

Office of the Health Care Advocate



SFY 2016 Annual Report

July 1, 2015 – June 30, 2016

CHIEF HEALTH CARE ADVOCATE

Trinka Kerr (tkerr@vtlegalaid.org)

STAFF ATTORNEYS

Kaili Kuiper | Lila Richardson | Christine Speidel | Marjorie Stinchcombe

HEALTH CARE ADVOCATES

Emily Bens | Eric Fanning | Ariel Jurmain
Laurie Larson | Amelia Schlossberg | John Smith | Emma Zavez

POLICY ANALYST

Julia Shaw

WEB MANAGER

Sandra Gluck

A Special Project of



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Background

The Vermont legislature created the Office of Health Care Ombudsman in 1998 to provide advice and advocacy for Vermonters with health care and health insurance concerns. In 2013 the legislature amended the statute and changed the program's name to the Office of the Health Care Advocate (HCA), effective January 1, 2014. The HCA is not a state agency. Rather, the HCA is part of Vermont Legal Aid (VLA), a statewide nonprofit law firm. We provide individual consumer assistance and act as a voice for the Vermont public on policies and matters related to health care and health insurance.

Consumer Assistance

The HCA helps individuals navigate the complexities of health insurance and assists them with health care problems. We advise and assist Vermont residents, regardless of income, resources or insurance status. Our services are free. As part of VLA, we are able to utilize the broad range and depth of legal knowledge of attorneys in the other VLA projects.

Individuals contact us through our Burlington-based statewide helpline (**1-800-917-7787**) and the *Vermont Legal Aid* and *Vermont Law Help* websites, as well as by walking into one of the five VLA offices located around the state. For each case, HCA advocates analyze the situation and provide information, advice and referrals or directly intervene and represent the individual.

One of our main goals is to help individuals get access to care. We give highest priority to individuals who are having difficulty getting immediate health care needs met, who are uninsured or who are about to lose their insurance. We give them information and advice about the insurance options in Vermont and assist if they have problems with enrollment. We also educate consumers about their rights and responsibilities and provide information about and assistance with appeals.

Our cases can involve any type of insurance, including all commercial plans as well as public programs such as Medicaid, Dr. Dynasaur and Medicare.

Public Advocacy

Part of the HCA's statutory mandate is to act as a voice for Vermont consumers in health care policy matters and as their advocate before government agencies. Our individual cases inform our public policy and advocacy efforts. Working on behalf of all Vermonters, we advocate for laws and administrative rules that provide better access to and improved quality of health care. We represent the public in rate review proceedings and other matters before the Green Mountain Care Board (the Board) and other state entities. Act 48 of 2011 and Act 171 of 2012 require the Board to consult with the HCA about their policies and activities and how they impact consumers.

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Highlights

During State Fiscal Year (SFY) 2016 (July 1, 2015 through June 30, 2016), the HCA consumer assistance hotline received 4,389 calls.¹ About 27% of these calls were from individuals on Medicaid programs run by the Department of Vermont Health Access (DVHA), 29% from individuals on commercial health plans, 16% from Medicare² beneficiaries and 13% from uninsured individuals.³

✦ **Total HCA call volume decreased 7% in SFY 2016, but some months hit record highs.**

This year's total volume of 4,389 calls was about 7% less than the record-breaking 4,695 calls we received in SFY 2015. But total call volume in SFY 2015 was 20% higher than the previous year's 3,907 calls. This year, we set record call volumes in August, November, and February.

Annual Call Totals All Cases											
	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
January	313	280	309	240	218	329	282	289	428	470	411
February	209	172	232	255	228	246	233	283	304	388	511
March	192	219	229	256	250	281	262	263	451	509	416
April	192	190	235	213	222	249	252	253	354	378	333
May	235	195	207	213	205	253	242	228	324	327	325
June	236	254	245	276	250	286	223	240	344	303	345
July	183	211	205	225	271	239	255	271	381	362	
August	216	250	152	173	234	276	263	224	342	346	
September	181	167	147	218	310	323	251	256	374	307	
October	225	229	237	216	300	254	341	327	335	311	
November	216	195	192	170	300	251	274	283	306	353	
December	185	198	214	161	289	222	227	340	583	369	
Total	2583	2560	2604	2616	3077	3209	3105	3257	4526	4423	2341

✦ **About 50% of all calls were related to Vermont Health Connect.**

After the launch of Vermont Health Connect (VHC) in 2013, the HCA's total call volume jumped about 30% and has consistently stayed 22-30% higher than the highest pre-VHC call volume. VHC's many problems were the main driver of the increase. In SFY 2016, we received 2,179 calls involving Vermont

¹ The term "call" also includes individuals who come to us through our website or as walk-ins.

² Medicare beneficiaries may also be on DVHA programs, like Medicaid or VPharm. This percentage comes from the Coverage Summary in the All Calls Data report.

³ These percentages are derived from the DVHA, Commercial Plan, and Uninsured data reports, plus Medicare numbers described in footnote 2. They do not add up to 100% because we do not ask callers what type of insurance coverage they have if it is not relevant to the issue they are calling us about. Also, some individuals have more than one type of insurance.

Health Connect. Problems with VHC billing were the primary reason consumers called us (526 calls), and complaints about VHC were the second most common problem cited by callers (405 calls).

✦ **Vermont Health Connect functionality slowly but steadily improved this year.**

At the end of this fiscal year, the pace and complexity of VHC problems finally seemed to be dropping. The ability of VHC to handle consumers' change of circumstance requests notably improved, and problems with billing also began to abate at the end of the year.

✦ **Calls related to eligibility decreased by 14%.**

Calls about eligibility for state benefits, including Medicaid and Advance Premium Tax Credits to help pay for plans sold through VHC, decreased by 14%, from 1,446 to 1,249.

✦ **6% of calls involved income tax issues generated by the Affordable Care Act.**

This was the second year that Americans' health insurance status had potentially serious tax consequences. We received 258 calls (6% of all callers) in which consumers identified their primary problem to be tax-related, compared to 303 (6%) last year. While we received a lot fewer calls requesting help to get corrected 1095-A tax forms, the consumer calls we received related to Form 1095-A brought many 2015 VHC account problems to light. Most of these involved VHC billing and enrollment errors.

✦ **The HCA saved Vermonters \$427,173 in SFY 2016, compared to \$684,945 last year and \$339,827 in SFY 2014.**

Through our individual consumer assistance program, the HCA saved Vermont consumers nearly half a million dollars by helping to get claims paid, coverage approved, or bills written off; getting clients onto insurance or preventing their coverage from being terminated or reduced; and helping them apply for hospital patient assistance or obtain reimbursements.

✦ **The HCA represented Vermont consumers before the Green Mountain Care Board in eight rate review proceedings.**

This was the fourth year that the HCA has been the public's voice in rate review cases. The HCA submitted written arguments in eight of the nine rate filings during SFY 2016. We argued for reduced increases for both carriers in the two most significant rate cases, the VHC filings for the 2016 calendar year plans that were reviewed in the summer of 2015. The Board approved rates that were 2.7% lower than the Blue Cross Blue Shield of Vermont (BCBSVT) request and .6% lower than the MVP request, resulting in overall rate increases of 5.9% for BCBSVT and 2.4% for MVP. The HCA also argued for BCBSVT reduce its contribution to surplus from 2% to 1%, and the Board approved.

✦ **The HCA also represented consumers in a rate review case before the Vermont Supreme Court.**

The HCA participated on behalf of Vermont consumers in the first Vermont Supreme Court appeal of a rate review decision by the Green Mountain Care Board. The Court's decision is pending.

✦ **The Court granted the HCA permission to file a friend of the court brief in a Vermont Health Connect appeal to the Vermont Supreme Court.**

The HCA filed a motion to participate as a friend of the court (*amicus curiae*) on behalf of a consumer in a Vermont Supreme Court appeal filed by the Department of Vermont Health Access involving eligibility for Qualified Health Plan subsidies under federal tax law. The Court granted the HCA's motion, and the HCA filed the *amicus curiae* brief just after the close of this fiscal year.

✦ **As the State worked to bend the curve on health care costs through various payment reforms, the HCA worked to protect consumers and improve the quality of patient care.**

The HCA, coordinating with colleagues in other VLA projects, actively participated in Vermont Health Care Innovation Project (VHCIP) activities on behalf of consumers to ensure that consumer protections and quality of care are not sacrificed in efforts to lower costs.

✦ **The HCA's legislative work focused on maintaining and improving access to health care for Vermonters.**

The HCA actively worked on many of the approximately 20 health care bills considered during the 2016 legislative session. Two bills that are particularly important to consumers that we advocated for are Act 113, which requires the Green Mountain Care Board to regulate Accountable Care Organizations (ACOs), and Act 162, which authorizes the licensing of a new mid-level dental provider, dental therapists, to expand access to dental care in the state.

✦ **The HCA engaged a variety of communication channels to inform and protect the public and to update health, social services, and other partner organizations that assist the public with health care issues.**

The HCA's tax attorney continued to be in high demand both locally and nationally to provide clear, accurate information about the tax implications of the Affordable Care Act, and our policy team produced *Consumer Principles for Vermont's All-Payer Model*, a white paper that viewed the model through a consumer lens and highlighted seven key principles to safeguard consumers. The HCA presented at 18 meetings and events, including helping to plan, moderate and present a full-day program focused on opioid addiction and how it impacts clients and our ability to provide civil legal services. We made extensive plain language revisions to more than 30 communications about health care to be provided to consumers from the State and health organizations regulated by the State, and we developed a training and checklist to the lower reading grade level of text and enhance document readability. Pageviews for the health section of the Vermont Law Help website increased by more than 57% this year, and our Dental Clinics Chart rose to the top spot from 12th place among all health PDFs downloaded.

Trinka Kerr
Chief Health Care Advocate
August 2016

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Consumer Assistance

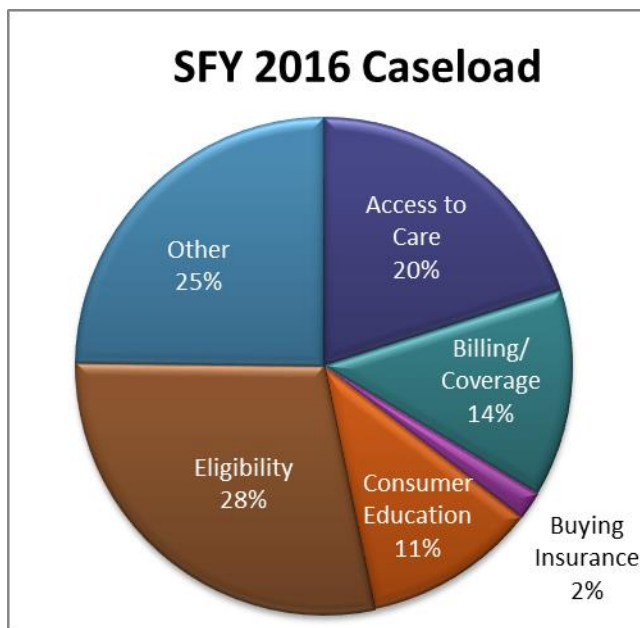
Description of Caseload

In State Fiscal Year (SFY) 2016, we handled 4,389 calls to our statewide hotline, compared to 4,695 in SFY 2015 and 3,907 in SFY 2014. We closed 4,338 cases during this period and had 254 cases pending at the end of June 2016.⁴ A total of 2,179 (49.7%) of the calls were related to Vermont Health Connect, compared to 45% in the previous year.

We assign each case to one or more of these six categories: *Access to Care*, *Billing and Coverage*, *Buying Insurance*, *Consumer Education*, *Eligibility*, and *Other*. While some cases span multiple categories, the case numbers in this section are based on the primary issue identified for each call in order to avoid counting the same case more than once.

While there were slight changes in the percentage of cases in several categories, the overall distribution of issues remained roughly the same as last year as these numbers show:

- Eligibility (28% compared to 31%)
- Other (25% compared to 20%)
- Access to Care (20%, the same as last year)
- Billing and Coverage (14%, the same as last year)
- Consumer Education (11% compared to 14%) and
- Buying Insurance (2% compared to 1%)



The pie chart above illustrates the comparative volume of calls for each category. Details are provided in the descriptions below.

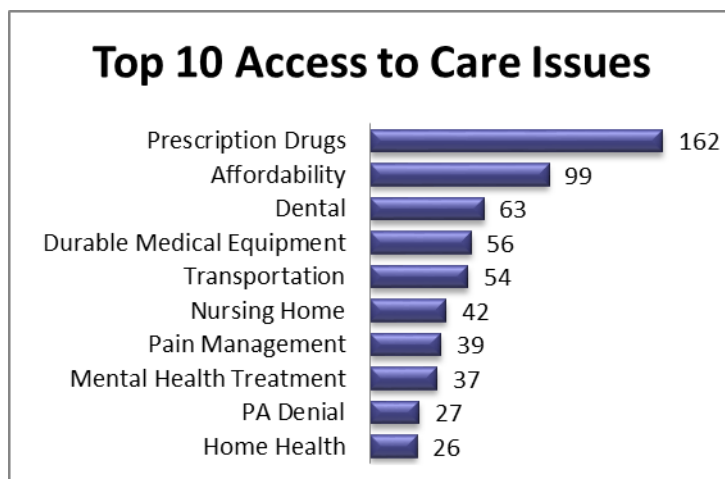
Access to Care

Access to Care cases are those in which individuals are seeking care. The number of calls reporting difficulties getting access to health care as the primary issue was 882, which is 4.3% lower than last year's total of 922. An additional 814 callers cited access issues as secondary to their primary problem.

⁴ These numbers do not add up to 4,386 total calls because some unresolved cases from the previous SFY were carried forward into this SFY.

