TO THE HOUSE OF REPRESENTATIVES:

The Committee on Health Care to which was referred House Bill No. 721 entitled "An act relating to expanding access to Medicaid and Dr. Dynasaur" respectfully reports that it has considered the same and recommends that the bill be amended by striking out all after the enacting clause and inserting in lieu thereof the following:

Sec. 1. SHORT TITLE

This act shall be known and may be cited as the "Medicaid Expansion Act of 2024."

Sec. 2. FINDINGS

The General Assembly finds that:

(1) Medicaid is a comprehensive public health insurance program, funded jointly by state and federal governments. Vermont's Medicaid program currently covers adults with incomes up to 133 percent of the federal poverty level (FPL), children up to 19 years of age from families with incomes up to 312 percent FPL, and pregnant individuals with incomes up to 208 percent FPL.

(2) States may customize their Medicaid programs with permission from the federal government through waivers and demonstrations. Vermont is the only state in the nation that operates its entire Medicaid program under a

comprehensive statewide demonstration, called the Global Commitment to Health, that offers the same services to residents in all regions of the State.

(3) Vermont's unique Medicaid program provides comprehensive coverage for a full array of health care services, including primary and specialty care; reproductive and gender-affirming care; hospital and surgical care; prescription drugs; long-term care; mental health, dental, and vision care; disability services; substance use disorder treatment; and some social services and supportive housing services.

(4) There are no monthly premiums for most individuals covered under Vermont's Medicaid program, and co-payments are minimal or nonexistent for most Medicaid coverage. For example, the highest co-payment for prescription drugs for a Medicaid beneficiary is just $3.00.

(5) Close to one-third of all Vermonters, including a majority of all children in the State, have coverage provided through Vermont Medicaid, making it the largest health insurance program in Vermont.

(6) In 2021, the six percent uninsured rate for Vermonters who had an annual income between 251 and 350 percent FPL was double the three percent overall uninsured rate. And for those 45 to 64 years of age, the estimated number of uninsured Vermonters increased more than 50 percent over the previous three years, from 4,900 uninsured in 2018 to 7,400 in 2021.

(7) Cost is the primary barrier to health insurance coverage for uninsured Vermonters. More than half (51 percent) of uninsured individuals identify cost as the only reason they do not have insurance.

(8) During the COVID-19 public health emergency, the uninsured rate for Vermonters with incomes just above Medicaid levels (between 139 and 200 percent FPL) fell from six percent in 2018 to two percent in 2021. This drop was due in large part to the federal Medicaid continuous coverage requirement, which allowed individuals to remain on Medicaid throughout the pandemic even if their incomes rose above the Medicaid eligibility threshold. A majority of Vermonters (56 percent) with incomes between 139 and 200 percent FPL were on Medicaid in 2021.

(9) The end of the public health emergency and the beginning of the federally required Medicaid "unwinding" means that many of these Vermonters are losing their comprehensive, low- or no-cost Medicaid health coverage.

(10) Almost nine in 10 (88 percent) insured Vermonters visited a doctor in 2021, compared with just 48 percent of uninsured Vermonters. Insured Vermonters are also significantly more likely to seek mental health care than uninsured Vermonters (34 percent vs. 21 percent).

(11) Marginalized populations are more likely than others to forgo health care due to cost. Vermonters who are members of gender identity

minority groups are the most likely not to receive care from a doctor because they cannot afford to (12 percent). In addition, eight percent of each of the following populations also indicated that they are unlikely to receive care because of the cost: Vermonters under 65 years of age who have a disability, Vermonters who are Black or African American, and Vermonters who are LGBTQ.

(12) Many Vermonters under 65 years of age who have insurance are considered "underinsured," which means that their current or potential future medical expenses are more than what their incomes can bear. The percentage of underinsured Vermonters is increasing, from 30 percent in 2014 to 37 percent in 2018 and to 40 percent in 2021.

