REPORT TO THE VERMONT LEGISLATURE

Department of Vermont Health Access

Report on the Vermont Pharmaceutical Assistance Program (VPharm)

In Accordance with
Act 113 of 2024 §E.306.5

Submitted to: House Committee on Health Care
House Committee on Human Services
House Committee on Appropriations
Senate Committee on Health and Welfare
Senate Committee on Appropriations

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AGENCY OF HUMAN SERVICES
Department of Vermont Health Access

Legislative Request

The purpose of this legislative report is to provide recommendations to the Vermont General Assembly regarding the Vermont Pharmaceutical Assistance Program (VPharm) to ensure alignment with the Medicare Savings Programs' eligibility expansion, as required in Act 113 of 2024, Sec. E.306.5:

> (b)(1) On or before January 15, 2025, the Agency of Human Services shall provide recommendations to the House Committees on Health Care, on Human Services, and on Appropriations and the Senate Committees on Health and Welfare and on Appropriations regarding the VPharm program to ensure alignment with the Medicare Savings Programs' eligibility expansions set forth in Sec. E.306.4 of this act, including:
>
> (A) whether the VPharm program should be modified or repealed as a result of the Medicare Savings Programs' eligibility expansions;
> (B) whether the benefits provided by the VPharm program should be delivered through an alternative program design;
> (C) the estimated fiscal impacts of implementing any recommended changes; and
> (D) when any recommended changes should take effect.
>
> (2) The Agency of Human Services and the Department of Vermont Health Access shall seek input from the Office of the Health Care Advocate and other interested stakeholders in developing the recommendations required by this subsection.

Executive Summary

The Department of Vermont Health Access (DVHA) facilitated and drafted this report on behalf of AHS because it is responsible for Medicaid eligibility and enrollment and administers the VPharm program.

DVHA and its community partner organizations believe it is premature to make recommendations on whether the VPharm program should be modified or repealed as a result of the Medicare Savings Programs' eligibility expansion. The expansion of eligibility for the Medicare Savings Programs will not be implemented until January 2026. Significant changes to Medicare's drug payment structure will begin in January 2025. These changes are expected to impact the costs to DVHA of administering the VPharm program, but the extent of the impact will not be known until next year. The recommendations that the Agency of Human Services is tasked with providing in Sec. E.306.5 of Act 113 of 2024 would benefit from another year of information gathering before being reported for the 2026 legislative session.

DVHA, in consultation with the Office of the Health Care Advocate at Vermont Legal Aid, the Association of Area Agencies on Aging, and Age Well Vermont, presents the following report in order to share information about the VPharm program, including current enrollment, costs, and its relationship to the Medicare Savings Programs and the federal Low Income Subsidy (LIS) program. This report can be expanded upon in 2025 with evidence of the impact to VPharm from federal changes to Medicare's drug coverage, as well as options for the future of the VPharm program.

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VERMONT

Introduction and Background

VPharm is a state pharmaceutical assistance program that provides supplemental pharmaceutical coverage for Vermonters with Medicare drug coverage who are not eligible for Medicaid and who have a household income no greater than 225 percent of the federal poverty level (FPL).[1] Since the inception of Medicare Part D in 2006, VPharm has been, and continues to be, an important source of financial assistance for thousands of limited-income elderly and disabled Vermonters. VPharm is codified in state statute at 33 V.S.A. § 2073. VPharm is also authorized through Vermont's Global Commitment to Health 1115 Demonstration waiver. VPharm covers Medicare prescription drug plan cost-sharing, including deductibles, co-payments, coinsurance, and the coverage gap (also called the donut hole, which will be eliminated nationally in 2025). VPharm also provides coverage for certain categories of Medicare excluded drug classes, such as certain prescription vitamins and mineral products, drugs used for weight gain or treatment of anorexia, and some over-the-counter drugs. These categories of drugs are covered for VPharm enrollees just as they are covered for Vermont Medicaid enrollees. In addition to this, VPharm 1 covers eye exams and diagnostic visits and tests related to vision.[2]

VPharm enrollees pay a monthly premium to DVHA. There are three tiers of VPharm – each tier has a different monthly premium. Eligibility for each tier is based on household income as summarized below:

VPharm Program Summary

Tier Level	Monthly Premium	Coverage	Drug co-payments
VPharm 1 (income up to and including 150% FPL)	$15	Medicare drug plan cost-sharing, some Medicare excluded drug classes, diabetic supplies, eye exams	$1-2
VPharm 2 (income above 150% up to and including 175% FPL)	$20	Medicare drug plan cost-sharing, some Medicare excluded drug classes, diabetic supplies	$1-2
VPharm 3 (income above 175% up to and including 225% FPL)	$50	Medicare drug plan cost-sharing, some Medicare excluded drug classes, diabetic supplies	$1-2

VPharm covers the Medicare prescription drug plan premium up to the Low-Income Subsidy (LIS) amount. LIS (also known as Extra Help) is a Medicare prescription drug

[1] VPharm income is calculated using VHAP income rules 5321 – 5323.

