

# THE OFFICE OF HEALTH CARE OMBUDSMAN

## Consumer Complaints Report

prepared for

Vermont's Health Benefits Exchange Implementation

August 2012



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**OFFICE OF HEALTH CARE OMBUDSMAN**  
**CONSUMER COMPLAINTS REPORT**

**I. INTRODUCTION**

The Office of Health Care Ombudsman (HCO), a special project of Vermont Legal Aid, Inc. (VLA), is a health insurance consumer assistance program which helps Vermont state residents resolve problems, answer questions, file complaints and appeals, and enroll in State health care programs. The HCO provides this help to Vermonters through a statewide hotline (800-917-7787), its website ([www.vtlegalaid.org](http://www.vtlegalaid.org)), and the five VLA offices located around the state. The Department of Vermont Health Access (DVHA) plans to use the HCO to provide these consumer services for the Vermont Health Benefits Exchange (Exchange).

DVHA will create the Exchange pursuant to the federal health care reform law, the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (ACA), and Vermont Act 48 of 2011, an act relating to a universal and unified health system. DVHA plans to begin operating the Exchange in October, 2013. Act 48 requires both the Exchange and the Navigators<sup>1</sup> to refer consumers to the HCO for help with problems and appeals.

As part of its preparation for implementation of the Exchange, DVHA has contracted with VLA for this analysis of the complaints and questions that the HCO has received from consumers over the previous three years. In order to use the most current data, we will examine the period from May 1, 2009, through April 30, 2012. Since its inception more than a dozen years ago, the HCO has categorized and recorded data about the problems it has helped resolve and the consumer education it has provided.

Although the focus of this report will be the last three years, it will also draw from data collected in earlier years to show longer term trends and to provide examples that are historically equivalent to the Exchange implementation. The two examples reviewed are the implementation of the federal Medicare prescription drug program concurrently with VPharm and Vermont's state subsidized Catamount Health programs.

This report concludes with a series of recommendations based on our analysis of the data and the HCO's twelve years of experience assisting health care consumers in Vermont.

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<sup>1</sup> Navigators, as mandated by the ACA, are individuals who will educate consumers about Exchange insurance plans and facilitate enrollment.

## II. ANALYSIS OF ALL HCO CALLS<sup>2</sup>

### ISSUE CATEGORIES OF CALLS

During the time period of May 1, 2009, to April 30, 2012, the HCO received a total of 8,968 calls. These calls were broken down into six categories based on the issues raised by the caller: Access, Billing/Coverage, Buying Insurance, Consumer Education, Eligibility, and Other.

**Access:** Problems with getting particular services, such as medications, mental health treatment, dental care, or durable medical equipment. Consumers with these issues have not yet received the service.

**Billing/Coverage:** Difficulties post-service. Usually these are related to claim denials by the insurer, coordination of benefits difficulties, communication problems with providers and insurers, or other problems related to bills for services.

**Buying Insurance:** Calls that were specifically about buying individual or small group plans. Because Vermont has such an array of Medicaid expansion programs, most callers seeking new insurance coverage are more interested in eligibility for State programs. As a result, most calls about available coverage options get coded as Eligibility cases. There are very few cases coded under Buying Insurance.

**Consumer Education:** HCO advocates spend a significant amount of time explaining consumer rights and responsibilities, eligibility rules and processes related to public programs, and basic health insurance literacy concepts including premium payments, cost-sharing, and utilization management mechanisms. In actuality, consumer education is provided in a majority of the HCO's calls. However, cases are coded as Consumer Education only if education was a primary focus of the call.

**Eligibility:** Eligibility for Vermont health care programs and Medicare. The State programs include Medicaid, Dr. Dynasaur, Medicaid for the Working Disabled, the Medicaid Spend Down program, the Vermont Health Assistance Program (VHAP), Catamount Health Premium Assistance (CHAP), the Employer Sponsored Premium Assistance programs (ESIA), VPharm and the other state pharmacy assistance programs, and the Medicare Savings Programs. Medicare eligibility includes Medicare Parts A, B, C and D. Eligibility cases can involve inquiries about possible eligibility, application problems, denials, or terminations.

**Other:** Cases that did not quite fit into any other category. These include calls about access to medical records, advance directives, changing providers, communication problems with various

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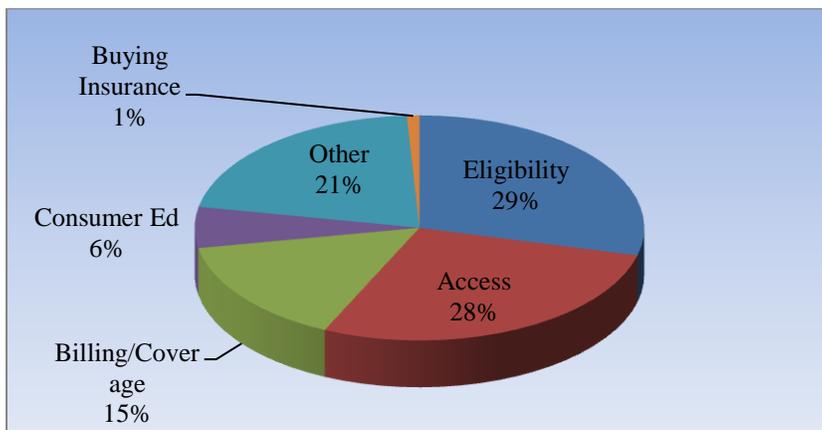
<sup>2</sup> The term "call" is used to mean any complaint or question the HCO received, whether through the hotline, the internet, or a walk-in visit to a VLA office.

entities, confidentiality concerns, complaints about providers, disability insurance, questions about how the Medicare Modernization Act works (Medicare Parts C and D), the interface between health insurance and family law, flexible spending accounts, medical debt collection, personal injury, power of attorney, pre-existing conditions, high premium rates, travel insurance, worker's compensation, and the like.

The breakdown of the 8,968 calls over the past three years was:

- Access: 2,508
- Billing/Coverage: 1,362
- Buying Insurance: 81
- Consumer Ed: 528
- Eligibility: 2,596
- Other: 1,893

**Figure 1: HCO Calls by Issue Category for Three Years: 5/1/2009 - 4/30/2012**



### **TRENDS AND CHANGES IN CALL VOLUME FOR EACH ISSUE CATEGORY**

Prior to the first year covered in this analysis, the HCO consistently received around 2,500 calls per calendar year (see Attachment A). In 2010 that number jumped by 17%. This increase was most likely due, at least in part, to problems with the Department for Children and Families' (DCF) effort at Modernization of its eligibility determination process. Figure 2 below illustrates the spike in Eligibility calls in Year 2 of this analysis. It may seem obvious, but this suggests that if the eligibility determination process run through the Exchange does not work smoothly, the HCO could see another big jump in call volume to do problem solving.

The fact that the total call volume remained elevated speaks to the longevity of the Great Recession and the trend toward more and more unaffordable health care, as more and more Vermonters tried to seek out affordable, quality insurance.

Calls related to Access increased in each of the analyzed years. This can probably be attributed to a number of changes in health care coverage. These changes include increased cost-sharing for consumers (such as higher deductibles, copays, and coinsurance) and increased utilization management (such as prior authorizations, pharmacy benefit management, limitations on using out of network providers, and caps on benefits such as physical therapy). Other Access problem areas are exclusions for pre-existing conditions, lack of insurance due to affordability, inability to navigate the eligibility process, and exclusions of particular services in the plan's contract.

### **TOTAL CALLS BY YEAR AND CATEGORY OF CALL**

**Year 1:** For the first year of the analysis, 5/1/2009 – 4/30/2010, the HCO received 2,570 calls. In descending order the call volume was:

- Eligibility: 744
- Access: 667
- Other: 531
- Billing/Coverage: 456
- Consumer Education: 138
- Buying Insurance: 34

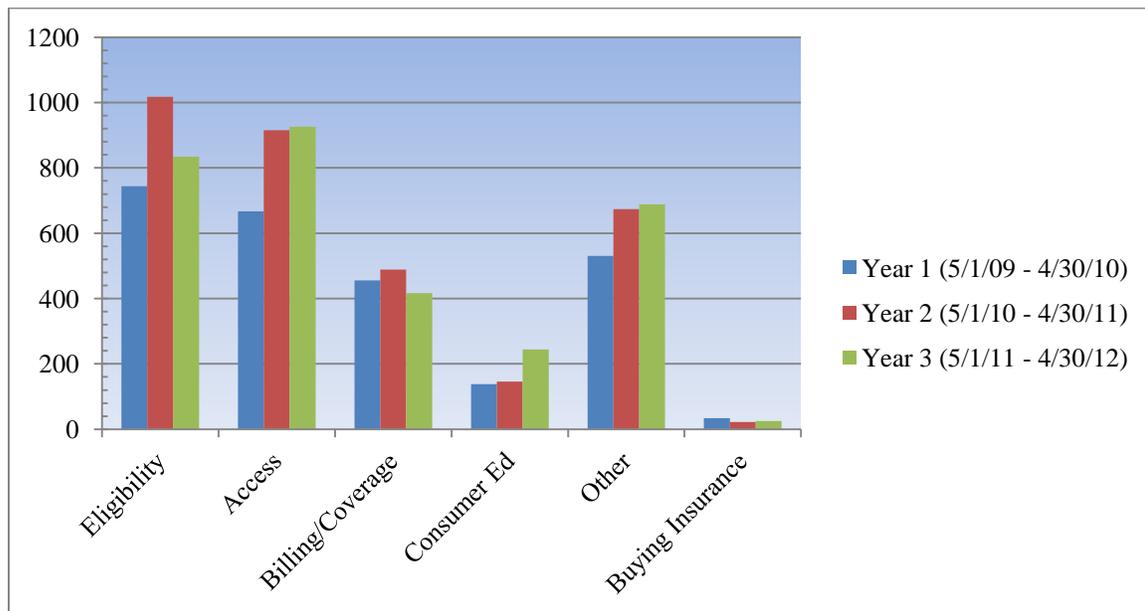
**Year 2:** For the second year of the analysis, 5/1/2010 – 4/30/2011, the HCO received 3,264 calls. In descending order the call volume was:

- Eligibility: 1,018
- Access: 915
- Other: 674
- Billing/Coverage: 489
- Consumer Education: 146
- Buying Insurance: 22

**Year 3:** For the third year of the analysis, 5/1/2011 – 4/30/2012, the HCO received 3,134 calls. In descending order the call volume was:

- Access: 926
- Eligibility: 834
- Other: 688
- Billing/Coverage: 417
- Consumer Education: 244
- Buying Insurance: 25

**Figure 2: Changes in Issue Categories for Three Years: 5/1/2009 – 4/30/2012**



### **III. ANALYSIS OF THE FOUR MAIN ISSUE CATEGORIES**

#### **ELIGIBILITY<sup>3</sup>**

Eligibility for insurance is the main reason that individuals call the HCO, with Access to specific types of health care a close second. Over the last three years, 29% of calls had Eligibility as the primary issue.<sup>4</sup> With the implementation of the Exchange, the rules and processes for eligibility will be very different from what they are today. The first step for many Vermonters using the Exchange will be a determination of their income. Household income will determine eligibility for Medicaid under the new ACA Medicaid rules. If found over income for Medicaid, individuals will be eligible for a sliding scale premium subsidy if their income is less than 400% of the Federal Poverty Level. There will be a higher number of Vermonters who will enter the State eligibility system seeking access to one of these programs.

To prepare for the Exchange, the State must identify current eligibility problems, determine how those problems might be fixed, and then apply that fix to the new Exchange eligibility system. In addition to these necessary improvements, the rules for Medicaid eligibility will be changing as a result of the ACA. This is immensely complex, and we do not yet have enough information from the federal government to understand how many aspects of the new health benefit system,

<sup>3</sup> This report covers Eligibility in greater depth than the other issue categories because it seems the most relevant to the Exchange implementation.

<sup>4</sup> Since many calls to the HCO hotline raise multiple issues, the HCO codes issues as primary and secondary. Every call has a primary issue assigned to it. Many calls have several secondary issues as well.

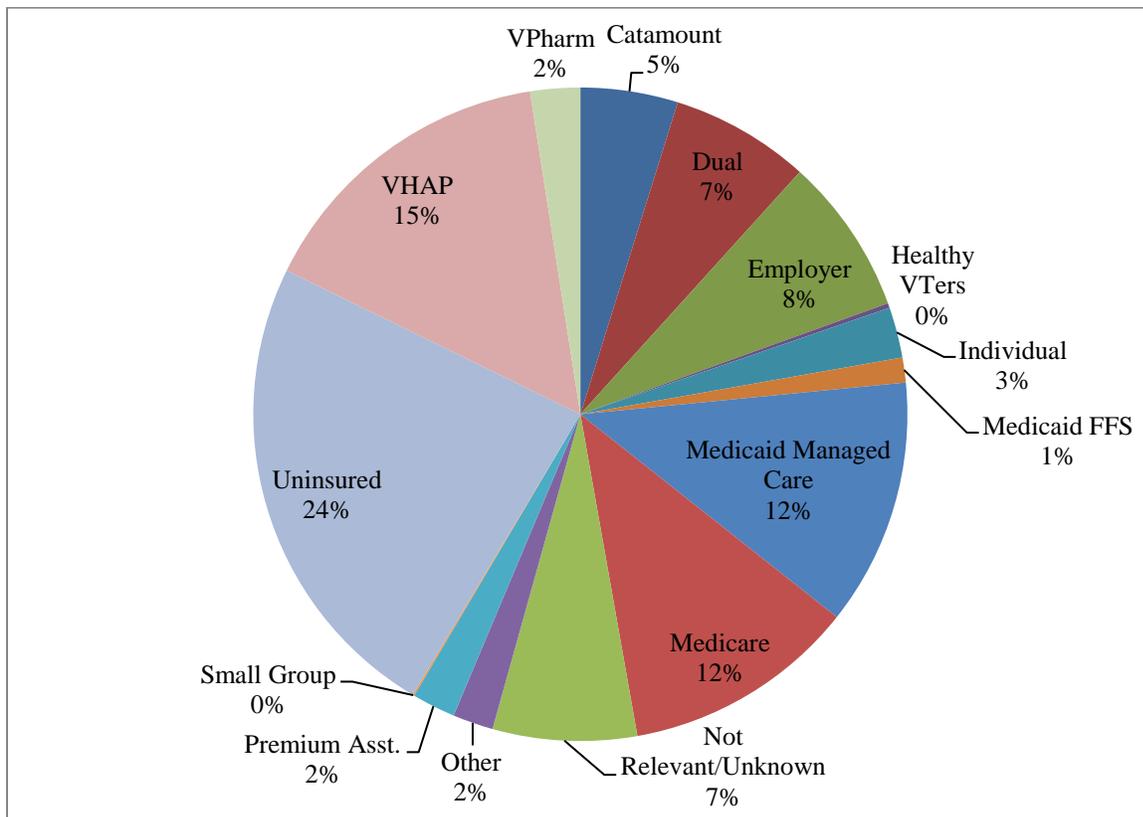
such as premium tax credits, reconciliation of said tax credits, and cost-sharing subsidies are going to work. It is safe to say that the number of Eligibility calls the HCO receives is going to significantly increase.

This section will identify current Eligibility issues across coverage types and will make recommendations for reducing the Eligibility problems which may arise.

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The HCO asks of all callers their current insurance status if it is relevant to their call. Figure 3 below shows the breakdown of Eligibility calls over the last three years by coverage type:

**Figure 3: Eligibility Calls by Insurance Status of Beneficiary**



The HCO gets its highest percentage of Eligibility calls from uninsured individuals at 24%. The second most Eligibility calls come from VHAP beneficiaries (15%), then Medicaid (13%, including Fee for Service, or FFS), and then Medicare beneficiaries (12%). For the purpose of this report, we are not addressing Medicare eligibility issues, as Medicare will not be a part of the initial implementation of the Exchange. Private insurance (employer and individual) calls

comprise 11% of all HCO Eligibility calls, and Catamount and Premium Assistance contribute minimally to overall Eligibility calls at only 7%.<sup>5</sup>

It is understandable that the uninsured have the highest percentage of Eligibility calls. Even if the reason for their call was initially related to Access (e.g., the caller thinks she has a medical problem but cannot afford to get treatment), the primary issue most often would end up being coded as Eligibility so the individual could then access the care that they need affordably. Only 16% of uninsured individuals have Access as the primary issue, compared to 28% for all coverage types over three years. It follows that 69% of uninsured callers have Eligibility as their primary issue, since the first priority for uninsured individuals is to get insurance. There is not much for the State to take from this in order to prepare for the Exchange except to acknowledge that all uninsured individuals are expected to go through the Exchange, unless they choose to take the tax penalty. The most current estimate of uninsured individuals in Vermont is about 47,000<sup>6</sup>.

One thing of note is that a greater percentage of uninsured callers had cases that required Direct or Complex Intervention by the HCO, at 36.5%. On average, only 21% of calls require Direct or Complex Intervention. This could mean that, with the introduction of more of the uninsured population to the State insurance system, both the State and the HCO will see an increase in cases that require more time and effort to resolve. With the current HCO data, it is hard to determine why it is that uninsured callers have more difficult cases.

Calls from beneficiaries with private, individual insurance comprised only 3% of the total Eligibility calls, but 42% of calls from beneficiaries with individual insurance had Eligibility as the primary issue. This is likely because individual insurance tends to be expensive and/or the coverage tends to be poor. In addition, these beneficiaries would likely be subject to the Twelve Month Uninsured Rule<sup>7</sup>, which HCO advocates must frequently discuss with individuals on private insurance who cannot afford their current plan. Of the 8,968 total calls in the last three years, there are only 94 cases with the Twelve Month Uninsured Rule as a primary or secondary issue, which does not seem to reflect the actual number of times this rule comes into play for HCO callers. More thorough record-keeping of this issue would likely have brought forth more accurate numbers.

The other private insurance category, employer sponsored insurance (ESI), makes up 8% of Eligibility calls across all coverage types, and Eligibility makes up only 20% of ESI beneficiary calls. This is significantly smaller than the percentage of Eligibility calls the HCO gets from

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<sup>5</sup> Most calls related to Catamount Health are from individuals who are not on Catamount, but want to be.

<sup>6</sup> Vermont Department of Financial Regulation 2009 Vermont Household Health Insurance Survey.

<sup>7</sup> The Twelve Month Uninsured Rule is a requirement that individuals be uninsured for at least twelve months before they can be eligible for either VHAP or Catamount Health. There are a number of exceptions to this rule.

beneficiaries on individual insurance (42%). This is likely due to the fact that, compared to individual insurance, ESI is relatively more affordable. The percentage of ESI Eligibility calls is also skewed downward because of the abnormally high percentage (29%) of calls that are about Billing and Coverage.<sup>8</sup> It is important to note that, even though our data shows that ESI Eligibility calls are relatively low compared to other types of insurance, the HCO does get many calls from individuals who would like to switch to a State plan for either affordability or coverage reasons.

The Exchange will be beneficial for many individual insurance and ESI beneficiaries because with the elimination of VHAP and Catamount, there will no longer be any Twelve Month Uninsured Rule. Beneficiaries will not be forced to stay on their high-cost, low-coverage plans anymore; they will be able to choose the plan with the level of coverage that they desire, and they will be able to get subsidies if they are income-eligible. Some beneficiaries who have been stuck on high-cost plans may even end up being eligible for Medicaid since the income limit will increase to 133% of the Federal Poverty Level.

