

STATE OF VERMONT  
AGENCY OF HUMAN SERVICES

DCF

Department for Children and Families

BULLETIN NO.: 07-24F

FROM: Joseph Patrissi, Deputy Commissioner  
Economic Services Division

DATE: September 10, 2007

SUBJECT: Implementation of the Act 191 Employer-Sponsored-Insurance  
and Catamount-Health Premium-Assistance Programs

CHANGES ADOPTED EFFECTIVE 10/1/07

INSTRUCTIONS

- Maintain Manual - See instructions below.
- Proposed Regulation - Retain bulletin and attachments until you receive Manual Maintenance \_\_\_\_\_
- Information or Instructions - Retain until \_\_\_\_\_

MANUAL REFERENCE(S):

4100-4110	M302.26	4000	4001.91
M150.1	M302.27	4001.2	4002.31

In its 2005-2006 session, the Vermont Legislature enacted Act 191, "An Act Relating to Health Care Affordability for Vermonters." Among other things, the new law created three new premium-assistance programs, designed to expand Vermonters' access to quality, affordable health care. This bulletin proposes rules establishing the eligibility and program criteria for these new benefits.

I.

Health Insurance Premium-Assistance Programs

A. *Background*

The new health-care programs are targeted at those with incomes that exceed the traditional Medicaid limits. Eligibility is based upon a variety of factors, including income, insurance status, the availability of an approved employer-sponsored insurance (ESI) plan, and the relative cost to the state of the individual's enrollment in the various programs. The initiatives include:

*Employer-Sponsored Insurance Premium-Assistance Program for VHAP-Eligible Individuals (VHAP-ESIA).* This is a premium-assistance program for adults who are eligible for the Vermont Health Access Plan (VHAP) and who have access to an approved ESI plan. VHAP-eligible individuals will

be required to participate in this program when the department determines that enrollment is cost-effective to the state. VHAP-ESIA subsidizes the employee's premium through a monthly payment. VHAP-ESIA also covers any required wraparound services, and certain cost-sharing obligations. It provides the same coverage that is available through VHAP, at the same cost to the beneficiary.

*Employer-Sponsored Insurance Premium-Assistance Program for Uninsured Individuals (Catamount-ESIA).* This is a premium-assistance program for adults who are uninsured and not eligible for VHAP and who have access to an approved ESI plan. This program offers financial assistance through a monthly payment for the purchase of ESI plans. It is available to uninsured Vermont residents with incomes at or below 300 percent of the federal poverty level (FPL) who are not eligible for VHAP-ESIA. In addition to a subsidy to defray the employee's premium, Catamount-ESIA covers some chronic-care cost-sharing.

*Catamount Health Premium Assistance Program (CHAP).* This is a premium-assistance program for adults who are uninsured and not eligible for VHAP and who do not have access to an approved ESI plan. This program offers financial assistance for the purchase of a Catamount Health policy. Individuals send their portion of the monthly premium to the state. The state then pays the cost of the Catamount Health plan to the insurance company. CHAP is available to Vermont residents with incomes at or below 300 percent of the FPL who are uninsured and who are not eligible for a public insurance program.

*Catamount Health (CH).* A separate insurance pool, offering a health-insurance product for uninsured Vermonters. Catamount policies provide comprehensive benefit plans. They are modeled after a preferred-provider organization plan with a \$250 deductible. For those who are participating in a chronic-care management program, cost sharing is not required for chronic-care management and preventive services.

The department does not administer CH and these rules do not address that program. However, in partnership with the Office of Vermont Health Access (OVHA), the department determines eligibility for CHAP, as well as the two ESIA programs. This rule establishes the eligibility and program criteria for all three of these premium-assistance programs. This bulletin also includes changes to existing VHAP rules needed to align them with Act 191 and new program requirements. It also includes premium changes required by Act 191 and a modification of the COBRA exception to the VHAP 12-month waiting rule.

The premium-assistance programs are set to be operational on October 1, 2007.

**B. Summary of Rule Changes and Additions**

- 4100 Program Overview – Describes the four new health-care programs of Act 191 and outlines the scope of the department’s administrative responsibilities regarding the programs.
- 4101 Definitions – Adds definitions of the terms used in the premium-assistance rules.
- 4102 Eligibility – States general principles of eligibility and, with the exception of M108, incorporates the provisions of Medicaid Rules M100-M199.
  - 4102.1 VHAP-ESIA – Specifies that eligibility for VHAP-ESIA is conditioned upon VHAP eligibility and access to an approved, cost-effective ESI plan.
  - 4102.2 VHAP-ESIA Participation as a Condition of VHAP Eligibility – Establishes participation in VHAP-ESIA as condition of continuing eligibility for VHAP.
  - 4102.3 Catamount-ESIA – Establishes conditions of eligibility.
  - 4102.4 CHAP – Establishes conditions of eligibility.
  - 4102.5 Prior Enrollment in a Health-Care Program – Exempts specified prior enrollments from twelve-month eligibility waiting period.
  - 4102.6 Medicare – Specifies that Medicare eligibility is a bar to eligibility for premium assistance.
  - 4102.7 Income Determinations – Incorporates VHAP Rule 4001.8 as standard for calculating income, in determining eligibility for premium assistance.
  - 4102.8 Availability of an ESI Plan – Ineligible Employees – Provides the standard for when an ineligible employee must enroll an eligible spouse in an available, approved and cost-effective ESI Plan.
- 4103 Eligibility Process – Section heading.
  - 4103.1 Application – Establishes application requirements.
  - 4103.2 Cooperation Requirements – Specifies cooperation requirements applicable to premium-assistance applicants and beneficiaries.
  - 4103.3 Screening; Initial Eligibility Determinations – Describes the department’s eligibility-screening responsibilities and initial enrollment determinations.

- 4103.4 Plan Information Request Letter (PIRL) – Sets parameters for department’s use of a PIRL and individual’s response obligations.
- 4103.5 Enrollment Determination – Establishes the process for review of a PIRL and determination of ESI plan approval and cost-effectiveness.
- 4103.6 Approval of ESI Plans – Sets the standard for approval of ESI plans.
- 4103.7 Methodology for Determining Cost-Effectiveness – Describes the process for determining whether individual’s enrollment in an available, approved ESI plan would be cost-effective to the state.
- 4103.8 VHAP or CHAP – Approved ESI Plan Not Available or Enrollment Not Cost-Effective – Specifies department’s obligations in circumstances in which it is determined that an individual who is eligible for VHAP or premium assistance does not have access to an approved, cost-effective ESI plan.
- 4103.9 VHAP-ESIA or Catamount-ESIA – Approved ESI Plan is Available and Enrollment is Cost-Effective – Describes notification and enrollment requirements that apply when it is determined that an individual has access to an approved, cost-effective ESI plan.
- 4103.10 Period of Eligibility and Enrollment – Specifies eligibility review requirements.
- 4103.11 New Access to ESI – Sets times at which ESI enrollment determinations may be made and beneficiary’s obligations that result from a determination that an ESI plan has become available and that enrollment is cost-effective.
- 4103.12 Plan Disenrollment – Establishes consequences of individual’s disenrollment from an approved, cost-effective ESI plan.
- 4103.13 Termination of ESIA; Plan No Longer Approved or Cost-Effective – Provides for termination of ESIA upon a determination that ESI plan is no longer available or that enrollment is no longer cost-effective.
- 4103.14 Notice-and-Appeal Rights – Establishes notice-and-appeal rights that apply to the premium-assistance programs.
- 4104 General Rules for Calculation of Premium-Assistance Amounts – States rules of general applicability for premium-assistance programs.
- 4105 VHAP-ESIA Benefits – Section heading.

- 4105.1 Premium Balances and Premium-Assistance Amounts – Establishes the standards for calculating the VHAP-ESIA subsidy amounts. States the department’s obligations regarding payment of the benefit to the beneficiary.
- 4105.2 VHAP Wraparound Coverage – Defines wraparound coverage for VHAP-ESIA beneficiaries.
- 4106 Uninsured ESIA Benefits – Section heading.
- 4106.1 Premium Balances and Premium-Assistance Amounts – Establishes the standards for calculating the Catamount-ESIA subsidy amounts. States the department’s obligations regarding payment of the benefit to the beneficiary.
- 4106.2 Chronic-Care Wraparound Coverage – Defines chronic-care wraparound coverage for Catamount-ESIA beneficiaries.
- 4107 CHAP Benefits – Section heading.
- 4107.1 Premium Balances and Premium-Assistance Amounts – Establishes the standards for calculating the CHAP subsidy amounts and premium payment obligations.
- 4108 Premium Balance Collection Methods – Establishes premium collection methods that apply to CHAP.
- 4109 Premium Payments – Sets the department’s obligations regarding payment of premium to CHAP beneficiary’s insurance carrier.
- 4110 Payment Adjustments – Section heading.
- 4110.1 Underpayments – Establishes the department’s obligations in the event of a benefit underpayment.
- 4110.2 Overpayments – Establishes rules for recovery of overpayments.
- M150.1 Payment System – Clarifies that coverage will not begin in the first day of a month after the full premium has been received, if the individual has not by then enrolled in Catamount Health.  
  
Cost Sharing Requirements – Amends rule to add VPharm programs and CHAP to partial-premium-payment hierarchy.
- M302.26 Children Under 18 (Dr. Dynasaur) – Lowers premium amounts, as required by Section 12 of Act 191.

- M302.27 Pregnant Women (Dr. Dynasaur) – Lowers premium amounts, as required by Section 12 of Act 191.
- 4000 Introduction – Adds reference to ESI enrollment requirement to section introducing VHAP rules.
- 4001.2 Uninsured or Underinsured – Excepts from VHAP 12-month waiting rule, those who no longer receive COBRA, VIPER, or other state continuation of ESI coverage. (Current exception applies only to those who no longer *qualify* for such coverage.)
- 4001.91 Premium – Lowers VHAP premium amounts, as required by Section 11 of Act 191.
- 4002.31 VHAP-Limited Coverage – Excepts from VHAP-Limited 12-month waiting rule, those who no longer receive COBRA, VIPER, or other state continuation of ESI coverage. (Current exception applies only to those who no longer *qualify* for such coverage.)

## II.

### Rulemaking Process

#### **A. Informal Public Input Process**

1. On September 28, 2006, department staff met with the Medicaid Advisory Board and provided it with an overview of the premium-assistance programs.
2. On January 11, 2007, department staff met with staff of the Department of Banking, Insurance, Securities & Health Care Administration and reviewed a draft of the proposed rule.
3. On February 12, 2007, department staff met with staff of the Legislature's Joint Fiscal Office and reviewed a draft of the proposed rule.
4. On February 16, 2007, department staff met with beneficiary and provider advocates and reviewed a draft of the proposed rule.
5. A draft of the proposed rule was filed with the Medicaid Advisory Board on February 20, 2007, and presented at its meeting on February 22, 2007.
6. On February 23, 2007, department staff met with employer advocates and reviewed a draft of the proposed rule.

7. On March 16, 2007, department staff met for a second time with beneficiary and provider advocates and reviewed a draft of the proposed rule.
8. The proposed rule was filed with the Interagency Committee on Administrative Rules (ICAR) on March 23, 2007, and presented at its meeting on April 9, 2007.
9. On May 1, 2007, department staff met with representatives from the Vermont Medical Society and reviewed a draft of the proposed rule.
10. The proposed rule was filed with the Senate Health and Welfare Committee, House Human Services Committee, and the Secretary of State's Office on April 13, 2007. The Office published notice of rulemaking on April 26, 2007 and May 3, 2007.
11. The department posted the proposed rule on its website and notified advocates and members of the public of the proposed rule.