We track 48 subcategories in *Access to Care*. As has been the case for years, Prescription Drugs posed the greatest number of access issues. We received calls from 177 Vermonters unable to promptly get necessary medications, compared to 227 total calls last year.

While the issues on this year's top ten Access to Care list are similar to those on last year's list, there was some interesting movement within the list. Nursing Home issues, which had fallen off the top ten list last year, moved into sixth place in SFY 2016 with a 50% increase in the number of callers who identified Nursing Home as their primary issue (42, compared with 28). Another issue that moved onto this year's list is Prior Authorization Denial, in ninth place with 27 calls. Issues that appeared on last year's top ten that do not appear on this year's list are Prescriptions – Medicaid Pharmacy Benefit Manager (15, compared to 52 last year) and Specialty Care (eleventh in SFY 2016 with 25 calls, compared to 29 last year).



Despite the fact that more Vermonters are insured, and a large proportion of Vermonters who purchased VHC plans qualified for cost-sharing reductions, more people find affordability to be a barrier to health care access. Affordability was the second most common Access to Care issue in SFY 2016 with 99 calls, compared to 91 last year. An additional 99 callers cited affordability as secondary to their primary access issue. Prescription drug problems were the most common Access to Care issue with 162 calls, compared to 175 last year. Another 139 callers named prescription access as secondary to their primary issue.

The number of calls about other top Access to Care issues compared to the number of calls last year were:

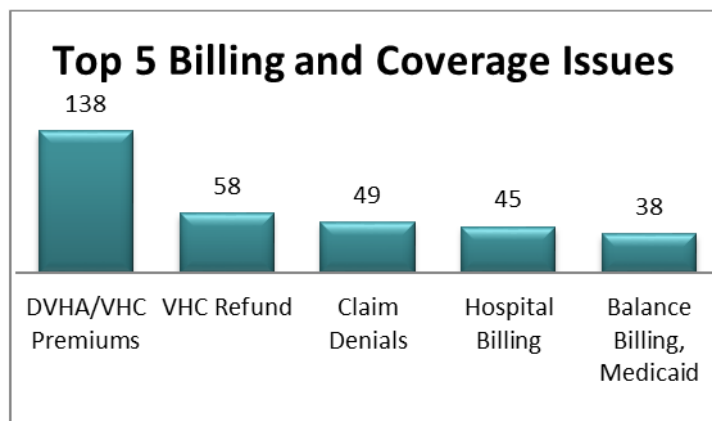
- Dental care, dentures, orthodontia (63, compared to 65 in SFY 2015)
- Durable medical equipment, supplies and wheelchairs (56, compared to 42)
- Transportation (54, compared to 49)
- Pain management treatment (39, compared to 42)
- Mental health treatment (37, compared to 32)
- Home health (26, compared to 25)

Billing and Coverage

Calls in this category are from Vermonters who received the care they needed, but subsequently experienced problems getting their insurance to pay for that care or had other problems with the billing process. In order to give higher priority to *Access to Care* and *Eligibility* calls, as a general rule we now

provide advice on ways to resolve billing problems, rather than providing direct intervention. Additionally, we enhanced the information on our website about resolving billing problems, and our voice mail message encouraged people to seek billing help on our website first. In SFY 2016, we answered 592 calls in this category, compared to 676 last year, a 12% decrease.

We track 35 subcategories of *Billing and Coverage* calls. DVHA/VHC Premiums, VHC Refund, Claim Denials, and Hospital Billing all remained among the top five billing and coverage issues faced by consumers who called the HCA in SFY 2016. Balance Billing, Medicaid calls displaced calls about non-DVHA/VHC Premiums (which dropped by 73%) in the top five *Billing and Coverage* issues.



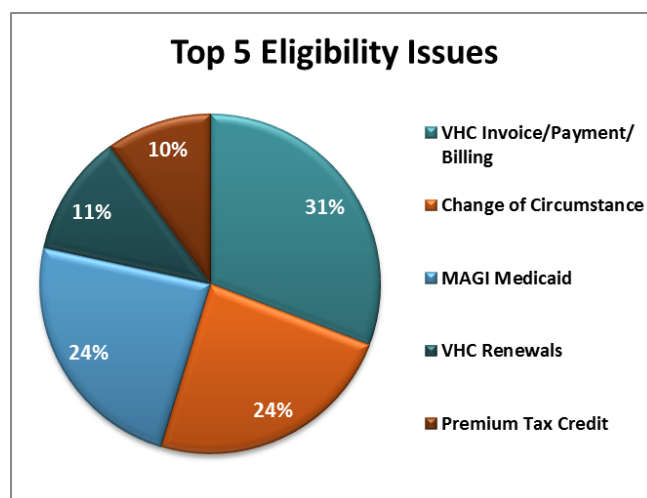
The number of calls about the top 5 issues compared to the number of calls last year were:

- DVHA/VHC Premiums (including Dr. Dynasaur) (138, compared to 54)
- VHC Refund (58, compared to 45)
- Claim Denials (49, compared to 47)
- Hospital Billing (45, compared to 66)
- Balance Billing, Medicaid (38, compared to 36)

Eligibility

The percentage of calls related to *Eligibility* for health care coverage offered through the state went from 30% in SFY 2014 and 31% in SFY 2015 to 28% in SFY 2016; yet it still topped the other five categories. Eligibility was the primary issue for 1,249 callers. An additional 2,166 callers named eligibility as a secondary issue for a total of 3,415.

In 2015, the top five subcategories within *Eligibility* had changed significantly, when it included only one of the top categories from SFY 2014. In SFY 2016, four of the SFY 2015 categories remained in the top five, but Premium Tax Credit replaced Confusing Notices.



The number of calls about the top five issues compared to the number of calls last year were:

- VHC Invoice/Payment/Billing (216, compared to 207 in SFY 2015)
- Change of Circumstance (167, compared to 218)

- MAGI Medicaid (166, compared to 122)
- VHC Renewals (81, compared to 99)
- Premium Tax Credit (70, compared to 20)

Of the 1,249 calls in which *Eligibility* was recorded as the primary issue, 940 (75%) were related to Vermont Health Connect. Specific Vermont Health Connect problems involving technology, application processing, change of circumstance, renewals, and invoice/payment and billing problems accounted for 303 (about 24%) of all *Eligibility* calls. Looking at both primary and secondary issues, the following subcategories provided significant challenges to our callers, even in those cases where they were not the primary issue: VHC Invoice/Payment Billing (310), Premium Tax Credit (250), MAGI Medicaid (219), and Change of Circumstance (189).

Types of Coverage

The HCA receives calls from Vermonters with all types of health insurance and from the uninsured. The chart below breaks down our calls by the caller's type of coverage. For SFY 2016, state health care programs included Medicaid FFS, Medicaid Managed Care, VPharm, and Healthy Vermonters. Commercial insurance comprised both individuals with small or large group coverage and those with individual coverage, including those who purchased Qualified Health Plans through Vermont Health Connect. In some cases, the caller's insurance status is not relevant to the problem, and the HCA does not ask for the information.

The breakdown this year, compared to the previous three years, is shown in the table below.

	2016	2015	2014	2013
State Programs	900 (20%)	1,313 (28%)	1,180 (30%)	1,053 (33%)
Commercial Insurance	1,135 (26%)	1,185 (25%)	573 (15%)	355 (11%)
Uninsured	558 (13%)	517 (11%)	501 (13%)	340 (11%)
Medicare	389 (9%)	480 (10%)	539 (14%)	400 (13%)
Dual Eligible ⁵	272 (6%)	303 (6%)	415 (11%)	405 (13%)
Dental	55 (1%)	18 (<1%)	N/A	N/A
Catamount & Premium Assistance ⁶	N/A	N/A	148 (4%)	149 (5%)
Other	154 (4%)	228 (5%)	80 (2%)	100 (3%)
Irrelevant/Unknown	926 (21%)	651 (14%)	471 (12%)	365 (12%)

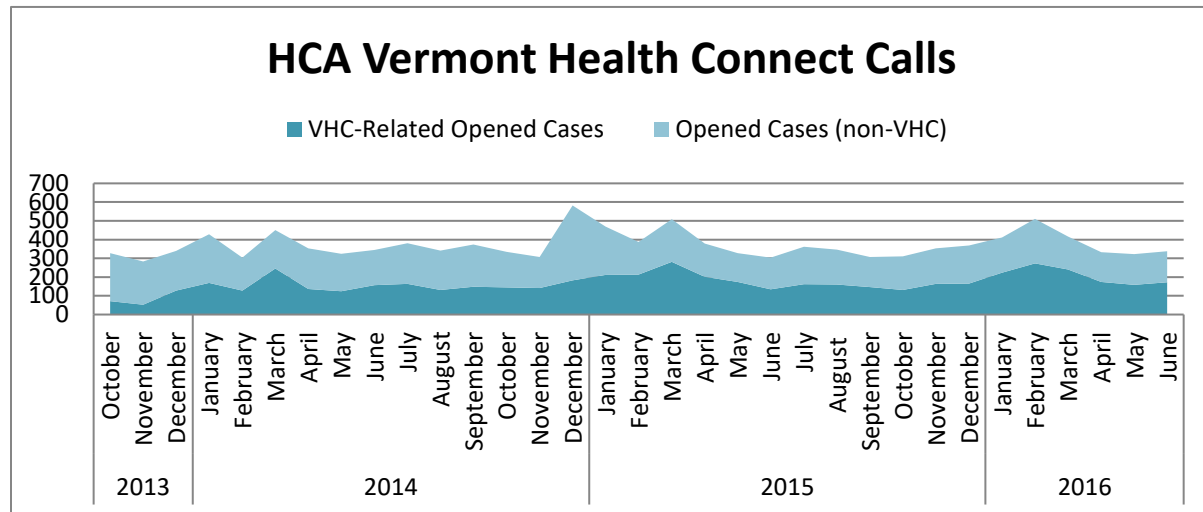
When beneficiaries who are Dual Eligible or have VPharm coverage are added into the Medicare total, about 16% of the calls were from Medicare beneficiaries in SFY 2016.

⁵ Dual Eligible means a beneficiary who is eligible for both Medicaid and Medicare.

⁶ The Catamount Health and Catamount Health Premium Assistance (CHAP) programs ended on March 31, 2014.

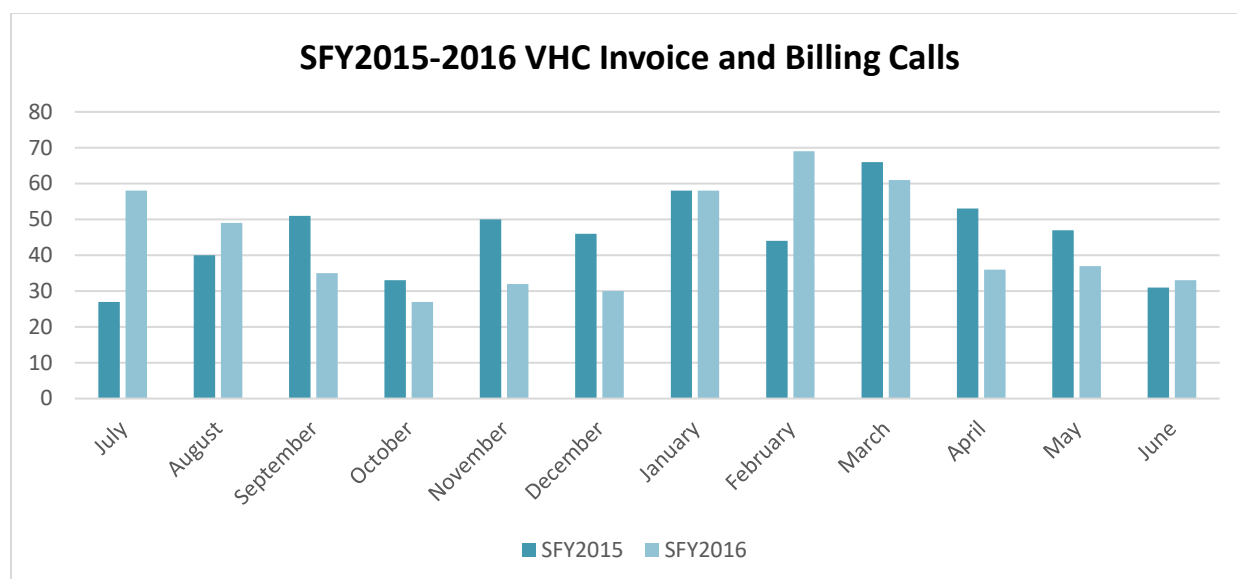
Vermont Health Connect Calls

Vermont launched its state-based exchange, Vermont Health Connect (VHC), on October 1, 2013. Vermonters seeking subsidies (premium assistance and cost-sharing reductions) must purchase plans through VHC. However, individuals who are not eligible for premium assistance can now enroll in VHC Qualified Health Plans (QHPs) directly through the carriers, as small businesses do.⁷

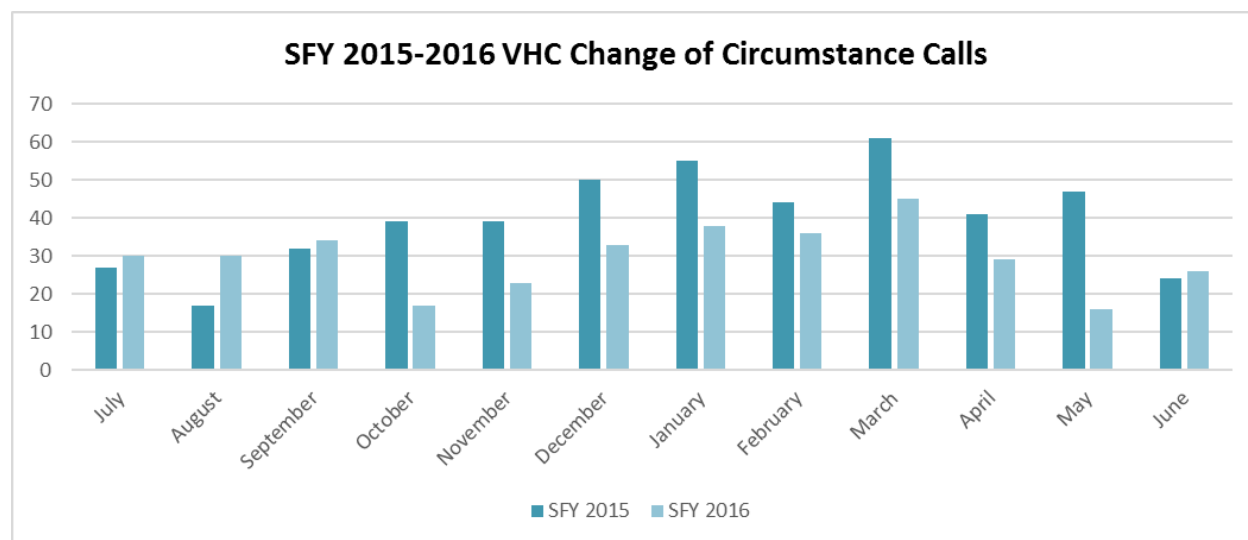


In SFY 2016, 2,179 (49.7%) of the calls received by the HCA were related to Vermont Health Connect. Since the launch of Vermont Health Connect, the HCA's call volume has stayed consistently above 300 calls per month, about 25% higher than pre-VHC. This increase has been due to the complexities of the new eligibility requirements as well as VHC's operational difficulties. Over the past year VHC's functionality has improved, although at a much slower pace than everyone hoped. While the overall number of VHC calls decreased slightly, we had more complex cases. We worked with VHC to establish an effective escalation path, and they developed systems that enabled them to resolve the problems we reported much more quickly.

