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Vermont Legal Aid  
**Office of the Health Care Advocate**

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Quarterly Report  
October 1, 2017- December 31, 2017  
to the  
Agency of Administration  
submitted by  
Michael Fisher, Chief Health Care Advocate  
Office of the Health Care Advocate



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January 22, 2018



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## Introduction

The Office of the Health Care Advocate (HCA) advocates for all Vermonters by doing both individual consumer assistance and systemic advocacy on health care issues. We work to increase access to high quality, affordable health care for all Vermonters when we represent the public before Green Mountain Care Board, state agencies, and the state legislature. Helping Vermonters navigate a shortened Open Enrollment Period was a central task for the HCA this past quarter. The HCA engaged in outreach and education to help Vermonters understand the shorter enrollment period. The HCA also worked with VHC and other stakeholders during Open Enrollment to share information and developments. We saw a 10% increase in our overall VHC calls, and particular increases in calls about Medicaid Eligibility, Premium Tax Credit Eligibility, Information about VHC, and Change of Circumstances.

The HCA is pleased to announce a new partnership with Kinney Drugs to provide advocacy for customers who encounter a problem getting their medication at the drugstore. We have worked to develop this partnership over several months. We created training materials for pharmacy staff and a direct referral system between the pharmacist and the HCA.

The HCA has also been responding to President Trump's decision to stop making cost-sharing reduction payments. The HCA is working with other stakeholders to protect consumers from cost increases and also stabilize the individual market.

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

The HCA supports Vermonters through individual advocacy as well as at the legislative and administrative policy level. Our priorities are informed by our daily work with Vermonters struggling with a health care system that often does not meet their needs, such as Newman's experience described in the case narrative at right. We work to control unnecessary costs and make the health care system sustainable, and to ensure that Vermont consumers are heard by providers and policy-makers.

### Newman's Story

Newman called the HCA because he had lost his insurance and needed medication. He had a plan on Vermont Health Connect (VHC), and had been receiving Premium Tax Credit (PTC) which helped lower the monthly payment. VHC had terminated his PTC. When he lost the PTC, the premium went up to \$500 month. When the HCA advocate investigated, the advocate discovered that VHC had sent Newman some requests for income information. Newman did not recall getting any notices. The advocate also realized VHC had not followed its own verification rules. Under VHC rules, it must try to electronically verify income with the federal government before requesting this information from the beneficiary. If VHC had done this, it would have been able to verify Newman's income. Newman's only income was from Social Security. Since VHC did not attempt to electronically verify the income first, the advocate asked for the plan and PTC to be reinstated. VHC agreed that it violated its own rules, and it should have electronically verified the income with Social Security. It reinstated Newman's VHC plan and his PTC. With the PTC in place again, Newman's monthly premium was under \$100 a month, an amount which he could afford to pay. He paid his premium and was able to pick up his medication.

## Individual Consumer Assistance

### Case Examples

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

#### **Anna's Story**

When Anna went to the pharmacy to pick up her asthma medication, she discovered that her Medicaid was not active. She had been on Medicaid for years, and did not understand what had happened. She also needed her asthma inhaler daily—and could not afford to pay for it out of pocket. When Anna had called the state of Vermont, she was told that she was on Medicaid. The pharmacy, however, kept telling her that she did not have any coverage. Anna called the HCA for help. The advocate discovered that although Anna had been approved for Medicaid coverage, it was not yet active in the pharmacy system. This made it look like she did not have any coverage. The advocate was able to get the pharmacy coverage activated, and Anna picked up her medication later that afternoon.

#### **Brennan's Story**

Brennan called the HCA because he did not understand why his Vermont Health Connect premium bill had increased by about \$30 a month. The advocate investigated and found that VHC had calculated his premium based on Brennan's new income. He had gotten a raise at the start of the year, and reported it to VHC. Because his income had increased, that meant he qualified for less premium tax credit (PTC), and the amount that he would have to pay each month had increased. That explained the increase in his monthly premium. The advocate confirmed that VHC had correctly calculated how much PTC Brennan was eligible for at his new pay rate. The advocate, however, also studied Brennan's paychecks, and realized that although it said that his pay rate had increased, he was still receiving the same gross amount as he had before the raise. He had not actually received his raise even though he had reported it to VHC, and his health care premium had increased because of it. After learning about this from the advocate, Brennan went to his Human Resources office, and they corrected the problem and also gave him a check for the back pay that he should have received. When Brennan started receiving his correct amount of income, it made it easier for him to pay the increased health care premium.

#### **Caroline's Story**

Caroline was in the hospital when she first found out that her Medicaid had ended. When the advocate did some research, she found that Caroline had been on both Medicaid and a Medicare Savings Program (MSP). The MSP paid for her Medicare Part B premium and covered her Medicare cost-sharing. She had been closed from both programs for 'failure to review.' The state had requested that Caroline do a new application to verify her eligibility, and she had not done this. Caroline did not remember receiving any notices. The advocates asked VHC about the notices, and it produced the verification request and the closure notices for both Medicaid and the MSP. When the advocate closely studied the closure notices, she found that they did not list a reason for a

closure. Under VHC's eligibility rules, all notices must include the reason why the program is being closed. Because the notices were not adequate, the advocate was able to have Caroline's Medicaid and MSP reinstated back to the month that they were closed. This meant that the bills related to her hospital stay could be covered. The advocate also helped Caroline file a new application, so that VHC would be able to review her eligibility going forward.

### **Sky's Story**

Sky called the HCA because her spouse had recently retired and enrolled in retiree insurance. The cost of the retiree insurance was reasonable for her spouse, about \$100 per month. But adding Sky to the retiree insurance would increase the cost to nearly \$900 a month. She had applied on VHC, but had been told that she was not eligible for PTC because of her spouse's retiree coverage. This meant that she would have to pay the full cost for a VHC plan, over \$500 per month. She could not afford that price. HCA advocate realized that VHC had made an error. If you are enrolled in retiree insurance, you are not eligible for PTC. Sky, however, was not enrolled in her spouse's retiree coverage. The advocate contacted VHC and argued that Sky was eligible for PTC. VHC agreed, and found her eligible for PTC, which made her monthly premium about \$200.

