STATE OF VERMONT

HUMAN SERVICES BOARD

In re) Fair Hearing No. A-06/10-280
)
Appeal of)

INTRODUCTION

The petitioner appeals a decision by the Department for Children and Families, Economic Services Division, terminating Vermont Health Access Program (VHAP) benefits because petitioner is eligible for Medicare. The issue is whether the petitioner is "uninsured" under the applicable statutes and regulations.

The material facts are not in dispute. The parties have briefed the issues. The following decision is based upon the underlying record and argument.

FINDINGS OF FACT

1. The petitioner is eighty-eight years old. He is a one-person household.

2. Petitioner's present income is $1,036.60 per month.[1] Petitioner does not qualify for Social Security benefits because he has less than forty quarters of coverage under Social Security.

[1] In the Department's brief, they aver that petitioner's income is a Canadian pension.

3. The Medicare program is comprised of Parts A (hospital coverage, B (doctor, home health and preventive care), and D (drug coverage). All enrollees are charged a monthly premium for Part B. In terms of Part A, only enrollees with less than forty quarters of coverage are charged a full monthly premium.[2] The parties agree that at most 1 percent of those individuals eligible for Medicare do not have the requisite forty quarters of coverage for free Part A coverage.

4. Petitioner is eligible to enroll in Medicare. Petitioner has chosen not to enroll in the Medicare program because of the cost.

5. Petitioner brought an earlier fair hearing to fight the termination of his VHAP benefits. Fair Hearing No. A-10/08-459 was resolved when the Department reversed its decision to terminate petitioner's VHAP benefits. A Notice of Decision issued on September 2, 2009 reinstated petitioner's VHAP benefits pending a correction to the

[2] A partial premium is charged for individuals having thirty quarters of coverage if they meet certain requirements.

Medicaid rules. During a change to other portions of the regulation defining "uninsured", the Department inadvertently deleted the language that Medicare eligible individuals were not eligible for VHAP. This correction became effective May 1, 2010.

6. On June 4, 2010, a Department worker, N.M., spoke to petitioner to explain that the Department intended to close his VHAP coverage if petitioner did not enroll in Medicare Part A during the next open enrollment period. Petitioner indicated that he would not enroll in Medicare Part A because the costs were too high; petitioner requested a fair hearing that same day.

7. The next open enrollment period for Medicare is January 1 through March 31, 2011 with benefits effective July 1, 2011.

8. The base premium charges for 2011 are $753.40/month for Part A and $176.80/month for Part B totaling $930.40/month. The Social Security Administration increases the premium costs to individuals who delay their enrollment.[3]

[3] The methods for determining Part A and B (1) base premium charges and (2) costs for those who delay enrollment are found at 42 U.S.C. §§ 1395i-2 and 1395o, and 42 C.F.R. §6 406.32(d) and 408.22.

In petitioner’s case, the charges for 2011 are $828.96/month for Part A and $409.64/month for Part B totaling $1,238.60/month.

9. Based on petitioner’s income, he qualifies for Vermont’s buy-in program for Part B but not Part A.

10. If petitioner enrolled in Medicare, the cost for Part A would leave petitioner with $203.64/month for his other necessities including medical costs not covered by Medicare.

ORDER

The Department’s decision is affirmed.

REASONS

The Legislature created the Vermont Health Access Plan (VHAP) “to provide health care coverage for uninsured or underinsured low income Vermonters”. 33 V.S.A. § 1973(b), W.A.M. § 5300. The VHAP program is a Medicaid waiver program that allows the State to waive certain Medicaid provisions such as income and resource limits in order to expand health care coverage. The VHAP program is part of the Global Commitment to Health Care and has been approved by the Centers for Medicare and Medicaid Services.

When Vermont applied for the Medicaid waiver for VHAP on February 23, 1995, the goal was to increase health care coverage to those individuals whose income was marginally above the Federal Poverty Limit (FPL), especially, working adults who did not have the funds for private health insurance. In addition, Vermont stated its intentions to place certain limits upon eligibility such as guarding against employers dropping health care benefits and diverting their employees to the State program.

Vermont statutes and regulations delineate who is considered uninsured or underinsured for purposes of VHAP eligibility. The Legislature enacted 33 V.S.A. § 1973(e)[4] as follows:

> An individual who is or becomes eligible for Medicare shall not be eligible for the Vermont health access plan.

The State regulations define "uninsured" in W.A.M. § 5312 as follows:

> Individuals are considered "uninsured" and meet this requirement, if they are not eligible for Medicare and have no other insurance that includes both hospital and physician services, and did not have such insurance within twelve months of application. . .

