

P A T H

Department of Prevention, Assistance, Transition, and Health Access

FROM Eileen I. Elliott, Commissioner
for the Secretary

BULLETIN NO. 02-19F

DATE 6/28/02

SUBJECTS Clarification of VHAP Rule on Uninsured
or Underinsured

CHANGES ADOPTED EFFECTIVE 7/1/02

INSTRUCTIONS

- Maintain Manual - See instructions below.**
- Proposed Regulation - Retain bulletin and attachments until you receive Manual Maintenance Bulletin: _____**
- Information or Instructions - Retain until _____**

MANUAL REFERENCE(S)

4000
4001

This bulletin changes the *Vermont Health Access Plan* (VHAP) eligibility rules as required by the fiscal year 2003 budget act, H. 766 (2002), enacted by the Vermont General Assembly. This bulletin was filed using the expedited rule-making process authorized by the budget act. The changes are summarized below.

Changes to VHAP Eligibility Rules

VHAP currently limits coverage to persons who are uninsured at the time they apply for benefits. Under current rules, some applicants who have lost other coverage may have to wait one year from the effective date of loss of other coverage to become eligible for VHAP. The budget act changes the eligibility rules for applicants who have had coverage for hospital and physician services in the past twelve months. Under the budget act, the one year waiting period is waived for certain individuals who have lost employer-sponsored coverage, college or university sponsored coverage, or applicants with income below 75 percent of the federal poverty level.

Summary of Written Comments

Written comments were received from the Office of Health Care Ombudsman seeking clarification about implementation and will be responded to separately. No other comments concerning the proposed rule were received.

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

Three dots at the bottom of a page after the last line of text and three dots at the top of the following page before the first line of text indicate that text has been moved.

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

<u>Manual Maintenance</u>	
<u>Remove</u>	<u>Insert</u>
PP&D Facing Page 4000 Dated 8/2/96	Nothing
4000 (98-23F)	4000 (02-19)
Nothing	4001.2 (02-19)

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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).

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

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 qualifying for 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.

The new provisions in this section, marked by a solid line at the left, will be implemented upon approval from the Centers for Medicare and Medicaid Services.