⁷ The HCA only provides help to individuals. We do not assist small businesses.



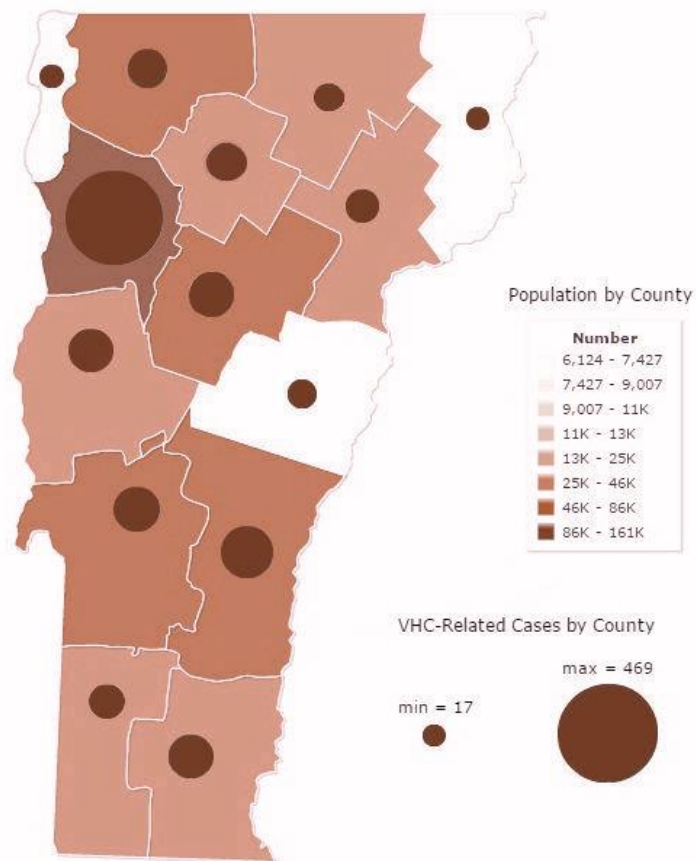
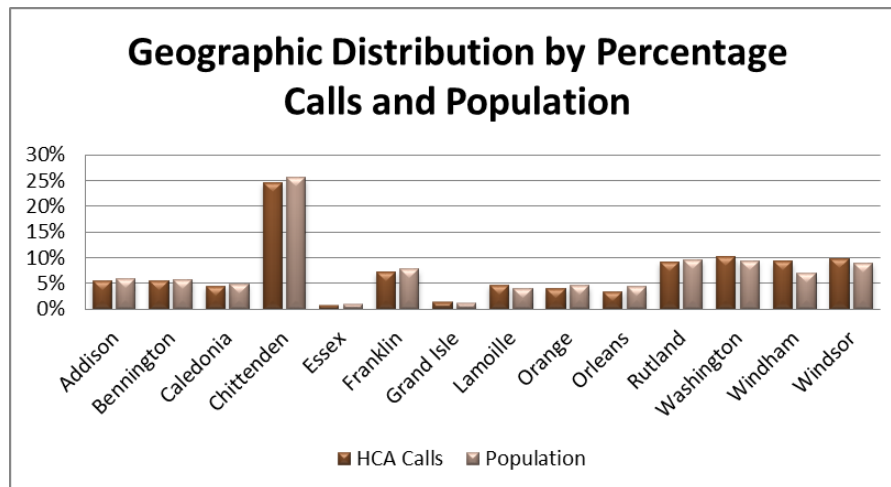
The top VHC issue consumers called us about was problems with invoices and billing. Vermonters reported getting incorrect invoices; making payments for months without receiving active coverage; VHC having no record of checks sent and cashed; and inconsistent information across the systems run by VHC, its premium processor and the carriers. By the end of the fiscal year, however, the number of billing cases started to fall.



Consumers have consistently had problems getting VHC to properly process customer changes like income or household size – and to do so in a timely manner. VHC significantly improved its ability to process such changes this year. Cases involving changes in circumstance fell from 476 to 356 (25%), when primary and secondary issues are considered.

Geographic Distribution of Calls

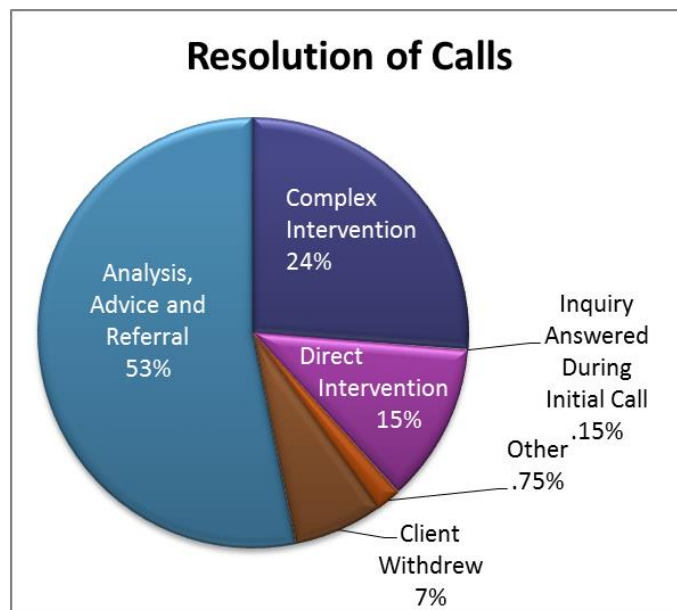
The HCA provides services statewide. While proportions varied in some counties, our calls are spread across the state in almost direct proportion to the population of the state. The chart below shows the percentage distribution of calls the HCA received in SFY 2016 compared with the general population distribution (based on 2014 census information).



Resolution of Calls

In SFY 2016, the HCA closed 4,338 cases, compared to 4,643 last year. When we close a case, we document how we resolved the case, where we referred the individual, and what materials we sent. The chart below shows the distribution of call resolutions, and the accompanying text defines the call resolutions and compares this year's totals with last year's:

- *Analysis, Advice and Referral* (advice and/or referral after analysis for cases that are slightly more complex): 2,307 calls (53%), compared to 2,588 calls (56%) in SFY 2015
- *Complex Intervention* (direct intervention that took more than two hours to resolve): 1,134 calls (26%), compared to 1,102 calls (24%)
- *Direct Intervention* (made calls or took other action on behalf of the client, up to two hours of work per case): 516 calls (12%), compared to 712 calls (15%)
- *Client Withdrew*: 290 calls (7%), compared to 199 (4%)
- *Inquiry Answered During Initial Call*: 7 calls (0.16%), compared to 7 (0.15%)
- *Other*: 82 calls (2%), compared to 35 calls (0.75%)



Appeals: The HCA helped individuals with 153 appeals. Of the appeals, 116 were Fair Hearings, 12 were Expedited Fair Hearings, 5 were Medicaid MCO internal appeals, 6 involved Medicare, and 14 were commercial plan appeals. Of the two types of Fair Hearings, 84% were related to VHC issues.

Outcomes

The HCA records outcomes whenever we know them. When we give advice, we frequently do not know the ultimate result of that advice. However, we make every effort to track our outcomes when possible.

The HCA saved individual consumers \$427,173.38 in SFY 2016.

The table below shows a summary of the services we provided to clients and the outcomes we obtained on their behalf in 2016, compared with 2015 and 2014.

Outcome Summary	SFY 2016	SFY 2015	SFY 2014
Advice or Education	2,252	2,479	1,971
Assisted with Application for Insurance	7	23	45
Bill Written Off	7	21	29
Claim Paid as a Result of HCA Intervention	14	32	35
Client Not Eligible for Benefit	15	17	32
Client Responsible for Bill	23	48	43
Estimated Eligibility for Insurance	62	79	188
Got Client onto Insurance	409	452	372
Obtained Coverage for Services	93	175	120
Other Access/Eligibility Outcome	421	371	274
Other Billing Assistance	187	204	97
Hospital Patient Assistance Provided	2	13	24
Prevented Termination or Reduction in Coverage	60	42	67
Reimbursement Obtained	71	82	63
Service Excluded Under Contract	0	3	3
Other Outcome	714	602	453
Grand Total	4,337	4,643	3,816

Case Examples

These five case examples demonstrate the kind of work we do:

1. The HCA prevented Medicaid termination and got an uninsured family member onto insurance. Mr. A received a notice from VHC saying that his Medicaid was going to be terminated because he was over income and that he needed to enroll in a Qualified Health Plan through VHC. Mr. A called the HCA for help. He told his advocate that his stepson had just found a job and that the income from that job had put the household over the Medicaid limit. He also noted that his stepson was uninsured. Upon investigation, the advocate learned that Mr. A did not claim the stepson as a dependent on his taxes. This meant that under Medicaid rules, the stepson's new income should not be included in the eligibility calculations, thus preserving Mr. A's Medicaid eligibility. The advocate also requested that the stepson be screened for a QHP with premium tax credits based on his own income. In the end, Mr. A kept his Medicaid and because this all occurred during the Open Enrollment Period, his stepson was able to get a QHP with a significant subsidy.
2. The HCA got coverage reinstated when consumer had no coverage, despite paying monthly premiums to VHC. When Ms. B went for her annual flu shot, she was told that she had no health

insurance. She called VHC about her QHP and learned that her coverage had been terminated and, in fact, she had not had any coverage for most of the year. Ms. B was mystified. She had paid her premiums and had had medical appointments on a regular basis. She needed multiple prescriptions and could not afford them without insurance, so she called the HCA. The HCA contacted VHC and found that Ms. B's coverage had closed after just one month of coverage in 2015, despite the fact that she had sent monthly payments. She had not received grace period notices warning her of the termination, nor had she received a termination notice. The HCA advocate argued that Ms. B's coverage be reinstated for the whole year. VHC agreed that her coverage should not have been closed and reinstated her. Ms. B was able to get the medications she needed and had peace of mind knowing that she now had the coverage she thought she had had all along.

3. The HCA identified other sources to defray medical costs when Medicare enrollment triggered the loss of Medicaid. Mr. C received a notice from VHC that his Medicaid coverage was closing. He did not understand why, since his income had not changed. The HCA advocate learned that Mr. C had recently become eligible for Medicare, which made him categorically ineligible for type of Medicaid that he had - Medicaid for Children and Adults (MCA). He was not income eligible for Medicaid for the Aged, Blind and Disabled (MABD), which a Medicare beneficiary can have. After analyzing Mr. C's situation, the advocate realized that Mr. C. was eligible for two other programs that could help defray his health care costs: VPharm, to help pay for prescriptions, and a Medicare Savings Program (MSP), which could pay his Medicare Part B premium. The advocate helped Mr. C apply for these programs and got the MSP granted retroactively because Mr. C should have been screened for that program when his MCA was terminated.
4. The HCA found mistakes that led a commercial drug plan to deny coverage and delay a \$640+ payment for a medication it should have covered. Mr. D called the HCA because his insurer had denied coverage for his medication. Mr. D had a commercial plan under COBRA, which required him to pay 20% of the cost of prescriptions. However, when he tried to pick up a prescription, his cost was over \$800--the entire cost of the prescription. The pharmacist said his plan had denied payment of its portion of the cost because he had secondary coverage, which he didn't. The HCA advocate called the drug plan with Mr. D and explained the situation to a supervisor. The supervisor agreed that an error had been made and advised that Mr. D would receive a written decision about coverage in 7-10 days. When Mr. D received the decision, however, it was a denial. This time the drug plan denied coverage because it said Mr. D was not an eligible member on the date of service - another mistake. The HCA advocate helped Mr. D appeal the denial. He won the appeal and the plan reimbursed Mr. D for more than \$640 - the 80% of the prescription cost the plan should have covered in the first place.
5. The HCA proved a VHC error that caused a large, incorrect tax bill. In June of 2015, Ms. E asked VHC to cancel her plan because she planned to move out of state. VHC told her it was too late to close the coverage by the end of the next week, but it could be closed at end of the following month. Ms. E paid her premium for July, her final month of coverage. When her 1095-A tax form arrived the next January, it showed that her coverage had continued for all of 2015 and that she had received

five months of Advance Premium Tax Credits (APTCs), despite the fact that she had not paid premiums for the final five months of the year. As a result, Ms. E owed a large tax bill to pay back APTCs she had not received. The HCA advocate found a record of Ms. E's call to VHC canceling the coverage. The advocate requested that VHC close Ms. E's plan as of the correct date and send her a new Form 1095-A reflecting the correct payments and closure date. Once Ms. E received the form, she filed an amended tax return, which reduced her tax bill significantly.