The last two coverage types that are of note are VHAP and Catamount and Premium Assistance.<sup>9</sup> After the uninsured, VHAP beneficiaries are the most likely coverage type to call with an Eligibility issue at 15%. Of the total VHAP calls, 39% are related to Eligibility. Compare this to the average of 28% across all coverage types. The HCO gets a lot of calls from VHAP beneficiaries regarding Eligibility because they not only have a hard time keeping up with premiums and paperwork, but they are also in a tight income eligibility window that moves them onto and off of VHAP to other programs like Premium Assistance or Medicaid. They are at the edge of the proverbial “cliff.”

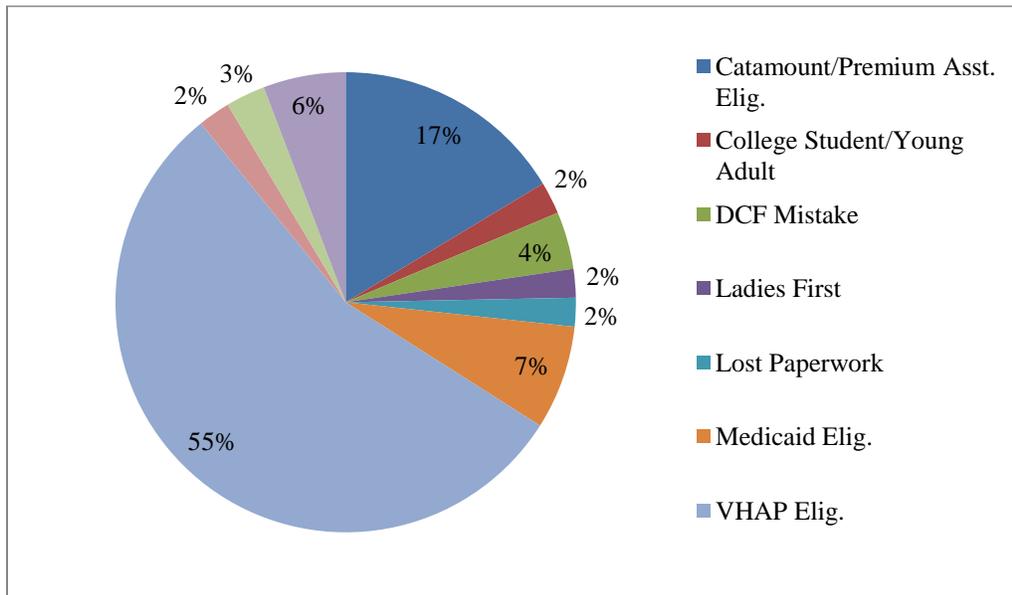
Figure 4 below shows the different Eligibility issues that VHAP beneficiaries have.

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<sup>8</sup> See more on Billing/Coverage on page 19.

<sup>9</sup> See more on Catamount and Premium Assistance on pages 12 and 25.

Figure 4: VHAP Eligibility Issues



At 55%, general eligibility is the predominant issue that the HCO codes for VHAP beneficiaries who call with an Eligibility issue. Within this 55%, the secondary issues would be the most telling, but our data programming cannot delve that deeply. We can infer that this 55% is comprised of a combination of the other eligibility issues that VHAP beneficiaries have. These issues include lost paperwork, Economic Service Division (ESD) mistakes, premium problems, etc. Many of the VHAP Eligibility calls are also from VHAP beneficiaries who have been found eligible for Catamount or Premium Assistance due to an income increase or a decrease in household size. This would be in addition to the 17% of calls that have Catamount/Premium Assistance as the primary issue.

The main reason individuals call the HCO when they transition from VHAP to Premium Assistance is that they do not understand either the structure of the programs, the paperwork, specific notices, or the enrollment process. Applicants and beneficiaries often do not understand the timeline of how CHAP (Premium Assistance) is supposed to work. They may not realize that they have to pick a plan or have their employer fill out a Plan Information Request Letter, so they lose coverage. Even if they do all the steps, if one thing is done out of order, they lose coverage. They may not realize that their premium bill went up, so they will pay the amount they always have paid, and then they will lose coverage. They may not be able to afford the increased premium rate, so they will opt to be uninsured instead. Between Catamount and CHAP beneficiaries, 41% of calls relate to Eligibility. The reasons Eligibility calls are so high for these beneficiaries are the same as for VHAP beneficiaries, except that Catamount and CHAP beneficiaries are already paying higher premium levels, and they have already succeeded in enrolling in the plan.

In the Exchange, VHAP and CHAP will be eliminated, and individuals will be able to pick a plan of their choice and stay on that plan. They will benefit from this, but they will still have to manage the receipt of fluctuating premium subsidies, fluctuating out-of-pocket assistance, as well as tax refunds or even IRS recoupment at end-of-year premium tax credit reconciliations, which could be very difficult for families and individuals to plan for and keep track of. Some current VHAP beneficiaries will still bounce from plan to plan if they are at the edge of the future Medicaid income limit of 133% of the Federal Poverty Level.

Transitioning in and out of State health care programs is difficult for beneficiaries as well as for the State. This is a phenomenon often referred to as “churn.” The HCO has seen that churn creates considerable confusion, affects continuity of care, and causes general frustration with the State enrollment and review processes. Beneficiaries will have gaps in coverage, and they may not even realize that they have lost their insurance until they are refused service by a provider due lack of coverage or get a bill from their provider. The HCO does not have great data to exemplify churn, but we do agree with the statistical findings in *Issues and Policies Around “Churning” in Health Insurance Plans*, by The Center for Community and Public Health (2011), which was specifically written for the state of Vermont in preparation for the Exchange. We believe the statistical findings in this report clearly illustrate the need to reduce churn.

Though the HCO does not have specific data on churn, from our experience in assisting a wide range of Vermonters, we can suggest special populations that would benefit from extra attention in the enrollment and review processes within the exchange. Suggested special populations are:

- Medicaid Spend Down beneficiaries
- Elderly
- Self-employed
- Seasonal workers
- Households with disabled individuals
- Immigrants
- Low-literacy individuals

These special populations are more vulnerable to churn, and by providing them with additional assistance, these beneficiaries would be less likely to lose coverage, to forgo or defer necessary treatment, or to incur medical debt. Churn also increases administrative costs so any churn reduction would reduce those costs as well. The HCO has learned that it is better to preemptively help individuals to prevent future problems. Sometimes all it takes is extensive consumer education, or a list or a chart outlining required documentation or steps. This kind of proactive education minimizes the probability that greater issues will arise later, which saves time and money in the long run.

## **Eligibility Issues**

The HCO subdivides the Eligibility category into the following issues<sup>10</sup>:

- Application process delay
- Buy In Programs
- Catamount Health
- Choices for Care
- Citizenship & Identity requirements
- College Student/Young Adult
- DCF Mistake
- Disability Determination
- Katie Beckett
- Long Term Care Medicaid
- Lost paperwork
- Mail problems/delayed premium bills, etc.
- Maximus/Member Services error
- Medicaid
- Medicaid for the Working Disabled
- Medicare
- Other DVHA Programs
- Prescription Drug Plan (Medicare Part D)
- Premium Assistance
- Seasonal Employment
- Small business owner
- Twelve month waiting period
- VHAP
- VHAP ESIA
- VPharm

### **Examples of Eligibility Cases**

- A VHAP beneficiary accidentally paid \$30 for her premium, rather than \$33. Because of this, she lost her coverage, didn't realize it, and then incurred a \$600 medical bill due to lack of coverage for that month. She would benefit from a grace period for premium payments.

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<sup>10</sup> Additional issues can be added to the HCO database. We expect to add and track more issues when the Exchange comes online.

- One particular client has called the HCO seven different times since 2004. Three of the times, she was on VHAP; two of the times she was on CHAP; and her insurance coverage was irrelevant the other two times. She has a TBI and is a seasonal worker, so she gets bumped around every year. It is incredibly confusing and frustrating for her. When she has a job her premiums increase and she can't afford the premiums or the cost-sharing. She has had multiple lapses in coverage. In 2010 she incurred over \$4,000 in medical bills because of this confusion. She would benefit from specialized eligibility assistance through the Exchange.
  
- A Medicaid beneficiary had been living in the same apartment for nine years. He had been sent a notice informing him that his whereabouts were unknown, and all of his State benefits (Medicaid, SLMB, and Food Stamps) would end in ten days. He had not seen this notice, so he had no idea. He was fortunately working with an HCO advocate on a different issue at the very same time. The advocate was informed of this beneficiary's potential termination through a conversation with Member Services. The advocate learned that a notice had been marked 'Return to Sender' and mailed back to the State. It turned out that this happened because the normal postal carrier for that route had quit, and the substitutes had somehow made this mistake. The HCO advocate spoke to Member Services again, because at this point there was only five days until all benefits would terminate. The customer service representative (CSR) did not attempt to resolve the situation and said that the State was within the required ten days to process any information changes. The HCO advocate was able to have Health Care AOPS<sup>11</sup> resolve the issue, but if this beneficiary had been on his own, he likely would have lost his benefits. This individual would have benefitted from a phone call from the State prior to his termination to double check his whereabouts. As a possible future scenario, if he were to call the Exchange call center to fix this last-minute situation on his own, the CSR should either rush the processing of the address change or refer him immediately to the HCO.

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<sup>11</sup> The HCO regularly works with Health Care Administrative Operations (HC-AOPS), which is a small group of extremely knowledgeable and experienced DCF employees who troubleshoot eligibility problems. They are part of the Health Access Eligibility Unit, within DCF's Economic Services Division. The HCO only contacts AOPS by email. They respond by emails as well, often within minutes but almost always in less than 24 hours.

