H.721

Introduced by Representatives Houghton of Essex Junction, Andrews of Westford, Anthony of Barre City, Arsenault of Williston, Berbeco of Winooski, Birong of Vergennes, Black of Essex, Bluemle of Burlington, Bongartz of Manchester, Bos-Lun of Westminster, Boyden of Cambridge, Brown of Richmond, Brumsted of Shelburne, Burke of Brattleboro, Burrows of West Windsor, Buss of Woodstock, Campbell of St. Johnsbury, Carpenter of Hyde Park, Chase of Chester, Chesnut-Tangerman of Middletown Springs, Cina of Burlington, Coffey of Guilford, Cole of Hartford, Conlon of Cornwall, Cordes of Lincoln, Dodge of Essex, Dolan of Essex Junction, Durfee of Shaftsbury, Elder of Starksboro, Emmons of Springfield, Farlice-Rubio of Barnet, Garofano of Essex, Goldman of Rockingham, Graning of Jericho, Headrick of Burlington, Holcombe of Norwich, Hooper of Burlington, Howard of Rutland City, Hyman of South Burlington, James of Manchester, Jerome of Brandon, Kornheiser of Brattleboro, Krasnow of South Burlington, LaBounty of Lyndon, LaLonde of South Burlington, Leavitt of Grand Isle, Logan of Burlington, Long of Newfane, McCann of Montpelier, McCarthy of St. Albans City, McFaun of Barre

Town, McGill of Bridport, Morris of Springfield, Mrowicki of Putney, Mulvaney-Stanak of Burlington, Notte of Rutland City, Noyes of Wolcott, Nugent of South Burlington, Ode of Burlington, Pajala of Londonderry, Patt of Worcester, Pouech of Hinesburg, Priestley of Bradford, Rachelson of Burlington, Rice of Dorset, Roberts of Halifax, Satcowitz of Randolph, Sheldon of Middlebury, Sims of Craftsbury, Small of Winooski, Stevens of Waterbury, Stone of Burlington, Templeman of Brownington, Toleno of Brattleboro, Torre of Moretown, Troiano of Stannard, Waters Evans of Charlotte, Whitman of Bennington, Williams of Barre City, and Wood of Waterbury

Referred to Committee on

Date:

Subject: Health; health insurance; Medicaid; Dr. Dynasaur

Statement of purpose of bill as introduced: This bill proposes to increase eligibility for the Dr. Dynasaur program and for Dr. Dynasaur-like coverage to include income-eligible young adults up to 26 years of age. The bill would increase the income eligibility thresholds for adults in the Medicaid program over time until they reach the same level as Dr. Dynasaur. The bill would require increased reimbursement rates to providers for delivering primary care, mental health, substance use disorder treatment, long-term care, and dental

services to Medicaid beneficiaries. The bill would modify the appointments to and duties of the Clinical Utilization Review Board and increase the income eligibility thresholds for Medicare Savings Programs. The bill would require Dr. Dynasaur to cover mental health services for children and young adults without a specific diagnosis if they have faced certain adverse life experiences. The bill would direct the Agency of Human Service to develop a proposal for a public option for small businesses to use to purchase health coverage for their employees and require the Agency to propose a schedule of sliding-scale cost-sharing requirements for the Medicaid program. The bill would also require the Agency to recommend modifications to specialty care reimbursement rates and to report on potential changes to the structure of Vermont's health insurance markets.

An act relating to expanding access to Medicaid and Dr. Dynasaur

It is hereby enacted by the General Assembly of the State of Vermont:

~~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. 33 V.S.A. § 1901 is amended to read:

§ 1901. ADMINISTRATION OF PROGRAM

(a)(1) The Secretary of Human Services or designee shall take appropriate action, including making of rules, required to administer a medical assistance program under Title XIX (Medicaid) and Title XXI (SCHIP) of the Social Security Act.

(2) The Secretary or designee shall seek approval from the General Assembly prior to applying for and implementing a waiver of Title XIX or Title XXI of the Social Security Act, an amendment to an existing waiver, or a

new state option that would restrict eligibility or benefits pursuant to the Deficit Reduction Act of 2005. Approval by the General Assembly under this subdivision constitutes approval only for the changes that are scheduled for implementation.