(13) Vermonters 18 to 24 years of age are the most likely to be underinsured among those under 65 years of age, with 37 percent or 38,700 young adults falling into this category.

(14) The highest rates of underinsurance are among individuals with the lowest incomes, who are just over the eligibility threshold for Medicaid. Among Vermonters under 65 years of age, 43 percent of those earning 139–150 percent FPL and 49 percent of those earning 151–200 percent FPL are underinsured.

(15) Underinsured Vermonters 18 to 64 years of age spend on average approximately 2.5 times more on out-of-pocket costs than fully insured

individuals, with an average of $4,655.00 for underinsured adults compared with less than $1,900.00 for fully insured individuals.

(16) Individuals with lower incomes or with a disability who turn 65 years of age and must transition from Medicaid to Medicare often face what is known as the "Medicare cliff" or the "senior and disabled penalty" when suddenly faced with paying high Medicare costs. Individuals with incomes between $14,580.00 and $21,876.00 per year, and couples with incomes between $19,728.00 and $29,580.00 per year, can go from paying no monthly premiums for Medicaid or a Vermont Health Connect plan to owing hundreds of dollars per month in Medicare premiums, deductibles, and cost-sharing requirements.

(17) The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, allows young adults to remain on their parents' private health insurance plans until they reach 26 years of age. The same option does not exist under Dr. Dynasaur, Vermont's public children's health insurance program established in accordance with Title XIX (Medicaid) and Title XXI (SCHIP) of the Social Security Act, however, so young adults who come from families without private health insurance are often uninsured or underinsured.

(18) In order to promote the health of young adults and to increase access to health care services, the American Academy of Pediatrics recommends that coverage under Medicaid and SCHIP, which in Vermont

means Dr. Dynasaur, be made available to all individuals from 0 to 26 years of age.

Sec. 3. AGENCY OF HUMAN SERVICES; TECHNICAL ANALYSIS; REPORTS

(a) The Agency of Human Services, in collaboration with interested stakeholders, shall undertake a technical analysis relating to expanding access to Medicaid and Dr. Dynasaur, to rates paid to health care providers for delivering services to individuals on Medicaid and Dr. Dynasaur, and to the structure of Vermont's health insurance markets.

(b) The technical analysis relating to expanding access to Medicaid and Dr. Dynasaur shall examine the feasibility of; consider the need for one or more federal waivers or one or more amendments to Vermont's Global Commitment to Health Section 1115 demonstration, or both, for; develop a proposed implementation timeline and estimated costs of implementation for; and estimate the programmatic costs of, each of the following:

(1) expanding eligibility for Medicaid for adults who are 26 years of age or older but under 65 years of age and not pregnant to individuals with incomes at or below 312 percent of the federal poverty level (FPL) by 2030;

(2) expanding eligibility for Dr. Dynasaur to all Vermont residents up to 26 years of age with incomes at or below 312 percent FPL by 2030;

(3) amending Vermont's Medicaid state plan to expand eligibility for Dr. Dynasaur to all Vermont residents up to 21 years of age with incomes at or below 312 percent FPL as soon as reasonably practicable;

(4) expanding eligibility for Dr. Dynasaur to all pregnant individuals with incomes at or below 312 percent by 2030;

(5) expanding eligibility for the Immigrant Health Insurance Plan established pursuant to 33 V.S.A. chapter 19, subchapter 9 to all individuals up to 65 years of age with incomes up to 312 percent FPL who have an immigration status for which Medicaid or Dr. Dynasaur is not available; and

(6) implementing a proposed schedule of sliding-scale cost-sharing requirements for beneficiaries of the expanded Medicaid, Dr. Dynasaur, and Immigrant Health Insurance Plan programs.