Quality Assurance and Consumer Satisfaction

The satisfaction of our clients is extremely important to us. To monitor how consumers feel about the way we provide our services, we send a Client Satisfaction Questionnaire (CSQ) to every client on whose behalf we intervene directly. We try to contact every client who requests follow up on the returned CSQ in order to resolve complaints or outstanding issues, but sometimes that is not possible due to high call volumes or challenges reaching the client.

This year we sent out 1,569 CSQs and 503 (32%) were returned. Of those returned, 98% said they were Satisfied or Very Satisfied with the service they received from our office. About 94% reported they were Very Satisfied. Thirteen individuals said they were not satisfied. Most of the dissatisfied individuals had cases that lacked sufficient merit to obtain the outcome they desired, and some thought we were a state agency and thus responsible for their problems with Vermont Health Connect. Many respondents used the CSQ as an opportunity to vent about their frustrations with VHC.

Here is a sampling of the comments on this year's CSQs:

Not only did I receive an outstanding outcome for my case, but I was treated as if I was an important person; and this was more than enough. I was hesitant about calling because I am a poor college student and I thought that this was the way I was supposed to live. But when my advocate explained that I had options to help with my diabetic supplies, the relief was instantaneous and overwhelming. Never did I feel like I was an obligation or a burden. Instead, I felt as if I was, for once, being heard about my concerns about the outrageous prices I had to pay in order just to stay alive month-to-month. I don't care about anyone's level of income, their past, or even their type of insurance, no human should have to EVER pay what I had to pay in order to stay alive. So, I would like to thank my advocate from the deepest parts of my heart and soul for everything you did for me. You lifted a weight that felt immovable off my shoulders. It may seem like something little, or even just your job, but to me, it was the world. Thank you!

I was astounded by the results—VHC had led me to believe I had NO CASE! What a professional, delightful, amazing young woman [my advocate is]! Long live [my advocate]!

[My advocate] is a rock star!

I felt as if I was, for once, being heard about my concerns about the outrageous prices I had to pay in order just to stay alive month-to-month.

I'm very frustrated with VHC and have paid late fees as a result of this system. I would have lost it had it not been for your team. I can't afford this insurance and it has caused great stress in my family. I'm now

We were getting nowhere in the several months leading up to your intervention and if you had not successfully helped us resolve our problem, the financial cost to our family would have been several thousand dollars.

in a payment plan with the IRS because of underestimating and VHC not updating our income. Never have I ever owed the IRS and paid fines and late fees. This has been a complete NIGHTMARE FOR ME!! We (my husband and I) are considering filing for divorce as a result of this mess. Thank you for all your support and help. You saved me from severe depression.

Thank you so much for all your diligent help. We were getting nowhere in the several months leading up to your intervention and if you had not successfully helped us resolve our problem, the financial cost to our family would have been several thousand dollars. Thank you!

Thank the Lord we have you folks protecting us.

Thank you all for looking out for the people who [do] not have a income or insurance. You are doing a good job. Thank you!

I felt like a human being again! I was very impressed! I can't tell you how happy I am that you came to my rescue! Thank you!

[My advocate] was extremely helpful and not only did she get my situation straightened out but she did it promptly and I so appreciated this because I had been dealing with this for 10 months. [She] was very professional and handled my case with ease and did so within 2-3 days! She should get a raise.

Yay! [My advocate] was knowledgeable and smart and very quick resolving our problem, also friendly and calming. I love Legal Aid. Your services through [my advocate] were valuable and welcome. Thank you.

The outcome could not have been better! Great help, great service! I have never before had help of this high caliber and quality. AAA+. [The advocate] who handled my case was outstanding! Thanks so much for helping me!

The outcome could not have been better! Great help, great service! I have never before had help of this high caliber and quality. AAA+.

[My advocate] is very knowledgeable [and] worked hard to ensure I got access to the insurance I needed. [She] was always helpful, pleasant to speak to, has a great sense of humor and was top notch professional. She is awesome! I am so grateful for your office and her dedication. Thank you!

Clone [my advocate]! ...After more than 6 months of trying to get my billing straightened out... I found your #, called and spoke to [my advocate], at the end of my rope, ready to drop my insurance ... [my advocate] reassured me, calmed me down, got all m[y] info, said he would call after some research, low and behold he did, on time! ...He was very helpful, and straightened out all my issues, without his help I would have given up, this is an extremely important service you provide, I have told everyone I know with

health insurance issues to contact you, and you helped many other people... [My advocate] reaffirmed my faith that some people still have pride in what they do! And enjoy their job!

[I am] very happy. I didn't know your agency existed. I'm your everyday common Joe, and it felt good having my rights enforced.

... knowing that there is someone out there that can help you is a relief. We would recommend anyone to call you and ask for help because you are there to listen and get things done.

Thank you so much for being there so we patients have a voice!

We thought we were going to lose our insurance and felt very "alone" in all of this process until we were able to talk to an advocate. She was really helpful, respectful and got the issue solved in a timely manner (which on our own we were trying to solve for months [and] getting nowhere!). Dealing with VHC on your own can be really frustrating and knowing that there is someone out there that can help you is a relief. We would recommend anyone to call you and ask for help because you are there to listen and get things

done.

It was so nice to have someone finally listen to me. Your office took a confusing, frustrating situation and step by step solved it for us. I'd been trying to solve this problem for a year and was getting nowhere—your office solved it in two months. We don't know what we would have done without [our advocate].

[My advocate] was an absolute godsend in helping me deal with our concerns and issues. [She] was always off the chart pleasant and calm/soothing. She made me feel like she had our back and was extremely knowledgeable.

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Public Advocacy

Green Mountain Care Board Activities

Rate Reviews

The HCA monitors all insurance carrier requests for changes in premium rates. Usually these involve requests for rate increases, but requests for decreases are also reviewed to ensure that any proposed decrease is large enough. Carriers filed nine rate review requests with the Board during SFY 2016. The HCA participated in eight rate review cases on behalf of Vermont consumers, but did not appear in one case because the plan has no members.

2016 VHC Plans

Two important rate review cases were pending at the beginning of this fiscal year: the filings for plans to be offered on Vermont Health Connect in 2016 by Blue Cross Blue Shield of Vermont (BCBSVT) and MVP. The two carriers had filed their requests for rate increases on May 15, 2015. The HCA worked closely with our independent actuary, Donna Novak of NovaRest, to analyze the exchange filings and to suggest questions that the Board's actuaries, Lewis and Ellis (L&E) should pose to the carriers. Ms. Novak also

prepared an expert report and testified as our witness at the hearings held on July 28 and July 29, 2015, at the Green Mountain Care Board. The HCA also cross-examined the insurers' witnesses and submitted written comments and arguments after the hearings.

Members of the public testified orally at the BCBSVT hearing, and almost 500 members of the public submitted written comments. Most of these expressed concern about the affordability of health insurance products on VHC.

BCBSVT, which expected to insure more than 65,000 Vermonters through VHC in 2016, requested an 8.6% average annual rate increase. The Board modified the request and approved a 5.9% annual increase. The Board's actuary, L&E, and the HCA recommended a number of small decreases to the requested rate which were adopted by the Board. The Board made additional small adjustments to the requested rate. The HCA argued for, and the Board approved, a 1% contribution to surplus rather than the 2% contribution requested by the carrier.

MVP, which expected to insure approximately 6,500 Vermonters through VHC, requested a 3% average annual rate increase. The carrier tried to keep its rate increase for 2016 low so that its products could be competitive with those offered by BCBSVT in the VHC marketplace. The Board approved a 2.4% increase for MVP, based on recommendations from L&E and the HCA.

MVP Group Plans

During the year, MVP Health Insurance Company sought approval of the manual rates, experience rating formula, and factors used to develop group-specific premium rates to be used in the insurer's Large Group AR42 product portfolio for the first and second quarters of 2016. The analysis by the Board's actuary recommended a small adjustment in the carrier's pharmacy trend to conform to the corresponding trend in MVP's 2016 VHC rate filing. The HCA requested that the Board adopt this actuarial recommendation and also reduce the requested 2% contribution to surplus. The Board initially issued a decision modifying the requested rate with the pharmacy reduction and a 0% contribution to surplus. However, after a Motion to Reconsider from MVP, the Board amended the decision to allow a 2% contribution to surplus.

MVP also filed a request for rate increases for small group plans grandfathered under the Affordable Care Act and renewing in the first quarter of 2016 (2.7% increase) and the second quarter of 2016 (a 2.3% increase). These rates affected approximately 281 policyholders and 2,107 covered lives, and membership in this closed block of business has been declining. The issues in this filing were similar to those in the Large Group filing and again the Board modified the pharmacy trend. It initially reduced the contribution to surplus to 0%, but on reconsideration it allowed the requested 2% contribution to surplus.

MVP also filed a rate request for five plans offered by the Agriservices Association, an association for farmers. Agriservices uses MVP's large group Minimum Premium Plan (MPP) funding arrangement for these grandfathered plans which renewed on December 1, 2015. MVP had told the Board in its prior filing that Agriservices intended to discontinue the plans after November 2015, but another request for

premium increases was filed in September 2015. The average annual increase requested was 26.9%. The HCA asked the Board to disapprove the rate request given the size of the requested increase and the history of the 2014 filing. The Board's Decision disapproved the requested rate increase and "encourage[d] the carrier to evaluate the plan's continued viability and affordability prior to any future request for additional rate increases."

After filing an unsuccessful Motion for Reconsideration of the Agriservices filing, MVP appealed the administrative decision to the Vermont Supreme Court. MVP claimed that the criteria used by the Board in denying the rate increase were unconstitutionally vague or in the alternative that the Board's findings of fact and conclusions were not consistent with the standards in the rate review statute. The insurer and the HCA filed briefs with the Supreme Court. The Solicitor General also filed a brief on behalf of the Board asking the Supreme Court to affirm the Board's decision. MVP, the HCA and the Solicitor General all participated in oral argument in front of the Supreme Court on June 21, 2016. The Supreme Court is now considering all the arguments presented in the case.

The Board also decided a third and fourth quarter MVP filing for grandfathered small group EPO/PPO products. The HCA asked the Board to reduce the requested Contribution to Surplus by 1%, and the Board agreed with this rate reduction. The HCA and the Board also agreed on changes recommended by the Board's actuary in the calculations of medical and pharmacy trend that offset each other and did not result in a rate change.

In its third and fourth quarter Large Group EPO/PPO filing, MVP requested a rate decrease. The HCA argued and the Board agreed that the rate change should be decreased even further based on changes in the medical and pharmacy trends and on actual experience. However, the Board did not agree with the HCA's recommendation that a larger reduction, based on experience and on a lower contribution to surplus, should be made. The final decision resulted in an average annual rate change of -12.3% for members renewing in the third quarter and -13.3% for those renewing in the fourth quarter instead of the -8.6% and -9.6% rate changes originally requested.

Cigna Group Plans

The Board also reviewed the 2016 Large Group Manual Rate Filing by CIGNA Health and Life Insurance Company (Cigna). Cigna requested rates which would produce an average annual rate change of -1.1% and ranged from -3.9% to 1.1%. The filing impacted 15 policyholders with 2,586 covered lives. The HCA requested that the Board reduce the requested 3.5% contribution to surplus to 1%. The Board issued a decision modifying the requested rate with a 1% contribution to surplus. This modification decreased the average annual rate by approximately 3.5%, which resulted in rates that were 2.5% lower than the rates originally requested.

BCBSVT Group Plans

In May 2016, the Board decided two related cases filed by BCBSVT. The HCA submitted memoranda arguing for rate reductions. These cases were factor filings for BCBSVT's Large Group Rating Program and for the Large Group Rating Program of the Vermont Health Plan (TVHP), a for-profit subsidiary of BCBSVT. The HCA argued that the requested contribution to reserves should be decreased from 2% to

1.3% for BCBSVT and from 2% to 0% for TVHP. However, the Board approved the filings without any modification.

2017 VHC Plans

Two significant new rate review cases were filed on May 11, 2016 for the 2017 products to be offered on VHC. BCBSVT requested an average 8.2% increase for its 2017 plans, which are expected to have 70,423 members. MVP requested an average increase of 8.8% for its plans with 6,614 members. During the months of May and June, L&E began to review the filings and to request additional information from the insurers. The HCA and our independent actuary also analyzed the two filings and suggested questions for L&E to pose to the insurers. Hearings were scheduled for July 20 and July 21, 2016, and the Board's decisions were due no later than August 9, 2016.

Certificate of Need

The HCA continues to monitor all Certificate of Need (CON) processes before the Board. There was a relatively small number of active certificate of need applications in the last fiscal year. However, a few of the applications were noteworthy.

