FINAL PROPOSED RULE #22-P16

Final Proposed Filing - Coversheet

Instructions:

In accordance with Title 3 Chapter 25 of the Vermont Statutes Annotated and the "Rule on Rulemaking" adopted by the Office of the Secretary of State, this filing will be considered complete upon filing and acceptance of these forms with the Office of the Secretary of State, and the Legislative Committee on Administrative Rules.

All forms shall be submitted at the Office of the Secretary of State, no later than 3:30 pm on the last scheduled day of the work week.

The data provided in text areas of these forms will be used to generate a notice of rulemaking in the portal of "Proposed Rule Postings" online, and the newspapers of record if the rule is marked for publication. Publication of notices will be charged back to the promulgating agency.

PLEASE REMOVE ANY COVERSHEET OR FORM NOT REQUIRED WITH THE CURRENT FILING BEFORE DELIVERY!

Certification Statement: As the adopting Authority of this rule (see 3 V.S.A. § 801 (b) (11) for a definition), I approve the contents of this filing entitled:

Health Benefits Eligibility and Enrollment Rule, Nonfinancial Eligibility Requirements (Part 3)

/s/ Todd Daloz , on 10/12/22
(signature) (date)

Printed Name and Title:
Todd Daloz, Deputy Secretary, Agency of Human Services

RECEIVED BY: _____

- ☐ Coversheet
- ☐ Adopting Page
- ☐ Economic Impact Analysis
- ☐ Environmental Impact Analysis
- ☐ Strategy for Maximizing Public Input
- ☐ Scientific Information Statement (if applicable)
- ☐ Incorporated by Reference Statement (if applicable)
- ☐ Clean text of the rule (Amended text without annotation)
- ☐ Annotated text (Clearly marking changes from previous rule)
- ☐ ICAR Minutes
- ☐ Copy of Comments
- ☐ Responsiveness Summary

State of Vermont
Agency of Human Services
280 State Drive
Waterbury, VT 05671-1000
www.humanservices.vermont.gov

Jenney Samuelson, Secretary
[phone] 802-241-0440
[fax] 802-241-0450

MEMORANDUM

To: Jim Condos, Secretary of State, Vermont Secretary of State Office
Sen. Mark A. MacDonald, Chair, Legislative Committee on Administrative Rules (LCAR)

From: Adaline Strumolo, Deputy Commissioner, Department of Vermont Health Access

Cc: Todd Daloz, Deputy Secretary, Agency of Human Services
Charlene Dindo, Committee Assistant, Legislative Committee on Administrative Rules
Louise Corliss, APA Coordinator, Secretary of State's Office

Date: October 18, 2022

Re: Agency of Human Services Final Proposed Rule Filing

Enclosed are the final proposed rule filings for the following Health Benefits Eligibility and Enrollment (HBEE) rule parts:

Amended:

- 22P014 HBEE Part One – General Provisions and Definitions
- 22P015 HBEE Part Two – Eligibility Standards
- 22P016 HBEE Part Three – Nonfinancial Eligibility Requirements
- 22P017 HBEE Part Five – Financial Methodologies
- 22P018 HBEE Part Seven – Eligibility and Enrollment Procedures

Public comments were received on HBEE Part Two and HBEE Part Three during the public comment period. No comments were received for the other parts. One general comment was received that was out of the scope of this rulemaking.

HBEE Part Two and HBEE Part Three were amended in response to comments from Vermont Legal Aid, Inc. (VLA). Please see the State's Responsiveness Summary and Summary of Technical Changes at the end of each rule package for the list of changes from the propose rule.

Changes are indicated in red and highlighted in grey in the annotated copy of the final proposed rule for HBEE Part Two and HBEE Part Three. No changes were made from the proposed rule in HBEE Part One, Part Five, and Part Seven.

If you have any questions, please contact Dani Fuoco, Policy Analyst, at 802-585-4265.

VERMONT

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Agency of Human Services
280 State Drive
Waterbury, VT 05671-1000
www.humanservices.vermont.gov

[phone] 802-241-0440
[fax] 802-241-0450

Jenney Samuelson, Secretary

Date: October 18, 2022

Re: Summary of Changes from proposed to final proposed rule filing for Health Benefits Eligibility and Enrollment (HBEE) rules (GCR 22-029 through 22-033)

In addition to the changes being made in response to public comments (see responsiveness summary), additional changes are being made to correct technical and typographical errors.

The following is a list of these additional changes and the reasons for them. All changes being made in HBEE rule are identified in gray highlight in the annotated version of the final proposed rule being filed contemporaneously herewith.

The changes, in order by section number, are as follows:

PART TWO

Section 8.05(k)(6)(iii) – To align more closely with federal law at 42 CFR § 435.225(b), add "the" before "appropriate" on the first line of text; replace "medical care in the community" with "institutional level of care outside of a medical institution;" add "and" before "the" on the second line of text; add "estimated Medicaid" before "cost" on the second line of text; replace "of which" with "of such care" after "cost" on the second line of text; add "Medicaid" before "cost" on the third line of text; replace "medical care in an appropriate medical institution" with "appropriate institutional care."

PART THREE

Section 17.03(c)(6) – To improve clarity, change "the" to "their" on the first line of text; to align with revisions being made in Section 3.00 (to definition of "pregnant woman") and Section 7.03(a)(2), delete "60-day" on the first line of text

Section 18.03(b) – To align with revisions being made in Section 3.00 (to definition of "pregnant woman") and Section 7.03(a)(2), change "60-day" to "post partum" on the fourth line of text; to improve clarity, add "," after "period" on the fourth line of text; to improve clarity, add "," after "delivery" on the fifth line of text

280 State Drive – Center Building
Waterbury, VT 05671-1000

OFFICE OF THE SECRETARY
TEL: (802) 241-0440
FAX: (802) 241-0450

JENNEY SAMUELSON
SECRETARY

TODD W. DALOZ
DEPUTY SECRETARY

STATE OF VERMONT
AGENCY OF HUMAN SERVICES

MEMORANDUM

TO: Jim Condos, Secretary of State

FROM: Jenney Samuelson, Secretary, Agency of Human Services

DATE: April 1, 2022

SUBJECT: Signatory Authority for Purposes of Authorizing Administrative Rules

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I hereby designate Deputy Secretary of Human Services Todd W. Daloz as signatory to fulfill the duties of the Secretary of the Agency of Human Services as the adopting authority for administrative rules as required by Vermont's Administrative Procedure Act, 3 V.S.A. § 801 et seq.

Cc: Todd W. Daloz

1. TITLE OF RULE FILING:
   Health Benefits Eligibility and Enrollment Rule, Nonfinancial Eligibility Requirements (Part 3)

2. PROPOSED NUMBER ASSIGNED BY THE SECRETARY OF STATE
   22P016

3. ADOPTING AGENCY:
   Agency of Human Services (AHS)

4. PRIMARY CONTACT PERSON:
   (A PERSON WHO IS ABLE TO ANSWER QUESTIONS ABOUT THE CONTENT OF THE RULE).

   Name: Danielle Fuoco

   Agency: Agency of Human Services

   Mailing Address: 280 State Drive, Center Building, Waterbury, Vermont 05671-1000

   Telephone: (802)585-4265 Fax: (802)241-0450

   E-Mail: danielle.fuoco@vermont.gov

   Web URL *(WHERE THE RULE WILL BE POSTED)*:
   https://humanservices.vermont.gov/rules-policies/health-care-rules

5. SECONDARY CONTACT PERSON:
   (A SPECIFIC PERSON FROM WHOM COPIES OF FILINGS MAY BE REQUESTED OR WHO MAY ANSWER QUESTIONS ABOUT FORMS SUBMITTED FOR FILING IF DIFFERENT FROM THE PRIMARY CONTACT PERSON).

   Name: Jessica Ploesser

   Agency: Agency of Human Services

   Mailing Address: 280 State Drive, NOB 1 South, Waterbury, VT 05671

   Telephone: (802)241-0454 Fax: (802)241-0450

   E-Mail: jessica.ploesser@vermont.gov

6. RECORDS EXEMPTION INCLUDED WITHIN RULE:
   (DOES THE RULE CONTAIN ANY PROVISION DESIGNATING INFORMATION AS CONFIDENTIAL; LIMITING ITS PUBLIC RELEASE; OR OTHERWISE, EXEMPTING IT FROM INSPECTION AND COPYING?) No

   IF YES, CITE THE STATUTORY AUTHORITY FOR THE EXEMPTION:

   N/A

   PLEASE SUMMARIZE THE REASON FOR THE EXEMPTION:

   N/A

7. LEGAL AUTHORITY / ENABLING LEGISLATION:

(THE SPECIFIC STATUTORY OR LEGAL CITATION FROM SESSION LAW INDICATING WHO THE ADOPTING ENTITY IS AND THUS WHO THE SIGNATORY SHOULD BE. THIS SHOULD BE A SPECIFIC CITATION NOT A CHAPTER CITATION).

3 V.S.A. 801(b)(11); 33 V.S.A. 1901(a)(1) and 1810

8. EXPLANATION OF HOW THE RULE IS WITHIN THE AUTHORITY OF THE AGENCY:
This rule amends an existing rule on eligibility and enrollment in the State of Vermont's health benefit programs. AHS's authority to adopt rules as identified above includes, by necessity, the authority to amend the rules to ensure continued alignment with federal and state guidance and law.

9. THE FILING HAS CHANGED SINCE THE FILING OF THE PROPOSED RULE.

10. THE AGENCY HAS INCLUDED WITH THIS FILING A LETTER EXPLAINING IN DETAIL WHAT CHANGES WERE MADE, CITING CHAPTER AND SECTION WHERE APPLICABLE.

11. SUBSTANTIAL ARGUMENTS AND CONSIDERATIONS WERE RAISED FOR OR AGAINST THE ORIGINAL PROPOSAL.

12. THE AGENCY HAS INCLUDED COPIES OF ALL WRITTEN SUBMISSIONS AND SYNOPSES OF ORAL COMMENTS RECEIVED.

13. THE AGENCY HAS INCLUDED A LETTER EXPLAINING IN DETAIL THE REASONS FOR THE AGENCY'S DECISION TO REJECT OR ADOPT THEM.

14. CONCISE SUMMARY (**150 WORDS OR LESS**):

This proposed rulemaking amends Parts 1, 2, 3, 5, and 7 of the 8-part Health Benefits Eligibility and Enrollment (HBEE) rule. Substantive revisions include: codifying the annual open enrollment period for qualified health plans from November 1 - January 15; adding a new income-based special enrollment period for qualified health plans that allows ongoing enrollment for those at or below 200% of the Federal Poverty Level (FPL); extending the Medicaid postpartum period for pregnant women from 60 days to 12 months; adding Compacts of Free Association (COFA) migrants as qualified non-citizens eligible for Medicaid and exempt from the 5-year bar; adding a reference to a standardized eligibility tool for Katie Beckett Medicaid; and expanding Medicaid eligibility for former

foster care children to include children aging out of foster care in another state. In response to comment, the rule also addresses the ACA's "family glitch" regarding affordability of employer coverage.

15. EXPLANATION OF WHY THE RULE IS NECESSARY:

The changes align HBEE with federal and state guidance and law, provide clarification, correct information, improve clarity, and make technical corrections. Substantive revisions include those listed in the concise summary above.

16. EXPLANATION OF HOW THE RULE IS NOT ARBITRARY:

The rules are required to implement state and federal health care guidance and laws. Additionally, the rules are within the authority of the Secretary, are within the expertise of AHS, and are based on relevant factors including consideration of how the rules affect the people and entities listed below.

17. LIST OF PEOPLE, ENTERPRISES AND GOVERNMENT ENTITIES AFFECTED BY THIS RULE:

Medicaid applicants/enrollees;

Individuals who wish to purchase health coverage including those who apply for premium and cost-sharing assistance;

Health insurance issuers;

Eligibility and enrollment assisters, including agents and brokers;

Health care providers;

Health law, policy and related advocacy and community-based organizations and groups including the Office of the Health Care Advocate;

Agency of Human Services including its departments; and Department of Financial Regulation.

18. BRIEF SUMMARY OF ECONOMIC IMPACT (150 WORDS OR LESS):

AHS anticipates that some of the proposed changes to HBEE will have an economic impact on the State's budget, beginning in SFY2023. The estimated gross annualized budget impact of expanding postpartum Medicaid coverage for pregnant women from 60 days to 12 months is ~$2 million and accounted for in AHS's FY2023 budget. The estimated gross annualized budget impact of expanding Medicaid coverage to

children who age out of foster care in any state is $52,700. There is no anticipated impact from the addition of COFA migrants.

Changes related to Qualified Health Plan enrollment are not expected to have an economic impact except insofar as any opportunity to encourage enrollment and maintain VT's low uninsured rate is fiscally positive for VT.

Other changes in Parts 1, 2, 3, 5, & 7 align the rule with federal and state guidance and law, provide clarification, correct information, improve clarity, and make technical corrections. These changes do not carry a specific economic impact on any person or entity.

19. A HEARING WAS HELD.

20. HEARING INFORMATION

(THE FIRST HEARING SHALL BE NO SOONER THAN 30 DAYS FOLLOWING THE POSTING OF NOTICES ONLINE).

IF THIS FORM IS INSUFFICIENT TO LIST THE INFORMATION FOR EACH HEARING, PLEASE ATTACH A SEPARATE SHEET TO COMPLETE THE HEARING INFORMATION.

Date: 8/17/2022

Time: 02:00 PM

Street Address: Cherry A Conference Room

Waterbury State Office Complex, 280 State Drive, Waterbury, VT

OR Virtual Hearing - Phone or Microsoft Teams

Call in (audio only)

(802) 522-8456; Conference ID: 738063547#

For Teams Link, view Public Notice in Global Commitment Register on AHS website.

Zip Code: 05671

Date:

Time: AM

Street Address:

Zip Code:

Date:

Time: AM

Street Address:

Zip Code:

Date:
Time: AM
Street Address:
Zip Code:

21. DEADLINE FOR COMMENT (NO EARLIER THAN 7 DAYS FOLLOWING LAST HEARING):
8/24/2022

KEYWORDS (PLEASE PROVIDE AT LEAST 3 KEYWORDS OR PHRASES TO AID IN THE SEARCHABILITY OF THE RULE NOTICE ONLINE).

HBEE
Health Benefits Eligibility and Enrollment
Vermont Health Connect
Exchange
Medicaid
QHP
Qualified Health Plan
Health Benefit
Pregnant
Foster Care
Special Enrollment Period
SEP
Annual Open Enrollment Period
AOEP
Post partum

Adopting Page

Instructions:

This form must accompany each filing made during the rulemaking process:

Note: To satisfy the requirement for an annotated text, an agency must submit the entire rule in annotated form with proposed and final proposed filings. Filing an annotated paragraph or page of a larger rule is not sufficient. Annotation must clearly show the changes to the rule.

When possible, the agency shall file the annotated text, using the appropriate page or pages from the Code of Vermont Rules as a basis for the annotated version. New rules need not be accompanied by an annotated text.

1. TITLE OF RULE FILING:
   Health Benefits Eligibility and Enrollment Rule, Nonfinancial Eligibility Requirements (Part 3)
2. ADOPTING AGENCY:
   Agency of Human Services (AHS)
3. TYPE OF FILING (*PLEASE CHOOSE THE TYPE OF FILING FROM THE DROPDOWN MENU BASED ON THE DEFINITIONS PROVIDED BELOW*):
   - **AMENDMENT** - Any change to an already existing rule, even if it is a complete rewrite of the rule, it is considered an amendment if the rule is replaced with other text.
   - **NEW RULE** - A rule that did not previously exist even under a different name.
   - **REPEAL** - The removal of a rule in its entirety, without replacing it with other text.

   This filing is **AN AMENDMENT OF AN EXISTING RULE** .

4. LAST ADOPTED (*PLEASE PROVIDE THE SOS LOG#, TITLE AND EFFECTIVE DATE OF THE LAST ADOPTION FOR THE EXISTING RULE*):

   Part 1 - General Provisions and Definitions, SOS # 21P005, effective 10/1/2021; Part 2 - Eligibility Standards, SOS # 18P044, effective 1/15/2019; Part 3 - Nonfinancial Eligibility Requirements, SOS # 18P045, effective 1/15/2019; Part 5 - Financial Methodologies,

SOS # 21P006, effective 10/1/2021; Part 7 - Eligibility and Enrollment Procedures, SOS # 21P007, effective 10/1/2021.

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Kristin L. Clouser, Secretary

INTERAGENCY COMMITTEE ON ADMINISTRATIVE RULES (ICAR) MINUTES

Meeting Date/Location: June 13, 2022, virtually via Microsoft Teams
Members Present: Chair Douglas Farnham, Brendan Atwood, Jared Adler, Jennifer Mojo, Diane Sherman, Mike Obuchowski and Donna Russo-Savage
Members Absent: John Kessler and Diane Bothfeld
Minutes By: Melissa Mazza-Paquette

- 2:01 p.m. meeting called to order, welcome and introductions.
- Committee discussion on process improvements is scheduled for the August meeting to allow for participation from all members.
- Review and approval of minutes from the May 9, 2022 meeting.
- No additions/deletions to agenda. Agenda approved as drafted.
- Note: An emergency rule titled 'Vital Records Emergency Rule', provided by the Agency of Human Services, Department of Health, was supported by ICAR Chair Farnham on May 16, 2022. This rulemaking implements a process for individuals to amend the marker on their birth certificate to reflect the individual's gender identity. Specifically, it does the following: 1) Defines the term "non-binary" to describe the additional gender identities that may be reflected on a birth certificate. 2) Creates a process for registrants to file their Affidavit of Gender Identity with the Department.
- One public comment made by Venn [Saint Wilder].
- Presentation of Proposed Rules on pages 2-10 to follow.
  1. 2021 Vermont Plumbing Rules, Department of Public Safety & Plumbers Examining Board, page 2
  2. Vital Records Rule, Agency of Human Services, Department of Health, page 3
  3. Rule 4.600 Definition of Electric Transmission Facility in 30 V.S.A. § 248, Public Utility Commission, page 4
  4. Health Benefits Eligibility and Enrollment Rule, General Provisions and Definitions (Part 1), Agency of Human Services, page 5
  5. Health Benefits Eligibility and Enrollment Rule, Eligibility Standards (Part 2), Agency of Human Services, page 6
  6. Health Benefits Eligibility and Enrollment Rule, Nonfinancial Eligibility Requirements (Part 3), Agency of Human Services, page 7
  7. Health Benefits Eligibility and Enrollment Rule, Financial Methodologies (Part 5), Agency of Human Services, page 8
  8. Health Benefits Eligibility and Enrollment Rule, Eligibility-and-Enrollment Procedures (Part 7), Agency of Human Services, page 9
  9. Administrative Rules of the Board of Nursing, Secretary of State, Office of Professional Regulation, page 10
- Next scheduled meeting is Monday, July 11, 2022 at 2:00 p.m.
- 3:25 p.m. meeting was paused for a 15-minute break
- Add discussion of strike-all rules for transparency at a future meeting as time allows.
- 3:50 p.m. meeting adjourned.

Proposed Rule: Health Benefits Eligibility and Enrollment Rule, Nonfinancial Eligibility Requirements (Part 3), Agency of Human Services

Presented By: Robin Chapman and Addie Strumolo

Motion made to accept the rule by Donna Russo-Savage, seconded by Jared Adler, and passed unanimously except for Brendan Atwood who abstained, with the following recommendations:

1. Proposed Filing Coversheet, #12: Spell out acronym 'QHP' and include acronym in parenthesis as it's the first time being used in the filing.
2. Public Input Maximization Plan, #4: Specify entities (not individuals) included in the 'Representatives of Vermont's Health Insurance Industry' and 'Health law, policy and related advocacy and community-based organizations and groups.'.

Economic Impact Analysis

Instructions:

In completing the economic impact analysis, an agency analyzes and evaluates the anticipated costs and benefits to be expected from adoption of the rule; estimates the costs and benefits for each category of people enterprises and government entities affected by the rule; compares alternatives to adopting the rule; and explains their analysis concluding that rulemaking is the most appropriate method of achieving the regulatory purpose. If no impacts are anticipated, please specify "No impact anticipated" in the field.

Rules affecting or regulating schools or school districts must include cost implications to local school districts and taxpayers in the impact statement, a clear statement of associated costs, and consideration of alternatives to the rule to reduce or ameliorate costs to local school districts while still achieving the objectives of the rule (see 3 V.S.A. § 832b for details).

Rules affecting small businesses (excluding impacts incidental to the purchase and payment of goods and services by the State or an agency thereof), must include ways that a business can reduce the cost or burden of compliance or an explanation of why the agency determines that such evaluation isn't appropriate, and an evaluation of creative, innovative or flexible methods of compliance that would not significantly impair the effectiveness of the rule or increase the risk to the health, safety, or welfare of the public or those affected by the rule.

1. TITLE OF RULE FILING:

   Health Benefits Eligibility and Enrollment Rule, Nonfinancial Eligibility Requirements (Part 3)

2. ADOPTING AGENCY:

   Agency of Human Services (AHS)

3. CATEGORY OF AFFECTED PARTIES:

   LIST CATEGORIES OF PEOPLE, ENTERPRISES, AND GOVERNMENTAL ENTITIES POTENTIALLY AFFECTED BY THE ADOPTION OF THIS RULE AND THE ESTIMATED COSTS AND BENEFITS ANTICIPATED:

   Categories of people, enterprises, and governmental entities that may be affected by these rules:

   Medicaid applicants/enrollees;

Individuals who wish to purchase health coverage including those who apply for premium and cost-sharing assistance;

Health insurance issuers (including standalone dental issuers);

Eligibility and enrollment assisters, including agents and brokers;

Health care providers;

Health law, policy and related advocacy and community-based organizations and groups including the Office of the Health Care Advocate;

Agency of Human Services including its departments; and Department of Financial Regulation.

Anticipated costs and benefits of this rule:

The Agency of Human Services anticipates that some of the proposed changes to HBEE will have an economic impact on the State's gross annualized budget, beginning in fiscal year 2023. The estimated gross annualized budget impact of expanding postpartum Medicaid coverage for pregnant women from 60 days to 12 months is expected to be approximately $2 million and is accounted for in AHS's FY2023 budget. The estimated gross annualized budget impact of expanding Medicaid coverage to children who age out of foster care in any state is $52,700. There is no anticipated economic impact from the addition of Compacts of Free Association (COFA) migrants at this time, as this population is not currently present in Vermont Medicaid.

An extended open enrollment period for qualified health plans (QHP) could result in increased QHP enrollment which would have a financial impact on health insurance issuers. However, this rulemaking codifies current practice, and AHS does not expect it to result in a meaningful difference in enrollment.

Allowing for a continuous enrollment opportunity through the income-based special enrollment period

could result in increased enrollment as well as upward rate pressure due to adverse selection (signing up for health insurance when utilization is expected). However, AHS consulted with the QHP issuers on this point and neither indicated a need to increase rates in anticipation of this enrollment opportunity. Instead, they strongly support this policy change to encourage continuous coverage.

Households accessing this special enrollment period will be eligible for federal and state subsidies. The federal government may pay out more in federal subsidies because of the special enrollment period. However, there is unlikely to be a fiscal impact on the State. AHS expects that most households enrolling through this special enrollment period will have previously been covered by Vermont Medicaid. Therefore, any increase in state subsidy expenditures would be offset by Medicaid savings.

Addressing the ACA's family glitch could result in more Vermonters becoming eligible for state and federal subsidies; however, AHS expects the population to be small and the subsidy costs to be borne primarily by the federal government.

Finally, any opportunity to encourage enrollment and maintain Vermont's low uninsured rate is fiscally positive for the State. It means less uncompensated care and a healthier risk pool to stabilize the insurance market.

The other changes in Parts 1, 2, 3, 5, and 7 align the rule with federal and state guidance and law, provide clarification, correct information, improve clarity, and make technical corrections. While these changes are made with a goal of reducing administrative burden on Vermonters and the State, they do not carry a specific economic impact on any person or entity.

4. IMPACT ON SCHOOLS:

INDICATE ANY IMPACT THAT THE RULE WILL HAVE ON PUBLIC EDUCATION, PUBLIC SCHOOLS, LOCAL SCHOOL DISTRICTS AND/OR TAXPAYERS CLEARLY STATING ANY ASSOCIATED COSTS:

No impact.

5. ALTERNATIVES: *CONSIDERATION OF ALTERNATIVES TO THE RULE TO REDUCE OR AMELIORATE COSTS TO LOCAL SCHOOL DISTRICTS WHILE STILL ACHIEVING THE OBJECTIVE OF THE RULE.*

   Not applicable.

6. IMPACT ON SMALL BUSINESSES:
   INDICATE ANY IMPACT THAT THE RULE WILL HAVE ON SMALL BUSINESSES (EXCLUDING IMPACTS INCIDENTAL TO THE PURCHASE AND PAYMENT OF GOODS AND SERVICES BY THE STATE OR AN AGENCY THEREOF):

   No impact.

7. SMALL BUSINESS COMPLIANCE: *EXPLAIN WAYS A BUSINESS CAN REDUCE THE COST/BURDEN OF COMPLIANCE OR AN EXPLANATION OF WHY THE AGENCY DETERMINES THAT SUCH EVALUATION ISN'T APPROPRIATE.*

   Not applicable.