[2] See VPharm Rule 5450 – Coverage for further details.

assistance program administered by the Social Security Administration. VPharm applicants/enrollees who may be eligible for LIS are required to apply. LIS pays before VPharm. Therefore, if a VPharm enrollee does not have LIS, DVHA pays more for that enrollee's drug benefit.

There are two ways someone can be enrolled in LIS:

1. **Apply for LIS directly with the Social Security Administration.** The household income limit is 150% FPL and there is a resource test.
2. **Be "deemed" eligible for LIS.** Individuals entitled to Medicare who are determined by a state Medicaid agency to be eligible for Medicaid and/or a **Medicare Savings Program** are automatically deemed eligible for LIS, even if the income and resource limits for these programs are higher than the LIS program limits.

Medicare Savings Programs (MSPs) are Medicaid-run programs that help cover Medicare premiums and other cost-sharing expenses for people with limited income. Individuals entitled to Medicare who apply for Medicaid or VPharm also receive an eligibility determination for MSPs. The 3 main MSPs are the Qualified Medicare Beneficiary (QMB) program, the Specified Medicare Low-Income Beneficiary program (SLMB), and the Qualified Individual (QI-1) program.

Medicare Savings Program Summaries

MSP	Benefits	Income Limit
Qualified Medicare Beneficiary (QMB) program	QMB pays premiums, deductibles, coinsurance and copayments for Medicare Part A and Part B.	100% FPL (no resource test)
Specified Low-Income Medicare Beneficiary (SLMB) program	SLMB pays the Medicare Part B premium only.	120% FPL (no resource test)
Qualifying Individual (QI-1) program	QI-1 pays the Medicare Part B premium only.	135% FPL (no resource test)

Analysis

What effect will the eligibility expansion of Medicare Savings Programs have on VPharm?

In Act 113 of 2024, the Vermont Legislature directed the Agency of Human Services to increase the QMB income limit to 145% FPL (effectively subsuming SLMB) and to increase the QI-1 income limit to the maximum percentage of the FPL allowed under federal law based on the increase to the income limit for QMB. DVHA calculates the new income limit for QI-1 to be 195% FPL. These changes to Medicare Savings Programs (MSPs) income limits will go into effect on January 1, 2026 (contingent on federal approval from CMS).

The eligibility expansion of MSPs that will take effect on January 1, 2026, does **not** change the VPharm program. However, it is likely to affect people enrolled in VPharm as more VPharm enrollees will become eligible for an MSP, and therefore be deemed eligible for the federal Low-Income Subsidy (LIS) program. While current VPharm enrollees will not experience a change in their out-of-pocket costs if they are newly deemed eligible for LIS, they would experience the benefits of LIS if they disenrolled from VPharm for any reason. VPharm enrollees newly deemed eligible for LIS will lower the cost to DVHA of covering these individuals.

Household size and income for VPharm are calculated using a different financial methodology than that which is used to determine eligibility for MSPs. For example, one person may be eligible for both QMB and VPharm 2 in 2024, depending on the source(s) of their household income and how that income is counted for each program. The LIS program uses a different financial methodology to determine household income than either VPharm or MSPs, although in 2026 Vermont's MSPs will be aligned with the LIS financial methodology and household size.

Because of the differing financial eligibility methodologies of MSPs, LIS, and VPharm, it is difficult to directly compare these programs. These differences also make it challenging to predict how eligibility expansion of MSPs will affect VPharm enrollment and expenditures. Many current VPharm 1 and VPharm 2 enrollees will newly qualify for MSPs, as well as an unknown number of VPharm 3 enrollees. How many people choose to opt out of VPharm altogether is unknown.

How have VPharm and LIS changed since 2006?

VPharm began on January 1, 2006, the same year that Medicare Part D and LIS began. In the nearly two decades since, there have been changes made at the federal level to Part D and LIS, but VPharm has largely remained unchanged. The table below provides a comparison of LIS benefits in 2010 to LIS benefits in 2024.

Table 1. Low Income Subsidy Program Summary 2010[3] vs 2024

Low Income Subsidy Level by Year	Monthly Premium	Annual Deductible	Copayments
Individuals with Medicare and Medicaid 2010	$0	$0	$1.10 - $2.50/generic $3.30 - $6.30/brand No copays after total drug spending reaches $6,440
Individuals with Medicare and Medicaid and income ≤ 100% FPL 2024	$0	$0	$1.55 for generic; $4.60/brand
Individuals with income < 135% FPL 2010	$0	$0	$2.50/generic; $6.30/brand No copays after total drug spending reaches $6,440
Individuals deemed eligible with income > 100% FPL 2024	$0	$0	$4.50/generic; $11.20/brand
Individuals with income 135% - 150% FPL 2010	Sliding scale up to $31.94	$63	15% of total costs up to $6,440 $2.50/generic; $6.30/brand thereafter
Individuals **not** deemed eligible with income < 150% FPL 2024	$0	$0	$4.50/generic; $11.20/brand Catastrophic coverage applies - no copays after total out of pocket drug spending reaches $8,000
VPharm 2010 & 2024	**$15/$20/$50**	**$0**	**$1 for drugs that cost less than $30** **$2 for drugs that cost $30 or more**

