TO THE HOUSE OF REPRESENTATIVES:

The Committee on Health Care to which was referred Senate Bill No. 262 entitled "An act relating to miscellaneous changes to the Medicaid program and the Department of Vermont Health Access" respectfully reports that it has considered the same and recommends that the House propose to the Senate that bill be amended by striking out all after the enacting clause and inserting in lieu thereof the following:

* * * Medicaid for Working Persons with Disabilities * * *

Sec. 1. 33 V.S.A. § 1902 is amended to read:

§ 1902. QUALIFICATION FOR MEDICAL ASSISTANCE

(a) In determining whether a person is medically indigent, the Secretary of Human Services shall prescribe and use an income standard and requirements for eligibility ~~which~~ that will permit the receipt of federal matching funds under Title XIX of the Social Security Act.

(b) Workers with disabilities whose income is less than 250 percent of the federal poverty level shall be eligible for Medicaid. The income also must not exceed the Medicaid protected income level for one or the Supplemental Security Income (SSI) payment level for two, whichever is higher, after disregarding ~~all~~ the earnings of the working individual with disabilities~~, any~~; Social Security disability insurance benefits, ~~and~~ including Social Security retirement benefits converted automatically from Social Security Disability

Insurance (SSDI), if applicable; any veteran's disability benefits; and, if the working individual with disabilities is married, all income of the spouse. Earnings of the working individual with disabilities shall be documented by evidence of Federal Insurance Contributions Act tax payments, Self-Employment Contributions Act tax payments, or a written business plan approved and supported by a third-party investor or funding source. The resource limit for this program shall be $10,000.00 for an individual and $15,000.00 for a couple at the time of enrollment in the program. Assets attributable to earnings made after enrollment in the program shall be disregarded.

* * * Eligibility for Health Vermonters and VPharm * * *

Sec. 2. 2013 Acts and Resolves No. 79, Sec. 53(d), as amended by 2014 Acts and Resolves No. 179, Sec. E.307, 2015 Acts and Resolves No. 58, Sec. E.307, 2016 Acts and Resolves No. 172, Sec. E.307.3, and 2017 Acts and Resolves No. 85, Sec. E.307, is further amended to read:

(d) Secs. 31 (Healthy Vermonters) and 32 (VPharm) shall take effect on January 1, 2014, except that the Agency of Human Services may continue to calculate household income under the rules of the Vermont Health Access Plan after that date if the system for calculating modified adjusted gross income for the Healthy Vermonters and VPharm programs is not operational by that date,

but not later than ~~December 31, 2018~~ the implementation of Vermont's Integrated Eligibility system.

* * * Increasing Income Threshold for Dr. Dynasaur Premiums * * *

Sec. 2a. 33 V.S.A. § 1901(c) is amended to read:

(c) The Secretary may charge a monthly premium, in amounts set by the General Assembly, per family for pregnant women and children 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 ~~185~~ 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.

* * * Provider Taxes * * *

Sec. 3. 33 V.S.A. § 1958 is amended to read:

§ 1958. APPEALS

(a) Any health care provider may submit a written request to the Department for reconsideration of the determination of the assessment within 20 days of notice of the determination. The request shall be accompanied by written materials setting forth the basis for reconsideration. If requested, the

Department shall hold a hearing within ~~20~~ 90 days from the date on which the reconsideration request was received. The Department shall mail written notice of the date, time, and place of the hearing to the health care provider at least ~~10~~ 30 days before the date of the hearing. On the basis of the evidence submitted to the Department or presented at the hearing, the Department shall reconsider and may adjust the assessment. Within 20 days ~~of~~ following the hearing, the Department shall provide notice in writing to the health care provider of the final determination of the amount it is required to pay based on any adjustments made by it. Proceedings under this section are not subject to the requirements of 3 V.S.A. chapter 25.

* * *

Sec. 4. 33 V.S.A. § 1959(a)(3) is amended to read:

(3) Ambulance agencies shall remit the assessment amount to the Department annually on or before ~~March 31, beginning with March 31, 2017~~ June 1.