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[4] The statutory bar on Medicare eligible individuals was added effective July 1, 2009 as Section E 307.2, HB 441, Act 1, 2009 Special Session. However, the Department, through its rule-making authority to define eligibility under 33 V.S.A. § 1973(b) had earlier barred Medicare eligible individuals from VHAP eligibility through rule making.

See PP&D issued on August 1, 2008 stating that individuals eligible for Medicare but not enrolled in Medicare are ineligible for VHAP.

Because petitioner is over sixty-five years old, he is eligible to enroll in the Medicare program. Unlike the vast majority of Medicare eligible individuals, petitioner faces premium payments for Part A because he does not have the requisite number of quarters for free Part A coverage. Petitioner chose not to enroll in Part A due to the cost.

The Board has considered cases in which the Department denied eligibility or terminated coverage for otherwise VHAP eligible individuals because they were eligible for Medicare. The prior cases involved petitioners who received Part A without charge but who refused to enroll in Part B due to the cost. Fair Hearing Nos. 15,548; 17,430; 17,611; and 19,973.

In the above cases, the Board found that Medicare eligible individuals do not qualify for VHAP because they do not meet the definition of "uninsured" under the applicable regulations. The Board found that a plain reading of the regulations supported the Department, and in Fair Hearing No. 15,548 on page 5 stated:

> The fact that he has chosen not to enroll for all its [Medicare] benefits does not mean that he is not qualified to receive them.

The petitioners in Fair Hearing Nos. 17,430 and 19,973 also argued that petitioner's expenses should be considered because of their limited income. However, the VHAP regulations do not take into account an individual's expenses when determining eligibility.

In addition, the petitioners in Fair Hearing Nos. 17,430 and 17,611 argued that the regulation's exclusion of Medicare eligible individuals was an unfair and unreasonable distinction to make. The Board disagreed based on the provision of hospital services for free to petitioners and the relatively low cost of physician services as compared to private insurance.

Since the Board decisions in the above VHAP cases, the Legislature amended 33 V.S.A. § 1973 in 2009 to specifically exclude Medicare eligible individuals from VHAP eligibility.

The petitioner argues that the intention of the VHAP program is not to place low income Vermonters in a position where they have to pay a premium for Part A Medicare that is equivalent to private insurance. However, the VHAP program is meant as an expansion of health coverage for certain low income Vermonters. The Legislature has the power to define "uninsured" and has exercised that power to exclude Medicare

eligible individuals from the VHAP program.[5] Under the plain meaning of the statute, petitioner is not eligible for VHAP.

The petitioner further argues that the Common Benefits Clause of the Vermont Constitution applies in his case.

Chapter 1, Article 7 of the Vermont Constitution states:

> 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 of that community.

The Vermont Supreme Court in Baker v. State, 170 Vt. 194 (1996) articulated the standard for legal review as:

> . . . 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 purpose; and (3) whether the classification is significantly underinclusive or overinclusive.
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> Baker, *supra* at page 214.

The governmental purpose is found at 33 V.S.A. § 1973 that states VHAP "is established to provide uninsured Vermont residents" health care coverage for low income Vermonters.

[5] The petitioner can seek an amendment from the Legislature so that the small percentage of individuals facing payment for Medicare Part A who meet the other eligibility criteria for VHAP will be considered "uninsured".

The Legislature then defines "uninsured" and finds that Medicare eligible individuals constitute one group who are not "uninsured".

The Vermont Legislature, over the years, acted to increase health care coverage of non-insured Vermonters consistent with the ability of the State to do so. The VHAP program remains in place so long as the waiver is in place. 33 V.S.A. § 1973(a).

The governmental purpose is to increase health insurance coverage for those who are not eligible for Medicare or those who do not have private or employer-sponsored insurance or those who have not lost their health insurance in the past twelve months except for certain enumerated reasons. To meet these goals, the Legislature has the authority to exclude certain low income Vermonters. See Fair Hearing No. 16,748 (Although the Board found that the Department violated the Common Benefits Clause in regard to the how the Department failed to determine whether an individual's loss of insurance during the twelve months prior to application was voluntary, the Board noted the Department's authority to promulgate regulations to carry out goals that might exclude certain low-income Vermonters.).

Health insurance is a significant benefit in our society. But, limiting VHAP to “uninsured” individuals promotes the State’s goal of extending coverage to those who do not have insurance or those who do not qualify for other programs such as Medicare. In addition, the classification is neither underinclusive nor overinclusive. Medicare eligible individuals are only one group who do not qualify for VHAP. Of those Medicare eligible individuals who meet the VHAP financial eligibility guidelines, at most 1 percent face a charge for Medicare Part A coverage. As such, the exclusion cannot be considered overinclusive. VHAP does not violate the Common Benefit Clause.

Accordingly, the Department’s decision is affirmed. 3 V.S.A. § 3091(d), Fair Hearing Rule No. 1000.4D.

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