(3) Income eligibility for Medicaid for an adult who is 26 years of age or older but under 65 years of age and is not pregnant shall be as follows:

(A) until January 1, 2026, 133 percent of the federal poverty level for the applicable family size;

(B) from January 1, 2026 until January 1, 2028, 185 percent of the federal poverty level for the applicable family size;

(C) from January 1, 2028 until January 1, 2030, 250 percent of the federal poverty level for the applicable family size; and

(D) beginning on January 1, 2030, 312 percent of the federal poverty level for the applicable family size.

(4) A manufacturer of pharmaceuticals purchased by individuals receiving State pharmaceutical assistance in programs administered under this chapter shall pay to the Department of Vermont Health Access, as the Secretary's designee, a rebate on all pharmaceutical claims for which State-only funds are expended in an amount that is in proportion to the State share of the total cost of the claim, as calculated annually on an aggregate basis, and

~~based on the full Medicaid rebate amount as provided for in Section 1927(a)~~ through (c) of the federal Social Security Act, 42 U.S.C. § 1396r-8.

(b) The Secretary shall make coverage under the Dr. Dynasaur program established in accordance with Title XIX (Medicaid) and Title XXI (SCHIP) of the Social Security Act available to the following individuals whose modified adjusted gross income is at or below 312 percent of the federal poverty level for the applicable family size:

(1) all Vermont residents up to 26 years of age; and

(2) pregnant individuals of any age.

(c) The Secretary may charge a monthly premium, in amounts set by the General Assembly, per family for pregnant ~~women and~~ individuals, children, and young adults eligible for medical assistance under Sections 1902(a)(10)(A)(i)(III), (IV), (VI), and (VII) of Title XIX of the Social Security Act, whose family income exceeds 195 percent of the federal poverty level, as permitted under section 1902(r)(2) of that act. Fees collected under this subsection shall be credited to the State Health Care Resources Fund established in section 1901d of this title and shall be available to the Agency to offset the costs of providing Medicaid services. Any co-payments, coinsurance, or other cost sharing to be charged shall ~~also~~ be ~~authorized and set~~ established by the Agency of Human Services as authorized by the General Assembly.

~~(d)(1) To enable the State to manage public resources effectively while~~ preserving and enhancing access to health care services in the State, the Department of Vermont Health Access is authorized to serve as a publicly operated managed care organization (MCO).

* * *

(3) The Agency of Human Services and Department of Vermont Health Access shall report to the Health ~~Care~~ Reform Oversight Committee about implementation of Global Commitment in a manner and at a frequency to be determined by the Committee. Reporting shall, at a minimum, enable the tracking of expenditures by eligibility category, the type of care received, and to the extent possible allow historical comparison with expenditures under the previous Medicaid appropriation model ~~(~~by department and program~~)~~ and, if appropriate, with the amounts transferred by another department to the Department of Vermont Health Access. Reporting shall include spending in comparison to any applicable budget neutrality standards.

(e) [Repealed.]

(f) The Secretary shall not impose a prescription co-payment for individuals under ~~age 21~~ 26 years of age enrolled in Medicaid or Dr. Dynasaur.

~~* * *~~

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

§ 1901e. GLOBAL COMMITMENT FUND

* * *

(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)–(F) of this subdivision annually as part of its budget presentation. The Agency may choose to provide the required information for only a subset of the Global Commitment investments in any one year, provided that the Agency shall provide the information for not less than 20 percent of all of the investments in any one year and shall rotate the investments on which it reports such that it provides the information set forth in subdivisions (A)–(F) of this subdivision for each investment at least once every five years. 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;

(E) the amount of return on the investment, if applicable; and

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

Sec. 5. 33 V.S.A. § 1905b is added to read:

§ 1905b. MEDICAID REIMBURSEMENT RATES FOR CERTAIN SERVICES

The Department of Vermont Health Access shall reimburse providers for delivering primary care, mental health, substance use disorder treatment, and long-term care services in amounts that are greater than or equal to 125 percent of the Medicare reimbursement rates then in effect for delivering the same services.

