Conferees Share Strategies for Meeting Current and Future Challenges

Major discussions at this year’s National Training Conference focused on the biggest challenges facing crime victim compensation programs today, including the effect of impending changes to national health insurance, the realities of human trafficking, and the constant threat of mass violence. Sponsored by the Office for Victims of Crime, U.S. Department of Justice, the conference drew more than 150 participants from compensation programs across the country for three days of important workshops and professional networking.

A wide variety of operational concerns were addressed during the conference, including managing mental health claims, finding a role for advocacy within a compensation program, creating easily readable application forms and materials, improving claims management software, addressing quality assurance in claims processing, and increasing restitution recovery. Several guest speakers provided foundational presentations on cross-cultural communication, intimate partner violence, self-care for people in stressful occupations, and victims rights in law and in the courts. Making decisions on claims; analyzing workflow; and managing a diverse workforce also were covered. As always, many from our own membership played crucial roles in facilitating sessions.

OVC Director Joye Frost announced three special grants to compensation programs for demonstration projects intended to improve operations and increase access to services. California’s project focuses on outreach to underserved populations; Iowa is studying ways to improve restitution recovery; and Vermont will address the needs of the disabled population.

Director Frost also noted that her office is developing a working protocol to assist states in planning for mass violence crimes. And with new VOCA assistance regulations beginning their public comment period prior to finalization, compensation grant rules are expected to be move forward in the near future as well.

The Oregon Department of Justice Crime Victims’ Services Division hosted the conference and provided crucial support in developing our agenda.

Next year’s national conference is in the planning stages. We’ll be meeting with our colleagues in VOCA assistance at the 2014 event, and we are awaiting approval from OVC for grant funds to hold the conference in Boston from August 18-21. More details will be provided to all programs as soon as it is available.

We’re grateful for the active participation of our membership, from which we draw the expertise to find new solutions to challenges shared by all compensation programs.
Many thanks to our hosts in Oregon for a very successful conference. The opportunities to explore common issues and, in particular, to discuss the Affordable Care Act, human trafficking, and mass casualty victim assistance gave us all the chance to receive updated information and consider new ideas. Helping states to prepare strategically for potential events and changes is a hallmark of our conference.

We welcome new Board members Jeff Wagaman of Kansas, Nicole Jenkins of Georgia, Ann Thomas of Iowa, and Michelle Crum of Florida, who were elected by the membership at the Business Meeting in Portland. In addition, the Executive Committee also named Larry Grubbs of Arizona and Ann Meola of Massachusetts to replace two Board members who resigned before the end of their terms.

Efforts have begun on planning the next conference with location discussions and times as well as the regional conferences next spring. You can contribute to the continued success by providing your input to desired workshops and discussions, plus we are always looking for member participation in presenting information you have experience with.

I want to congratulate the three programs that recently received special grants from OVC to improve their work. California’s Victim Compensation and Government Claims Board was awarded funding to enhance access and delivery of needed services to underserved communities and populations. Vermont’s Office of Crime Victim Services will focus on outreach to disability communities, and on some technological adaptations that will allow for online applications. And Iowa will use its grant to improve restitution-recovery throughout the state. The work done by these states will be shared with all compensation programs so that everyone can benefit. We wish them well with their work.

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Continuing Resolution Holds 
VOCA Cap Level . . . for now

Congressional Committees 
Raise Cap, but CR Controls

While ongoing budget maneuvers in Congress are not likely to affect VOCA compensation grants — they’ll remain at the 60%-of-state-payout level, barring some unprecedented and unexpected change — the overall cap on VOCA spending remains up in the air for this fiscal year. Congressional Appropriations Committees acted to raise the cap from its current $730 million, but a Continuing Resolution (CR) that would maintain most federal programs at current levels controls where the VOCA cap ends up...at least for now.

It’s possible that either the House Committee proposal of $745 million, or the Senate Committee’s $765 million — or some number in between — could end up being the VOCA cap. Last year, it took Congress until March, when a CR expired, to raise the cap from $705 million to the current $730 million.

And that creates a problem in terms of when this year’s grants will become available. Until OVC knows what the cap is, it can’t calculate either compensation grants or assistance grants, since it doesn’t know how much to allocate for each grant program. A CR doesn’t provide the certainty necessary to set these figures, since it could be changed prior to the end of the fiscal year.