***B. Formal Notice and Comment Period***

1. A public hearing was held on May 14, 2007, at 1:00 p.m., in the Agency of Human Services's Skylight Conference Room, State Office Complex, Waterbury, Vermont.
2. Written comments were accepted up until 4:30 p.m., on May 21, 2007. The department's responses to comments are set forth in the following section.
3. On July 6, 2007, copies of the final proposed rule are expected to be filed with the Secretary of State and the Legislative Committee on Administrative Rules (LCAR).
4. The department will present the rule to LCAR as soon as possible.
5. The department expects to file the final rule no later than September 14, 2007.
6. The rule is expected to be effective on October 1, 2007.

**C. Responses to Public Comments**

The department received written comments from the Office of Health Care Ombudsman, Vermont Legal Aid, Inc., and the Vermont Coalition for Disability Rights. The comments are summarized in italics below and are followed by the department's responses.

**4100 – Program Overview**

*To support the state's health-care marketing and branding efforts, Catamount Health might better be referred to in the rules as "Catamount."*

The premium-assistance program names can be changed at a later date to conform to any rebranding decisions made in connection with the state's health-care marketing and outreach initiative.

**4101 – Definitions**

*The definition of "chronic care" should be modified to include the possibility that the ESI wrap could include treatment of some acute complications, if such treatment is called for in the blueprint for health in section 702 of Title 18.*

The last sentence of the definition will be amended as follows:

Excluded from chronic care is the treatment of acute complications related to chronic conditions unless such treatment is specified in the blueprint for health, as provided in 4106.2(c).

*Those who lose ESI due to an involuntary reduction in hours of employment should be exempted from the 12-month VHAP, CH, and premium-assistance waiting period.*

The legislature set the terms of the waiting period in Act 191. It reconfirmed those terms (with slight modification) in H. 229. Consequently, the department is not at liberty to contemplate the proposed change.

**4102.2 – VHAP-ESIA as a Condition of VHAP Eligibility**

*Individuals should not be required to enroll in a spouse or civil-union partner's ESI plan when a complaint for divorce, legal separation, dissolution, or petition for relief from abuse has been filed by a spouse or partner against the other.*

The subsection will be amended as follows:

(b) Except as provided in paragraph (c) of this subsection, failure to meet this requirement shall result in both of the following:

\* \* \*

- (c) An individual shall not be required to enroll in a spouse or civil-union partner’s ESI plan pursuant to this subsection if a complaint for divorce, legal separation, dissolution, or petition for relief from abuse has been filed by one spouse or partner against the other.

*The phrase “disqualification from participation” could be interpreted to imply some time period during which the individual is absolutely ineligible for assistance. To avoid any confusion, the rules should explicitly allow consumers to reapply at any time, and receive benefits if they are willing to enroll in ESI that is approved, available, and cost-effective.*

4102.2(b)(2) will be amended as follows:

Disqualification from participation in any premium-assistance program for the period in which the individual remains unenrolled in a required ESI plan. The individual may, at any time, requalify by reapplying for premium assistance; enrolling in an approved, available, and cost-effective ESI plan; and otherwise satisfying program requirements.

#### **4102.4 – CHAP**

*H. 229 amended 33 V.S.A. § 1983(b) to provide that, for a period of twelve months following disenrollment from a listed public health-benefit plan, the individual may enroll in CHAP. Therefore, the rule should be amended to provide for such a twelve-month protection period.*

The provision in question states: “An individual receiving benefits [under listed public-benefit health programs] within 12 months of applying for Catamount Health assistance shall not be required to wait 12 months to be eligible.” The comment suggests that this provides the individual with a one-year “protection period.” Presumably, during this period, the individual would be permitted to enroll in CHAP, without regard to any intervening disqualifying events, such as the purchase of private insurance or enrollment in an ESI plan without premium assistance.

The department does not read the provision as creating a unique protection period for the benefit of those who leave a public-benefit program for CHAP. Rather, like similar provisions in sections 5 and 14 of H. 229, this provision was intended to clarify that the waiting period applies only to those who had had private insurance or employer-sponsored coverage during the prior twelve-month period. See, the statutory definitions of “uninsured” for each of the various programs. 8 V.S.A. § 4080f(a)(9) (CH), 33 V.S.A. § 1973(e) (VHAP), 33 V.S.A. § 1974(c)(a)(B) (ESIA), 33 V.S.A. § 1982(2) (CHAP).

#### **4102.5 – Prior Enrollment in a Health-Care Program**

*This rule should be changed to conform with the proposed change to 4102.4.*

While the commenter acknowledges that H. 229’s changes to 33 V.S.A. § 1983(b) do not impose upon the ESIA program the same kind of “protection period” claimed above in relation to CHAP, the commenter contends that the department is implicitly authorized to adopt by rule a similar protection period for ESI and should do so, as there is no basis for differing approaches across programs. For the reasons discussed above, the department does not read the law as creating a twelve-month “protection period” in any case.

*This subsection should be amended to clarify that applicants whose most recent insurance was a state program are not subject to the twelve-month waiting period.*

The twelve-month waiting period only applies to those who had private insurance or employer-sponsored coverage without premium assistance. To clarify, the provision will be rewritten as follows:

- (a) An individual is ineligible for premium assistance for the twelve-month period following loss of private insurance or ESI without premium assistance unless coverage ends for a reason set forth in 4101(1)(1) or (2).
- (b) No waiting period is imposed because of the loss of:
  - (1) Medicaid;
  - (2) VHAP;
  - (3) Dr. Dynasaur;
  - (4) VHAP-ESIA;
  - (5) Catamount-ESIA;
  - (6) CH with or without premium assistance, or
  - (7) Any other health-benefit plan authorized under Title XIX or Title XX of the Social Security Act.

#### **4102.6 – Medicare**

*This subsection should be amended to clarify that only those who are eligible for free Medicare Part A are ineligible for premium assistance.*

Commenters point out that individuals who are eligible for Medicare must pay \$410 per month for Part A (hospital coverage) if they have 29 or fewer work quarters. People with 30 to 39 quarters must pay \$226 per month. Commenters recommend that those who do not have access to no-cost Part A benefits be eligible for premium assistance.

Section 3 of H. 229 provides that “an individual who is eligible for Medicare may not purchase Catamount Health.” Section 17 provides that “an individual who is or becomes eligible for Medicare shall not be eligible for premium assistance under this chapter.” The department is sympathetic to the commenters’ request. However, an exception to the disqualification requires a legislative change.

### 4103.1 – Application

*The last sentence in paragraph (a) provides: “Applications are acted upon in the order they are received.” This provision should be deleted from the rule, as it is more appropriate for procedures.*

This provision is contained in other program rules. *See, e.g., M114 and 4002.1.* It will be kept here to assure consistency.

*As a security precaution, the state should not use the individual’s social security number as an identifier.*

The department is required to obtain social security numbers from program applicants and utilize them for specified purposes. 42 C.F.R. § 435.910. The department uses social security numbers as unique identifiers for applicants and program beneficiaries. As time and system changes permit, the department will explore alternative means of identifying program applicants and beneficiaries.

### 4103.2 – Cooperation Requirements

*The subsection should provide that individuals who make a good-faith effort to obtain and provide requested information do not violate cooperation requirements.*

An individual could encounter difficulty in obtaining requested information from an employer. For this reason, 4103.4(d) authorizes an allowance of additional time for compliance. However, as only the individual has the legal authority to compel the employer to provide the necessary information, the ultimate responsibility for securing it must remain with the individual.

*The subsection is confusing in that it may be read to require VHAP applicants to enroll in CH.*

The subsection will be redrafted as follows:

(a) In addition to any other cooperation requirements that the individual may be subject to, all VHAP and premium-assistance applicants and beneficiaries must cooperate as follows:

(1) All applicants and beneficiaries must:

(i) Provide information regarding other health coverage and access to ESI. The required information includes:

(A) The names of any spouse or civil-union partner in the household currently covered by or with access to ESI;

(B) The name of the employee and the employer offering the plan; and

(C) Any requested information regarding the plan.

- (ii) Report to the department any changes in enrollment status, employee's premium share, household composition, employment, income, residence, and access to ESI within ten days from the date the change occurs.
    - (iii) Timely comply with all program requirements.
  - (2) To receive CHAP, applicants and beneficiaries must:
    - (i) Enroll in, and remain enrolled in, CH;
    - (ii) Submit verification of CH enrollment; and
    - (iii) Timely pay required premiums to the state.
  - (3) To receive Catamount-ESIA or VHAP-ESIA, applicants and beneficiaries must:
    - (i) Enroll in, and remain enrolled in, an approved, available, and cost-effective ESI plan, as provided in subsection 4103.9, below;
    - (ii) Submit verification of plan enrollment; and
    - (iii) Timely pay employee's share of the premium share or premium balance.
- (b) Failure to cooperate as specified in this rule, will result in denial of premium assistance and termination of any VHAP, VHAP-ESIA, Catamount-ESIA, or CHAP benefits that the individual may have been receiving.

### **4103.3 – Screening; Initial Eligibility Determinations**

*When the department initially determines VHAP eligibility, does a notice issue immediately?*

Yes. Pursuant to subparagraph (b)(2) of this subsection, the department will notify the individual upon determination of VHAP eligibility.

*If, after screening the applicant for program eligibility, it appears that the individual may be eligible for Medicaid, will a new application be required?*

If the applicant completes and submits one of the all-health-care-programs forms (202 or 202 Med), the department will have the information needed to make a Medicaid eligibility determination. However, as the WIC-Dr. Dynasaur-VHAP form (010B) does not solicit information regarding household resources, if it appears that the applicant who submits this form may be eligible for Medicaid, the department will mail the applicant a Supplemental Resource Sheet for Medicaid (010R). The applicant will need to complete and return this one-page form to pursue Medicaid eligibility.

*If more than one application is required, the date of the first application should control the commencement of coverage.*

If the applicant submits a Supplemental Resource Sheet for Medicaid (010R) and is found to be eligible for Medicaid, the date of the initial application will control the coverage start date.

*If Medicaid eligibility is a possibility, the applicant should be informed of this immediately.*

The department will notify the applicant of the possibility of Medicaid coverage upon completion of the initial screening process.

#### **4103.4 – Plan Information Request Letter (PIRL)**

*Applicants who have been dealing with department may not understand that they will need to send information to the Office of Vermont Health Access (OVHA).*

The PIRL will clearly state that the information needs to be returned to OVHA and will be sent with a self-addressed envelope for return mailing.

*The rule should require ESD eligibility workers to forward the PIRL to OVHA if the applicant erroneously returns it to the department.*

If an applicant does erroneously send a document to ESD, workers will forward it to OVHA. A rule in this regard is not needed.

*Applicants should be advised that they may request assistance from OVHA if they are unable to obtain required information. The department's workers should be required to relay any such request to OVHA.*

PIRLs and extension letters will contain a statement informing applicants of how they may obtain assistance. Department staff can be counted on to relay requests for assistance without a rule requiring this routine behavior.

*A provision should be added to the rule that permits OVHA to contact the employer or insurance carrier before a PIRL response is received, if the action is requested by the applicant and authorized by the employee.*

As is discussed below, existing rules and an authorization incorporated into the application authorize contact with collaterals to secure needed information. Thus, OVHA will have the authority to make the suggested contacts in appropriate cases.