(c)(1) The technical analysis relating to Medicaid provider reimbursement rates shall include:

(A) an analysis of the expected enrollment by proposed expansion population for each of the programs described in subsection (b) of this section;

(B) an examination of the insurance coverage individuals in each proposed expansion population currently has, if any, and the average reimbursement rates under that coverage by provider type as a percentage of the Medicare rates for the same services;

~~(C) an analysis of how current Vermont Medicaid rates compare to rates paid to Vermont providers, by provider type, under Medicare and average commercial health insurance fee schedules;~~

(C) an assessment of how other states' public option and Medicaid buy-in programs set provider rates, which providers are included, the basis for those rates by provider type, and any available data regarding the impacts of those rates on provider participation and patient access to care;

(D) an estimate of the costs to the State, by provider type, if providers were reimbursed at 125 percent, 145 percent, ~~and~~ 160 percent**, and 200 percent** of Medicare rates;

(E) if a fee schedule is benchmarked to Medicare rates, how best to structure a methodology that avoids federal Medicare rate cuts while ensuring appropriate inflationary indexing;

~~(G) an estimate of the costs to the State and an analysis of the advantages and disadvantages of benchmarking rates for RBRVS-equivalent professional services based on the average commercial health insurance rates paid to Vermont providers rather than the Medicare fee-for-service physician fee schedule;~~

(F) if rate differentials will continue between primary care and specialty care services under the RBRVS fee schedule, an estimate of the costs of including comprehensive prenatal, labor and delivery, postpartum, **other**

**reproductive health care services,** and psychiatric services under the primary care rate; **and**

(G) a proposed methodology for comparing Medicaid home health and pediatric palliative care rates against Medicare home health prospective payment system or Medicare hospice rates;

~~(J) a proposed alternative payment methodology for federally qualified health centers (FQHCs) that sets a percentage greater than 115 percent of the Medicare FQHC encounter rate as the minimum encounter rate paid to health centers for included Medicaid services, recognizing that the Department of Vermont Health Access must pay FQHCs a Medicaid prospective payment system rate calculated in accordance with Section 1902(bb)(2) of the Social Security Act; and~~

~~(K) a proposed process for annually reviewing Vermont Medicaid's reimbursement rates for dental services and evaluating progress toward achieving other recommendations detailed in the report of the Dental Access and Reimbursement Working Group established pursuant to 2019 Acts and Resolves No. 72, Sec. E.306.3.~~

(2) As used in this subsection, "provider type" means **the designated and specialized service agencies and** each category of health care provider **that provides services** for which the Department of Vermont Health Access maintains a reimbursement methodology, including hospital inpatient services;

hospital outpatient services; professional services reimbursed based on the RBRVS fee schedule for both primary care and specialty care services; services provided by federally qualified health centers and rural health centers; suppliers of durable medical equipment, prosthetics, orthotics, and supplies; clinical laboratory services; home health services; hospice services; pediatric palliative care services; ambulance services; anesthesia services; dental services; assistive community care services; and applied behavior analysis services.

(d) The technical analysis relating to Vermont's health insurance markets shall include:

(1) determining the potential advantages and disadvantages to individuals, small businesses, and large businesses of modifying Vermont's current health insurance market structure, including the impacts on health insurance premiums and on Vermonters' access to health care services;

(2) exploring other affordability mechanisms to address the 2026 expiration of federal enhanced premium tax credits for plans issued through the Vermont Health Benefit Exchange; and

(3) examining the feasibility of creating a public option or other mechanism through which otherwise ineligible individuals or employees of small businesses, or both, could buy into Vermont Medicaid coverage.

(e) The sums of $250,000.00 from the General Fund and $100,000.00 in federal funds are appropriated to the Agency of Human Services in fiscal year 2025 for the technical analysis required by this section.

