STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. B-01/13-59
	)	
Appeal of	)	

INTRODUCTION

Petitioner appeals the determination of the Vermont Department for Children and Families ("Department"), through its Health Access Eligibility Unit, that she is not eligible for the Vermont Health Access Program (VHAP) or any other publicly-supported health insurance program. The following facts are adduced from documents and testimony entered into the record during hearings held February 14 and March 14, and representations of the parties during telephone status conferences held April and May 3, followed by memoranda from the Department in support of its position. The principal issue is whether petitioner meets the definition of "uninsured" under the applicable regulations.

FINDINGS OF FACT

1. Petitioner is a household of one with her sole source of income from a retirement distribution of $1,749.32 per month.

2. Petitioner's divorce was finalized in November of 2012. During her marriage of 11 years, petitioner's husband maintained her health insurance through individual coverage in her name only with Blue Cross/Blue Shield.

3. Petitioner never paid her insurance premium bills herself or received the bills. Prior to her divorce, she was unaware that her insurance coverage was in her name only and not through a joint spousal plan.

4. Petitioner's divorce settlement included a provision that her ex-husband continue paying her health insurance premium for an additional three months after the date of the divorce. This obligation ended as of February 1, 2013.

5. Petitioner's premium payment was approximately $500 per month. In conjunction with the end of her ex-husband's obligation to pay the premium, petitioner terminated her private health insurance.[1] She testified that the high

[1] The parties spent considerable time focused on petitioner's initial claim that she had been led to terminate her private insurance based on the Department's representation that she would be eligible for a publicly-sponsored health program. After the Department produced audio files of phone conversations between petitioner and Department workers, it was determined that petitioner had mistakenly recalled communications with a third-party, a Blue Cross Blue Shield customer representative. There was no evidence that any agent of the Department led her to believe she would be immediately eligible for one of the Department's health insurance programs if she terminated her private insurance.

premium amount was unaffordable given her fixed monthly income.

6. Petitioner applied for health coverage through the Department and was denied because she did not meet the definition of "uninsured" due to the termination of her private health insurance.[2]

ORDER

The Department's decision is affirmed.

REASONS

In order to qualify for VHAP, or a program such as Catamount Health Premium Assistance (CHAP), an individual must meet the definition of "uninsured":

> 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 the 12 months prior to the month of application, unless they meet one of the exceptions specified below.
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> . . . .
>
> B. An individual who lost private insurance or employer-sponsored coverage during the prior 12 months for the following reasons:
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> 1. The individual's coverage ended because of:

[2] While financial eligibility was not a focus of this appeal given the denial on other grounds, it appears as though petitioner would otherwise be eligible for Catamount Health Premium Assistance (CHAP) at a minimum.

> 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 coverage for the primary purpose of discontinuing employer-sponsored coverage and establishing their eligibility for Catamount Health;
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> b. death of the principal insurance policyholder;
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> c. Divorce or dissolution of a civil union;
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> d. No longer receiving coverage as a dependent under the plan of a parent or caretaker relative; or
>
> e. no longer receiving COBRA, VIPER, or other state continuation coverage. . .

VHAP Rule 5312 (in pertinent part).

Petitioner's private insurance terminated too recently to carry her beyond the 12-month "waiting period" required by the rule. She otherwise does not meet any of the exceptions to the rule. While her divorce resulted in the eventual end of her ex-husband's obligation to pay her monthly premium, the health insurance remained available for her to continue with on an individual basis, regardless of its lack of affordability to her.[3]

[3] An earlier line of Board cases held that the termination of health insurance that is unaffordable could be construed as not "voluntary" and therefore meet eligibility requirements. See e.g, Fair Hearing No. 20,360. However, these cases and the prior regulations were superseded in 2007 by the Global Commitment Waiver, which incorporated the definition of uninsured found in Rule 5312. See e.g. Fair Hearing No. B-04/09-222. This more specific definition of uninsured does not include an exception for someone in petitioner's circumstances.

The Department's decision is consistent with the applicable regulations. Therefore, the Board is required to affirm. 3 V.S.A. § 3091(d), Fair Hearing Rule No. 1000.4D.

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