* * * Medicaid; Asset Verification * * *

Sec. 5. 33 V.S.A. § 403 is added to read:

§ 403. BANKS AND AGENCIES TO FURNISH INFORMATION

(a) An officer of a financial institution, as described in 8 V.S.A. § 11101(32); a credit union; or an independent trust company in this State, when requested by the Commissioner of Vermont Health Access, shall furnish

to the Commissioner **or to an agent of the Department of Vermont Health Access** information in the possession of the bank or company with reference to any person or his or her spouse who is applying for or is receiving assistance or benefits from the Department of Vermont Health Access. **The Department of Vermont Health Access shall issue instructions to the financial institution detailing the nature of the request and the information necessary to satisfy the request.**

(b) Any governmental official or agency in the State, when requested by the Commissioner of Vermont Health Access, shall furnish to him or her information in the official's or agency's possession with reference to aid given or money paid or to be paid to any person or person's spouse who is applying for or is receiving assistance or benefits from the Department of Vermont Health Access.

(c) The Commissioner of Taxes, when requested by the Commissioner of Vermont Health Access, and unless otherwise prohibited by federal law, shall compare the information furnished by an applicant or recipient of assistance with the State income tax returns filed by such person and shall report his or her findings to the Commissioner of Vermont Health Access. Each application for assistance shall contain a form of consent, executed by the applicant, granting permission to the Commissioner of Taxes to disclose such information to the Commissioner of Vermont Health Access.

(d) On the first day of each month, the register of probate in each unit of the Superior Court shall provide to the Commissioner of Vermont Health Access a list of all estates, including testate, intestate, and small estates, opened during the previous calendar month within the jurisdiction of that Probate Division. The list shall contain the following information for each estate:

(1) the decedent's full name;

(2) the decedent's date of birth;

(3) the decedent's date of death;

(4) the last four digits of the decedent's Social Security number;

(5) the docket number;

(6) the date on which the estate was opened; and

(7) the full name and contact information for the executor or administrator or his or her legal representative.

Sec. 6. 33 V.S.A. § 404 is added to read:

§ 404. MEDICAID APPLICATIONS; ASSET VERIFICATION

Option #1 (Vermont Legal Aid (VLA) request) for subsec. (a):

(a)(1) The Department of Vermont Health Access shall provide notice to applicants to and beneficiaries of the Medicaid Long-Term Care and Medicaid for the Aged, Blind, and Disabled programs, written in plain

and accessible language, explaining the Department's electronic asset verification program, including:

(A) that by signing the authorization for release of financial information as part of the application for assistance or benefits from the Department of Vermont Health Access, the applicant or beneficiary is giving the Department permission to conduct electronic asset verification; and

(B) a description of the scope of the asset verification and the duration of the release of financial information.

(2) Applicants to and beneficiaries of the Medicaid Long-Term Care and Medicaid for the Aged, Blind, and Disabled programs shall be permitted to obtain a copy of any information gathered during the electronic asset verification process.

Option #2 (DVHA proposal) for subsec. (a):

(a) The Department of Vermont Health Access shall collaborate with the Office of the Health Care Advocate to ensure that applicants to and beneficiaries of the Medicaid Long-Term Care and Medicaid for the Aged, Blind, and Disabled programs receive notice written in plain and accessible language explaining the electronic asset verification system.

(b) The Department of Vermont Health Access shall modify its application forms for the Medicaid Long-Term Care and Medicaid for the

Aged, Blind, and Disabled programs as needed to enable applicants to authorize financial institutions to disclose to the Department and its agents information about the applicant's assets in order to verify the applicant's eligibility for the applicable program.

(c) In the event that the financial information of a person other than the applicant or beneficiary is necessary in order to determine the applicant's or beneficiary's eligibility for the Medicaid Long-Term Care or Medicaid for the Aged, Blind, and Disabled program, the Department of Vermont Health Access shall provide written notice regarding the asset verification process to that person and shall obtain the person's written authorization prior to requesting his or her financial information from a financial institution.

Sec. 7. RULEMAKING

The Vermont Supreme Court may promulgate rules under 12 V.S.A. § 1 to implement the provisions of Sec. 5, **33 V.S.A. § 403,** of this act.

Sec. 8. 8 V.S.A. § 10204 is amended to read:

§ 10204. EXCEPTIONS

This subchapter does not prohibit any of the activities listed in this section. This section shall not be construed to require any financial institution to make any disclosure not otherwise required by law. This section shall not be construed to require or encourage any financial institution to alter any

procedures or practices not inconsistent with this subchapter. This section shall not be construed to expand or create any authority in any person or entity other than a financial institution.