### **Ruby's Story**

Ruby called the HCA because she had applied for Medicaid and had been turned down. She did not understand why and wanted to appeal the decision. After talking to Ruby, the advocate learned that Ruby had a green card and had been in the United States for two years. The advocate explained that because Ruby had only been in the United States for two years, she was not eligible for Medicaid yet. She was subject to what is called the 'five year bar.' This meant that Ruby would not be eligible for certain public benefit programs, including Medicaid, until she has been in the United States for five years. Ruby had very little income, and did not understand how she would be able to afford to get insurance. She also had some pressing medical needs. Although she was not eligible for Medicaid because of the 'five year bar,' she is eligible for PTC. The HCA advocate explained that the 'five year bar' does not apply PTC. You need to show that you are in the United States lawfully, and Ruby is here lawfully. The advocate assisted with the application, and Ruby was found eligible for PTC. With the PTC, Ruby only pays about \$10 per month. Once she was able to sign up for coverage, Ruby was able to schedule an appointment with her provider.

### **Marina's Story**

Marina called the HCA because her Medicaid application had been denied. She needed to get a prescription filled and could not afford to do that without coverage. Marina had adopted her grandchildren, and she received an adoption subsidy for both children. The children had coverage under Dr. Dynasuar, but Marina did not have anything. When she applied for Medicaid on VHC, VHC had included the adoption subsidies in her monthly income total, which made her ineligible for Medicaid. The HCA advocate quickly realize that the adoption subsidies, however, should not be included in the calculation. They are not taxable income, and should have been excluded from the income calculation. Once the subsidies were removed, Marina was found eligible for Medicaid and was able to pick up her prescription.

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## Overview

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

The HCA received 890 calls<sup>1</sup> this quarter. We divided these calls into five issue categories. The figures below are based on the All Calls data. The percentage and number of calls in each issue category, based on the caller’s primary issue, were as follows:

- **19.55%** (174) about **Access to Care**
- **13.26%** (118) about **Billing/Coverage**
- **1.91%** (17) about **Buying Insurance**
- **13.71%** (122) about **Consumer Education**
- **29.78%** (265) about **Eligibility** for state and federal programs
- **21.80%** (194) were categorized as **Other**, which includes Medicare Part D, communication problems with providers or health benefit plans, access to medical records, changing providers or plans, confidentiality issues, and complaints about insurance premium rates, as well as other issues.

We have a customized case management system that allows us to track more than one issue per case. This enables us to see the total number of calls that involved a particular issue. For example, although 218 of our cases had eligibility for state and federal healthcare programs listed as the primary issue, a total of 359 cases had eligibility listed as a secondary concern.

In each section of this Narrative, we indicate whether we are referring to data based on just primary issues, or primary and secondary issues combined. Determining which issue is the “primary” issue is sometimes difficult when there are multiple causes for a caller’s problem. This has proven to be particularly true for Vermont Health Connect (VHC) cases. See the breakdowns of the issue numbers in the individual data reports for a more detailed look at how many callers had questions about issues in addition to the “primary” reason for their call.

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

The full quarterly report for October 1- December 31, 2017 includes:

- This narrative, which contains sections on **Individual Consumer Assistance**, **Consumer Protection Activities** and **Outreach and Education**
- Seven data reports, including three based on the caller’s insurance status:
  - **All calls/all coverages:** 890 calls (compared to 825 last quarter)

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



- **Department of Vermont Health Access (DVHA) beneficiaries:** 259 calls (242 calls last quarter)
- **Commercial plan beneficiaries:** 209 calls (167 calls last quarter)
- **Uninsured Vermonters:** 77 calls (74 calls last quarter)
- **Vermont Health Connect (VHC):** 254 calls (231 calls last quarter)
- **Reportable Activities (Summary & Detail):** 83 activities and 20 documents

## Priorities

### A. The HCA focused on educating consumers about a shorter Open Enrollment Period.

Because Open Enrollment was shorter this year, consumers had less time to make decisions about their 2018 coverage. The HCA was concerned that consumers would not realize that their premiums may have increased, and would be left on more expensive plans. The HCA did outreach through social media, released press releases, gave interviews, and continually updated VLA's website. During Open Enrollment, the HCA met with stakeholders on a weekly basis to assess how Open Enrollment was going and stay updated on new developments.

### B. The HCA launched a partnership Kinney Drugstores

The HCA advocates had noticed that many consumers first discover that they have an insurance problem when they go to the pharmacy to pick up a prescription. We also realized that pharmacists were on the front-line helping consumers. We wanted to collaborate—so we could reach these consumers more quickly, and also help the pharmacists do their jobs. We developed a substantive training about how the HCA can help consumers, a referral process so pharmacists could quickly refer their customers, and also provided pharmacies with HCA materials. We have already started getting referrals from the drugstores, and we are planning on expanding this project to other area pharmacies in the future.

### C. The HCA collaborated with other stakeholders to respond to the federal government's decision to stop funding cost-sharing reductions.

After the federal government decided to stop funding the Cost Sharing Reduction (CSR) payments in 2017, the HCA immediately started working with other stakeholders to develop a strategy to protect consumers from cost increases and also support and stabilize the individual market for the future. The HCA is participating in a stakeholder group addressing the CSR issue, and also had multiple attorneys participate in the 2019 Qualified Health Plan (QHP) plan design process.

### D. Access to Treatment for Hepatitis C Virus

This quarter, the HCA actively worked to improve Vermonter's access to hepatitis C treatment. This project included advocacy before state boards as well as participation in the Vermont Department of Health Hepatitis C Task Force. We are pleased that Vermont has moved forward with improvements to access to treatment for this illness. The HCA will continue to work on making sure Vermonters are aware of their treatment options and will continue to oppose any barriers to effective treatments.

### E. Overall call volume increased this quarter due to Open Enrollment

The total call volume increased by 8% (890 this quarter vs. 825). Nearly 10% of those calls involved getting consumers onto new coverage, preventing the loss of coverage, or obtaining coverage for services. We saved consumers \$46,327 this quarter.

