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QUARTERLY REPORT
January 1, 2014 – March 31, 2014
to the
Agency of Administration
submitted by
Trinka Kerr, Chief Health Care Advocate
April 21, 2014

I. Introduction

The Office of the Health Care Advocate (HCA) provides consumer assistance to individual Vermonters on questions and problems related to health insurance and health care. The HCA also engages in consumer protection activities on behalf of the public before the Green Mountain Care Board, other state agencies and the state legislature.

The following information is contained in this quarterly report:

- This narrative which includes sections on **Individual Consumer Assistance, Consumer Protection Activities** and **Outreach and Education**
- Six data reports
  - **All calls/all coverages**: 1,185 calls
  - **DVHA beneficiaries**: 472 calls or **40%** of total calls
  - **Commercial plan beneficiaries**: 270 calls or **23%**
  - **Uninsured Vermonters**: 164 calls or **14%**
  - **Vermont Health Connect**: 540 calls or **46%** (this data report draws from the above data sets)
  - **Reportable Activities (Summary & Detail):** 191 activities, 54 documents

II. Individual Consumer Assistance

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

The HCA received 1,185 calls this quarter. We divided these calls into five issue categories. The figures below are based on the All Calls data. See the other data reports for a similar breakdown based on the insurance status of the caller, or whether the call was related to a Vermont Health Connect (VHC) issue. The percentage and number of calls in each issue category based on the caller's primary issue was as follows:

- **18.14%** (215) of our total calls were regarding **Access to Care**;
- **16.62%** (197) were regarding **Billing/Coverage**;
- **4.47%** (53) were questions regarding **Buying Insurance;**
- **8.61%** (102) primarily involved **Consumer Education**;
- **32.24%** (382) were regarding **Eligibility** for VHC programs and Medicare; and
- **19.92%** (236) were categorized as **Other**, which includes Medicare Part D, communication problems with providers or plans, access to medical records, changing providers or plans, confidentiality issues, and complaints about insurance premium rates, as well as other issues.

We have a customized case management system. This system 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. For example, although 382 cases had Eligibility for state health care programs as the primary issue, there were actually a total of 929 calls in which we spent a significant amount of time assisting consumers regarding eligibility for health insurance. In each section of this narrative we record whether we are referring to data based on just primary issues, or primary and secondary issues combined. One call can involve multiple secondary issues. [See the breakouts of the issue numbers in the individual data reports for a more detailed look at how many callers had questions about issues in addition to the primary reason for their call.]

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

A. Record level call volume: the HCA received 42% more calls this quarter compared to 2013, primarily due to continued implementation problems with Vermont Health Connect.

The state launched its health benefit exchange, Vermont Health Connect (VHC), on October 1, 2013, as required by the federal Affordable Care Act (ACA). Despite continued improvements in VHC's functionality, significant implementation difficulties persisted this quarter. As a result, our call volume hit record high levels. Call volume increased by 25% over last quarter.

We received 1,185 calls this quarter, compared to 950 last quarter. This compares to 835 calls in the first quarter of 2013. Thus, our SFY Q 3 call volume was 42% higher than last year's. Because 46% of our calls this quarter were related to VHC, it seems safe to assume that this big increase was directly attributable to problems with the exchange.

Our 436 call volume in March set an all time record for any month. To understand what this means, we checked the call volume after a previous big program change, the launch of Medicare Part D in January 2006. We received 313 calls that January, which was the all time record at that time. Historically, it has been unusual for our call volume to exceed 300 calls in any month.

Call volume in each month this quarter hit a new record for that month. January's volume was 44% higher than January 2013, February's was just 7% higher, but March's volume was a whopping 66% higher than March 2013. The March call volume increase was mainly due to the end of this year's VHC Open Enrollment Period, which occurred on March 31, 2014.

Our call volume probably would have been even higher but for the fact that VHC still did not send out the legally required written Notices of Decision (NODs) to applicants during this quarter. The HCA phone number is on DVHA NODs and is one of the main ways that consumers find out about our services. We complained earlier about the lack of notices. Our understanding is that VHC now has the capability to send out NODs and is just beginning to do so. The additional delay in NODs this past quarter was in part due to concern that sending the notices would generate even more calls and further overwhelm the VHC call center during the last weeks of the Open Enrollment Period.

