TABLE OF CONTENTS

HIV/AIDS

5800 HIV/AIDS (10/01/1995, 95-27)

The General Assembly of the State of Vermont, in its 1992 passage of H.937, directed the Department of Social Welfare to develop an "HIV/AIDS Health Insurance Assistance Program." Specifically, Section 124 of H.937 directs that:

> "(a) The Department of Social Welfare, in cooperation with the Department of Health, shall develop and implement an HIV/AIDS insurance assistance program.
>
> (2) The program shall pay all or a portion of continuation health insurance premiums for those eligible individuals with HIV/AIDS for whom it can be determined that continuation of private insurance coverage is less costly to the state than other alternatives.
>
> (c) Eligibility for this program shall be limited to individuals whose household income does not exceed 200% of the federal poverty level, after deducting unreimbursed medical expenses and health insurance premiums from gross income, and whose assets, exclusive of the primary residence and certain other exclusions to be defined by the Department of Social Welfare, do not exceed $10,000.00."

Expenditures shall not exceed the funds appropriated annually by the General Assembly for this program.

The policies which follow implement this program.

Eligibility

5810 Eligibility (10/01/1992, 92-36)

An individual must meet the following requirements to be found eligible for this program.

Residence

5811 Residence (10/01/1992, 92-36)

An individual must be living in (i.e. a resident of) Vermont to meet the State Resident requirement. Temporary absences to visit or obtain necessary medical care do not end Vermont residence.

Member of Covered Group

5812 Member of Covered Group (10/01/1992, 92-36)

An individual must meet the following criteria to be a member of the covered group:

- be too ill with an HIV-related illness to continue to work a sufficient number of hours to afford individual or group health insurance (see Income Level);
- have been enrolled, prior to the reduction or termination of hours of employment, in a health insurance plan the continuation of which is determined by the Department to be less costly to the state than other alternatives.

Financial Need

5820 Financial Need (10/01/1992, 92-36)

An individual must be a member of a household with total income and resources under the following limits to meet this requirement.

Definition of Household

5821 Definition of Household (10/01/1992, 92-36)

The household includes the individual with an HIV-related illness and all of the following persons living in his/her household: his/her spouse, his/her unmarried and unemancipated children (biological and adopted) and stepchildren who are under the age of twenty-one, and the mother(s)/father(s) (biological or adoptive) of the included children and stepchildren.

Income Level

5822 Income Level (10/01/1992, 92-36)

The total gross income of the household must not exceed 200 percent of the federal poverty guideline for the same size household to meet this requirement. (Gross income means that no deductions are allowed for employment expenses such as FICA, taxes withheld, union dues, transportation, dependent care expenses, etc.) Only unreimbursed medical expenses and health insurance premiums are deducted in determining gross income.

The total gross income from self employment is the adjusted gross income after business expenses, including depreciation, have been deducted.

5823 Resource Limit (10/01/1992, 92-36)

The total countable resources of the household must not exceed $10,000.00. The following resources are not counted:

- the individual's primary residence;
- the value of vehicles owned by members of the household;
- the value of life insurance; or
- the value of personal belongings.

5830 Coverage (10/01/1992, 92-36)

Individuals found eligible for this program are eligible for:

- payment of their health insurance premium including payment for family coverage if that is what the individual had prior to reducing/terminating employment;
- until the funds appropriated by the Vermont General Assembly are exhausted.

The program will not pay:

- premiums for new insurance (i.e. it will not purchase insurance for individuals who do not have an existing individual or group health plan); nor
- deductibles or coinsurance.

Application

5840 Application (10/01/1992, 92-36)

An individual or his/her representative may file an application and must provide the applicant's Social Security number.

An application may be filed by mailing a signed HIV/AIDS application form to the Economic Services Division, Department for Children and Families, 103 So. Main Street, Waterbury, VT 05671-1201.

The following documents, if they apply to any persons in the applicant's household, must be provided to the Department:

Physician's Certification

The individual must provide written certification from his/her physician that due to HIV-related illness, he/she is, or will be within 3 months, unable to continue working or has had, or will have, to reduce his/her hours of employment.

Verification of Income

Verification of income must be provided at the time of application or review. Acceptable forms of verification include but are not limited to:

- paystubs
- income tax forms
- written employer statements
- self employment business records
- award letters (i.e. Social Security, VA)

Verification of Resources

Verification of resources must be provided at the time of application or review. Acceptable forms of verification include but are not limited to:

- bank books and/or statements
- stock/bond certificates
- deeds
- property tax records

In addition to the above, it is the applicant's responsibility to provide all necessary information relative to his/her health insurance, including company name and address, employer name and address, premium amount verification and any other information which may be required.

The applicant/recipient is responsible for reporting any changes in his/her residence, income, resources, medical condition, or other circumstances affecting eligibility to the Medicaid Division within 10 days of the change.

5841 Application Decision (10/01/1992, 92-36)

Applications will be processed by the Economic Services Division within 30 days of receipt of a completed application form and required verification/documentation. Individuals will be notified in writing of all decisions made pertaining to their eligibility.

5842 Period of Eligibility (10/01/1992, 92-36)

Individuals who meet the eligibility criteria will be accepted into the program as long as the projected expenditures of individuals already enrolled in the program are not expected to exhaust the funds appropriated for the fiscal year.

Eligibility will be reviewed annually for each participant, or sooner, if changes occur which affect ongoing eligibility.

Payment of premiums under this program will continue until the earliest of the following occurs:

A. the recipient becomes eligible for Medicaid payment of the premiums;

B. the recipient obtains other health insurance including Medicare;

C. the recipient no longer meets any of the eligibility criteria;

D. the recipient dies; or

E. funding for the program is exhausted.

If eligibility for this program ends, a notice will be sent to the individual at least 10 days before the effective date of the adverse action.

Payment Methodology

5843 Payment Methodology (10/01/1992, 92-36)

Premium payment will be made on behalf of eligible recipients to:

A. the recipient's employer, or

B. the recipient's insurer, or

C. the recipient, if premiums are being deducted directly from his/her paycheck.

Right to Appeal

5845 Right to Appeal (10/01/1992, 92-36)

Any applicant/recipient has the right to appeal any decision of the Department relating to their HIV/AIDS Health Insurance Assistance Program eligibility, and to request a fair hearing before the Human Services Board. A request for a fair hearing must be made within ninety (90) days of the date the notice of the decision being appealed was made. A request for a hearing is defined as a clear expression, oral or written, that the applicant/recipient wishes to appeal a decision. A recipient will continue to have the premiums paid pending the outcome of the appeal.