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Premium Assistance

5900 Premium Assistance (10/01/2007, 07-24)

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 individuals 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 employees 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 employees 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 (DVHA), the department determines eligibility for CHAP, as well as two ESIA programs.

INTERPRETIVE MEMO

[X] Premium Assistance Rule Interpretation **[ ] Premium Assistance Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 5901 **Date of this Memo** 11/01/2008 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

UPDATE:

Individuals who qualify for, but are no enrolled in Medicare

Individuals who qualify for, but are not enrolled in full Medicare (e.g. Medicare Part A and Part B OR Medicare Part C) are ineligible for VHAP. An individual who enrolls in Medicare is eligible for VHAP from the enrollment date through the day before the Medicare start date.

Current insurance ending in the future for a reason meeting the exception criteria. Insured individuals who are otherwise eligible for VHAP may enroll in the program if:

- Insurance coverage will end for a reason that qualifies for an exception to the waiting period;
- The application is received within 60 days of the insurance end date;
- Any premium that is required is paid and;
- The individual's insurance remains the primary payer of claims incurred period to the end date.

Prior coverage through another public entity. Vermont residents who have terminated prior coverage that was sponsored by another public entity are exempt from the twelve-month waiting period.

Multiple insurance losses within a 12 month period. In cases where an individual has multiple private, employer-sponsored or college insurance losses within a 12 month period, the most recent loss reason supersedes all prior loss reasons.

INTERPRETIVE MEMO

[X] Premium Assistance Rule Interpretation **[ ] Premium Assistance Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 5901 **Date of this Memo** 11/01/2008 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

UPDATE:

No longer receiving COBRA, VIPER or other state continuation coverage (Rule 5901 (L)(5)(e)

This no 12–month waiting period for those who:

- choose not to sign up for a continuation coverage plan when one is available to them, or
- sign up for the coverage but cancel it before it is effective, or
- enroll in the coverage and cancel it after it is effective but prior to the end of the allowed continuation period

INTERPRETIVE MEMO

[X] Premium Assistance Rule Interpretation **[ ] Premium Assistance Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 5901 Date of this Memo 12/01/2009 Page 1 of 1
This Memo: [X] is New [ ] Replaces one dated _____

UPDATE:

Women fully enrolled in CHAP, Catmount-ESIA or VHAP-ESIA will have their premium assistance continue if they become pregnant and are found eligible for Dr. Dynasaur or Medicaid for pregnant women. The carrier will be the primary insurance and Medicaid will be secondary insurance. The State will pay the ESI and Catamount premiums in full through the post-partum eligibility period. Contact COPS to be sure that the case is set up correctly for continued payments.

Women who are in the process of enrollment when they report a pregnancy will have the process stopped. Medicaid/Dr. Dynasaur will be granted and will be the primary insurance.

Definitions

5901 Definitions (12/04/2008, 08-40)

A. Approved employer-sponsored insurance (ESI). An ESI plan that meets the coverage criteria established in rule 5924.2 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 rule 5962(C).

D. Cost-effective. The program option that is the least costly to the state. The methodology for determining cost-effectiveness is described in rule 5924.3 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. Employees 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.

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 individuals private insurance or employer-sponsored coverage ended because of:

   a. 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

b. Death of the principal insurance policy holder;

c. Divorce or dissolution of a civil union;

d. No longer qualifying as a dependent under the plan of a parent or caretaker relative;

e. 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.

3.

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. Subdivision (a) 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 rules 5952 and 5962 below.)

Eligibility

5910 Eligibility (10/01/2007, 07-24)

Individuals are eligible for premium assistance if they meet the financial and nonfinancial requirements set forth in this rule. Except for rule 7104, the provisions of Medicaid rules 4100-4177 and 7101 – 7203 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.

VHAP-ESIA

5911 VHAP-ESIA (10/01/2007, 07-24)

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 employees 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 criteria (rules 5300-5360) and the eligibility rules in Medicaid rules 4100-4177 and 7101 – 7203 and have access to an approved, cost-effective ESI plan. If eligible, an individual is granted VHAP while an ESIA determination is being made.

5911.1 VHAP-ESIA Enrollment (10/01/2007, 07-24)

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 partners 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.

