost of an independent review has ranged from $16,000 to $17,500 for a single Medicare supplemental filing. The cost for DFR's actuary's analyses for major medical filings can range from $2,000 to $5,000 after applying a discounted rate. An independent actuary could prove costly, and both the HCO and DFR would like to avoid passing those costs on to consumers in the form of premium increases.

In addition to cost, the DFR reports that the independent actuary for the Medicare supplemental health insurance rate review process does not generate many analyses that differ significantly from those produced by the DFR's actuary. This issue, combined with the fact that DFR is now required by law to consider whether a proposed major medical rate is affordable, promotes quality care, and promotes health care access, indicates that an independent actuary managed by DFR in addition to its own actuary may result in duplicative analyses for major medical rate reviews and be less helpful than anticipated.

The HCO has also explored the possibility of hiring their own independent actuaries to review the carriers' SERFF filings during the time period of DFR's filing review. The actuaries have indicated that such a review is of limited value if they do not have the opportunity to direct questions to the carrier

before completing an opinion on the filing. If the rate review process continues without an independent actuary through DFR, the HCO requests an increase in its funding for actuarial services. It also asks that its actuary have the ability to pose interrogatories to the insurer or otherwise receive information from DFR before the deadline for the GMCB's decision starts to run.

In lieu of an independent actuary, the HCO also recommends that all questions posed to the carrier from DFR's actuary and responses from the carrier should be posted on the DFR's web site when the file is deemed complete as is done in Oregon. This would provide the HCO with valuable background information prior to DFR's recommendation to better inform the HCO's analysis. Additionally, posting DFR's questions and responses will inform the public of the issues in the rate filing.

Administration recommendation to evaluate options for consolidating the two-step rate review process

At this time, the HCO, DFR, the GMCB, and the health insurance carriers are dissatisfied with Vermont's rate review process. While the current structure was an appropriate way to transition the GMCB into reviewing health insurance rates, the two-agency, two-step structure of the review process should be consolidated in some fashion. In light of the evolving landscape around insurance rates and Vermont's health insurance exchange, statutory changes to the rate review process should be carefully evaluated but not enacted at this time. Options for consolidation include:

- Consolidate the process at the GMCB: Insurers would file rate requests with the GMCB rather than DFR. The GMCB would then conduct the entire review process, including the information-gathering stage with the carrier, an actuary, and any other parties. DFR would represent the public interest by advising the GMCB on insurer solvency and the standards set out in 8 V.S.A. § 4062 of affordability, care quality, and accessibility to health care.

- Consolidate the process at DFR: Under this alternative, the GMCB would no longer review individual rate filings, and DFR would approve, modify, or disapprove the requests. GMCB would represent the public interest to DFR after creating policy parameters regarding rate filings through an open process with public and consumer input.

Under either of the above scenarios, a public advocate besides DFR or GMCB could be created elsewhere in state government and charged with representing the public interest in rate proceedings.

As mentioned earlier, the current process results in practical inefficiencies. For example, each agency must incur the "start-up costs" required to get up to speed on every rate filing, causing the State to expend more personnel time and resources than necessary. In addition, a consolidated, one-agency process would likely allow the State to shorten the total time spent reviewing each rate request. At a minimum, a one-step process would obviate the need for the added 30-day review window for the GMCB to review DFR's recommendation.

Next, because the GMCB reviews each filing through the prism of Act 48, its informational needs and review priorities are not always in perfect synch with DFR. In practice, this means that the GMCB often needs to ask DFR or the insurers for additional information after receiving DFR's recommendation. Under one roof, the process would flow more seamlessly because the same set of agency priorities would steer the review of each filing from the outset.

