

Office of the Health Care Advocate



SFY 2017 Annual Report

July 1, 2016 – June 30, 2017

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A Special Project of



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Introduction

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.

The Office of the Health Care Advocate experienced some important changes during this state fiscal year with the retirement of former Chief Health Care Advocate Trinka Kerr and former staff attorney Lila Richardson, who dedicated their professional lives to advocating for low-income Vermonters. Even as the HCA has evolved with new leadership and staff, we maintain our commitment to increasing health care access for all Vermonters. We continue to represent the voices and experiences of Vermonters who don't have lobbyists to represent them at the various health policy tables throughout State Government. We are proud of numerous important achievements on behalf of Vermonters.

The HCA plays an important watchdog role that is independent of political or bureaucratic pressures. Our policy advocacy and our individual advocacy inform each other and give us a grounded perspective on the importance of the work. Every day we talk to Vermonters who can't afford to pay their monthly health care premium, or can't find a doctor, or are unable to pick up their prescription. Affordability and access to care issues are not theoretical for Vermont families, and should not be seen as theoretical to policy makers.

The HCA joined with other Vermont advocates in calling for increased access to curative Hepatitis C medication. This coalition doggedly pushed Medicaid to change its restrictive coverage criteria and to give people living with Hepatitis C access to curative medicines that also protect their families and community. Though a part of this work took place after the fiscal year concluded, we have made some important gains in improving access for this population of Vermonters.

We get calls every day from Vermonters struggling to afford health care. The uncertainty about the fate of the Affordable Care Act has added another layer of confusion and anxiety for consumers. The HCA worked on over 3700 cases this year, helping consumers navigate an increasingly complicated field.

The lack of a clear standard for measuring affordability is a glaring challenge for policy makers and

Testimonial from a Vermonter

From a Client Satisfaction
Questionnaire

My Advocate was very understanding and helpful. When I initially called I was Very stressed and worried. She immediately put me at ease because I felt that I was being heard and understood and was in capable hands. I am very pleased with the speed and efficiency in which my case was resolved. My Advocate was able to straighten out an accounting mess that was a year old in one week. I spent countless hours on the phone with VHC before contacting your office. Thank you, thank you, thank you! Your service is priceless. Thank you for being free though 😊

Vermont families alike. This year the HCA engaged in the process of quantifying the health care affordability crisis. This work will be helpful to policy makers as they seek to understand the challenges that Vermonters are facing. In addition, clearly charting our affordability crisis exposes a common experience for Vermonters who often feel isolated and overwhelmed by an unresponsive and unaffordable system.

Finally, the HCA worked to bring health care stakeholders together to speak out against policy proposals that will clearly hurt Vermonters. It speaks volumes about who we are as Vermonters when entities who are often adversaries during the regulatory process can come together to support each other in our goals of providing better access to affordable quality care.

Case Examples

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

Levi's Story

When Levi went to the emergency room, he found out that he did not have any insurance. He was surprised because he thought that he was on Medicaid. The HCA looked into the issue, and found that Levi's Medicaid had been closed at the end of 2016. This meant that he had been without insurance coverage for nearly six months—an issue because, under the Affordable Care Act, consumers must pay a penalty for the months they go uninsured unless they qualify for an exemption. The advocate discovered that VHC closed Levi's Medicaid without sending the required closure notice. The advocate worked to get his Medicaid reinstated back to January, meaning that Levi's trip to the emergency room would be covered, and that Levi would not owe a penalty for not having insurance coverage for the first half of the year. Between the hospital claims and the penalty, the HCA saved Levi nearly one thousand dollars.

Richard's Story

Richard had been hitchhiking to his daily appointments at the substance abuse clinic. He had no insurance coverage and no car, and his only income was from disability payments. He had no friends or family who could help him get to his appointments. He was afraid he'd miss an appointment and relapse. When Richard called the HCA for help, the HCA advocate realized that Richard was eligible for Medicaid for the Aged Blind and Disabled (MABD). She helped him complete his application, submitted his application for him, and asked for it to be expedited. He was found eligible the same day the application was submitted. This meant that he would be able to get his prescriptions with low copayments and would not have to pay out of pocket for his medical appointments at the clinic. With this Medicaid coverage, Richard was entitled to transportation to his appointments at the substance abuse clinic. The HCA advocate intervened with the transportation office, and was able to quickly set up rides for him.

Anne's Story

Anne recently immigrated to the United States and was living with her son. She suddenly became ill and had to go the Emergency Room. She had almost no monthly income and no way to pay her bills. When she applied with Vermont Health Connect (VHC), she was told she was not eligible for Medicaid. VHC also told her that she was not eligible for a Premium Tax Credit (PTC) to help reduce the cost of her insurance coverage. This would mean that she would need to pay the full cost of a plan by herself—which would be nearly \$500 a month for a silver plan. She could not afford to do this, so she called the HCA for help. VHC had been correct when they told Anne that she was not eligible for Medicaid. A rule called the “five year bar” generally means that qualified lawful immigrants like Anne are not eligible to get Medicaid for a five-year waiting period. VHC had been wrong, however, when they told her she was not eligible for PTC. The HCA advocate showed that the “five year bar” did not apply to Anne’s eligibility for PTC. This meant that Anne was eligible to get PTC to help reduce her monthly costs. The HCA asked VHC to screen her again for PTC. VHC found her eligible, and the final cost of her plan was less than \$25 per month.