*Which agency is responsible for sending the PIRL? ESD and OVHA's shared responsibilities raises the possibility of bureaucratic errors.*

OVHA sends the PIRL. As the ACCESS system automatically generates the form, the shared agency responsibilities will have no bearing upon process accuracy.

*The first sentence of 4103.4(d) should be changed from the permissive to the mandatory form.*

The paragraph shall be amended as follows:

The time limit for responding to a PIRL shall be extended if . . . .

*Paragraph (e) should be amended to specify that the sanction for noncompliance is limited to termination of health-care benefits.*

The paragraph shall be amended as follows:

If the individual fails to respond to the PIRL within the time period provided, the department will deny VHAP, VHAP-ESIA, Catamount-ESIA, or CHAP, or terminate any of these health-care benefits that the individual had been receiving.

#### **4103.5 – Enrollment Determination**

*OVHA should not contact an individual’s employer without express written permission from the employee to do so.*

As noted above, as only the individual has the legal authority to compel the employer to provide the necessary information, the ultimate responsibility for securing it must remain with the individual. That said, in some instances, it may be Existing all-healthcare-programs rule M127 provides for contact with sources other than the applicant regarding eligibility for benefits. Such collateral sources, include, among others, employers. The rule provides that, “[w]hen information given by the client is either insufficient or questionable, contact with a collateral source may be made without the client’s consent.” Also, health-care application forms include a provision authorizing the department to contact sources outside the applicant’s household to verify eligibility.

*OVHA should be required to attempt to gather the missing information directly from the employer when (1) the applicant so requests, (2) the employee gives express written permission, and (3) it appears necessary or prudent.*

As noted above, as only the individual has the legal authority to compel the employer to provide the necessary information, the ultimate responsibility for securing it must remain with the individual. That said, in some instances, it may be efficacious for OVHA or the department to independently seek information from collateral sources. The rule authorizes such activities without shifting the burden of producing information from the applicant to OVHA or the department.

*Since OVHA may extend the time period for returning a completed PIRL for good cause, the provision in paragraph (b) that relates to the imposition of a sanction should be expressed in the permissive, rather than the mandatory form.*

This provision calls for the imposition of a sanction if the individual fails to provide the requested information “within the time period provided . . . .” This includes any extension of time for compliance. As noncompliance by the end of this period will, in all cases, result in denial or termination, the provision as drafted is accurate.

*The rules should limit the time in which OVHA must determine that an approved ESI plan is available and cost-effective.*

Paragraph (d) of this subsection shall be amended as follows:

OVHA shall determine whether an approved ESI plan is available to the individual, and if so, whether the individual's enrollment in the plan will be cost-effective. This determination shall be made within ten days of the date that OVHA receives all of the information requested for this purpose.

#### **4103.8 – VHAP or CHAP–Approved ESI Plan Not Available or Enrollment Not Cost-Effective**

*What is the start date for CHAP?*

As application for CH and CHAP is a serial process, the start date for CHAP will depend on the CH carriers' policies and procedures. They have not as yet been finalized.

#### **4103.9 – VHAP-ESIA or Catamount-ESIA–Approved ESI Plan is Available and Enrollment is Cost-Effective**

*What is to happen when ESI enrollment is required but the individual must wait for an extended period of time before enrollment is permitted?*

The applicant is expected to enroll in the ESI plan "at the earliest time permitted by the employer." 4103.9(a)(1). If there is a period of time between the individual's receipt of the Plan Sign-Up Letter (PSL) and the time the individual is permitted to enroll, that period will be accounted for in the enrollment deadline, included in the PSL. Section 20 of H. 229 should help to minimize enrollment delay. That provision defines as a qualifying event, a finding that an employee must enroll in an ESI plan to qualify for premium assistance.

*For good cause, the individual should be given additional time to return the PSL. More than ten days may be needed to gather information and submit the PSL, given that the PSL will include a request for additional information regarding the specifics of the ESI plan.*

Virtually all of the plan specifics are gathered at the PIRL stage. The PSL will only ask the individual to enroll and to provide information such as the group number and enrollment date. The time allotted is sufficient for these purposes.

*If enrollment in the ESI plan requires payment of a premium, OVHA should provide the first premium-assistance payment before enrollment.*

As ESIA payments are made prospectively, the individual will have received the subsidy before the first ESI payroll deduction is made.

#### 4103.12 – Plan Disenrollment

*Under the rule, if an individual loses VHAP-ESIA because his or her employer reduces his or her work hours, the employee also loses eligibility for VHAP. The definition of uninsured should be changed to include the involuntary loss of work hours which results in the loss of ESI.*

As was noted above, the legislature set the terms of the waiting period in Act 191. It reconfirmed those terms (with slight modification) in H. 229. Consequently, the department is not at liberty to contemplate the proposed change. While those who lose ESI for the reason set forth in the comment are subject to the waiting period before becoming eligible for VHAP or premium assistance, H. 229 provided that, once enrolled in VHAP-ESIA or Catamount-ESIA, loss of ESI would not subject the individual to a waiting period. The subsection as proposed is inconsistent with that provision. Accordingly, the subsection shall be rewritten as follows:

- (a) If the employee disenrolls from an ESI plan because the plan is no longer available, the individual shall be enrolled in VHAP or CHAP.
- (b) If the employee disenrolls in an ESI plan while the plan remains available, premium assistance and VHAP shall terminate. The individual may, at any time, requalify by reapplying for premium assistance, enrolling in an approved, available and cost-effective ESI plan, and otherwise satisfying program requirements.

*Paragraph (b) should be revised to clarify that the individual may restore his or her eligibility for VHAP and premium-assistance programs at any time, by agreeing to enroll in an approved, cost-effective ESI plan.*

The amendment made in response to the previous comment incorporates this change.

#### 4103.14 – Notice-and-Appeal Rights

*Why does (a) refer to “eligibility and enrollment determinations” and (e) only to “eligibility decisions?”*

No distinction is intended. Paragraph ( e) will be amended as follows:

A VHAP or premium-assistance applicant or beneficiary has a right to appeal eligibility and enrollment decisions and to request a fair hearing before the Human Services Board.

*Why doesn't enrollment continue pending appeal, if the appeal is “based solely on a benefit reduction or elimination which is required by federal or state law affecting some or all beneficiaries?”*

This is a standard, cross-program provision that recognizes that services will not be maintained during the pendency of an appeal when rule or statutory changes reduce or eliminate benefits. *See, e.g., M143.*

#### **4104 – General Rules for Calculation of Subsidy Amounts**

*As proposed, no subsidy will be paid in any month in which the subsidy amount is less than \$10.00. This will make a VHAP-ESIA beneficiary worse off than a VHAP beneficiary. This is inconsistent with the intent of Act 191. The cutoff for premium payment should be a lower dollar amount.*

The rule will be amended to lower the payment threshold to \$5.00.

*Even if the department sets a minimum payment amount, an individual who remains eligible for a small subsidy should be able to collect the subsidy once the aggregate amount owed reaches the minimum payment amount.*

As just noted, the payment threshold will be reduced by half. The administrative effort that would be associated with tracking monthly amounts below the thresholds and generating payment when the aggregate exceeds the threshold is not cost-effective.

#### **4105.1 – Premium Balances and Subsidy Amounts**

*Direct electronic fund transfer of the premium subsidy to an individual's bank account should not be mandatory. There may be very valid reasons for an individual to prefer to get a check rather than direct deposit. For example, accounts can be subject to seizure for various financial difficulties. Beneficiaries who are in financial difficulty should not also face the loss of health insurance.*

The direct-deposit requirement is a standard, cross-program provision, imposed as part of the department's obligation to operate programs as efficiently as possible. While it would undoubtedly be a hardship for an individual to have a deposited subsidy seized, this should not jeopardize coverage, as the employee's share of the premium is directly withdrawn from his or her paycheck.

#### **4105.3 – VHAP-ESIA Wraparound Coverage**

*Paragraph (d) should be clarified to reflect the prohibition against balance-billing of Medicaid beneficiaries.*

This issue is fully addressed in the agreement that each Medicaid provider enters into with OVHA.

#### **4106.1 – Premium Balances and Subsidy Amounts**

*For the reasons summarized above, direct electronic fund transfer of the premium subsidy to an individual's bank account should not be mandatory.*

See, response to comment regarding 4105.1

### **4106.2 – Chronic-Care Wraparound Coverage**

*This subsection limits the Catamount-ESIA Chronic-Care Wraparound Coverage to services relating to those chronic conditions specified in the blueprint for health. However, as the list of conditions in the blueprint is illustrative only, all conditions that require chronic care should be included in the wrap.*

In H.531, the legislature added to the blueprint for health, a process for the adoption and implementation of clinical quality and performance measures for the management of chronic conditions. The provision requires that, by July 1, 2007, measures are adopted for each of the chronic conditions included in the Medicaid Chronic Care Management Program. It goes on to note that such conditions include, but are not limited to, five identified conditions. It then sets out the following schedule for the adoption of additional measures:

[A]t least one set of clinical quality and performance measures will be added each year and a uniform set of clinical quality and performance measures for all chronic conditions to be addressed by the blueprint will be available for use by health insurers and health care providers by January 1, 2010.

This provision unambiguously calls for a staged adoption of measures: At the outset, measures for all of the conditions included in the Medicaid Chronic Care Management Program must be adopted by July 1, 2007. Thereafter, at the rate of at least one a year, measures must be added until, by the beginning of January, 2010, measures are in place for “all chronic conditions to be addressed by the blueprint.”

In another provision of H. 531, the legislature clarified that the conditions covered in the Catamount-ESIA Chronic-Care Wrap are to align with those for which clinical quality and performance measures have been adopted under the blueprint:

Until an approved employer-sponsored plan is required to meet the standard in subdivision (4)(B)(ii) of this subsection, the subsidy shall include premium assistance and assistance to cover cost-sharing amounts for chronic care health services covered by the Vermont health access plan *that are related to evidence-based guidelines for ongoing prevention and clinical management of the chronic condition [sic] specified in the blueprint for health in section 702 of Title 18.*

Clearly, the intent was to provide wraparound coverage for prevention and clinical management of chronic conditions, in the manner prescribed by the blueprint. As the implementation of the standards for such care is governed by the schedule set forth in the blueprint, so too is the scope of wraparound coverage. The rule tracks the schedule set forth in the blueprint.

*Paragraph (e) should be clarified to reflect the prohibition against balance-billing of Medicaid beneficiaries.*

This issue is fully addressed in the agreement that each Medicaid provider enters into with OVHA.

### 4108 – Premium Balance Collection Methods

*Subparagraph (b)(1) of this section should be phrased differently to more accurately reflect the transaction. The individual authorizes the bank to make an electronic fund transfer to the state. It seems backward to say the individual authorizes the state to make withdrawals.*

The first sentence of subparagraph will be amended as follows:

The eligible individual authorizes the bank to make an electronic fund transfer of the monthly premium balance directly from a savings or checking account to the department.

*The coupon and envelope should be mailed to the individual, not the family.*

The second sentence of subparagraph (b)(2) will be amended as follows:

A premium-payment coupon and pre-addressed envelope are mailed to the head of household before the premium balance is due.