Sec. 6. 33 V.S.A. § 1992 is amended to read:

§ 1992. MEDICAID COVERAGE FOR ADULT DENTAL SERVICES

* * *

(b) The Department of Vermont Health Access shall develop a reimbursement structure for dental services in the Vermont Medicaid program that encourages dentists, dental therapists, and dental hygienists to provide preventive care by providing reimbursement rates that are greater than or equal

~~to 125 percent of the rates then in effect through the commercial dental insurer~~ with the largest market share in Vermont for delivering the same services.

Sec. 7. 33 V.S.A. § 2031 is amended to read:

§ 2031. CREATION OF CLINICAL UTILIZATION REVIEW BOARD

(a) ~~No later than June 15, 2010, the Department of Vermont Health Access shall create a~~ The Clinical Utilization Review Board is established in the Department of Vermont Health Access to examine existing medical services, emerging technologies, and relevant evidence-based clinical practice guidelines and make recommendations to the Department regarding coverage, unit limitations, place of service, and appropriate medical necessity of services in the State's Medicaid programs.

(b)(1) The Board shall comprise 10 members with diverse medical experience, to be appointed as follows:

(A) four members, appointed by the Governor upon recommendation of the Commissioner of Vermont Health Access;

(B) three members, appointed by the Speaker of the House; and

(C) three members, appointed by the President Pro Tempore of the Senate.

(2) The Board shall solicit additional input as needed from individuals with expertise in areas of relevance to the Board's deliberations. The Medical

~~Director of the Department of Vermont Health Access shall serve as the State's~~ liaison to the Board.

(3) Board member terms shall be staggered, but in no event longer than three years from the date of appointment.

(4) The Board shall meet at least quarterly~~, provided that the Board shall meet no less frequently than once per month for the first six months following its formation~~.

(c) The Board shall have the following duties and responsibilities:

(1) Identify and recommend to the Commissioner of Vermont Health Access opportunities to improve quality, efficiencies, and adherence to relevant evidence-based clinical practice guidelines in the Department's medical programs by:

(A) examining high-cost and high-use services identified through the programs' current medical claims data;

(B) reviewing existing utilization controls to identify areas in which improved utilization review might be indicated, including use of elective, nonemergency, out-of-state outpatient and hospital services;

(C) reviewing medical literature on current best practices and areas in which services lack sufficient evidence to support their effectiveness;

(D) conferring with commissioners, directors, and councils within ~~the Agency of Human Services and the Department of Financial Regulation, as~~

appropriate, to identify specific opportunities for exploration and to solicit recommendations;

(E) identifying appropriate but underutilized services and recommending new services for addition to Medicaid coverage;

(F) determining whether it would be clinically and fiscally appropriate for the Department of Vermont Health Access to contract with facilities that specialize in certain treatments and have been recognized by the medical community as having good clinical outcomes and low morbidity and mortality rates, such as transplant centers and pediatric oncology centers;

(G) consulting with the Department's Drug Utilization Review Board as appropriate to coordinate Medicaid prescription drug coverage in connection with covered services in order to optimize patient outcomes; and

~~(G)~~(H) considering the possible administrative burdens or benefits of potential recommendations on providers, including examining the feasibility of exempting from prior authorization requirements those health care professionals whose prior authorization requests are routinely granted.

(2) Recommend to the Commissioner of Vermont Health Access the most appropriate mechanisms to implement the recommended evidence-based clinical practice guidelines. Such mechanisms may include prior authorization, prepayment, postservice claim review, and frequency limits. Recommendations shall be consistent with the Department's existing

~~utilization processes, including those related to transparency, timeliness, and~~ reporting. Prior to submitting final recommendations to the Commissioner of Vermont Health Access, the Board shall ensure time for public comment is available during the Board's meeting and identify other methods for soliciting public input.

(d) The Commissioner may adopt a mechanism recommended pursuant to subdivision (c)(2) of this section with or without amendment, provided that if the Commissioner proposes to amend the mechanism recommended by the Board, ~~he or she~~ the Commissioner shall request the Board to consider the amendment before the mechanism is implemented or is filed as a proposed administrative rule pursuant to 3 V.S.A. § 838.