* * *

(26) Disclosure of information sought by the Department of Vermont Health Access or its agents pursuant to the Department's authority and obligations under 33 V.S.A. § 403.

* * * Maximum Out-of-Pocket Prescription Drug Limit for Bronze Plans * * *

Sec. 9. 2016 Acts and Resolves No. 165, Sec. 6(f), as amended by 2017 Acts and Resolves No. 25, Sec. 3, is further amended to read:

(f)~~(1)~~ The Director of Health Care Reform in the Agency of Administration, in consultation with the Department of Vermont Health Access and the Office of Legislative Council, shall determine whether the Secretary of the U.S. Department of Health and Human Services has the authority under the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the federal Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (ACA), to waive annual limitations on out-of-pocket expenses or actuarial value requirements for bronze-level plans, or both. On or before October 1, 2016, the Director shall present information to the Health Reform Oversight Committee regarding the authority of the Secretary of the U.S. Department of Health and Human Services to waive out-

of-pocket limits and actuarial value requirements, the estimated costs of applying for a waiver, and alternatives to a waiver for preserving the out-of-pocket prescription drug limit established in 8 V.S.A. § 4089i.

~~(2) If the Director of Health Care Reform determines that the Secretary has the necessary authority, then on or before March 1, 2019, the Commissioner of Vermont Health Access, with the Director's assistance, shall apply for a waiver of the cost-sharing or actuarial value limitations, or both, in order to preserve the availability of bronze-level qualified health benefit plans that meet Vermont's out-of-pocket prescription drug limit established in 8 V.S.A. § 4089i.~~

Sec. 10. 33 V.S.A. § 1814 is added to read:

§ 1814. MAXIMUM OUT-OF-POCKET LIMIT FOR PRESCRIPTION DRUGS IN BRONZE PLANS

(a)(1) Notwithstanding any provision of 8 V.S.A. § 4089i to the contrary, the Green Mountain Care Board may approve modifications to the out-of-pocket prescription drug limit established in 8 V.S.A. § 4089i for one or more bronze-level plans.

(2) The Department of Vermont Health Access shall certify at least two standard bronze-level plans that include the out-of-pocket prescription drug limit established in 8 V.S.A. § 4089i, as long as the plans comply with federal requirements. Notwithstanding any provision of

8 V.S.A. § 4089i to the contrary, the Department may certify one or more bronze-level qualified health benefit plans with modifications to the out-of-pocket prescription drug limit established in 8 V.S.A. § 4089i.

(b)(1) For each individual enrolled in a bronze-level qualified health benefit plan for the previous two plan years who had out-of-pocket prescription drug expenditures that met the out-of-pocket prescription drug limit established in 8 V.S.A. § 4089i for the most recent plan year for which information is available, the health insurer shall, absent an alternative plan selection or plan cancellation by the individual, automatically reenroll the individual in a bronze-level qualified health plan for the forthcoming plan year with an out-of-pocket prescription drug limit at or below the limit established in 8 V.S.A. § 4089i.

(2) Prior to reenrolling an individual in a plan pursuant to subdivision (1) of this subsection, the health insurer shall notify the individual of the insurer's intent to reenroll the individual automatically in a bronze-level qualified health plan for the forthcoming plan year with an out-of-pocket prescription drug limit at or below the limit established in 8 V.S.A. § 4089i unless the individual contacts the insurer to select a different plan and of the availability of bronze-level plans with higher out-of-pocket prescription drug limits. The health insurer shall collaborate with the

Department of Vermont Health Access and the Office of the Health Care Advocate as to the notification's form and content.

*** * * Notices to Exchange Applicants and Enrollees * * ***

Sec. 11. 33 V.S.A. § 1803(e) is added to read:

(e) The Vermont Health Benefit Exchange shall ensure that all materials mailed to applicants for and enrollees in qualified health benefit plans are sent in an envelope bearing a return address and that the outside of any envelope containing a grace period notice clearly indicates that the materials enclosed relate to the status of the enrollee's health insurance coverage.