### 4110.2 – Overpayments

*Paragraph (c) imposes a new method of recovery of benefits in the state's health-care programs. Recouping up to ten percent of a current monthly benefit could render a beneficiary unable to continue on health insurance. It should not be the only option of the department decides it must recover payment. The beneficiary should be given the option as to how he or she wants to repay the department.*

This recovery provision is needed in these health-care programs because—unlike other health-care programs—premium assistance may involve a cash payment to the beneficiary. The method for recovery is modeled after approaches employed in the department's other cash-benefits programs. Reduction in future benefits is but one of two mechanisms authorized for recovery. The rule also permits recovery of an overpayment through beneficiary repayment. If this option is utilized, it must be on terms that are mutually acceptable to the department and the beneficiary. To clarify the available options, paragraph (c) will be rewritten as follows:

- (c) The beneficiary may elect to repay an overpayment through a lump-sum cash payment or, with the agreement of the department, installment payments. If the installment method elected, the monthly payment amount must be at least ten percent of the current monthly health-care benefit or \$10.00 per month, whichever is more. Installment terms must be recorded in a written document, signed by the beneficiary and an authorized representative of the department. If the beneficiary fails to submit a payment in accordance with the terms of an agreed-upon repayment schedule, the claim becomes delinquent and subject to collection through reduction in premium-assistance benefits or as otherwise provided for by law. If the beneficiary fails to elect a recovery method, recovery will be made by a reduction in the amount of any current or future premium-assistance payment the household may receive. The monthly reduction shall equal ten percent of the monthly benefit or \$10.00, whichever is more.

*A provision should be added allowing the department to waive an overpayment if the beneficiary was without fault, and recovery would cause substantial hardship to the beneficiary or his or her family. This is similar to the Social Security standard for overpayments.*

OVHA has estimated that the average monthly assistance amount for Catamount-ESIA is about \$110. The average benefit for VHAP-ESIA is about ten dollars more. Thus, recovery under this provision would be limited to about eleven or twelve dollars a month. While these amounts are not trivial to low-income Vermonters, they are substantially less than the recoupment potentials associated with other public-benefits programs. On balance, the value that would be conferred by a waiver procedure would be substantially outweighed by the administrative difficulties inherent in the evaluation of faultlessness and substantial hardship.

#### **4002.3 – Period of Eligibility and Enrollment**

*The proposed change to this subsection allows VHAP to be terminated if a VHAP-ESIA beneficiary loses ESI coverage for a reason that is not listed in § 4101(1). The list should be changed to include the involuntary loss of work hours which results in the loss of ESI.*

The change described in response to the comment regarding 4103.12 eliminates the need for an amendment of this subsection.

#### **D. Other Changes**

In addition to the changes made in response to the public comments, a number of nonsubstantive, stylistic changes have been made throughout the rule. Also, the following substantive changes were made:

#### **4102.8– Availability of an ESI Plan – Ineligible Employees**

The proposed rule would have required ineligible employees to enroll eligible spouses in their ESI plans whenever such plans were available, approved, and cost-effective. The final proposed rule only requires such enrollment when the employee is already enrolled in an ESI plan. This new subsection specifies that the ESI plan shall only be available to an eligible household member if the employee is already enrolled in the ESI plan.

#### **4103.6 – Approval of ESI Plans**

Subparagraph (b)(3) was amended to correct the in-network deductible limits for approval of ESI plans.

#### **4103.8 – Approved ESI Plan Not Available or Enrollment Not Cost-Effective**

Paragraph (c) was amended to increase the amount of time for returning a CHAP PSL from ten days to thirty.

### **4105.2 – VHAP-Ineligible Employees**

This section was deleted as unnecessary after VHAP-ineligible employees were relieved of the obligation to enroll in ESI to effectuate coverage of otherwise-eligible spouses.

### **4108 – Premium Balance Collection Methods**

Subparagraph (b)(3) was added to permit individuals to pay premiums with credit cards.

### **M150.1 – Cost Sharing Requirements**

Paragraph B. was amended to clarify that CHAP coverage will not begin in the first day of a month after the full premium has been received, if the individual has not as yet enrolled in CH.

\* \* \* \* \*

The text of Act 191 is posted on the Legislature's website at:

<http://www.leg.state.vt.us/docs/legdoc.cfm?URL=/docs/2006/acts/ACT191.HTM>

To get more information about the Administrative Procedures Act and the rules applicable to state rulemaking go to the website of the Office of the Vermont Secretary of State at: <http://vermont-archives.org/apa/rules.html> or call Louise Corliss at 828-2863.

For information on upcoming hearings before the Legislative Committee on Administrative Rules go to the website of the Vermont Legislature at: <http://www.leg.state.vt.us/schedule/schedule2.cfm> or call 828-5760.

\* \* \* \* \*

Vertical lines in the left margin indicate significant changes. Dotted lines at the left indicate changes to clarify, rearrange, correct references, etc., without changing content.

**Manual Holders:** Please maintain manuals assigned to you as follows:

**Manual Maintenance**

**Medicaid Rules**

	<b><u>Remove</u></b>		<b><u>Insert</u></b>
Nothing		TOC P.1 (4100)	(07-24)
Nothing		TOC P.2	(07-24)
Nothing		4100	(07-24)
Nothing		4101	(07-24)
Nothing		4101 P.2	(07-24)
Nothing		4102	(07-24)
Nothing		4102.3	(07-24)
Nothing		4102.4 P.2	(07-24)
Nothing		4102.8	(07-24)
Nothing		4103.2	(07-24)
Nothing		4103.2 P.2	(07-24)
Nothing		4103.3 P.2	(07-24)
Nothing		4103.4	(07-24)
Nothing		4103.5	(07-24)
Nothing		4103.6	(07-24)
Nothing		4103.7	(07-24)
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Nothing		4103.12	(07-24)
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Nothing		4104	(07-24)
Nothing		4105.2	(07-24)
Nothing		4106	(07-24)
Nothing		4106.2	(07-24)
Nothing		4107	(07-24)
Nothing		4108	(07-24)
Nothing		4110	(07-24)
Nothing		4110.2	(07-24)
M150.1 P.2	(05-09)	M150.1 P.2	(07-24)
M150.1 P.3	(05-09)	M150.1 P.3	(07-24)
M302.26	(05-31)	M302.26	(07-24)
M302.27	(05-31)	M302.27	(07-24)

**Refugee - VHAP Rules**

**VHAP Rules**

4000	(02-19)	4000	(07-24)
4001.2	(02-37)	4001.2	(07-24)
4001.91	(05-31)	4001.91	(07-24)
4002.3 P.2	(05-09)	4002.3 P.2	(07-24)

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4100 Program Overview

In 2006, the Vermont Legislature enacted Act 191, An Act Relating to Health Care Affordability for Vermonters. Among other things, the new law created four new health-care programs, designed to expand Vermonters' access to quality, affordable health care. These programs are targeted at those with incomes that exceed the traditional Medicaid limits. Eligibility is based upon a variety of factors, including income, insurance status, the availability of an approved employer-sponsored insurance (ESI) plan, and the relative cost to the state of the individual's enrollment in the various programs. The initiatives include:

*Employer-Sponsored Insurance Premium-Assistance Program for VHAP-Eligible Individuals (VHAP-ESIA).* This is a premium-assistance program for adults who are eligible for the Vermont Health Access Plan (VHAP) and who have access to an approved ESI plan. VHAP-eligible individuals will be required to participate in this program when the department determines that enrollment is cost-effective to the state. VHAP-ESIA subsidizes the employee's premium through a monthly payment. VHAP-ESIA also covers any required wraparound services, and certain cost-sharing obligations. It provides the same coverage that is available through VHAP, at the same cost to the beneficiary.

*Employer-Sponsored Insurance Premium-Assistance Program for Uninsured Individuals (Catamount-ESIA).* This is a premium-assistance program for adults who are uninsured and not eligible for VHAP and who have access to an approved ESI plan. This program offers financial assistance through a monthly payment for the purchase of ESI plans. It is available to uninsured Vermont residents with incomes at or below 300 percent of the federal poverty level (FPL) who are not eligible for VHAP-ESIA. In addition to a subsidy to defray the employee's premium, Catamount-ESIA covers some chronic-care cost-sharing.

*Catamount Health Premium Assistance Program (CHAP).* This is a premium-assistance program for adults who are uninsured and not eligible for VHAP and who do not have access to an approved ESI plan. This program offers financial assistance for the purchase of a Catamount Health policy. Individuals send their portion of the monthly premium to the state. The state then pays the cost of the Catamount Health plan to the insurance company. CHAP is available to Vermont residents with incomes at or below 300 percent of the FPL who are uninsured and who are not eligible for a public insurance program.

*Catamount Health (CH).* A separate insurance pool, offering a health-insurance product for uninsured Vermonters. Catamount policies provide comprehensive benefit plans. They are modeled after a preferred-provider organization plan with a \$250 deductible. For those who are participating in a chronic-care management program, cost sharing is not required for chronic-care management and preventive services.

The department does not administer CH and these rules do not address that program. However, in partnership with the Office of Vermont Health Access (OVHA), the department determines eligibility for CHAP, as well as two ESIA programs.

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4101

4101 Definitions

- (a) Approved employer-sponsored insurance (ESI). An ESI plan that meets the coverage criteria established in subsection 4103.6 below.
- (b) Available ESI plan. An ESI plan that the employee may enroll in within ninety days.
- (c) “Chronic care” means health services provided by a health care professional for an established clinical condition that is expected to last a year or more and that requires ongoing clinical management attempting to restore the individual to highest function, minimize the negative effects of the condition, and prevent complications related to chronic conditions. Examples of chronic conditions include diabetes, hypertension, cardiovascular disease, cancer, asthma, pulmonary disease, substance abuse, mental illness, spinal cord injury, and hyperlipidemia. Chronic care includes any day-to-day monitoring, treatment, and therapy of chronic conditions. This includes consultations by any health-care professionals, medication, investigations (blood tests, radiology) etc. Excluded from chronic care is the treatment of acute complications related to chronic conditions unless such treatment is specified in the blueprint for health, as provided in 4106.2(c).
- (d) Cost-effective. The program option that is the least costly to the state. The methodology for determining cost-effectiveness is described in subsection 4103.7 below.
- (e) Cost sharing. Any health-care co-payments, deductibles, or co-insurance that an individual or family is required to pay, in addition to a premium.
- (f) Employee. The applicant or a member of the applicant household who is eligible to enroll in ESI (irrespective of VHAP eligibility). “Employee” includes a retiree who is eligible to enroll in an ESI plan that is offered to the retiree by a former employer.
- (g) Employee’s share of the premium. The monthly portion of the ESI premium that is charged to the employee, before receipt of premium assistance.
- (h) Employer-sponsored insurance (ESI). Health insurance or a group health plan offered to employees and retirees by an employer.
- (i) Premium assistance. Financial assistance that is provided for the purchase of health insurance offered under an approved ESI plan or a CH plan.
- (j) Premium balance. The monthly portion of the premium that the employee or individual is responsible for, after receipt of premium assistance.
- (k) Resident. An individual who lives in Vermont with the intent to remain in the state permanently or for an indefinite period of time.

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4101 Definitions (Continued)

- (l) Uninsured. An individual who does not qualify for Medicare, Medicaid, VHAP, or Dr. Dynasaur and had no private insurance or employer-sponsored coverage that includes both hospital and physician services within twelve months prior to the month of application, or lost private insurance or employer-sponsored coverage during the prior twelve months for any of the following reasons:
- (1) The individual's private insurance or employer-sponsored coverage ended because of:
    - (i) Loss of employment, unless the employer has terminated its employees for the primary purpose of discontinuing employer-sponsored coverage and establishing their eligibility for CH;
    - (ii) Death of the principal insurance policy holder;
    - (iii) Divorce or dissolution of a civil union;
    - (iv) No longer qualifying as a dependent under the plan of a parent or caretaker relative;
    - (v) No longer receiving COBRA, VIPER, or other state continuation coverage; or
  - (2) College- or university-sponsored health insurance became unavailable to the individual because the individual graduated, took a leave of absence, or otherwise terminated studies.
- (m) Wraparound services or coverage. Any health-care services not included in an approved ESI plan, or any cost sharing the ESI plan imposes, that the state is obligated to pay for. (See subsections 4105.3 and 4106.2 below.)

