

STATE OF VERMONT

HUMAN SERVICES BOARD

In re) Fair Hearing No. 16,748
)
Appeal of)

INTRODUCTION

The petitioner appeals a decision by the Department of Prevention, Assistance, Transition, and Health Access (PATH) denying her application for Vermont Health Access Program (VHAP) benefits. The issue is the validity of the Department's regulation imposing a 12-month waiting period for VHAP for low-income persons who have had but who lost health insurance during the twelve months prior to application.

FINDINGS OF FACT

The parties have stipulated to the following facts:

1. J.O. is the petitioner in this appeal of a decision denying her eligibility for VHAP coverage.
2. The petitioner is 55 years old and lives with her adult disabled daughter, R.O., in West Rutland, Vermont.
3. The petitioner's only source of income is \$804 per month in Social Security benefits which are paid in conjunction with her adult disabled daughter. She is financially eligible for VHAP coverage.

4. Prior to April, 2000, petitioner purchased health insurance coverage through Mutual of Omaha. Coverage under that policy began in approximately 1987. Initially, the policy had a \$500 deductible; by 1994, the deductible had increased to \$2,500.

5. At the time the petitioner's health care coverage ended in April, 2000, she was paying premiums of \$114.10 per month.

6. Since 1992, the petitioner has paid approximately \$10,800 in premiums to Mutual of Omaha.

7. Effective April, 2000, the petitioner was terminated from Mutual of Omaha. The company claimed that her April monthly premium was received on June 5, 2000, after the 31 day grace period had expired. In addition, Mutual of Omaha indicated that her policy would not be reinstated based on her claims history.

8. After intervention by the Vermont Department of Banking, Insurance, Securities and Health Care Administration ("BISHCA"), Mutual of Omaha offered the petitioner a new policy. However, the new policy had a deductible of \$3,500, which was \$1,000 higher than the policy that was canceled. The premiums were set to increase from \$114.10 per month to approximately \$120 per month.

9. The petitioner declined to purchase the new policy offered to her by Mutual of Omaha because she believed it was unaffordable given her income.

10. The petitioner's monthly income is insufficient to meet her monthly expenses for food, clothing, shelter and non-covered medical expenses. It is a significant hardship for her to pay monthly insurance premiums of \$120 for health insurance coverage. When coupled with her deductible, her total costs for medical expenses would represent 51% of her annual income.

11. The petitioner applied for VHAP coverage on October 11, 2000. The Department denied eligibility for VHAP pursuant to VHAP § 4001.2 on October 16, 2000, stating that the petitioner had insurance within the last twelve months which had been terminated without good cause.

The following additional findings of fact are made based on documents in the record and a further hearing held in this matter:

12. The petitioner requested a fair hearing on October 17, 2000. Following her appeal, the Board heard another case challenging the validity of the VHAP twelve-month waiting rule. Fair Hearing No. 16,414. The Board concluded on January 22, 2001 in a decision that included nine pages of legal analysis that the regulation at issue conflicted with

federal law. That decision was reversed by the Secretary of the Agency of Human Services on February 5, 2001 in a brief order which contained a one sentence legal explanation. The Secretary's reversal was appealed. (A copy of that reversal is attached to the Department's Supplemental Memorandum.)

13. Following this decision by the Board, the petitioner's attorney sought to consolidate her case with four other cases handled by other legal services attorneys that she felt involved similar facts and legal issues. The Department objected to the consolidation of all five cases but on April 4, 2001 agreed to consolidate the petitioner's case with two of the cases, Fair Hearing No. 16,596 and Fair Hearing No. 16,802, as they contained similar facts and legal issues.

14. The petitioner was found eligible for VHAP benefits in April of 2001 based on the passage of a year since she last had health insurance. The appeal continued in order to determine whether the petitioner should have been found eligible for benefits back to her initial application date of October 11, 2000.

15. For some months, the parties pursued settlement negotiations regarding both the consolidated cases and those which were not consolidated. The Board was notified by the

parties that all cases had been settled except the instant one.