Charlie's Story

When Charlie received his health insurance bill for January 2017, it was over a thousand dollars, almost double what he had been paying. Charlie could not afford to pay the bill, and his family was in danger of losing health insurance for non-payment. The HCA discovered that VHC had removed Charlie’s subsidies because IRS data showed he had not filed his 2015 taxes. (People with subsidized health insurance must file their taxes to keep getting subsidies.) The HCA determined the information that the IRS sent to VHC had not been accurate. Charlie had filed his taxes well before the deadline. Charlie’s case was not unusual. A recent Treasury Department study of the 2016 open enrollment period found that the IRS provided erroneous data about tax filing in 25% of the cases reviewed. (See <https://www.treasury.gov/tigta/auditreports/2017reports/201743022fr.pdf>) This erroneous data can delay or prevent an individual from getting the subsidies for which they are eligible. The HCA advocate showed VHC that Charlie had filed his taxes in time, and was able to get his subsidies reinstated for January.

Paul's Story

When Paul received his invoice for his Qualified Health Plan (QHP) on VHC for 2017, the amount was more than double what he had been paying. He could not afford to pay that amount. When the advocate investigated, she found that he had been found ineligible for premium tax credits (PTC). The PTC helped reduce his monthly premium by hundreds of dollars a month. VHC said that the reason he was ineligible was that he had failed to file his taxes. If a consumer receives PTC, they need to file taxes and “reconcile” the amount of PTC that they received during the year. During that process, the IRS checks to see if the consumer received the correct amount of PTC based on their yearly income. If you do not file your taxes and reconcile, you will not be able to get PTC the following year. Paul had filed his taxes, which meant he was eligible for PTC. When VHC did his renewal, however, an error showed he had

failed to file taxes and reconcile. The HCA advocate pointed out the error, and VHC restored Paul's subsidies. After his subsidies were restored, his premium was reduced by over \$250 dollars per month. The HCA advises consumers year-round on tax issues related to the ACA.

Elizabeth's Story

Elizabeth called the HCA because she had an appointment with a specialist, but she did not have a way to get to that appointment. She was not able to drive and did not have a car. In the past, she always relied on Medicaid transportation to get to her appointments. When she tried to schedule a ride, however, she was told that she was no longer had Medicaid. She had filled out a new application, and had believed she was all set. Then, she had received a letter asking her to fill out another application. Despite filling out a second application, she was still being told that she did not have coverage. The HCA advocate looked into the problem, and found that Elizabeth had completed the wrong Medicaid application the first time she applied. Elizabeth is eligible for Medicaid for the Aged, Blind and Disabled (MABD). This type of Medicaid has a different application than the Medicaid on VHC (Medicaid for Children & Adults). The advocate found out that the State of Vermont did have Elizabeth's second and correct application, but it had not been processed yet. The advocate intervened and asked for that application to be processed immediately. It was processed and Elizabeth was found eligible for MABD. She was able to schedule her ride and get to her appointment.

Katherine's Story

Katherine called the HCA because she could not afford her monthly health insurance premium. She had been on Medicaid earlier in the year, but VHC had reviewed her eligibility and found her ineligible for Medicaid. She was enrolled in a Qualified Health Plan (QHP) on VHC, but it was too expensive for her. Katherine had heart surgery scheduled, and she could not have a lapse in her coverage. When the advocate looked at Katherine's information, she found that VHC was counting her income incorrectly. Katherine was a home care provider, which meant that she cared for an individual with a disability who lived in her home. She was receiving a 'difficulty of care' stipend each month for this care. The IRS considers Katherine's stipend to be non-taxable income. This means that VHC should not have included the stipend when calculating Katherine's eligibility for Medicaid. When the income was properly calculated, Katherine was found eligible for Medicaid. The HCA advocate was able to get the Medicaid reinstated back to the time that it was closed, and Katherine was refunded the premiums she paid for her QHP.

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 1,414 CSQs and 433 (31%) were returned. Of those returned, 97% said they were Satisfied or Very Satisfied with the service they received from our office. About 98% reported they were treated with Dignity and Respect by our Advocates.

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

[My Advocate] was Awesome!! He made me feel heard and respected my feelings very very helpful and professional.

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!! I was at the end of my rope.

My advocate was terrific – this case was pretty complicated and she handled it very professionally – Just wish VHC was as helpful as you guys.

I was treated like a person, with respect. Some of the people in the state treat me like they don't want to be bothered to help me, like they're better than me and I'm nothing but dirt! I haven't always been at this level. I used to have a job that supported myself and my mom. I also was in customer service. I had good and bad days. I only hope that I always treated everyone as well as [My Advocate]

treated me.

[My Advocate] went above and beyond to help me navigate a very difficult process.

I understand many of the problems that are organic to a system with many departments – it is often difficult with the volume of information received to always be up to date. It was brutal setting aside hours each day, speaking with almost a new person each time to find some cohesive and useful direction when asking for help. For me personally, my physical issues that brought me to the place of needing assistance were humiliating enough. Having to explain things over and over again to various departments was exhausting, frustrating, and often left me in tears after I realized that the effort for that day resulted in having to make additional phone calls to additional departments.

At this point in time with more paperwork to do, I am truly grateful for the efforts made on my behalf, I hope for an easier and better solution for all. Thank you for your help.

Everyone that worked with me was excellent and caring

I'm so grateful for my advocates help but unhappy with VHC communication.

[My Advocate] was quite respectful and treated me with dignity, which does not always happen with some agencies that serve low income people with a disability.

I would like to extend my sincere appreciation and thanks to [My Advocate]! Throughout the entire process, she remained persistent and diligent in resolving my premium issues with satisfaction. Thank

you! Your office provides invaluable help to all Vermonters to solve problems related to our health care especially where premiums are incorrectly calculated which was my situation! Keep up the good work! [My Advocate] saved me from extreme emotional distress during a really difficult time when I did not have the capacity to deal with the Vermont Health Connect once more. She is amazing. I wish more people knew about your services.