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4102

## 4102 Eligibility

Individuals are eligible for premium assistance if they meet the financial and nonfinancial requirements set forth in this rule. Except for M108, the provisions of Medicaid Rules M100-M199 are generally incorporated into this rule. However, if there is a conflict between a provision in the Medicaid rules and in this rule, the provision in this rule shall apply.

### 4102.1 VHAP-ESIA

*Employer-Sponsored Insurance Premium-Assistance Program for VHAP-Eligible Individuals (VHAP-ESIA).* This is a premium-assistance program for adults who are eligible for the Vermont Health Access Plan (VHAP) and who have access to an approved ESI plan. VHAP-eligible individuals will be required to participate in this program when the department determines that enrollment is cost-effective to the state. VHAP-ESIA subsidizes the employee's premium through a monthly payment. VHAP-ESIA also covers any required wraparound services, and certain cost-sharing obligations. It provides the same coverage that is available through VHAP, at the same cost to the beneficiary.

To be eligible for VHAP-ESIA, an individual must meet all of the VHAP eligibility rules (4000.1-4000.92) and the eligibility rules in Medicaid Rules M100-M199 and have access to an approved, cost-effective ESI plan. If eligible, an individual is granted VHAP while an ESIA determination is being made.

### 4102.2 VHAP-ESIA Participation as a Condition of VHAP Eligibility

- (a) Enrollment in an ESI plan with VHAP-ESIA is a condition of eligibility for VHAP if the plan is approved and available, and enrollment is determined to be cost-effective. If the employee in the household is a spouse or civil-union partner, the employee is responsible for enrolling the VHAP-eligible spouse in the ESI plan.
- (b) Except as provided in paragraph (c) of this subsection, failure to meet this requirement shall result in both of the following:
  - (1) Termination of VHAP eligibility; and
  - (2) Disqualification from participation in any premium-assistance program for the period in which the individual remains unenrolled in a required ESI plan. The individual may, at any time, requalify by reapplying for premium assistance; enrolling in an approved, available, and cost-effective ESI plan; and otherwise satisfying program requirements.
- (c) An individual shall not be required to enroll in a spouse or civil-union partner's ESI plan pursuant to this subsection if a complaint for divorce, legal separation, dissolution, or petition for relief from abuse has been filed by one spouse or partner against the other.

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4102.3

#### 4102.3 Catamount-ESIA

*Employer-Sponsored Insurance Premium-Assistance Program for Uninsured Individuals (Catamount-ESIA)*. This is a premium-assistance program for adults who are uninsured and not eligible for VHAP and who have access to an approved ESI plan. This program offers financial assistance through a monthly payment for the purchase of ESI plans. It is available to uninsured Vermont residents with incomes at or below 300 percent of the federal poverty level (FPL) who are not eligible for VHAP-ESIA. In addition to a subsidy to defray the employee's premium, Catamount-ESIA covers some chronic-care cost-sharing.(a) An individual is eligible for Catamount-ESIA if the individual:

- (a) Is uninsured (see, paragraph (l) of section 4101);
- (b) Is a Vermont resident;
- (c) Has income at or below 300 percent of the FPL;
- (d) Is age eighteen or older and is not claimed on a tax return as a dependent of a resident of another state; and
- (e) Meets the other eligibility requirements in Medicaid Rules M100-M199;
- (f) Has access to an approved, cost-effective, ESI plan.

#### 4102.4 CHAP

*Catamount Health Premium Assistance Program (CHAP)*. This is a premium-assistance program for adults who are uninsured and not eligible for VHAP and who do not have access to an approved ESI plan. This program offers financial assistance for the purchase of a Catamount Health policy. Individuals send their portion of the monthly premium to the state. The state then pays the cost of the Catamount Health plan to the insurance company. CHAP is available to Vermont residents with incomes at or below 300 percent of the FPL who are uninsured and who are not eligible for a public insurance program.

Except as provided in paragraph (b), an individual is eligible for CHAP if the individual:

- (a) Is uninsured (see, paragraph (l) of section 4101);
- (b) Is a Vermont resident;
- (c) Has income at or below 300 percent of the FPL;
- (d) Is eighteen or older and is not claimed on a tax return as a dependent of a resident of another state;

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4102.4 CHAP (Continued)

- (e) Meets the other eligibility requirements in Medicaid Rules M100-M199; and
- (f) Does not have access to an approved, cost-effective, ESI plan.

4102.5 Prior Enrollment in a Health-Care Program

- (a) An individual is ineligible for premium assistance for the twelve-month period following loss of private insurance or ESI without premium assistance unless coverage ends for a reason set forth in 4101(l)(1) or (2).
- (b) No waiting period is imposed because of the loss of:
  - (1) Medicaid;
  - (2) VHAP;
  - (3) Dr. Dynasaur;
  - (4) VHAP-ESIA;
  - (5) Catamount-ESIA;
  - (6) CH with or without premium assistance, or
  - (7) Any other health-benefit plan authorized under Title XIX or Title XX of the Social Security Act.

4102.6 Medicare

An individual who qualifies for Medicare, regardless of actual enrollment, shall not be eligible for premium assistance.

4102.7 Income Determinations

A household's income shall be calculated in accordance with VHAP rule 4001.8.

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4102.8 Availability of an ESI Plan – Ineligible Employees

When an ineligible employee has access to an approved, cost-effective ESI plan, the ESI plan shall only be available to an eligible household member if the employee is enrolled in the ESI plan.

4103 Eligibility Process4103.1 Application

- (a) Forms. Individuals must apply for premium assistance on an application form that the department provides for this purpose. Applications must be filed with the Health Access Eligibility Unit or a district office of the Economic Services Division (ESD) of the Department for Children and Families (DCF). Applications are acted upon in the order they are received.
- (b) Social Security Number. An applicant must furnish a social security number or apply for a social security number unless the individual is a member of a religious organization that objects to the use of a social security number. An applicant who substantiates membership in such an organization shall be given an alternate identification number. Social security numbers are used to verify information through electronic data matches.
- (c) Verification. Except as is specifically required, the applicant or beneficiary is not generally required to provide verification of the information provided. However, the department may require verification if: the information is questionable, verification is outstanding for another ESD benefit program, or the applicant or beneficiary has refused to provide a social security number because of a religious objection. Individuals are notified on the application form of the verification actions the department may take.

**4103.2**    Cooperation Requirements

- (a) In addition to any other cooperation requirements that the individual may be subject to, all VHAP and premium-assistance applicants and beneficiaries must cooperate as follows:
- (1) All applicants and beneficiaries must:
    - (i) Provide information regarding other health coverage and access to ESI. The required information includes:
      - (A) The names of any spouse or civil-union partner in the household currently covered by or with access to ESI;
      - (B) The name of the employee and the employer offering the plan; and
      - (C) Any requested information regarding the plan.
    - (ii) Report to the department any changes in enrollment status, employee's premium share, household composition, employment, income, residence, and access to ESI within ten days from the date the change occurs.
    - (iii) Timely comply with all program requirements.
  - (2) To receive CHAP, applicants and beneficiaries must:
    - (i) Enroll in, and remain enrolled in, CH;
    - (ii) Submit verification of CH enrollment; and
    - (iii) Timely pay required premiums to the state.
  - (3) To receive Catamount-ESIA or VHAP-ESIA, applicants and beneficiaries must:
    - (i) Enroll in, and remain enrolled in, an approved, available, and cost-effective ESI plan, as provided in subsection 4103.9;
    - (ii) Submit verification of plan enrollment; and
    - (iii) Timely pay employee's share of the premium or premium balance.

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- (b) Failure to cooperate as specified in this rule, will result in denial of premium assistance and termination of any VHAP, VHAP-ESIA, Catamount-ESIA, or CHAP benefits that the individual may have been receiving.

4103.3 Screening; Initial Eligibility Determinations

- (a) Upon receipt of a health-care application, and based upon the information provided, the department shall screen the applicant for eligibility for all of Vermont's health-care programs. If it appears that the individual may be eligible for Medicaid, the individual will be notified of the option to apply for that benefit.
- (b) VHAP-Eligible Applicants.
- (1) If the department initially determines that the individual is eligible for VHAP, it shall enroll the individual in that program.
  - (2) The department shall also assess whether the individual may have access to an ESI plan. This assessment may be made upon information including, but not limited to:
    - (i) The individual's statements;
    - (ii) Information known to the department regarding insurance offerings of household members' employers; and
    - (iii) Household job income suggesting hours of employment sufficient to qualify the individual for participation in an ESI plan.
  - (3) If it appears that the VHAP-eligible individual may have access to an ESI plan, the VHAP eligibility notice shall include a statement indicating that continued eligibility is subject to a determination of whether enrollment in an ESI plan with VHAP-ESIA is required.
  - (4) For as long as the individual remains eligible for VHAP, the individual will continue to receive VHAP benefits. However, as is provided in subsection 4103.11 below, if it is subsequently determined that the individual is eligible for VHAP-ESIA, the individual must enroll in the ESI plan at the earliest time permitted by the employer.

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4103.3 Screening: Initial Eligibility Determinations (Continued)

(c) VHAP-Ineligible Applicants.

- (1) If the department initially determines that an individual is not eligible for VHAP but is eligible for premium assistance, it shall then assess whether the individual may have access to an ESI plan. This assessment may be made as is provided in subparagraph (b)(2) of this subsection.
- (2) If it does not appear that the individual has access to an ESI plan, the individual shall be offered the opportunity to purchase a CH policy with CHAP. (See 4103.8.)

(d) If it appears that the individual may have access to an ESI plan, OVHA shall determine whether the plan is an approved plan. If so, OVHA will determine if:

- (1) The plan is available; and
- (2) It would be cost-effective to the state to require the individual to enroll in the plan with premium assistance.

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#### 4103.4 Plan Information Request Letter

- (a) The Plan Information Request Letter (PIRL) solicits information pertinent to OVHA's determinations of whether an ESI plan is approved, available, and cost-effective. (See 4103.2(a)(1)). The PIRL shall indicate that the completed form is to be returned to OVHA.
- (b) A PIRL may be sent:
  - (1) After eligibility for premium assistance is initially determined;
  - (2) When eligibility is redetermined;
  - (3) When it appears that the availability of an ESI plan may have changed; or
  - (4) When it appears that the individual's ESI-plan coverage or cost may have changed.
- (c) The individual shall have an initial period of at least ten days to respond to the PIRL. If the response is not submitted within the time period prescribed in the initial PIRL, the department shall send a second request, affording at least ten additional days for a response.
- (d) The time limit for responding to a PIRL shall be extended if the individual has, in good faith, tried to respond to the request, but has been unable to do so within the prescribed period of time. For example, an extension will be granted if the individual's inability to respond is due to an employer's delay in responding to the individual's request for plan information.
- (e) If the individual fails to respond to the PIRL within the time period provided, the department will deny VHAP, VHAP-ESIA, Catamount-ESIA, or CHAP, or terminate any of these health-care benefits that the individual had been receiving.