Whether someone with LIS also benefits from having VPharm depends on several factors – their household income, individual health condition, the number of prescription drugs they take, whether those drugs are available as generic, and whether those drugs fall into Medicare excluded drug classes that Medicaid covers. Individuals with many prescription medications and/or brand name drugs are likely to save money by enrolling in VPharm.

[3] 2010 LIS benefit information from "The Medicare Part D Low-Income Subsidy Program: Experience to Date and Policy Issues for Consideration" accessed 16 Nov 2024 at https://www.kff.org/wp-content/uploads/2013/01/8094.pdf.

Table 2. Estimated Out of Pocket Costs to Enrollee of VPharm vs LIS in 2024

Costs to enrollee by program	LIS/Extra Help only	VPharm 1	VPharm 2	VPharm 3
Monthly Premium[4]	$0	$15	$20	$50
Co-payments[5]	Up to $4.60 for generic drugs; up to $11.20 for brand name drugs[6]	$1-2	$1-2	$1-2
Coinsurance	$0	$0	$0	$0
Deductible	$0	$0	$0	$0
Coverage Gap	$0	$0	$0	$0
Examples:				
Annual total cost for an enrollee w/ 1 monthly prescription in 2024	Up to $55.20 - $134.40	$192 - $204	$252 - $264	$612 - $624
Annual total cost for an enrollee with two 90-day prescriptions in 2024	Up to $36.80 - $89.60	$188 - $204	$248 - $264	$608 - $624
Annual total cost for enrollee with 6 monthly prescriptions in 2024	Up to $331.20 - $806.40	$252 - $324	$312 - $384	$672 - $744
Annual total cost for an enrollee with five 90-day and 1 monthly prescriptions in 2024	Up to $147.20 - $358.40	$212 - $244	$272 - $304	$632 - $664
Annual total cost for enrollee with 12 monthly prescriptions in 2024	Up to $662.40 - $1,612.80	$324 - $468	$384 - $528	$744 - $888

[4] A VPharm enrollee could incur extra out-of-pocket costs if they select a Medicare drug plan with a monthly premium that is higher than the LIS benchmark.

[5] LIS co-payments change each calendar year. In 2025, the LIS co-payments will increase to be up to $4.90 for generic drugs and up to $12.15 for brand name drugs. VPharm co-payments, which are set in statute at 33 V.S.A. § 2073(d)(1), have remained the same for many years.

[6] Introduction to the Change in Low Income Subsidy (Extra Help) Copayment Notice, accessed 5 Aug 2024: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/LimitedIncomeandResources/downloads/11199.pdf

How many people are enrolled in VPharm and MSPs?

As of August 15, 2024, **9,161** people were enrolled in VPharm. Of these, 5,146 were also enrolled in a Medicare Savings Program (MSP).

Table 3. Enrollment by Program

	VPharm 1	VPharm 2	VPharm 3	Total VPharm	No VPharm
Vpharm Only (No LIS, No MSP)	251	1,322	1,147	2,720	N/A
LIS (No MSP)	764	299	232	1,295	N/A
MSP/LIS	4,991	102	53	5146	2,666
Total Enrollment (VPharm/LIS/ MSP)	**6,006**	**1,723**	**1,432**	**9161**	**2,666**

What does it cost the Department of Vermont Health Access to administer the VPharm program?

For the VPharm program, the Global Commitment budget[7] includes Medicare excluded drug classes, Medicare drug plan premiums, and vision analysis/eye exams (vision benefit is for VPharm1 only). The State-only budget funds Medicare drug plan cost-sharing (deductible, coinsurance, co-payments, and the coverage gap).[8]

[7] Global Commitment funding is blended federal and state funding under Vermont's Global Commitment to Health 1115 waiver.

[8] While the VPharm program is authorized through Vermont's 1115 Global Commitment to Health demonstration waiver, federal funds are not available for drugs covered by the Medicare prescription drug program for any Part D eligible individual or for any cost sharing for such drugs. See 42 CFR §423.906.

Table 4. VPharm Budget SFY'25 As Passed (Per Member Per Month PMPM based on August 2024 enrollment of 9,161 members)[9]

	VPharm 1	VPharm 2	VPharm 3	SFY25 As Passed Budget
Global Commitment	$2,871,602	$ 607,795	$553,751	$4,033,149
PMPM	$39.84	$29.40	$32.22	
State Only GF	$800,373	$1,493,625	$1,505,401	$3,798,639
PMPM	$11.11	$72.24	$87.60	
Total Budget	**$ 3,671,975**	**$ 2,101,420**	**$ 2,059,152**	**$7,831,788**

[9] PMPMs based on actual enrollment as of 8/15/24 and the SFY25 AP Budget

The table below describes the difference between what DVHA pays for VPharm enrollees with and without the Low Income Subsidy (LIS).