16. On August 21, 2001, the hearing officer recommended to the Board that the Department's twelve-month rule be invalidated in this case because it conflicted with federal law. The decision relied on the reasoning of the Board in Fair Hearing No. 16,414, the case on appeal to the Supreme Court. At the hearing before the Board, the Department revealed that Fair Hearing No. 16,414 was no longer before the Supreme Court because it had been recently settled. The Department also asked the Board to consider an e-mail containing an opinion on the issue from its federal program director which it had attached to its memo but which had not been considered as part of the evidence. The hearing officer also expressed concern that no evidence had been placed in the record showing that the petitioner had incurred medical expenses from October 11, 2000 to April of 2001 for which she would have needed VHAP benefits.

17. The Board decided to remand the case so that (1) the hearing officer could inquire as to whether the settlement of the case before the Supreme Court indicated that the Department had changed its position with regard to its imposition of the twelve-month waiting rule for certain

persons who had dropped insurance coverage; (2) the Department could have an opportunity to offer the e-mail into evidence; and (3) information regarding the petitioner's medical expenses could be offered into evidence.

18. A further hearing was held for that purpose. The Department, however, refused to say (citing the attorney-client privilege) whether the Supreme Court case had settled based on a change in the Department's legal position, revealing only that the petitioner had withdrawn the appeal after a "communication" from the Department. The Department maintained that its legal position in that case has no bearing on this one.

19. The Department presented evidence that the senior administrator of the Office of Vermont Health Access had, at the request of the Director of that office, contacted the VHAP program officer in the federal Centers for Medicare and Medicaid Services to seek an opinion as to whether Vermont's Regulation at 4001.2 was consistent with the original waiver request and subsequent protocols. This request was made on June 26, 2001 as part of the Department's response to fair hearings filed challenging this provision. The request and opinion received by e-mail is attached hereto as Exhibits No. One and No. Two.

20. The petitioner presented evidence, which was not disputed by the Department, that she had incurred \$432.84 in medical bills between October 22, 2000 and April 1, of 2001 which would have been paid by VHAP if the petitioner had been found eligible.

ORDER

The decision of the Department of PATH finding the petitioner ineligible for VHAP benefits from October 11, 2000 to April 1, 2001 based on a twelve-month waiting requirement which commenced when the petitioner originally lost insurance in April of 2000 is reversed.

REASONS

The Vermont Health Access Plan (VHAP) was created for the purpose of "providing expanded access to health care benefits for uninsured low-income Vermonters". W.A.M. § 4000. The state regulation defining "uninsured" includes the following:

Uninsured or Underinsured

An individual meets this requirement if he/she does not qualify for Medicaid, does not have 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. The requirement that the applicant not have had such insurance during this 12-month period is waived if the department has agreed to pay all costs

of insurance because it is found it is cost-effective to do so or if the individual lost access to employer-sponsored insurance during this period because of:

- (a) loss of employment, or
- (b) death or divorce, or
- (c) loss of eligibility for coverage as a dependent under a policy held by the individual's parent(s).

W.A.M. § 4001.2

The petitioner first argues that the above provision is inconsistent with the federal Medicaid law governing the conditions under which Vermont can administer the VHAP program. She second argues that the regulation violated her rights under the Common Benefits clause of the Vermont Constitution. Finally, the petitioner argues that the Department is arbitrarily administering the above provision by granting ad hoc waivers to some persons in order to settle their appeals but not to others, again in violation of the Common Benefits clause of the Vermont Constitution.

I. ARBITRARY TREATMENT

With regard to the petitioner's final argument it should be noted at the outset that the allegation is a serious one but one which cannot be supported by any facts actually on the

record.¹ The Department's refusal to reveal whether it did make exceptions to its regulations in order to settle similar cases is very troubling. There can be no doubt that a state agency administering welfare benefits has an obligation to treat every similarly situated citizen in the same way under the state and federal constitutions. See Vermont Constitution, Chapter 1, Article 7 and the 14th Amendment to the U.S. Constitution. The Board has specifically held in a prior case that the Department may not administer the Medicaid program on an ad hoc and arbitrary basis and so cannot legally "compromise any individual case based on anything other than applicable law and regulations". Fair Hearing No. 13,296, pp. 5 and 6, June 9, 1995. At this point, the Board presumes that the Department has acted legally and in good faith in settling not only the case on appeal to the Supreme Court but also the companion cases to this one. It is unfortunate, however, that the Department has been unwilling to offer a confirmation of this on the record as it creates an unfortunate appearance of impropriety in the settlement of these cases.