B. Vermont Health Connect, the Department for Children and Families, and Blue Cross Blue Shield of Vermont have made heroic efforts to make sure consumers get the care they need.

Many consumers are experiencing severe problems getting enrolled correctly. VHC, DCF and BCBS have all worked tirelessly and closely with the HCA to make sure Vermonters who have problems with their coverage are not going without medical care that they need as a result. The HCA contacts VHC, DCF and BCBS daily on behalf of individual consumers. Sometimes it can take weeks or months to get some problems fixed (especially those related to the lack of the change of circumstance functionality), but if a consumer has an urgent medical need it seems that together we have been finding ways to get people on coverage. We appreciate everyone's efforts and willingness to collaborate with us.

C. The top issues generating calls

This section includes both primary and secondary issues. The most common issues raised by callers were requests for information about VHC and applying for VHC programs, Medicaid eligibility, complaints about VHC, and communication problems with the Department for Children and Families (DCF), which includes the Health Access Eligibility Unit (HAEU).

Problems with access to prescription drugs jumped this quarter, which appeared to be primarily due to insurance eligibility problems.

All Calls (1,185, compared to 949 last quarter)

1. Information about VHC 231 (compared to 167 last quarter)
2. VHC complaints 230 (this is a new code)
3. Information about DVHA programs 139 (156 last quarter)
4. Communication Problems with DCF 138 (83 last quarter)
5. MAGI Medicaid eligibility 131 (89 last quarter)
6. Complaints about Providers 118 (88 last quarter)
7. Access to Prescription Drugs 112 (74 last quarter)
8. Buying QHPs through VHC 111 (51 last quarter)
9. VHC website/technology 108 (this is a new code)
10. Medicaid (non-MAGI) eligibility 104 (102 quarter)

DVHA Beneficiary Calls (472, compared to 417 last quarter)

1. Complaints about Providers 73 (48 last quarter)
2. Information about DVHA programs 60 (62 last quarter)
3. Access to Prescription Drugs 60 (35 last quarter)
4. Information about VHC 54 (65 last quarter)
5. Communication Problems with DCF 52 (38 last quarter)
6. MAGI Medicaid eligibility 50 (42)
7. Medicaid (non-MAGI) eligibility 46 (50 last quarter)
8. Affordability of health care 40 (50 last quarter)
9. VHC complaints 37 (this is a new code)
10. Provider billing problems 26 (11 last quarter)

Commercial Plan Beneficiary Calls (270, compared to 146 last quarter)

1. VHC complaints 125 (12 last quarter)
2. Information about VHC 87 calls (52 last quarter)
3. Buying QHPs through VHC 53 (21 last quarter)
4. VHC website/technology 53 (this is a new code)
5. Premium billing 43 (11)
6. VHC invoice problem 29 (this is a new code)
7. Affordability of health care 27 (24)
8. Communication problem with DCF 25 (9 last quarter)
9. Communication problem with plan 25 (8 last quarter)
10. Change of circumstance 25 (this is a new code)

Vermont Health Connect Calls (540, compared to 249 last quarter)

1. VHC complaints 230 (37 last quarter)
2. Information about VHC 228 (164 last quarter)
3. MAGI Medicaid eligibility 127 (85 last quarter)
4. Buying QHPs through VHC 110 (49 last quarter)
5. VHC website/technology 108 (this is a new code)
6. Communication Problems with DCF 105 (27 last quarter)

7. Premium Tax Credit eligibility 79 (31 last quarter)
8. Information about applying for DVHA programs 72 (51 last quarter)
9. Medicaid eligibility 63 (27)
10. Premium billing 60 (7 last quarter)

D. Hotline call volume by type of insurance:

The HCA received 1,185 total calls this quarter. Callers had the following insurance status:

- **DVHA programs** (Medicaid, VHAP, Premium Assistance, VPharm, or both Medicaid and Medicare aka dual eligibles) insured **40%** (472 calls), compared to 44% (417) last quarter;
- **Medicare**[1] (Medicare only, Medicare Advantage Plans, Medicare and a Medicare Supplemental Plan aka Medigap, Medicare and Medicaid aka dual eligibles, Medicare and Medicare Savings Program aka Buy-In program, Medicare and Part D, or Medicare and VPharm) insured **23%** (269), compared to 31% (295) last quarter;
- **Commercial plans** (employer sponsored insurance, individual or small group plans, and Catamount Health plans) insured **23%** (270), compared to 15% (146) last quarter; and
- **Uninsured** callers made up **14%** (164) of the calls, compared to 12% (114) last quarter.
- In the remainder of calls the insurance status was either unknown or not relevant.