*Recommendations:*

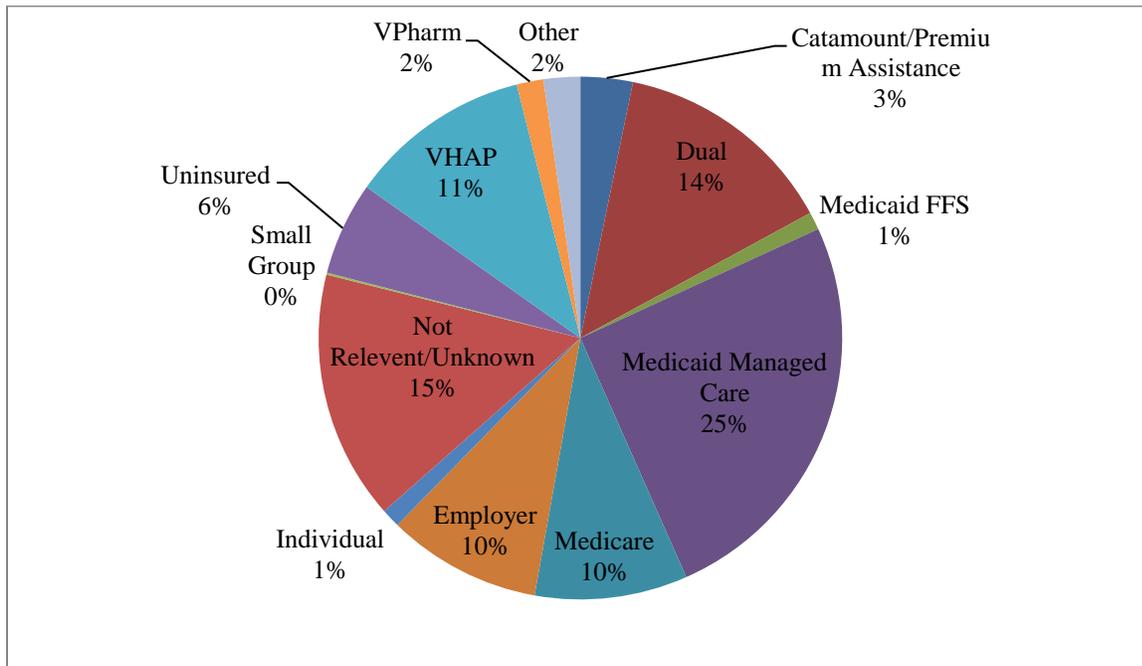
- 1. Provide a grace period for all beneficiaries who, for one reason or another, do not submit their premium bill on time.*
- 2. Make a phone call to beneficiaries before terminating benefits, especially if the reason for termination is whereabouts unknown or for not responding to requested information.*
- 3. Increase Medicaid Spend Down periods from six months to twelve months, or institute some other change to reduce the frequency of Spend Down redeterminations.*
- 4. Provide additional assistance to special populations who are more vulnerable to churn.*
- 5. Provide extensive consumer education well before implementation of the Exchange on all aspects of cost sharing and subsidies in the Exchange.*
- 6. Provide basic consumer education on important considerations in choosing a plan, i.e. premiums, deductibles, copays, coinsurance and out-of-pocket maximums.*
- 7. Provide step-by-step written and oral explanations for any multi-step processes in advance.*
- 8. Provide simple checklists for any required documentation and multi-step processes in advance.*
- 9. Provide the HCO with contacts who are able to troubleshoot problems, like Health Care AOPS.*

## **ACCESS**

Access calls make up the second largest issue category of complaints that the HCO receives. Over three years, 28% of calls have been related to Access, which is just shy of the amount of Eligibility calls that the HCO gets. For the purposes of this report, Access issues take a back seat to Eligibility issues, since the Exchange will most drastically change how the eligibility system works. The most important way to alleviate Access issues for beneficiaries, once the Exchange is implemented, is to ensure that any calls about Access received by the Exchange call center are referred to the HCO as is required by Act 48.

The breakdown of Access calls by coverage type reveals that the driving force behind our Access calls comes from Medicaid beneficiaries. Figure 5 below shows this breakdown.

**Figure 5: Access Calls by Coverage**



Beneficiaries on Medicaid programs (including Dual<sup>12</sup>, FFS, Managed, and VHAP categories) take up half of the HCO’s total Access calls, with Medicaid Managed Care beneficiaries taking up the largest portion at 25%. VHAP Access calls are relatively lower at 11%, but this is likely due to the fact that there are more individuals on Medicaid (including Dr. Dynasaur) than on VHAP. In addition, many Medicaid beneficiaries tend to have higher medical needs than non-Medicaid recipients. It is notable that individuals on Catamount/Premium Assistance and other commercial plans take up a relatively smaller proportion of Access calls.

By looking at coverage types and their beneficiaries’ varying probabilities to call with an Access issue, it is clear that beneficiaries on State-administered health insurance programs are more likely to call the HCO with an Access issue than beneficiaries on commercial plans. There is a 44% chance that both Dual Eligible and Medicaid Managed Care beneficiaries will have an Access issue when they call. Medicaid FFS and VHAP beneficiaries have 28% and 27% chances, respectively, of calling with an Access issue. There is only a 23% chance that an ESI beneficiary will call with an Access issue, and for Catamount/Premium Assistance beneficiaries, the chance is only 18% (compare this to the average of 28% across all coverage types). As stated above, Access calls from the uninsured are low because the primary issue for these individuals is to obtain insurance coverage.

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<sup>12</sup> “Dual eligibles” are individuals who are on both Medicaid and Medicare.

There is a clear disparity in Access calls between State-administered health plans and commercial plans. There could be many reasons for this. It is likely that Medicaid and VHAP beneficiaries are better informed of and are more often referred to the HCO when they have Access issues. Transportation problems also drive Medicaid Access calls upward. This data could also be reflective of the general health or literacy differences between individuals on commercial plans and individuals on State plans. The rate at which the State compensates providers for services also affects Access because it limits the availability of providers. There are quite a few providers who do not feel it is worthwhile to be enrolled with Vermont Medicaid, or who limit the number of Medicaid patients they will see. In particular, Medicaid beneficiaries have a very hard time finding dentists.

### **Examples of Access Cases**

- A family of four was stuck in another state after Tropical Storm Irene because their Vermont home had become inaccessible due to road damage. The mother tried to get her medications but was told by the pharmacist that she and her family no longer had Vermont Medicaid. It was urgent that she get her medications and she could not wait up to 30 days to get a new application processed. She called Senator Bernie Sanders' office for help. His office referred her to the HCO. The HCO determined that her review paperwork had been lost as a result of the storm. By using Health Care AOPS the HCO was able to get the entire family back on Medicaid immediately. The mother was able to pick up her prescriptions within hours. This individual benefitted from the fact that the HCO has contacts within the State who can resolve issues quickly when it is appropriate.
- A Medicaid beneficiary had a Pain Contract with his provider enabling him to get narcotics to manage pain from a severe back injury. He failed a urinalysis test, which was a breach of this contract. As a result, his provider discharged him from the practice. The beneficiary was red-flagged for this breach of contract, and it was impossible for him to find a new provider in his area. He could not travel far to see a doctor because of the great pain that traveling caused him. He went a full eight months without medical care after being dropped because no doctor wanted to take on a pain management patient who had failed a urinalysis. This individual eventually called the HCO, and we were able to set him up with the Vermont Chronic Care Initiative (VCCI). The VCCI worker was able to locate a nearby doctor, and was willing to go to medical appointments to support and advocate for the beneficiary. This hands-on assistance from VCCI was exactly what this individual needed in order to get medical care again.
- A Medicaid beneficiary called the HCO because she was unable to get transportation to her medical appointments. She was going to a methadone clinic five times a week and was getting rides from an 80 year old woman from her church. This elderly friend was

eventually unable to drive her as frequently. As a result, some days, she just couldn't get to the clinic. The resulting withdrawal symptoms made her ill, which made it difficult for her to care for her young children. She had been denied Medicaid transportation by DVHA a few years earlier, but because of her disability, had been unable to gather the necessary information to get Medicaid transportation again. DVHA said that she had access to other vehicles, which was not the case. She also did not have a driver's license. With the HCO's help, she was able to get Medicaid rides again. She would have benefitted from an HCO referral when she was first denied the service.