5912 Catamount-ESIA (10/01/2007, 07-24)

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 employees premium, Catamount-ESIA covers some chronic-care cost-sharing. An individual is eligible for Catamount-ESIA if the individual:

A. Is uninsured (see, paragraph (L) of rule 5901);

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 4100–4177 and 7101 – 7203;

F. Has access to an approved, cost-effective, ESI plan.

CHAP

5913 CHAP (10/01/2007, 07-24)

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 rule 5901);

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;

E. Meets the other eligibility requirements in Medicaid Rules 4100 – 4177 and 7101 – 7203; and

F. Does not have access to an approved, cost-effective, ESI plan.

Prior Loss of Insurance

5914 Prior Loss of Insurance (12/04/2008, 08-52)

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 rule 5901(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.

Medicare

5915 Medicare (07/03/2008, 08-22)

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

Income Determinations

5916 Income Determinations (12/04/2008, 08-52)

A. A household's income shall be calculated in accordance with VHAP rule 5320.

B. For Catamount-ESIA and CHAP eligibility only, if the household's countable income (as determined in accordance with the preceding paragraph) is greater than 200 percent FPL but less than or equal to 300 percent FPL, the department will disregard additional earned income in an amount up to $400.00 per household. The program premium shall be based on income counted in accordance with this paragraph. This rule shall only apply prospectively.

ESI Available to Ineligible Member

5917 ESI Available to Ineligible Member (10/01/2007, 07-24)

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.

Eligibility Process

5920 Eligibility Process (10/01/2007, 07-24)

Application

5921 Application (10/01/2007, 07-24)

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.

5922 Cooperation Requirements (12/04/2008, 08-40)

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:

a. Provide information regarding other health coverage and access to ESI. The required information includes:

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

ii. The name of the employee and the employer offering the plan; and

iii. Any requested information regarding the plan.

b. Report to the department any changes in enrollment status, employees premium share, household composition, employment, income, residence, and access to ESI within ten days from the date the change occurs.

c. Timely comply with all program requirements.

2. To receive CHAP, applicants and beneficiaries must:

a. Enroll in, and remain enrolled in, CH;

b. Submit verification of CH enrollment; and

c. Timely pay required premiums to the state.

3. To receive Catamount-ESIA or VHAP-ESIA, applicants and beneficiaries must:

a. Enroll in, and remain enrolled in, an approved, available, and cost-effective ESI plan, as provided in rule 5924.5;

b. Submit verification of plan enrollment; and

c. Timely pay employees share of the premium 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.

C. If an individual:

1. Fails to timely complete and return a required Plan Information Sign-Up Letter (PIRL) rule 5924 or Plan Sign-Up Letter (PSL) rule 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.

Screening; Initial Eligibility

5923 Screening; Initial Eligibility (10/01/2007, 07-24)

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:

a. The individuals statements;

b. Information known to the department regarding insurance offerings of household members employers; and

c. 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 rule 5925.1 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.

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 rule 5924.4.)

D. If it appears that the individual may have access to an ESI plan, DVHA shall determine whether the plan is an approved plan. If so, DVHA 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.

Plan Information Request Letter

5924 Plan Information Request Letter (10/01/2007, 07-24)

A. The Plan Information Request Letter (PIRL) solicits information pertinent to DVHAs determinations of whether an ESI plan is approved, available, and cost-effective. (See rule 5922(A)(1)). The PIRL shall indicate that the completed form is to be returned to DVHA.

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 individuals 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 individuals inability to respond is due to an employers delay in responding to the individuals 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.

5924.1 Enrollment Determination (10/01/2007, 07-24)

A. Upon timely receipt of a PIRL response, DVHA shall review it for completeness. If the form is incomplete, DVHA 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 DVHA 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, DVHA 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. DVHA shall determine whether an approved ESI plan is available to the individual, and if so, whether the individuals enrollment in the plan will be cost-effective. This determination shall be made within ten days of the date that DVHA receives all of the information requested for this purpose.

Plan Information Request Letter

5924.2 Approval of ESI Plans (10/01/2007, 07-24)

A. VHAP-ESIA or Catamount-ESIA will only be extended to subsidize the cost of plans that DVHA 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:

a. Physician visits;

b. Inpatient care;

c. Outpatient services, including:

i. Diagnostics;

ii. Physical therapy, and

iii. Surgery;

d. Prescription drugs;

e. Emergency room services;

f. Ambulance services;

g. Mental health and substance abuse treatment;

h. Medical equipment and supplies; and

i. 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 plans 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.

5924.3 Determining Cost-Effectiveness (10/01/2007, 07-24)

A. DVHA 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 DVHA database. (DVHA collects data about approved ESI plans from a variety of sources, including other beneficiaries, employers, and insurance carriers.)

3. DVHA records.

Plan Information Request Letter

4. Additional information DVHA may request from the individual, the employee, and, where appropriate and necessary, the employer or insurance carrier.