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4103.5 Enrollment Determination

- (a) Upon timely receipt of a PIRL response, OVHA shall review it for completeness. If the form is incomplete, OVHA may either:
  - (1) Return the PIRL to the individual, with an indication of the additional information required, or
  - (2) Attempt to gather the missing information directly from the individual's employer.
- (b) If OVHA returns an incomplete PIRL, it shall provide the individual with a period of at least ten days to provide the requested information. If the individual fails to provide the requested information within the time period provided, the department will deny VHAP, VHAP-ESIA, Catamount-ESIA, or CHAP, or terminate any benefits that the individual had been receiving.
- (c) If, after receipt of a complete PIRL response, OVHA determines that it needs additional information to complete its enrollment determination, it may request it from the individual, the employee, and, where appropriate and necessary, the employer or insurance carrier.
- (d) OVHA shall determine whether an approved ESI plan is available to the individual, and if so, whether the individual's enrollment in the plan will be cost-effective. This determination shall be made within ten days of the date that OVHA receives all of the information requested for this purpose.

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4103.6 Approval of ESI Plans

- (a) VHAP-ESIA or Catamount-ESIA will only be extended to subsidize the cost of plans that OVHA approves as comprehensive and affordable.
- (b) An ESI plan will be approved if it conforms to the following standards:
  - (1) The plan includes coverage for:
    - (i) Physician visits;
    - (ii) Inpatient care;
    - (iii) Outpatient services, including:
      - (A) Diagnostics;
      - (B) Physical therapy, and
      - (C) Surgery;
    - (iv) Prescription drugs;
    - (v) Emergency room services;
    - (vi) Ambulance services;
    - (vii) Mental health and substance abuse treatment;
    - (viii) Medical equipment and supplies; and
    - (ix) Maternity care.
  - (2) Once statewide participation in the Vermont blueprint for health is achieved, the plan includes appropriate coverage of chronic conditions as specified in the blueprint and in accordance with the standards established in section 702 of Title 18.
  - (3) The plan's in-network deductible for health-care services is not in excess of: \$500 for an individual and \$1,000 for two people or a family.

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4103.7 Methodology for Determining Cost-Effectiveness

- (a) OVHA shall base determinations of cost-effectiveness on information gathered from the following sources:
- (1) Information submitted by the individual in the application for benefits and in response to a PIRL.
  - (2) Information contained within the OVHA database. (OVHA collects data about approved ESI plans from a variety of sources, including other beneficiaries, employers, and insurance carriers.)
  - (3) OVHA records.
  - (4) Additional information OVHA may request from the individual, the employee, and, where appropriate and necessary, the employer or insurance carrier.
- (b) OVHA will use the information about the ESI plan to compare the cost of premium assistance with the expense the state is likely to incur if the state elects to enroll the individual in an alternative program (*i.e.*, VHAP, for VHAP-eligible individuals or CHAP, for those who are ineligible for VHAP).
- (c) For VHAP-eligible individuals, enrollment in an ESI plan is deemed cost-effective when the premium assistance plus the projected cost of wraparound coverage is less than the projected cost of covering the individual through VHAP.
- (d) For VHAP-ineligible individuals, enrollment in an ESI plan is deemed cost-effective when the premium assistance plus the projected cost of wraparound coverage is less than the cost of the CH premium assistance the state will pay if the individual purchases a CH plan with premium assistance.

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4103.8

4103.8 VHAP or CHAP – Approved ESI Plan Not Available or Enrollment Not Cost-Effective

- (a) If OVHA determines that an approved ESI plan is not available or that the individual's enrollment in an available plan would not be cost-effective, the department shall act as follows:
- (1) If the individual is otherwise eligible for VHAP, the department shall send the individual a notice advising that VHAP coverage shall continue.
  - (2) If the individual is not eligible for VHAP, but has household income at or below 300 percent of the federal poverty level, the department shall send the individual:
    - (i) Notices shall include:
      - (A) Appraisal of the availability of CHAP.
      - (B) An explanation that enrollment in a CH plan is voluntary, but that premium assistance is only available to those who enroll in a CH plan;
      - (C) Referral to plan enrollment information;
      - (D) Notice that, if the CHAP option is chosen, the individual must return a completed CHAP Plan Sign-Up Letter (PSL) to OVHA and send payment of the first month's premium balance. Failure to return a completed PSL within the specified time period will result in denial of CHAP;
      - (E) Notice that the individual must pay a monthly premium to the state before CHAP can begin and must timely pay a monthly premium to the state for CHAP to continue. Failure to pay the premium within the specified time period will result in the denial of CHAP or program termination.
      - (F) Notice that, if CHAP is elected, the individual will be required to enroll in ESI, if the department subsequently determines that an approved, cost-effective plan is available.
    - (ii) Premium bill. An initial premium bill. The bill shall indicate that payment is owed, only if the individual elects to participate in CHAP.
    - (iii) CHAP Plan Sign-Up Letter. After the initial premium payment is received, the individual will receive a CHAP PSL requesting information regarding the specifics of any CH plan that the individual elects to enroll in.

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4103.8 VHAP or CHAP – Approved ESI Plan Not Available or Enrollment Not Cost-Effective  
(Continued)

- (b) Premium due date. The individual will have thirty days to pay the premium. Eligibility for CHAP will be terminated if the premium is not received by the premium due date.
- (c) CHAP PSL time frame. The individual will have thirty days to return the completed CHAP PSL. If the individual does not return the PSL by the due date, the department will deny CHAP, even if the premium payment is timely received.
- (d) If the CHAP PSL and premium payment are timely received, OVHA will initiate payment of CHAP. coverage begins on the start date indicated on the PSL.

4103.9 VHAP-ESIA or Catamount-ESIA – Approved ESI Plan Is Available and Enrollment is Cost-Effective

- (a) If OVHA determines that it will be cost-effective for the individual to enroll in an available ESI plan with ESIA, the individual will receive an ESI Plan Sign-Up Letter (PSL). The PSL shall include:
  - (1) An instruction, directing enrollment in the ESI plan at the earliest time permitted by the employer;
  - (2) A request for additional information from the individual regarding the specifics of the ESI plan; and
  - (3) Notice that failure to return a completed PSL, failure to enroll in the ESI plan, or disenrollment from the plan while the plan remains available will render the individual ineligible for premium assistance and result in the termination of any VHAP benefit that may have been granted.
- (b) The individual shall be provided with a period of at least ten days to return the completed PSL to OVHA.
- (c) Upon receipt of a completed PSL, OVHA will initiate payment of premium assistance to the individual, as provided in subsection 4106.1.
- (d) If the individual fails to return the completed PSL within the time period provided or fails to enroll in the ESI plan, the department will deny the application and terminate any VHAP benefit that may have been granted.

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4103.10

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#### 4103.10 Period of Eligibility and Enrollment

Eligibility for all premium-assistance programs is subject to annual review. Eligibility review will be completed before the end of each certification period to assure uninterrupted coverage if the individual remains eligible, complies in a timely manner with review requirements, and pays any required premium by the due date. An individual who fails to timely comply with review and premium requirements shall receive a termination notice mailed at least eleven days before the termination date. A failure to timely comply may result in a gap in coverage.

#### 4103.11 New Access to ESI

- (a) Decisions about whether a VHAP or CHAP applicant or beneficiary will be required to enroll in an approved ESI plan may be made in conjunction with:
- (1) Initial determinations of eligibility;
  - (2) Periodic redeterminations of eligibility;
  - (3) Eligibility redeterminations resulting from changes in access to ESI (*e.g.*, work status, residency, income, household composition, etc.); and
  - (4) The department's receipt of information indicating that an individual applying for or receiving VHAP or CHAP has access to and is eligible to enroll in an approved ESI plan.
- (b) A VHAP or CHAP beneficiary who becomes eligible for an ESI plan must notify the department of that change and cooperate with the department as provided in this rule.
- (c) If the department determines that the plan is an available, approved ESI plan and that it would be cost-effective for the individual to enroll in the plan, the individual will be notified of the determination and informed that plan enrollment with ESIA is a condition of retaining program eligibility. The individual must enroll in the plan at the earliest time permitted by the employer.
- (d) During the period of review, and pending enrollment in the ESI plan, the individual shall continue to be enrolled in VHAP or CHAP.

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4103.12 Plan Disenrollment

- (a) If the employee disenrolls from an ESI plan because the plan is no longer available, the individual shall be enrolled in VHAP or CHAP.
- (b) If the employee disenrolls in an ESI plan while the plan remains available, premium assistance and VHAP shall terminate. The individual may, at any time, requalify by reapplying for premium assistance, enrolling in an approved, available and cost-effective ESI plan, and otherwise satisfying program requirements.

4103.13 Termination of ESIA; ESI Plan No Longer Approved or Cost-Effective

Premium assistance will terminate if OVHA withdraws its approval of an ESI plan or determines that an individual's continued enrollment in a plan is no longer cost-effective. If premium assistance is terminated in this manner, VHAP-ESIA participants will return to the VHAP program and Catamount-ESIA participants will be offered the opportunity to purchase a CH policy with CHAP.

4103.14 Notice-and-Appeal Rights

- (a) Premium-assistance applicants and beneficiaries shall receive timely notification of department eligibility and enrollment determinations.
- (b) Notices will be in writing and sent by first-class mail to the most current address on file for the individual.
- (c) Notices shall:
  - (1) State the reason for any adverse decisions; and
  - (2) Explain the individual's right to request a fair hearing before the Human Services Board.
- (d) A notice of termination must be sent at least eleven days prior to disenrollment.
- (e) A VHAP or premium-assistance applicant or beneficiary has a right to appeal eligibility and enrollment decisions and to request a fair hearing before the Human Services Board.
- (f) A request for a fair hearing must be made within ninety days of the date the notice of the decision being appealed was mailed.

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4103.14 Notice and Appeal Rights (Continued)

- (g) Except as provided in paragraph (h) below, enrollment shall continue without change pending resolution of an appeal if:
- (1) The appeal challenges a decision to terminate a benefit;
  - (2) The beneficiary requests a hearing before the effective date of the termination; and
  - (3) The beneficiary has fully paid any required premiums.
- (h) Enrollment will not continue pending appeal if:
- (1) The appeal is based solely on a benefit reduction or elimination which is required by federal or state law affecting some or all beneficiaries, or
  - (2) The challenged decision does not require the minimum advance notice (see Notice of Decision at M141).
- (i) Beneficiaries appealing the amount of their premium balances or premium assistance must pay at the billed amount until the dispute is resolved in order for coverage to continue. If the fair-hearing process is concluded in favor of the beneficiary, the beneficiary will be reimbursed for any premium amounts overpaid.
- (j) VHAP beneficiaries who request a hearing after the effective date of termination will not receive continued benefits. In such a case, however, if the fair-hearing process is concluded in favor of the beneficiary, the department will pay the costs incurred in securing what would have been covered services during the appeal period. Payment will be made to the beneficiary if the beneficiary actually paid out of pocket to the provider. Otherwise, payment will be made to the provider.
- (k) Premium-assistance beneficiaries who request a hearing after the effective date of termination will not receive premium assistance pending resolution. If the fair-hearing process is concluded in favor of the beneficiary, the beneficiary's remedy will be reinstatement and reimbursement for the amount of premium assistance and wraparound coverage that would have been provided, had the benefit remained in effect.
- (l) Beneficiaries may waive their right to continued benefits. If they do so and are successful on an appeal, benefits will be paid retroactively.
- (m) For grievances and appeals regarding services for which the state is a payor, Medicaid Rules M180 and M181 apply.