(e)(1) At least annually, the Commissioner shall report to the House Committees on Health Care and on Human Services and the Senate Committee on Health and Welfare the services that the Board has reviewed, considered, or recommended pursuant to subdivision (c)(1)(E) of this section.

(2) Within 30 days following the receipt of an inquiry from a legislative committee or committees regarding new or expanded Medicaid coverage of any service, the Commissioner shall provide the inquiry to the Board for its consideration. The Commissioner shall include the Board's response to each such inquiry in the Commissioner's next report submitted pursuant to subdivision (1) of this subsection.

(3) Nothing in this section shall be construed to limit the authority of the General Assembly to require Medicaid coverage of any service.

Sec. 8. 33 V.S.A. § 2092 is amended to read:

§ 2092. DR. DYNASAUR-LIKE COVERAGE FOR CERTAIN VERMONT RESIDENTS

* * *

(b) The Agency of Human Services shall provide hospital, medical, dental, and prescription drug coverage equivalent to coverage in the Vermont Medicaid State Plan to the following categories of Vermont residents who have an immigration status for which Medicaid coverage is not available and who are otherwise uninsured:

(1) children and young adults under ~~19~~ 26 years of age whose household income does not exceed the income threshold for eligibility under the Vermont Medicaid State Plan; and

(2) pregnant individuals whose household income does not exceed the income threshold for eligibility under the Vermont Medicaid State Plan for coverage during their pregnancy and for postpartum coverage equivalent to that available under the Vermont Medicaid State Plan.

* * *

Sec. 9. 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. 10. MEDICAID COVERAGE OF MENTAL HEALTH SERVICES FOR CHILDREN AND YOUNG ADULTS WITHOUT A DIAGNOSIS

The Department of Vermont Health Access shall amend its rules and provider manuals as necessary to ensure that children and young adults up to 26 years of age receive coverage for mental health services without a specific mental health diagnosis if they have one or more of the following life experiences:

(1) separation from a parent or guardian due to incarceration or immigration;

(2) death of a parent or guardian;

(3) death of a family member or friend by suicide;

(4) foster home placement;

(5) food insecurity or housing instability, or both;

(6) exposure to domestic violence or other traumatic events;

(7) maltreatment;

(8) severe and persistent bullying; or

(9) experience of discrimination based on race, ethnicity, gender identity, sexual orientation, religion, learning differences, or disability.

Sec. 11. PUBLIC OPTION; AGENCY OF HUMAN SERVICES; REPORT

On or before January 15, 2025, the Agency of Human Services shall provide to the House Committee on Health Care and the Senate Committee on Health and Welfare a proposal for providing small businesses with the option to purchase coverage for their employees through Vermont Medicaid in addition to the existing option of purchasing health insurance coverage for their employees in plans offered through or outside the Vermont Health Benefit Exchange.

Sec. 12. MEDICAID SLIDING-SCALE COST-SHARING REQUIREMENTS; REPORT

On or before January 15, 2025, the Agency of Human Services shall provide to the House Committees on Health Care, on Human Services, and on Appropriations and the Senate Committees on Health and Welfare and on Appropriations a proposed schedule for sliding-scale cost-sharing requirements for Medicaid and Dr. Dynasaur beneficiaries, including the estimated fiscal

impact of those cost-sharing requirements. The proposed schedule shall not include any co-payment requirements in excess of those in effect on January 1, 2024 for Medicaid beneficiaries at or below 133 percent of the federal poverty level and shall not include any prescription drug co-payments for Dr. Dynasaur beneficiaries under 26 years of age.

Sec. 13. SPECIALTY CARE REIMBURSEMENT RATES; REPORT

On or before January 15, 2025, the Agency of Human Services shall provide to the House Committees on Health Care and on Human Services and the Senate Committee on Health and Welfare recommendations for modifications to reimbursement rates for providers of specialty care services to increase access to those services for Medicaid and Dr. Dynasaur beneficiaries.