8. COMPARISON:
   COMPARE THE IMPACT OF THE RULE WITH THE ECONOMIC IMPACT OF OTHER ALTERNATIVES TO THE RULE, INCLUDING NO RULE ON THE SUBJECT OR A RULE HAVING SEPARATE REQUIREMENTS FOR SMALL BUSINESS:
   There are no alternatives to the adoption of this rule. The rule is required to implement state and federal law.

9. SUFFICIENCY: *DESCRIBE HOW THE ANALYSIS WAS CONDUCTED, IDENTIFYING RELEVANT INTERNAL AND/OR EXTERNAL SOURCES OF INFORMATION USED.*
   AHS has analyzed and evaluated the anticipated costs and benefits to be expected from the adoption of these rules including considering the costs and benefits for each category of persons and entities described above. There are no alternatives to the adoption of this rule; it is necessary to ensure continued alignment with federal and state guidance and law on eligibility and enrollment in health benefits programs.

Environmental Impact Analysis

Instructions:

In completing the environmental impact analysis, an agency analyzes and evaluates the anticipated environmental impacts (positive or negative) to be expected from adoption of the rule; compares alternatives to adopting the rule; explains the sufficiency of the environmental impact analysis. If no impacts are anticipated, please specify "No impact anticipated" in the field.

Examples of Environmental Impacts include but are not limited to:

- Impacts on the emission of greenhouse gases
- Impacts on the discharge of pollutants to water
- Impacts on the arability of land
- Impacts on the climate
- Impacts on the flow of water
- Impacts on recreation
- Or other environmental impacts

1. TITLE OF RULE FILING:

   Health Benefits Eligibility and Enrollment Rule, Nonfinancial Eligibility Requirements (Part 3)

2. ADOPTING AGENCY:

   Agency of Human Services (AHS)

3. GREENHOUSE GAS: *EXPLAIN HOW THE RULE IMPACTS THE EMISSION OF GREENHOUSE GASES (E.G. TRANSPORTATION OF PEOPLE OR GOODS; BUILDING INFRASTRUCTURE; LAND USE AND DEVELOPMENT, WASTE GENERATION, ETC.):*
   No impact.

4. WATER: *EXPLAIN HOW THE RULE IMPACTS WATER (E.G. DISCHARGE / ELIMINATION OF POLLUTION INTO VERMONT WATERS, THE FLOW OF WATER IN THE STATE, WATER QUALITY ETC.):*
   No impact.

5. LAND: *EXPLAIN HOW THE RULE IMPACTS LAND (E.G. IMPACTS ON FORESTRY, AGRICULTURE ETC.):*
   No impact.

6. RECREATION: *EXPLAIN HOW THE RULE IMPACT RECREATION IN THE STATE:*
   No impact.

7. CLIMATE: *EXPLAIN HOW THE RULE IMPACTS THE CLIMATE IN THE STATE:*
   No impact.

8. OTHER: *EXPLAIN HOW THE RULE IMPACT OTHER ASPECTS OF VERMONT'S ENVIRONMENT:*
   No impact.

9. SUFFICIENCY: *DESCRIBE HOW THE ANALYSIS WAS CONDUCTED, IDENTIFYING RELEVANT INTERNAL AND/OR EXTERNAL SOURCES OF INFORMATION USED.*
   No impact.

Public Input Maximization Plan

Instructions:

Agencies are encouraged to hold hearings as part of their strategy to maximize the involvement of the public in the development of rules. Please complete the form below by describing the agency's strategy for maximizing public input (what it did do, or will do to maximize the involvement of the public).

This form must accompany each filing made during the rulemaking process:

1. TITLE OF RULE FILING:

   Health Benefits Eligibility and Enrollment Rule, Nonfinancial Eligibility Requirements (Part 3)

2. ADOPTING AGENCY:

   Agency of Human Services (AHS)

3. PLEASE DESCRIBE THE AGENCY'S STRATEGY TO MAXIMIZE PUBLIC INVOLVEMENT IN THE DEVELOPMENT OF THE PROPOSED RULE, LISTING THE STEPS THAT HAVE BEEN OR WILL BE TAKEN TO COMPLY WITH THAT STRATEGY:

   AHS consulted with key stakeholders on the development of policies in this rulemaking. The Medicaid post partum extension was supported by the General Assembly and advocacy groups including the Office of the Health Care Advocate. AHS worked with the Department of Financial Regulation on the Qualified Health Plan changes. The open enrollment period and income-based special enrollment period are both modeled on changes made by the federal government. AHS discussed the proposals with the General Assembly, Office of the Health Care Advocate/Vermont Legal Aid, Medicaid & Exchange Advisory Committee, and Qualified Health Plan issuers, and took their input in rule development. AHS notified the Medicaid and Exchange Advisory Committee of this rulemaking ahead of filing, including the estimated timeframe for filing and the proposed revisions to the rule.

Public Input

The proposed rule was posted on the AHS website for public comment, and a public hearing was held on August 17, 2022. No one attended the hearing. When the rule was filed with the Office of the Secretary of State, AHS provided notice and access to the rule, through the Global Commitment Register, to stakeholders and all persons who subscribe to the Global Commitment Register.

The public comment period ended August 24, 2022. Comments were received from Vermont Legal Aid on Part 2 and Part 3 of the HBEE rule. A general comment was also received on a topic outside the scope of the HBEE rule. Part 2 and Part 3 have been amended since the proposed filing. The comments received, responsiveness summary, and a list of technical changes are included with this filing. There are no changes to Parts 1, 5, and 7 since the proposed filing.

The Global Commitment Register is a database that provides notification of policy changes and clarifications of existing Medicaid policy, including rulemaking, under Vermont's 1115 Global Commitment to Health waiver. Anyone can subscribe to the Global Commitment Register. Subscribers receive email notification of the filing including hyperlinks to the documents posted on the Global Commitment Register and an explanation of how to be further involved in the rulemaking.

4. BEYOND GENERAL ADVERTISEMENTS, PLEASE LIST THE PEOPLE AND ORGANIZATIONS THAT HAVE BEEN OR WILL BE INVOLVED IN THE DEVELOPMENT OF THE PROPOSED RULE:

Agency of Human Services including its departments;

Agency of Administration;

Department of Financial Regulation;

Medicaid and Exchange Advisory Committee;

Representatives of Vermont's Health Insurance Industry, including the Qualified Health Plan issuers;

Health law, policy and related advocacy and community-based organizations and groups, including the Office of the Health Care Advocate at Vermont Legal Aid.

Comments on Rule 22P014
1557-Reg-Revision-QA-FINAL-2022.pdf

Hello, please Excuse my last submission as I was attempting to copy and paste this document.

On behalf of stakeholders, my family member included, I'd like the committee to allow a comprehensive service system that allows contracted supports which are not available at any designated agencies to follow this law. Currently, ABA providers must operate at a fiscal loss when providing a contracted service under HCAR rule of $30.11 cap. This is discriminatory in use of federal funding.

I'd appreciate a chance to discuss this issue further.
Thank you so much,
A parent of adult daughter with hcbs waiver

Submitted Electronically to:
Medicaid Policy Unit
AHS.MedicaidPolicy@vermont.gov

In re: GCR 22-029 to 22-033
Health Benefits Eligibility and Enrollment Rules Update

Dear Medicaid Policy Unit,

Thank you for the opportunity to comment on the proposed program changes to the Health Benefits Eligibility and Enrollment Rules.

The Office of the Health Care Advocate (HCA) and the Disability Law Project (DLP) at Vermont Legal Aid submit the following comments in response to the proposed HBEE changes:

Part Two:

Categorical Eligibility for Foster Children

The HCA and the DLP support the proposed changes in Rule 9.03(e) to expand categorical eligibility for foster children. The proposed rule expands eligibility for former foster children to include former foster children from other states. Under the current rule, this category had been limited to former foster children from Vermont. We strongly support this expansion.

We suggest some clarification to Rule 9.03 (e)(iii) that defines eligible former foster children. The rule currently reads,

"If the individual attained 18 years of age on or after January 1, 2023, . . ."

In approximately half the states in the country, foster care has been extended beyond age eighteen. (*See* Extending Foster Care Beyond 18 (ncsl.org)) The proposed rule should not be read in a limited way that would define this category to include only foster children who leave foster care at eighteen. It should be interpreted to also include foster children who leave foster after age eighteen.

Disabled Child Home Care Eligibility

The HCA and the DLP oppose the proposed eligibility changes to 8.05(k)(6) Disabled Child in Home Care (DCHC, Katie Beckett).

We have two concerns with this proposed rule change:

1. "Institutional level of care" is an evolving standard. In 1965 when the federal Medicaid program began, many children with serious medical conditions lived in institutions. Institutionalized medical services for children continued through 1981, when the Katie Beckett Medicaid Waiver was passed under President Ronald Reagan. It was through the advocacy of parents and Olmstead litigation that our medical system moved towards providing care so that children with serious medical conditions could live at home.

   The rule references skilled nursing facilities and intermediate care facilities as two of the three standards. Yet, Vermont does not have these institutions for children. Children are also explicitly excluded from the Choices for Care program which provides coverage for nursing facility care. Even when Vermont had an ICF-DD, this facility, too, had exclusion criteria for admission that made it inaccessible to children. It is better for children's development, and it is fiscally prudent for children to live at home, when medically advised. Vermont has worked hard to increase the amount of care that children can receive at home.

   Requiring eligibility tied to modern standards of admissions for institutions that do not exist in Vermont will make it almost impossible to for children to be found eligible for Katie Beckett Medicaid. Furthermore, to require proof that "without the receipt of institutional level of care in the home, the individual would be required to continue to reside in an institution," as described in (6)(i)(B)(II), is another standard that is impossible to meet.

   Parents have shared with us that they would rather lose everything they have, any savings, their jobs, and their homes, than send their child to an out of state institution, even if supports are inadequate at home. In other words, it is not without severe stress and financial burdens that parents can care for their medically needy children at home. It is financially better for the Vermont Medicaid program to have children receive medical care at home. To enable this to continue, DVHA needs to use the institutional standard of 1965.

   We urge DVHA to delete 8.05 (6)(1)(A and B).

2. No information exists that supports the proposition that a standardized level of care tool is necessary or helpful for these eligibility determinations. It is unclear what problem DVHA is trying to solve by use of a standardized tool. Proposing an as-yet-unidentified tool without any stakeholder input leads us to conclude that DVHA

believes too many children are mistakenly found eligible for Katie Beckett Medicaid.

In our experience, children are frequently found ineligible for coverage either on a first application or at a continuing eligibility review. We have seen no evidence given the regular stream of children and families with meritorious cases in need of assistance with denials and terminations that the current process for Katie Beckett eligibility is erroneously generous.

Furthermore, in representing dozens of children in appeals in Katie Beckett cases, the medical needs and interventions are extremely individualized. We have not seen a pattern or "type" of case that would be amenable to fitting into the standards of a tool. We have not seen a draft of any tool, so it is hard to envision how the diverse experiences of a
small number of medically needy children can be standardized.

We urge DVHA to not change the rule to require a tool. There has been no community conversation or consensus on the value of a standardized tool, or the contents of a standardized tool. It is possible that DVHA may find that no tool is either helpful or practical. Research and community engagement should precede any potential change to this rule.

We urge DVHA to cut sections (A-C).

Part Three

The HCA suggests that HBEE Rule 23.02 be amended to mirror the proposed federal rules that address the "family glitch." The Department of Treasury and the IRS have released proposed rules on this issue, and the HBEE rules should mirror the proposed federal rules. The proposed rules will change how affordability is calculated for family members when one member of the household has an offer of employer insurance.

Under current regulations employer-based health insurance is defined as "affordable" if the coverage solely for the employee, and not for family members, meets the affordability requirements. That means that affordability is calculated based on what it would cost for the employee to purchase a self-only plan. If the cost of the employee only plan meets the current affordability test, the employee *and their family members* are not eligible for Advance Premium Tax Credit (APTC). This is called the "family glitch" because it makes family members ineligible for APTC, even though the cost of a *family plan* with the employer is not "affordable." The proposed rule change would allow for two separate calculations: one for the employee and the other for family members. Under the proposed federal rules, if the cost of covering family members were not affordable, they would be eligible for APTC. This

change addresses a long-standing problem and will allow more Vermonters to enroll in affordable coverage on Vermont Health Connect.

Thank you for the opportunity to comment. Please feel free to reach out should you have any questions.

Sincerely,

/s/ Marjorie Stinchcombe
Marjorie Stinchcombe
Helpline Director
Office of the Health Care Advocate
Vermont Legal Aid

/s/ Rachel Seelig
Rachel Seelig
Director
Disability Law Project
Vermont Legal Aid

/s/ Barb Prine
Barb Prine
Staff Attorney
Disability Law Project
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State of Vermont
Agency of Human Services
280 State Drive
Waterbury, VT 05671-1000
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Jenney Samuelson, *Secretary*
[phone] 802-241-0440
[fax] 802-241-0450

Date: October 18, 2022

Re: Response to comments received from the public for the Health Benefits Eligibility & Enrollment (HBEE) Rule Update (Proposed GCR 22-029 to 22-033)

A summary of the comments received on the proposed HBEE rule and the Agency of Human Services' responses to those comments is as follows:

General Comment

Comment: On behalf of stakeholders, my family member included, I'd like the committee to allow a comprehensive service system that allows contracted supports which are not available at any designated agencies to follow this law. Currently, ABA providers must operate at a fiscal loss when providing a contracted service under HCAR rule of $30.11 cap. This is discriminatory in use of federal funding. I'd appreciate a chance to discuss this issue further.

Response: The agency appreciates this comment and the concern raised by the commenter. While the commenter's concern speaks to an issue that is outside the scope of this rulemaking effort, the agency will take the concern into consideration.

Comments by Rule Sections

PART TWO

8.05(k)(6) Disabled child in home care (DCHC, Katie Beckett)

Comment 1 from Vermont Legal Aid:

Vermont Legal Aid (VLA) states, "We urge DVHA to delete 8.05 (6)(1)(A and B)." VLA's full comments are part of the final proposed rulemaking filing. VLA opposes proposed 8.05(k)(6)(i)(A)-(B), including for the following reasons:

- *"Requiring eligibility tied to modern standards of admissions for institutions that do not exist in Vermont will make it almost impossible to [sic] for children to be found eligible for Katie Beckett Medicaid."*

- *"... to require proof that 'without the receipt of institutional level of care in the home, the individual would be required to continue to reside in an institution,' as described in (6)(i)(B)(II), is another standard that is impossible to meet."*
- *"DVHA needs to use the institutional standard of 1965."*

Response:

The proposed amendments to the rule at 8.05(k)(6) are not intended to change the current legal standard for eligibility for the optional Medicaid category, Disabled Child in Home Care (DCHC or the "Katie Beckett provision"), including the federal requirement that the individual require an institutional level of care.[1] The intent of the proposed changes is to (1) improve clarity of the institutional level of care eligibility requirement, (2) indicate that Vermont Medicaid may use a standardized medical assessment tool to determine level of care in the future, (3) align the rule with current operations and federal law regarding the frequency of reviews of clinical eligibility, and (4) make technical changes to align the rule with federal law.

While the agency's proposed changes were not intended to change the legal standard for meeting institutional level of care, the agency is revising 8.05(k)(6)(i), including due to the commenter's feedback. Specifically, the agency has revised 8.05(k)(6)(i)(A)-(B) in two ways:

- Removed the references to federal regulations at 8.05(k)(6)(i)(A). This change aligns the rule more closely with the corresponding federal regulation, 42 CFR 435.225; and
- Removed 8.05(k)(6)(i)(B)(II) as recommended by the commenter.

The only remaining changes from those proposed to 8.05(k)(6)(i)(A)-(B) are (1) final proposed 8.05(k)(6)(i)(A)(I) newly defines "medical institution" by aligning the definition with federal law, 42 CFR 435.225(b)(1), which states that to qualify for this Medicaid category, a disabled child must require care in a hospital, SNF [skilled nursing facility], or an ICF [intermediate care facility], and (2) final proposed 8.05(k)(6)(i)(A)(II) aligns with 42 CFR 435.225(a) and clarifies that a disabled child must be living in the home to qualify for DCHC.

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[1] Explanation of why this Medicaid category is referred to as the "Katie Beckett provision:" At five months old Katie Beckett contracted a devastating brain infection. She suffered paralysis that left her hospitalized on a ventilator for three years. Katie's middle-class family had a million dollars of health insurance, but that was soon exhausted. While she was institutionalized, Medicaid paid for her medical care but when she improved enough to live with her family, her Medicaid was terminated. Katie required professional nurses to meet her needs at home, but Medicaid would not cover it because her family's income was too high. Under the law, Medicaid would only pay for Katie's care if she remained in an institutional setting. Katie's family faced a dilemma, whether to leave her in the hospital or bring her home where there was a lack of certainty about the care that would be provided to her.

In 1981, President Ronald Reagan heard about Katie's dilemma and personally intervened. President Reagan created the Katie Beckett Waiver. The waiver allowed Katie, and children like her who required an institutional level of care, but could safely receive this care at home, to receive their care at home while retaining their Medicaid coverage, regardless of their parents' income. Katie grew up to be an accomplished motivational speaker and was a champion for people with disabilities until her death in her 30s. In 1982, Congress expanded what had been accomplished by the Katie Beckett Waiver by creating a new state plan option in Medicaid pursuant to Section 134 of the Tax Equity and Fiscal Responsibility Act (TEFRA), sometimes referred to as "the Katie Beckett provision."

The commenter's interpretation that level of care for DCHC should be determined by standards that existed in 1965 is contrary to federal law. The level of care standard for DCHC Medicaid has never been tied to the institutional level of care standard of 1965. The Medicaid program was first implemented in 1965, but it was not until 1981 that President Reagan created the Katie Beckett Waiver, and it was not until 1982 that Congress made a related state plan option available to states. There is nothing in federal law or CMS guidance that supports that the Medicaid agency should use the institutional level of care standard from 1965 in determining eligibility for DCHC. 42 CFR 435.225 states in full:

§ 435.225 Individuals under age 19 who would be eligible for Medicaid if they were in a medical institution.

(a) The agency may provide Medicaid to children 18 years of age or younger who qualify under section 1614(a) of the Act, who would be eligible for Medicaid if they were in a medical institution, and who are receiving, while living at home, medical care that would be provided in a medical institution.

(b) If the agency elects the option provided by paragraph (a) of this section, it must determine, in each case, that the following conditions are met:

(1) The child requires the level of care provided in a hospital, SNF, or ICF.

(2) It is appropriate to provide that level of care outside such an institution.

(3) The estimated Medicaid cost of care outside an institution is no higher than the estimated Medicaid cost of appropriate institutional care.

(c) The agency must specify in its State plan the method by which it determines the cost-effectiveness of caring for disabled children at home.

(55 Federal Register 48608, 11/21/90)

Finally, the commenter mentions the lack of certain medical institutions within Vermont; however, the existence of such institutions within Vermont's borders is not relevant to the legal requirements for DCHC Medicaid eligibility and is outside the scope of this rulemaking. The level of care analysis in DCHC is not a placement decision; it is solely to determine eligibility for this Medicaid category.

The agency agrees with the commenter that the DCHC Medicaid category is a critical category for some Vermont families. It is the only means for some disabled children who require an institutional level of care, but whose household income is too high to qualify for Dr. Dynasaur, to avoid institutionalization by the Medicaid agency paying for them to receive that level of care in their home.

Comment 2 from Vermont Legal Aid:

Vermont Legal Aid (VLA) states, "We urge DVHA to cut sections (A- C)." VLA's full comments are part of the final proposed rulemaking filing. VLA opposes proposed 8.05(k)(6)(i)(A)-(C), including for the following reasons:

- *"No information exists that supports the proposition that a standardized level of care tool is necessary or helpful for these eligibility determinations. It is unclear what problem DVHA is trying to solve by use of a standardized tool."*
- *"We have not seen a pattern or 'type' of case that would be amenable to fitting into the standards of a tool. We have not seen a draft of any tool, so it is hard to envision how the diverse experiences of a small number of medically needy children can be standardized."*
- *"There has been no community conversation or consensus on the value of a standardized tool, or the contents of a standardized tool."*

Response:

Vermont Medicaid plans to move to the use of a standardized tool to determine level of care for DCHC eligibility to ensure objective, accurate, and reliable decision making. Much of the care that Vermont Medicaid covers program wide is approved using standardized tools. Such tools are designed to be as objective as possible to achieve the highest "interrater reliability," i.e., that two screeners would answer the same way for the same individual. This promotes best practices by ensuring proper and fair eligibility determinations and will provide greater consistency across Vermont Medicaid.

Presently, Vermont Medicaid is seeking to amend 8.06(k)(6) to indicate that it may designate a standardized assessment tool to determine whether an individual qualifies for an institutional level of care for DCHC. The proposed amendment does not require Vermont Medicaid to designate a tool, but does provide that if the agency designates one, that it must be used in all DCHC level of care decisions. Vermont Medicaid has not selected a standardized tool for deciding level of care in DCHC. The agency informed the commenter, prior to its submission of comments, that it would be seeking its and other stakeholder's input on the standardized level of care tool prior to one being implemented.

Federal law gives Medicaid agencies flexibility in deciding whether to use a standardized tool and if so, which tool. As of 2015, standardized assessment tools were used by the District of Columbia and all 50 state Medicaid agencies in their Medicaid long term support and services (LTSS) programs, including to determine level of care.[2]

Vermont Medicaid has used standardized tools for many years, to determine service needs and eligibility for programs, including level of care. Historically, Vermont Medicaid used a "homegrown" tool to determine if level of care was met in DCHC cases, and, more recently, it has used criteria that functions as a tool and includes a multipage narrative that explains when level of care is met. The Department of Disabilities, Aging, and Independent Living (DAIL) uses a standardized tool to determine eligibility, including level of care, in the Choices for Care program, which allows individuals who require an institutional level of care to receive care in their home to avoid institutionalization. DAIL also uses standardized tools to determine eligibility and/or service needs for individuals applying for or enrolled in

[2] Medicaid and CHIP Payment and Access Commission (MACPAC) – Functional Assessments for Long-Term Services and Supports. https://www.macpac.gov/wp-content/uploads/2016/06/Functional-Assessments-for-Long-Term-Services-and-Supports.pdf. Accessed September 7, 2022.

the Traumatic Brain Injury Program, the Adult High Technology Program, and the Attendant Services Program.

Additionally, Vermont Medicaid uses a standardized tool to determine eligibility for services for children who are medically fragile, including those who need medically complex nursing services in the home. The Department of Vermont Health Access (DVHA) and the Department of Mental Health use InterQual standardized tools to determine both whether level of care is met in certain settings and whether a service authorization request for mental health, substance use disorder, behavioral health services, and medical services should be approved (e.g., inpatient hospitalization, inpatient psychiatric hospitalization; eating disorder treatment in inpatient, residential, PHP and IOP settings; Applied Behavioral Analysis; and psychiatry, across all ages). InterQual is a nationally recognized evidence-based platform that is used by health insurers, Medicaid agencies, and facilities nationwide.

In summary, the use of "tools" to make certain eligibility decision, including level of care, and service authorization decisions is widespread at Vermont Medicaid and at Medicaid agencies across the country. Such tools promote objective and fair decisions through the use of the proper administration of an appropriate assessment tool implemented by a trained person.

The agency is not amending proposed 8.05(k)(6)(i)(C) except to remove the proposed name of the standardized tool from the rule.

9.03(e) Former foster child

Comment: The HCA (Office of the Health Care Advocate at Vermont Legal Aid) and the DLP (Disability Law Project at Vermont Legal Aid) support the proposed changes in Rule 9.03(e) to expand categorical eligibility for foster children. The proposed rule expands eligibility for former foster children to include former foster children from other states. Under the current rule, this category had been limited to former foster children from Vermont. We strongly support this expansion.

We suggest some clarification to Rule 9.03 (e)(iii) that defines eligible former foster children. The rule currently reads,

"If the individual attained 18 years of age on or after January 1, 2023, . . ."

Response: The agency appreciates the commenters' support of this expansion. The agency agrees with the commenters that clarification defining eligible former foster children would be helpful in light of the expansion of eligibility to include foster children from other states that have foster care extended beyond 18. The agency is adding text to the rule to make this clarification.

PART THREE

23.02 Affordable coverage for employer-sponsored MEC

Comment: The HCA (Office of the Health Care Advocate at Vermont Legal Aid) suggests that HBEE Rule 23.02 be amended to mirror the proposed federal rules that address the "family glitch." The Department of Treasury and the IRS have released proposed rules on this issue, and the HBEE rules should mirror the proposed federal rules. The proposed rules will change how affordability is calculated for family members when one member of the household has an offer of employer insurance.

Under current regulations employer-based health insurance is defined as "affordable" if the coverage solely for the employee, and not for family members, meets the affordability requirements. That means that affordability is calculated based on what it would cost for the employee to purchase a self-only plan. If the cost of the employee only plan meets the current affordability test, the employee and their family members are not eligible for Advance Premium Tax Credit (APTC). This is called the "family glitch" because it makes family members ineligible for APTC, even though the cost of a family plan with the employer is not "affordable." The proposed rule change would allow for two separate calculations: one for the employee and the other for family members. Under the proposed federal rules, if the cost of covering family members were not affordable, they would be eligible for APTC. This change addresses a long-standing problem and will allow more Vermonters to enroll in affordable coverage on Vermont Health Connect.