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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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Key Projects

Access to Treatment for Hepatitis C Virus

This year the HCA continued our work with a coalition of organizations to improve access to treatment for Hepatitis C Virus (HCV) for Vermont Medicaid beneficiaries. This coalition had important successes this year advocating successfully to DVHA's Drug Utilization Review Board (DURB) for the removal of Medicaid's restrictive and illegal criteria for accessing curative HCV treatment. In October 2016 the DURB voted to reduce the level of liver damage required for treatment of HCV, and to stop restricting patients with current or past substance use from accessing treatment at the October meeting. The Coalition continued in its advocacy into the next fiscal year achieving further successes.

The HCA is pleased that the DURB ultimately voted to lift the liver damage restriction on hepatitis C treatment, as is required by federal Medicaid law. Treatment of every patient with hepatitis C is the standard of care. There is no medical justification for denying treatment because the patient's liver isn't damaged enough. Curing people with hepatitis C will have immediate and long-term benefits for individual Vermonters and for our communities. The HCA and the coalition will continue to advocate for Medicaid to allow treatment of hepatitis C by primary care providers.

Rate Review

The HCA's works diligently every year on behalf of Vermonters in the Rate Review process bringing a consumer voice to these proceedings. The HCA monitors all insurance carrier requests to the Green Mountain Care Board for changes in premium rates requested by commercial insurance carriers. These are usually rate increases. There were multiple rate cases before the board during SFY 2017 including the 2017 Vermont Health Connect (VHC) Filings.

The HCA was a party in the Vermont Supreme Court's review of the Board's December 2015 decision disapproving the rate request for five plans offered by the Agriservices Association. Agriservices, an association for farmers, uses MVP's large group Minimum Premium Plan funding arrangement for grandfathered plans with a contract renewing with a December 1, 2015 effective date. MVP requested a very large average annual rate increase of 26.9%. The HCA asked the Board to disapprove the requested rates and the Board's December 2015 decision disapproved the increase. In January, MVP asked the Board to reconsider its decision. The HCA opposed this request and the Board refused to change its initial decision. MVP then appealed the Board's 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, the HCA and the Solicitor General on behalf of the Green Mountain Care Board filed briefs in March and April 2016. The HCA asked the Supreme Court to find the statute constitutional and uphold the Board decision, and the Solicitor General also asked the 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 in June. The Supreme Court issued its decision on September 23, 2016. It found the rate review statute constitutional but agreed with MVP's argument that the Board's conclusions of law were not supported by specific findings of fact that related to the statutory criteria. The Court sent the case back to the Board for new findings.

Access to Screening Mammography

During this fiscal year, the HCA became aware that Act 25 of 2013, which requires first dollar coverage of screening mammography including additional views, has largely not been implemented. We believe that a significant number of women have been and continue to be charged cost-sharing and deductibles for call-back mammograms that should be fully covered under Vermont law. The HCA met and communicated with representatives from the American Cancer Society, Central Vermont Medical Center, the University of Vermont Medical Center, Blue Cross Blue Shield of Vermont, and the Department of Financial Regulation to try to identify where problems are occurring and rectify them. We produced an opinion piece that appeared in many news publications informing Vermonters about this issue and informing them that we would like to hear from them if they had experienced such charges. We continue to work on assisting these Vermonters. This law had an implementation date of over three and a half years ago, and yet it continues to not be followed. We are actively pursuing full implementation, which would save many Vermont women hundreds of dollars each year.

New Online Help Tool

In the spring of 2017 we starting writing content for a new Health section for the online help tool on our website. It is found at https://vtlawhelp.org/triage/vt_triage and can be accessed from most pages of our website. A more detailed description of the tool will appear later in the report.

Health Care Coalition

The HCA played a facilitation role with a broad group of Vermont stakeholders to find common ground about the Federal threats to Vermonters' access to care this year. This advocacy extended into the next fiscal year and included press releases focused on two of the proposals to repeal and replace the Affordable Care Act and a memo highlighting the future risks due to Federal budgetary actions and inaction. In addition to the HCA, the participating organizations in this effort included Blue Cross Blue Shield of Vermont, Bi-State Primary Care Association, MVP, Planned Parenthood of Northern New England, UVM Medical Center, Vermont Association of Hospitals and Health Systems, VT Coalition of Clinics for the Uninsured, Vermont Care Partners: VT Council of Developmental and Mental Health Services, Vermont Medical Society, Vermont Program for Quality in Health Care (VPQHC), and VNAs of Vermont.

