

STATE OF VERMONT
AGENCY OF HUMAN SERVICES

DCF

Department for Children and Families

BULLETIN NO.: 08-40F

FROM: Joseph Patrissi, Deputy Commissioner
Economic Services Division

DATE: November 20, 2008

SUBJECT: Amendments to the Vermont Health Access Program (VHAP),
Employer-Sponsored Insurance Assistance (ESIA) Program, and
the Catamount Health Assistance Program (CHAP)

CHANGES ADOPTED EFFECTIVE: 12/4/08

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):

4001.2 (5312)	4102.5 (5914)	4103.14 (5930)	4107.1 (5963)
4101 (5901)	4103.3 (5923)	4106.1 (5961)	4108 (5970)

This bulletin proposes changes to the health-care programs referred to above. The changes implement:

- (i) A premium-indexing requirement,
- (ii) Interim coverage, pending transition between health-care programs;
- (iii) A new premium-assistance waiting period relating to the high-deductible exception to Catamount Health (CH) waiting period;
- (iv) A limitation on reenrollment in a health-care program prior to completion of certain requirements that were unmet in a prior application attempt; and
- (v) Statutory modifications of the definition of "uninsured." The proposed changes are summarized below.

Comment Period

A public hearing was held on Monday, October 13, 2008 at 2:00 p.m., in the DCF Commissioner's Conference Room, 5 North, State Office Complex, Waterbury, Vermont. No one attended.

No written comments were received from members of the public. However, we did make several changes to the proposed rule in response to internal staff comments. The changes are summarized as follows:

4106.1(a) (5961(a)): Catamount-ESIA premium-balance table eliminated as redundant. Timing for adjustment of premium balances changed from “January” to “once each year.”

4107 (5963): Methodology for indexing CHAP premium balances clarified. Timing of adjustment is amended to link the process to carrier premium increases, which could be made from one to four times each year. Example on page two amended to better represent premium-balance-adjustment methodology.

4108.2 (5970): Adds VHAP to the list of programs eligible for seamless coverage at times of transition.

The last change clarifies a benefit that we had intended to include in the proposed rule. We do not believe that the other changes will adversely impact applicants or beneficiaries.

Summary of Rule Changes

New Number	Current Number	Description of change
5312 5901	4001.2 4101(I)	Modifies the definition of “uninsured” to include: (i) loss of employer- or college-sponsored insurance because of reduced hours or course of study and (ii) domestic-violence exception to 12-month waiting period.
5914	4102.5	Provides that individuals who are enrolled in CH solely under the high-deductible standard outlined in 8 V.S.A. § 4080f(a)(9) are not eligible for premium assistance for the 12-month period following the date of enrollment in CH.
5922	4103.2	Bars enrollment in a health-care program prior to completion of certain application requirements when those requirements are not met in connection with a prior application for benefits.
5930	4103.14	Clarifies that coverage pending appeal is unavailable in cases where appeal is solely based upon termination of seamless coverage.
5961	4106.1	Establishes methodology for indexing Catamount-ESIA premium balances.
5963	4107.1	Establishes methodology for indexing CHAP premium balances.
5970	4108	Provides for continuation of coverage pending transition between health-care programs.

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/aparules/> 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.

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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
Refugee - VHAP Rules
VHAP Rules

	<u>Remove</u>		<u>Insert</u>
4001.2	(07-24)	4001.2	(08-40)
Nothing		4001.2 P.2	(08-40)
<u>Premium-Assistance Program Rules</u>			
4101 P.2	(07-24)	4101 P.2	(08-40)
4102.4 P.2	(08-22)	4102.4 P.2	(08-40)
4103.2 P.2	(07-24)	4103.2 P.2	(08-40)
4103.14 P.2	(07-24)	4103.2 P.2	(08-40)
4106	(08-22)	4106	(08-40)
4107	(08-22)	4107	(08-40)
Nothing		4107.1 P.2	(08-40)
4108	(07-24)	4108	(08-40)

4001.2 Uninsured

“Uninsured” means:

- (a) An individual with household income, after allowable deductions, at or below 75 percent of the federal poverty guideline for households of the same size;
- (b) An individual who had no private insurance or employer-sponsored coverage that includes both hospital and physician services within 12 months prior to the month of application;
- (c) An individual who lost private insurance or employer-sponsored coverage during the prior 12 months for the following reasons:
 - (1) The individual’s coverage ended because of:
 - (i) Loss of employment, including a reduction in hours that results in ineligibility for employer-sponsored coverage, unless the employer has terminated its employees or reduced their coverage for the primary purpose of discontinuing employer-sponsored coverage and establishing their eligibility for Catamount Health;
 - (ii) Death of the principal insurance policyholder;
 - (iii) Divorce or dissolution of a civil union;
 - (iv) No longer receiving coverage as a dependent under the plan of a parent or caretaker relative; or
 - (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, decreased enrollment below a threshold set for continued coverage, or otherwise terminated studies. However, students under the age of 23 enrolled in a program of an institution of higher education are not eligible for coverage, if they:
 - (i) Have elected not to purchase health insurance covering both hospital and physician services offered by their educational institution; or
 - (ii) Are eligible for coverage through the policy held by their parents, but their parents have elected not to purchase this coverage.

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4001.2 P.2

4001.2 Uninsured (Continued)

- (d) (A) The individual lost health insurance as a result of domestic violence. The individual shall provide the agency of human services with satisfactory documentation of the domestic violence. The documentation may include a sworn statement from the individual attesting to the abuse, law enforcement or court records, or other documentation from an attorney or legal advisor, member of the clergy, or health care provider, as defined in section 9402 of Title 18. Information relating to the domestic violence, including the individual's statement and corroborating evidence, provided to the agency shall not be disclosed by the agency unless the individual has signed a consent to disclose form. In the event the agency is legally required to release this information without consent of the individual, the agency shall notify the individual at the time the notice or request for release of information is received by the agency and prior to releasing the requested information.
- (B) This subdivision shall take effect upon issuance by the Centers for Medicare and Medicaid Services of approval of an amendment to the Global Commitment for Health Medicaid Section 1115 Waiver allowing for a domestic violence exception to the Catamount Health premium assistance waiting period.
- (e) Notwithstanding any other provision of law, when an individual is enrolled in Catamount Health solely under the high deductible standard outlined in 8 V.S.A. § 4080f(a)(9), the individual shall not be eligible for the Vermont health access plan for the 12-month period following the date of enrollment in Catamount Health.

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, including a reduction in hours that results in ineligibility for employer-sponsored coverage, unless the employer has terminated its employees or reduced their hours 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 receiving coverage as a dependent under the plan of a parent or caretaker relative;
 - (v) No longer receiving COBRA, VIPER, or other state continuation coverage.
 - (2) College- or university-sponsored health insurance became unavailable to the individual because the individual graduated, took a leave of absence, decreased enrollment below a threshold set for continued coverage, or otherwise terminated studies.
 - (3)
 - (i) The individual lost health insurance as a result of domestic violence. The individual shall provide the agency of human services with satisfactory documentation of the domestic violence. The documentation may include a sworn statement from the individual attesting to the abuse, law enforcement or court records, or other documentation from an attorney or legal advisor, member of the clergy, or health care provider, as defined in section 9402 of Title 18. Information relating to the domestic violence, including the individual's statement and corroborating evidence, provided to the agency shall not be disclosed by the agency unless the individual has signed a consent to disclose form. In the event the agency is legally required to release this information without consent of the individual, the agency shall notify the individual at the time the notice or request for release of information is received by the agency and prior to releasing the requested information.
 - (ii) Subdivision (i) of this subdivision (3) shall take effect upon issuance by the Centers for Medicare and Medicaid Services of approval of an amendment to the Global Commitment for Health Medicaid Section 1115 Waiver allowing for a domestic violence exception to the Catamount Health premium assistance waiting period.
- (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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4102.4 P.2

4102.4 CHAP (Continued)

- (e) Meets the other eligibility requirements in Medicaid Rules (4100) 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 (5901) 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.
- (c) Notwithstanding any other provision of law, when an individual is enrolled in Catamount Health solely under the high-deductible standard outlined in 8 V.S.A. § 4080f(a)(9), the individual shall not be eligible for VHAP or premium assistance for the 12-month period following the date of enrollment in Catamount Health.

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 (5320) 4001.8.

4103.2 Cooperation Requirements

- (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.
- (c) If an individual:
 - (1) Fails to timely complete and return a required Plan Information Sign-Up Letter (PIRL) (4103.4) 5924 or Plan Sign-Up Letter (PSL) (4103.9) 5924.5;
 - (2) Subsequently reapplies for benefits within twelve months; and
 - (3) Is again required to complete and return a PIRL or PSL,

the individual will not be enrolled in any health-care program until after the required forms are timely completed and returned.

