TESTIMONY ON H.721/S.240

Presented to

Vermont House Health Care Committee

and

Vermont Senate Health and Welfare Committee

January 2024

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Chair Houghton, Chair Lyons, and members of both the House Health Care Committee and the Senate Health and Welfare Committee:

My name is Hayden Dublois, and I am a Visiting Fellow at the Opportunity Solutions Project (OSP), a non-profit organization dedicated to advancing public policy solutions. I am also a former Vermonter who appreciates the opportunity to weigh in on this important policy discussion. Thank you for the opportunity to submit written testimony on two companion pieces of legislation, H.721 and S.240.

OSP strongly opposes this legislation—particularly Section 3—for the following reasons:

1. **Vermont already has a low uninsured rate with expanded access to Medicaid**
2. **This legislation would substantially expand Medicaid and crowd out other forms of coverage**
3. **This proposal would cost the state and medical providers dearly**

Reason 1: Vermont Already Has a Low Uninsured Rate with Expanded Access to Medicaid

Vermont has one of the lowest uninsured rates in the nation.[1] It also has expanded Medicaid eligibility to 138 percent of the federal poverty level (FPL) to able-bodied adults, and taken advantage of numerous other flexibilities to offer Medicaid coverage to expanded populations.[2]

The uninsured rate statistics cited in the findings of this legislation inappropriately focus on the Medicaid unwinding process that occurred in 2023. For several years during the COVID-19 pandemic, thousands of Vermonters were kept on Medicaid despite having income levels well in excess of the eligibility thresholds. This caused the Medicaid rolls to swell significantly. The necessary unwinding process was critical to help ensure Medicaid was preserved for those truly in need of the program, not able-bodied adults with incomes above eligibility thresholds.

Many of these individuals leaving Medicaid undoubtably transitioned onto subsidized insurance through Vermont Health Connect (VHC), used insurance through their employer, or re-enrolled on Medicaid. As a result, the necessary decline in Medicaid enrollment is only one side of the coin that ignores the other coverage options this group is taking advantage of.

Reason 2: This Legislation Would Substantially Expand Medicaid and Crowd Out Other Forms of Coverage

The proposal contained in this legislation would expand Medicaid in two ways: by expanding Dr. Dynasaur (the state's Children's Health Insurance Program, or CHIP) to Vermonters up to age 26, and by expanding Medicaid eligibility to able-bodied adults from 138 percent FPL to 317 percent FPL. [Notably, the 133 percent FPL and 312 percent FPL figures in the legislation ignore the additional five percent income disregard given to able-bodied adults on Medicaid.][3]

Under this proposal, **a four-person adult household in Vermont could report nearly $100,000 in annual income and still receive Medicaid coverage.[4] Even a single adult could earn nearly $50,000 per year and still remain on Medicaid.[5]**

This **near doubling of the Medicaid eligibility thresholds would undoubtably increase enrollment and expenditures,** all while running afoul of the true purpose of the Medicaid program: to help the most vulnerable.

Moreover, today, **all Vermonters earning up to 317 percent FPL—and beyond—currently qualify for free or heavily subsidized private insurance on Vermont Health Connect via federal premium tax credits.[6]**

Current Subsidized Insurance Costs for a Single Individual in Vermont on VHC

Annual Income Level (in dollars)	Income level (as a % of the FPL)	Premium Expense Today on VHC for Lowest-Cost Plan
150%	$22,590	$0.07 per month
200%	$30,120	$0.07 per month
250%	$37,650	$0.07 per month
300%	$45,180	$12.13 per month

Source: Author's calculations using VHC plan comparison tool for lowest-cost plan

Current Subsidized Insurance Costs for a Family of Four in Vermont on VHC

Annual Income Level (in dollars)	Income level (as a % of the FPL)	Premium Expense Today on VHC for Lowest-Cost Plan
150%	$46,800	$0.15 per month
200%	$62,400	$0.15 per month
250%	$78,000	$0.15 per month
300%	$93,600	$45.27 per month

Source: Author's calculations using VHC plan comparison tool for lowest-cost plan

As you can see, **virtually all of the individuals in the income ranges that would be covered by expanded Medicaid in the proposed legislation already have access to extremely low-cost, heavily subsidized private insurance today.** In addition to premium tax credits subsidizing their premiums, many of these individuals also benefit from cost-sharing subsidies for their out-of-pocket expenses.[7]

Unfortunately, **if this legislation passed, it would shift all of these individuals from their private plans onto Medicaid, since eligibility for federal premium tax credits is canceled if an individual is eligible for Medicaid.[8]**

This would be a disaster. This proposal would not expand coverage—it would shift it from private coverage paid for by the federal government to Medicaid paid for, in part, by the State of Vermont.