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Consumer Assistance

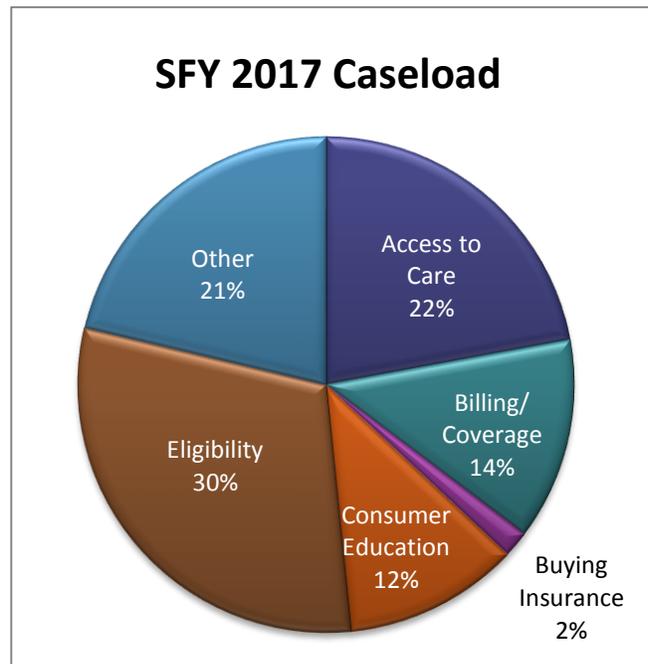
Description of Caseload

In State Fiscal Year (SFY) 2017, we handled 3,742 calls to our statewide hotline, compared to 4,389 calls in SFY 2016 and 4,695 in SFY 2015. We closed 3,848 cases during this period and had 149 cases pending at the end of June 2017.¹ A total of 1,503 (40.2%) of the calls were related to Vermont Health Connect, compared to 49.7% 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 (30% compared to 28%)
- Other (21% compared to 25%)
- Access to Care (22% compared to 20%)
- Billing and Coverage (14%, the same as last year)
- Consumer Education (11% compared to 14%) and
- Buying Insurance (2%, the same as last year)



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

¹ These numbers do not add up to 3,742 total calls because some unresolved cases from the previous SFY were carried forward into this SFY.

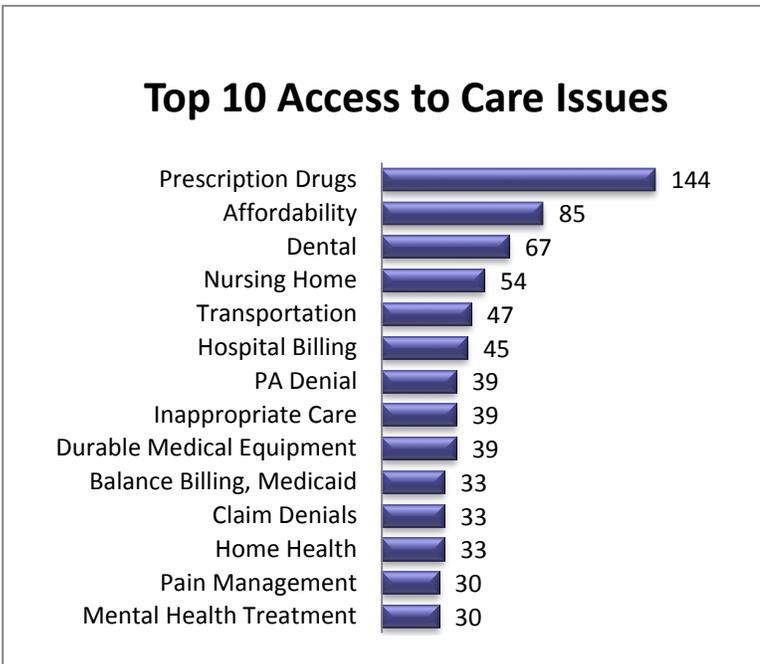
difficulties getting access to health care as the primary issue was 827, which is 6.2% lower than last year’s total of 882. An additional 705 callers cited access issues as secondary to their primary problem.

We track 49 subcategories in *Access to Care*.² As has been the case for years, Prescription Drugs posed the greatest number of access issues. We received calls from 156 Vermonters unable to promptly get necessary medications, compared to 177 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 was not on the top ten list in SFY 2015 and had moved into sixth place in SFY 2016, rose to fourth place with the number of callers who identified Nursing Home as their primary issue (54, compared with 42 last year and 28 in SFY 2015). Issues not on the list last year that appear on this year’s list are hospital billing, inappropriate care, Medicaid balance billing, and claim denials.

Despite the fact that more Vermonters are insured, and a large proportion of Vermonters who purchased VHC plans qualified for cost-sharing reductions, many 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 85 calls, compared to 99 last year. An additional 52 callers cited affordability as secondary to their primary access issue. Prescription drug problems were the most common Access to Care issue with 144 calls, compared to 162 last year. Another 102 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 (67, compared to 63)
- Transportation (47, compared to 63 in SFY 2016)
- Durable medical equipment, supplies and wheelchairs (39, compared to 56)
- Home health (33, compared to 26)
- Pain management treatment (30, compared to 39)

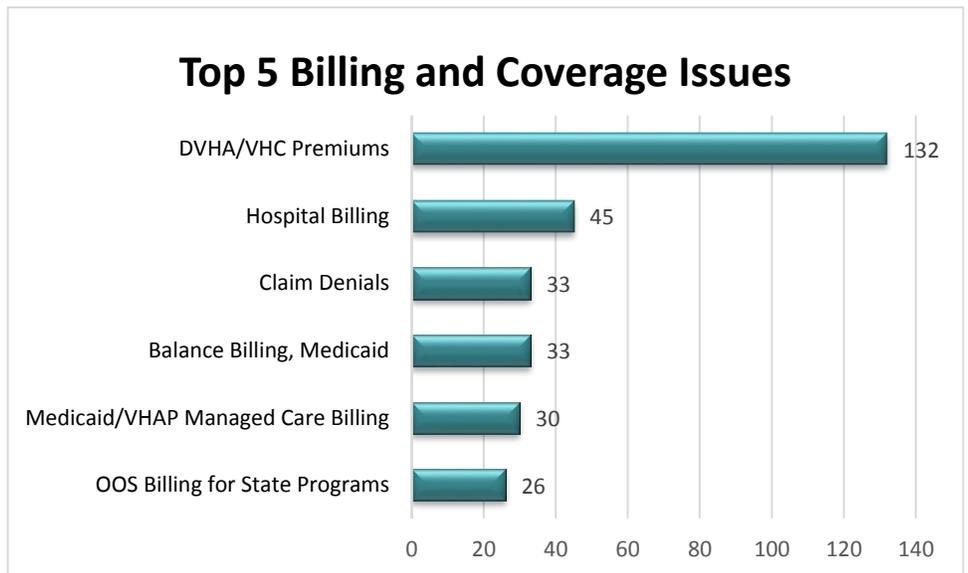
² In this fiscal year, we added the category “Provider Directory Problems” as a subcategory.