¹ Even though the Department would not say whether it granted waivers to the other individuals who appealed, the other six persons who filed appeals on this matter were also represented by Vermont Legal Aid. Presumably, then the petitioner's attorneys know if the rules were waived for these other individuals but did not put that information into evidence.

II. CONFLICT WITH FEDERAL LAW

The petitioner's first legal argument in this case is that the Department's regulation at W.A.M. § 4001.2 is in conflict with federal law. The Department, for its part, argues that its regulation is consistent with the Medicaid waiver and that the board is not authorized to make a determination of conflict of law in this matter. The Department argues that the Board is bound by the determination of the Secretary of the Agency of Human Services in her reversal of Fair Haring No. 16,414 in which the Secretary found that there is no conflict.

The Department correctly points out that any Medicaid decision of the Board which is approved by the Secretary is "the final and binding decision of the agency" under 3 V.S.A. § 3091(h)(2). The Department argues that it must follow that any Medicaid decision which is reversed by the Secretary must also be final and binding on the agency. The Department argues that because the Board is part of the agency it is stripped of its statutory authority to determine conflicts in state or federal law by any prior decision in which the Secretary has addressed this issue and reversed the Board.

There is no authority for the Department's argument. Even if the statute did specifically state that reversals by

the Secretary are "final and binding on the agency", such a provision would have no effect on the Board. The Board is not the "agency" referred to in the statute. The Board is a separate entity which was created to operate within the agency for the purpose of hearing appeals. 3 V.S.A. § 3091(1). The Board's statutory duties in this case, and every case, are clearly spelled out by statute. Among those duties is an obligation to determine whether the Department's regulation is in "conflict with state or federal law". 3 V.S.A. § 3091(d), Stevens v. Department of Social Welfare, 159 Vt. 408, 416.

There is no reason for the Board not to carry out its statutory duties in this case.²

In order to determine whether there is a conflict between the Department's regulations and federal law, it is first necessary to establish what federal regulations govern Vermont's VHAP program. This is the point of main controversy between the parties because the pertinent part of the "federal

² Even if the Department's arguments could be considered correct, the Secretary's decision did not reach the constitutional issues which are presented here and offered only the most cursory explanation for the reversal of the prior finding of conflict with federal law with virtually no legal analysis. Such cursory decisions by the Secretary were disfavored by the Supreme Court in Howard, et. al. v. DSW, 163 Vt. 109 (1994). To rely on that decision to preclude the petitioner's right to be heard here under 3 V.S.A. § 3091 would be a gross denial of due process. The Secretary continues to have the authority under 3 V.S.A. § 3091(h)(1) to reverse this Medicaid program decision because it implicates the operation of Departmental regulations.

law" which applies in this case is not contained in the Social Security statutes themselves. See 42 U.S.C. 1396a. The Vermont Health Access Plan was created and receives the bulk of its funding under a "waiver" application which was filed by the State of Vermont and approved by the Department of Health and Human Services through its Centers for Medicare and Medicaid Services (formerly HCFA). 42 U.S.C. § 1315. Under the terms of this statute the Secretary of HHS "may waive compliance with any (state plan) requirements. . .to the extent and for the period he (sic) finds necessary to enable such State or States to carry out such project. . ." Id. When a waiver is requested, a state agency is bound by federal Medicaid law except as expressly provided by the terms of its waiver granted by HHS. See Boulet v. Celluci, 107 F.Supp.2d 61 (D. Mass., July 14, 2000); Makin v. Hawaii, 114 F.Supp.2d 1017 (D. Hawaii, November 26, 1999).

In February of 1995, the Vermont Agency of Human Services appealed to HHS for a waiver to implement and fund its VHAP program. The terms of the waiver were subsequently approved by HHS. In April of 1995, the legislature enacted 33 V.S.A. § 1972 to set up a trust fund to finance the state's share. The purpose of the VHAP program according to the statute was to "finance health care for uninsured or underinsured low

income Vermonters pursuant to statutes or rules that expand medical assistance programs through a federal waiver or otherwise". Id.