The two-step process also presents efficiency challenges from a case management perspective. First, the 30-day time constraint on the GMCB's review makes it difficult for the GMCB, the insurers, and the HCO, in its public advocacy role, to make sure that the GMCB gets the information it needs and the parties are able to fully explain their positions. In a one-step process, one agency could manage each rate filing from beginning to end, allocating time as needed to fit the complexity of the filing and the needs of the insurers and other process participants, including the insurers' need for some measure of predictability as to when they can market their products and rates. In addition, the HCO, or any person or entity representing the public interest, would no longer be constrained by a 30-day review window and could engage throughout the review process, from the initial rate filing up to shortly before a decision. Further, as discussed above, a consolidated process could be coupled with the creation of state institutional capacity, either with DFR (if the review is housed with the GMCB) or elsewhere in state government, dedicated to representing the public interest in rate review.

Finally, in terms of transparency, the current process makes it difficult for Vermonters to follow the progress of a particular rate request as it moves from DFR to the GMCB. Rate requests are filed with DFR up to four months before the GMCB ultimately renders a decision. The passage of time and the hand-off from one state agency to another complicates Vermonters' ability to monitor a rate request as it moves through the process. The joint website produced by DFR and GMCB may partially alleviate this issue through its subscriber list and notifications, but ultimately a one-step process as opposed to a two-step process provides the greatest simplicity and more incentive for public participation.

The joint bill from GMCB and DFR includes a study of the current rate review process with the goal of concrete suggestions to reform the current process. We request that the legislature provide us with the opportunity for a more in-depth analysis of consumer protection in the rate review process through this study.

Conclusion

Vermont has created a consumer advocacy system that is similar to other systems in Vermont and in other states. At this point it is not clear that any particular model used elsewhere or used in Vermont for other policy areas is ideal. This is an area worthy of continued discussion as Vermont's regulatory processes and the role of the GMCB evolve. Vermont's individual assistance work is very strong, but in order to maximize consumer protection, Vermont should better coordinate the relationship between individual assistance and public advocacy, particularly in the area of rate review. For rate review, a study of the current rate review process will produce recommendations for stronger and more efficient

consumer advocacy. In order to better coordinate public advocacy overall, the State should review its contracts with the HCO across all agencies and redesign contractual requirements and assess contract amounts to assure that funds flowing to the HCO are better-coordinated and correlate with the highest priorities for consumer protection and advocacy, to assure that funds are adequate to support the expected activities and to better-specify performance expectations.

Appendix

Current and Recent HCO Grants and Contracts

(as of 12/4/12)

Agency	Type of Grant/Contract	Start Date	End Date	Total Current Grant Amount	Source of Funding	Status
DFR	Main advocacy Grant (core funding)	7/1/2012	6/30/2013	$215,000	State dollars	4 Year Contract- Expires 6/30/2013
DVHA	Main advocacy Grant (core funding)	7/1/2012	6/30/2013	$307,000	State & federal dollars	4 Year Contract- Expires 6/30/2013
DFR	Consumer Assistance - CAP III	10/15/2012	8/31/2013	$200,000	Federal dollars (ACA)	1 year, possible renewal, ends 8/31/13
DFR	Rate Review (Cycle II)	10/1/2012	9/30/2013	$150,000	Federal dollars (ACA)	2nd year of 3 year contract - ends 9/30/14
DFR	Website/outreach - CAP II	9/1/2012	8/31/2013	$128,000	Federal dollars (ACA)	One year (one-time) contract, ends 8/31/2013
DVHA	Exchange Grant	7/1/2012	11/10/2012	$135,000	Federal dollars (ACA)	1 year, one time - already ended