- Mental health treatment (30, compared to 37)

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 2017, we answered 494 calls in this category, compared to 592 last year, a 17% decrease.

We track 35 subcategories of *Billing and Coverage* calls. DVHA/VHC Premiums, Hospital Billing, Claim Denials, and Medicaid Balance Billing all remained among the top five billing and coverage issues faced by consumers who called the HCA in SFY 2017. Calls about Medicaid/VHAP Managed Care Billing and Out-of-State Billing for State Programs rose onto the list this year, and calls about VHC Refunds dropped from the top five *Billing and Coverage* issues (decreasing significantly from 58 calls last year to 23 in SFY 2017).



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

- DVHA/VHC Premiums (including Dr. Dynasaur) (132, compared to 138)
- Hospital Billing (45, the same as last year)
- Claim Denials (33, compared to 49)
- Balance Billing, Medicaid (33, compared to 38)
- Medicaid/VHAP Managed Care Billing (30, compared to 23)
- OOS Billing for State Programs (26, compared to 21)

Eligibility

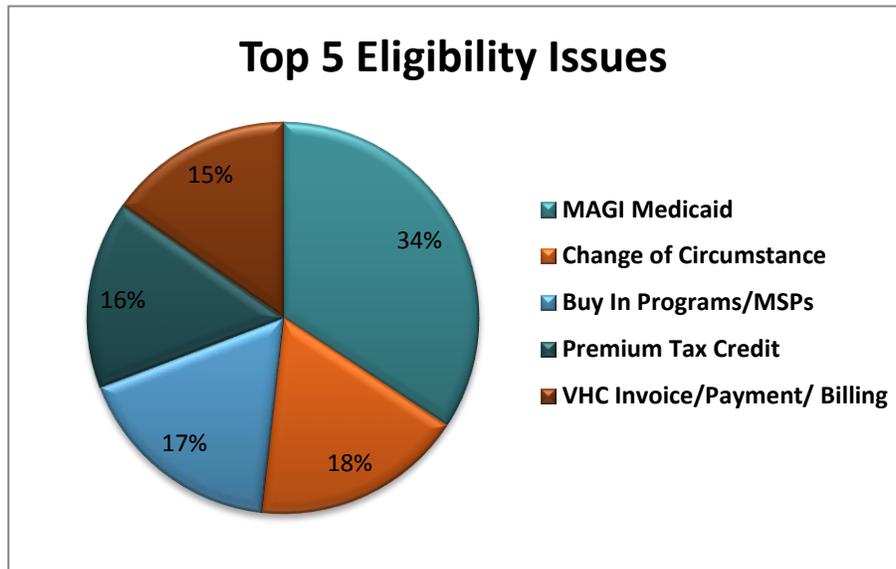
The percentage of calls related to *Eligibility* for health care coverage offered through the state went from 28% in SFY 2016 to 30% in SFY 2017 and still topped the other five categories. Eligibility was the

primary issue for 1,134 callers. An additional 2,236 callers named eligibility as a secondary issue for a total of 3,370.

In SFY 2017, four of the top SFY 2016 eligibility issues remained in the top five, but VHC Renewals dropped off of the list (9 calls in SFY 2017 compared to 81 calls in SFY 2016) while Buy-In Programs/MSPs rose into the top five. Calls about VHC Invoice/Payment/Billing, which was the top issue in SFY 2016 by a significant margin of 49 calls, decreased by 61% in SFY 2017. The number of calls about the top five issues compared to the number of calls last year were:

- MAGI Medicaid (189, compared to 166 in SFY 2016)
- Change of Circumstance (97, compared to 167)
- Buy-In Programs/MSPs (96, compared to 64)
- Premium Tax Credit (86, compared to 70)
- VHC Invoice/Payment/Billing (84, compared to 216)

Of the 1,134 calls in which *Eligibility* was recorded as the primary issue, 718 (63%) were related to Vermont Health Connect. This is a decrease from SFY 2016, when 75% of *Eligibility* calls were related to VHC. Specific Vermont Health Connect problems involving technology, application processing, change of circumstance, renewals, and invoice/payment and billing



problems accounted for 203 (about 18%) of all *Eligibility* calls. Looking at secondary issues, the following subcategories provided significant challenges to our callers, even in those cases where they were not the primary issue: MAGI Medicaid (289), Premium Tax Credit (251), Medicaid (non-MAGI) (142), Change of Circumstance (138), and Special Enrollment Periods (134).

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 2017, 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.

Insurance	SFY 2017	SFY 2016	SFY 2015	SFY 2014
State Programs	917 (21%)	900 (20%)	1,313 (28%)	1,180 (30%)
Commercial Insurance	708 (16%)	1,135 (26%)	1,185 (25%)	573 (15%)
Uninsured	482 (11%)	558 (13%)	517 (11%)	501 (13%)
Medicare	497 (11%)	389 (9%)	480 (10%)	539 (14%)
Dual Eligible ³	210 (5%)	272 (6%)	303 (6%)	415 (11%)
Dental	16 (<1%)	55 (1%)	18 (<1%)	N/A
Catamount & Premium Assistance ⁴	N/A	N/A	N/A	148 (4%)
Other	105 (2%)	154 (4%)	228 (5%)	80 (2%)
Irrelevant/Unknown	807 (18%)	926 (21%)	651 (14%)	471 (12%)

When beneficiaries who are Dual Eligible or have VPharm coverage are added into the Medicare total, about 20% of the calls were from Medicare beneficiaries in SFY 2017.