The 1995 waiver request contained both a narrative portion and a portion where specific exemptions were sought from Medicaid regulations. See "The Vermont Health Access Plan: A Statewide Medicaid Demonstration Waiver Initiative", February 23, 1995. In general, the narrative portion sought a waiver of income limits and categorical eligibility requirements in order to expand medical benefits to persons who had income equaling up to 150 percent of the federal poverty guidelines and who were neither parents with dependent children, disabled nor aged. The Department reported to the federal government that it wished to help low-income Vermonters who lack insurance, including working families whose total income is "still inadequate to pay private health insurance premiums and those who have no linkage to employer-based health coverage". Id. p. 1. Emphasis was placed on serving those with the greatest need first and ensuring that the limited enrollment slots would go to those with the lowest incomes. Id. p. 3. Special concern was expressed for low-income families who resisted purchasing costly individual

insurance because their income was "more urgently needed for basic living expenses".

The narrative explained to the federal government that the state intended to enact "special rules" to prevent employers from dropping health plans for low-income employees who might then be eligible for VHAP. Id. p. 4. The Department stated that is intended to enact a program designed to limit eligibility in the following way:

Coverage will be limited to persons within defined income limits who are uninsured at the time they apply for benefits under VHAP. Applicants who voluntarily drop other health insurance coverage will have to wait one year (from the effective date of loss of other coverage) to become eligible for VHAP.

Subsequent to this narrative, the Department specifically set out a list of Medicaid provisions from which it wished to be exempted. Id. pp. 78-83. In order to enact the "uninsured" provision and the "twelve-month waiting" provision, the Department needed a waiver of the specific provisions in the Medicaid law which conflicted with its VHAP plan. Among those are provisions which prohibit waiting periods and which clearly allow recipients to have other health insurance. See 42 U.S.C. § 1396(a)(8) and 42 U.S.C.

§ 1396a(a)(25).³ Curiously, the Department did not specifically ask to waive those provisions. Technically, then those provisions which are not expressly waived would still operate in the new Medicaid waiver program. See Boulet and Makin, supra. This failure to ask for a specific waiver would seemingly be a ground alone to determine that the above provisions (prohibiting waiting periods and allowing other insurance) are still in effect. If that is the case, the Department's regulation which indisputably provides for a waiting period for certain otherwise eligible individuals and which completely eliminates persons who have other insurance from the program conflicts on its face with the federal provisions.

However, the petitioner does not argue that the Department failed to ask for a specific waiver of provisions which conflict with these portions of the VHAP plan. Rather, the petitioner argues that the representations made in the narrative stating that persons would not be covered if they had voluntarily dropped health insurance in the prior twelve

³ 42 U.S.C. § 1396a(a)(8) requires that a State plan "must provide that assistance shall be furnished with reasonable promptness for all eligible individuals." 42 U.S.C. § 1396a(a)(25) is a complex section requiring states to use Medicaid only to pay for services not covered by other insurance and to recover from other health insurance any amounts for which they should be liable. This provision clearly contemplates that persons may be eligible for Medicaid even if they have other insurance.

months is the principle which was approved by the Medicaid division under the waiver law and now has the force and effect of federal law. The Department does not disagree with that assertion. In fact, the Department has offered a statement by the federal officer in charge of the VHAP project confirming that the demonstration application is the blueprint for the program and that the policies and procedures used by the Department must not conflict with "the Medicaid statute, regulation, or the approved waivers, expenditure authorities, or terms and conditions of the section 1115 demonstration". (Emphasis added.) See Attachment No. 2.

The parties agree then that the "federal law" which is applicable in this case is the language in the waiver which restricts the coverage.⁴ That language states that coverage is limited "to persons. . .who are uninsured at the time they apply for benefits" unless the applicant has "voluntarily dropped other health insurance coverage" in which case that

⁴ The Department has put forth an alternative argument that its current "Protocol" dated January 2001 which contains the exact language of its regulation with regard to recently insured applicants should be viewed as an update on its original application. There was no evidence offered that this protocol was approved as an actual amendment to the original waiver. The Department itself offered a statement from the federal project officer that, like procedures and regulations, operational protocols flesh out the details of the state plans. It cannot be found, therefore, that protocols are the "official amendments" referred to by the federal officer as necessary to change the blueprint. Presumably, an amendment to the waiver application would have to come in the form of an amended application with

person would "have to wait for a year (from the effective date of loss of other coverage) to become eligible for VHAP". 1995 VHAP Waiver Application at p. 14, see above.