VERMONT LEGAL AID

Office of Health Care Ombudsman

Budget for July 1, 2013 to June 30, 2014

		HCO Advocacy		HCO Rate Review		Total SFY 2014
Personnel						
Project Director	$	49,833.53	$	30,952.50	$	80,786.03
Attorneys	$	59,139.51	$	113,561.40	$	172,700.91
Lay Advocates and Para Professional Staff	$	246,290.52		$3,449.83	$	249,740.35
Management Professional Staff	$	72,016.02	$	19,917.28	$	91,933.30
Clerical Support	$	27,518.78	$	19,026.99	$	46,545.77
Total Salaries	**$**	**454,798.35**	**$**	**186,908.00**	**$**	**641,706.35**
Fringe Benefits	**$**	**260,715.68**	**$**	**79,664.67**	**$**	**340,380.35**
Total Personnel	**$**	**715,514.04**	**$**	**266,572.66**	**$**	**982,086.70**
Operating Costs						
Occupancy	$	72,553.68	$	20,065.98	$	92,619.67
Office Supplies and Other Office Overhead	$	8,561.91	$	2,367.94	$	10,929.85
Copiers and Other Office Equipment	$	6,706.64	$	1,854.84	$	8,561.48
Computer Services and Support	$	16,879.13	$	4,227.76	$	21,106.88
Total Operating	**$**	**104,701.36**	**$**	**28,516.52**	**$**	**133,217.88**
Grant or Contract Specific Expenses						
Travel	$	2,542.56	$	987.61	$	3,530.18
Training	$	9,195.15	$	5,059.27	$	14,254.42
Law Library	$	4,721.72	$	3,998.01	$	8,719.73
Other HCO Specific Costs	$	3,600.00	$	1,242.24	$	4,842.24
Total Specific Expenses	**$**	**20,059.44**	**$**	**11,287.12**	**$**	**31,346.56**
Administrative Overhead						
Administrative Support Expenses	$	11,770.23	$	3,255.26	$	15,025.49
Depreciation	$	12,379.61	$	3,423.80	$	15,803.41
Total Administrative Overhead	**$**	**24,149.84**	**$**	**6,679.06**	**$**	**30,828.90**
TOTAL GRANT COSTS	**$**	**864,424.68**	**$**	**313,055.36**	**$**	**1,177,480.04**

HCO Advocacy - Funded by on-going DFR and DVHA contracts and possible federal ACA Consumer assistance contract, but it is uncertain whether and to what extent additional federal funding will be available. Proposal s*upports .6 FTE Director, 1 FTE Attorney Supervisor and 7 FTE Advocates*

HCO Rate Review/ GMCB - Rate Review work funded by federal ACA Rate Review contract and GMCB work would be funded by new DFR contract Proposal s*upports .4 FTE Director and 2 FTE Attorneys;*

Actuarial Services - The HCO is recommending that independent actuarial services be separately funded by the State to support HCO's rate review work on behalf of the public.

VERMONT LEGAL AID

Office of Health Care Ombudsman

Budget for VLA FY 2013 (October 1, 2012 to September 30, 2013)

	HCO Advocacy	HCO Rate Review	HCO Exchange	HCO Outreach	Total VLA FY 2013
Personnel					
Project Director	$ 49,341.69	$ 11,960.93	$ 8,771.35	$ 7,973.96	$ 78,047.93
Attorneys	$ 49,825.66	$ 75,045.36	$ -	$ -	$ 124,871.02
Lay Advocates and Para Professional Staff	$ 172,923.94	$ 2,018.45	$2,753.13	$36,074.50	$ 213,770.03
Management Professional Staff	$ 55,699.18	$ 11,656.62	$ 1,538.72	$ 8,769.41	$ 77,663.93
Clerical Support	$ 21,120.96	$ 11,132.44	$ 1,469.52	$ 8,375.07	$ 42,097.99
Total Salaries	**$ 348,911.43**	**$ 111,813.80**	**$ 14,532.72**	**$ 61,192.94**	**$ 536,450.89**
Fringe Benefits	**$ 195,311.61**	**$ 45,712.82**	**$ 5,962.53**	**$ 31,329.83**	$ 278,316.78
Total Personnel	**$ 544,223.04**	**$ 157,526.62**	**$ 20,495.25**	**$ 92,522.77**	**$ 814,767.68**
Operating Costs					
Occupancy	$ 56,115.03	$ 11,743.64	$ 1,550.20	$ 8,834.88	$ 78,243.76
Office Supplies and Other Office Overhead	$ 8,858.00	$ 1,383.39	$ 182.61	$ 1,040.74	$ 11,464.75
Copiers and Other Office Equipment	$ 6,104.74	$ 1,082.87	$ 142.94	$ 814.65	$ 8,145.21
Computer Services and Support	$ 11,844.06	$ 2,468.19	$ 310.06	$ 16,846.22	$ 31,468.53
Total Operating	**$ 82,921.83**	**$ 16,678.10**	**$ 2,185.82**	**$ 27,536.50**	**$ 129,322.25**
Grant or Contract Specific Expenses					
Travel	$ 2,148.21	$ 576.57	$ 676.65	$ 676.65	$ 4,078.09
Training	$ 7,355.27	$ 6,587.13	$ 633.95	$ 1,488.72	$ 16,065.07
Law Library	$ 2,855.78	$ 2,334.06	$ 231.24	$ 243.20	$ 5,664.29
Other HCO Specific Costs	$ 1,843.91	$ 392.96	$ 960.45	$ 3,152.16	$ 6,349.48
Total Specific Expenses	**$ 14,203.17**	**$ 9,890.73**	**$ 2,502.29**	**$ 5,560.73**	**$ 32,156.93**
Adminstrative Overhead					
Administrative Support Expenses	$ 9,080.94	$ 1,900.44	$ 250.87	$ 1,429.73	$ 12,661.98
Depreciation	$ 9,551.09	$ 1,998.83	$ 263.85	$ 1,503.75	$ 13,317.53
Total Administrative Overhead	**$ 18,632.04**	**$ 3,899.28**	**$ 514.72**	**$ 2,933.47**	**$ 25,979.50**
Actuarial Services		**$ 25,000.00**			
TOTAL GRANT COSTS	**$ 659,980.08**	**$ 212,994.73**	**$ 25,698.08**	**$ 128,553.48**	**$ 1,002,226.36**