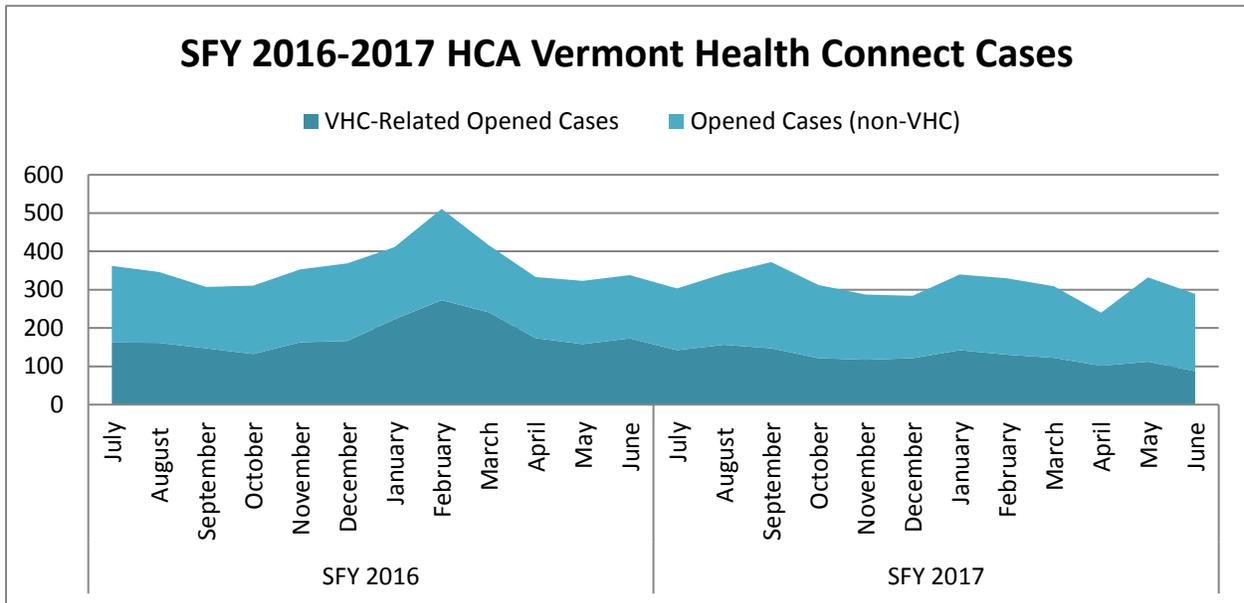
Vermont Health Connect Calls

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.⁵

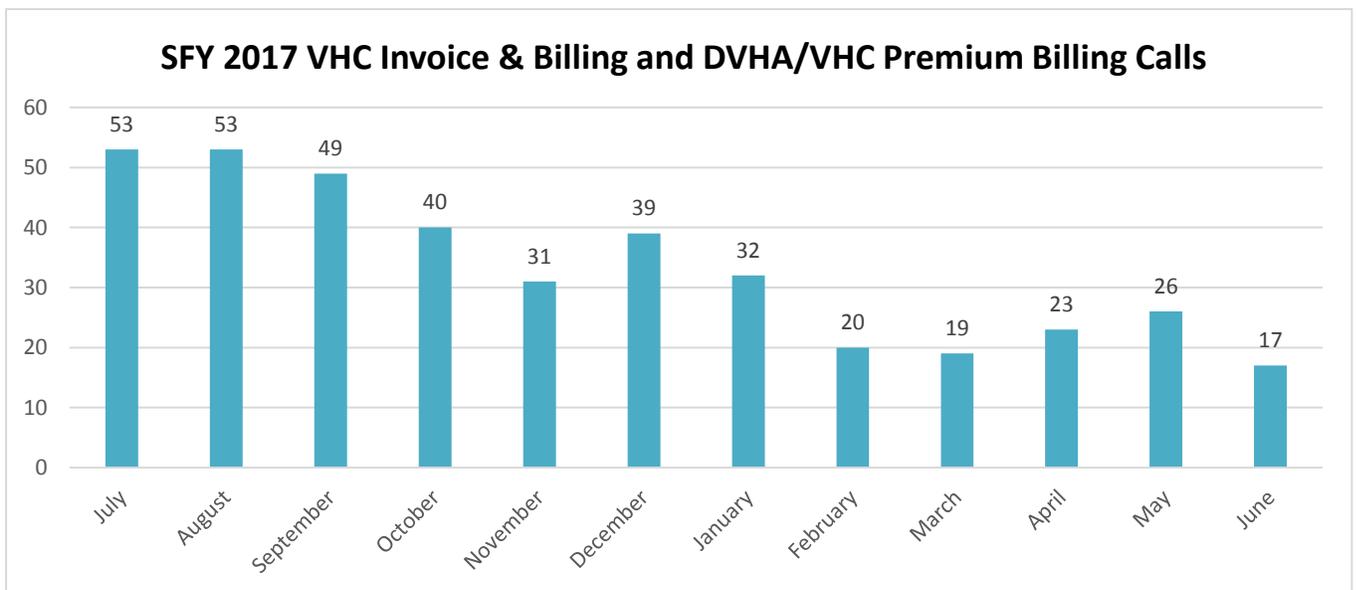
³ Dual Eligible means a beneficiary who is eligible for both Medicaid and Medicare.