*Recommendations:*

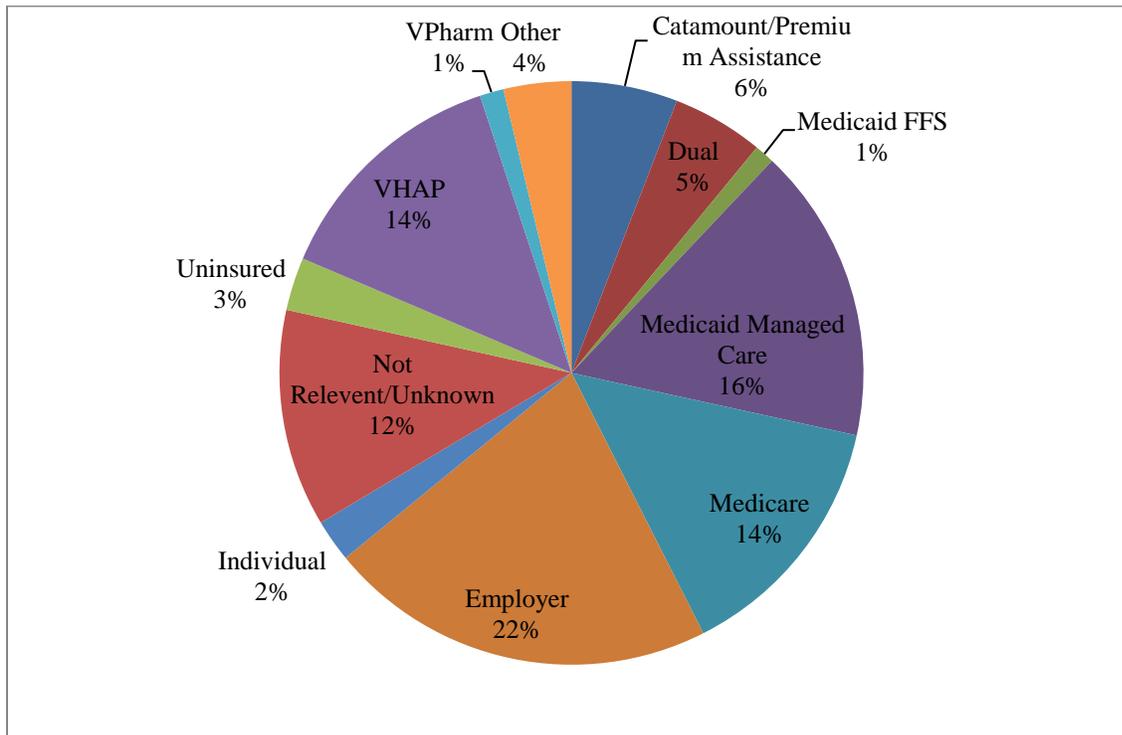
- 1. Refer any Access issues that the State call centers receive to the HCO as soon as possible.*
- 2. As much as possible align the benefit packages across all the Exchange insurance plans to reduce consumer confusion.*
- 3. Make managed care programs such as VCCI available to all beneficiaries in the Exchange, and align the services provided in these programs. In particular, beneficiaries need assistance to find providers and need other supports to get to medical appointments.*
- 4. Educate beneficiaries about utilization management practices, such as requirements to see in-network providers, seek prior authorization for particular services or undergo step therapy.*

## **BILLING/COVERAGE**

Billing/Coverage calls take up a smaller portion of the HCO's total call volume, but at 18% of calls over three years, Billing/Coverage is still a significant problem for beneficiaries. As with Access issues, the Billing/Coverage complaint analysis is secondary to the analysis of Eligibility complaints in terms of the Exchange implementation. The primary concern related to Billing/Coverage issues, for Exchange implementation purposes, would be to ensure that individuals with these types of problems be immediately referred to the HCO.

Looking at the Billing/Coverage calls across coverage types, as compared to calls about Access, reveals a reversal of call probabilities between State insurance beneficiaries and commercial insurance beneficiaries. While commercial insurance beneficiaries are less likely than State insurance beneficiaries to call with an Access issue, they are more likely to call with a Billing/Coverage issue after having received the service. This implies that as more beneficiaries are commercially insured through the Exchange, there will be more problems with Billing/Coverage. See Figure 6 below with a breakdown of Billing/Coverage calls by coverage type.

**Figure 6: Billing Calls by Coverage**



Commercial insurance beneficiary calls total to 30% of all Billing/Coverage calls. This includes ESI at 22%, Catamount/Premium Assistance at 6% and individual insurance at 2%. Medicaid Managed Care comes in at 16%, and Medicaid FFS and Dual-eligible beneficiaries are only at 1% and 5%, respectively.

When an individual on ESI calls the HCO, they most likely have a Billing/Coverage problem. ESI beneficiary calls involve a Billing/Coverage issue 29% of the time (the average across all coverage types is only 18%). Beneficiaries on VHAP have Billing/Coverage issues 18% of the time, while Medicaid (FFS or Managed) beneficiaries call about this only 15% of the time.

When the Exchange is implemented, many more Vermonters will have commercial insurance plans, and thus there are likely to be more calls regarding Billing/Coverage issues. The State and the HCO should be prepared for this. The State should ensure that beneficiaries are explicitly given their appeal rights and made aware that the HCO can potentially help with appeals. Currently, the HCO can only give advice for Billing/Coverage problems and cannot represent people in appeals due to limited resources. Sometimes the HCO can refer to Vermont Legal Aid projects or other organizations for representation.

## Examples of Billing Cases

- A VHAP beneficiary called the HCO about her hospital billing problems. She was very frustrated because she had already made many calls herself trying to resolve the problems. She called both the State and the hospital multiple times. Neither was helpful. The State repeatedly said she should call the hospital; the hospital said it did not “make phone calls,” and she should call the State. After many conversations, she was given the HCO number. The HCO was able to get DVHA to do outreach to the hospital, and the billing problem was promptly resolved. This person would have avoided a lot of frustration and worry if she had been immediately referred to the HCO.
  
- An individual with a commercial employer sponsored insurance plan (ESI) had surgery after getting a Prior Authorization (PA) from the insurance company. Despite having a PA in place, the plan ultimately denied the claims for this surgery. The beneficiary was suddenly on the hook for \$65,000, even though he thought he had done everything to ensure coverage. On his own, he appealed the denial but lost at both the first and second levels of internal appeal. He unfortunately was not made aware of the services of the HCO until he had already exhausted the internal appeals process. Because the plan was a grandfathered self-insured out-of-state ESI plan, there was no further right to appeal. This beneficiary would have benefitted from an earlier referral to the HCO.

### *Recommendations:*

- 1. Inform beneficiaries of their appeal rights as explicitly and as often as possible.*
- 2. Refer beneficiaries who call the Exchange call centers with Billing or Coverage problems to the HCO as soon as possible.*
- 3. Monitor closely the approval and denial data from all insurance carriers in the Exchange.*
- 4. Investigate any abnormally high rates of denials.*
- 5. Prepare for an increase in Billing and Coverage problems and appeals.*

## CONSUMER EDUCATION

The HCO does not have particularly good data on the frequency of Consumer Education calls because tracking of this data has only recently been emphasized. Although Consumer Education is provided to many hotline callers, it tends not to be the primary reason for the call. Only relatively recently has the HCO been able to track secondary issues in its database. Nonetheless, Consumer Education has been included in this report due to its great importance. Health insurance consumer literacy will be extremely important for successful implementation of the Exchange.

*Recommendations:*

- 1. Start the consumer education campaign about the Exchange as early as possible. The HCO recommends starting to educate the public at least six months before enrollment begins.*
- 2. Provide consumer education materials for all populations: rural communities; the elderly; illiterate, low-literate, and non-English speaking communities; young adults and students; households with disabled individuals; seasonal workers; self-employed individuals; small businesses; associations; providers; community-based organizations, etc.*
- 3. In addition to education about the Exchange, also provide basic health insurance literacy training to explain to newcomers to private insurance how it works. It will be extremely important for individuals to have at least basic knowledge of insurance principles and practices, like the requirement of timely payment of premiums, cost-sharing and utilization management practices.*

#### **IV. HISTORICAL CHANGES SIMILAR TO THE EXCHANGE**

In the past six years, Vermont has had two major changes in government health insurance programs. The first was the start of the Medicare prescription drug benefit, Part D, in January, 2006, as a result of the federal Medicare Modernization Act of 2003 (MMA). Simultaneously, the State transitioned its state pharmacy assistance programs into a new program called VPharm. The second major change was the start of the four Catamount Health programs in October 2007: VHAP ESIA, CHAP, Catamount ESIA and Catamount Health. Both of these expansions in coverage involved complex hybrid programs comprised of private health insurance companies and government subsidies. Both resulted in increased calls to the HCO, and may provide some suggestions for ways to improve the roll out of the Exchange which will also provide a hybrid benefit (commercial plans with government premium and cost-sharing subsidies).

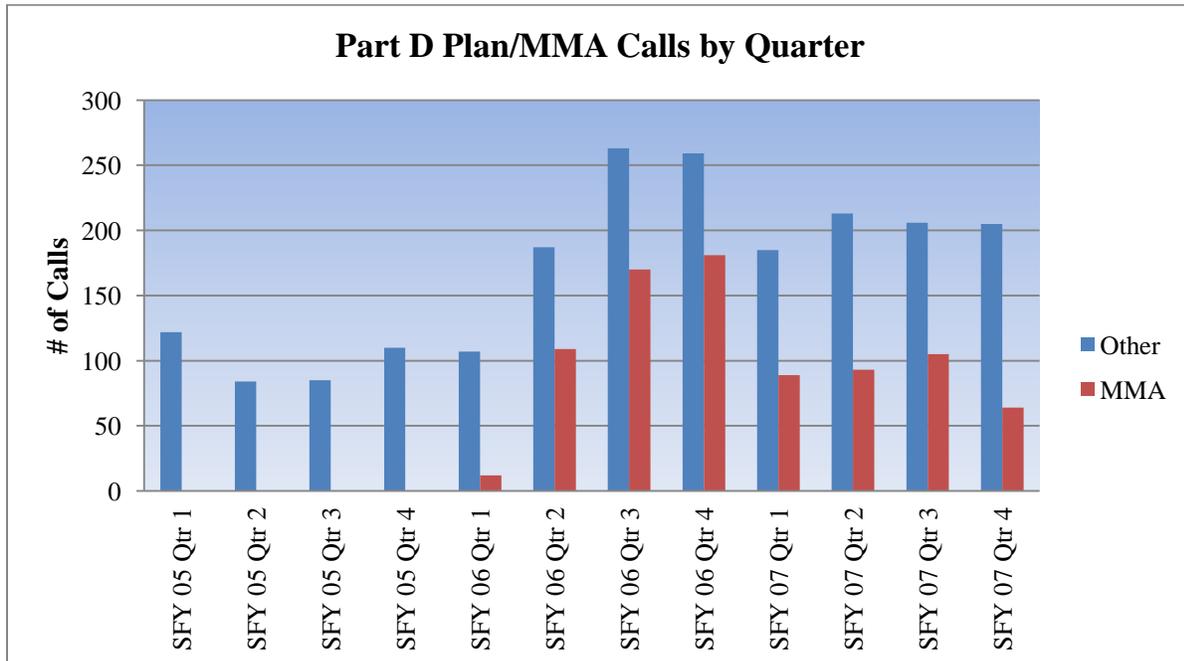
#### **IMPLEMENTATION OF MEDICARE PART D AND VPARM**

Many lessons can be learned from the start of Medicare Part D. Although there was significant lead time—almost three years—from the passage of the MMA to the implementation of the prescription drug benefit, the start was still very rocky. This was partly due to the complexity of the law and the complexity of its interface with Vermont’s prescription drug programs. This change shares quite a few similarities to the implementation of the Exchange.