Response: The agency agrees with this comment. The agency is adding text to the rule at 23.02 to address the "family glitch" consistent with the rule proposed by the Internal Revenue Service (IRS) on April 7, 2022. The IRS has indicated that it will finalize this policy change prior to 2023. In revising this section of the rule, the agency is also simplifying the rule text by eliminating examples at (d), some of which are outdated under the family glitch change, and instead referring to the current illustrative examples provided by the IRS.

Annotated Text

Table of Contents

Part Three
Nonfinancial eligibility requirements

15.00 Nonfinancial eligibility requirements, in general (01/15/2017, GCR 16-096)

This part catalogs the nonfinancial eligibility requirements that apply across all health benefits. The provisions that assign these requirements to a particular program or benefit are set forth in Part Two of this rule.

16.00 Social Security number (01/15/2017, GCR 16-096)

16.01 Medicaid[1] (01/15/2017, GCR 16-096)

(a) In general

(1) Except as provided in paragraph (b) of this subsection, as a condition of Medicaid eligibility, each individual (including children) seeking Medicaid must furnish their Social Security number.

(2) AHS will advise the individual of:

(i) The statute or other authority under which it is requesting the individual's Social Security number; and

(ii) The uses that will be made of each Social Security number, including its use for verifying income, eligibility, and amount of medical assistance payments under §§ 53.00 through 56.00.

(3) If an individual cannot recall their Social Security number or Social Security numbers or has not been issued a Social Security number, AHS will:

(i) Assist the individual in completing an application for a Social Security number;

(ii) Obtain evidence required under SSA regulations to establish the age, the citizenship or non-citizenship status, and the true identity of the individual; and

(iii) Either send the application to SSA or, if there is evidence that the individual has previously been issued a Social Security number, request SSA to furnish the number.

(4) Services to an otherwise eligible individual will not be denied or delayed pending issuance or verification of the individual's Social Security number by SSA or if the individual meets one of the exceptions in paragraph (b) of this subsection.

(5) The Social Security number furnished by an individual will be verified to insure the Social Security number was issued to that individual, and to determine whether any other Social Security numbers were issued to that individual. See § 55.02(a) for information on the verification process.

[1] 42 CFR § 435.910.

(b) Exception

(1) The requirement of paragraph (a)(1) of this subsection does not apply, and a Medicaid identification number will be given, to an individual who:

(i) Is not eligible to receive a Social Security number;

(ii) Does not have a Social Security number and may only be issued a Social Security number for a valid non-work reason in accordance with 20 CFR § 422.104; or

(iii) Refuses to obtain a Social Security number because of well-established religious objections. The term "well-established religious objections" means that the individual is a member of a recognized religious sect or division of the sect, and adheres to the tenets or teachings of the sect or division of the sect and for that reason is conscientiously opposed to applying for or using a national identification number including a Social Security number.

(2) The Medicaid identification number may be either a Social Security number obtained on the individual's behalf or another unique identifier.

(3) An individual who has a Social Security number is not subject to this exception and must provide such number.

(c) Social Security numbers of Medicaid non-applicants.[2] AHS may request the Social Security number of a person who is not applying for Medicaid for themselves provided that:

(1) Provision of such Social Security number is voluntary;

(2) Such Social Security number is used only to determine an applicant's or enrollee's eligibility for a health-benefits program or for a purpose directly connected to the administration of the state plan; and

(3) At the time such Social Security number is requested, AHS provides clear notice to the individual seeking assistance, or person acting on such individual's behalf, that provision of the non-applicant's Social Security number is voluntary and information regarding how the Social Security number will be used.

16.02 QHP[3] (01/15/2017, GCR 16-096)

(a) An individual applying for a QHP, with or without APTC or CSR, and who has a Social Security number must provide it. The number provided will be verified by AHS. See § 55.02(a) for information on the verification process.

(b) Except as provided in paragraph (c) of this subsection, a person who is not seeking coverage for themselves need not provide a Social Security number.

[2] 42 CFR § 435.907(e)(3).

[3] 45 CFR § 155.310(a)(3).

(c) An application filer seeking APTC must provide the Social Security number of a tax filer who is not an applicant only if an applicant attests that the tax filer has a Social Security number and filed a tax return for the year for which tax data would be utilized for verification of household income and family size.[4]

17.00 Citizenship and immigration status[5] (01/01/2023~~01/15/2019~~, GCR 22-03~~18-062~~)

17.01 Definitions (01/01/2023~~01/15/2019~~, GCR 22-03~~18-062~~)

(a) U.S. Citizen

(1) An individual born in the 50 states, the District of Columbia, Puerto Rico, Guam, Virgin Islands, and the Northern Mariana Islands (except for individuals born to foreign diplomats);

(2) A naturalized citizen; or

(3) An individual who otherwise qualifies for U.S. citizenship under § 301 of the Immigration and Nationality Act (INA), 8 USC §§ 1401.

(b) Citizenship[6]. Includes status as a "national of the United States," and includes both citizens of the United States and non-citizen nationals of the United States.

(c) National[7]

(1) An individual who:

(i) Is a U.S. citizen; or

(ii) Though not a citizen, owes permanent allegiance to the United States.

(2) For purposes of determining health-benefits eligibility, including verification requirements, citizens and non-citizen nationals of the United States are treated the same.

(3) As a practical matter, non-citizen nationals include individuals born in American Samoa or Swains Island.

(d) Qualified non-citizen.[8] An individual who is:

[4] 45 CFR § 155.305(f)(6).

[5] This section establishes the health-benefits citizenship and immigration-status eligibility requirements. Rules covering the related attestation and verification requirements and outlining documentary evidence are set forth in § 54.00.

[6] 42 CFR § 435.4.

[7] 8 USC § 1101(a)(22).

[8] 42 CFR § 435.4 ("qualified non-citizen" includes the term "qualified alien" as defined at 8 USC § 1641(b) and (c)); 42

(1) A lawful, permanent resident of the United States (LPR);

(2) A refugee, including:

(i) An individual admitted to the United States under § 207 of the INA;

(ii) A Cuban or Haitian entrant, as defined in § 501(e)(2) of the Refugee Education Assistance Act of 1980. There are three general categories of individuals who are considered "Cuban and Haitian entrants." A Cuban/Haitian national meets the definition of "Cuban and Haitian entrant" if he or she:

(A) Was granted parole status as a Cuban/Haitian entrant (Status Pending) on or after April 21, 1980 or has been paroled into the United States on or after October 10, 1980;

(B) Is the subject of removal, deportation or exclusion proceedings under the Immigration and Nationality Act and with respect to whom a final, nonappealable, and legally enforceable order of removal, deportation or exclusion has not been entered; or

(C) Has an application for asylum pending with the Department of Homeland Security (DHS) and with respect to whom a final, nonappealable, and legally enforceable order of removal, deportation or exclusion has not been entered.

(iii) An Amerasian, admitted to the United States under § 584 of the Foreign Operations Export Financing, and Related Programs Appropriation Act, 1988 (as contained in § 101(e) of Public Law 100-202 and amended by the 9th proviso under Migration and Refugee Assistance in title II of the Foreign Operations Export Financing, and Related Programs Act, 1989, Public Law 100-461, as amended);

(3) An asylee, as defined in § 208 of the INA;

(4) A non-citizen whose deportation has been withheld under:

(i) § 243(h) of the INA, as in effect prior to April 1, 1997, (the effective date of § 307 of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (IIRIRA), division C of Public Law 104-208); or

(ii) § 241(b)(3) of the INA, as amended by § 305(a) of division C of Public Law 104-208;

(5) An non-citizen who has been granted parole for at least one year by the USCIS under § 212(d)(5) of the INA;

(6) A non-citizen who has been granted conditional entry under § 203(a)(7) of the INA;

(7) A battered non-citizen, as defined in paragraph (e) of this subsection;

(8) A victim of a severe form of trafficking, in accordance with the Victims of Trafficking and Violence Protection Act of 2000 (22 USC § 7105(b))~~§ 107(b)(1) of the Trafficking Victims Protection Act of 2000~~; ~~or~~

CFR § 435.406(a)(2).

(9) An American Indian, born outside the U.S. and who enters and re-enters and resides in the U.S. is, for Medicaid purposes, considered a lawful permanent resident and, as such, a qualified non-citizen. This includes:

(i) An American Indian who was born in Canada and who is of at least one-half American Indian blood. This does not include the non-citizen spouse or child of such an Indian or a non-citizen whose membership in an Indian tribe or family is created by adoption, unless such person is of at least 50% American Indian blood.

(ii) An American Indian who is a member of a Federally-recognized Indian tribe, as defined in § 4(e) of the Indian Self-Determination and Education Assistance Act, 25 USC § § 450b(e); or.[9]

~~(ii)~~(10) A citizen of the Republic of the Marshall Islands, the Federated States of Micronesia, or the Republic of Palau (Compact of Free Association migrants).[10]

(e) Battered non-citizen

(1) An individual who is:

(i) A victim of battering or cruelty by a spouse or a parent, or by a member of the spouse or parent's family residing in the same household as the victim and the spouse or parent consented to, or acquiesced in the battery or cruelty;

(ii) The parent of a child who has been such a victim, provided that the individual did not actively participate in the battery or cruelty; or

(iii) The child residing in the same household of such a victim.

(2) For the purposes of establishing qualified non-citizen status, the battered non-citizen must meet all of the following conditions:

(i) The individual must no longer be residing in the same household as the perpetrator of the abuse or cruelty;

(ii) The battery or cruelty must have a substantial connection with the need for medical assistance; and

(iii) The individual must have been approved for legal immigration status, or have a petition pending that makes a prima facie case for legal immigration status, under one of the following categories:

(A) Permanent residence under the Violence Against Women Act (VAWA);

(B) A pending or approved petition for legal permanent residence filed by a spouse or parent on USCIS Form I-130 or Form I-129f; or

[9] Abenaki is not a federally-recognized tribe.

[10] Consolidated Appropriations Act of 2021, § 208.

(C) Suspension of deportation or cancellation of removal under VAWA.

(f) Nonqualified non-citizen. A non-citizen who does not meet the definition of qualified non-citizen (§17.01(d)).

(g) Lawfully present in the United States. An individual who is a non-citizen and who:

(1) Is a qualified non-citizen, as defined in paragraph (d) of this subsection;

(2) Is in a valid nonimmigrant status, as defined in 8 USC § 1101(a)(15) or otherwise under the immigration laws (as defined in 8 USC § 1101(a)(17));

(3) Is paroled into the United States in accordance with 8 USC § 1182(d)(5) for less than 1 year, except for an individual paroled for prosecution, for deferred inspection or pending removal proceedings;

(4) Belongs to one of the following classes:

(i) Granted temporary resident status in accordance with 8 USC § 1160 or 1255a, respectively;

(ii) Granted Temporary Protected Status (TPS) in accordance with 8 USC § 1254a, and individuals with pending applications for TPS who have been granted employment authorization;

(iii) Granted employment authorization under 8 CFR § 274a.12(c);

(iv) Family Unity beneficiaries in accordance with § 301 of 101, as amended;

(v) Under Deferred Enforced Departure (DED) in accordance with a decision made by the President;

(vi) Granted Deferred Action status;

(vii) Granted an administrative stay of removal under 8 CFR part 241;

(viii) Beneficiary of approved visa petition who has a pending application for adjustment of status;

(5) Is an individual with a pending application for asylum under 8 USC § 1158, or for withholding of removal under 8 USC § 1231, or under the Convention Against Torture who—

(i) Has been granted employment authorization; or

(ii) Is under the age of 14 and has had an application pending for at least 180 days;

(6) Has been granted withholding of removal under the Convention Against Torture;

(7) Is a child who has a pending application for Special Immigrant Juvenile status as described in 8 USC § 1101(a)(27)(J); or

(8) Is lawfully present in American Samoa.~~; or~~

(9) [Reserved]~~Is a victim of a severe form of trafficking in persons, in accordance with the Victims of Trafficking and Violence Protection Act of 2000, Public Law 106-386, as amended (22 USC § 7105(b)).~~

(10) *Exception.* An individual with deferred action under DHS's deferred action for childhood arrivals process, as described in the Secretary of Homeland Security's June 15, 2012, memorandum, shall not be considered to be lawfully present with respect to any of the above categories in paragraphs (1) through (~~8~~9) of this definition.

(h) Non-citizen.[11] Has the same meaning as the term "alien," as defined in section 101(a)(3) of the INA, (8 USC § 1101(a)(3)) and includes any individual who is not a citizen or national of the United States, defined at 8 USC § 1101(a)(22).

17.02 General Rules (01/15/2017, GCR 16-096)

(a) Health benefits, in general. Except as provided in paragraphs (b) through (d) of this subsection, as a condition of eligibility for health benefits, an individual must be a citizen or national of the United States and, for purposes of enrollment in a QHP, must reasonably expect to be a citizen or national for the entire period for which QHP enrollment is sought.

(b) Enrollment in Medicaid. An individual who is a non-citizen is eligible for Medicaid if the individual otherwise satisfies the eligibility requirements and is:

(1) A qualified non-citizen who is not subject to the five-year bar under § 17.03(b); or

(2) A non-citizen who is not subject to the five-year bar under § 17.03(c).

(c) Enrollment in a QHP, with or without APTC or CSR. An individual who is a non-citizen who is lawfully present in the United States is eligible for enrollment in a QHP, with or without APTC or CSR, if the individual otherwise satisfies the eligibility requirements for a QHP and is reasonably expected to be a non-citizen who is lawfully present for the entire period for which QHP enrollment is sought.

(d) Emergency medical services.[12] An individual who is ineligible for Medicaid solely because of immigration status is eligible for the treatment of emergency medical conditions if all of the following conditions are met:

(1) The individual has, after sudden onset, a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in serious:

(i) Jeopardy to the individual's health;

(ii) Impairment of bodily functions; or

(iii) Dysfunction of any bodily organ or part.

(2) The individual meets all eligibility requirements for Medicaid except that non-qualified non-citizens need

[11] 42 CFR § 435.4.

[12] A legally-present individual who is enrolled in a QHP, with or without subsidies, is nevertheless eligible for emergency Medicaid. See CMS Response to Comment, 77 FR 17144, 17170.

not present a Social Security number or document immigration status.

(3) Emergency medical services do not include organ transplant procedures or routine prenatal or post partum care.

17.03 Medicaid five-year bar for qualified non-citizens (01/01/202301/01/2018, GCR 22-03117-045)

(a) Qualified non-citizens subject to 5-year bar.[13] Non-citizens who enter the United States on or after August 22, 1996, as qualified non-citizens are not eligible to receive Medicaid for five years from the date they enter the country. If they are not qualified non-citizens when they enter, the five-year bar begins the date they become a qualified non-citizen. The following qualified non-citizens are subject to the five-year bar:

(1) Lawful permanent residents (LPRs);

(2) Non-citizens granted parole for at least one year;

(3) Non-citizens granted conditional entry (however, as a practical matter the five-year bar will never apply to such non-citizens, since, by definition, they entered the U.S. and obtained qualified non-citizen status prior to August 22, 1996); and

(4) Battered non-citizens.

(b) Qualified non-citizens not subject to 5-year bar.[14] The following qualified non-citizens are not subject to the five-year bar:

(1) Refugees;

(2) Asylees;

(3) Cuban and Haitian Entrants;[15]

(4) Victims of a severe form of trafficking;

(5) Non-citizens whose deportation is being withheld;

(6) Qualified non-citizens who are:

(i) Honorably discharged veterans;

(ii) On active duty in the U.S. military; or

[13] 42 CFR § 435.406(a)(2); 8 USC § § 1613(a).

[14] 42 CFR § 435.406(a)(2); 8 USC § § 1613(b).

[15] From former PP&D at 4172.

(iii) The spouse (including a surviving spouse who has not remarried) or unmarried dependent child of an honorably discharged veteran or individual on active duty in the U.S. Military;

(7) Non-citizens admitted to the country as Amerasian immigrants;

(8) Legal permanent residents who first entered the United States under another exempt category (i.e., as a refugee, asylee, Cuban or Haitian entrant, trafficking victim, or non-citizen whose deportation was being withheld) and who later converted to the LPR status;~~.~~

(9) Haitians granted Humanitarian Parole status; ~~and~~

(10) Citizens and nationals of Iraq and Afghanistan with Special Immigrant status; and.[16]

~~(10)~~(11) Citizens of the Republic of the Marshall Islands, the Federated States of Micronesia, and the Republic of Palau (Compact of Free Association migrants).[17]

(c) Non-citizens not subject to 5-year bar.[18] The five-year bar does not apply to:

(1) Non-citizens who are applying for treatment of an emergency medical condition only;

(2) Non-citizens who entered the United States and became qualified non-citizens prior to August 22, 1996; and

(3) Non-citizens who entered prior to August 22, 1996, and remained "continuously present" in the United States until becoming a qualified non-citizen on or after that date. Any single absence of more than 30 consecutive days or a combined total absence of 90 days before obtaining qualified non-citizen status is considered to interrupt "continuous presence."

(i) Non-citizens who do not meet "continuous presence" are subject to the five-year bar beginning from the date they become a qualified non-citizen.

(ii) Non-citizens do not have to remain continuously present in the United States after obtaining qualified non-citizen status.

(4) Members of a Federally-recognized Indian tribe;

(5) American Indians born in Canada to whom § 289 of the INA applies; and

(6) Children up to 21 years of age and women during pregnancy and their 60-day postpartum period, who are lawfully residing in the United States and otherwise eligible. AHS will verify that the child or pregnant

[16] From former PP&D at 4173.

[17] Consolidated Appropriations Act of 2021, § 208.

[18] Interim Guidance on Verification of Citizenship, Qualified Alien Status and Eligibility Under Title IV of the Personal Responsibility and Work Opportunity Act of 1996; 62 Federal Register 61344 and 61415 (November 17, 1997).

woman is lawfully residing in the United States at the time of the individual's initial eligibility determination and at the time of eligibility redeterminations. A child or pregnant woman will be considered to be lawfully residing in the United States if they are:

(i) A qualified non-citizen as defined in § 431 of PRWORA (8 USC § 1641)(see 17.01(d));

(ii) A non-citizen in non-immigration status who has not violated the terms of the status under which they were admitted or to which they have changed after admission;

(iii) A non-citizen who has been paroled into the United States pursuant to § 212(d)(5) of the INA (8 USC § 1182(d)(5)) for less than 1 year, except for a non-citizen paroled for prosecution, for deferred inspection or pending removal proceedings;

(iv) A non-citizen who belongs to one of the following classes:

(A) Non-citizens currently in temporary resident status pursuant to § 210 or 245A of the INA (8 USC § 1160 or 1255a, respectively);

(B) Non-citizens currently under Temporary Protected Status (TPS) pursuant to § 244 of the INA (8 USC § 1254a), and pending applicants for TPS who have been granted employment authorization;

(C) Non-citizens who have been granted employment authorization under 8 CFR § 274a.12(c)(9), (10), (16), (18), (20), (22), or (24);

(D) Family Unity beneficiaries pursuant to § 301 of Pub. L. 101-649, as amended;

(E) Non-citizens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;

(F) Non-citizens granted an administrative stay of removal under 8 CFR § 241;

(G) Non-citizens currently in deferred action status; or

(H) Non-citizens whose visa petitions have been approved and who have pending applications for adjustment of status;

(v) A pending applicant for asylum under § 208(a) of the INA (8 USC § 1158) or for withholding of removal under § 241(b)(3) of the INA (8 USC § 1231) or under the Convention Against Torture who:

(A) Has been granted employment authorization; or

(B) Is under the age of 14 and has had an application pending for at least 180 days;

(vi) A non-citizen who has been granted withholding of removal under the Convention Against Torture;

(vii) A child who has a pending application for Special Immigrant Juvenile status as described in § 101(a)(27)(J) of the INA (8 USC § 1101(a)(27)(J));

(viii) A non-citizen who is present in American Samoa under the immigration laws of American Samoa; or

(ix) A victim of severe trafficking in persons, in accordance with the Victims of Trafficking and Violence

Protection Act of 2000, Pub. L. 106-386, as amended (22 USC § 7105(b)).

(x) Exception: An individual with deferred action under the Department of Homeland Security's deferred action for the childhood arrivals process, as described in the Secretary of Homeland Security's June 15, 2012 memorandum, shall not be considered to be lawfully present with respect to any of the above categories in paragraphs (i)-(ix) who are considered to be lawfully residing in the United States.

(d) Ineligible non-citizens/nonimmigrants. The following categories of individuals are ineligible non-citizens/non-immigrants and are not eligible for Medicaid:

(1) Foreign government representatives on official business and their families and servants;

(2) Visitors for business or pleasure, including exchange visitors;

(3) Non-citizens in travel status while traveling directly through the U.S.;

(4) Crewmen on shore leave;

(5) Foreign students;

(6) International organization representation personnel and their families and servants;

(7) Temporary workers including agricultural contract workers; and

(8) Members of foreign press, radio, film, or other information media and their families.

18.00 Assignment of rights and cooperation requirements for Medicaid (01/01/202301/01/2018, GCR 22-03117-045)

18.01 In general[19] (01/15/2017, GCR 16-096)

As a condition of initial and continuing eligibility, a legally-able individual who is applying for or enrolled in Medicaid must meet the requirements related to the pursuit of medical support, third-party payments, and the requirement to enroll or remain enrolled in a group health insurance plan, as provided for below.

18.02 Assignment of rights to payments (01/15/2017, GCR 16-096)

(a) In general. An individual who is applying for, or enrolled in Medicaid, with the legal authority to do so, must assign their rights to medical support and third-party payments for medical care. If they have the legal authority to do so, they must also assign the rights of any other individual who is applying for or enrolled in Medicaid to such support and payments.

(b) Exceptions. No assignment is required for:

[19] 42 CFR § 435.610; Former Medicaid Rules 4138-4138.4.

(1) Medicare payments; or

(2) Cash payments from the Department of Veterans Affairs for aid and attendance.

18.03 Cooperation in Obtaining Payments (01/01/202301/01/2018, GCR 22-03117-045)

(a) In general

(1) Applicants must attest that they will cooperate, and enrollees must cooperate in:

(i) Establishing the identity of a child's parents and in obtaining medical support and payments, unless the individual establishes good cause for not cooperating as described in § 18.04; and

(ii) Identifying and providing information to assist in pursuing third parties who may be liable to pay for care and services under the plan, unless the individual establishes good cause for not cooperating as described in § 18.04.

(2) To meet this requirement, an individual may be required to:

(i) Provide information or evidence relevant and essential to obtain such support or payments;

(ii) Appear as a witness in court or at another proceeding;

(iii) Provide information or attest to lack of information under penalty of perjury; or

(iv) Take any other reasonable steps necessary for establishing parentage or securing medical support or third-party payments.

(b) Exception. An unmarried pregnant woman with income under 208 percent of the FPL is exempted from the requirement to cooperate in establishing paternity or obtaining medical support and payments from, or derived from, the father of the child she expects to deliver or from the father of any of her children born out-of-wedlock. She shall remain exempt through the end of the calendar month in which the post partum60-day period, beginning with the date of her delivery, ends.

18.04 Good cause for noncooperation (01/15/2017, GCR 16-096)

(a) In general. An individual who is applying for or enrolled in Medicaid may request a waiver of the cooperation requirement under § 18.03. Those to whom a good-cause waiver for noncooperation has been granted are eligible for Medicaid, provided that all other program requirements are met. AHS will grant such waivers when either of the following circumstances has been substantiated to AHS's satisfaction:

(1) Compliance with the cooperation requirement is reasonably anticipated to result in physical or emotional harm to the individual responsible for cooperating or the person for whom medical support or third-party payments are sought. Emotional harm means an emotional impairment that substantially affects an individual's functioning; or

(2) Compliance with the cooperation requirement would entail pursuit of medical support for a child:

(i) Conceived as a result of incest or rape from the father of that child;

(ii) For whom adoption proceedings are pending; or

(iii) For whom adoptive placement is under active consideration.

(b) Required documentation. An Individual requesting a waiver of the cooperation requirement bears the primary responsibility for providing the documentation AHS deems necessary to substantiate their claims of good cause. AHS will consider an individual who has requested a good-cause waiver and submitted the required documentation to be eligible for Medicaid while a decision on the request is pending.

(c) Review of good-cause waiver. A review of the continued existence of good cause circumstances upon which a waiver has been granted is required no less frequently than at each redetermination of eligibility for those cases in which determination of good cause is based on a circumstance that may change. A formal decision based upon resubmission of evidence is not required, however, unless AHS determines that a significant change of circumstances relative to good cause has occurred.

18.05 Enrollment in a health insurance plan (01/15/2017, GCR 16-096)

(a) An individual who is applying for, or enrolled in Medicaid, may be required to enroll or remain enrolled in a group health insurance plan for which AHS pays the premiums. (See Medicaid Covered Services Rule (MCSR) 7108.) Payment of group health insurance premiums shall be made only under the conditions specified in this subsection and in MCSR 7108.1 and remain entirely at AHS's discretion. Such payment of premiums shall not be considered an entitlement for any individual.