⁴ The Catamount Health and Catamount Health Premium Assistance (CHAP) programs ended on March 31, 2014.

⁵ The HCA only provides help to individuals. We do not assist small businesses.



In SFY 2017, 1,503 (40%) of the calls received by the HCA were related to Vermont Health Connect. This is a significant decrease from the proportion in SFY 2016, when the 2,179 calls related to Vermont Health Connect accounted for 49% of total calls. Since the launch of Vermont Health Connect, the HCA’s call volume has averaged above 300 calls per month. The overall VHC numbers reflect that the system is functioning better and that problems are being resolved more quickly.



The top VHC issue consumers called us about was problems with invoices and billing. Vermonters reported getting incorrect invoices 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.

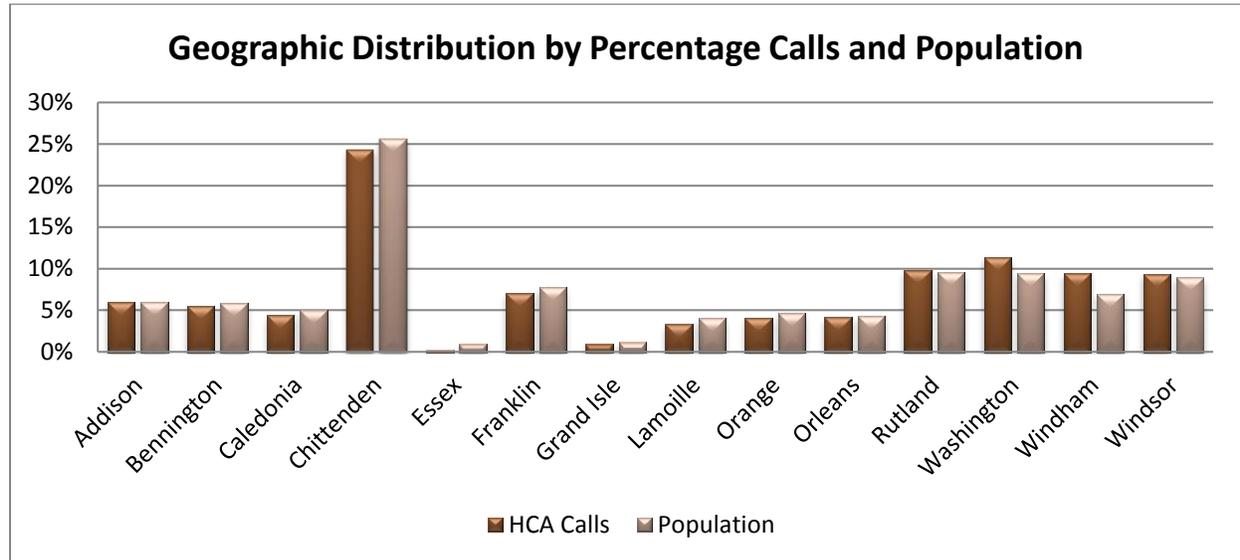
Resolution of Calls

In SFY 2017, the HCA closed 3742 cases, compared to 4,338 last year. When we close a case, we document how we resolved the case, where we referred the individual, and what materials we sent. In SFY 2017, the HCA saved consumers \$268,292.41.

Outcome Summary	SFY 2017	SFY 2016	SFY 2015
Advice or Education	2,174	2,252	2,479
Assisted with Application for Insurance	7	7	23
Bill Written Off	14	7	21
Claim Paid as a Result of HCA Intervention	24	14	32
Client Not Eligible for Benefit	22	15	17
Client Responsible for Bill	19	23	48
Estimated Eligibility for Insurance	138	62	79
Got Client onto Insurance	347	409	452
Obtained Coverage for Services	86	93	175
Other Access/Eligibility Outcome	328	421	371
Other Billing Assistance	91	187	204
Hospital Patient Assistance Provided	3	2	13
Prevented Termination or Reduction in Coverage	62	60	42
Reimbursement Obtained	32	71	82
Service Excluded Under Contract	2	0	3
Other Outcome	499	714	602
Grand Total	3,848	4,337	4,643

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 2017 compared with the general population distribution (based on 2014 census information).



Public Advocacy

SFY 2017 was a busy and productive year for the HCA’s public advocacy team. The HCA actively participated in many proceedings before the Green Mountain Care Board including QHP and large group insurance rate review proceedings, hospital budget and certificates of need proceedings, ACO regulation development and numerous other meetings and proceedings.

The HCA also actively participated in other systemic advocacy activities engaging in the legislative process by both responding to legislative questions as well as actively bringing a consumer voice to legislative policy considerations. The HCA commented on proposed Federal and State rules including the eligibility and enrollment rules (HBEE) and Medicaid covered services rules (HCAR). The HCA also edited multiple health care notices to make them more readable and understandable. We participated in health care tax advocacy for individuals and on a systemic level. The HCA participated in numerous other public commissions and boards.

The HCA engaged in a number of outreach and public education activities, partnering with various community organizations to get the word out about issues that consumers need to be mindful of when accessing insurance and health care as well as information about the services that the HCA has to offer to Vermonters who need an advocate’s assistance. These outreach activities included significant focus

on health care-related tax issues as well as eligibility, and communications focused on helping Vermonters understand and manage the exchange marketplace.