E. Dispositions of closed cases

<u>All Calls</u>
We closed 1,114 cases this quarter, compared to 936 last quarter.

- 30% (330 cases) were resolved by brief analysis and advice;
- 26% (291) were resolved by brief analysis and referral;
- 22% (242) of the cases were complex interventions, which involves complex analysis, usually direct intervention, and more than two hours of an advocate's time (complex cases rose 32% this quarter);
- 19% (214) were resolved by direct intervention, including calling an insurance company, calling providers, writing letters, gathering supporting medical documentation, etc.;
- <1% (2) of the cases were resolved in the initial call, down from 50 calls last quarter.
- In the remaining cases, clients withdrew, resolved the issue on their own, or had some other outcome
- <u>Appeals</u>: 20 cases involved help with appeals: 4 commercial plan appeals, 12 Fair Hearings, 1 DVHA internal MCO appeal and 4 Medicare. With all the problems VHC was having, we expected a sharp increase in appeals. However, because VHC was

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

aware of the high number of errors in processing eligibility, it resolved most complaints outside of the appeal system.

DVHA Beneficiary Calls

We closed 455 DVHA cases this quarter, compared to 424 last quarter.

- 26% (118 cases) were resolved by brief analysis and advice;
- 30% (137) were resolved by brief analysis and referral;
- 19% (85) were considered complex intervention, which involves complex analysis, usually direct intervention, and more than two hours of an advocate's time;
- 24% (107) were resolved by direct intervention on the caller's behalf, including advocacy with DVHA and providers, writing letters, and gathering medical information;
- No DVHA beneficiary calls were resolved in the initial call, down from 24 last quarter.
- In the remaining cases, clients withdrew, resolved the issue on their own, or had some other outcome.
- Appeals: 13 cases involved appeals: 12 Fair Hearings and 1 internal MCO appeal.

Commercial Plan Beneficiary Calls

We closed 239 cases involving individuals on commercial plans,, compared to 134 last quarter.

- 35% (84 cases) were resolved by brief analysis and advice;
- 18% (43) were resolved by brief analysis and referral;
- 22% (53) were considered complex intervention, which involves complex analysis, usually direct intervention, and more than two hours of an advocate's time;
- 21% (51) were resolved by direct intervention on the caller's behalf, including advocacy with the carrier and providers, writing letters, and gathering medical information;
- No calls from commercial plan beneficiaries were resolved in the initial call, down from 7 last quarter..
- In the remaining cases clients withdrew, resolved the issue on their own, or had some other outcome.
- Appeals: 4 cases involved appeals.

F. Case outcomes

All Calls

The HCO helped 115 people get enrolled in insurance plans and prevented 17 insurance terminations or reductions. We obtained coverage for services for 29 people. We got 32 claims paid, written off or reimbursed. We assisted 13 people complete applications and estimated VHC insurance program eligibility for 53 more. We provided other billing assistance to 31 individuals. We obtained hospital patient assistance for 5 people. We provided 602 individuals with advice and education. We obtained other access or eligibility outcomes for 75 more people, many of whom we expected to be approved for medical services and state insurance.

We encourage clients to call us back if they are subsequently denied insurance or a medical service after our assessment and advice. In total, this quarter the **HCA saved individual consumers $39,505.67** in cases opened this quarter**.** The amount of savings for state fiscal year 2014 up to March 31, 2014, is **$159,122.61.**

G. Case examples

Here are a few examples of how we helped Vermonters this quarter:

1. Ms. A could not get post-surgery medication because her insurance had been incorrectly terminated for nonpayment of premium. Ms. A went to the emergency room because she was having severe abdominal pain, and was rushed into surgery. After she came home from the hospital, her husband went to pick up her prescriptions. The pharmacist told him that Ms. A had no insurance coverage. Because he could not afford the full cost of the medication, Mr. A left the pharmacy empty handed. He called VHC Member Services, but could not get through, so he called the HCA. The HCA advocate determined that Mr. A's VHAP coverage had been improperly closed for nonpayment, as Mr. A had in fact paid the premium. The advocate was able to get the processing of the payment expedited and get the As' VHAP reinstated so that Mr. A could get his wife the medication she needed. By getting their coverage reinstated, the HCA saved the As over $5,000: the cost of her prescriptions, the hospitalization and the surgery.