(b) As a condition of continuing eligibility, an individual may be required to remain enrolled in an individual health insurance plan, provided that they are enrolled in a plan for which the state has been paying the premiums on a continuous basis since July 2000.

(c) For the purposes of this subsection and MCSR 7108.1, a group health insurance plan is a plan that meets the definition of a group health insurance plan specified in 8 V.S.A. § 4079. An individual health insurance plan is a plan that does not meet that definition.

19.00 Incarceration and QHP eligibility (01/15/2017, GCR 16-096)

19.01 In general[20] (01/15/2017, GCR 16-096)

An incarcerated individual, other than an individual who is incarcerated pending the disposition of charges, is ineligible for enrollment in a QHP.

19.02 Exception[21] (01/15/2017, GCR 16-096)

[20] 26 CFR § 1.36B-2(a)(4); 45 CFR § 155.305(a)(2).

[21] 26 CFR § 1.36B-2(a)(4); See §§ 1312(f)(1)(B) and 1312(f)(3) of the ACA (42 USC § 18032(f)(1)(B) and (f)(3)) and 26 CFR § 1.36B-3(b)(2).

An incarcerated individual may be an applicable tax filer if a family member is eligible to enroll in a QHP.

20.00 Living arrangements for Medicaid eligibility purposes (01/01/2018, GCR 17-045)

20.01 In general[22] (01/01/2018, GCR 17-045)

Individuals or couples meet the living-arrangement requirement for Medicaid eligibility purposes if they live in:

(a) Their own home;

(b) The household of another; or

(c) The following public institutions:

(1) The Vermont Psychiatric Care Hospital (VPCH) or successor entity or entities, if the individual is:

(i) Under the age of 21 (if a Medicaid enrollee is a patient of VPCH upon reaching their 21st birthday, eligibility may be continued to the date of discharge or their 22nd birthday, whichever comes first, as long as they continue to meet all other eligibility requirements); or

(ii) Age 65 or older.

(2) An intermediate care facility for people with developmental disabilities (ICF-DD).

(3) A facility supported in whole or in part by public funds whose primary purpose is to provide medical care other than the treatment of mental disease, including nursing and convalescent care, inpatient care in a hospital, drug and alcohol treatment, etc.

(d) A private facility, if:

(1) The primary purpose of the facility is to provide medical care other than the treatment of mental diseases, including nursing and convalescent care, inpatient care in a hospital, drug and alcohol treatment, etc.; and

(2) The facility meets the following criteria:

(i) There is no agreement or contract obliging the institution to provide total support to the individual;

(ii) There has been no transfer of property to the institution by the individual or on their behalf, unless maintenance by the institution has been of sufficient duration to fully exhaust the individual's equity in the property transferred at a rate equal to the monthly charges to other residents in the institution; and

(iii) There is no restriction on the individual's freedom to leave the institution.

(3) An individual under the age of 21 or age 65 or older meets the living arrangement requirement if they live

[22] Former Medicaid Rules 4218 and 4332

at the Brattleboro Retreat. In addition, an individual who is a patient at the facility upon reaching their 21st birthday, has eligibility continued to the date of discharge or their 22nd birthday, whichever comes first, as long as they continue to meet all other eligibility requirements.

20.02 Correctional facility (01/01/2018, GCR 17-045)

(a) In general.[23] An individual living in a correctional facility, including a juvenile facility, is not precluded from being determined eligible for Medicaid or from retaining their Medicaid eligibility if they were eligible before becoming incarcerated. However, the individual's Medicaid benefits will be suspended during their incarceration period (described in (b) below).

(b) Incarceration period. Incarceration begins on the date of admission and ends when the individual moves out of the correctional facility.

(c) Inpatient exception: Transfer to a medical facility.[24] While incarcerated, Medicaid is available when the inmate is an inpatient in a medical institution not under the control of the corrections system. Such institutions include a hospital, nursing facility, juvenile psychiatric facility, or intermediate care facility.

20.03 Determination of residence in an institution (01/15/2017, GCR 16-096)

Residence in an institution is determined by the dates of admission and discharge. An individual at home in the community on a visiting pass is still a resident of the institution.

20.04 Homeless individuals (01/15/2017, GCR 16-096)

A homeless individual is considered to be living in their own home.

20.05 Financial responsibility and living arrangement (01/15/2017, GCR 16-096)

The financial responsibility of relatives varies depending upon the type of living arrangement.

21.00 Residency (01/01/2023~~01/01/2018~~, GCR 22-03~~17-045~~)

21.01 In general[25] (01/15/2017, GCR 16-096)

AHS will provide health benefits to an eligible Vermont resident.

[23] 42 CFR §§ 435.1009 and 435.1010.

[24] 42 CFR §§ 435.1009 and 435.1010. This is also based on various letters from CMS to states, inquiring about the availability of federal funds participation for inmate inpatient health care.

[25] 42 CFR § 435.403; 45 CFR § 155.305(a)(3). Note: The Exchange rules speak in terms of residence within the Exchange's "service area." However, as there will be a single "service area" in Vermont, for both Medicaid and QHP enrollment, this rule speaks in terms of residence within the state.

21.02 Incapability of indicating intent (01/15/2017, GCR 16-096)

For purposes of this section, an individual is considered incapable of indicating intent regarding residency if the individual:

(a) Has an I.Q. of 49 or less or has a mental age of 7 years or less, based on tests acceptable to AHS;

(b) Is judged legally incompetent; or

(c) Is found incapable of indicating intent based on medical documentation obtained from a physician, psychologist, or other person licensed by the state in the field of intellectual disabilities.

21.03 Who is a state resident (01/15/2017, GCR 16-096)

A resident of the state is any individual who:

(a) Meets the conditions in §§ 21.04 through 21.08; or

(b) Meets the criteria specified in an interstate agreement under § 21.10.

21.04 Placement by a state in an out-of-state institution[26] (01/01/2023~~01/15/2017~~, GCR 22-03~~16-096~~)

(a) Any state agency, including an entity recognized under state law as being under contract with the state for such purposes, that arranges for an individual to be placed in an institution located in another state is recognized as acting on behalf of the state in making a placement. For purposes of this subsection, "institution" includes foster care homes licensed under 45 CFR § 1355.20 that provide food, shelter and supportive services to one or more people unrelated to the proprietor. The state arranging or actually making the placement is considered as the individual's state of residence.

(b) Any action beyond providing information to the individual and the individual's family would constitute arranging or making a state placement. However, the following actions do not constitute state placement:

(1) Providing basic information to individuals about another state's Medicaid program and information about the availability of health care services and facilities in another state.

(2) Assisting an individual in locating an institution in another state, provided the individual is capable of indicating intent and independently decides to move.

~~(3)~~(c) When a competent individual leaves the facility in which the individual is placed by a state, that individual's state of residence for Medicaid purposes is the state where the individual is physically located.

~~(4)~~(d) Where a placement is initiated by a state because the state lacks a sufficient number of appropriate facilities to provide services to its residents, the state making the placement is the individual's state of

[26] 42 CFR § 435.403(e).

residence.

21.05 An individual receiving Aid to the Aged, Blind, and Disabled (AABD)[27] (01/15/2017, GCR 16-096)

(a) In general. For an individual of any age who is receiving a state supplemental payment (in Vermont, known as AABD), the state of residence is the state paying the state supplemental payment.

(b) Exception.[28] A transient worker may claim Vermont as their state of residence and be granted Medicaid if they meet all other eligibility criteria. These individuals may be granted Vermont Medicaid even though they continue to receive a state supplement payment from another state.

21.06 An individual age 21 and over[29] (01/15/2017, GCR 16-096)

Except as provided in § 21.05, with respect to individuals age 21 and over:

(a) For an individual not residing in an institution, as defined in § 3.00, including a licensed foster care providing food, shelter, and supportive services to one or more persons unrelated to the proprietor, the state of residence is the state where the individual is living and:

(1) Intends to reside, including without a fixed address; or

(2) Has entered the state with a job commitment or is seeking employment (whether or not currently employed).

(b) For an individual not residing in an institution, as described in (a) of this subsection, who is incapable of stating intent, the state of residence is the state where the individual is living.

(c) For any institutionalized individual who became incapable of indicating intent before age 21, the state of residence is:

(1) That of the parent applying for Medicaid on the individual's behalf, if the parents reside in separate states (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's);

(2) The parent's or legal guardian's state of residence at the time of placement (if a legal guardian has been

[27] Effective January I, I974, the major portion of Vermont's federal-state program of AABD became the federal program of Supplemental Security Income (SSI) through amendment of title XVI of the Social Security Act. SSI guarantees a minimum national standard of assistance to aged, blind or disabled persons at full federal expense. Vermont supplements the SSI payment with a state-funded payment. While, federal government abandoned the AABD program title, Vermont has retained this name for this state supplementary payment. See, AABD Rule 2700.

[28] Former Medicaid Rule 4217(A).

[29] 42 CFR § 435.403(h); 45 CFR §§ 155.305(a)(3)(i) and (iii).

appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's);

(3) The current state of residence of the parent or legal guardian who files the application if the individual is institutionalized in that state (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's); or

(4) The state of residence of the person or party who files an application is used if the individual has been abandoned by his or her parent(s), does not have a legal guardian and is institutionalized in that state.

(d) For any institutionalized individual who became incapable of indicating intent at or after age 21, the state of residence is the state in which the individual is physically present, except where another state makes a placement.

(e) For any other institutionalized individual, the state of residence is the state where the individual is living and intends to reside. An institutionalized individual cannot be considered a Vermont resident if the individual owns a home (see § 29.08(a)(1)) in another state which the individual intends to return to, even if the likelihood of return is apparently nil.[30]

21.07 An individual receiving Title IV-E payments[31] (01/01/2023~~01/15/2017~~, GCR 22-03~~16-096~~)

For an individual of any age who is receiving federal payments for foster care or adoption assistance under Title IV-E of the Act, the state of residence is the state where the individual lives.

21.08 An individual under age 21[32] (01/15/2017, GCR 16-096)

For an individual under age 21 who is not eligible for Medicaid based on receipt of assistance under Title IV-E of the Act, as addressed in § 21.07, and is not receiving a state supplementary payment, as addressed in § 21.05, the state of residence is as follows:

(a) For an individual who is capable of indicating intent and who is emancipated from his or her parent or who is married, the state of residence is determined in accordance with § 21.06(a).

(b) For an individual not described in paragraph (a) of this subsection, not living in an institution, not eligible for Medicaid based on receipt of assistance under Title IV-E of the Act, and not receiving a state supplementary payment, the state of residence is:

(1) The state where the individual resides, including without a fixed address; or

[30] Former Medicaid Rule 4217(F).

[31] 42 CFR § 435.403(g); 45 CFR § 155.305(a)(3)(iii).

[32] 42 CFR § 435.403(i); 45 CFR §§ 155.305(a)(3)(ii) and (iii). Paragraphs (a) and (b) are derived from what was formerly 42 CFR § 435.403(h). Subparagraphs (1) and (2) are new. Paragraph (c) was originally designated as 42 CFR § 435.403(h)(4).

(2) The state of residency of the parent or caretaker, in accordance with § 21.06(a), with whom the individual resides.

(c) For any institutionalized individual who is neither married nor emancipated, the state of residence is:

(1) The parent's or legal guardian's state of residence at the time of placement (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's); or

(2) The current state of residence of the parent or legal guardian who files the application if the individual is institutionalized in that state (if a legal guardian has been appointed and parental rights are terminated, the state or residence of the guardian is used instead of the parent's).

21.09 Specific prohibitions[33] (01/15/2017, GCR 16-096)

AHS will not:

(a) Deny health-benefits eligibility because an individual has not resided in Vermont for a specified period.

(b) Deny health-benefits eligibility to an individual in an institution, who satisfies the residency rules set forth in this section, on the grounds that the individual did not establish residence in Vermont before entering the institution.

(c) Deny or terminate a Vermont resident's health-benefits eligibility because of that person's temporary absence from the state, as defined in § 21.13, if the person intends to return to Vermont when the purpose of the absence has been accomplished, unless, for purposes of Medicaid eligibility, another state has determined that the person is a resident there (see § 21.13(c)).

21.10 Interstate agreements[34] (01/15/2017, GCR 16-096)

A state may have a written agreement with another state setting forth rules and procedures resolving cases of disputed residency. These agreements may establish criteria other than those specified in §§ 21.07 and 21.08, but must not include criteria that result in loss of residency in both states or that are prohibited by § 21.09. The agreements must contain a procedure for providing health benefits to individuals pending resolution of the case. States may use interstate agreements for purposes other than cases of disputed residency to facilitate administration of the program, and to facilitate the placement and adoption of a Title IV-E individual when the child and his or her adoptive parent(s) move into another state.

21.11 Cases of disputed residency[35] (01/15/2017, GCR 16-096)

[33] 42 CFR § 435.403(j).

[34] 42 CFR § 435.403(k); 45 CFR § 155.305(a)(3)(iii).

[35] 42 CFR § 435.403(m); 45 CFR § 155.305(a)(3)(iii).

If Vermont and any other state cannot resolve which state is the individual's state of residence, the state where the individual is physically located is the state of residence.

21.12 Special rule for tax households with members in multiple Exchange service areas[36] (01/15/2017, GCR 16-096)

(a) Except as specified in paragraph (b) of this subsection, if all of the members of a tax household are not within the same Exchange service area, in accordance with the applicable standards in §§ 21.04 through 21.08, any member of the tax household may enroll in a QHP through any of the Exchanges for which one of the tax filers meets the residency standard.

(b) If both spouses in a tax household enroll in a QHP through VHC, a tax dependent may only enroll in a QHP through VHC, or through the Exchange that services the area in which the dependent meets a residency standard described in §§ 21.04 through 21.08.

21.13 Temporary absences from the state[37] (01/01/2018, GCR 17-045)

(a) In general. Temporary absences from Vermont do not interrupt or end Vermont residence.

(b) Definition. An absence is temporary if the individual leaves the state with the intent to return when the purpose of the absence has been accomplished. Examples include, but are not limited to, absences for the purposes of:

(1) Visiting;

(2) Obtaining necessary medical care;

(3) Obtaining education or training under a program of Vocational Rehabilitation, Work Incentive, or higher education program; or

(4) Residence in a long-term care facility in another state, if arranged by an agent of the State of Vermont, unless the individual or their parents or legal guardian, as applicable, state intent to abandon Vermont residence and to reside outside Vermont upon discharge from long-term care.

(c) Exception. For purposes of Medicaid eligibility, an absence is not temporary if another state verifies that the individual meets the residency standard of such other state.[38]

21.14 Vermont residence as Medicaid payment requirement (01/15/2017, GCR 16-096)

[36] 45 CFR § 155.305(a)(3)(iv).

[37] 45 CFR § 155.305(a)(3)(v).

[38] 42 CFR § 435.403(j)(3).

An individual must be a resident of Vermont at the time a medical service is rendered in order for Vermont Medicaid to pay for that service. The service, however, does not have to be rendered in Vermont subject to certain restrictions.[39]

22.00 Pursuit of potential unearned income for Medicaid eligibility[40] (01/15/2017, GCR 16-096)

(a) As a condition of eligibility for Medicaid, an individual is required to take all necessary steps to obtain any annuities, pensions, retirement, or disability benefits to which they may be entitled, unless they can show good cause for not doing so. Annuities, pensions, retirement, and disability benefits include, but are not limited to, veterans' compensation and pensions, OASDI benefits, railroad retirement benefits, and unemployment compensation. Application for these benefits, when appropriate, must be verified prior to granting or continuing Medicaid.

(b) Individuals are not required to apply for Medicare part B or for cash assistance programs such as SSI/AABD or Reach Up as a condition of eligibility for Medicaid.

23.00 Minimum essential coverage (01/01/2023~~01/01/2018~~, GCR 22-03~~17-045~~)

23.01 Minimum essential coverage (01/01/2018, GCR 17-045)

(a) In general.[41] Minimum essential coverage means coverage under any of the following: Government-sponsored programs, eligible employer-sponsored plans, grandfathered health plans, individual health plans and certain other health-benefits coverage.

Individuals and their tax dependents must have minimum essential coverage (MEC) to avoid the shared responsibility payment (penalty) imposed by the Internal Revenue Service unless they qualify for an exemption from this payment. See § 23.06 for details on the eligibility determination for MEC exemptions.

In addition, individuals who are eligible to enroll in health coverage that qualifies as MEC under this section are not eligible to receive federal tax credits and cost-sharing reductions if they enroll in a QHP. See §§ 23.01(b) through 23.01(e) for details on health coverage that qualifies as MEC for purposes of considering eligibility for the federal premium tax credit. As stated in § 23.01(c)(2), for an employer-sponsored plan to be considered as MEC when an employee or related individual applies for APTC, the plan must be affordable and meet minimum value criteria. See § 23.02 for details on affordability, and § 23.03 for details on minimum value.

See §§ 55.02(c) and (d) for descriptions of the process for verifying eligibility for MEC when determining eligibility for APTC and CSR.

[39] 42 CFR § 431.52.

[40] Former Medicaid Rule 4137.

[41] 26 USC § 5000A(f); 26 CFR § 1.36B-2(c).

(b) Government-sponsored MEC

(1) In general.[42] Subject to the limitation in paragraph (b)(2), an individual is eligible for government-sponsored MEC for purpose of considering eligibility for the federal premium tax credit if, as of the first day of the first full month the individual may receive benefits under the program, the individual meets the criteria for coverage under one of the following government-sponsored programs:

(i) The Medicare program under part A of Title XVIII of the Act, except for an individual who must pay a premium for part A coverage and who chooses not to enroll in part A coverage (see § 23.01(e)(1));

(ii) The Medicaid program under Title XIX of the Act, except for the following individuals:

(A) A woman who becomes pregnant while enrolled in a QHP and who, though eligible for Medicaid as a pregnant woman pursuant to § 7.03(a)(2), chooses not to enroll in Medicaid (see § 23.01(e)(5)).

(B) An individual who becomes eligible for Medicaid coverage as medically needy only after meeting a spenddown. Such individual may apply to HHS for a hardship exemption from the personal responsibility payment as described in § 23.06(a).

(C) An individual who is receiving coverage limited to family planning services as described in § 9.03(g).

(D) An individual who is receiving coverage limited to the treatment of emergency services as described in § 17.02(d);

(iii) The CHIP program under Title XXI of the Act;

(iv) Medical coverage under chapter 55 of Title 10, United States Code, including coverage under the TRICARE program;

(v) A health care program under chapter 17 or 18 of Title 38, United States Code, as determined by the Secretary of Veterans Affairs, in coordination with the Secretary of HHS and the Secretary of the Treasury; or

(vi) A health plan under § 2504(e) of Title 22, United States Code (relating to Peace Corps volunteers).

(2) Obligation to complete administrative requirements to obtain coverage.[43] An individual who meets the eligibility criteria for government-sponsored MEC must complete the requirements necessary to receive benefits. An individual who fails by the last day of the third full calendar month following the event that establishes eligibility under (b)(1) of this subsection to complete the requirements to obtain government-sponsored MEC (other than a veteran's health-care program) is treated as eligible for government-sponsored MEC as of the first day of the fourth calendar month following the event that establishes eligibility.

[42] 26 USC § 5000A(f)(1)(A); 26 CFR § 1.36B-2(c)(2)(i)

[43] 26 CFR § 1.36B-2(c)(2)(ii).

(3) Special rule for coverage for veterans and other individuals under chapter 17 or 18 of Title 38, USC §.[44] An individual is eligible for MEC under a health-care program under chapter 17 or 18 of Title 38, USC section only if the individual is enrolled in a health-care program under chapter 17 or 18 of Title 38, USC section identified as MEC in regulations issued under § 5000A of the Code.

(4) Retroactive effect of eligibility determination.[45] If an individual receiving APTC is determined to be eligible for government-sponsored MEC that is effective retroactively (such as Medicaid), the individual is treated as eligible for MEC under that program no earlier than the first day of the first calendar month beginning after the approval.

(5) Determination of Medicaid or CHIP ineligibility.[46] An individual is treated as not eligible for Medicaid or a similar program for a period of coverage under a QHP if, when the individual enrolls in the QHP, the individual is determined to be not eligible for Medicaid.

(6) Examples.[47] The following examples illustrate the provisions of this paragraph (b):

(i) Example 1. Delay in coverage effectiveness. On April 10, 2015, Tax filer D applies for coverage under a government-sponsored health-care program. D's application is approved on July 12, 2015, but her coverage is not effective until September 1, 2015. Under paragraph (b)(1), D is eligible for government-sponsored MEC on September 1, 2015.

(ii) Example 2. Time of eligibility. Tax filer E turns 65 on June 3, 2015, and becomes eligible for Medicare. Under § 5000A(f)(1)(A)(i), Medicare is MEC. However, E must enroll in Medicare to receive benefits. E enrolls in Medicare in September, which is the last month of E's initial enrollment period. Thus, E may receive Medicare benefits on December 1, 2015. Because E completed the requirements necessary to receive Medicare benefits by the last day of the third full calendar month after the event that establishes E's eligibility (E turning 65), under paragraph (b)(1) and (b)(2) of this subsection, E is eligible for government-sponsored MEC on December 1, 2015, the first day of the first full month that E may receive benefits under the program.

(iii) Example 3. Time of eligibility, individual fails to complete necessary requirements. The facts are the same as in Example 2, except that E fails to enroll in the Medicare coverage during E's initial enrollment period. E is treated as eligible for government-sponsored MEC under paragraph (b)(2) of this subsection as of October 1, 2015, the first day of the fourth month following the event that establishes E's eligibility (E turning 65).

[44] 26 CFR § 1.36B-2(c)(2)(iii).

[45] 26 CFR § 1.36B-2(c)(2)(iv).

[46] 26 CFR § 1.36B-2(c)(2)(v). The phrase in this section: "or considers (within the meaning of 45 CFR § 155.302(b))" was omitted from this paragraph, as AHS does not conduct "assessment[s] of eligibility for Medicaid and CHIP" within the meaning of 45 CFR § 155.302(b), but rather, determines eligibility for such programs.

[47] These examples are extracted from 26 CFR § 1.36B-2(c)(2)(vi).

(iv) Example 4. Retroactive effect of eligibility. In November 2014, Tax filer F enrolls in a QHP for 2015 and receives APTCs. F loses her part-time employment and on April 10, 2015, applies for coverage under the Medicaid program. F's application is approved on May 15, 2015, and her Medicaid coverage is effective as of April 1, 2015. Under paragraph (b)(4), F is eligible for government-sponsored MEC on June 1, 2015, the first day of the first calendar month after approval.

(v) Example 5. Determination of Medicaid ineligibility. In November 2014, Tax filer G applies to enroll in health coverage for 2015. AHS determines that G is not eligible for Medicaid and estimates that G's household income will be 140 percent of the FPL for G's family size for purposes of determining APTCs. G enrolls in a QHP and begins receiving APTCs. G experiences a reduction in household income during the year and his household income for 2015 is 130 percent of the FPL (within the Medicaid income threshold). However, under paragraph (b)(5), G is treated as not eligible for Medicaid for 2015.

(vi) Example 6. Mid-year Medicaid eligibility redetermination. The facts are the same as in Example 5, except that G returns to the Exchange in July 2015 and AHS determines that G is eligible for Medicaid. AHS approves G for coverage and AHS discontinues G's APTCs effective August 1. Under paragraphs (b)(4) and (b)(5), G is treated as not eligible for Medicaid for the months when G is covered by a QHP. G is eligible for government-sponsored MEC for the months after G is approved for Medicaid and can receive benefits, August through December 2015.

(c) Employer-sponsored MEC

(1) Definition: related individual. For purposes of this subsection and §§ 23.02 through 23.04, a related individual is an individual who is not an employee of an employer offering an eligible employer-sponsored plan, but who can enroll in such plan because of their relationship to the employee. This definition has a similar meaning as the definition of "dependent" for purposes of the Small Employer Health-Benefits Program under Part Six of this rule.

(2) In general.[48] An employee and related individual who may enroll in an eligible employer-sponsored plan are eligible for MEC under the plan for purposes of considering eligibility for the federal premium tax credit for any month only if the plan is affordable (§ 23.02) and provides minimum value (§ 23.03). Government-sponsored programs described in paragraph (b) of this subsection are not eligible employer-sponsored plans.

(3) Plan year.[49] For purposes of this paragraph, a plan year is an eligible employer-sponsored plan's regular 12-month coverage period (or the remainder of a 12-month coverage period for a new employee or an individual who enrolls during a special enrollment period).

(4) Eligibility for months during a plan year

[48] 26 CFR § 1.36B-2(c)(3)(i).

[49] 26 CFR § 1.36B-2(c)(3)(ii).

(i) Failure to enroll in plan.[50] An employee or related individual may be eligible for MEC under an eligible employer-sponsored plan for a month during a plan year if the employee or related individual could have enrolled in the plan for that month during an open or special enrollment period for the plan year. If an enrollment period relates to coverage for not only the upcoming plan year (or the current plan year in the case of an enrollment period other than an open enrollment period), but also coverage in one or more succeeding plan years, this paragraph applies only to eligibility for the coverage in the upcoming plan year (or the current plan year in the case of an enrollment period other than an open enrollment period).

(ii) Waiting periods.[51] An employee or related individual is not eligible for MEC under an eligible employer-sponsored plan during a required waiting period before the coverage becomes effective.