(f)**(1)** On or before January 15, 2025, the Agency of Human Services shall submit the technical analysis required by this section to the House Committees on Health Care and on Appropriations and to the Senate Committees on Health and Welfare, on Finance, and on Appropriations. The analysis shall include the feasibility of each item described in subsections (b)–(d) of this section; the federal strategy for achieving each item, including identification of any necessary federal waivers, the process for obtaining such waivers, and the likelihood of approval for each such waiver; the costs, both programmatic costs and technological and operational costs; a timeline for implementation of each recommended action; and a description of any legislative needs.

**(2) On or before January 15, 2026, the Agency of Human Services shall provide the following to the House Committees on Health Care and on Appropriations and to the Senate Committees on Health and Welfare, on Finance, and on Appropriations:**

**(A) an analysis of how current Vermont Medicaid rates compare to rates paid to Vermont providers, by provider type, under Medicare and average commercial health insurance fee schedules; and**

**(B) an estimate of the costs to the State and an analysis of the advantages and disadvantages of benchmarking rates for RBRVS-equivalent professional services based on the average commercial health insurance rates paid to Vermont providers rather than the Medicare fee-for-service physician fee schedule.**

Sec. 4. 33 V.S.A. § 1901e is amended to read:

§ 1901e. GLOBAL COMMITMENT FUND

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(c)(1) Annually, on or before October 1, the Agency shall provide a detailed report to the Joint Fiscal Committee that describes the managed care organization's investments under the terms and conditions of the Global Commitment to Health Medicaid Section 1115 waiver, including the amount of the investment and the agency or departments authorized to make the investment.

(2) In addition to the annual report required by subdivision (1) of this subsection, the Agency shall provide the information set forth in subdivisions (A)–(E) of this subdivision annually as part of its budget presentation. The Agency may choose to provide the required information for the subset of the Global Commitment investments being independently evaluated in any one year. The information to be provided shall include:

(A) a detailed description of the investment;

(B) which Vermonters are served by the investment;

(C) the cost of the investment;

(D) the efficacy of the investment; and

(E) where in State government the investment is managed, including the division or office responsible for the management.

Sec. 5. 33 V.S.A. §1901c is added to read:

§ 1901c. MEDICAID COVERED SERVICE CONSIDERATIONS; REPORT

Annually on or before January 15, the Commissioner of Vermont Health Access shall report to the House Committee on Health Care and the Senate Committee on Health and Welfare regarding each service that the Department of Vermont Health Access considered for new, modified, expanded, or reduced coverage under the Vermont Medicaid program during the preceding fiscal year, including the reason for considering the service, the factors considered, the stakeholders consulted, the coverage decision made, and the rationale for the decision.

Sec. 6. MEDICARE SAVINGS PROGRAMS; INCOME ELIGIBILITY

The Agency of Human Services shall make the following changes to the Medicare Savings Programs:

(1) increase the Qualified Medicare Beneficiary (QMB) Program income threshold to 150 percent of the federal poverty level (FPL);

(2) eliminate the Specified Low-Income Medicare Beneficiary (SLMB) Program; and

(3) increase the Qualifying Individual (QI) Program income threshold to 185 percent FPL.

Sec. 7. MEDICAID STATE PLAN AMENDMENTS

(a) The Agency of Human Services shall request approval from the Centers for Medicare and Medicaid Services to amend Vermont's Medicaid state plan to make adjustments to the Medicare Savings Programs as set forth in Sec. 6 of this act.

(b) If amendments to Vermont's Medicaid state plan or to Vermont's Global Commitment to Health Section 1115 demonstration, or both, are necessary to implement any of the other provision of this act, the Agency of Human Services shall seek approval from the Centers for Medicare and Medicaid Services as expeditiously as possible.

Sec. 8. EFFECTIVE DATES

This act shall take effect on passage, except that Sec. 6 (Medicare Savings Programs; income eligibility) shall take effect upon approval by the Centers for Medicare and Medicaid Services of the amendment to Vermont's Medicaid state plan as directed in Sec. 7(a).

(Committee vote: _____)

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Representative _____

FOR THE COMMITTEE