2. Mr. B and his family were incorrectly denied Medicaid. Mr. B and his wife were very low income and were on VHAP and their children were on Dr. Dynasaur. Knowing that the VHAP program was ending, Mr. B applied for other coverage in December by calling the VHC Customer Support Center. After two hours on the phone, the customer service representative told him the family was not eligible for Medicaid or Dr. Dynasaur and would have to buy a Qualified Health Plan for the family to continue coverage. The CSR did not adequately explain the subsidies they might get to reduce the cost of the premium. Very discouraged, Mr. B concluded that they could not afford insurance. However, he was very worried because his wife had a chronic health condition and needed coverage. He called the HCA in January and asked for our help. The HCA advocate determined that VHC had not calculated the family's income correctly under the new rules. The advocate contacted VHC multiple times in order to get the income calculation corrected. In the end, both parents were found eligible for Medicaid and the children for Dr. Dynasaur.

3. Vermont Health Connect refused to refund a large erroneous payment. While paying his bills, Mr. C inadvertently placed a check to another payee into his VHC premium payment envelope. The check was for $4,000, a very significant sum to the household; his premium was only about $48. Even though the $4,000 check was not made out to VHC, VHC cashed it and applied it to the Mr. C's account. When Mr. C realized what had happened, he called VHC immediately and asked that the check be refunded. He was informed it was not possible for VHC to make any refunds. The customer service

representative explained that the only option was to have the check applied as a credit to future health care premiums. This would have been an advance payment covering seven years of premiums! Mr. A then called the HCA . The HCA advocate contacted VHC and initially was also told that VHC did not have the capability to make refunds. She persisted and eventually VHC did refund the check. The HCA saved Mr. C $3,952.

4. Ms. D, a refugee on VHAP, was incorrectly denied Medicaid. Ms. D called the HCA after she was found ineligible for Medicaid when she applied through VHC. Immigrants who have not lived in the U.S. legally for at least five years are not eligible for Medicaid. However, there are exceptions to this rule, including having refugee status. The VHC application does not include questions that would enable VHC to determine whether a non-citizen meets an exception to the five year bar. The HCA advocate recognized that Ms. D fell into this exception and contacted VHC to explain that Ms. D was eligible for Medicaid. VHC subsequently put her on Medicaid and back-dated her coverage to the date of her application.

H. Recommendations to DVHA

1. *The change of circumstance functionality must be made operational soon.*

This is the biggest problem we see. We know VHC is well aware of this issue and working on it, but it is a huge problem, affecting thousands of people and wreaking havoc. We would be remiss if we didn't mention it.

2. *The glitches in the invoice and payment system must be fixed and the functionality to easily make refunds developed and deployed.*

We continue to hear from consumers who say they are not getting invoices, are not getting correct invoices, and whose premium payments are not being processed in a timely manner. It is very difficult for the HCA to pinpoint what the exact problems are, because these problems are not happening to everyone. In addition, VHC must have the capacity to refund incorrect payments. Aside from the rare situations like case example #3 above, we are also hearing from individuals who are receiving incorrect subsidies and thus paying significantly more in premiums than they should have to. They should be able to get refunds.

3. *Maximus and Health Access Eligibility Unit staff need additional training, resource materials and supervision.*

We continued to hear incorrect information from some Maximus customer service representatives and HAEU staff. We also heard the same thing from consumers and navigators. These errors cause confusion and serious problems for consumers. We report these errors to VHC frequently, but sometimes we just try to fix them. We also met about every two weeks

with Maximus and VHC staff to talk through problems we were seeing, and had a separate face-to-face meeting with HAEU and DCF staff. We appreciate the difficulties in running large call centers which must handle complex information, but because the mistakes can be so harmful, there should be an increased effort to improve training, resource materials and quality control.