The question for the Board is whether the language cited in the above paragraph conflicts with the provisions of Section 4001.2 cited in the first paragraph (p. 8) of this analysis. There is no dispute between the parties about the meaning of the Department's regulation. It eliminates from eligibility all persons who currently have or who during the past twelve months have had insurance covering hospital and physician services. A waiver is granted from that disqualification for persons who once had but who lost employer-sponsored insurance due to loss of employment, death, divorce or loss of dependent status under a policy held by parents. A waiver may also be granted for persons who currently have insurance if the Department determines to cover the cost of the premium.

The Department argues that the regulation is consistent with the principle found in its waiver application because it does exempt certain individuals who have involuntarily lost their insurance in the twelve months prior to application. In

specific requests for waivers which must be approved by the federal officer in charge of the Medicaid program.

support of its contention, the Department argues that the "interpretation" of the Secretary of the Agency that there is no conflict is entitled to deference. Similarly it argues that the "interpretation" of the federal officer who is in charge of the VHAP program (see Exhibit No. 2) finding that the language in the regulation at W.A.M. § 4001.2 is consistent with the VHAP 1115 application should also be given deference on this issue.

The relevant issue here is not the meaning of a state regulation but rather the meaning of the federal law. No deference is owed to the Department in interpreting federal laws. Brisson v. Department of Social Welfare, 167 Vt. 148, 152 (1997). Certainly deference would be due to the federal government in interpreting its own law--in this case the meaning of the waivers it granted. However, no interpretation of the waiver by the federal government as to the meaning of the waiver provision was offered in this case. All that was offered by the federal officer was an unexplained opinion that there was no conflict between the waiver and the regulation. The Board is not bound by that opinion. As was stated previously in this analysis, the decision as to whether there is a conflict between state and federal law in any appeal is

the statutory province of the Human Services Board. 3 V.S.A. § 3091(d).

The conclusion reached by the Board is that there is a conflict between the clear language of the waiver application and that used in the regulation. The Department told the federal government in its application that Vermont intended to deviate quite radically from the requirements of the Medicaid program by creating a program in which any person whose income fell below certain increased income limits could get health assistance. The only persons who would not get the benefits of this program were persons who were insured (both hospital and physicians services) at the time of application and those who had voluntarily dropped such insurance in the last twelve months. (See the citation on page 15 above.) Those persons could become eligible after they had no insurance for twelve months. The protocols and regulations adopted pursuant to that waiver eliminate all persons who have insurance (including hospital and physicians services) at the time of application. That prohibition is clearly consistent with the waiver application. However, the regulations also eliminate persons who have had insurance at any time during the prior twelve months without any reference to whether the loss of insurance was voluntary or not. That is not what the

Department said it would do in the application. The Department's failure to include in the regulation a provision exempting all persons who did not "voluntarily" drop insurance creates a clear conflict with its original waiver.

To be sure, as the Department points out, certain exceptions were granted for a handful of situations in which persons had insurance during the last twelve months. Exceptions were made for those who lost access to employer-sponsored insurance because of loss of employment, death, or divorce, or change of dependent status under a parent's insurance. The Department does not attempt to argue that these are the only situations in which persons could be said to have involuntarily lost health insurance.⁵ Rather the Department argues that these are the only situations it has chosen to include and that it has the authority to make these choices.

Again, the Department's position begs the issue. It clearly has the authority to design its own medical benefits program. The Department has done so and has expressed the parameters of this program in its federally approved waiver

⁵ For example, many persons lost health coverage because their insurer has gone out of business, because they have had a dispute with the insurer, because their insurer was their school and their coverage stopped when they left the school or because their premiums were raised beyond the

application. However, it does not have the authority to violate the terms of its own program. The Department said very clearly that it would eliminate from immediate eligibility only those persons who had voluntarily dropped health coverage in the last twelve months. Since the Department's regulation does not set up any test for "voluntariness", the Department has acted outside of the scope of its own federally approved waiver. The regulation as adopted must fail because of the lack of authority with which it was enacted.