Sec. 14. MERGED INSURANCE MARKETS; REPORT

(a) The Agency of Human Services, in consultation with interested stakeholders, shall evaluate Vermont's health insurance markets to determine the potential advantages and disadvantages to individuals, small businesses, and large businesses, including the impacts on health insurance premiums and access to health care services, of:

(1) maintaining a health insurance market structure in which the individual and small group markets are merged and the large group market is separate;

(2) moving to a fully merged market structure in which individuals, small groups, and large groups are merged into a single market; and

(3) moving to a fully separated market structure in which individuals, small groups, and large groups each purchase health insurance in a separate market.

(b) On or before January 15, 2025, the Agency of Human Services shall submit its findings and any recommendations for modifications to the current market structure to the House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance.

(c) The sum of $250,000.00 is appropriated from the General Fund to the Agency of Human Services in fiscal year 2025 to carry out the study required by this section.

Sec. 15. 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. 9 of this act.

(b) If amendments to Vermont's Medicaid state plan 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 to enable implementation of all provisions of this act at the times specified in the act.

Sec. 16. EFFECTIVE DATES

(a) The following provisions shall take effect on January 1, 2025:

(1) in Sec. 3 (33 V.S.A. § 1901), subsection (b) (increasing eligibility for Dr. Dynasaur to income-eligible individuals up to 26 years of age) and the amendments to subsection (c); and

(2) Sec. 8 (33 V.S.A. § 2092).

(b) The following provisions shall take effect on January 1, 2026:

(1) Sec. 5 (33 V.S.A. § 1905b; Medicaid rates for primary care and mental health services); and

(2) Sec. 6 (33 V.S.A. § 1992; Medicaid rates for dental services).

(c) Sec. 9 (Medicare Savings Program; 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. 15(a).

(d) In Sec. 7 (33 V.S.A. § 2031; Clinical Utilization Review Board), subdivision (b)(1) shall take effect on passage, with the appointments to be made by the Speaker of the House and the President Pro Tempore of the Senate to occur upon the expiration of the terms of the members of the Board serving as of the effective date of this act in an alternating manner until all

~~members have been appointed to the Board in compliance with the provisions~~ of subdivision (b)(1).

~~(c) The remaining provisions shall take effect on passage.~~

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

§ 1901. ADMINISTRATION OF PROGRAM

* * *

(b) The Secretary shall make coverage under the Dr. Dynasaur program established in accordance with Title XIX (Medicaid) and Title XXI (SCHIP) of the Social Security Act available to the following individuals whose modified adjusted gross income is at or below 312 percent of the federal poverty level for the applicable family size:

(1) all Vermont residents up to 21 years of age; and

(2) pregnant individuals of any age.

(c) The Secretary may charge a monthly premium, in amounts set by the General Assembly, per family for pregnant ~~women and~~ individuals, children, and young adults eligible for medical assistance under Sections 1902(a)(10)(A)(i)(III), (IV), (VI), and (VII) of Title XIX of the Social Security Act, whose family income exceeds 195 percent of the federal poverty level, as permitted under section 1902(r)(2) of that act. Fees collected under this subsection shall be credited to the State Health Care Resources Fund established in section 1901d of this title and shall be available to the Agency to offset the costs of providing Medicaid services. Any co-payments, coinsurance, or other cost sharing to be charged shall also be authorized and set by the General Assembly.

* * *

Sec. 4. 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) 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 by 2030; and

(4) 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;

(D) 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;

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

(F) 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) 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

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

(2) As used in this section, "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)(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 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. 5. 33 V.S.A. § 1901e is amended to read:

§ 1901e. GLOBAL COMMITMENT FUND

* * *

(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. 6. 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. 7. 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 190 percent of the federal poverty level (FPL);

(2) increase the Specified Low-Income Medicare Beneficiary (SLMB) Program income threshold to 210 percent FPL; and

(3) increase the Qualifying Individual (QI) Program income threshold to 225 percent FPL.

Sec. 8. 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 expand eligibility for the Medicare Savings Programs as set forth in Sec. 7 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. 9. REPEAL OF VPHARM PROGRAM

33 V.S.A. § 2073 (VPharm assistance program) is repealed on the later of January 1, 2027 or 12 months following approval by the Centers for Medicare and Medicaid Services of the amendment to Vermont's Medicaid state plan to expand eligibility for the Medicare Savings Programs as set forth in Secs. 7 and 8(a) of this act.