(iii) Example.[52] The following example illustrates the provisions of this paragraph (c)(4):

(A) Tax filer B is an employee of Employer X. X offers its employees a health insurance plan that has a plan year (within the meaning of paragraph (c)(3)) from October 1 through September 30. Employees may enroll during an open season from August 1 to September 15. B does not enroll in X's plan for the plan year October 1, 2014, to September 30, 2015. In November 2014, B enrolls in a QHP for calendar year 2015.

(B) B could have enrolled in X's plan during the August 1 to September 15 enrollment period. Therefore, unless X's plan is not affordable for B or does not provide minimum value, B is eligible for MEC under X's plan for the months that B is enrolled in the QHP during X's plan year (January through September 2015).

(5) Post-employment coverage.[53] A former employee (including a retiree), or an individual related (within the meaning of this paragraph (c)) to a former employee, who may enroll in eligible employer-sponsored coverage or in continuation coverage required under federal law or a state law that provides comparable continuation coverage is eligible for MEC under this coverage only for months that the former employee or related individual is enrolled in the coverage.

(d) Other coverage that qualifies as MEC. The following types of coverage are designated as MEC for purposes of considering eligibility for the federal premium tax credit[54]:

(1) *Self-funded student health coverage.* Coverage offered to students by an institution of higher education (as defined in the Higher Education Act of 1965), where the institution assumes the risk for payment of claims, are designated as MEC for plan or policy years beginning on or before December 31, 2014. For coverage beginning after December 31, 2014, sponsors of self-funded student health coverage may

[50] 26 CFR § 1.36B-2(c)(3)(iii)(A).

[51] 26 CFR § 1.36B-2(c)(3)(iii)(B).

[52] 26 CFR § 1.36B-2(c)(3)(iii)(C).

[53] 26 CFR § 1.36B-2(c)(3)(iv).

[54] 26 USC § 5000A(f)(1)(E).

apply to be recognized as MEC.

(2) *Refugee Medical Assistance supported by the Administration for Children and Families.* Coverage under Refugee Medical Assistance, authorized under § 412(e)(7)(A) of the INA, provides up to eight months of coverage to certain noncitizens who are considered refugees.

(3) *Medicare advantage plans.* Coverage under the Medicare program pursuant to part C of Title XVIII of the Act, which provides Medicare parts A and B benefits through a private insurer.

(4) *State high risk pool coverage.* State high risk pools are designated as MEC for plan or policy years beginning on or before December 31, 2014. For coverage beginning after December 31, 2014, sponsors of high risk pool coverage may apply to be recognized as MEC.

(e) Eligibility based on enrollment.[55] An individual is eligible for MEC under the following programs for purposes of considering eligibility for the federal premium tax credit only if the individual is enrolled in the coverage:

(1) *Medicare part A coverage requiring payment of premiums.* Coverage offered under Medicare for which the individual must pay a premium for Medicare part A coverage under § 1818 of the Act.

(2) *State high risk pools.* Health coverage offered by a state under a qualified high risk pool as defined in § 2744(c)(2) of the PHS Act, to the extent the program is covered by a designation by HHS as MEC.

(3) *Student health plans.* Self-funded health coverage offered by a college or university to its students, to the extent the plan is covered by a designation by HHS as MEC.

(4) *TRICARE programs.* Coverage under the following TRICARE programs:

(i) The Continued Health Care Benefit Program (10 USC § 1078);

(ii) Retired Reserve (10 USC § 1076e);

(iii) Young Adult (10 USC § 1110b); and

(iv) Reserve Select (10 USC § 1076d).

(5) *MCA coverage for a pregnant woman enrolled in a QHP.* Coverage offered under Medicaid for a pregnant woman pursuant to the criteria described in § 7.03(a)(2) if the woman was enrolled in a QHP when she became pregnant.[56]

23.02 Affordable coverage for employer-sponsored MEC (01/01/202301/15/2017, GCR 22-03116-096)

[55] See, IRS Notice 2013-41.

[56] See, IRS Notice 2014-71.

An individual will not be eligible for a federal premium tax credit if the employer-sponsored plan in which they may enroll is affordable. The details of affordability are described in this subsection.

(a) In general

(1) Affordability for employee.[57] Except as provided in paragraph (a)(3) of this subsection, an eligible employer-sponsored plan is affordable for an employee if the portion of the annual premium the employee must pay, whether by salary reduction or otherwise (required contribution), for self-only coverage does not exceed the required contribution percentage (as defined in paragraph (c)) of the applicable tax filer's household income for the benefit year.

(2) Affordability for related individual.[58] Except as provided in paragraph (a)(3) of this subsection, an eligible employer-sponsored plan is affordable for a related individual if the employee's required contribution for family coverage under the plan ~~portion of the annual premium the employee must pay for self-only coverage~~ does not exceed the required contribution percentage, as defined ~~described~~ in paragraph (c)~~(a)(1)~~ of this subsection, of the applicable tax filer's household income for the benefit year. For purposes of this paragraph (a)(2), an employee's required contribution for family coverage is the portion of the annual premium the employee must pay for coverage of the employee and all other individuals included in the employee's family who are offered coverage under the eligible employer-sponsored plan.

(3) Employee safe harbor.[59] An employee or a related individual who is eligible for a safe harbor as defined in this sub clause will not be subject to repayment of APTC based on the finding that affordable MEC was in fact available to them for all or part of a plan year, should such fact be discovered at a time subsequent to enrollment in a QHP.

(i) An employer-sponsored plan is not affordable for an employee or a related individual for a plan year if, when the employee or a related individual enrolls in a QHP for a period coinciding with the plan year (in whole or in part), it is determined that the eligible employer-sponsored plan is not affordable for that plan year.

(ii) This paragraph does not apply to a determination made as part of the redetermination process described in § 75.00 unless the individual receiving a redetermination notification affirmatively responds and provides current information on affordability.

(iii) This paragraph does not apply for an individual who, with reckless disregard for the facts, provides incorrect information concerning the portion of the annual premium for coverage for the employee or related individual under the plan.

[57] 26 CFR § 1.36B-2(c)(3)(v)(A)(1).

[58] 26 CFR § 1.36B-2(c)(3)(v)(A)(2).

[59] 26 CFR § 1.36B-2(c)(3)(v)(A)(3).

(4) Wellness program incentives.[60] Nondiscriminatory wellness program incentives offered by an eligible employer-sponsored plan that affect premiums are treated as earned in determining an employee's required contribution for purposes of affordability of an eligible employer-sponsored plan to the extent the incentives relate exclusively to tobacco use. Wellness program incentives that do not relate to tobacco use or that include a component unrelated to tobacco use are treated as not earned for this purpose. For purposes of this subsection, the term "wellness program incentive" has the same meaning as the term "reward" in 26 CFR § 54.9802-1(f)(1)(i).

(5) Employer contributions to health reimbursement arrangements.[61] Amounts newly made available for the current plan year under a health reimbursement arrangement that an employee may use to pay premiums, or may use to pay cost-sharing or benefits not covered by the primary plan in addition to premiums, reduce the employee's required contribution if the health reimbursement arrangement would be integrated, as that term is used in IRS Notice 2013-54 (2013-40 IRB 287), with an eligible employer-sponsored plan for an employee enrolled in the plan. The eligible employer-sponsored plan and the health reimbursement arrangement must be offered by the same employer. Employer contributions to a health reimbursement arrangement reduce an employee's required contribution only to the extent the amount of the annual contribution is required under the terms of the plan or otherwise determinable within a reasonable time before the employee must decide whether to enroll in the eligible employer-sponsored plan.

(6) Employer contributions to cafeteria plans.[62] Amounts made available for the current plan year under a cafeteria plan, within the meaning of 26 USC § 125, reduce an employee's or a related individual's required contribution if:

(i) The employee may not opt to receive the amount as a taxable benefit;

(ii) The employee may use the amount to pay for minimum essential coverage; and

(iii) The employee may use the amount exclusively to pay for medical care, within the meaning of 26 USC § 213.

(7) [Reserved]

~~(iii)~~(8) Multiple offers of coverage. An individual who has offers of coverage under eligible employer-sponsored plans from multiple employers, either as an employee or a related individual, has an offer of affordable coverage if at least one of the offers of coverage is affordable under paragraph (a)(1) or (a)(2) of this subsection.

[60] 26 CFR § 1.36B-2(c)(3)(v)(A)(4).

[61] 26 CFR § 1.36B-2(c)(3)(v)(A)(5).

[62] 26 CFR § 1.36B-2(c)(3)(v)(A)(6).

(b) Affordability for part-year period.[63] Affordability under paragraph (a)(1) of this subsection is determined separately for each employment period that is less than a full calendar year or for the portions of an employer's plan year that fall in different benefit years of an applicable tax filer (a part-year period). Coverage under aAn eligible employer-sponsored plan is affordable for a part-year period if the ~~employee's~~ annualized required contribution for self-only coverage, in the case of an employee, or family coverage, in the case of a related individual, under the plan for the part-year period does not exceed the required contribution percentage of the applicable tax filer's household income for the benefit year. The employee's annualized required contribution is the employee's required contribution for the part-year period times a fraction, the numerator of which is 12 and the denominator of which is the number of months in the part-year period during the applicable tax filer's benefit year. Only full calendar months are included in the computation under this paragraph.

(c) Required contribution percentage.[64] The required contribution percentage for 2014 is 9.5 percent. For plan years beginning in a calendar year after 2014, the percentage will be adjusted by the ratio of premium growth to income growth for the preceding calendar year and may be further adjusted to reflect changes to the data used to compute the ratio of premium growth to income growth for the 2014 calendar year or the data sources used to compute the ratio of premium growth to income growth. Premium growth and income growth will be determined under IRS-published guidance. In addition, the percentage may be adjusted for plan years beginning in a calendar year after 2018 to reflect rates of premium growth relative to growth in the consumer price index.

(d) Examples.[65] For examples illustrating these provisions, see 26 CFR § 1.36B-2(c)(3)(v)(D). ~~The following examples illustrate the provisions of § 23.02. Unless stated otherwise, in each example the tax filer is single and has no tax dependents, the employer's plan is an eligible employer-sponsored plan and provides minimum value, the employee is not eligible for other MEC, and the tax filer, related individual, and employer-sponsored plan have a calendar benefit year.~~

~~(1) Example 1. Basic determination of affordability. In 2014 Tax filer C has household income of $47,000. C is an employee of Employer X, which offers its employees a health insurance plan that requires C to contribute $3,450 for self-only coverage for 2014 (7.3 percent of C's household income). Because C's required contribution for self-only coverage does not exceed 9.5 percent of household income, under paragraph (a)(1), X's plan is affordable for C, and C is eligible for MEC for all months in 2014.~~

~~(2) Example 2. Basic determination of affordability for a related individual. The facts are the same as in Example 1, except that C is married to J and X's plan requires C to contribute $5,300 for coverage for C and J for 2014 (11.3 percent of C's household income). Because C's required contribution for self-only coverage ($3,450) does not exceed 9.5 percent of household income, under paragraph (a)(2) of this subsection, X's plan is affordable for C and J, and C and J are eligible for minimum essential coverage for~~

[63] 26 CFR § 1.36B-2(c)(3)(v)(B).

[64] 26 CFR § 1.36B-2(c)(3)(v)(C). For plan years after 2014, the required contribution percentage will be updated in accordance with IRS-published guidance, available at www.irs.gov. For example, the required contribution percentage for 2016 is located at: https://www.irs.gov/pub/irs-drop/rp-14-62.pdf.

[65] 26 CFR § 1.36B-2(c)(3)(v)(D).

all months in 2014.

(3) Example 3. Determination of unaffordability at enrollment

(i) Tax filer D is an employee of Employer X. In November 2013 AHS projects that D's 2014 household income will be $37,000. It also verifies that D's required contribution for self-only coverage under X's health insurance plan will be $3,700 (10 percent of household income). Consequently, AHS determines that X's plan is unaffordable. D enrolls in a QHP and not in X's plan. In December 2014, X pays D a $2,500 bonus. Thus, D's actual 2014 household income is $39,500 and D's required contribution for coverage under X's plan is 9.4 percent of D's household income.

(ii) Based on D's actual 2014 household income, D's required contribution does not exceed 9.5 percent of household income and X's health plan is affordable for D. However, when D enrolled in a QHP for 2014, AHS determined that X's plan was not affordable for D for 2014. Consequently, under paragraph (a)(3), X's plan is not affordable for D and D is not eligible for MEC under X's plan for 2014.

(4) Example 4. Determination of unaffordability for plan year. The facts are the same as in Example 3, except that X's employee health insurance plan year is September 1 to August 31. AHS determines in August 2014 that X's plan is unaffordable for D based on D's projected household income for 2014. D enrolls in a QHP as of September 1, 2014. Under paragraph (a)(3), X's plan is not affordable for D and D is not eligible for MEC under X's plan for the coverage months September to December 2014 and January through August 2015.

(5) Example 5. No affordability information affirmatively provided for annual redetermination.

(i) The facts are the same as in Example 3, except AHS redetermines D's eligibility for APTCs for 2015. D does not affirmatively provide AHS with current information regarding affordability and AHS determines that D's coverage is not affordable for 2015 and approves APTCs based on information from the previous enrollment period. In 2015, D's required contribution for coverage under X's plan is 9.4 percent of D's household income.

(ii) Because D does not respond to AHS's notification and AHS makes an affordability determination based on information from an earlier year, the employee safe harbor in paragraph (a)(3) does not apply. D's required contribution for 2015 does not exceed 9.5 percent of D's household income. Thus, X's plan is affordable for D for 2015 and D is eligible for MEC for all months in 2015.

(6) Example 6. Determination of unaffordability for part of plan year (part-year period)

(i) Tax filer E is an employee of Employer X beginning in May 2015. X's employee health insurance plan year is September 1 to August 31. E's required contribution for self-only coverage for May through August is $150 per month ($1,800 for the full plan year). AHS projects E's household income for purposes of eligibility for APTCs as $18,000. E's actual household income for the 2015 benefit year is $20,000.

(ii) Under paragraph (b) of this subsection, whether coverage under X's plan is affordable for E is determined for the remainder of X's plan year (May through August). E's required contribution for a full plan year ($1,800) exceeds 9.5 percent of E's household income (1,800/18,000 = 10 percent).

Therefore, AHS determines that X's coverage is unaffordable for May through August. Although E's actual household income for 2015 is $20,000 (and E's required contribution of $1,800 does not exceed 9.5 percent of E's household income), under paragraph (a)(3), X's plan is unaffordable for E for the part of the plan year May through August 2015. Consequently, E is not eligible for MEC under X's plan for the period May through August 2015.

(7) Example 7. Affordability determined for part of a benefit year (part-year period)

(i) Tax filer F is an employee of Employer X. X's employee health insurance plan year is September 1 to August 31. F's required contribution for self-only coverage for the period September 2014 through August 2015 is $150 per month or $1,800 for the plan year. F does not enroll in X's plan during X's open season but enrolls in a QHP for September through December 2014. F does not request APTCs and does not ask AHS to determine whether X's coverage is affordable for F. F's household income in 2014 is $18,000.

(ii) Because F is a calendar year tax filer and Employer X's plan is not a calendar year plan, F must determine the affordability of X's coverage for the part-year period in 2014 (September-December) under paragraph (b) of this subsection. F determines the affordability of X's plan for the September through December 2014 period by comparing the annual premiums ($1,800) to F's 2014 household income. F's required contribution of $1,800 is 10 percent of F's 2014 household income. Because F's required contribution exceeds 9.5 percent of F's 2014 household income, X's plan is not affordable for F for the part-year period September through December 2014 and F is not eligible for MEC under X's plan for that period.

(iii) F enrolls in coverage for 2015 and does not ask AHS to approve APTCs or determine whether X's coverage is affordable. F's 2015 household income is $20,000.

(iv) F must determine if X's plan is affordable for the part-year period January 2015 through August 2015. F's annual required contribution ($1,800) is 9 percent of F's 2015 household income. Because F's required contribution does not exceed 9.5 percent of F's 2015 household income, X's plan is affordable for F for the part-year period January through August 2015 and F is eligible for MEC for that period.

(8) Example 8. Coverage unaffordable at year end. Tax filer G is employed by Employer X. In November 2014, AHS determines that G is eligible for affordable employer-sponsored coverage for 2015. G nonetheless enrolls in a QHP for 2015 but does not receive APTC. G's 2015 household income is less than expected and G's required contribution for employer-sponsored coverage for 2015 exceeds 9.5 percent of G's actual 2015 household income. Under paragraph (a)(1) of this subsection, G is not eligible for MEC under X's plan for 2015.

(9) Example 9. Wellness program incentives

(i) Employer X offers an eligible employer-sponsored plan with a nondiscriminatory wellness program that reduces premiums by $300 for employees who do not use tobacco products or who complete a smoking cessation course. Premiums are reduced by $200 if an employee completes cholesterol screening within the first six months of the plan year. Employee B does not use tobacco and the cost of his premiums is $3,700. Employee C uses tobacco and the cost of her premiums is $4,000.

(ii) Under paragraph (a)(4) of this subsection, only the incentives related to tobacco use are counted toward the premium amount used to determine the affordability of X's plan. C is treated as having earned the $300 incentive for attending a smoking cessation course regardless of whether C actually attends the course. Thus, the required contribution for determining affordability for both Employee B and Employee C is $3,700. The $200 incentive for completing cholesterol screening is treated as not earned and does not reduce their required contribution.

23.03 Minimum value for employer-sponsored MEC[66] (01/15/2017, GCR 16-096)

An individual will not be eligible for a federal premium tax credit if the employer-sponsored plan in which they may enroll provides minimum value. An eligible employer-sponsored plan provides minimum value only if the percentage of the total allowed costs of benefits provided under the plan is greater than or equal to 60 percent, and the benefits under the plan include substantial coverage of inpatient hospital services and physician services.

23.04 Enrollment in eligible employer-sponsored plan (01/15/2017, GCR 16-096)

(a) In general.[67] Except as provided in paragraph (b) of this subsection, the requirements of affordability and minimum value do not apply for months that an individual is enrolled in an eligible employer-sponsored plan.

(b) Automatic enrollment.[68] An employee or related individual is treated as not enrolled in an eligible employer-sponsored plan for a month in a plan year or other period for which the employee or related individual is automatically enrolled if the employee or related individual terminates the coverage before the later of the first day of the second full calendar month of that plan year or other period or the last day of any permissible opt-out period provided by the employer-sponsored plan or in regulations to be issued by the Department of Labor, for that plan year or other period.

(c) Examples.[69] The following examples illustrate the provisions of this subsection:

(1) Example 1. Tax filer H is employed by Employer X in 2014. H's required contribution for self-only employer coverage exceeds 9.5 percent of H's 2014 household income. H enrolls in X's calendar year plan for 2014. Under paragraph (a) of this subsection, H is eligible for MEC for 2014 because H is enrolled in an eligible employer-sponsored plan for 2014.

(2) Example 2. The facts are the same as in Example 1, except that H terminates plan coverage on June 30, 2014. Under paragraph (a) of this subsection, H is eligible for MEC under X's plan for January through June 2014 but is not eligible for MEC under X's plan for July through December 2014.

(3) Example 3. The facts are the same as in Example 1, except that Employer X automatically enrolls H in

[66] 45 CFR § 156.145; see, also, 26 CFR §§ 1.36B-2(c)(3)(vi) and 1.36B-6.

[67] 26 CFR § 1.36B-2(c)(3)(vii)(A).

[68] 26 CFR § 1.36B-2(c)(3)(vii)(B).

[69] 26 CFR § 1.36B-2(c)(3)(vii)(C).

the plan for calendar year 2015. H terminates the coverage on January 20, 2015. Under paragraph (b) of this subsection, H is not eligible for MEC under X's plan for January 2015.

23.05 Special eligibility rules[70] (01/01/2018, GCR 17-045)

(a) Related individual not claimed as a personal exemption deduction. An individual who may enroll in MEC because of a relationship to another person eligible for the coverage, but for whom the other eligible person does not claim a personal exemption deduction, is treated as eligible for MEC under the coverage only for months that the related individual is enrolled in the coverage.

(b) VHC unable to discontinue APTC

(1) *In general.* If an individual who is enrolled in a QHP for which advance credit payments are made informs VHC that the individual is or will soon be eligible for other MEC and that advance credit payments should be discontinued, but VHC does not discontinue advance credit payments for the first calendar month beginning after the month the individual informs VHC, the individual is treated as eligible for the other MEC no earlier than the first day of the second calendar month beginning after the first month the individual may enroll in the other MEC.

(2) *Medicaid or CHIP.* If a determination is made that an individual who is enrolled in a QHP for which advance credit payments are made is eligible for Medicaid or CHIP but the advance credit payments are not discontinued for the first calendar month beginning after the eligibility determination, the individual is treated as eligible for Medicaid or CHIP no earlier than the first day of the second calendar month beginning after the eligibility determination.

23.06 Eligibility determinations for MEC exemptions[71] (01/01/2018, GCR 17-045)

(a) In general.[72] AHS will satisfy the requirement to determine eligibility for an exemption from the shared responsibility payment by adopting an exemption eligibility determination made by HHS.

[70] 26 CFR § 1.36B-2(c)(4).

[71] See, 45 CFR §§ 155.600 through 155.635.

[72] 45 CFR § 155.625. Exemption applications and instructions are located at www.healthcare.gov/health-coverage-exemptions.

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Part Three
Nonfinancial eligibility requirements

15.00 Nonfinancial eligibility requirements, in general (01/15/2017, GCR 16-096)

This part catalogs the nonfinancial eligibility requirements that apply across all health benefits. The provisions that assign these requirements to a particular program or benefit are set forth in Part Two of this rule.

16.00 Social Security number (01/15/2017, GCR 16-096)

16.01 Medicaid[1] (01/15/2017, GCR 16-096)

(a) In general

(1) Except as provided in paragraph (b) of this subsection, as a condition of Medicaid eligibility, each individual (including children) seeking Medicaid must furnish their Social Security number.

(2) AHS will advise the individual of:

(i) The statute or other authority under which it is requesting the individual's Social Security number; and

(ii) The uses that will be made of each Social Security number, including its use for verifying income, eligibility, and amount of medical assistance payments under §§ 53.00 through 56.00.

(3) If an individual cannot recall their Social Security number or Social Security numbers or has not been issued a Social Security number, AHS will:

(i) Assist the individual in completing an application for a Social Security number;

(ii) Obtain evidence required under SSA regulations to establish the age, the citizenship or non-citizenship status, and the true identity of the individual; and

(iii) Either send the application to SSA or, if there is evidence that the individual has previously been issued a Social Security number, request SSA to furnish the number.

(4) Services to an otherwise eligible individual will not be denied or delayed pending issuance or verification of the individual's Social Security number by SSA or if the individual meets one of the exceptions in paragraph (b) of this subsection.

(5) The Social Security number furnished by an individual will be verified to insure the Social Security number was issued to that individual, and to determine whether any other Social Security numbers were issued to that individual. See § 55.02(a) for information on the verification process.

[1] 42 CFR § 435.910.

(b) Exception

(1) The requirement of paragraph (a)(1) of this subsection does not apply, and a Medicaid identification number will be given, to an individual who:

(i) Is not eligible to receive a Social Security number;

(ii) Does not have a Social Security number and may only be issued a Social Security number for a valid non-work reason in accordance with 20 CFR § 422.104; or

(iii) Refuses to obtain a Social Security number because of well-established religious objections. The term "well-established religious objections" means that the individual is a member of a recognized religious sect or division of the sect, and adheres to the tenets or teachings of the sect or division of the sect and for that reason is conscientiously opposed to applying for or using a national identification number including a Social Security number.

(2) The Medicaid identification number may be either a Social Security number obtained on the individual's behalf or another unique identifier.

(3) An individual who has a Social Security number is not subject to this exception and must provide such number.

(c) Social Security numbers of Medicaid non-applicants.[2] AHS may request the Social Security number of a person who is not applying for Medicaid for themselves provided that:

(1) Provision of such Social Security number is voluntary;

(2) Such Social Security number is used only to determine an applicant's or enrollee's eligibility for a health-benefits program or for a purpose directly connected to the administration of the state plan; and

(3) At the time such Social Security number is requested, AHS provides clear notice to the individual seeking assistance, or person acting on such individual's behalf, that provision of the non-applicant's Social Security number is voluntary and information regarding how the Social Security number will be used.

16.02 QHP[3] (01/15/2017, GCR 16-096)

(a) An individual applying for a QHP, with or without APTC or CSR, and who has a Social Security number must provide it. The number provided will be verified by AHS. See § 55.02(a) for information on the verification process.

(b) Except as provided in paragraph (c) of this subsection, a person who is not seeking coverage for themselves need not provide a Social Security number.

[2] 42 CFR § 435.907(e)(3).

[3] 45 CFR § 155.310(a)(3).

(c) An application filer seeking APTC must provide the Social Security number of a tax filer who is not an applicant only if an applicant attests that the tax filer has a Social Security number and filed a tax return for the year for which tax data would be utilized for verification of household income and family size.[4]

17.00 Citizenship and immigration status[5] (01/01/2023, GCR 22-031)

17.01 Definitions (01/01/2023, GCR 22-031)

(a) U.S. Citizen

(1) An individual born in the 50 states, the District of Columbia, Puerto Rico, Guam, Virgin Islands, and the Northern Mariana Islands (except for individuals born to foreign diplomats);

(2) A naturalized citizen; or

(3) An individual who otherwise qualifies for U.S. citizenship under § 301 of the Immigration and Nationality Act (INA), 8 USC §§ 1401.