4. *The applications must be changed to incorporate questions which garner more nuanced information about citizenship status.*

The HCA received 35 calls related to eligibility problems related to citizenship status, up from 6 last quarter. Of these, 33 were due to VHC's inability to distinguish among the various possible exceptions to the five year bar rule. [See the case example #4 above.]

5. *Applicants need more information regarding what income is countable and who should be included in the household.*

More information could be provided on the application, on a page of the website, or both. This is especially important while the change of circumstance functionality is not working. Many of the COCs involve mistakes made completing the application in these two areas.

6. *Communication among all levels of VHC and DCF staff, as well as with the Navigators and the HCA, needs to be improved.*

Often it seems like the various parts of the state working on VHC issues are not talking to each other. As various policy and operational issues are worked through, we are sometimes surprised by who doesn't appear to have received certain information. We have seen some improvement in the information coming to the HCA very recently, which is great.

7. *Legally proper and timely Notices of Decision need to start going out to all VHC applicants.*

The state is legally required to send NODs when an applicant's eligibility for a health care program or subsidy has been determined. We know the state worked on the NODs for months while the VHC functionality to automatically issue them was developed. We are not sure whether the functionality is fully deployed or that these notices are going out yet for every applicant now. These notices should be going out now.

8. *Copayments for prescriptions for individuals on Medicaid whose income is less than 75% of the Federal Poverty Level should be eliminated.*

The switch from VHAP to Medicaid has created an unexpected problem for some people. Prior to the implementation of the Affordable Care Act, many Vermonters whose income was less than 150% FPL (185% for parents) were on VHAP and had no copayments for medications. Today people with income below 133% FPL are on expanded Medicaid. Medicaid has copayments for prescriptions of $1, $2, or $3, depending on the cost of the medication.

The HCA has received an increased number of complaints (12) from very low income individuals who, now that they are on Medicaid instead of VHAP, are unable to afford their medications. Most of these callers had income below 75% FPL (about $730 per month), and some had no income at all. Someone who has applied for SSI and is living on General Assistance may have income as low as $254 per month. These folks cannot afford these new copayments. Copayments for very low income individuals should be abolished.

I. Table of all calls by month and year

All Cases											
	2004	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
January	252	178	313	280	309	240	218	329	282	289	417
February	188	160	209	172	232	255	228	246	233	283	302
March	257	188	192	219	229	256	250	281	262	263	436
April	203	173	192	190	235	213	222	249	252	253	
May	210	200	235	195	207	213	205	253	242	228	
June	176	191	236	254	245	276	250	286	223	240	
July	208	190	183	211	205	225	271	239	255	271	
August	236	214	216	250	152	173	234	276	263	224	
September	191	172	181	167	147	218	310	323	251	256	
October	172	191	225	229	237	216	300	254	341	327	
November	146	168	216	195	192	170	300	251	274	283	
December	170	175	185	198	214	161	289	222	227	339	
Total	2409	2200	2583	2560	2604	2616	3077	3209	3105	3256	1155

III. Consumer protection activities

A. Rate review work

Insurance carriers filed 14 new rate cases with the Green Mountain Care Board (GMCB) in this calendar quarter. This is the first quarter where the two-step review process with the Department of Financial Regulation and the GMCB has been replaced by a new rate review system. The entire rate review process is now conducted by the GMCB, which also hired a new actuarial firm, Lewis & Ellis, to review the filings. The HCA met with actuaries from the new firm when they visited Vermont in January.

The HCA filed Notices of Appearance in all 14 of the new 2014 filings. We also filed two memoranda covering six of the filings. No contested hearings were held for these cases this quarter. The GMCB decisions are due in April.

In addition to our rate review case work, we reviewed the new GMCB rate review website and suggested changes to some of the content. We identified issues with the way that individuals interested in being notified about new rate filings could sign up for this information.

We also updated materials about rate review on our own website, www.vtlawhelp.org/health, and added more information about how the public can participate in rate review cases.