Sec. 10. 2013 Acts and Resolves No. 73, Sec. 60(10), as amended by 2017 Acts and Resolves No. 73, Sec. 14, 2018 Acts and Resolves No. 187, Sec. 5, 2019 Acts and Resolves No. 71, Sec. 21, 2021 Acts and Resolves No. 73, Sec. 14, and 2023 Acts and Resolves No. 78, Sec. E.306.1, is further amended to read:

(10) Secs. 48–51 (health care claims tax) shall take effect on July 1, 2013 and Sec. 52 (Health IT-Fund; sunset) shall take effect on July 1, ~~2025~~ 2027.

Sec. 11. 2019 Acts and Resolves No. 6, Sec. 105, as amended by 2019 Acts and Resolves No. 71, Sec. 19, 2022 Acts and Resolves No. 83, Sec. 75, and 2023 Acts and Resolves No. 78, Sec. E.306.2, is further amended to read:

Sec. 105. EFFECTIVE DATES

* * *

(b) Sec. 73 (further amending 32 V.S.A. § 10402) shall take effect on July 1, ~~2025~~ 2027.

Sec. 12. APPROPRIATIONS

(a) In fiscal year 2025, the sum of $1,200,000.00 in Global Commitment funds is appropriated to the Agency of Human Services to implement the Dr. Dynasaur eligibility expansion set forth in Sec. 3 of this act.

(1) In fiscal year 2025, the sum of $360,000.00 is appropriated from the General Fund to the Agency of Human Services, Global Commitment appropriation for the State match for implementation of the Dr. Dynasaur eligibility expansion set forth in Sec. 3 of this act.

(2) In fiscal year 2025, the sum of $840,000.00 in federal funds is appropriated to the Agency of Human Services, Global Commitment appropriation for implementation of the Dr. Dynasaur eligibility expansion set forth in Sec. 3 of this act.

(b) In fiscal year 2025, the sum of $450,000.00 in Global Commitment funds is appropriated to the Agency of Human Services for the technical analysis required by Sec. 4 of this act.

(1) In fiscal year 2025, the sum of $250,000.00 is appropriated from the General Fund to the Agency of Human Services, Global Commitment appropriation for the State match for the technical analysis required by Sec. 4 of this act.

(2) In fiscal year 2025, the sum of $200,000.00 in federal funds is appropriated to the Agency of Human Services, Global Commitment appropriation for the technical analysis required by Sec. 4 of this act.

(c) The sum of $200,000.00 is appropriated to the Department of Vermont Health Access in fiscal year 2025, of which $100,000.00 is from the General Fund and $100,000.00 is in federal funds, to implement the Medicare Savings Programs eligibility expansion as set forth in Sec. 7 of this act.

(d) It is the intent of the General Assembly to use a portion of the revenues generated through the amended taxes and fees in Secs. 13–15 of this act to fund the appropriations set forth in this section.

Sec. 12. EFFECTIVE DATES

This act shall take effect on passage, except:

(1) Sec. 3 (33 V.S.A. § 1901; Dr. Dynasaur eligibility expansion) shall take effect on January 1, 2026;

~~(2) Sec. 7 (Medicare Savings Programs; income eligibility) shall take effect upon the later of January 1, 2026 or approval by the Centers for Medicare and Medicaid Services of the amendment to Vermont's Medicaid state plan as directed in Sec. 8(a); and~~

~~(3) Sec. 12 (appropriations) shall take effect on July 1, 2024.~~

Sec. 13. 32 V.S.A. § 5811(18) is amended to read:

(18) "Vermont net income" means, for any taxable year and for any corporate taxpayer:

(A) the taxable income of the taxpayer for that taxable year under the laws of the United States, without regard to 26 U.S.C. § 168(k), and excluding income that under the laws of the United States is exempt from taxation by the states:

(i) increased by:

(I) the amount of any deduction for State and local taxes on or measured by income, franchise taxes measured by net income, franchise taxes for the privilege of doing business and capital stock taxes; ~~and~~