Table 5. Costs to DVHA of VPharm enrollees with and without LIS in 2024

With LIS	**VPharm 1 With LIS**	**VPharm 2 With LIS**	**VPharm 3 With LIS**
Monthly Medicare Part D Premium	$0 if enrollee chooses LIS plan; up to $43.53/month for non-LIS plan	$0 if enrollee chooses LIS plan; up to $43.53/month for non-LIS plan	$0 if enrollee chooses LIS plan; up to $43.53/month for non-LIS plan
Deductible	$0	$0	$0
Co-payment/Coinsurance (Initial Coverage)	Difference between VPharm and LIS copays (up to $10.20/drug)	Difference between VPharm and LIS copays (up to $10.20/drug)	Difference between VPharm and LIS copays (up to $10.20/drug)
Coverage Gap (Donut Hole)	N/A	N/A	N/A
Medicare excluded drug classes	Covered same as Medicaid	Covered same as Medicaid	Covered same as Medicaid
Vision exams and diagnostic visits	Covered	N/A	N/A
Without LIS	**VPharm 1 (no LIS)**	**VPharm 2 (no LIS)**	**VPharm 3 (no LIS)**
Monthly Medicare Part D Premium	Up to $43.53 monthly	Up to $43.53 monthly	Up to $43.53 monthly
Deductible	Up to $545	Up to $545	Up to $545
Co-payment/Coinsurance (Initial Coverage)	A set Co-payment amount or 25% co-insurance drug cost (plan dependent, until the member out-of-pocket cost reaches a total of $5,030).	A set Co-payment amount or 25% co-insurance drug cost (plan dependent, until the member out-of-pocket cost reaches a total of $5,030).	A set Co-payment amount or 25% co-insurance drug cost (plan dependent, until the member out-of-pocket cost reaches a total of $5,030).

Coverage Gap (Donut Hole)[10] *Note: All formulary drugs will be discounted at 75% leaving DVHA with a 25% cost through end of the year 2024 once the total drug cost spend reaches $8,000*	Estimate $2,970 - (The coverage gap ends after out-of-pocket costs reach $8,000)	Estimate $2,970 - (The coverage gap ends after out-of-pocket costs reach $8,000)	Estimate $2,970 - (The coverage gap ends after out-of-pocket costs reach $8,000)
Medicare excluded drug classes	Covered same as Medicaid	Covered same as Medicaid	Covered same as Medicaid
Vision exams and diagnostic visits	Covered	N/A	N/A

What is the LIS Benchmark Premium, and why is it relevant?

VPharm expands drug plan coverage options for Vermonters. The State Health Insurance Program (SHIP) reports that VPharm, by covering Medicare drug plan premiums up to the LIS benchmark regardless of whether the plan has basic and enhanced coverage, allows people to find plans that better meet their prescription drug needs. The benchmark premium is the maximum monthly Medicare drug plan premium that will be determined and paid for individuals qualifying for LIS.

Each Medicare drug plan premium has a cost associated with basic and enhanced coverage. LIS will not pay any portion of a monthly drug plan premium for enhanced coverage costs even when the plan premium is below the LIS benchmark. This is because LIS only covers the basic portion of the drug plan premium.

The LIS benchmark premium amount is used by DVHA to determine premium subsidy amounts for the VPharm program's non-LIS members. VPharm members not eligible for LIS receive subsidies for Medicare drug plan premiums up to the LIS benchmark **regardless** of basic and enhanced coverage.

Examples:

- If you qualify for LIS (but do not have VPharm) and the LIS benchmark premium is $40, the LIS program will pay for the premium of a "basic" Medicare drug plan up to this premium level and you will have a $0 monthly premium for your drug coverage for limited plan selections.
    - In 2024, Vermont has **3 plans** that offer basic coverage and are under the LIS benchmark.

[10] The coverage gap (also called the donut hole) will be eliminated federally in calendar year 2025, and annual out-of-pocket costs for Medicare Part D will be capped at $2,000. More information about changes to Medicare Part D in 2025 from the Inflation Reduction Act are available at CMS.gov.

- If you qualify for LIS (also have VPharm) and the LIS benchmark premium is $40, VPharm will pay for the premium of a Medicare drug plan up to this premium level, including enhanced coverage, and you will have a $0 monthly premium for your drug coverage for limited plan selections.
  - In 2024, Vermont has **7 plans** that offer basic and enhanced coverage and are under the LIS benchmark.