In July 2015, the Board released its decision to approve the University of Vermont Medical Center's \$187 million Inpatient Bed project. The University of Vermont Medical Center (UVM MC) responded by asking the Board for formal clarification and modification of the order. We reviewed the Board's decision, submitted oral testimony at the hearing on UVM MC's motion to modify, reviewed UVM MC's proposed alternative financing plan for the project, submitted questions in response to the alternative financing plan, and attended several status conferences regarding UVM MC's request for clarification and modification and proposed alternative financing plan. We also tracked UVM MC's compliance with the Board's terms in the CON decision.

Early in the last fiscal year, the Board received a certificate of need application to open Green Mountain Surgery Center which proposed to provide elective, non-emergency surgical procedures for patients who do not require hospitalization. The application claimed that the new facility would expand affordable outpatient surgery services options available in Chittenden County. We intervened as an interested party and submitted questions to the applicant to investigate whether the project would improve quality and not increase costs. We continued to monitor new information about the project and are considering submitting an additional set of questions for the applicant.

During this time period, the HCA also submitted comments to the Board describing our concerns with Copley Hospital's proposed surgical suite construction project. Our concerns focused on the hospital's financial reliance on its specialized orthopedic practice, financial projections, and allocation of resources to address identified community needs.

Genesis Healthcare, Inc. submitted a proposal to purchase five Vermont nursing homes. Vermont Legal Aid's Long Term Care Ombudsman appeared as an interested party in the proceeding, as permitted by statute. She consulted with the HCA in preparation for the hearing in June 2016.

Hospital Budget Review

The HCA participated in the Board's hospital budget process during the first quarter of this fiscal year. Prior to the public hearings in August 2015, we reviewed the information that each of the state's 14 hospitals submitted to the Board, including their Community Health Needs Assessments (CHNAs). We also reviewed each hospital's financial assistance policy (FAP) in light of new federal regulations that go into effect on October 1, 2016. We submitted suggested questions to the Board and attended all three days of hearings. After the hearings we submitted comments, which focused on the hospitals' FAPs, hospital consolidation and integration, access to care, evidence-based medicine, and the hospitals' CHNAs. After the budget review process was complete, we submitted a formal request asking the Board to include in its hospital budget guidance for the following fiscal year a requirement for hospitals to show how they plan to comply with the new federal rules on FAPs.

Act 152, which was enacted during this fiscal year, gives the Office of the Health Care Advocate an expanded role in the Board's hospital budget review process going forward. Beginning in the next fiscal year, the HCA will have the right to receive copies of all materials related to the hospital budget review, ask questions of employees of the Green Mountain Care Board, submit written questions to the Board to be asked of hospitals in advance of the hearings, submit written comments for the Board's consideration, and ask questions and provide testimony at the Board's hospital budget review hearings.

The HCA submitted five sets of comments related to hospital budget review. During the year the Board developed its guidance for hospitals to use in the next budget review cycle for the 2017 fiscal year, which begins in October 2016. The HCA submitted comments requesting changes to the proposed guidance. For example, we urged the Board to set a net patient revenue growth rate based on general economic indicators rather than trends in health care spending to improve affordability, and we requested that the Board require hospitals to report on their financial assistance policies and their efforts to address the needs identified in their Community Health Needs Assessments. The HCA met with the Board's Director of Health System Finances to discuss the comments.

The Board also analyzed and reviewed the hospitals' actual budget amounts compared to their approved budgets for fiscal year 2015 which ended in September 2015. The Board heard presentations from the University of Vermont Medical Center and Central Vermont Medical Center (part of the same hospital network) and from Rutland Regional Medical Center about the facilities' proposed use of excess net patient revenue for 2015. The HCA submitted comments supporting UVM MC and CVMC's proposal to spend money on investments in community resources and on reducing commercial rates.

Other Green Mountain Care Board Activities

In the last fiscal year, we submitted eight sets of formal comments and one set of informal comments to the Board. In the fall, we submitted formal comments to the Board outlining consumer principles for the all-payer model which we based on our policy paper, [Consumer Principles for Vermont's All-Payer Model](#).

We also submitted comments addressing the Board's proposal to lift the moratorium on the VHCURES data, which would allow non-state entities to access the information. In the comments, we supported lifting the moratorium, but we urged the Board to only allow data releases to non-state entities when the data will be used to improve healthcare quality, affordability, and/or access to Vermonters; we asked the Board to post data requests and provide a public comment period of at least ten days before issuing a decision on a request; and we recommended that the Board require any entity that is granted access to VHCURES data to agree that the entity cannot claim confidentiality or intellectual property rights over its research results against the state of Vermont. The Council plans to adopt all three recommendations.

We submitted a formal letter to the Board in reaction to draft Accountable Care Organization (ACO) standards presented by the Board's staff at its June 9, 2016 meeting. These standards related to the Board's new responsibility to regulate Accountable Care Organizations. The letter pressed the Board to incorporate all of the quality standards required by Act 113 into any new standards for ACOs. An additional set of informal comments provided feedback to the Board on ways the HCA might want to access and use VHCURES data in the future to inform our work.

The HCA monitored the Board's activities for the year including attending the Board's weekly public meetings (40), periodic Advisory Committee meetings (2), and Data Governance meetings (11). We attended additional Board meetings about hospital budgets (2) and had multiple meetings with Board staff (7).

All-Payer Model

In the last fiscal year, the Board staff facilitated meetings of stakeholders to discuss and outline the governance structure, provider payment policies, and related parameters for an all-payer model (APM) and a single Accountable Care Organization to implement the APM in Vermont. The HCA has made it a priority to monitor the APM and unified ACO planning processes for potential consumer protection concerns. We participated in various aspects of the process including joining the provisional board for the new ACO in late March. We attended more than 60 meetings related to the planning process, including meetings of the provisional board, the ACO Payment Subgroup, the ACO Rostering Subgroup, and the All-Payer Model Quality Measurement Subgroup.

In late winter and spring, we worked on the proposed business plan which consisted of reviewing multiple drafts of the plan, participating in eight conference calls with various stakeholders, and submitting six sets of formal comments. The HCA also submitted two sets of comments on the draft roosting agreement and successfully advocated for edits which make it much more readable for consumers. Finally, the HCA helped organize three informational meetings for consumer groups to learn more about the proposed All-Payer Model.

Vermont Health Care Innovation Project Activities

The State of Vermont is currently in year three of a \$45 million State Innovation Model (SIM) grant from the federal government. The SIM grant funds the Vermont Health Care Innovation Project (VHCIP),

which aims to expand and integrate innovative health care provider payment and information technology reforms to support a high-performing health care system in Vermont. The VHCIP governance structure includes a Steering Committee, a Core Team, and numerous stakeholder work groups. The HCA has been participating in the VHCIP as a stakeholder since the beginning of the grant. During this fiscal year, the work group structure transitioned from seven work groups that met monthly to six work groups - four that met monthly and two that met quarterly.

The Chief Health Care Advocate is an active member of the VHCIP Steering committee. In the first quarter of SFY 2016, HCA staff members participated as active members in six of the seven original work groups. In the second through fourth quarters, we participated in three of the six new VHCIP work groups:

- Health Data Infrastructure
- Payment Model Design and Implementation
- Population Health

The HCA monitored the activities of the VHCIP Core Team as an interested party. Staff members from other projects at Vermont Legal Aid participated in the Practice Transformation Work Group and the Disability and Long Term Services and Supports Work Group. Additionally, the HCA participated in regular meetings of the VHCIP Evaluation Steering Committee, submitted numerous sets of comments to work groups, the Core Team, and state agencies. HCA staff members attended multiple other VHCIP-related events including the Centers for Medicare and Medicaid Innovation Site Visit Stakeholder Meeting and the Provider Grant Outcomes Congress.

The VHCIP payment reform pilot projects include Vermont's Medicaid and Commercial Accountable Care Organization (ACO) Shared Savings Programs. The HCA has continued to advocate for robust quality measurement and to work with Vermont's ACOs to improve consumer engagement. Additionally, the HCA actively advocated for H. 812/Act 113 during the 2016 legislative session, which creates consumer protections and a regulatory structure for Vermont's ACOs (see *Legislative Advocacy*).

Systemic Advocacy

In addition to providing services to individual Vermonters, the HCA works for systemic change on their behalf. Because we talk to consumers every day and track data, we can provide valuable insights to policy makers. We see trends in problem areas and try to get them fixed. We inform public agencies and the legislature about the health care concerns of consumers, and we make recommendations for changes. We monitor, analyze, and comment on federal and state laws and regulations. We collaborate with federal and state advocacy organizations in order to strengthen the voice of consumers in the public debate. We promote the development of consumer organizations and educate citizens about their rights and responsibilities. Our systemic advocacy includes litigation, administrative advocacy, and legislative advocacy as well as other activities.

Litigation

In Re: J.H.

The HCA filed a motion to participate as a friend of the court (*amicus curiae*) on behalf of a consumer in a Vermont Supreme Court appeal filed by the Department of Vermont Health Access. DHVA filed the appeal after the Human Services Board ruled in favor of the consumer in a Fair Hearing, deciding that the consumer was eligible to receive Qualified Health Plan subsidies under federal tax law. The Court granted the HCA's motion, and the HCA filed the *amicus curiae* brief on July 1, just after the close of this fiscal year. The Court's decision is pending.

In Re: MVP Health Insurance Company 2015 Agriservices GMCB Rate Filing

The HCA submitted a brief and argued on behalf of Vermonters in the first Vermont Supreme Court appeal from a Green Mountain Care Board rate review case. The HCA supported the Board's denial of a large rate increase requested by MVP. The Solicitor General, representing the Board, also briefed and argued the case. The Court's decision is pending.

Article on the ACA and Indian Health Care

The HCA's tax attorney co-authored an article exploring the impact of the ACA on American Indian and Alaska Native consumers that was published in the American Bar Association (ABA) Section of Taxation's NewsQuarterly. *The ACA, the Service, and the Indian Health Care Delivery System* was co-authored with Heather Erb, an attorney in private practice in Washington State. The article addresses the intersection of the ACA and Indian tax issues and offers recommendations for addressing the unique Indian tax issues related to enrollment in the state and federal health insurance marketplaces. All members of the ABA Section of Taxation receive a copy of the NewsQuarterly.

Legislative Advocacy

HCA staff members frequently speak to state legislators, attend committee hearings, submit reports on the trends and cases we are seeing, and provide written and oral testimony to standing committees. When the legislature is not in session, we report regularly to the House Health Care Committee and monitor the Health Reform Oversight Committee, the Joint Fiscal Committee, and other committees that take up issues related to health care.

The Chief Health Care Advocate gave a presentation on H. 812 at Vermont Legal Aid's Legislative Breakfast and testified on new Health Benefits Eligibility and Enrollment (HBEE) regulations before the Legislative Committee on Administrative Rules.

In all, the HCA participated in over 170 legislative activities, including attending over 100 committee hearings, testifying 49 times, submitting 25 documents to legislative committees, meeting informally with legislators, and collaborating with other advocates on legislative initiatives.

Vermont's legislature took up at least 20 health care bills. The HCA focused on maintaining and improving access to health care for Vermonters and ensuring that consumers are protected as health

care reform moves forward. A number of the bills we worked on were enacted, including:

H.812 / Act 113 of 2016

The HCA advocated for H.812, now Act 113 of 2016, which requires the Green Mountain Care Board to regulate Accountable Care Organizations and provides protections for patients attributed to ACOs, including grievance and appeals processes. Previously the state was not required to regulate ACOs.

S.20 / Act 161 of 2016

The HCA advocated for S.20, now Act 161 of 2016, which creates a mid-level dental provider (Dental Therapist) in Vermont in order to improve access to dental care, particularly for children, seniors, and Medicaid beneficiaries. The HCA receives numerous calls from and web page views by consumers seeking access to dental care.

S.62 / Act 136 of 2016

The HCA advocated for S.62, now Act 136 of 2016, which allows, in limited circumstances, a surrogate to provide or withhold consent on a patient's behalf for a do-not-resuscitate order or clinician order for life-sustaining treatment.

S.216 / Act 165 of 2016

The HCA supported allowing the Green Mountain Care Board to permit some 2018 Vermont Health Connect bronze plans to use a prescription out of-pocket maximum amount that is higher than the maximum amount previously allowed under Vermont law. Doing so will enable plan designs to lower cost sharing for other medical costs. Without these adjustments, it may become impossible to design bronze plans to meet federal standards. The proposal for plan design changes will be developed by the 2018 Qualified Health Plan Work Group. The HCA also supported other sections of the bill related to increasing drug cost transparency.

S. 245 / Act 143 of 2016

The HCA supported the provision in S. 245, now Act 143 of 2016, to require hospitals to notify patients when they acquire medical practices and other service providers, including disclosure of any new charges resulting from hospital affiliations.

S.255 / Act 152 of 2016

The HCA advocated for the provisions in S.255, now Act 152 of 2016, that maintain regulatory protections for consumers in commercial health care plans and require the Department of Financial Regulation to file reports showing how many complaints are filed about violations of these consumer protection standards. The HCA also supported language giving our office an expanded role in the Green Mountain Care Board's hospital budget review process. Beginning in the next fiscal

year, the HCA will have the authority to receive copies of all materials related to the hospital budget review, to ask questions of employees of the Green Mountain Care Board, to submit written questions that the Board will ask of hospitals, to submit written comments for the Board's consideration, and to ask questions and provide testimony at the Board's hospital budget review hearings.

Administrative Advocacy

The HCA works for systemic change through state and federal agencies. This year, our administrative advocacy focused primarily on Vermont Health Connect, including developing an effective escalation path for our complex cases and working on many notices. We also participated in numerous councils, coalitions, and work groups.

Vermont Health Connect

Escalation Path

This year the HCA worked extensively with VHC to develop an efficient escalation path for cases involving complex issues. We communicated with VHC on a daily basis, provided feedback on the process, met with VHC 29 times to discuss the most complex cases, and worked to further improve the escalation path in order to resolve cases more quickly and decrease the number of cases on the list more rapidly.