The VOCA statute sets a specific formula for distributing the funds among different grant categories, and the overall cap is key to the calculation. Since a Continuing Resolution usually covers only a portion of the federal fiscal year, and then expires (usually to be renewed again), it creates uncertainty about what the final number will be. Even when the final figure for the cap is established, opening up the grant-application process can still be delayed, as it was this past fiscal year, since Congress has to approve the OJP “spend plan” for allocating grant management and administrative costs among OVC and other bureaus. This past fiscal year, grants finally weren’t available until late in the summer.

Most compensation programs have adjusted to grant funds coming late in the federal fiscal year, by which time they’re into a new state fiscal year. But there are some compensation programs whose state funds are depleted well before June 30, and that depend on getting an in fusion of federal funds in the spring to pay pending applications. Delays for these programs can create hardships for victims.

Managers Meet to Discuss 
Mass-Violence Response

A number of compensation and assistance managers whose states have experienced major mass-casualty crimes met OVC Director Joye Frost in Denver on November 14 to discuss lessons learned and to make recommendations for future action. Colorado’s Nancy Feldman, Tony Tilger, Rob Gallup, Amy Greer, and Wendy Buter were joined by compensation managers Ann Meola of Massachusetts, Linda Cimino of Connecticut, Mary Vail Ware of Virginia, and Suzanne Breedlove of Oklahoma; and VOCA assistance managers Kate Henderson of Arizona and Daniel Cooper of Massachusetts during the day-long meeting. NACVCB Executive Director Dan Eddy and NAVAA Executive Director Steve Derene also attended.

Welcome . . .

Elizabeth Cronin is now the director of the New York Office of Victim Services. She served most recently as director of Office of Legal Affairs in the U.S. Court of Appeals for the 2nd Circuit in New York City; she previously was a prosecutor in the Westchester County District Attorney’s Office.
Will the Affordable Care Act Change Victim Compensation?

A lively discussion about the potential affects of the Affordable Care Act took place at our recent National Conference in Portland, Oregon. Below are some of the issues discussed, and some thoughts on how the ACA may change the way compensation programs operate.

Will the ACA reduce the number of claims a compensation program receives?

It’s hard to imagine that there won’t be some reduction in caseloads as a result of the ACA. Its goal is to provide health-care coverage to a substantial number of the 48 million Americans currently lacking it. And compensation programs pay a majority of their benefits for medical care provided to uninsured or under-insured victims. If the ACA results in more people covered by Medicaid or insurance policies, it should lead to fewer victims with out-of-pocket bills. The unknown is how many.

A Gallup poll reported on December 3, 2013, says that 63% of those who are currently uninsured plan to obtain coverage; 28% say they will pay the tax penalty instead of getting coverage. This would mean the percentage of uninsured Americans could drop from about 16% to as low as 5%, the study says. While this only indicates an intention, is it possible that such a substantial reduction in the uninsured could be reflected in a significant drop in claims?

But aren’t young people more likely to become victims, and to lack insurance, and aren’t they resisting getting coverage?

Yes, young people are disproportionately victims of crime; and with 27% uninsured between the ages of 19 and 34, they are less likely to have insurance than older Americans. But it’s unclear whether they won’t try to get health-care coverage. The Gallup poll noted above says 68% of uninsured people under age 30 plan to get coverage, compared to 60% aged 30 and older. A recent Harvard Institute of Politics study indicates only 3 in 10 uninsured young Americans likely would seek to obtain coverage, with another 41% being “50-50” on the decision.

When could programs begin seeing a drop in claims?

In fact, compensation programs already may be feeling the effect of one of the ACA’s initial changes going back to 2010, which was to mandate that young people aged 25 and under be allowed to remain on their parents’ insurance plans. It’s estimated that at least 3 million young people already have taken advantage of this provision of the ACA. And since young people are more likely to become victims, it’s likely that at least some significant number of these newly covered people now have less need to seek compensation for out-of-pocket medical bills.

Initially, the ACA was to be implemented fully by January 1st of the coming year, which is the deadline for individuals to meet the law’s mandate to be insured, and also was the target date for employers with 50 or more employees to provide insurance. However, the employer mandate was delayed a year, and operational difficulties on the Healthcare.gov Website have limited individual enrollment. But the individual mandate remains in effect, and those individuals not covered by their employers are supposed to gain health-care coverage on their own.