	All Calls (2007-2017)										
	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
January	280	309	240	218	329	282	289	428	470	411	340
February	172	232	255	228	246	233	283	304	388	511	330
March	219	229	256	250	281	262	263	451	509	416	308
April	190	235	213	222	249	252	253	354	378	333	240
May	195	207	213	205	253	242	228	324	327	325	332
June	254	245	276	250	286	223	240	344	303	339	289
July	211	205	225	271	239	255	271	381	362	304	278
August	250	152	173	234	276	263	224	342	346	343	280
September	167	147	218	310	323	251	256	374	307	372	267
October	229	237	216	300	254	341	327	335	311	312	312
November	195	192	170	300	251	274	283	306	353	287	307
December	198	214	161	289	222	227	340	583	369	284	271
<b>Total</b>	2560	2604	2616	3077	3209	3105	3257	4526	4423	4237	3554

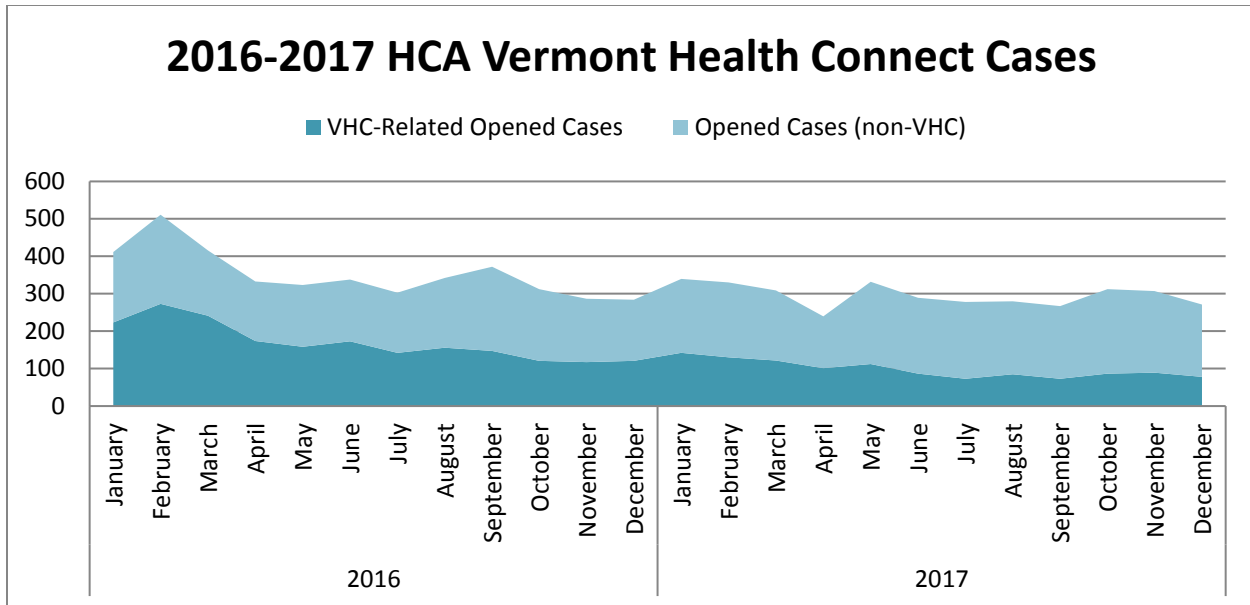
#### F. Calls concerning Vermont Health Connect increased due to Open Enrollment.

The volume of calls concerning Vermont Health Connect increased by 10%, compared to the previous quarter (254 vs. 231). We saw a particular jump in calls about Premium Tax Credit (PTC) eligibility (67 vs. 34). Consumers had questions about how much PTC they would be eligible for in 2018 when they were considering whether to stay on the same plan or switch. During Open Enrollment, the HCA did a lot of consumer education about VHC and Medicaid. We also saw a jump in cases from consumers asking for information about VHC (50 vs. 35 last quarter), and we talked to 60 people about applying for State of Vermont health care programs. This quarter, 73 VHC cases required complex interventions that took more than two hours of an advocate's time to resolve, and 37 required a direct intervention to resolve the case.

The HCA continues to resolve its cases by working directly with Tier 3 Health Access Eligibility Unit (HAEU) workers, who are trained to resolve all aspects of complex cases. In addition, the HCA meets with VHC each week to discuss cases as needed, and has regular email contact with Tier 3. This quarter we had significant increase in our escalated cases (73 vs. 44 last quarter). Of the 73 escalated cases, 50 were resolved within the quarter.

Tier 3 also now works on resolving Green Mountain Care cases (VPharm, Medicaid for Aged Blind and Disabled (MABD), Medicare Saving Programs, and Medicaid Spenddowns). This quarter we had a jump in cases for consumers having issues with either Medicare Savings Programs (52 vs. 40) and MABD (63 vs. 45).





**G. Medicaid eligibility calls represented 21% of all our cases (188 calls/ 890 total calls). Consumers need assistance with all types of Medicaid.**

Medicaid eligibility was again the top issue generating calls. We had 97 calls about eligibility for MAGI (expanded) Medicaid, 63 about eligibility for Medicaid for the Aged Blind and Disabled (MABD), and 28 about Medicaid Spenddowns. MAGI Medicaid and MABD Medicaid have different eligibility and income rules, and HCA advocates assess and advise on eligibility for both programs. Consumers frequently have questions about what counts as income, who should be counted in their household, what expenses can be used to meet a Spenddown, how to complete renewal paperwork, and whether their eligibility decision is correct.

**H. The top issues generating calls**

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

**All Calls 890 (compared to 825 last quarter)**

1. MAGI Medicaid eligibility 97 (77)
2. Complaints about providers 80 (87)
3. Premium Tax Credit eligibility 70 (34)
4. Medicaid eligibility (non-MAGI) 63 (45)
5. Information/applying for DVHA programs 60 (60)
6. Buy-in programs/Medicare Savings Programs 52 (40)
7. Consumer education about Medicare 51 (31)
8. Information about VHC 50 (35)
9. Access to prescription drugs/pharmacy 44 (41)

10. Other: Not health related 41 (35)
11. Change of Circumstance 39 (22)
12. Fair hearing appeals 36 (39)
13. Eligibility for VHC grace periods 29 (35)
14. Confusing notice 29 (27)
15. Termination of insurance 28 (36)
16. Medicaid spend down (eligibility) 28 (34)
17. VPharm eligibility 27 (28)
18. Mammography billing/coverage 27 (11)
19. Provider billing problems 26 (22)
20. Hospital billing 25 (31)
21. Nursing home complaint 25 (24)
22. Special enrollment periods (eligibility) 23 (33)
23. VHC invoice/billing problem affecting eligibility 22 (37)
24. Buying QHPs through VHC 21 (8)