- If you do **not** qualify for LIS and the LIS benchmark premium is $40, VPharm will pay for the premium of a Medicare drug plan up to this premium level, including enhanced coverage, and you will have a $0 monthly premium for your drug coverage for limited plan selections.
  - In 2024, Vermont has **7 plans** that offer basic and enhanced coverage and are under the LIS benchmark.

In 2025, Vermont will have 3 plans that offer basic coverage under the LIS benchmark premium, and one of these plans is sanctioned. Sanctioned plans are not permitted to enroll new members. The SHIP counselors who assist Vermonters in choosing a Medicare drug plan have informed DVHA that it is hard to match people with a drug plan that meets their needs when the plan selection is this limited. See Appendix A for charts that show estimated VPharm beneficiary premium payments per Vermont Medicare drug plan in 2024 and 2025.

The table below lists DVHA's total expenditures for Medicare drug plan premiums for the VPharm program in state fiscal year 2024. Although VPharm 1 has nearly double the enrollment of VPharm 2 and VPharm 3 combined, it has the lowest premium expenditures.

Table 6. VPharm Total Expenditures for Medicare Drug Plan Premiums

Total Expenditures*	VPharm Tier
$141,196	VPharm 1
$431,485	VPharm 2
$374,570	VPharm 3

***SFY2024**

Options for the future of VPharm

What criteria should be considered when evaluating if VPharm should be modified or repealed?

DVHA considered the following criteria in its evaluation of VPharm for this report:

- Impact to current VPharm beneficiaries
- Impact to other low-income Vermonters on state health care programs

- Cost to the state
- Capacity of DVHA to implement
- The structure of other states' pharmacy assistance programs

Option 1: Make no changes (do nothing)

- **Impact to Beneficiaries:** No impact.
- **Cost to AHS:** This option would not change the cost to the state to operate the program. Cost is described in various ways earlier in this report.
- **Capacity to Implement:** With nothing to implement, this option would allow more time to gather information that could better inform the options below. DVHA has been taking steps to streamline eligibility processes for VPharm enrollees following the end of COVID-19 public health emergency, including limiting renewals and nonpayment terminations and facilitating reinstatements. This will promote operational stability over the next year while assessing future changes to the program.

Option 2: Eliminate VPharm

- **Impact to Beneficiaries:**
    - Any VPharm enrollee who is not eligible for LIS or MSPs under the eligibility expansion to 195% FPL would have increased out of pocket costs under their Medicare drug plan due to elimination of VPharm. They would have no assistance paying drug plan premiums or cost-sharing.
    - VPharm enrollees who are eligible for MSPs under the expansion will also be impacted. The drug plan selection for LIS is more limited – any current VPharm enrollees who require a non-LIS plan to meet their prescription drug needs will have to pay their Medicare drug plan premium out of pocket. They will also no longer receive coverage for certain Medicare excluded drug classes or limited vision services (latter is VPharm 1 only). Some or all of these costs may be offset by the money saved on their monthly Medicare Part B premiums.
- **Cost to AHS:** Programmatic cost savings from eliminating VPharm will be better estimated once the Medicare 2025 drug payment structure impacts are known and the Vermont MSP expansion is implemented. The fiscal estimate for the MSP expansion included an offset from estimated savings to the VPharm program. Cost savings to the state would be the net remaining programmatic cost of the current VPharm program.
- **Capacity to Implement:** DVHA is not able to implement before 2027.

Option 3: Eliminate VPharm and subsidize prescription copayments for Vermonters with LIS who are on Medicaid and MSP

- **Impact to Beneficiaries:**

  - Any VPharm enrollee who is not eligible for LIS or MSPs under the eligibility expansion to 195% FPL would have increased out of pocket costs under their Medicare drug plan due to elimination of VPharm. They would have no assistance paying drug plan premiums or cost-sharing.
  - VPharm enrollees who are eligible for MSPs under the expansion will continue to pay $1-$2 copayments for their prescription drugs. However, the drug plan selection for LIS is more limited – any current VPharm enrollees who require a non-LIS plan to meet their prescription drug needs will have to pay their Medicare drug plan premium out of pocket. They will also no longer receive coverage for certain Medicare excluded drug classes or limited vision services (latter is VPharm 1 only). Some or all of these costs may be offset by the money saved on their monthly Medicare Part B premiums.
  - Fully dual eligible individuals (who have Medicare and Medicaid) will benefit from lower drug copayments that are equal to VPharm enrollee drug copayments.
- **Cost to AHS:** This cost will depend on the level of subsidy provided. Programmatic savings of option 2 could offset this cost.
- **Capacity to Implement:** As with Option 2, DVHA is not able to implement before 2027. Drug copayment wrap involves changes to billing systems.

Option 4 and Option 5 are presented by the Office of the Health Care Advocate (with support from the additional community organizations consulted for this report).

Option 4: Restructure VPharm to offer premium help **only** up to 350% FPL.