Notices

At VHC's request, the HCA commented on numerous notices in an effort to make them more readable and consumer friendly. We had six meetings with VHC about notices and submitted 22 sets of comments.

Consumer Experience Work Group

The HCA participated in four meetings of this stakeholder work group, which was convened by Blue Cross Blue Shield of Vermont to discuss ways to improve the consumer experience for Vermonters using VHC.

2017 Qualified Health Plan Work Group

The HCA participated in this stakeholder group (four meetings), which was convened by DVHA to help develop recommended changes to benefit design for Qualified Health Plans offered on Vermont Health Connect in 2017. The group met made recommendations for the 2017 QHPs to the Green Mountain Care Board.

2018 Qualified Health Plan Work Group

This stakeholder group was convened by DVHA to help develop recommended changes to benefit design for QHPs offered on Vermont Health Connect in 2018. The legislature set up a process for

discussing the effect that the maximum out-of-pocket expense limit for prescription drugs in Vermont law has on plan design, especially at the bronze plan metal level, with the knowledge that the new federal standards being developed for 2018 plans may make it impossible for the state to develop plan designs for bronze plans that meet both the federal rules and the state limit for prescription spending. The HCA continues to participate in this stakeholder group, which held its first meeting in the last quarter of this fiscal year.

Health Benefits Eligibility and Enrollment (HBEE) Rules

The HCA submitted two sets of formal comments to AHS on emergency amendments to Part Seven of the Health Benefits Eligibility and Enrollment (HBEE) rule and on proposed amendments to other parts of the HBEE rule. After the comment period closed, AHS made additional changes to the final proposed rule to reflect new legislation and federal rulemaking. The HCA met with AHS and health insurance issuers to discuss the changes. The HCA raised concerns over implementation of the new Special Enrollment Period (SEP) for pregnant women created by the legislature effective July 1, 2016, which was not one of the additions to the rule proposed by AHS.

The HCA attended LCAR's review of the rule and afterward met with AHS staff to discuss ongoing operational and rules issues. These include a potential ambiguity in the rule on application of payments and implementation of the above-mentioned SEP for pregnant women. The HCA followed up to ensure that legislative intent was implemented despite the postponement of rulemaking on that issue. AHS committed to working with the HCA and other stakeholders on proposed rule language.

Federal Comments

The HCA submitted formal comments to HHS on its proposed Notice of Benefit and Payment Parameters for 2017, which included changes to health care penalty exemptions, employer appeals of employee APTC eligibility, eligibility verification rules, and other exchange matters. Several changes supported by HCA were adopted in the final rule.

Qualified Health Plan (QHP) Rule

In May, the HCA submitted formal comments on a pre-rulemaking draft of DVHA's QHP certification and direct enrollment rule, Standards for Issuers Participating in the Vermont Health Benefits Exchange. The HCA's comments emphasized the need for the rule to be written in plain language so that it will be accessible to consumers and assisters as well as health insurance issuers. The HCA also advocated limiting consumer and issuer liability for mistakes made by VHC and creating a formal guidance system so that sub-regulatory guidance is accessible to consumers and the public.

After submitting comments, the HCA attended a follow-up stakeholder meeting with DVHA and AHS to discuss the rule. DVHA accepted several changes suggested in the HCA's comments. The HCA will continue to advocate for consumers as the rule moves into the formal rulemaking process this

summer. In addition, the HCA will participate in two workgroups that were formed to discuss retroactive account changes and billing and enrollment.

Tax Issues

The HCA participated in weekly 1095-A stakeholder phone calls (third and fourth quarters), advocated for policy changes on VHC tax issues, and provided input on policies and practices for VHC implementation of employer appeals of employee APTC eligibility.

Other Administrative Advocacy

Medicaid and Exchange Advisory Board

The Chief Health Care Advocate was an active participant in the Medicaid and Exchange Advisory Board (MEAB), participating in nine MEAB meetings, chairing the MEAB work group on Improving Access to Medicaid services (three meetings), and participating in the MEAB work group on Individuals and Families.

Vermont Information Technology Leaders (VITL) HIPAA Violation

The HCA filed a complaint with the Office for Civil Rights (OCR) regarding a HIPAA violation by Vermont Information Technology Leaders (VITL). At a meeting with HCA staff, Green Mountain Care Board staff and other stakeholders, VITL staff shared the protected health information (PHI) of a number of Vermonters during a demonstration of a new product. The PHI was visible to the people present at the meeting as well as to those attending via WebEx.

The HCA brought the breach to the attention of those in the meeting, sent VITL a letter about the violation, met with VITL leadership, and filed an OCR complaint. VITL told the HCA that it has reported the data breach to the relevant medical practice, assigned a new staff member to the role of Privacy and Security Officer, and conducted training of its staff regarding HIPAA. The HCA provided feedback to VITL's counsel on the draft privacy training presentation.

42 C.F.R. Part 2 Advisory Group

The HCA participated in the 42 C.F.R. Part 2 Advisory Group convened by DVHA. This group is working on ways the Vermont Health Information Exchange (VHIE) can protect patient privacy in compliance with federal rules on substance abuse information in medical records without excluding these patients' records from the Exchange. We attended four meetings of the advisory group this year.

Health Information Technology Plan

In February, the HCA submitted formal comments on Vermont's 2016 draft Health Information Technology Plan. Our comments focused on concerns with the costs, preparation, and other resources needed to implement the ambitious plan; the value the state will receive for the costs of

health information technology; the need for experts within state government on health information confidentiality and privacy; and the need for effective provider quality measurements. In addition, we urged VITL and the state to focus on efforts to gain patient consent for the Vermont Health Information Exchange (VHIE). Finally, we asked the state to prioritize the use of technology for care coordination.

The HCA attended two State Health Information Technology Plan workshops.

Rule 09-03 Work Group

The HCA was actively involved in the Rule 09-03 (formerly known as Rule 10) work group (10 meetings), which was set up in Act 54 of the 2015 legislative session. The work group's purpose is to help the Agency of Administration, the Green Mountain Care Board and the Department of Financial Regulation evaluate the necessity of maintaining provisions in Rule 09-03 for regulating insurers. The rule contains consumer protection and quality requirements for managed care organizations as well as consumer protection and quality requirements for insurers in areas such as the adequacy of provider networks and the way insurers conduct prior authorization reviews for requested services.

The group also reviewed requirements for the insurers to report about the claims for covered services that they deny. The HCA advocated for provisions in the statute and rule that would maintain regulatory protections for consumers in commercial health care plans, would improve the reports insurers provide about denied claims, and would require DFR to file quarterly reports showing how many complaints are filed about violations of the consumer protection standards in Rule 09-03.

The Administration presented proposed language for statutory changes to implement the work group's proposals in S.255, and the HCA testified about this bill. DFR and the HCA negotiated a compromise section requiring annual reports, aggregated for all insurers, about the complaints DFR receives regarding violations of the rule. After S.255 passed during the legislative session, the work group met to discuss the rule before the Administration begins the formal rule-making process under the Administrative Procedures Act.

Health Care Administrative Rules (HCAR)

In March, prior to formal rulemaking, Vermont Legal Aid and the HCA submitted formal comments on the first round of proposed Health Care Administrative Rules (HCAR). We asked for clarification regarding informed consent for sterilizations. We opposed the content of a rule on Medicaid Non-Covered Services: Experimental and Investigational Services, including arguing that the definitions of "services" and "experimental or investigational" be completely rewritten with input from medical professionals and other stakeholders. We also raised general questions and concerns regarding the HCAR process. As a result, AHS made revisions to its proposed rule on sterilizations and did not move forward with formal rulemaking on Medicaid non-covered services. AHS agreed that additional stakeholder engagement is warranted on the HCAR process generally. The HCA will

participate in stakeholder input opportunities related to HCAR as they arise and continues to monitor HCAR rulemaking as proposed changes are periodically released.

VPharm Rules

VPharm is Vermont's State Pharmacy Assistance Program, which wraps around Medicare Part D prescription drug coverage. The HCA submitted formal comments supporting SHIP's comments and requesting that the new monthly VPharm reviews be suspended for the period October to December, to prevent confusion during the annual open enrollment period for Medicare Part D.

Vermont Hepatitis Task Force

The HCA is participating in this task force convened by the Vermont Department of Health to work on issues related to Hepatitis C in Vermont. The HCA attended the first meeting of the task force, which was held during the last quarter of this fiscal year. Earlier in the year the HCA submitted a letter to DVHA requesting changes to its Hepatitis C treatment criteria.

The ACA and Taxes

The HCA submitted formal comments suggesting changes to a confusing IRS notice and on the IRS Taxpayer Advocate Service's Employer Shared Responsibility Estimator Tool.

The HCA also submitted concerns and suggestions to the National Taxpayer Advocate's senior attorney advisor for ACA issues and to the Department of the Treasury's legislative policy office for health care.

The HCA met with representatives from the IRS ACA Office and the Center on Budget and Policy Priorities to discuss issues of concern for the 2016 tax filing season. We suggested improvements that could be made to Form 1095-B to assist consumers and tax preparers in filing accurate tax returns.

We advocated with AHS and the IRS Stakeholder Liaison to add benchmark plan information to Forms 1095-A for consumers with unsubsidized plans. Currently those consumers are unable to claim a Premium Tax Credit without undergoing additional review and verification by the IRS, which can be time-consuming.

Other Activities

The HCA attended:

- Three meetings of the Oral Health Care for All Coalition Leadership Team
- Three meetings of the University of Vermont Medical Center Mental Health Program Quality Committee
- Community Health Accountable Care (CHAC)'s first Consumer Advisory Group meeting, provided information about the HCA, and submitted written feedback about the meeting to CHAC

The HCA met with AHS to discuss Vermont's long-term care programs and their relationship to AHS's Health Benefits Eligibility and Enrollment (HBEE) rule, which implements the Affordable Care Act in Vermont. The HCA advocated for clearer public guidance and emphasized the need to address outdated regulations that conflict with the HBEE rule.

We submitted formal and informal comments, written feedback, and proposed language regarding administrative actions impacting consumers, including:

- Comments on Vermont's Global Commitment to Health Comprehensive Quality Strategy to AHS, CMS and HHS
- Comments and written feedback to the Agency of Administration on the draft Universal Primary Care Study
- Comments on a draft billing and enrollment timeline document addressing VHC's new enrollment and recurring billing and dunning policy
- Comments on VHC's "Introduction to VHC" booklet
- Formal comments to HHS on a proposed rule implementing the ACA's anti-discrimination provisions
- Comments to AHS on the Secretary of Administration's budget presentation

The HCA met with DVHA Commissioner Steven Costantino about stakeholder engagement and the Act 75 Unified Pain Management Advisory Council. And we corresponded with DVHA about VPharm annual notices and the Human Services Board (HSB) about its new VHC appeal form and submitted comments on the form.

Affordable Care Act Tax-Related Activities

Since major parts of the federal Patient Protection and Affordable Care Act (ACA) were implemented in 2014, tax law has become important to effective health advocacy. Consumers who lack an understanding of how the tax system interacts with the health insurance system or have difficulty navigating the tax filing process are in danger of losing access to subsidized health insurance.

As we highlighted in our last annual report, VHC's operational problems have added to the confusion and can cause significant federal tax problems for consumers. While VHC improved its operations significantly during SFY 2016, though much more slowly than we had hoped, additional functional improvements must be made to reduce "workarounds" and to help consumers understand and comply with their obligations at tax time.

The HCA continued to employ a half-time tax attorney, who also staffs the Low Income Taxpayer Clinic at VLA. Having a tax attorney on staff allowed the HCA to stay up to date on the IRS's ACA implementation efforts and educate our advocates to effectively field calls related to the ACA and Vermont Health Connect. The tax attorney consulted with HCA advocates when particularly difficult tax issues arose in HCA cases, and accepted HCA case referrals for representation before the IRS.

Administrative Advocacy

As federal implementation of the ACA continued in SFY 2016, the HCA engaged in administrative advocacy to ensure that the consumer perspective would be heard. Our administrative advocacy efforts, detailed above in Administrative Advocacy – The ACA and Taxes, include commenting on changes to the federal regulations applicable to VHC as well as substantial state-level advocacy with VHC and other state agencies. In the last year, the HCA continued to communicate frequently with VHC regarding substantive tax issues and practical problems as they arose. For example, we advocated with VHC to correct errors in its income eligibility calculations.

Direct Advocacy

The HCA hotline advocates engaged in significant consumer education on tax-related issues, as consumers continued to call with tax-related questions. Many Vermont consumers called HCA after receiving IRS notification in July and August 2015 that they had failed to reconcile their 2014 insurance subsidies (APTC, advance payments of the premium tax credit) and would not be eligible for 2016 APTC unless they remedied the error. Some of these consumers had actually filed tax returns, but had failed to include Form 8962 to reconcile their APTC. These consumers generally did not understand the reconciliation requirement or why they had received the IRS notice. We also received significant tax-related calls in the third and fourth quarters of SFY 2016 when consumers were filing tax returns, struggling to understand IRS letters, and confronting their tax bills. The HCA helped many consumers get account changes made and, where appropriate, get amended tax forms from VHC.

The 2016 tax filing season was much calmer than 2015, with a lot fewer requests for corrected tax forms from VHC. However, consumer calls related to forms 1095-A brought many 2015 account problems to light. Most of these problems involved billing and enrollment errors. Some consumers discovered that their payments had been lost or misapplied or that their plan had not been terminated as requested, when Form 1095-A unexpectedly showed unpaid months of coverage. We saw many cases in which consumers appeared to receive excess APTC after their accounts should have been terminated according to the regulations. As a result, the consumers faced tax bills that they often did not owe and could not afford to pay. In response to these cases, we advocated with VHC and the insurance carriers for a uniform application of the grace period and termination rules. We have received assurances that the system has improved, which should reduce the number of reconciliation-related problems in the next tax season. The HCA continues to monitor VHC billing and enrollment problems.