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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4103.14 P.2

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,
 - (2) The challenged decision does not require the minimum advance notice (see Notice of Decision at M141), or
 - (3) The appeal is based solely upon termination of interim seamless coverage provided pursuant to 4108 below.
- (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.

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

- (a) Pursuant to 33 V.S.A. § 1974(c)(3), the department set the initial Catamount-ESIA premium balances at amounts equal to the premium balances established in statute for CHAP. To ensure future program parity, once each year the Catamount-ESIA premium balances shall be adjusted to equal the CHAP premium balances in effect at that time. Catamount-ESIA premium balances are published in P-2420 A of the department's Medicaid Procedures.
- (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 \$65.00 or \$65.00.
- (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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4107 CHAP Benefits4107.1 Premium Balances and Premium-Assistance Amounts

- (a) Premium Balances are published in P-2420 A of the department's Medicaid Procedures.
- (b) Initial CHAP premium balances were established in statute. (33 V.S.A. § 1984(b)). That provision directs the department to index premium balances to the overall growth in spending per enrollee in Catamount Health. The following methodology shall be used for this purpose:
 - (1) Premium balances established in statute are the "base premium balances."
 - (2) One to four times each year, the CH carriers will review product premiums and set new rates. Following the first premium changes, the department will proportionately adjust the base premium balances, rounding to the nearest whole dollar. The new premium balances become the "adjusted-base" premium balances. The department shall likewise readjust adjusted-base premium balances following the carriers' every subsequent premium change.
 - (3) If new base premium balances are established in statute, the department shall subsequently adjust the new base premium balances in the same manner provided above.
 - (4) New applicants shall pay the premium balance in effect on the date of enrollment.
 - (5) Premium balances charged to enrolled beneficiaries are subject to change on enrollment anniversary dates. The new premium balances will correspond to the premium balances in effect on the enrollment anniversary date.

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4107.1 P.2

4107 CHAP Benefits4107.1 Premium Balances and Premium-Assistance Amounts (Continued)

(6) This methodology is illustrated as follows:

Date	Premium	% Increase Over Prior Dec. Premium	Premium Balance 200-225% FPL
Dec. 31, 2008	\$393.00		\$110.00
July, 2009	\$432.00	10%	\$121.00
January, 2010	\$441.00	2%	\$123.00
July, 2010	\$454.00	3%	\$127.00

In this example, in July of 2009, the CH premium increases by 10%. Therefore, the premium balance is likewise increased by 10% (from \$110.00 to \$121.00). In January of 2010, the CH premium increases from \$432 to \$441 an increase of 2%. Therefore, the premium balance for those applying on or after January 1 (or having an anniversary date that falls on or after January) is \$123.00 (2% more than \$121.00). The following July, the premium balance will be increased to \$127.00 (3% more than \$123.00). The beneficiary premium balance will be \$127 for those applying on or after July 1; the premium balance for beneficiaries will increase when the beneficiaries reach their anniversary dates, beginning with the July anniversary date.

- (c) 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 \$135 and the monthly CHAP premium assistance would be \$350 minus \$135 or \$215.
- (d) 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 \$215. The premium balance would be: \$135 plus \$50 (\$400 minus \$350), or \$185.
- (e) 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

4108 Seamless Coverage

From time to time, a beneficiary's changed circumstances may require a change from one health-care program to another. For example, a childless adult who is enrolled in VHAP will lose eligibility for that program when income rises above 150% FPL and become eligible for CHAP. This rule ensures that individuals retain coverage during program transitions brought about by changed circumstances.

4108.1 Transitions between VHAP and VHAP-ESIA

Coverage during transitions between VHAP and VHAP-ESIA is provided for in subsections 4103.3(b)(4) and (5925.1) 4103.11(d) above.

4108.2 Transitions from Medicaid, Dr. Dynasaur, VHAP, or VHAP-ESIA

Beneficiaries who become ineligible for Medicaid, Dr. Dynasaur, VHAP, or VHAP-ESIA due to changed circumstances shall retain coverage pending enrollment in an alternative premium-assistance program, if they:

- (a) Remain eligible for an alternative premium-assistance program and
- (b) Timely comply with the eligibility requirements pertaining to the alternative premium-assistance program.