B. DVHA 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.

5924.4 No Cost-Effective or Available ESI (10/01/2007, 07-24)

A. If DVHA 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:

a. Notices shall include:

i. Apprisal of the availability of CHAP.

ii. 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;

iii. Referral to plan enrollment information;

iv. Notice that, if the CHAP option is chosen, the individual must return a completed CHAP Plan Sign-Up Letter (PSL) to DVHA 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;

v. 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.

vi. 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.

b. Premium bill. An initial premium bill. The bill shall indicate that payment is owed, only if the individual elects to participate in CHAP.

Plan Information Request Letter

c. 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.

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, DVHA will initiate payment of CHAP. Coverage begins on the start date indicated on the PSL.

5924.5 Cost-Effective ESI Available (10/01/2007, 07-24)

A. If DVHA 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 DVHA.

C. Upon receipt of a completed PSL, DVHA will initiate payment of premium assistance to the individual, as provided in rule 5961.

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.

Eligibility Period and Enrollment

5925 Eligibility Period and Enrollment (10/01/2007, 07-24)

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.

5925.1 New Access to ESI (10/01/2007, 07-24)

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.

5925.2 Plan Disenrollment (10/01/2007, 07-24)

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.

5925.3 ESI No Longer Approved or Cost-Effective (10/01/2007, 07-24)

Premium assistance will terminate if DVHA 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.

5926 Seamless Coverage (12/04/2008, 08-52)

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.

A. Transitions between VHAP and VHAP-ESIA Coverage during transitions between VHAP and VHAP-ESIA is provided for in subsections 5923.B.4 and 5923.1.D above.

B. 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:

1. Remain eligible for an alternative premium-assistance program and

2. Timely comply with the eligibility requirements pertaining to the alternative premium-assistance program.

Notice and Appeal Rights

5930 Notice and Appeal Rights (12/04/2008, 08-40)

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.

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 rule 4150).

3. The appeal is based solely upon termination of interim seamless coverage provided pursuant to rule 5926.

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.

Notice and Appeal Rights

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 7110 and 7110.2 apply.

Premium-Assistance Amounts

5940 Premium-Assistance Amounts (10/01/2007, 07-24)

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.

VHAP-ESIA Benefits

5950 VHAP-ESIA Benefits (10/01/2007, 07-24)

5951 Premium Balances and Assistance Amounts (10/01/2007, 07-24)

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 5331.

B. The VHAP-ESIA premium-assistance amount is the difference between the employees share of the premium and the premium balance. For example, if the employees 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 employees 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 employees 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.

VHAP Wraparound Coverage

5952 VHAP Wraparound Coverage (10/01/2007, 07-24)

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, rules 5331 and 5332).

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.

Catamount-ESIA Benefits

5960 Catamount-ESIA Benefits (10/01/2007, 07-24)

Premium Balances and Assistance Amounts

5961 Premium Balances and Assistance Amounts (12/04/2008, 08-40)

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 employees share of the premium and the premium balance. Thus, for example, if the employees share of the premium is $130.00 per month and the households 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 employees 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 employees 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.

INTERPRETIVE MEMO

[X] Premium Assistance Rule Interpretation **[ ] Premium Assistance Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 5962 Date of this Memo 07/10/2012 Page 1 of 1
This Memo: [X] is New [ ] Replaces one dated _____

Pursuant to Act 120 of the 2012 Legislative Session of the Vermont General Assembly, 33 V.S.A 1974 (c) 3 has been amended to provide that the subsidy for cost sharing shall include assistance to cover cost-sharing amounts for supplemental prescription drug coverage equivalent to the benefits offered by the Vermont health access plan.

Chronic-Care Wraparound Coverage

5962 Chronic-Care Wraparound Coverage (10/01/2007, 07-24)

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, DVHA 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.

5963 Premium Balances and Assistance Amounts (12/04/2008, 08-40)

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 statue 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 statue, 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.

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 rule 5970. The department is responsible for transmitting the full CH premium amount (the premium balance plus the CHAP premium assistance) directly to the CH carrier.

Premium Balance Collection Methods

5970 Premium Balance Collection Methods (10/01/2007, 07-24)

A. The premium-collection provisions set forth in Medicaid Rule 4160 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 cashiers 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.

Premium Payments

5971 Premium Payments (10/01/2007, 07-24)

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.

Payment Adjustments

5972 Payment Adjustments (10/01/2007, 07-24)

5972.1 Underpayments (10/01/2007, 07-24)

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.

5972.2 Overpayments (10/01/2007, 07-24)

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 individuals 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.