- **Summary:** Eliminate the VPharm premium / fee of $15 / $20 / $50 per month. Offer premium assistance up to the Medicare LIS benchmark to individuals with household income up to 350% FPL who are not otherwise eligible for full Medicaid. Eliminate other VPharm program benefits.
- **Impact to Beneficiaries:**
  - Any VPharm enrollee with LIS who needs to enroll in a non-LIS Medicare drug plan would continue to receive help paying the premium up to the LIS benchmark.
  - VPharm enrollees would no longer pay a VPharm premium / fee which would allow these individuals to redirect these savings towards lowering their out-of-pocket drug costs. This would reduce churn (consumers moving on and off VPharm) due to non-payment of premium.
  - Would expand Medicare Part D premium help to population that has no help under current VPharm program (households at 225 – 350% FPL).
  - VPharm enrollees with MSP / LIS up to 195% would continue to receive help paying cost-sharing for Medicare drug coverage via LIS.

    - VPharm enrollees not eligible for MSP or LIS would be responsible for all out of pocket costs for prescription drugs according to their Medicare drug plan.
    - All current VPharm enrollees would experience reduction in benefits with elimination of coverage for excluded drugs and vision services.
- **Cost to AHS:** The cost to the state is unknown at this time but will depend on if this restructured program is matched by federal funds under the 1115 Global Commitment waiver.
- **Capacity to Implement:** DVHA is not able to implement before 2028.

Option 5: Restructure VPharm to offer progressive benefit structure

- **Summary:**
    - 0-195% FPL: Eliminate the VPharm premium / fee of $15 / $20 / $50 per month. Offer premium assistance up to the Medicare LIS benchmark to individuals with household income up to 195% FPL who are not otherwise eligible for full Medicaid. Continue to offer copay assistance for Medicare Part D drugs and excluded drugs and vision assistance (equivalent to what is offered in VPharm 1). Increase drug co-pays to $3 / $5.
    - 196% FPL – 350% FPL: Possibly eliminate VPharm premium / fee. Offer premium assistance up to the Medicare benchmark.
- **Impact to Beneficiaries:**
    - 0 – 195% FPL: Continuity or expansion of benefits for majority of VPharm population. Eliminates the VPharm premium ($15 / $20 / $50) and allows individuals to re-direct spending towards drug cost-sharing. Slight increase in drug co-pays.
    - 196% - 225% FPL: Current VPharm enrollees in this range would continue to receive help paying Medicare drug premiums; however, they would experience a reduction in current benefits: no more help with cost-sharing, Medicare excluded drugs, or vision.
    - 225 – 350% FPL: Would benefit from Medicare Part D premium help for the first time. Could redirect savings towards their drug cost-sharing.
- **Cost to AHS:**
    - The cost to the state is unknown at this time but will depend on if this restructured program is matched by federal funds under the 1115 Global Commitment waiver.
- **Capacity to Implement:** DVHA is not able to implement before 2028.

Recommendations and Considerations

DVHA and its community partner organizations believe that it is premature to make recommendations on whether the VPharm program should be modified or repealed as a result of the Medicare Savings Programs' eligibility expansion in Act 113 of 2024.

Significant changes to Medicare's drug payment structure will begin in January 2025.[11] These changes are expected to impact the costs to DVHA of administering the VPharm program, but the extent of the impact will not be known until next year. The recommendations that the Agency of Human Services is tasked with providing in Sec. E.306.5 of Act 113 of 2024 would benefit from another year of information gathering before being presented in the 2026 legislative session.

The expansion of eligibility for the Medicare Savings Programs will not be implemented until January 2026. The community partner organizations that contributed to this report recommend that any decisions on modifying or repealing VPharm be delayed even further until 2027. This would allow the state to examine the degree of impact that the expansion of eligibility for the Medicare Savings Programs has on enrollment and expenditures in the VPharm program.

However, any modifications to VPharm or alternative program designs require amending the VPharm statute as well as amending the 1115 Global Commitment to Health demonstration waiver. Modifications to the VPharm program must be negotiated with CMS. DVHA feels that 2027 will be too late to make modifications to VPharm in the Global Commitment waiver, as the renewal request for this waiver must be submitted to CMS by the end of CY2026 (the current waiver is effective through December 31, 2027). The Global Commitment waiver has historically been renewed every five years. Any changes to the VPharm program that the Legislature would like to implement for 2028 – 2032 should be discussed in the 2026 legislative session.

Any modifications to the VPharm program or alternative program designs will require IT programming in Vermont Medicaid's legacy eligibility system, and possibly the health care and pharmacy claims systems as well. Programming changes in these systems requires ample time to schedule and execute. VPharm program modifications will also require updates to multiple health care program applications, business processes, and administrative rulemaking.