**Vermont Health Connect Calls 254 (compared to 231 last quarter)**

1. MAGI Medicaid eligibility 84 (66)
2. Premium Tax Credit eligibility 67 (34)
3. Information about VHC 47 (34)
4. Change of Circumstance 33 (20)
5. Eligibility for VHC grace periods 29 (35)
6. Fair hearing appeals 24 (26)
7. VHC invoice/payment/billing problem affecting eligibility 22 (37)
8. Buying QHPs through VHC 20 (6)
9. Termination of insurance 19 (28)
10. VHC complaints 17 (16)
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**DVHA Beneficiary Calls 259 (compared to 241 last quarter)**

1. MAGI Medicaid eligibility 36 (36)
2. Medicaid eligibility (non-MAGI) 33 (17)
3. Complaints about providers 25 (26)
4. Access to prescription drugs/pharmacy 21 (13)
5. Buy-in programs/Medicare Savings Programs 19 (11)
6. Information/applying for DVHA programs 17 (19)
7. Provider billing problems 17 (8)
8. Access to specialty care 14 (11)
9. Access to transportation 13 (10)
10. Medicaid/VHAP Managed Care Billing 13 (17)
11. Fair hearing appeals 12 (10)
12. Consumer education about Medicare 11 (6)
13. VPharm eligibility 11 (4)

### Commercial Plan Beneficiary Calls 209 (compared to 166 last quarter)

1. Premium Tax Credit eligibility 48 (18)
2. MAGI Medicaid eligibility 26 (11)
3. Information about VHC 25 (16)
4. Change of circumstance 19 (9)
5. Eligibility for VHC grace periods 18 (17)
6. Mammography 16 (9)
7. VHC invoice/payment/billing problem related to eligibility 14 (22)
8. DVHA/VHC premium billing 13 (7)
9. VHC renewals 13 (2)
10. Consumer education about Medicare 13 (13)
11. IRS reconciliation 12 (5)
12. Hospital billing 11 (9)

The HCA received 890 total calls this quarter. Callers had the following insurance status:

- **DVHA program beneficiaries** (Medicaid, Medicare Savings Program also called Buy-In program, VPharm, or both Medicaid and Medicare also known as “dual eligible”): 29.1% (259 calls), compared to 29.2% (241 calls) last quarter
- **Medicare<sup>2</sup> beneficiaries** (Medicare only, Medicare Advantage Plans, Medicare and a Medicare Supplemental Plan aka Medigap, Medicare and Medicaid also known as “dual eligible,” Medicare and Medicare Savings Program also called Buy-In program, Medicare and Part D, or Medicare and VPharm): 28.7% (255 calls), compared to 26% (218 calls) last quarter
- **Commercial plan beneficiaries** (employer-sponsored insurance, small group plans, or individual plans): 23.5% (209 calls), compared to 20% (166 calls) last quarter
- **Uninsured**: 8.7% (77 calls), compared to 9% (74 calls) last quarter

## Case Results

### A. Dispositions of Closed Cases

#### All Calls

We closed 885 cases this quarter, compared to 808 last quarter:

- 35% (312 cases) were resolved by brief analysis and referral
- 29% (261) were resolved by brief analysis and advice
- 18% (160) of the cases were complex interventions involving complex analysis, usually direct intervention, and more than two hours of an advocate’s time
- 9% (78) were resolved by direct intervention, including calling an insurance company, calling providers, writing letters, gathering supporting medical documentation, etc.

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

- In the remaining cases (74), clients withdrew, resolved the issue on their own, or had some other outcome.

Appeals: The HCA assisted 24 individuals with appeals: 21 Fair Hearings, 1 Commercial Insurance – Internal 2<sup>nd</sup> Level appeal, 1 Medicare Part D appeal, and 1 Medicaid MCO Internal appeal.

### **DVHA Beneficiary Calls**

We closed 257 DVHA cases this quarter, compared to 250 last quarter:

- 38% (98 cases) were resolved by brief analysis and/or referral
- 25% (64) were resolved by brief analysis and/or advice
- 20% (51) were considered complex intervention, which involves complicated analysis, usually direct intervention, and more than two hours of an advocate's time
- 12% (31) were resolved by direct intervention on the caller's behalf, including advocacy with the carrier and providers, writing letters, and gathering medical information
- In the remaining cases clients withdrew, resolved the issue on their own, or had some other outcome.

Appeals: The HCA assisted 7 DVHA beneficiaries with appeals: 5 Fair Hearings, 1 Medicare Part D appeal, and 1 Medicaid MCO Internal appeal.

### **Commercial Plan Beneficiary Calls**

We closed 199 cases involving individuals on commercial plans, compared to 153 last quarter:

- 38% (76 cases) were resolved by brief analysis and/or advice
- 25% (50) were considered complex intervention, which involves complicated analysis, usually direct intervention, and more than two hours of an advocate's time
- 20% (40) were resolved by brief analysis and/or referral
- 11% (22) were resolved by direct intervention on the caller's behalf, including advocacy with the carrier and providers, writing letters, and gathering medical information
- In the remaining cases clients withdrew, resolved the issue on their own, or had some other outcome.

Appeals: The HCA assisted 19 commercial plan beneficiaries with appeals: 17 Fair Hearings, 1 Commercial Insurance – Internal 2<sup>nd</sup> Level appeal, and 1 Medicare Part D appeal.

## **B. Case Outcomes**

The HCA helped 48 people get enrolled in insurance plans and prevented 21 insurance terminations or reductions. We obtained coverage for services for 21 people. We got 20 claims paid, written off, or reimbursed. We estimated VHC insurance program eligibility for 37 more. We provided other billing assistance to 16 individuals. We provided 477 individuals with advice and education. One person was not eligible for the benefit they sought, and nine were responsible for the bill they disputed. We obtained other access or eligibility outcomes for 164 more people.