HCO Advocacy - Funded by on-going DFR and DVHA contracts and one-time DFR (ACA) contract. Supports .6 FTE Director, .9 FTE Attorney and 4.9 FTE Advocates

HCO Rate Review - Funded by 3-year DFR contract; Supports .15 FTE Director and 1.25 FTE Attorney; includes $25,000 estimated payments to Actuaries

HCO Exchange - Funded by the last payment in the one-time DVHA (ACA) contract; based on contract delieverables ; supports .12 FTE Director and .1 FTE Attorney

HCO Outreach - Funded by one-time DFR (ACA) contract; supports .1 FTE Director, .9 FTE Outreach Specialist

Comparison Table of Consumer Protection Organizations

Organization	Duties	Staff	Funding for fiscal year
Connecticut	Individual assistance and public advocacy for consumers covered by private health insurance	1 Director 1 Attorney 12 Advocates (anticipated for 2013)	$1,478,865 (requested for SFY 2013)
Maine	Major medical rate review advocacy	1.25 FTE Attorneys .35 Admin Support Contracted Actuary Contracted Economist	$213,636 ($106 818 for 6-month contract in 2010)
Oregon- OSPIRG	Major medical rate review advocacy	1 Health Care Advocate 1 Community Outreach Organizer 1 Contracted Actuary	$114,344 ($314,448 for Jan. 2012-Sept. 2014)
VT Dept. of Public Service	Individual assistance, public advocacy, long range planning, energy efficiency, and making and administering contracts for the purchase of power on behalf of the state	CAPI: 1 Chief & 4 Consumer Affairs Specialists Pub. Ad. Div.: 1 Dir., 5 Staff Attys, 1 Legal Sec. Fin. & Econ.: 1 Dir., 1 Fin. Admin., 2 Utilities Fin. & Econ. Analysts, 1 Utilities Rate Analyst, 1 Utilities Fin. Analyst, 1 Case Project Manager	Total requested appropriations: $16,163,445 for SFY 2013, including $10,345,714 in special funds.
DFR Consumer Specialists	Individual assistance for consumers covered by any type of insurance—estimated 65% of calls are health care insurance	4 Consumer Specialists	$372,244 for SFY 2013
HCO	Individual assistance and public advocacy for consumers on all health care-related issues, includes major medical rate review advocacy	1 Director 2 Attorneys 5 Advocates	$1,002,226 for VLA FY 2013 $1,177,480 for VLA FY 2014