DVHA recommends restarting this conversation during the 2026 legislative session. However, there are certain technical considerations that arose during the development

[11] Changes to Medicare Part D from the Inflation Reduction Act are available at CMS.gov.

of this report that the Department includes here not as recommendations but for legislative awareness:

1. **Alignment of VPharm and MSP financial methodologies** – VPharm statutory language at 33 V.S.A. 2072(a)(3) indicates VPharm eligibility can be calculated using modified adjusted gross income (MAGI) methodologies. VPharm has never been calculated using MAGI-based methodologies. This language was added to statute in 2013 when Vermont was implementing changes under the Affordable Care Act and moving toward a single-payer system. Due to system challenges it was never operationalized, and it is unclear whether there would be any benefit to doing so in the future. VPharm applicants, if being screened for Medicaid, fall into eligibility categories (including MSPs) that must use non-MAGI methodologies. Removing this MAGI language from the VPharm statute could allow for alignment of VPharm and MSP financial methodologies in the future.

2. **Alignment of QMB and LIS income limits** – Act 113 of 2024 increased the income limit for QMB from 100% FPL to 145% FPL. The income limit for LIS is 150% FPL. Aligning Vermont's QMB income limit with LIS could provide administrative efficiencies in implementation.[12] It would also allow Vermont to increase the income limit for QI-1 to 202% FPL. QI-1 is entirely federally funded and would deem more Vermonters eligible for LIS.

3. **Other pharmacy benefit programs** – While VPharm provides a pharmaceutical benefit to eligible Medicare enrollees, the Healthy Vermonters Program is a discount drug plan that allows other Vermonters who do not qualify for Medicaid because their income is too high to purchase prescriptions at Medicaid rates. 33 V.S.A. § 2003. This program has low uptake and utilization, and certain features in the original legislation were never enacted. A review of the Healthy Vermonters statute to align with program implementation may be helpful in assessing the future of VPharm as it relates to other pharmacy programs in the state.

Finally, the community partner organizations contributing to this report make the following recommendation for further adjustment of MSP eligibility limits. This is not a recommendation of the Department.

4. **Alignment of MSP and VPharm income limits**– DVHA's community partner organizations support the exploration of further increasing the income limit for MSPs to 225% FPL. By aligning the income limit for QI-1 with the income limit for VPharm 3, Vermont could maximize federal dollars available through LIS for

[12] When a Vermonter applies directly to SSA for LIS, the SSA sends their data (called "LIS leads data") to DVHA. DVHA is required to treat LIS leads data as an application for MSPs. Aligning the QMB income limit with the LIS income limit would make the eligibility criteria for QMB/LIS nearly identical in Vermont in 2026.

enrollees currently on VPharm. In order for CMS to approve expanding QI-1 to 225% FPL, the QMB income limit would need to be increased to at least 167% FPL. This would have a significant fiscal impact on the state budget.

Appendices

Appendix A – VPharm Medicare Part D Premium Payment Charts (2024 & 2025)

	CMS Payment (100% LIS)		Vermont Payment (100% LIS)		Est. Beneficiary Payment (100% LIS)		Vpharm Payment (No LIS)		Vpharm Beneficiary Payment (No LIS)	
	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025
Aetna (SilverScript Choice)	$43.50	$50.70	$0.00	$0.00	$7.40	$0.00	$43.53	$50.70	$7.37	$0.00
Aetna /SilverScript Plus)	$43.50	N/A	$0.00	N/A	$67.00	N/A	$43.53	N/A	$66.97	N/A
Aetna (SilverScript SmartRX)	$13.30	N/A	$0.00	N/A	$2.40	N/A	$15.70	N/A	$0.00	N/A
Blue MedicareRx (Value Plus)	$43.50	$49.60	$0.00	$0.00	$9.90	$0.00	$43.53	$49.60	$9.87	$0.00
Blue MedicareRx (Premier)	$43.50	$52.50	$0.00	$0.00	$112.30	$138.30	$43.53	$52.52	$112.27	$138.28
Cigna HealthSpring Rx(Secure)	$43.50	$52.50	$0.00	$0.00	$10.80	$36.80	$43.53	$52.52	$10.77	$36.78
Cigna Healthspring Rx (Secure-Xtra)	$43.50	$52.50	$0.00	$0.00	$47.10	$60.40	$43.53	$52.52	$47.07	$60.38
Cigna Healthspring RX (Saver RX)	$3.80	$7.50	$0.00	$0.00	$18.10	$21.30	$21.90	$28.80	$0.00	$0.00
Clear Spring Health (Value RX)	$24.80	$6.30	$0.00	$0.00	$0.00	$0.00	$24.80	$6.30	$0.00	$0.00
Clear Spring Health (Premier RX)	N/A	$48.20	N/A	$0.00	N/A	$25.90	N/A	$52.52	N/A	$21.58

