

1 TO THE HOUSE OF REPRESENTATIVES:

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

7 Sec. 1. SHORT TITLE

8 This act shall be known and may be cited as the “Medicaid Expansion Act
9 of 2024.”

10 Sec. 1. FINDINGS

11 The General Assembly finds that:

12 (1) Medicaid is a comprehensive public health insurance program,
13 funded jointly by state and federal governments. Vermont’s Medicaid program
14 currently covers adults with incomes up to 133 percent of the federal poverty
15 level (FPL), children up to 19 years of age from families with incomes up to
16 312 percent FPL, and pregnant individuals with incomes up to 208 percent
17 FPL.

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

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

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

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

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

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

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

4 (8) During the COVID-19 public health emergency, the uninsured rate
5 for Vermonters with incomes just above Medicaid levels (between 139 and
6 200 percent FPL) fell from six percent in 2018 to two percent in 2021. This
7 drop was due in large part to the federal Medicaid continuous coverage
8 requirement, which allowed individuals to remain on Medicaid throughout the
9 pandemic even if their incomes rose above the Medicaid eligibility threshold.
10 A majority of Vermonters (56 percent) with incomes between 139 and
11 200 percent FPL were on Medicaid in 2021.

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

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

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

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

7 (12) Many Vermonters under 65 years of age who have insurance are
8 considered “underinsured,” which means that their current or potential future
9 medical expenses are more than what their incomes can bear. The percentage
10 of underinsured Vermonters is increasing, from 30 percent in 2014 to
11 37 percent in 2018 and to 40 percent in 2021.

12 (13) Vermonters 18 to 24 years of age are the most likely to be
13 underinsured among those under 65 years of age, with 37 percent or
14 38,700 young adults falling into this category.

15 (14) The highest rates of underinsurance are among individuals with the
16 lowest incomes, who are just over the eligibility threshold for Medicaid.
17 Among Vermonters under 65 years of age, 43 percent of those earning 139–
18 150 percent FPL and 49 percent of those earning 151–200 percent FPL are
19 underinsured.

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

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

3 (16) Individuals with lower incomes or with a disability who turn
4 65 years of age and must transition from Medicaid to Medicare often face what
5 is known as the “Medicare cliff” or the “senior and disabled penalty” when
6 suddenly faced with paying high Medicare costs. Individuals with incomes
7 between \$14,580.00 and \$21,876.00 per year, and couples with incomes
8 between \$19,728.00 and \$29,580.00 per year, can go from paying no monthly
9 premiums for Medicaid or a Vermont Health Connect plan to owing hundreds
10 of dollars per month in Medicare premiums, deductibles, and cost-sharing
11 requirements.

12 (17) The Patient Protection and Affordable Care Act, Pub. L. No. 111-
13 148, allows young adults to remain on their parents’ private health insurance
14 plans until they reach 26 years of age. The same option does not exist under
15 Dr. Dynasaur, Vermont’s public children’s health insurance program
16 established in accordance with Title XIX (Medicaid) and Title XXI (SCHIP) of
17 the Social Security Act, however, so young adults who come from families
18 without private health insurance are often uninsured or underinsured.

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

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

3 Sec. 2. AGENCY OF HUMAN SERVICES; TECHNICAL ANALYSIS;
4 REPORTS

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

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

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

19 (2) expanding eligibility for Dr. Dynasaur to all Vermont residents up to
20 26 years of age with incomes at or below 312 percent FPL by 2030;

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

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

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

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

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

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

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

1 (C) an analysis of how current Vermont Medicaid rates compare to
2 rates paid to Vermont providers, by provider type, under Medicare;

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

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

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

13 (G) if rate differentials will continue between primary care and
14 specialty care services under the RBRVS fee schedule, an estimate of the costs
15 of including comprehensive prenatal, labor and delivery, postpartum, other
16 reproductive health care services, and psychiatric services under the primary
17 care rate; and

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

1 (2) As used in this subsection, “provider type” means the designated and
2 specialized service agencies and each category of health care provider that
3 provides services for which the Department of Vermont Health Access
4 maintains a reimbursement methodology, including hospital inpatient services;
5 hospital outpatient services; professional services reimbursed based on the
6 RBRVS fee schedule for both primary care and specialty care services;
7 services provided by federally qualified health centers and rural health centers;
8 suppliers of durable medical equipment, prosthetics, orthotics, and supplies;
9 clinical laboratory services; home health services; hospice services; pediatric
10 palliative care services; ambulance services; anesthesia services; dental
11 services; assistive community care services; and applied behavior analysis
12 services.