Since the regulation fails, the petitioner's application must be measured against the parameters of the controlling waiver provision to see if she "voluntarily" dropped her health insurance. The petitioner's income is \$805 per month, an amount that is about 110 percent of the poverty level. As such, she is among the poorest of the persons that the program purportedly seeks to help. Premiums, deductibles and co-pays which she used to pay under her private insurance program averaged out to about \$300 per month, or 51 percent of her income. Regulations found in the VHAP program define persons with income levels under \$1,047 per month as in need of

point of affordability. Virtually all of these situations have been appealed to the Board in the past.

government assistance with health care. P-2420 B (16). The Department has also calculated that persons with the petitioner's income level are able to pay only \$40 every six months as a premium and are limited to \$750 per year in co-payments. W.A.M. § 4001.91 and 4001.92. It is clear, and the stipulated facts show, that the petitioner was unable to meet her basic necessities and pay for health insurance. The petitioner simply could not afford to pay for private insurance. Such an inability to pay cannot be termed a "voluntary" withdrawal from her health insurance under any definition of that word. The petitioner, therefore, should not have been required to face a waiting period for health care benefits when she applied in October 11, 2001.

III CONFLICT WITH THE VERMONT CONSTITUTION

Ordinarily, a finding of a conflict with a federal law would obviate the need for any further analysis of a regulation. However, it seems important in this case to decide the petitioner's claim of violation of the Vermont Constitution's Common Benefits clause. The reasons for this are twofold: first, the Secretary has already indicated in her reversal of Fair Hearing No. 16,414 that she is not persuaded that a conflict with federal law exists and is likely to take the same position with regard to this decision;

second, it would be easy for the Department to amend its waiver request to match its regulation and it seems likely, based upon the federal officer's prior unquestioning approval of the regulation, that it could easily obtain federal approval. In fairness to the petitioner, and to avoid further delay and litigation, the constitutional issue will be addressed.

The Common Benefits clause of the Vermont Constitution reads in pertinent part:

That government is, or ought to be, instituted for the common benefit, protection, and security of the people, nation, or community, and not for the particular emolument or advantage of any single person, family, or set of persons, who are a part only of that community.

Vt. Const., Ch I, Art 7

The petitioner claims in this case that the Department's twelve-month rule preventing her from getting VHAP benefits has deprived her of a common benefit and protection afforded to all other low-income persons who are without health insurance. The Department for its part argues that it has the right to set policy which excludes certain persons from benefits in order to attain legitimate governmental objectives and that its policies must be upheld if they contain some rationality.

The recent decision by the Supreme Court in Baker v. State, 170 Vt. 194, 744 A2d.864 (1996)⁶ thoroughly discusses the protections of the "Common Benefits" clause and the tests to be used in reviewing constitutionality under it. The Court described this clause as "the first and primary safeguard of the rights and liberties of all Vermonters". Id. at 202. It further described the clause as one that, as interpreted by Vermont case law, "has consistently demanded in practice that statutory exclusions from publicly-conferred benefits and protections must be 'premised on an appropriate and overriding public interest'". Id. at 206, citing State v. Ludlow Supermarkets, Inc., 141 Vt. 261, 268.⁷

In Baker the Supreme Court stated that it was the role of the body engaged in legal review to

. . .ultimately ascertain whether the omission of a part of the community from the benefit, protection and security of the challenged law bears a reasonable and just relation to the governmental purpose. Consistent with the core presumption of inclusion, factors to be considered in this determination may include: (1) the significance of the benefits and protections of the challenged law; (2) whether the omission of members of the community from the benefits and protections of the challenged law promotes the government's stated goals;

⁶ This is the so-called "civil unions" case.

⁷ In so declaring, the Court rejected traditional Equal Protection tests used to apply the provisions of the federal equal rights amendments in favor of tests more suited to this particular provision. Baker, supra at 204, 206.

and (3) whether the classification is significantly underinclusive or overinclusive.