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## Consumer Protection Activities

### A. Certificate of Need

The HCA participates in Certificate of Need (CON) processes as an “interested party” to ensure that approved health care investments are in the best interests of Vermonters. In January 2017, the HCA intervened in the University of Vermont Medical Center’s (UVMCC) CON for a replacement electronic health record system (EHR). UVMCC proposed to migrate four of its hospitals to a unified health record system purchased from the Epic Systems Corporation. The proposed project has a total cost of ownership of approximately 150 million dollars over six years. In November 2017, the HCA appeared at the hearing before the Green Mountain Care Board (Board) on the matter. Subsequent to the hearing, the HCA filed a post-hearing memorandum for the Board’s consideration. In the post-hearing memorandum and at the hearing, while acknowledging the potential benefits of EHRs, the HCA raised several examples of substantial cost-overruns in Epic EHR implementations by top-tier hospital and health systems and an increased potential for the provision of inappropriate care. In light of these and other concerns, the HCA asked the Board to make any approval of UVMCC’s CON subject to enhanced reporting requirements and other process and procedural safeguards to protect Vermont consumers. The Board approved UVMCC’s CON subject to conditions to ensure that the EHR promotes quality and engaged care and that UVMCC uses metrics to evaluate the impact of the EHR on the health network.

### B. Other Green Mountain Care Board Activities

During the last quarter, the HCA participated in several stakeholder groups organized by the Green Mountain Care Board in addition to attending weekly Green Mountain Care Board meetings, a Green Mountain Care Board advisory committee meeting, and periodic meetings with Board staff and/or individual Board members. One stakeholder group was organized to discuss potential changes to state statutes that impact the Green Mountain Care Board’s work. As a part of this work, the Board proposed changes to the Certificate of Need Statute. The HCA participated in these meetings and submitted written comments on the proposed rule changes. These written comments asked for any CON statute changes to provide details on the process for expedited review including the role an interested party would play in an expedited process, and we proposed that the window for requesting interested party status should be changed. The HCA is concerned that the current lack of transparency on expedited review processes impedes advocates’, the public’s, and other potential stakeholders’ abilities to participate in the process in an effective way. Further, the current statute requires that if anyone wants to apply for interested party status but misses the initial application window, they must wait until the application is closed to apply for the status. Allowing potential applicants a longer period to apply for interested party status during the regular review period would help to avoid complicating the review process at the end.

In the last quarter, we also attended a meeting of Green Mountain Care Board staff and hospital Chief Financial Officers convened to discuss potential changes to the Board’s Hospital Budget Review process. We separately met with the Board’s Director of Health Systems Finance to discuss the FY 2019 Budget Review. We agreed that the HCA would submit requests for information to be added to the Board’s 2019 Hospital Budget Guidance. This should allow the HCA to obtain some information we would like to review sooner and in a more efficient manner than is possible during the July and August budget review period.

As a part of our comments on the ACO budget process last quarter, we asked the Board to form a stakeholder group to develop standard forms and metrics for its regulatory processes that would allow for comparison of documentation across review processes. For example, it would be helpful

to be able to easily compare care coordination programs, utilization trends, provider payment increases, and cost factors currently outside the control of state-level actors (e.g, pharmaceuticals) across the Board's reviews. Standard forms and metrics would allow the Board, the HCA, other stakeholders, and the public to compare the information reported by each entity and more easily identify duplication, inconsistencies, points of consensus, and areas of concern.

In addition, we participated in a stakeholder group discussing state reactions to federal changes that negatively impact the state. The first topic the group addressed was the loss of Cost Sharing Reduction funding from the federal government. The HCA extensively researched the issue and agree with the group's consensus that the best option for Vermonters is to add the cost of the lost funding to subsidized silver plans. This allows the costs to be absorbed by increased federal premium tax credit funds. The HCA also participated in a Billback stakeholder group, which discussed ways to improve fairness in the distribution of Billback fees among health care entities.

Finally, the HCA presented before the Green Mountain Care Board at a weekly meeting last quarter. We provided the Board and the public with information on our hotline that works to improve Vermonters' access to health care. We also previewed an affordability analysis that our office has been working on. The analysis takes into account costs of living for various income levels and whether there is enough money left over for the costs of premiums and cost sharing for health insurance exchange plans. The analysis shows significant affordability issues in Vermont's individual health insurance market.

### **C. Rate Review**

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

One new rate filing was submitted during the quarter covering October 2017 through December 2017. The HCA filed a Notice of Appearances in this case. Additionally, two rate filings were pending at the beginning of the quarter that affected Vermont consumers and in which the HCA appeared. One additional filing was pending at the start of the quarter; however, no individuals were enrolled in the offered plan.

The two pending rate filings that affected Vermonters involved premium rates for the 2018 plans that MVP will offer for grandfathered small groups and 1<sup>st</sup> and 2<sup>nd</sup> quarter large group PPOs. These two rate filings affected approximately 3,700 members. The grandfathered small group filing affected approximately 1,700 members and the 1<sup>st</sup> and 2<sup>nd</sup> quarter large group PPO filing affected approximately 2,000 members.

The HCA submitted memoranda in both of these filings. The HCA did not object to the proposed rate due to recent and emerging federal funding and regulatory changes that introduced substantial uncertainty into the Vermont health insurance market. However, the HCA expressed its concern that rate growth for both books of business outpaced Vermont's economic growth, indicative of a general trend towards decreasing health care affordability.

The new rate filing filed during this quarter is CIGNA's Vermont Large Major Medical Filing. CIGNA proposes a 6.2% average annual rate change to its manual rating formula and the rate will affect approximately 498 Vermonters. HCA will file a memorandum in this matter in February 2018.



#### **D. Accountable Care Organization Budget Review**

This quarter, the Board completed its first Accountable Care Organization (ACO) Budget Review. Act 113 of 2016 requires the Board to review ACO budgets starting in 2018 (for fiscal year 2019), so the Board used this year as a test year and reviewed the ACOs' fiscal year 2018 budgets. During the quarter, one of Vermont's two ACOs (Community Health Accountable Care (CHAC)) withdrew its budget submission. The Board completed its review of the remaining ACO (OneCare Vermont)'s budget and approved the budget with conditions. The HCA continued to actively participate in the Board's review of OneCare's budget. This quarter, we received and reviewed OneCare's second budget submission. We submitted written questions to OneCare and received written answers to our questions. We participated in OneCare's November 2 budget review hearing and asked questions of OneCare's executives. Prior to the hearing, we submitted an additional document asking OneCare to explain the flow of money in various scenarios. In late November we met with OneCare and Board staff via telephone to discuss these scenarios. We had an additional phone call with the Board and OneCare staff to clarify OneCare's risk model and attended a OneCare Governing Board meeting at which the budget was discussed.