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

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

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

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

4 (e) The sums of \$250,000.00 from the General Fund and \$100,000.00 in
5 federal funds are appropriated to the Agency of Human Services in fiscal year
6 2025 for the technical analysis required by this section.

7 **(1) In fiscal year 2025, the sum of \$450,000.00 in Global**
8 **Commitment funds is appropriated to the Agency of Human Services for**
9 **the technical analysis required by this section.**

10 **(2) In fiscal year 2025, the sum of \$320,000.00 is appropriated from**
11 **the General Fund to the Agency of Human Services, Global Commitment**
12 **appropriation for the State match for the technical analysis required by**
13 **this section.**

14 **(3) In fiscal year 2025, the sum of \$130,000.00 in federal funds is**
15 **appropriated to the Agency of Human Services, Global Commitment**
16 **appropriation for the technical analysis required by this section.**

17 (f)(1) On or before January 15, 2025, the Agency of Human Services shall
18 submit the technical analysis required by this section to the House Committees
19 on Health Care and on Appropriations and to the Senate Committees on Health
20 and Welfare, on Finance, and on Appropriations. The analysis shall include
21 the feasibility of each item described in subsections (b)–(d) of this section; the

1 federal strategy for achieving each item, including identification of any
2 necessary federal waivers, the process for obtaining such waivers, and the
3 likelihood of approval for each such waiver; the costs, both programmatic
4 costs and technological and operational costs; a timeline for implementation of
5 each recommended action; and a description of any legislative needs.

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

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

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

18 Sec. 3. 33 V.S.A. § 1901e is amended to read:

19 § 1901e. GLOBAL COMMITMENT FUND

20 * * *

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

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

13 (A) a detailed description of the investment;

14 (B) which Vermonters are served by the investment;

15 (C) the cost of the investment;

16 (D) the efficacy of the investment; and

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

19 Sec. 4. 33 V.S.A. §1901c is added to read:

20 § 1901c. MEDICAID COVERED SERVICE CONSIDERATIONS; REPORT

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

9 Sec. 5. MEDICARE SAVINGS PROGRAMS; INCOME ELIGIBILITY

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

12 (1) increase the Qualified Medicare Beneficiary (QMB) Program
13 income threshold to ~~150~~ 190 percent of the federal poverty level (FPL);

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

16 (3) increase the Qualifying Individual (QI) Program income threshold to
17 ~~185~~ **225** percent FPL.

18 Sec. 6. MEDICAID STATE PLAN AMENDMENTS

19 (a) The Agency of Human Services shall request approval from the Centers
20 for Medicare and Medicaid Services to amend Vermont’s Medicaid state plan

1 to make adjustments to expand eligibility for the Medicare Savings Programs
2 as set forth in Sec. 5 of this act.

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

8 **Sec. 7. REPEAL OF VPHARM PROGRAM**

9 **33 V.S.A. § 2073 (VPharm assistance program) is repealed on the later**
10 **of July 1, 2026 or six months following approval by the Centers for**
11 **Medicare and Medicaid Services of the amendment to Vermont’s**
12 **Medicaid state plan to expand eligibility for the Medicare Savings**
13 **Programs as set forth in Secs. 5 and 6(a) of this act.**

14 **Sec. 8. MEDICARE SAVINGS PROGRAM EXPANSION;**

15 **APPROPRIATION**

16 **The sum of \$200,000.00 is appropriated to the Agency of Human**
17 **Services in fiscal year 2025, of which \$100,000.00 is from the General**
18 **Fund and \$100,000.00 is in federal funds, to implement the Medicare**
19 **Savings Program expansion as set forth in Sec. 5 of this act.**

20 **Sec. 9. EFFECTIVE DATES**

1 This act shall take effect on passage, except that Sec. 5 (Medicare Savings
2 Programs; income eligibility) shall take effect upon **the later of January 1,**
3 **2026 or** approval by the Centers for Medicare and Medicaid Services of the
4 amendment to Vermont’s Medicaid state plan as directed in Sec. 6(a), and Sec.
5 **8 (Medicaid Savings Program expansion; appropriation) shall take effect**
6 **on July 1, 2024.**

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(Committee vote: _____)

Representative _____

FOR THE COMMITTEE