Open enrollment for Medicare Part D prescription drug plans (PDPs) began in October 2005 (SFY ’06, Qtr 2). Actual coverage began in January 2006 (SFY’06, Qtr 3). As can be seen in

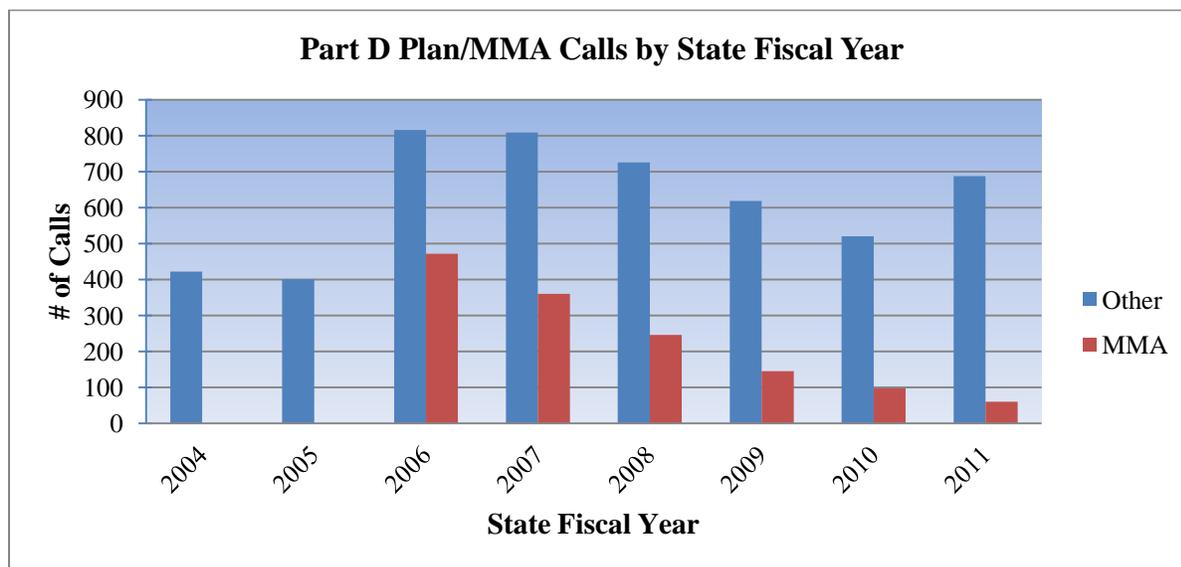
Figure 7 below, MMA related calls began dribbling into the HCO during the summer of 2005 (SFY '06, Qtr 1). They increased significantly in the fall of 2005 (SFY '06, Qtr 2) when open enrollment began, but then really jumped in SFY '06, Qtr 3 when the PDPs began their coverage. MMA calls to the HCO then steadily decreased from the peak in the first few months of coverage. This decrease gradually occurred over the next five years. See Figure 8 below.

**Figure 7: Part D Plan/MMA Calls by Quarter**



When Medicare Part D coverage began in January 2006, the HCO had a 79% increase in call volume from the previous month: 175 calls in December 2005 jumped to 313 calls in January 2006 (see Attachment A). That was back in the day when the HCO monthly call volume rarely exceeded 200 calls, so this was a huge increase. At the time, DVHA also scrambled to deal with the deluge of problems and had to establish a temporary state call center to manage all the MMA-related calls for several months.

Figure 8: Part D Plan/MMA Calls by State Fiscal Year



Some of the problems related to system glitches and everyone's unfamiliarity with the new programs. However, this was surely exacerbated by the fact that individuals could enroll in Part D plans until December 31, 2005, with the expectation of coverage as of January 1, 2006. This was an unrealistic time frame, which was eventually changed several years later. In addition, the State subsidy, VPharm, had to be paid and directed in a timely manner to the proper Part D plan prior to the start of coverage. In retrospect it is not surprising that the system did not work well at first.

The HCO prepared for the launch of Medicare Part D by coordinating with the State Health Insurance Assistance Program (SHIP) and by participating in a statewide workgroup. HCO advocates were trained along with SHIP counselors on how Part D was supposed to work. SHIP counselors did a tremendous amount of training and individual counseling for Medicare beneficiaries prior to the implementation of Part D. SHIP and the HCO backed each other up but also carved out areas of specialty: SHIP counselors helped individuals with enrollment, HCO advocates helped solve problems. SHIP counselors are analogous to Navigators in the Exchange world. It will be extremely important for HCO advocates to receive much of the same training that Navigators receive and to be able to coordinate with the various groups who will be Navigators.

The group education and one-on-one counseling that SHIP provided Medicare beneficiaries was critical. Medicare beneficiaries are a vulnerable population as they are all either elderly, disabled, or both, and needed a tremendous amount of assistance. Similar assistance should be provided to vulnerable populations who use the Exchange.

The start of the Exchange has the capacity for generating a similar spike in need for consumer assistance because it will involve many individuals moving to commercial plans for the first time, as well as government subsidies for those plans. Moreover, the subsidies for Part D were through the State's VPharm program, so it was relatively easy for the HCO to get enrollment problems resolved. With the Exchange, problems with the premium subsidies will not be so easy to fix. The premium tax credits, which will be through the federal Internal Revenue Service, could present difficulties if the HCO has no contacts there. In addition, it would seem that it would be better if the State developed the IRS contacts. Our experience is that federal bureaucracies listen to the State more than a Vermont entity they have never heard of.

*Recommendations:*

- 1. Prepare in advance for significant confusion and difficulties at the start of enrollment and the start of coverage. Be prepared to provide a high level of consumer assistance during this initial period.*
- 2. Anticipate that demand for consumer assistance will gradually decrease over the following years.*
- 3. Whenever possible, provide vulnerable populations with special assistance, designated workers, or assigned Navigators.*
- 4. Allow for a processing period between the date of application for enrollment and the onset of actual enrollment or coverage, i.e. do not promise that individuals who enroll on December 31<sup>st</sup> will have coverage on January 1<sup>st</sup>.*
- 5. Develop contacts at the IRS to troubleshoot problems and enable faster resolution of federal premium tax credit and cost-sharing subsidy problems. This would be best as a state function.*
- 6. Give the HCO contacts within the Exchange who can resolve problems quickly, similar to the way the HCO uses Health Care AOPS now.*
- 7. Help arrange contacts for the HCO within the individual insurance plans sold in the Exchange to facilitate prompt resolution of consumer problems.*
- 8. Include HCO advocates in trainings for Navigators and any other applicable trainings or workgroups.*
- 9. Support collaboration and coordination between the Navigators, the Exchange, and the HCO.*

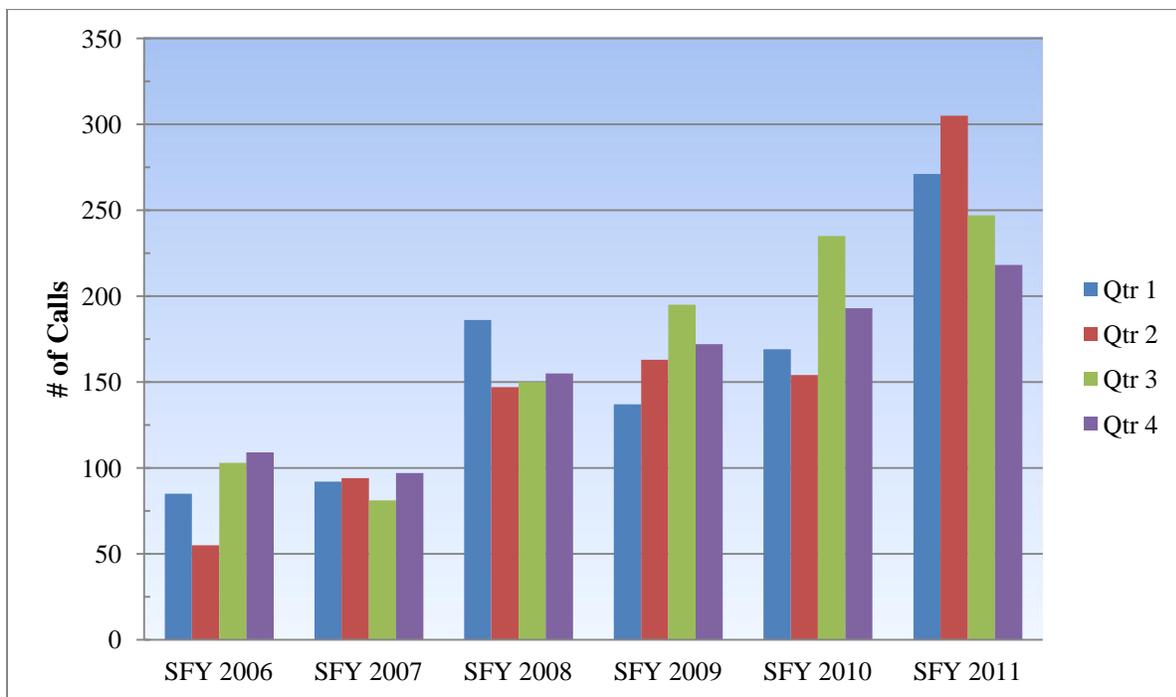
## **IMPLEMENTATION OF CATAMOUNT HEALTH**

In October 2007, Vermont began enrolling uninsured individuals into its new Catamount Health insurance program. This program consists of four different insurances which are based on an individual's income level and the availability of approved employer sponsored insurance: VHAP ESIA (premium assistance for employer sponsored insurance), CHAP (premium

assistance to purchase Catamount Health plans), Catamount ESIA (premium assistance for employer sponsored insurance) and Catamount Health (available for individual purchase at full price). Catamount Health plans are offered by two commercial carriers, BlueCross BlueShield of Vermont and MVP. As a result of this influx of uninsured individuals into the State insurance system, HCO Eligibility calls significantly increased. However, unlike the increase from the start of Medicare Part D, the call volume has never decreased. In fact, Eligibility calls have never even come close to their previous levels.