All of the details of the HCA's public, administrative, outreach and other activities was reported upon in detail in the four quarterly reports that make up SFY 2017. These quarterly reports can easily be found at the following link. <https://vtlawhelp.org/hca-reports>

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Coordination

The HCA works closely with the Long Term Care Ombudsman Project 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
- Blue Cross Blue Shield of Vermont
- Center on Budget and Policy Priorities
- Community Catalyst
- Community Health Accountable Care (CHAC)
- Community of Vermont Elders (COVE)
- Connecticut Health Policy Project
- Consumers Union
- 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
- Ladies First

- MVP
- 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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Health Website

The Health section of our Vermont Law Help website offers more than 250 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 36% compared to last year (40,367 pageviews compared to 29,606 in FY2016).

The top 10 health pages were:

- Medicaid Income Limits (13,078 pageviews)
- Health Home Page (4,223)
- Dental Services (1,938)
- Vermont Choices for Care (1,589)
- Health Insurance, Taxes and You (1,181)
- Services Covered by Medicaid (1,044)
- Medicaid Resource Limits (860)
- Medical Marijuana Registry Patient Form (655)
- Choices for Care Long-Term Care Medicaid Income Limits (631)

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

- Services Covered by Medicaid (+156% – 1,044 pageviews in 2017, compared with 408 in 2016)
- Medicaid Resource Limits (+95% – 860 in 2017, compared with 441 in 2016)
- Vermont Choices for Care (+89% – 1,589 in 2017, compared with 840 in 2016)
- Medicaid Income Limits (+56% – 13,078 views in 2017, compared with 8,394 in 2016)
- Dental Services (+31% – 1,938 in 2017, compared with 1,480 in 2016)

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 trends to monitor:

- Dr. Dynasaur (+309% – 213 pageviews in 2017, compared with 52 in 2016)
- Ladies First Health Program (+290% – 164 in 2017, compared with 42 in 2016)
- Prescription Assistance - State Pharmacy Programs (+260% – 198 in 2017, compared with 55 in 2016)
- Resources for Uninsured Vermonters (+244% – 124 in 2017, compared with 36 in 2016)
- Transportation (Medicaid) (+194% – 229 in 2017, compared with 78 in 2016)
- Health Insurance (+106% – 410 in 2017, compared with 199 in 2016)
- Medicare Savings Plans / Buy In Programs (+72% – 506 in 2017, compared with 294 in 2016)

PDF Downloads

Of the list of unique documents that were downloaded from the entire Vermont Law Help website, 32% were on health topics. This year we saw a 3% increase in downloads of health-related documents.

- 18 were created for consumers. The top consumer-focused downloads were:
 - Vermont Dental Clinics Chart (downloaded 469 times)
 - Advance Directive Short Form (228)
 - Advance Directive Long Form (86)

- Vermont Medicaid Coverage Exception Request form (74)
- Blue Cross Blue Shield of VT Annual Report 2014 (71)
- 8 were prepared for lawyers, advocates and assisters who help consumers with tax issues related to the Affordable Care Act. The top advocate-focused downloads were:
 - Hospital Financial Assistance Fact Sheet (47)
 - PTC Allocation Rules Summary (24)
 - Low-Income Taxpayers and the Affordable Care Act (20)
 - PTC Allocation Spreadsheet (16)
- 5 covered topics related to health policy. The top policy-focused downloads were:
 - VT ACO Shared Savings Program Quality Measures (32)
 - Consumer Principles for Vermont's All-Payer Model Nov 2015 (14)

The Vermont Dental Clinics Chart took the top spot among the health-focused downloads and ranked 4th among all PDF downloads on the Vermont Law Help website. The Advance Directive Short Form comes next and ranks 7th among all PDF downloads on the website. These were the top health-related downloads last year as well.

New Online Help Tool

In the spring of 2017 we starting writing content for a new Health section for the online help tool on our website. It is found at https://vtlawhelp.org/triage/vt_triage and it can be accessed from most pages of our website. Our first health topic was posted on June 19 and it featured both Vermont Health Connect and work-based health insurance information. More sections were added over the next four months (Medicare, Medicaid, complaints, finding low-cost care and long-term care).

The website visitor answers a few questions to find specific health care information they need. The new feature addresses some of the most popular questions that are posed to the HCA. In addition to our deep collection of health-related web pages, the online help tool adds a new way to access helpful information -- at all hours of the day and night. The website user can also call the HCA or fill in our online form to get personal help from an advocate.

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Income

Department of Vermont Health Access		
Medicaid Funds (part Federal)	\$	433,654
Vermont Health Connect		300,000
Vermont Department of Financial Regulation		
State DFR Core		173,752
Green Mountain Care Board		
State Bill Back Funds		510,000
Additional legislative funds		<u>40,000</u>
TOTAL CONTRACT FUNDING	\$	<u><u>1,457,406</u></u>

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Vermont Legal Aid, Inc.
CONTRACT EXPENDITURES
HCA ANNUAL REPORT SFY 2017

Personnel

Project Director	\$ 55,606
Attorneys and Health Care Policy Analyst	267,507
Lay Advocates and Para Professional Staff	294,297
Management Staff	157,388
Other (Fringe Benefits)	259,595
Total Personnel	<u>1,034,393</u>

Other Direct Costs

Office Operations	70,217
Project Space	88,565
Other	23,988
Total Other Direct Costs	<u>182,770</u>

Purchased Services

Law Line Subcontract	17,173
Consultants	86,510
Total Purchased Services	<u>103,683</u>

CONTRACT EXPENDITURES

	<u><u>\$ 1,320,846</u></u>
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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

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

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Burlington, Vermont 05401
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<http://www.vtlegalaid.org/health>