Throughout the 2016 tax filing season, we continued to hear from consumers who reported difficulty enrolling in coverage with VHC and faced a tax penalty as a result of not having coverage. Tax preparers also reported seeing consumers in this situation. We are concerned that these reports persist in VHC's third year. We advised consumers and tax preparers to seek Congressional help in these situations, since the federal agency with responsibility for hardship exemptions (HHS) originally did not recognize a hardship for penalties caused by marketplace error. Perhaps as a result of these Congressional inquiries, HHS has apparently changed its position and has granted some hardship exemptions for people who were unable to enroll because of VHC error.

Litigation

The HCA's tax advocacy extended to litigation this year. In May 2016, the HCA learned of a pending appeal before the Vermont Supreme Court on a question that has not arisen before in any reported case involving eligibility for APTC. The Court must interpret federal law to decide whether contingent eligibility for employer-sponsored insurance denies an employee's spouse access to APTC. The consumer in the case is self-represented. Because low- and moderate-income consumers generally cannot afford an unsubsidized VHC plan, the case (*In re J.H.*) will decide whether consumers in this situation have practical access to affordable health insurance. To ensure that consumers' voices are represented as this legal question is decided, the HCA filed a motion asking for permission to submit a legal argument as *amicus curiae*, friend of the court. The Court granted our motion. (We filed our brief on July 1, one day after the close of this fiscal year.)

Education

To address consumers' confusion and misunderstanding of the tax implications of the Affordable Care Act, the HCA engaged in a significant number of outreach and education activities. They are detailed below in the Outreach and Education section.

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Coordination

The HCA works closely with the Long-Term Care Ombudsman and other VLA attorneys. In addition, we coordinate our efforts with many consumer and advocacy groups and other organizations that are working to expand access to health care. The HCA worked with the following organizations on consumer-oriented initiatives during this fiscal year:

- AARP Vermont
- Alliance for a Just Society
- American Bar Association Section of Taxation Individual and Family Tax Committee
- American Bar Association Tax Section Pro Bono and Tax Clinics Committee
- American Cancer Society of Vermont
- American Civil Liberties Union (ACLU)
- Association of Africans Living in Vermont
- Bi-State Primary Care Association
- Center on Budget and Policy Priorities
- Community Catalyst
- Community Health Accountable Care (CHAC)
- Community of Vermont Elders (COVE)
- Connecticut Health Policy Project
- Consumers Union

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- Dartmouth-Hitchcock Medical Center
 - Department of Vermont Health Access
 - Disability Rights Vermont
 - Families USA
 - Healthfirst
 - Iowa Legal Aid
 - IRS Office of Chief Counsel
 - IRS Taxpayer Advocate Service
 - National Health Law Program
 - National Immigration Law Center
 - National Viral Hepatitis Round Table
 - New Haven Legal Assistance Association
 - Northwest Health Law Advocates
 - Oklahoma Indian Legal Services
 - OneCare Vermont
 - Open Door Clinic
 - Peoples Health and Wellness Clinic
 - Planned Parenthood of Northern New England
 - Procedurally Taxing
 - State Health Insurance Assistance Program (SHIP)
 - University of Vermont Medical Center
 - Vermont Association of Hospitals and Health Systems
 - Vermont Council of Developmental and Mental Health Services
 - Vermont Dental Hygienists' Association
 - Vermont Family Network
 - Vermont Health Connect
 - Vermont Information Technology Leaders (VITL)
 - Vermont Low Income Advocacy Council (VLIAC)
 - Vermont Medical Society
 - Vermont Oral Health Care for All Coalition
 - Vermont Public Interest Research Group (VPIRG)
 - Villanova University Tax Clinic
 - Voices for Civil Justice
 - Voices for Vermont's Children

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Act 134 of 2016 Report

Legislative Request

This past session, the legislature included the following language in the Miscellaneous Tax Bill, requesting that the HCA include in this report recommendations regarding possible changes to the HCA's responsibilities:

Sec. 28a. OFFICE OF THE HEALTH CARE ADVOCATE; REPORT

In the annual report submitted by the Office of the Health Care Advocate for calendar year 2016 pursuant to 18 V.S.A. § 9603(a)(11), the Office shall provide recommendations regarding whether:

- (1) the Office of the Health Care Advocate should be relieved of obligations to serve as a voting member of any advisory group, task force, or similar group in order to fulfill more effectively the Office's consumer advocacy function;
- (2) Vermont Health Connect-related consumer issues should be directed in the first instance to the insurance carrier for resolution; and
- (3) any other statutory or structural changes to strengthen the role of the Office of the Health Care Advocate in providing systemic advocacy.

A list of our statutory duties is at the end of this report. See Attachment A, HCA Statutory Duties.

HCA Response

(1) Should the HCA continue to serve as a voting member of any advisory group, task force or similar group in order to fulfill more effectively its consumer advocacy function?

Yes. It is important for the HCA to be fully informed about all health system policy activities in the state and to know all of the players. It is also important for us to be in the room (or on the phone) in order to speak up on behalf of consumers. One of the best ways to do this is to be actively involved in the many stakeholder groups in the state. Although this can be time-consuming, it is valuable. We use our knowledge of consumer complaints, concerns, and confusion to inform policy makers in the groups, and we advocate for policies that improve quality and access to care and protect consumers' rights. Knowledge of what is happening in the state also enables us to better assist consumers and encourage them to participate in health care policy decisions and advocate for issues to improve the system and their care.

(2) Should VHC-related consumer issues be directed to the insurance carriers for resolution?

No. The HCA currently refers the appropriate cases to the carriers. In other cases, we work closely with BCBSVT or MVP to resolve customer problems. The majority of the problems that come to us, however, are issues that only VHC or DVHA can fix. The carriers cannot do anything about eligibility issues, and eligibility issues underlie a lot of the current problems.

Our statistics show that only 188 of the 4,389 calls we received this year involved problems with commercial insurers. In comparison, 298 of the calls involved problems that DVHA needed to resolve and 1,780 involved problems that only VHC could resolve. In many cases, by the time callers reached us, they were highly frustrated because they had spent numerous hours and often had received multiple, conflicting answers to their problems. Or they had received no answers and did not receive promised callbacks. Of the 153 appeals the HCA helped people with this year, only 14 were commercial plan appeals. Fair hearings no longer solely deal with Medicaid programs. This year 107 (84%) of the 128 Fair Hearings involved VHC issues.

Referring calls to the carriers is not a means to free up time for more systemic advocacy. Rather, dealing with the thorny and complex problems that consumers call us about and detecting the patterns in those calls help us to identify and advocate for systemic changes that benefit many more Vermonters.

(3) Are there other statutory or structural changes that might strengthen the role of the HCA in providing systemic advocacy?

The current model combining individual consumer assistance with policy advocacy is serving Vermont well. While we have a lot of duties, they are of high value to Vermonters and additionally provide the Office of the Health Care Advocate with the information we need to fulfill our policy and regulatory responsibilities.

The existing mix of responsibilities is effective and efficient, providing ease of access for consumers who have one place to call to get answers and advocacy to assist them in resolving any type of health insurance problem. Many people have more than one type of insurance, and many of our calls involve multiple issues. Having a wide spectrum of responsibilities and participating in a broad range of stakeholder groups enables us to be fully informed and more authoritative both when helping individuals and when advocating for policy changes.

The HCA provides an important unfiltered feedback loop to members of the administration and lawmakers as well as the public. For example, we provide timely consumer complaint data and first-hand awareness of trends when policy proposals are being considered. The quality of this feedback loop is dependent on maintaining a well informed and independent HCA.

Other policy responsibilities, such as representing the public in rate reviews, CONs, and hospital budgets and writing white papers that focus attention on how changes in health care delivery may impact consumers build depth of knowledge that helps us to be more effective when advising clients and when providing information to or testifying before the legislature.

Our tax attorney is well-known and highly respected throughout Vermont and the nation for her understanding of and ability to communicate clearly about the tax implications of the ACA. Her work enables us to help consumers resolve serious tax problems and to ensure that the State's rules, procedures and processes address the structures that cause or exacerbate those problems.

If our call volume were to decrease significantly, it might be possible to reduce the number of hotline advocates and shift those resources to systemic work, i.e. hiring another attorney or policy analyst.

However, despite the improvements in VHC functionality, our call volume has not dropped significantly. And, even if it did, we might want to keep the same number of advocates in order to provide faster service to callers (right now we are not usually able to answer the phone live, and it can take several business days for us to be able to return lower-priority calls) and a broader range of service, i.e. representation at Fair Hearings and more assistance with billing problems.

A larger policy team would enable us to do more systemic advocacy. However, in light of the State's fiscal constraints, we have not pressed for funding for more policy staff. Instead, we are strategically using consultants to fill gaps in our skill sets and knowledge base as a means to expand our systemic impact without hiring more staff. For example, we contract with an actuary for rate review cases and a hospital finance consultant for hospital budget proceedings to efficiently increase our ability to influence outcomes.

In summary, as the primary health care consumer advocacy organization in the state, it is important for us to be an independent, knowledgeable voice for consumers in as many stakeholder groups as possible. We have systems in place to manage participation in the groups as efficiently as possible, and we frequently coordinate with other organizations as well as with other Vermont Legal Aid lawyers who are involved in work to improve access to health care.

Outreach and Education

The HCA engaged in direct outreach and used a variety of communication channels to inform and update the public, as well as health, social services, and other partner organizations that assist the public, with health issues. The HCA presented in person and via webinar to local, state and national groups and conducted other outreach; produced written materials; worked with the State to ensure that notices and other important health communications for consumers were written in plain language with appropriate grade and readability levels; sustained a strong health focus on Vermont Legal Aid's Facebook page; and worked diligently to keep the website updated to provide the latest and most accurate information to Vermont consumers.

Outreach

Presentations

The HCA presented individually or as part of a panel at 18 meetings and events where we directly reached more than 600 consumers, advocates, and staff members of organizations that serve the public. The HCA tax attorney continued to be in high demand both locally and nationally to provide clear, accurate information about the tax implications of the Affordable Care Act.

Presentations included speaking at the Trans Town Hall, sponsored by the Pride Center, about transitional medical services, how to get insurance, and available resources; providing an overview of the HCA and our statutory authority to work on behalf of consumers at the Vermont Bar Association annual meeting; participating in a panel discussion of Vermont's history of innovative health care

policies sponsored by Consumers Union; providing information about the HCA and about Medicaid reviews to the Washington County Mental Health Services; and presenting information about the All Payer Waiver and H.812 (an act relating to implementing an all-payer model and oversight of accountable care organizations) to the Senior Solutions Advisory Council.

The HCA played a central role in planning, moderating and presenting a full-day program at this year's statewide Legal Services Staff College focused on gaining a better understanding of opioid addiction, increasing awareness of resources for and obstacles to treatment and prevention in Vermont, and the impact opioid addiction has had on the ability to effectively provide civil legal services to clients.

Print Materials

The HCA published a white paper, *Consumer Principles for Vermont's All-Payer Model*, which looked at the model through a consumer lens and highlighted seven key principles based on information that was current at the time. The principles, along with a link to the paper, were published in Community Catalyst's biweekly newsletter and other publications.

The HCA tax attorney authored or co-authored three significant articles including one exploring the impact of the ACA on American Indian and Alaska Native consumers; a revised excerpt of the chapter on the Affordable Care Act that was originally published by the ABA in the 6th edition of its manual, *Effectively Representing Your Client Before the IRS*; and an ACA update that alerted tax providers to new challenges for 2016. The HCA tax attorney also created a short reference document, *Allocation of Premium Tax Credits Rules Summary*, to assist tax preparers with allocation questions.

Promoting Plain Language in Health Communications

On average, people in the U.S. read at a 6th – 8th grade level, and health literacy (knowledge of important medical and insurance terms) is extremely low. Yet, important notices and other communications that may impact a person's ability to receive, qualify for, or pay for services are often written at a 10th grade level or higher.

Over the past year, the HCA has provided extensive feedback on and revisions to more than 30 communications about health care to consumers from the State and health organizations regulated by the State.

In addition, the HCA also developed a PowerPoint presentation, *Using Plain Language to Improve Readability (and Understanding)*, and a plain language checklist to guide both the writing and layout of documents to increase readability. The HCA offered a session on the topic at our annual staff college, and the materials are available on our internal website.

Email Outreach

The HCA wrote five articles that were published in three issues of Vermont Legal Aid's e-newsletter *Justice Quarterly*, which is distributed directly to approximately 350 subscribers and averages about the same number of total opens per campaign. The HCA articles explained two different forms of late-

payment forgiveness available from the IRS for consumers affected by ACA implementation problems; raised awareness that Vermont Health Connect's six-month delay in using the 2015 Federal Poverty Level guidelines to determine eligibility had likely resulted in some people being incorrectly denied coverage for Medicaid and Dr. Dynasaur; provided an overview of Vermont Health Connect open enrollment and reminded readers to refer those having problems with a VHC plan to call the HCA; provided a link to proposed regulations banning discrimination in health care and information on how to comment; and described the Medicaid review process and informed readers that not responding may result in loss of coverage.

Social/Other Media

In June 2015, Vermont Legal Aid launched a highly active Facebook page, which has attracted over 630 followers. Two out of six members of the Facebook Admin team are on the HCA staff, so the posts have covered a broad range of health topics including informing consumers about the kinds of assistance the Office of the Healthcare Advocate provides, publicizing events such as Green Mountain Care Board hearings on proposed Vermont Health Connect plan rates and free dental clinics, and sharing breaking news on health care topics. The Facebook page enjoys a good level of engagement among our followers including post likes and shares, as well as some comments. Approximately 50 people have reached out to VLA for assistance via private message.