Notably, however, HCO calls regarding Eligibility spiked in the quarter before Catamount began (SFY '08, Qtr 1). See Figure 9 below. This is most likely attributable to the intense news coverage prior to the start of Catamount, as well as the multi-pronged outreach and media campaign the State launched to educate Vermonters about these new insurance products. This is probably also due to the start of the Great Recession and the increasingly high costs of other commercial products. It is hard to attribute the sustained high level of Eligibility calls to Catamount alone.

**Figure 9: Eligibility Calls by State Fiscal Year Quarter**



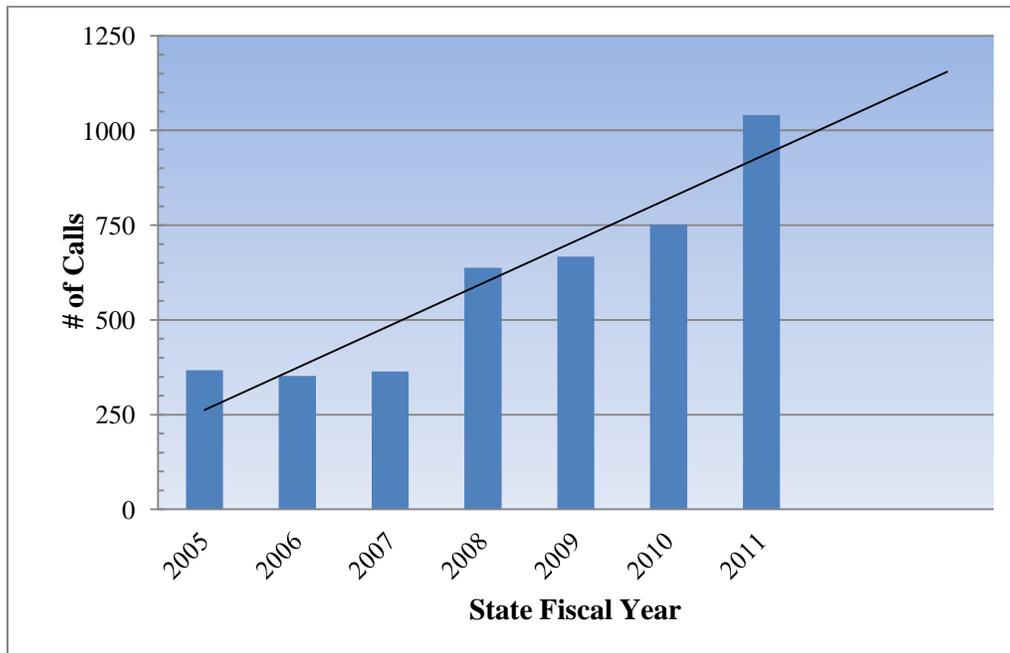
The lessons from Catamount include a very real need for better education of consumers about how a subsidy program works. Many callers to the HCO hotline told the HCO advocates that they did not understand that paying their premium a few days late had consequences. Some assumed that there would be a grace period for payment. Some assumed they could pay their

premium to the State online at the last minute.<sup>13</sup> Many did not realize they were going to have such significant cost-sharing on a Catamount Health plan. Other problems included the multi-step enrollment process and difficult-to-decipher State notices. This confusion over the basics of the program has led to a steady HCO call volume from individuals seeking help to get, maintain or use their Catamount coverage.

The general trend from SFY '05 to '11 has been an increase in HCO Eligibility calls (see Figure 10 below). As mentioned, the increase in 2008 is likely related to the start of Catamount and the onset of the Great Recession. Notably the biggest increase in overall calls, however, did not occur until 2010 (see Attachment A). This was when DCF was having difficulties implementing its new eligibility Modernization system, which was a definite driver of increased calls.

The trend line in Figure 10 below shows the forecasted increase in Eligibility calls in the coming years. This trend will certainly be affected by the implementation of the Exchange, but based on the HCO's experience with the Catamount expansion and the continued lack of affordable health care, this line is expected to continue upward.

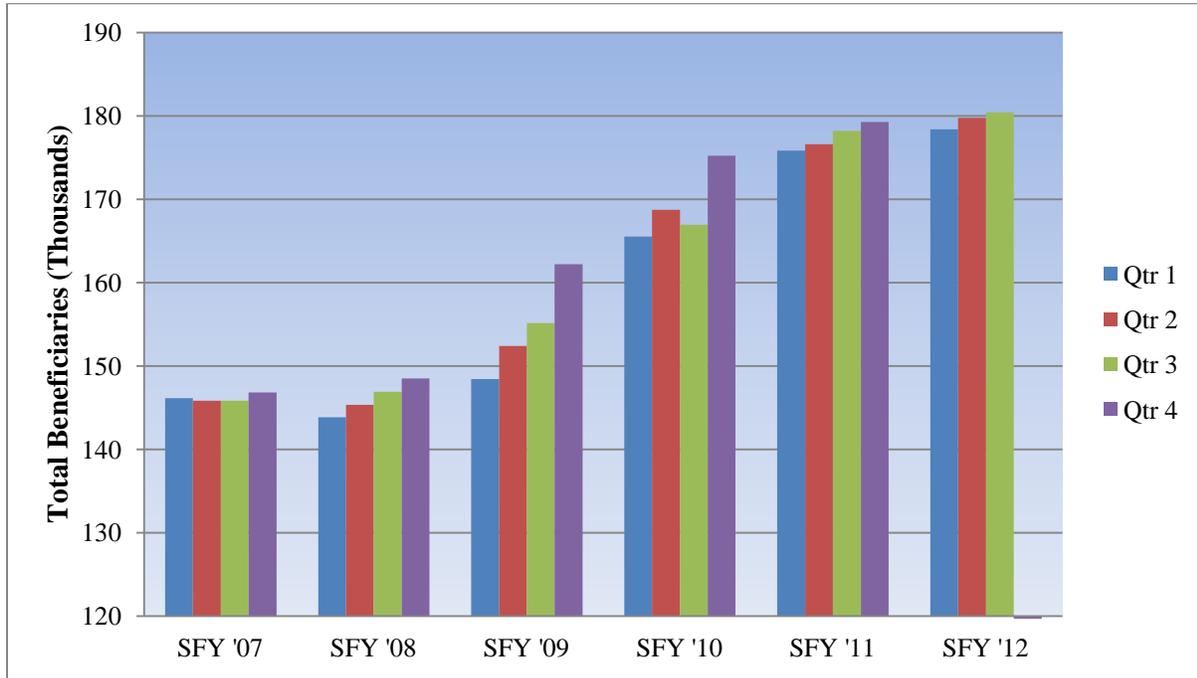
**Figure 10: HCO Eligibility Calls by State Fiscal Year**



<sup>13</sup> The State does not currently have the technical capacity to do this.

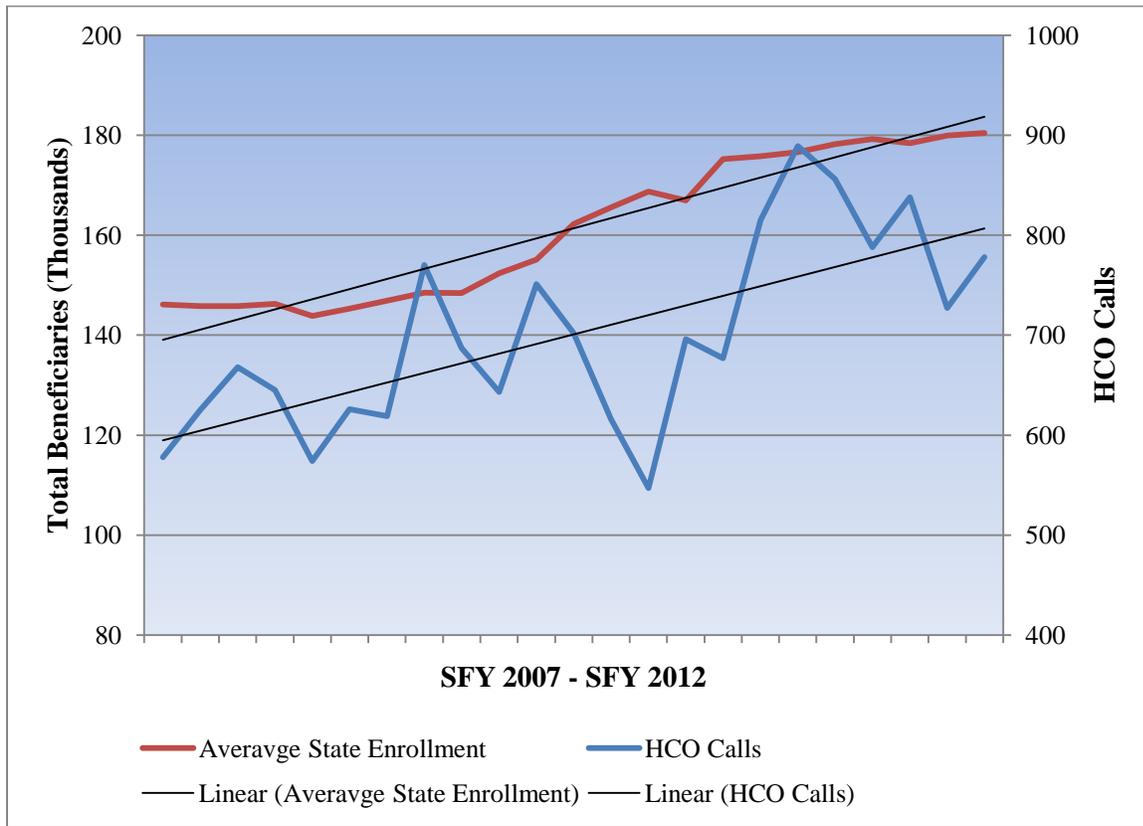
Figures 11, 12, and 13 below illustrate that the increase in total State enrollment directly correlates to the number of calls the HCO receives.