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4104

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4104      General Rules for Calculation of Premium-Assistance Amounts

- (a) In general, the premium-assistance amount depends on the net income of the household on the most recent approved version of eligibility on the case record at the time the bill or premium-assistance payment is generated.
- (b) No premium assistance shall be paid for any month in which the assistance amount is less than \$5.00.

4105      VHAP-ESIA Benefits

4105.1      Premium Balances and Premium-Assistance Amounts

- (a) The VHAP-ESIA premium balance is equal to the amount of the VHAP premium that would have been paid, had the individual only been enrolled in VHAP. The VHAP premium amounts are set forth in VHAP rule 4001.91.
- (b) The VHAP-ESIA premium-assistance amount is the difference between the employee's share of the premium and the premium balance. For example, if the employee's share of the premium is \$120 and the premium balance is \$33, the monthly VHAP-ESIA premium assistance owing to the individual would be \$120 minus \$33 or \$87, which is paid to the individual.
- (c) If the employer offers more than one approved ESI plan, the individual may enroll in the plan of choice, provided that ESI enrollment remains cost-effective. The premium-assistance amount will be calculated as provided in paragraph (b), regardless of any differences in plan costs.
- (d) At the beginning of the month that the employee's premium share is due, the household shall receive the premium-assistance benefit. Monthly payments may be made either by mailing a check or electronically transferring payment to the designated account. If the household has a bank or credit-union account, direct deposit to the account is the required payment method.
- (e) In cases where the employee's share of the premium is paid before the commencement of premium assistance (*e.g.*, when plan enrollment occurs on a day other than the first of the month), the department shall reimburse the household for the prorated premium-assistance amount due for the period in issue.

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4105.2

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4105.2 VHAP-ESIA Wraparound Coverage

- (a) VHAP-ESIA wraparound coverage includes:
- (1) VHAP-covered health-care services not included in the approved ESI plan, and
  - (2) Cost sharing incurred under the ESI plan for VHAP-covered services that exceeds the cost-sharing requirements for VHAP enrollees. (See, 4001.91 and 4001.92).
- (b) To qualify for wraparound coverage, VHAP-ESIA enrollees must be served by a Medicaid-participating provider within the ESI network who agrees to bill the state for the wraparound services and cost sharing up to the Medicaid-allowed amount.
- (c) VHAP-ESIA enrollees will receive an ID card. This card, together with the individual's ESI group-health card is presented to health-care providers at the point of service to signify the department's responsibility for any VHAP-ESIA wraparound coverage. Payments for wraparound coverage will be made at the Medicaid rate.
- (d) The individual shall be fully responsible for the cost of any service that is not included in the ESI plan or VHAP.

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4106

4106 Catamount-ESIA Benefits4106.1 Premium Balances and Premium-Assistance Amounts

(a) The individual's premium balance shall be:

% FPL	Catamount-ESIA Premium Balance	
	Single	Two-Person
>150% but ≤200%	\$ 60.00	\$120.00
>200% but ≤225%	\$ 90.00	\$180.00
>225% but ≤250%	\$110.00	\$220.00
>250% but ≤275%	\$125.00	\$250.00
>275% but ≤300%	\$135.00	\$270.00

- (b) The Catamount-ESIA premium-assistance amount is the difference between the employee's share of the premium and the premium balance. Thus, for example, if the employee's share of the premium is \$130.00 per month and the household's income is at 195 percent of the FPL, the monthly ESIA premium-assistance would be \$130.00 minus \$60.00 or \$70.00.
- (c) If the employer offers more than one approved ESI plan, the individual may enroll in the plan of choice, provided that ESI enrollment remains cost-effective. The premium assistance will be calculated as provided in paragraph (a), regardless of any differences in plan costs.
- (d) At the beginning of the month that the employee's premium share is due, the household shall receive the premium-assistance benefit.. Monthly payments may either be made by mailing a check or electronically transferring payment to the designated bank. If the household has a bank or credit-union account, direct deposit to the account is the required payment method.
- (e) In cases where the employee's share of the premium is paid before the commencement of subsidy payments (*e.g.*, when plan enrollment occurs on a day other than the first of the month), the department shall reimburse the household for the prorated premium-assistance amount due for the period in issue.

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4106.2

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4106.2 Chronic-Care Wraparound Coverage

- (a) Until January 1, 2009, or statewide participation in the Vermont blueprint for health is achieved, the Catamount-ESIA program shall provide wraparound coverage for the cost sharing incurred under the ESI plan for VHAP-covered chronic care, as defined in paragraph (c).
- (b) To qualify for wraparound coverage, Catamount-ESIA enrollees must be served by a Medicaid-participating provider within the ESI network who agrees to bill the state for the wraparound cost sharing up to the Medicaid-allowed amount.
- (c) The services subject to wraparound coverage under this subsection are the chronic-care health services covered by the Vermont Health Access Plan to treat the chronic conditions specified in the blueprint for health in section 702 of Title 18. Annually, after consultation with the director of the blueprint for health, OVHA shall establish in procedure the codes that are associated with treatments for chronic conditions that are eligible for the assistance provided for in this paragraph.
- (d) Catamount-ESIA enrollees will receive an ID card. This card, together with the individual's ESI group health card, is to be presented to health-care providers at the point of service to signify the department's responsibility for any Catamount-ESIA wraparound coverage.
- (e) The individual shall be fully responsible for the cost of any service that is not covered by the ESI plan or VHAP.

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4107

4107 CHAP Benefits4107.1 Premium Balances and Premium-Assistance Amounts

- (a) The individual's premium balance for the lowest-cost CH plan shall be:

% FPL	CHAP Premium Balance	
	Single	Two-Person
>150% but ≤200%	\$ 60.00	\$120.00
>200% but ≤225%	\$ 90.00	\$180.00
>225% but ≤250%	\$110.00	\$220.00
>250% but ≤275%	\$125.00	\$250.00
>275% but ≤300%	\$135.00	\$270.00

- (b) The premium-assistance amount for the lowest-cost CH plan is the difference between the full CH premium and the CHAP premium balance. For example, if the lowest-cost CH premium is \$350 per month and the household's income is at 230 percent of the FPL, the individual's premium balance would be \$110 and the monthly CHAP premium assistance would be \$350 minus \$110 or \$240.
- (c) For CH plans other than the lowest cost plan, the individual's premium balance shall be the sum of the premium balance as set out in paragraph (a) and the difference between the premium for the lowest cost plan and the premium for the plan in which the individual is enrolled. Thus, if in the example above, the individual chooses a CH plan with a monthly premium of \$400, the individual's premium assistance remains \$240. The premium balance would be: \$110 plus (\$400 minus \$350), or \$160.
- (d) CHAP program participants pay their premium balances to the department, as provided in section 4108 below. The department is responsible for transmitting the full CH premium amount (the premium balance plus the CHAP premium assistance) directly to the CH carrier.

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4108

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4108      Premium Balance Collection Methods

- (a) The premium-collection provisions set forth in Medicaid Rule M150 are incorporated into this rule.
- (b) The department may collect premium balances from CHAP participants using any or all of the following methods:
  - (1) Electronic funds transfer (EFT): The eligible individual authorizes the bank to make an electronic fund transfer of the monthly premium balance directly from a savings or checking account to the department. The individual is given an EFT form to fill out. The individual will be notified by letter if the EFT premium payment was not successful.
  - (2) Direct pay: The individual pays the premium balance to the department by check or money order every month. A premium-payment coupon and pre-addressed envelope are mailed to the head of household before the premium balance is due. The check or money order and the premium payment are mailed to the department.
  - (3) The individual may pay with a credit card by providing the card information on the payment coupon.
  - (4) Cash may be exchanged for a free cashier's check at participating contracted banks.
- (c) If full payment of the premium balance is not timely received, the department will send a termination notice to the individual.
- (d) Incomplete electronic fund transfers and dishonored checks are treated as non-payments.

4109      Premium Payments

Every month that the department receives a premium-balance payment from a CHAP beneficiary, it shall forward that sum, along with the premium assistance amount, to the beneficiary's CH provider.

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4110

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4110 Payment Adjustments4110.1 Underpayments

- (a) Department errors that result in underpayment of premium assistance shall be promptly corrected retroactively under the following conditions:
- (1) When the information was available to the department at the time the error occurred to enable authorization of the correct amount.
  - (2) Retroactive corrected payment shall be authorized only for the twelve months preceding - the month in which the underpayment is discovered. Payments shall be authorized irrespective of current receipt of, or eligibility for, benefits.
  - (3) The retroactive corrective payments shall not be considered as income in the month paid or in the following month.
- (b) Corrective payments shall be retroactive to the effective date of the incorrect action, not subject to the above limitations, when:
- (1) Ordered as a result of a fair hearing or court decision.
  - (2) Authorized by the Commissioner as the result of a department decision rendered on a formal appeal prior to hearing.
- (c) Retroactive corrective payments will be applied first to any outstanding unrecovered overpayment. The amount of corrective payment remaining, if any, shall be paid to the beneficiary.

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4110.2

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4110.2 Overpayments

- (a) Overpayments of premium assistance, whether resulting from administrative error, beneficiary error, or payments made pending a fair hearing which is subsequently determined in favor of the department, shall be subject to recovery. Recovery of an overpayment can be made through beneficiary repayment or by a reduction in the amount of any current or future premium-assistance payment the household may receive.
- (b) No recovery shall be attempted if the overpayment took place more than twelve months prior to the date of discovery unless the overpayment was caused by the individual's willful withholding of information which affected the amount of payment. In such cases, recovery of overpayments which took place within a three-year period prior to the date of discovery can be attempted.
- (c) The beneficiary may elect to repay an overpayment through a lump-sum cash payment or, with the agreement of the department, installment payments. If the installment method elected, the monthly payment amount must be at least ten percent of the current monthly health-care benefit or \$10.00 per month, whichever is more. Installment terms must be recorded in a written document, signed by the beneficiary and an authorized representative of the department. If the beneficiary fails to submit a payment in accordance with the terms of an agreed-upon repayment schedule, the claim becomes delinquent and subject to collection through reduction in premium-assistance benefits or as otherwise provided for by law. If the beneficiary fails to elect a recovery method, recovery will be made by a reduction in the amount of any current or future premium-assistance payment the household may receive. The monthly reduction shall equal ten percent of the monthly benefit or \$10.00, whichever is more.

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M150.1 P.2

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M150     Payment System

M150.1   Cost Sharing Requirements (Continued)

B.       Premium

This section describes the general premium rules and process. Additional rules applicable to the specific coverage groups subject to these premium rules vary, and are described in the following sections: Dr. Dynasaur (M302.26 and M302.27), VHAP (4000), VHAP-Pharmacy (3300), and VScript (3200).

Coverage always begins on the first day of a month and only after the full premium has been received. Beneficiaries must pay the full monthly premium before coverage will begin, even if the department finds them eligible in all other respects before the first day of the next month. Coverage will not begin in the first day of a month after the full premium has been received, if the individual has not yet enrolled in Catamount Health. Applicants for Dr. Dynasaur may also be granted coverage during the months of application and billing provided all eligibility criteria were met during those months and the department has received and processed any premiums required for those months. They may also be granted retroactive coverage provided the requirements specified in M113 are met.

The department's premium billing cycle is designed to make it as easy as possible for beneficiaries to maintain their monthly premium payments and avoid loss of coverage. The department's automated premium collection and distribution system manages the receipt and processing on the day of receipt of premiums if paid according to the billing directions.