Finally, the HCA worked to amend the GMCB's policy regarding the treatment of confidential materials in rate review cases. We negotiated with the Board's General Counsel and the attorneys for Blue Cross and Blue Shield of Vermont (BCSBSVT) and MVP to extend the deadline for destroying confidential materials after the appeal deadline and to allow us to keep a record of some hearing materials which contain confidential information. All parties agreed to the deadline extension. The negotiation regarding retaining confidential material is ongoing.

B. Green Mountain Care Board and Vermont Health Care Innovation Project

Pursuant to Act 48 of 2011 and Act 171 of 2012, the GMCB is required to consult with the HCA about various health care reform issues. The HCA is directed in Act 79 of 2013 to "suggest policies, procedures, or rules to the GMCB in order to protect patients' and consumers' interests." This quarter we:

- Attended 11 GMCB public meetings
- Attended one meeting of the GMCB Advisory Committee
- Met once with General Counsel for the GMCB
- Met twice with the Chair of the GMCB
- Reviewed 3 new certificate of need applications, and the conceptual CON report for Fletcher Allen Health Care's proposed new 120 bed inpatient facility
- Participated in the state's Vermont Health Care Innovation Project (VHCIP) in the following ways:
    - Participated in two meetings as a member of the VHCIP Steering Committee
    - Participated, along with representatives from other projects of Vermont Legal Aid, as "active members" in five of the seven VHCIP work groups: the Payment Models Work Group, the Quality and Performance Measures Work Group, the Disability and Long Term Services and Supports Work Group (formerly the Duals Demonstration Work Group), the Population Health work Group and the Care Models and Care Management Work Group
    - Participated along with representatives from other projects of Vermont Legal Aid, as "interested parties" in two of the seven work groups: the Governor's Workforce Work Group and the Health Information Exchange/Health Information Technology Work Group
    - Attended five meetings of the Core Team
    - Submitted comments to the Quality and Performance Measures Work Group recommending new measures to be considered for the second year of the Accountable Care Organizations (ACO) Shared Savings Programs

    - Provided input to the VHCIP staff on the content of its new website
    - Submitted recommendations to the VHCIP Project Director, DVHA Director of Payment Reform, and GMCB Director of Payment Reform on patient notices for the Medicaid and commercial ACOs
- Participated in the Patient Experience Survey RFP review
- Submitted comments to the GMCB regarding changes in the health care benefit design for the VHC Qualified Health Plans in 2015
- Submitted comments regarding proposed changes to the Vermont Information Technology Leaders (VITL) consent policy

QHP Plan Design

The HCA submitted brief comments to the GMCB supporting a proposed 2015 plan design adjustment for pediatric dental benefits for the VHC Qualified Health Plans requested by the Department of Vermont Health Access.

VITL's Consent Policy

VITL is a nonprofit organization that is assisting Vermont health care providers in adopting and using health care information technology to improve patient care. In this quarter, the HCA learned that VITL had proposed a change to its patient consent policy which would allow health care providers to gain access to a patient's protected health information on the Health Information Exchange which VITL manages. VITL changed its policy from requiring individual providers to obtain consent from each of their patients to a global opt-in policy. The global opt-in policy means that patients would be asked to sign one consent form covering all of their current and future providers who join the Health Information Exchanges.

The HCA identified a number of concerns with the policy which affect consumer/patient rights including the scope of the global opt-in consent; the absence of plain language consent forms, revocation forms, and informational materials; and the lack of protections against security breaches of patients' private health information proposed to be stored on the Exchange.

The HCA submitted public comments on the proposed revisions to the consent policy to the Agency of Administration and two sets of public comments to the GMCB. The Agency of Administration adopted some of the changes the HCA recommended regarding clarifying language in the consent policy. The GMCB responded to the HCA's comments by ordering VITL, at the HCA's request, to work with the HCA to develop plain language information materials including consent forms, revocation forms, and supplemental materials.

The HCA developed sample plain language consent forms and revocation forms. Together, the HCA and VITL are in the process of creating the final versions of the consent form, the revocation form, and a companion informational brochure on the Health Information Exchange. VITL's original consent form was written at a reading level of grade 18, which should be understandable to readers with six years post-high-school education. The HCA and VITL's current draft of the consent form is at a seventh grade reading level.