In late December we submitted written comments to the Board asking the Board not to approve OneCare's budget unless OneCare agreed to additional transparency, accountability, and consumer protection measures. Specifically, we outlined concerns about the lack of executed contracts for Board review, the lack of tools to adequately monitor utilization, quality, and access, the lack of sufficient quality, access and experience metrics, and the lack of sufficient grievance and appeal processes. We also asked the Board to ensure that OneCare sufficiently invests in community-based services, and to encourage OneCare to invest in programs aimed at improving care, reducing costs, and addressing social determinants of health for vulnerable and high-cost populations.

In its budget order, the Board approved OneCare's budget and applied conditions. The conditions require OneCare to submit its payer contracts to the Board upon execution and to consult with the HCA to establish a grievance and appeals process consistent with Rule 5.000, among others.

#### **E. Accountable Care Organization Rule**

This quarter, the Green Mountain Care Board's proposed Rule 5.000 Oversight of Accountable Care Organizations went before the Legislative Committee on Administrative Rules (LCAR) for a second time. Prior to the first hearing before LCAR (in the previous quarter), we submitted written comments asking for annual enrollee notification of attribution, whistleblower protections, and information regarding care management mechanisms. We also asked for a requirement for referral to the Attorney General (AG) for anticompetitive behavior along with clarification that individual Board members and staff could report potential anticompetitive behavior to the AG's office without Board consensus. Early this quarter we worked with the Board, at LCAR's request, to try to address these concerns. The Board discussed this topic at one of its regular public meetings and agreed to some of our suggested changes including improved patient notice language, stronger whistleblower protections, and referral to the AG for anticompetitive behavior. LCAR approved the rule at its October 12 meeting.

#### **F. Affordable Care Act Tax-related Activities**

Tax-related calls from consumers declined this quarter, but tax issues are still regularly encountered in our VHC cases.

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

affecting, or appearing to affect, the Vermont healthcare landscape. The HCA's tax attorney analyzed multiple federal changes this quarter, including the cessation of federal cost-sharing subsidy reimbursements to insurance companies, and changes made in the Tax Cuts and Jobs Act.

As in prior quarters, the HCA's tax attorney consulted with HCA advocates when particularly difficult IRS-related issues arose in HCA cases. During this quarter, the tax attorney advised the HCA on 15 technical assistance questions. She also responded to 30 technical assistance questions from Vermont tax preparers and legal aid attorneys. Question topics included shared responsibility exemptions, difficulties encountered in premium tax credit audits, and collection options for excess premium tax credits. The most common issues for consultation were premium tax credit audits and other post-filing correspondence from the IRS.

In December, the HCA's tax attorney met with the IRS Office of Chief Counsel's Healthcare Counsel to discuss emerging issues including how tax privacy restrictions affect consumers' ability to find out why their VHC premium subsidies are ending. This is an issue we will continue to monitor.

The HCA continued to engage in tax-related outreach and educational activities this quarter. They are detailed below in the **Outreach and Education** section.

## G. Other Activities

### Administrative Advocacy

#### ✧ Access to Screening Mammography

This quarter the HCA continued to advocate for implementation of Act 25 of 2013, which requires first-dollar coverage of screening mammography including additional views. We believe that hundreds of women have been and continue to be charged cost-sharing and deductibles for call-back mammograms that should be fully covered under Vermont law. This law had an implementation date of over three and a half years ago, and yet it continues to not be followed. We are actively pursuing full implementation, which would save many Vermont women hundreds of dollars each year and reduce the financial barriers that make it harder for Vermonters to access these preventative cancer screenings. This quarter we wrote an op-ed that was printed in a number of media outlets to raise awareness about this issue. Our office received a number of calls in response to our outreach on this issue.

#### ✧ Access to Treatment for Hepatitis C Virus

This quarter the HCA wrote another letter to DVHA's Drug Utilization Review Board (DURB) asking the DURB to remove all remaining restrictions on access to hepatitis C treatment for Medicaid beneficiaries. The DURB reviewed the criteria at its October meeting and voted to remove the liver damage (fibrosis) requirement, opening up treatment to Medicaid beneficiaries with hepatitis C regardless of their disease stage. We testified before the DURB in support of this change and advocated for DVHA to implement the DURB's recommendation immediately. In early December, DVHA issued a letter to providers indicating that it would implement the DURB's recommended change as of 1/1/18.

Additionally, the HCA continues to actively participate in the Vermont Department of Health Hepatitis C Task Force. We attended one meeting of the task force this quarter and met with the VDH Hepatitis C Coordinator to discuss task force priorities.

### ❖ **Family and Medical Leave Insurance (FaMLI) Coalition**

The HCA continued to participate in the FaMLI Coalition this quarter, advocating for paid family and medical leave for all Vermonters. We attended one meeting of the coalition this quarter and conducted outreach for coalition events.

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

In 2016, the Department of Vermont Health Access (DVHA) began a multi-year revision of Medicaid rules. Eventually all Medicaid rules will be amended and adopted under the title of Health Care Administrative Rules (HCAR). HCA supports the HCAR project and has committed significant resources to leading VLA's review of all HCAR rules, both in draft form and when officially proposed.

The HCAR process continued this quarter. We submitted formal public comments on DVHA's proposed rule describing non-covered services. The comments were a joint effort with the Senior Citizens Law Project (SCLP) of VLA. The non-covered services rule is an important rule for Medicaid providers and beneficiaries, because it delineates the coverage limits of Medicaid. The proposed rule adopted several positive changes which we had advocated in our informal comments this past July. However, we still have substantial concerns about how this proposed rule would impact Medicaid beneficiaries' ability to access appropriate and necessary care. We again urged DVHA to consult with a variety of medical professionals before publishing a final proposed rule.