Id. at 214

The part of the community which is omitted from VHAP benefits by the Department's new waiver regulation is low-income persons who have had health insurance covering hospital and physician services within twelve months of their application and who do not meet any of the exceptions listed for waiver. See VHAP 4001.2, cited on p. 8 above. The stated purposes for these new eligibility requirements found in the Department's waiver application are as follows:

B. Goals and Objectives of the Program

. . .

Eligibility

Vermont will seek to de-link eligibility for Medical Assistance or health care coverage from eligibility for other public assistance programs under this initiative. Specifically, the State will seek approval from the Health Care Financing Administration to implement new eligibility standards which are based on a simplified income test with no resource test applied. Thereafter, eligibility for subsidized health care coverage in Vermont will be based on an individual's or family's income as a percentage of the federal poverty level and insurance (uninsured) status.

Affordability

. . . Vermont will establish an overall cap on the level of state expenditures to be made under the waiver program for newly eligible individuals. Vermont will monitor, on an ongoing basis, its position relative to the cap. When

obligated expenditures reach 90% of the cap, the state may lower the income threshold to ensure that the remaining enrollment slots are available to those with the lowest incomes. Thus those in greatest need will be served first.

. . .some low wage workers may not be able to afford their share of the premium in an employer-sponsored plan. If they meet income guidelines, these uninsured workers may be brought into their employer's plan by covering the employee's premium contributions (up to 50%) of their employer's plan. Special rules will apply to ensure that employers do not drop existing employer-sponsored coverage or deny newly added employer-based coverage to lower-income workers. Through this program the State hopes to reduce the cost burden for lower-income workers, while encouraging employers who do not offer coverage to their employees to begin contributing toward the cost of health care. . . .

C. Purpose and Value of the Demonstration

The Vermont Health Access Plan demonstration is a multifaceted reform initiative which simultaneously addresses several key shortcomings of current state and federal health care programs. Unlike many other state-based reform initiatives implemented to date, the Vermont Health Access Plan directly addresses:

- the problems faced by individuals and families with incomes only marginally above the poverty level in maintaining health insurance policies at current market premium levels;

. . . .

The plan, as described in this application, affords the Health Care Financing Administration a unique opportunity to assess the impact of a new and expansive program approach on these problem areas. The demonstration has great potential value in terms of evaluating:

. . . .

- the response of the small employer market to a subsidized program for low-wage workers; and

- the effect on providers and delivery systems in a small, rural state of achieving near universal coverage (when the Vermont Health Access Plan is fully implemented, Vermont expects that nearly 95% of its citizens will be insured).

The Vermont Health Access Plan: A
Statewide Medicaid Demonstration
Waiver Initiative, February 23, 1995,
Chapter I - Background, Context, and
Purpose.

In addition to these stated objectives in the waiver application, the legislature set out specific program goals in the statute which set up the VHAP trust fund:

(a) The Vermont health access trust fund is hereby established in the state treasury for the purpose of establishing a health access program to finance health care coverage for uninsured or underinsured low income Vermonters pursuant to statutes or rules that expand medical assistance programs through a federal waiver or otherwise. Further purposes of this fund and the health access program are to increase the number of low income residents with health benefits coverage, integrate certain publicly-funded beneficiaries into mainstream medical care, bring Medicaid beneficiaries into managed care plans, extend pharmaceutical benefits to low income elderly and disabled individuals, enhance access to health care benefits paid under the Medicaid program by increasing reimbursement levels for physicians and other providers, and replace unanticipated reductions in federal Medicaid receipts resulting from federal action.

33 V.S.A. § 1972

The Department agrees that one of the goals underlying the exclusion of people who have had insurance in the past year is as stated in the above application: to prevent

employers from dropping existing health care coverage for their low-income employees. The Department also urges that there is a second reason: to make sure that the "chronically" uninsured get the benefits. That goal, however, appears nowhere in the statute or the waiver application. The closest goal to that claimed by the Department is to assure that the lowest income persons are served first by this program. This is quite different from serving the most chronically uninsured. If assisting only the "chronically" uninsured were truly a goal of this program then it would not make sense to exempt persons who lost employer-provided health care from the twelve-month rule. Employed persons are the most likely to have health insurance and certainly those who had recently obtained health insurance from employers before are the most likely to obtain it again.