**Figure 11: Average Enrollment in State Programs SFY 2007 – SFY 2012**



As an overall trend, as State enrollment has gone up over the past five years, so has the total number of HCO calls. The expectation, then, is that as more Vermonters use the Exchange and take advantage of the federal subsidies, the HCO will continue to see increases in its call volume.

**Figure 12: State Enrollment vs. HCO Calls SFY 2007 – SFY 2012**



**Figure 13: HCO Calls as a Percentage of Enrollment SFY 2007 – SFY 2012**



Here are our recommendations stemming from our experience with the implementation of other major health care programs.

*Recommendations:*

- 1. The State and the HCO must be prepared for increased inquiries about the Exchange prior to the start of enrollment. Media coverage, public education, and outreach will increase awareness of the Exchange so there must be resources already in place to handle individual inquiries prior to the 2014 implementation date.*
- 2. Provide a significant amount of public and individual education about how the Exchange works, including a step-by-step guide to using the Exchange.*
- 3. Educate consumers about how the federal subsidies work at the start of coverage.*
- 4. Provide counseling and educational materials on how commercial insurance works, especially the importance of timely payment of premiums.*
- 5. Provide this basic health insurance literacy information online, in-person and at all outreach presentations.*
- 6. Provide beneficiaries the opportunity to pay premiums by mail, online, or over the phone with a credit or debit card.*

## V. CONCLUSION

Vermonters will begin enrolling through the Exchange in the months leading up to 2014. This gives the State just over a year to complete designing and implementing a health benefit system that will serve about 227,000<sup>14</sup> consumers. The implementation of the Exchange will be a lot of work and will require a good deal of foresight in order to predict and plan for the potential issues consumers will face. Inevitably, there will be glitches in the system that no amount of planning can prevent, but the State will need to be able to identify these issues and adapt quickly as they crop up. The State will need to work closely with the HCO, Navigators, and other partner agencies to identify problems and attempt to fix them quickly and systematically. It is important that the Exchange work smoothly right from the beginning so that Vermonters do not lose confidence in the State's ability to implement its plan for universal health care in the future.

Fortunately, the State has some experience to draw on. Looking back at changes in Vermont's health care programs historically, we can identify what has worked and what has not worked. The HCO has had a distinct vantage point on how Vermonters have been affected by changes in the way they pay for health care. The HCO's unique knowledge of what consumers need and want from a health benefit system puts our office in a good position to provide the State with recommendations for implementation of the Exchange.

This report includes a list of recommendations at the end of each main section, and a compilation of all those recommendations follows this conclusion.

The HCO urges the State to carefully consider each of the recommendations. Like the State, we want the Exchange to function smoothly from day one to give Vermonters improved access to quality health care.

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<sup>14</sup> This is a combination of the number of individuals currently on State programs and the estimated number of currently uninsured Vermonters.

## **VI. RECOMMENDATIONS**

1. *Prepare in advance for significant confusion and difficulties at the start of enrollment AND the start of coverage. Be prepared to provide a high level of consumer assistance during this initial period. Media coverage, public education, and outreach will increase awareness of the Exchange, so there must be resources already in place to handle individual inquiries prior to the expected enrollment start date of October 2013.*
2. *After the start date, anticipate that the attendant increased demand for consumer assistance will decrease over a lengthy period of time, perhaps years, not months.*
3. *Start the consumer education campaign about the Exchange as early as possible. The Office of Health Care Ombudsman (HCO) recommends starting to educate the public at least six months before enrollment begins. It will not be easy to explain how to choose a plan on the Exchange, or the mechanics of the premium tax credits, the end-of-year premium tax reconciliation, and the cost-sharing subsidies.*
4. *Provide extensive, more general consumer education well before implementation of the Exchange. Many consumers, especially newcomers to private health insurance, will need basic health insurance literacy training to understand how it works. Consumer education should include at least the following:*
  - *important considerations in choosing a plan, e.g. premiums, deductibles, co-pays, coinsurance, out-of-pocket maximums, drug formularies, and provider networks;*
  - *the importance of paying premiums in a timely manner;*
  - *all aspects of cost sharing; and*
  - *utilization management practices, such as requirements to see in-network providers, seek prior authorization for particular services, or undergo step therapy.*
5. *Basic health insurance literacy information, materials, and tutorials should be provided online, in-person, and at outreach presentations.*
6. *Provide, in advance, step-by-step written and oral explanations for any multi-step processes, and provide checklists for beneficiaries to keep track of what they need to do next. Step-by-step guides should be made for how to use the Exchange and for what to consider in choosing a plan.*
7. *Provide consumer outreach and education, including written materials for a variety of special populations:*
  - *rural communities;*
  - *the elderly;*
  - *illiterate, low-literate, and non-English speaking communities;*
  - *young adults and students;*
  - *households with disabled individuals;*
  - *seasonal workers;*

- *self-employed individuals;*
  - *small businesses;*
  - *trade associations;*
  - *providers; and*
  - *community-based organizations, etc.*
8. *Provide additional assistance to special populations who are more vulnerable to churn, including special assistance, designated workers, or assigned Navigators. These vulnerable groups include:*
    - *the elderly;*
    - *illiterate, low-literate, and non-English speaking communities;*
    - *young adults and students;*
    - *households with disabled individuals;*
    - *seasonal workers; and*
    - *self-employed individuals.*
  9. *Allow for a processing period between the date of application for enrollment and the onset of actual enrollment or coverage, i.e. do not promise that individuals who enroll on December 31<sup>st</sup> will have coverage on January 1<sup>st</sup>. Provide the HCO with contacts who are able to troubleshoot problems:*
    - *at the Internal Revenue Service to enable faster resolution of federal premium tax credit and cost-sharing subsidy problems;*
    - *within the Exchange, similar to the way the HCO uses Health Care AOPS now; and*
    - *within the individual insurance plans sold in the Exchange.*
  10. *As much as possible align the benefit packages across all the Exchange insurance plans to reduce confusion.*
  11. *Encourage chronic care management programs and Blueprint Community Health Teams in all plans in the Exchange, and align the services provided in these programs. In particular, beneficiaries need assistance finding providers and other supports such as transportation.*
  12. *Monitor closely the approval and denial data from all insurance carriers in the Exchange.*
  13. *Investigate any abnormally high rates of coverage denials by plans in the Exchange.*
  14. *Inform beneficiaries of their appeal rights as explicitly and as often as possible.*
  15. *Refer beneficiaries who contact the Exchange with problems to the HCO as early as possible.*
  16. *Create a workgroup and other ways to support collaboration and coordination among the Navigators, the Exchange, and the HCO.*
  17. *Include HCO advocates in trainings for Navigators and other applicable trainings.*

18. *Provide beneficiaries the opportunity to pay premiums by mail, online, and over the phone with a credit or debit card.*
19. *Provide a grace period for beneficiaries who do not submit their premium payment on time.*
20. *Provide advance, written notice of termination of health benefits purchased through the Exchange.*
21. *Telephone beneficiaries before terminating benefits, especially if the reason for termination is whereabouts unknown or failure to respond to requested information.*
22. *Increase Medicaid Spend Down periods from six months to twelve months, or institute some other change to reduce the frequency of Spend Down redeterminations.*
23. *Prepare for an increase in Billing and Coverage problems and appeals.*

## VII. ATTACHMENTS

### ATTACHMENT A

#### HCO CALL TOTALS BY MONTH AND YEAR (CHART)

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
<b>January</b>	241	252	178	313	280	309	240	218	329	282
<b>February</b>	187	188	160	209	172	232	255	228	246	233
<b>March</b>	177	257	188	192	219	229	256	250	281	262
<b>April</b>	161	203	173	192	190	235	213	222	249	252
<b>May</b>	234	210	200	235	195	207	213	205	253	
<b>June</b>	252	176	191	236	254	245	276	250	286	
<b>July</b>	221	208	190	183	211	205	225	271	239	
<b>August</b>	189	236	214	216	250	152	173	234	276	
<b>September</b>	222	191	172	181	167	147	218	310	323	
<b>October</b>	241	172	191	225	229	237	216	300	254	
<b>November</b>	227	146	168	216	195	192	170	300	251	
<b>December</b>	226	170	175	185	198	214	161	289	222	
<b>Total</b>	2578	2409	2200	2583	2560	2604	2616	3077	3209	1249

## ATTACHMENT B

### HCO CALL TOTALS BY MONTH AND YEAR (RADAR GRAPH)