(b) Citizenship[6]. Includes status as a "national of the United States," and includes both citizens of the United States and non-citizen nationals of the United States.

(c) National[7]

(1) An individual who:

(i) Is a U.S. citizen; or

(ii) Though not a citizen, owes permanent allegiance to the United States.

(2) For purposes of determining health-benefits eligibility, including verification requirements, citizens and non-citizen nationals of the United States are treated the same.

(3) As a practical matter, non-citizen nationals include individuals born in American Samoa or Swains Island.

(d) Qualified non-citizen.[8] An individual who is:

[4] 45 CFR § 155.305(f)(6).

[5] This section establishes the health-benefits citizenship and immigration-status eligibility requirements. Rules covering the related attestation and verification requirements and outlining documentary evidence are set forth in § 54.00.

[6] 42 CFR § 435.4.

[7] 8 USC § 1101(a)(22).

[8] 42 CFR § 435.4 ("qualified non-citizen" includes the term "qualified alien" as defined at 8 USC § 1641(b) and (c)); 42

(1) A lawful, permanent resident of the United States (LPR);

(2) A refugee, including:

(i) An individual admitted to the United States under § 207 of the INA;

(ii) A Cuban or Haitian entrant, as defined in § 501(e)(2) of the Refugee Education Assistance Act of 1980. There are three general categories of individuals who are considered "Cuban and Haitian entrants." A Cuban/Haitian national meets the definition of "Cuban and Haitian entrant" if he or she:

(A) Was granted parole status as a Cuban/Haitian entrant (Status Pending) on or after April 21, 1980 or has been paroled into the United States on or after October 10, 1980;

(B) Is the subject of removal, deportation or exclusion proceedings under the Immigration and Nationality Act and with respect to whom a final, nonappealable, and legally enforceable order of removal, deportation or exclusion has not been entered; or

(C) Has an application for asylum pending with the Department of Homeland Security (DHS) and with respect to whom a final, nonappealable, and legally enforceable order of removal, deportation or exclusion has not been entered.

(iii) An Amerasian, admitted to the United States under § 584 of the Foreign Operations Export Financing, and Related Programs Appropriation Act, 1988 (as contained in § 101(e) of Public Law 100-202 and amended by the 9th proviso under Migration and Refugee Assistance in title II of the Foreign Operations Export Financing, and Related Programs Act, 1989, Public Law 100-461, as amended);

(3) An asylee, as defined in § 208 of the INA;

(4) A non-citizen whose deportation has been withheld under:

(i) § 243(h) of the INA, as in effect prior to April 1, 1997, (the effective date of § 307 of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (IIRIRA), division C of Public Law 104-208); or

(ii) § 241(b)(3) of the INA, as amended by § 305(a) of division C of Public Law 104-208;

(5) An non-citizen who has been granted parole for at least one year by the USCIS under § 212(d)(5) of the INA;

(6) A non-citizen who has been granted conditional entry under § 203(a)(7) of the INA;

(7) A battered non-citizen, as defined in paragraph (e) of this subsection;

(8) A victim of a severe form of trafficking, in accordance with the Victims of Trafficking and Violence Protection Act of 2000 (22 USC § 7105(b));

CFR § 435.406(a)(2).

(9) An American Indian, born outside the U.S. and who enters and re-enters and resides in the U.S. is, for Medicaid purposes, considered a lawful permanent resident and, as such, a qualified non-citizen. This includes:

(i) An American Indian who was born in Canada and who is of at least one-half American Indian blood. This does not include the non-citizen spouse or child of such an Indian or a non-citizen whose membership in an Indian tribe or family is created by adoption, unless such person is of at least 50% American Indian blood.

(ii) An American Indian who is a member of a Federally-recognized Indian tribe, as defined in § 4(e) of the Indian Self-Determination and Education Assistance Act, 25 USC § § 450b(e); or[9]

(10) A citizen of the Republic of the Marshall Islands, the Federated States of Micronesia, or the Republic of Palau (Compact of Free Association migrants).[10]

(e) Battered non-citizen

(1) An individual who is:

(i) A victim of battering or cruelty by a spouse or a parent, or by a member of the spouse or parent's family residing in the same household as the victim and the spouse or parent consented to, or acquiesced in the battery or cruelty;

(ii) The parent of a child who has been such a victim, provided that the individual did not actively participate in the battery or cruelty; or

(iii) The child residing in the same household of such a victim.

(2) For the purposes of establishing qualified non-citizen status, the battered non-citizen must meet all of the following conditions:

(i) The individual must no longer be residing in the same household as the perpetrator of the abuse or cruelty;

(ii) The battery or cruelty must have a substantial connection with the need for medical assistance; and

(iii) The individual must have been approved for legal immigration status, or have a petition pending that makes a prima facie case for legal immigration status, under one of the following categories:

(A) Permanent residence under the Violence Against Women Act (VAWA);

(B) A pending or approved petition for legal permanent residence filed by a spouse or parent on USCIS Form I-130 or Form I-129f; or

[9] Abenaki is not a federally-recognized tribe.

[10] Consolidated Appropriations Act of 2021, § 208.

(C) Suspension of deportation or cancellation of removal under VAWA.

(f) Nonqualified non-citizen. A non-citizen who does not meet the definition of qualified non-citizen (§17.01(d)).

(g) Lawfully present in the United States. An individual who is a non-citizen and who:

(1) Is a qualified non-citizen, as defined in paragraph (d) of this subsection;

(2) Is in a valid nonimmigrant status, as defined in 8 USC § 1101(a)(15) or otherwise under the immigration laws (as defined in 8 USC § 1101(a)(17));

(3) Is paroled into the United States in accordance with 8 USC § 1182(d)(5) for less than 1 year, except for an individual paroled for prosecution, for deferred inspection or pending removal proceedings;

(4) Belongs to one of the following classes:

(i) Granted temporary resident status in accordance with 8 USC § 1160 or 1255a, respectively;

(ii) Granted Temporary Protected Status (TPS) in accordance with 8 USC § 1254a, and individuals with pending applications for TPS who have been granted employment authorization;

(iii) Granted employment authorization under 8 CFR § 274a.12(c);

(iv) Family Unity beneficiaries in accordance with § 301 of 101, as amended;

(v) Under Deferred Enforced Departure (DED) in accordance with a decision made by the President;

(vi) Granted Deferred Action status;

(vii) Granted an administrative stay of removal under 8 CFR part 241;

(viii) Beneficiary of approved visa petition who has a pending application for adjustment of status;

(5) Is an individual with a pending application for asylum under 8 USC § 1158, or for withholding of removal under 8 USC § 1231, or under the Convention Against Torture who—

(i) Has been granted employment authorization; or

(ii) Is under the age of 14 and has had an application pending for at least 180 days;

(6) Has been granted withholding of removal under the Convention Against Torture;

(7) Is a child who has a pending application for Special Immigrant Juvenile status as described in 8 USC § 1101(a)(27)(J); or

(8) Is lawfully present in American Samoa under the immigration laws of American Samoa.

(9) [Reserved]

(10) *Exception.* An individual with deferred action under DHS's deferred action for childhood arrivals process,

as described in the Secretary of Homeland Security's June 15, 2012, memorandum, shall not be considered to be lawfully present with respect to any of the above categories in paragraphs (1) through (8) of this definition.

(h) Non-citizen.[11] Has the same meaning as the term "alien," as defined in section 101(a)(3) of the INA, (8 USC § 1101(a)(3)) and includes any individual who is not a citizen or national of the United States, defined at 8 USC § 1101(a)(22).

17.02 General Rules (01/15/2017, GCR 16-096)

(a) Health benefits, in general. Except as provided in paragraphs (b) through (d) of this subsection, as a condition of eligibility for health benefits, an individual must be a citizen or national of the United States and, for purposes of enrollment in a QHP, must reasonably expect to be a citizen or national for the entire period for which QHP enrollment is sought.

(b) Enrollment in Medicaid. An individual who is a non-citizen is eligible for Medicaid if the individual otherwise satisfies the eligibility requirements and is:

(1) A qualified non-citizen who is not subject to the five-year bar under § 17.03(b); or

(2) A non-citizen who is not subject to the five-year bar under § 17.03(c).

(c) Enrollment in a QHP, with or without APTC or CSR. An individual who is a non-citizen who is lawfully present in the United States is eligible for enrollment in a QHP, with or without APTC or CSR, if the individual otherwise satisfies the eligibility requirements for a QHP and is reasonably expected to be a non-citizen who is lawfully present for the entire period for which QHP enrollment is sought.

(d) Emergency medical services.[12] An individual who is ineligible for Medicaid solely because of immigration status is eligible for the treatment of emergency medical conditions if all of the following conditions are met:

(1) The individual has, after sudden onset, a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in serious:

(i) Jeopardy to the individual's health;

(ii) Impairment of bodily functions; or

(iii) Dysfunction of any bodily organ or part.

(2) The individual meets all eligibility requirements for Medicaid except that non-qualified non-citizens need

[11] 42 CFR § 435.4.

[12] A legally-present individual who is enrolled in a QHP, with or without subsidies, is nevertheless eligible for emergency Medicaid. See CMS Response to Comment, 77 FR 17144, 17170.

not present a Social Security number or document immigration status.

(3) Emergency medical services do not include organ transplant procedures or routine prenatal or post partum care.

17.03 Medicaid five-year bar for qualified non-citizens (01/01/2023, GCR 22-031)

(a) Qualified non-citizens subject to 5-year bar.[13] Non-citizens who enter the United States on or after August 22, 1996, as qualified non-citizens are not eligible to receive Medicaid for five years from the date they enter the country. If they are not qualified non-citizens when they enter, the five-year bar begins the date they become a qualified non-citizen. The following qualified non-citizens are subject to the five-year bar:

(1) Lawful permanent residents (LPRs);

(2) Non-citizens granted parole for at least one year;

(3) Non-citizens granted conditional entry (however, as a practical matter the five-year bar will never apply to such non-citizens, since, by definition, they entered the U.S. and obtained qualified non-citizen status prior to August 22, 1996); and

(4) Battered non-citizens.

(b) Qualified non-citizens not subject to 5-year bar.[14] The following qualified non-citizens are not subject to the five-year bar:

(1) Refugees;

(2) Asylees;

(3) Cuban and Haitian Entrants;[15]

(4) Victims of a severe form of trafficking;

(5) Non-citizens whose deportation is being withheld;

(6) Qualified non-citizens who are:

(i) Honorably discharged veterans;

(ii) On active duty in the U.S. military; or

[13] 42 CFR § 435.406(a)(2); 8 USC § § 1613(a).

[14] 42 CFR § 435.406(a)(2); 8 USC § § 1613(b).

[15] From former PP&D at 4172.

(iii) The spouse (including a surviving spouse who has not remarried) or unmarried dependent child of an honorably discharged veteran or individual on active duty in the U.S. Military;

(7) Non-citizens admitted to the country as Amerasian immigrants;

(8) Legal permanent residents who first entered the United States under another exempt category (i.e., as a refugee, asylee, Cuban or Haitian entrant, trafficking victim, or non-citizen whose deportation was being withheld) and who later converted to the LPR status;

(9) Haitians granted Humanitarian Parole status;

(10) Citizens and nationals of Iraq and Afghanistan with Special Immigrant status; and[16]

(11) Citizens of the Republic of the Marshall Islands, the Federated States of Micronesia, and the Republic of Palau (Compact of Free Association migrants).[17]

(c) Non-citizens not subject to 5-year bar.[18] The five-year bar does not apply to:

(1) Non-citizens who are applying for treatment of an emergency medical condition only;

(2) Non-citizens who entered the United States and became qualified non-citizens prior to August 22, 1996; and

(3) Non-citizens who entered prior to August 22, 1996, and remained "continuously present" in the United States until becoming a qualified non-citizen on or after that date. Any single absence of more than 30 consecutive days or a combined total absence of 90 days before obtaining qualified non-citizen status is considered to interrupt "continuous presence."

(i) Non-citizens who do not meet "continuous presence" are subject to the five-year bar beginning from the date they become a qualified non-citizen.

(ii) Non-citizens do not have to remain continuously present in the United States after obtaining qualified non-citizen status.

(4) Members of a Federally-recognized Indian tribe;

(5) American Indians born in Canada to whom § 289 of the INA applies; and

(6) Children up to 21 years of age and women during pregnancy and their postpartum period, who are lawfully residing in the United States and otherwise eligible. AHS will verify that the child or pregnant

[16] From former PP&D at 4173.

[17] Consolidated Appropriations Act of 2021, § 208.

[18] Interim Guidance on Verification of Citizenship, Qualified Alien Status and Eligibility Under Title IV of the Personal Responsibility and Work Opportunity Act of 1996; 62 Federal Register 61344 and 61415 (November 17, 1997).

woman is lawfully residing in the United States at the time of the individual's initial eligibility determination and at the time of eligibility redeterminations. A child or pregnant woman will be considered to be lawfully residing in the United States if they are:

(i) A qualified non-citizen as defined in § 431 of PRWORA (8 USC § 1641)(see 17.01(d));

(ii) A non-citizen in non-immigration status who has not violated the terms of the status under which they were admitted or to which they have changed after admission;

(iii) A non-citizen who has been paroled into the United States pursuant to § 212(d)(5) of the INA (8 USC § 1182(d)(5)) for less than 1 year, except for a non-citizen paroled for prosecution, for deferred inspection or pending removal proceedings;

(iv) A non-citizen who belongs to one of the following classes:

(A) Non-citizens currently in temporary resident status pursuant to § 210 or 245A of the INA (8 USC § 1160 or 1255a, respectively);

(B) Non-citizens currently under Temporary Protected Status (TPS) pursuant to § 244 of the INA (8 USC § 1254a), and pending applicants for TPS who have been granted employment authorization;

(C) Non-citizens who have been granted employment authorization under 8 CFR § 274a.12(c)(9), (10), (16), (18), (20), (22), or (24);

(D) Family Unity beneficiaries pursuant to § 301 of Pub. L. 101-649, as amended;

(E) Non-citizens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;

(F) Non-citizens granted an administrative stay of removal under 8 CFR § 241;

(G) Non-citizens currently in deferred action status; or

(H) Non-citizens whose visa petitions have been approved and who have pending applications for adjustment of status;

(v) A pending applicant for asylum under § 208(a) of the INA (8 USC § 1158) or for withholding of removal under § 241(b)(3) of the INA (8 USC § 1231) or under the Convention Against Torture who:

(A) Has been granted employment authorization; or

(B) Is under the age of 14 and has had an application pending for at least 180 days;

(vi) A non-citizen who has been granted withholding of removal under the Convention Against Torture;

(vii) A child who has a pending application for Special Immigrant Juvenile status as described in § 101(a)(27)(J) of the INA (8 USC § 1101(a)(27)(J));

(viii) A non-citizen who is present in American Samoa under the immigration laws of American Samoa; or

(ix) A victim of severe trafficking in persons, in accordance with the Victims of Trafficking and Violence

Protection Act of 2000, Pub. L. 106-386, as amended (22 USC § 7105(b)).

(x) Exception: An individual with deferred action under the Department of Homeland Security's deferred action for the childhood arrivals process, as described in the Secretary of Homeland Security's June 15, 2012 memorandum, shall not be considered to be lawfully present with respect to any of the above categories in paragraphs (i)-(ix) who are considered to be lawfully residing in the United States.

(d) Ineligible non-citizens/nonimmigrants. The following categories of individuals are ineligible non-citizens/non-immigrants and are not eligible for Medicaid:

(1) Foreign government representatives on official business and their families and servants;

(2) Visitors for business or pleasure, including exchange visitors;

(3) Non-citizens in travel status while traveling directly through the U.S.;

(4) Crewmen on shore leave;

(5) Foreign students;

(6) International organization representation personnel and their families and servants;

(7) Temporary workers including agricultural contract workers; and

(8) Members of foreign press, radio, film, or other information media and their families.

18.00 Assignment of rights and cooperation requirements for Medicaid (01/01/2023, GCR 22-031)

18.01 In general[19] (01/15/2017, GCR 16-096)

As a condition of initial and continuing eligibility, a legally-able individual who is applying for or enrolled in Medicaid must meet the requirements related to the pursuit of medical support, third-party payments, and the requirement to enroll or remain enrolled in a group health insurance plan, as provided for below.

18.02 Assignment of rights to payments (01/15/2017, GCR 16-096)

(a) In general. An individual who is applying for, or enrolled in Medicaid, with the legal authority to do so, must assign their rights to medical support and third-party payments for medical care. If they have the legal authority to do so, they must also assign the rights of any other individual who is applying for or enrolled in Medicaid to such support and payments.

(b) Exceptions. No assignment is required for:

[19] 42 CFR § 435.610; Former Medicaid Rules 4138-4138.4.

(1) Medicare payments; or

(2) Cash payments from the Department of Veterans Affairs for aid and attendance.

18.03 Cooperation in Obtaining Payments (01/01/2023, GCR 22-031)

(a) In general

(1) Applicants must attest that they will cooperate, and enrollees must cooperate in:

(i) Establishing the identity of a child's parents and in obtaining medical support and payments, unless the individual establishes good cause for not cooperating as described in § 18.04; and

(ii) Identifying and providing information to assist in pursuing third parties who may be liable to pay for care and services under the plan, unless the individual establishes good cause for not cooperating as described in § 18.04.

(2) To meet this requirement, an individual may be required to:

(i) Provide information or evidence relevant and essential to obtain such support or payments;

(ii) Appear as a witness in court or at another proceeding;

(iii) Provide information or attest to lack of information under penalty of perjury; or

(iv) Take any other reasonable steps necessary for establishing parentage or securing medical support or third-party payments.

(b) Exception. An unmarried pregnant woman with income under 208 percent of the FPL is exempted from the requirement to cooperate in establishing paternity or obtaining medical support and payments from, or derived from, the father of the child she expects to deliver or from the father of any of her children born out-of-wedlock. She shall remain exempt through the end of the calendar month in which the post partum period, beginning with the date of her delivery, ends.

18.04 Good cause for noncooperation (01/15/2017, GCR 16-096)

(a) In general. An individual who is applying for or enrolled in Medicaid may request a waiver of the cooperation requirement under § 18.03. Those to whom a good-cause waiver for noncooperation has been granted are eligible for Medicaid, provided that all other program requirements are met. AHS will grant such waivers when either of the following circumstances has been substantiated to AHS's satisfaction:

(1) Compliance with the cooperation requirement is reasonably anticipated to result in physical or emotional harm to the individual responsible for cooperating or the person for whom medical support or third-party payments are sought. Emotional harm means an emotional impairment that substantially affects an individual's functioning; or

(2) Compliance with the cooperation requirement would entail pursuit of medical support for a child:

(i) Conceived as a result of incest or rape from the father of that child;

(ii) For whom adoption proceedings are pending; or

(iii) For whom adoptive placement is under active consideration.

(b) Required documentation. An Individual requesting a waiver of the cooperation requirement bears the primary responsibility for providing the documentation AHS deems necessary to substantiate their claims of good cause. AHS will consider an individual who has requested a good-cause waiver and submitted the required documentation to be eligible for Medicaid while a decision on the request is pending.

(c) Review of good-cause waiver. A review of the continued existence of good cause circumstances upon which a waiver has been granted is required no less frequently than at each redetermination of eligibility for those cases in which determination of good cause is based on a circumstance that may change. A formal decision based upon resubmission of evidence is not required, however, unless AHS determines that a significant change of circumstances relative to good cause has occurred.

18.05 Enrollment in a health insurance plan (01/15/2017, GCR 16-096)

(a) An individual who is applying for, or enrolled in Medicaid, may be required to enroll or remain enrolled in a group health insurance plan for which AHS pays the premiums. (See Medicaid Covered Services Rule (MCSR) 7108.) Payment of group health insurance premiums shall be made only under the conditions specified in this subsection and in MCSR 7108.1 and remain entirely at AHS's discretion. Such payment of premiums shall not be considered an entitlement for any individual.

(b) As a condition of continuing eligibility, an individual may be required to remain enrolled in an individual health insurance plan, provided that they are enrolled in a plan for which the state has been paying the premiums on a continuous basis since July 2000.

(c) For the purposes of this subsection and MCSR 7108.1, a group health insurance plan is a plan that meets the definition of a group health insurance plan specified in 8 V.S.A. § 4079. An individual health insurance plan is a plan that does not meet that definition.

19.00 Incarceration and QHP eligibility (01/15/2017, GCR 16-096)

19.01 In general[20] (01/15/2017, GCR 16-096)

An incarcerated individual, other than an individual who is incarcerated pending the disposition of charges, is ineligible for enrollment in a QHP.

19.02 Exception[21] (01/15/2017, GCR 16-096)

[20] 26 CFR § 1.36B-2(a)(4); 45 CFR § 155.305(a)(2).

[21] 26 CFR § 1.36B-2(a)(4); See §§ 1312(f)(1)(B) and 1312(f)(3) of the ACA (42 USC § 18032(f)(1)(B) and (f)(3)) and 26 CFR § 1.36B-3(b)(2).

An incarcerated individual may be an applicable tax filer if a family member is eligible to enroll in a QHP.

20.00 Living arrangements for Medicaid eligibility purposes (01/01/2018, GCR 17-045)

20.01 In general[22] (01/01/2018, GCR 17-045)

Individuals or couples meet the living-arrangement requirement for Medicaid eligibility purposes if they live in:

(a) Their own home;

(b) The household of another; or

(c) The following public institutions:

(1) The Vermont Psychiatric Care Hospital (VPCH) or successor entity or entities, if the individual is:

(i) Under the age of 21 (if a Medicaid enrollee is a patient of VPCH upon reaching their 21st birthday, eligibility may be continued to the date of discharge or their 22nd birthday, whichever comes first, as long as they continue to meet all other eligibility requirements); or

(ii) Age 65 or older.

(2) An intermediate care facility for people with developmental disabilities (ICF-DD).

(3) A facility supported in whole or in part by public funds whose primary purpose is to provide medical care other than the treatment of mental disease, including nursing and convalescent care, inpatient care in a hospital, drug and alcohol treatment, etc.

(d) A private facility, if:

(1) The primary purpose of the facility is to provide medical care other than the treatment of mental diseases, including nursing and convalescent care, inpatient care in a hospital, drug and alcohol treatment, etc.; and

(2) The facility meets the following criteria:

(i) There is no agreement or contract obliging the institution to provide total support to the individual;

(ii) There has been no transfer of property to the institution by the individual or on their behalf, unless maintenance by the institution has been of sufficient duration to fully exhaust the individual's equity in the property transferred at a rate equal to the monthly charges to other residents in the institution; and

(iii) There is no restriction on the individual's freedom to leave the institution.

(3) An individual under the age of 21 or age 65 or older meets the living arrangement requirement if they live

[22] Former Medicaid Rules 4218 and 4332

at the Brattleboro Retreat. In addition, an individual who is a patient at the facility upon reaching their 21st birthday, has eligibility continued to the date of discharge or their 22nd birthday, whichever comes first, as long as they continue to meet all other eligibility requirements.

20.02 Correctional facility (01/01/2018, GCR 17-045)

(a) In general.[23] An individual living in a correctional facility, including a juvenile facility, is not precluded from being determined eligible for Medicaid or from retaining their Medicaid eligibility if they were eligible before becoming incarcerated. However, the individual's Medicaid benefits will be suspended during their incarceration period (described in (b) below).

(b) Incarceration period. Incarceration begins on the date of admission and ends when the individual moves out of the correctional facility.

(c) Inpatient exception: Transfer to a medical facility.[24] While incarcerated, Medicaid is available when the inmate is an inpatient in a medical institution not under the control of the corrections system. Such institutions include a hospital, nursing facility, juvenile psychiatric facility, or intermediate care facility.

20.03 Determination of residence in an institution (01/15/2017, GCR 16-096)

Residence in an institution is determined by the dates of admission and discharge. An individual at home in the community on a visiting pass is still a resident of the institution.

20.04 Homeless individuals (01/15/2017, GCR 16-096)

A homeless individual is considered to be living in their own home.

20.05 Financial responsibility and living arrangement (01/15/2017, GCR 16-096)

The financial responsibility of relatives varies depending upon the type of living arrangement.

21.00 Residency (01/01/2023, GCR 22-031)

21.01 In general[25] (01/15/2017, GCR 16-096)

AHS will provide health benefits to an eligible Vermont resident.

[23] 42 CFR §§ 435.1009 and 435.1010.

[24] 42 CFR §§ 435.1009 and 435.1010. This is also based on various letters from CMS to states, inquiring about the availability of federal funds participation for inmate inpatient health care.

[25] 42 CFR § 435.403; 45 CFR § 155.305(a)(3). Note: The Exchange rules speak in terms of residence within the Exchange's "service area." However, as there will be a single "service area" in Vermont, for both Medicaid and QHP enrollment, this rule speaks in terms of residence within the state.