(II) to the extent such income is exempted from taxation under the laws of the United States ~~by~~, the amount received by the taxpayer on and after January 1, 1986 as interest income from state and local obligations, other than obligations of Vermont and its political subdivisions, and any dividends

or other distributions from any fund to the extent such dividend or distribution is attributable to such Vermont State or local obligations;

(III) the amount of any deduction for a federal net operating loss; and

(IV) the amount of any deduction allowed under 26 U.S.C. § 250(a); and

(ii) decreased by:

* * *

Sec. 14. 32 V.S.A. § 5832 is amended to read:

§ 5832. TAX ON INCOME OF CORPORATIONS

A tax is imposed for each calendar year, or fiscal year ending during that calendar year, upon the income earned or received in that taxable year by every taxable corporation, reduced by any Vermont net operating loss allowed under section 5888 of this title, such tax being the greater of:

(1) an amount determined in accordance with the following schedule:

Vermont net income of the corporation for the taxable year allocated or apportioned to Vermont under section 5833 of this title	*Tax*
$0-10,000.00	*6.00%*
10,001.00-25,000.00	*$600.00 plus 7.0% of the excess over $10,000.00*

25,001.00 and over $1,650.00 plus ~~8.5%~~ 10% of the excess over 25,000.00

or

(2)(A) $75.00 for small farm corporations. "Small farm corporation" means any corporation organized for the purpose of farming, which during the taxable year is owned solely by active participants in that farm business and receives less than $100,000.00 Vermont gross receipts from that farm operation, exclusive of any income from forest crops; or

(B) An amount determined in accordance with section 5832a of this title for a corporation that qualifies as and has elected to be taxed as a digital business entity for the taxable year; or

(C) For C corporations with Vermont gross receipts from $0.00–$500,000.00, the greater of the amount determined under subdivision (1) of this section or $100.00; or

(D) For C corporations with Vermont gross receipts from $500,001.00–$1,000,000.00, the greater of the amount determined under subdivision (1) of this section or $500.00; or

(E) For C corporations with Vermont gross receipts from $1,000,001.00–$5,000,000.00, the greater of the amount determined under subdivision (1) of this section or $2,000.00; or

(F) For C corporations with Vermont gross receipts from $5,000,001.00–$300,000,000.00, the greater of the amount determined under subdivision (1) of this section or $6,000.00; or

(G) For C corporations with Vermont gross receipts greater than $300,000,000.00, the greater of the amount determined under subdivision (1) of this section or $100,000.00.

Sec. 15. 9 V.S.A. § 5302 is amended to read:

§ 5302. NOTICE FILING

* * *

(e) At the time of the filing of the information prescribed in subsection (a), (b), (c), or (d) of this section, except investment companies subject to 15 U.S.C. § 80a-1 et seq., the issuer shall pay to the Commissioner a fee of ~~$600.00~~ $740.00. The fee is nonrefundable.

(f) Investment companies subject to 15 U.S.C. § 80a-1 et seq. shall pay to the Commissioner an initial notice filing fee of ~~$2,000.00~~ $2,250.00 and an annual renewal fee of ~~$1,650.00~~ $1,900.00 for each portfolio or class of investment company securities for which a notice filing is submitted.

* * *

Sec. 16. EFFECTIVE DATES

(a) This section and Secs. 1 (short title), 2 (findings), 4 (technical analysis and reports), 5 (Global Commitment investments), 6 (Medicaid covered service

considerations), 8 (Medicaid state plan amendments), 9 (repeal of VPharm program), and 10 and 11 (extension of Health IT-Fund) shall take effect on passage.

(b) Sec. 3 (33 V.S.A. § 1901; Dr. Dynasaur eligibility expansion) shall take effect on January 1, 2026.

(c) Sec. 7 (Medicare Savings Programs; income eligibility) shall take effect upon the later of January 1, 2026 or approval by the Centers for Medicare and Medicaid Services of the amendment to Vermont's Medicaid state plan as directed in Sec. 8(a).

(d) Secs. 12 (appropriations) and 15 (securities registration fee) shall take effect on July 1, 2024.

(e) Secs. 13 (add-back of corporate income tax deductions) and 14 (corporate income tax brackets) shall take effect on January 1, 2025 and apply to taxable years beginning on and after January 1, 2025.