For purposes of this analysis, the pertinent goals of the program are found to be those actually expressed in the statute and the waiver request: to provide health coverage for uninsured persons with the lowest incomes who would have a difficult time affording private insurance and to prevent employers from dropping existing health coverage for their low-income employees.

There is no question that the State of Vermont through the Agency of Human Services has the authority to promulgate a program with the above goals and to make regulations to carry out these goals which might exclude certain low-income persons from receiving benefits. The only question for constitutional analysis is whether the exclusion of certain low-income persons from the benefits conferred by this program bears a "just and reasonable relation to the legislative goals". Baker, supra at 204,. The first step in the analysis of this relation under the Supreme Court's test set out in Baker is to determine the "significance" of the benefits and protections at issue.

There can be little argument that the benefits involved here are of tremendous importance to the low-income citizens of this state. This program enables Vermonters who cannot afford private insurance to obtain the benefits of health care. Without these benefits these citizens will be at risk for incurring health expenses which impact on their ability to provide for other necessities or will force them to forego needed medical care. The value of these benefits is well recognized in the Department's narrative of its goals set out above.

The second factor to consider in a determination of whether the exclusions are just and reasonable is the extent to which the exclusions promote the goals of the program. It is in this area that the Department's regulations begin to fail. Certainly the general exclusion of all persons who had insurance in the last year would carry out the goal of preventing employers from dropping existing health coverage for low-income employees. The one-year exclusion from receiving benefits is undoubtedly a powerful disincentive for employers who might attempt to substitute the state's program for their own. However, it is difficult to see how the exclusion of all who had any kind of health coverage promotes the other expressed goals of the program.

Most troubling in this regard is the relationship between these exclusions and those goals which seek both to ensure that those with the lowest incomes will be served and to address "the problems faced by individuals with incomes only marginally above the poverty level in maintaining health insurance policies at current market premium levels". The one-year exclusion rule does not look to see whether the excluded person is among those groups which the legislation seeks to assist. As a result, even the lowest income persons can be excluded without regard to any analysis of whether

their income was a problem in maintaining a private health insurance policy. Excluding these persons does not promote the goals expressed by either the legislature or the Department in the promulgation of this program. In fact, these exclusions directly thwart these other goals.

The final factor discussed by the Supreme Court is an analysis of whether the regulation at issue is "overinclusive" or "underinclusive". These terms are used to describe a regulation that sweeps in persons who are unnecessary to achieving its goal or leaves out persons who are necessary. As was discussed above, the Department's regulation, in addition to eliminating low-income persons whose existing health insurance was dropped by their employers--a stated goal--also eliminates a number of other persons who do not fall into that category. The principle of general ineligibility for persons who have had insurance in the twelve months prior to application serves to exclude persons who had no connection with employer-sponsored health insurance. For example, it also excludes those with insurance sponsored by an educational institution or those who had private insurance. It must be concluded that the Department's regulation is over-inclusive in that it keeps many people from receiving benefits who are not part of the problem group targeted by the program.

In summary, the Department has developed a program in which it has determined to provide significant public benefits to low-income citizens. It decided to eliminate eligibility for all but a few low-income persons who had insurance for the past year in order to prevent employers from dropping existing insurance programs for low-income employees. Included in those exclusion provisions are many of the persons the program was designed to help: those with the lowest income who cannot afford private health coverage. Many of these persons had no connection whatsoever to employer-provided health insurance, the area of concern for abuse. The petitioner is one such person. With an income at about 110 percent of poverty level, she is among the poorest of the persons the program seeks to help. The Department does not dispute that her marginal income greatly impacts upon her ability to purchase private insurance and provide for her basic necessities. The petitioner has had no connection for many years, if ever, to employer-sponsored insurance.

These facts and factors, when considered in combination, lead inexorably to the conclusion that the means used by the Department to achieve its goals in this case are not just and reasonable and that they thus run afoul of state constitutional requirements proscribing the arbitrary

deprivation of public benefits. The Department's regulation at W.A.M. § 4001.2 which generally eliminates low-income persons from eligibility because they had health insurance within 12 months of application is constitutionally impermissible. Therefore, the regulation cannot be applied to exclude the petitioner from receiving benefits. The petitioner should have been found eligible for VHAP benefits at the time of her application in October of 2000 and should not have been subjected to a further waiting period.

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