21.02 Incapability of indicating intent (01/15/2017, GCR 16-096)

For purposes of this section, an individual is considered incapable of indicating intent regarding residency if the individual:

(a) Has an I.Q. of 49 or less or has a mental age of 7 years or less, based on tests acceptable to AHS;

(b) Is judged legally incompetent; or

(c) Is found incapable of indicating intent based on medical documentation obtained from a physician, psychologist, or other person licensed by the state in the field of intellectual disabilities.

21.03 Who is a state resident (01/15/2017, GCR 16-096)

A resident of the state is any individual who:

(a) Meets the conditions in §§ 21.04 through 21.08; or

(b) Meets the criteria specified in an interstate agreement under § 21.10.

21.04 Placement by a state in an out-of-state institution[26] (01/01/2023, GCR 22-031)

(a) Any state agency, including an entity recognized under state law as being under contract with the state for such purposes, that arranges for an individual to be placed in an institution located in another state is recognized as acting on behalf of the state in making a placement. For purposes of this subsection, "institution" includes foster care homes licensed under 45 CFR § 1355.20 that provide food, shelter and supportive services to one or more people unrelated to the proprietor. The state arranging or actually making the placement is considered as the individual's state of residence.

(b) Any action beyond providing information to the individual and the individual's family would constitute arranging or making a state placement. However, the following actions do not constitute state placement:

(1) Providing basic information to individuals about another state's Medicaid program and information about the availability of health care services and facilities in another state.

(2) Assisting an individual in locating an institution in another state, provided the individual is capable of indicating intent and independently decides to move.

(c) When a competent individual leaves the facility in which the individual is placed by a state, that individual's state of residence for Medicaid purposes is the state where the individual is physically located.

(d) Where a placement is initiated by a state because the state lacks a sufficient number of appropriate facilities to provide services to its residents, the state making the placement is the individual's state of residence.

[26] 42 CFR § 435.403(e).

21.05 An individual receiving Aid to the Aged, Blind, and Disabled (AABD)[27] (01/15/2017, GCR 16-096)

(a) In general. For an individual of any age who is receiving a state supplemental payment (in Vermont, known as AABD), the state of residence is the state paying the state supplemental payment.

(b) Exception.[28] A transient worker may claim Vermont as their state of residence and be granted Medicaid if they meet all other eligibility criteria. These individuals may be granted Vermont Medicaid even though they continue to receive a state supplement payment from another state.

21.06 An individual age 21 and over[29] (01/15/2017, GCR 16-096)

Except as provided in § 21.05, with respect to individuals age 21 and over:

(a) For an individual not residing in an institution, as defined in § 3.00, including a licensed foster care providing food, shelter, and supportive services to one or more persons unrelated to the proprietor, the state of residence is the state where the individual is living and:

(1) Intends to reside, including without a fixed address; or

(2) Has entered the state with a job commitment or is seeking employment (whether or not currently employed).

(b) For an individual not residing in an institution, as described in (a) of this subsection, who is incapable of stating intent, the state of residence is the state where the individual is living.

(c) For any institutionalized individual who became incapable of indicating intent before age 21, the state of residence is:

(1) That of the parent applying for Medicaid on the individual's behalf, if the parents reside in separate states (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's);

(2) The parent's or legal guardian's state of residence at the time of placement (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the

[27] Effective January I, I974, the major portion of Vermont's federal-state program of AABD became the federal program of Supplemental Security Income (SSI) through amendment of title XVI of the Social Security Act. SSI guarantees a minimum national standard of assistance to aged, blind or disabled persons at full federal expense. Vermont supplements the SSI payment with a state-funded payment. While, federal government abandoned the AABD program title, Vermont has retained this name for this state supplementary payment. See, AABD Rule 2700.

[28] Former Medicaid Rule 4217(A).

[29] 42 CFR § 435.403(h); 45 CFR §§ 155.305(a)(3)(i) and (iii).

parent's);

(3) The current state of residence of the parent or legal guardian who files the application if the individual is institutionalized in that state (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's); or

(4) The state of residence of the person or party who files an application is used if the individual has been abandoned by his or her parent(s), does not have a legal guardian and is institutionalized in that state.

(d) For any institutionalized individual who became incapable of indicating intent at or after age 21, the state of residence is the state in which the individual is physically present, except where another state makes a placement.

(e) For any other institutionalized individual, the state of residence is the state where the individual is living and intends to reside. An institutionalized individual cannot be considered a Vermont resident if the individual owns a home (see § 29.08(a)(1)) in another state which the individual intends to return to, even if the likelihood of return is apparently nil.[30]

21.07 An individual receiving Title IV-E payments[31] (01/01/2023, GCR 22-031)

For an individual of any age who is receiving federal payments for foster care or adoption assistance under Title IV-E of the Act, the state of residence is the state where the individual lives.

21.08 An individual under age 21[32] (01/15/2017, GCR 16-096)

For an individual under age 21 who is not eligible for Medicaid based on receipt of assistance under Title IV-E of the Act, as addressed in § 21.07, and is not receiving a state supplementary payment, as addressed in § 21.05, the state of residence is as follows:

(a) For an individual who is capable of indicating intent and who is emancipated from his or her parent or who is married, the state of residence is determined in accordance with § 21.06(a).

(b) For an individual not described in paragraph (a) of this subsection, not living in an institution, not eligible for Medicaid based on receipt of assistance under Title IV-E of the Act, and not receiving a state supplementary payment, the state of residence is:

(1) The state where the individual resides, including without a fixed address; or

(2) The state of residency of the parent or caretaker, in accordance with § 21.06(a), with whom the individual

[30] Former Medicaid Rule 4217(F).

[31] 42 CFR § 435.403(g); 45 CFR § 155.305(a)(3)(iii).

[32] 42 CFR § 435.403(i); 45 CFR §§ 155.305(a)(3)(ii) and (iii). Paragraphs (a) and (b) are derived from what was formerly 42 CFR § 435.403(h). Subparagraphs (1) and (2) are new. Paragraph (c) was originally designated as 42 CFR § 435.403(h)(4).

resides.

(c) For any institutionalized individual who is neither married nor emancipated, the state of residence is:

(1) The parent's or legal guardian's state of residence at the time of placement (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's); or

(2) The current state of residence of the parent or legal guardian who files the application if the individual is institutionalized in that state (if a legal guardian has been appointed and parental rights are terminated, the state or residence of the guardian is used instead of the parent's).

21.09 Specific prohibitions[33] (01/15/2017, GCR 16-096)

AHS will not:

(a) Deny health-benefits eligibility because an individual has not resided in Vermont for a specified period.

(b) Deny health-benefits eligibility to an individual in an institution, who satisfies the residency rules set forth in this section, on the grounds that the individual did not establish residence in Vermont before entering the institution.

(c) Deny or terminate a Vermont resident's health-benefits eligibility because of that person's temporary absence from the state, as defined in § 21.13, if the person intends to return to Vermont when the purpose of the absence has been accomplished, unless, for purposes of Medicaid eligibility, another state has determined that the person is a resident there (see § 21.13(c)).

21.10 Interstate agreements[34] (01/15/2017, GCR 16-096)

A state may have a written agreement with another state setting forth rules and procedures resolving cases of disputed residency. These agreements may establish criteria other than those specified in §§ 21.07 and 21.08, but must not include criteria that result in loss of residency in both states or that are prohibited by § 21.09. The agreements must contain a procedure for providing health benefits to individuals pending resolution of the case. States may use interstate agreements for purposes other than cases of disputed residency to facilitate administration of the program, and to facilitate the placement and adoption of a Title IV-E individual when the child and his or her adoptive parent(s) move into another state.

21.11 Cases of disputed residency[35] (01/15/2017, GCR 16-096)

[33] 42 CFR § 435.403(j).

[34] 42 CFR § 435.403(k); 45 CFR § 155.305(a)(3)(iii).

[35] 42 CFR § 435.403(m); 45 CFR § 155.305(a)(3)(iii).

If Vermont and any other state cannot resolve which state is the individual's state of residence, the state where the individual is physically located is the state of residence.

21.12 Special rule for tax households with members in multiple Exchange service areas[36] (01/15/2017, GCR 16-096)

(a) Except as specified in paragraph (b) of this subsection, if all of the members of a tax household are not within the same Exchange service area, in accordance with the applicable standards in §§ 21.04 through 21.08, any member of the tax household may enroll in a QHP through any of the Exchanges for which one of the tax filers meets the residency standard.

(b) If both spouses in a tax household enroll in a QHP through VHC, a tax dependent may only enroll in a QHP through VHC, or through the Exchange that services the area in which the dependent meets a residency standard described in §§ 21.04 through 21.08.

21.13 Temporary absences from the state[37] (01/01/2018, GCR 17-045)

(a) In general. Temporary absences from Vermont do not interrupt or end Vermont residence.

(b) Definition. An absence is temporary if the individual leaves the state with the intent to return when the purpose of the absence has been accomplished. Examples include, but are not limited to, absences for the purposes of:

(1) Visiting;

(2) Obtaining necessary medical care;

(3) Obtaining education or training under a program of Vocational Rehabilitation, Work Incentive, or higher education program; or

(4) Residence in a long-term care facility in another state, if arranged by an agent of the State of Vermont, unless the individual or their parents or legal guardian, as applicable, state intent to abandon Vermont residence and to reside outside Vermont upon discharge from long-term care.

(c) Exception. For purposes of Medicaid eligibility, an absence is not temporary if another state verifies that the individual meets the residency standard of such other state.[38]

21.14 Vermont residence as Medicaid payment requirement (01/15/2017, GCR 16-096)

[36] 45 CFR § 155.305(a)(3)(iv).

[37] 45 CFR § 155.305(a)(3)(v).

[38] 42 CFR § 435.403(j)(3).

An individual must be a resident of Vermont at the time a medical service is rendered in order for Vermont Medicaid to pay for that service. The service, however, does not have to be rendered in Vermont subject to certain restrictions.[39]

22.00 Pursuit of potential unearned income for Medicaid eligibility[40] (01/15/2017, GCR 16-096)

(a) As a condition of eligibility for Medicaid, an individual is required to take all necessary steps to obtain any annuities, pensions, retirement, or disability benefits to which they may be entitled, unless they can show good cause for not doing so. Annuities, pensions, retirement, and disability benefits include, but are not limited to, veterans' compensation and pensions, OASDI benefits, railroad retirement benefits, and unemployment compensation. Application for these benefits, when appropriate, must be verified prior to granting or continuing Medicaid.

(b) Individuals are not required to apply for Medicare part B or for cash assistance programs such as SSI/AABD or Reach Up as a condition of eligibility for Medicaid.

23.00 Minimum essential coverage (01/01/2023, GCR 22-031)

23.01 Minimum essential coverage (01/01/2018, GCR 17-045)

(a) In general.[41] Minimum essential coverage means coverage under any of the following: Government-sponsored programs, eligible employer-sponsored plans, grandfathered health plans, individual health plans and certain other health-benefits coverage.

Individuals and their tax dependents must have minimum essential coverage (MEC) to avoid the shared responsibility payment (penalty) imposed by the Internal Revenue Service unless they qualify for an exemption from this payment. See § 23.06 for details on the eligibility determination for MEC exemptions.

In addition, individuals who are eligible to enroll in health coverage that qualifies as MEC under this section are not eligible to receive federal tax credits and cost-sharing reductions if they enroll in a QHP. See §§ 23.01(b) through 23.01(e) for details on health coverage that qualifies as MEC for purposes of considering eligibility for the federal premium tax credit. As stated in § 23.01(c)(2), for an employer-sponsored plan to be considered as MEC when an employee or related individual applies for APTC, the plan must be affordable and meet minimum value criteria. See § 23.02 for details on affordability, and § 23.03 for details on minimum value.

See §§ 55.02(c) and (d) for descriptions of the process for verifying eligibility for MEC when determining eligibility for APTC and CSR.

[39] 42 CFR § 431.52.

[40] Former Medicaid Rule 4137.

[41] 26 USC § 5000A(f); 26 CFR § 1.36B-2(c).

(b) Government-sponsored MEC

(1) In general.[42] Subject to the limitation in paragraph (b)(2), an individual is eligible for government-sponsored MEC for purpose of considering eligibility for the federal premium tax credit if, as of the first day of the first full month the individual may receive benefits under the program, the individual meets the criteria for coverage under one of the following government-sponsored programs:

(i) The Medicare program under part A of Title XVIII of the Act, except for an individual who must pay a premium for part A coverage and who chooses not to enroll in part A coverage (see § 23.01(e)(1));

(ii) The Medicaid program under Title XIX of the Act, except for the following individuals:

(A) A woman who becomes pregnant while enrolled in a QHP and who, though eligible for Medicaid as a pregnant woman pursuant to § 7.03(a)(2), chooses not to enroll in Medicaid (see § 23.01(e)(5)).

(B) An individual who becomes eligible for Medicaid coverage as medically needy only after meeting a spenddown. Such individual may apply to HHS for a hardship exemption from the personal responsibility payment as described in § 23.06(a).

(C) An individual who is receiving coverage limited to family planning services as described in § 9.03(g).

(D) An individual who is receiving coverage limited to the treatment of emergency services as described in § 17.02(d);

(iii) The CHIP program under Title XXI of the Act;

(iv) Medical coverage under chapter 55 of Title 10, United States Code, including coverage under the TRICARE program;

(v) A health care program under chapter 17 or 18 of Title 38, United States Code, as determined by the Secretary of Veterans Affairs, in coordination with the Secretary of HHS and the Secretary of the Treasury; or

(vi) A health plan under § 2504(e) of Title 22, United States Code (relating to Peace Corps volunteers).

(2) Obligation to complete administrative requirements to obtain coverage.[43] An individual who meets the eligibility criteria for government-sponsored MEC must complete the requirements necessary to receive benefits. An individual who fails by the last day of the third full calendar month following the event that establishes eligibility under (b)(1) of this subsection to complete the requirements to obtain government-sponsored MEC (other than a veteran's health-care program) is treated as eligible for government-sponsored MEC as of the first day of the fourth calendar month following the event that establishes eligibility.

[42] 26 USC § 5000A(f)(1)(A); 26 CFR § 1.36B-2(c)(2)(i)

[43] 26 CFR § 1.36B-2(c)(2)(ii).

(3) Special rule for coverage for veterans and other individuals under chapter 17 or 18 of Title 38, USC §.[44] An individual is eligible for MEC under a health-care program under chapter 17 or 18 of Title 38, USC section only if the individual is enrolled in a health-care program under chapter 17 or 18 of Title 38, USC section identified as MEC in regulations issued under § 5000A of the Code.

(4) Retroactive effect of eligibility determination.[45] If an individual receiving APTC is determined to be eligible for government-sponsored MEC that is effective retroactively (such as Medicaid), the individual is treated as eligible for MEC under that program no earlier than the first day of the first calendar month beginning after the approval.

(5) Determination of Medicaid or CHIP ineligibility.[46] An individual is treated as not eligible for Medicaid or a similar program for a period of coverage under a QHP if, when the individual enrolls in the QHP, the individual is determined to be not eligible for Medicaid.

(6) Examples.[47] The following examples illustrate the provisions of this paragraph (b):

(i) Example 1. Delay in coverage effectiveness. On April 10, 2015, Tax filer D applies for coverage under a government-sponsored health-care program. D's application is approved on July 12, 2015, but her coverage is not effective until September 1, 2015. Under paragraph (b)(1), D is eligible for government-sponsored MEC on September 1, 2015.

(ii) Example 2. Time of eligibility. Tax filer E turns 65 on June 3, 2015, and becomes eligible for Medicare. Under § 5000A(f)(1)(A)(i), Medicare is MEC. However, E must enroll in Medicare to receive benefits. E enrolls in Medicare in September, which is the last month of E's initial enrollment period. Thus, E may receive Medicare benefits on December 1, 2015. Because E completed the requirements necessary to receive Medicare benefits by the last day of the third full calendar month after the event that establishes E's eligibility (E turning 65), under paragraph (b)(1) and (b)(2) of this subsection, E is eligible for government-sponsored MEC on December 1, 2015, the first day of the first full month that E may receive benefits under the program.

(iii) Example 3. Time of eligibility, individual fails to complete necessary requirements. The facts are the same as in Example 2, except that E fails to enroll in the Medicare coverage during E's initial enrollment period. E is treated as eligible for government-sponsored MEC under paragraph (b)(2) of this subsection as of October 1, 2015, the first day of the fourth month following the event that establishes E's eligibility (E turning 65).

[44] 26 CFR § 1.36B-2(c)(2)(iii).

[45] 26 CFR § 1.36B-2(c)(2)(iv).

[46] 26 CFR § 1.36B-2(c)(2)(v). The phrase in this section: "or considers (within the meaning of 45 CFR § 155.302(b))" was omitted from this paragraph, as AHS does not conduct "assessment[s] of eligibility for Medicaid and CHIP" within the meaning of 45 CFR § 155.302(b), but rather, determines eligibility for such programs.

[47] These examples are extracted from 26 CFR § 1.36B-2(c)(2)(vi).

(iv) Example 4. Retroactive effect of eligibility. In November 2014, Tax filer F enrolls in a QHP for 2015 and receives APTCs. F loses her part-time employment and on April 10, 2015, applies for coverage under the Medicaid program. F's application is approved on May 15, 2015, and her Medicaid coverage is effective as of April 1, 2015. Under paragraph (b)(4), F is eligible for government-sponsored MEC on June 1, 2015, the first day of the first calendar month after approval.

(v) Example 5. Determination of Medicaid ineligibility. In November 2014, Tax filer G applies to enroll in health coverage for 2015. AHS determines that G is not eligible for Medicaid and estimates that G's household income will be 140 percent of the FPL for G's family size for purposes of determining APTCs. G enrolls in a QHP and begins receiving APTCs. G experiences a reduction in household income during the year and his household income for 2015 is 130 percent of the FPL (within the Medicaid income threshold). However, under paragraph (b)(5), G is treated as not eligible for Medicaid for 2015.

(vi) Example 6. Mid-year Medicaid eligibility redetermination. The facts are the same as in Example 5, except that G returns to the Exchange in July 2015 and AHS determines that G is eligible for Medicaid. AHS approves G for coverage and AHS discontinues G's APTCs effective August 1. Under paragraphs (b)(4) and (b)(5), G is treated as not eligible for Medicaid for the months when G is covered by a QHP. G is eligible for government-sponsored MEC for the months after G is approved for Medicaid and can receive benefits, August through December 2015.

(c) Employer-sponsored MEC

(1) Definition: related individual. For purposes of this subsection and §§ 23.02 through 23.04, a related individual is an individual who is not an employee of an employer offering an eligible employer-sponsored plan, but who can enroll in such plan because of their relationship to the employee. This definition has a similar meaning as the definition of "dependent" for purposes of the Small Employer Health-Benefits Program under Part Six of this rule.

(2) In general.[48] An employee and related individual who may enroll in an eligible employer-sponsored plan are eligible for MEC under the plan for purposes of considering eligibility for the federal premium tax credit for any month only if the plan is affordable (§ 23.02) and provides minimum value (§ 23.03). Government-sponsored programs described in paragraph (b) of this subsection are not eligible employer-sponsored plans.

(3) Plan year.[49] For purposes of this paragraph, a plan year is an eligible employer-sponsored plan's regular 12-month coverage period (or the remainder of a 12-month coverage period for a new employee or an individual who enrolls during a special enrollment period).

(4) Eligibility for months during a plan year

[48] 26 CFR § 1.36B-2(c)(3)(i).

[49] 26 CFR § 1.36B-2(c)(3)(ii).

(i) Failure to enroll in plan.[50] An employee or related individual may be eligible for MEC under an eligible employer-sponsored plan for a month during a plan year if the employee or related individual could have enrolled in the plan for that month during an open or special enrollment period for the plan year. If an enrollment period relates to coverage for not only the upcoming plan year (or the current plan year in the case of an enrollment period other than an open enrollment period), but also coverage in one or more succeeding plan years, this paragraph applies only to eligibility for the coverage in the upcoming plan year (or the current plan year in the case of an enrollment period other than an open enrollment period).

(ii) Waiting periods.[51] An employee or related individual is not eligible for MEC under an eligible employer-sponsored plan during a required waiting period before the coverage becomes effective.

(iii) Example.[52] The following example illustrates the provisions of this paragraph (c)(4):

(A) Tax filer B is an employee of Employer X. X offers its employees a health insurance plan that has a plan year (within the meaning of paragraph (c)(3)) from October 1 through September 30. Employees may enroll during an open season from August 1 to September 15. B does not enroll in X's plan for the plan year October 1, 2014, to September 30, 2015. In November 2014, B enrolls in a QHP for calendar year 2015.

(B) B could have enrolled in X's plan during the August 1 to September 15 enrollment period. Therefore, unless X's plan is not affordable for B or does not provide minimum value, B is eligible for MEC under X's plan for the months that B is enrolled in the QHP during X's plan year (January through September 2015).

(5) Post-employment coverage.[53] A former employee (including a retiree), or an individual related (within the meaning of this paragraph (c)) to a former employee, who may enroll in eligible employer-sponsored coverage or in continuation coverage required under federal law or a state law that provides comparable continuation coverage is eligible for MEC under this coverage only for months that the former employee or related individual is enrolled in the coverage.

(d) Other coverage that qualifies as MEC. The following types of coverage are designated as MEC for purposes of considering eligibility for the federal premium tax credit[54]:

(1) *Self-funded student health coverage.* Coverage offered to students by an institution of higher education (as defined in the Higher Education Act of 1965), where the institution assumes the risk for payment of claims, are designated as MEC for plan or policy years beginning on or before December 31, 2014. For coverage beginning after December 31, 2014, sponsors of self-funded student health coverage may

[50] 26 CFR § 1.36B-2(c)(3)(iii)(A).

[51] 26 CFR § 1.36B-2(c)(3)(iii)(B).

[52] 26 CFR § 1.36B-2(c)(3)(iii)(C).

[53] 26 CFR § 1.36B-2(c)(3)(iv).

[54] 26 USC § 5000A(f)(1)(E).

apply to be recognized as MEC.

(2) *Refugee Medical Assistance supported by the Administration for Children and Families.* Coverage under Refugee Medical Assistance, authorized under § 412(e)(7)(A) of the INA, provides up to eight months of coverage to certain noncitizens who are considered refugees.

(3) *Medicare advantage plans.* Coverage under the Medicare program pursuant to part C of Title XVIII of the Act, which provides Medicare parts A and B benefits through a private insurer.

(4) *State high risk pool coverage.* State high risk pools are designated as MEC for plan or policy years beginning on or before December 31, 2014. For coverage beginning after December 31, 2014, sponsors of high risk pool coverage may apply to be recognized as MEC.

(e) Eligibility based on enrollment.[55] An individual is eligible for MEC under the following programs for purposes of considering eligibility for the federal premium tax credit only if the individual is enrolled in the coverage:

(1) *Medicare part A coverage requiring payment of premiums.* Coverage offered under Medicare for which the individual must pay a premium for Medicare part A coverage under § 1818 of the Act.

(2) *State high risk pools.* Health coverage offered by a state under a qualified high risk pool as defined in § 2744(c)(2) of the PHS Act, to the extent the program is covered by a designation by HHS as MEC.

(3) *Student health plans.* Self-funded health coverage offered by a college or university to its students, to the extent the plan is covered by a designation by HHS as MEC.

(4) *TRICARE programs.* Coverage under the following TRICARE programs:

(i) The Continued Health Care Benefit Program (10 USC § 1078);

(ii) Retired Reserve (10 USC § 1076e);

(iii) Young Adult (10 USC § 1110b); and

(iv) Reserve Select (10 USC § 1076d).

(5) *MCA coverage for a pregnant woman enrolled in a QHP.* Coverage offered under Medicaid for a pregnant woman pursuant to the criteria described in § 7.03(a)(2) if the woman was enrolled in a QHP when she became pregnant.[56]

23.02 Affordable coverage for employer-sponsored MEC (01/01/2023, GCR 22-031)

[55] See, IRS Notice 2013-41.

[56] See, IRS Notice 2014-71.

An individual will not be eligible for a federal premium tax credit if the employer-sponsored plan in which they may enroll is affordable. The details of affordability are described in this subsection.

(a) In general

(1) Affordability for employee.[57] Except as provided in paragraph (a)(3) of this subsection, an eligible employer-sponsored plan is affordable for an employee if the portion of the annual premium the employee must pay, whether by salary reduction or otherwise (required contribution), for self-only coverage does not exceed the required contribution percentage (as defined in paragraph (c)) of the applicable tax filer's household income for the benefit year.

(2) Affordability for related individual.[58] Except as provided in paragraph (a)(3) of this subsection, an eligible employer-sponsored plan is affordable for a related individual if the employee's required contribution for family coverage under the plan does not exceed the required contribution percentage, as defined in paragraph (c) of this subsection, of the applicable tax filer's household income for the benefit year. For purposes of this paragraph (a)(2), an employee's required contribution for family coverage is the portion of the annual premium the employee must pay for coverage of the employee and all other individuals included in the employee's family who are offered coverage under the eligible employer-sponsored plan.

(3) Employee safe harbor.[59] An employee or a related individual who is eligible for a safe harbor as defined in this sub clause will not be subject to repayment of APTC based on the finding that affordable MEC was in fact available to them for all or part of a plan year, should such fact be discovered at a time subsequent to enrollment in a QHP.