C. Other Activities

- The Chief Health Care Advocate participated in:
    - 3 Medicaid and Exchange Advisory Board (MEAB) meetings
    - 1 Governor's Consumer Advisory Council meeting
    - 1 Single Payer Advocates meeting
    - 1 Improving Access Work Group meeting (subgroup of the MEAB)
- Continued to discuss and informally comment on the development of the Agency of Human Services Health Benefit Eligibility and Enrollment regulations, which are now going through the formal Administrative Procedures Act process.
- Commented on VHC notices at least 7 times.
- Participated in at least 81 legislative activities, testified 13 times, and submitted 9 documents to legislative committees, mostly related to VHC and S. 252 (on Green Mountain Care).
- Developed and posted two policy papers on our website:
    - *Low Income Taxpayers and the Affordable Care Act*
    - *Accountable Care Organizations – What is the Evidence?*
- Posted new information on our website related to VHC changes for small employers and Catamount and VHAP beneficiaries.
- HCA staff attended one training, the Families USA Health Action 2014 Conference January 23-25, 2014 in Washington, D.C.
- The HCA has also begun to participate in two national e-mail forums organized by The Consumer Union, The Health Cost Forum and a Rate Review Group.
- We also developed a training on VHC eligibility and enrollment for other Vermont Legal Aid projects and staff.

D. Collaboration with other organizations

The HCA worked with the following organizations this quarter:

- ACLU
- Planned Parenthood
- Voices for Vermont's Children
- Vermont CARES
- Disability Rights Vermont
- VPIRG
- Vermont Campaign for Health Care Security
- Vermont Family Network

IV. Outreach and education

A. Website

Vermont Law Help is a statewide website that is maintained by Vermont Legal Aid and Law Line of Vermont. The site includes a substantial Health section with more than 150 pages of consumer-focused information that is maintained by the HCA. Since the launch of Vermont Health Connect, we have worked diligently to keep the site updated in order to provide the latest and most accurate information to Vermont consumers.

Vermonters Continued to Seek Information Related to VHC and Health Care Reform
Comparing the health site's Google Analytics with the same quarter last year, we continue to see significant increases in the number of pages being accessed by Vermonters seeking information about and assistance with health care:

- Pageviews of the Health Home Page **increased by 130.61%** (874 vs. 379)
- Pageviews of All Health Pages **increased by 69.23%** (1,760 vs. 1,040)
- Unique pageviews of All Health Pages **increased by 74.92%** (1,130 vs. 646) Unique page views counts only the first view of a page by each user; repeat views of the same page from the same computer are not counted.

17 out of the 25 most-visited pages in the health section provided information related to health insurance topics:

- Vermont Health Connect, health care reform, and Vermont's sunsetting health care programs (13)
- Information about all types of health insurance, Medicare, regulation, and employer-sponsored insurance (4)

Health Care Policy Page
This quarter, the HCA launched a new page to share policy papers and comments that represent the HCA's work to represent consumers before the Green Mountain Care Board, the legislature, and state agencies, committees, boards and task forces.

The new Health Care Policy page was the **fourth most visited page in the health section** after the home, Vermont Health Connect and health insurance pages. Visitors spent an average of five minutes, more than four times the site average, viewing the policy page. "Low-Income Taxpayers and the Affordable Care Act for Non-Tax Lawyers" and "Accountable Care Organizations: What is the Evidence?" were the **second and third most-downloaded** out of all PDFs on the entire Vermont Law Help website, with 29 and 15 downloads each, respectively.

Other policy papers and comments posted on the Health Care Policy or Health Insurance Rate Review pages were among the 40 different titles that were downloaded from the Vermont Law Help site.

Client Engagement
The bounce rate reflects the number of visits in which the person leaves the site from the entrance page without engaging with (i.e. clicking on links within) the page. A lower bounce rate represents a higher level of engagement. Continuing the positive trend we have seen since

we began to improve Vermont Law Help's Health section a year ago, the bounce rate was down by 31% this quarter, from an unacceptably high bounce rate of 67% last year to 46% this year. The time spent on a single page has also declined, which is often viewed as a negative statistic. But in this case, it reflects our efforts to create shorter, more focused pages that provide better access to important health care information to consumers with lower reading skills.