* * * Human Services Board; Fair Hearings * * *

Sec. 12. 3 V.S.A. § 3091 is amended to read:

§ 3091. HEARINGS

* * *

(e)(1) The Board shall give written notice of its decision to the person applying for fair hearing and to the Agency.

(2) Unless a continuance is requested or consented to by an aggrieved person, decisions and orders concerning Temporary Assistance to Needy Families (TANF) under 33 V.S.A. chapter 11, TANF-Emergency Assistance (TANF-EA) under Title IV of the Social Security Act, and medical assistance

(Medicaid) under 33 V.S.A. chapter 19 shall be issued by the Board within 75 days ~~of~~ after the request for hearing.

(3) Notwithstanding any provision of subsection (c) or (d) or subdivision (1) of this subsection (e) to the contrary, in the case of an expedited Medicaid fair hearing, the Board shall delegate both its fact-finding and final decision-making authority to a hearing officer, and the hearing officer's written findings and order shall constitute the Board's decision and order in accordance with timelines set forth in federal law.

* * *

(h)(1) Notwithstanding subsections (d) and (f) of this section, the Secretary shall review all Board decisions and orders concerning TANF, TANF-EA, Office of Child Support Cases, Medicaid, and the Vermont Health Benefit Exchange. The Secretary shall:

(A) adopt a Board decision or order, except that the Secretary may reverse or modify a Board decision or order if:

(i) the Board's findings of fact lack any support in the record; or

Option #1 (VLA request):

(ii) the decision or order ~~**implicates the validity or applicability of**~~ **violates** any Agency policy or rule~~.~~; and

Option #2 (DVHA proposal):

(ii) the decision or order **~~implicates the validity or applicability of any Agency~~** **misinterprets or misapplies** policy or rule~~.~~; and

(B) issue a written decision setting forth the legal, factual, or policy basis for reversing or modifying a Board decision or order.

* * *

(i) In the case of an appeal of a Medicaid covered service decision made by the Department of Vermont Health Access or any entity with which the Department of Vermont Health Access enters into an agreement to perform service authorizations that may result in an adverse benefit determination, the right to a fair hearing granted by subsection (a) of this section shall be available to an aggrieved beneficiary only after that individual has exhausted, or is deemed to have exhausted, the Department of Vermont Health Access's internal appeals process and has received a notice that the adverse benefit determination was upheld.

Sec. 13. APPEAL OF MEDICAID COVERED SERVICE DECISIONS; FAIR HEARING; RULEMAKING

The **~~Department of Vermont Health Access~~ Agency of Human Services** shall adopt rules pursuant to 3 V.S.A. chapter 25 establishing a process by which the **~~Department~~ Agency** shall ensure that a Medicaid beneficiary who files a request for a fair hearing with the Human Services Board prior to exhausting the **~~Department's~~ Department of Vermont Health Access's**

internal appeals process receives ~~**appropriate assistance with filing the**~~ **consideration by the Department as though the beneficiary had properly filed an** internal appeal and, if the internal appeal results in an adverse determination, **that the Department shall provide to the beneficiary appropriate assistance** with filing a timely request for a fair hearing with the Human Services Board if the beneficiary wishes to do so.

*** * * Exchange Open Enrollment Extension * * ***

Sec. 14. 2019 EXCHANGE OPEN ENROLLMENT; EXTENSION

The Commissioner of Vermont Health Access shall request approval from the Centers for Medicare and Medicaid Services to extend the open enrollment period through January 31, 2019 for qualified health benefit plans to be offered through the Vermont Health Benefit Exchange for the 2019 plan year.

* * * Repeal * * *

Sec. 15. REPEAL

33 V.S.A. § 2010 (actual price disclosure and certification of prescription drugs) is repealed.

* * * Effective Dates * * *

Sec. 16. EFFECTIVE DATES

This act shall take effect on passage, except:

(1) Notwithstanding 1 V.S.A. § 214, Secs. 4 (ambulance agency provider tax) and 5(a)–(c) (Medicaid; asset verification) shall take effect on passage and apply retroactively to January 1, 2018; and

(2) Sec. 5(d) (monthly list of new probate estates) shall take effect on October 1, 2018.

(Committee vote: _____)

_____

Representative _____

FOR THE COMMITTEE