Individuals would be forced to take inferior Medicaid that reimburses providers at lower levels and is accepted at fewer providers, and abandon their current private plans. Based on 2023 open enrollment figures for the 2024 plan year, **as many as 15,000 Vermonters would be impacted by this change and forced to move off of their subsidized private insurance and onto Medicaid.**[9]

Reason 3: This Legislation Would Cost the State and Medical Providers Dearly

Today, the thousands of Vermonters earning between 138 percent FPL and 317 percent FPL benefit from access to the heavily subsidized private coverage described above. The premium tax credits and cost-sharing subsidies of this coverage are paid for by the federal government.

If Vermont were to expand Medicaid to 317 percent FPL—thus shifting these individuals off of their private plans and onto Medicaid—it would pick up a portion of the cost. And because the federal government's enhanced match rate of 90 percent only applies up to 138 percent FPL, the state will pay a significant amount. Based on Vermont's Federal Medical Assistant Percentage (FMAP), **the state would have to bear 41.8 percent of the cost for each new enrollee on Medicaid in this income range.**[10] **That stands in stark contrast to the $0 the state contributes to their federal health subsidies for private insurance today.**

Put simply, **the state would be sacrificing the benefits of federally financed private insurance for thousands of Vermonters and replacing it with, in part, state-financed Medicaid.**

Additionally, Vermont's already struggling medical providers would suffer dramatically. Medicaid reimburses providers at roughly 60 percent of what private insurance pays.[11] **By shifting more individuals off of their private plans and onto Medicaid, provider reimbursements will plummet.** While Section 5 of the legislation allegedly increases provider reimbursement payments, it indicates no plan on how to finance what would be a monumental expenditure.

Based on the most recent filings to the U.S. Department of Human Services, **Vermont's hospitals alone suffered from a combined $176 million Medicaid shortfall in 2021 because the cost to treat Medicaid patients far exceeded the revenue gained**.[12] **Shifting thousands more Vermonters off of private insurance and onto Medicaid would be catastrophic for these providers.**

Conclusion

Legislators can and should reject H.721/S.240, particularly the provisions contained in Section 3 of the legislation. This proposal would unnecessarily shift thousands of Vermonters—with some earning $100,000 per year—from subsidized private coverage to Medicaid, with the state and medical providers bearing an unknown but certainly significant cost. This legislation would not achieve its intended goals of expanding access to health care, and would instead cost taxpayers and providers millions.

[1] U.S. Census Bureau, "Uninsured Rates Decreased in Over Half of U.S. States in 2022," U.S. Census Bureau (2023), https://www.census.gov/library/stories/2023/09/health-insurance-coverage.html.
[2] Centers for Medicare and Medicaid Services, "Medicaid, Children's Health Insurance Program, & Basic Health Program Eligibility Levels," U.S. Department of Health and Human Services (2013), https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-childrens-health-insurance-program-basic-health-program-eligibility-levels/index.html.
[3] Centers for Medicare and Medicaid Services, "With respect to MAGI conversion, how will the 5% disregard be applied?," U.S. Department of Health and Human Services (2013), https://www.medicaid.gov/faq/respect-magi-conversion-how-will-5-disregard-be-applied/index.html.
[4] Author's calculations based on 2024 federal poverty levels.
[5] Ibid.
[6] Centers for Medicare and Medicaid Services, "Plan Year 2024 Qualified Health Plan Choice and Premiums in HealthCare.gov Marketplaces," U.S. Department of Health and Human Services (2023), https://www.cms.gov/files/document/2024-qhp-premiums-choice-report.pdf.
[7] Centers for Medicare and Medicaid Services, "Cost Sharing Reductions," U.S. Department of Health and Human Services (2023), https://www.healthcare.gov/lower-costs/save-on-out-of-pocket-costs/.
[8] Congressional Research Service, "Health Insurance Premium Tax Credit and Cost-Sharing Reductions," CRS (2023), https://crsreports.congress.gov/product/pdf/R/R44425.
[9] Author's calculations based on 2023 open enrollment public use files from CMS.
[10] Kaiser Family Foundation, "Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier," KFF (2024), https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.
[11] John D. Shatto & M. Kent Clemens, "Projected Medicare expenditures under an illustrative scenario with alternative payment updates to Medicare providers," U.S. Department of Health and Human Services (2018), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and Reports/ReportsTrustFunds/Downloads/2018TRAlternativeScenario.pdf.
[12] Author's calculations based on 2021 revenue and cost reports filed by hospitals to the U.S. Department of Health and Human Services.