(i) An employer-sponsored plan is not affordable for an employee or a related individual for a plan year if, when the employee or a related individual enrolls in a QHP for a period coinciding with the plan year (in whole or in part), it is determined that the eligible employer-sponsored plan is not affordable for that plan year.

(ii) This paragraph does not apply to a determination made as part of the redetermination process described in § 75.00 unless the individual receiving a redetermination notification affirmatively responds and provides current information on affordability.

(iii) This paragraph does not apply for an individual who, with reckless disregard for the facts, provides incorrect information concerning the portion of the annual premium for coverage for the employee or related individual under the plan.

(4) Wellness program incentives.[60] Nondiscriminatory wellness program incentives offered by an eligible

[57] 26 CFR § 1.36B-2(c)(3)(v)(A)(1).

[58] 26 CFR § 1.36B-2(c)(3)(v)(A)(2).

[59] 26 CFR § 1.36B-2(c)(3)(v)(A)(3).

[60] 26 CFR § 1.36B-2(c)(3)(v)(A)(4).

employer-sponsored plan that affect premiums are treated as earned in determining an employee's required contribution for purposes of affordability of an eligible employer-sponsored plan to the extent the incentives relate exclusively to tobacco use. Wellness program incentives that do not relate to tobacco use or that include a component unrelated to tobacco use are treated as not earned for this purpose. For purposes of this subsection, the term "wellness program incentive" has the same meaning as the term "reward" in 26 CFR § 54.9802-1(f)(1)(i).

(5) Employer contributions to health reimbursement arrangements.[61] Amounts newly made available for the current plan year under a health reimbursement arrangement that an employee may use to pay premiums, or may use to pay cost-sharing or benefits not covered by the primary plan in addition to premiums, reduce the employee's required contribution if the health reimbursement arrangement would be integrated, as that term is used in IRS Notice 2013-54 (2013-40 IRB 287), with an eligible employer-sponsored plan for an employee enrolled in the plan. The eligible employer-sponsored plan and the health reimbursement arrangement must be offered by the same employer. Employer contributions to a health reimbursement arrangement reduce an employee's required contribution only to the extent the amount of the annual contribution is required under the terms of the plan or otherwise determinable within a reasonable time before the employee must decide whether to enroll in the eligible employer-sponsored plan.

(6) Employer contributions to cafeteria plans.[62] Amounts made available for the current plan year under a cafeteria plan, within the meaning of 26 USC § 125, reduce an employee's or a related individual's required contribution if:

(i) The employee may not opt to receive the amount as a taxable benefit;

(ii) The employee may use the amount to pay for minimum essential coverage; and

(iii) The employee may use the amount exclusively to pay for medical care, within the meaning of 26 USC § 213.

(7) [Reserved]

(8) Multiple offers of coverage. An individual who has offers of coverage under eligible employer-sponsored plans from multiple employers, either as an employee or a related individual, has an offer of affordable coverage if at least one of the offers of coverage is affordable under paragraph (a)(1) or (a)(2) of this subsection.

(b) Affordability for part-year period.[63] Affordability under paragraph (a)(1) of this subsection is determined separately for each employment period that is less than a full calendar year or for the portions of an employer's plan year that fall in different benefit years of an applicable tax filer (a part-year period). Coverage under an

[61] 26 CFR § 1.36B-2(c)(3)(v)(A)(5).

[62] 26 CFR § 1.36B-2(c)(3)(v)(A)(6).

[63] 26 CFR § 1.36B-2(c)(3)(v)(B).

eligible employer-sponsored plan is affordable for a part-year period if the annualized required contribution for self-only coverage, in the case of an employee, or family coverage, in the case of a related individual, under the plan for the part-year period does not exceed the required contribution percentage of the applicable tax filer's household income for the benefit year. The employee's annualized required contribution is the employee's required contribution for the part-year period times a fraction, the numerator of which is 12 and the denominator of which is the number of months in the part-year period during the applicable tax filer's benefit year. Only full calendar months are included in the computation under this paragraph.

(c) Required contribution percentage.[64] The required contribution percentage for 2014 is 9.5 percent. For plan years beginning in a calendar year after 2014, the percentage will be adjusted by the ratio of premium growth to income growth for the preceding calendar year and may be further adjusted to reflect changes to the data used to compute the ratio of premium growth to income growth for the 2014 calendar year or the data sources used to compute the ratio of premium growth to income growth. Premium growth and income growth will be determined under IRS-published guidance. In addition, the percentage may be adjusted for plan years beginning in a calendar year after 2018 to reflect rates of premium growth relative to growth in the consumer price index.

(d) Examples.[65] For examples illustrating these provisions, see 26 CFR § 1.36B-2(c)(3)(v)(D).

23.03 Minimum value for employer-sponsored MEC[66] (01/15/2017, GCR 16-096)

An individual will not be eligible for a federal premium tax credit if the employer-sponsored plan in which they may enroll provides minimum value. An eligible employer-sponsored plan provides minimum value only if the percentage of the total allowed costs of benefits provided under the plan is greater than or equal to 60 percent, and the benefits under the plan include substantial coverage of inpatient hospital services and physician services.

23.04 Enrollment in eligible employer-sponsored plan (01/15/2017, GCR 16-096)

(a) In general.[67] Except as provided in paragraph (b) of this subsection, the requirements of affordability and minimum value do not apply for months that an individual is enrolled in an eligible employer-sponsored plan.

(b) Automatic enrollment.[68] An employee or related individual is treated as not enrolled in an eligible employer-sponsored plan for a month in a plan year or other period for which the employee or related individual is automatically enrolled if the employee or related individual terminates the coverage before the later of the first

[64] 26 CFR § 1.36B-2(c)(3)(v)(C). For plan years after 2014, the required contribution percentage will be updated in accordance with IRS-published guidance, available at www.irs.gov. For example, the required contribution percentage for 2016 is located at: https://www.irs.gov/pub/irs-drop/rp-14-62.pdf.

[65] 26 CFR § 1.36B-2(c)(3)(v)(D).

[66] 45 CFR § 156.145; see, also, 26 CFR §§ 1.36B-2(c)(3)(vi) and 1.36B-6.

[67] 26 CFR § 1.36B-2(c)(3)(vii)(A).

[68] 26 CFR § 1.36B-2(c)(3)(vii)(B).

day of the second full calendar month of that plan year or other period or the last day of any permissible opt-out period provided by the employer-sponsored plan or in regulations to be issued by the Department of Labor, for that plan year or other period.

(c) Examples.[69] The following examples illustrate the provisions of this subsection:

(1) Example 1. Tax filer H is employed by Employer X in 2014. H's required contribution for self-only employer coverage exceeds 9.5 percent of H's 2014 household income. H enrolls in X's calendar year plan for 2014. Under paragraph (a) of this subsection, H is eligible for MEC for 2014 because H is enrolled in an eligible employer-sponsored plan for 2014.

(2) Example 2. The facts are the same as in Example 1, except that H terminates plan coverage on June 30, 2014. Under paragraph (a) of this subsection, H is eligible for MEC under X's plan for January through June 2014 but is not eligible for MEC under X's plan for July through December 2014.

(3) Example 3. The facts are the same as in Example 1, except that Employer X automatically enrolls H in the plan for calendar year 2015. H terminates the coverage on January 20, 2015. Under paragraph (b) of this subsection, H is not eligible for MEC under X's plan for January 2015.

23.05 Special eligibility rules[70] (01/01/2018, GCR 17-045)

(a) Related individual not claimed as a personal exemption deduction. An individual who may enroll in MEC because of a relationship to another person eligible for the coverage, but for whom the other eligible person does not claim a personal exemption deduction, is treated as eligible for MEC under the coverage only for months that the related individual is enrolled in the coverage.

(b) VHC unable to discontinue APTC

(1) *In general.* If an individual who is enrolled in a QHP for which advance credit payments are made informs VHC that the individual is or will soon be eligible for other MEC and that advance credit payments should be discontinued, but VHC does not discontinue advance credit payments for the first calendar month beginning after the month the individual informs VHC, the individual is treated as eligible for the other MEC no earlier than the first day of the second calendar month beginning after the first month the individual may enroll in the other MEC.

(2) *Medicaid or CHIP.* If a determination is made that an individual who is enrolled in a QHP for which advance credit payments are made is eligible for Medicaid or CHIP but the advance credit payments are not discontinued for the first calendar month beginning after the eligibility determination, the individual is treated as eligible for Medicaid or CHIP no earlier than the first day of the second calendar month beginning after the eligibility determination.

[69] 26 CFR § 1.36B-2(c)(3)(vii)(C).

[70] 26 CFR § 1.36B-2(c)(4).

23.06 Eligibility determinations for MEC exemptions[71] (01/01/2018, GCR 17-045)

(a) In general.[72] AHS will satisfy the requirement to determine eligibility for an exemption from the shared responsibility payment by adopting an exemption eligibility determination made by HHS.

[71] See, 45 CFR §§ 155.600 through 155.635.

[72] 45 CFR § 155.625. Exemption applications and instructions are located at www.healthcare.gov/health-coverage-exemptions.

VERMONT **GENERAL ASSEMBLY**

The Vermont Statutes Online

Title 3 : Executive

Chapter 025 : Administrative Procedure

Subchapter 001 : General Provisions

(Cite as: 3 V.S.A. § 801)

§ 801. Short title and definitions

(a) This chapter may be cited as the "Vermont Administrative Procedure Act."

(b) As used in this chapter:

(1) "Agency" means a State board, commission, department, agency, or other entity or officer of State government, other than the Legislature, the courts, the Commander in Chief, and the Military Department, authorized by law to make rules or to determine contested cases.

(2) "Contested case" means a proceeding, including but not restricted to rate-making and licensing, in which the legal rights, duties, or privileges of a party are required by law to be determined by an agency after an opportunity for hearing.

(3) "License" includes the whole or part of any agency permit, certificate, approval, registration, charter, or similar form of permission required by law.

(4) "Licensing" includes the agency process respecting the grant, denial, renewal, revocation, suspension, annulment, withdrawal, or amendment of a license.

(5) "Party" means each person or agency named or admitted as a party, or properly seeking and entitled as of right to be admitted as a party.

(6) "Person" means any individual, partnership, corporation, association, governmental subdivision, or public or private organization of any character other than an agency.

(7) "Practice" means a substantive or procedural requirement of an agency, affecting one or more persons who are not employees of the agency, that is used by the agency in the discharge of its powers and duties. The term includes all such requirements, regardless of whether they are stated in writing.

(8) "Procedure" means a practice that has been adopted in writing, either at the election of the agency or as the result of a request under subsection 831(b) of this title. The term includes any practice of any agency that has been adopted in writing, whether or not labeled as a procedure, except for each of the following:

(A) a rule adopted under sections 836-844 of this title;

(B) a written document issued in a contested case that imposes substantive or procedural requirements on the parties to the case;

(C) a statement that concerns only:

(i) the internal management of an agency and does not affect private rights or procedures available to the public;

(ii) the internal management of facilities that are secured for the safety of the public and the individuals residing within them; or

(iii) guidance regarding the safety or security of the staff of an agency or its designated service providers or of individuals being provided services by the agency or such a provider;

(D) an intergovernmental or interagency memorandum, directive, or communication that does not affect private rights or procedures available to the public;

(E) an opinion of the Attorney General; or

(F) a statement that establishes criteria or guidelines to be used by the staff of an agency in performing audits, investigations, or inspections, in settling commercial disputes or negotiating commercial arrangements, or in the defense, prosecution, or settlement of cases, if disclosure of the criteria or guidelines would compromise an investigation or the health and safety of an employee or member of the public, enable law violators to avoid detection, facilitate disregard of requirements imposed by law, or give a clearly improper advantage to persons that are in an adverse position to the State.

(9) "Rule" means each agency statement of general applicability that implements, interprets, or prescribes law or policy and that has been adopted in the manner provided by sections 836-844 of this title.

(10) "Incorporation by reference" means the use of language in the text of a regulation that expressly refers to a document other than the regulation itself.

(11) "Adopting authority" means, for agencies that are attached to the Agencies of Administration, of Commerce and Community Development, of Natural Resources, of Human Services, and of Transportation, or any of their components, the secretaries of those agencies; for agencies attached to other departments or any of their components, the commissioners of those departments; and for other agencies, the chief officer of the agency. However, for the procedural rules of boards with quasi-judicial powers, for the Transportation Board, for the Vermont Veterans' Memorial Cemetery Advisory Board, and for the Fish and Wildlife Board, the chair or executive secretary of the board shall be the adopting authority. The Secretary of State shall be the adopting authority for the Office of Professional Regulation.

(12) "Small business" means a business employing no more than 20 full-time

employees.

(13)(A) "Arbitrary," when applied to an agency rule or action, means that one or more of the following apply:

(i) There is no factual basis for the decision made by the agency.

(ii) The decision made by the agency is not rationally connected to the factual basis asserted for the decision.

(iii) The decision made by the agency would not make sense to a reasonable person.

(B) The General Assembly intends that this definition be applied in accordance with the Vermont Supreme Court's application of "arbitrary" in Beyers v. Water Resources Board, 2006 VT 65, and In re Town of Sherburne, 154 Vt. 596 (1990).

(14) "Guidance document" means a written record that has not been adopted in accordance with sections 836-844 of this title and that is issued by an agency to assist the public by providing an agency's current approach to or interpretation of law or describing how and when an agency will exercise discretionary functions. The term does not include the documents described in subdivisions (8)(A) through (F) of this section.

(15) "Index" means a searchable list of entries that contains subjects and titles with page numbers, hyperlinks, or other connections that link each entry to the text or document to which it refers. (Added 1967, No. 360 (Adj. Sess.), § 1, eff. July 1, 1969; amended 1981, No. 82, § 1; 1983, No. 158 (Adj. Sess.), eff. April 13, 1984; 1985, No. 56, § 1; 1985, No. 269 (Adj. Sess.), § 4; 1987, No. 76, § 18; 1989, No. 69, § 2, eff. May 27, 1989; 1989, No. 250 (Adj. Sess.), § 88; 2001, No. 149 (Adj. Sess.), § 46, eff. June 27, 2002; 2017, No. 113 (Adj. Sess.), § 3; 2017, No. 156 (Adj. Sess.), § 2.)

VERMONT **GENERAL ASSEMBLY**

The Vermont Statutes Online

Title 33 : Human Services

Chapter 019 : Medical Assistance

Subchapter 001 : Medicaid

(Cite as: 33 V.S.A. § 1901)

§ 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) [Repealed.]

(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) [Repealed.]

(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 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.

(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).

(2) To the extent permitted under federal law, the Department of Vermont Health Access shall be exempt from any health maintenance organization (HMO) or MCO statutes in Vermont law and shall not be considered to be an HMO or MCO for purposes of State regulatory and reporting requirements. The MCO shall comply with the federal rules governing managed care organizations in 42 C.F.R. Part 438. The Vermont rules on the primary care case management in the Medicaid program shall be amended to apply to the MCO except to the extent that the rules conflict with the federal rules.

(3) The Agency of Human Services and Department of Vermont Health Access shall report to the Health Care 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 enrolled in Medicaid or Dr. Dynasaur.

(g) The Department of Vermont Health Access shall post prominently on its website the total per-member per-month cost for each of its Medicaid and Medicaid waiver programs and the amount of the State's share and the beneficiary's share of such cost.

(h) To the extent required to avoid federal antitrust violations, the Department of Vermont Health Access shall facilitate and supervise the participation of health care professionals and health care facilities in the planning and implementation of payment reform in the Medicaid and SCHIP programs. The Department shall ensure that the process and implementation include sufficient State supervision over these entities to comply with federal antitrust provisions and shall refer to the Attorney General for appropriate action the activities of any individual or entity that the Department determines, after notice and an opportunity to be heard, violate State or federal antitrust laws without a countervailing benefit of improving patient care, improving access to health care, increasing efficiency, or reducing costs by modifying payment methods. (Added 1967, No. 147, § 6; amended 1997, No. 155 (Adj. Sess.), § 21; 2005, No. 159 (Adj. Sess.), § 2; 2005, No. 215 (Adj. Sess.), § 308, eff. May 31, 2006; 2007, No. 74, § 3, eff. June 6, 2007; 2009, No. 156 (Adj. Sess.), § E.309.15, eff. June 3, 2010; 2009, No. 156 (Adj. Sess.), § I.43; 2011, No. 48, § 16a, eff. Jan. 1, 2012; 2011, No. 139 (Adj. Sess.), § 51, eff.

May 14, 2012; 2011, No. 162 (Adj. Sess.), § E.307.6; 2011, No. 171 (Adj. Sess.), § 41c; 2013, No. 79, § 23, eff. Jan. 1, 2014; 2013, No. 79, § 46; 2013, No. 131 (Adj. Sess.), § 39, eff. May 20, 2014; 2013, No. 142 (Adj. Sess.), § 98; 2017, No. 210 (Adj. Sess.), § 3, eff. June 1, 2018.)

VERMONT **GENERAL ASSEMBLY**

The Vermont Statutes Online

Title 33 : Human Services

Chapter 018 : Public-private Universal Health Care System

Subchapter 001 : Vermont Health Benefit Exchange

(Cite as: 33 V.S.A. § 1810)

§ 1810. Rules

The Secretary of Human Services may adopt rules pursuant to 3 V.S.A. chapter 25 as needed to carry out the duties and functions established in this subchapter. (Added 2011, No. 48, § 4.)

VERMONT

Proposed Rules Postings
A Service of the Office of the Secretary of State

Search Rules

Deadline For Public Comment

Deadline: Aug 24, 2022

The deadline for public comment has expired. Contact the agency or primary contact person listed below for assistance.

Rule Details

Rule Number:	22P016
Title:	Health Benefits Eligibility and Enrollment Rule, Nonfinancial Eligibility Requirements (Part 3).
Type:	Standard
Status:	Proposed
Agency:	Agency of Human Services
Legal Authority:	3 V.S.A. 801(b)(11); 33 V.S.A. 1901(a)(1) and 1810
Summary:	This proposed rulemaking amends Parts 1, 2, 3, 5, and 7 of the 8-part Health Benefits Eligibility and Enrollment (HBEE) rule. Parts 1, 5 and 7 were last amended effective October 1, 2021. Parts 2 and 3 were last amended effective January 15, 2019. Substantive revisions include: codifying the annual open enrollment period for qualified health plans from November 1 - January 15; adding a new income-based special enrollment period for qualified health plans that allows ongoing enrollment for those at or below 200 of the Federal Poverty Level (FPL); extending the Medicaid postpartum period for pregnant women from 60 days to 12 months; adding Compacts of Free Association (COFA) migrants as qualified non-citizens eligible for Medicaid and exempt from the 5-year bar; and expanding Medicaid eligibility for former foster care children to include children aging out of foster care in another state.

Persons Affected:	Medicaid applicants/enrollees; Individuals who wish to purchase health coverage including those who apply for premium and cost-sharing assistance; Health insurance issuers; Eligibility and enrollment assisters, including agents and brokers; Health care providers; Health law, policy and related advocacy and community-based organizations and groups including the Office of the Health Care Advocate; Agency of Human Services including its departments; and Department of Financial Regulation.
Economic Impact:	AHS anticipates that some of the proposed changes to HBEE will have an economic impact on the State's budget, beginning in SFY2023. The estimated gross annualized budget impact of expanding postpartum Medicaid coverage for pregnant women from 60 days to 12 months is ~$2 million and accounted for in AHS's FY2023 budget. The estimated gross annualized budget impact of expanding Medicaid coverage to children who age out of foster care in any state is $52,700. There is no anticipated impact from the addition of COFA migrants. Changes related to Qualified Health Plan enrollment are not expected to have an economic impact except insofar as any opportunity to encourage enrollment and maintain VT's low uninsured rate is fiscally positive for VT. Other changes in Parts 1, 2, 3, 5, & 7 align the rule with federal and state guidance and law, provide clarification, correct information, improve clarity, and make technical corrections. These changes do not carry a specific economic impact on any person or entity.
Posting date:	Jul 13,2022

Hearing Information

Information for Hearing # 1

Hearing date:	08-17-2022 2:00 PM ADD TO YOUR CALENDAR
Location:	Waterbury State Office Complex, Cherry A Conference Room
Address:	280 State Drive
City:	Waterbury
State:	VT
Zip:	05671
Hearing Notes:	Also via MS Teams: Call in (audio only) 802-522-8456 Conference ID: 738063547# or visit: https://teams.microsoft.com/l/meetup-join/193ameeting_NzJjZWJjOTUtMjVlMS00ZTJkLTk4YzAtZjFkYTU3MTUxZmEw40thread.v2/0?context7b22Tid223a2220b4933b-baad-433c-9c02-70edcc7559c6222c22Oid223a22beb0dd2a-7ce6-4285-9bad-e79977845027227d

Contact Information

Information for Primary Contact

PRIMARY CONTACT PERSON - A PERSON WHO IS ABLE TO ANSWER QUESTIONS ABOUT THE CONTENT OF THE RULE.

Level:	Primary
Name:	Danielle Fuoco
Agency:	Agency of Human Services
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City:	Waterbury
State:	VT
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Telephone:	802-585-4265
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Email:	danielle.fuoco@vermont.gov

SEND A COMMENT

Website Address: https://humanservices.vermont.gov/rules-policies/health-care-rules

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Information for Secondary Contact

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Keyword Information

Keywords:

HBEE
Health Benefits Eligibility and Enrollment
Vermont Health Connect
Exchange
Medicaid
QHP
Qualified Health Plan
Health Benefit
Pregnant
Foster Care
Special Enrollment Period
SEP
Annual Open Enrollment Period
AOEP
Post Partum

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	The Islander (islander@vermontislander.com)	Tel: 802-372-5600 FAX: 802-372-3025
	Vermont Lawyer (hunter.press.vermont@gmail.com)	Attn: Will Hunter

FROM: APA Coordinator, VSARA **Date of Fax:** July 12, 2022

RE: The "Proposed State Rules " ad copy to run on **July 21, 2022**

PAGES INCLUDING THIS COVER MEMO: **2**

NOTE **8-pt font in body. 12-pt font max. for headings - single space body. Please include dashed lines where they appear in ad copy. Otherwise minimize the use of white space. Exceptions require written approval.**

If you have questions, or if the printing schedule of your paper is disrupted by holiday etc. please contact VSARA at 802-828-3700, or E-Mail sos.statutoryfilings@vermont.gov, Thanks.

PROPOSED STATE RULES

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By law, public notice of proposed rules must be given by publication in newspapers of record. The purpose of these notices is to give the public a chance to respond to the proposals. The public notices for administrative rules are now also available online at https://secure.vermont.gov/SOS/rules/ . The law requires an agency to hold a public hearing on a proposed rule, if requested to do so in writing by 25 persons or an association having at least 25 members.

To make special arrangements for individuals with disabilities or special needs please call or write the contact person listed below as soon as possible.

To obtain further information concerning any scheduled hearing(s), obtain copies of proposed rule(s) or submit comments regarding proposed rule(s), please call or write the contact person listed below. You may also submit comments in writing to the Legislative Committee on Administrative Rules, State House, Montpelier, Vermont 05602 (802-828-2231).

Note: The five rules below have been promulgated by the Agency of Human Services who has requested the notices be combined to facilitate a savings for the agency. When contacting the agency about these rules please note the title and rule number of the rule(s) you are interested in.

- Health Benefits Eligibility and Enrollment Rule, General Provisions and Definitions (Part 1). - 22P014
- Health Benefits Eligibility and Enrollment Rule, Eligibility Standards (Part 2). - 22P015
- Health Benefits Eligibility and Enrollment Rule, Nonfinancial Eligibility Requirements (Part 3). - 22P016
- Health Benefits Eligibility and Enrollment Rule, Financial Methodologies (Part 5). - 22P017
- Health Benefits Eligibility and Enrollment Rule, Eligibility-and-Enrollment Procedures (Part 7). - 22P018

AGENCY: Agency of Human Services

CONCISE SUMMARY: This proposed rulemaking amends Parts 1, 2, 3, 5, and 7 of the 8-part Health Benefits Eligibility and Enrollment (HBEE) rule. Parts 1, 5 and 7 were last amended effective October 1, 2021. Parts 2 and 3 were last amended effective January 15, 2019. Substantive revisions include: codifying the annual open enrollment period for qualified health plans from November 1 - January 15; adding a new income-based special enrollment period for qualified health plans that allows ongoing enrollment for those at or below 200% of the Federal Poverty Level (FPL); extending the Medicaid postpartum period for pregnant women from 60 days to 12 months; adding Compacts of Free Association (COFA) migrants as qualified non-citizens eligible for Medicaid and exempt from the 5-year bar; and expanding Medicaid eligibility for former foster care children to include children aging out of foster care in another state.

FOR FURTHER INFORMATION, CONTACT: Danielle Fuoco, Agency of Human Services, 280 State Drive, Center Building, Waterbury, Vermont 05671-1000 Tel: 802-585-4265 Fax: 802-241-0450 Email: danielle.fuoco@vermont.gov URL: https://humanservices.vermont.gov/rules-policies/health-care-rules.

FOR COPIES: Jessica Ploesser, Agency of Human Services, 280 State Drive, Center Building, Waterbury, Vermont 05671-1000 Tel: 802-585-0454 Fax: 802-241-0450 Email: jessica.ploesser@vermont.gov.