### ❖ **Health Benefits Eligibility and Enrollment Rule**

During this quarter, AHS issued a final proposed rule incorporating several of the comments HCA had made in the prior quarter. In November, Chief Advocate Michael Fisher testified before the Legislative Committee on Administrative Rules (LCAR) to explain the HCA's position on the special enrollment period for pregnant women. The HCA disagrees with DVHA's interpretation of the special enrollment period for pregnancy, which was created by the Vermont legislature in 2016. Pregnant women should be permitted to change health plans because of the overriding public interest in maternal and child health. We believe that the statutory language could be read to apply to current VHC enrollees as well as uninsured individuals, and that DVHA should interpret the statute in that way for public policy reasons. As DVHA did not agree, we expect to raise the issue before the legislature in 2018.

### ❖ **Vermont Health Connect Escalation Path**

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

### ❖ **Comments on Vermont Health Connect Notices**

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

### ❖ **Medicaid and Exchange Advisory Board**

This quarter, the Chief Health Care Advocate continue to co-chair and actively participate in Vermont's Medicaid and Exchange Advisory Board (MEAB). The Chief attended and chaired three meetings of the MEAB during the quarter, and presented on the work of the HCA at one meeting of the MEAB.

### ❖ **Comments on Essential Health Benefits**

The HCA endorsed a Families USA letter to the federal Department of Health and Human Services (HHS) regarding the importance of strong federal standards for Essential Health Benefits.

### ❖ **Comments on HHS Proposed Notice of Benefit and Payment Parameters for 2019**

The HCA commented in opposition to several proposed changes that would relax federal ACA standards or harm consumers. For example, we strongly support maintaining the current requirement that exchanges directly notify enrollees who will lose subsidies for failure to reconcile premium tax credits. The HCA also commented in support of some provisions of the Proposed Notice, including changes that would make it easier for consumers to end their coverage.

### ❖ **Comments on HHS Draft Strategic Plan**

The HCA submitted comments on HHS's draft strategic plan for fiscal years 2018 through 2022. Among other comments, we raised concerns regarding access to reproductive health care, and we objected to statements within the strategic plan that promote the religious belief that life begins at conception.

## **Legislative Activities**

There were no official legislative meetings this quarter. The HCA hosted a legislator access to care roundtable meeting at the Burlington office. We also continued to engage legislative leaders during the quarter to keep them up to date on the issues that the HCA was working on. In addition, the HCA partnered with a number of legislators this quarter in providing services to constituents with health care questions and concerns. The Chief Health Care Advocate traveled to member's home communities in the southern part of the state to discuss local access to care issues and educate legislators about the work of the HCA.

## **Collaboration with Other Organizations**

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

- Advocates for Basic Legal Equality (ABLE) Ohio
- AIDS Project of Southern Vermont
- American Civil Liberties Union of Vermont
- Bi-State Primary Care
- Blue Cross Blue Shield of Vermont
- Families USA
- HIV/HCV Resource Center
- Howard Center Safe Recovery
- IRS Office of Chief Counsel
- IRS Taxpayer Advocate Service
- Ladies First
- Let's Grow Kids
- MVP Health Care
- National Health Law Program
- OneCare Vermont
- Planned Parenthood of Northern New England
- Public Assets Institute

- University of Vermont Medical Center
- Vermont Association of Hospitals and Health Systems
- Vermont Care Partners
- Vermont CARES
- Vermont Coalition of Clinics for the Uninsured
- Vermont Department of Health
- Vermont Health Connect
- Vermont Medical Society
- Vermont Prisoners’ Rights Office
- Vermont Program for Quality in Health Care
- Professor James Maule, Villanova Law School
- VNAs of Vermont
- Voices for Vermont’s Children

## Outreach and Education

### A. Increasing Reach and Education through the Website

Vermont Law Help is a statewide website maintained by Vermont Legal Aid and Law Line of Vermont. The site includes a substantial Health section (<https://vtlawhelp.org/health>) with more than 250 pages of consumer-focused health information maintained by the HCA.

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

### Popular Web Pages

The total number of **health pageviews increased by 23%** in the reporting quarter ending December 31, 2017 (11,687 pageviews), compared with the same quarter in 2016 (9,490 pageviews). This is noteworthy because the total number of pageviews for the entire Vermont Law Help website increased by only about 11%.

The top-20 health pages on our website this quarter with change over last year:

- [Income Limits – Medicaid](#) – 3,198 pageviews (1% ↓)
- [Health](#) – section home page – 1,295 (33% ↑)
- [Vermont Choices for Care](#) – 429 (34% ↑)
- [Resource Limits – Medicaid](#) – 414 (209% ↑)
- [Dental Services](#) – 381 (20% ↓)
- [Services Covered by Medicaid](#) – 372 (17% ↑)
- [Long-term Care](#) – 218 (69% ↑)
- [HCA Online Help Request Form](#) – 209 (99% ↑)
- [Health Insurance, Taxes and You](#) – 205 (26% ↓)
- [Choices for Care Resource Limits](#) – 195 (47% ↑)
- [Medical Marijuana Registry Patient Form](#) – 192 (63% ↑)
- [Medicaid](#) – 179 (17% ↑)
- [Choices for Care Income Limits](#) – 171 (2% ↓)
- [Medicaid and Medicare dual eligible](#) – 168 (4% ↑)
- [Advance Directives and Living Wills](#) – 157 (8% ↑)

- [Medicare Savings / Buy-In Programs](#) – 155 (72% ↑)
- [Federally Qualified Health Centers](#) – 148 (29% ↑)
- [Long-term Care Help](#) (new page) – 144 (100% ↑)
- [Vermont Health Connect – main page](#) – 143 (138% ↑)
- [Advance Directive Forms](#) – 137 (73% ↑)

Besides the pages listed above, other spikes in interest in our pages included:

- [Prescription Assistance – State Pharmacy Programs](#) (up from 38 pageviews last year to 132 pageviews this year)
- [Medicaid Transportation](#) (up from 37 to 120)
- [Choices for Care Requirements](#) (new page up from 0 to 99)
- [HCA Policy Papers](#) (new page up from 0 to 85)
- [Cost-Sharing Reductions](#) (up from 17 to 70)
- [Premium Tax Credits](#) (up from 20 to 69)
- [Ladies First Health Program](#) (up from 10 to 43)