Recent reports indicate that more people are successfully gaining coverage through the federal Website, and that enrollment has been even more substantial in those states that created their own enrollment Websites. And Medicaid expansion is well underway in those states that have chosen this option. In October, Medicaid applications were up 15% from normal, and more than 1.4 million people became newly enrolled. This is of importance mainly for those states choosing to expand Medicaid (see below).

Will any impact from the ACA be felt uniformly, in all states?

The major difference among states has to do with whether a state has chosen to expand Medicaid, as called for in the ACA. The Supreme Court ruled that this choice could be made by each individual state, and so far, 25 states and D.C. have chosen to expand
The impact of the ACA is likely to differ among states, depending primarily on Medicaid expansion

their Medicaid programs. For those states that do expand Medicaid, eligibility will be widened considerably, to all adults with incomes below 138% of the federal poverty level, including single adults. (Medicaid historically has been available only to children, their parents, the disabled, and the aged, and the income threshold has been significantly lower).

In addition, regardless of where they live, all Americans with incomes beginning above that 138%-of-poverty level, up to 400% of the poverty level, are eligible for federal tax credits to help pay for insurance premiums. These subsidies will be available through the insurance marketplaces, either run by states or the federal government. So, in states expanding Medicaid, the ACA is structured to offer all lower-income people either coverage through Medicaid or help in purchasing insurance.

In states not expanding Medicaid, a substantial number of people will fall into a “coverage gap,” since their incomes are not low enough for them to qualify for Medicaid eligibility as currently defined by those states, nor high enough to be eligible for the tax credits. In these states, people whose income is between 100% to 138% of the federal poverty level may be eligible for insurance-premium subsidies. But Medicaid eligibility generally starts well below the federal poverty level, so an estimated 5 million people in states not expanding Medicaid will be neither poor enough to qualify for Medicaid, nor have incomes high enough to qualify for insurance subsidies.

There also appears to be a difference among states with regard to individuals purchasing policies through state-run as opposed to federally operated marketplaces; with more policies being purchased in those states that set up their own marketplaces and actively encouraged individuals to become insured.

Which states are expanding Medicaid and are more likely to see some drop in claims?

Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Hawaii, Illinois, Iowa, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Rhode Island, Vermont, Washington, and West Virginia are moving forward with Medicaid expansion, and the debate is ongoing in several others (Florida, Indiana, and Tennessee).

Won’t some people, particularly if they’re young and healthy, purchase high-deductible plans that will still leave large out-of-pocket costs?

Yes, high-deductible plans are being offered through the insurance marketplaces. Policies are categorized as bronze, with a 60% cost-coverage level; silver, at 70%; gold, at 80%, and platinum, at 90%. In addition, people under age 30 can purchase “bare-bones” catastrophic coverage.

High-deductible and catastrophic-coverage policies will be particularly attractive to young and low-income people. We know that most compensation claims are paid at relatively low levels, since most victims do not suffer catastrophic injuries. The average nationwide is around $3,000, and while this covers a wide range of expenses, and every claim is different, it certainly is possible that even with insurance coverage, many crime victims will have significant deductibles and co-pays that will remain an out-of-pocket cost for them.

The ACA says there can’t be lifetime limits on insurance, and there are certain out-of-pocket cost limits. But the bottom line is that even if many more people get insurance coverage, out-of-pocket costs are not going to disappear.

Can someone simply wait until they get injured (or sick), and then get insurance to cover their bills?

No. Individuals can only get insurance during open enrollment periods. The current one began October 1 and will end March 31. While some hardship exceptions exist, insurance generally won’t be available through the ACA outside the enrollment periods.

In addition, just as now, insurance policies newly purchased are not required to cover expenses incurred before the policy went into effect. While no one can be denied for pre-existing conditions, and this might come into play for long-term or ongoing medical care relating to injuries, it would be wrong to think that a victim who quickly signs up for insurance will not have to pay for the costs of their injuries.

Is there a federal prohibition on paying victim compensation to someone who fails to get coverage?