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Humana (Preferred Rx Plan)	$43.50	$52.50	$0.00	$0.00	$24.00	$50.00	$43.53	$52.52	$23.97	$49.98
Humana (Walmart)	$43.50	$52.50	$0.00	$0.00	$64.90	$90.90	$43.53	$52.52	$64.87	$90.88
Humana (Enhanced)	$43.50	$49.50	$0.00	$0.00	$11.10	$15.40	$43.53	$52.52	$11.07	$12.38
Mutual of Omaha (RX Plus)	$43.50	N/A	$0.00	N/A	$67.30	N/A	$43.53	N/A	$67.27	N/A
Mutual of Omaha (Premier)	$43.50	N/A	$0.00	N/A	$58.90	N/A	$43.53	N/A	$58.87	N/A
Mutual of Omaha (RX Essential)	$2.40	N/A	$0.00	N/A	$25.50	N/A	$27.90	N/A	$0.00	N/A
UnitedHealthcare (AARP MedicareRx Preferred)	$43.50	$52.50	$0.00	$0.00	$66.70	$55.00	$43.53	$52.52	$66.67	$54.98
UnitedHealthcare (AARP Medicare Rx Saver Plus)	$34.50	$52.50	$0.00	$0.00	$0.00	$17.00	$34.50	$52.52	$0.00	$16.98
UnitedHealthcare (AARP Walgreens)	$43.50	N/A	$0.00	N/A	$29.00	N/A	$43.53	N/A	$28.97	N/A
WellCare (Classic)	$36.80	$28.30	$0.00	$0.00	$0.00	$0.00	$36.80	$28.30	$0.00	$0.00
WellCare - Vaue Script	$0.00	$0.00	$0.00	$0.00	$0.50	$12.40	$0.50	$12.40	$0.00	$0.00
WellCare (Value Plus)	$35.80	$52.50	$0.00	$0.00	$43.00	$59.80	$43.53	$52.52	$35.27	$59.78

Note: N/A = Plan not available in given year
Vermont SPAP Premium Benchmark for members with NO LIS:
2024= $43.53
2025=$52.52

Appendix B – State Pharmaceutical Assistance Programs – A snapshot of other state programs

State	Funding	Eligibility Criteria	Income Eligibility (% FPL)	Benefits	Requirement to apply for LIS?
New York	State only	Age 65+ or disabled, residency, Medicare Part D, NO full-benefit Medicaid	Fee Plan: Up to 137% Deductible Plan: 137%-514%	Helps pay Part D premiums , cost-sharing for Part D Rx (and certain other Rx) after Part D deductible is met	Yes
Rhode Island	State only	Age 65+ or disabled and ages 55-64, residency, Medicare Part D, cannot have LIS	Level 1: <246% Level 2: 246%-309% Level 3: 309%-541% Level 4: Ages 55-64, Disabled, <= 541%	Pays 15%-60% of the cost of Rx in Part D deductible and Rx not covered by Part D plan (if on RI formulary)	No
Connecticut	*N/A (State consortium bulk - purchasing)*	Residency in CT >6 Months	None	Up to 80% discount on certain Rx	N/A
Maine	State only	Age 62+ or disabled, residency, Medicare Part D	<185% (+25% if they spend 40% of income on Rx) <50k/75k per couple in liquidity	80% OOP costs covered (after Part D or other insurance) on certain covered service-related Rx. After $1k cap is met, 80% cost-share for any eligible Rx.	No
Massachusetts	State Only	Age 65+ or disabled, residency, enrolled in creditable coverage, no full-benefit Medicaid	Category 0: <135% Cat 1: <150% Cat 2: <188% Cat 3: 188-225% Cat 4: 225-300% Cat 5 (w/fees): 300-500%	Cost-sharing after OOP maximum (on Rx plan deductibles and Rx co-pays met); one-time, 72-hour supply of any medication rejected/not otherwise covered	Yes

New Hampshire	N/A *(State consortium bulk - purchasing)*	Residency in NH	None	Up to 80% discount on certain Rx (in formulary), at participating pharmacies	N/A
Vermont	State and Federal Funds (1115 Waiver)	Age 65+ or disabled, Residency, Medicare Part D	VPharm 1: <= 150% VPharm 2: 150% <= 175% VPharm 3: 175%<= 225%	Medicare drug plan cost-sharing, premium assistance up to LIS premium “benchmark”	Yes
Wisconsin	State and Federal Funds (1115 Waiver); Federal matching funds for <200% FPL enrollees	Age 65+ or Disabled, Residency, cannot have full-benefit Medicaid	Level 1: <160% Level 2A: 161%-200% Level 2B: 201%-240% Level 3: +240% (with spenddown to 240%);	Cost-sharing (OOP Rx costs covered after deductible, then $5-$15 co-pays) Comprehensive coverage similar to Medicare Part D, wraps other insurance (e.g. Medicare B, D)	No
Maryland	State only	Age 65+ or disabled, Medicare recipient < 300% FPL, no full-benefit Medicaid	<=300%	Helps pay Part D or Advantage Plan Premium up to $75/month	No

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