### Popular PDF Downloads

31 out of 80 (39%) of the unique PDFs downloaded from the Vermont Law Help website were on health care topics. Of those unique health-related PDF titles:

- 17 were created for consumers. The top five consumer-focused PDF downloads were:
  - [Vermont Dental Clinics Chart](#) (117 downloads)
  - [Advance Directive, short form](#) (112 downloads)
  - [Advance Directive, long form](#) (73 downloads)
  - [Vermont Medicaid Coverage Exception Request Form](#) (19 downloads)
  - [Simple 5-Step Guide to Getting DME through Medicaid](#) (16 downloads)
  - The advance directive forms were accessed more often this year as compared to the same period last year (185 downloads versus 54 last year).
- 5 were prepared for lawyers, advocates and assisters who help consumers with tax issues related to the Affordable Care Act. The top advocate-focused download was:
  - [PTC Rule Allocation Summary](#) (5 downloads)
- 10 covered topics related to health policy. The top policy-focused download was:
  - [HCA Press Release: Medicaid Review Board Lifts Liver Damage Restriction on Life Saving Cures for Vermonters with Hepatitis C](#) (13 downloads)

Our [Vermont Dental Clinics Chart](#) is the **fifth most downloaded of all PDFs** downloaded from the entire Vermont Law Help website.

The [Advance Directive Short Form](#) is the **sixth most downloaded of all PDFs** downloaded from the entire Vermont Law Help website.

### New Online Help Tool Adds to Our Reach

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

The website visitor answers a few questions to find specific health care information they need. The new feature addresses some of the most popular questions that are posed to the HCA. In addition to our



deep collection of health-related web pages, the online help tool adds a new way to access helpful information — at all hours of the day and night. The website user can also call us or fill in our online form to get personal help from an advocate.

Website visitors used this new tool to access health care information **136 times** during this quarter, signifying a 91% increase over the previous quarter.

Of the 52 health care topics that were accessed, the top topics were:

- Dental Services - I need help finding a low-cost dentist and paying for dental care.
- Long-Term Care - I want to go over my long-term care options (nursing homes, in-home care, and more).
- VHC - I want to apply for Vermont Health Connect for myself or my children.
- Complaints - I want to file a complaint against a doctor.
- Advance Directives - I need help with an advance directive or living will.

## **B. Other Outreach and Educational Activities**

### **Op Ed: Mammograms are Free in Vermont (October 3, 2017)**

Chief Health Care Advocate Michael Fisher published an opinion piece in the Burlington Free Press to spread the word about changes to Vermont law that require no-cost mammography screenings and follow-up screenings. The HCA was concerned that the law had not been implemented in the years since its passage. The news item generated several calls to the HCA from consumers with mammogram bills.

### **Mauled Again (October 11, 2017)**

The HCA's tax attorney analyzed the regulations governing liability for advance premium tax credit payments when a young adult dependent erroneously enrolls himself in subsidized coverage.

### **Outreach to Agricultural Guestworkers (October 21, 2017)**

HCA staff visited three orchards in Windham County to distribute outreach materials and answer health care and health insurance questions from agricultural workers with H-2A visas. Topics discussed included Vermont Health Connect enrollment, health insurance subsidies, how to get emergency medical care, and the penalty for going without insurance. We met with 31 workers in total.

### **Vermont Edition (October 27, 2017)**

Chief Health Care Advocate Michael Fisher and Sean Sheehan from Vermont Health Connect appeared on Vermont Edition, *A Checkup on VHC*. The program addressed VHC's functionality ahead of open enrollment, and discussed the range of policies and financial assistance available.

### **VPR News (October 27, 2017)**

Chief Health Care Advocate Michael Fisher appeared on a VPR News segment, *Vermont Health Connect Has Solved Many of Its Problems as New Enrollment Begins*.

### **University of Vermont Tax School (November 8 & 15, 2017)**

The HCA's tax attorney spoke to attendees at both sessions of the UVM Tax School about VHC open enrollment and the subsidies available to taxpayers. She explained that the federal decision to stop cost-sharing subsidy reimbursements for insurers did not affect Vermont health insurance options for 2018. About 350 tax professionals (enrolled agents, CPAs, attorneys, and un-credentialed preparers) attended.

**VPR News (December 6, 2017)**

Chief Advocate Michael Fisher appeared on a VPR News segment, *Chief Health Care Advocate Says Families Struggling to Meet Basic Needs*.

**Annual Low-Income Taxpayer Clinic Grantee Conference (December 6, 2017)**

The HCA's tax attorney was featured on a panel that presented "Affordable Care Act: Hot Topics and Developments" to about 75 attendees. Attendees were largely directors and staff attorneys from Low-Income Taxpayer Clinics (LITC) and staff from the IRS Taxpayer Advocate Service (TAS). The presentation was a collaboration with the IRS Taxpayer Advocate Service and the IRS Office of Chief Counsel.

**VPR News (December 11, 2017)**

Chief Advocate Michael Fisher appeared on a VPR News segment, *State Officials: Enrollment For The Affordable Care Act Ends Friday, Act Now*.

**VPR News (December 22, 2017)**

Chief Advocate Michael Fisher appeared on a VPR News segment, *State Health Care Board Gives Green Light To Major Payment Reform Plan*.

**Kinney Drugs Referral Program (December 2017)**

The HCA and Kinney Drugs developed referral procedures and a referral form so that consumers at the pharmacy will have easy access to an HCA advocate in case of problems with healthcare or health insurance. HCA staff met with Kinney Drugs representatives to explain HCA services and the problems that HCA can help consumers resolve.

**C. Promoting Plain Language in Health Communications**

During this quarter, the HCA provided feedback and revisions to promote the use of plain language and increase consumers' accessibility to and understanding of important communications from the state and other health organizations regulated by the state. The HCA made plain language edits and edits/comments to improve comprehension of message and ability to resolve the problem being addressed in the following notices/letters:

- Bronze Plan design brochure
- BCCTP steps notice
- BCCTP brochure
- VHC catastrophic brochure
- VHC Silver CSR plans brochure
- Dr. Dynasaur premium increase notice
- Healthy Vermonters outreach
- Comments on voice and text messages for VHC customers
- Comments on notice to QHP subscribers with out of state addresses
- Comments of EE202-MM, verification notice of Indian status

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