The HCA also wrote three guest blog posts for *Procedurally Taxing*, a widely read national blog covering issues related to tax procedure and administration. The posts reviewed the first tax year of the Affordable Care Act and previewed what to expect in the future.

Other Outreach

The HCA staffed a table at a conference, Coming to the USA: A Focus on Healthcare Challenges, sponsored by the University of Vermont College of Medicine's Department of Family Medicine. Approximately 250 medical students attended, along with some medical professionals and community members. The goal was to raise awareness about the issues and barriers that New Americans may face. The HCA engaged in conversations, answered questions, and handed out approximately 100 brochures.

Health Website

The *Health section* of our Vermont Law Help website offers more than 200 pages of consumer-focused information maintained by the HCA. The health section also provides easy access to an online intake form that allows Vermonters across the state to submit a request for assistance 24/7.

Pageviews

Overall, the health section pageviews increased this year by more than 57% compared with last year. (29,530 pageviews, compared with 18,495 in 2015) We added two new, well-received pages that explain Form 1095-A (248 pageviews) and Forms 1095-B and -C (246 pageviews).

Several pages that showed significant increases in the number of pageviews this year include:

- Medical Marijuana Registry Patient Form (+1,345% – 665 views in 2016, compared with 46 in 2015)
- Dental Services (+227% – 1,479 in 2016, compared with 452 in 2015)
- Health Insurance, Taxes and You (+146% – 1,080 in 2016, compared with 439 in 2015)
- Medicaid income limits (+118% – 8,402 views in 2016, compared with 3,854 in 2015)

While the overall numbers are smaller than those mentioned above, the percentages by which the views of the following pages increased are worth noting and may indicate important trends to monitor:

- How to Get Your Medical Records (+152% – 131 in 2016, compared with 52 in 2015)
- Medical Debt (+153% – 109 in 2016, compared with 43 in 2015)
- Medical Billing Problems (+110% – 103 in 2016, compared with 49 in 2015)
- Vermont Coalition of Clinics for the Uninsured (+119% – 81 in 2016, compared with 37 in 2015)
- Transportation (Medicaid) (+225% – 78 in 2016, compared with 24 in 2015)
- Medical Marijuana Registry Caregiver Form (+467% – 68 in 2016, compared with 12 in 2015)
- Moving from a Vermont Health Connect Plan to Medicare (+611% – 64 in 2016, compared with 9 in 2015)

PDF Downloads

Thirty-four percent more total PDFs were downloaded from the Vermont Law Help website this year (5,046) than were downloaded last year (3,760). Of the 130 **unique** PDF downloads, more than half (72) were on health topics. Almost half (34) of the health-focused PDF titles downloaded provided information specifically for consumers. The other 38 health-focused PDF titles were white papers, presentations and supporting materials prepared by the HCA tax lawyer and members of the policy team.

Notably, the Vermont Dental Clinics Chart was downloaded 346 times, easily taking the top spot among all of the health-focused downloads and ranking third among all PDF downloads. Consumer Principles for Vermont's All-Payer Model, a white-paper written by the policy team in November 2015, took the top spot in the policy category with 36 downloads. And Low-Income Taxpayers and the Affordable Care Act took first place in the tax category with 34 downloads.

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Contract Funding

Department of Vermont Health Access		
Medicaid Funds (part Federal)	\$	433,654
Vermont Health Connect		300,000
Vermont Department of Financial Regulation		
Federal CAP Grant		110,716
State DFR Core		173,752
Green Mountain Care Board		
Rate Review Grant		50,000
State Bill Back Funds		350,000
Additional legislative funds		40,000
TOTAL CONTRACT FUNDING	Total	\$ 1,458,122
LESS APPLIED TO SFY15 EXPENDITURES		(37,896)
NET CONTRACT FUNDING		\$ 1,420,226

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Contract Expenditures

Personnel

Project Director	\$ 88,315
Attorneys	266,198
Lay Advocates and Para Professional Staff	261,882
Management Professional Staff	134,468
Clerical and Support Services	34,765
Total Salaries	785,628
Fringe Benefits	306,654
Total Personnel	1,092,282

Operating Costs

Occupancy	89,938
Office Supplies and Other Office Overhead	14,953
Equipment Rental, Repair and Maintenance	7,824
Computer Services and Support	29,411
Total Operating Costs	142,126

Contract Specific Expenses

Travel	10,960
Training	5,444
Law Library	3,962
Other Specific Costs	2,769
Law Line Sub-Contract	21,735
Professional Actuarial Services	39,710
Total Contract Specific Expenses	84,580

Administrative Overhead

Administrative Support Expenses	20,009
Depreciation	9,340
Total Administrative Overhead	29,349

TOTAL CONTRACT COSTS	\$ 1,348,337
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Attachment A

Health Care Advocate Statutory Duties

Current Duties

Title 18: Health

Chapter 229: Office of the Health Care Advocate

§ 9602. Office of the Health Care Advocate; composition

- Chief must have expertise in the fields of health care and advocacy
- May employ legal counsel, admin staff, and other employees and contractors as needed

§ 9603. Duties and authority

The HCA shall:

- Assist health insurance consumers with health insurance plan selection
- Accept referrals from Vermont Health Connect and navigators
- Help consumers understand their rights and responsibilities under health insurance plans
- Provide information to the public, agencies, legislators, etc. regarding problems and concerns of health insurance consumers and recommendations for resolving problems and concerns
- Identify, investigate, and resolve complaints on behalf of health insurance consumers, and assist consumers with filing and pursuit of complaints and appeals
- Analyze and monitor the development and implementation of federal, State, and local laws, rules, and policies relating to patients and health insurance consumers
- Facilitate public comment on laws, rules, and policies, including those of health insurers
- Suggest policies, procedures, or rules to the Board to protect consumers' interests
- Promote the development of citizen and consumer organizations
- Annual report on activities, performance, and fiscal accounts

The HCA may:

- Review the health insurance records of a consumer who has provided written consent
- Pursue administrative, judicial, and other remedies on behalf of any individual health insurance consumer or group of consumers
- Represent the interests of Vermonters in cases requiring a hearing before the Board

§ 9604. Duties of State agencies

- State agencies shall comply with reasonable requests from the HCA for information and assistance

§ 9605. Confidentiality

- HCA cannot disclose the identity of a complainant or individual without consent

§ 9606. Conflicts of interest

- HCA, employees, and contractors cannot have any conflict of interest including direct involvement in licensing, certification, or accreditation of a health care facility; ownership interest or investment in, employment or compensation by, or management of, a health care facility, insurer, or provider

§ 9607. Funding; intent

- The HCA shall specify in its annual report its expenditures including the amount for actuarial services
- The HCA shall maximize the amount of federal and grant funds available to support the HCA

Title 18: Health**Chapter 043: Licensing Of Hospitals****§ 1911a. Notice of hospital observation status**

- Hospital notices of observation status must include statement that the individual may contact the Office of the Health Care Advocate and contact information for the HCA

Title 08: Banking and Insurance**Chapter 107: Health Insurance****Subchapter 001: Generally****§ 4062. Filing and approval of policy forms and premiums**

- The HCA may within 30 calendar days after the Board receives an insurer's rate request submit to the Board suggested questions regarding the filing for the Board to provide to its actuary
- The HCA may submit to the Board written comments on an insurer's rate request. The Board shall post the comments on its website and shall consider the comments prior to issuing its decision.
- The HCA may appeal a decision of the Board approving, modifying, or disapproving the insurer's proposed rate to the Vermont Supreme Court

Title 18: Health**Chapter 220: Green Mountain Care Board****Subchapter 001: Green Mountain Care Board****§ 9374. Board membership; authority**

- The Board shall seek advice from the HCA
- The HCA shall advise the Board regarding policies, procedures, and rules
- The HCA shall represent the interests of Vermont patients and Vermont consumers of health insurance and may suggest policies, procedures, or rules to the Board in order to protect patients' and consumers' interests

§ 9377. Payment reform; pilots

- The Board shall convene a broad-based group of stakeholders, including the HCA, to advise the Board in developing and implementing pilot projects and to advise the Board in setting policy goals

Title 18: Health**Chapter 221: Health Care Administration****Subchapter 005: Health Facility Planning****§ 9440. Procedures**

- The HCA may participate in any administrative or judicial review of a certificate of need application and shall be considered an interested party upon filing a notice of intervention with the Board

§ 9445. Enforcement

- If any person offers or develops any new health care project without first having been issued a certificate of need or certificate of exemption the HCA may maintain a civil action to enjoin, restrain, or prevent such violation

Title 33: Human Services**Chapter 018: Public-private Universal Health Care System****Subchapter 001: Vermont Health Benefit Exchange****§ 1805. Duties and responsibilities**

- VHC must refer consumers to the HCA for assistance with grievances, appeals, and other issues

§ 1807. Navigators

- Navigators must refer any enrollee with a grievance, complaint, or question regarding his or her health benefit plan, coverage, or a determination under that plan or coverage to the HCA and any other appropriate agency

Title 33: Human Services**Chapter 004: Department of Vermont Health Access****§ 402. Medicaid and Exchange Advisory Committee**

- One-quarter of the members of the MEAB shall be advocates for consumer organizations

Act 113 of 2016**18 V.S.A. chapter 227 is added to read:****Chapter 227: All-Payer Model****§ 9551. All-Payer Model**

- In order to implement an all-payer model, the Board and Agency of Administration shall ensure, in consultation with the HCA, that robust patient grievance and appeal protections are available

18 V.S.A. § 9382 is added to read:**§ 9382. Oversight of Accountable Care Organizations**

- To be certified by the Board, ACOs must offer assistance to health care consumers, including providing contact information for the HCA and sharing de-identified complaint and grievance information with the HCA at least twice annually
- In the Board's review of budgets of ACO(s) with more than 10,000 attributed lives in VT, the HCA may receive copies of all materials, ask questions of Board employees, submit written questions to the Board that the Board will ask of the ACO in advance of any hearing, submit written comments for the Board's consideration, and ask questions and provide testimony in any hearing held in conjunction with the Board's ACO budget review
- The HCA shall not disclose further any confidential or proprietary information provided to the HCA in the ACO budget review process

S. 243**§ 4255. Controlled Substances and Pain Management Advisory Council**

- The Controlled Substances and Pain Management Advisory Council shall include a representative of the HCA

S. 255**18 V.S.A. § 9456(d) is amended to read:**

- The HCA shall have the right to receive copies of all materials related to the hospital budget review and may:
 - Ask questions of Board employees
 - Submit questions to the Board that the Board will ask of hospitals in advance of any hospital budget review hearing
 - Submit written comments for the Board's consideration
 - Ask questions and provide testimony in any hospital budget review hearing
- The HCA shall not further disclose any confidential or proprietary information provided to the HCA

18 V.S.A. § 9414a is amended to read:**§ 9414a. Annual Reporting by Health Insurers**

- DFR and the HCA shall post on their websites links to the standardized form completed by each health insurer

Sec. 10. Recommendations for Potential Alignment

- The Director of Health Care Reform in collaboration with the Board and DFR shall compare the requirements in federal law applicable to Vermont's ACOs and to DVHA in its role as a public MCO with Vermont's MCO rules to identify opportunities for alignment, including mental health standards. The Director shall make recommendations on or before December 15, 2017 to HHC, SHW, and SFC on appropriate ways to improve alignment. In preparing recommendations, the Director shall consult with interested stakeholders, including the HCA.

Past Duties

Act 54 of 2015

Sec. 44. Uniform Forms; Mental Health Quality Assurance; Evaluation

- The Director of Health Care Reform in collaboration with the Board and DFR shall evaluate the necessity of maintaining provisions regarding common claims forms and procedures, uniform provider credentialing, and suspension of interest accrual for failure to pay claims if the failure was not within the insurer's control; the necessity of maintaining provisions requiring the Commissioner to review and examine an MCO's administrative policies and procedures, quality management and improvement procedures, credentialing practices, members' rights and responsibilities, preventive health services, medical records practices, member services, financial incentives or disincentives, disenrollment, provider contracting, and systems and data reporting capacities; the necessity of maintaining provisions directing the Commissioner to require health insurance companies to submit materials related to mental health quality assurance; the appropriate entity to assume responsibility for any such function that should be retained and the appropriate enforcement process; and the requirements in federal law applicable to DVHA in its role as a public MCO in order to identify opportunities for greater alignment between federal law and 18 V.S.A. § 9414(a)(1).
- In performing this evaluation, the Director shall consult regularly with interested stakeholders, including the Office of the Health Care Advocate.
- On or before December 15, 2015, the Director shall provide his or her findings and recommendations to HHC, SHW, SFC, and HROC.

Sec. 6. Notice of Observation Status for Patients with Commercial Insurance

- The General Assembly requests that VAHHS and the HCA consider the appropriate notice of hospital observation status that patients with commercial insurance should receive and the circumstances under which such notice should be provided. VAHHS and the HCA should provide their findings and recommendations to HHC and SHW on or before January 15, 2016.

Act 75 of 2013

Sec. 14. Unified Pain Management System Advisory Council

- The Unified Pain Management System Advisory Council must advise the Commissioner of Health on matters relating to the appropriate use of controlled substances in treating chronic pain and addiction and in preventing prescription drug abuse
- The Unified Pain Management System Advisory Council shall include a representative of the HCA

Other Duties

The HCA is also often asked to participate in task forces, councils, and work groups when the Legislature mandates state agencies to create them. While these are not statutory duties for the HCA, they are essentially required.

Office of the Health Care Advocate

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

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