No. Victim compensation programs can continue to pay benefits to people who do not meet the ACA’s mandate. OVC has said it is looking at this issue, but there is nothing currently in the ACA, or in any other federal rule, that tells programs to stop paying.
**Out-of-pocket costs aren’t going to disappear, if people choose to purchase high-deductible policies**

**Do states retain last-payer status under the ACA?**

Yes. Nothing in the ACA changes this; essentially the ACA simply increases the number of people with private insurance plans similar to those available today. Federal law continues to state clearly that Medicaid and other federal benefit programs shall pay first. State law controls relationships with insurance.

**Can someone simply refuse to meet the ACA mandate to be insured?**

Yes. This isn’t a crime, resulting in a fine or jail time. Instead, it’s a violation that only results in a tax penalty. Starting in 2014, Americans will complete a form telling the IRS how they’re covered, and if they’re not, a tax penalty will be assessed, to be taken out of income earned in 2014. The penalty is quite low for the current year, and goes up incrementally, based on income, in future years. The penalty is intended to encourage people to spend the money on insurance rather than sending it to the IRS.

**Are any compensation programs planning to deny benefits to victims not in compliance with the ACA?**

This was discussed at our National Conference. No programs have moved in that direction yet; no state laws or rules have been adopted to enforce such an eligibility restriction. During the discussion, it was pointed out that Americans have a choice either to be insured or to pay a tax penalty under the ACA. In addition, there are many gaps and exceptions to the insurance mandate. For example, if someone can’t find a policy that costs less than 8% of her income, there is no tax penalty. So it could be difficult administratively to determine whether a victim was out of compliance, and an inquiry into the financial means of the victim might be required, adding to the paperwork and processing burden, and raising questions about the validity of claimant responses.

But shouldn’t all the new coverage options be considered collateral resources available to the victim, and thus result in a reduction of benefits based on what could have been paid by insurance or Medicaid? In discussing this at our conference, it was noted that some individuals currently do not choose to pay for insurance available through their employers, or to sign up for Medicaid, and no one penalizes them for this now. The ACA does mandate coverage, but it also allows for the choice to pay the tax penalty rather than buy insurance. More practically, with the wide range of policies available, and different co-pays and deductibles, it could be difficult to determine just how much of a bill the victim could have had paid from an insurance policy.

Would declining eligibility to individuals not gaining health-care coverage provide an incentive for people to enroll? Individuals do not anticipate becoming crime victims, and statistically speaking, it is extremely rare for someone to suffer a violent victimization resulting in injury requiring medical attention. So it’s difficult to imagine a compensation program’s policy in this regard affecting any decisions to enroll or gain coverage. Instead, a policy denying those who ignore the mandate would be more of a penalty or punishment for those failing to make one of the two choices available under the ACA; or, conversely a reward for those who did meet the ACA mandate. But it likely would not drive people to gain coverage.

Still, it’s undeniable that such an approach would save on medical benefits paid by a program, costs that would be borne either by victims, or the service providers.

**Can we predict the future based on the experience in Massachusetts, which implemented an insurance mandate several years ago?**

The short answer is, not really. For whatever reason (likely because it already had a high percentage of people covered by insurance), the Massachusetts program historically has paid a lower proportion of its total outlay toward medical expenses. This percentage, well below 50% (in comparison to most states, which pay well above 50% of their benefits toward medical bills), has not altered appreciably since implementation of the Massachusetts mandate in 2006. Back in 2001, the program paid out a total of $3.1 million, of which $717,000, or about 23%, was in medical bills; in 2012, the payout was $3.3 million, of which $1.1 million, or 33%, was for medical care. Claims have remained relatively stable over the past decade. In other words, there has been no huge drop in medical bills or claims as a result of the Massachusetts insurance mandate.

Massachusetts does have the lowest percentage of its population uninsured, at 4.9%, probably because of the mandate. The national median is 16%. Vermont, Hawaii, Connecticut, Minnesota, and Wisconsin have rates under 10%; 12 states have uninsured rates higher than 20%, topping out at 27% in Texas.

**Bottom line?**

Lots of questions . . . Few definitive answers! We’ll be following developments closely, particularly in states expanding Medicaid. Stay tuned —
National Association of Crime Victim Compensation Boards

Training Calendar 2014

National Training Conference
August 18-21, 2014*
Boston*

*This is the tentative date and city for our 2014 National Training Conference. More information will be provided when details are finalized. The conference is open to all victim compensation program managers, staff and board members.

NACV CB Regional Conferences
We’ll be developing our Spring 2014 Regional Conferences soon. Information will be sent to all member programs.