The department will:

- send premium bills at least 25 days before the last day of the month, which is the date that coverage will end if the department does not receive the payment;
- mail beneficiaries a notice of impending closure at least 11 days before coverage ends for nonpayment of a premium;
- reinstate coverage without a break in benefits if the department receives the payment by the last day of the month, or the first business day following the last day of the month in which the due date falls.

When households with more than one coverage group make a partial payment of a bill that includes more than one premium, the payment will be applied as payment of one or more premiums in full rather than as a partial payment of all of the billed premiums. Beneficiaries who want to choose which premium to pay must call the Member Services number on the bill to record that designation on the case record.

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M150.1 P.3

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M150     Payment SystemM150.1   Cost Sharing Requirements (Continued)

In the event the beneficiary has not made the designation, the department will apply the partial payment to the following coverage groups in the following order: (1) Dr. Dynasaur; (2) VHAP; (3) VHAP-Pharmacy (or VPharm 1); (4) VScript (or VPharm 2 or 3); and (5) Catamount Health Assistance Program. If there is more than one beneficiary in the same coverage group with the same premium amount, the department will apply the partial payment to the first beneficiary listed on the bill.

In the event of an overpayment, the department will retain and reflect it as a credit on the next premium bill. When coverage ends, to expedite a possible reinstatement if requested, the department will wait 30 days before reimbursing a beneficiary any credit remaining on the account. If coverage remains closed for 30 days, DCF will issue a refund within 10 business days thereafter. If it will be a financial hardship to apply an overpayment in this way, beneficiaries may request that the department reimburse the overpayment within 30 days.

The department will automatically reimburse a beneficiary the amount of a premium within 30 days from when coverage terminates before the month the premium pays for because the beneficiary:

- moves out of state;
- moves from a premium-based coverage group to a non-premium-based group;
- becomes ineligible because of an increase of income; or
- dies.

In addition to premiums, health care beneficiaries may also be responsible for copayments for some services, which are described below.

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M302.26

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**M302.26 Children Under 18 (Dr. Dynasaur)**

Children under age 18 who would be eligible for ANFC-related Medicaid except that their income or resources exceed the maximums are categorically eligible for Dr. Dynasaur as long as their household income does not exceed 300 percent of the federal poverty level (FPL). There is no resource test under this provision.

Premiums as specified in M150-M150.2 are required for the following individuals within this coverage group. Individuals requesting Dr. Dynasaur with income above 185 percent of the FPL but no more than 225 percent are required to pay a monthly premium of \$15 per household before coverage will begin or continue. Those with incomes above 225 percent but no more than 300 percent of the FPL must pay a \$20 monthly premium if the family has other insurance that includes hospital and physician coverage and a \$40 monthly premium if the family has no insurance besides Dr. Dynasaur.

When a single household includes more than one individual eligible for Dr. Dynasaur coverage, the household must pay the highest applicable Dr. Dynasaur premium.

Children who are members of federally designated American Indian or Alaskan Native tribes, as designated by the federal Bureau of Indian Affairs do not have to pay a premium if their household income is more than 225% but less than or equal to 300% FPL and they have no other insurance. Abenaki is not a federally designated tribe. If other children in the household are beneficiaries but not members of a federally-designated tribe, then the household is still responsible for the premium.

Children qualifying for Medicaid under Dr. Dynasaur and the Disabled Child in Home Care (DCHC/Katie Beckett) coverage group (see M200.23(d)) may select which of the two sets of rules that they wish to have determine their eligibility. An applicant applying under the DCHC coverage group who is eligible under Dr. Dynasaur shall receive Dr. Dynasaur coverage while the application is pending.

To assist applicants in making a decision between the two coverage groups, the department will provide the applicant with the requirements specific to the two groups, including the service delivery systems used, the process for determining eligibility, the time for processing applications, and the cost-sharing requirements of beneficiaries in each group.

DCF updates its income maximums based on the FPL annually on January 1 using a methodology similar to the one employed by the federal government in setting the FPLs. In years when the actual FPL exceeds DCF's income maximum, DCF will issue a second increase on April 1.

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M302.27

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**M302.27 Pregnant Women (Dr. Dynasaur)**

Pregnant women who would be eligible for ANFC-related Medicaid except that their income or resources exceed the maximums are categorically eligible for Dr. Dynasaur as long as their family income does not exceed 200 percent of the federal poverty level (FPL), without regard to any change in their Medicaid group's income during pregnancy and during the 60-day post-pregnancy period, which ends on the last day of the month during which the 60<sup>th</sup> day falls. There is no resource test under this provision.

Although a woman may be granted up to three months retroactive coverage if she was pregnant and met all eligibility criteria, she is not eligible for the 60-day post-pregnancy period if she applies after her pregnancy has ended. However, she may be eligible after her pregnancy ends based on another categorical criterion or coverage provision and a different income test.

Pregnant women with income above 185 percent of the FPL but no more than 200 percent are required to pay a monthly premium of \$15 for coverage.

When a single household includes more than one individual eligible for Dr. Dynasaur coverage, the household must pay the highest applicable Dr. Dynasaur premium.

DCF updates its income maximums based on the FPL annually on January 1 using a methodology similar to the one employed by the federal government in setting the FPLs. In years when the actual FPL exceeds DCF's income maximum, DCF will issue a second increase on April 1.

**M302.28 Other ANFC-Related Categorically Eligible Coverage Groups**

- (a) (Newborns) A child born to a woman eligible for and receiving Medicaid on the date of the child's birth is categorically eligible for ANFC-related Medicaid. The child is deemed eligible for two months after birth. The child remains eligible for up to twelve months if the child remains in the same household as the mother and the mother remains eligible, or would be eligible if pregnant. Children are considered members of their mother's household if they are continuously hospitalized after birth, unless the mother has legally relinquished control or abandoned them.
- (b) (Adoption or Foster Care) Children under the age of 21 living in Vermont for whom an adoption assistance agreement is in effect or foster care maintenance payments are being made (by any state) under title IV-E of the Act are automatically eligible for ANFC-related Medicaid. Committed children in the custody of SRS not IV-E eligible must pass the applicable eligibility tests before their eligibility for Medicaid can be established.

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#### 4000 Introduction

The General Assembly of the State of Vermont, in enacting Act 14 (1995), created a health security trust fund for the purpose of providing expanded access to health care benefits for uninsured low-income Vermonters. This coverage is provided under the Vermont Health Access Plan for the uninsured (VHAP).

Access is expanded by an approved waiver from the Health Care Financing Administration (HCFA) that eliminates the Medicaid categorical test and the resource test for individuals age 18 or over. Vermont's approved 1115 Research and Demonstration Medicaid Waiver also authorizes the Agency of Human Services to require enrollment in managed care as a condition of eligibility for this new coverage group and to limit the covered services provided to VHAP beneficiaries. Additional provisions of the Medicaid program are waived. (Refer to M100 section of policy Purpose-Medicaid Program and Purpose-Vermont Health Access Plan). If an individual has access to an employer-sponsored-insurance (ESI) plan, enrollment in the ESI plan with premium assistance is a condition of eligibility for VHAP if the plan is approved and available, and the department determines that enrollment will be cost-effective. (4102.2).

The policies that follow implement the Vermont Health Access Plan (VHAP) program, including the requirements for eligibility and, if required, for enrollment in managed health care plans. The requirement to enroll in a managed health care plan is subject to plan availability and capacity.

#### 4001 Eligibility

An individual must meet all of the following requirements (4001.1 - 4001.91) to be found eligible for this program.

##### 4001.1 Age

An individual age 18 or over meets the age requirement.

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4001.2

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4001.2 Uninsured or Underinsured

Individuals meet this requirement if they do not qualify for Medicare and have no other insurance that includes both hospital and physician services, and did not have such insurance within the 12 months prior to the month of application, unless they meet one of the following exceptions specified below.

## (a) Exceptions related to loss of employer-sponsored coverage

Individuals who had coverage under another health insurance plan within the 12 months prior to the month of application meet this requirement if their employer-sponsored coverage ended because of:

- loss of employment;
- death of the principal insurance policyholder;
- divorce or dissolution of a civil union;
- no longer qualifying as a dependent under the plan of a parent or caretaker relative; or
- no longer receiving COBRA, VIPER or other state continuation coverage.

## (b) Exceptions related to loss of college or university-sponsored coverage

Individuals who had coverage under another health insurance plan within the 12 months prior to the month of application meet this requirement if college or university-sponsored health insurance became unavailable to them because they graduated, took a leave of absence, or otherwise terminated their studies.

Students under the age of 23 enrolled in a program of an institution of higher education are not eligible for coverage, however, if they:

- have elected not to purchase health insurance covering both hospital and physician services offered by their educational institution; or
- are eligible for coverage through the policy held by their parents, but their parents have elected not to purchase this coverage.

## (c) Exceptions related to loss of coverage for low-income applicants

Individuals who had coverage under another health insurance plan within the 12 months before the month of application also meet this requirement if their household income, after allowable deductions, is at or below 75 percent of the federal poverty guideline for households of the same size.

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4001.9 Cost-Sharing Requirements4001.91 Premium

Individuals meet this requirement when they have paid any required premium as specified in M150 - M150.2. The amount of the premium for each individual increases according to VHAP income maximums (P-2420) based on the federal poverty level (FPL) as shown in the following chart:

<u>Income Maximums</u>	<u>Monthly Premium per Individual</u>
0 - 50% FPL	\$ 0
> 50% but ≤ 75% FPL	\$7.00
> 75% but ≤ 100% FPL	\$25.00
> 100% but ≤ 150% FPL	\$33.00
> 150% but ≤ 185% FPL	\$49.00

4001.92 Copayment

There is a copayment requirement of \$25 per medically necessary hospital emergency room visit, as defined in M103.3 (13) and (37).

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4002 Eligibility Process4002.3 Period of Eligibility and Enrollment (Continued)

Individuals who have been disenrolled from the VHAP program must file a new application for the program before eligibility may be re-established.

A review of eligibility will be completed before the end of each certification period to assure uninterrupted coverage if the individual remains eligible, complies in a timely manner with review requirements, and pays any required premium by the due date. An individual who fails to comply timely with review requirements and paying any required premium shall receive a termination notice mailed at least 11 days before the termination date. A failure to comply timely may result in a gap in coverage.

4002.31 VHAP-Limited Coverage

Individuals applying for VHAP will receive limited coverage, as described in the Medicaid Procedures Manual section P-4003, at no cost between the date the department determines eligibility and the date full coverage begins. Full coverage begins on the first day of the month after the department has processed the full premium payment as specified at M150-M150.2. Individuals who do not pay the full premium by the due date are responsible for all bills incurred during that limited coverage period. The notice of eligibility the department sends individuals describes the limited coverage and includes a warning that failure to pay the full premium by the due date will result in no coverage for any bills incurred since the date of eligibility. Individuals will also be notified of the requirement that they must choose a primary care provider by the premium due date, or one will be chosen for them by the department.

When an individual's coverage is cancelled in whole or in part due to nonpayment of the premium and the individual attempts to reenroll within twelve months, limited coverage will be provided only if the individual meets one of the five exceptions listed below.

(A) The individual or spouse had employer-sponsored insurance that terminated because of:

- loss of employment;
- death of the principal insurance policyholder;
- divorce or dissolution of a civil union;
- no longer qualifying as a dependent under the plan of a parent or caretaker relative; or
- no longer receiving COBRA, VIPER or other state continuation coverage.